ZURICH

Corporate Care
Group Income Protection

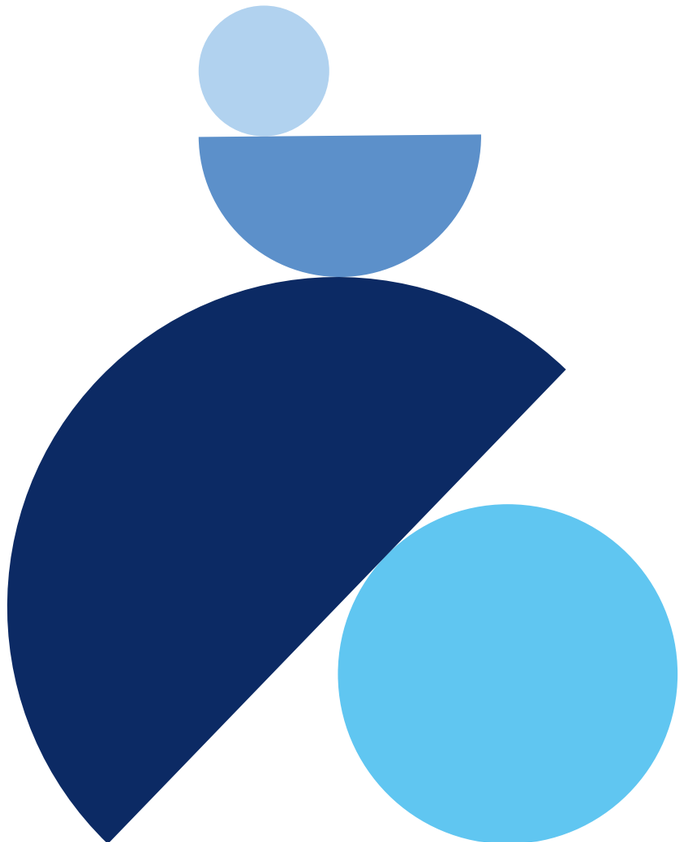
Product Disclosure Statement
and Policy Terms

Issue date: 1 April 2022

About Zurich

Zurich is a leading multi-line insurer that serves its customers in global and local markets. With about 55,000 employees, it provides a wide range of property and casualty, life insurance products and services in more than 215 countries and territories. In Australia, group life insurance solutions are provided by OnePath Life Limited ABN 33 009 657 176, AFSL 238341 as part of the Zurich Financial Services Australia Group.

The ultimate holding company of the group, Zurich Insurance Group Ltd, is listed on the SIX Swiss Exchange.



Our industry code

The Life Insurance Code of Practice is our promise to you and the insured members

When you take out group insurance for your members or your employees, it's important that you and your members or your employees receive the highest standards of service in all your dealings with us. That's why we've adopted the Life Insurance Code of Practice ('The Code').

The Code is the life insurance industry's commitment to mandatory customer service standards and it's designed to protect customers.

The Code explains our commitments as an industry

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

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

Key Code promises

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

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

Getting a copy

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

Contents

About this PDS and Policy

This document is a combined Product Disclosure Statement and Policy Terms (PDS and Policy). It sets out the benefits, features, options and risks of Zurich Group Income Protection Insurance (also referred to as Group Salary Continuance Insurance).

The information in this PDS and Policy will help you to decide whether this product is suitable to you, as well as assist you in comparing products available from other life insurers that you may be considering. You should read this PDS and Policy carefully and keep it in a safe place.

This PDS and Policy also contains the standard terms and conditions for Zurich Group Income Protection Insurance. If you apply and your application is accepted, we will issue a ***policy schedule*** to you. The ***policy schedule*** may include additional or amended terms and conditions that apply to your benefits. You should read this PDS and Policy, together with your ***policy schedule***, to understand the particular benefits that apply to you.

The information in this PDS and Policy, including taxation information, is based on the continuance of present laws and our interpretation of those laws.

Who issues Zurich Group Income Protection Insurance?

OnePath Life Limited (OnePath Life) ABN 33 009 657 176, AFSL 238341 is the issuer of this product – known as Zurich Group Income Protection Insurance (also referred to as Group Salary Continuance Insurance). OnePath Life is a company within the Zurich Financial Services Australia Group.

The invitation to purchase a Zurich Group Income Protection Insurance product is only made to persons receiving this PDS and Policy in Australia. It is not made, directly or indirectly, to persons in any other country.

Changes to information in this PDS and Policy

The information in this PDS and Policy is up-to-date at the time it was written – see the date at the front of the document.

The information in this PDS and Policy may change over time. You can get updated information at www.zurich.com.au/group-insurance/cover or ask us for a free paper copy by calling 1800 648 921. If the change is materially adverse, we will issue a supplementary or replacement PDS and Policy.

We also reserve the right to change matters which do not form part of the PDS and Policy. This includes administrative matters.

This PDS and Policy is not personal advice

The information in this PDS and Policy is general information only and does not take into account your personal circumstances, financial situation or needs. You should consider whether the information is appropriate for you, considering your objectives, financial situation and needs.

How to read this PDS and Policy

The following sections in this PDS and Policy explain the terms and conditions, how you can apply for and when to claim benefits for Zurich Group Income Protection Insurance.

Part 1: General Information

Part 2: Policy Terms

Throughout this PDS and Policy, the following words will have the meanings set out in the table below:

References to	To be read as
'we', 'our', 'us', 'OnePath Life'	OnePath Life Limited ABN 33 009 657 176, AFSL 238341, and includes any properly appointed delegates.
'you', 'your'	The applicant(s) for Zurich Group Income Protection Insurance or the owner of the ***policy***, and includes the ***policy owner's*** properly appointed delegates.
'your *policy*', 'a *policy*', 'the *policy*'	The documents issued by us to you. Please refer to the definition of ***policy*** in Part 2: Policy Terms – Section 9 (Dictionary) for the documents that make up your ***policy***.
'PDS and Policy'	This document which comprises the Zurich Group Income Protection Insurance Product Disclosure Statement and Policy Terms.

Some expressions and words throughout this PDS and Policy, and the ***proposal form***, have a special meaning. These words and expressions are shown in ***bold italic*** type and are defined in the Dictionary in Part 2: Policy Terms – Section 9 of this PDS and Policy. Other words and expressions with special meanings will be defined in the ***policy schedule*** which will be issued to you if you purchase this product.

Terms that are defined in the ***policy schedule*** prevail over any inconsistent term in the Dictionary, unless we agree otherwise.

Headings appear in this PDS and Policy for ease of reference, and are not relevant to the interpretation of the PDS and Policy.

Any words indicating the singular can also mean the plural and vice versa.

If special terms or conditions apply to the benefits provided to ***insured members*** generally, they are shown in your ***policy schedule***. An ***insured member*** may also be accepted for cover on special conditions. If this happens, we will notify you in writing.

Zurich Group Income Protection Insurance has been designed for consumers with certain needs and objectives

The 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 created a target market determination (TMD) for the product in this document. The TMD 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 the product is to be sold. You can find the TMD for Zurich Group Income Protection Insurance on our website at www.zurich.com.au/group-insurance/cover.

Setting up your policy

Step 1 – Obtaining a quotation

To establish a ***policy***, you need to first obtain a quotation for Zurich Group Income Protection Insurance.

In requesting a quotation, you will need to decide what level of ***monthly benefit insured members*** ought to be provided with, how soon the ***policy*** should start, the ***waiting period*** that is to apply, the ***benefit period***, and what optional benefits should apply. If you wish to request a quotation, please contact one of our Partnership Managers.

In response to a request for a quotation, we may provide you with a ***quotation summary***. A ***quotation summary*** is guaranteed for 90 days unless we agree to change this period.

It is important that you read and understand the information provided in this PDS and Policy before applying.

Step 2 – Accepting a quotation

Should you choose to accept our offer, you must notify us in writing before the end of the quotation guarantee period. You can do this by completing the form supplied with the ***quotation summary*** and returning the completed documentation to the contact details below, along with the premium or deposit premium due.

In order for us to establish your ***policy***, the following information is required from you:

- a completed ***proposal form*** signed by you
- an ***at work certificate*** signed by you or a ***participating employer*** (as relevant) in respect of each person to be covered
- a final list of persons to be covered under your ***policy*** and the ***member information*** which includes details of all proposed ***insured members*** who have been seconded overseas by their employer to work. To assist you in providing the ***member information***, we may give you a specific form or agree with you a basis to provide the ***member information*** electronically
- 'transfer terms' information, if relevant (refer to Part 2: Policy Terms – clause 2.4 for information on transfer terms) and
- the first annual premium or deposit premium we advise you is payable.

The documentation is to be provided to:

Group Insurance Administration
GPO Box 4129
Sydney NSW 2001
Email group.risk@zurich.com.au

Any premium or deposit premium due is to be paid via EFT. The bank account details are included in our invoice to you.

Step 3 – Issuing your policy

This PDS and Policy does not constitute a legally binding contract of insurance between you and us.

A contract with us is formed when:

- we accept your ***proposal form***
- we issue an 'On-risk' letter, and
- you have paid the premium or deposit premium due.

Once all our requirements are met, we shall issue you with a ***policy schedule***. The ***policy schedule*** confirms your cover and contains important details of your insurance.

More information

If you want to know more about obtaining a quotation for Zurich Group Income Protection Insurance, our dedicated Partnership Managers can assist. You can also:

- contact Group Insurance Administration on 1800 648 921
- visit our website at www.zurich.com.au/group-insurance

Part 1: General information

What is Group Income Protection Insurance?

At a glance

Group Income Protection Insurance can be a great way to add value to employees' remuneration packages or offer competitive insurance through a superannuation fund. Cover is provided through a group policy, which means one contract – owned by an employer or superannuation fund trustee – providing cover for a group of employees or members of a superannuation fund.

Zurich Group Income Protection Insurance provides a benefit of up to 75% of the ***salary*** of an ***insured member*** while they are unable to work due to illness or injury. The flexible nature of the insurance allows you to tailor insurance cover for the group by choosing the most appropriate benefit design.

The built-in benefits, features and options are summarised in the table below.

Please read Part 2: Policy Terms for full details of when we pay under any benefit, feature or option.

Built-in benefits and features summary

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Total Disability Benefit	If an ***insured member*** is unable to work due to illness or injury, we will pay you the ***monthly benefit*** while the ***insured member*** remains ***disabled***. We cease paying the ***monthly benefit*** at the end of the ***benefit period*** even if the ***insured member*** continues to be ***disabled***. The maximum ***monthly benefit*** you can receive in respect of an ***insured member*** is generally 75% of the ***insured member's monthly salary***. There is an option to select a different set of maximum ***monthly benefit*** where the maximum ***monthly benefit*** you can receive in respect of an ***insured member*** is generally 75% of the ***insured member's monthly salary*** for the first 24 consecutive months and 50% of the ***insured member's monthly salary*** thereafter. If this option is chosen, different Total Disability, Partial Disability definitions and rehabilitation requirement will apply and will be stated in the ***policy schedule***. ***Monthly benefits*** paid may be reduced by income or other payments made to, or in respect of, the ***insured member***.	✓	30
Partial Disability Benefit	If an ***insured member*** returns to work or is capable of returning to work after a period of ***total disability*** but has reduced working capacity, we will pay you a portion of the ***monthly benefit*** while their working capacity is reduced. We cease payments at the end of the ***benefit period*** even if the ***insured member*** continues to be ***disabled*** or has reduced working capacity at that time.	✓	31

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Enhanced Bereavement Benefit	If an ***insured member*** dies or is diagnosed with a ***terminal illness***, we will pay you three times the ***insured member's monthly benefit*** as a lump sum subject to a maximum amount payable of $60,000	✓	31
Specific Injury Benefit	If an ***insured member*** suffers a specific injury within 180 days of the event which caused it, we will pay you a ***monthly benefit*** regardless of whether the ***insured member*** is ***totally disabled***. Benefits commence immediately upon the ***insured member*** being diagnosed with the specific injury and continue for the nominated payment period for that specific injury.	x	31
Recurring Disablement Feature	If the ***insured member*** suffers a relapse of the injury or illness that caused the ***insured member*** to obtain a ***disability*** benefit within six months of their claim ending, no further ***waiting period*** will apply. The relapse will be considered as the continuance of the earlier period of ***disability*** and ***disability*** benefits will be restricted to the remaining balance of the ***benefit period*** (if any).	✓	33
Early Notification Incentive Benefit	If we are notified of a claim within 30 days of the event which causes the claim and we accept the claim, we will pay you an amount equal to 25% of the first month's ***disability*** benefit.	✓	32
Emergency Domestic Travel Benefit	If an ***insured member*** requires ***emergency transportation*** within Australia to a hospital while in receipt of a Total Disability Benefit (other than ambulance transportation), we will reimburse the expenses incurred for ***emergency transportation*** of the ***insured member*** up to $1,000.	x	33
Grief Support Program	If an ***insured member*** is diagnosed with a ***terminal illness***, we will offer the ***insured member*** and their ***immediate family members*** access to our Grief Support Program at no cost to the ***insured member*** and their ***immediate family members***.	✓	33
Practical Support Feature	We will offer to reimburse the ***insured member***, up to $500 in total, on expenses that provide practical support such as the costs of cleaning, meal preparation, transport for medical appointments and goal related activity aimed at improving health or wellness, to support them in the first 12 months of claim.	x	33
Transfer terms	We may agree to take over the level of insurance benefits provided by your previous insurer and provide equivalent benefits.	✓	24
Worldwide cover	Cover is provided worldwide, although some restrictions apply if the ***insured member*** is not an ***Australian resident*** and is working outside Australia (see below).	✓	26

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Cover during paid and unpaid leave	We provide cover for a maximum period of 24 months if the ***insured member*** is on paid or unpaid leave.	✓	26
Cover while working outside Australia	We automatically cover ***Australian residents*** working outside Australia for you or a ***participating employer*** for any length of time. ***Insured members*** who are not ***Australian residents*** are covered for up to three years while working outside Australia.	✓	27
Extended Cover	We will provide cover for up to a maximum of 60 days if an ***insured member*** ceases to satisfy the ***eligibility criteria***. For superannuation policies, extended cover is not available in some instances where the ***eligibility criteria*** ceases to be satisfied.	✓	27
Continuation Option	If an ***insured member's*** cover ends because they cease to be employed by you or a ***participating employer***, they may be able to apply to us for an individual policy providing ***disability*** benefits without being required to undergo medical ***underwriting***.	✓	28
Interim Accident Cover	While we consider a person's application to become an ***insured member***, we will provide cover for a ***disability*** that arises from an ***accident*** for a period of up to 90 days.	✓	26
Return to work assistance	We may pay some or all of the expenses incurred by an ***insured member*** participating in a return to work program, if we believe that such a program may help the ***insured member*** return to work. Please refer to page 19 for more information about the rehabilitation service we offer.	✓	32
Workplace modification assistance	We may pay some or all of the expenses required to modify an ***insured member's*** place of employment if we believe such modification is necessary to enable the ***insured member*** to return to work.	✓	33
Premium waiver	You do not have to pay premiums in respect of ***insured members*** who are ***on claim***.	✓	43
Discounts	A discount on premiums will apply if the premium is paid annually and full payment is made within 30 days of the due date. We will also discount your premiums if you purchase Zurich Group Life Insurance simultaneously with Zurich Group Income Protection Insurance.	✓	43
Guaranteed continuing cover	The ***policy*** will continue if premiums are paid when due, regardless of changes to the health of ***insured members***.	✓	21

Optional features

Generally, the following optional features are available at an extra cost. They will only apply where you have selected the relevant option for your ***policy***.

