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Zurich Wealth Protection

Product Disclosure Statement
and policy conditions

Issue Date: 29 March 2021

Issue date: 4 May 2021

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Zurich Wealth Protection

Supplementary Product Disclosure Statement

This document is a Supplementary Product Disclosure Statement (SPDS) for the Zurich Wealth Protection Product Disclosure Statement (PDS) dated 29 March 2021 and must be read together with the PDS.

This SPDS has been issued to correct an error and specify the total disability definition that applies after 24 months of benefits have been paid under Zurich Income Protector and Zurich Business Expenses.

Change to the PDS:

The following definition replaces the definition on page 98 of the PDS.

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

- not working in paid work
- unable to do one or more of the *important income-producing duties* of their *primary occupation*.

We'll use the life insured's *primary occupation* in the 12 consecutive months immediately before the claim to measure the reduction.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

The life insured must be following the advice and recommended treatment of a *medical practitioner*.

The definition changes if the life insured becomes totally disabled when they haven't been working for more than 12 consecutive months due to unemployment, long service leave or parental leave. In this case, ability to work is based on any occupation they are reasonably qualified for by education, training, or experience.

After we pay 24 months of total disability benefits, partial disability benefits or a combination of both, the definition changes. Ability to work is no longer based on a specific occupation. The life insured is only totally disabled from that point onwards if:

- they are not working in paid work
- they are unable to do one or more of the *important income-producing duties* of each occupation they are reasonably qualified for by education, training, or experience
- they are following the advice and recommended treatment of a *medical practitioner*.

Issuer information

This SPDS and the life insurance products described in it are issued by Zurich Australia Limited ABN 92 000 010 195, AFSL 232510.

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

Our contact details are as follows:

131 551

client.service@zurich.com.au

Zurich Customer Care
Locked Bag 994
North Sydney NSW 2059

General information only

The information contained in this SPDS 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 product having regard to your objectives, financial situation and needs.

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

Zurich Australia Limited
ABN 92 000 010 195, AFSL 232510
Website: zurich.com.au

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Thank you for considering Zurich Wealth Protection.

This document explains Zurich Wealth Protection insurance policies

This document is a product disclosure statement or PDS. It explains how Zurich Wealth Protection works and what it does and doesn't cover. Please read this document carefully to decide if Zurich Wealth Protection is right for you before you apply for a policy.

Zurich Wealth Protection policies are:

- Zurich Protection Plus
- Zurich Income Protector Plus
- Zurich Income Protector
- Zurich Business Expenses
- Zurich Child Cover.

If we issue a policy to you, this document will become your policy conditions

If we issue a Zurich Wealth Protection policy to you, we'll send you a policy schedule which will confirm the details of your cover and this document will become your copy of the policy conditions. Please store both documents together in a safe place.

We've divided this document into logical sections

Zurich Wealth Protection policies are comprehensive and this document contains a lot of information. To help you find what you're looking for before you apply and after your policy is in place, we've divided the content into logical sections.

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Here's how to read this document

This document contains information about Zurich Wealth Protection policies, as well as the policy conditions.

We've italicised defined terms

In this document, all terms appearing in *italics* are defined terms with special meanings which are explained in the 'Definitions' section, starting on page 91.

We are Zurich Australia Limited

'Zurich', 'us', 'our' and 'we' means Zurich Australia Limited ABN 92 000 010 195, AFSL 232510. Our contact details are on the inside back cover of this document.

Zurich is the issuer of this document and the issuer of the insurance policies described in it.

You normally means the person applying for insurance

In this document, 'you' means the person making the insurance decisions and applying for cover. This is usually the policy owner. However, if you take out insurance as a member of a superannuation fund, the policy owner will be the trustee of the superannuation fund. In this case, 'you' means the life insured as the person making the insurance decisions and applying for cover.

This document contains general information only

The information in this document is general information only and doesn't consider your individual objectives, financial situation, or specific needs. Please carefully consider these factors when you decide whether each policy is appropriate for you personally.

We recommend getting specialist advice before you purchase Zurich Wealth Protection policies

For example, professional financial advice and taxation advice will help you make informed decisions regarding these policies.

We'll post any changes which affect this document on our website

The information in this document is up to date when issued but some information can change. For example, management fees change every year on 1 March as explained in the 'Calculation of premiums and payment information' section, starting on page 75. Changes like this, that are not materially adverse, will be posted on our website in the section: zurich.com.au/lifepds. You can also request a paper or electronic copy of any updated information without charge.

If there is a materially adverse change to the information in this document, we'll issue a supplementary or replacement document.

How to contact us

In this document we explain that there are times when you need to contact us to keep your insurance aligned with your situation. You're also welcome to contact us any time if you have questions. Our contact details are on the inside back cover of this document.

Our industry code and complaints

The life insurance code of practice is our promise to you

When you take out life insurance, it's important that you get the highest standards of service in all your dealings with us. That's why we've adopted the Life Insurance Code of Practice.

It's the life insurance industry's commitment to mandatory customer service standards and it's designed to protect you, our customer.

The code explains our commitments as an industry

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

The Code covers many aspects of your relationship with us, from buying insurance to making a claim, to providing options if you experience financial hardship or require more support. An independent committee, the Code Compliance Committee, monitors the Code to ensure effective compliance by life insurers. The committee can sanction insurers if they don't correct Code breaches.

Key code promises

1. We'll be honest, fair, respectful, transparent, timely and where possible we'll use plain language in our communications with you.
2. We'll monitor sales by our staff and our authorised representatives to ensure sales are appropriate.
3. If we discover that an inappropriate sale has occurred, we'll discuss a remedy with you, such as a refund or a replacement policy.
4. We'll provide more support if you have difficulty with the process of buying insurance or making a claim.
5. When you make a claim, we'll explain the claim process to you and keep you informed about our progress in making a decision on your claim.
6. We'll make a decision on your claim within the timeframes defined in the Code and if we can't meet these timeframes you can access our complaints process.
7. If we deny your claim, we'll explain the reasons in writing and let you know the next steps if you disagree with our decision.
8. We'll restrict the use of investigators and surveillance, to ensure your legitimate right to privacy.
9. The independent Code Compliance Committee will monitor our compliance with the Code.
10. If we don't correct Code breaches, sanctions can be imposed on us.

Certainty for trauma definitions

The Code also explains minimum standard trauma definitions which apply to some conditions covered under Zurich Protection Plus and Zurich Child Cover. The definitions create a minimum standard across all life insurers who are members of the Financial Services Council (FSC).

Minimum standard trauma definitions apply to the first $2 million of any trauma cover issued on or after 1 July 2017, which is when the Code began.

At claim time, where there is a minimum standard trauma definition in the Code for your trauma condition, we'll assess your claim against both:

- the definition in our PDS
- the corresponding minimum standard medical definition in the Code that is current when the insured event occurs.

You'll qualify for a benefit if the life insured meets either of the definitions.

The committee will regularly review the minimum standard trauma definitions. We'll automatically apply updated definitions to your policy once they are part of the Code.

Getting a copy

You can find the Code on the FSC website fsc.org.au

We can help if you need support

We recognise that some customers need more help than others. 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. They can also help if you make a change to your policy, if you make a claim or if you want to make a complaint. If you contact us and we identify that you need more support or that you're experiencing financial hardship, we'll do our best to help. This could involve helping you to understand how your policy works or explaining the options available under your policy.

Follow this process to make a complaint

Contact us if you have a complaint about any policy described in this document. Our contact details are on the inside back cover of this document. We'll do our best to resolve your complaint promptly and keep you informed of progress as we work with you.

You can find out more about our complaints resolution process and timeframes by reading our Disputes Resolution Factsheet. The factsheet is available on our website: zurich.com.au.

If you're not satisfied with our response, you can raise the matter with the Australian Financial Complaints Authority (AFCA). The AFCA provides a free dispute resolution scheme to consumers and small businesses for all financial products and services.

Contact details for the AFCA are as follows:

1800 931 678

info@afca.org.au

Australian Financial Complaints Authority
GPO Box 3, Melbourne VIC 3001

afca.org.au

What is Zurich Wealth Protection?

Zurich Wealth Protection is insurance you can tailor to meet your needs

Zurich Wealth Protection is a flexible suite of life insurance policies. This document explains each of the policies, so that you can select a combination of insurances and ownership structures to meet your needs. Your financial adviser will help you with this process.

The table below shows the main benefits. Each policy offers a range of in-built benefits, as well as a number of optional benefits which allow you to tailor cover. The choices you make about each policy will affect the breadth and the cost of your cover.

You'll find the policy conditions applying to each type of insurance in the next sections of this document.

Choose policies that suit you best

Zurich Protection Plus This policy contains three different types of cover which all pay a lump sum amount when an insured event happens. You can select one, two or all three of the covers, depending on your needs.	**Death cover**	Death cover provides a payment if the life insured dies. We can pay the death benefit early in the case of terminal illness, to help the life insured get their financial affairs in order. Death benefits are designed to clear debts and to help family members maintain lifestyle following the loss of a loved-one. Death benefits can also be used for business purposes.
	TPD cover	Total and permanent disablement cover provides a payment if the life insured suffers total and permanent disablement which meets the TPD definition in your policy. Depending on the cover chosen, TPD cover can also provide partial payments at earlier stages of disablement and for less severe conditions. TPD benefits are designed to help fund expenses associated with long term disability and to help family members maintain lifestyle in the absence of an income-earner. TPD benefits can also be used for business purposes.
	Trauma cover	Trauma cover provides a payment if the life insured suffers a trauma condition which is covered by the policy and meets our specific definition of that condition. We have our own definition of each covered condition as we only cover trauma events at a specific level of severity. Depending on the cover chosen, trauma cover can also provide partial payments for some earlier stage defined conditions. Trauma benefits are designed to help fund expenses and recovery time, resulting from serious health events.
Zurich Income Protector Plus and Zurich Income Protector	Income protection provides a monthly benefit if the life insured is disabled due to sickness or injury and is unable to work. If the life insured is still working, but has reduced hours or income due to disability, income protection can pay a part-benefit to help with the resulting reduction in income. You select how quickly benefits are payable when the life insured is disabled, as well as the maximum period of time that benefits are payable for each disability. Income protection is designed to financially support the life insured's recovery and return to work.	
Zurich Business Expenses	Business expenses cover provides a monthly benefit that reimburses either allowable business expenses or key person replacement costs if the life insured is disabled. In most cases the disability must continue for longer than the selected waiting period. Business expenses benefits are designed to keep your business operating for up to two years while the life insured recovers from a disability.	
Zurich Child Cover	Child cover provides a lump sum payment if the insured child suffers a trauma condition which is covered by the policy and meets our specific definition of that condition. Child cover also includes a death and terminal illness benefit as well as a carer benefit, which can provide financial support if the insured child suffers a health condition which isn't a covered trauma condition. Child cover is designed to minimise the financial impact of serious child illness or injury.	

You can select the most appropriate policy owner

You can tailor Zurich Wealth Protection policies to suit your individual needs.

Benefits under life insurance policies are usually payable on an event like 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, for example husband and wife, family trust trustees, business partners or individual SMSF trustees. Your financial adviser can provide you with more information on policy structures for your individual situation.

If you don't want to hold any of your insurance in superannuation, then you can select from the full range of policies and available ownership structures shown in the table below.

Available ownership structures are shown here

Policies available	Policy owner	Life insured	Benefits payable to
• Zurich Protection Plus • Zurich Income Protector Plus • Zurich Income Protector • Zurich Business Expenses • Zurich Child Cover	**You** as an individual (can be via a platform)	**You** or another individual	**You** or Nominated beneficiary (for death benefits if you're the only policy owner and the life insured)
	You as a corporation	Individual	Policy owner

When you apply for cover outside of superannuation, the policy is issued directly to you as the policy owner. Some policies, like income protection and business expenses are generally only available on your own life. You can apply for other policies on your own life or the life of another person. For example, you could take out a policy with your partner as the life insured, as their death or disability would impact your financial situation.

Where multiple individuals are policy owners, each will own the policy as joint tenants. This means that on the death of a policy owner, their share passes to the surviving joint tenants. If we agree to a different arrangement, we'll document it 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 is generally paid to the life insured's legal personal representative or nominated beneficiaries.

If you hold your cover in super, your cover choices are restricted

Zurich Protection Plus, Zurich Income Protector Plus and Zurich Income Protector can be held in superannuation. One way to set this up is for your own self-managed superannuation fund (SMSF) trustee to own the policy. Alternatively, you can become a member of a superannuation fund which offers Zurich Wealth Protection.

The advantage of holding cover in superannuation is that premiums can be funded by superannuation investments and contributions. A disadvantage of holding cover in superannuation is that some benefits aren't available or are restricted. For example, trauma insurance can't be held in superannuation because most trauma events wouldn't meet a condition of release under superannuation law. An important limitation affecting income protection cover held in superannuation is that benefits aren't payable if you're not working for gain or reward when your disability starts. For example, if you're unemployed, between jobs or on unpaid leave, you're not covered under a superannuation policy. Please discuss this option with your financial adviser to make sure it's appropriate for you personally.

Under superannuation ownership, the trustee is the policy owner and we pay any insurance benefits under the policy to the trustee. Where you take out Zurich Wealth Protection as a member of a superannuation fund, the trustee may release benefits to you if the trustee is satisfied that you meet a superannuation condition of release under superannuation law and in line with the trust deed of the superannuation fund.

Available superannuation ownership structures are shown here

Policies available	Policy owner	Life insured	Benefits payable to
• Zurich Protection Plus • Zurich Income Protector Plus • Zurich Income Protector (benefits adjusted to comply with superannuation laws)	**You** as SMSF trustee or trustees (individual or corporation) (can be via a platform)	SMSF member	SMSF trustee or trustees
	Trustee of an *eligible superannuation fund* (can be via a platform)	**You** (applying for cover through your superannuation fund)	Policy owner (trustee)

As some policies and benefits can't be held in superannuation, you can use our superannuation optimiser solution to split cover into superannuation and non-superannuation components. We'll issue some cover to a superannuation trustee and some cover to you individually.

Superannuation ownership, superannuation optimiser and superannuation platforms, are explained in the section 'Holding this insurance in superannuation', starting on page 59.

The policies are guaranteed to continue provided you pay premiums

Provided you pay premiums within 30 days of the due date, these policies are guaranteed to continue up until the end date of the benefits you've chosen, regardless of any changes in your health or pastimes.

These policies cover you 24 hours a day, seven days a week, worldwide, which means you remain protected during holidays and overseas work assignments. However, residency can affect how the policies work. If you're thinking about moving overseas, read the 'Making changes to your policy' section, starting on page 80.

Your policy has a guaranteed upgrade of benefits

If we improve the terms of the benefits described in this document without any change in the standard premium rates, we'll incorporate the improvement in your policy. The improved terms won't apply to any existing medical condition, or any injuries already sustained when the improvement is applied.

We'll let you know about any benefit upgrades that affect your policy via the policy anniversary notice that we send you every year. We'll also include information about any policy upgrades on our website in the section: zurich.com.au/existingcustomers.

There are risks that come with holding these policies

Risks which come with holding Zurich Wealth Protection policies include:

- the insurance you've chosen might be inadequate to fully protect your financial needs based on your circumstances now or in the future
- if premiums aren't paid when due, the policy will lapse, the life insured will no longer be covered, and you can't make a claim
- if you don't comply with your duty of disclosure, or if you don't answer our application questions about the life insured correctly, we may not pay your claim, pay only a portion of your claim, vary your cover, or void your cover. The duty of disclosure is explained in the 'Applying for cover' section, starting on page 65.

Zurich Protection Plus

Zurich Protection Plus can provide cover for health events, death and terminal illness

The benefits payable under the Zurich Protection Plus policy depend on the covers you select. The policy can pay a lump sum on the life insured's death, terminal illness, total and permanent disablement (TPD) or if the life insured suffers a specified trauma condition.

The policy conditions for Zurich Protection Plus are set out in this section.

The benefits payable under this policy depend on the cover you select and the health event the life insured suffers

The tables below show where you need to choose a level of cover.

Death cover

Cover	What this cover provides
Death cover	A benefit payable on death or advanced if the life insured is terminally ill.

TPD cover

Two levels of total and permanent disablement cover are available, platinum TPD and TPD.

Level of cover	What this cover provides
Platinum TPD	A fully featured level of cover, including: • a benefit payable on total and permanent disablement based on the TPD definition on the policy schedule. Available definitions include own occupation, any occupation, and domestic duties. • the TPD advancement benefit, for specific events • partial payments at earlier stages of disablement and for less severe conditions. Platinum TPD isn't available in superannuation but partial payments can be accessed via superannuation optimiser.
TPD	A lower cost level of cover which provides: • a benefit payable on total and permanent disablement based on the TPD definition on the policy schedule. Available definitions include own occupation, any occupation, domestic duties, and modified. • the TPD advancement benefit, for specific events. If TPD is set up in superannuation, a permanent incapacity restriction will apply to the policy, so that benefits are only paid if the definition of permanent incapacity under superannuation law is met.

If you choose to hold your TPD cover in superannuation, benefits are only payable if the life insured meets a condition of release under superannuation law. See the section 'Holding this insurance in superannuation', starting on page 59, for more information.

Trauma cover

Two levels of cover are available, trauma plus and trauma.

Level of cover	What this cover provides
Trauma plus	A fully featured level of cover, including: • a benefit payable on diagnosis or occurrence of one of 42 insured trauma conditions • a boosted payment on paralysis • partial payments of 20% for 13 extra insured trauma conditions.
Trauma	A lower cost level of cover which provides: • a benefit payable on diagnosis or occurrence of one of 42 insured trauma conditions • a boosted payment on paralysis.

Linking death, TPD and trauma benefits reduces overlap and cost

If your benefits are linked, a TPD or trauma claim will reduce the other benefits in the policy by the amount paid. For example, if you have a death benefit amount of $500,000 and a linked trauma benefit amount of $100,000 and we pay you $100,000 for a trauma claim, the death benefit amount will reduce to $400,000. This is usually a cost-effective way to access more cover.

This document assumes that death, TPD and trauma benefits are linked, as this is the most common way to set up a policy. However, your financial adviser will help you to determine the most appropriate structure for your situation and we'll set up your policy accordingly.

Zurich Protection Plus policy conditions

The information below forms part of the Zurich Protection Plus policy conditions. Words or expressions shown in *italics* have their meaning explained in the 'Definitions' section.

When we accept your application, we'll issue a policy schedule. The policy schedule shows:

- the life insured covered under the policy
- the benefits you've selected
- the amount of cover for each at the start of the policy
- any extra-cost optional benefits selected
- the premium structure
- benefit end dates
- any special conditions that apply to your policy specifically.

The life insured is only covered for the benefits and amounts shown on the policy schedule. Each benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefits end' on page 29.

Cover is automatically increased in line with inflation each year unless you contact us with alternate instructions. Your options are explained in the section 'Inflation protection' on page 25.

You can make changes to your policy. If you apply for optional benefits or increases to the benefit amounts after the policy starts, changes are only effective if we accept the application after assessing the life insured's health, occupation, and pastimes.

If cover is held in superannuation

If the policy is issued to the trustee of a superannuation fund, benefits are subject to the superannuation restrictions and limitations described on page 28.

If the policy is one of two related policies issued under superannuation optimiser, the policy schedule will show whether the policy is the superannuation policy or the non-superannuation policy. The section 'Holding this insurance in superannuation', starting on page 59, provides important information and terms for superannuation optimiser.

The related policies issued under a superannuation optimiser structure will both end automatically if either one of the policies ends. This happens because each policy contains only part of the cover and can't exist without the other part. If one of the policies is paid in advance, we'll refund any unused premiums. If we need to refund any contributions made to the superannuation policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

Some benefits don't apply if the policy is issued to the trustee of a superannuation fund. These are clearly marked.

This policy can pay benefits on death, terminal illness, TPD and insured trauma events

This section explains when benefits become payable.

Benefits payable under the death cover

If the life insured is covered for the death benefit and an insured event occurs, the following benefits are payable.

The insured event must occur both:
- while this benefit and policy is in-force
- before the death benefit ends.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 27.

Benefit name	What this benefit pays	Can it be held in superannuation?
Death & terminal illness benefit	Pays a lump sum on death or diagnosis of *terminal illness*.	Yes
Advancement for funeral expenses	Advances up to $15,000 of the death benefit amount towards funeral expenses.	No
Accidental injury benefit	Advances part or all the death benefit amount if the life insured suffers an *accidental injury* which results in a specified injury. Covered events include loss of use of a hand or foot, and loss of sight.	Yes, life insured must also meet the superannuation definition of permanent incapacity as explained in the section 'Holding this insurance in superannuation', starting on page 59.

Death benefit

We'll pay the death benefit if the life insured dies.

Terminal illness benefit

We'll advance the death benefit if the life insured is diagnosed with a *terminal illness*.

The amount we'll advance is the death benefit amount on the date the life insured's *terminal illness* is certified, even if we don't see the certifications until a later date.

Advancement for funeral expenses

We'll advance up to $15,000 of the death benefit amount towards payment of funeral expenses while a death benefit claim is being assessed.

This benefit doesn't apply if the policy is issued to the trustee of a superannuation fund.

Accidental injury benefit

We'll pay the lower of 25% of the death benefit amount and $500,000 if the life insured suffers an *accidental injury* which causes the entire and irrevocable loss of any of the following:
- the use of one hand
- the use of one foot
- the sight in one eye.

We'll pay the lower of 100% of the death benefit amount and $2,000,000 if the life insured suffers an *accidental injury* which causes the entire and irrevocable loss of any of the following:
- the use of both hands
- the use of both feet
- the sight in both eyes
- any two of: the use of one hand, the use of one foot, the sight in one eye.

If the policy is issued to the trustee of a superannuation fund, the accidental injury benefit is only payable if the life insured also meets the superannuation definition of permanent incapacity.

The accidental injury benefit isn't payable if:
- a benefit is paid for the same *injury* under TPD cover or trauma cover
- the *injury* is the result of war, whether declared or not. War doesn't include acts of terrorism
- the *injury* is a result of intentional self-inflicted injuries or attempted suicide.

Benefits payable under the TPD cover

If the life insured is covered for the TPD benefit and an insured event occurs, the following benefits are payable.

The insured event must occur both:
- while this benefit and policy is in-force
- before the TPD benefit ends.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 27.

Benefit name	What this benefit pays	Can it be held in superannuation?
TPD benefit	Pays a lump sum if the life insured suffers a permanent disability that meets the selected or allocated TPD definition. Our different TPD definitions are explained below. Qualifying periods apply to TPD benefits.	Yes, life insured must also meet the superannuation definition of permanent incapacity as explained in the section 'Holding this insurance in superannuation', starting on page 59.
TPD advancement benefit	Advances 25% (up to $500,000) of the TPD benefit amount if the life insured suffers *loss of a hand or foot* or *loss of sight in one eye*.	No, but we'll pay this benefit from the related policy if you take superannuation optimiser.
Funeral benefit	Pays $5,000 on death if death cover isn't selected.	Yes
Partial impairment benefit (platinum only)	Pays 40% or 65% of the TPD benefit amount if the life insured suffers *functional impairment* of two or three *extended activities of daily living (extended ADLs).*	No, but we'll pay this benefit from the related policy if you take superannuation optimiser.

TPD benefit

We'll pay the TPD benefit if the life insured meets the relevant definition of *total and permanent disablement*.

The policy schedule shows the definition of *total and permanent disablement* that applies.

The amount we'll pay is the benefit amount current on the earlier of:
- the date when the definition is met
- where there is a three-month qualification period as part of the definition, the start of that period.

This means that under the *own occupation TPD* or *any occupation TPD* policy definitions, the benefit amount is based on the date when the life insured stopped work because of the disability that led to the claim. It isn't when evidence confirms that the disability is permanent.

While we assess a claim, premiums continue to be payable. However, if the TPD benefit is paid, we'll refund any TPD premiums paid after the date when the life insured stopped work as part of the claim.

If the policy is issued to the trustee of a superannuation fund, the TPD benefit is subject to the superannuation restrictions and limitations described on page 28.

Where the policy schedule shows that superannuation optimiser applies, TPD cover may be held over two related policies. In this case, a benefit is only payable under one of these policies if the life insured is totally and permanently disabled. See the section 'TPD cover held across two policies' on page 61 for more information.

Excerpts from our definitions are set out on the next page to show how this policy provides each type of TPD. While the summary explains how the definitions differ, claims will always be assessed against the TPD definition. You can find the TPD definitions in the 'Definitions' section, starting on page 91.

The definition of TPD will determine when you can claim

When you apply for TPD cover, a definition of TPD is either chosen by you or allocated to you, depending on the life insured's occupation. The definition selected will determine the criteria against which the life insured's disability is assessed when you claim.

Available definitions under platinum TPD and TPD are:
- *own occupation TPD*
- *any occupation TPD*
- *domestic duties TPD*
- *modified TPD.*

The name of each definition describes to the main focus of that definition, for example if you select 'own occupation TPD' then at claim time the life insured is assessed against their ability to do their own occupation ever again. However, each definition includes several ways to qualify for a benefit.

The requirements of the TPD definitions vary and are summarised below. We'll only pay a TPD benefit if the life insured meets our insurance definition of TPD, and there is supporting evidence of permanency. The opinion of the life insured's *medical practitioner* is important and will be used in our assessment, but we'll also review other medical and occupational information available to us when you claim to determine if the definition is met.

TPD definition	Type of TPD cover provided	
	Before the policy anniversary when the life insured is 65	From the policy anniversary when the life insured is 65
Own occupation TPD This definition is available to people who are in paid employment for a minimum of 16 hours per week.	• Unlikely to do their own occupation ever again • Loss of functional capacity • Significant impairment to their whole body • Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity	• Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity
Any occupation TPD This definition is available to people who are in paid employment for a minimum of 16 hours per week.	• Unlikely to do a suited occupation ever again • Loss of functional capacity • Significant impairment to their whole body • Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity	• Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity
Domestic duties TPD This definition is available to people whose main occupation is to maintain the family home.	• Unlikely to perform domestic duties ever again • Unlikely to do a suited occupation ever again (if working an average of at least 16 hours per week before the claim) • Loss of functional capacity • Significant impairment to their whole body • Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity	• Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity
Modified TPD This definition is available to everyone who is eligible for TPD cover.	• Loss of limbs and/or sight • Unable to look after themselves ever again • Loss of intellectual capacity	

The terms used in the table on the previous page are explained below:

Type of TPD cover	When a benefit is payable
Unlikely to do their own occupation ever again	Due to *sickness* or *injury*, the life insured: • hasn't been working in their *own occupation* for a continuous period of at least three months • is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again. **own occupation** means the life insured's occupation, business, or employment at the start of the *sickness* or *injury* causing *total and permanent disablement*. If the life insured isn't working in their occupation, business or employment for remuneration or reward, then own occupation is the occupation, business, or employment the life insured most recently worked in for remuneration or reward.
Unlikely to do a suited occupation ever again	Due to *sickness* or *injury*, the life insured: • hasn't been working for a continuous period of at least three months • is so incapacitated that they're unlikely to be able to work in *any occupation* ever again. **any occupation** means any occupation, business, or employment the life insured is suited to by education, training, or experience. Earnings from this occupation, business or employment should be more than 25% of the life insured's most recent 12 months of work for remuneration or reward.
Unlikely to perform domestic duties ever again	Due to *sickness* or *injury*, the life insured: • is unable to perform all of the *domestic duties* without an adult person assisting, for a continuous period of at least three months • is unable to leave their home without an adult person assisting for a continuous period of at least three months • has been following the advice of a *medical practitioner* and engaging in appropriate treatment for the *sickness* or *injury* in the three-month period • is so incapacitated that they require ongoing medical care • is so incapacitated that they're unlikely to be able to perform all of the *domestic duties* without an adult person assisting, ever again.
Loss of functional capacity	Due to *sickness* or *injury*, the life insured suffers *functional impairment* of at least four *extended ADLs*.
Significant impairment to their whole body	Due to *sickness* or *injury*, the life insured suffers permanent and irreversible *whole person impairment* of at least 60%.
Loss of limbs and/or sight	Due to *sickness* or *injury*, the life insured suffers *loss of hands or feet*, *loss of* sight or both *loss of a hand or foot* and *loss of sight in one eye*.
Unable to look after themselves ever again	Due to *sickness* or *injury*, the life insured suffers a total and irreversible inability to perform at least two of the *activities of daily living* without the help of another person.
Loss of intellectual capacity	Due to *sickness* or *injury*, the life insured suffers *loss of independent existence* or *cognitive loss*.

Some of the above definitions will only be met if the life insured survives for 14 days after meeting the definition. Definitions can be found in the 'Definitions' section, starting on page 91.

Only the modified TPD definition applies when the life insured reaches 65

From the policy anniversary when the life insured is 65, claims are only assessed against the *modified TPD* definition, regardless of the definition selected when the policy starts. The TPD benefit amount is only payable if the life insured meets the *modified TPD* definition.

Modified TPD describes a more severe level of disability than an own occupation, any occupation, or domestic duties definition, meaning the life insured is less likely to qualify for a benefit. However, the reduction in cover is reflected in the cost which is lower than it would be for other definitions at older ages.

We'll remind you about this change when the life insured approaches 65 so that you have time to seek advice and decide whether to continue the cover.

Cover over $3 million reduces automatically when the life insured reaches 65

On the policy anniversary when the life insured is 65, any TPD cover exceeding $3,000,000 will be reduced to $3,000,000. This maximum benefit amount of $3,000,000 per life insured will apply across all policies issued by us.

We'll remind you about this change when the life insured approaches 65 so that you have time to specify which cover is reduced if you have multiple covers. If you don't contact us before the policy anniversary, we'll apply a proportionate reduction.

