ZURICH

Corporate Care Group Life Insurance

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.

Getting a copy

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

Contents

About Zurich 2

About this PDS and Policy 6

- Who issues Zurich Group Life Insurance?
- Changes to information in this PDS and Policy
- This PDS and Policy is not personal advice
- How to read this PDS and Policy
- Zurich Group Life Insurance has been designed for consumers with certain needs and objectives
- Setting up your policy
- More information

Part 1: General information 9

- What is Zurich Group Life Insurance?
- Insurance risks
- Duty to Take Reasonable Care Not to Make a Misrepresentation
- Privacy
- Choice of fund legislation
- Zurich Group Life Insurance to be held in superannuation
- Enquiries and Complaints
- Internationally mobile employees
- Underwriting requirements
- Making a claim
- How the cost of cover is calculated

Part 2 17

1. POLICY TERMS

1.1 Overview
1.2 Duration of the policy
1.3 Notices
1.4 Guaranteed continuing cover
1.5 Varying the policy

2. ELIGIBILITY AND PERIOD OF COVER 18

2.1 Who can become an insured member?
2.2 Becoming an insured member
2.3 Automatic acceptance
2.4 Transfer terms
2.5 Automatic increases in the insured benefit
2.6 Life Events Cover
2.7 Applications for cover
2.8 Interim Accident Cover
2.9 Maximum benefit level
2.10 Member categories
2.11 Worldwide cover
2.12 Cover during paid and unpaid leave
2.13 Cover while working outside Australia
2.14 Extended Cover
2.15 When cover ends for insured members
2.16 Continuation Option
2.17 Applications for transferred cover

3. BENEFITS 28

3.1 Death Benefit
3.2 Terminal Illness Benefit
3.3 TPD Benefit
3.4 Standard and non-standard TPD definition
3.5 Grief Support

4. BENEFIT LIMITATIONS 30

4.1 Exclusions
4.2 Pre-existing conditions
4.3 When the insured benefit payable is reduced
4.4 Repayment of benefits
4.5 Life Events Cover limitation
4.6 Breach of law

5. COSTS 32

5.1 Premium rates
5.2 Payment of premiums
5.3 Minimum annual premium
5.4 Calculating the premium
5.5 When the premium is due
5.6 Guarantee of premium rates
5.7 When we can change the premium rates and/or the minimum annual premium
5.8 Misstatement of age
5.9 Stamp duty, taxes and expenses
5.10 Interest
5.11 Discounts
5.12 Premiums paid other than annually

6. CLAIMS 35

6.1 Notification of claim
6.2 How to make a claim
6.3 Payment of a claim
6.4 Overseas claims assessment
6.5 Reimbursement of claim costs

7. GENERAL CONDITIONS 37

7.1 Risk profile
7.2 Administration
7.3 Profit sharing
7.4 Records
7.5 Changes to member and other information
7.6 Termination of policy
7.7 Governing law
7.8 Currency
7.9 Statutory fund
7.10 Cooling-off period for policy
7.11 Cooling-off period for members of a superannuation fund

8. DICTIONARY 39

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 Life Insurance.

The information in this PDS and Policy will help you to decide whether this product is suitable for 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 Life 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 Life Insurance?

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

The invitation to purchase Zurich Group Life 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 Life 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 Life 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 8 (Dictionary) for the documents that make up your ***policy***.
'PDS and Policy'	This document, which comprises the Group Life 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 8 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 Life Insurance has been designed for consumers with certain needs and objectives

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

We've created a target market determination (TMD) for each 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 Life 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 Life Insurance. 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 Life 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 Life Insurance?

At a glance

Group Life 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 Life Insurance provides a lump sum benefit in the event of an ***insured member's*** death, ***terminal illness*** or ***total and permanent disablement*** (***TPD***). The flexible nature of Zurich Group Life 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
Death Cover	If an ***insured member*** dies, we will pay you a lump sum benefit.	✓	28
Terminal Illness Cover	If an ***insured member*** is diagnosed with an illness which is likely to lead to their death within 12 months, we will pay you a lump sum benefit.	✓	28
TPD Cover	If the ***insured member*** becomes ***TPD*** and meets the conditions of the applicable TPD definition, we will pay you a lump sum benefit.	✓	28
Transfer terms	We may agree to take over the level of insurance benefits provided by your previous insurer and provide equivalent benefits.	✓	20
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).	✓	23
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.	✓	24
Cover while working outside Australia	We automatically cover ***Australian residents*** working outside Australia for their ***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.	✓	24
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.	✓	24
Death Cover Continuation Option	If an ***insured member's*** Death 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 Death Cover without being required to undergo medical ***underwriting.***	✓	25

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Interim Accident Cover	While we consider a person's application to become an ***insured member***, we will provide cover for death and ***TPD*** that arises from an ***accident*** for a period of up to 90 days. Interim Accident Cover does not apply to applications for Life Events Cover or ***transferred cover***.	✓	23
Discounts	A discount will apply if the premium is paid annually in advance and within 30 days of the due date or if you purchase Zurich Group Income Protection Insurance simultaneously with Zurich Group Life Insurance.	✓	34
Guaranteed continuing cover	Your ***policy*** will continue each year upon payment of the premium, regardless of changes to the health of ***insured members***.	✓	17
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***.	✓	29

Optional features

Generally, the following optional features are available at an extra cost.

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Life Events Cover	If selected, the ***insured member*** may apply to increase their ***insured benefit*** without having to supply medical evidence once in any 12 month period (subject to a maximum of three events) when a ***specific life event*** occurs.	✓	21
TPD Cover Continuation option	If an ***insured member's*** TPD Cover ends because they cease to be employed by you or a ***participating employer,*** they may apply to us for an individual policy providing TPD Cover without being required to undergo medical ***underwriting***.	✓	26
Non-standard TPD definitions	Alternative TPD definitions are available ("***own occupation***" TPD definition is not available for a policy issued to the trustee of a superannuation fund)	✓	29
Terminal Illness definition	An optional ***terminal illness*** definition based on a certification period of 24 months (if selected)	✓	28
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	14

Availability of cover

The table below sets out the limits and options available under Zurich Group Life 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 (including stamp duty)	$15,000
Maximum benefit level	Death Cover – unlimited Terminal Illness Cover - $3 million TPD Cover – $5 million
Benefit expiry age	65 years for 'to age 65' cover, 67 years for 'to age 67' cover and 70 years for 'to age 70' cover
Duration of cover	Age-based terms: to age 65, to age 67 and to age 70
Premium payment frequency	Annually, half yearly, quarterly or monthly

Please refer to the 'Benefits' section on page 28 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 a benefit for death, ***terminal illness*** or T***PD*** (as applicable) caused wholly or partly, directly or indirectly, by a ***pre-existing condition***
- if an ***insured member*** is insured for ***limited cover*** pursuant to clause 2.4.2.2 of Part 2: Policy Terms, we will not pay a benefit for death, ***terminal illness*** or ***TPD*** (as applicable) 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 Life 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 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.