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Superannuation Contribution Benefit	You may choose to insure an additional amount of your ***insured members'*** salaries in the form of a Superannuation Contribution Benefit.	✓	34
Alternative Benefit Expiry Age Benefit	Age-based terms of 'to age 67' or 'to age 70' are available subject to certain conditions.	✓	38
Escalation Benefit	If you select this option, an ***insured member's monthly benefit*** will increase each year while a claim is being paid. The ***monthly benefit*** will increase by the lesser of the annual ***CPI*** increase and the ***escalation factor***.	✓	34
Nurse Care Benefit	If an ***insured member*** is ***totally disabled***, confined to bed and receiving full-time nursing care during the ***waiting period***, we will pay 1/30 of the ***monthly benefit*** each day for a maximum of 30 days or until the end of the waiting period, whichever occurs first.	X	34
Recovery Assistance Benefit	Where the ***insured member*** is receiving a Total Disability Benefit, and becomes ***totally and permanently disabled*** within 12 months of the ***date of disability***, if you have selected this option, we will pay you an additional lump sum amount as indicated in the table below:	X	35

Age next birthday as at the date you ceased work	Amount of the Recovery Assistance Benefit
Up to age 56	$50,000
57	$45,000
58	$40,000
59	$35,000
60	$30,000
61	$25,000
62	$20,000
63	$15,000
64	$10,000
65	$5,000

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Early Cash Benefit	If an ***insured member*** suffers an early cash condition (of which there are eight), we will pay the ***insured member's monthly benefit*** for a maximum of six months. Not available if the Trauma Recovery Benefit is selected.	X	35
Trauma Recovery Benefit	If an ***insured member*** suffers any of the trauma recovery events (as defined in Section 9 of Part 2: Policy Terms – Dictionary), we will pay you the ***insured member's monthly benefit*** for a maximum of six months. This benefit is payable during the ***waiting period***. Not available if the Early Cash Benefit is selected.	X	36
Immediate Family Member Benefit	If, while in receipt of the Total Disability Benefit, the ***insured member*** has been confined to bed and they require care from an ***immediate family member***, we may pay you an additional amount of up to $3,000 per month, for a maximum period of three months.	X	37
Relocation Benefit	We will reimburse the cost of a single standard economy airfare up to three times the ***insured member's monthly benefit*** if the ***insured member*** returns to Australia while ***totally disabled*** or ***partially disabled***.	X	37
Enhanced Recovery Assistance Benefit	If the ***insured member*** is ***totally and permanently disabled*** at the end of the 5 years, 7 years or 10 years (as applicable) ***benefit period*** we will pay you an additional lump sum equal to one times the ***salary*** of the ***insured member*** subject to a maximum of $100,000.	X	38
Internationally mobile employees	On application, we may be prepared to provide cover to internationally mobile employees that might otherwise not be able to obtain cover.	X	17
Tailored Package	We can create a tailored package of benefits to best suit your needs. Speak to one of our dedicated Partnership Managers to learn about the options we offer.	✓	N/A

Availability of cover

The table below sets out the limits and options available under Zurich Group Income Protection Insurance. The ***policy schedule*** will confirm the actual limits and options that apply to your ***policy***.

Minimum benefit entry age	15 years	
Maximum benefit entry age	64 years for 'to age 65' and 'to age 67' cover, and 69 years for 'to age 70' cover	
Minimum number of persons to commence a policy	20	
Minimum annual premium (excluding stamp duty)	$15,000	
Maximum monthly benefit level	$30,000	
Benefit expiry age	65 years, 67 years or 70 years as applicable	
Maximum salary replacement percentage	75% of the ***salary*** of the ***insured member***	
Maximum Super Contribution Benefit	12% of the ***salary*** of the ***insured member***	
Waiting period options	30, 60, 90, 180 and 365 days	
Benefit period options	Fixed term periods:	Age-based terms:
	2 years	to age 65
	5 years	to age 67
	7 years	to age 70
	10 years	
Premium payment frequency	Annually, half yearly, quarterly or monthly	

Please refer to the 'Benefits' section on page 30 of Part 2: Policy Terms for further details on the benefits provided.

Insurance risks

You should be aware of the following insurance risks:

- if the premium is not received by us within 30 days of the due date, we may give you 30 days written notice to cancel or terminate your ***policy***. We are entitled to interest on any amount due. We may not accept an ***insured member's*** claim that arises after the premium due date until outstanding premiums have been paid.
- the maximum amount of the insurance cover you select may not be sufficient to provide adequate insurance cover for an ***insured member*** in the event of their illness or injury
- we are not bound to accept your ***proposal form***
- if you or an ***insured member*** do not comply with the Duty to Take Reasonable Care Not to Make a Misrepresentation (see below), we may avoid the contract, or avoid cover in respect of an ***insured member***
- if an ***insured member*** is insured for ***new events cover***, we will not pay any benefit for a ***disability*** caused wholly or partly, directly or indirectly, by a ***pre-existing condition***
- if an ***insured member*** is insured for ***limited cover*** pursuant to clause 2.4.2 of Part 2: Policy Terms, we will not pay any benefit for a ***disability*** caused by an illness or injury which directly or indirectly caused the transferring member to be not ***at work*** on the last ***normal business day*** immediately before the ***transfer date***.

Duty to Take Reasonable Care Not to Make a Misrepresentation

When applying for insurance, there is a legal duty under a consumer insurance contract to take reasonable care not to make a misrepresentation to the insurer.

We give notice to any applicant for Zurich Group Income Protection Insurance that a *policy* issued under this PDS and Policy will be a consumer insurance contract. Accordingly, to meet this duty you 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.

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.

Guidance for answering our questions

You are responsible for the information you provide to us. When answering our questions, you 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 broker.
- review your application carefully. If someone else helped prepare your application (for example, your broker), 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 would now answer our questions 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.

Telephone contact

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

If you need help

It's important that you understand this information and the questions we ask. Ask us 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 you do 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 you 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.

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. This will include ***insured members*** and applicants for cover under this PDS and Policy.

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 broker 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 broker, 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 some of the relevant Australian laws that may apply:

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

We must also comply with updates to these laws and any associated regulations. In addition to these, other acts may require or authorise us to collect your personal information.

We may use personal information (but not sensitive information) collected about you to tell you about other products and services we offer. If you don't want your personal information to be used in this way, please contact us.

If you want to know more

We can provide:

- a list of service providers and business partners that we typically may share your information with
- a list of countries in which recipients of your information are likely to be located
- details of how you can access or correct the information we hold about you
- information about how to make a complaint.

For further information about our Privacy Policy please click this link, contact us by phone on 133 667 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.

Zurich Group Income Protection Insurance to be held in superannuation

Zurich Group Income Protection Insurance can be owned through superannuation. It is important to note however that superannuation law limits the circumstances when superannuation funds can pay benefits.

This may mean that if the ***policy*** is to be owned by a superannuation fund trustee, any ***insured benefit*** that we pay to the superannuation fund trustee can only be released by the superannuation fund trustee if it can be paid under superannuation law. If you are a superannuation fund trustee and wish to hold the ***policy*** for superannuation fund members, we recommend that you seek independent expert advice as to whether ***insured benefits*** under the ***policy*** will be able to be paid from the fund.

Additional eligibility requirements apply to a policy that is owned by a superannuation fund trustee and certain benefits and features may not be available to ***insured members*** under such a policy. Cover for members under a policy that is owned by a superannuation fund trustee may also cease in certain circumstances. Further details on these are provided in the 'Built-in benefits and features summary' on page 9 and in clauses 2.3.4, 2.3.5 and 2.14 of Part 2: Policy Terms.

Internationally mobile employees

On application, we may provide cover for employees of an Australian company that conduct business internationally. This cover will apply to ***Australian Residents*** and non-***Australian Residents*** who reside and work outside of Australia for the Australian company.

If we accept the application, we will issue a separate ***policy schedule*** for those to be insured on amended terms.

This optional cover is only available to persons receiving this PDS and Policy in Australia. It is not available, directly or indirectly, to persons in any other country.

This optional cover is not available to a trustee of a superannuation fund.

Speak to your Partnership Manager should you be interested in more details on this optional cover.

Enquiries and Complaints

Our customer service team is your first point of contact for any enquiries, raising concerns or providing feedback – this includes understanding where you are not satisfied with our products or the information, service or a response that we have provided, so we have an opportunity to make things right.

We have internal dispute resolution procedures in place for resolving complaints, which is a free service to you and your representatives.

How can I make a complaint?

We have dedicated people here to help, who will listen carefully and try to resolve your complaint as quickly as possible.

Our team can be contacted by using any of the methods listed below.

Phone: 132 062
Email: insurancefeedback@onepath.com.au
In writing: GPO Box 4148
Sydney NSW 2001

To assist you better, you may wish to provide the following information when contacting us about your complaint:

- Your name
- Your ***policy*** number (if applicable)
- How you would prefer to be contacted by us (phone number and/or email address)
- What we haven't done so well - i.e. details of your complaint
- The outcome you would like us to provide in relation to the complaint.

Need help or additional assistance to make a complaint?

We understand some people need help to make a complaint and you are able to ask someone to speak with us on your behalf, such as a relative, friend or legal representative, where we have your consent.

We will also provide additional assistance to those who require help to understand their ***policy*** or lodge a complaint. This might include older persons, individuals experiencing financial hardship, managing a disability or mental health condition, individuals experiencing family violence or those that are from a non-English speaking background or indigenous community.

We will take steps to ensure that all customers are provided with the service they need and will work with you or your representative to identify how best to provide support.

Should you require additional assistance, please contact us on 132 062 so we can provide the necessary support to help you manage your complaint.

Hearing and speech impaired customers can contact us via the National Relay Service on 1300 555 727.

Customers requiring translation assistance can contact the Translating and Interpreting Service on 131 450 and request they contact us on your behalf

If you require further support there are various organisations that are available to help such as Beyond Blue www.Beyondblue.org.au

What happens after I raise my complaint?

We will confirm that we have received your complaint within 1 business day (or as soon as practicable) and work with you to provide an outcome as quickly as possible.

If we need more than 5 days to review and resolve your concerns, we will refer you to our Dispute Resolution Team who will undertake further investigations.

Your dedicated contact will keep you regularly updated with the progress and will work with you to discuss options to resolve your complaint.

Once we have come to a decision on the outcome of your complaint we will discuss this with you.

We will write to you, where required, and our response will outline the outcome of your complaint. In most instances, our complaints decision will be provided no later than 30 calendar days Where we cannot resolve your complaint within this timeframe we will advise you in writing.

What if I'm not satisfied with your proposed decision or resolution to my complaint?

If you are not satisfied with our response you can have your complaint reviewed by an External Dispute Resolution (EDR) scheme.

The Australian Financial Complaints Authority (AFCA) is an EDR scheme that provides a fair and independent complaint resolution procedure. AFCA is a free service to customers and their contact details are:

Website: www.afca.org.au
Email: info@afca.org.au
Telephone: 1800 931 678 (free call)
In writing: Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

If your complaint relates to a privacy matter, you can contact the Office of the Australian Information Commissioner (OAIC):

Website: www.oaic.gov.au
Telephone: 1300 363 992
In writing: Office of the Australian Information Commissioner
GPO Box 5218
Sydney NSW 2001

Please note there are time limits for lodging disputes with AFCA or OAIC, which are available by contacting each organisation directly.

What happens once AFCA makes a decision?

We are bound by decisions made by AFCA that are accepted by you. However, if you are not satisfied with AFCA's decision, you may seek another course of action.

Underwriting requirements

Our standard ***underwriting*** requirements are outlined in our 'Underwriting Guide', which can be downloaded from www.zurich.com.au/group-insurance or obtained by calling Group Insurance Administration on 1800 648 921.

In some circumstances, we will require information from the ***insured member*** in addition to the Group Risk Personal Statement. Where this is the case, we shall request this information from the ***insured member***. We may also request additional medical, personal, or financial information on a case-by-case basis.

A copy of the standard Group Risk Personal Statement can be found at onepath.com.au/insurance-forms-and-brochures. Once completed, it should be submitted to:

Group Insurance Administration
GPO Box 4129
Sydney NSW 2001
Email: group.risk@zurich.com.au

Rehabilitation

We provide a range of rehabilitation support services that are tailored to suit the claimant's individual return-to-work goals.

Our rehabilitation takes a holistic and collaborative approach to support your employees with their recovery and work goals. Our multi-disciplinary team have extensive experience in occupational rehabilitation, managing psychological and physical conditions across diverse industries including construction, education, finance, defence, and corporate organisations.

Our Rehabilitation Team has qualifications in rehabilitation counselling, pain management and health and exercise physiology.

The services below may be offered to those claimants suitable to undergo our ***Rehabilitation program***:

Initial needs assessment

This assessment helps us to identify and access the right type of rehabilitation services for the claimant through exploration of medical and vocational factors.

Gradually build up the claimant's work capacity and endurance

We work with the claimant and their employer (if applicable) to develop a Return to Work Plan. This may involve reduced hours and duties which are gradually increased as the claimant's condition improves. Workstation modifications and aids may also make returning to work easier.

Career Counselling

If the claimant can't return to the same role, we undertake a vocational assessment of their education, employment history and transferrable skills to identify suitable alternative employment or retraining options.

Helping the claimant prepare for job seeking

We help the claimant build the confidence to be job-ready by assisting them with resume preparation, sourcing job leads and developing the skills for successful interviews.

Helping with work-readiness

If the claimant is not quite ready to return to work, they may benefit from assistance with developing a daily structure, incorporating exercise, goal setting, and re-engagement in the community, as a stepping stone to returning to work.

Business coaching

If the claimant is pursuing self-employment, they can talk to us about whether business coaching may be viable.

How we can help

If you'd like more information, please feel free to contact the Rehabilitation Team directly at claims.rehabilitation@zurich.com.au.

Making a claim

We understand that when an ***insured member*** needs 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 or the ***insured member*** may be able to use our online lodgement service, depending on the type of claim being made. You can contact us if you'd prefer to have a claim form sent to you.

The ***insured member*** is responsible for providing all supporting documents for the claim. In some cases, they may need to pay for those documents. For example, where a medical report is required. Most of the medical and financial information they will need to prove their claim will be information that they already have. The documents they submit should be legible, unaltered and include proof to support the claim. If we can't use the information they provide for any reason, we'll let you know why that is and will discuss what alternative documents can be provided. Any missing documents may delay the claim process.

Before we can pay a claim, we must have evidence to fully support that the relevant policy terms and conditions have been met. If the ***insured member*** withholds information that we reasonably require to make this assessment, it will delay the claim and could impact the claims decision.

For information about making a claim, refer to Section 7 of Part 2: Policy Terms.

If you want to know more about making a claim for a Group Income Protection Insurance benefit:

- contact Group Insurance Claims on 1800 648 921
- visit our website at www.zurich.com.au/group-insurance

How the cost of cover is calculated?

The premium is the amount you pay for the ***insured members*** in your plan. It includes the cost of the ***policy*** and any optional benefits selected, as well as any government charges that apply. Your annual premium will be at least the minimum annual premium (exclusive of stamp duty) shown in your ***policy schedule***. The premium is payable in respect of an ***insured member*** from the date the ***insured member's*** cover commences under the ***policy*** until the date cover ends. We will calculate the premium having regard to the number of ***insured members*** covered under the ***policy*** at the ***review date*** and the amount and type of the benefits provided. If this changes in the period until the next ***review date***, we will recalculate the premium at that time to reflect this.

There is a range of factors taken into account when the premium is calculated for your plan. The premium will be affected by significant factors such as:

- the sum insured – the larger the sum insured the larger the premium
- the age demographic of ***insured members*** – the premium generally increases with age
- the gender demographic of ***insured members***
- the occupation of ***insured members*** – generally, occupations with hazardous duties or higher occupational risk have higher premium rates
- industry related loadings or discounts
- the grouping of polices
- whether premiums are paid annually or by instalment (a frequency loading will apply if the premium is paid other than annually in advance)
- the claims history of your plan, and
- the applicable commission levels agreed between you and an intermediary.

Generally, the premium rates will be guaranteed from the ***policy start date*** to the end of the ***premium rate guarantee period***. We can change the premium rate at the end of the ***premium rate guarantee period*** or during the ***premium rate guarantee period*** under limited circumstances.

Factors which can result in changes to premiums include those above as well as changes in the costs we incur in providing our cover (e.g. the cost of claims we pay), capital and regulatory requirements, expected policyholder behaviour (including how long cover is held) and economic factors including interest and inflation rates, levels of employment and market returns.

For more details on the cost of cover, please refer to clause 6 of Part 2.

You can terminate the ***policy*** at any time by giving us at least 30 days written notice.

Part 2:
1. Policy Terms

1.1 Overview

The information in Sections 1–9 of this Part 2: Policy Terms sets out the terms and conditions upon which we agree to insure your ***insured members***, the benefit(s) we may pay in the event of a claim, and the rights and obligations which you and we must observe. Together with the ***policy schedule*** we issue to you, which contains information on limits, conditions and options selected, it constitutes your ***policy.***

These terms and conditions include details of persons who are eligible to be covered as ***insured members***, how this happens, and when the cover ends.

The standard benefits provided for ***insured members*** are described in Section 3. Optional benefits may apply to some or all ***insured members***, as set out in Section 4.

There are some circumstances in which we will not pay all, or part of, the benefit amount and these are detailed in Section 5.

The payment of benefits is subject to you and the ***insured member*** satisfying our claim procedures as set out in Section 7.

1.2 Duration of the policy

The ***policy*** commences on the ***policy start date*** and remains in force, as long as you pay the premium in accordance with Section 6 and observe the terms of the ***policy***, until the earlier of the:

- ***policy*** expiry date, shown in the ***policy schedule***
- date the ***policy*** is terminated under clause 8.6.

1.3 Notices

Notices to, or by, us under the ***policy*** must be in writing and can be delivered by post or email. We will send notifications to you at the postal or email address you last advised us. Notifications to us should be sent by post to our ***principal office*** in Sydney or by email to group.risk@zurich.com.au

1.4 Guaranteed continuing cover

Your ***policy*** will be renewed each year if you continue to pay the premium and satisfy the other terms of the ***policy***, regardless of changes in the health of your ***insured members***.

1.5 Varying the policy

You may apply to us in writing to change the terms of your ***policy***. Any such variation is only effective if confirmed by us in writing.

Any insurance already in place will be unaffected by such an application up until the effective date of the variation. If you apply to make such a change, and we approve your application, we will provide confirmation by issuing a new ***policy schedule***. We will also issue a new ***policy schedule*** at the expiry of the ***premium rate guarantee period***.