TPD advancement benefit

We'll advance part of the TPD benefit amount if the life insured suffers *loss of a hand or foot* or *loss of sight in one eye*.

The amount payable is the lower of 25% of the TPD benefit amount and $500,000. The TPD advancement benefit will be reduced by the amount of any trauma benefit paid for *loss of a hand or foot* or *loss of sight in one eye*.

The TPD advancement benefit is only payable once. The maximum amount we'll pay under the TPD advancement benefit is $500,000 across all cover held with us for the life insured.

The TPD benefit amount will be reduced by the amount paid under the TPD advancement benefit.

This benefit doesn't apply if the policy is issued to the trustee of a superannuation fund.

Funeral benefit

This benefit only applies if you select TPD cover but don't select death cover. The funeral benefit isn't payable if TPD cover is part of a superannuation optimiser structure and there is death cover on the related policy.

We'll pay $5,000 on the death of the life insured.

We won't pay this funeral benefit if:

- the life insured's death was caused by suicide within 13 months of the TPD benefit start date or the most recent policy reinstatement
- we've paid a TPD benefit other than a TPD advancement benefit or partial impairment benefit.

Partial impairment benefit

This benefit only applies if platinum TPD is selected, as shown on the policy schedule. The benefit ends on the policy anniversary when the life insured is 65.

We'll advance part of the TPD benefit amount if the life insured suffers *functional impairment* of a specified number of *extended ADLs* as set out in the table below.

Partial impairment level	Proportion of TPD benefit amount payable
Functional impairment of at least three *extended ADL* categories	65%
Functional impairment of at least two *extended ADL* categories	40%

A benefit is only payable once at each partial impairment level.

The TPD benefit amount will be reduced by the amount paid under the partial impairment benefit.

If platinum TPD is held through superannuation, superannuation optimiser applies, and the partial impairment benefit will be held on the non-superannuation policy. See the section 'TPD cover held across two policies' on page 61 for more information.

Benefits payable under the trauma cover

If the life insured is covered for the trauma benefit and an insured event occurs, the following benefits are payable.

The insured event must occur both:
- while this benefit and policy is in-force
- before the trauma benefit ends.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 27.

Where the insured event is a procedure or surgery, a benefit is only payable if the procedure or surgery occurs.

Benefit name	What this benefit pays	Can it be held in superannuation?
Trauma benefit	Pays a lump sum on diagnosis or occurrence of one of 42 covered conditions. We don't cover all traumatic health events. Our specific definition of the condition applies to any claim and describes a certain severity.	No, but trauma benefits can be accessed via superannuation optimiser.
Paralysis booster benefit	Doubles the benefit payable for paralysis, to a maximum of $2,000,000.	
Funeral benefit	Pays $5,000 on death if death cover isn't selected.	
Partial trauma benefit (plus only)	Advances 20% of the trauma benefit amount for 13 covered conditions. Our specific definition of the condition applies to any claim and describes a certain severity. The maximum advance is $100,000. Multiple claims can be made for *angioplasty (minimally invasive cardiac surgery)*. Up to $20,000 is advanced per event for that surgery.	

Trauma benefit

We'll pay the trauma benefit if the life insured is diagnosed with any one of the insured trauma conditions listed in the table on the next page. Our insurance definition for each covered condition can be found in the section 'These definitions are specific to trauma cover', starting on page 99. The definitions describe health events at a specified severity. We won't pay a benefit if the life insured's condition doesn't meet our specific definition.

The amount payable is the trauma benefit amount on the date when the definition is met.

A 90-day exclusion period applies to trauma conditions in the list marked with an asterisk (*). The exclusion period applies when you apply for cover and if cover is ever reinstated. See 'What this policy doesn't cover' on page 27.

If you have any trauma cover which isn't linked to death cover, then that trauma benefit amount isn't payable for an insured event unless the life insured survives for at least 14 days after meeting the definition.

Insured trauma conditions for the trauma benefit

Cancers and tumours at the specified severity

benign tumour in the brain or spinal cord (with neurological deficit)
*cancer (excluding early stage cancers)**

Heart conditions at the specified severity

angioplasty (triple vessel)
aortic surgery
cardiac arrest (out of hospital)
cardiomyopathy (with significant permanent impairment)
*coronary artery bypass surgery**
*heart attack (of specified severity)**
heart valve surgery
idiopathic pulmonary arterial hypertension (with permanent impairment)

Severe accident, loss of sight, hearing, speech, limbs, paralysis, and loss of independence

diplegia (paralysis booster applies to this condition)
hemiplegia (paralysis booster applies to this condition)
loss of hands, feet or sight
loss of hearing
loss of independence
loss of sight
loss of speech
major head trauma (with permanent neurological deficit)
paraplegia (paralysis booster applies to this condition)
quadriplegia (paralysis booster applies to this condition)
severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days)
severe burns (of specified extent)

Neurological conditions at the specified severity

bacterial meningitis or meningococcal septicaemia (with severe life impact)
coma (of specified severity)
dementia including alzheimer's disease (diagnosis)
encephalitis (with permanent neurological deficit)
motor neurone disease (diagnosis)
multiple sclerosis (with impairment level)
muscular dystrophy (with impairment level)
parkinson's disease (diagnosis)
*stroke (of specified severity)**

Blood conditions

aplastic anaemia (requiring treatment)
medically acquired HIV
occupationally acquired hepatitis B or C
occupationally acquired HIV

Other serious covered conditions at the specified severity

chronic kidney failure (end stage)
chronic liver disease (end stage)
chronic lung disease (end stage)
diabetes (of specified severity)
major organ transplant (or waiting list)
pneumonectomy
severe rheumatoid arthritis (with permanent daily life impact)

Paralysis booster benefit

We'll double the trauma benefit payable (to a maximum of $2,000,000) if the life insured is diagnosed with *diplegia, hemiplegia, paraplegia* or *quadriplegia.*

Each condition has an insurance definition which can be found in the section 'These definitions are specific to trauma cover', starting on page 99. We won't pay a benefit if the life insured's condition doesn't meet our specific definition.

Funeral benefit

This benefit only applies if you select trauma cover but don't select death cover. The funeral benefit isn't payable if trauma cover is part of a superannuation optimiser structure and there is death cover on the related policy.

We'll pay a benefit of $5,000 on the death of the life insured if a trauma benefit isn't payable.

We won't pay this funeral benefit if:

- the life insured's death was caused by suicide within 13 months of the trauma benefit start date or the most recent reinstatement of the policy
- we've paid a trauma benefit other than a partial trauma benefit.

Partial trauma benefit

This benefit only apples if trauma plus is selected, as shown on the policy schedule.

We'll advance part of the trauma benefit if the life insured is diagnosed with any one of the insured trauma conditions listed in the table below. Our insurance definition for each covered condition can be found in the section 'These definitions are specific to trauma cover', starting on page 99. We won't pay a benefit if the life insured's condition doesn't meet our specific definition.

The amount payable is 20% of the trauma benefit amount on the date when the definition is met. We'll pay a maximum benefit amount of $20,000 for *angioplasty (minimally invasive cardiac surgery)* and a maximum of $100,000 for all other covered conditions.

A 90-day exclusion period applies to trauma conditions in the list marked with an asterisk (*). The exclusion period applies when you apply for cover and if cover is ever reinstated. See 'What this policy doesn't cover' on page 27.

Only the insured trauma condition *angioplasty (minimally invasive cardiac surgery)* can be claimed more than once. For any repeat claims, we'll pay a minimum of $10,000.

Insured trauma conditions for the partial trauma benefit

Cancers and tumours at the specified severity

*carcinoma in situ (limited sites)**
*chronic lymphocytic leukaemia (early stage)**
*melanoma (early stage)**
*prostate cancer (early stage)**

Heart condition at the specified severity

*angioplasty (minimally invasive cardiac surgery)**

Neurological condition at the specified severity

muscular dystrophy (diagnosis)

Other serious covered conditions at the specified severity

*colostomy or ileostomy**
*diabetes (type 1) first diagnosed after age 30**
facial reconstructive surgery and/or skin grafting
*guillain barre syndrome**
loss of a hand or foot or sight in one eye
loss of hearing in one ear
severe rheumatoid arthritis (that fails to respond to treatment)

You can purchase optional benefits to boost your cover

You can select optional benefits when you apply for your policy and they will apply from the policy start date. You can also add options after your policy starts. Added optional benefits don't apply to any *sickness* or *injury* that occurs or is apparent within 90 days of the option being added. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition. For example, a reinstatement or buy-back can't be actioned after a claim for *sickness* or *injury* that occurs in the first 90 days after the option is added.

Optional benefits only apply if they are shown on the policy schedule. The policy schedule also shows the end date applying to each optional benefit and the benefit amount, if these need to be separately stated.

The optional benefits are summarised in these tables, and the policy conditions for each follow after the tables.

Option name	What this option does	Can it be held in superannuation?
Premium waiver option	Waives premiums on the policy if the life insured is severely disabled and can't work.	Yes
Business future cover option	Allows increases in death, TPD and trauma cover each year without health assessment.	No
Needlestick cover option	Pays a lump sum if the life insured contracts certain blood borne diseases in an occupational accident. This option is designed for people who work in exposure-prone occupations.	No, but we'll pay this benefit from the related policy if you take superannuation optimiser.

Premium waiver option

We'll waive the premiums for this policy if the life insured is totally disabled for at least three consecutive months before the policy anniversary when they're 69. We'll continue to waive the premium while they remain totally disabled.

'Totally disabled' means either of the following:

- due to *sickness* or *injury*, the life insured is unable to perform their usual occupation and they're not working for remuneration or reward. The life insured must be following the advice and recommended treatment of a *medical practitioner*
- due to *sickness* or *injury*, the life insured is unable to perform at least two *activities of daily living*.

Under this option, 'usual occupation' means the occupation the life insured spent the most time working in during the 12 months before *sickness* or *injury*. However, a different definition applies if the life insured has been unemployed or on long service or parental leave for more than 12 consecutive months immediately before the *sickness* or *injury*. In this case, usual occupation is any occupation they are reasonably qualified for by education, training, or experience.

You must pay premiums in the three-month period to qualify for this waiver. We'll refund any premiums paid in those three months if the life insured qualifies for the waiver.

We'll also waive premiums for this policy for up to three months if the life insured is involuntarily unemployed other than as a direct result of a *sickness* or *injury*. To qualify for this waiver, the policy must have been in-force for 12 months before the claim is made, and the life insured must be registered with an employment agency. A total of three months premium can be waived because of unemployment over the life of the policy.

The premium waiver option ends when one of the following happens:

- the death of the life insured
- when we receive written instruction to cancel this option
- the policy anniversary when the life insured is 69
- when the policy ends.

Some restrictions apply to the premium waiver option

This option is only available if the life insured has been in paid employment for more than 16 hours per week.

We won't waive premiums where *sickness* or *injury* occurs as a direct result of:

- an intentional self-inflicted act
- attempted suicide
- *uncomplicated pregnancy or childbirth*
- an act of war, whether declared or not. War doesn't include acts of terrorism.

If this option is added to the policy after it starts, premiums won't be waived for *sickness* or *injury* that occurs or is apparent within 90 days of the option being added. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

Business future cover option

This option is designed for business insurance arrangements. You can increase cover more easily when the value of the business arrangement detailed in your application increases, as no further health assessment is required. Cover can only be increased in line with an increase in the value of the business arrangement. One increase can be made each policy year.

When this option is selected, it will be shown on your policy schedule, along with the nature of your business insurance arrangement. This can be key person insurance, loan/guarantor protection, buy-sell/shareholder or partnership protection.

You can only increase the death, TPD and trauma benefit amount if:

- the benefit being increased has been in place for a minimum of 12 months
- we haven't paid a benefit and there is no entitlement to a benefit under this policy
- we or any other life insurer haven't waived or aren't currently waiving premiums because of a *sickness* or *injury*
- you request a death benefit increase before the policy anniversary when the life insured is 65
- you request a TPD or trauma benefit increase before the policy anniversary when the life insured is 60.

We'll need evidence of an increase in value

An application to increase cover must include proof of the increase in value of the business arrangement. Proof includes financial information covering the last 12 months or the last financial year. The valuation method used to evidence an increase must be the same method used when applying for this option. If the policy is a combination of key person insurance, loan/guarantor protection and/or buy-sell, we'll need proof of each relevant event.

You don't have to increase death, TPD and trauma cover at the same time. However, if TPD or trauma cover are increased, then death cover must be increased by at least the same amount at the same time. Increases are only effective after we process your application.

Cover can be increased to three-times the cover amount at the benefit start date, capped at:

- $15,000,000 for the death benefit
- $5,000,000 for the TPD benefit
- $2,000,000 for the trauma benefit.

If your business insurance arrangement is for multiple purposes then any increases under this option must be proportionate to the different purposes that formed the basis of this policy.

Any special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

You can't use this option to increase cover which has been reinstated under another policy benefit or option.

Needlestick cover option

We'll pay up to $1,000,000 if the life insured becomes infected with HIV, hepatitis B or hepatitis C. The infection must result from an accident while the life insured is working in their normal occupation. The infection must meet one of the following definitions:

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

The amount payable is the needlestick cover benefit amount on the date when the definition is met. The needlestick cover benefit amount doesn't increase under inflation protection.

The maximum combined amount we'll pay for either covered event under all policies issued by us is $2,000,000. This doesn't include any TPD benefits or income protection benefits.

You can apply for the needlestick cover option until the life insured reaches age 65. The option expires on the policy anniversary when the life insured is 75.

Options that reinstate cover

If your policy contains linked benefits, then a claim on one benefit will reduce the others. The following optional benefits provide for cover to be reinstated after a claim, depending on the combination of covers you select.

Option name	What this option does	Can it be held in superannuation?
Double TPD option	Reinstates death cover 14 days after a TPD claim. If the full TPD benefit amount is paid, death cover is reduced by the TPD claim amount. This option restores the death cover to the pre-claim amount. Premium for the reinstated death cover is waived for the remaining life of the policy.	Yes
Buy-back death option (TPD)	Reinstates death cover 12 months after a TPD claim. If the full TPD benefit amount is paid, death cover is reduced by the TPD claim amount. This option restores the death cover to the pre-claim amount.	Yes
Double trauma option	Reinstates death cover 14 days after a trauma claim. If the full trauma benefit amount is paid, death cover is reduced by the trauma claim amount. This option restores the death cover to the pre-claim amount. Premium for the reinstated death cover is waived for the remaining life of the policy.	Death and TPD cover on a related super policy can be reinstated if you take superannuation optimiser.
Buy-back TPD option	Reinstates TPD cover over three years after a trauma claim. If the full trauma benefit amount is paid, TPD cover is reduced by the trauma claim amount. This option restores the TPD cover to the pre-claim amount.	
Buy-back death option (trauma)	Reinstates death cover 12 months after a trauma claim. If the full trauma benefit amount is paid, death cover is reduced by the trauma claim amount. This option restores the death cover to the pre-claim amount.	
Trauma reinstatement option	Reinstates trauma cover 12 months after a full or partial trauma claim. This option restores the trauma cover to the pre-claim amount. Only unrelated conditions are covered after the reinstatement.	No

Double TPD option

This option reinstates the death benefit after we pay the TPD benefit.

The premium for the death benefit amount reinstated is waived until the death benefit end date.

We'll reinstate the death benefit to the pre-claim amount if:
- the life insured survives for 14 days after we pay the TPD benefit
- the TPD definition is met before the policy anniversary when the life insured is 65
- the life insured stops work more than 90 days after the option starts if the option is added after the policy start date.

The death benefit can't be reinstated if it is reduced after we pay a TPD advancement benefit or partial impairment benefit.

On the policy anniversary when the life insured is 65, double TPD cover automatically converts to standard TPD cover. We'll remind you about this change when the life insured approaches 65 so that you have time to seek advice and decide whether to continue the cover.

Buy-back death option (TPD)

This option reinstates the death benefit after we pay the TPD benefit.

We'll reinstate the death benefit to the pre-claim amount 12 months after we pay the TPD benefit if:

- the TPD definition is met before the policy anniversary when the life insured is 74
- the life insured stops work more than 90 days after the option starts if the option is added after the policy start date.

The death benefit can't be reinstated if it is reduced after we pay a TPD advancement benefit or partial impairment benefit.

Premium for the reinstated death benefit will be based on:

- the life insured's age on the reinstatement date
- premium rates and calculation factors for the benefit on the reinstatement date
- the gender and smoking status that applied to the pre-claim benefit.

Any special conditions, exclusions, or premium loading applied to the pre-claim benefit, will also apply to the reinstated benefit.

If you don't want the cover to be reinstated, you can ask us not to reinstate it. You can also choose to reinstate only part of the amount.

After the death benefit is reinstated, you can't increase the reinstated cover using the future insurability features.

Double trauma option

This option reinstates the death benefit after we pay the trauma benefit.

The premium for the death benefit amount reinstated is waived until the death benefit end date.

We'll reinstate the death benefit to the pre-claim amount if:

- the life insured survives for 14 days after we pay the trauma benefit
- the trauma definition is met before the policy anniversary when the life insured is 64
- the trauma condition occurs more than 90 days after the option starts if the option is added after the policy start date.

The death benefit can't be reinstated if it is reduced after we pay a partial trauma benefit payment.

Any exclusions which applied to the cover reduced will also apply to the cover reinstated.

On the policy anniversary when the life insured is 64, the double trauma option ends and cover automatically converts to standard trauma. We'll remind you about this change when the life insured approaches 64 so that you have time to seek advice and decide whether to continue the cover.

If you select both trauma reinstatement option and double trauma option, the trauma cover that will be reinstated after a trauma claim will be standard trauma rather than double trauma.

Buy-back TPD option

This option reinstates the TPD benefit after we pay the trauma benefit.

We'll reinstate the TPD benefit to the pre-claim amount over three years if:

- the trauma definition is met before the policy anniversary when the life insured is 65
- the life insured is working full-time in their usual occupation
- the trauma condition occurs more than 90 days after the option starts if the option is added after the policy start date.

The TPD benefit can't be reinstated if it is reduced after we pay a partial trauma benefit.

The three-year reinstatement works like this:

- 1/3 of the trauma benefit is reinstated 12 months after we pay the trauma benefit, if the life insured has returned to full-time work in their usual occupation for at least six continuous months
- a further 1/3 of the trauma benefit is reinstated 24 months after we pay the trauma benefit, if the life insured has returned to full-time work in their usual occupation for at least 18 continuous months
- the final 1/3 of the trauma benefit is reinstated 36 months after we pay the trauma benefit if the life insured has returned to full-time work in their usual occupation for at least 30 continuous months.

We'll contact you to confirm the life insured is working ahead of the relevant dates. You can tell us then if you don't want the cover to be reinstated. Or you can choose to reduce the proportion of TPD cover reinstated each year.

Under this option, 'usual occupation' means the occupation the life insured spent the most time working in during the 12 months before *sickness* or *injury*. However, a different definition applies if the life insured has been unemployed or on long service or parental leave for more than 12 consecutive months immediately before the *sickness* or *injury*. In this case, usual occupation is any occupation they are reasonably qualified for by education, training, or experience.

Premium for the reinstated TPD benefit will be based on:

- the life insured's age on the reinstatement date
- premium rates and calculation factors for the benefit on the reinstatement date
- the gender and smoking status that applied to the pre-claim benefit.

Any special conditions, exclusions, or premium loading applied to the pre-claim benefit will also apply to the reinstated benefit.

After the TPD benefit is reinstated, you can't:
- make a claim under the reinstated TPD benefit for an event which is the same as, or is related to, the event that we paid the trauma benefit for
- increase the reinstated cover using the future insurability feature.

Buy-back death option (trauma)

This option reinstates the death benefit after we pay the trauma benefit.

We'll reinstate the death benefit to the pre-claim amount 12 months after we pay the trauma benefit if:
- the trauma definition is met before the policy anniversary when the life insured is 74
- the trauma condition occurs more than 90 days after the option starts if the option is added after the policy start date.

The death benefit can't be reinstated if it is reduced after we pay a partial trauma benefit.

Premium for the reinstated death benefit will be based on:
- the life insured's age on the reinstatement date
- premium rates and calculation factors for the benefit on the reinstatement date
- the gender and smoking status that applied to the pre-claim benefit.

Any special conditions, exclusions, or premium loading applied to the pre-claim benefit, will also apply to the reinstated benefit.

If you don't want the cover to be reinstated, you can ask us not to reinstate it. You can also choose to reinstate only part of the amount.

After the death benefit is reinstated, you can't increase the reinstated cover using the future insurability features.

Trauma reinstatement option

This option reinstates the trauma benefit after we pay the trauma benefit or partial trauma benefit.

We'll reinstate the trauma benefit to the pre-claim amount 12 months after we pay a benefit if:
- the trauma definition is met before the policy anniversary when the life insured is 74
- the trauma condition occurs more than 90 days after the option starts if the option is added after the policy start date.

Premium for the reinstated trauma benefit will be based on:
- the life insured's age on the reinstatement date
- premium rates and calculation factors for the benefit on the reinstatement date
- the gender and smoking status that applied to the pre-claim benefit.

Any special conditions, exclusions, or premium loading applied to the pre-claim benefit, will also apply to the reinstated benefit.

If you don't want the cover to be reinstated, you can ask us not to reinstate it. You can also choose to reinstate only part of the amount.

This option doesn't apply to any trauma benefit which has already been reinstated using this option. You can't increase any reinstated trauma benefit using the future insurability feature.

After cover is reinstated, we'll only pay a claim under the reinstated cover if the specified trauma event, symptoms, or diagnosis first occurs after the trauma cover is reinstated.

We won't pay a claim under the reinstated trauma cover if the specified trauma:
- is the same condition as the original specified trauma
- is directly or indirectly caused by the original specified trauma or its symptoms
- is directly or indirectly caused by the event which caused the original specified trauma
- is a *loss of independence*
- is a 'heart condition' if the original claim was for a 'heart condition'
- is a *stroke (of specified severity)* or paralysis (directly or indirectly resulting from a *stroke (of specified severity)*) and the original specified trauma was a heart condition.

Under this option, 'heart condition' means any of the following specified traumas:
- *angioplasty (triple vessel)*
- *aortic surgery*
- *cardiomyopathy (with significant permanent impairment)*
- *coronary artery bypass surgery*
- *heart attack (of specified severity)*
- *heart valve surgery*
- *idiopathic pulmonary arterial hypertension (with permanent impairment).*

Your policy includes these features automatically

Your policy automatically includes the following features, regardless of the covers selected. Superannuation restrictions are shown where they apply.

Feature name	What this feature does	Does this feature apply to cover held in superannuation?
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 82.	Yes
Inflation protection	Increases cover every year, unless declined by you, without health assessment.	Yes
Future insurability	Allows an increase in death, TPD and trauma cover without health assessment when certain life events happen, for example, marriage or birth of a child.	Yes
Future insurability for business	Allows an increase in death cover without health assessment if certain business events occur. You can use this feature if you tell us your policy is for a business purpose when you apply. We'll show your business purpose on your policy schedule at the start of the policy.	No
Accommodation expenses	Reimbursement of some travel and accommodation expenses for a *partner*, child, brother, sister, or parent who travels more than 100km from home to be with the life insured who is confined to bed. Expenses are only payable if we've paid or are paying a benefit for terminal illness, TPD or trauma, and the life insured requires full-time care.	No, feature can be accessed via superannuation optimiser.
Financial planning advice	We'll reimburse up to $3,000 for financial advice following a claim payment under this policy. If we pay a benefit for death, terminal illness, TPD or trauma and the cover has been in place for five years or more, the limit on this benefit increases to $6,000.	Yes, we'll pay this benefit directly (not via the trustee).
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover and you can't make a claim. Up to 12 months of suspension can be taken over the life of the policy. Cover suspension is explained on page 81.	Yes, unless the policy is funded by a platform account.

Inflation protection

We'll increase your insurance cover each year to protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. They apply to the death benefit amount, TPD benefit amount and trauma benefit amount.

The benefit amount is increased by the higher of:
- 5%
- any increase in *consumer price index* (CPI).

Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

You don't have to accept any increase we offer. You can:
- reject one increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

Future insurability

You can increase the death, TPD or trauma benefit amount without health assessment when any of the following covered events happen.

If the life insured:
- marries, registers a partnership, or begins co-habiting with a partner
- divorces, de-registers a partnership, or ends co-habiting with a partner
- becomes a parent following the birth or adoption of a child
- experiences a significant increase in salary (minimum 15%)
- takes out a new mortgage on their principal place of residence
- increases their mortgage on their principal place of residence
- takes out a new investment property loan
- becomes a full-time carer
- becomes a widow or widower, following the death of a partner.

If the life insured's child:
- starts secondary school
- turns 18.

You're eligible to make an increase if:
- you provide evidence of the event
- the benefit being increased has been in place for a minimum of 12 months
- the covered event happens before the policy anniversary when the life insured is 54
- we haven't paid a benefit and there is no entitlement to a benefit under any Zurich policy for the life insured
- we or any other life insurer haven't waived or aren't currently waiving premiums for the life insured because of a *sickness* or *injury*.

One increase can be made per policy year within 30 days of either:
- the date of any covered event
- the policy anniversary after the date of any covered event.

The minimum increase amount is $10,000. The maximum increase available is 25% of the death, TPD or trauma benefit amount on the benefit start date, up to $200,000. Where the event is based on a mortgage or investment property loan, the increase can't exceed the new loan or increase in loan amount.

Any special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

Some limitations apply to future insurability

The following limitations apply to increases under this feature:
- the sum of all increases under this feature can't exceed the benefit amount on the benefit start date or $1,000,000
- in any 12-month period, the maximum increase is 50% of the benefit amount on the benefit start date
- the TPD benefit amount can't be increased to more than $5,000,000
- the trauma benefit amount can't be increased to more than $2,000,000
- any TPD benefit with an own occupation or any occupation definition can only be increased if the life insured is in paid work for at least 16 hours per week when the increase is requested.

In the first six months after an increase, the extra benefit amount will only apply to events which are caused by *accidental death* or *accidental injury*. Only *accidental death* or *accidental injury* that happens after the date of the increase is covered.

You can't use this feature to increase cover which is reinstated under an optional benefit.

Future insurability for business

This benefit is designed for business insurance arrangements. Using this benefit, you can increase death cover when there is an increase in the value of the business arrangement detailed in your application, without any further health assessment. Cover can only be increased in line with an increase in the value of the business arrangement. One increase can be made each policy year.

When you apply for cover, if you tell us that your cover is for key person insurance, loan/guarantor protection, buy-sell/shareholder or partnership protection, we'll show that business purpose on your policy schedule.

You can only increase the death benefit amount if:

- your policy schedule shows a business purpose
- the benefit being increased has been in place for a minimum of 12 months
- you request an increase before the policy anniversary when the life insured is 54
- you haven't selected the business future cover option
- the policy isn't issued to the trustee of a superannuation fund.

An application for increase must include proof of the increase in value of the business arrangement. Proof includes financial information covering the last 12 months or the last financial year. The valuation method used to evidence an increase must be the same method used when applying for cover.

In any 12-month period, increases are limited to 50% of the death benefit amount on the death benefit start date. Over the life of the policy, the total of all increases available is the lower of the cover amount applying on the death benefit start date and $1,000,000.

Any special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

In the first six months after an increase, the extra benefit amount is only payable on *accidental death*.

You can't use this option to increase cover which has been reinstated under another optional benefit.

Accommodation expenses

This feature isn't available if the policy is issued to the trustee of a superannuation fund.

We'll reimburse some travel and accommodation expenses for an immediate family member who is separated from the life insured at a difficult time. 'Immediate family member' means *partner*, child, brother, sister, or parent.

The following criteria must all be met to qualify for reimbursement:

- we've paid or are paying a terminal illness benefit, TPD benefit or trauma benefit
- the life insured is confined to bed due to the covered condition
- the life insured is 100 kilometres or more away from their home, or the immediate family member's home
- an immediate family member travels with the life insured or travels to be with the life insured.

We'll reimburse up to $500 of travel expenses. We'll also reimburse a maximum of $500 per day for accommodation, for up to 30 days. Expense claims should be lodged with us as soon as possible after we pay a benefit.

This benefit is payable only once per health event across all policies issued by us providing cover for the life insured. We'll only reimburse expenses following a full benefit payment. Payment of the TPD advancement benefit, partial impairment benefit or partial trauma benefit won't result in any expense reimbursement.

'Confined to bed' means that a *medical practitioner* confirms that the life insured is confined to bed and needs the full-time care of a nurse or personal carer for more than two consecutive days.

'Nurse' means a nurse legally registered to practice in Australia or a nurse legally registered to practice in another country who has an equivalent qualification. Nurse doesn't include:

- the policy owner, their relative, business partner or employee
- the life insured, their relative, business partner or employee.

'Personal carer' means a person the life insured is totally dependent on for care, and doesn't include:

- 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.

The only time when an immediate family member or employee will be considered a personal carer is where they have stopped full-time work or taken leave specifically to care for the life insured.

Financial planning advice

We'll reimburse up to $3,000 towards the cost of financial planning advice required as a result of a full benefit payment under this policy. We won't reimburse financial planning expenses following payment of the TPD advancement benefit, partial impairment benefit or partial trauma benefit.

To claim this reimbursement, we'll need:
- a copy of the Statement of Advice which refers to the insurance claim
- your invoice, as proof of the expense.

We'll increase the reimbursement limit if the benefit we pay has been in-force for five years or more when the insured event occurs. In this case we'll double the amount from $3,000 to $6,000.

What this policy doesn't cover

Exclusions under death cover

We won't pay the death benefit for death caused by an event or condition specified as an exclusion on the policy schedule.

We won't pay the death benefit for death caused by suicide within 13 months of:
- the death benefit start date
- the start date of any death benefit increase applied for (but only for the increase)
- the most recent policy reinstatement.