Choice of fund legislation

If you are not a trustee of a complying superannuation fund and you have taken out your ***policy*** in order to meet the minimum death insurance requirements under the ***choice of fund legislation***, the ***choice of fund legislation*** stipulates that employers are unable to receive any potential benefit from such insurance if it is to meet that requirement. As such, you must pass on any benefits from the ***policy*** to the ***insured member's*** estate or beneficiary(ies). If you do not pass on these benefits, you may be in breach of your Superannuation Guarantee obligations and a Superannuation Guarantee shortfall may arise.

Zurich Group Life Insurance to be held in superannuation

Zurich Group Life 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 2.15 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 our customers 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.

You can contact the team 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

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 6 of Part 2: Policy Terms.

If you want to know more about making a claim for a Group Life 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 5 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 1–8 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 and are subject to an overriding limit of the ***maximum benefit level*** in respect of each ***insured member***.

There are some circumstances in which we will not pay all, or part of the benefit amount and these are detailed in Section 4.

The payment of benefits is subject to you and the ***insured member*** satisfying our claim procedures as set out in Section 6.

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 5 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 Section 7.6.

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 2.11 and 2.13), 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, 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 2.7.

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 an insurance benefit from any source for total and permanent disablement, terminal illness 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 you or a ***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 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 ***insured benefit***.

An application is required for cover in excess of the ***AAL*** as set out in clause 2.7.

Where we accept an application for cover or additional cover under clause 2.7, 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 respective ***maximum benefit levels*** for death and ***TPD***.

2.4.1 Transfer terms for Death Cover

We will provide Death Cover for all transferring members insured under the previous policy who are ***eligible persons*** on and from the ***transfer date***.

2.4.2 Transfer terms for TPD Cover

We will provide TPD Cover from the ***transfer date*** for all transferring members insured under the previous policy who are ***eligible persons***, and who were ***at work*** on the last ***normal business day*** immediately before the ***transfer date***.

2.4.2.1 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 take over the same amount of the TPD Cover 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.

2.4.2.2 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:

- Death Cover, and
- TPD Cover that is ***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 insured benefit

2.5.1 Where the insured member is automatically accepted

Provided the ***insured member*** is in ***active employment***, the ***insured member's insured 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 ***insured benefit*** is up to 25% of the ***insured member's insured benefit*** (as determined immediately before the increase) and provided the increased ***insured benefit*** is not more than the ***AAL***.

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

In all other circumstances, an application is required as explained in clause 2.7.

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 benefit level*** (as outlined in the ***quotation summary*** or ***policy schedule***).

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

2.6 Life Events Cover

2.6.1 Conditions for Life Events Cover

If Life Events Cover applies it will be shown in the ***policy schedule***.

Provided a ***specific life event*** occurs after the commencement of an ***insured member's*** cover under the ***policy***, the ***insured member*** may apply to us to increase their ***insured benefit*** without supplying medical evidence subject to all of the following conditions:

- at the time of applying for the increase in cover the ***insured member*** has not made nor is entitled to make a claim in relation to the ***policy*** or any life insurance policy whether it is issued by us or any other insurer
- the ***insured member*** has not applied for an increase in cover under this option in the previous 12 month period
- if we accept an application under Life Events Cover for an ***insured member***, the increase in cover will be on the same terms and conditions as the acceptance terms that currently apply to the ***insured member's*** cover under the ***policy*** and shall include any loadings or exclusions applicable to the cover for the ***insured member***
- your ***policy*** is still in force and cover for the ***insured member*** has not ceased
- the application to increase under this section must be made within 90 days of the occurrence of the ***specific life event***
- the acceptance date will be the date the application is accepted by us.

If the conditions set out in clause 2.6 are satisfied and we accept an ***insured member's*** application for Life Events Cover:

- we will issue a ***decision note*** to you in respect of the ***insured member***, and
- Life Events Cover will commence on the date we accept the ***insured member's*** application.

The amount of increase in the ***insured benefit*** available to an ***insured member*** on the happening of a ***specific life event*** is one unit of cover if cover is ***unit based cover***, or 25% of the ***insured member's*** cover (as at the date the ***insured member*** applies for additional cover under this option) if the ***insured member's*** cover is ***fixed dollar cover*** or ***formula based cover***. However, the increase cannot exceed $250,000 or cause the ***insured member's insured benefit*** to exceed the ***maximum benefit level***.

The proof we require for an ***insured member's insured benefit*** to be increased upon the occurrence of a ***specific life event*** is set out in the table below.

2.6.2 Limitations applicable to Life EventsCover

Life Events Cover is only available to an ***insured member*** aged less than 55 years of age at the date of the ***specific life event***.

In the event that the ***specific life event*** is marriage, we will increase the ***insured benefit*** under the Life Events Cover Option in respect of an ***insured member's*** marriage only once during the period the ***insured member*** is covered by the ***policy***.

A maximum of one increase in the ***insured member's insured benefit*** in any 12 month period applies together with a maximum of three increases in the ***insured member's*** Death only or Death and TPD Cover under the ***policy*** while they remain an ***insured member*** under the ***policy***.

During the first six consecutive months from the date an increase to an ***insured benefit*** commences under this clause, the increased amount is only payable if the ***insured member's*** death or ***total and permanent disablement*** is caused by an ***accident***. Following the expiry of the six consecutive month period, the ***insured member's*** Life Events Cover will no longer be limited to ***accidents*** only.