2. Eligibility and period of cover

2.1 Who can become an insured member?

Only an ***eligible person*** can become an ***insured member*** under the ***policy***.

An ***eligible person*** is a person who:

- satisfies the eligibility rules in the ***policy schedule***
- is an ***Australian resident*** or holder of a ***visa***
- resides in Australia (unless the person is outside Australia as set out in clauses 2.10 and 2.12)
- is employed and working at least 14 hours per week as a ***permanent employee*** (including any ***contractor***) and
- is aged at least the ***minimum benefit entry age*** and not more than the maximum benefit entry age on the day they are first eligible for cover, or if an application for cover is required, on the date that the ***eligible person*** applies for cover.

An ***eligible person*** accepted as an ***insured member*** under clause 2.2 is covered for the benefits described in Section 3 and Section 4 (where applicable), provided they continue to meet the ***eligibility criteria*** outlined in the ***policy schedule*** and the terms of the ***policy***.

2.2 Becoming an insured member

An ***eligible person*** can become an ***insured member*** in one of the following ways:

- by ***automatic acceptance terms*** as set out in clause 2.3
- by operation of our transfer terms as set out in clause 2.4
- by applying to us online or in writing as set out in clause 2.6.

Cover for an ***eligible person*** is subject to you providing to us both the premium for the cover and all ***member information*** in respect of the ***eligible person***, by the following times:

- where ***automatic acceptance terms*** applies, within 30 days after the ***policy start date*** or ***review date*** following the day the person first satisfies the ***eligibility criteria***
- where transfer terms apply, within 90 days after the ***policy start date***
- where an application for cover is required, within 30 days after the date the ***eligible person*** was first eligible to apply to become an ***insured member***, or
- as otherwise agreed in writing by us.

To assist you in providing ***member information***, we may give you a specific form or allow you to provide the information electronically. ***Member information*** must be provided in respect of all ***eligible persons***.

2.3 Automatic acceptance

2.3.1 Automatic acceptance level

When you establish your plan, we may agree to provide an ***automatic acceptance level*** (***AAL***). An ***AAL*** is the maximum amount of cover available without ***eligible persons*** needing to give us any evidence of good health. The amount of any ***AAL*** we agree to provide depends on a number of factors and will only be provided where all of the following conditions are met:

- there are at least 20 ***insured members*** at the ***policy start date*** and at least 20 ***insured members*** at each annual ***review date*** (unless we agree otherwise in writing)
- you provide an ***at work certificate*** where one is required for all ***eligible persons*** that are to become ***insured members*** under this ***policy***
- we are your sole insurer for this type of insurance, and
- at least 75% of all ***eligible persons*** (or as otherwise agreed to by us in writing) shall become ***insured members*** at the ***policy start date***.

2.3.2 When an eligible person is covered under automatic acceptance

An ***eligible person*** may be automatically accepted up to the ***AAL*** for the applicable type of cover under the ***policy***, without needing to give us evidence of good health, provided all of the following conditions are met:

- the ***AAL*** shown in the ***policy schedule*** is for an amount other than 'nil'
- the eligibility rules are clearly defined and do not allow an individual to determine if they will become a member of the plan on a discretionary basis, i.e. as a result of the person's individual choice
- the ***eligible person*** is ***at work*** with you or a ***participating employer*** on:
  - the ***policy start date*** (or, if not a ***normal business day***, the last ***normal business day*** before the ***policy start date***), or
  - the day they first satisfy the ***eligibility criteria*** as confirmed by an ***at work certificate*** in the case of an ***eligible person*** meeting the ***eligibility criteria*** on a date after the ***policy start date***
- the ***eligible person*** satisfies any other terms that we may apply
- the ***eligible person*** must not be entitled to payment of any insurance benefit from any source for an illness or injury or be in a waiting period for such a benefit
- the ***eligible person*** must not have previously been accepted for cover under your plan by ***automatic acceptance terms*** unless:
  - the ***eligible person*** was previously accepted for cover under ***automatic acceptance terms*** and the cover provided at that time ceased under the ***policy*** solely because they ceased employment with a ***participating employer***, and
  - the ***eligible person*** has recommenced employment with the ***participating employer***,

  in which case the requirement to give us evidence of good health will not apply to the ***eligible person*** upon recommencing employment with you or a ***participating employer***.

2.3.3 Automatic acceptance and eligible persons not at work

An ***eligible person*** who is not ***at work*** as a result of an illness or injury on the ***policy start date*** or on the day the ***eligibility criteria*** was first met by the ***eligible person*** (as the context requires), shall become an ***insured member*** for ***new events cover*** only.

When the ***insured member*** returns to the pre-disability duties (working the same hours and in the same capacity without limitation) they performed when they were last ***at work***, the ***insured member's new events cover*** will cease and will be replaced with ***standard cover*** from that date.

2.3.4 Automatic Acceptance for superannuation members

Where the ***policy owner*** is the trustee of a superannuation fund (and in addition to the eligibility requirements under clause 2.3.2), to be automatically accepted up to the ***AAL*** an ***eligible person*** must also:

- has a balance equal to or greater than $6,000 in their ***member's account*** and, where they became a member of the superannuation fund on or after 1 April 2020, be at least 25 years of age, or
- provide you with a ***PMIF member election*** within 120 days of the issue date of the welcome letter issued to the ***eligible person*** by the ***policy owner*** as trustee of the superannuation fund, or
- be a ***PMIF exempt member***.

Where the person first becomes eligible for insurance under this ***policy*** by providing you with a ***PMIF member election***, they will become an ***insured member*** for ***new events cover*** only. Should the ***insured member*** be ***at work*** for 30 consecutive days after their cover commenced under the ***policy***, the ***insured member's new events cover*** will cease and will be replaced with ***standard cover*** on the 31st consecutive day.

Where the person first becomes eligible for insurance under this ***policy*** by, subsequent to becoming a member of the superannuation fund, having a balance equal to or greater than $6,000 in their ***member's account*** and, where they became a member of the superannuation fund on or after 1 April 2020, being at least 25 years of age they will become an ***insured member*** for ***new events cover*** if they have not been ***at work*** for 60 consecutive days immediately prior to that date. Should the ***insured member*** subsequently be ***at work*** for 30 consecutive days on or after 12 months from the date their cover commenced under the ***policy***, the ***insured member's new events cover*** will cease and will be replaced with ***standard cover*** on the 31st consecutive day.

Where the person first becomes eligible for insurance under this ***policy*** by being or becoming a ***PMIF exempt member***, they will become an ***insured member*** for ***new events cover*** if they are not ***at work*** on that date. Should the ***insured member*** return to their pre-disability duties (working the same hours and in the same capacity without limitation) they performed when they were last ***at work***, the ***insured member's new events cover*** will cease and will be replaced with ***standard cover*** from that date.

2.3.5 Commencement of cover

Cover under ***automatic acceptance terms*** which is provided where an ***eligible person***:

- makes a ***PMIF member election***; or
- is or becomes a ***PMIF exempt member***,

commences from the date that the ***PMIF member election*** is received by you, or the ***eligible person*** first becomes a ***PMIF exempt member*** (as relevant).

Cover under ***automatic acceptance terms*** which is provided where an ***eligible person***, subsequent to becoming a member of the superannuation fund, has a balance equal to or greater than $6,000 in their ***member's account*** and, where they became a member of the superannuation fund on or after 1 April 2020, they are at least 25 years of age, commences from the date that the first mandated employer superannuation contribution is received

by you after the ***insured member*** first satisfies these requirements.

Otherwise, cover for an ***insured member*** accepted under ***automatic acceptance terms*** will commence on the later of the ***policy start date*** and the date the ***eligible person*** first meets the ***eligibility criteria***.

Upon commencement of cover, the ***insured member*** is covered for the lesser of:

- the ***AAL***, and
- the ***monthly benefit***.

An application is required for cover in excess of the ***AAL*** as set out in clause 2.6.

Where we accept an application for cover or additional cover under clause 2.6, cover will commence on the date we accept the application in writing subject to the terms of that acceptance (if any) which we will specify in the ***decision note***.

2.3.6 Variation in automatic acceptance terms and AAL

Any variation to the ***automatic acceptance terms*** will be outlined in the ***policy schedule***.

If the number of ***insured members*** covered under the ***policy*** falls below 75% (or as otherwise agreed to by us in writing) of persons eligible for cover based on the ***eligibility criteria***, we may remove the ***AAL*** after consultation with you. Where this occurs, the cover we provide for existing ***insured members*** as at the date the ***AAL*** is removed will not be impacted.

When an ***AAL*** increases, the higher ***AAL*** may apply to all existing ***insured members*** irrespective of whether they have been declined cover above the previous lower ***AAL*** or excluded or loaded for cover above the previous lower ***AAL***. Any loading, limitation or exclusion previously applied will only apply above the new higher ***AAL***. We will advise you in writing if we agree to do this and the date from which the change becomes effective.

2.4 Transfer terms

Transfer terms will apply if, before this ***policy*** starts:

- we are satisfied with the underwriting standards of the previous insurer, and
- we have notified you in writing of our agreement to offer transfer terms.

Transfer terms will only apply to those persons who were insured under your previous plan at the ***transfer date***.

Where we agree to offer transfer terms and you comply with all our requirements, all transferring members will be covered for an ***insured benefit*** on underwriting terms no less favourable than those provided by the previous insurer. This means that we will apply the same underwriting terms or rules, if any, that applied in respect of an individual ***insured member*** under the previous policy including ***forward underwriting limits***, premium loadings, restrictions, exclusions and any limitations. In some circumstances, we may apply exceptions to this treatment under the transfer terms but will let you know where we do so.

In addition to any specific terms we specify in writing, transfer terms are subject to all of the following conditions:

- all information we need about the operation and terms of the previous policy in writing including, but not limited to, individual names, level and type of insured benefits and the applicable underwriting acceptance terms is provided to us no later than 90 days after the ***transfer date***, unless we agree otherwise in writing
- premiums are paid for all transferring members to whom we agree to provide cover under these transfer terms
- cover is provided in accordance with our ***quotation summary*** including, but not limited to, our ***maximum monthly benefit level***.

We will provide cover from the ***transfer date*** for ***eligible persons*** who are ***at work*** on the last ***normal business day*** immediately before the ***transfer date***.

2.4.1 Not at work for reasons other than illness or injury

For any transferring member insured under the previous policy who is not ***at work*** on the last ***normal business day*** immediately before the ***transfer date*** for reasons other than illness or injury, we will provide the same amount of Total Disability, Partial Disability and Specific Injury cover (if applicable) issued under the previous policy provided that:

- on the day before the first day of the relevant absence, the transferring member was ***at work***, and
- during the period where the transferring member was absent from work prior to the ***transfer date***, they were not absent due to an illness or injury.

2.4.2 Not at work due to illness or injury

Transferring members insured under the previous policy who were not ***at work*** on the last ***normal business day*** immediately before the ***transfer date*** due to illness or injury will be provided with ***limited cover*** from the ***transfer date***.

When the transferring member returns to the pre-disability duties (working the same hours and in the same capacity without limitation) they last performed when they were ***at work***, the ***limited cover*** will cease and the ***insured member*** will be covered on the same basis as an ***insured member*** who was ***at work*** on the last ***normal business day*** immediately before the ***transfer date*** provided the ***eligible person*** is not entitled to a benefit under the previous policy.

2.4.3 Special cases

We may negotiate with you special transfer terms in respect of transferring members. These special terms will only apply where we have notified you in writing that such special terms are offered.

2.4.4 Transfer terms and AALs

When a plan is transferred to us and we apply a higher ***AAL***, the higher ***AAL*** may apply to all transferred ***insured members*** including those who were declined cover above the previous insurer's ***AAL***, or who had loadings or exclusions applied to their cover above the previous insurer's automatic acceptance level. We will advise you in writing if we agree to do this.

Any loading or exclusions that previously applied to the cover above the previous insurer's automatic acceptance level will only apply above the new higher ***AAL***.

2.4.5 Financial Services Council Guidance Note 11 – Group Insurance Takeover Terms

We will comply with the ***FSC Guidance Note*** to the extent of any inconsistency with the ***policy*** except where special terms are negotiated under clause 2.4.3

2.5 Automatic increases in the monthly benefit

2.5.1 Where the insured member is automatically accepted

Provided the ***insured member*** is in ***active employment***, the ***insured member's monthly benefit*** may increase automatically on either:

- the ***review date***
- another date during a 12-month period which is specified in the ***policy schedule***.

You or the ***insured member*** will not need to apply to us in writing if the increase in the ***monthly benefit*** is up to 25% of the ***insured member's monthly benefit*** (as determined immediately before the increase) and provided the increased ***monthly benefit*** is not more than the ***AAL***.

Where you on behalf of an ***insured member*** or the ***insured member*** seek to have the ***insured member's monthly benefit*** increase by more than 25%, they will need to apply to us in writing and be ***underwritten*** for the part of the ***monthly benefit*** that is in excess of 25% of the ***insured member's monthly benefit***. We may agree to waive this requirement.

In all other circumstances, an application is required as explained in clause 2.6.

2.5.2 Other instances

If an ***insured member*** has been forward ***underwritten*** to a ***forward underwriting limit***, we may agree to accept increases in the ***insured member's insured benefit*** up to the ***forward underwriting limit***, without requiring the ***insured member*** to provide further medical evidence, so long as the increase is a result of the application of the formula by which ***insured benefits*** are calculated.

We will only agree to a ***forward underwriting limit*** in respect of an ***insured member*** when:

- we have ***underwritten*** and approved the ***insured member's*** application for cover or increased cover, and
- we have notified you in writing of the ***forward underwriting limit***, which may be up to a ***maximum monthly benefit level*** (as outlined in the ***quotation summary*** or ***policy schedule***).

We may impose lower ***forward underwriting limits*** at our discretion.

2.6 Applications for cover

An application in writing is required for all or part of the cover for an ***eligible person*** or an ***insured member*** in each of the following circumstances:

- if ***automatic acceptance terms*** do not apply or an ***eligible person*** was not automatically accepted
- an ***eligible person*** requires cover in excess of the ***AAL***
- if transfer terms do not apply
- in respect of an increase in the ***insured benefit***, if an increase is not automatically provided pursuant to clause 2.5
- if an ***insured member's*** cover stops under the ***policy*** for any reason, except where the ***insured member*** recommences employment with their ***participating employer*** as described in clause 2.3.2
- they require cover that is not ***new events cover***.

An application can only be made for cover up to the ***maximum monthly benefit level***.

When considering an application, we may request medical and other information from the ***eligible person*** or ***insured member***. We can accept or decline an application for any reason, or accept an application subject to the application of exclusions, a premium loading or any other special conditions which we consider appropriate.

Until we accept or reject the application, Interim Accident Cover may apply as set out in clause 2.7.

If we accept an application, we will issue a ***decision note***.

Where we issue a ***decision note*** in respect of an ***insured member***, the terms outlined in the ***decision note*** prevail over any inconsistent terms in the ***policy*** (including the ***policy schedule***).

Premiums will be charged from the effective date of any cover we approve.

2.7 Interim Accident Cover

Interim Accident Cover is provided for all, or that part, of the cover for which an application under clause 2.6 is required.

Interim Accident Cover starts from the date an application for cover is received by us.

Interim Accident Cover will end upon the earlier of:

- the date we notify you or the ***insured member*** in writing that we accept or reject the application for cover or increase in the ***insured benefit***
- 90 days after the date Interim Accident Cover starts
- the date that cover otherwise ceases in accordance with clause 2.14
- the date the application is cancelled or withdrawn.

If an ***insured member*** or ***eligible person*** suffers ***disability*** as the result of an ***accident*** during the period in which Interim Accident Cover applies, we will pay you the Interim Accident Cover Benefit. We pay the Interim Cover Benefit each month after the ***waiting period*** while the ***insured member*** or ***eligible person*** remains ***disabled.*** Payment of the Interim Cover Benefit will cease should the ***insured member*** or ***eligible person*** be no longer ***disabled*** or at the expiry of the ***benefit period*** (whichever comes first).

The Interim Accident Cover Benefit is the lesser of:

- the ***monthly benefit*** amount applied for in the application for cover
- the ***maximum monthly benefit level***.

Interim Accident Cover provides a Total Disability Benefit or Partial Disability Benefit only. It does not cover the ***insured member*** or ***eligible person*** for a Specific Injury Benefit or any other built-in benefits, built-in features or any optional benefits.

2.8 Maximum monthly benefit level

The ***insured member's insured benefit*** cannot exceed the ***maximum monthly benefit level***.

2.9 Member categories

The eligibility rules may refer to different categories of ***insured members***. In that case, an ***eligible person*** is covered for the ***monthly benefit*** with the ***waiting period*** and ***benefit period*** applicable to the category in which they are accepted as an ***insured member.*** The ***maximum monthly benefit level***, the ***AAL*** and any optional benefits (as set out in Section 4) may also vary between categories of ***insured members***.

