ZURICH

Zurich Wealth Protection

Product Disclosure Statement
and policy conditions

Issue Date: 1 November 2025

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 Safeguard
- 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, 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 96. Some definitions are explained in the product sections for Zurich Income Safeguard and Zurich Business Expenses, for easier referencing.

'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.

Zurich Wealth Protection has been designed for consumers with certain needs and objectives

Each product explained in this document has been designed for consumers with certain objectives, financial situations and needs. Not all products are suitable for all consumers and you need to consider, with the help of any financial adviser advising you, whether the product is right for you.

We've made a target market determination for each product in this document. The determination sets out key attributes of the product, the needs and objectives it is intended to address, eligibility requirements, financial capacity expectations, some key exclusions and how it is to be sold. You can find these documents on our website at zurich.com.au/tmd.

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

The information in this document is up to date when issued but some information can change. Changes 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.

View and update your details any time

You can view your policy information, or update your payment or contact details, 24/7 online. Simply login or register with My Zurich (zurich.com.au/myzurich).

Life Insurance Code of Practice (Code)

We are committed to following the Life Insurance Code of Practice (the Code) and have adopted all of its requirements.

The Code sets out insurers' obligations to consumers during all stages of the life insurance process including:
- When you buy a policy, make a claim or deal with us; and
- When we deal with claims, complaints and requests for information; and
- When we help you if you experience financial hardship or need extra support.

As a subscriber to the Code, we make a number of key promises to consumers, including commitments to be honest, respectful and clear in all our interactions and communications. The Code also requires us to be fair, timely, transparent and accountable when providing services.

Specific 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 trauma definition in the Code for your trauma condition, we'll assess your claim against both the:
- definition in our PDS
- corresponding 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 Code Compliance Committee will regularly review the specific trauma definitions in the code. We'll automatically apply updated definitions to your policy once they are part of the Code.

If you would like more information about the Code, please visit our website at zurich.com.au/licop.

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 can 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.

Customer concerns

We value your feedback and we're committed to ensuring we work with you to resolve your concerns.

Our Customer Care team is your first point of contact for raising complaints or providing feedback. You can contact us directly via phone, email or in writing and we'll do our best to resolve your issue fairly, respectfully and efficiently, and will keep you informed of our progress.

Our contact details are as follows:

131 551

client.service@zurich.com.au

Zurich Customer Care
Locked Bag 994
North Sydney NSW 2059

If you're not satisfied with our response to your complaint, your concerns will be escalated to our Dispute Resolution Team. Our specialists will work closely with you to find a solution quickly and amicably.

Further help

If you're not satisfied with our response to your complaint, you can have your complaint reviewed free of charge by the Australian Financial Complaints Authority (AFCA), which is an external dispute resolution scheme.

Before AFCA can investigate your complaint, they generally require you to have first given us the opportunity to resolve it. AFCA provides a fair and independent complaint resolution service.

Contact details for AFCA are as follows:

1800 931 678

info@afca.org.au

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

afca.org.au

Please note there are time limits for lodging a dispute with AFCA, which are available by contacting AFCA.

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 can 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 the policies that suit you best

Zurich Protection Plus

This policy contains three different types of cover which all pay a lump sum amount.

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 can clear debts and help family members maintain their 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 can help family members maintain their 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 can help fund expenses and recovery time resulting from severe health events.

Zurich Income Safeguard

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 in a reduced capacity due to sickness or injury, income protection can pay a part-benefit to help with the resulting reduction in income. You select how quickly benefits are first payable after the life insured is disabled, as well as the maximum period of time that benefits are payable for each claim.

Income protection can 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 for longer than the selected waiting period.

Business expenses benefits can 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 can minimise the financial impact of severe child illness or injury.

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 85.

Your cover will increase to help you keep up with cost of living
Cover will increase every year without health assessment to help allow for increases in the cost of living. You can decline increases when they're offered if you don't need more cover. This is explained in each of the policy sections of this document.

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. Information about the cover suspension feature can be found on page 84.

If you have existing insurance cover

If you indicate or agree, as part of your application, that any existing insurance for the life insured will be replaced by cover under this policy, then this policy is subject to a special condition that any benefit we pay under this policy will be reduced by any benefit payable under the existing insurance. This condition is limited to the extent to which the total benefit payable for the life insured exceeds our underwriting limits for that cover type. This may result in no reduction of benefits if limits were not exceeded at the time of application. The limits may depend on the life insured's particular circumstances. Contact us or your financial adviser for more information about limits that may apply to each cover type.

Where to find useful policy parameters

The section 'Useful parameters for each policy are summarised here', starts on page 71. In this section you'll find a snapshot of each policy, including entry ages, end ages, cover limits, and a list of benefits and features.

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 self-managed superannuation fund (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 tables on the next page.

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 total and permanent 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.

You may apply to us to transfer the ownership of your policy using a form acceptable to us. However, we may refuse to transfer ownership of your policy where:

a) there is or will be an arrangement or facility with an entity for the transfer of a legal or beneficial interest in your policy (such as a co-ownership arrangement or a change of ownership); and
b) that arrangement or facility involves an entity that carries or carried on (or is or was authorised to carry on) a financial services business in connection with the transfer of legal or beneficial interests in life policies, or a similar business; and

c) under or in connection with that arrangement or facility:
   (i) there is or may in future be an assessment of the life insured (e.g. a health assessment or statistical modelling); and
   (ii) an entity, other than you, is entitled to receive directly or indirectly all or some of the benefits that may become payable under the policy.

We will not refuse to transfer ownership of a life policy between trustees of regulated superannuation funds, or between entities where the policy covers a class of employees.

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

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

An 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.

Under superannuation ownership, the trustee is the policy owner and we pay any insurance benefits under the policy to the trustee. If your insurance is owned by an *eligible superannuation fund*, we may agree with the trustee to pay income protection benefits to the life insured directly, to avoid delays. We'll also reimburse eligible financial planning advice expenses to the life insured directly, where applicable.

Where you take out Zurich Wealth Protection as a member of a superannuation fund, the trustee may only release benefits to you if the trustee is satisfied that you meet a condition of release under superannuation law.

As some benefits can't be held in superannuation, our superannuation optimiser solution will 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 64.

Available ownership structures are shown here

Policies available outside of superannuation	Policy owner	Life insured	Benefits payable to
• Zurich Protection Plus • Zurich Income Safeguard • 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

Policies available in superannuation	Policy owner	Life insured	Benefits payable to
• Zurich Protection Plus • Zurich Income Safeguard (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)

The policies are guaranteed to continue provided you pay premiums

Provided you pay premiums, 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 83.

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.

Any improvements will apply to future claims only and not to past or current claims. The improvements won't apply to claims arising from conditions which first occur, are first diagnosed, or which first become reasonably apparent, before the improvement effective date.

Your cover won't be reduced because of the guaranteed upgrade. If you are inadvertently disadvantaged in any way, the previous policy wording will apply.

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 at: 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 be cancelled, the life insured will no longer be covered, and you can't make a claim
- if you don't comply with your duty to take reasonable care not to make a misrepresentation, your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced. The duty to take reasonable care not to make a misrepresentation is explained in the 'Applying for cover' section, starting on page 68.

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 paid outside of superannuation if superannuation optimiser is selected.
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.

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 if you suffer one of 43 defined Trauma conditions listed and all elements of that condition are confirmed by evidence dated while this benefit and the policy is in-force • 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 if you suffer one of 43 defined Trauma conditions listed and all elements of that condition are confirmed by evidence dated while this benefit and the policy is in-force • 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 can 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, starting on page 96.

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
- whether your premiums are variable age-stepped or variable premiums
- 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 31.

Cover is automatically increased each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 27.

You can apply to 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 30.

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 64, 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

The benefits payable under this policy are summarised in the table below. A full explanation of each benefit follows the table.

We'll pay a benefit only for an event that occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 29.

Benefit name	What this benefit pays	Can it be held in superannuation?
Death & terminal illness benefit	Pays a lump sum on death or *terminal illness*.	Yes
Advancement for funeral expenses	Advances up to $15,000 of the death benefit to reimburse 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 64.

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 to reimburse 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 either of the following:

- *loss of use of a hand or foot*
- *loss of sight in one eye*.

We'll pay the lower of 100% of the death benefit amount and $2 million if the life insured suffers an *accidental injury* which causes any of the following:

- *loss of use of hands or feet*
- *loss of sight*
- *loss of use of hands, feet or sight*.

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.

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.

Benefits payable under the TPD cover

The benefits payable under this policy are summarised in the table below. A full explanation of each benefit follows the table.

We'll pay a benefit only for an event that occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 29.

Benefit name	What this benefit pays	Can it be held in superannuation?
TPD benefit	Pays a lump sum if the life insured suffers a total and permanent disability that meets the selected or allocated TPD definition. The different TPD definitions are explained on the next page. Qualifying periods apply to TPD benefits.	Yes, the life insured must also meet the superannuation definition of permanent incapacity as explained in the section 'Holding this insurance in superannuation', starting on page 64.
TPD advancement benefit	Advances 25% (up to $500,000) of the TPD benefit amount if the life insured suffers *loss of use of a hand or foot or loss of sight in one eye*.	No, but we'll pay these benefits from the related policy if you take superannuation optimiser.
Partial impairment benefit (platinum TPD 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)*.	

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 30.

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 65 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 96.

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 are:
- *own occupation TPD*
- *any occupation TPD*
- *domestic duties TPD*
- *modified TPD*.

The name of each definition describes 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 • certain occupations.	• 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	
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	
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	Solely 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 following the advice of a *medical practitioner* and has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury* • is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again despite having undergone or continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*. **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	Solely due to *sickness* or *injury*, the life insured: • hasn't been working for a continuous period of at least three months • is following the advice of a *medical practitioner* and has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury* • is so incapacitated that they're unlikely to be able to work in *any occupation* ever again despite having undergone or continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*. **any occupation** means any occupation, business, or employment the life insured is suited for by education, training, or experience. Earnings from this occupation, business or employment should be more than 25% of the life insured's earnings from their most recent 12 months of work for remuneration or reward.
Unlikely to perform domestic duties ever again	Solely due to *sickness* or *injury*, the life insured: • has been unable to perform all of the *domestic duties* without an adult person assisting, for a continuous period of at least three months • has been 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	Solely due to *sickness* or *injury*, the life insured suffers *functional impairment* of at least four *extended ADLs*.
Significant impairment to their whole body	Solely 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 use of hands or feet*, *loss of sight* or both *loss of use of a hand or foot* and *loss of sight in one eye*.

Type of TPD cover continued	When a benefit is payable continued
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 96.

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 million will be reduced to $3 million. This maximum benefit amount of $3 million per life insured will apply across all *Zurich life insurance policies*.

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 use 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 use 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 *Zurich life insurance policies* 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.

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%

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

A benefit is only payable once at each partial impairment level. The most we'll pay under this benefit if two claims are made is 65% of the TPD benefit amount at the date when the life insured first meets our definition of *functional impairment*.

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 65 for more information.

Benefits payable under the trauma cover

The benefits payable under this policy are summarised in the table below. A full explanation of each benefit follows the table.

We'll pay a benefit only if you suffer a defined Trauma condition listed and this is confirmed by evidence dated while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 29.

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

Benefit name	What this benefit pays
Trauma benefit	Pays a lump sum if you suffer a defined Trauma condition listed and this is confirmed by evidence dated while this benefit and the policy is in-force. We don't cover all traumatic health events. Our specific definition of the condition applies to any claim and describes a certain severity.
Paralysis booster benefit	Doubles the benefit payable for paralysis, to a maximum of $2 million. Our specific definitions for *diplegia, hemiplegia*, *paraplegia* and *quadriplegia* apply to this benefit.
Partial trauma benefit (trauma 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 suffers any one of the defined trauma conditions listed in the 'Insured trauma conditions for the trauma benefit' table on the next page, and this is confirmed by evidence dated while this benefit and the policy is in-force. Our insurance definition for each covered condition can be found in the section 'These definitions are specific to trauma cover', starting on page 103. 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 29.

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

Paralysis booster benefit

We'll double the trauma benefit payable (to a maximum of $2 million) 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 103. We won't pay a benefit if the life insured's condition doesn't meet our specific definition.

Partial trauma benefit

This benefit only applies 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 'Insured trauma conditions for the partial trauma benefit' 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 103. 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 29.

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 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, use of limbs, paralysis, and loss of independence
diplegia (paralysis booster applies to this condition)
hemiplegia (paralysis booster applies to this condition)
loss of use 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 and with cognitive impairment)
encephalitis (with permanent neurological deficit)
motor neurone disease (diagnosis)
multiple sclerosis (recurrent episodes with impairment level)
muscular dystrophy (with impairment level)
parkinson-plus syndrome (specified)
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 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)

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 (with symptoms)

Other 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 use 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 (excluding the Continuous Care option) 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 tables on this page and on page 23, 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 totally disabled.	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.
Continuous Care option	Helps cover financial loss occurring as a result of the life insured requiring care due to *sickness* or *injury* for the rest of their life.	Yes

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 premiums 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 suited 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 involuntary unemployment over the life of the policy.

The premium waiver option ends when one of the following happens:
- the death of the life insured
- if we receive notification to cancel the option, the end of the period of cover for this optional benefit you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the life insured is 69
- when the policy ends.

Some restrictions apply to the premium waiver option
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.

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

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 accept your application.

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

- $15 million for the death benefit
- $5 million for the TPD benefit
- $2 million 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 million 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 *Zurich life insurance policies* is $2 million. 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.

Continuous Care option

This option can help cover financial loss occurring as a result of the life insured requiring care due to *sickness* or *injury* for the rest of their life. The continuous care benefit, for example, can contribute to the cost of a family member needing to take time off or cease working to provide the care to the life insured. It can be applied for and added to a Zurich Protection Plus policy either as an additional benefit or on its own.

Continuous care benefit

We'll pay the continuous care benefit amount if this option applies to the policy, as shown on the policy schedule, while both the policy and option are in-force, and solely as a result of *sickness* or *injury*:

(a) the life insured has been disabled to the extent that the life insured has required, and has been under, *continuous care* for at least 3 consecutive months, and
(b) the life insured has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*, and
(c) despite having undergone or continuing to undergo all reasonable and appropriate treatment, and after the use of all reasonable aids and home modifications, the life insured is disabled to the extent that the life insured requires *continuous care* for the rest of their life with no reasonable prospect that the disability will improve.

The prognosis of the disability in (c) must be supported by a specialist *medical practitioner* taking into account appropriate treatment. Disabilities for which the relevant specialist cannot give a clear prognosis are not covered.

The *sickness* or *injury*, its symptoms and effects on functional impairment must be confirmed by a *medical practitioner* considered an appropriate specialist physician for the *sickness* or *injury*. The claim must be supported by objective medical evidence and confirmatory investigations including, but not limited to, clinical, radiological, histological and laboratory evidence.