Life Events Cover is not available if we have declined the ***insured member's*** application for additional cover under clause 2.7.

Specific life event (occurring after the commencement of the insured member's cover) Evidence to be provided by the insured member	
The ***insured member's*** marriage (or upon the subsistence of an ***interdependent relationship*** for two years or more).	A completed application form and: • for marriage – a copy of the ***insured member's*** marriage certificate in respect of a marriage recognised under the *Marriage Act 1961* (Cth) • for an ***interdependent relationship*** – a copy of evidence that establishes the subsistence of that relationship for at least two years.
A dependent child of the ***insured member*** starts secondary school.	A completed application form and a copy of a letter of admission from the secondary school the dependent child will be attending.
The ***insured member*** or their spouse gives birth to or adopts a child.	A completed application form and a copy of the birth certificate or the adoption documentation.
The ***insured member*** takes out or increases a mortgage on their principal place of residence with an accredited mortgage provider* (excludes redraw and refinancing).	A completed application form and written confirmation from the ***insured member's*** accredited mortgage provider(s) of: • the amount and effective date of the mortgage, where the ***insured member*** takes out a new mortgage • the amount of the mortgage immediately preceding the increase, the effective date of the increase and the current level of the increased mortgage, where the ***insured member*** increases their mortgage, whether with an existing or different mortgage provider.

* Accredited mortgage provider means an authorised deposit-taking institution (as defined in the *Banking Act 1959*) or other reputable financial services business, program or trustee which provides mortgage loans as part of its ordinary business activities and is accredited with the Mortgage Industry Association of Australia.

2.7 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 your ***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***.

Where the ***insured member's insured benefit*** is determined by a benefit formula that comprises a ***superannuation account balance*** component and the i***nsured member*** transfers all or part of their ***superannuation account balance*** to another superannuation fund under ***portability legislation***, the ***insured benefit*** will be reduced in accordance with clause 4.3. In those circumstances, an application for cover will need to be made, and accepted by us, if the amount of ***insured benefit*** under the ***policy*** immediately prior to the transfer of ***superannuation account balance*** is to be maintained.

An application can only be made for cover up to the ***maximum 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 2.8.

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.

2.8 Interim Accident Cover

Interim Accident Cover is provided for all, or that part, of the cover for which an application under clause 2.7 is required. Interim Accident Cover does not apply to applications for Life Events Cover or ***transferred cover***.

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 2.15
- the date the application is cancelled or withdrawn.

If an ***insured member*** or ***eligible person*** dies or suffers ***total and permanent disablement*** as the result of an ***accident*** during the period in which Interim Accident Cover applies, we will pay you the Interim Accident Cover Benefit.

The Interim Accident Cover Benefit is the lesser of:

- the benefit amount applied for in the application for cover
- the difference between the level of increased cover applied for and the current level of cover
- the ***maximum benefit level***.

2.9 Maximum benefit level

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

2.10 Member categories

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

2.11 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 2.12 and 2.13 below.

2.12 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 during the period of paid or unpaid leave, the ***waiting period*** commences on the ***date of disablement***.

2.13 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 person that is not an ***Australian resident***) is travelling outside Australia during periods of paid or unpaid leave, and subject to cover continuing to be made available under clause 2.12, cover will continue for that ***insured member***.

2.14 Extended Cover

Subject to the terms of the ***policy***, we will provide Death Cover and TPD Cover (if applicable) 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 2.16
  - 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***.

2.15 When cover ends for insured members

2.15.1 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 5.5
- 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 a ***TPD*** claim is accepted by us and a ***TPD benefit*** is paid under your ***policy*** in respect of the ***insured member***
- the date a ***terminal illness*** claim is accepted by us and a ***terminal illness benefit*** which is equal to the amount of the Death Cover is paid under your ***policy*** in respect of that ***insured member.*** To avoid doubt, if the amount of the Death Cover is greater than the amount of the ***terminal illness benefit*** paid or payable in respect of the ***insured member***, the remaining amount of Death Cover continues
- the date the ***insured member*** permanently retires from employment (TPD Cover only, Death Cover may continue)
- the date the ***insured member*** ceases to meet the ***eligibility criteria***, or where they are provided with Extended Cover as set out in clause 2.14, 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 2.12
- when the ***insured member*** is working outside Australia for a period longer than we have agreed to provide cover for under clause 2.13
- the date your ***policy*** ends or is terminated, except to the extent discussed in clause 2.15.2, and
- 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***.

2.15.2 If the Policy terminates

If your ***policy*** terminates and ***takeover terms*** apply, our ongoing liability to pay a ***terminal illness benefit*** or ***TPD 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).

2.16 Continuation Option

2.16.1 Death Cover 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 an individual policy with us on their life for Death Cover equal to, or less than, the ***death benefit*** provided by your ***policy***.

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, and
- not be eligible to receive, or have received, death, ***terminal illness*** or ***TPD benefits*** under your ***policy*** or any other policy issued by an insurer.

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.

2.16.2 TPD Cover Continuation Option

If a TPD Cover Continuation Option applies, it is shown in your ***policy schedule***. It is not a standard feature of the ***policy***.

Where it applies, 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 an individual policy with us on their life for TPD Cover equal to, or less than, the ***TPD benefit*** provided by your ***policy***.

To exercise the TPD Cover Continuation Option, the person must satisfy the conditions that apply to a Death Cover Continuation Option as set out under clause 2.16.1 and must exercise a Death Cover Continuation Option at the same time. In addition, the person must be engaged in an occupation which is not an excluded occupation under the individual policy and working the minimum hours required under the individual policy.

2.16.3 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 your ***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***.

2.17 Applications for transferred cover

An ***insured member*** can apply for additional cover if on the date we accept their application, they:

- have death only cover or death and total and permanent disablement cover under a ***previous life policy*** with another insurer through a superannuation fund (‘***previous cover***’) and wish to transfer that ***previous cover*** into the ***policy*** (‘***transferred cover***’)
- have not made, or are not entitled to make, a claim and is not eligible to be paid a benefit in relation to the ***previous cover***
- do not have their ***previous cover*** provided through a self-managed superannuation fund or a non-superannuation policy.