2.10 Worldwide cover

We will provide worldwide, 24 hour cover for an ***insured member*** regardless of whether they are away on business or holiday, subject to clauses 2.11 and 2.12 below.

2.11 Cover during paid and unpaid leave

An ***insured member*** is covered under the ***policy*** for a period of up to 24 months while on paid or unpaid leave (including ***parental leave***), subject to all of the following conditions being met:

- the premium in respect of the ***insured member*** must continue to be paid during the period of leave
- the ***insured member's*** employer must approve the period of leave, prior to the ***insured member*** commencing leave
- the identity of ***insured members*** on unpaid or paid leave and the number of ***insured members*** on such leave must be provided to us when requested and at least annually with the ***member information***
- the ***insured member's*** employer must hold appropriate leave records in respect of that ***insured member*** that includes:
  - the date the paid or unpaid leave is to commence
  - the date the ***insured member*** is expected to return to work.

Prior notification to us of the unpaid or paid leave is not required.

If cover for an ***insured member*** on paid or unpaid leave is required beyond 24 months, an application in writing to extend cover beyond 24 months is required prior to the expiration of the 24 months. We may accept or decline that application at our sole discretion.

If an ***insured member*** becomes ***disabled*** while cover is being provided for them under this clause, the ***waiting period*** commences on the ***date of disablement***.

2.12 Cover while working outside Australia

An ***insured member*** who is an ***Australian resident*** and working outside Australia for you or a ***participating employer*** will be covered under the ***policy*** while they are working outside Australia. Prior notification to us of the ***insured member's*** travel is not required.

If the ***insured member*** is not an ***Australian resident*** but holds a ***visa***, they will be covered under the ***policy*** for up to three years while working outside Australia for you or a ***participating employer***. If cover is required beyond three years, an application in writing is required prior to the expiration of the three years. We may accept or decline that application at our sole discretion.

Cover is subject to the following conditions:

- the premium in respect of the ***insured member*** must continue to be paid during the period the ***insured member*** is working outside Australia
- we reserve the right to impose conditions on the cover, and review cover, at the end of the ***premium rate guarantee period***, or if there is no ***premium rate guarantee period***, at the ***review date***. If we impose such terms we will give you notice in writing, and
- any details regarding the location of ***insured members*** residing outside Australia must be provided to us upon request and at least annually with the ***member information*** at the ***review date***.

You must retain records of the following:

- the duration of time the ***insured members*** are working outside Australia
- the number of ***insured members*** working outside Australia
- the location of ***insured members***.

To avoid doubt, if the ***insured member*** (including a non-***Australian resident***) is travelling outside Australia during periods of paid or unpaid leave and subject to cover continuing to be made available under clause 2.11, cover will continue for that ***insured member***.

2.13 Extended Cover

Subject to the terms of the ***policy***, we will provide cover under the ***policy*** to an ***insured member*** for a maximum of 60 days after the date they cease to meet the ***eligibility criteria*** subject to the following conditions:

- as at the date the ***insured member*** ceased to meet the ***eligibility criteria***, the ***insured member*** had not received, nor was entitled to receive, a benefit under the ***policy***, nor was the ***insured member*** in a ***waiting period*** for such a benefit, and
- the Extended Cover will cease on the earlier of:
  - the date the ***insured member*** reaches the ***benefit expiry age***
  - 60 days after the date the ***insured member*** ceases to meet the ***eligibility criteria***
  - the date cover for the ***insured member*** commences under a retail policy of insurance issued by us under clause 2.15
  - the date the ***insured member*** is ***gainfully working***.

Where the ***policy owner*** is the trustee of a superannuation fund, no cover under this clause will be available under the ***policy*** in respect of an ***insured member*** where the ***insured member*** ceases to meet the ***eligibility criteria***:

- at 11.59pm on the last day of the ***inactivity period***, except where the ***insured member*** is a ***PYS exempt member*** at that time, or
- because they have ceased to be a ***PMIF exempt member***.

2.14 When cover ends for insured members

2.14.1 Events of termination

An ***insured member's*** cover will end on the earlier of:

- where the ***insured member*** cancels the cover, the later of the date we receive written notification from the ***insured member*** to cancel the cover and the date specified in the ***insured member's*** request to cancel the cover
- the date the ***insured member*** who is not an ***Australian resident*** is not eligible to work in Australia (whether that is because they no longer hold a ***visa*** or for any other reason)
- the date the ***insured member*** reaches the ***benefit expiry age***
- the date we cancel and/or avoid your ***policy***, or cover in respect of an ***insured member***, in accordance with our legal rights

- the date we cancel and/or avoid your ***policy***, or cover in respect of an ***insured member***, because you have not paid the premium when due in accordance with clause 6.5
- the date the ***insured member*** commences ***active service*** with the armed forces of any country (except where the ***insured member*** is a member of the Australian Defence Force Reserves, in which case, cover for all benefits will cease only when the Reservist becomes the subject of a call-out order under the *Defence Act 1903* (Cth))
- the date the ***insured member*** dies
- the date the ***insured member*** permanently retires from employment
- the date the ***insured member*** ceases to meet the ***eligibility criteria***, or where they are provided with Extended Cover as set out in clause 2.13, the date that Extended Cover ends
- the date the ***insured member*** is on leave for longer than we have agreed to provide cover for under clause 2.11
- the date the ***insured member*** is working outside Australia for a period longer than we have agreed to provide cover for under clause 2.12
- the date your ***policy*** ends or is terminated, except to the extent discussed in clause 2.14.2.
- where the ***policy owner*** is the trustee of a superannuation fund, an ***insured member's*** cover will also end:
  - at 11.59pm on the last day of the ***inactivity period***, except where the ***insured member*** is a ***PYS exempt member*** at that time, and
  - immediately should the ***insured member*** cease to be a ***PMIF exempt member***.

2.14.2 If your policy terminates

If your ***policy*** terminates and ***takeover terms*** apply, our ongoing liability to pay a ***disability*** benefit to a person who was an ***insured member*** on the date of termination will be determined in accordance with the ***FSC Guidance Note*** (see clause 2.4.5).

2.15 Continuation Option

If an ***insured member's*** cover ends because they no longer satisfy the ***eligibility criteria*** due to the cessation of employment with you or a ***participating employer*** (as relevant), the person has the option to apply for a Continuation Option.

Unless agreed otherwise, the ***insured member*** may apply for an individual policy with us on their life with a benefit period, waiting period and monthly benefit available under the individual policy which are no more favourable than those which applied for that ***insured member*** under the ***policy***. The monthly benefit under the individual policy will be limited to the applicable percentage of the person's new monthly salary from their gainful occupation. The monthly benefit is generally based on the average monthly earnings for the 12 months immediately prior to the claim, or the nominated insured amount, whichever is the lesser.

We will not require the person to provide medical evidence, however our assessment of their application for an individual policy will take into account other factors such as:

- overseas travel/residence
- existing insurance
- occupation/duties
- income and working hours
- pastimes/pursuits
- smoker status.

To exercise the Continuation Option the person must:

- be 60 years of age or less
- apply in writing by completing an application for the individual policy within 90 days of the date they cease to be an ***eligible person*** as a result of ceasing employment with you or a ***participating employer*** (as relevant)
- be:
  - an ***Australian resident*** or holder of a ***visa*** we consider acceptable, and
  - not residing outside Australia (unless we agree otherwise)
- provide any information we consider relevant that does not relate to medical information
- acknowledge that any restrictions, limitations or loadings that apply to the ***insured member's*** cover under your ***policy*** will apply to the new individual policy
- not be eligible to receive ***disability*** benefits under your ***policy*** or any other policy issued by an insurer in the last 2 years, and
- apply for an indemnity contract only.

If you or another person or entity is receiving or is eligible to receive a benefit payment in respect of the ***insured member*** under the ***policy***, then we will not issue a Continuation Option in respect of that ***insured member***.

If the ***policy*** terminates or is transferred to another insurer a Continuation Option will not be available to any ***insured member*** under the ***policy***. Where the ***policy*** is issued to a superannuation fund, this includes the circumstance where the ***policy*** is terminated and replaced as a result of a successor fund transfer.

To avoid doubt, if the person's application for a Continuation Option is accepted by us, the person will not be covered under the ***policy*** between the date the ***insured member's*** cover ends under the ***policy*** and the date cover commences under the individual policy.

2.15.1 Conditions for the individual policy

If the person's application is accepted by us, cover under the individual policy commences in accordance with the terms of that policy. The premium rate under the individual policy will be based on the rates applicable at the time the person's application is accepted by us and may be more than under your ***policy***, and any restrictions, limitations and premium loadings that applied under the ***policy*** will apply under the individual policy.

The individual policy issued will be one that provides cover that in our opinion is similar to this ***policy***.

3. Benefits

3.1 The benefits we pay

In this section we describe the benefits for which ***insured members*** are covered.

The benefit paid under the ***policy*** is a ***monthly benefit***. If a payment is for part of a month, then it will be calculated on the basis of 1/30 of the ***monthly benefit*** amount for each day the benefit is payable.

To be eligible for benefits under the ***policy***, an ***insured member*** must, as at the ***date of disability***, have been ***gainfully working*** for an average of at least 14 hours per week as a ***permanent employee*** (including an eligible ***contractor***) for the six months immediately prior to the ***date of disability***.

An ***insured member*** who is ***gainfully working*** for at least 14 hours per week as a ***permanent employee*** (including an eligible ***contractor***) and has worked for less than six months immediately prior to the ***date of disability***, will also be eligible for benefits under the ***policy*** if the ***insured member*** has been working an average of 14 hours per week since they commenced ***gainfully working*** as a ***permanent employee*** (including an eligible **contractor**).

Any change in employment status during periods of leave, in accordance with clause 2.11, will not affect any entitlements to cover.

3.2 Waiting period

We will pay a ***disability*** benefit only after the end of the ***waiting period***. The ***waiting period*** commences on the ***date of disablement***.

During the ***waiting period***, the ***insured member*** may return to work once to perform the normal duties and hours of their occupation, for up to five consecutive days, without having to recommence the ***waiting period***. If this happens, we will add the number of days of work to the ***waiting period***. If the ***insured member*** returns to work, performing the normal duties of their occupation during the ***waiting period***, on more than one occasion, the ***waiting period*** starts again.

A separate ***waiting period*** applies for each separate illness or injury of the ***insured member*** which causes ***disability*** for which the ***insured member*** can claim under the ***policy*** unless the ***insured member*** is claiming under the provisions of Recurring Disablement (see clause 3.9).

3.3 Total Disability Benefit

We will pay you the ***monthly benefit*** during the ***benefit period*** when an ***insured member*** is ***totally disabled*** for longer than the ***waiting period***. To be eligible for the Total Disability Benefit, the ***insured member*** must have been:

- ***totally disabled*** for at least 7 days out of the first 12 consecutive days of the ***waiting period***
- continuously ***disabled*** for the balance of the ***waiting period***, and
- at the expiry of the ***waiting period***, ***totally disabled***.

The Total Disability Benefit starts to accrue from the day after the end of the ***waiting period***.

The ***monthly benefit*** is payable, in respect of an ***insured member***, monthly in arrears and stops at the earlier of:

- the end of the ***benefit period***
- the date the ***insured member*** attains the ***benefit expiry age***
- the death of the ***insured member***
- the date the ***insured member*** is no longer ***totally disabled***
- for an ***insured member*** on a ***visa***, the date the ***insured member's*** employment contract and/or ***visa*** expires or is otherwise terminated, or the date the ***insured member*** permanently departs Australia
- the date the ***insured member*** has been receiving benefits for longer than 12 consecutive months while residing outside Australia, in accordance with clause 5.5.

3.4 Partial Disability Benefit

We will pay you a proportion of the ***monthly benefit*** during the ***benefit period*** when an ***insured member*** is ***partially disabled*** at the expiry of the ***waiting period***. To be eligible for the Partial Disability Benefit, the ***insured member*** must have been:

- ***totally disabled*** for at least 7 days out of the first 12 consecutive days of the ***waiting period***
- ***disabled*** for the balance of the ***waiting period***, and
- continuously ***disabled*** since the end of the ***waiting period***.

The proportion of the ***monthly benefit*** will be calculated as follows:

$$\frac{(A - B)}{A} \times C \quad \text{where:}$$

A is the total monthly value of the ***insured member's salary***

B is the monthly income the ***insured member*** receives, or is capable of earning, for the month in which they are ***partially disabled***. If the ***insured member*** is not working to their assessed capacity then 'B' will be the amount they could expect to earn if they were. When we assess capacity, consideration will be given to medical evidence, and other factors related to the ***insured member's*** condition. 'B' must be less than the amount of 'A'. If 'B' is negative in a month, we will treat 'B' as zero.

C is the ***monthly benefit***.

The Partial Disability Benefit begins to accrue if the ***insured member*** is ***partially disabled*** and the ***waiting period*** has ended.

The Partial Disability Benefit is payable monthly in arrears and stops being paid at the earlier of:

- the end of the ***benefit period***
- the date the ***insured member*** attains the ***benefit expiry age***
- the death of the ***insured member***
- the date the ***insured member*** is no longer ***partially disabled***
- the date the ***insured member*** receives, or becomes capable of earning, a monthly income equal to or greater than their ***monthly salary*** for 2 consecutive months.
- for an ***insured member*** on a ***visa***, the date the ***insured member's*** employment contract and/or ***visa*** expires or is otherwise terminated, or the date the ***insured member*** permanently departs Australia
- the date the ***insured member*** has been receiving benefits for longer than 12 consecutive months while residing outside Australia, in accordance with clause 5.5.

3.5 Enhanced Bereavement Benefit

If an ***insured member*** dies or is diagnosed with a ***terminal illness*** while covered under the ***policy***, we will pay three times the ***monthly benefit*** amount as a lump sum, subject to a maximum of $60,000.

Only one payment can be made under this clause. If we pay the Enhanced Bereavement Benefit for ***terminal illness***, we will not pay it upon the death of the ***insured member***.

3.6 Specific Injury Benefit

This benefit is not available if you are the trustee of a superannuation fund.

If an ***insured member*** suffers a specific injury as set out in the table 'Specific injuries covered under the ***policy***' within 180 days of the event that caused it, we will pay you the ***monthly benefit*** for the nominated payment period, but not beyond the date the ***benefit period*** expires or the date the ***insured member*** attains the ***benefit expiry age***.

Only one Specific Injury Benefit is ever payable in respect of an ***insured member***. If an ***insured member*** is suffering from more than one specific injury at the same time, we will pay you the ***monthly benefit*** only in respect of the specific injury which has the longest nominated payment period. We will pay this benefit whether or not the ***insured member*** is ***disabled***.

This benefit is payable during the ***waiting period***.

The Specific Injury Benefit is paid instead of, not in addition to, a Total or Partial Disability Benefit. If the ***benefit period*** is 2 years, 5 years, 7 years or 10 years, the maximum period for which we will pay Total Disability Benefits and/or 'Partial Disability Benefits' is reduced by the number of months for which we have already paid the Specific Injury Benefit.

If the ***insured member*** dies during the nominated payment period, we will pay you a lump sum equal to the greater of:

- the total of remaining ***monthly benefits*** payable under this clause
- the Enhanced Bereavement Benefit as set out in clause 3.5.

Specific injuries covered under the policy

Specific injury	Nominated payment period
Paralysis*	60 months†
Loss of both feet or both hands‡	24 months
Loss of any combination of two of: • a hand • a foot • sight in one eye‡	24 months
Loss of one leg or one arm‡	12 months
Loss of one foot or one hand or sight in one eye‡	12 months
Loss of thumb and index finger of the same hand‡	6 months
Fractures§ of the:	
• thigh or pelvis	3 months
• leg (between and not including the knee and foot), or knee cap	2 months
• upper arm including the elbow and shoulder bone	2 months
• skull (except bones of the nose or face)	2 months
• lower arm (including wrist but excluding the elbow, hand and fingers)	1.5 months
• jaw or collarbone	1.5 months

* Paralysis means the total and permanent loss of function of two or more limbs.

† If you have selected a two year ***benefit period***, this payment period is reduced to 24 months.

‡ Loss means either the:

- total and permanent loss of the use and control of the hand from the wrist, or the foot from the ankle joint
- complete severance of the thumb and index finger from the first phalangeal joint
- irrecoverable total loss of an eye or the sight in an eye.

§ Fracture means any fracture that requires a pin, traction, a plaster cast or other immobilising structure.

The diagnosis of the specific injury must be made by a treating ***specialist medical practitioner.*** We may reasonably require that another ***specialist medical practitioner*** confirm the diagnosis and certification and we will pay for the cost of that ***specialist medical practitioner*** and reasonable travel costs.

If the ***insured member*** is ***disabled*** at the end of the nominated payment period during which a Specific Injury Benefit was paid and the ***benefit period*** has not ended, we will waive the ***waiting period*** for the ***disability*** benefit and pay the ***disability*** benefit for the remainder of the ***benefit period*** whilst the ***insured member*** is still ***disabled***.

If the Escalation Benefit applies to the ***policy***, the Specific Injury Benefit will also be subject to the terms of clause 4.3.