In addition to the above, certain events must meet a specified severity. If the care is needed in whole or in part due to:

(i) any mental health or behavioural condition classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or in any other clinically recognised diagnostic manual (including any replacement or successor to DSM) excluding conditions captured in (ii), the life insured must meet an impairment percentage of 47 or above on the Psychiatric Impairment Rating Scale (PIRS), or
(ii) cognitive decline due to neuro-degenerative conditions (for example dementia such as Alzheimer's disease), the life insured must meet a Mini Mental State Examination score of 15 or less out of 30. In this case, a PIRS result is not required, or
(iii) any condition or symptom that relies on medical symptoms alone without the support of abnormal test results from medical imaging, pathology or blood tests that explain the symptoms, for example conditions or symptoms including chronic fatigue syndrome or fibromyalgia, the life insured must have suffered permanent and irreversible *whole person impairment* of at least 60%.

Home modification advancement benefit

We'll pay a home modification advancement benefit if this option applies to the policy, as shown on the policy schedule, while both the policy and option are in-force, and solely as a result of *sickness* or *injury*:

(i) the life insured is unable to move from place-to-place by walking or with the assistance of a walking aid, and they're unlikely to be able to ever again, or
(ii) the life insured is unable to climb a set of stairs without the assistance of another person, and they're unlikely to be able to ever again, or
(iii) the life insured suffers *loss of sight*.

The amount payable is the lower of 10% of the continuous care benefit amount and $200,000.

The home modification advancement benefit is only payable once. The maximum amount we'll pay under the home modification advancement benefit is $200,000 across all Zurich Protection Plus policies for the life insured. The continuous care benefit amount will be reduced by the amount paid under the home modification advancement benefit.

Care advancement benefit

We'll pay a care advancement benefit of $10,000 if this option applies to the policy, as shown on the policy schedule, while both the policy and option are in-force when the life insured:

(i) had a claim paid on a TPD benefit under the TPD cover for a Zurich Protection Plus policy, and
(ii) solely as a result of *sickness* or *injury* the life insured has been disabled to the extent that a family member has had to stop paid employment for at least one month to care for the life insured at home or the life insured has incurred paid care costs for at least one month through an appropriate provider who is not a family member.

The care advancement benefit is only payable once. The care advancement benefit only applies if the continuous care benefit amount is $250,000 or more. The maximum amount we'll pay under the care advancement benefit is $10,000 across all Zurich Protection Plus policies for the life insured. The continuous care benefit amount will be reduced by the amount paid under the care advancement benefit.

Continuous Care definition

continuous care means daily assistance by another adult person required to sustain life or attend to bodily functions, for no less than 6 hours a day. 'Continuous' does not mean that the carer must spend every minute of the day providing personal care. Care may be provided in long blocks, short regular intervals or a combination of periods.

For care that has been required, in the 3 consecutive months period, this must be evidenced through any of the following:

(i) hospitalisation
(ii) paid care costs through an appropriate provider who is not a family member
(iii) a family member providing the care, who was previously working full-time, with evidence of no longer working (for example, carer's leave or termination notice) and loss of income
(iv) a family member providing the care, who was previously not working, with evidence of hiring home support which was previously not in place of at least 6 hours each day
(v) a family member providing the care, who was previously working part-time, with evidence of:
- for the days previously working, no longer working (for example, carer's leave or termination notice) and loss of income, and
- for the days not working, evidence of hiring home support which was previously not in place of at least 6 hours each day or evidence of paid care through an appropriate provider.

General terms applying to all benefits under the Continuous Care option

The amount payable for each benefit under the Continuous Care option is the amount effective on the date when the life insured has first satisfied all the requirements of that benefit.

If the Continuous Care option is set up in superannuation, each benefit is only payable if the life insured also meets the definition of permanent incapacity under superannuation law.

Continuous Care option eligibility conditions:
- Entry ages between 15 to 60
- Minimum benefit amount of $250,000
- Maximum benefit amount of $5 million for Continuous Care option
- Maximum combined amount of $5 million for the Continuous Care option and TPD cover.

The continuous care benefit is automatically increased under the inflation protection feature each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 27.

The following features do not apply to the Continuous Care option:
- Future insurability
- Future insurability for business.

Exclusions under Continuous Care option

We won't pay the continuous care benefit or home modification advancement benefit if the *sickness* or *injury* is caused by either of the following:
- 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.

The 90-day elimination period does not apply to the Continuous Care option.

When the Continuous Care option ends

This option ends when the first of the following happens:
- the policy anniversary when the life insured is 65
- payment of the total continuous care benefit amount
- we receive notification to cancel the Continuous Care option, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- the Continuous Care option end date shown on the policy schedule
- when the policy ends.

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.

If you add any of these options to your policy after it starts, you can only make use of the options for claim events that occur at least 90 days after the option is added.

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 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.	
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.	
Trauma reinstatement option	Reinstates trauma cover 12 months after a full or partial trauma claim. To reinstate death cover and linked trauma cover at the same time, select the buy-back death option (trauma) or the double trauma option in conjunction with this option. This option restores the trauma cover to the pre-claim amount. Only unrelated conditions are covered after the reinstatement.	No

The Double TPD option and Double trauma option reinstate cover at no cost, as they include a premium waiver.

Premium for any other reinstated 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 apply to all reinstated benefits.

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
- TPD definition is met before the policy anniversary when the life insured is 65
- 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
- life insured stops work because of the TPD event 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.

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
- trauma definition is met before the policy anniversary when the life insured is 64
- 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.

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 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
- 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.

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.

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
- life insured is working full time in their usual occupation
- 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 amount is reinstated as TPD benefit 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 amount is reinstated as TPD benefit 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 amount is reinstated as TPD benefit 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 suited for by education, training, or experience.

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.

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
- trauma condition occurs more than 90 days after the option starts if the option is added after the policy start date.

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
- directly or indirectly caused by the original specified trauma or its symptoms
- directly or indirectly caused by the event which caused the original specified trauma
- a *loss of independence*
- a 'heart condition' if the original claim was for a 'heart condition'
- 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 85.	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 outside of superannuation if superannuation optimiser is selected.
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 84.	Yes, unless the policy is funded by a platform account.

Inflation protection

We'll increase your insurance cover each year to help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. Inflation protection will continue to apply to cover at or above the maximum sum insured. They apply to the death benefit amount, TPD benefit amount, trauma benefit amount and continuous care 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 the 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
- 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 amount 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 limits apply to future insurability

The following limits 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 million
- 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 million
- the trauma benefit amount can't be increased to more than $2 million
- the TPD benefit amount can't be increased to an amount that would result in the combined TPD benefit and the Continuous Care option benefit amount being more than $5 million
- 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 events that happen after the date of the increase are 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 million.

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 an 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. Accommodation costs are only covered while the life insured is confined to bed. 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 *Zurich life insurance policies* 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 practise in Australia or a nurse legally registered to practise in another country who has an equivalent qualification. Nurse doesn't include the:
- policy owner, their relative, business partner or employee
- 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 from $3,000 to $6,000 if the cover has been in place for five years or more on the date of the event that triggers the claim.

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
- start date of any death benefit increase applied for (but only for the increase)
- 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 use of a hand or foot, loss of sight in one eye* or *functional impairment* caused by either of the following:
- 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 the trauma condition is caused by either of the following:
- 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.

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 18 that are marked with an asterisk (*). The start of the elimination period can vary:

New cover

For new trauma cover applications, the elimination period starts on the benefit start date for that cover. We won't ever pay a claim for those trauma conditions if during the elimination period either of the following happens:
- the condition occurs or is apparent. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition
- surgery for the conditions is recommended to the life insured.

Cover increases

For cover increases, the elimination period starts on the benefit start date of any increase in trauma benefit, and only applies to the increase portion of the cover. We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended to the life insured.

Reinstated cover or cover suspension

When there is a break in cover and the policy re-starts, the elimination period starts from the date the policy is reinstated or, if after cover suspension, from the cover suspension end date. We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended to the life insured.

In all circumstances, 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.

We won't apply the 90-day elimination period if immediately before the trauma benefit started, the life insured held cover for the same trauma condition 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.

Some angioplasty procedures won't be paid as separate claims

For *angioplasty* (*minimally invasive cardiac surgery*), double vessel procedures completed in two sessions within a two-month period, or that are the result of the same investigation which demonstrated the need for the procedures, will be considered to be one procedure, and a benefit will only be paid once.

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

We won't pay the trauma benefit for a trauma condition 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

The following exclusions apply to the insured trauma conditions *medically acquired HIV*, *occupationally acquired hepatitis B or C* and *occupationally acquired HIV*, as well as the needlestick cover option.

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)
- 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 a trauma condition 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.

Continuous Care option benefit reductions

The continuous care benefit amount is reduced by the amount paid or advanced under any of the following:
- home modification advancement benefit
- care advancement 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
- if we receive notification to cancel the death benefit, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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
- if we receive notification to cancel the TPD benefit, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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
- if we receive notification to cancel the trauma benefit, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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:
- if we receive notification to cancel the option, the end of the period of cover for the optional benefit you have paid premiums for, adjusted for any premium refunds payable
- 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. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy the related policy ends (if superannuation optimiser applies)
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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 Safeguard

Zurich Income Safeguard covers you for health events that prevent the life insured from working and earning income

Zurich Income Safeguard provides a monthly benefit if the life insured is unable to work solely due to sickness or injury for longer than the specified 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.

When you need to claim under this policy, we want to partner with the life insured on their journey to recovery

When a sickness or injury occurs, we understand it can be a difficult and emotional time and we are here to help support the life insured on their return-to-health journey.

This is our commitment to the life insured

Being engaged in work is a benefit to you, your family and society and we want to help you make a safe return to health and work. We see it as part of our commitment to you when you have a policy with us.

While everyone is affected differently by sickness and injuries, there are expected recovery times for most sicknesses and injuries. We'll work with you and your medical practitioner to ensure you are getting the best treatment possible should your recovery be taking longer than expected.

Expectations during a claim

The claim process is explained in the 'Making a claim' section of this document, starting on page 88. To ensure transparency, the following sets out what we expect of you during a claim, and what you can expect from us.

What you can expect of us	Our expectations of you
We will: ✓ make payments for the duration of your claim in a timely way ✓ make the claims process as straightforward as we reasonably can ✓ work with you, your treating medical practitioners and where appropriate, our rehabilitation teams, to support you on your recovery journey. We'll support your return to your previous occupation, however, if evidence indicates that a return to your previous occupation is unlikely, we'll work with you, your treating medical practitioners and where appropriate our rehabilitation teams, to support your return to a suitable occupation based on your education, training, or experience ✓ provide access to and funding for appropriate rehabilitation or retraining programs, which may include job seeking, graduated return to work plans, reasonable retraining and other work readiness programs ✓ adhere to the Life Insurance Code of Practice and its principles of conduct such as being open, fair and honest.	You will: ✓ lodge your claim as soon as you can after a sickness or injury ✓ follow the advice of any treating medical practitioner on an ongoing basis, including recommended courses of treatment and rehabilitation to strive for maximum possible improvement ✓ co-operate in assessments of your capacity for work, rehabilitation progress or future employment prospects ✓ actively participate and co-operate in planning for your return to work, including attending reasonable retraining for other suitable employment ✓ make reasonable efforts to return to work in suitable employment.

Zurich Income Safeguard policy conditions

The information below forms part of the Zurich Income Safeguard policy conditions.

When we accept your application, we'll issue you with a policy schedule.

The policy schedule shows:

- the policy owner and the life insured covered under the policy
- the insured monthly benefit at the start of the policy
- the benefit period
- the waiting period
- any extra-cost optional benefits selected
- whether your premiums are variable age-stepped or variable premiums
- 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 43.

Cover is automatically increased each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 44.

You can apply to make changes to your policy. If you apply for optional benefits 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.

The words or expressions shown in *italics* that are specific to this policy have their meaning explained on page 39 in the section 'What we mean by the terms we use'. Words or expressions that we use throughout this document, like *medical practitioner*, are explained in the 'Definitions' section, starting on page 96.

If cover is held in superannuation, restrictions apply

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

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.

Monthly benefits are only payable under this policy if the life insured meets the superannuation definition of temporary incapacity.

Cover while unemployed in superannuation

The life insured won't meet the temporary incapacity definition and be eligible to receive monthly benefits if they're unemployed when *sickness* or *injury* occurs. You can only claim total or partial disability benefits under this policy during unemployment if *sickness* or *injury* is the reason the life insured is unemployed.

However, we provide complimentary cover if the life insured is totally or partially disabled due to *sickness* or *injury* while unemployed. Please see page 66 for further details on the eligibility conditions and an explanation of how this works.

Insured monthly benefit

The insured monthly benefit is the amount of monthly benefit shown on the policy schedule when your policy starts, plus any indexation, as explained in the section 'Inflation protection' on page 44. 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.

The insured monthly benefit is the maximum amount we'll pay for any month.

When you apply for cover, you can insure up to 70% of the life insured's annual income up to an annual income of $300,000. After that, a sliding scale applies. You can insure 50% of the next $200,000 of annual income and 25% of annual income above $500,000. When we say annual income, we mean the annual equivalent of (or 12-times) *monthly income*.

The maximum insured monthly benefit you can apply for is $30,000 per month, plus an additional amount up to $30,000 per month restricted to a 1-year or 2-year benefit period. If you separately insure your superannuation contributions using our super contributions option, explained on page 47, then these maximums include the super contributions monthly benefit amount. The overall maximum of $60,000 per month applies to income protection and business expenses cover combined.

This policy provides indemnity cover, which means that the monthly benefit payable if you make a claim is based on the life insured's annual income at the time of the claim. The monthly benefit we pay will be adjusted to reflect income the life insured receives or is entitled to receive as well as *other payments* received in the month because of *sickness* or *injury*, for example, sick leave benefits.

Benefit calculation examples are provided on page 42.

It's important to check your level of cover against your income to make sure it suits your needs. We don't refund premiums where your insured monthly benefit is higher than *pre-claim earnings* at claim time. If your income changes, you may need to adjust the insured monthly benefit to make sure you're not insured for more than you could receive or less than your *pre-claim earnings* would support. Your financial adviser can support you with this process.

Benefits payable under this policy

The benefits payable under this policy are summarised in the table below. A full explanation of each benefit follows the table.

We'll pay a benefit only if total or partial disability occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 47.

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 benefit if the life insured is partially disabled after the waiting period.

What you need to know about how the claims journey works

The next few pages of this document provide guidance on what you can expect and important milestones when making a claim under your Zurich Income Safeguard policy. The waiting period and benefit period are important aspects of your cover and will be shown on your policy schedule.

How to qualify for a monthly benefit payment

To qualify for a monthly benefit, you must first satisfy the waiting period requirements. Once the waiting period requirements are met, we will calculate the benefit payable.

The waiting period

The waiting period is the period you must wait before the benefit period starts and you become eligible for a monthly benefit.

During the waiting period, you must follow the advice and recommended treatment of a *medical practitioner*. We may also provide you with rehabilitation support during the waiting period so we encourage you to tell us of your *sickness* or *injury* as soon as you can.

You must continue to pay premiums that fall due during the waiting period. If we accept your claim, these premiums will be refunded to you with the first benefit payment.

Choice of waiting periods

The waiting periods available are 30-days, 60-days, 90-days, 1-year, and 2-years.

The waiting period starts on medical consultation

The waiting period starts when the life insured consults a *medical practitioner* and receives advice confirming the total or partial disability.

The waiting period doesn't apply if the claim is a recurring claim. Recurring claims are explained on page 43.