The following terms and conditions apply to applications for ***transferred cover***:

- the ***insured member*** must satisfactorily complete the application form we provide, which will contain questions regarding the ***insured member's*** health that they will need to answer to our satisfaction
- we will determine the application only upon receipt of all evidence we reasonably require to assess the application and verify the ***previous cover***, its validity and currency
- if we accept the application, we will issue a ***decision note*** to you in respect of the ***insured member*** and ***transferred cover*** will be provided in accordance with all of the following:
  - ***transferred cover*** commences on the date we accept the application
  - ***transferred cover*** is provided conditionally upon cancellation of the ***previous cover***. If the ***previous cover*** is not validly cancelled upon our acceptance of the application for ***transferred cover***, then in the event we accept a claim for death, ***terminal illness*** or ***total and permanent disablement*** in respect of the ***insured member***, we will reduce any benefit payable under the ***policy*** by the amount equal to the amount of ***previous cover*** that should have been cancelled
  - if, as at the date we accept the application, the ***insured member's existing cover*** is subject to ***special acceptance terms***, those terms:
    i. will not apply to the ***transferred cover*** unless we advise you in writing, and
    ii. will continue to apply to the insured amount of ***existing cover***.
  - if the ***insured member's previous cover*** is subject to a special condition, premium loading or an exclusion (‘***previous cover terms***’), we may accept the application subject to ***special acceptance terms*** or decline the application at our discretion. If we accept the application subject to ***special acceptance terms***, those ***special acceptance terms*** will not apply to the ***insured member's existing cover***
  - the terms and conditions of the ***policy*** apply to the ***transferred cover***
  - the ***transferred cover*** will be in addition to the ***existing cover***
  - the amount of ***transferred cover*** does not count towards any ***automatic acceptance level*** that may apply in respect of the ***insured member***
  - the type and amount of ***transferred cover*** we accept is such that provides the ***insured member*** with at least as much and as close as possible to the amount of the ***previous cover*** except that:
    i. the amount will be rounded up to the next multiple of $1,000 if it is not already a multiple of $1,000
    ii. the transferred cover cannot exceed $1 million even if the previous cover was a higher amount
    iii. the total combined amount of ***transferred cover*** and ***existing cover*** cannot exceed the ***maximum benefit level***.

3. Benefits

3.1 Death Benefit

If an ***insured member*** with Death Cover dies, we will pay you the ***death benefit*** in respect of that ***insured member*** provided their Death Cover has not ended as at the date of their death.

The ***death benefit*** becomes payable on the date of their death.

3.2 Terminal Illness Benefit

If an ***insured member*** with Death Cover suffers ***terminal illness***, we will pay you a ***terminal illness benefit*** in respect of that ***insured member*** provided their Death Cover has not ended as at the date of the latest ***written certification*** by a ***medical practitioner*** which we accept as evidence of ***terminal illness***.

The ***terminal illness benefit*** becomes payable on the date of the latest ***written certification*** by a ***medical practitioner*** which we accept as evidence of ***terminal illness***.

Where the ***terminal illness benefit*** is less than the ***death benefit***, the ***death benefit*** otherwise payable in respect of the ***insured member*** will be reduced by the amount of the ***terminal illness benefit*** paid.

You can choose either of the following ***terminal illness*** definitions to apply to your plan:

- ***Terminal illness*** – Standard Definition based on a 12 month ***certification period***, or
- ***Terminal illness*** – Non-standard Definition based on a 24 month ***certification period***.

Where a non-standard ***terminal illness*** definition applies to your plan, it will be shown in your ***policy schedule***.

3.3 TPD Benefit

If an ***insured member*** with TPD cover becomes ***totally and permanently disabled***, we will pay you a ***TPD benefit*** in respect of that ***insured member*** provided their TPD cover has not ended as at the ***event date***.

3.3.1 Tapering of TPD benefits

Where the ***TPD benefit*** does not reduce gradually to be nil by the ***benefit expiry age***, unless we otherwise agree in writing, an ***insured member's TPD benefit*** will automatically decrease by:

- 10% per annum from the ***insured member's*** 61st birthday, if the ***benefit expiry age*** is 70
- 20% per annum from the ***insured member's*** 63rd birthday, if the ***benefit expiry age*** is 67, or
- 20% per annum from the ***insured member's*** 61st birthday, if the ***benefit expiry age*** is 65.

Where the ***benefit expiry age*** is an age other than age 65, age 67 or age 70, the amount by which the ***insured benefit*** reduces will be contained in your ***policy schedule***.

Example: Where ***benefit expiry age*** is 70

TPD sum insured	Age	Tapered TPD benefit	Reduction factor
$500,000	Up to 60	$500,000	0%
	61	$450,000	10%
	62	$400,000	20%
	63	$350,000	30%
	64	$300,000	40%
	65	$250,000	50%
	66	$200,000	60%
	67	$150,000	70%
	68	$100,000	80%
	69	$50,000	90%
	70	$0	100%

Example: Where ***benefit expiry age*** is 67

TPD sum insured	Age	Tapered TPD benefit	Reduction factor
$500,000	Up to 62	$500,000	0%
	63	$400,000	20%
	64	$300,000	40%
	65	$200,000	60%
	66	$100,000	80%
	67	$0	100%

3.3.2 TPD benefits for insured members aged 67 and over

An ***insured member*** aged 67 years or over as at the ***event date*** is ineligible for Part 1 and Part 2 of the TPD definition and is only eligible for Part 3, Part 4 and Part 5 of the TPD definition and for ***specific medical conditions***. The more restrictive TPD benefits from age 67 apply when the TPD benefit expiry age exceeds age 67 and is reflected in the pricing at these advanced ages.

3.4 Standard and non-standard TPD definitions

You can choose one of the following ***TPD*** definition options for your plan.

- Standard ***TPD*** Definition
- ***TPD*** Definition Option 1 (Own Occupation)
- ***TPD*** Definition Option 2 (Incapable of ever)
- ***TPD*** Definition Option 3 (No minimum hours)
- Non-standard ***TPD*** Definition available at request

The ***TPD*** definition that applies to your plan will be shown in your ***policy schedule***.

The parts of the ***TPD*** definition applicable under each option are set out in the table below.