We won't apply the suicide exclusion if, immediately before the death benefit started, the life insured held death cover for at least 13 consecutive months with us or another insurer, and we replaced it. We'll only waive the suicide exclusion on the amount of death cover we replaced.

Exclusions under TPD cover

We won't pay the TPD benefit for *total and permanent disablement*, *loss of a hand or foot*, *loss of sight in one eye* or *functional impairment* caused directly or indirectly by:
- an intentional self-inflicted act or attempted suicide
- any event or medical condition specified as an exclusion on the policy schedule.

Exclusions under trauma cover

We won't pay the trauma benefit if an insured event is caused directly or indirectly by either of the following:
- an intentional self-inflicted act or attempted suicide
- any event or medical condition specified as an exclusion on the policy schedule.

A 90-day elimination period applies to some trauma conditions

Some insured trauma conditions have a 90-day elimination period. The elimination period applies to the trauma conditions on pages 17 and 18 that are marked with an asterisk (*).

We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs, is first diagnosed, or the symptoms leading to diagnosis are apparent
- surgery for the condition is recommended to the life insured.

'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

We won't pay a benefit for any trauma condition that is directly or indirectly related to a condition that we won't pay a claim for in the elimination period. For example, where *loss of independence* is caused by *stroke (of specified severity)* that occurs in the 90-day elimination period.

The elimination period starts when a trauma cover application (including a fully completed life insured's statement) is lodged with us. For cover increases, the elimination period starts on the benefit start date of any increase in trauma benefit.

The same 90-day elimination period applies to the policy when there is a break in cover and the policy re-starts. The elimination period starts from the date the policy is reinstated or after cover suspension, from the cover suspension end date.

We won't apply the 90-day elimination period if immediately before the trauma benefit started, the life insured held cover for the same insured event with us or another insurer for more than 90 days, and we replaced it. We'll only waive the elimination period on the amount of trauma cover we replaced. This waiver can also apply to any increases in the trauma benefit that meet the same criteria.

Angioplasty procedures within six months of each other aren't covered

We won't pay a benefit for *angioplasty (minimally invasive cardiac surgery)* if the procedure occurs within six months of an *angioplasty (minimally invasive cardiac surgery)* procedure that we paid a benefit for.

Elective and donor transplant surgery isn't covered in the first six months

We won't pay the trauma benefit for an insured event that is 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
- for an increase in the trauma benefit amount, the date of the increase.

AIDS, HIV, hepatitis B and hepatitis C infection have specific exclusions

We don't cover infection with Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus or hepatitis B or hepatitis C where infection is acquired by sexual activity or recreational intravenous drug use.

A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if:

- a medical cure is found for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus (whichever applies)
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious.

A benefit isn't payable for hepatitis B if:

- a medical cure is found for hepatitis B
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis B, before making a claim.

A benefit isn't payable for hepatitis C if:

- a medical cure is found for hepatitis C
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis C, before making a claim.
- the life insured hasn't yet taken at least two Australian government subsidised courses of treatment (or an equivalent treatment program) which could result in a cure, before making a claim.

You can't claim under TPD and trauma for the same event

If the life insured is covered for both trauma cover and TPD cover and a claim for the same insured event can be made under both covers, we'll only pay under the trauma cover. If the TPD benefit amount is higher, we'll also pay a TPD benefit of the difference in the sums insured.

Superannuation restrictions and limitations apply

If the policy is issued to a superannuation trustee, we'll only pay benefits that the trustee can release under superannuation law when the claim is assessed.

TPD benefits are only payable if the life insured meets the superannuation definition of permanent incapacity.

Any claim we pay reduces the amount available for further claims

When a benefit is paid under the policy, the death, TPD and trauma benefits are reduced by the amount paid, and the premium is re-calculated. The new premium will be based on the reduced levels of cover from the next premium due date after payment of the relevant benefit.

Benefit reductions also apply across two policies if one policy replaces the other or where the policies are related through superannuation optimiser.

Death cover benefit reductions

The death benefit amount is reduced by the amount paid or advanced, under any of the following:

- terminal illness benefit
- advancement for funeral expenses
- accidental injury benefit
- TPD benefit
- TPD advancement benefit
- partial impairment benefit
- trauma benefit
- partial trauma benefit
- paralysis booster benefit.

TPD cover benefit reductions

The TPD benefit amount is reduced by the amount paid or advanced under any of the following:

- terminal illness benefit
- accidental injury benefit
- TPD advancement benefit
- partial impairment benefit
- trauma benefit
- partial trauma benefit
- paralysis booster benefit.

Trauma cover benefit reductions

The trauma benefit amount is reduced by the amount paid or advanced under any of the following:

- terminal illness benefit
- accidental injury benefit
- TPD benefit
- TPD advancement benefit
- partial impairment benefit
- partial trauma benefit
- paralysis booster benefit.

When the benefits end

When the death benefit ends

The death benefit ends when one of the following happens:

- payment of the total death benefit amount
- when we receive written instruction to cancel the death benefit
- the death benefit end date shown on the policy schedule
- death of the life insured
- when the policy ends.

When the TPD benefit ends

The TPD benefits end when one of the following happens:

- payment of the total TPD benefit amount
- when we receive written instruction to cancel the TPD benefit
- the TPD benefit end date shown on the policy schedule
- death of the life insured
- when the policy ends.

When the trauma benefit ends

The trauma benefits end when one of the following happens:

- payment of the total trauma benefit amount
- when we receive written instruction to cancel the trauma benefit
- the trauma benefit end date shown on the policy schedule
- death of the life insured
- when the policy ends.

When the optional benefits end

Each optional benefit ends when one of the following happens:

- when we receive written instruction to cancel the option
- the optional benefit end date
- when the policy ends.

Some optional benefits don't have an end date shown on the policy schedule. In that case, the optional benefit ends when the policy ends, unless the benefit explanation specifies an earlier end date.

When the policy ends

The policy ends when one of the following happens:

- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium within 30 days of its due date
- the related policy ends (if superannuation optimiser applies)
- when we receive written instruction to cancel this policy
- the policy anniversary when the life insured is 99
- if the policy doesn't have death cover, payment of the TPD benefit or the trauma benefit which results in all TPD and trauma cover amounts reducing to nil (unless the buy-back TPD option or trauma reinstatement option applies)
- payment of 100% of the death benefit
- death of the life insured.

Zurich Income Protector Plus and Zurich Income Protector

Zurich Income Protector Plus and Zurich Income Protector cover you for health events that prevent the life insured from working and earning income

Income protection insurance provides a *monthly benefit* if the life insured is unable to work solely due to *sickness* or *injury* and is *totally disabled* or *partially disabled* for longer than the waiting period. Income protection insurance replaces some lost income, so that the life insured can concentrate on recovery without having to worry about how to cover ongoing expenses.

The policy conditions for Zurich Income Protector Plus and Zurich Income Protector are set out in this section.

The benefits payable under this policy depend on the cover you select

Two levels of cover are available, Zurich Income Protector Plus and Zurich Income Protector.

Level of cover	What this cover provides
Zurich Income Protector Plus	A fully featured level of cover, including: • three ways to qualify for a benefit, known as a three-tier definition of disability • day-one partial, meaning it is possible to claim a partial disability benefit without ever being *totally disabled* (if cover is held in super, the life insured must also meet the superannuation definition of temporary incapacity) • a full suite of benefits, including accommodation expenses (when held outside of superannuation) and confined to bed benefit.
Zurich Income Protector	A lower cost 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 life insured must be 'unable to perform one or more *important income-producing duties*' and there is no three-tier definition • after the total disability benefit, partial disability benefit or combination of both benefits has been paid for 24 months, the ability to work is no longer based on a specific occupation • the accommodation expenses and confined to bed benefit aren't included.

Cover under both policies is indemnity, which means the *monthly benefit* payable if you make a claim is based on the life insured's *pre-disability income*. The *insured monthly benefit* is the maximum amount we'll pay.

When you apply for cover, the maximum amount you can insure is 75% of the life insured's annual *income* up to $320,000. After that, a sliding scale applies. You can insure 50% of the next $240,000 of annual *income* and 25% of any balance.

Cover held in superannuation

If you choose to hold your income protection cover in superannuation, benefits are only payable if the life insured meets 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. See the section 'Holding this insurance in superannuation', starting on page 59, for more information.

Monthly benefit amount

The *insured monthly benefit* is the maximum amount that is payable for any month.

Examples are provided on page 35 to show how the monthly total and partial disability benefits are calculated.

We'll apply offsets to any benefit payments

See the section 'We apply offsets to income benefit payments' on page 44.

Related claims

After we pay a total or partial disability claim, if the life insured is disabled again from the same cause or a related cause, we'll treat this as a continuation of the same claim. The policy conditions that apply to the related claim will be those that applied at the start of the original claim. If the policy has a benefit period of 1-year, 2-years or 5-years, the benefit period will apply across the combined claims.

If a related claim occurs:
- within 12 months of returning to work, the waiting period won't apply
- more than 12 months after returning to work, the waiting period will apply.

If we class the life insured's occupation as 'special risk' or SR, then six months will replace 12 months. The policy schedule will show if the life insured's occupation is special risk.

Related claims can mean either:
- claiming twice for the same *sickness* or *injury*
- claims affecting different parts of the body. An example of different insured events that have a related cause is degenerative damage to both knees, claimed at different times. Both knees could be damaged seriously enough to meet our definition of *totally disabled*. However, if the disability is due to degenerative damage, then the cause of the second claim is the same as, or related to, the cause of the first claim.

Zurich Income Protector Plus and Zurich Income Protector policy conditions

The information below forms part of the Zurich Income Protector Plus and Zurich Income Protector policy conditions. Where terms vary between Zurich Income Protector Plus and Zurich Income Protector, this is clearly explained. Words or expressions shown in *italics* have their meaning explained in the 'Definitions' section.

When we accept your application, we'll issue a policy schedule. The policy schedule shows:
- the life insured covered under the policy
- if your cover is Zurich Income Protector Plus or Zurich Income Protector
- the *insured monthly benefit* at the start of the policy
- the benefit period
- the waiting period
- any extra-cost optional benefits selected
- the premium structure
- benefit end dates
- any special conditions that apply to your policy specifically.

The life insured is only covered for the benefits and amounts shown on the policy schedule. Each benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefits end' on page 45.

You can make changes to your policy. If you apply for optional benefits or increases to the benefits after the policy starts, changes are only effective if we accept the application after assessing the life insured's health, occupation, and pastimes.

If cover is held in superannuation

If the policy is issued to the trustee of a superannuation fund, benefits are subject to the superannuation restrictions and limitations described on page 45.

If the policy is one of two related policies issued under superannuation optimiser, the policy schedule will show whether the policy is the superannuation policy or the non-superannuation policy. The section 'Holding this insurance in superannuation', starting on page 59, provides important information and terms for superannuation optimiser.

The related policies issued under a superannuation optimiser structure will both end automatically if either one of the policies ends. This happens because each policy contains only part of the cover and can't exist without the other part. If one of the policies is paid in advance, we'll refund any unused premiums. If we need to refund any contributions made to the superannuation policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

Some benefits don't form part of the policy if the policy is issued to the trustee of a superannuation fund. These are clearly marked.

These policies cover disability that prevents the life insured from working

This section explains when benefits become payable.

Benefits payable under Zurich Income Protector Plus and Zurich Income Protector

If the life insured is covered under the policy and an insured event occurs, the following benefits are payable.

The insured event must occur both:
- while this benefit and policy is in-force
- before the *insured monthly benefit* ends.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 44.

Benefit name	What this benefit pays	Can it be held in superannuation?
Total disability benefit	We'll pay a benefit if the life insured is *totally disabled* after the waiting period.	Yes, life insured must also meet the superannuation definition of temporary incapacity.
Partial disability benefit	We'll pay a proportion of the total disability benefit if the life insured is *partially disabled* after the waiting period. The benefit payable is based on the life insured's income before the claim compared to income during the claim.	Yes
Specified injury benefit	We'll waive the waiting period and pay this benefit right away if the life insured suffers a specified injury from a range of covered events. Covered events include *quadriplegia*, loss of hands, feet or sight and certain fractures. This benefit is paid instead of the total or partial disability benefit. If the waiting period is 1-year or 2-years, the specified injury benefit doesn't apply.	No, but we'll pay this benefit from the related policy if you take superannuation optimiser.
Confined to bed benefit (plus only)	We'll waive the waiting period and pay this benefit right away if the life insured is disabled and confined to bed for more than two days and unable to earn any income. This benefit is paid instead of the total or partial disability benefit. If the waiting period is 1-year or 2-years, the confined to bed benefit doesn't apply.	Yes
Accommodation expenses (plus only)	Reimbursement of some travel and accommodation expenses for a *partner*, child, brother, sister, or parent who travels more than 100km from home to be with the life insured who is confined to bed. Expenses are only payable if we've paid or are paying a total disability benefit, specified injury benefit, day 4 accident benefit or confined to bed benefit.	No, but we'll pay these benefits from the related policy if you take superannuation optimiser.
Rehabilitation benefit	We want to help the life insured in their recovery and return to work. We'll reimburse the cost of workplace modifications, rehabilitation programs and other expenses that we agree with you in advance. We don't cover health costs typically covered by Medicare or private health insurance.	
Funeral benefit	We'll pay a lump sum of four-times the *insured monthly benefit* to help with immediate expenses if the life insured dies during a claim.	Yes

Two important aspects of this policy are the selected waiting period and the benefit period

Both are shown on your policy schedule.

The **waiting period** is the period of time the life insured must be disabled before we'll pay a benefit.

The waiting period begins on the date of disability, which is when both of the following occur:

- the life insured is *totally disabled* or *partially disabled* due to *sickness* or *injury*
- they have consulted a *medical practitioner* about their disability.

Under Zurich Income Protector, the life insured must be *totally disabled* for at least five consecutive days during the waiting period.

The **benefit period** is the maximum period of time that we'll pay a *monthly benefit* when the life insured suffers from the same or a related *sickness* or *injury* during the life of the policy.

The benefit period for any claim starts at the end of the waiting period.

All benefits end on the policy anniversary when the life insured is 65 unless the life insured has a 'special risk' or SR occupation. In this case, they end on the policy anniversary when the life insured is 60. If your policy has a 1-year, 2-year or 5-year benefit period, then the benefit end date might be reached before the entire benefit period is paid. The cost of cover at older ages factors-in shorter claim payment periods to allow for this outcome.

If the life insured is already covered by employment-related salary continuance with a 2-year benefit period, you might select a 2-year waiting period on your policy. In this case, if you need to claim, you'll be eligible for monthly benefits under the salary continuance cover first and we'll start the waiting period at the beginning of that claim. If the life insured returns to work during the salary continuance claim under recurrent disability provisions, we'll extend the 2-year waiting period to reflect the time at work.

Total disability benefit

This is how you qualify for a total disability benefit, depending on the level of cover you choose:

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

The benefit we pay will be the lower of:

- the *insured monthly benefit*, less any offsets that apply
- the monthly equivalent of our benefit limit, less any offsets that apply.

Our benefit limit is based on annual *income*:

- 75% of the first $320,000 of *pre-disability income*
- 50% of the next $240,000 of *pre-disability income*
- 25% of the balance of *pre-disability income*.

Offsets are explained on page 44.

The total disability benefit is paid 15 days after the waiting period ends, provided claim requirements are met, and monthly after that. Benefits are generally paid two weeks in arrears and two weeks in advance. If the claim ends part-way through a month, we'll pay a proportionate benefit. Benefits for any period shorter than two weeks are paid as 1/30th of the total disability benefit for each day.

The total disability benefit is payable until one of the following happens:
- the life insured is no longer *totally disabled*
- the benefit period ends
- the *insured monthly benefit* end date
- when the policy ends
- death of the life insured.

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 45.

Partial disability benefit

This is how you qualify for a partial disability benefit, depending on the level of cover you choose:

Zurich Income Protector Plus	Zurich Income Protector
We'll pay the partial disability benefit if the life insured is: • *totally disabled* or *partially disabled* for the duration of the waiting period • remains *partially disabled* after the waiting period ends.	We'll 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 • remains *partially disabled* after the waiting period ends.

This is how we calculate a monthly benefit:

$$\frac{\textit{pre-disability income} - \textit{post-disability income}}{\textit{pre-disability income}} \times \text{the monthly amount we'd pay if the life insured was eligible for a total disability benefit (before applying any offsets)}$$

We'll need evidence of any *post-disability income* before we can pay a partial disability benefit.

The partial disability benefit will then be reduced if any offsets apply. Offsets are explained on page 44.

The partial disability benefit is payable 15 days after the waiting period ends, provided claim requirements are met, and monthly in arrears after that. If the claim ends part-way through a month, we'll pay a proportionate benefit. Benefits for any period shorter than two weeks are paid as 1/30th of the partial disability benefit for each day.

If this benefit is paid beyond 12 months, *pre-disability income* is increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before the anniversary of your claim. If there is no increase in CPI, then no increase will apply.

The partial disability benefit is payable until one of the following happens:
- the life insured is no longer *partially disabled*
- the benefit period ends
- the *insured monthly benefit* end date
- when the policy ends
- death of the life insured.

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 45.

Calculation of total and partial disability benefits

Here are some examples to show how the monthly total and partial disability benefits are calculated.

Assumptions:
- the *insured monthly benefit* when you claim is $6,000
- as the life insured is earning less than $320,000 per year, the examples reflect 75% of *pre-disability income*
- the life insured isn't eligible for any other benefits for the disability, so no offsets apply.

When the life insured is totally disabled	Regular *income* *Income* in the two years before claim is $8,000 per month	Fluctuating *income* *Income* in the two years before claim is $6,000 per month
The total disability benefit is the lower of: • the *insured monthly benefit* less any offsets • 75% of *pre-disability income* less any offsets	*pre-disability income* is $8,000 We pay the lower of: • $6,000 • 75% of $8,000 = $6,000	*pre-disability income* is $6,000 We pay the lower of: • $6,000 • 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 *pre-disability income* is $8,000	**Fluctuating *income*** *post-disability income* is $3,600 *pre-disability income* is $6,000
The partial disability benefit is proportionate to the income loss	We pay: $\frac{\$8{,}000 - \$4{,}800}{\$8{,}000} \times \$6{,}000$ = $2,400	We pay: $\frac{\$6{,}000 - \$3{,}600}{\$6{,}000} \times \$4{,}500$ = $1,800

Specified injury benefit

This benefit doesn't apply if:

- the policy is issued to the trustee of a superannuation fund
- the policy is issued with a 1-year or 2-year waiting period.

The specified injury benefit is payable if any one of the specified injuries happen to the life insured during the waiting period. We'll pay a monthly benefit for the duration of the specified injury benefit period shown in the table below. The monthly benefit is the amount we would pay under the total disability benefit.

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 (femur) or pelvis (pubis)	3
Fracture of a leg between the knee and foot (tibia, fibula), kneecap (patella), skull (cranium, excluding bones of the face or nose), upper arm between the elbow and shoulder (humerus), shoulder blade (scapula)	2
Fracture of a forearm including wrist but excluding elbow or hand (radius, ulna), jaw (mandible), collar bone (clavicle)	1.5

'Loss' means that the life insured can't use that body part 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. 'Fracture' means any fracture resulting from an accident requiring fixation, immobilisation or plaster cast as treatment.

The specified injury benefit is payable until one of the following happens:

- the specified injury benefit period ends
- the benefit period ends
- death of the life insured.

We won't pay for more than one specified injury per event.

We won't 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'll pay the total or partial disability benefit. Payments will begin on the later of:

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

Confined to bed benefit

This benefit only applies to Zurich Income Protector Plus.

If the waiting period is 1-year or 2-years, the confined to bed benefit doesn't apply.

We'll pay the confined to bed benefit if the life insured is both:

- confined to bed because of *sickness* or *injury*
- unable to earn any income from personal exertion during that period.

We'll 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 and is only paid for up to 180 days.

The confined to bed benefit is the amount we would pay under the total disability benefit.

'Confined to bed' means that a *medical practitioner* states in writing that the life insured is confined to bed and they need the full-time care of a nurse or personal carer for more than two consecutive days.

'Nurse' means a nurse legally registered to practice in Australia or a nurse legally registered to practice in another country who has an equivalent qualification. Nurse does not include:

- the policy owner, their relative, business partner or employee
- the life insured, their relative, business partner or employee.

'Personal carer' means a person the life insured is totally dependent on for care and doesn't include any of the following:
- the life insured's immediate family member. 'Immediate family member' means *partner*, child, brother, sister, or parent
- an employee of the life insured or an employee of the life insured's immediate family member
- the life insured's employer.

The only time when an immediate family member will be considered a personal carer is where they have stopped full-time work or taken leave specifically to care for the life insured.

Accommodation expenses

This benefit only applies to Zurich Income Protector Plus.

This benefit doesn't apply if the policy is issued to the trustee of a superannuation fund.

We'll reimburse some accommodation and travel expenses for an immediate family member if the life insured is more than 100km from home when we pay a claim. 'Immediate family member' means *partner*, child, brother, sister, or parent.

The benefit is only payable if both of the following occur:
- we're paying a total disability benefit, specified injury benefit, day 4 accident benefit or confined to bed benefit
- the life insured is 100 kilometres or more away from home and is confined to bed due to the condition we're paying a benefit for.

The accommodation benefit reimburses the following:
- travel costs, up to $500
- accommodation costs, up $500 per day, limited to 30 days in any 12-month period.

'Confined to bed' means that a *medical practitioner* states in writing that the life insured is confined to bed and they need the full-time care of a nurse or personal carer for more than two consecutive days.

'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, their relative, business partner or employee
- the life insured, their relative, business partner or employee.

'Personal carer' means a person the life insured is totally dependent on for care and doesn't include any of the following:
- 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.

The only time when an immediate family member will be considered a personal carer is where they have stopped full-time work or taken leave specifically to care for the life insured.

Rehabilitation benefit

This benefit doesn't apply if the policy is issued to the trustee of a superannuation fund.

We'll pay the rehabilitation benefit when the life insured has qualified for the total or partial disability benefit or specified injury benefit. We'll also pay the rehabilitation benefit in the waiting period if the life insured would otherwise qualify for the total or partial disability benefit.

The rehabilitation benefit reimburses the following costs:
- if the life insured's workplace needs modification for a return to paid work, we'll pay up to three-times the monthly total or partial disability benefit, depending on which definition is met
- if the life insured takes part in rehabilitation program or requires special equipment designed to assist workforce re-entry, we'll pay up to 12-times the monthly total or partial disability benefit depending on which definition is met. We won't cover health costs which are typically covered by Medicare or private health insurance.

In addition to the reimbursements, we'll increase the total disability or partial disability benefit we pay while the life insured takes part in a rehabilitation program. We'll pay an extra 20% of the monthly total or partial disability benefit, depending on which definition is met, for up to 12 months.

'Rehabilitation program' means a program or plan that has been designed by an appropriately tertiary qualified occupational or rehabilitation specialist to assist the life insured's return to work. The return to work can be either:
- in the life insured's usual occupation
- in any other occupation the life insured is suited to by training, education, or experience.

It's important that you let us know about your rehabilitation plans. We want to help you to return to wellness but can only cover rehabilitation expenses that will improve your ability to work. Make sure you check with us before you incur any expenses as not all expenses are covered. We'll review your plans and confirm what is covered as soon as we can.

Funeral benefit

We'll pay the funeral benefit 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'll pay a lump sum of four-times the *insured monthly benefit*.

If the life insured is also covered under any other Zurich income policy, we'll only pay this benefit once.

You can purchase optional benefits to boost your cover

You can select optional benefits when you apply for your policy and they will apply from the policy start date. You can also add options after your policy starts. Added optional benefits don't apply to any *sickness* or *injury* that occurs or is apparent within 90 days of the option being added. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

Optional benefits only apply if they are shown on the policy schedule.

The optional benefits are summarised in this table, and the policy conditions for each follow after the tables.

Some options aren't available if the policy is held in superannuation. Some options aren't available if the life insured has a high-risk occupation, which are occupations we describe on the policy schedule as 'special risk' or SR. The table below shows both eligibility restrictions.

Option name	What this option does	Available to SR occupations	Can it be held in superannuation?
Increasing claims option	Increases benefits annually with CPI while on claim.	Yes	Yes
Super contributions option	Allows you to cover up to 100% of regular superannuation contributions in addition to the total or partial disability benefit, so that superannuation savings can continue while on claim.	No	Yes
Day 4 accident option	Pays benefits during the waiting period if the life insured is disabled due to *injury*. This option is only available with waiting periods of 14 or 30 days.	No	Yes
Future insurability option	Allows an increase in cover without health assessment every year.	No	Yes
Family care option	Pays benefits to a surviving *partner* for up to five years if the life insured dies while on claim.	Yes	No, but we'll pay these benefits from the related policy if you take superannuation optimiser.
Lump sum accident option	Pays a lump sum once if the life insured suffers an *injury* which causes *accidental death* or a specified loss. For example, loss of hands, feet, or sight.	No	
Trauma advancement option	Advances benefit payments if the life insured suffers a specified trauma. Our specific definition of the condition applies to any claim and describes a certain severity.	No	
Needlestick cover option	Pays a lump sum if the life insured contracts certain blood borne diseases in an occupational accident. This option is designed for people who work in exposure-prone occupations.	Yes	

Increasing claims option

We'll index your claim payments. If the total or partial disability benefit is paid beyond 12 months, the benefit is increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before the anniversary of your claim. If there is no increase in CPI, then no increase will apply.

Super contributions option

We'll pay the super contributions monthly benefit, or a proportion of the super contributions monthly benefit, when we pay any of the following:

- total disability benefit
- partial disability benefit
- specified injury benefit
- confined to bed benefit
- day 4 accident benefit.

We'll pay the super contributions monthly benefit amount multiplied by the proportion of the *insured monthly benefit* we're paying as one of the above benefits.

Benefit payments are 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 before the claim.

Inflation protection, the increasing claims option and the future insurability option apply to the super contributions option.

When you select this benefit, you automatically direct us to pay any super contributions monthly benefit payable to a complying superannuation fund of your choice.

Day 4 accident option

We'll pay the day 4 accident benefit if the life insured is *totally disabled* due to an *injury* for more than three consecutive days during the waiting period. We'll pay 1/30th of the total disability benefit for each day of the waiting period that the life insured continues to be *totally disabled* solely due to *injury*.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

Future insurability option

The Future insurability benefit allows you to increase the *insured monthly benefit* and any super contributions monthly benefit by up to 15% on every policy anniversary without any further health assessment. Cover can only be increased in line with an increase in income.

You'll need to provide evidence to show that you can support the increase. An increase can be made once in each policy year. We must receive your request to apply an increase within 30 days of a policy anniversary.

You can't increase cover if:

- the request to increase is made after the policy anniversary when the life insured is 54
- we're paying benefits or have ever paid benefits under the policy
- the increase will result in the *insured monthly benefit* exceeding the monthly equivalent of our benefit limit
- the increase will result in a super contributions monthly benefit which is higher than the actual average monthly superannuation contributions the life insured or the life insured's employer made in the 12 months before the request to increase.

Our benefit limit is based on annual *income* at the date when you apply for the increase:

- 75% of the first $320,000 of *pre-disability income*
- 50% of the next $240,000 of *pre-disability income*
- 25% of the balance of *pre-disability income*.

Any other special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

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

The following limitations apply to increases under this benefit:

- the sum of all increases under this benefit can't exceed the *insured monthly benefit* amount on the benefit start date
- any increase under this benefit can't cause the *insured monthly benefit* amount to exceed $30,000
- the *insured monthly benefit* can't be increased for any income changes until the future insurability option has been in-force for 12 months.

Family care option

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

We'll pay the family care benefit if the life insures dies while a *monthly benefit* is being paid and leaves a surviving *partner*.

We'll continue to pay the *partner* a *monthly benefit* for up to five years after death. We'll only pay the benefit while the *partner* lives, but not beyond the balance of the benefit period or the *insured monthly benefit* end date.

The amount payable will be adjusted in the same way as it would have been adjusted if the life insured had continued living.

Lump sum accident option

We'll pay the lump sum accident benefit if the life insured suffers an *injury* which causes one of the events set out in the following table, within 180 days of the accident. The amount payable is the percentage of the lump sum accident benefit amount at the date of the event, as shown in the table.

'Loss' means that the life insured can't use that body part 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.

We'll only pay an amount under this benefit once over 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	100%
…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	50%
…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%

Trauma advancement option

We'll pay a benefit for six months, regardless of whether the life insured is disabled, if they suffer one of the trauma conditions listed below. The trauma advancement benefit is paid in advance as a lump sum during the waiting period.

The trauma advancement benefit is the lower of:
- the *insured monthly benefit*
- 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 meeting any one of the following four trauma condition definitions:
- *cancer (excluding early stage cancers)*
- *coronary artery bypass surgery*
- *heart attack (of specified severity)*
- *stroke (of specified severity).*

These insured trauma conditions all have a 90-day elimination period. We won't ever pay a claim for these trauma conditions if, during the elimination period, either of the following happens:
- the condition occurs, is first diagnosed, or the symptoms leading to diagnosis are apparent
- surgery for the condition is recommended to the life insured.

'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

The elimination period starts when a Zurich Income Protector Plus or Zurich Income Protector application (including a fully completed life insured's statement) is lodged with us. For cover increases, the elimination period starts on the benefit start date of any increase in the trauma advancement benefit.

The same 90-day elimination period applies to the policy when there is a break in cover and the policy re-starts. The elimination period starts from the date the policy is reinstated or after cover suspension, from the cover suspension end date.