3.7 Early Notification Incentive Benefit

Where we accept a claim for a Total Disability Benefit or Partial Disability Benefit in respect of an ***insured member***, we will pay you the Early Notification Incentive Benefit if the ***insured member***, no later than 30 days after the occurrence of the event giving rise to a claim:

- notifies us of their intention to make a claim to receive benefits under the ***policy***, and
- provides us with the information required by us to establish the occurrence of the event giving rise to the claim.

The Early Notification Incentive Benefit that we will pay you is 25% of the amount payable for their ***disability*** for the first month (or if this is for less than one month, a pro-rata amount for each day the ***insured member*** is ***disabled***).

The Early Notification Incentive Benefit does not apply to the Specific Injury Benefit or to any other optional benefits.

This benefit is paid in addition to any other non optional benefit that becomes payable (with the exception of the Specific Injury Benefit) and only becomes payable at the expiration of the ***waiting period***.

3.8 Return to work assistance

If we are of the opinion that participation in rehabilitation or a return to work program may help an ***insured member*** return to work, we may pay some or all of the program expenses approved by us directly to the appropriate service provider. Any payments will be made at our discretion.

For information about Rehabilitation refer to Part 1: General Information on page 9.

3.9 Recurring disablement

If an ***insured member*** was previously ***on claim*** ('Original Claim') and the Original Claim ceased because they were no longer ***disabled***, and another claim is made in respect of the same or related illness or injury ('Recurrent Claim') , we will treat the Recurrent Claim as a continuation of the Original Claim and the ***waiting period*** is waived subject to all of the following conditions:

- the ***insured member*** becomes ***disabled*** as a result of the same or related illness or injury within six months of the Original Claim ending, and
- subject to clause 2.4.5, the ***policy*** and the ***insured member's*** cover is still in force.

This means that the Recurrent Claim is part of the same ***benefit period*** as the Original Claim. We will only pay ***disability*** benefits for the remaining ***benefit period***, which has been reduced by the Original Claim. If the Original Claim had been paid until the expiration of the ***benefit period,*** then no further disability benefits are payable under the Recurrent Claim.

We will consider an ***insured member*** to be suffering from a separate injury or illness and a new ***waiting period*** and ***benefit period*** will apply if the Recurrent Claim is made after the expiration of six months since the Original Claim ceased.

3.10 Workplace modification assistance

If the ***insured member*** is receiving Total Disability Benefits or Partial Disability Benefits and we agree that their place of employment requires modification for their return to work, we may pay all or some of the modification expenses to a service provider. The maximum payment is three times the ***insured member's monthly benefit***, and any payments will be made at our discretion.

A payment under this clause may only be made once in respect of each ***insured member***.

3.11 Emergency Domestic Travel Benefit

This benefit is not available if you are the trustee of a superannuation fund.

If we are paying benefits under this ***policy*** in respect of an ***insured member*** being ***totally disabled*** and the ***insured member*** requires ***emergency transportation*** within Australia to a hospital for treatment of the medical condition for which we are paying benefits, we will reimburse the expenses incurred for ***emergency transportation*** of the ***insured member***.

The amount we will reimburse is the lesser of:

- the expenses actually incurred for the ***emergency transportation***
- the ***insured member's monthly benefit***
- $1,000.

The Emergency Domestic Travel Benefit will be reduced by the amount of any payments made by, or recoverable from, another source in respect of the same ***emergency transportation*** expense. The ***insured member*** is obliged to inform us if they have the right to apply for, or have received, a similar benefit from any other source. Where the ***insured member*** refuses to provide such information, we may refuse to pay the benefit.

This benefit is only payable once in respect of each claim of ***total disability*** made by an ***insured member*** and is payable in addition to any other benefit that becomes payable but is not payable during the ***waiting period***. Ambulance transportation is excluded.

3.12 Grief Support

If an ***insured member*** is diagnosed with a ***terminal illness*** we will offer the ***insured member*** and their ***immediate family members*** access to our Grief Support Program at no cost to the ***insured member*** or their ***immediate family members***.

3.13 Practical Support Benefit

This benefit is not available if you are the trustee of a superannuation fund.

We will pay you up to a total of $500 to allow reimbursement to the ***insured member*** for expenses providing practical support such as costs of cleaning, meal preparation, transport for medical appointments and goal related activity aimed at improvement on health or wellness to support the ***insured member*** in the first 12 months of claim.

4. Optional Benefits

4.1 When optional benefits will apply

Cover for an optional benefit only applies in respect of an ***insured member***, or a category of ***insured members***, if you have elected that it is to apply to your ***policy*** and paid the premium for that optional benefit.

All optional benefits (if any) and any non-standard terms that apply to your ***policy*** are outlined in your ***policy schedule***.

4.2 Superannuation Contribution Benefit

If the Superannuation Contribution Benefit (SCB) applies, when a Total Disability Benefit or Partial Disability Benefit is payable in respect of an ***insured member***, the ***insured member*** will also be provided with a benefit calculated as set out below.

The SCB:

- is calculated based on 1/12 of the SCB percentage factor (set out in your ***policy schedule***) of the ***insured member's salary***
- is paid to you in addition to the ***monthly benefit***, and
- combined with the ***monthly benefit***, is subject to the ***maximum monthly benefit level***, ***AAL*** and any ***forward underwriting limit*** that applies to the ***insured member***.

The amount of the SCB payable will be reduced proportionally where the ***insured member*** is entitled to a Partial Disability Benefit.

The terms that apply to the payment of ***disability*** benefits in the ***policy*** also apply to the payment of the SCB.

No SCB is payable during the ***waiting period***.
We will pay the SCB directly to a superannuation provider nominated by you or the ***insured member*** for the ***insured member's*** benefit. Or we will pay it to you subject to proof we may request that the amount is subsequently forwarded to a superannuation provider for the ***insured member's*** benefit.

This benefit will only be paid in circumstances permitted by the relevant laws relating to superannuation contributions and taxation. The superannuation provider must be a superannuation fund as defined in relevant superannuation and taxation laws.

4.3 Escalation Benefit

If the Escalation Benefit applies, 12 months after an ***insured member*** has been continuously ***on claim*** for a ***disability*** benefit (including Specific Injury Benefits), the ***monthly benefit*** and any Superannuation Contribution Benefit will be increased by the lesser of the change in ***CPI*** during that time and the ***escalation factor***. If the change in the CPI during that time is negative, the ***monthly benefit*** and any Superannuation Contribution Benefit will remain as they are.

The adjusted benefit will be similarly increased upon the expiry of each 12 month period for which an ***insured member*** is continuously ***on claim*** for a ***disability*** benefit (including Specific Injury Benefit).

The Escalation Benefit will be applied to increase the ***monthly benefit*** even if it causes the ***monthly benefit*** to exceed the maximum ***monthly benefit*** level, ***AAL*** or any forward underwriting level that applies to the ***insured member***.

When the ***insured member*** ceases to be ***on claim***, the ***monthly benefit*** reverts to the amount which applied prior to benefit escalation under this clause.

4.4 Nurse Care Benefit

This benefit is not available if you are the trustee of a superannuation fund.

If the Nurse Care Benefit applies in respect of an ***insured member***, an amount equal to 1/30 of the ***monthly benefit*** is payable to you for each day, after the first three consecutive days, an ***insured member*** is:

- ***totally disabled*** during the ***waiting period***
- confined to bed or hospitalised for more than three consecutive days on the advice of the ***insured member's medical practitioner***, and
- in receipt of full-time nursing care which is certified by the ***insured member's medical practitioner*** as necessary for the treatment of the ***insured member's disability***, provided the nursing care is performed by a registered and qualified nurse who does not normally reside in the same household and who is not a relative of the ***insured member***.

The Nurse Care Benefit is payable for a maximum of 30 days, or until the expiry of the ***waiting period***, whichever occurs first.

This benefit is paid in addition to any other benefits that are paid during the ***waiting period.***

4.5 Recovery Assistance Benefit

This benefit is not available if you:

- are the trustee of a superannuation fund, or
- select the Enhanced Recovery Assistance Benefit.

If the Recovery Assistance Benefit applies in respect of an ***insured member,*** we will pay you the Recovery Assistance Benefit set out in the table 'Recovery Assistance Benefit Periods under the ***policy***' if:

- the ***insured member*** is receiving a Total Disability Benefit, and
- the ***insured member*** becomes ***totally and permanently disabled*** within 12 months of the ***date of disability*** for ***total disability***.

Recovery Assistance Benefit Periods under the *policy*

Age next birthday when ceased work	Amount of Recovery Assistance Benefit
Up to age 56	$50,000
57	$45,000
58	$40,000
59	$35,000
60	$30,000
61	$25,000
62	$20,000
63	$15,000
64	$10,000
65	$5,000
66 and older	$0

The Recovery Assistance Benefit is payable in addition to any other benefits which may be payable under the ***policy***. Only one Recovery Assistance Benefit is ever payable in respect of an ***insured member***.

4.6 Early Cash Benefit

This benefit is not available if you:

- are the trustee of a superannuation fund, or
- select the Enhanced Recovery Assistance Benefit.

Under the Early Cash Benefit, we will pay you the ***monthly benefit*** monthly in advance for the relevant payment period from the date the ***insured member*** suffers an early cash condition. This benefit is payable whether or not the ***insured member*** is ***disabled***. This benefit is payable during the ***waiting period***.

The duration of the period for which we pay an Early Cash Benefit is determined by the payment period that is applicable to the ***waiting period*** that applies to your plan, as set out below:

Waiting period	Payment period
30 days	6 months
60 days	4 months
90 days	3 months

Only one Early Cash Benefit is ever payable in respect of an ***insured member***. If an ***insured member*** is suffering from more than one early cash condition at the same time we will only pay for one early cash condition.

We will not pay you any other benefit under the ***policy*** while we are paying you the Early Cash Benefit.

The following early cash conditions are included under the Early Cash Benefit and are defined in Part 2: Policy Terms – Section 9:

- ***burns (severe)***
- ***cancer (excluding early stage cancers)***
- ***chronic kidney failure (end stage)***
- ***coronary artery bypass surgery***
- ***heart attack (diagnosed)***
- ***heart valve surgery***
- ***organ transplant (major)***
- ***stroke (diagnosed).***

If the ***insured member*** is ***disabled*** after the Early Cash Benefit period ends due to an early cash condition for which we have paid this benefit, we will pay a Total Disability Benefit or Partial Disability Benefit (as applicable). There is no ***waiting period*** for a ***disability*** benefit in this circumstance. If the ***benefit period*** is 2 years, 5 years, 7 years or 10 years, the maximum period for which we will pay Total Disability Benefits and/or Partial Disability Benefits is reduced by the number of months for which we have already paid the Early Cash Benefit.

4.7 Trauma Recovery Benefit

This benefit is not available if you:

- are the trustee of a superannuation fund, or
- select the Early Cash Benefit.

We will pay you the ***monthly benefit*** if a trauma recovery event happens to the ***insured member*** while the ***policy*** in respect of that ***insured member*** is in force.

This benefit is payable whether or not the ***insured member*** is ***disabled***. This benefit is payable during the ***waiting period***.

The ***insured member's monthly benefit*** will be paid in advance each month until the earlier of:

- the end of the payment period of six months for that trauma recovery event
- when the ***insured member's*** cover ceases under the ***policy*** pursuant to clause 2.14
- the date of the ***insured member's*** death.

If the ***insured member*** suffers either another trauma recovery event or a specific injury (see clause 3.6) while we are paying a Trauma Recovery Benefit, we will pay one benefit only.

The benefit we will pay is that which provides for the longest payment period. The Trauma Recovery Benefit is payable only once in respect of any ***insured member***.

If the ***insured member*** is ***disabled*** at the end of the payment period of six months due to the trauma recovery event for which we have paid this benefit, we will pay a Total or Partial Disability Benefit (as applicable) from the later of the:

- end of the payment period for the trauma recovery event
- end of the ***waiting period***.

If the ***benefit period*** is 2 years, 5 years, 7 years or 10 years, the maximum period for which we will pay Total Disability Benefits and/or 'Partial Disability Benefits' is reduced by the number of months for which we have already paid the Trauma Recovery Benefit.

The following trauma recovery events are included under the Trauma Recovery Benefit and are defined in Section 9:

Trauma recovery events
*Angioplasty – triple vessel**
*aortic surgery**
Aplastic anaemia (requiring treatment)
benign brain tumour (permanent impairment or requiring surgical intervention)†
burns (severe)
cancer (excluding early stage cancers)†*
cardiomyopathy (permanent and irreversible)
chronic kidney failure (end stage)
chronic liver disease (end stage)
chronic lung disease (end stage)†
cognitive loss (permanent)
coma (of specified severity)
coronary artery bypass surgery†*
dementia including Alzheimer's disease (diagnosed)†
diabetes (of specified severity)†*
head trauma (permanent and irreversible)†
heart attack (diagnosed)†*
*heart valve surgery**
HIV (medically acquired)
HIV (occupationally acquired)
intensive care (prolonged)
loss of independent existence (permanent)
loss or paralysis of limb (permanent)
meningitis and/or meningococcal disease (permanent and irreversible)
motor neurone disease (diagnosed)†
multiple sclerosis (with impairment level)†
muscular dystrophy (with impairment level)†
organ transplant (major)
parkinson's disease (diagnosed)†
primary pulmonary hypertension (idiopathic pulmonary arterial hypertension with permanent impairment)
rheumatoid arthritis (severe)†*
Specific Loss – Loss of either sight, hearing or speech
stroke (diagnosed)†*
terminal illness†

* There is no Trauma Recovery Benefit payable if this trauma recovery event first occurs or is first diagnosed, or the symptoms leading to the trauma recovery event occurring or being diagnosed first become ***reasonably apparent***, during the first 90 days that cover under the ***policy*** commences in respect of the ***insured member***.

† This trauma recovery event must be diagnosed and certified by a ***specialist medical practitioner*** approved by us.

4.8 Immediate Family Member Benefit

This benefit is not available if you are the trustee of a superannuation fund.

If, while an ***insured member*** is covered under the ***policy***:

- a ***medical practitioner*** certifies that the ***insured member*** is confined to bed due to illness or injury and they require care,
- the ***insured member*** is in receipt of Total Disability Benefits, and
- as a direct result of the ***insured member's*** illness or injury, an ***immediate family member*** ceases to earn any income solely because the ***insured member*** needs the ***immediate family member*** to care for them,

we will pay you up to an additional 50% of the ***monthly benefit*** which the ***insured member*** is receiving, subject to a maximum payment of $3,000 per month, for a maximum of three months.

Payment of the Immediate Family Member Benefit will be made in arrears, is payable in addition to any other benefits that become payable but is not payable during the ***waiting period***.

The ***immediate family member*** must:

- not have been employed by the ***insured member*** or be an employee of an entity under the control of the ***insured member*** or of which the ***insured member*** is a principal or director, and
- provide the proof that we reasonably require to confirm that the ***immediate family member*** ceased to earn any income solely to provide the ***insured member*** with care.

The proof that we may require may take the form of pay slips, employment records or financial records from the ***immediate family member***. We may refuse to make any payments where proof to our satisfaction is not provided.

4.9 Relocation Benefit

This benefit is not available if you are the trustee of a superannuation fund.

We will pay the Relocation Benefit once while an ***insured member*** is ***on claim*** if the ***insured member***:

- becomes ***totally disabled*** while outside of Australia
- remains ***totally disabled*** for at least 30 days, and
- returns to Australia while ***totally disabled*** or ***partially disabled***.

The amount we will reimburse is the lesser of:

- the cost of a single standard economy airfare for a scheduled commercial flight by the most direct route to the airport in Australia nearest to where the ***insured member*** resides, which is reasonable in the circumstances
- expenses actually incurred by the ***insured member*** in changing previously made air travel arrangements
- three times the ***insured member's monthly benefit***.

This benefit is only payable once in respect of each claim for ***total disability***.

Payment of the benefit is payable in addition to any other benefit that becomes payable and is payable during the ***waiting period***.

This benefit is conditional upon proof from you that:

- there is no more than 15% of ***insured members*** working outside Australia at any one time, and
- at the last ***review date***, with the provision of ***member information***, we have been advised of the number of ***insured members*** working outside Australia and the countries that such ***insured members*** reside in.

We may refuse to make any payments under this clause where proof to our satisfaction is not provided.

4.10 Alternative Benefit Expiry Age Benefit

If the ***benefit expiry age*** requested by you and accepted by us is an age other than age 65 ('Alternative Benefit Expiry Age'), as shown in your ***policy schedule***, an ***insured member*** may have cover under the ***policy*** up to the Alternative Benefit Expiry Age subject to the following conditions:

- a specific category may have cover up to the Alternative Benefit Expiry Age so long as the number of ***insured members*** in that category is no less than 20 (unless we agree otherwise), and
- an ***eligible person*** who joins the plan at age 65 or older and is aged less than the Alternative Benefit Expiry Age, must apply to us in writing and we must accept that ***eligible person's*** application if the ***eligible person*** is to have the ***benefit period*** extend beyond age 65 or be covered to the Alternative Benefit Expiry Age.