Waiting period requirements

Solely due to *sickness* or *injury* the life insured must be all of the following:

- totally disabled for at least 7 out of 12 consecutive days during the waiting period
- totally or partially disabled for the remainder of the waiting period
- following the advice and recommended treatment of a *medical practitioner*.

Totally disabled during the waiting period means the life insured is both:

- unable to do each and every *important income-producing duty* of their *primary occupation*
- not working in their *primary occupation* or in any other *gainful occupation*.

Partially disabled during the waiting period means the life insured meets either of the following criteria:

- has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation*
- is unable to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition.

The benefit period

The benefit period is the maximum period of time that we'll pay a monthly benefit.

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

A separate benefit period will apply to each claim for *sickness* or *injury*, except for certain recurring claim situations. See 'Recurring claims' on page 43.

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. Our waiting period may be served while you are receiving monthly benefits under the salary continuance cover.

Benefits are payable if the life insured is totally or partially disabled after the waiting period

The tables on this page and the next two pages explain how to qualify for a benefit, depending on the chosen benefit period and waiting period.

If the life insured has capacity to work (in their *primary occupation* or in another *gainful occupation*, as applicable), then they won't meet our definition of totally disabled. In this case we'll assess the claim under the partial disability definition and will use the partial disability calculation to work out the benefit amount payable.

For policies with a waiting period of 30, 60 or 90 days and benefit period of 1-year, 2-years or 5-years

Throughout the claim, the benefit payable will depend on the life insured's ability to work in their *primary occupation* after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled	Qualifying for a benefit when the life insured is partially disabled
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled means the life insured meets all of the following criteria: • has no capacity to do each and every *important income-producing duty* of their *primary occupation* • is not working in their *primary occupation* or in any other *gainful occupation* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled means both of the following: The life insured meets either of the following criteria: • has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation* • has no capacity to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

For policies with waiting periods of 30, 60 or 90 days and benefit period to age 65

During the first two years of a claim, the benefit payable will depend on the life insured's ability to work in their *primary occupation* after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled in the first two years of a claim	Qualifying for a benefit when the life insured is partially disabled in the first two years of a claim
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled in the first two years of a claim means the life insured meets all of the following criteria: • has no capacity to do each and every *important income-producing duty* of their *primary occupation* • is not working in their *primary occupation* or in any other *gainful occupation* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled in the first two years of a claim means both of the following: The life insured meets either of the following criteria: • has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation* • has no capacity to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly* income that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

After we pay 24 months of total disability benefits, partial disability benefits or a combination of both, the occupation we use to assess working capacity changes. Instead of the life insured's *primary occupation*, we will consider any *gainful occupation* the life insured is suited for by education, training, or experience.

The 24-month period includes months when a monthly benefit is payable, even if the amount payable is reduced to nil because of *other payments*, *monthly income*, or *ongoing income*, or any combination of them.

Qualifying for a benefit when the life insured is totally disabled after the first two years	Qualifying for a benefit when the life insured is partially disabled after the first two years
We'll continue to pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled after the first two years of a claim means the life insured meets all of the following criteria: • is not working • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll continue to pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled after the first two years of a claim means both of the following: The life insured meets either of the following criteria: • has capacity to work in any *gainful occupation* they are suited for by education, training, or experience, but earnings are reduced • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

For policies with a waiting period of 1-year or 2-years

The benefit payable will depend on the life insured's ability to work in any *gainful occupation* they are suited for by education, training, or experience, after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled	Qualifying for a benefit when the life insured is partially disabled
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled means the life insured meets all of the following criteria: • is not working • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled means both of the following: The life insured meets either of the following criteria: • has capacity to work in any *gainful occupation* they are suited for by education, training, or experience, but earnings are reduced • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

What we mean by the terms we use

This is a selection of key words (defined terms) that are important to help you better understand how Zurich Income Safeguard works.

actively participating in a rehabilitation or retraining program means the life insured is actively engaged in a rehabilitation or retraining program they have the capacity to undertake, and which is designed to create a pathway to return to their *primary occupation*, or, if this is unlikely, a pathway for any *gainful occupation* they are suited for by their education, training, or experience.

If the life insured stops participating in a rehabilitation or retraining program on the advice of their treating *medical practitioner*, we'll need written documentation from the treating *medical practitioner* explaining:

- the reasons that the life insured has been advised to stop participating in the rehabilitation or retraining program
- how long the rehabilitation or retraining program is expected to be paused
- whether the rehabilitation or retraining program could be modified rather than paused
- the medical information used by the treating *medical practitioner* in forming their opinion.

If the life insured completes a rehabilitation or retraining program but has not returned to a *gainful occupation*, we will work with the life insured to determine whether an additional rehabilitation or retraining program could assist.

gainful occupation means employed or self-employed for gain or reward. This includes any paid position of employment including the life insured's *primary occupation*.

important income-producing duty means each duty that is essential to the life insured's ability to produce *monthly income* from their *primary occupation* or a *gainful occupation* (as applicable).

injury means bodily injury caused by an accident. The accident must occur while the policy is in-force.

monthly income means either:

- if the life insured is self-employed or a working director, the total remuneration package before tax and excluding superannuation guarantee calculated monthly, and the life insured's share of the gross monthly income generated by the business after allowing for the expenses incurred in deriving that income. This also includes *ongoing income* in any form that the life insured or any related person or entity on the life insured's behalf, receive, derive or are entitled to receive from any nature or form of business which the life insured engaged in
- in all other circumstances, the life insured's total remuneration package before tax and excluding superannuation guarantee, and inclusive of regular bonuses, calculated monthly.

In both instances, monthly income does not include dividends, interest, rental income, proceeds from the sale of assets or royalties. For example, it does not include dividends from shares in a publicly listed bank.

ongoing income means any net profit (income less expenses), salary, payment, or income in any form that the life insured or any related person or entity on the life insured's behalf, receive, derive, or are entitled to receive from any nature or form of business which the life insured engaged in either before the claim or while on claim.

Ongoing income does not include dividends, interest, rental income, proceeds from the sale of assets or royalties. For example, it does not include dividends from shares in a publicly listed bank. It also does not include any superannuation payments as required to meet superannuation guarantee contribution requirements.

other payments are any of the following received because of the life insured's *sickness* or *injury*:

- payments from any other disability income, sickness or injury policies, including insurance provided by the life insured's employer or which forms part of the life insured's superannuation plan, that you didn't tell us about when you applied for cover, or that you told us you were replacing with this cover to the extent required to ensure the combined maximum amount paid in total does not exceed the life insured's *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 and the maximum monthly benefit payable
- payments from compulsory insurance schemes such as workers' compensation or accident compensation for loss of income
- paid leave from an employer, including sick leave, annual leave or long service leave
- common law settlements.

pre-claim earnings means the life insured's average *monthly income* for the 12 consecutive months immediately before the life insured's total or partial disability.

If *monthly income* reduces by 25% or more in the 12 consecutive months before the life insured's disability compared to the previous 12 consecutive months, other than as a result of unemployment or sabbatical leave, then pre-claim earnings is the higher of the average *monthly income* in the:

- 24 consecutive months before the life insured's total or partial disability
- financial year before the life insured's total or partial disability.

The definition changes if the life insured is on parental leave at the date of the total or partial disability or in the 12 months before the total or partial disability. In this case we will use the average *monthly income* for the 12 consecutive months before the period of leave started.

If a benefit is paid beyond 12 months, pre-claim earnings are 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.

primary occupation means any type of business, profession, service, trade, or employment which encompasses the duties predominantly carried out by the life insured at the time of *sickness* or *injury*.

If the *sickness* or *injury* occurs while the life insured is unemployed, or on parental or sabbatical leave, primary occupation means any type of business, profession, service, trade, or employment which encompasses the duties predominantly carried out by the life insured at the last occupation they had before unemployment, parental leave, or sabbatical leave.

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.

How we calculate the monthly benefit payable

This policy covers the life insured for up to 70% of income prior to *sickness* or *injury*. Their *sickness* or *injury* and return to work journey may mean that they are either totally or partially disabled at various times. Totally disabled and partially disabled in this section means as defined in the tables on pages 36 to 38.

When you qualify for a benefit because the life insured is totally disabled, the amount you may receive in total from us and all other sources is 70%. However, when you qualify for a benefit because the life insured is partially disabled, the amount you may receive in total from us and all other sources can be higher to support and encourage an active return to any *gainful occupation*.

Total disability benefit

Each month you qualify for a benefit because the life insured is totally disabled, we pay the lower of the:

- insured monthly benefit reduced by *other payments* received in the month
- annual equivalent of (or 12-times) *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 to get a monthly amount. This amount is reduced by *other payments* received in the month and any *ongoing income*.

Partial disability benefit

Each month you qualify for a benefit because the life insured is partially disabled, we pay the lower of the:

- insured monthly benefit reduced by *other payments* received in the month
- annual equivalent of (or 12-times) *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 to get a monthly amount. This amount is reduced by *other payments* received in the month and 70% of *monthly income*. *Monthly income* is adjusted to the life insured's maximum earning potential if the life insured is not working at their full capacity. This is explained below.

If the life insured isn't working at their full capacity

If the life insured isn't working at their full capacity, we calculate *monthly income* as their maximum earning potential for the respective month. This is calculated as follows:

For policies with a to age 65 benefit period and a 30-day, 60-day or 90-day waiting period:

- during the first two years of a claim, we'll calculate *monthly income* based on what the life insured's maximum earning potential would reasonably be if they were working at capacity. Maximum earning potential will be based on the life insured's *primary occupation*.
- after two years on claim, we will base maximum earning potential on any *gainful occupation* the life insured is suited for by education, training, or experience.

For policies with a 1-year, 2-year or 5-year benefit period and a 30-day, 60-day or 90-day waiting period, we will calculate *monthly income* based on what the life insured's maximum earning potential would reasonably be if they were working at capacity. Maximum earning potential will be based on the life insured's *primary occupation*.

For policies with a 1-year or 2-year waiting period, we'll base maximum earning potential on any *gainful occupation* the life insured is suited for by education, training, or experience.

To determine maximum earning potential, we'll consider these three things:
- available medical evidence, including the opinion of the life insured's *medical practitioner*
- employability assessment
- any other relevant factors directly related to the life insured's medical condition, including information they provide to us.

Payments that impact the monthly benefit we pay

The monthly benefit amount we pay will be reduced by *other payments* received in the same month.

The monthly benefit will also be reduced by *monthly income* if you are partially disabled and *ongoing income* if you are totally disabled for the claim month.

If we are already paying benefits, we'll tell you 30 days before we adjust future payments because we change what we determine as the life insured's maximum earning potential.

If *monthly income* or *ongoing income* is negative in a month, we will treat the amount as zero.

We won't offset:
- business expenses benefits which reimburse actual business expenses
- total and permanent disability benefits, trauma benefits, terminal illness benefits or lump sum superannuation benefits
- sums awarded by a court for pain and suffering.

We'll convert lump sum payments to monthly amounts
Any *other payments*, *monthly income*, or *ongoing income* received as a lump sum compensation payment for loss of earnings that can't be allocated to specific months will be converted to a monthly amount.

We'll allocate 1% of the loss of earnings component of the lump sum to each month that we pay the total or partial disability benefit for up to five years.

We won't offset any remaining balance of the lump sum.

Benefits are paid monthly

The total disability benefit is paid 15 days after the waiting period ends, provided claim requirements are met, and monthly after that. Benefits for total disability are generally paid two weeks in arrears and two weeks in advance. Benefits for partial disability are generally paid entirely in arrears since we need evidence of income in the relevant month to work out the benefit amount.

If any claim ends part way through a month, we'll pay 1/30th of the monthly benefit for each day during this period.

We don't refund premiums where your insured monthly benefit is higher than *pre-claim earnings* at claim time.

Some claims may be paid in advance

If medical evidence supports the life insured's inability to work for three months or less, most often for *injury* claims, we may pay monthly benefits in advance. Each claim is different, and we can't always make advance payments for income protection claims. Eligibility depends on the life insured's occupation, the relevant *sickness* or *injury* and the waiting period. 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 up to three months up-front.

Policies with a 1-year or 2-year waiting period are not eligible for payments in advance.

We'll only pay one or more monthly benefits in advance if a *medical practitioner* certifies that the life insured is totally disabled at the end of the waiting period and is likely to remain disabled for between one and three months.

If the life insured is still disabled at the end of the period paid in advance, the claim will continue on a regular monthly payment basis.

You must provide us with information on your earnings and income

We may require you or the life insured to provide us with timely financial information for the benefit payment period. Financial evidence may include submitted tax returns or other financial documentation which confirms the life insured's *monthly income* and *ongoing income* (if applicable).

We may adjust the monthly benefit over the claim period

We may calculate the amount of the total or partial disability benefit that we would otherwise have paid if the life insured's *monthly income* or *ongoing income* was averaged over the claim period, and either:
- recover any excess amount of monthly benefit paid
- reduce the amount of any future monthly benefits payable until the excess amount has been recovered
- pay any shortfall in monthly benefit.

Benefit calculation examples

Here are some examples which show how the amount payable will differ depending on whether the life insured is totally or partially disabled, and the income they have in the claim month.

In these examples, the life insured has *pre-claim earnings* of $10,000, an insured monthly benefit of $7,000 and receives $500 per month from a sports injury insurance claim during the claim period.

Total disability benefit calculation	
Lower of these two amounts:	
1. The insured monthly benefit **reduced by** *other payments* received in the month	$7,000 Less: *other payments* received: $500 = $6,500
2. The annual equivalent of *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 **reduced by** *other payments* received in the month and *ongoing income*.	$7,000 Less: • *other payments* received: $500 • *ongoing income*: nil = $6,500
Monthly benefit payable is lower of 1 and 2	= $6,500 monthly benefit
Total income for the month from all sources	*Other payments* received: $500 Monthly benefit payable: $6,500 Total: $7,000

In the following partial disability examples, the first life insured is working at full capacity and has a *monthly income* of $2,000. The second life insured isn't working, however has maximum earning potential of $2,000.

Partial disability benefit calculations	Working at capacity	Not working at capacity
Lower of these two amounts:		
1. the insured monthly benefit **reduced by** *other payments* received in the month	$7,000 Less: *other payments* received: $500 = $6,500	$7,000 Less: *other payments* received: $500 = $6,500
2. The annual equivalent of *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12	$7,000	$7,000
If working at capacity **reduced by** *other payments* received in the month and 70% of *monthly income*.	Less: • *other payments* received: $500 • 70% of *monthly income*: $1,400 = $5,100	
If not working at capacity **reduced by** *other payments* received in the month and 70% of maximum earning potential.		Less • *other payments* received: $500 • 70% of maximum earning potential: $1,400 = $5,100
Monthly benefit payable is lower of 1 and 2	$5,100 monthly benefit	$5,100 monthly benefit
Total income for the month from all sources	*Other payments* received: $500 *Monthly income*: $2,000 Monthly benefit payable: $5,100 Total: $7,600	*Other payments* received: $500 *Monthly income*: $0 Monthly benefit payable: $5,100 Total: $5,600

Recurring claims

This section explains what happens if you need to make a new claim because of a recurrence of a *sickness* or *injury* resulting in disability.