We won't apply the 90-day elimination period if immediately before the trauma benefit started, the life insured held trauma cover for the same insured event with us or another insurer for more than 90 days, and we replaced it. We'll only waive the elimination period on the amount of trauma cover we replaced. This waiver can also apply to any increases in the trauma advancement benefit that meet the same criteria.

We won't pay any other benefit under this policy while the trauma advancement benefit is being paid. If at the end of six months the life insured is *totally disabled* or *partially disabled* because of the same insured event, we'll pay the total or partial disability benefit. Payments will begin on the later of:

- the end of the trauma advancement benefit period
- the end of the waiting period.

We'll only pay a trauma advancement benefit once for each insured event. No benefit is payable after the benefit end date.

The insured event must be diagnosed and certified by a *medical practitioner* considered to be an appropriate specialist physician. 'Appropriate' will differ from claim to claim as it depends on the medical condition, standard medical practice, and the specialist physician's qualifications in the relevant area of medicine. If we require verification of the diagnosis and certification by a second physician, we'll pay for the cost of the physician and any reasonable travel costs.

Needlestick cover option

We'll pay up to $1,000,000 if the life insured becomes infected with HIV, hepatitis B or hepatitis C. The infection must result from an accident while the life insured is working in their normal occupation. The infection must meet one of the following definitions:

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

The amount payable is the needlestick cover benefit amount on the date when the definition is met. The needlestick cover benefit amount doesn't increase under inflation protection.

The maximum combined amount we'll pay for either covered event under all policies issued by us is $2,000,000. This doesn't include any TPD benefits or income protection benefits.

Your policy includes these features automatically

Your policy automatically includes the following features.

Feature name	What this feature does
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 82.
Inflation protection	Increases cover every year, unless declined by you, without health assessment.
Waiver of premium	Premiums are waived while we're paying a *monthly benefit*.
Medical professionals feature (plus only)	Provides special terms for medical professionals who contract HIV, hepatitis B, or C and have their occupational duties restricted as a result.
Waiting period reduction feature	Allows for a 1-year or 2-year waiting period to be reduced to a 1-year or 90-day waiting period if the life insured leaves an employer and their salary continuance cover through their employer ends as a result.
Involuntary unemployment	Premiums are waived for up to three months if the life insured is involuntarily unemployed. This feature isn't available if the life insured has a high-risk occupation, which are occupations we describe on the policy schedule as 'special risk' or SR.
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover, and you can't make a claim. Up to 12 months of suspension can be taken over the life of the policy. Cover suspension is explained on page 81. This feature isn't available if the cover is funded by a platform account.

Inflation protection

We'll increase your insurance cover each year to protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary.

The benefit amount is increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

If there is no increase in CPI, then no increase will be offered.

You don't have to accept CPI increases. As income protection claims are based on the life insured's *income*, please take care to ensure that your *insured monthly benefit* remains aligned with *income* to avoid paying any unnecessary premium. If you don't want any increase we offer, you can:

- reject one increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection increases apply automatically during any claim that continues beyond a policy anniversary. 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 after the claim is finalised and won't apply to the calculation of benefits during a claim.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

Waiver of premium

We'll waive any premium due while a *monthly benefit* is payable, even if the amount payable is reduced to nil because offsets apply. We'll also refund premium paid for the waiting period if we pay a *monthly benefit*.

Medical professionals feature

This feature only applies to Zurich Income Protector Plus.

If a medical professional contracts HIV, hepatitis B or hepatitis C, professional guidelines may restrict their ability to perform certain procedures. Inability to practice will reduce income well before the *sickness* results in a physical inability to perform occupational duties.

We'll take these professional guidelines into account when we assess the life insured's ability to perform their *important income-producing duties*. This will allow them to meet the definition of *totally disabled* or *partially disabled*, if the following conditions are met:

- the life insured is a medical professional with an occupation class of A1M on the policy schedule
- the life insured becomes infected with HIV, hepatitis B or hepatitis C which is confirmed by documented proof
- when the life insured is infected, their usual income-producing duties include exposure-prone procedures, as defined by the relevant professional governing body
- based on professional governing body guidelines in their state, the life insured must stop performing exposure-prone procedures due to their HIV or hepatitis B or hepatitis C status
- the life insured is eligible for the total or partial disability benefit, apart from a physical inability to work.

The medical professionals feature won't apply if:

- a treatment is available which renders the HIV or hepatitis B or hepatitis C virus (whichever applies) inactive and non-infectious
- the life insured 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 was available before infection.

Waiting period reduction feature

This feature is designed to provide flexibility to policies which have a waiting period of 1-year or 2-years because the life insured has salary continuance cover through their employer. We'll allow the waiting period to be reduced to 1-year or 90-days if the salary continuance cover ends because the life insured changes employer.

This feature isn't available if any of the following apply. 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 when you apply to reduce the waiting period
- isn't working in full-time paid employment with a new employer.

You must request a waiting period reduction within 30 days of the life insured ending employment with the employer who provided salary continuance cover. You'll need to provide us with evidence to support your request, which means evidence of the salary continuance cover, and of the change in employment.

Your premium will be adjusted to reflect any change made to the waiting period under this feature.

Involuntary unemployment

This feature doesn't apply to any life insured who is either:
- self-employed
- working in a high-risk occupation, which we describe on the policy schedule as 'special risk' or SR.

We'll waive the premium for up to three months if all the following apply:
- the life insured is involuntarily unemployed, other than as a direct result of *sickness* or *injury*
- the life insured is registered with an employment agency
- unemployment started at least 12 months after the start of the policy or, if the policy is ever reinstated, the date of reinstatement
- at least 12 months has passed since we last waived premium under this feature.

'Involuntary unemployment' means that the life insured becomes unemployed due to retrenchment, redundancy, or employer insolvency. It also includes furlough, but only where the life insured is not receiving *income*. Involuntary unemployment doesn't 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.

We apply offsets to income benefit payments

Offsets are applied to payments received in the same month that we pay a total disability benefit, specified injury benefit, or confined to bed benefit.

If your policy isn't held in superannuation

We'll offset other disability income policies that weren't disclosed to us in your application.

The other offsets below only apply if the life insured's occupation category is A3, A4, B1, B2, B3 or SR, as shown on the policy schedule.

The monthly benefit amount will be reduced by payments from any of the following sources which are paid due to the life insured's *sickness* or *injury*:
- workers' compensation
- common law settlements
- other legislated benefits.

If your policy is held in superannuation

The monthly benefit amount will be reduced by payments from any of the following sources which are paid due to the life insured's *sickness* or *injury*:
- sick leave entitlements
- other disability income policies
- workers' compensation
- common law settlements
- other legislated benefits.

What we won't offset

We won't offset a benefit which 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
- a lump sum total and permanent disablement or trauma benefit

Further, we won't include these payments as *post-disability income*.

What we mean by some of the terms we use in this section

For these offsets:
- a disability income policy is any personal or group disability insurance policy, which is also known as income protection. It includes cover under a mortgage repayment policy or consumer credit insurance policy, which pays a regular benefit due to the life insured's *sickness* or *injury*.
- where amounts are paid or payable in a lump sum and can't be allocated to specific months, 1/60th of the lump sum will be applied to each month for a maximum period of five years.

What this policy doesn't cover

Exclusions under income protection cover

We won't pay any benefits for *sickness* or *injury* occurring as a direct or indirect result of any of the following:
- an intentional self-inflicted act
- attempted suicide
- *uncomplicated pregnancy or childbirth*
- an act of war, whether declared or not. War doesn't include acts of terrorism
- any event or medical condition specified as an exclusion on the policy schedule.

When we won't pay a benefit:

We won't pay a benefit:
- for any period while the life insured is in jail
- if the life insured unreasonably refuses to undergo the medical treatment including rehabilitation to treat their condition as recommended by their *medical practitioner*
- 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
  - for any increase in the *insured monthly benefit*, the date of the increase
- for a disability where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

The needlestick cover option has specific exclusions

We don't cover infection with Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus or for hepatitis B or hepatitis C where infection is acquired by sexual activity or recreational intravenous drug use.

A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if:
- a medical cure is found for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus (whichever applies)
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious.

A benefit isn't payable for hepatitis B if:
- a medical cure is found for hepatitis B
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis B, before making a claim.

A benefit isn't payable for hepatitis C if:
- a medical cure is found for hepatitis C
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis C, before making a claim
- the life insured hasn't yet taken at least two Australian government subsidised courses of treatment (or an equivalent treatment program) which could result in a cure, before making a claim.

We won't pay more than one benefit at a time

We'll 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 disability benefit and specified injury benefit
- total disability benefit and trauma advancement benefit
- partial disability benefit and specified injury benefit
- 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.

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

Superannuation restrictions and limitations apply

If the policy is issued to a superannuation trustee, we'll only pay benefits that the trustee can release under superannuation law when the claim is assessed. Benefits are capped at the superannuation payment limit, which is explained on page 60.

Income protection benefits are only payable if the life insured meets the superannuation definition of temporary incapacity or permanent incapacity. If superannuation optimiser applies, any benefit for permanent incapacity is payable under the non-superannuation component.

When the benefits end

When the insured monthly benefit ends

The *insured monthly benefit* ends when one of the following happens:
- the *insured monthly benefit* end date
- death of the life insured
- when the policy ends.

When the optional benefits end

Each optional benefit ends when one of the following happens:
- when we receive written instruction to cancel the option
- the optional benefit end date
- when the policy ends.

Some optional benefits don't have an end date shown on the policy schedule. In that case, the optional benefit ends when the policy ends, unless the benefit explanation specifies an earlier end date.

When the policy ends

The policy ends when one of the following happens:
- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium within 30 days of its due date
- the related policy ends (if superannuation optimiser applies)
- when we receive written instruction to cancel this policy
- death of the life insured unless a benefit continues to be payable under the family care option.

Zurich Business Expenses

Zurich Business Expenses covers your business future when you're not working

Business expenses insurance provides a *monthly benefit* that can reimburse ongoing fixed business expenses or the costs to hire a replacement employee while the life insured is disabled due to a *sickness* or *injury*.

The policy conditions for Zurich Business Expenses are set out in this section.

The benefits payable under this policy depend on the cover you select

Two types of cover are available. Both are based on the actual monthly expenses of the business, but one covers expenses and the other covers the cost of a key person to replace the life insured. In both cases, the maximum we'll pay is the *insured monthly benefit*.

Benefit type	How this benefit type works
Ongoing fixed expenses	We pay a benefit based on *allowable business expenses* incurred each month. You can insure up to 100% of *allowable business expenses* which include items such as rent on a business premises, electricity, and rates.
Key person replacement	We pay a benefit based on *key person replacement costs* incurred each month to replace the life insured in the business. No benefit is payable if there are no costs incurred in any month. You can insure up to 75% of *key person replacement costs*.

Business expenses benefit amount

The *insured monthly benefit* is the maximum amount that is payable for any month.

When we pay a benefit, we first calculate the business expenses benefit amount. The calculation depends on the benefit type selected, which is shown on your policy schedule. While the benefit payable will never exceed the *insured monthly benefit*, in some cases it may be less than the *insured monthly benefit*.

The business expense benefit amount for ongoing fixed expenses, is the lower of:
- the *insured monthly benefit* on the date of disability
- the life insured's share of monthly *allowable business expenses* incurred while they are *totally disabled* or *partially disabled*.

The business expense benefit amount for key person replacement, is the lower of:
- the *insured monthly benefit* on the date of disability
- 75% of the monthly *key person replacement costs* incurred while the life insured is *totally disabled* or *partially disabled*.

After we pay a business expenses claim, if the life insured's disability recurs from the same cause or a related cause, we'll treat this as a continuation of the same claim. The policy conditions that apply to the related claim will be those that applied at the start of the original claim. And the maximum benefit of 24-times the *insured monthly benefit* will apply across the combined claims.

If a related claim occurs:
- within six months of returning to work, the waiting period won't apply
- more than six months after returning to work, the waiting period will apply.

A related claim doesn't only mean claiming twice for the same *sickness* or *injury* and can be claims affecting different parts of the body. An example of different insured events that we would consider related are damaged knees, claimed at different times. Both knees could be damaged seriously enough to meet our definition of *totally disabled*. However, if the disability is due to degenerative damage, then the cause of the second claim would be the same as, or related to, the cause of the first claim.

We'll apply offsets to any benefit payments

See the section 'We apply offsets to business expenses benefit payments' on page 52.

Zurich Business Expenses policy conditions

The information below forms part of the Zurich Business Expenses policy conditions. Words or expressions shown in *italics* have their meaning explained in the 'Definitions' section.

When we accept your application, we'll issue a policy schedule. The policy schedule shows:
- the life insured covered under the policy
- if the benefit type is ongoing fixed expenses or key person replacement
- the *insured monthly benefit* at the start of the policy
- the benefit period
- the waiting period
- any extra-cost optional benefits selected
- the premium structure
- benefit end dates
- any special conditions that apply to your policy specifically.

The life insured is only covered for the benefits and amounts shown on the policy schedule. Each benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefits end' on page 53.

You can make changes to your policy. If you apply for the optional benefit or to increase the benefit amount after the policy starts, changes are only effective if we accept the application after assessing the life insured's health, occupation, and pastimes.

This policy covers disability that prevents the life insured from working

This section explains when benefits become payable.

Benefits payable under business expenses cover

If the life insured is covered under the policy and an insured event occurs, the following benefits are payable.

The insured event must occur both:
- while this benefit and policy is in-force
- before the *insured monthly benefit* ends.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 53.

Benefit name	What this benefit pays
Total disability benefit	We'll pay a benefit if the life insured is *totally disabled* after the waiting period.
Partial disability benefit	We'll pay a proportion of the total disability benefit if the life insured is *partially disabled* after the waiting period.
Funeral benefit	We'll pay a lump sum of four-times the *insured monthly benefit* to help with immediate expenses if the life insured dies during a claim.

When we determine the benefit payable in each month, we'll apportion pre-paid or accrued *allowable business expenses* and *key person replacement costs* over the period they relate to.

Two important aspects of this policy are the selected waiting period and the benefit period

Both are shown on your policy schedule.

The **waiting period** is the period of time the life insured must be disabled before we'll pay a benefit.

The waiting period begins on the date of disability, which is when all the following occur:

- the life insured is *totally disabled* or *partially disabled* due to *sickness* or *injury*
- they have been *totally disabled* for at least five consecutive days
- they have consulted a *medical practitioner* about their disability.

The **benefit period** is the maximum period of time that we'll pay a *monthly benefit* when the life insured suffers from the same or a related *sickness* or *injury* during the life of the policy.

The benefit period for any claim starts at the end of the waiting period.

If payments have been made for the entire benefit period, a new benefit period for an unrelated condition can only start after the life insured makes a successful return to work. A successful return to work means working an average of at least 20 hours per week for six months, during which time the life insured isn't *totally disabled* or *partially disabled*.

Total disability benefit

We'll 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
- remains *totally disabled* after the waiting period ends.

The total disability benefit payable is the business expenses benefit amount, reduced by any offsets that apply. Offsets are explained on page 52.

The total disability benefit is paid 15 days after the waiting period ends, provided claim requirements are met, and monthly in arrears after that. If the claim ends part-way through a month, we'll pay a proportionate benefit. Benefits for any period shorter than two weeks are paid as 1/30th of the total disability benefit for each day.

The total disability benefit is payable until one of the following happens:

- the life insured is no longer *totally disabled*
- the benefit period ends
- the *insured monthly benefit* end date
- when the policy ends
- death of the life insured.

Partial disability benefit

We'll 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 the waiting period
- remains *partially disabled* after the waiting period ends.

This is how we calculate a monthly benefit, depending on the benefit type you choose:

Ongoing fixed expenses

The partial disability benefit is calculated using this formula:

$$\frac{\textit{pre-disability business income} - \textit{post-disability business income}}{\textit{pre-disability business income}} \times \text{the monthly amount we'd pay if the life insured was eligible for a total disability benefit (before applying any offsets)}$$

Key person replacement

The partial disability benefit is calculated as the lower of:

- the business expenses benefit amount
- a portion of the *insured monthly benefit* based on hours worked, as shown below.

Hours worked per week	Maximum percentage of the *insured monthly benefit*
Up to 15 hours	75%
More than 15 hours but less than 30 hours	50%
30 hours or more	25%

The partial disability benefit will then be reduced if any offsets apply. Offsets are explained on page 52.

The partial disability benefit is payable 15 days after the waiting period ends, provided claim requirements are met, and monthly in arrears after that. If the claim ends part-way through a month, we'll pay a proportionate benefit. Benefits for any period shorter than two weeks are paid as 1/30th of the partial disability benefit for each day.

The partial disability benefit is payable until one of the following happens:

- the life insured is no longer *partially disabled*
- the benefit period ends
- the *insured monthly benefit* end date
- when the policy ends
- death of the life insured.

Funeral benefit

We'll pay the funeral benefit if the life insured dies while the total disability benefit, partial disability benefit or day 4 accident benefit is payable.

We'll pay a lump sum of four-times the *insured monthly benefit*, up to a maximum of $75,000.

You can purchase an optional benefit to boost your cover

You can select the optional day 4 accident benefit when you apply for your policy and it will apply from the policy start date. You can also add the option after your policy starts.

The day 4 accident benefit is summarised in the table, and the policy conditions are set out below.

Day 4 accident benefit only applies if it is shown on the policy schedule.

Option name	What this option does
Day 4 accident option	Pays benefits during the waiting period if the life insured is disabled due to *injury*. This option is only available with waiting periods of 14-days or 30-days.

Day 4 accident option

We'll pay the day 4 accident benefit if the life insured is *totally disabled* due to an *injury* for more than three consecutive days during the waiting period. We'll pay 1/30th of the total disability benefit for each day of the waiting period that the life insured continues to be *totally disabled* solely due to *injury*.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

Your policy includes these features automatically

Your policy automatically includes the following features.

Feature name	What this feature does
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 82.
Inflation protection	Increases cover every year, unless declined by you, without health assessment.
Future insurability	Allows an increase in cover without health assessment every year.
Waiver of premium	Premiums are waived while we're paying a *monthly benefit*.
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover and you can't make a claim. Up to 12 months of suspension can be taken over the life of the policy. Cover suspension is explained on page 81.

Inflation protection

We'll increase your insurance cover each year to protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary.

The benefit amount is increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

If there is no increase in CPI, then no increase will be offered.

You don't have to accept CPI increases. As business expenses claims are based on your situation at time of claim, please take care to ensure that your *insured monthly benefit* remains aligned with your ongoing fixed expenses or key person costs to avoid paying any unnecessary premium. If you don't want any increase we offer, you can:

- reject one increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

Future insurability

This feature allows you to increase cover by up to 15% when there is an increase in the value of your business, without any further health assessment. Cover can only be increased in line with an increase in the value of the business arrangement.

You'll need to provide evidence to show that the financial position of the business supports the increase. An increase can be made once in each policy year.

The following maximums apply to any increase. The amounts are based on the *insured monthly benefit* at the date when you apply for the increase.

For ongoing fixed expenses, the *insured monthly benefit* can't exceed:

- the life insured's share of monthly *allowable business expenses*
- $60,000 per month (this includes existing business expenses or income protection insurance with us or another insurer).

For key person replacement, the *insured monthly benefit* can't exceed:

- 75% of the *key person replacement costs*
- $60,000 per month (this includes existing business expenses or income protection insurance with us or another insurer).

The combined total of all increases to the *insured monthly benefit* made under this feature can't exceed the *insured monthly benefit* originally issued.

Any special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

You can't increase cover if:

- the change in business value is $500 or less
- the life insured's share of *business income* has decreased in the last 12 months
- the policy has been in-force for less than 12 months
- the policy was issued with a medical premium loading of 75% or more
- the change in business value occurs after the policy anniversary when the life insured is 54
- we've paid a claim for the life insured under any income protection or business expenses insurance
- the life insured is eligible to claim under any income protection or business expenses insurance held with us.

Waiver of premium

We'll waive any premium due while a *monthly benefit* is payable, even if the amount payable is reduced to nil because offsets apply. We'll also refund premium paid for the waiting period if we pay a *monthly benefit*.

We apply offsets to business expenses benefit payments

Any business expenses benefit we pay for the total or partial disability benefit will be reduced if you're also receiving benefits for *sickness* or *injury* from another source.

If the benefit type is ongoing fixed expenses:

- we'll reduce the business expenses benefit we pay by the amount of any business expense benefit you receive under another similar policy
- we'll only reduce the business expenses benefit payable to ensure that your combined benefit doesn't exceed 100% of *allowable business expenses*
- we won't apply an offset if you told us about the other cover when you applied for this policy and we agreed in writing not to apply a reduction.

If the benefit type is key person replacement:

- we'll reduce the business expenses benefit we pay by the amount of any business expense benefit or disability income benefit you receive under another similar policy
- we won't apply an offset if you told us about the other cover when you applied for this policy and we agreed in writing not to apply a reduction
- we'll reduce the benefit we pay under this policy to nil if an income protection benefit is payable for the same period and it exceeds the benefit that we would otherwise pay under this policy.

If the benefit type is ongoing fixed expenses, and more than one person generates income in the life insured's business, we'll apportion *allowable business expenses* in equal proportion to work out the life insured's share.

What this policy doesn't cover

Exclusions under business expenses cover

We won't pay a benefit for a disability caused directly or indirectly by any of the following:

- an intentional self-inflicted act
- attempted suicide
- *uncomplicated pregnancy or childbirth*
- an act of war, whether declared or not. War doesn't include acts of terrorism
- any event or medical condition specified as an exclusion on the policy schedule.

When we won't pay a benefit:

We won't pay a benefit:

- for any period while the life insured is in jail
- for key person replacement, if the life insured is no longer employed by your business or stops being a business owner before the claim
- if the life insured unreasonably refuses to undergo medical treatment including rehabilitation to treat their condition, as recommended by their *medical practitioner*
- 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
  - for any increase in the *insured monthly benefit*, the date of the increase
- for any *allowable business expenses* or *key person replacement costs* that aren't supported by evidence
- for a disability where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct.

We won't pay more than one benefit at a time

We'll 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 disability benefit and day 4 accident benefit
- partial disability benefit and day 4 accident benefit.

For key person replacement, we won't pay any benefit for the same period that we're paying an income protection insurance benefit for the same life insured.

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

When the benefits end

When the business expenses benefit ends

The business expenses benefit ends when one of the following happens:

- the *insured monthly benefit* end date
- death of the life insured
- when the policy ends.

When the day 4 accident option ends

The day 4 accident option ends when one of the following happens:

- when we receive written instruction to cancel the option
- the optional benefit end date
- when the policy ends.

When the policy ends

The policy ends when one of the following happens:

- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium within 30 days of its due date
- when we receive written instruction to cancel this policy
- death of the life insured.

Zurich Child Cover

Zurich Child Cover covers your children for certain health events

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 unexpected expenses resulting from your child's sickness or injury. Or it could allow you or your *partner* to take time off work to care for your child while they're unwell.

Multiple children can be covered under the one policy.

The policy conditions for Zurich Child Cover are set out in this section.

These benefits are payable under child cover

Benefit name	What this benefit pays
Trauma benefit	We'll pay the child cover benefit amount if an insured child suffers one of 18 covered conditions.
Injury advancement benefit	Advances $10,000 is if an insured child suffers one of the following: • *loss of a hand or foot or sight in one eye* • *severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days).*
Carer benefit	We'll pay a monthly carer benefit of $5,000 if the policy owner or the policy owner's *partner* stops full-time paid work to care for an insured child at home (unless a trauma benefit is payable). This benefit only applies if the child cover benefit amount is $200,000 or more.
Death & terminal illness benefit	We'll pay a lump sum of up to $200,000 on death or diagnosis of *terminal illness*.

Zurich Child Cover policy conditions

The information below forms part of the Zurich Child Cover policy conditions. Words or expressions shown in *italics* have their meaning explained in the 'Definitions' section.

When we accept your application, we'll issue a policy schedule. The policy schedule shows:

- each insured child covered under this policy
- the benefit amount that applies to each insured child at the start of the policy
- the benefit end date for each insured child
- any special conditions that apply to your policy specifically.

Each insured child is only covered for the amount shown on the policy schedule. The benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefit ends' on page 58.

You can make changes to your policy. If you apply to add an insured child or to increase the benefit amounts after the policy starts, changes are only effective if we accept your application after assessing the child's health.

Cover is automatically increased in line with inflation each year unless you contact us with alternate instructions. Your options are explained in the section 'Inflation protection' on page 57.

This policy covers children for traumatic health events, terminal illness and death

This section explains when benefits become payable.

Benefits payable under child cover

If the insured child is covered under the policy and an insured event occurs, the following benefits are payable.

The insured event must occur both:

- while this benefit and policy is in-force
- before the child cover benefit ends.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 58.

Trauma benefit

We'll pay the child cover benefit amount if the insured child is diagnosed with any one of the insured trauma conditions listed in the table on the next page. Our insurance definition for each covered condition can be found in the section 'These definitions are specific to trauma cover', starting on page 99. The definitions describe health events at a specified severity. We won't pay a benefit if the insured child's condition doesn't meet our specific definition.

The amount payable is the child cover benefit amount on the date when the definition is met.

A 90-day exclusion period applies to trauma conditions in the list marked with an asterisk (*). The exclusion period applies when you apply for cover and if cover is ever reinstated. See 'What this policy doesn't cover' on page 58.

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 meeting the definition.

We'll only pay the trauma benefit for one insured trauma condition for each insured child.

Insured trauma conditions for the child trauma benefit

Cancers and tumours at the specified severity

benign tumour in the brain or spinal cord (with neurological deficit)
*cancer (excluding early stage cancers)**

Heart condition at the specified severity

cardiomyopathy (with significant permanent impairment)

Severe accident, loss of sight, hearing, speech, limbs, and paralysis

diplegia
hemiplegia
loss of hands, feet or sight
loss of hearing
loss of sight
loss of speech
major head trauma (with permanent neurological deficit)
paraplegia
quadriplegia
severe burns (of specified extent)

Neurological conditions at the specified severity

bacterial meningitis or meningococcal septicaemia (with severe life impact)
encephalitis (with permanent neurological deficit)
*stroke (of specified severity)**

Other serious covered conditions at the specified severity

chronic kidney failure (end stage)
major organ transplant (or waiting list)

Injury advancement benefit

We'll advance $10,000 if an insured child suffers one of the following extra insured events:

- *loss of a hand or foot or sight in one eye*
- *severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days).*

We'll only pay the injury advancement benefit for one insured event for each insured child. The child cover benefit amount applying to an insured child is reduced by the amount advanced under this benefit.

Carer benefit

This benefit only applies if the child cover benefit amount is $200,000 or more.

We'll pay a monthly carer benefit of $5,000 if the policy owner or the policy owner's *partner* stops full-time paid employment to care for an insured child at home.

The insured child must be confined to bed for a minimum of five consecutive days and must be following the advice and recommended treatment of a *medical practitioner*.

This benefit isn't payable if the trauma benefit has been paid or is payable. This benefit is payable 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 only payable for one carer, which can either be the policy owner or their *partner*.

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

Under this benefit, 'full-time paid employment' means working 20 hours or more per week in paid work.

Terminal illness benefit

We'll advance the death benefit if an insured child is diagnosed with a *terminal illness*.

The amount we'll advance is the death benefit amount on the date the insured child's *terminal illness* is certified, even if we don't see the certifications until a later date.

Death benefit

We'll pay the death benefit if an insured child dies.

The death benefit is the lower of:

- the child cover benefit amount for the insured child
- $200,000.

Your policy includes these features automatically

Your policy includes the following features.

Feature name	What this feature does
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 82.
Inflation protection	Increases cover every year, unless declined by you, without health assessment.
Cover increase feature	Allows a $10,000 increase in cover without health assessment on the insured child's 6th, 10th, and 14th birthdays.
Continuation of cover	Allows the insured child to convert to an adult policy without health assessment once they reach age 15.
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover and you can't make a claim. Up to 12 months of suspension can be taken over the life of the policy. Cover suspension is explained on page 81.

Inflation protection

We'll increase your insurance cover each year to protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary.

The child cover benefit amount is increased by the higher of:
- 5%
- any increase in *consumer price index* (CPI).

Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

You don't have to accept any increase we offer. You can:
- reject one increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

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

Cover increase feature

You can increase the child cover benefit amount for each insured child by $10,000 on their 6th, 10th, and 14th birthdays, without health assessment.

This feature can be used provided:
- cover for the insured child won't exceed the maximum of $500,000
- we haven't paid a benefit and there is no entitlement to a benefit under this policy for the insured child.

The feature can only be used within 30 days of any of the specified birthdays.

Continuation of cover

An insured child can apply to continue cover under their own policy once they're 15 years old, without assessment of health.

Within 30 days of any policy anniversary after the insured child's 15th birthday, they can apply in writing for a new death and trauma cover policy for the same benefit amount. We'll ask if they're a smoker, so that we can charge the correct premium, but won't assess any other aspects of their health.

The new policy will be the most comparable policy we offer when the insured child applies to continue cover. The premiums for the new policy will be those applying when it is issued. Any special conditions, exclusions, or premium loading that applied to the original policy may also apply to the new policy.

Continuation of cover is only available if we haven't paid a benefit under this policy for the insured child.

What this policy doesn't cover

Exclusions under child cover

We won't pay a benefit if an insured event is caused directly or indirectly by any of the following:

- an intentional self-inflicted act in the first 13 months
- attempted suicide in the first 13 months
- an act of the policy owner or person who will otherwise be entitled to the benefit payable, intending to harm the insured child
- any event or medical condition specified as an exclusion on the policy schedule.

A 90-day elimination period applies to some trauma conditions

Some insured trauma conditions have a 90-day elimination period. The elimination period applies to the trauma conditions on page 56 that are marked with an asterisk (*).