The ***TPD*** definition including all Parts 1–5 are set out in Section 8 of this PDS and Policy.

TPD Definition	Specific Medical Conditions	Part 1a Any Occupation	Part 1b Own Occupation	Part 1c Any Occupation No minimum hours	Part 2 Incapable of ever (Any Occupation)	Part 3 Activities of Daily Work	Part 4 Normal Domestic Duties	Part 5 Mental Health
Standard TPD Definition	✓	✓	x	x	x	✓	x	✓
TPD Definition Option 1 (Own Occupation)	✓	x	✓	x	x	✓	x	✓
TPD Definition Option 2 (Incapable of ever)	✓	✓	x	x	✓	✓	x	✓
TPD Definition Option 3 (No minimum hours)	✓	x	x	✓	x	✓	x	✓
Non-Standard TPD Definition	*	*	*	*	*	*	*	*

* Non-Standard ***TPD*** Definition is available on request and will comprise the parts of the ***TPD*** Definition selected.

3.5 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*** and their ***immediate family members***.

4. Benefit Limitations

4.1 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***

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

In addition, we will not pay any benefits under your ***policy*** for anything we have specifically excluded as shown in your ***policy schedule***.

4.2 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 a benefit for death, ***terminal illness*** or ***TPD*** (as applicable) caused wholly or partly, directly or indirectly, by a ***pre-existing condition***.

If the ***insured member*** is insured for ***limited cover*** pursuant to clause 2.4.2.2, we will not pay a benefit for death, ***terminal illness*** or ***TPD*** (as applicable) 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***.

4.3 When the insured benefit payable is reduced

The ***insured member's insured benefit*** may be reduced in the following situations:

- if, during the period of Extended Cover (see clause 2.14) an ***insured member*** becomes covered under a policy from another insurer providing similar benefits (the Subsequent Policy), we may reduce or refuse to pay any ***insured benefit*** which may become payable under your ***policy***, by the amount of any similar benefit paid, or payable, in respect of him or her under the Subsequent Policy, if the death, ***terminal illness*** or ***total and permanent disability*** arose or occurred during the period of Extended Cover
- if an ***insured member's*** sum insured is determined by a benefit formula that comprises a ***superannuation account balance*** component and the ***insured member*** transfers all or part of their superannuation benefit to another fund under ***portability legislation***, the ***insured member's insured benefit*** will be reduced by the amount of the ***superannuation account balance*** that was transferred to the superannuation fund
- if we issue a ***policy*** to you, or a cover under the ***policy***, on the condition that it replaces insurance issued by another insurer and the insurance being replaced is not cancelled, the amount of any benefits paid under the ***policy*** will be reduced by any benefits paid or payable under the insurance that was replaced.

4.4 Repayment of benefits

Any ***insured benefit*** paid by us must be repaid by you to the extent that the ***insured benefit***, or part of the ***insured benefit***, was not payable under the terms of your ***policy***.

4.5 Life Events Cover limitation

If the ***insured member's insured benefit*** has increased due to a ***specific life event***, for the first six months following the increase, we will only pay the increased portion of the ***insured benefit*** if the ***insured member's*** death or ***total and permanent disablement*** results from an ***accident***.

4.6 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.

5. Costs

5.1 Premium rates

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

5.2 Payment of premiums

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

5.3 Minimum annual premium

The annual premium that must be paid will be at least the minimum annual premium shown in your ***policy schedule***.

If the premium we calculate is less than the minimum annual premium, you must pay the minimum annual premium. If you do not pay the minimum annual premium, we may cancel or terminate your ***policy*** by giving you at least 30 days written notice in accordance with clause 7.6.

5.4 Calculating the premium

We calculate the premium which will apply to your ***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 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 2.15.

We will calculate the premium having regard to the number of ***insured members*** covered under your ***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 your ***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 5.11 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.

5.5 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, your ***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.***

5.6 Guarantee of premium rates

Subject to clause 5.7, premium rates will be guaranteed from the ***policy start date*** to the end of the ***premium rate guarantee period***.

5.7 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 7.1 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.

5.8 Misstatement of age

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

5.9 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 Life 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 group life insurance product.

5.9.1 Stamp duty

Stamp duty is included in the premium rates.

5.9.2 Other expenses

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

- any federal, state or territory taxes and charges (other than stamp duty, which is included in the premium rates). References in your ***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 your ***policy***.

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

5.9.3 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.

5.10 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.

5.11 Discounts

5.11.1 Combined plan discount

If you establish a Zurich Group Income Protection 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 Income Protection policy remains the same as the annual ***review date*** chosen for this ***policy,*** and both policies remain in force.

5.11.2 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 5.5. All details will be outlined in your ***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.

5.12 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. Claims

6.1 Notification of claim

In the case of a claim for a ***TPD benefit***, you must advise us of a claim or potential claim as soon as practicable after the ***event date*** to enable a proper assessment of the claim.

You must make all reasonable efforts to ensure that each ***insured member*** covered for a ***TPD benefit*** knows that they must advise you of circumstances giving rise to a potential claim to enable you to advise us promptly.

6.2 How to make a claim

We will generally send claim forms to you, the ***insured member***, or in the case of a deceased ***insured member***, their legal personal representative, 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 after the ***event date*** 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*** promptly.

We generally ask for medical information and evidence to enable a claim for a ***TPD benefit*** or ***terminal illness benefit*** to be assessed.

During the course of a ***TPD*** claim, the ***insured member*** may be required to be interviewed, attend vocational assessments and rehabilitation, and provide us with all information required in order to determine their eligibility for benefits.

6.3 Payment of a claim

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

- the ***insured member's*** age.
- where the ***insured member*** was accepted (or an increase in the ***insured benefit*** payable 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*** entitlement to claim the applicable ***insured benefit***

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:

- an original or certified death certificate (if applicable), a birth certificate (or other proof of birth to our satisfaction) and all other documentation we require
- medical reports as we require from any treating ***medical practitioners*** (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
- financial documentation (including, without limitation, tax returns, notices of assessment, group certificates and the like)
- all other relevant information we request, and
- when reasonable required by us the ***insured member*** will:
  - undergo an employability assessment, and
  - be interviewed.