4.11 Enhanced Recovery Assistance Benefit

This benefit is not available if you:

- are the trustee of a superannuation fund, or
- select the Recovery Assistance Benefit.

This benefit is only available for the following ***benefit period***s:

- 5 years
- 7 years
- 10 years

If the Enhanced Recovery Assistance Benefit applies in respect of an ***insured member***, we will pay you one times the ***insured member's salary*** subject to a maximum of $100,000 if:

- the ***insured member*** has been ***on claim*** (including Recurrent Claims) and received a Total Disability Benefit or Partial Disability Benefit for the entire ***benefit period***
- we are satisfied that, while ***on claim***, the ***insured member*** has applied their best endeavours to participate in any return to work program recommended by us or their ***medical practitioner***, and
- at the end of the ***benefit period***, the ***insured member*** is ***totally and permanently disabled***.

The Enhanced Recovery Assistance Benefit is payable in addition to any other benefits which may be payable under the ***policy***. Only one Enhanced Recovery Assistance Benefit is ever payable in respect of an ***insured member***.

5. Benefit Limitations

5.1 Exclusions

We will not pay a benefit under the ***policy*** if the event giving rise to the claim is caused directly or indirectly, wholly or partially:

- by ***war***, or an act of ***war***, occurring in Australia or New Zealand
- by an ***insured member*** engaging in ***war service***
- by an ***insured member's*** intentional self-inflicted act
- by an ***insured member*** engaging in ***illicit drug use***
- by ***uncomplicated pregnancy or childbirth***.

In effecting the ***policy***, you acknowledge that a benefit may not be paid under the ***policy*** in respect of an ***insured member*** who dies in ***war service***.

We may reduce or refuse to pay any benefits:

- that arises directly or indirectly from the ***insured member*** participating in criminal activity
- while the ***insured member*** is imprisoned or on remand in a correctional or rehabilitation facility
- if the ***insured member*** unreasonably refuses to ***actively participating in a rehabilitation program*** they have the capacity to undertake as approved by their ***medical practitioner***
- if the ***insured member*** unreasonably refuses to undergo the medical treatment (including rehabilitation) to treat their condition as recommended by their ***medical practitioner***
- if you or the ***insured member*** do not comply with our reasonable claim requirements
- for a ***total disability*** 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 ***insured member's*** professional qualification is restricted or revoked due to misconduct or if their employer stops trading; and

We cannot reimburse any expenses which:

- we are not permitted by law to reimburse, or
- are regulated by the *National Health Act 1953 (Cth)* or the *Private Health Insurance Act 2007 (Cth)*.

5.2 Pre-existing conditions

If an ***insured member*** is insured for ***new events cover*** pursuant to clause 2.3.3 or clause 2.3.4, we will not pay any benefit for a ***disability*** caused wholly or partly, directly or indirectly, by a ***pre-existing condition***.

If the ***insured member*** is insured for ***limited cover*** pursuant to clause 2.4.2, we will not pay any benefit for a ***disability*** caused by an illness or injury which directly or indirectly caused the transferring member to be not ***at work*** on the last ***normal business day*** immediately before the ***transfer date***.

5.3 Reduction of the monthly benefit

5.3.1 Other payments

The Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Early Cash Benefit and Trauma Recovery Benefit will be reduced by ***other payments***.

With respect to ***other payments*** payable as a lump sum, where all or a part of that lump sum cannot be allocated to specific months, we will convert the lump sum or part of the lump sum (as relevant) to income on the basis of 1% for each month that we pay the ***monthly benefit***, for a maximum of eight years. The balance of the lump sum, if any, will not be offset.

5.3.2 Claims incurred on or after age 65

If the ***insured member's disability*** commences when the ***insured member*** is age 65 or older and the ***benefit expiry age*** applicable to the ***insured member*** is greater than 65 years, the ***maximum monthly benefit level*** applicable to the ***insured member*** is capped at $10,000 or the ***maximum replacement ratio***, whichever is the lesser.

5.4 Repayment of benefits

Any benefit paid by us must be repaid either:

- to the extent we were entitled to reduce the benefit paid, but did not do so for any reason
- to the extent that the benefit was paid in respect of an ***insured member***, where all or part of the benefit was not payable under the terms of the ***policy***.

5.5 Overseas travel

If an ***insured member*** travels or resides outside Australia for a period in excess of 12 consecutive months while ***on claim***, payment of any benefits by us will cease.

If the ***insured member*** returns to permanently reside in Australia and provides us with satisfactory evidence of their continuous ***disablement***, we may at our discretion, recommence benefits payments. If we recommence benefit payments, we will not make any payment in respect of a period where the ***insured member*** was not entitled to benefits in accordance with this clause.

5.6 Multiple disabilities

We pay one ***monthly benefit*** at a time, even if the ***insured member*** suffers more than one illness or injury. This applies to the Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Trauma Recovery Benefit and Early Cash Benefit.

5.7 Other limitations

Your ***policy schedule,*** or the ***decision note*** issued in respect of an ***insured member,*** may contain certain exclusions or limitations. We will not pay any benefits under the ***policy*** for anything we have specifically excluded as shown in your ***policy schedule*** or ***decision note*** issued in respect of an ***insured member,*** and payments will be subject to the limitations set out in those respective documents.

5.8 Breach of law

You agree that we may delay, block or refuse to process any transaction without incurring any liability if we suspect that either:

(a) the transaction may breach any laws or regulations in Australia or any other country

(b) the transaction involves any person (natural, corporate or governmental) that is itself sanctioned or is connected, directly or indirectly, to any person that is sanctioned under economic and trade sanctions imposed by the United States, the European Union or any country

(c) the transaction may directly or indirectly involve the proceeds of, or be applied for the purposes of, conduct which is unlawful in Australia or any other country.

We may delay or withhold paying a benefit if that payment may breach any law or regulation, including any sanctions regulations.

You must provide all information to us which we reasonably require in order to manage our economic and trade sanctions risk or to comply with any laws or regulations in Australia or any other country.

You agree that we may disclose any information concerning you or an ***insured member*** to any law enforcement, regulatory agency or court where required by any such law or regulation in Australia or elsewhere.

6. Costs

6.1 Premium rates

The premium rates will be set out in the ***quotation summary*** and in your ***policy schedule***.

6.2 Payment of premiums

The ***policy*** does not start until the first premium due has been paid, or we accept a deposit premium.

6.3 Minimum annual premium

Your annual premium will be at least the minimum annual premium (exclusive of stamp duty) shown in your ***policy schedule***.

If the premium we calculate is less than the minimum annual premium, you must pay the minimum annual premium, plus stamp duty. If you do not pay the minimum annual premium, we may cancel or terminate the ***policy*** by giving you at least 30 days written notice in accordance with clause 8.6.

We may vary the minimum annual premium in accordance with clause 6.7.

6.4 Calculating the premium

We calculate the premium which will apply to the ***policy*** from the ***policy start date*** until the first ***review date*** based on the ***member information*** we are initially provided. Thereafter, we will calculate the annual premium at each ***review date*** irrespective of the premium payment frequency, based on ***member information*** you must provide to us. If you do not provide us with the ***member information*** within 30 days of the date we advise you of the information we require, we will estimate and notify you of an interim premium.

The premium is payable in respect of an ***insured member*** from the date the ***insured member's*** cover commences under the ***policy*** until the date cover ends under clause 2.14.

We will calculate the premium having regard to the number of ***insured members*** covered under the ***policy*** at the ***review date*** and the amount and type of the benefits provided. If this changes in the period until the next ***review date***, we will recalculate the premium at that time to reflect this and:

- if you have paid too much, we will apply the overpayment to reduce the next premium due, or
- if you have not paid enough, we will notify you of the additional premium you owe (the adjustment premium).

If the ***policy*** ends, any overpayment of premium is refunded or any adjustment premium is payable, as the case may be, immediately.

We may also apply loadings to individual ***insured members*** based on our assessment of individual risks. Where we do this, we will notify you.

A range of factors are taken into account when the premium is calculated for your plan. The premium will be affected by significant factors such as:

- the sum insured – the larger the sum insured the larger the premium
- the age demographic of ***insured members*** – the premium generally increases with age
- the gender demographic of ***insured members***
- the occupation of ***insured members*** – generally, occupations with hazardous duties or higher occupational risk have higher premium rates
- industry related loadings or discounts
- the grouping of polices, refer to 'Discounts' in clause 6.11 for further information
- whether premiums are paid annually or by instalment (a frequency loading will apply if the premium is paid other than annually in advance),
- the claims history of your plan, and
- the applicable commission levels agreed between you and an intermediary.

6.5 When the premium is due

The first premium is due on, before or within 30 days of the ***policy start date*** or, if you have paid a deposit premium, on the date specified when we notify you of the balance of the premium payable until the first ***review date***. Thereafter, premiums are due within 30 days of the ***review date***, or such later date as set out in your ***policy schedule***.

Any interim premium or adjustment premium we advise is due on the date specified in the notice advising you of the interim or adjustment premium.

If the premium, interim premium or adjustment premium is not paid by you when due, the ***policy*** may not commence or we may cancel your ***policy.*** We will give you notice and the opportunity to pay the overdue premium before we cancel your ***policy***. If a benefit is payable to you for any claim with an ***event date*** occurring when the premium, interim premium or adjustment premium is overdue, we will not pay the benefit unless you pay us the overdue premium prior to the date we cancel your ***policy.***

6.6 Guarantee of premium rates

Subject to clause 6.7, premium rates will be guaranteed from the ***policy start date*** to the end of the ***premium rate guarantee period***.

6.7 When we can change the premium rates and/or the minimum annual premium

We calculate the premium using the premium rates shown in the ***premium rate schedule***. We can change the premium rates or the minimum annual premium either:

- at expiration of the ***premium rate guarantee period***
- at any time on or after the ***review date*** provided a ***premium rate guarantee period*** is not in force
- at any time in the event of ***war*** occurring in Australia or New Zealand
- at any time if clause 8.1 applies
- if there is a change in any government charge, licence fee, tax or any other impost that is directly or indirectly attributable to the ***policy***

If we change the premium rates or the minimum annual premium, we will provide you with at least 30 days' notice.

6.8 Misstatement of age

If an ***insured member's*** age is misstated, we reserve the right to adjust the premium or the ***insured benefit*** based on the ***insured member's*** correct age.

6.9 Stamp duty, taxes and expenses

The taxation implications of insurance benefits and premiums under non-superannuation and superannuation policies will differ depending on individual circumstances. You should consider all potential taxation consequences that may

apply to the premiums and benefit payments under a Zurich Group Income Protection Insurance product.

Your specific circumstances are not taken into account in providing this information. It is important that you seek professional and independent taxation advice specific to your circumstances regarding the taxation implications of purchasing a non-superannuation or superannuation income protection insurance product.

6.9.1 Stamp duty

Stamp duty is payable in addition to the premium rates.

This is a charge levied by each state and territory government (except the ACT) and we pass it on to the appropriate state or territory revenue office. The amount of stamp duty payable varies according to the ***insured member's*** state or territory of residence and may change from time to time.

An up-to-date listing of the percentage or dollar amount of duty that applies to ***insured members***' premiums can be obtained by contacting Group Insurance Administration on 1800 648 921.

6.9.2 Other expenses

In addition to the premium, you are required to pay:

- any federal, state or territory taxes and charges or any other government charges (the premium rates do not include such taxes, duties and charges, but references in the ***policy*** to payment of the premium include any such additional amounts), and
- any expenses we incur in administering any function required of us by a federal, state or territory government under any legislation in relation to the ***policy***.

We reserve the right to recoup these charges through the premium you pay for the ***policy***, and increase the premium to cover any increase in these charges.

6.9.3 Goods and Services Tax (GST) implications

The ***policy*** is input taxed for GST purposes. This means that no GST is payable by us on the premium you pay. There is no GST charged on the premium payable for your cover.

In the event that the ***policy*** or the premium applicable to one or more specific benefit types is no longer input taxed for GST purposes, we reserve the right to charge GST in addition to the premium which you are required to pay. If this occurs we will notify you in writing.

6.10 Interest

We may charge you interest on any amount due to us which is outstanding for more than 30 days. Interest will be calculated based on the five-year Australian government bond yield plus 3%pa as at the date the premium initially became due, as published in the *Australian Financial Review*. If this rate is no longer published, we will determine a similar replacement rate.

6.11 Discounts

6.11.1 Combined plan discount

If you establish a Zurich Group Life Insurance policy with the same ***policy start date*** and annual ***review date*** as this ***policy***, we will reduce the annual premium for both policies by 2.5%. This discount will only continue to apply while the annual ***review date*** of the Zurich Group Life Insurance policy remains the same as the annual ***review date*** chosen for this ***policy***, and both policies remain in force.

6.11.2 Annual on-time payment discount

A premium discount will apply if the annual premium is paid annually in advance and within 30 days of the due date specified in clause 6.5. All details will be outlined in the ***policy schedule***.

If the annual premium is not paid within 30 days of the due date, the annual on-time payment discount will not apply.

6.12 Premiums paid other than annually

A frequency loading will apply if the premium is paid other than annually in advance. All details will be outlined in the ***policy schedule***.

6.13 When we will waive the premium

We will waive the payment of the premium in respect of an ***insured member*** receiving a Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Recovery Assistance Benefit, Early Cash Benefit (if applicable) or Trauma Recovery Benefit (if applicable).

7. Claims

7.1 Notification of Claim

You must advise us in writing of any claim or potential claim promptly. You must make all reasonable efforts to:

- ensure the ***insured member*** knows they must advise you as soon as they become ***disabled***, and
- make enquiries if an ***insured member*** is on sick leave.

7.2 How to make a claim

We will generally send claim forms to you or the ***insured member*** within five days of receiving notice of a claim. Providing claim forms for completion does not constitute an admission of liability in respect of any claim lodged.

Claim forms must be completed promptly to enable a proper assessment of the claim, otherwise it may make the claim more difficult to establish. A delay may also affect our ability to assess the claim event (eg we are not provided with evidence that was current as at the date when the event occurred).

In the event of the death of an ***insured member***, you or a representative acting on behalf of the ***insured member's*** estate should notify us of the death of the ***insured member*** as soon as reasonably possible.

7.3 Payment of a claim

Payment of a claim is conditional upon us receiving properly executed claim forms and proof of all the following:

- the ***insured member's*** age
- where the ***insured member*** was accepted (or an increase in benefit was accepted) under ***automatic acceptance terms***, underwriting or our transfer terms, that you and the ***insured member*** met all our requirements
- the ***insured member's disability*** or other entitlement to claim
- any income received during the ***benefit period***
- the ***insured member's salary***, and
- any relevant payments received during the ***benefit period***.

You or the ***insured member*** need to provide us with the relevant evidence and authorities that we require to assess the claim. The information we need may vary according to the type of claim being made. Our typical requirements are set out below:

- evidence of absence from work, for example, medical certification, reports and copies of leave records from the ***insured member's*** employer, if appropriate
- evidence that provides details of the ***insured member's*** occupational and employment arrangements, including duties, responsibilities, hours and place of work
- evidence of other insurance cover on the ***insured member***
- evidence of pre-disability earnings, ***salary*** or monthly income, ongoing income, and evidence of any payments received while on claim
- financial evidence including copies of personal and business tax returns, assessment notices and other financial evidence to prove the ***insured member's*** income
- medical reports from treating ***medical practitioner***s (at your, or the ***insured member's***, expense)
- evidence of investigations which support the claimable condition, for example, clinical, radiological, histological, laboratory evidence or copies of medical records or reports from treating ***medical practitioner*** or from independent ***specialist medical practitioner***
- we may need the ***insured member*** to undergo reasonable examinations and tests conducted by a ***specialist medical practitioner***. If we request an examination or test by a ***specialist medical practitioner***, we'll pay for it. We'll also cover reasonable travel costs
- the insured member being under the regular care of, and ***following the advice of a medical practitioner***, and
- when reasonably required by us (and at our expense) the ***insured member*** will:
  - undergo an employability assessment
  - be interviewed
  - agree to an audit of their financial circumstances, and
  - provide any other relevant information.

If the ***insured member*** fails to attend any pre-arranged consultation, they will be liable to pay any charges incurred by us in arranging the consultation.

7.4 Reimbursement of claim costs

Any costs incurred outside Australia in connection with a claim in respect of an ***insured member*** who is outside Australia in accordance with clause 2.10, 2.11 or 2.12 must be paid by you or the ***insured member***. We may agree to reimburse these costs at our discretion.

8. General Conditions

8.1 Risk profile

During the ***premium rate guarantee period***, by written notice to you we may:

- stop accepting new ***insured members***
- increase the premium rate (including during the ***premium rate guarantee period***)
- vary the ***automatic acceptance terms***
- vary or remove the ***AAL***
- require you to pay the minimum annual premium as outlined in clause 6.3

if:

- the number of ***insured members*** changes by more than 25%,
- the number of ***insured members*** covered under the ***policy*** falls below 75% (or as otherwise agreed to by us in writing) of persons eligible for cover based on the ***eligibility criteria***, or
- any other aspect of the risk profile of ***insured members*** changes which adversely impacts the risk under this ***policy***, including:
  - changes in age, sex, occupations, locations in which the ***insured members*** work or reside,
  - any changes to business activity of the ***policy owner*** or the ***participating employer***, or
  - a change in any government legislation

from that which existed at the start of the latest ***premium rate guarantee period***.