We won't ever pay a claim for those trauma conditions if, during the elimination period, either of the following happens:

- the condition occurs, is first diagnosed, or the symptoms leading to diagnosis are apparent
- surgery for the condition is recommended for the insured child.

'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition.

The elimination period starts when a fully completed child cover application is lodged with us. For cover increases, the elimination period starts on the benefit start date of any increase in child cover benefit.

The same 90-day elimination period applies to the policy when there is a break in cover and the policy re-starts. The elimination period starts from the date the policy is reinstated or after cover suspension, from the cover suspension end date.

We won't apply the 90-day elimination period if immediately before the child cover started, the insured child was covered under another policy for the same insured event with us or another insurer for more than 90 days, and we replaced it. We'll only waive the elimination period on the amount of benefit we replaced. This waiver can also apply to any increases in the benefit that meet the same criteria.

Any claim we pay reduces the amount available for further claims

When a benefit is paid under the policy, the death and trauma benefits are reduced by the amount paid, and the premium is re-calculated. The new premium will be based on the reduced levels of cover from the next premium due date after payment of the relevant benefit.

Death cover benefit reductions

The death benefit amount is reduced by the amount paid or advanced, under any of the following:

- terminal illness benefit
- trauma benefit
- injury advancement benefit.

Trauma cover benefit reductions

The trauma benefit amount is reduced by the amount paid or advanced, under any of the following:

- terminal illness benefit
- injury advancement benefit.

When the benefit ends

The child cover benefit ends for each insured child when one of the following happens:

- payment of the child cover benefit amount
- when we receive written instruction to cancel the benefit
- the child cover benefit end date shown on the policy schedule
- the policy anniversary when the insured child is 18
- the death of the insured child
- when the policy ends.

When the policy ends

The policy ends when one of the following happens:

- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium within 30 days of its due date
- when we receive written instruction to cancel this policy
- the policy anniversary when the last insured child is 18
- payment of 100% of the child cover benefit relating to the last insured child under the policy
- death of the last insured child covered under the policy.

Holding this insurance in superannuation

Holding insurance cover in superannuation can be tax effective

Holding insurance in superannuation can be a tax-effective strategy which doesn't affect your day-to-day cashflow.

If you use superannuation to fund insurance, then depending on the fund, you may be eligible for a 15% tax saving that the trustee passes on to members.

However, using superannuation savings to fund insurance will reduce your retirement savings. Please discuss this option with your financial adviser to make sure that it is an appropriate option for you personally.

The owner of the policy is the trustee of the relevant fund

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

If a benefit becomes payable under a policy held within superannuation, we'll pay it to the trustee. The trustee must pay the benefit in line with the governing rules of the superannuation fund and superannuation law.

Self-managed superannuation funds

If you're the trustee of a self-managed superannuation fund, it's 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
- superannuation law that limits when you can pay benefits out of the fund.

Eligible superannuation funds

If you don't have a self-managed superannuation fund, Zurich Wealth Protection policies are also available through *eligible superannuation funds* where the trustee is the policy owner, and the life insured is a fund member. The trustee is solely responsible for paying the premium for the member by the due date from the member's account or contributions.

In this situation, we may agree with the trustee to send notices to the life insured directly, so that you receive up to date information about your insurance.

You can find more information about applying for insurance within superannuation through membership of an *eligible superannuation fund* in the PDS and other documents issued by the fund trustee.

Restrictions apply to insurance held in superannuation

Superannuation fund trustees must ensure that insurance benefits are aligned with the superannuation payment rules under superannuation law. We've applied restrictions to the insurance benefits we offer to superannuation fund trustees in line with these requirements.

The only types of insurance that we allow to be held within superannuation are death cover, TPD cover and income protection.

The following terms have definitions under superannuation law. 'Superannuation law' includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations. We'll use these terms and apply the limit as if we're the trustee of the relevant superannuation fund and the life insured is a member of the fund.

Temporary incapacity is a term used in superannuation law which generally refers to situations when income protection benefits can be paid.

To meet the definition, the life insured must stop paid work (also defined under superannuation law) due to *sickness* or *injury* for a period of at least one full day during the waiting period.

Permanent incapacity is a term used in superannuation law which generally refers to situations when TPD benefits can be paid.

To meet the definition, the life insured must have all the necessary certifications required to establish permanency in superannuation law.

Superannuation payment limit is the maximum insurance benefit amount that can be paid to a member of a superannuation fund under superannuation law and applies to superannuation income protection benefits.

The limit is designed to make sure the life insured doesn't receive more in total during a claim (including all insurance benefits and income) than before a claim. The benefit we pay under the policy for any month is capped to avoid this happening.

How superannuation restrictions affect death, TPD and trauma cover

Death cover in superannuation

If death cover is held in superannuation, any claim for terminal illness must meet the extra certification requirements set out in the definition of terminal illness. This definition can be found on page 97.

TPD cover in superannuation

If TPD cover is held in superannuation, when you make a claim, the life insured must also meet the superannuation definition of permanent incapacity.

If your insurance is held in superannuation, the following TPD benefits are excluded:
- TPD advancement benefit
- partial impairment benefit (platinum only).

TPD cover can be structured within superannuation in two ways:
- wholly within superannuation, with a permanent incapacity restriction
- held across two policies under the superannuation optimiser structure. Benefits that don't meet the superannuation definition of permanent incapacity are excluded from the superannuation policy but will be held on a non-superannuation policy.

Your policy schedule will show which structure applies to your policy.

If you choose to move your TPD cover outside of superannuation by cancelling and replacing it without health, financial, and occupational assessment, the TPD cover on the new policy will also be subject to the permanent incapacity restriction. If your policy is subject to this restriction, it will be shown on your policy schedule.

Trauma cover can't be held in superannuation

Trauma cover can't be held in superannuation, as trauma benefits aren't aligned with the superannuation payment rules under superannuation law.

You can use superannuation optimiser to make TPD and trauma cover more flexible

Superannuation optimiser can apply to TPD cover held:

- across two policies (this applies to all TPD with an own occupation definition and platinum TPD when held within superannuation)
- in one policy (either within or outside superannuation linked to other cover on another policy).

It can also apply to trauma cover held:

- in one policy (outside superannuation linked to other cover on a superannuation policy).

TPD cover held across two policies

When superannuation optimiser applies and TPD cover is held across two policies, one of the policies is issued to the trustee of a superannuation fund. This is the superannuation policy and the TPD cover on this policy is the superannuation component. The remainder of the cover is issued on a non-superannuation policy and the TPD cover on this policy is the non-superannuation component. We'll determine which policy will pay a benefit based on the information available when we assess your claim. The two policies are known as 'related' policies.

As explained in 'Benefits payable under TPD cover' on page 12, the definition of TPD converts to *modified TPD* on the policy anniversary when the life insured is 65. The TPD cover under the non-superannuation policy will end on the policy anniversary when the life insured is 65. From then on, only the superannuation policy will provide TPD cover and it will be *modified TPD*.

The TPD cover under each related policy is explained in the table below.

Superannuation component	Non-superannuation component
All TPD claims are first assessed under the TPD benefit of this policy.	Claims are assessed under the TPD benefit of this policy only once it has been determined that no claim is payable under the superannuation component.
The life insured meets both of these definitions: • *total and permanent disablement* • permanent incapacity (under superannuation law).	The life insured meets the definition of *total and permanent disablement* but doesn't meet the superannuation definition of permanent incapacity.

TPD claims under the superannuation policy

If a TPD claim is made, an assessment will first be made under the superannuation component to determine if:

- the life insured meets the definition of TPD shown on the policy schedule
- the life insured meets the superannuation definition of permanent incapacity.

If both requirements are met and a benefit is payable under the superannuation policy, we'll pay the benefit to the trustee of the superannuation fund. The trustee will release the benefit from the superannuation fund to the member, subject to the governing rules of the superannuation fund and superannuation law.

TPD claims under the non-superannuation policy

If both requirements aren't met, the claim will then be assessed under the non-superannuation component. The life insured may meet the definition of TPD shown on the policy schedule but not meet the superannuation definition of permanent incapacity. In this case, the benefit is paid directly to the policy owner of the non-superannuation policy and isn't subject to fund governing rules or superannuation law.

The TPD advancement benefit and partial impairment benefit (which forms part of platinum TPD), are only payable under the non-superannuation policy.

Where cover is split across policies, they must stay in step with each other

The amount of the TPD cover under each policy must always be equal. A payment under one policy which reduces the TPD cover will also reduce the TPD cover under the related policy, as well as reducing the sums insured of any other linked covers under the two policies.

If you request a decrease to the TPD cover, it will be applied to both policies. Similarly, if you apply to increase the TPD cover, you must apply to increase the cover on both policies. If the TPD cover is cancelled on one of the policies, the TPD cover on the other policy will also end. If one of the policies is paid in advance, we'll refund any unused premiums. If cover suspension is taken, it will be applied to both policies at the same time.

TPD cover held in one policy

When superannuation optimiser applies and TPD cover is held in one policy and any death and trauma cover for the life insured is held on another policy, the benefits are linked across the two related policies. A claim for TPD will be assessed under the policy where the TPD cover is held. Benefit payments under either related policy will reduce the benefit payable on the other policy.

Trauma cover held in one policy

When superannuation optimiser applies and trauma cover is held in a non-superannuation policy, any death and TPD cover is held in a related superannuation policy. In this scenario, the benefits are linked across the two related policies and benefit payments under either related policy will reduce the benefit payable on the other policy.

How superannuation restrictions affect income protection

Income protection can be structured within superannuation in two ways:

- wholly within superannuation, with restrictions designed to meet superannuation law or
- via the superannuation optimiser structure. Benefits that don't meet the superannuation definition of temporary incapacity are excluded from the superannuation policy but will be held on a non-superannuation policy.

You can use superannuation optimiser to make income protection more flexible

Income protection cover can be issued as two separate related policies linked to each other under the superannuation optimiser structure.

One policy will be issued to the trustee of a superannuation fund. This is the superannuation policy and the cover it provides is the superannuation component. The income protection benefits held under this policy are restricted by us to ensure any disability payments will be consistent with superannuation law.

The remainder of the cover is issued on a non-superannuation policy and the cover on this policy is the non-superannuation component.

We'll split the cover across two policies

If you take superannuation optimiser with Zurich Income Protector Plus or Zurich Income Protector:

- the specified injury benefit, rehabilitation benefit and accommodation expenses aren't available under the superannuation policy but are available under the non-superannuation policy
- the family care option, lump sum accident option, trauma advancement option, and needlestick cover option can only be included in the non-superannuation policy
- we won't pay a benefit under the superannuation policy for the same period that we pay the specified injury benefit, rehabilitation benefit, or trauma advancement benefit under the non-superannuation policy.

The cover under each related policy is explained in the table below.

Superannuation component	Non-superannuation component
This component pays: • total and partial disability benefits that meet the superannuation definition of temporary incapacity, up to the superannuation payment limit • funeral benefit. Benefits excluded: • if a benefit is payable under the non-superannuation component for specified injury benefit, rehabilitation benefit or trauma advancement benefit, then total and partial disability benefits aren't payable under this component for the same period.	This component pays: • total and partial disability benefits that don't meet the superannuation definition of temporary incapacity • any total and partial disability benefit amounts that exceed the superannuation payment limit • specified injury benefit • accommodation expenses • any benefits payable under these options, if selected: family care option, lump sum accident option, trauma advancement option, and needlestick cover option.

The outcome at claim time is the same as if the cover is issued on a single policy

The total benefits that are payable under the policies together won't exceed the amount that would otherwise be payable if the policy had been issued to a single policy owner. The non-superannuation component only provides cover for a benefit also listed under the superannuation component where, because of the superannuation optimiser restrictions, the superannuation component can't pay the benefits.

The benefit entitlements may be split across the two policies. For example, there may be instances when 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 policies.

When a claim is made, the benefits payable will determine which policy they are paid from. We'll pay the benefit under the appropriate policy based on the information available when the claim assessment occurs.

Income claims under the superannuation policy

Claims for the following benefits are payable under the superannuation policy:
- total disability benefit (including payments under the day 4 accident option, if selected)
- partial disability benefit
- confined to bed benefit
- funeral benefit.

If the life insured meets the superannuation definition of temporary incapacity, then any claim assessment for the total disability benefit, partial disability benefit or confined to bed benefit will first be made under the superannuation policy. Any benefit payable under the superannuation policy will be capped if they will otherwise exceed the superannuation payment limit.

We won't pay benefits from the superannuation policy for the same period that a benefit has been paid or is payable from the non-superannuation policy under the specified injury benefit or trauma advancement benefit.

We'll pay the lower of:
- the benefit amount calculated under the terms of the insurance
- the superannuation payment limit.

If a benefit is payable under the superannuation policy, we'll pay the benefit to the trustee of the superannuation fund. The trustee will release the benefit from the superannuation fund to the member, subject to the governing rules of the superannuation fund and superannuation law.

Income claims under the non-superannuation policy

If you make a claim, the amount payable will be:

- any amount payable under the specified injury benefit, accommodation expenses, rehabilitation benefit or benefit payable under the family care 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 we can't pay under the superannuation policy because the life insured doesn't meet the superannuation definition of temporary incapacity
- any amount payable under the Zurich Income Protector Plus or Zurich Income Protector terms which exceeds the superannuation payment limit that we can't pay under the superannuation policy.

Any benefit that becomes payable for the non-superannuation component is paid to the policy owner of the non-superannuation policy and isn't subject to superannuation law.

Where cover is split across policies, they must stay in step with each other

The policy schedule will show if a policy is related to another policy under superannuation optimiser and the policy number to which it is related. The *insured monthly benefit* under both related policies must always be the same. The benefit period and waiting period under each policy must also be the same. If 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. If one of the policies is paid in advance, we'll refund any unused premiums.

During a claim, we'll apply the policy conditions each month to determine whether a benefit is payable under the superannuation policy or the non-superannuation policy. Sometimes we'll apportion the total amount payable across the two policies. The payment of a benefit under one policy will also count towards the benefit period of the other policy.

Some policy features also stay in step

The following features will also work in step across both policies:

- if we waive premium on one policy because a claim is payable, we'll waive the premiums payable under both policies
- if we waive premium on one policy due to involuntary unemployment, we'll waive the premiums payable under both policies
- if cover suspension is taken, it will be applied to both policies at the same time.

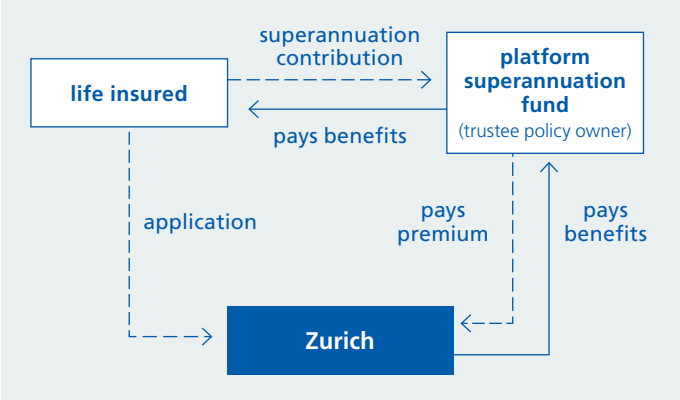
Some superannuation platforms offer our insurance

You can take death cover, TPD cover and income protection cover through selected superannuation platforms. Your financial adviser can tell you which platforms offer our insurance. Platforms offer the convenience of consolidated finances and reporting.

If you include Zurich insurance in your platform account, you'll pay premiums 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 available frequencies may vary by platform.

If premiums aren't 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.

The diagram below shows how this works.



The PDS prepared by the trustee of the platform superannuation fund will contain more information about how the platform works.

Superannuation restrictions apply to platform policies

Restrictions apply to the benefits which can be held in superannuation. In summary, the cover available via a superannuation platform is as follows:

- death cover
- TPD cover which will meet the superannuation definition of permanent incapacity
- income protection cover which will meet the superannuation definition of temporary incapacity.

Benefits which aren't available with superannuation ownership are identified in the section 'Useful parameters for each policy are summarised here', starting on page 67.

Superannuation optimiser can be used to split cover between a superannuation platform policy and a second policy held outside super. Superannuation optimiser is explained earlier in this section of the document.

Applying for cover

Here's how to apply for cover

Here is an easy step-by-step diagram which shows how to put Zurich Wealth Protection cover in place, with the help of your financial adviser.

Work out what you need	The first step involves a discussion with your financial adviser. They will help work out what types of cover you need, how much cover, the most appropriate ownership structure and any tailoring required for your situation. Once the details are agreed with you, you'll be given a personalised premium quote.
Make sure you understand what you're applying for	This document contains all the information you need to know about Zurich Wealth Protection policies. Please read it carefully to make sure you understand the policy or policies you plan to apply for. If you're applying for cover through a superannuation fund, make sure you read the PDS issued by the trustee of that fund as well to understand the implications of taking insurance through super.
Complete an application	We'll ask about the life insured's health, financial situation, lifestyle and pastimes. Your financial adviser will help you complete and submit the application electronically. If you elect to use our Health Connect tele-interview service, then you can provide most of the details over the phone. If you don't want to share that information with your adviser, you can ask us to keep it private.
Up to 90 days of interim cover applies	As soon as you submit an application which includes valid payment details, we provide up to 90 days of interim cover. Interim cover is cover for accidental death and accidental injury, and the cover you have is based on the covers you apply for. Interim cover generally ends when we finish our assessment, which is when we issue a policy or we decline the application. Interim cover is temporary and has its own policy conditions which are set out in the 'Interim cover' section, starting on page 82.
We assess your application	We assess the information in the application. Any health condition the life insured tells us about will be covered under the policy unless we're unable to offer cover or specifically exclude the condition. Depending on factors including age, health, cover applied for and benefit amount we may need more information directly from the life insured, from the life insured's doctor or we may request a medical examination or test. If any medical test we request as part of your application returns an abnormal result, we'll provide that result to the doctor identified in your application. Most applications are assessed without any medical testing.
Any revised terms are agreed with you	If our application assessment results in a premium loading or special exclusion, then your financial adviser will be in touch with you to agree the revised terms. Any revised terms form part of your application and we'll only issue a policy if you agree to them. You can end the process here if you don't want to go ahead with the application on revised terms.
Policy is issued	Once we complete our assessment and accept your application, a policy schedule is created and sent to you. The policy schedule shows the details of the individual policy, including sums insured and cover start and end dates. Any special conditions and exclusions that have been agreed will be shown on the policy schedule.
Store your documents	This document contains the policy conditions. Please keep it together with your policy schedule so that you can find both documents easily if you need to make a claim. You'll also need your documents if you decide to alter your cover.

Only Australian residents can apply for Zurich Wealth Protection policies

These policies are only available to people located in Australia when they apply for cover. We can't accept cash or applications signed and submitted from outside Australia.

Cover is available to Australian residents and people who are in the process of applying for permanent residency and are living in Australia. All parties to any policy issued must be Australian residents, including policy owners, lives insured and the person, company or fund that is paying the premium. The policies are designed for Australian residents and their operation and your rights may be restricted if you or the life insured becomes a resident of another country.

Your duty of disclosure

When completing your application, it's important that you answer the questions correctly. The duty of disclosure applies to you as the proposed policy owner and the proposed life insured. Please familiarise yourself with how the duty of disclosure can affect your application and any policies issued.

The duty of disclosure applies to you and the proposed life insured

Before entering into a life insurance contract, you must tell us anything that you know, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms. The same duty applies to the proposed life insured.

The duty applies until we agree to provide the insurance. After insurance is issued, it applies before the insurance contract is extended, varied or reinstated.

You don't have to tell us about some things

We don't need to be told anything that:

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

The proposed life insured has the same duty

The duty of disclosure applies to you and the proposed life insured (if that's not you). The proposed life insured must also tell us anything they know, or could reasonably be expected to know, that may affect our decision to provide the insurance and on what terms. If they don't do this, their failure to tell us something may be treated as your failure. The consequences of this are set out below.

If we're not told something

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

If we're not told something that we are required to be told, and we wouldn't have insured you if we had been told, we may avoid the contract within three years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance. This would be worked out using a formula that takes into account the premium that would have been payable if there was no failure. If the insurance contract provides death cover, we may only exercise this right within three years of entering into the contract.

If we choose not to avoid the insurance contract or reduce the amount of insurance, we have another option. We may, at any time vary the contract in a way that places us in the same position we would've been in if we'd been told everything we should have been told. This right doesn't apply if the contract provides death cover.

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

You have a 30-day cooling-off period

After we send you a policy schedule, you have 30 days to check that your policy meets your needs. In the 30-day cooling-off period, you can cancel the policy and receive a full refund of any premiums paid, provided you haven't made a claim. Your right to cancel the policy and receive a refund ends if you make a claim or make use of any other rights under your policy in the 30 days.

If your policy has superannuation ownership and we need to refund any contributions made to the policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

How to cancel your policy

To cancel your policy during the cooling-off period or any time after that, choose the most convenient option for you:

- over the phone, provided you are the only policy owner
- in writing as a letter sent by post
- in writing as an email attachment.

Our contact details are on the inside back cover of this document.

Useful parameters for each policy are summarised here

Zurich Protection Plus

Death cover Provides a lump sum payment if the life insured dies or is diagnosed with a terminal illness.		
Entry ages	10 – 70	
End age	99	
Minimum benefit amount	$50,000	
Maximum benefit amount	No maximum – available cover depends on individual needs	
Increasing cover after the policy begins	You can apply for a cover increase until the policy anniversary when the life insured is 69	
	non-superannuation ownership	superannuation ownership
Death cover Benefits and features	• death & terminal illness benefit • advancement for funeral expenses • accidental injury benefit • future insurability for business • future insurability • accommodation expenses • financial planning advice	• death & terminal illness benefit • accidental injury benefit • future insurability • financial planning advice
Optional benefits	• premium waiver option • business future cover option • needlestick cover option	• premium waiver option

Zurich Protection Plus

TPD cover

Provides a lump sum payment if the life insured suffers total and permanent disablement.
You can choose either:

- Platinum TPD, with one of the following TPD definitions: own occupation, any occupation, domestic duties
- TPD, with one of the following TPD definitions: own occupation, any occupation, domestic duties, modified.

Entry ages	15 – 60 15 – 65 (modified definition)
End age	99 (modified definition applies from age 65) 65 if linked to trauma Limited cover applies from the policy anniversary when the life insured is 65 when the definition changes to *modified TPD*, the benefit amount is capped at $3,000,000 and double TPD becomes standard TPD
Minimum benefit amount	$50,000
Maximum benefit amount	• $5 million platinum TPD (own occupation or any occupation definitions) or TPD (own occupation, any occupation, or modified TPD definitions) • $2 million platinum TPD or TPD (domestic duties definition)
Increasing cover after the policy begins	You can apply for a cover increase until the policy anniversary when the life insured is 59

	non-superannuation ownership	superannuation ownership
Platinum TPD Benefits and features	• TPD benefit • TPD advancement benefit • funeral benefit • partial impairment benefit • future insurability • accommodation expenses • financial planning advice	Platinum TPD can't be held in superannuation
TPD Benefits and features	• TPD benefit • TPD advancement benefit • funeral benefit • future insurability • accommodation expenses • financial planning advice	• TPD benefit • funeral benefit • future insurability • financial planning advice
Optional benefits	• double TPD option • buy-back death option • premium waiver option • business future cover option • needlestick cover option	• double TPD option • buy-back death option • premium waiver option

Zurich Protection Plus

Trauma cover Provides a lump sum payment if the life insured suffers a specified trauma condition and meets our definition. You can choose either trauma plus or trauma.	
Entry ages	15 – 59
End age	75
Minimum benefit amount	$50,000
Maximum benefit amount	• $2 million • $1 million (domestic duties)
Increasing cover after the policy begins	You can apply for a cover increase until the policy anniversary when the life insured is 59
Trauma plus Benefits and features	• trauma benefit • paralysis booster benefit • funeral benefit • partial trauma benefit • future insurability • accommodation expenses • financial planning advice
Trauma Benefits and features	• trauma benefit • paralysis booster benefit • funeral benefit • future insurability • accommodation expenses • financial planning advice
Optional benefits	• double trauma option • buy-back TPD option • buy-back death option • trauma reinstatement option • premium waiver option • business future cover option • needlestick cover option

Zurich Income Protector Plus and 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.

You can choose either Income Protector Plus or Income Protector.

Entry ages	19 – 60	
End age	65	
Eligibility The life insured must be in paid work	Full-time and part-time permanent employees or self-employed workers: minimum 20 hours per week Fixed-term contractors and casual workers: minimum 24 hours per week	
Minimum insured amount	$1,500 per month	
Maximum insured amount	$30,000 per month, plus up to $30,000 per month restricted to a 1-year or 2-year benefit period This maximum applies to income protection and business expenses cover combined	
Increasing cover after the policy begins	You can apply for a cover increase until the policy ends	
Waiting periods available	• 14-days • 30-days • 60-days • 90-days • 180-days • 1-year • 2-years	
Benefit periods available	• 1-year • 2-years • 5-years • to age 65	
	Non-superannuation ownership	**Superannuation ownership**
Income Protector Plus Benefits and features	• total disability benefit • partial disability benefit • specified injury benefit • confined to bed benefit • accommodation expenses benefit • rehabilitation benefit • funeral benefit • waiver of premium • medical professionals feature • waiting period reduction feature • involuntary unemployment	• total disability benefit • partial disability benefit • confined to bed benefit • funeral benefit • waiver of premium • medical professionals feature • waiting period reduction feature • involuntary unemployment
Income Protector Benefits and features	• total disability benefit • partial disability benefit • specified injury benefit • rehabilitation benefit • funeral benefit • waiver of premium • waiting period reduction feature • involuntary unemployment	• total disability benefit • partial disability benefit • funeral benefit • waiver of premium • waiting period reduction feature • involuntary unemployment
Optional benefits	• increasing claims option • super contributions option • day 4 accident option • future insurability option • family care option • lump sum accident option • trauma advancement option • needlestick cover option	• increasing claims option • super contributions option • day 4 accident option • future insurability option

Income protection and business expenses cover restrictions for some occupations Some restrictions apply to occupations which we class as 'special risk' or SR. Your financial adviser can tell you if your occupation is in this group, and your occupation class will be shown on the policy schedule. SR means that your day-to-day duties make you more likely to claim for sickness or injury than most people. SR restrictions are summarised in this table.		
Entry ages	19 – 53	
End age	60	
Choice of cover	Income protection: Zurich Income Protector Business expenses: ongoing fixed expenses or key person replacement cover	
Waiting periods available	• 30-days • 60-days • 90-days	
Income protection benefit periods available	• 1-year • 2-years • 5-years	
Maximum insured amount	$10,000 per month	
	Non-superannuation ownership	Superannuation ownership
Income protection optional benefits	• increasing claims option • family care option • needlestick cover option	• increasing claims option

Zurich Business Expenses

Business expenses cover provides a monthly benefit that reimburses allowable business expenses or key person replacement costs if the life insured is disabled, in most cases, for longer than the specified waiting period.

You can choose either cover for ongoing fixed expenses or key person replacement cover.

Entry ages	19 – 60
End age	65
Eligibility	The life insured must be working a minimum of 20 hours per week
Minimum insured amount	$1,000 per month
Maximum insured amount	$60,000 per month This maximum applies to income protection and business expenses cover combined
Increasing cover after the policy begins	You can apply for a cover increase until the policy ends
Waiting periods available	• 14-days • 30-days • 60-days • 90-days
Benefit period	• 12-times the *insured monthly benefit* over a period of 24 months
Benefit type	• ongoing fixed expenses • key person replacement
Benefits and features	• total disability benefit • partial disability benefit • funeral benefit • future insurability • waiver of premium
Optional benefit	• day 4 accident option

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
End age	18
Minimum benefit amount	$10,000
Maximum benefit amount	$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	You can apply for a cover increase until the policy anniversary when the insured child is 17
Benefits and features	• trauma benefit • injury advancement benefit • carer benefit • death & terminal illness benefit • cover increase feature • continuation of cover

These features apply to all of the policies explained in this document

Interim cover starts as soon as you apply

Temporary accident cover is in place as soon as you apply. You can find the policy conditions in the 'Interim cover' section, starting on page 82.

Your cover will keep up with cost of living

Cover will increase every year without health assessment to allow for increase in cost of living. You can decline increases when they're offered if you don't need more cover.

You can suspend your cover if you're finding it hard to pay premiums

The cover suspension feature allows up to 12 months break in cover to ease financial pressure. This feature isn't available on policies that are funded by a platform account.

If you have death cover, you can name beneficiaries

If you are the only policy owner and the life insured, you can nominate beneficiaries to receive the death benefit. You don't need to nominate beneficiaries if your policy has joint owners, as death benefits are paid to the surviving owner if one owner dies.

The following rules apply to beneficiary nominations:

- you must be the only policy owner and the life insured to make a valid nomination
- a beneficiary must be an individual, corporation or trust
- you can't make contingent nominations which are nominations that provide for multiple scenarios
- a nomination must be properly executed in the form we specify before we can accept it
- you can change or revoke a nomination any time but the change is only effective when receive and accept it
- you can only have one nomination in-force at any time and can't supplement a nomination. To add beneficiaries, you 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 beneficiary dies before you, we'll pay the portion of the death benefit for that beneficiary to your legal personal representative
- if a beneficiary is alive when you die, but we're notified of their death before we can pay the death benefit, then we'll pay the entitlement to the deceased beneficiary's legal personal representative
- a beneficiary has no rights under the policy, other than to receive policy proceeds after a claim has been admitted by us. They can't 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 relating to a nomination overrides the nomination.

Calculation of premiums and payment information

The premium is the amount you pay for your insurance cover

It includes the cost of the policy and any optional benefits selected, as well as the management fee and any government charges that apply. The following terms in this part of the PDS form part of all policies.