Where an ***insured member*** dies outside of Australia, we may require proof of the ***insured member's*** death to take the form of an original death certificate or copy of the death certificate that is certified by the Australian Embassy in the country of the ***insured member's*** death. If such proof is not produced, we may refuse to pay the ***death benefit***.

6.4 Overseas claims assessment

We may require an ***insured member*** claiming a ***terminal illness benefit*** or ***TPD benefit*** while outside of Australia to return to Australia, at the ***insured member's*** own expense, for claim assessment and where the ***insured member*** refuses to do so, we may refuse to pay a benefit.

6.5 Reimbursement of claim costs

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

7. General Conditions

7.1 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 5.3

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***.

7.2 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.

7.3 Profit sharing

The ***policy*** may be entitled to participate in profits that are based on self-experience profit sharing. If you are eligible and have elected to participate in self-experience profit sharing, all details will be specified in your ***policy schedule***.

7.4 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 your ***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.

7.5 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.

7.6 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 5.3 and 5.5 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 from receipt of our written notice.

7.7 Governing law

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

7.8 Currency

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

7.9 Statutory fund

Your ***policy*** is issued from the statutory fund shown in your ***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.

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

7.10 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***.

7.11 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.

8. 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.

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.

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.

Activity/Activities of daily work means:

- bending – the ability to bend, kneel or squat to pick something up from the floor and straighten up again.
- communicating – the ability to:
  - clearly hear with or without a hearing aid or alternative aid if required
  - comprehend and express oneself by spoken or written language with clarity and
  - interact with others by listening, comprehending and speaking on a day-to-day basis and in a work environment.
- vision (reading) – the ability to read, with or without correction with suitable lenses, to the extent that an ophthalmologist can certify that:
  - visual acuity is equal to, or better than, 6/48 in both eyes, or
  - constriction is within or greater than 20 degrees of fixation in the eye with the better vision.
- walking – the ability to walk more than 200m on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body.
- lifting – the ability to lift, carry or otherwise move objects weighing up to 5kg using one or both hands.
- manual dexterity – the ability, with reasonable precision and success, to:
  - use at least one hand, its thumb and fingers, including the ability to pick up and manipulate small objects, and
  - use a keyboard.

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***.

Casual employee means an ***eligible 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 ***terminally ill*** and ***terminal illness***.

Choice of Fund legislation means *Superannuation Guarantee (Administration) Act 1992*, the *Superannuation Guarantee (Administration) Regulations 2018*, the *Superannuation Guarantee Charge Act 1992*, as amended from time to time, or any other present or future law of the Commonwealth of Australia or any state or territory, which we may determine to be relevant law for the purposes of this definition.

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.

Date of disablement means:

a. for Part 1a, Part 1b, Part 1c, Part 2, and Part 4 of the ***TPD*** definition, the first day after the expiry of the ***waiting period***;

b. for all other parts of the ***TPD*** definition, the first day that all of the elements of the definition are satisfied.

Death benefit is the amount applying to the ***insured member*** by reference to the ***policy schedule*** or the ***decision note*** as at the ***insured member's*** date of death.

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.

DSM means the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA).

If the Diagnostic and Statistical Manual of Mental Disorders is no longer used or published, we will use another manual similar to it for the determination as determined by the Royal Australian and New Zealand College of Psychiatrists.

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***.

Employer approved leave means a person is:

a. employed or self-employed for reward or financial benefit, or the hope of reward or financial benefit, in any business, trade, profession, vocation, calling, occupation or employment; and

b. on leave that has been approved by the person's Employer prior to the commencement of that leave (except for approved sick leave or leave taken for reasons related to injury or illness).

Event date means:

a. for Part 1a, Part 1b, Part 1c, and Part 2 of the ***TPD*** definition, the first day of the ***waiting period*** during which the ***insured member***, solely because of injury or illness, has not worked

a. for Part 3 of the ***TPD*** definition, the first day that the ***insured member***, solely because of injury or illness, is totally unable to perform at least three ***activities of daily work***

a. for Part 4 of the ***TPD*** definition, the first day of the ***waiting period*** during which the ***insured member***, solely because of injury or illness, has been unable to perform ***normal domestic duties***, leave their ***home*** unaided or work in any occupation

a. for Part 5 of the ***TPD*** definition, the first day of the 12-month period during which the ***insured member***, solely because of a mental health condition, has not worked.

Existing cover means any insured amount of cover that the ***insured member*** held under your ***policy*** prior to the date the application for ***transferred cover*** was accepted by us.

Fixed dollar cover means the amount of the benefit for Death Cover and/or the amount of the benefit for TPD Cover that you, the ***insured member***, or the ***insured member's*** employer (if applicable), has requested and we have agreed to provide that is fixed at a specific amount.

Formula based cover means the amount of the benefit for Death Cover and/or TPD Cover which has been determined via the application of a formula for cover chosen by you or by the ***participating employer*** and agreed to by us. Formula based cover is determined by reference to an ***insured member's*** salary.

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***.

Gainfully working means a person is:

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

b. on ***employer approved leave***.

Home means the ***insured member's*** principal place of residence.

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 11.59pm 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.

Insured benefit means any benefit provided under your ***policy*** as the context requires including the ***TPD benefit***, the ***terminal illness benefit*** and/or the ***death 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.

Interdependent relationship means a close personal relationship between two people who live together, where one or each of them provides the other with financial support, and one or each of them provides the other with domestic support and care.

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 benefit level means the maximum benefit level as shown 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 means a member of the plan for which the Trustee holds this ***policy*** (whether the member is currently insured or insurable under this ***policy*** or not).

Member's account means an account in the plan held by you for a ***member*** (where we have issued this ***policy*** to the trustee of a 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 or country of residence including details of persons who have been seconded overseas by their employer for work
- employee/member status (i.e. whether the person is on unpaid or paid leave)
- date the person first satisfied the ***eligibility criteria*** and, if required, an ***at work certificate***
- date the person joined the company
- sum insured (in Australian dollars) and formula for cover.

Minimum benefit entry age means the minimum benefit entry age as shown in the ***policy schedule***.

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) under the ***policy***.

Normal business day means any day which is not a weekend or a public holiday on which an ***insured member's*** employer normally operates.