8.2 Administration

To enable us to properly administer the ***policy***, you must notify us of the entry and exit of individual ***insured members*** at the ***review date*** or at such other intervals agreed between you and us.

8.3 Profit sharing

Generally we do not offer profit sharing for Zurich Group Income Protection policies.

Most plans will be non-profit, but in some cases we may offer a self-experience profit-sharing formula.

Where we offer profit sharing, it will be detailed in your ***policy schedule***.

8.4 Records

You must maintain records of the ***member information*** and all relevant information relating to each claim, including the ***insured member's*** attendance record and duties (claims information).

You must also retain records regarding the duration of time ***insured members*** are working outside Australia, the number of them and their overseas location. You must give us any ***member information*** or claims information we request.

You must provide, or procure your agents or administrators to provide, us or our nominated representative, access to inspect, audit and take copies of the ***member information***, claims information or other information or records relevant to the ***policy***. We will conduct such an audit only during normal office hours and only after we have given you reasonable notice. We will also take all reasonable steps to minimise any inconvenience to you.

8.5 Changes to member and other information

You must notify us of any changes to ***member information*** or other information relevant to the ***policy*** which we advise, within 30 days after the ***review date***, or as we otherwise agree in writing with you.

If you do not advise us of a change in an ***insured member's salary*** (or if included, performance-related annual bonuses and commissions) in accordance with this clause, and pay any additional premium if an increase in cover is accepted without application, then we may pay a benefit based on the ***insured member's salary*** previously advised to us.

8.6 Termination of Policy

You can terminate the ***policy*** at any time by giving us at least 30 days' written notice.

We may only terminate the ***policy*** in the circumstances explained in clauses 6.3 and 6.5 or in accordance with our legal rights.

You must inform the ***insured members*** of the notice that we serve upon you to terminate as soon as possible and no later than 14 working days of receipt from our written notice.

8.7 Governing law

The ***policy*** is governed by the law that applies in the state or territory of Australia in which the ***policy*** is registered.

8.8 Currency

All payments to, or from, us are to be made in Australian currency. If the ***insured member*** is working outside Australia, the ***salary*** of the ***insured member*** must be advised to us in Australian currency and we will take no responsibility for foreign exchange risk.

8.9 Statutory fund

The ***policy*** is issued from the statutory fund shown in the ***policy schedule***, but does not give you any rights of ownership of the assets of that fund. The statutory fund from which the ***policy*** is issued will depend on whether it is ordinary or superannuation business.

The ***policy*** does not acquire a cash surrender value.

8.10 Cooling-off period for policy

You may cancel your ***policy*** within 14 days of the earlier of:

- the date you receive your ***policy schedule***
- the date you receive an 'On-risk' letter confirming our acceptance of your application or ***proposal form***
- the end of the fifth day after the ***policy start date***.

You may cancel your ***policy*** during the cooling-off period by giving us notice in writing and returning your ***policy schedule***. If you do this, we will terminate your ***policy*** and will refund any money paid (except any amounts of taxation which we are unable to recover). However, you cannot exercise your right to cancel your ***policy*** or get a refund at any time after an ***insured member*** has made a claim for benefits under the ***policy***.

8.11 Cooling-off period for members of a superannuation fund

If the ***policy*** is issued to a superannuation fund trustee, we will refund all premiums for cover on an ***insured member*** where, within 14 days of the date they receive the letter from you advising them of this cover, they request you to cancel that cover. We will cancel that cover from its commencement and we will not pay any claim that may arise in relation to the ***insured member*** during that 14 day period.

9. Dictionary

Terms described in the ***policy schedule*** or ***decision note*** have the meaning shown there, while the following terms in this PDS and Policy have the following meanings:

Accident means an external event which was unexpected and unintended causing death or injury of the ***insured member***.

The following situations are not accidents, and any claims arising from these situations are excluded:

- one of the contributing causes of death or injury was any of the following conditions:
  - illness
  - disease
  - allergy
  - any gradual onset of a physical or mental infirmity.
- the injury or death, which was unintended and unexpected, was the result of an intentional act or omission, or
- the ***insured member*** was injured or died as a result of an activity in respect of which they assumed the risk or courted disaster, irrespective of whether they intended injury or death.

Active employment means the ***insured member*** is ***gainfully working*** and is:

- actively performing all the duties of their occupation, free from any limitation due to illness or injury or on leave taken for reasons unrelated to injury or illness, and
- is capable of actively performing all the duties and usual hours of their occupation free from any limitation due to illness or injury.

Active service refers to an ***insured member's*** occupation as part of a military force (including without limitation the defence force, including the army, the navy, the air force or like). Reserve duty is excluded.

Actively participating in a rehabilitation program (for own occupation) means the ***insured member*** is actively engaged in a ***rehabilitation program*** they have the capacity to undertake, and which is designed to create a pathway for the ***insured member*** to return to their ***usual occupation***.

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

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

If the ***insured member*** completes a ***rehabilitation program*** but has not returned to their ***usual occupation***, we will work with the ***insured member*** to determine whether an additional ***rehabilitation program*** could assist.

We may cease, suspend, or reduce benefits if the ***insured member*** fails to commit to and undertake reasonable rehabilitation that the ***insured member*** has the capacity to undertake and which is expected to assist a return to their ***usual occupation***.

At work means the ***insured member*** is:

- actively performing all the duties of their occupation free from any limitation due to illness or injury
- working their usual hours free from any limitation due to illness or injury, and
- not in receipt of and/or entitled to claim income support benefits from any source including workers' compensation benefits, statutory motor accident benefits or disability income benefits (including government income support benefits).

An ***insured member*** who does not meet these requirements is correspondingly described as not ***at work***.

At work certificate means the form in which you certify those ***eligible persons*** who were ***at work*** and not ***at work*** on the requisite date.

Australian resident means an Australian citizen, a New Zealand citizen or a permanent resident within the meaning of the *Migration Act 1958* (Cth).

Automatic acceptance level/AAL means the automatic acceptance level shown in the ***policy schedule***.

Automatic acceptance terms has the meaning set out in clause 2.3.

Benefit expiry age means the age at which cover ceases as set out in the ***policy schedule***.

Benefit period is the maximum period of time that benefits will be paid for any one illness or injury of an ***insured member*** is ***disabled***.

Casual employee means a person working on a temporary, as required basis, is paid on an hourly basis for the period worked, does not accrue entitlements for sick leave and annual leave, and who is not otherwise a ***permanent employee***.

Certification period has the meaning given in the definition of ***terminal illness***.

Contractor means a person is performing all the normal duties of their work, is working on a contracted basis for at least 14 hours per week and is under a fixed term contract of not less than one year in duration.

Consumer Price Index/CPI means the Consumer Price Index (all groups: all capital cities) published by the Australian Bureau of Statistics at the relevant time or a replacement index we select.

Date of disability/date of disablement means:

- in relation to ***disability***,
  - the first date, after ceasing working in their ***usual occupation***, the ***insured member*** attends a medical consultation with a ***medical practitioner*** and is certified as having no capacity to perform one or more duties of their ***usual occupation*** necessary to produce ***salary***.
- in relation to TPD, the first day after the expiry of the ***TPD waiting period***.

Decision note means the document we issue in respect of an ***insured member*** when that ***insured member's*** application for cover, an increase in cover, or variation in cover has been assessed and determined by us, setting out details of the following:

- the type and level of ***insured benefits*** provided for that ***insured member*** (if any)
- the date the cover starts or an increase in cover starts, and
- any special conditions applying.

Disability/Disabled/Disablement means ***total disability*** or ***partial disability*** in relation to an ***insured member*** (as the context requires).

Eligibility criteria means the rules for eligibility set out in clause 2.1 of the ***policy*** and the ***policy schedule***.

Eligible person means a person who meets the ***eligibility criteria***.

Emergency transportation means emergency transportation where, in the opinion of a ***medical practitioner***, an ***insured member*** requires immediate treatment in circumstances where there is a serious threat to the ***insured member's*** life or health. Ambulance transportation is excluded.

Escalation factor is defined in the ***policy schedule***.

Event date means (in relation to ***TPD***) the first day of the ***TPD waiting period*** during which the ***insured member*** has not worked solely because of injury or illness.

Following the advice of a medical practitioner means the ***insured member*** is following the advice of the treating ***medical practitioner*** on an ongoing basis including recommended courses of treatment and rehabilitation.

Forward underwriting limit means the amount up to which we will accept future increases in the ***insured benefits***, without further application from an ***insured member***.

FSC Guidance Note means The Financial Services Council Guidance Note No. 11 Group Insurance Takeover Terms dated 9 May 2013.

Full-time means working at least 30 hours per week.

Gainful employment means any occupation or work for reward or financial benefit, or the hope of reward of financial benefit, whether on a permanent or temporary basis, and whether or not of a lesser grade, status or level of remuneration or for lesser hours than the ***insured member's*** occupation(s) held prior to the ***event date*** (in relation to ***TPD***) or ***Date of Disablement*** (in relation to ***disability***).

Gainfully working means employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment.

Illicit drug use means:

- the use of an illegal drug, which is a drug that is prohibited from manufacture, sale or possession in Australia. For example, cannabis, cocaine, heroin and amphetamine-type stimulants
- 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.

Immediate family member means a:

- spouse
- son, daughter, father, mother, brother, sister, father-in-law or mother-in-law, or
- person in a bona fide domestic living arrangement and is financially interdependent. You must provide us with satisfactory evidence that there is an established and ongoing interdependency.

Inactive with reference to a ***member's account*** has the meaning given to it in section 68AAA(3) of the *Superannuation Industry (Supervision) Act 1993* (Cth).

Inactivity period means the continuous period of 16 months ending on or after 11.59 pm on 30 June 2019 during which a ***member's account*** has been ***inactive***. For the avoidance of doubt, the ***inactivity period*** may commence before 11.59pm on 30 June 2019.

Indemnity contract means an individual policy which calculates a claimant's benefit entitlements based on their income at the time of claim rather than at the time the claimant's application for cover under that policy was accepted.

Insured benefit means any benefit provided under the ***policy*** as the context requires including the Total Disability Benefit, the Partial Disability Benefit, the Specific Injury Benefit and any optional benefit as varied by any ***decision note*** that we issued in respect of an individual ***insured member***.

Insured member refers to a person who is covered by your ***policy*** and is either an employee or ***contractor*** of an employer or partner in a partnership where your ***policy*** is employer owned, or a member of a superannuation fund where your ***policy*** is owned by a trustee of a superannuation fund.

Limited cover means cover other than cover for an illness or injury which directly or indirectly caused the transferring member to be not ***at work*** on the last ***normal business day*** immediately before the ***transfer date***.

Maximum benefit entry age means the maximum benefit entry age as shown in the ***policy schedule***.

Maximum monthly benefit level means the maximum monthly benefit level shown in the ***policy schedule***.

Maximum replacement ratio means the maximum percentage of the ***insured member's monthly salary*** we will pay as a ***monthly benefit***, and is the lesser of:

- either:
  - 75% of the ***insured member's monthly salary***; or
  - 75% of the ***insured member's monthly salary*** for the first 24 consecutive months and 50% of the ***insured member's monthly salary*** thereafter, (as selected for your ***policy*** and stated in the ***policy schedule***) and
- the maximum replacement ratio stated in the ***policy schedule***.

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 to a medical practitioner legally registered to practise in Australia.

Medical practitioner generally includes the ***insured member'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.

Medical practitioner does not include:

- the ***insured member***, their spouse, relative, business partner, employer or employee
- other para-medical professionals including (but not limited to) psychologists, chiropractors, physiotherapists, optometrist or naturopaths.

Member's account means, in regard to an ***insured member*** under a ***policy*** issued to you as the trustee of the superannuation fund, the account held by you for their interest in the superannuation fund.

Member information means all information in respect of an eligible person which we advise you we require which can include, but is not limited to the following:

- name
- date of birth
- sex
- occupation
- state, territory and country of residence including details of persons who have been seconded overseas by their employer for work
- ***salary*** (in Australian currency)
- employee/member status (i.e. whether the person is on unpaid or paid leave)
- date the person joined the company
- date the person first satisfied the ***eligibility criteria***, and
- if required, an ***at work*** certificate.

Minimum benefit entry age is 15 years.

Monthly benefit is the amount shown in the ***policy schedule*** or, where we have issued a ***decision note***, the amount specified in the ***decision note*** we issue in respect of that ***insured member***. Where we have issued a ***decision note*** in respect of an individual ***insured member***, the amount specified therein shall prevail.

Monthly salary means ***salary*** divided by 12.

New events cover means cover where the ***insured member*** will not be covered for any ***pre-existing condition***. The ***insured member*** will only be covered for an illness which became apparent to the ***insured member***, or any injury which occurred to the ***insured member***, on or after the date that cover commenced, recommenced or increased (as applicable).

Normal business day means any day which is not a weekend or a public holiday, on which businesses normally operate.

On claim means the dates for which you are eligible to receive a benefit in respect of the ***insured member*** under the ***policy***.

Other payments means amounts payable (including settlement* or commutation amounts) in respect of the ***insured member***:

- by way of a statutory scheme, or a compulsory insurance scheme, that pays amounts for, or calculated by reference to, loss of income or earning capacity (including amounts for past or future economic loss). Examples of such schemes include workers' compensation and compulsory third-party motor vehicle insurance
- in respect of, or calculated by reference to, loss of income or earning capacity (including amounts for past or future economic loss), whether the amount is payable under legislation or otherwise
- by way of damages under common law, in respect of, or calculated by reference to, loss of income or earning capacity (including amounts for past or future economic loss)
- in respect of, or calculated by reference to, any paid ***parental leave***, where the ***insured member*** suffers ***disability*** during a period of ***parental leave***
- for the purpose of income or expense replacement, or covering the financial obligations that the ***insured member*** has to other parties, under any other disability, injury or illness insurance policy.

It does not include amounts for, or calculated by reference to:

- Disability Support Pension payable by Centrelink or its successors
- sick leave
- annual leave
- redundancy payments
- long service leave entitlements
- investment income
- total and permanent disability benefits, trauma benefits or terminal illness benefits.

* To avoid doubt, settlement amounts include but are not limited to settlements made out of court in respect of legal proceedings or contemplated legal proceedings.

Parental leave includes maternity leave, paternity leave and/or adoption leave.

Part-time means working at least 14 hours per week, but less than 30 hours per week.

Partial disability/partially disabled means, solely as a result of illness or injury, the ***insured member*** is:

- capable of performing their ***usual occupation*** in a reduced capacity, and only has capacity to earn a monthly income that is less than their ***monthly salary***, or
- incapable of performing one or more duties of their ***usual occupation*** necessary to produce ***salary, gainfully working*** and receiving monthly income that is less than their ***monthly salary***, and
- ***following the advice of a medical practitioner*** in relation to their illness or injury for which they are claiming.

The ***insured member*** will be considered capable of performing their ***usual occupation*** in a reduced capacity even if such work is not made available to the ***insured member***.

Participating employer means you or any participating employer mentioned in the ***policy schedule***.

Permanent employee means an ***eligible person*** working on a permanent basis and not as a ***casual employee***.

PMIF exempt member means an ***eligible person*** in respect of whom you are permitted to provide insurance cover despite sections 68AAB and 68AAC of the *Superannuation Industry (Supervision) Act 1993* (Cth), other than an ***eligible person*** you are permitted to provide insurance cover in respect of only because the ***eligible person***:

- has made a ***PMIF member election***; or
- at the time, has a balance equal to or greater than $6,000 in their ***member's account*** and, where they became a member of the superannuation fund on or after 1 April 2020, they are at least 25 years of age.

PMIF member election means an election by the member under section 68AAB or 68AAC of the *Superannuation Industry (Supervision) Act 1993 (Cth).*

Policy means the documents issued by us to you and includes:

- the terms outlined in Part 2 of this PDS and Policy (as updated or supplemented from time to time)
- the sections titled 'Who issues Zurich Group Income Protection Insurance?' and 'How to read this PDS and Policy' on pages 6 and 7 respectively of this PDS and Policy
- the ***policy schedule***
- any notices issued or received by us under your ***policy***
- the ***decision note*** (if applicable), and
- any written variation to your ***policy***.

Policy owner means the policy owner shown in the ***policy schedule***.

Policy schedule means the document we send you which sets out details of your ***policy***, including any special conditions, amendments or endorsements. A new ***policy schedule*** will be issued at any time there is a change in your ***policy*** such as a variation of benefits. The new ***policy schedule*** will apply from the effective date shown on the new ***policy schedule***.

Policy start date means the policy start date shown in the ***policy schedule***.

Pre-existing condition means an injury that first occurred, or an illness which first became apparent, to the ***insured member***, or any directly or indirectly related condition, before the date cover in respect of that ***insured member*** commenced, recommenced or increased.