We calculate your initial premium based on the life insured and the cover you select

We calculate premiums based on:

- the amount of cover
- any optional benefits you choose
- whether you select stepped or level premiums
- the level of cover selected where a choice is available
- the benefit period and waiting period (for income benefits only)
- the frequency of your premium payments
- the life insured's gender and current age
- whether or not the life insured is a smoker
- the life insured's occupation
- the life insured's health
- any pastimes the life insured participates in
- whether you or the life insured qualify for a discount
- the period of time since health, financial, and occupational assessment.

A number of factors affect the cost of your cover

The cost of your cover is generally higher if:

- you select a higher benefit amount
- you include more optional benefits
- you pay premiums half-yearly, quarterly or monthly
- you select a higher level of cover where a choice is available
- you select a longer benefit period or a shorter waiting period (for income benefits only)
- the life insured is older
- the life insured is male (for death cover) or female (for TPD, trauma cover and income benefits)
- the life insured is a smoker
- the life insured's occupation includes hazardous duties or higher occupational risk
- the life insured isn't in good health or has underlying heath issues
- life insured participates in hazardous pastimes.

The cost of your cover is generally lower if:

- you select a lower benefit amount
- you include fewer or no optional benefits
- you pay premiums yearly
- you select a lower level of cover where a choice is available
- you select a shorter benefit period or a longer waiting period (for income benefits only)
- the life insured is younger
- the life insured is female (for death cover) or male (for TPD, trauma cover and income benefits)
- the life insured is a non-smoker who has not smoked tobacco, e-cigarettes (vaping) or any other substance and has not used a nicotine product in the past 12 months
- policy discounts apply.

The cost of cover will vary over time

The premium payable from the start of the policy to the first policy anniversary is shown on the policy schedule.

The cost of your cover will vary over time depending on:

- the premium structure you select
- the period of time since health, financial, and occupational assessment
- whether you or the life insured qualify for a discount under the terms of any special program we offer
- whether you accept inflation protection offers
- whether we change premium rates. Such changes would apply to all policies in the same category.

Here are the reasons why premiums can vary

Some of the factors used in calculating a premium change from year to year:

- 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
- stepped premiums may be lower at the start of the policy, on the basis that the life insured's health has been recently assessed
- discounts under any special program we offer will have their own terms that allow for changes
- inflation protection increases are extra amounts of cover added to your policy if you accept them at policy anniversary
- we may make changes to premium rates for all policies in the same category if the cost of providing cover increases.

Factors which can result in changes to premium rates include changes in:

- costs we incur in providing Zurich Wealth Protection, for example claim cost. The amount we pay in claims will be higher than expected if we pay more claims than expected, if we pay higher benefit amounts than expected, if we pay benefits for longer periods than expected, and if emerging industry experience and trends show an increase in long term claims cost
- commission costs
- the cost of reinsurance
- capital requirements
- expected policyholder behaviour across the portfolio, including how long Zurich Wealth Protection is held
- economic factors such as interest rates, inflation rates, employment level and market returns
- tax, government, or other mandatory charges
- operating expenses
- other factors we consider important to us continuing to provide Zurich Wealth Protection.

These factors can be higher or lower than expected over time.

When inflation protection increases are offered, we calculate stepped and level premiums for the new cover based on:

- the same factors shown on the previous page for initial premium calculation, except that we don't review the life insured's health, occupation, and pastimes
- any premium loading already applying to the existing cover, which will also apply to the increase amount
- the life insured's age at the policy anniversary.

The difference between stepped and level premiums

Life insurance is long-term cover, which makes it different to other types of insurance like car insurance where the item being insured is re-valued each year. Unless you ask us to make changes, we only assess your medical and financial information at the start of the policy. When we calculate the premium each year, the change in your premium will depend on whether you've selected stepped or level premiums.

Stepped premiums generally increase each year based on rates for the life insured's age. Level premiums for the benefit amount at policy outset are based on the age of the life insured when cover begins. Level premiums are 'averaged out' or smoothed, which means they are generally higher than stepped premiums during the initial years, but lower than stepped premiums in later years. If you plan to keep your policy for longer than 10-12 years, level premiums may save you money over the life of your policy.

Both stepped and level premiums can change as they aren't guaranteed or 'fixed', as explained below.

Stepped and level premiums for any increase in cover, including inflation protection increases, are based on the age of the life insured at the date of the increase.

For death, TPD and trauma cover, level premiums don't stay level for the life of the policy. Level premiums convert to stepped premiums on the policy anniversary when the life insured is 64. The reason for this is that level premiums smooth the cost during the ages when most people have cover. If level premiums were calculated over all ages, including older ages when people are more likely to claim, they would be less affordable. The impact of the change from level to stepped is that the cost will increase substantially on the anniversary when the life insured is 64. This is because the stepped premium will then be based on age 64, 65, 66 and so on, unlike the smoothed premium for younger ages that applied previously.

We'll remind you about this change when the life insured approaches 64 so that you have time to seek advice and decide whether to continue the cover.

The cost of your cover will usually increase each year

Regardless of whether you choose stepped or level premiums, the overall policy premium will increase:

- if the benefit amount increases, for example when inflation protection increases are applied
- when the management fee indexes each year
- if the policy is impacted by any change in stamp duty
- if we change the premium rates for all policies in the same category.

Premium rates aren't guaranteed and can change

Whether stepped or level premiums apply, premium rates for the policies explained in this document aren't guaranteed and can change. This will only occur following a review of our premium rates against the cost of providing cover, as explained on the previous page. Any change will affect all policies in the same category, not just your individual policy. We'll tell you about any changes to premium rates at least 30 days before to the change takes effect. The premium payable from the start of your policy is shown on your policy schedule and won't change before the first policy anniversary unless you ask us to make an alteration to your policy.

We have changed premium rates for all policies in the same category in the past. You can find information about premium increases we have made in recent years on our website in the section: zurich.com.au/existingcustomers.

Choice of payment methods and timing

You can choose to pay premiums as shown in the table below. If you choose any frequency other than yearly, a frequency loading will apply.

Method of payment	First premium	Monthly	Quarterly	Half-yearly	Yearly
Direct debit	✓	✓	✓	✓	✓
Credit card	✓	✓ Direct debit	✓ Direct debit	✓	✓
BPAY®	✓	✗	✗	✓	✓
Platform deduction	First premium is waived	✓	✓	✓	✓
Rollover from an *eligible superannuation fund*	✓	✗	✗	✗	✓

You can pay insurance premiums from a platform account

You can take Zurich Protection Plus, Zurich Income Protector Plus and Zurich Income Protector through selected platforms. Platforms offer the convenience of consolidated finances and reporting. If you include Zurich insurance in your platform account, you'll pay premiums by automatic deduction from the platform account on the same day each month, quarter, half-year or year, depending on your chosen payment frequency.

If premiums aren't 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.

Please read the PDS prepared by the platform provider for information about how the platform works.

If the platform is a superannuation platform, the PDS will be prepared by the trustee of the platform superannuation fund. You can find more information about superannuation platforms in the section 'Some superannuation platforms offer our insurance' on page 64.

Management fees and stamp duty apply

Management fees and stamp duty may apply to your policy. If we increase the management fee (other than fee indexation which is explained below) we'll tell you about the change at least 30 days before it happens.

We charge one management fee for each life insured

We charge a management fee which contributes to the cost of managing your policy. We only charge one fee per life insured when more than one policy is applied for at the same time.

The fee payable depends on your selected premium payment frequency, as shown below.

Premium frequency	Management fee payable	Yearly equivalent
Monthly	$9.87	$118.44
Quarterly	$29.58	$118.32
Half-yearly	$49.33	$98.66
Yearly	$98.66	$98.66

The management fees above apply for new policies from 1 March 2021 until 28 February 2022. Our published management fee changes each year on 1 March, in line with any change in the *consumer price index* (CPI). The new management fee is based on the annual percentage change in CPI published for the most recent December quarter.

We'll confirm the fee each year when we send you a policy anniversary notice. You can also find updated management fees on our website, zurich.com.au.

Stamp duty is a government charge

State governments impose stamp duty on life insurance policies and those duties vary from state to state. Any stamp duty that applies is included in the cost of your policy, generally as a separately stated amount. If changes in the law or a change in the life insured's residency result in a higher rate of stamp duty, the extra duty will be added to your premium or deducted from insurance benefits.

Other charges may apply

Goods and Services Tax (GST) isn't currently payable on insurance premiums for the policies described in this document.

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

Unpaid premiums will cause cover to lapse

The premium is payable on the due date shown on the policy schedule and any notices we send you after that. You must pay premiums to keep the policy in-force. We can only accept premiums paid in Australian dollars.

If you don't pay premiums within 30 days of the due date, your policy will be cancelled, and you won't be covered. We'll send you a warning notice if your policy is about to be cancelled so that you have time to prevent unintended cancellation. You may also be able to reinstate your cover after it lapses. You can find information about reinstatements in the 'Making changes to your policy' section, starting on page 80.

Your financial adviser will explain the quoted premium

A premium illustration will be created for you

The illustration will show the cost of each cover and any optional benefits you select as well as the details of any fees and stamp duty that may apply. Your financial adviser can explain the illustration and answer any questions you may have.

You can also contact us if you have questions about how premiums are calculated. The premium illustration created when you apply for cover is specifically tailored to you, but we can provide premium rates for the policies described in this document on request.

Your financial adviser may receive commission from us

The policies explained in this document can be tailored to meet your needs, which is why they are only available via financial advisers. We pay commission to financial advisers and other representatives who choose to be remunerated that way. Your financial adviser will tell you if they plan to receive commission. Commission amounts will be explained in the documents they give you which will include a Financial Services Guide and may also include a Statement of Advice. We pay commission out of the premiums you pay us. Commission is not an additional amount you have to pay.

Refunds of premium when cover reduces or ends

If you pay your premium monthly and you make a change to your policy, we'll generally make the change effective on the next premium due date. This ensures you always have the cover you've paid for. If your change reduces the cost of your cover, no premium refund is due.

If you're paying premiums yearly, half-yearly or quarterly, we'll refund any excess premium as at the date of the change, provided the next premium due date is more than a month away. If the next premium due date is less than a month away, we'll make the change effective on that date and won't refund any premium.

If you make any other overpayment of premium, we'll only refund amounts which exceed $5.00.

If your policy has superannuation ownership and we need to refund any contributions made to the policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

Implications for your tax return

Some premiums are tax deductible and some benefits are assessable

Please discuss the tax implications of your insurance with your tax adviser, as they will take your individual circumstances into account. We can only provide general information to be used as a guide, based on current taxation laws, their continuation and their interpretation.

This information is based on individual policy owners. Different tax implications may arise depending on policy ownership. The taxation of superannuation is complex and will depend on your age, the type of contribution and the status of the beneficiary.

Zurich Protection Plus

In most cases, you can't claim a tax deduction for the premiums you pay for your policy. One exception to this is if you take out a Zurich Protection Plus policy as key person insurance in a business. In this case, some or all 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 isn't 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 tax purposes.

This tax outcome assumes either:

- death benefits are either received by the original beneficial owner or by an owner who acquired the policy for no consideration
- other benefit payments are received by the life insured or a relative of the life insured including a partner, brother, sister, but not for example, a cousin.

If your situation varies from either of these assumptions, there may be different taxation results.

Zurich Income Protector Plus, Zurich Income Protector and Zurich Business Expenses

The premiums you pay for replacement of income cover can generally be claimed as a tax deduction by both employees and self-employed people. Some premiums can't be claimed as a tax deduction, including those payable for the lump sum accident option, family care option, needlestick cover option, and certain other non-assessable ancillary covers.

Any total disability benefits, partial disability benefits and super contributions option benefits you receive from your policy will generally be assessable as income and must be included in your tax return. However, lump sum amounts under the lump sum accident option and needlestick cover option aren't generally taxable.

This tax outcome assumes benefits are either received by:

- the original beneficial owner or by an owner who acquired the policy for no consideration
- the life insured.

If your situation varies from either of these assumptions, there may be different taxation results.

We'll tell you the amount of premium you've paid for your policy during each financial year and the portion paid for replacement of income benefits.

If you've insured your monthly superannuation contributions using the super contributions option, then these benefits will be applied directly to your fund as superannuation contributions. This benefit counts as part of your income for tax purposes and we don't deduct or withhold tax from it. If you're self-employed you may be entitled to a deduction on some or all superannuation contributions made on your behalf.

Zurich Child Cover

You can't claim a tax deduction for the premiums you pay for this policy. As a tax deduction isn't 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.

Policies held by superannuation trustees are deductible to the fund rather than individuals

Zurich Protection Plus, Zurich Income Protector Plus and Zurich Income Protector 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.

For self-managed superannuation funds, please 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 changes to your policy

You can make changes once your policy is in place

In most cases we need a written request to make a change to your policy. Depending on the change you want to make, we may ask for further information or require a specific application form. If we agree, we'll confirm any changes in writing. A financial adviser can't change or waive any policy conditions.

Your cover is flexible

These policies are very flexible and are designed to provide long-term protection which will change in line with your needs.

How to increase your cover

You can increase cover over time, to reflect your changing insurance needs, for example:

- you can accept yearly indexation increases
- you can make use of the future insurability feature by increasing cover when certain specified events occur
- you can apply for an increase in cover, subject to health, financial, and occupational assessment
- you can make other changes to your policy, for example adding extra-cost optional benefits or for income protection cover, changing parameters like the waiting period and benefit period.

Applications for new options and other changes that increase your cover are subject to health, financial, and occupational assessment. This includes increases in cover, apart from increases that are allowed for in policy features, for example, inflation protection.

How to reduce the cost of your cover

You can also reduce your cover to help manage the cost of your insurance over time. This could be a helpful change to consider if you have stepped premiums, which generally increase each year as you get older.

Here are some ways you can reduce the cost of your insurance:

- you can reduce your cover each year so that your premium doesn't increase (you can choose the proportion where you have multiple covers)
- you can reduce your premium by reducing your cover
- you can make other changes to your policy, for example removing extra-cost optional benefits or for income protection cover, changing parameters like the waiting period and benefit period.

You can also reject automatic indexation increases at any anniversary to maintain the same level of cover.

Please contact us if you would like to discuss any of these options. Our contact details are on the inside back cover of this document.

Transferring ownership of a policy

If you want to change the ownership of your policy from one owner to another, you can use a memorandum of transfer which is available from us. The memorandum of transfer can't be used to change ownership in some instances for example from a non-superannuation owner to a superannuation fund. In this situation you can cancel and replace your policy to transfer ownership.

If the policy owner is the trustee of an *eligible superannuation fund*, the life insured can apply to convert cover to a non-superannuation policy. The life insured can convert the cover any time while they're a member of the fund or within 30 days of leaving the fund.

Tell us if you move overseas

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 that apply outside of Australia may affect our ability to continue to service your policy in the way that the policy conditions say we will.

We don't offer tax advice, so if you or the life insured decide to live outside Australia, we also recommend getting advice on the tax consequences of changing country of residence. We won't be held responsible for any negative tax outcomes that result from a change in residence.

You may be able to reinstate your cover

If your cover is cancelled or lapsed, you can reinstate cover in the first 30 days. We'll reinstate cover immediately on your request, provided all outstanding premium is paid. If you're reinstating cover because you changed your mind after you cancelled it, we'll need the reinstatement request in writing.

If the policy is reinstated in this period, we won't pay benefits for any condition which occurs or is apparent while the policy is lapsed or cancelled. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

After 30 days, you can only apply to reinstate cover if your policy was cancelled due to non-payment of premium. You'll need to complete a reinstatement application so that we can assess your health, financial situation, lifestyle, and pastimes. You have 12 months to apply for reinstatement using this shorter application process. The 12 months starts on the due date of the first unpaid premium. We don't guarantee reinstatement will be available. We may decline to reinstate or impose conditions on any cover offered.

If we accept your reinstatement application, cover will start again from the date of acceptance, which we'll confirm in writing. Before this time, there is no cover. Benefits aren't payable for any condition which occurs or is apparent while a policy is lapsed or cancelled.

Reinstatement doesn't mean continuous cover. Some benefits explained in this document are affected by a reinstatement in cover such as exclusion periods which re-start. Please review the section of this document which explains the cover you've selected for further information.

If you're struggling, you can suspend cover and premiums for a period of time

The policies explained in this document include the cover suspension feature unless the policy is funded by a platform account.

Cover suspension feature

The cover suspension feature allows you to put your cover on hold for a chosen period, during which time there is no cover, and you can't make a claim for an event that occurs. The benefit of this feature is that you can stop your premium payments for a period of time to reduce financial pressure and cover will resume without a re-apply process. When the cover suspension ends the policy begins again. Depending on the cover you have, there may be exclusion periods which re-start and affect your ability to make a claim. Make sure you review the details of your cover before you suspend your cover so that you understand how the suspension will affect you.

We'll suspend your cover if you ask us to, on any policy which has been continuously in-force for at least 12 months. Cover suspension can be activated for one to 12 months, starting from the latest unpaid premium due date. We won't refund any premiums paid when cover suspension is put in place.

When you request cover suspension, we'll confirm the details in writing. Our confirmation will outline the cover suspension start and end dates as well as the next premium due date.

From the cover suspension start date until the cover suspension end date (the cover suspension period):

- the policy isn't in-force for any life insured
- no premiums are required for that period
- inflation protection increases will continue to be offered if a policy anniversary passes.

Events that are normally covered under the policy aren't covered at any time if, before the end of the cover suspension period, either:

- the event occurs
- the life insured is aware of symptoms or a diagnosis.

You can still make a claim for an insured event which occurred before the cover suspension start date if the conditions for a benefit were met when cover suspension started. For example, if you suspend trauma cover after the life insured has an *angioplasty (minimally invasive cardiac surgery)* which meets our definition, then you can lodge a claim for that event.

If the life insured is aware of a health concern before cover suspension, taking cover suspension will prevent you from making a claim for that condition. Using the same example, if the life insured has chest pains before you suspend trauma cover, and they need an angioplasty during or after cover suspension, this event won't be covered. The reason it's not covered is that the life insured was aware of a potential health problem that was not yet claimable before the cover suspension started.

The policy will be back in-force again automatically on the cover suspension end date if the premium is paid within 30 days of the next premium due date. The policy will end if the requested premium isn't paid within 30 days.

You can extend the cover suspension or you can end it early

In both cases, you need to tell us that you want to make a change at least 14 days before the cover suspension is due to end. This allows time for us to process your change and send you revised documents.

Any change is only effective when we confirm it in writing.

If the cover suspension period is reduced, an extra exclusion applies:

- the policy doesn't cover any insured event which occurs or is apparent in the first 90 days after the revised cover suspension end date. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

Using cover suspension affects the cover provided by your policy

The cover suspension feature affects the cover provided by your policy after the cover goes back into force.

After the cover suspension end date:

- the policy must be continuously in-force for another 12 months before you can suspend cover again
- the policy is effectively reinstated, which means some benefits aren't payable for set periods after the cover suspension end date. Exclusions that apply for a period of time after a reinstatement, apply for the same period of time after the cover suspension end date.

You can only suspend cover once in any 12-month period and for a maximum of 12 months over the life of the policy.

Interim cover

We provide interim cover while we assess your application

We provide up to 90 days of interim cover against *accidental death* and *accidental injury*, depending on the covers applied for. Interim cover starts when an application is submitted, provided it includes valid payment details.

Interim cover ensures that you have some basic cover in place once you're taking active steps to get comprehensive cover. Interim cover doesn't apply if you already have insurance in place with us or another insurer and you've told us that you're replacing the existing insurance.

Interim cover generally ends when we finish our assessment, which is when we issue a policy, or we decline the application. Interim cover is temporary and has its own policy conditions which are set out below.

Interim cover isn't comprehensive insurance cover

Interim cover doesn't necessarily provide the same coverage as the policy or policies being applied for. Benefit caps apply, regardless of how much cover you apply for. The terms of interim cover are set out in this section. These terms can't be varied or extended by us or your financial adviser. All words appearing in *italics* are defined terms with special meanings which are explained in the 'Definitions' section, starting on page 91.

Interim cover is for people who are applying for new cover

Interim cover is available to you if you're applying for insurance cover which isn't intended to replace cover you already have with us or another insurer.

If you're applying to increase insurance with us (including where you're applying to replace existing cover at the same time), then interim cover applies only to the amount of the increase, up to the relevant limits set out in this interim cover.

Interim cover doesn't apply to all applicants

You're not eligible for interim cover if any of the following applies:

- you have current insurance with us or another insurer which provides the same or similar cover and which you've told us will be replaced by the cover being applied for
- you have a current application or interim cover with us or another insurer for insurance of a similar type which provides the same or similar cover
- you had interim cover or other insurance cover with us in the previous 24 months of a similar type that ended (except where you're increasing cover on an existing policy)
- you previously applied for insurance of a similar type with us or another insurer and the application was declined, deferred, or postponed.

When we say other insurance cover which is the same or similar, we mean insurance which is an individual policy as well as insurance which is part of a package, for example a mortgage protection policy which contains different insurance covers bundled together.

You're not eligible for interim cover if the insurance you've applied for wouldn't be accepted, based on our normal assessment criteria.

When interim cover starts

Interim cover starts on the interim cover effective date, which is the date that you complete our electronic Zurich Wealth Protection application for the policy or policies you're applying for and you arrange future premium payments. To arrange premium payments, you can:

- complete a payment authority with valid payment details
- complete a rollover authority with valid payment details
- set up a platform account.

If you select our Health Connect tele-interview option to complete some of the application, interim cover will still start on the date that you complete our electronic application. We won't delay the start of the interim cover until your tele-interview occurs, even though your application will be incomplete.

When interim cover ends

Interim cover ends when your application is withdrawn, which is when one of the following happens:

- the date when you or your financial adviser withdraws your application by contacting us
- 90 days after the effective date
- when we decline your application in writing
- when insurance cover starts under another contract of insurance, including interim cover, which covers the life insured and is intended to replace this interim cover
- 21 days after we tell 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 and you haven't agreed to the alteration
- 28 days after the effective date if your financial adviser hasn't submitted your application to us.

Exclusions apply to interim cover

Interim cover doesn't apply in these situations:

- if we would have declined your application, based on our normal heath, financial, and occupational assessment criteria
- if you apply for more cover than we would accept, based on our normal heath, financial, and occupational assessment criteria. If this happens, we won't provide interim cover for the excess amount
- if the event leading to the claim occurs while the life insured is outside Australia.

We won't pay a benefit where the event leading to the claim is caused directly or indirectly by:

- suicide or attempted suicide
- intentional self-inflicted *injury* or act
- the taking of drugs other than as prescribed by a doctor
- engaging in any criminal activities
- engaging in any pursuit or occupation which would cause us to reject the application for insurance or apply special conditions to acceptance of the application for insurance
- an act of war, whether declared or not. War doesn't include acts of terrorism
- military service, other than death while on war service.

Your duty of disclosure also applies to interim cover

When you apply for Zurich Wealth Protection policies, you'll declare that you've read and understood your duty of disclosure. This duty also applies to interim cover. We may void your interim cover if you misrepresent anything on your application form. Please read about your duty of disclosure in the 'Applying for cover' section, starting on page 65.

Contact us if you want to check on your interim cover

Contact us if you want to confirm the currency of your interim cover if you or your financial adviser don't have the details. Our contact details are on the inside back cover of this document.

Your interim cover depends on what you've applied for

We'll provide you with interim cover from the interim cover effective date until the interim cover end date, provided you meet the interim cover eligibility criteria. Interim cover is subject to the specific terms set out in this section.

Interim cover is:

- limited to the type or types of insurance you applied for in the application
- subject to these terms, conditions, and exclusions
- subject to the other relevant terms, conditions, and exclusions of the policy conditions for the insurance you've applied for, except where the policy conditions provide greater cover than this interim cover.

If you've submitted more than one application to us, the maximums set out below apply across all applications being assessed.

Death cover

If you've applied for death cover, we'll pay a benefit on the life insured's *accidental death* during the period of this interim cover. The amount we'll pay for any life will be the lower of:

- $1,000,000
- the amount of cover you're applying for
- the amount of cover the life insured would have been accepted for under our normal heath assessment criteria.

TPD cover

If you've applied for TPD cover, we'll pay a benefit if the life insured is disabled and suffers *loss of hands, feet or sight* as a result of an *accidental injury* during the period of this interim cover. The life insured must survive at least 14 days after the loss. If the application is for a policy to be owned by the trustee of a superannuation fund, the life insured must also meet the superannuation definition of permanent incapacity.

The amount we'll pay for any life will be the lower of:

- $600,000
- the amount of cover you're applying for
- the amount of cover the life insured would have been accepted for under our normal heath, financial, and occupational assessment criteria.

Trauma cover

If you've applied for trauma cover, we'll pay a benefit if the life insured suffers one of these conditions, solely as a result of *accidental injury* during the period of this interim cover. The life insured must survive the *accidental injury* for at least 14 days without being on life support:

- *coma (of specified severity)*
- *loss of sight*
- *major head trauma (with permanent neurological deficit)*
- paralysis *(paraplegia, quadriplegia, hemiplegia, diplegia)*
- *severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days)*
- *severe burns (of specified extent).*

The amount we'll pay for any life will be the lower of:

- $600,000
- the amount of cover you're applying for
- the amount of cover the life insured would have been accepted for under our normal heath assessment criteria.

Income protection or business expenses cover

If you've applied for income protection or business expenses, we'll 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 stops work
- the life insured is unable to earn from personal exertion any income or generate any *business income* for a period of at least the chosen waiting period
- the life insured must be following the advice and recommended treatment of a *medical practitioner*.

We'll pay the benefit if the life insured sustains an *accidental injury*, which occurs after this interim cover starts.

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

- $5,000
- the *insured monthly benefit* you're applying for
- the amount of cover the life insured would have been accepted for under our normal heath, financial, and occupational assessment criteria.

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

Child cover

If you've applied for child cover, we'll pay a benefit if an 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:

- *loss of hands, feet or sight*
- *loss of speech*
- *major head trauma (with permanent neurological deficit)*
- *paraplegia*
- *quadriplegia*
- *severe burns (of specified extent).*

The amount we'll pay for any insured child will be the lower of:

- $200,000
- the amount of cover you're applying for.

You need to provide evidence if you make a claim under interim cover

If you need to 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 end date, including proof that you completed our application.

If your claim is successful, you must pay us the premium for this cover, which is what we would have charged you for the policy you applied for, to cover the period up until the date that we admit your claim.

Making a claim

Here's how to make a claim

We understand that when you need to claim it can be a very difficult and emotional time. We aim to make the claim process as straightforward as possible.

Please tell us about any event that could result in a claim as soon as you can.

It's easy to lodge a claim with us. The first step is to complete our claim form, which must be signed and returned to us. You may be able to use our tele-lodgement service, depending on the type of claim you're making. We'll let you know if this service is available to you.

You can access a claim form on our website: zurich.com.au or you can contact us if you'd prefer to have a claim form sent to you.

You'll need to gather supporting documents

You'll need to provide the relevant evidence required to assess your claim. Any missing documents may delay the claim process.

You're responsible for providing all standard supporting documents for your claim. In some cases, you may need to pay for those documents. For example, where a medical report is required. Most of the medical and financial information you need to prove your claim will be information that you already have.

The documents you submit should be legible, unaltered and include proof to support your claim. If we can't use the information you provide for any reason, we'll let you know why that is and will discuss with you what alternative documents can be provided.

You may need to prove the information provided at application

In assessing the claim we'll rely on any information that you or the life insured told us as part of the application. If we didn't verify information when you applied for cover, we reserve the right to verify it when you make a claim.

Here's our standard list of claim requirements

We require the following information to assess your claim:

- proof of a claimable event or condition and when it occurred
- supporting evidence from an appropriate specialist *medical practitioner*
- proof of the life insured's age
- proof of incurred costs where the benefit payment is based on reimbursement.

We may also ask for proof of entitlement to receive payment and a signed discharge from the person entitled to receive payment.

In addition to the standard requirements, we need information that is specific to the type of claim you're making

Documents for TPD, trauma and child cover claims

For TPD, trauma and child cover benefits, proof of any insured event must be supported by:

- confirmatory investigations including, but not limited to, clinical, radiological, histological and laboratory evidence
- if a trauma claim is a result of a surgical procedure, evidence that the procedure was medically necessary.

For any trauma claim, the insured event must be diagnosed and certified by a *medical practitioner* considered to be an appropriate specialist physician. 'Appropriate' will differ from claim to claim as it depends on the medical condition, standard medical practice, and the specialist physician's qualifications in the relevant area of medicine. If we require verification of the diagnosis and certification by a second physician, we'll pay for the cost of the physician and any reasonable travel costs.

Medicine is constantly evolving. Where the diagnostic techniques used in our trauma condition definitions are impractical to apply or have been superseded due to medical improvements, we'll consider other appropriate and medically recognised tests.

Documents for funeral claims

For any funeral benefits or funeral expenses claims, the claim can be lodged by the person who is eligible to receive the death benefit or by the life insured's legal personal representative. The claim must include the funeral invoice and either a copy of the death certificate or cause of death certificate.

Documents for income protection claims

We need the following for income protection claims:

- evidence of absence from work, for example medical certification, reports and copies of leave records from the life insured's employer, if appropriate
- financial evidence including evidence of other insurance cover on the life insured
- evidence of pre-application income, *pre-disability income* and *post-disability income* and evidence of any payments received while on claim
- evidence of confirmatory investigations which support the claimable condition, for example, clinical, radiological, histological and laboratory evidence. This could include copies of medical records or reports from treating doctors or from independent specialists, if we request them
- copies of personal and business tax returns, assessment notices and other financial evidence to prove the life insured's income, if we request it.