If the benefit period is to age 65, then no waiting period applies if a disability recurs from the same or related *sickness* or *injury* within 12 months of the original claim end date. A new waiting period will only apply if a disability recurs from the same or related *sickness* or *injury* after 12 months.

If the benefit period is 1-year, 2-years, or 5-years, whether the waiting period will apply and how long we will pay the claim for depends on the gap between claims and whether the life insured has fully recovered from the original claim. The table below shows how this works. For this purpose, fully recovered means the life insured has been employed in a *gainful occupation* and has been working without restriction for at least two consecutive years since they were last claiming a monthly benefit.

If a disability recurs from the same or related *sickness* or *injury* and the benefit period is 1-year, 2-years, or 5-years	
First 12 months from original claim end date	More than 12 months after original claim end date
No waiting period applies. The remaining benefit period will reduce by any previous claims. If we've already paid benefits for the full benefit period, no further benefit is payable.	**If the life insured has fully recovered** The waiting period applies. A new benefit period will begin for the new claim. **If the life insured has not fully recovered** The waiting period applies. The remaining benefit period will reduce by any previous claims. If we've already paid benefits for the full benefit period, no further benefit is payable.

When the benefits end

We stop paying the total disability benefit on the date the life insured stops being totally disabled. Totally disabled in this section means as defined in the tables on pages 36 to 38

We also stop paying the total disability benefit (even if the life insured continues to be totally disabled) when any one of the following happens:

- the benefit end date
- the death of the life insured
- when the policy ends, as explained on page 48.

We stop paying the partial disability benefit on the date the life insured stops being partially disabled. Partially disabled in this section means as defined in the tables on pages 36 to 38.

We also stop paying the partial disability benefit (even if the life insured continues to be partially disabled) when any one of the following happens:

- the benefit end date
- where the claim has continued beyond two years, on the date when the life insured has capacity to either:
  - earn an annual income of $300,000 and is working at full capacity in any *gainful occupation*. Annual income is the annual equivalent of (or 12-times) *monthly income*
  - work at full capacity for 40 hours in their *primary occupation*
- the death of the life insured
- when the policy ends, as explained on page 48.

When the optional benefits end

Each optional benefit ends when one of the following happens:

- if we receive notification to cancel the option, the end of the period of cover for the optional benefit you have paid premiums for, adjusted for any premium refunds payable
- the optional benefit end date
- when the policy ends, as explained on page 48.

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.

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
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 85.
Inflation protection	Increases cover every year, unless declined by you, without health assessment.
Waiver of premium	Premiums are waived while a monthly benefit is payable, even if the amount payable is reduced to nil.
Rehabilitation or retraining expenses (paid direct to provider)	If the monthly benefit is payable, we will also pay expenses for a reasonable rehabilitation or retraining program. This feature doesn't apply if the policy is issued to the trustee of a superannuation fund.
Waiting period reduction feature	Allows 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.
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 cover suspension can be taken over the life of the policy. Cover suspension is explained on page 84. 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 help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. Inflation protection will continue to apply to cover at or above the maximum sum insured.

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 the 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 of *other payments*, *monthly income*, and *ongoing income*. We'll also refund premium paid for the waiting period if a monthly benefit is payable.

If you have a 1-year or 2-year waiting period, we'll waive premiums due as you approach the policy end date, to reflect the fact that you won't be able to make a new claim. The policy will remain in-force so that you're still covered for a recurring claim or in case you have a waiting period underway. If you have a 1-year waiting period, we'll waive any premium due in the last 12-months of the policy and if you have a 2-year waiting period we'll waive any premium due in the last 24-months of the policy.

Rehabilitation or retraining expenses (paid direct to provider)

If a monthly benefit is payable, we will also pay expenses for a reasonable rehabilitation or retraining program for the life insured.

A reasonable rehabilitation or retraining program means a program that:

- may include job seeking, graduated return to work plans, retraining and other work readiness programs
- has been assessed by a specialist in the life insured's condition as likely to result in a return to remunerative work
- is not considered treatment that is eligible for a Medicare benefit or pharmaceutical benefit for any part of the service provided
- is not considered part of treatment provided in, or associated with, a hospital. We can't reimburse any expenses that we are not permitted by law to reimburse. We will not reimburse any expenses that are regulated by the National Health Act 1953 (Cth) or the Private Health Insurance Act 2007 (Cth)
- is not considered treatment that is entitled to be reimbursed from another source.

It's important that you let us know about your rehabilitation plans. We want to help the life insured to return to wellness and can meet rehabilitation or retraining expenses that will improve their 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.

The maximum amount payable under this feature is 24 times the insured monthly benefit.

Payments under this benefit will be made directly to the provider.

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

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.

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 table.

The future insurability and super contributions 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.

Option name	What this option does
Increasing claims option	Increases benefits annually with CPI while on claim.
Future insurability option	Allows an increase in cover without health assessment every year.
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.
Severity booster option	Increases the monthly benefit payable by 20% for specific conditions during the first six months on claim.

Increasing claims option

We'll index your claim payments. If the monthly 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.

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. 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, explained below
- 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
- the insured monthly benefit has been issued with a medical loading (shown on the policy schedule).

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

- 70% of the first $300,000 of annual income
- 50% of the next $200,000 of annual income
- 25% of the balance of annual income.

Annual income means the annual equivalent of (or 12-times) *monthly income*.

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

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, inclusive of any super contributions monthly benefit amount
- the insured monthly benefit can't be increased for any income changes until the future insurability option has been in-force for 12 months.

Super contributions option

We'll pay the super contributions monthly benefit when we pay a monthly benefit for total or partial disability.

The monthly benefit payable is a proportion of the insured amount, based on the amount we're paying as a monthly benefit for total or partial disability, as follows:

$$\frac{\text{monthly benefit payable}}{\text{insured monthly benefit}} \times \text{super contributions monthly benefit}$$

The maximum we pay each month is the lower of these two amounts:

- the average monthly superannuation contributions made by the life insured or on behalf of the life insured by an employer in the 12 months before the claim
- the super contributions monthly benefit amount.

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

If this benefit becomes payable, any super contributions monthly benefit is payable to a complying superannuation fund of your choice.

Severity booster option

We'll pay the severity booster if the life insured meets the conditions listed under either the 'Health event' or 'Hospitalised during the waiting period' headings below. Totally and partially disabled in this section means as defined in the table on page 36.

We'll only pay the severity booster benefit once, for the same period where it would otherwise be possible to qualify under both sections. This benefit is only available to policies with a 30-day waiting period.

This benefit does not increase any super contributions monthly benefit amount payable.

Health event

We'll boost the monthly benefit payable by 20% for the first six months on claim if the life insured suffers any one of the below health events and is totally or partially disabled when the waiting period ends:

- *severe burns*
- *invasive cancer (of stage 3 or 4)*
- *leukaemia, lymphoma, and blood related cancers (of stage 3 or 4).*

Each condition has an insurance definition which can be found in the 'Definitions' section, starting on page 96. We won't pay a benefit if the life insured's condition doesn't meet our specific definition.

Hospitalised during the waiting period

If the life insured is hospitalised for at least 10 consecutive days for a *sickness* or *injury* during the waiting period and is totally or partially disabled after the waiting period ends, we'll boost the monthly benefit payable by 20% for the first month on claim.

If the life insured remains in hospital after the first month on claim, we'll boost the monthly benefit by 20% for each day the life insured is in hospital for up to five months. We'll pay 1/30th of the monthly benefit for each day during this period.

What this policy doesn't cover

Exclusions under income protection cover

We won't pay any benefits for *sickness* or *injury* occurring as a result of any event or medical condition specified as an exclusion on the policy schedule, or as a direct or indirect result of any of the following:

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

We won't pay a benefit:

- that arises directly or indirectly from the life insured participating in criminal activity and for any period the life insured is incarcerated due to their participation in criminal activity
- if the life insured unreasonably refuses to undergo the medical treatment including rehabilitation to treat their condition as recommended by their *medical practitioner*
- for total or partial 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 total or partial 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 restricted or revoked due to misconduct or if their employer stops trading.

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 a combination of both the total disability benefit and partial disability 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.

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. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy.
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- death of the life insured.

Zurich Business Expenses

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

Business expenses insurance provides a monthly benefit to 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
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*.
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 the business premises, electricity, and rates.

What we mean by key person replacement costs

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 the company.

What we mean by allowable business expenses

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.

Zurich Business Expenses policy conditions

The information below forms part of the Zurich Business Expenses policy conditions.

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

- the policy owner and 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
- whether your premiums are variable age-stepped or variable premiums
- 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 55.

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

The words or expressions shown in *italics* that are specific to this policy have their meaning explained on the previous page and in the section 'What we mean by the terms we use' on page 53. Words or expressions that we use throughout this document, like *medical practitioner*, are explained in the 'Definitions' section, starting on page 96.

Insured monthly benefit

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

The insured monthly benefit is the amount of monthly benefit shown on the policy schedule when your policy starts, plus any indexation, as explained in the section 'Inflation protection' on page 56. 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.

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
- 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.

We'll apply offsets to any benefit payments

See the section 'We apply offsets to business expenses benefit payments' on page 54.

Benefits payable under this policy

The benefits payable under this policy are summarised in the table below. A full explanation of each benefit follows the table.

We'll pay a benefit only if total or partial disability occurs while this benefit and the policy is in-force.

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

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.

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.

What you need to know about how the claims journey works

The next few pages of this document provide guidance on what you can expect and important milestones when making a claim under your Zurich Business Expenses policy. The waiting period and benefit period are important aspects of your cover and will be shown on your policy schedule.

How to qualify for a monthly benefit payment

To qualify for a monthly benefit, you must first satisfy the waiting period requirements. Once the waiting period requirements are met, we will calculate the benefit payable.

The waiting period

The waiting period is the period you must wait before the benefit period starts and you become eligible for a monthly benefit.

During the waiting period, you must follow the advice and recommended treatment of a *medical practitioner*. We may also provide you with rehabilitation support during the waiting period so we encourage you to tell us of your *sickness* or *injury* as soon as you can.

You must continue to pay premiums that fall due during the waiting period. If we accept your claim, these premiums will be refunded to you with the first benefit payment.

Choice of waiting periods

The waiting periods available are 30-days, 60-days, and 90-days.

The waiting period starts on medical consultation

The waiting period starts when the life insured consults a *medical practitioner* and receives advice confirming the total or partial disability.

The waiting period doesn't apply if the claim is a recurring claim. Recurring claims are explained on page 55.

Waiting period requirements

Solely due to *sickness* or *injury* the life insured must be all of the following:

- totally disabled for at least 7 out of 12 consecutive days during the waiting period
- totally or partially disabled for the remainder of the waiting period
- following the advice and recommended treatment of a *medical practitioner*.

Totally disabled during the waiting period means the life insured is both:

- unable to do each and every *important business income-producing duty* of their *primary occupation*
- not working in their *primary occupation* or any other *gainful occupation*.

Partially disabled during the waiting period means the life insured meets either of the following criteria:

- has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation*
- is unable to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition.

The benefit 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 policies have a benefit period of 1-year. In practice this is 12-times the insured monthly benefit payable over a period of up to 24 months.

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.

Depending on the life insured's age when you claim, 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.

Benefits are payable if the life insured is totally or partially disabled after the waiting period

The table below explains how to qualify for a benefit.

If the life insured has capacity to work (in their *primary occupation* or in another *gainful occupation*, as applicable), then they won't meet our definition of totally disabled. In this case we'll assess the claim under the partial disability definition and will use the partial disability calculation to work out the benefit amount payable.

The benefit payable will depend on the life insured's ability to work in their *primary occupation* after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled	Qualifying for a benefit when the life insured is partially disabled
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled means the life insured meets all of the following criteria: • has no capacity to do each and every *important business income-producing duty* of their *primary occupation* • is not working in their *primary occupation* or in any other *gainful occupation* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled means both of the following: The life insured meets either of the following criteria: • has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation* • has no capacity to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition. And the life insured meets both of the following criteria: • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

What we mean by the terms we use

This is a selection of key words (defined terms) that are important to help you better understand how Zurich Business Expenses works.

actively participating in a rehabilitation or retraining program means the life insured is actively engaged in a rehabilitation or retraining program they have the capacity to undertake, and which is designed to create a pathway to return to their *primary occupation*, or, if this is unlikely, a pathway for any *gainful occupation* they are suited for by their education, training, or experience.

If the life insured stops participating in a rehabilitation or retraining program on the advice of their treating *medical practitioner*, we'll need written documentation from the treating *medical practitioner* explaining:

- the reasons that the life insured has been advised to stop participating in the rehabilitation or retraining program
- how long the rehabilitation or retraining program is expected to be paused
- whether the rehabilitation or retraining program could be modified rather than paused
- the medical information used by the treating *medical practitioner* in forming their opinion.

If the life insured completes a rehabilitation or retraining program but has not returned to a *gainful occupation*, we will work with the life insured to determine whether an additional rehabilitation or retraining program could assist.

business income 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.

gainful occupation means employed or self-employed for gain or reward. This includes any paid position of employment including the life insured's *primary occupation*.

important business income-producing duty means each duty that is essential to the life insured's ability to produce *pre-claim business income* from their business.

injury means bodily injury caused by an accident. The accident must occur while the policy is in-force.

post-claim business income means the life insured's share of *business income* for the relevant month while they are partially disabled due to *sickness* or *injury*. Post-claim business income excludes any monthly benefit payable under the policy.

pre-claim business income means the monthly average of the life insured's share of *business income* for the 12 months before total disability or partial disability.

primary occupation means any type of business, profession, service, trade, or employment which encompasses the duties predominantly carried out by the life insured at the time of *sickness* or *injury*.

If the *sickness* or *injury* occurs while the life insured is unemployed, or on parental or sabbatical leave, primary occupation means any type of business, profession, service, trade, or employment which encompasses the duties predominantly carried out by the life insured at the last occupation they had before unemployment, parental leave, or sabbatical leave.

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.

How we calculate the monthly benefit payable

The life insured's *sickness* or *injury* and return to work journey may mean that they are either totally or partially disabled at various times. Totally disabled and partially disabled in this section means as defined in the table on page 52.

Total disability benefit

The total disability benefit payable for each month you qualify for a benefit because the life insured is totally disabled, is the business expenses benefit amount, as explained on page 50, reduced by any offsets that apply. Offsets are explained on this page.

Partial disability benefit

This is how we calculate a monthly benefit for each month you qualify for a benefit because the life insured is partially disabled, depending on the benefit type you choose:

Ongoing fixed expenses

The partial disability benefit is calculated using this formula:

$$\frac{\textit{pre-claim business income} - \textit{post-claim business income}}{\textit{pre-claim business income}} \times$$

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, as explained on page 50.
- a portion of the insured monthly benefit based on hours worked by the life insured, as shown in the table 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.

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.

Benefits are paid monthly

The total disability benefit is paid 15 days after the waiting period ends, provided claim requirements are met, and monthly after that. Benefits for total and partial disability are paid in arrears since we need evidence of expenses or income in the relevant month to work out the benefit amount.

If any claim ends part way through a month, we'll pay 1/30th of the monthly benefit for each day during this period.

Recurring claims

This section explains what happens if you need to make a new claim because of a recurrence of a *sickness* or *injury* resulting in disability.