Normal domestic duties mean the tasks performed by an ***insured member*** whose sole occupation is to maintain their family ***home***. These tasks are unassisted:

- cleaning: using domestic appliances and equipment to clean and maintain the ***home***
- cooking : using kitchen and cooking utensils, appliances, and equipment to prepare more than the most basic meals for the family
- laundry: washing, drying, and ironing the family's clothes or linens to basic standards
- shopping: purchasing and unpacking everyday household provisions for the family, and
- taking care of dependent children (where applicable).

Normal domestic duties do not include duties performed outside the ***insured member's home*** for salary, reward or profit.

Other Factors
In determining if the ***insured member*** satisfies ***TPD*** definitions Parts 1a, 1c, 2, 3, 4 and 5 we may have regard to all relevant information available to us. This includes, but is not limited to;

a. information relevant to the ***insured member's*** future capability to return to work;

b. the entirety of an ***insured member's*** previous gainful or non-gainful work, their past education, training or experience, and the ***insured member's*** transferrable skills, irrespective of the date that the work, skill, training, education and/or the experience was undertaken or obtained.

We will not take into account an ***insured member's*** previous status or level of seniority.

Own occupation means the ***insured member's*** occupation immediately prior to the ***event date***.

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.

Participating employer means you or any participating employer named 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 Life 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***.

Portability legislation means the provisions of the *Superannuation Industry (Supervision) Regulations 1994*, as amended from time to time, which regulate the transfer or rollover of superannuation benefits, or any present or future law of the Commonwealth of Australia or any state or territory which we may determine to be relevant law for the purposes of this definition.

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***.

Previous cover means death only cover or death and total and permanent disablement cover under a ***previous life policy*** with another insurer through a superannuation fund.

Previous cover terms means any special condition, premium loading or exclusion that applies to the ***insured member's previous cover***.

Previous life policy means a 'life policy' under the *Life Insurance Act 1995* (Cth) that we agree to treat as a previous life policy for the purposes of the ***policy***.

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 Life 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 Life Insurance quotation we issue you. It contains the ***premium rate schedule*** and the terms on which we will offer cover to your prospective plan.

Reasonable retraining or rehabilitation means:

a. any further education, training, experience or rehabilitation the ***insured member*** has undertaken since the ***event date***; or

b. any further education, training, experience or rehabilitation the ***insured member*** has capacity to undertake and can be reasonably expected to do based on their previous education, training or experience.

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

Special acceptance terms include exclusions, premium loadings and other special conditions we apply to the ***insured member's*** cover.

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.

Specific life event means:

- the ***insured member's*** marriage or involvement in a ***interdependent relationship*** for two or more years
- the date on which a dependent child of the ***insured member*** starts secondary school
- the date on which the ***insured member*** or the ***insured member's*** spouse gives birth to or adopts a child, or
- the date on which the ***insured member*** takes out or increases a mortgage on their principal place of residence with an accredited mortgage provider (excludes redraw and refinancing).

Specific Medical Condition means any of the following conditions:

1. ***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

2. ***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

3. ***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

4. ***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 an occupational physician, causing either:

   a. 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

   b. a total and irreversible inability to perform at least one ***activity of daily living*** without the assistance of another adult person.

5. ***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.

6. ***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.

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

8. ***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***.

9. ***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

10. ***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 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.

11. ***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).

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.

Superannuation account balance means the dollar value of the accumulation fund maintained by you (where we have issued this ***policy*** to the trustee of a superannuation fund) in respect of an ***insured member*** under your plan.

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/Terminally ill – **Standard Definition** 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 for Death Cover under the ***policy***.

Terminal illness/Terminally ill – **Non-Standard Definition** 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 24 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 for Death Cover under your ***policy***.

Terminal illness benefit means, in respect of an ***insured member***, the lesser of:

- the ***death benefit*** as at the date of the latest written certification, and
- $3 million.

Total and Permanent Disablement/Totally and Permanently Disabled/TPD means:

Part 1a – Any occupation

An ***insured member*** satisfies all of the following a, b, c, d and e:

a. is aged 66 years or less on the ***event date***;

b. is ***gainfully working*** for an average of at least 14 hours per week as a ***permanent employee*** (including an eligible ***contractor***) on the day immediately prior to:

   i. the ***event date***; or

   ii. the date the period of ***employer approved leave*** begins if the ***event date*** occurs during the period of ***employer approved leave***;

c. has either:

   i. worked for at least six consecutive months or more immediately prior to the ***event date*** or the date the period of ***employer approved leave*** begins; or

   ii. worked for less than six consecutive months immediately prior to the ***event date*** or the date the period of ***employer approved leave*** begins but has in fact worked for an average of 14 hours or more per week since commencing cover under your ***policy***,

d. is following the advice of a ***medical practitioner*** in relation to their illness or injury for which they are claiming. The ***insured member*** must be at a stage where, despite any further treatment, their injury or illness is not expected to improve or recover sufficiently to enable a return to ***gainful employment***; and

e. based on medical or other evidence satisfactory to us and after taking into consideration ***other factors***, solely because of injury or illness, the ***insured member***:

   i. has not worked at any time during the ***waiting period***, and

   ii. as at the ***date of disablement*** is unlikely ever to be able to work in any ***gainful employment*** for which they:

      A. are reasonably suited by education, training or experience; or

      B. may become reasonably suited due to ***reasonable retraining or rehabilitation***.

Part 1b – Own occupation

An ***insured member*** satisfies all of the following a, b, c, d and e:

a. is aged 66 years or less on the ***event date***;

b. is ***gainfully working*** for an average of at least 14 hours per week as a ***permanent employee*** (including an eligible ***contractor***) on the day immediately prior to:

   i. the ***event date***; or

   ii. the date the period of ***employer approved leave*** begins if the ***event date*** occurs during the period of ***employer approved leave***;

c. has either:

   i. worked for at least six consecutive months or more immediately prior to the ***event date*** or the date the period of ***employer approved leave*** begins; or

   ii. worked for less than six consecutive months immediately prior to the ***event date*** or the date the period of ***employer approved leave*** begins but has in fact worked for an average of 14 hours or more per week since commencing cover under your ***policy***,

d. is following the advice of a ***medical practitioner*** in relation to their illness or injury for which they are claiming. The ***insured member*** must be at a stage where, despite any further treatment, their injury or illness is not expected to improve or recover sufficiently to enable a return to their ***own occupation***; and

e. based on medical or other evidence satisfactory to us, including information relevant to the ***insured member's*** future capability to return to work, solely because of injury or illness, the ***insured member***:

   i. has not worked at any time during the ***waiting period***, and

   ii. as at the ***date of disablement*** is unlikely ever to be able to work in their ***own occupation*** following reasonable rehabilitation which is designed to enable a return to their ***own occupation***.