Premium rate guarantee period means the premium rate guarantee period shown in the ***policy schedule***.

Premium rate schedule means the premium rate table shown in the ***policy schedule***.

Principal office means our office located at 118 Mount Street, North Sydney NSW 2060.

Proposal form means the application form we will provide you to complete in order for you to purchase a Group Income Protection Insurance product from us.

PYS exempt member means a member in respect of whom you are permitted to provide insurance cover under section 68AAA of the *Superannuation Industry (Supervision) Act 1993* (Cth) despite the ***member's account*** being ***inactive*** for the ***inactivity period***.

Quotation summary means the Group Income Protection Insurance quotation we issue you. It contains the draft ***premium rate schedule*** and the terms on which we will offer cover to you.

Reasonably apparent means a reasonable person in the circumstances could be expected to have been aware of the symptoms.

Rehabilitation program means a program that is:

- developed by an accredited and appropriately qualified health professional, likely to result in a return to remunerative work in your previous occupation;
- not considered treatment that is eligible for a Medicare benefit or pharmaceutical benefit for any part of the service provided; and
- not considered part of treatment provided in, or associated with, a hospital.

We cannot reimburse any expenses that we are not permitted by law to reimburse, or are regulated by the *National Health Act 1953* (Cth) or the *Private Health Insurance Act 2007* (Cth). General medical consultations and medical therapy consultations, including physiotherapy, psychotherapy and hydrotherapy are excluded.

Review date means an annual date agreed to between you and us as shown in the ***policy schedule***.

Salary means:

- where the ***insured member*** is employed, the annual cash salary remuneration which the insured member receives from their employer for the ***insured member's*** personal exertion immediately prior to the ***insured member*** becoming ***disabled***. If salary includes non-cash benefits or fringe benefits provided as a direct substitute for salary or the inclusion of performance-related commission and bonuses, this will be shown in the ***policy schedule***, or
- where the ***insured member*** directly or indirectly owns all or part of the business from which they earn their usual income, the gross amount earned by the business in the 12 months immediately prior to the ***insured member*** becoming ***disabled***, as a direct result of the ***insured member's*** personal exertion or activities through their ***usual occupation*** after allowing for the costs and expenses incurred in deriving that income.

To avoid doubt, the requirement that the salary must be received for the ***insured member's*** personal exertion will not apply if the ***insured member*** becomes ***disabled*** during a period of paid or unpaid leave. When this happens, we will calculate the ***insured member's monthly benefit*** based on the salary applicable to the ***insured member*** immediately prior to the ***insured member*** becoming ***disabled***, as confirmed by you at the time of claim.

Specialist medical practitioner means a ***medical practitioner*** who is a specialist practising in the relevant medical field of the ***insured member's*** illness or injury.

Standard cover means the ***insured member*** will be covered on the same basis as if they were admitted under clause 2.3.2 from that date.

Takeover terms means the terms that apply to the transfer of cover under the ***policy*** to another insurer including but not limited to the terms that specify when the new or incoming insurer becomes responsible for claims, the acceptance terms on which the incoming insurer takes over the cover and when cover under the ***policy*** ceases in respect of transferring members.

Terminal illness means an illness or injury where all of the following a, b, c, d and e are satisfied in respect of an ***insured member***.

a. two ***medical practitioners*** certify in writing ***('written certification')*** that the ***insured member*** suffers from an illness or has incurred an injury that, despite reasonable medical treatment, is likely to result in the ***insured member's*** death within 12 months from the date of ***written certification*** ('***certification period***')

b. we are satisfied from medical or other evidence that the ***insured member*** will likely, despite reasonable medical treatment, die from the illness or injury within the ***certification period***

c. at least one of the ***medical practitioners*** is a ***specialist medical practitioner***

d. for each ***written certification***, the ***certification period*** has not ended, and

e. the ***written certification*** by both ***medical practitioners*** must be dated during the period the ***insured member*** is insured under the ***policy***.

Total disability/totally disabled (for own occupation) means solely as a result of illness or injury, the ***insured member*** is:

- medically certified as being incapable of performing one or more duties of their ***usual occupation*** necessary to produce ***salary***,
- not engaged in any occupation, and
- ***following the advice of a medical practitioner*** in relation to their illness or injury for which they are claiming.

The ***insured member*** won't be considered unable to perform a duty of their ***usual occupation*** if they refuse to accept:

- any reasonable omission, modification or substitution of that duty, or
- the use of any appropriate assistive aids that would enable the ***insured member*** to perform that duty.

Total and Permanent Disablement/Totally and Permanently Disabled/TPD means, in relation to the optional Recovery Assistance Benefit and Enhanced Recovery Assistance Benefit, the ***insured member*** is ***gainfully working*** at the time they suffer an illness or injury and based on medical or other evidence satisfactory to us, solely because of that injury or illness, the ***insured member***:

- has not worked during the entire ***TPD waiting period***, and
- as at the ***date of disablement*** is unlikely ever to work in any ***gainful employment*** for which they are reasonably suited by education, training or experience despite reasonable rehabilitation or retraining.

TPD waiting period means a 91 consecutive day period.

Transfer date means the date your ***policy*** commenced with us.

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.

Underwritten/underwriting means the process we undertake to assess an ***eligible person's*** application for cover including obtaining and considering information concerning their medical, health and employment status and such other information as we, at our discretion, require.

Usual occupation means the occupation in which the ***insured member*** is regularly engaged at the time they suffer an injury or illness which leads to their ***disability***.

Visa means a current and valid visa permitting residency (excluding a visa allowing permanent residency in Australia) or employment in Australia issued in accordance with the *Migration Act 1958* (Cth) or any amending or replacing Act which enables an ***eligible person*** or ***insured member*** to work in Australia.

Waiting period is the number of consecutive days for which an ***insured member*** must be ***totally disabled*** or ***partially disabled***, as the case may be, before the Total or Partial Disability Benefit is payable.

War includes, but is not limited to, declared war and armed aggression by one or more countries resisted by any country, combination of countries or international organisations.

War service includes but is not limited to, participation in an action to defend a country or region from civil disturbance or insurrection, or in an effort to maintain peace in a country or region.

Written certification has the meaning given in the definition of ***terminal illness***.

Early Cash Benefit Conditions and Trauma Recovery Events

The conditions that are included in the Early Cash Benefit and Trauma Recovery Benefit are listed in clauses 4.6 and 4.7. The definitions that apply to each of the conditions are as follows (if a definition requires test(s) and the test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose the condition of the same degree of severity, or greater):

Activity/Activities of daily living means:

- bathing and/or showering
- dressing and undressing
- eating and drinking
- using a toilet to maintain personal hygiene
- getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or with assistance of a walking aid.

Angioplasty – triple vessel means the actual undergoing of angioplasty to three or more coronary arteries within the same procedure or via two procedures no more than two months apart. Angiographic evidence, showing obstruction of three or more coronary arteries, is required to confirm that the procedure is medically necessary.

Aortic surgery means surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta performed either by open surgery or by thoracoscopic or laparoscopic minimally invasive 'keyhole' techniques. Aortic surgery doesn't include percutaneous angioplasty or any other intravascular techniques.

Aplastic anaemia (requiring treatment) means bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring one of the following treatments:

- immunosuppressive agents
- bone marrow transplantation
- peripheral blood stem cell transplant.

Benign brain tumour (permanent impairment or requiring surgical intervention) means the diagnosis of a benign (non-malignant) tumour in the brain or an acoustic neuroma which results in the ***insured member***:

- suffering at least 25% permanent whole person impairment as defined in the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment approved by us, or
- being permanently unable to perform at least one of the ***activities of daily living*** without the physical assistance of another adult person, or
- undergoing a craniotomy to remove the tumour.

Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.

Burns (severe) means tissue injury caused by thermal, electrical or chemical agents causing full thickness burns to either:

- 20% or more of the body surface area as measured by the 'Rule of Nines' or the Lund and 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.

Cancer (excluding early stage cancers) means the diagnosis of one or more malignant tumours including leukaemia, lymphoma and Hodgkin's disease characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

- Melanomas are covered if they either:
  - have a TNM classification of at least T1b
  - have evidence of ulceration
  - are at least Clark Level 3 depth of invasion
  - are at least 1.0mm Breslow thickness

as determined by histological examination.

- Prostatic cancer is covered if it is either:
  - a TNM classification of at least T1c
  - a Gleason score of at least 6
  - required to have 'major interventionist treatment' to arrest the spread of malignancy.

'Major interventionist treatment' includes removal of the entire prostate, radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment.

- Carcinoma in situ* of the breast is covered if either:
  - treatment requires the removal of the entire breast
  - treatment requires breast conserving surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy).
- Carcinoma in situ* of the testicle is covered if treatment requires the removal of the testicle.

* Carcinoma in situ is covered where the procedures are required to be performed specifically to arrest the spread of malignancy and are considered the appropriate and necessary treatment.

The following cancers are not covered:

- all hyperkeratoses or basal cell carcinomas of the skin
- all other melanomas
- all other prostatic cancers
- all squamous cell carcinomas of the skin unless there has been a spread to other organs
- chronic lymphocytic leukaemia less than Rai Stage 1
- all other tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2, and CIN-3), or which are histologically described as pre malignant, or which are classified as FIGO Stage 0, or which have a TNM classification of Tis. 'FIGO' refers to the staging method of the International Federation of Gynaecology and Obstetrics.

Cardiomyopathy (permanent and irreversible) means impaired ventricular function resulting in significant impairment. The degree of permanent and irreversible 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 together with permanent jaundice, ascites or encephalopathy.

Chronic lung disease (end stage) means end stage lung disease requiring permanent supplementary oxygen, as confirmed by a ***specialist medical practitioner***.

Cognitive loss (permanent) means a total and permanent deterioration or loss of intellectual capacity due to the loss of or damage to neurons in the brain (or through acquired brain injuries or progressive neurodegenerative disease) that has required the ***insured member*** to be under continuous care and supervision by another adult person for at least six consecutive months; that has been clinically observed and evidenced by accepted standardised testing, and that at the end of the six month period they are likely to require ongoing continuous care and assistance by another adult person to perform any of the ***activities of daily living*** in addition to a score of 15 or less out of 30 in a Mini Mental State Examination or equivalent evidence from an alternative neuro-psychometric test.

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 and or a coma that has been induced medically.

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 (diagnosed) means both of the following:

- unequivocal diagnosis of permanent and irreversible dementia or Alzheimer's disease confirmed by a consultant neurologist or geriatrician
- the ***insured member*** requires continual supervisory care as the result of cognitive impairment. The impairment must be evidenced by a Mini Mental State Examination score of 24 or less out of 30 or the results of another equivalent neuro-psychometric test.

Diabetes (of specified severity) means severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist. The condition must be evidenced by at least two of the following:

- proliferative retinopathy
- Diabetic neuropathy causing severe motor impairment, severe autonomic impairment or both severe motor and autonomic impairment
- peripheral vascular disease leading to chronic infection or gangrene, requiring a surgical procedure
- severe diabetic nephropathy causing chronic irreversible renal impairment as measured by a corrected creatinine clearance less than 30ml/min.

Head trauma (permanent and irreversible) means cerebral injury resulting in permanent neurological deficit, as confirmed by a ***medical practitioner*** who is a consultant neurologist and/or a rehabilitation physician, causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment approved by us, or
- a total and irreversible inability to perform at least one ***activity of daily living*** without the assistance of another adult person.

Heart attack (diagnosed) means the death of a portion of heart muscle arising from inadequate blood supply to the relevant area. The diagnosis must be supported by the following being present and consistent with acute myocardial infarction (and not due to medical intervention):

- rise and/or fall of cardiac biomarkers (such as Troponins or cardiac enzyme CK-MB), with at least one value above the 99th percentile of the upper reference range of laboratory normal, and
- one of the following:
  - acute new cardiac symptoms and signs consistent with myocardial infarction
  - new ST elevation
  - new T wave changes
  - new Left bundle branch block (LBBB)
  - new pathological Q waves.

If the above test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose 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, myocardial infarctions arising from elective percutaneous coronary interventions or coronary bypass grafting that do not satisfy the requirements of the ESC/ACCF/
- AHA/WHF 3rd Edition of the 'universal definition of myocardial infarction', and
- elevations of troponins in the absence of overt ischaemic disease (for example but not limited to, myocarditis, apical ballooning, cardiac contusion, pulmonary embolism or drug toxicity).

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 intraarterial procedures.

HIV (medically acquired) 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 ***insured member***
- 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.

HIV (occupationally acquired) means infection with Human Immunodeficiency Virus (HIV) due to an accident at work in the ***insured member'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.

Intensive care (prolonged) means severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days) which includes both of the following:

- the ***insured member*** is admitted to an authorised intensive care unit of an acute care hospital due to accident or illness
- while in intensive care, the ***insured member*** requires continuous mechanical ventilation by tracheal intubation for 10 consecutive days, 24 hours a day

Loss of independent existence (permanent) means a condition whereby we have determined the ***insured member*** is totally and irreversibly unable to perform at least two of the five ***activities of daily living*** without the assistance of another adult person.

Loss or paralysis of limb (permanent) means the total and permanent loss of use of a whole hand or a whole foot as a result of illness or injury, or the total and permanent loss of the use of one arm or one leg as a result of paralysis.

Meningitis and/or meningococcal disease (permanent and irreversible) means all potential manifestations of bacterial meningitis or meningococcal septicaemia resulting in both of the following:

- permanent and irreversible neurological deficit confirmed by a specialist physician
- permanent and irreversible inability to perform at least one of the ***activities of daily living***.

Motor neurone disease (diagnosed) means the unequivocal diagnosis of a progressive form of debilitating motor neurone disease, as confirmed by a ***medical practitioner*** who is a consultant neurologist.

Multiple sclerosis (with impairment level) means a disease characterised by demyelination in the brain and/or spinal cord. Multiple Sclerosis must be unequivocally diagnosed. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities. Diagnosis must be confirmed by neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, and evoked auditory responses. Multiple sclerosis must be certified by an appropriate ***specialist medical practitioner***.

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***.

Organ transplant (major) means the ***insured member***:

- undergoes human-to-human or animal-to-human organ transplant, or
- has been placed on an Australian waiting list approved by us, or
- undergoes permanent mechanical replacement for one or more of the following organs:
  - kidney
  - heart
  - lung
  - liver
  - pancreas
  - small bowel
  - the transplant of bone marrow (excluding autologous).

Stem cell transplant performed to treat auto-immune disease or for cosmetic purposes is excluded from transplant.

This treatment must be considered medically necessary and the condition affecting the organ deemed untreatable by any other means other than organ transplant, as confirmed by a specialist physician.

Parkinson's disease (diagnosed) means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of:

- rigidity
- tremor
- akinesia from degeneration of the nigrostriatal system.

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

Primary pulmonary hypertension (Idiopathic pulmonary arterial hypertension with permanent impairment) means primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation and resulting in significant and permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment. If the above test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose Idiopathic pulmonary arterial hypertension of the same degree of severity, or greater, as outlined above.

Rheumatoid arthritis (severe) means the unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. To fulfil the criteria for severe rheumatoid arthritis there must be all of the following:

- diagnosis of rheumatoid arthritis as specified by the '2010 Rheumatoid Arthritis Classification Criteria'*
- symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or four large joints (ankles, knees, hips, elbows, shoulders)
- have failed at least six months of intensive treatment with two conventional disease-modifying antirheumatic drugs (DMARDs). This excludes corticosteroids and non-steroidal anti-inflammatories
- the disease must be progressive and non-responsive to all conventional therapy^.

* American College of Rheumatology and European League Against Rheumatism.

^ Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for rheumatoid arthritis.

Specific Loss – Loss of either sight, hearing or speech

Loss of sight means permanent and irrecoverable loss of sight due to injury or illness, 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 illness 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.

Hearing loss (permanent in both ears) means, due to illness or injury, the total and permanent loss of hearing in both ears to the extent that the loss is greater than 90 decibels across all frequencies. Deafness (permanent in both ears) does not cover the situation where an insured member can hear, either partially or fully, with the assistance of an aid (apart from a Cochlear implant).

Stroke (diagnosed) means the diagnosis of a stroke that meets all of the following:

- cerebrovascular incident producing neurological deficits lasting more than 24 hours, and
- evidenced by acute onset of new objective neurological signs and symptoms, and
- evidenced by neuro-imaging changes consistent with the signs and symptoms, and
- confirmed by a ***medical practitioner*** who is a consultant neurologist.

Includes where there is infarction of brain tissue, intracranial or subarachnoid haemorrhage or embolisation from extracranial source.

Transient ischaemic attacks, migraine, vascular disease affecting the eye, optic nerve or vestibular functions, and incidental imaging findings (CT or MRI brain scan without clearly related clinical symptoms (silent stroke)), or as a result of hypoxia and trauma are excluded.

If neuro-imaging is unavailable, then we will consider a claim based on conclusive evidence of unequivocal diagnosis by two specialist consultant neurologists.

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