Whether the waiting period will apply and how long we will pay the claim for depends on the gap between claims and whether the life insured has fully recovered from the original claim. The table below shows how this works. For this purpose, fully recovered means the life insured has been employed in a *gainful occupation* and has been working without restriction for at least two consecutive years since they were last claiming a monthly benefit.

If a disability recurs from the same or related *sickness* or *injury*	
First 12 months from original claim end date	More than 12 months after original claim end date
No waiting period applies. The remaining benefit period will reduce by any previous claims. If we've already paid benefits for the full benefit period, no further benefit is payable.	**If the life insured has fully recovered** The waiting period applies. A new benefit period will begin for the new claim. **If the life insured has not fully recovered** The waiting period applies. The remaining benefit period will reduce by any previous claims. If we've already paid benefits for the full benefit period, no further benefit is payable.

When the benefits end

We stop paying the total and partial disability benefit on the date the life insured stops being totally or partially disabled. Totally disabled and partially disabled in this section means as defined in the table on page 52.

We also stop paying the total and partial disability benefit (even if the life insured continues to be totally or partially disabled) when any one of the following happens:

- the benefit end date
- where we have paid a monthly benefit (whether for total or partial disability or both) for a cumulative period of 24 months
- when the business ceases to operate
- the death of the life insured
- when the policy ends, as explained on page 58.

Your policy includes these features automatically

Your policy automatically includes the following features, regardless of the covers selected.

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 85.
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 a monthly benefit is payable, even if the amount payable is reduced to nil.
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 cover suspension can be taken over the life of the policy. Cover suspension is explained on page 84.

Inflation protection

We'll increase your insurance cover each year to help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. Inflation protection will continue to apply to cover at or above the maximum sum insured.

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 the 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 across all *Zurich life insurance policies*.

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 a monthly benefit is payable.

What this policy doesn't cover

Exclusions under business expenses cover

We won't pay a benefit for a disability caused by any event or medical condition specified as an exclusion on the policy schedule, or directly or indirectly by any of the following:

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

When we won't pay a benefit

We won't pay a benefit:

- that arises directly or indirectly from the life insured participating in criminal activity and for any period the life insured is incarcerated due to their participation in criminal activity
- 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 any *allowable business expenses* or *key person replacement costs* that aren't supported by evidence
- for a total or partial 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 total or partial 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 restricted or 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 total disability benefit and partial disability 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 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. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy.
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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 if an insured child suffers one of the following: • *loss of use 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 *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, starting on page 96.

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 63.

You can apply to 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 under the inflation protection feature each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 61.

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

This section explains when benefits become payable.

Benefits payable under child cover

The benefits payable under this policy are summarised in the table on the previous page. A full explanation of each benefit follows below.

We'll pay a benefit only for an event that occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 62.

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 'Insured trauma conditions for the child trauma benefit' table. Our insurance definition for each covered condition can be found in the section 'These definitions are specific to trauma cover', starting on page 103. 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 62.

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, use of limbs, and paralysis
diplegia
hemiplegia
loss of use 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 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 that occurs while this benefit and the policy is in-force:

- *loss of use 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 one injury advancement benefit 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 carer benefit is only payable while the insured child is confined to bed and requires full-time care while this benefit and the policy is in-force.

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* while the policy is in-force.

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 while the policy is in-force.

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 85.
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 84.

Inflation protection

We'll increase your insurance cover each year to help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. Inflation protection will continue to apply to cover at or above the maximum sum insured.

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 the 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.

When the new policy is issued, all cover for the child under this policy will automatically end.

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 the claim is caused by any event or medical condition specified as an exclusion on the policy schedule, or 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.

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 60 that are marked with an asterisk (*). The start of the elimination period can vary:

New cover

For new child cover applications, the elimination period starts on the benefit start date for that cover. We won't ever pay a claim for those trauma conditions if during the elimination period either of the following happens:
- the condition occurs or is apparent. 'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition
- surgery for the conditions is recommended to the insured child.

Cover increases

For cover increases, the elimination period starts on the benefit start date of any increase in child cover benefit, and only applies to the increase portion of the cover. We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended for the insured child.

Reinstated cover or cover suspension

When there is a break in cover and the policy re-starts, the elimination period starts from the date the policy is reinstated or, if after cover suspension, from the cover suspension end date. We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended for the insured child.

In all circumstances, 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.

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 trauma condition 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
- if we receive notification to cancel the child cover, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- 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 will generally be eligible for a 15% tax saving that the trustee can pass on to members.

However, using superannuation savings to fund insurance will reduce your retirement savings. You can 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 generally 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. We may also agree with the trustee to pay income protection benefits to the life insured directly, to avoid delays.

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, Zurich Income Safeguard and the Continuous Care option.

The terms 'temporary incapacity' and 'permanent incapacity' have definitions under superannuation law which includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations. The term 'superannuation payment limit' is a term we use to describe cashing restrictions that apply to some superannuation benefits. 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 in 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 total and permanent disability 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 101.

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.

Continuous Care option in superannuation

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

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 (for example, TPD with an own occupation definition and platinum TPD)
- in one policy (either a policy held in superannuation or a policy held outside of superannuation, linked to cover on another policy).

It can also apply to trauma cover held:
- in one policy (outside superannuation linked to 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 the 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
- 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.

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

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

Income protection can be structured wholly within superannuation, with restrictions designed to meet superannuation law.

Benefits are capped at the superannuation payment limit.

Complimentary cover supplements income protection held in superannuation

If your policy is held in superannuation, and the life insured is unemployed when *sickness* or *injury* occurs, no benefit is payable under Zurich Income Safeguard. However, we provide complimentary cover for this situation.

Complimentary Zurich Income Safeguard (complimentary cover) is provided to the life insured.

Complimentary cover is only provided to the life insured while the relevant Zurich Income Safeguard policy remains in force. No premiums are payable for complimentary cover and benefits are payable to the life insured directly.

The terms of the complimentary cover do not form part of the policy with the policy owner of the Zurich Income Safeguard policy.

How the complimentary cover works

Complimentary cover provides identical benefits and on the same terms as the Zurich Income Safeguard policy, including all the additional benefits, features and selected optional benefits, except that the complimentary cover doesn't exclude payment of a benefit because the life insured is unemployed when *sickness* or *injury* occurs.

Complimentary cover only applies in the event the life insured is unemployed at the time of *sickness* or *injury* and no benefit is payable under your Zurich Income Safeguard policy. Unemployed means that the life insured is not working for gain or reward.

Assessment of claims for a total or partial disability benefit

We will first assess a claim for the total or partial disability benefit against the Zurich Income Safeguard policy.

If the life insured is unemployed at the time of the *sickness* or *injury* and does not qualify for a benefit, we will assess a claim for a benefit under the complimentary cover.

We will only ever pay a monthly benefit under the complimentary cover if the life insured is unemployed at the time of *sickness* or *injury* and doesn't qualify for a benefit under Zurich Income Safeguard.

If we are paying under the complimentary cover, we will waive the premium for your Zurich Income Safeguard policy.

Certain features of both covers are the same

Under the complimentary cover, the following are the same as your Zurich Income Safeguard policy:
- the benefit payable, waiting period and benefit period
- the life insured
- extra-cost optional benefits.

If any of the above features under your Zurich Income Safeguard policy change, the complimentary cover will automatically change in the same way. For instance, if the insured monthly benefit amount is reduced or increased under your Zurich Income Safeguard policy, the insured monthly benefit amount on the complimentary cover will be reduced or increased (as applicable) by the same amount.

If a cover suspension is taken, it will be applied to both policies at the same time.

The taxation implications of a benefit payment will differ depending on whether we pay a benefit to the trustee of your superannuation fund or directly to the life insured under complimentary cover, or as a superannuation benefit you receive from the trustee of your superannuation fund. We recommend you seek advice from a tax adviser.

When complimentary cover ends

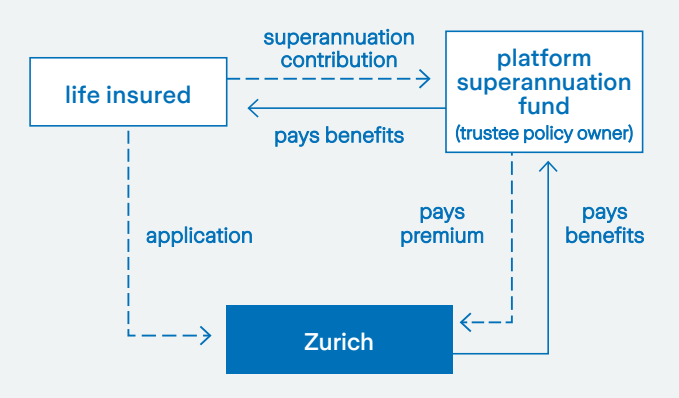
Complimentary cover and eligibility for any benefit under the complimentary cover ends when the Zurich Income Safeguard covering the life insured ends.

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.

The diagram below shows how this works.



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 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
- Continuous Care option 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 71.

Superannuation optimiser can be used to split cover between a superannuation platform policy and a second policy held outside superannuation. 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, in this case with personal advice from 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 superannuation.
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 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 financial 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 interim 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 85.
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. Most applications are assessed without any medical testing. 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.
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 change your cover.

The duty to take reasonable care not to make a misrepresentation

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into. To meet this duty, each person whose life is to be insured must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

The duty applies to this contract as a consumer insurance contract.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance of each life to be insured. The information given to us in response to our questions is vital to our decision.

Guidance for answering our questions

You are responsible for the information provided to us. Each person answering our questions should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask us before you respond
- answer every question
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume we will ask others such as your doctor
- review your application carefully. If someone else helped prepare your application (for example, your financial adviser), please check every answer, and if necessary, make any corrections.

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we'll let you know whether it has any impact on the cover.

If you need help

It's important that you and every person answering our questions understands this information and the questions we ask. Ask us or your financial adviser for help if you have difficulty answering our questions or understanding the application process.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

What can we do if the duty is not met?

If a person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether we can exercise one of these remedies depends on a number of factors, including all of the following:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was
- what we would have done if the duty had been met. For example, whether we would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

If you have death cover, you can name beneficiaries

If your policy is held in superannuation, you can generally make death benefit nominations with the trustee. The PDS issued by the trustee of the fund will provide more information.

If you are the only policy owner and the life insured, you can nominate beneficiaries to receive the death benefit. You can't 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.

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 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.

You have a 30-day cooling-off period

You have 30 days from when your policy starts to check that your policy meets your needs. In the 30-day cooling-off period, you can cancel the policy for any reason 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 or if the policy owner is the trustee of an *eligible superannuation fund*
- 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	15 – 70	
End age (policy anniversary when the life insured is the age shown)	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 • inflation protection • future insurability • future insurability for business • accommodation expenses • financial planning advice	• death & terminal illness benefit • accidental injury benefit • inflation protection • future insurability • financial planning advice
Optional benefits	• premium waiver option • business future cover option • needlestick cover option	• premium waiver option
Automatic inclusions	• interim cover • cover suspension (not available if funded by platform)	• interim cover • cover suspension (not available if funded by platform)

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 (policy anniversary when the life insured is the age shown)	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 million 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) • Maximum combined amount of $5 million TPD cover and the Continuous Care option • $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 • partial impairment benefit • inflation protection • future insurability • accommodation expenses • financial planning advice	Platinum TPD can't be held in superannuation
TPD Benefits and features	• TPD benefit • TPD advancement benefit • inflation protection • future insurability • accommodation expenses • financial planning advice	• TPD benefit • inflation protection • future insurability • financial planning advice
Optional benefits	• double TPD option • buy-back death option • premium waiver option • business future cover option • needlestick cover option • continuous care option	• double TPD option • buy-back death option • premium waiver option • continuous care option
Automatic inclusions	• interim cover • cover suspension (not available if funded by platform)	• interim cover • cover suspension (not available if funded by platform)

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 (policy anniversary when the life insured is the age shown)	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 • partial trauma benefit • inflation protection • future insurability • accommodation expenses • financial planning advice
Trauma Benefits and features	• trauma benefit • paralysis booster benefit • inflation protection • future insurability • accommodation expenses • financial planning advice
Optional benefits	• double trauma option • buy-back death option • buy-back TPD option • trauma reinstatement option • premium waiver option • business future cover option • needlestick cover option
Automatic inclusions	• interim cover • cover suspension (not available if funded by platform)

Zurich Income Safeguard

Income protection

Income protection provides a monthly benefit if the life insured is unable to work due to a sickness or injury that causes ongoing restricted capacity for longer than the specified waiting period.

Cover restrictions that apply to some occupations are outlined on page 76.

Entry ages	19 – 60	
End age (policy anniversary when the life insured is the age shown)	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 hours are a guideline only, based on the life insured's current situation. We'll ask about working history as part of the application process.	
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 If you separately insure your superannuation contributions using our super contributions option, explained on page 47, then these maximums include the super contributions monthly benefit amount. The overall maximum of $60,000 per month 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	• 30-days • 60-days • 90-days • 1-year • 2-years	
Benefit periods available	• 1-year • 2-years • 5-years • to age 65	
	non-superannuation ownership	**superannuation ownership**
Benefits and features	• total disability benefit • partial disability benefit • inflation protection • waiver of premium • rehabilitation or retraining expenses (paid direct to provider) • waiting period reduction feature	• total disability benefit • partial disability benefit • inflation protection • waiver of premium • waiting period reduction feature • complimentary cover if unemployed at time of sickness or injury
Optional benefits	• increasing claims option • future insurability option • super contributions option • severity booster option	• increasing claims option • future insurability option • super contributions option • severity booster option
Automatic inclusions	• interim cover • cover suspension (not available if funded by platform)	• interim cover • cover suspension (not available if funded by platform)

Zurich Business Expenses

Business expenses cover	
Business expenses cover provides a monthly benefit that reimburses allowable business expenses or key person replacement costs if the life insured is unable to work due to a sickness or injury that causes ongoing restricted capacity for longer than the specified waiting period. **You can choose either cover for ongoing fixed expenses or key person replacement cover.** **Cover restrictions that apply to some occupations are outlined on the next page.**	
Entry ages	19 – 60
End age (policy anniversary when the life insured is the age shown)	65
Eligibility	The life insured must be working a minimum 20 hours per week Minimum hours are a guideline only, based on the life insured's current situation. We'll ask about working history as part of the application process.
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	• 30-days • 60-days • 90-days
Benefit period	All policies have a benefit period of 1-year. In practice this is 12-times the insured monthly benefit payable over a period of up to 24-months.
Benefits and features	• total disability benefit • partial disability benefit • inflation protection • waiver of premium
Automatic inclusions	• interim cover • cover suspension

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.

People with SR occupations can apply for Zurich Income Safeguard and either type of cover under Zurich Business Expenses, ie. ongoing fixed expenses or key person replacement cover.

SR restrictions are summarised in this table.