Part 1c – Any occupation (No minimum hour requirement)

An ***insured member*** satisfies all of the following a, b, c and d:

a. is aged 66 years or less on the ***event date***;

b. is ***gainfully working*** as a ***permanent employee*** (including an eligible ***contractor***) on the day immediately prior to:

   i. the ***event date***; or

   ii. the date the period of ***employer approved leave*** begins if the ***event date*** occurs during the period of ***employer approved leave***;

c. is following the advice of a ***medical practitioner*** in relation to their illness or injury for which they are claiming. The ***insured member*** must be at a stage where, despite any further treatment, their injury or illness is not expected to improve or recover sufficiently to enable a return to ***gainful employment***; and

d. based on medical or other evidence satisfactory to us and after taking into consideration ***other factors***, solely because of injury or illness, the ***insured member***:

   i. has not worked at any time during the ***waiting period***, and

   ii. as at the ***date of disablement*** is unlikely ever to be able to work in any ***gainful employment*** for which they:

      A. are reasonably suited by education, training or experience; or

      B. may become reasonably suited due to ***reasonable retraining or rehabilitation***.

Part 2 – Incapable of ever (any occupation)

An ***insured member*** satisfies all of the following a, b, c and d:

a. is aged 66 years or less on the ***event date***;

b. is ***gainfully working*** but has not worked for an average of at least 14 hours per week in the last six consecutive months (or the actual period of time the ***insured member*** worked if less than six consecutive months) immediately prior to:

   i. the ***event date***; or

   ii. the date the period of ***employer approved leave*** begins if the ***event date*** occurs during the period of ***employer approved leave***;

c. is following the advice of a ***medical practitioner*** in relation to their illness or injury for which they are claiming. The ***insured member*** must be at a stage where, despite any further treatment, their injury or illness is not expected to improve or recover sufficiently to enable a return to ***gainful employment***; and

d. based on medical or other evidence satisfactory to us and after taking into consideration ***other factors***,, solely because of injury or illness, the ***insured member***:

   i. has not worked during the entire ***waiting period***;

   ii. as at the ***date of disablement*** is incapable of ever working in any ***gainful employment*** for which they:

      A. are reasonably suited by education, training or experience; or

      B. may become reasonably suited due to ***reasonable retraining or rehabilitation***

Part 3 – Activities of daily work

An ***insured member*** satisfies all of the following a, b and c:

a. solely because of injury or illness, the ***insured member*** is totally and irreversibly unable to perform at least three ***activities of daily work***;

b. is following the advice of a ***medical practitioner*** in relation to their illness or injury for which they are claiming. The ***insured member*** must be at a stage where, despite any further treatment, their injury or illness is not expected to improve or recover sufficiently to enable a return to ***gainful employment***; and

c. based on medical or other evidence satisfactory to us and after taking into consideration ***other factors***, solely because of injury or illness, the ***insured member*** as at the ***date of disablement*** is incapable of ever working in any ***gainful employment*** for which they:

   i. are reasonably suited by education, training or experience; or

   ii. may become reasonably suited due to ***reasonable retraining or rehabilitation***

Part 4 – Normal domestic duties

An ***insured member*** satisfies all of the following a and b:

a. is following the advice of a ***medical practitioner*** in relation to their illness or injury for which they are claiming. The ***insured member*** must be at a stage where, despite any further treatment, their injury or illness is not expected to improve or recover sufficiently to enable a return to ***gainful employment***; and

b. based on medical or other evidence satisfactory to us and after taking into consideration ***other factors***, solely because of injury or illness, the insured member:

   i. has been unable to perform ***normal domestic duties***, leave their ***home*** unaided or work in any occupation during the ***waiting period***, and

   ii. as at the ***date of disablement*** is unlikely ever to be able to perform ***normal domestic duties*** or work in any ***gainful employment*** for which they:

      A. are reasonably suited by education, training or experience; or

      B. may become reasonably suited due to ***reasonable retraining or rehabilitation***

Part 5 – Mental health

An ***insured member*** satisfies all of the following a, b, c, d and e:

a. the ***insured member's*** mental health condition has been diagnosed by a Psychiatrist using criteria outlined in the ***DSM***;

b. has not worked any time for 12 consecutive months (this 12 months does not apply where the ***insured member*** is suffering one or more of the ***specific medical conditions***) from the ***event date*** due to the mental health condition;

c. has been under the regular ongoing and appropriate care of a Psychiatrist for at least 12 months (unless we agree a shorter period) who considers that the ***insured member*** has exhausted all reasonable and appropriate treatment options;

d. has been assessed by a Psychiatrist approved by us under the Psychiatric Impairment Rating Scale as having an impairment of 19% or above; and

e. based on medical or other evidence satisfactory to us and after taking into consideration ***other factors*** solely because of the mental health condition, the ***insured member*** is incapable of ever working in any ***gainful employment*** for which they:

   i. are reasonably suited by education, training or experience; or

   ii. may become reasonably suited due to ***reasonable retraining or rehabilitation***

We may waive the ***waiting period*** and provide immediate assessment where an ***insured member*** is suffering ***specific medical conditions*** and all claim requirements have been received by us.

Total and Permanent Disability Benefit/TPD Benefit means the amount specified in the ***policy schedule*** in relation to the ***insured member*** as at the ***event date***, as varied by any ***decision note*** we issue in respect of an individual ***insured member*** (if any).

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

Transferred cover means cover that the ***insured member*** wishes to transfer into the ***policy*** in accordance with clause 2.17.

Unit based cover means cover that is based on a number of units, where one unit represents a set amount at a certain age.

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.

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 means a 91 consecutive day period.

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 ***terminally ill*** and ***terminal illness***.

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