When we need to calculate the amount of the benefit payable, the life insured must allow us to examine their business and personal financial circumstances.

Late income protection claims

Please alert us to any *sickness* or *injury* which may become a claim as soon as you can. The best way to provide prompt notification of a claim in writing is to complete our claim form. We need medical and financial evidence dated when the *sickness* or *injury* starts to establish and assess your claim. If you don't tell us about the life insured's *sickness* or *injury* when it happens and the delay affects our ability to confirm the claim event and relevant dates, it may affect your claim.

Documents for business expenses claims

We need the following for business expenses claims:

- financial evidence including evidence of other insurance cover on the life insured
- evidence of *pre-disability business income* and *post-disability business income*, as well as evidence of *allowable business expenses* or *key person replacement costs* incurred (whichever applies) and any payments received while on claim
- evidence of confirmatory investigations which support the claimable condition, for example, clinical, radiological, histological and laboratory evidence. This could include copies of medical records or reports from treating doctors or from independent specialists, if we request them
- copies of personal and business tax returns, assessment notices and other financial evidence to prove the life insured's income, if we request it.

When we need to calculate the amount of the benefit payable, the life insured must allow us to examine their business and personal financial circumstances.

Questions you might have about making a claim

Is a medical examination required?

We may need a diagnosis to be verified by a specialist *medical practitioner* we appoint. To do this we may require the life insured to undergo reasonable examinations and tests. If we request an examination or test by a *medical practitioner* we appoint, we'll pay for it. We'll also cover reasonable travel costs.

Are income protection claims ever paid in advance?

Sometimes. If medical evidence supports the life insured's inability to work for a set period, most often for *injury* claims, we may advance the payment of monthly benefits. Each claim is different, and we can't always make advance payments for income protection claims. Eligibility depends on the life insured's occupation and the relevant injury. For example, if the life insured is a plumber and they break a leg, we know how long recovery is likely to take and may pay the full claim up-front.

Can I use financial year paperwork?

Yes. We understand that it is often easier to provide financial information based on financial year. Where we ask for the life insured's average monthly *income* in the 12 or 24 months immediately before a point in time, we can be flexible. We'll accept information for the financial year or years rather than strictly the 12 or 24 months before, if you have evidence which is aligned to financial years.

Can my claim be paid in a foreign currency?

No. We pay all claims in Australian dollars.

We pay benefits to the policy owner, unless beneficiaries have been nominated

Payment of benefits under policies held by superannuation trustees

If a benefit is payable under a Zurich Wealth Protection policy held in superannuation, we'll pay it to the trustee. The trustee will release the benefit from the superannuation fund to the member, subject to the governing rules of the superannuation fund and superannuation law. The trustee may need to conduct further assessment to satisfy themselves that all rules and laws have been met. Members can generally make death benefit nominations with the trustee. The PDS issued by the trustee of the fund will provide more information. For certain *eligible superannuation funds*, we may pay income protection benefits directly to the member on behalf of the trustee.

Payment of the death benefit under Zurich Protection Plus

If a valid beneficiary nomination applies when the life insured dies, we'll pay the death benefit to the chosen recipients in the proportions specified. If the nomination is subject to external dispute resolution processes, we'll pay benefits as directed by a court or by the relevant dispute resolution authority.

If there is no valid beneficiary nomination when the life insured dies, we'll pay any death benefit to:

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

Payment of all other benefits

We'll pay all benefits under this policy to the policy owner unless otherwise specified in these policy conditions.

Don't forget that tax is payable on income protection benefits

Any total disability benefits, partial disability benefits and super contributions option benefits you receive from your policy will generally be assessable as income and must be included in your tax return. You can find more information in the 'Implications for your tax return' section on page 79.

Examples of what we pay

Here are some examples of what we would pay out under each policy.

Protection for loved-ones on your death or terminal illness

David has a **Zurich Protection Plus** policy with $1,000,000 death cover.

David took death cover to make sure that his wife and young children would be taken care of if something unexpected happened to him.

Two years after taking out his policy, David has a tragic cancer diagnosis, and his treating doctors confirm he won't survive another 24 months.

As death cover includes a terminal illness benefit, we'll pay the full $1,000,000 to David now so that he can take an active role in planning his family's financial future.

Replacing lost income if you'll never work again

Ling has a **Zurich Protection Plus** policy with $800,000 TPD cover.

Ling took TPD cover as her plan-B in case she ever had to stop work due to poor health.

Eight years after taking out her policy, Ling is involved in a serious car accident and is lucky to survive. She suffers extensive permanent physical injuries. While she can live a comfortable life with support from her family, she'll never be able to work as a pharmacist ever again.

Ling meets her policy definition of TPD, and her treating doctors confirm that she'll never work again, so we'll pay the benefit of $800,000. The benefit will help fund Ling's gap in expected earnings and will contribute to out of pocket expenses she'll face in adapting her world to work best for her.

Funding for time off or the cost of treatment

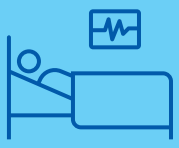
Deepak has a **Zurich Protection Plus** policy with $200,000 trauma cover.

Deepak took trauma cover because as a self-employed contractor, he wanted to fund time off work if he had a serious health event. He also wanted a financial buffer against out of pocket expenses and treatments that a serious illness could bring.

Five years after taking out his policy, Deepak is diagnosed with a serious heart condition, and has to undergo heart surgery.

As Deepak's *aortic surgery* is a defined trauma event under his policy, we'll pay the benefit of $200,000. The benefit payment will fund time to recover from his heath event before thinking about work commitments again.

Reducing financial stress while you focus on recovery



Joe has a **Zurich Income Protector** policy with an insured monthly benefit of $7,500, which will pay benefits up to age 65.

Joe took income protection cover because he was worried about the financial well-being of his young family if sickness or injury stopped him from working. He knew his job in real estate would stop paying him an income as soon as his sick leave ran out and that his savings wouldn't stretch very far after that.

Two years after taking out his policy, Joe suffers a double fracture of his tibia and fibula in a football tackle. He has a few days in hospital and following surgery is off work for almost eight weeks. Even though his recovery is going to plan, his leg must be elevated and he can't put any weight on it.

Joe selected a 30-day waiting period on his policy, so we'd normally pay him a monthly benefit 15 days after the waiting period ends. However, Joe's policy automatically includes the specified injury benefit, which means the waiting period doesn't apply and we'll pay him a benefit as soon as his claim is assessed. Fracture of the tibia or fibula pays the monthly benefit for two months, which for Joe amounts to $15,000.

When Joe returns to work, he won't be up to full-time work immediately. If he initially returns to work part-time, we'll pay him a partial disability benefit. This will top-up the income he'll earn from his employer and will allow him to make a more gradual return to work. It'll also support his mental recovery as he can get involved in his work and connect with colleagues again.

Keeping your business afloat when you're not there

Kartika has a **Zurich Business Expenses** policy with an insured monthly benefit of $10,000.

Kartika took a business expenses policy to ensure that her hairdressing business would continue to operate if she couldn't be there due to sickness or injury. She already has income protection insurance, but knows she'll need protection for the business too. Otherwise any income protection benefits will soon disappear into the business.

Six years after taking out the policy, Kartika suffers a back injury in her home gym and has needs spinal fusion surgery. While she makes a strong recovery, she can't stand for long periods of time and must let her trusted employees keep the business running for almost six months.

As Kartika earns the main share of the business income, and she does hair for weddings and functions herself, business income is hit hard without her. Business income won't cover all the operating costs.

Kartika's business expenses policy has a 30 day waiting period, so we'll cover her fixed expenses for nearly five months. The policy will allow the business to keep running without financial pressure while Kartika is away. Most importantly, she won't have to cut wages, or lose any loyal staff. She'll have a functioning business to go back to when she's able to return.

Giving you space to focus on your child's health

Paul and Aurora have a **Zurich Child Cover** policy with $100,000 cover for their young daughter Lola.

3 years after taking the policy, Lola has a leukaemia diagnosis, which needs ongoing treatment for around six months.

As *cancer (excluding early stage cancers)* is a defined trauma event under the policy, we'll pay the benefit of $100,000. Even if Paul and Aurora have health insurance, and the out-of-pocket medical expenses aren't unaffordable, the insurance benefit gives them options. For example, Aurora can now afford to take a break between consulting assignments to be with Lola. The insurance gives the family breathing space so they can focus the energy they want to on their daughter during a difficult time.

General policy conditions

These conditions apply to the policies explained in this document

These general policy conditions apply to all of the following policies:

- Zurich Protection Plus
- Zurich Income Protector Plus
- Zurich Income Protector
- Zurich Business Expenses
- Zurich Child Cover.

These general policy conditions apply in addition to the policy specific policy conditions set out in the previous sections of this document.

What we mean by policy documents

Your policy is made up of the policy conditions in this PDS and the latest policy schedule. The policy schedule will be sent to you when the policy is issued. We'll issue an updated policy schedule after a change.

The policy schedule shows details of the policy including:

- the policy type
- the policy start date
- ownership details
- the life insured
- the amount of cover
- any optional benefits chosen
- any policy conditions specific to your policy
- the benefit end date or dates.

The policy start date shown on the policy schedule and the anniversary of that date is used throughout this document as a reference point in time. For example, benefits generally end on the policy anniversary when the life insured is a certain age.

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

Benefit start dates and policy conditions

The benefit start date on the policy schedule determines which policy conditions apply to each benefit. A policy issued while this PDS is current will be subject to the terms explained in this PDS. If you vary your policy after the policy state date, and a new benefit start date appears on your policy schedule, the policy conditions for the altered benefit will be those in the PDS current on the benefit start date, unless otherwise agreed.

Benefits which aren't available to new customers

You can apply to vary an existing policy with a benefit or option which was explained in your original PDS, but isn't explained in this document, because it's no longer available. If we accept your application, the policy conditions for the benefit or option are set out in the original PDS.

We'll let you know if insured conditions become redundant

If any of our insured conditions become redundant, for example if a cure is found for an insured event, we'll let you know what that means for your cover.

This policy doesn't have a cash value

This policy only provides the insurance benefits explained in this document. It doesn't have a cash value. We'll put premiums paid for this policy in our No. 2 Statutory Fund and pay claims under this policy from that 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.

We'll communicate with you as the policy owner

All communications, including instructions, requests, and notifications must be made between the policy owner and us except where we've agreed a different approach. For example, we'll issue communications to the life insured in the case of life insurance policies issued to an *eligible superannuation fund*.

Zurich's legal obligations and your privacy

We have specific legal obligations

We and other companies within the worldwide Zurich group of companies have obligations under Australian and foreign laws. We won't do anything that would put us at risk of breaking Australian law or laws in any other country. This applies no matter what is included in the policy conditions. This may include suspending or cancelling your policy.

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

We may cancel the policy if we consider you, the life insured, your directors and officers or beneficial owners to be a sanctioned person. We may also cancel the policy if you conduct an activity which is sanctioned according to trade or economic sanctions laws and regulations.

Further, we won't provide any cover, service or benefit to any party if this may breach trade or economic sanctions laws or regulations.

This policy is based on the legal and regulatory requirements that apply when the policy is issued. The policy may be affected by changes to these requirements.

Privacy

We're bound by the Privacy Act 1988 (Cth). Before providing us with any personal or sensitive information, read this outline to understand what we'll do with your information. If you're not the only person providing information, then the other people providing information need to know this too.

We collect and use personal information to manage your insurance

We collect, use, process, and store personal information and, in some cases, sensitive information about you for several purposes. Purposes include complying with our legal obligations, assessing your application for insurance, managing the insurance, improving customer service or products and to manage claims. If you don't agree to provide us with the information, we may not be able to process your application, manage your cover or assess your claims. Other than from you, we may also collect information from government offices and third parties to assess an application or a claim.

By providing us or your financial adviser with your information, you consent to our use of this information which includes us sharing your information with other parties where relevant for the purposes. Other parties can include the policy owner, your financial adviser and their licensee, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our banking gateway providers and credit card transaction processors, and our business partners. We may also use or disclose your information as authorised or required by law within Australia or overseas.

These are the relevant Australian laws that may apply:

- 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
- Family Law Act 1975 (Part VIIIB).

We must also comply with updates to these laws and any associated regulations. In addition to these, other acts may require or authorise us to collect your personal information.

We may use personal information (but not sensitive information) collected about you to tell you about other products and services we offer. If you don't want your personal information to be used in this way, please contact us.

If you want to know more

We can provide:

- a list of service providers and business partners that we typically may share your information with
- 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
- information about how to make a complaint.

For further information about Zurich's Privacy Policy please click the privacy link on our homepage zurich.com.au, contact us by phone on 132 687 or email us at privacy.officer@zurich.com.au.

Our data commitment

We understand that data security is an important concern. You can rest assured that we'll:

- keep your data safe
- never sell personal data
- not share personal data without being transparent about it
- put data to work so we can better protect you.

Definitions

These definitions are used throughout this document

Definitions for specified trauma conditions start on page 99.

accidental death means death caused by an accident. The accident must be a violent, external, and visible event and death must occur within three calendar months of the accident.

accidental injury means bodily injury caused by an accident. The accident must be a violent, external, and visible event and must occur while the policy is in-force.

activities of daily living are:
- bathing and showering
- dressing and undressing
- eating and drinking
- using a toilet
- moving from place to place by walking, wheelchair or with the help of a walking aid.

allowable business expenses means normal day-to-day expenses incurred in the life insured's business. They include, but aren't limited to:
- accounting and audit fees
- bank fees and charges
- cleaning costs
- electricity, gas and water charges
- property rates
- equipment hire
- motor vehicle leases, registration and insurance
- business related insurance premiums (not including this policy)
- interest payments on business loans and mortgages
- office leasing fees
- rents on business premises
- salaries (including superannuation) and payroll tax of employees not directly involved in generating income or revenue
- regular advertising costs
- telephone costs
- fees for professional associations
- cost of a locum less any earnings generated by the locum
- printing, postage and stationery costs
- contracted maintenance
- contracted advertising
- contracted security
- any other expenses agreed by us.

The following expenses aren't covered:
- the life insured's personal remuneration, salary, fees or drawings from the business
- cost of goods or merchandise
- repayments of capital on a loan or mortgage (other than repayments directly related to identifiable business assets, which are no more than the minimum repayments required by the loan or mortgage, and which have been in place for at least six consecutive months before the life insured's disability)
- costs of implements of profession
- premiums payable on this policy
- salaries (including superannuation) and payroll tax of employees directly involved in generating income or revenue
- depreciation
- salaries of immediate family members unless they were employed more than 30 days before the date of the life insured's disability. 'Immediate family member' means *partner*, child, brother, sister, or parent.

any occupation means any occupation, business, or employment the life insured is suited to by education, training, or experience. Earnings from this occupation, business or employment should be more than 25% of the life insured's most recent 12 months of work for remuneration or reward.

any occupation TPD means due to *sickness* or *injury*, the life insured meets the criteria set out in (a) or (b) or (c) or (d) below:

(a) both of the following:
  - hasn't been working for a continuous period of at least three months
  - is so incapacitated that they're unlikely to be able to work in *any occupation* ever again.

(b) both of the following:
  - has suffered permanent and irreversible *whole person impairment* of at least 25%
  - is so incapacitated that they're unlikely to be able to work in *any occupation* ever again.

(c) *functional impairment* of at least four *extended ADL* categories.

(d) permanent and irreversible *whole person impairment* of at least 60%.

A claim for *whole person impairment* is only payable if the life insured survives at least 14 days after they meet the definition. The definition isn't met if the life insured is declared brain dead in the 14 days.

We'll assess the life insured's capacity for future work using a combination of the following:
- medical opinion provided by a specialist in the life insured's condition
- employability assessments prepared by allied health providers
- labour market information
- any other available evidence of the life insured's condition, including evidence provided by the life insured and anyone acting for the life insured.

business income (for Zurich Business Expenses) means the monthly income of the business in which the life insured is working for remuneration or reward. The income amount is before expenses and before tax.

cognitive loss means a total and permanent deterioration or loss of intellectual capacity. The loss of intellectual capacity must be evidenced by both of the following:

- necessary, continuous care and supervision by another person for at least three consecutive months
- a score of 15 or less out of 30 in a Mini Mental State Examination or equivalent evidence from an alternative neuro-psychometric test.

At the end of the three-month period, medical evidence must confirm that the life insured is likely to require ongoing continuous care and supervision by another person.

consumer price index means the 'Weighted Average of Eight Capital Cities Index' as published by the Australian Bureau of Statistics. If that index is no longer published or is significantly changed, a comparable replacement index will be applied.

domestic duties means the following tasks, whether or not the life insured performed these tasks prior to the *sickness* or *injury*:

- cleaning: using domestic appliances and equipment to clean and maintain the home
- cooking: using kitchen and cooking utensils, appliances, and equipment to prepare more than the most basic meals for the family
- laundry: washing, drying, and ironing the family's clothes or linens to basic standards
- shopping: purchasing and unpacking everyday household provisions for the family.

domestic duties TPD means due to *sickness* or *injury*, the life insured meets the criteria set out in (a) or (b) or (c) or (d) below:

(a) all of the following:
  - is unable to perform all of the *domestic duties* without an adult person assisting for a continuous period of at least three months
  - is unable to leave their home without an adult person assisting for a continuous period of at least three months
  - has been following the advice of a *medical practitioner* and engaging in appropriate treatment for the *sickness* or *injury* in the three-month period
  - is so incapacitated that they require ongoing medical care
  - is so incapacitated that they're unlikely to be able to perform all of the *domestic duties* without an adult person assisting, ever again.

(b) both of the following:
  - has suffered permanent and irreversible *whole person impairment* of at least 25%
  - is so incapacitated that they're unlikely to be able to work in *any occupation* ever again.

(c) *functional impairment* of at least four *extended ADL* categories.

(d) permanent and irreversible *whole person impairment* of at least 60%.

A claim for *whole person impairment* is only payable if life insured survives at least 14 days after they meet the definition. The definition isn't met if the life insured is declared brain dead in the 14 days.

We'll assess the life insured's capacity for future work using a combination of the following:

- medical opinion provided by a specialist in the life insured's condition
- employability assessments prepared by allied health providers
- labour market information
- any other available evidence of the life insured's condition, including evidence provided by the life insured and anyone acting for the life insured.

eligible superannuation fund means a superannuation fund which offers members access to Zurich Wealth Protection insurance.

extended activities of daily living/extended ADLs are the six categories of extended ADLs set out on the next page. Each category is made up of a list of specific tasks. If the life insured can't perform the stated number of specific tasks within a category, the whole category is scored as an inability to perform that extended ADL category.

The ability to perform the tasks of each extended ADL category must be assessed by a medical specialist appropriate to the medical condition causing the impairment, using our Activities of Daily Living score sheet.

The scoring method works like this:

Degree of impairment	Score
A life insured who is independent in performing a task is regarded as able to do that task.	'can', 'normal' or 'good'
A life insured who makes use of assistive devices or requires the supervision of another person in performing a task is regarded as requiring help to do the task.	'with help', 'minimal' or 'average' Examples of assistive devices are walking frames, raised toilet seats, shower or bath benches. Glasses and hearing aids aren't classified as assistive devices.
A life insured who is completely dependent on another person(s) to perform a task 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 test or tests.

When a life insured is being measured on their ability to perform any extended ADL category tasks:
- scoring must record all impairment
- assistive devices must be used, where they are available.

Supporting objective medical evidence or investigations must be provided for each task of an extended ADL category scored.

The extended ADL categories, specific tasks and scoring 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
- holding
- pinching
- percussive movements
- sensory discrimination

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)
- sexual function
- social interaction
- understand concepts
- memory
- problem solving
- stress adaptation
- sleep pattern
- recreational/social activities

Score required in order to be considered unable to perform this ADL category:
- 'cannot' or 'poor' in at least four specific tasks.

functional impairment means both of the following:
- the presence of a medically recognised disease or disorder
- a resulting inability to perform a specified number of the *extended activities of daily living* categories, while on optimal therapy if therapy is appropriate.

The functional impairment must be:
- present for a minimum of six months
- permanent and irreversible
- assessed using the scoring criteria set out in the definition of *extended ADLs*.

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

income means income calculated:
- after the deduction of expenses incurred in producing that income
- before the deduction of tax.

Income 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 is self-employed:
- income also includes the life insured's share of net income of the business, based on role in the business and ownership, if they are an owner. Income from the life insured's business is calculated after the deduction of expenses incurred in producing that income but before the deduction of tax
- income doesn't include investment income, such as rental income from third parties and interest
- 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 drawings.

Income doesn't include superannuation contributions if the super contributions option has been selected, except where assessing whether the life insured is *totally disabled* or *partially disabled*.

injury means bodily injury caused by an accident. The accident must occur while the policy is in-force.

insured monthly benefit means the amount of monthly benefit shown on the policy schedule when your policy starts, plus indexation in line with the policy conditions. If you make a change to your policy and we issue a revised policy schedule, the insured monthly benefit will be updated on the revised policy schedule.

Benefit calculations for a claim are based on the insured monthly benefit as at the start of the waiting period.

key person replacement costs means the cost of a locum or replacement person who is paid for by the policy owner while the life insured is disabled.

Costs include salary, wages, packaged fringe benefits, regular bonuses, regular overtime payments, pre-tax superannuation contributions and payroll tax.

Key person replacement costs doesn't include the cost of a locum or replacement person who:
- is the life insured or policy owner's immediate family member. 'Immediate family member' means partner, child, brother, sister, or parent.
- has a controlling interest in the company or a related entity and the policy is owned by a company.

loss of a hand or foot means the total and irreversible loss of the use of:
- an entire hand or
- an entire foot.

loss of hands, feet or sight means the total and irreversible loss of the use of two or more of:
- an entire hand
- an entire foot
- sight in one eye, to the extent that even when aided, one of the following applies:
  - eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart
  - the degree of vision is less than or equal to 20 degrees of arc.

loss of hands or feet means the total and irreversible loss of the use of two or more of:
- an entire hand or
- an entire foot.

loss of independent existence means the total and irreversible inability to perform at least two of the *activities of daily living* without the help of another person.

loss of sight means permanent and irrecoverable loss of sight, to the extent that one of the following applies:
- even when aided, eyesight is reduced in both eyes to 6/60 or worse of central visual acuity on the Snellen test chart
- the degree of vision is less than or equal to 20 degrees of arc.

loss of sight in one eye means the permanent and irrecoverable loss of sight in one eye to the extent that even when aided, one of the following applies:
- eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart
- the degree of vision is less than or equal to 20 degrees of arc.

medical practitioner means one of the following:
- a medical practitioner legally registered to practise in Australia
- a medical practitioner legally registered to practise in another country who has equivalent qualification.

Medical practitioner generally includes the life insured's general practitioner and any treating specialists involved in diagnosis and management of their condition. For mental health claims, it can include a treating psychiatrist.

Where we need an opinion from a specific medical specialist appropriate to the medical condition, we'll specify.

Medical practitioner doesn't include:
- the policy owner, their relative, business partner or employee
- the life insured, their relative, business partner or employee
- other para-medical professionals such as psychologists, chiropractors, physiotherapists, or naturopaths.

modified TPD means the life insured has suffered one of the following:
- *loss of hands or feet*
- *loss of sight*
- both *loss of a hand or foot* and *loss of sight in one eye*
- *loss of independent existence*
- *cognitive loss.*

A claim for *loss of hands or feet*, *loss of sight*, both *loss of a hand or foot* and *loss of sight in one eye* or *loss of independent existence* is only payable if life insured survives at least 14 days after they meet the definition. The definition isn't met if the life insured is declared brain dead in the 14 days.

monthly benefit means a benefit payable under the policy conditions, including the total or partial disability benefit and other benefits paid in place of the total or partial disability benefit. Those benefits are specified injury, confined to bed, day 4 accident and trauma advancement.

Under the Zurich Business Expenses policy, it means the total or partial disability benefit and day 4 accident benefit.

occupationally acquired hepatitis B or C means infection with hepatitis B or hepatitis C due to an accident at work, in the life insured's normal occupation.

Any accident which may become a claim must be supported by a negative hepatitis B surface antigen test or negative hepatitis C antibody test taken after the accident. The infection must be evidenced by sero-conversion from hepatitis B surface antigen negative to hepatitis B surface antigen positive or hepatitis C antibody negative to hepatitis C antibody positive within six months of the accident.

We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result.

A benefit isn't payable for hepatitis B if:
- a medical cure is found for hepatitis B
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis B, before making a claim.

A benefit isn't payable for hepatitis C if:
- a medical cure is found for hepatitis C
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis C, before making a claim.
- the life insured hasn't yet taken at least two Australian government subsidised courses of treatment (or an equivalent treatment program) which could result in a cure, before making a claim.

occupationally acquired HIV means infection with Human Immunodeficiency Virus (HIV) due to an accident at work in the life insured's normal occupation.

Any accident which may become a claim must be supported by a negative HIV antibody test taken after the accident. The infection must be evidenced by sero-conversion of the HIV infection within six months of the accident.

We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result.

A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if:
- a medical cure is found for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus (whichever applies)
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious.

own occupation means the life insured's occupation, business, or employment at the start of the *sickness* or *injury* causing *total and permanent disablement*, unless the life insured has been working in a new occupation for less than six months.

If the life insured isn't working in their occupation, business or employment for remuneration or reward, then own occupation is the occupation, business, or employment the life insured most recently worked in for remuneration or reward.

The definition changes if the life insured changes occupation and has been working in their new occupation for less than six months at the start of the *sickness* or *injury* causing *total and permanent disablement*. In this case, own occupation is the last occupation, business, or employment the life insured worked in for a continuous period of at least six months.

own occupation TPD means due to *sickness* or *injury*, the life insured meets the criteria set out in (a) or (b) or (c) or (d) below:

(a) both of the following:
  – hasn't been working in their *own occupation* for a continuous period of at least three months
  – is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again.

(b) both of the following:
  – has suffered permanent and irreversible *whole person impairment* of at least 25%
  – is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again.

(c) *functional impairment* of at least four *extended ADL* categories.

(d) permanent and irreversible *whole person impairment* of at least 60%.

A claim for *whole person impairment* is only payable if life insured survives at least 14 days after they meet the definition. The definition isn't met if the life insured is declared brain dead in the 14 days.

partially disabled (for Zurich Income Protector and Zurich Business Expenses) means the life insured is working or is capable of working, but solely due to *sickness* or *injury* they experience a reduction in income. The life insured must be following the advice and recommended treatment of a *medical practitioner*.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

To qualify as partially disabled the life insured's ability to do *important income-producing duties* in their *primary occupation* must be reduced by at least 20%.

We'll use the life insured's *primary occupation* in the 12 consecutive months immediately before the claim to measure the reduction.

The definition changes if the life insured becomes partially disabled when they haven't been working for more than 12 consecutive months due to unemployment, long service leave or parental leave. In this case, ability to work is based on any occupation they are reasonably qualified for by education, training, or experience.

After we pay 24 months of total disability benefits, partial disability benefits or a combination of both, the definition changes. Ability to work is no longer based on a specific occupation. The life insured is only partially disabled from that point onwards if:

- their ability to do *important income-producing duties* in each occupation they are reasonably qualified for by education, training or experience is reduced by at least 20%
- they are following the advice and recommended treatment of a *medical practitioner*.

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* they experience a reduction in income. The life insured must be following the advice and recommended treatment of a *medical practitioner*.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

To qualify as partially disabled, the life insured must have a reduction of 20% or more in the ability to do one of the following:

- *important income-producing duties*
- generate *income*
- maintain the number of hours worked in their *primary occupation*.

We'll use the life insured's *primary occupation* in the 12 consecutive months immediately before the claim to measure the reduction.

The definition changes if the life insured becomes partially disabled when they haven't been working for more than 12 consecutive months due to unemployment, long service leave or parental leave. In this case, ability to work is based on any occupation they are reasonably qualified for by education, training, or experience.

partner means a person the life insured is legally married to or is in a partnership with. Partnership means a prescribed relationship which is registered under State or Territory law for the purposes of the Acts Interpretation Act 1901.

post-disability business income (for Zurich Business Expenses) means the life insured's share of *business income* for the relevant month while they are *partially disabled* due to *sickness* or *injury*. Post-disability business income excludes any *monthly benefit* payable under the policy.

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

In the first three months that we pay a *monthly benefit*, we'll calculate post-disability income as nil if the life insured is earning 10% or less of *pre-disability income*.

We'll only pay benefits where loss of income is due to *sickness* or *injury*. Where *income* is reduced due to other causes, we'll adjust post-disability income so that it only reflects the proportion of *income* lost due to *sickness* or *injury*. If we make any adjustment, we'll do this using:

- medical evidence, including the opinion of the life insured's *medical practitioner*
- any other information we've gathered to assess the claim, including information from the policy owner and life insured.

pre-disability business income (for Zurich Business Expenses) means the monthly average of the life insured's share of *business income* for the 12 months before *total disability* or *partial disability*.

pre-disability income means the life insured's highest average monthly *income* over any consecutive 12 months in the 24 months before the waiting period starts.

We'll extend the 24 month time-frame by up to 12 months if the life insured has taken unpaid leave, long service leave, parental leave, or sabbatical leave in this period. This will result in a higher average amount. For example, if the life insured has been on parental leave for six months in the 24 months before *sickness* or *injury*, then 24 months becomes 30 months.

primary occupation means any type of business, service, trade, or employment which encompasses the duties predominantly carried out by the life insured. Primary occupation isn't specific to any place of employment, employer, or position.

sickness means sickness or disease including any pre-existing sickness or disease that the life insured told us about in the application that we agreed to cover.

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.