Entry ages	19 – 53
End age (policy anniversary when the life insured is the age shown)	60
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
Income protection optional benefits available	• increasing claims option • severity booster option

Zurich Child Cover

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 (policy anniversary when the insured child is the age shown)	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 • inflation protection • cover increase feature • continuation of cover
Automatic inclusions	• interim cover • cover suspension

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 cost of managing your policy 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 your premiums are variable age-stepped or variable 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 and employment arrangement
- the life insured's current and past health
- any pastimes the life insured participates in
- whether you or the life insured qualify for a discount
- your insurance coverage across TPD and IP covers relative to your *income to retirement* (for TPD benefits only)
- the period of time since health, financial and occupational assessment for variable age-stepped premium. There are two options available as to how this will be priced into your premiums, which must be chosen at application and cannot be changed after the policy starts:
  - Lower upfront pricing (standard) – Premiums are lower in the initial years compared to the Flatter pricing option.
  - Flatter pricing – Premiums are initially higher compared to the Lower upfront pricing (standard) option. Premiums will generally be lower than the Lower upfront pricing (standard) option after the 4th or 5th policy anniversary. If Flatter pricing is selected this will be shown on your policy schedule.

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)
- you insure more relative to the life insured's *income to retirement* (for TPD 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 health issues
- the life insured participates in hazardous pastimes
- the period of time that has passed since the health, financial and occupational assessment is longer (for variable age-stepped premiums).

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)
- you insure less relative to the life insured's *income to retirement* (for TPD 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
- the life insured is a salary-based employee (for income benefits only)
- policy discounts apply
- the life insured's health, financial and occupational assessment has been recently completed (for variable age-stepped premiums).

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.

Factors used in calculating the premium that can change from year to year include:

- whether your premiums are variable age-stepped or variable premiums
- the period of time since health, financial and occupational assessment. Premiums are generally higher for variable age-stepped premiums if the period of time that has passed since the health, financial and occupational assessment is longer and lower if the life insured's health, financial and occupational assessment has been recently completed.
- whether you or the life insured qualify for a premium rating factor or 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:

- variable age-stepped premiums are generally lower than variable premiums at the start of the policy, but variable age-stepped premiums generally increase each year as the life insured gets older whereas variable premiums do not
- variable age-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 calculate premiums by reference to a table of premium rates. In setting premium rates, we consider the category and the cost of setting up and administering the policy. 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 could 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 affecting our ability to continue providing cover and meeting claims under this product.

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

When inflation protection increases are offered, we calculate variable age-stepped and variable 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, employment arrangement, 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 variable age-stepped and variable 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 variable age-stepped or variable premiums.

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

Both variable age-stepped and variable premiums can change as they aren't guaranteed or 'fixed'.

Variable age-stepped and variable 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, variable premiums convert to variable age-stepped premiums on the policy anniversary when the life insured is 64. The reason for this is that variable premiums smooth the cost during the ages when most people have cover. If variable 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 variable to variable age-stepped is that the cost will increase substantially on the anniversary when the life insured is 64. This is because the variable age-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 which premium type you choose, 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 management fee is applicable
- 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 variable age-stepped or variable 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 earlier in this section. 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 the change takes effect.

The premium payable from the start of your policy is shown on your policy schedule. Each anniversary notice we send you will outline your premium for the next policy year. These premium amounts we tell you about won't change before the next policy anniversary unless you ask us to make a change to your policy. If you ask us to change your policy before your next policy anniversary and we have a premium increase underway, your policy will automatically attract the new premium rates at the time of the change which means they will apply earlier than they otherwise would.

We've 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 month's premium is waived	✓	✓	✓	✓
Rollover from an *eligible superannuation fund*	✓	×	×	×	✓

Management fees and stamp duty apply

Management fees may apply to your policy. The management fee contributes to the cost of managing the policy. The premium illustration available from your financial adviser before you apply for cover, and your policy schedule, will show any applicable management fees. If we increase the management fee (other than fee indexation which is explained below the table) we'll tell you about the change at least 30 days before it takes effect.

The fee payable depends on your selected premium payment frequency, as shown below.

For policies from 1 November 2025 to 28 February 2026

Premium frequency	Management fee payable	Yearly equivalent
Monthly	$11.75	$141.00
Quarterly	$35.18	$140.72
Half-yearly	$58.68	$117.36
Yearly	$117.33	$117.33

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, at 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.

You can pay insurance premiums from a platform account

You can take Zurich Protection Plus and Zurich Income Safeguard through selected platforms. Your financial adviser can tell you which platforms offer our insurance.

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 PDS prepared by the platform provider, or fund trustee for superannuation, will explain how the platform works.

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 and certain other distributors. We pay commission to financial advisers and other distributors who choose to be remunerated that way. Your financial adviser or other distributor 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.

Unpaid premiums will cause cover to be cancelled

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 the premium on the due date, we may cancel your policy. If we decide to cancel your policy, we'll write to you at least 30 days before and provide you with the opportunity to pay the premium before we cancel. We won't cover any events that happen once your policy is cancelled.

You may be able to reinstate your cover after it is cancelled. You can find information about reinstatements in the 'Making changes to your policy' section, starting on page 83.

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 and the policy is cancelled, or changed so that the premium payable decreases, before the next annual, half-yearly or quarterly instalment is due, we will pay a pro-rata refund based on the number of whole months remaining in the period of cover you have paid premiums for.

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, where it is held outside of superannuation. 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 Safeguard 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.

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.

This tax outcome assumes benefits are either received by the:
- original beneficial owner or by an owner who acquired the policy for no consideration
- 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 and Zurich Income Safeguard 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
- make use of the future insurability feature by increasing cover when certain specified events occur
- apply for an increase in cover, subject to health, financial, and occupational assessment
- 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 variable age-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 premium by reducing your cover
- 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 policy 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.

Converting cover out of super

If the policy owner is the trustee of an *eligible superannuation fund*, the life insured can apply to convert cover to a non-superannuation owned by themselves. 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

Since your policy might no longer operate as you expect or be suitable to your changed circumstances, we ask that you let us know if you, a life insured or a policy beneficiary start residing overseas. Additionally, we recommend that you first take professional advice on any legal and taxation implications if you, the life insured or a policy beneficiary consider residing overseas in the future. Unfortunately, we are not able to provide that advice, and Zurich cannot accept responsibility for any adverse legal or taxation outcomes on your policy from a person taking up residence overseas.

You may be able to reinstate your cover

If your cover is cancelled, you can reinstate cover in the first 30 days. We'll reinstate cover immediately on your request, provided all outstanding premium is paid.

If the policy is reinstated in this period, we won't pay benefits for any condition which occurs while the policy is cancelled. We also won't pay benefits if the life insured is aware of symptoms or a diagnosis relating to the condition while the policy is cancelled.

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 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 next premium due date. We can't backdate the start of a cover suspension, so you must pay any outstanding premiums before cover can be suspended. When you put cover suspension in place, we won't refund any premiums already paid. If you have paid premiums in advance, cover suspension will begin on the date you have paid premiums up to.

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
- life insured is aware of symptoms or a diagnosis of the event.

You can still make a claim for an 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 plus 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 by the next premium due date. If you don't pay the premium by the next premium due date, we may cancel the policy. You can find information about cancellation of the policy due to non-payment in the 'Unpaid premiums will cause cover to be cancelled' section on page 81.

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 event that would normally be covered under the policy 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
- 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 96.

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 *Zurich life insurance policies* 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 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.

If you select our online questionnaire option to complete some of the application, interim cover starts once you've completed the online questionnaire and the electronic application has been submitted to us.

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 change.

Exclusions apply to interim cover

Interim cover doesn't apply if:
- we would have declined your application, based on our normal health, financial, and occupational assessment criteria
- you apply for more cover than we would accept, based on our normal health, financial, and occupational assessment criteria. If this happens, we won't provide interim cover for the excess amount
- 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
- *illicit drug use*
- 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 to take reasonable care not to make a misrepresentation also applies to interim cover

When you apply for Zurich Wealth Protection policies, you'll declare that you've read and understood your duty to take reasonable care not to make a misrepresentation. 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 to take reasonable care not to make a misrepresentation in the 'Applying for cover' section, starting on page 68.

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 under Zurich Protection Plus, 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 million
- the amount of cover you're applying for
- the amount of cover the life insured would have been accepted for under our normal health assessment criteria.

TPD cover

If you've applied for TPD cover under Zurich Protection Plus, we'll pay a benefit if the life insured is disabled and suffers *loss of use 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 health, financial, and occupational assessment criteria.

Continuous Care option

If you've applied for the Continuous Care option under Zurich Protection Plus, we'll pay a benefit if the life insured is disabled and suffers *loss of use 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:

- $200,000
- the amount of continuous care benefit you're applying for
- the amount of continuous care benefit the life insured would have been accepted for under our normal health, financial, and occupational assessment criteria.

Trauma cover

If you've applied for trauma cover under Zurich Protection Plus, 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)*
- *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 health assessment criteria.

Income protection or business expenses cover

If you've applied for Zurich Income Safeguard or Zurich 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
- is unable to earn *monthly income* or generate any *business income* for a period of at least the chosen waiting period
- is 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 health, financial, and occupational assessment criteria.

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

Child cover

If you've applied for Zurich 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 use 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 the relevant 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 or you can contact us if you'd prefer to have a claim form sent to you.

Please note any transfer of ownership is not available during a claim, or if you are aware of an event that could become a claim.

You'll need to gather supporting documents

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. Any missing documents may delay the claim process.

In some cases, we use a third party to collect the information we need from you and your treating doctor. We'll let you know how this will work if it applies to your claim.

Before we can pay a claim, we must have evidence to fully support that the relevant policy terms and conditions have been met. If you withhold information that we reasonably require to make this assessment, it will delay your claim and could result in a declined claim.

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.

You must provide us with information, and authorities to obtain information, that we reasonably require to assess your claim. This includes information and authorities we need to:

- verify the information provided in your application, including any health information and information relating to the life insured's income at that time
- investigate any non-disclosure or misrepresentation made by you. This may give us a right to avoid or vary your policy, or to refuse to pay 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 claim requirements, we need information specific to the type of claim you're making

The information we need may vary according to the type of claim you're making. Our typical requirements are set out below. We may request information or documents that are not listed below but which are reasonably required to assess your claim.

Documents for TPD, trauma, severity booster and child cover claims

Claims 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 TPD claims, evidence that provides details of the life insured's occupational and employment arrangements, including duties, responsibilities, hours and place of work as well as occupational history.

Illnesses and injuries must be diagnosed by a ***medical practitioner*** and certified by a specialist physician practicing in the area related to the illness or injury which has led to your claim and has the specialist physician's qualifications in the relevant area of medicine. A specialist physician excludes a general practitioner or specialist general practitioner, unless otherwise agreed by us. We may reasonably require verification of the diagnosis and certification by an appropriate second specialist physician of our choice and we'll pay for the cost of that physician and any reasonable travel costs. We will consider all medical evidence provided to us by your treating ***medical practitioner***, specialist physician or any independent specialists.

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 Continuous Care option claims

For claim requirements for the Continuous Care option refer to pages 21 to 22.

Documents for death and funeral claims

Claims for death benefits and funeral expenses 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
- evidence that provides details of the life insured's occupational and employment arrangements, including duties, responsibilities, hours and place of work
- financial evidence including evidence of other insurance cover on the life insured
- evidence of *pre-claim earnings*, *monthly earnings*, *ongoing 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, financial, and occupational 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-claim business income* and *post-claim 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.

Return to wellness obligations

If you have an income protection claim with us, we'll provide rehabilitation support which can help the life insured with recovery and with retraining, if required. Rehabilitation can be used to get the life insured back to their same occupation or help them to return to work in a new occupation. It can also be used to improve health and wellbeing.

If the life insured's capacity is restricted, and they're not fully recovered, but may be able to return to some work, we'll reach out and ask them to participate in a rehabilitation or retraining program. Any program we ask the life insured to attend is aimed at working collaboratively with the life insured towards their goals as they recover. We'll reimburse the cost of rehabilitation or retraining that we ask the life insured to do.

Questions you might have about making a claim

Is a medical examination required?

You may be asked to undergo independent medical examinations we reasonably require to assess the claim taking into account evidence already provided. This is at our expense. 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 a financial year. Where we ask for the life insured's average monthly income in the 12 months immediately before a point in time, we can be flexible. We'll accept information for the financial year rather than strictly the 12 months before, if you have evidence which is aligned to financial year.

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
- policy owner's estate, or as otherwise permitted, 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 82.

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 million 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 $1 million 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 major 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's treating doctors confirm that she'll never work again, and she meets her policy definition of TPD, 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 the cost of long-term care

Josephine holds a **Zurich Protection Plus** policy with a $1 million Continuous Care option.

Josephine took the Continuous Care option in conjunction with her TPD cover to ensure financial security for her family if she needs long-term care due to an unexpected serious health condition. The TPD cover will replace Josephine's lost income, while the Continuous Care option will fund her care needs.

Ten years after taking out the policy, Josephine suffers a permanent severe brain injury, rendering her unable to care for herself independently for the rest of her life. She requires *continuous care* for more than 6 hours a day. Consequently, her partner left their job to provide the necessary full-time care.

As the Continuous Care option helps cover financial loss due to continuous care required for permanent *sickness* or *injury*, Josephine can claim her Continuous Care benefit and receive $1 million. This contributes to alleviating the financial burden where Josephine's partner who was previously working full-time had to stop working to provide care 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 severe health event. He also wanted a financial buffer against out-of-pocket expenses and treatments that a severe illness could bring.

Five years after taking out his policy, Deepak is diagnosed with a severe 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 health event before thinking about work commitments again.

Reducing financial stress while you focus on recovery

Joe has a **Zurich Income Safeguard** 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'll pay him a monthly benefit of $7,500 if he is totally disabled and his earnings support this monthly benefit amount at the time of the claim. We'll make the first payment 15 days after the waiting period ends, provided we have all the evidence we need and have completed our assessment.

When Joe returns to work, he won't be up to full-time work immediately. If he makes a gradual return to work, we'll pay him a partial disability benefit while he's working at reduced capacity. This will top-up the income he'll earn from his employer. 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 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.

Three 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 Safeguard
- 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.

Benefits which aren't available to new customers

You may be able to 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 illness covered under your policy, we'll let you know what that means for your policy.

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*.

If you choose to receive communications by post, any notice we send will be effective on the earlier of when it arrives, and when it should have been delivered, based on standard postal delivery times.

Zurich's legal obligations and your privacy

Compliance with laws

Your policy conditions do not operate to the extent they would require you or Zurich to do something that risks breaking a law relevant to the contract. This applies despite anything to the contrary written in the policy conditions, which are deemed to be varied or nullified to the extent needed to remove the risk of illegality.

In limited cases, current Australian and overseas laws regulating us and other companies in the worldwide Zurich insurance group can restrict us from accepting premium payments, making claim payments or reimbursements, or conducting other financial transactions on life insurance policies we issue. We may also need to suspend or cancel cover when that is the only action that can be taken to comply – in those cases, if the law allows, we will give you prior notice so that you can explain the matters of concern before we act. New or changed Australian or overseas laws may equally affect such policies.

Australian and overseas trade and economic sanctions laws and regulations are one example of laws that may affect a policy we issue. We will not provide any cover, service or benefit for any person that we reasonably consider to be sanctioned by those laws and will cancel your policy if we reasonably consider that you, a life insured or a policy beneficiary are either a sanctioned person or conducting an activity sanctioned by these laws. We would in those cases then allow you 14 days to show that the person is not a sanctioned person and have cover restored.

Some countries' laws continue applying to their residents, nationals or citizens after they stop living there. Overseas laws can also apply to residents, nationals or citizens of other countries (such as Australia) while they are in that country or if they have another type of connection specified in that country's law. Those overseas laws can apply to the owner, life insured, beneficiary or premium payer of a policy to restrict (or even prevent) us from receiving premiums or doing other activities required to service a policy. In other cases, those laws may impose extra requirements or even prevent us from providing cover at all.

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, managing claims and dealing with potential misrepresentation. 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 1936
- 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

In addition to these definitions:
- specific definitions for Zurich Income Safeguard start on page 39
- specific definitions for Zurich Business Expenses are on pages 49 and 53
- definitions for specified trauma conditions start on page 103.

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.

any occupation means any occupation, business, or employment the life insured is suited for by education, training, or experience. Earnings from this occupation, business or employment should be more than 25% of the life insured's earnings from their most recent 12 months of work for remuneration or reward.

any occupation TPD means solely 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:
  - hasn't been working for a continuous period of at least three months
  - is following the advice of a *medical practitioner* and has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*
  - is so incapacitated that they're unlikely to be able to work in *any occupation* ever again despite having undergone or continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness or injury*.

(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.

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. 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
- a score of 15 or less out of 30 in a Mini Mental State Examination or equivalent evidence from an alternative neuro-psychometric test.

continuous care means daily assistance by another adult person required to sustain life or attend to bodily functions, for no less than 6 hours a day. 'Continuous' does not mean that the carer must spend every minute of the day providing personal care. Care may be provided in long blocks, short regular intervals or a combination of periods.

For care that has been required, in the 3 consecutive months period, this must be evidenced through any of the following:

(i) hospitalisation

(ii) paid care costs through an appropriate provider who is not a family member

(iii) a family member providing the care, who was previously working full-time, with evidence of no longer working (for example, carer's leave or termination notice) and loss of income

(iv) a family member providing the care, who was previously not working, with evidence of hiring home support which was previously not in place of at least 6 hours each day

(v) a family member providing the care, who was previously working part-time, with evidence of:
  - for the days previously working, no longer working (for example, carer's leave or termination notice) and loss of income, and
  - for the days not working, evidence of hiring home support which was previously not in place of at least 6 hours each day or evidence of paid care through an appropriate provider.

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 solely 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:
  - has been unable to perform all of the *domestic duties* without an adult person assisting for a continuous period of at least three months
  - has been 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 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.

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. The use of assistive devices, aids or special equipment to independently perform a task, other than wheelchairs and walking frames, is also regarded as able to do that task. Examples of assistive devices, aids and special equipment are raised toilet seats, shower or bath seats, benches and rails, glasses and hearing aids.	'can', 'normal' or 'good'
A life insured who is completely dependent on another adult 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 must be provided for each task of an extended ADL category scored and must include confirmatory investigations including, but not limited to, specialist reports, clinical, radiological, histological and laboratory evidence.

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.

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.

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.

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.

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.

ADL category 6: Advanced functions

Specific tasks:
- travel (riding, driving)
- sexual function
- social interaction (one on one)
- understand concepts
- memory
- problem solving
- stress adaptation
- sleep pattern
- recreational/social activities (social interaction in a group setting)

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*.

illicit drug use means:
- the use of an illegal drug, which is a drug that is prohibited from manufacture, sale or possession in Australia such as cannabis, cocaine, heroin and amphetamine-type stimulants. Illicit drug use includes circumstances where no legal penalty can result from use of an illicit drug such as in jurisdictions where its use is not, or is no longer, criminalised
- the use, other than as prescribed by a *medical practitioner*, of a pharmaceutical, which is a drug that is available from a pharmacy, over the counter or by prescription. For example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids
- the use, other than as prescribed by a *medical practitioner*, of any psychoactive substances which are legal or illegal. For example, kava, synthetic cannabis and other synthetic drugs, or inhalants such as petrol, paint or glue.

income to retirement is calculated as at the date of application for new cover or increase in cover, as relevant:

Annual Income x years to age 65.

For example, a 40 year old earning $80,000 per year including superannuation at the time of application, their income to retirement would be:

$80,000 x 25 (years to age 65) = $2,000,000

injury means bodily injury caused by an accident. The accident must occur while the policy is in-force.

invasive cancer (of stage 3 or 4) (for Zurich Income Safeguard) means the life insured is confirmed by histological evidence to have cancerous tumours which meet either of the following criteria:
- stage 3 or 4 according to the TNM classification confirmed by imaging
- totally incurable where all treatment regimens and modalities have failed.

The diagnosis must be confirmed by a *medical practitioner* who is an appropriate specialist.

leukaemia, lymphoma, and blood related cancers (of stage 3 or 4) (for Zurich Income Safeguard) means the life insured is confirmed by diagnostic testing (including histological testing when appropriate) to have any of the following disorders:
- the diagnosis of aplastic anaemia
- the diagnosis of multiple myeloma
- the diagnosis of leukaemia, except chronic lymphocytic leukaemia
- Hodgkin's or non-Hodgkin's lymphoma stage 3 or 4.

The diagnosis must be confirmed by a *medical practitioner* who is an appropriate specialist.

loss of use of a hand or foot means the total and irreversible loss of the use of either:
- an entire hand
- an entire foot.

loss of use 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 use of hands or feet means the total and irreversible loss of the use of two or more of:
- an entire hand
- 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 specialist physician appropriate to the medical condition (who is not a general practitioner or specialist general practitioner), we'll specify the specialist physician(s).

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 including (but not limited to) psychologists, chiropractors, physiotherapists, or naturopaths.

modified TPD means the life insured has suffered one of the following:
- *loss of use of hands or feet*
- *loss of sight*
- both *loss of use of a hand or foot* and *loss of sight in one eye*
- *loss of independent existence*
- *cognitive loss*.

A claim for *loss of use of hands or feet*, *loss of sight*, both *loss of use of a hand or foot* and *loss of sight in one eye* or *loss of independent existence* 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.

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 solely 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:
  - hasn't been working in their *own occupation* for a continuous period of at least three months
  - is following the advice of a *medical practitioner* and has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*
  - is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again despite having undergone or continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness or injury*.

(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 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.

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.

severe burns (for Zurich Income Safeguard) means tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness) burns to at least one of the following:

- 20% or more of the body surface area as measured by The Rule of Nines or the Lund & Browder Body Surface chart
- 50% or more of both hands, requiring surgical debridement and/or grafting
- 50% or more of both feet, requiring surgical debridement and/or grafting
- 50% or more of the face, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

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 *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
  - *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
  - *modified TPD* definition
- 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 65.

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.

Zurich life insurance policies mean any:

- Zurich Wealth Protection policy
- Zurich Active policy issued on or after 1 October 2016
- other policy originally issued by Zurich Australia Limited (ABN 92 000 010 195) prior to 1 August 2022 acquired following individual underwriting
- other policy issued as a replacement of any of the above, but excluding any group life policy held by a corporate or trustee of a superannuation fund to provide cover for a defined group of people.

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 or their branches, within the same procedure or via two procedures no more than three months apart. Angiographic evidence showing obstruction 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 any of the following:
- percutaneous angioplasty
- endovascular aortic repair
- other intravascular techniques.

aplastic anaemia (requiring treatment) means bone marrow failure that meets both of the following:
- is characterised by an almost complete absence of haematopoietic stem cells, resulting in low levels of red and white blood cells and platelets
- requires treatment with one or more of the following:
  - immunosuppressive agents
  - bone marrow transplantation
  - bone marrow stimulating agents
  - 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 permanent and irreversible neurological deficit confirmed by a specialist physician and one of the following:
- permanent and irreversible inability to perform at least one of the *activities of daily living* without the help of another adult person
- permanent and irreversible *whole person impairment* of at least 25%.

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 or other equivalent diagnostic investigation.

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 or arising from the pituitary gland (including pituitary neuroendocrine tumours). Tumours in or arising from the pituitary gland are covered only if the life insured undergoes 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 both:
- confirmed by histological examination, or appropriate pathological testing in the case of non-solid tumours
- characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue.

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 1
- 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.
- all cancers of the bladder unless having progressed to at least TNM classification T1N0M0
- all pituitary neuroendocrine tumours unless one of the following applies:
  - there is evidence of metastatic spread
  - the life insured undergoes surgical removal by open craniotomy.
- all tumours which are histologically classified as pre-malignant, non-invasive, high-grade dysplasia, borderline or having low malignant potential.

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-1 and CIN-2)
- 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 (cessation of cardiac function resulting in loss of consciousness, loss of respiratory effort and loss of signs of circulation) that isn't associated with any medical procedure, occurs out of hospital or any other medical facility, and is documented by an electrocardiogram (ECG) showing asystole or ventricular fibrillation.

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
- documentation of the administration of Cardiopulmonary Resuscitation (CPR) by an attending ambulance officer or hospital clinical staff
- Automated External Defibrillator (AED) data.

Cardiac arrest related to alcohol, drug or medication abuse is excluded.

cardiomyopathy (with significant permanent impairment) means impaired ventricular function resulting in significant permanent physical impairment. The degree of impairment must be at least Class 3 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 and with cognitive impairment) means the unequivocal diagnosis of dementia or Alzheimer's disease that meets all of the following:

- is characterised by the presence of marked impairment of cognitive functioning evidenced by a Mini Mental State Examination score of 24 or less out of 30 or the results of another equivalent neuro-psychometric test
- the life insured requires continual supervisory care by another adult person as the result of cognitive impairment
- the condition must be permanent and associated with an underlying disease of the nervous system
- the diagnosis must be made by a consultant neurologist or geriatrician.

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 peripheral vascular disease resulting in amputation
- 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 autoimmune mediated insulin dependent diabetes mellitus (IDDM) after the age of 30. Diagnosis must be made by a consultant endocrinologist.

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 permanent neurological deficit and one of the following:

- a permanent and irreversible inability to perform at least one of the *activities of daily living* without the help of another adult person
- permanent and irreversible *whole person impairment* of at least 25%.

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, or elective cosmetic surgery.

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:

- acute cardiac signs and symptoms consistent with myocardial infarction
- acute ECG changes indicative of acute ischaemia (new ST-T changes, new T wave changes or new left bundle branch block (LBBB))
- new pathological Q waves
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, not undertaken or the tests are superseded due to technical advances, we'll consider other appropriate and medically recognised tests that unequivocally diagnose acute symptomatic myocardial infarction of the same degree of severity, or greater, as outlined above.

The following are not covered under this definition:
- other acute coronary syndromes including but not limited to angina pectoris, where there is no biochemical evidence of myocardial injury
- myocardial infarctions arising from elective percutaneous coronary interventions or coronary artery bypass grafting
- elevations of troponins in the absence of an ischaemic cause (for example but not limited to, myocarditis, apical ballooning (Takotsubo cardiomyopathy), cardiac contusion, pulmonary embolism or drug toxicity)
- myocardial infarction not associated with an acute episode of cardiac symptoms and/or signs, acute ECG changes or changes in cardiac biomarkers.

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 3 of the New York Heart Association classification of cardiac impairment.

loss of use 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 use 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, 1,000 and 1,500 Hz.

loss of hearing in one ear means irreversible hearing impairment in the worst ear. Even with amplification, the average hearing threshold must be 91dB or greater as measured at 500, 1,000 and 1,500 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* without the help of another adult person
- the life insured requires continual supervisory care by another adult person 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 permanent neurological deficit and one of the following:
- a permanent and irreversible inability to perform at least one of the *activities of daily living* without the help of another adult person
- permanent and irreversible *whole person impairment* of at least 25%.

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. Melanoma in situ is specifically excluded.

motor neurone disease (diagnosis) means unequivocal diagnosis of Motor Neurone Disease.

The diagnosis must be made by an appropriate medical specialist.

multiple sclerosis (recurrent episodes with impairment level) means the unequivocal diagnosis of multiple sclerosis confirmed by a consultant neurologist.

Diagnosis must be supported by confirmatory neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging), evoked visual responses, and evoked auditory responses. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities.

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*.

muscular dystrophy (with symptoms) means the unequivocal diagnosis of muscular dystrophy, as confirmed by a consultant neurologist or other appropriate specialist physician on the basis of confirmatory neurological investigation. The condition must be evidenced by permanent neurological deficit. Diagnosis without the presence of signs and symptoms is excluded.

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-plus syndrome (specified) means the unequivocal diagnosis by a consultant neurologist of one of the following Parkinson-Plus syndromes:
- multisystem atrophy
- progressive supranuclear palsy.

All other types of parkinsonism, including secondary parkinsonism due to medication, are excluded.

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% or more of both hands, requiring surgical debridement and/or grafting
- 50% or more of both feet, requiring surgical debridement and/or grafting
- 50% or more of the face, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

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 three disease-modifying antirheumatic drugs (DMARDs) including one bDMARD, taken consistently for a period of at least nine months. This excludes corticosteroids and non-steroidal anti-inflammatories.

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 three disease-modifying anti-rheumatic drugs (DMARDs) including one bDMARD, taken consistently for a period of at least nine months. This excludes corticosteroids and non-steroidal anti-inflammatories
- 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 or your adviser if you need help

We or your adviser can answer questions about any of the policies explained in this document.

We or your adviser can also help you with changes 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 or your adviser in the most convenient way for you:

131 551

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:

zurich.com.au/existingcustomers
- previous versions of this PDS
- information about policy upgrades that may affect you
- information about premium rate increases in recent years

zurich.com.au/controlyourcover
- tips on how to manage the cost of your cover over time

zurich.com.au/tmd
- Target Market Determinations (TMDs) for the products in this PDS. TMDs describe who each product may be suitable for, based on likely needs, objectives, and financial situation.

zurich.com.au/myzurich
View or update your details online
Login or register for My Zurich, our 24/7 self-service customer portal, where you can:
- view your policy information
- access policy-related documents
- update your payment or contact details
- decline inflation protection increases
- update beneficiary details.

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 Australia Limited
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Zurich Customer Care: 131 551
Website: zurich.com.au

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ZURICH

Zurich Insurance-only Superannuation Plan

Product Disclosure Statement

Issue Date: 1 October 2024

The issuer

This Product Disclosure Statement (PDS) has been prepared by Brighter Super Trustee (ABN 94 085 088 484 AFSL 230511) ('Trustee') & Zurich Australia Limited (ABN 92 000 010 195 AFSL 232510) ('Zurich').

The Trustee for Brighter Super (ABN 23 053 121 564) ('Fund') is the issuer of this PDS. Brighter Super may refer to the Trustee or the Fund as the context may be. This PDS contains important information for members of the Fund. The different entities of Zurich and Brighter Super are not guaranteed by or responsible for, or liable in respect of, products and services provided by the other. The Zurich Insurance-only Superannuation Plan is a division of Brighter Super ('Zurich Plan').

The Trustee 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 Fund if their fund membership is only under the Zurich Insurance-only Superannuation Plan.

The Trustee holds the insurance policy on your behalf as a member of the Zurich Plan.

This PDS refers to the Zurich Wealth Protection and Zurich Active PDSs issued by Zurich Australia Limited with an issue date 1 October 2024, 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. You should read both PDSs before making a decision. The Trustee is not the issuer of the insurance policies or the Zurich Wealth Protection and Zurich Active PDSs.