Terminal illness must be confirmed and certified by both of the following:

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

Extra certification is required if the policy is held in superannuation to comply with superannuation law. In this case:

- two certifications are always required
- the period of life expectancy certified by each of the two *medical practitioners*, must not have ended.

total and permanent disablement (TPD) means the type of TPD shown on your policy schedule. Only total and permanent disablement due to *sickness* or *injury* is covered.

Before the policy anniversary when the life insured is 65:

- to qualify for an own occupation TPD benefit, the life insured must meet the *own occupation TPD* or *modified TPD* definition
- to qualify for an any occupation TPD benefit, the life insured must meet the *any occupation TPD* or *modified TPD* definition
- to qualify for a domestic duties TPD benefit, the life insured must either:
  - meet the *domestic duties TPD* definition
  - meet the *any occupation TPD* definition, if they have been working for remuneration or reward for an average of at least 16 hours per week in the six months before stopping work
- to qualify for a modified TPD benefit, the life insured must meet the *modified TPD* definition.

From the policy anniversary when the life insured is 65, the only way to qualify for a TPD benefit, regardless of the definition on the policy schedule, is if the life insured meets the *modified TPD* definition, due to *sickness* or *injury*.

If a permanent incapacity restriction is shown on the policy schedule, the life insured must also meet the definition of permanent incapacity under superannuation law, in addition to the above definition requirements

If superannuation optimiser applies to your policy, you can find the rules that apply to TPD benefit payments on page 61.

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

- not working in paid work
- unable to do one or more of the *important income-producing duties* of their *primary occupation*.

We'll use the life insured's *primary occupation* in the 12 consecutive months immediately before the claim to measure the reduction.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

The life insured must be following the advice and recommended treatment of a *medical practitioner*.

The definition changes if the life insured becomes totally disabled when they haven't been working for more than 12 consecutive months due to unemployment, long service leave or parental leave. In this case, ability to work is based on any occupation they are reasonably qualified for by education, training, or experience.

After we pay 24 months of total disability benefits, partial disability benefits or a combination of both, the definition changes. Ability to work is no longer based on a specific occupation. The life insured is only partially disabled from that point onwards if:

- their ability to do *important income-producing duties* in each occupation they are reasonably qualified for by education, training or experience is reduced by at least 20%
- they are following the advice and recommended treatment of a *medical practitioner*.

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

- not working for remuneration or reward and unable to perform one or more of the *important income-producing duties* of the *primary occupation*
- not working for remuneration or reward and their ability to generate *income* in their *primary occupation* is reduced by 80% or more
- not working more than 10 hours per week for remuneration or reward and unable to perform their *important income-producing duties* for more than 10 hours per week.

We'll use the life insured's *primary occupation* in the 12 consecutive months immediately before the claim to measure the reduction.

'Solely' means that no benefit is payable where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is revoked due to misconduct or if their employer stops trading.

The life insured must be following the advice and recommended treatment of a *medical practitioner*.

The definition changes if the life insured becomes totally disabled when they haven't been working for more than 12 consecutive months due to unemployment, long service leave or parental leave. In this case, ability to work is based on any occupation they are reasonably qualified for by education, training, or experience.

If the life insured is working less than 24 hours per week when they become totally disabled, we'll replace '10 hours' with 'five hours' to determine eligibility for the total disability benefit.

uncomplicated pregnancy or childbirth means pregnancy, childbirth or termination which doesn't result in any serious medical complication. Included are participation in an IVF or similar program, normal discomforts such as morning sickness, backache, ankle swelling or bladder problems, giving birth, miscarriage, or a termination. Uncomplicated pregnancy also includes conditions which first appear during pregnancy and are recognised as pregnancy-related, temporary conditions. These include carpel tunnel syndrome, varicose veins and high blood pressure.

whole person impairment means whole person impairment based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition. We'll consider other appropriate and medically recognised tests that measure whole person impairment at the same degree of severity or greater. The examining doctor will be given specific scoring criteria.

These definitions are specific to trauma cover

angioplasty (minimally invasive cardiac surgery) means the actual undergoing of thoracoscopic, laparoscopic, 'minimally invasive' or 'keyhole' surgery to treat or repair one of the following:
- a narrowing or blockage of one or more coronary arteries
- an obstruction of the aorta or a coarctation of the aorta.

Angioplasty (minimally invasive cardiac surgery) doesn't include investigative or diagnostic procedures.

angioplasty (triple vessel) means the actual undergoing of angioplasty to three or more coronary arteries within the same procedure or via two procedures no more than two months apart. Angiographic evidence, showing obstruction of three or more coronary arteries, is required to confirm that the procedure is medically necessary.

aortic surgery means surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta performed either by open surgery or by thoracoscopic or laparoscopic minimally invasive 'keyhole' techniques.

Aortic surgery doesn't include percutaneous angioplasty or any other intravascular techniques.

aplastic anaemia (requiring treatment) means bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring one of the following treatments:
- immunosuppressive agents
- bone marrow transplantation
- peripheral blood stem cell transplant.

bacterial meningitis or meningococcal septicaemia (with severe life impact) means all potential manifestations of bacterial meningitis or meningococcal septicaemia resulting in both of the following:
- permanent and irreversible neurological deficit confirmed by a specialist physician
- permanent and irreversible inability to perform at least one of the *activities of daily living*.

benign tumour in the brain or spinal cord (with neurological deficit) means a non-malignant tumour in the brain or spinal cord which is histologically described and which produces neurological deficit, resulting in one of the following:
- a permanent and irreversible inability to perform at least one of the *activities of daily living*
- the undergoing of surgery to remove the tumour.

The impairment must be certified by an appropriate medical specialist.

The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.

Benign tumour in the brain or spinal cord (with neurological deficit) doesn't include any of the following:
- cysts, granulomas and cerebral abscesses
- malformations in, or of, the arteries or veins of the brain
- tumours in the pituitary gland. Tumours in the pituitary gland are covered only if the life insured undergoes total surgical removal by open craniotomy.

cancer (excluding early stage cancers) 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. The severity of the condition will mean either:
- the life insured requires major interventionist therapy including surgery to remove the tumour, radiotherapy, chemotherapy, biological response modifiers or any other major treatment
- the tumour is sufficiently advanced such that major interventionist therapy is no longer recommended.

Cancer (excluding early stage cancers) doesn't include any of the following:
- chronic lymphocytic leukaemia less than Rai stage I
- all cancers described as carcinoma in situ. Carcinoma in situ of the breast is covered only if it requires one of the following:
  - the removal of the entire breast, including nipple sparing mastectomy
  - breast conserving surgery and radiotherapy
  - 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, isn't covered.
- all skin cancers unless one of the following applies:
  - they have metastasised to other organs
  - the tumour is a malignant melanoma of stage T1bN0M0 or higher
- all cancers of the prostate unless one of the following applies:
  - histological classification is a Gleason score of 7 or above
  - the tumour has progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system
  - major interventionist therapy or hormonal therapy has been undertaken specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment. Major interventionist therapy includes a total prostatectomy, chemotherapy, radiotherapy or brachytherapy.

carcinoma in situ (limited sites) means a carcinoma in situ characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues.

'Invasion' means one or both of the following:
- an infiltration of normal tissue beyond the basement membrane
- an 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. FIGO means the staging method of The Federation Internationale de Gynecologie et d'Obstetrique.

Only carcinoma in situ of the following sites is covered:
- cervix uteri (excluded are Cervical Intraepithelial Neoplasia (CIN) classifications CIN-I and CIN-II)
- corpus uteri
- fallopian tube – the tumour must be limited to the tubal mucosa
- ovary
- penis or testicle
- perineum
- vagina, vulva or breast.

cardiac arrest (out of hospital) means cardiac arrest that isn't associated with any medical procedure, is documented by an electrocardiogram (ECG), occurs out of hospital and is one of the following:
- cardiac asystole
- ventricular fibrillation with or without ventricular tachycardia.

If an ECG isn't available, we'll consider other medical evidence that confirms an out of hospital cardiac arrest has occurred.

Examples of suitable evidence include but aren't limited to:
- ambulance and hospital medical reports confirming cardiac arrest
- the administration of Cardiopulmonary Resuscitation (CPR) by an attending ambulance officer or hospital clinical staff
- Automated External Defibrillator (AED) data.

cardiomyopathy (with significant permanent impairment) means impaired ventricular function resulting in significant permanent physical impairment. The degree of impairment must be at least Class III of the New York Heart Association classification of cardiac impairment.

chronic kidney failure (end stage) means end stage renal failure presenting as chronic irreversible failure of both kidneys to function. The condition must be evidenced by one of the following:
- permanent regular renal dialysis
- renal transplant.

chronic liver disease (end stage) means end stage liver failure, with the diagnosis based on both of the following:
- permanent jaundice or ascites
- encephalopathy or liver biopsy.

chronic lung disease (end stage) means end stage lung disease, including chronic obstructive pulmonary disease and interstitial lung disease. The condition must require long term continuous oxygen therapy prescribed by a specialist physician and meet one of the following measures:
- persistent FEV1 less than 30% predicted
- DLCO less than 40% predicted.

chronic lymphocytic leukaemia (early stage) means the presence of chronic lymphocytic leukaemia diagnosed as Rai stage 0, which is defined to be in the blood and bone marrow only.

colostomy or ileostomy means the creation of a permanent and irreversible opening, linking the colon and/or ileum to the external surface of the body.

coma (of specified severity) means a state of unconsciousness with no reaction to external stimuli or internal function. The coma must have a documented Glasgow Coma Scale of eight or less and must continue for a continuous period of at least 72 hours.

Coma (of specified severity) doesn't include coma resulting from drug or alcohol intake.

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.

Coronary artery bypass surgery doesn't include angioplasty, other intra-arterial procedures, or laser procedures.

dementia including alzheimer's disease (diagnosis) means both of the following:
- unequivocal diagnosis of permanent and irreversible dementia or Alzheimer's disease confirmed by a consultant neurologist or geriatrician
- the life insured requires continual supervisory care as the result of cognitive impairment. The impairment must be evidenced by a Mini Mental State Examination score of 24 or less out of 30 or the results of another equivalent neuro-psychometric test.

diabetes (of specified severity) means severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist. The condition must be evidenced by at least two of the following:

- severe diabetic retinopathy resulting in visual acuity even when aided of 6/36 or worse in both eyes
- severe diabetic neuropathy causing motor impairment, autonomic impairment or both motor and autonomic impairment
- diabetic gangrene resulting in surgical intervention
- severe diabetic nephropathy causing chronic irreversible renal impairment as measured by a corrected creatinine clearance less than 30ml/min.

diabetes (type 1) first diagnosed after age 30 means the diagnosis of insulin dependent diabetes mellitus (IDDM) after the age of 30 by an appropriate consultant physician.

diplegia means the permanent and total loss of function of both sides of the body resulting from disease, illness or injury of the brain or spinal cord.

encephalitis (with permanent neurological deficit) means an inflammatory disease of the brain caused by viral or bacterial infection, resulting in both of the following:

- permanent neurological deficit
- a permanent and irreversible inability to perform at least one of the *activities of daily living*.

The impairment must be certified by an appropriate medical specialist.

facial reconstructive surgery and/or skin grafting means skin grafting or plastic or reconstructive surgery above the neck which is deemed medically necessary for the treatment of facial disfigurement. The procedure must result directly from an *accidental injury* requiring inpatient hospital treatment.

Facial reconstructive surgery and/or skin grafting doesn't include surgery for isolated nasal fractures.

guillain barre syndrome means both of the following:

- an unequivocal diagnosis of guillain barre syndrome by a neurologist
- the life insured has been unable to perform at least one of the *activities of daily living* for a continuous period of three calendar months.

heart attack (of specified severity) means the death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. The diagnosis must be supported by a diagnostic change 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
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block (LBBB))
- development of pathological Q waves in the ECG
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive or our stated diagnostic techniques are impractical to apply or have been superseded, we'll consider other appropriate and medically recognised tests.

Heart attack (of specified severity) doesn't include any of the following:

- a rise in biological markers resulting from an elective percutaneous procedure for coronary artery disease which isn't performed as necessary treatment for a heart attack
- other acute coronary syndromes including but not limited to angina pectoris
- other causes of cardiac biological marker rise including but not limited to pulmonary embolism
- viral myocarditis.

heart valve surgery means surgery considered medically necessary to repair or replace cardiac valves due to heart valve defects or abnormalities that can't be corrected by non-surgical techniques.

Heart valve surgery doesn't include angioplasty or intra-arterial procedures.

hemiplegia means the permanent and total loss of function of one side of the body resulting from disease, illness or injury of the brain or spinal cord.

idiopathic pulmonary arterial hypertension (with permanent impairment) means idiopathic pulmonary arterial hypertension with substantial right ventricular enlargement. The condition must be evidenced by investigations including cardiac catheterisation. Resulting physical impairment must be at least equivalent to Class III of the New York Heart Association classification of cardiac impairment.

loss of a hand or foot or sight in one eye means the total and irreversible loss of use of one of the following:
- an entire hand
- an entire foot
- sight in one eye, to the extent that even when aided, one of the following applies:
  - eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart
  - the degree of vision is less than or equal to 20 degrees of arc.

loss of hands, feet or sight means the total and irreversible loss of the use of two or more of:
- an entire hand
- an entire foot
- sight in one eye, to the extent that even when aided, one of the following applies:
  - eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart
  - the degree of vision is less than or equal to 20 degrees of arc.

loss of hearing means irreversible hearing loss in the better ear. Even with amplification, the average hearing threshold must be 91dB or greater as measured at 500, 1000 and 1500 Hz.

loss of hearing in one ear means irreversible hearing impairment in the worse ear. Even with amplification, the average hearing threshold must be 91dB or greater as measured at 500, 1000 and 1500 Hz.

loss of independence means one of the following permanent and irreversible conditions resulting from illness or injury:
- inability to perform at least two of the *activities of daily living*
- the life insured requires continual supervisory care due to cognitive impairment. The impairment must be evidenced by a Mini Mental State Examination score of 15 or less out of 30 or the results of another equivalent neuro-psychometric test.

The life insured must have been continuously impaired by the condition for a period of at least three months.

loss of sight means permanent and irrecoverable loss of sight, to the extent that one of the following applies:
- even when aided, eyesight is reduced in both eyes to 6/60 or worse of central visual acuity on the Snellen test chart
- the degree of vision is less than or equal to 20 degrees of arc.

loss of speech means the total loss of natural and assisted speech due to *sickness* or *injury*.

Loss of speech must have existed continuously for a period of at least three months and be permanent and irreversible.

Loss of speech doesn't include loss of speech related to any psychological cause.

major head trauma (with permanent neurological deficit) means accidental cerebral injury resulting in both of the following:
- permanent neurological deficit
- a permanent and irreversible inability to perform at least one of the *activities of daily living*.

The impairment must be certified by a consultant neurologist.

major organ transplant (or waiting list) means one of the following:
- the life insured undergoes an organ transplant
- on specialist medical advice, the life insured goes onto an official Australian acute care hospital waiting list for organ transplant
- the life insured undergoes permanent mechanical replacement of an organ.

Only events relating to the following organs are covered:
- kidney
- heart
- liver
- lung
- pancreas
- small bowel
- bone marrow.

Major organ transplant (or waiting list) doesn't include the transplantation of any other organs, or parts of any organ, or of any other tissue.

medically acquired HIV means infection with Human Immunodeficiency Virus (HIV) which on the balance of probabilities, arose from one of the following medically necessary events:

- a blood transfusion
- transfusion with blood products
- organ transplant to the life insured
- assisted reproductive techniques
- a medical procedure or operation performed by a doctor or dentist.

Only medical events performed in Australia by a recognised and registered health professional are covered.

We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result.

A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if:

- a medical cure is found for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus (whichever applies)
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious.

melanoma (early stage) means the diagnosis of a malignant melanoma on biopsy which is classified as stage T1aN0M0.

motor neurone disease (diagnosis) means unequivocal diagnosis of Motor Neurone Disease.

The diagnosis must be made by an appropriate medical specialist.

multiple sclerosis (with impairment level) means a disease characterised by demyelination in the brain and spinal cord. Multiple Sclerosis must be unequivocally diagnosed. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities.

Diagnosis must be confirmed by neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, and evoked auditory responses.

The impairment must be certified by an appropriate medical specialist.

muscular dystrophy (diagnosis) means the unequivocal diagnosis of muscular dystrophy. The condition must be evidenced by permanent neurological deficit and neurological investigations confirmed by a specialist physician.

muscular dystrophy (with impairment level) means the unequivocal diagnosis of muscular dystrophy, supported by both of the following:

- evidence of permanent neurological deficit confirmed by a specialist physician as a definite result of the diagnosis of muscular dystrophy
- a permanent and irreversible inability to perform at least one of the *activities of daily living*.

occupationally acquired hepatitis B or C means infection with hepatitis B or hepatitis C due to an accident at work, in the life insured's normal occupation.

Any accident which may become a claim must be supported by a negative hepatitis B surface antigen test or negative hepatitis C antibody test taken after the accident. The infection must be evidenced by sero-conversion from hepatitis B surface antigen negative to hepatitis B surface antigen positive or hepatitis C antibody negative to hepatitis C antibody positive within six months of the accident.

We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result.

A benefit isn't payable for hepatitis B if:

- a medical cure is found for hepatitis B
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis B, before making a claim.

A benefit isn't payable for hepatitis C if:

- a medical cure is found for hepatitis C
- the life insured elected not to take an available medical treatment which prevents infection with hepatitis C, before making a claim.
- the life insured hasn't yet taken at least two Australian government subsidised courses of treatment (or an equivalent treatment program) which could result in a cure, before making a claim.

occupationally acquired HIV means infection with Human Immunodeficiency Virus (HIV) due to an accident at work in the life insured's normal occupation.

Any accident which may become a claim must be supported by a negative HIV antibody test taken after the accident. The infection must be evidenced by sero-conversion of the HIV infection within six months of the accident.

We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result.

A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if:
- a medical cure is found for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus (whichever applies)
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious.

paraplegia means the permanent and total loss of use of both legs resulting from disease, illness or injury of the brain or spinal cord.

parkinson's disease (diagnosis) means an unequivocal diagnosis of degenerative idiopathic Parkinson's disease confirmed by a consultant neurologist.

Parkinson's disease (diagnosis) doesn't include any other type of Parkinsonism, for example, secondary to medication.

pneumonectomy means the removal of an entire lung.

prostate cancer (early stage) means prostatic cancers that aren't covered under the definition of *cancer (excluding early stage cancer)* in these definitions and are histologically described as TNM classification T1 according to the TNM staging method or a Gleason Score of 6 or less.

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 (with mechanical ventilation for 10 consecutive days) means both of the following:
- the life insured is admitted to an authorised intensive care unit of an acute care hospital due to accident or illness
- while in intensive care, the life insured requires continuous mechanical ventilation by tracheal intubation for 10 consecutive days, 24 hours a day.

severe burns (of specified extent) means tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness) burns to at least one of the following:
- 20% of the body surface area as measured by The Rule of Nines or the Lund & Browder Body Surface chart
- 50% of each hand
- 50% of the face.

severe rheumatoid arthritis (that fails to respond to treatment) means unequivocal diagnosis of rheumatoid arthritis confirmed by a rheumatologist or clinical immunologist. The condition must be evidenced by failure to respond to at least two disease-modifying anti-rheumatic drugs (DMARDs), excluding corticosteroids and non-steroidal anti-inflammatories, taken consistently for a period of at least nine months.

severe rheumatoid arthritis (with permanent daily life impact) means unequivocal diagnosis of rheumatoid arthritis confirmed by a rheumatologist or clinical immunologist. The condition must be evidenced by both:
- failure to respond to at least two disease-modifying anti-rheumatic drugs (DMARDs), excluding corticosteroids and non-steroidal anti-inflammatories, taken consistently for a period of at least nine months
- a permanent and irreversible inability to perform at least one of the *activities of daily living*.

Severe rheumatoid arthritis (with permanent daily life impact) doesn't include degenerative osteoarthritis or any other arthritides.

stroke (of specified severity) means a cerebrovascular event producing neurological sequela lasting at least 24 hours. The stroke must be evidenced by CT (Computerised Tomography), MRI (Magnetic Resonance Imaging) or similar scan which clearly shows one of the following:
- infarction of brain tissue
- intracranial or subarachnoid haemorrhage.

Stroke (of specified severity) doesn't include:
- 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.

Contact us

Contact us if you need help

We can answer questions about any of the policies explained in this document 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 want to make use of an option on your policy.

Please contact our Customer Care team in the most convenient way for you:

131 551

client.service@zurich.com.au

Zurich Customer Care
Locked Bag 994
North Sydney NSW 2059

Find out more when it suits you best

We have plenty of information on our website to help you. We also have a self-service portal you can sign-up to.

zurich.com.au

Here are some useful locations on our website:

- for a previous version of this PDS: zurich.com.au/existingcustomers
- for information about policy upgrades that may affect you: zurich.com.au/existingcustomers
- for information about premium rate increases in recent years: zurich.com.au/existingcustomers
- for tips on how to manage the cost of your cover over time: zurich.com.au/controlyourcover
- our 24/7 self-service customer portal: zurich.com.au/myzurich

Keep in touch with your financial adviser too

Your financial adviser is your first point of contact for financial advice. We can only provide you with factual information about these policies and how they work.

ZURICH

Zurich Insurance-only Superannuation Plan

Product Disclosure Statement

Issue Date: 29 March 2021

This Product Disclosure Statement ('PDS') is issued by Equity Trustees Superannuation Limited ABN 50 055 641 757 AFSL 229757 RSE 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 29 March 2021 (Zurich Plan PDS) covers financial products issued by the Trustee and insurance products issued by Zurich under Zurich Wealth Protection and Zurich Active policies. The Trustee and Zurich each take full responsibility for the whole of the Zurich Plan PDS. Nevertheless and for the avoidance of doubt, Zurich is not an RSE licensee and legally not able to issue interests in superannuation funds, and the Trustee is not a licenced insurer and legally not able to issue insurance policies. Zurich is not responsible for the operation of the Zurich Plan, and the Trustee of the Plan is not responsible for the operation, nor is the issuer of, the insurance policies and any associated programs or discounts issued or offered by Zurich Australia Limited.

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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 RSE 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 29 March 2021, as supplemented or replaced from time to time, for which Zurich is responsible. The Zurich Wealth Protection and Zurich Active 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 and Zurich Active 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 smartmonday.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 12).

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** which provides 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.
- **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 the Zurich Wealth Protection PDS and Zurich Active 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 12). 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 12. 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 and Zurich Active 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 (eg. 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 and Zurich Active 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 and Zurich Active 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.
- The Zurich Wealth Protection PDS and Zurich Active 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 Zurich Wealth Protection Financial planning advice reimbursement benefit will not form part of the Zurich Insurance-only Superannuation policy contract terms. Instead it will be provided under a separate insurance certificate, made by Zurich directly to you.
- The terms and conditions applicable to insurance cover differ depending on whether you have insurance cover directly under the Zurich Wealth Protection PDS or Zurich Active 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 claim or vary a deduction for personal super contributions' 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, 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 or Zurich Active policy is referred to as the premium and is determined by Zurich. Zurich charges a management fee on Zurich Wealth Protection 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 Trustee pays the premium (including any management fee charged by Zurich and stamp duty) with amounts you contribute or rollover to the Zurich Plan. Zurich may pay commissions to your financial adviser from the money it receives. Commissions are not paid by the trustee and are not additional to these premiums.

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 12.

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 if 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 can make super contributions on behalf of their employees by submitting data and payments electronically in a consistent and simplified manner prescribed by the Australian Taxation Office (ATO) and must do so for contributions made as part of their regular payroll cycle.

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 67, or aged 67 to 74 and have met either the Work Test or the Work Test Exemption.

To satisfy the Work Test, you need to be Gainfully Employed for at least 40 hours during any 30 consecutive day period in the financial year in which the contribution is received. The test needs to be met each year after you reach age 67 where contributions continue to be made. 'Gainfully Employed' means being employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation, or employment.

If you do not satisfy the Work Test, then you may be eligible for the Work Test Exemption if you satisfy ALL of the following criteria:

- you have met the Work Test in the previous financial year; and
- you had a total superannuation balance below $300,000 on 30th June of the previous financial year (consolidated balance across ALL your superannuation funds); and
- you have not previously used the Work Test Exemption between the ages 65-74.

Spouse contributions cannot be made for you unless you are aged under 75. Compulsory employer contributions can be made for you regardless of your age.

If you are not eligible to contribute to superannuation, you may wish to contribute via rollover from another complying superannuation fund, in which case your membership of the Fund can continue. If you are over the age of 67 and do not inform the trustee whether or not you are eligible to contribute to superannuation, the trustee may transfer the ownership of the policy to you so you can apply to convert your cover to a non-superannuation policy. For information about the documentation needed to covert your cover to a non-superannuation policy, or to discuss changing the payment type to rollover, contact Zurich's Customer Care team on 131 551.

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.

Where contributions have been paid to Zurich for the purpose of paying insurance premiums during a period when you were ineligible to contribute (eg. did not meet the Work Test, or were over the age of 75), those premiums will not be refunded by Zurich. This is because Zurich provides insurance cover for the period the premiums have paid for. Zurich is not responsible for monitoring eligibility to contribute.

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 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 may not exceed the concessional contributions cap, but when added to an individual's taxable income and certain other amounts, exceed $250,000 for an income year. 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 or limiting the number of allowable rollovers in a 12 month period, 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 or Zurich Active 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. You should check if your nominated super fund is an untaxed fund before arranging a rollover.

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 30 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 'Refunds' in the next column).

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 12) within 21 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.

At any time while you are a member of the fund, or within 30 days of leaving the fund, you can apply to have cover converted to a non-superannuation policy by contacting Zurich.

For further information about the cessation of cover, 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 12.

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 AUSfund.

The Australian Prudential Regulation Authority (APRA) has approved AUSfund 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 AUSfund:

- you will become a member of the AUSfund and will be subject to its governing rules;
- your account will be invested according to the investment strategy of the AUSfund;
- the AUSfund 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:

Post:	**AUSfund** Locked Bag 5132, Parramatta NSW 2124
Email:	admin@ausfund.com.au
Telephone:	1300 361 798

Refer to the PDS for the AUSfund for more information.

Legislation is before Parliament to facilitate the closure of Eligible Rollover Funds by 30 June 2021. If this legislation passes, amounts that would previously have been sent to the Fund's ERF will instead be paid to the ATO. The Trustee may also voluntarily transfer amounts to the ATO in certain circumstances where the trustee believes it is in the best interests of that member.

Should an amount be transferred to the ATO:

- the ATO will be able to proactively transfer that amount to a person's active superannuation account; and
- information about ATO-held super will be available to members at ato.gov.au or through a myGov account linked to the ATO.

The Trustee will provide members with prior written notice of transfers to the ERF or the ATO.

Any changes or updates relating to ERFs will be made available on our website smartmonday.com.au.

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 8).

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 ($215,000 for the 2020/21 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 advising the trustee how you wish any death benefit to be paid from the Zurich Plan. You may nominate your dependants (as defined in *superannuation law*) or a legal personal representative to receive a lump sum benefit.

To make a nomination simply complete and return the original or a scanned copy of the Binding Death Benefit Nomination (non-lapsing) form. The form is available on the Zurich website zurich.com.au or by calling Zurich's Customer Care team on 131 551.

In order to be valid and effective your nomination must meet the following criteria:

- 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 must not be signed by an attorney or any other agent on your behalf;
- it complies with any other form and content requirements of the Trustee from time to time.

To remain a valid and effective nomination, a nominated beneficiary must still be a dependant at the time of death. If your nomination, or a part of it, is no longer valid and effective at the time of payment, the Trustee cannot pay the death benefit (or that part of it) in accordance with the nomination and will, instead, apply the process set out below.

The nomination will also 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 Binding Death Benefit Nomination (non-lapsing) form.

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.

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 a new Binding Death Benefit Nomination (non-lapsing) form.

Details of any nomination that you have made will be included in your annual statement, however the validity and effectiveness of any nomination is only determined by the Trustee as 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 *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 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 benefit 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 6) 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 11) and the Anti-money laundering and counter terrorism-financing requirements (see page 11) 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 ATO;
- 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.

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).

Trustee Privacy Statement

Important: You should also read Zurich's privacy statement available on the Zurich website, 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 smartmonday.com.au/governance.
A copy of the Insurer's Privacy Statement is available in the Zurich PDSs and online at zurich.com.au.

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 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 smartmonday.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 smartmonday.com.au. You may elect to have a hard copy of the annual report sent to you free of charge.

Insurance in Superannuation Voluntary Code of Practice

The Trustee has adopted the Insurance in Superannuation Voluntary Code of Practice which commenced 1 July 2018. The Trustee has published its transition plan for the Aon Master Trust on the smartMonday website smartmonday.com.au/governance and will transition to all of the standards of the Code, with some exceptions by 1 January 2022.

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 (03) 9621 7275; or
- write to us.

  Complaints Officer
  Zurich Insurance-only Superannuation Plan
  C/- 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 Australian Financial Complaints Authority (AFCA), which provides a free dispute resolution scheme to consumers and small businesses for all financial products and services.

Contact details for AFCA are as follows:

The Australian Financial Complaints Authority
Online: www.afca.org.au
Email: info@afca.org.au
Telephone: 1800 931 678
Post: Australian Financial Complaints Authority
GPO Box 3, Melbourne VIC 3001

Equity Trustees Superannuation Limited
ABN 50 055 641 757 AFSL 229757 RSE L0001458
Level 1, 575 Bourke Street Melbourne VIC 3000
GPO Box 2307 Melbourne VIC 3001

Zurich Australia Limited
ABN 92 000 010 195, AFSLN 232510
Zurich Customer Care: 131 551
Email: client.service@zurich.com.au
Website: zurich.com.au

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