About the Fund

Brighter Super has been a complying regulated superannuation fund since 1 July 1995 within the meaning of the Superannuation Industry (Supervision) Act 1993 (Cth) (SIS Act). It is able to accept superannuation guarantee contributions as well as other additional employer contributions and rollovers.

Brighter Super is governed by a Trust Deed which outlines the governing rules of the Fund. A copy of the Trust Deed is available at brightersuper.com.au/about-us/governance. You can obtain a copy of the Trust Deed free of charge by contacting us. Under the terms of the Deed, the Trustee has the power to amend any of the provisions of the Deed if permitted by relevant law.

An annual report about the management and financial condition of the Fund is prepared each year. You can view the annual report online at brightersuper.com.au/about-us/governance/annual-reports. You may also elect to have a hard copy of the annual report sent to you free of charge.

About Zurich Australia Limited

Zurich Australia Limited (ABN 92 000 010 195 AFSL 232510) ('Zurich') provides the insurance cover described in this PDS. Further information about the insurance cover 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 financial adviser acting on your behalf. You should consider both this PDS issued by the Trustee and the relevant PDS issued by Zurich 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 Zurich. With the Trustee's consent, Zurich may engage other service providers to assist with aspects of the Plan's administration.

The information contained in this 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 PDS, taking into account your objectives, financial situation and needs, before acting on any information in the PDS. Information about tax provided in this PDS is a guide only and is based on our understanding of the tax laws current at the date of the 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 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 PDS is current at the time of preparation of this PDS. Information contained in this 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. 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 14).

In this PDS:

- 'Fund' refers to Brighter Super
- 'Trustee' refers to Brighter Super Trustee
- 'You', 'Your' refers to the person who will become the life insured
- 'Member' refers to a member of the Zurich Plan

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This PDS dated 1 October 2024 covers the financial product issued by the Trustee and provides a summary of the insurance products issued by Zurich under Zurich Wealth Protection and Zurich Active policies. 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 licensed insurer and legally not able to issue insurance policies. Zurich does not issue, underwrite or guarantee the superannuation interest described in this PDS. The Trustee 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.

This PDS provides important information that will help you understand the types of insurance benefits available and the tax treatment that may apply, your options for meeting the costs of the insurance, and the potential risks of holding insurance through superannuation.

While the Trustee has determined that insurance cover described in the Zurich PDSs can be held through superannuation, this does not mean that it is suitable for your personal situation, objectives or needs.

Introducing the Zurich Insurance-only Superannuation Plan

The Trustee provides members with access to death and disablement insurance cover within superannuation. Your account does not have an account balance and is not subject to investment returns.

Your insurance policy will commence once you have become a member of the Zurich Plan and Zurich has confirmed acceptance of your insurance application. The Trustee will only accept your application for membership of the Zurich Plan if your application for insurance is accepted by Zurich and you have provided the Trustee with your Tax File Number (TFN)[1].

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.

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 PDS.

The insurance benefits available through the Zurich Plan have been designed for consumers with certain objectives, financial situations and needs. Not all insurance benefits are suitable for all consumers and you need to consider, with the help of any financial adviser advising you, whether they are right for you. Zurich has made a target market determination for each insurance benefit available through the Zurich Plan. The determination sets out key attributes of the insurance, the needs and objectives it is intended to address, eligibility requirements, financial capacity expectations, some key exclusions and how it is to be sold. You can find these documents on the Zurich website at zurich.com.au/tmd.

The insurance benefits available

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. You have 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.

The insurance products available through superannuation under this PDS are:

- **Zurich Wealth Protection** which provides the following types of insurance:
  - Life insurance – providing cover for death and terminal illness;
  - Total and Permanent Disablement insurance (TPD) – 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 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. 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.

Holding insurance cover through superannuation

It is important to note that there are differences between holding insurance cover directly from Zurich and holding insurance cover through a superannuation account. These differences include:

- When you have insurance cover through superannuation, 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 superannuation.
- Insurance cover held through superannuation 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

[1]You are not required by law to provide us with your TFN, However, if you would like to participate in this product, your Tax File Number is necessary.

insurance cover described in the Zurich Wealth Protection PDS and Zurich Active PDS can be held through a superannuation account. 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 superannuation cannot be based on your permanent incapacity to perform your own occupation only.
- 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 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 6.
- If you have a complaint relating to insurance cover held in the Zurich Plan, Zurich will assist with the processing of such complaints in line with the Trustee's complaint handling process amended from time to time.

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 superannuation. Benefits not included through superannuation 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 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 or the Fund.

For further information about the differences, refer to the Zurich PDSs available from the Trustee or Zurich on request at no charge, or consult your financial adviser.

The suitability of insurance cover available to you via the Fund depends on your individual circumstances. The Trustee and Zurich are unable to provide personal financial advice to you in relation to insurance cover through superannuation.

Before applying for insurance cover under a Zurich Wealth Protection or Zurich 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 Fund for this purpose.
- When completing an application for insurance, if you do not comply with your duty to take reasonable care not to make a misrepresentation, your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced. The duty to take reasonable care not to make a misrepresentation is explained in the Zurich PDSs.
- 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, 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 a financial adviser before applying for insurance cover and becoming a member of the Fund. Your financial 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. See page 9 for more information on conditions of release.

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 may apply 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 (if applicable) for a year being higher the more frequent your premium payments are.

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 the year.

Further information about the calculation of insurance premiums, including management fees, if applicable charged by Zurich, can be found in the relevant Zurich PDS.

Other fees and costs

The Trustee pays the premium (including any management fee, if applicable, 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. Zurich also pays a Fund Administration Fee to the Trustee to cover the costs associated with administering the product within the Fund. In addition to the Fund Administration Fee paid by Zurich, the Trustee may also charge an additional Fund Insurance Administration Fee to further cover operating costs incurred in providing insurance to members which is recouped from the tax deduction available to the Trustee on insurance premiums. These payments are not an additional cost to you and may vary from time to time.

The Trustee does not charge any additional fees or costs to members associated with their membership of the Zurich Plan. The Trustee may bill you directly for any liability arising under any government charges or imposts relating to your Fund 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, Zurich will accept contributions and initiate rollovers (where a member consents) to the Fund 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 (if applicable) 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 or half-yearly, contributions can also be made by BPAY®. If you choose to make contributions by BPAY®, Zurich will provide you with payment instructions each year.

As these accounts do not offer a superannuation savings or investments facility, the Trustee cannot accept contributions in excess of the premiums due. The Trustee is also unable to accept Government contributions into these accounts. If the Trustee is unable to accept or allocate money to your account, the money will be returned without interest. Any interest earned on the unallocated money while in the Fund's bank account will be allocated to the Fund's General Reserve.

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* SuperStream is the prescribed mechanism for employers to 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) as part of their regular payroll cycle.

Eligibility to contribute to superannuation

To make contributions to the Fund, 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) on or before the 28th day after the end of the month in which you turn 75, and subject to contribution caps.

From 1 July 2022, there have been changes to the eligibility age in respect of the work test for personal superannuation contributions.

Please visit **www.ato.gov.au** for more information in relation to work test changes. .

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 75 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 convert 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, certain conditions must be met

as determined by the Trustee as set out in this PDS. This includes the condition that you provide us with your TFN when you apply for membership of the Fund[1].

Where contributions have been paid to Zurich for the purpose of paying insurance premiums during a period when you 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). 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 15% tax liability for certain concessional contributions may apply if your combined income and concessional contributions for Division 293 purposes exceeds $250,000 in the financial year. In this case, the ATO will issue you a Division 293 notice, if you receive a notice from the ATO, you should not elect for amounts to be released from the Zurich Plan, as you do not have an account balance in the Zurich Plan.

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.

[1]You are not required by law to provide us with your TFN, However, if you would like to participate in this product, your Tax File Number is necessary.

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 by 15%. For example, if the premium due (including management fee and stamp duty) is $1,000 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. The result is that the premium you pay is reduced by 15%. You will be notified of the reduced amount required before the partial rollover request is sent to your nominated fund. Notice will be given to you if this practice changes. 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 superannuation 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 for the Zurich Plan. 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 in full 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, Zurich will notify you directly of the premium obligations. If contributions or rollovers are not received by Zurich when the premium is due, Zurich may 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, and any application may be declined. 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 for any reason (for example, 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 if applicable) paid to Zurich. Any amount in the Zurich Plan that is subject to preservation will be repaid by way of transfer to another complying superannuation fund. Please see the 'Refunds' information provided on the following page.

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 and include the details of the superannuation fund you would like your refund transferred to – see Zurich's contact details on page 14) within 30 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 apply to 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. 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), 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 Zurich Plan, or within 30 days of leaving the Zurich Plan, 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 14.

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), the refund must be rolled over to another complying superannuation fund unless you satisfy a condition of release.

If you paid your premium via a rollover, your premium is reduced by 15%, therefore reducing the amount required to be rolled over. In the case of a refund, your refund amount is based on the rollover amount received (from your superannuation fund), not the gross premium amount.

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 superannuation 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 ATO.

Benefit payments and tax

Death, terminal illness and total and permanent disability benefits can only be paid to eligible members in the form of a lump sum. Income protection benefits are paid to eligible members in the form of a regular income stream.

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 will not be made under the policy until the Trustee has determined to whom the benefit must be paid. This might be you, your beneficiary, your legal personal representative or one or more of your dependants. In the case of death benefits, you may nominate your beneficiaries (see page 10).

The Trustee will only pay the amount it is entitled to receive from Zurich less any tax that must be withheld. Any benefits paid are treated as superannuation benefits for tax purposes. Where required, tax payable on a benefit will be withheld before an amount is paid by or on behalf of the Trustee. In some cases where a superannuation benefit is payable, the Trustee may direct Zurich to pay the benefit directly to members.

Conditions of release

There are rules in place to restrict when your super can be accessed. Where the terms and conditions of the Zurich policy are met, Zurich pays the insurance benefit to the Trustee. These benefits will generally be categorised as preserved amounts and can only be accessed on meeting a 'condition of release'.

Generally, the Trustee pays your benefits from the Fund as a lump sum. Conditions of release include:

- reaching your preservation age and you have permanently retired
- ceasing a gainful employment arrangement on or after reaching age 60
- reaching age 65, whether you have retired or not
- reaching your preservation age (payment restricted to a transition to retirement pension)
- permanent or temporary incapacity^
- severe financial hardship ^
- compassionate grounds ^
- terminal medical condition^
- death

^ Under superannuation law there are strict qualifying criteria that must be met in each of these circumstances.

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. Any insurance benefit received by the Trustee from Zurich will not attract investment earnings for the period that it is held in the Zurich Plan, as there is no account balance or investment component for these accounts

The taxation of lump sum death benefits will depend on the relationship between the deceased member 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 10 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 will depend on your age and other circumstances. If you are aged 60 or more, the benefit is generally tax free unless it includes an untaxed element. If you are under age 60, any tax-free component can be received free of tax. The balance of the benefit may be taxable, depending on whether you have reached your preservation age and you meet the taxation definition of Disability Superannuation Benefit.

Your preservation age depends on your date of birth as follows:

Before 1/7/1960	age 55
1/7/1960 – 30/6/1961	age 56
1/7/1961 – 30/6/1962	age 57
1/7/1962 – 30/6/1963	age 58
1/7/1963 – 30/6/1964	age 59
From 1/7/1964	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 ($245,000 for the 2024/2025 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.

In order to meet the taxation definition of Disability Superannuation Benefit, the Trustee will require certificates from two legally qualified medical practitioners confirming that because of the ill health, it is unlikely that you can ever be gainfully employed in a capacity for which you are reasonably qualified because of education, experience or training.

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 practising 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. 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 at 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, 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 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.

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 the 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. This means an entire nomination will become automatically invalid in the event of marriage, divorce or entering or ending an equivalent de facto relationship.

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 the probate limit of $350,000), 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 six 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 Brighter Super Trust Deed. In relation to the insurance benefits provided by the Trustee, 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 (during the cooling-off period – see page 7) 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 superannuation is a 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 Fund 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.

These are risks of holding insurance through superannuation. For details on the risks applicable to the insurance itself, please refer to and consider the information provided on risks within the relevant Zurich PDS.

Your financial adviser and how to apply

This superannuation product (including the insurance available through this product) is available through financial advisers. Your financial 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 financial adviser a commission for selling the insurance. You can obtain details from your financial adviser of any commission paid. The commission is paid by Zurich out of insurance premiums it receives from the Fund. Commissions are not paid by the Trustee.

Your financial adviser can assist you to make an application for membership of the Fund, along with an application for insurance. If your financial adviser lodges an online application on your behalf, the financial 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 financial 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 financial adviser to act on your behalf in relation to the application and, if you choose to submit an online application, you have appointed your financial adviser to help you complete and submit the application.
- You have received this 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, such as information about your health, financial situation, lifestyle and pastimes, 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 13) and the Anti-money laundering and counter-terrorism financing requirements (see page 13) contained in this 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 Fund 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 Fund until you provide your TFN.

Trustee Privacy Policy

Brighter Super respects the privacy of your personal information. You can find out how we use and protect your personal details by getting a copy of our Privacy policy at brightersuper.com.au/about-us/governance/reports-and-policies/privacy. A paper copy of our privacy policy can be provided free of charge on request.

The way in which Zurich collects, uses and discloses your personal and sensitive information (personal information) is explained in Zurich's Privacy Policy. Please refer to the Zurich Wealth Protection and Zurich Active PDS for information on how your personal information will be used.

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.

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.

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 financial adviser are recorded.

Privacy Officer

Brighter Super

Telephone: 1800 444 396

Email: info@brightersuper.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 45 days unless an alternative timeframe applies (for example a complaint about a death benefit distribution must be resolved within 90 days of the end of the 28 day objection period).

If you have a complaint, Zurich's Customer Care team is your first point of contact for raising complaints or providing feedback. You can contact Zurich directly via phone, email or in writing and Zurich will resolve your issue fairly, respectfully and efficiently, and will keep you informed of their progress.

If you're not satisfied with our response to your complaint, your concerns will be escalated to Zurich's Dispute Resolution Team who will work closely with you to find a solution quickly and amicably.

Zurich's contact details can be found in the 'Who to contact' section of this PDS.

You can also contact Brighter Super Trustee, the contact details for the Complaints officer are:

Email: complaints@brightersuper.com.au

Telephone: 1800 444 396

Post: Complaints Officer
Brighter Super
GPO Box 264
Brisbane Qld 4001

You may wish to refer the matter directly to the Australian Financial Complaints Authority (AFCA), which provides an independent dispute resolution service that is free to consumers. However, please note that AFCA will usually refer the complaint back to the Trustee for resolution through the Trustee's complaints handling process.

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

Time limits or other limits may apply to complaints to AFCA and so you should act promptly or otherwise consult the AFCA website to find out if or when a time limit relevant to your circumstances expires, or information about other limits.

Further details about the complaints handling process, are available on request by contacting the Zurich Plan administrator.

Brighter Super Trustee
ABN 94 085 088 484, AFSL 230511, RSE L0000178
Level 20, 333 Ann Street, Brisbane QLD 4000
GPO Box 265, Brisbane QLD 4001

Zurich Australia Limited
ABN 92 000 010 195, AFSL 232510
Zurich Customer Care: 131 551
Email: client.service@zurich.com.au
Website: zurich.com.au

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