Flexible Lifetime® – Protection Product Disclosure Statement

Issued 20 May 2013

protect those you love
with the one who's

always

been there

® Registered trade mark

About AMP

AMP has been insuring Australians for more than 160 years, and we are now the largest independent wealth management company in Australia and New Zealand.

AMP now protects and helps more than 4 million customers in Australia and New Zealand, and employs 6,200 employees across Australia, New Zealand, and Asia.

We understand that insurance is all about peace of mind and are committed to being a financially responsible insurer. We want to ensure our customers are looked after should the unthinkable happen to them.

AMP insurance exists to provide a safety net for our customers when they need it. In 2012, AMP paid $726.8 million in claims to our customers.

We strive to provide insurance that secures your tomorrow by protecting what you have today.

The issuers

The insurance products referred to in this document are issued by AMP Life Limited ABN 84 079 300 379, AFS Licence No. 233671 (AMP Life). The superannuation product referred to in this document (see page 27) is issued by AMP Superannuation Limited ABN 31 008 414 104, AFS Licence No. 233060 (Trustee).

AMP Life and the Trustee are the joint issuers of this Product Disclosure Statement. Each issuer takes full responsibility for the whole of this document. However, an issuer is not responsible for the products issued by the other issuer.

No other company in the AMP group guarantees the performance of AMP Life's or the Trustee's obligations to customers or assumes any liability to customers in connection with the products.

The meaning of words used in this document

Throughout this document:

– 'AMP Life', 'we', 'us' and 'our' means AMP Life Limited, and

– 'you', 'your' and 'yourself' means the plan owner (or, where cover is acquired through the AMP Superannuation Savings Trust, the insured person, except that any benefit payment will be made by AMP Life to the Trustee).

We use other terms that have specific meanings. These words and their meanings are set out in the dictionary on pages 65 to 74.

This offer is available only to persons receiving it (including electronically) within Australia. We can't accept cash or applications signed and mailed from outside Australia. Monies received or paid must always be in Australian dollars.

Financial Review Smart Investor Blue Ribbon Awards 2012 – Trauma Cover Optimum has been named winner in the category for Trauma insurance in 2010 and 2012.

Changes to the information in this document

As the information in this document may change from time to time, you can obtain updated information simply by visiting **amp.com.au/pdsupdates** or by calling us on 133 888 to request a free paper copy of the updated information. If the change to the information is materially adverse, we will issue a Supplementary Product Disclosure Statement.

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About Flexible Lifetime – Protection

Flexible Lifetime – Protection offers a range of plans that can be tailored to meet your personal insurance needs, helping secure your tomorrow by protecting what you have today. This summary will help you understand the types of insurance cover offered and what solution they offer if you need to make a claim.

Life Protection Plan see page 8

There are 3 types of cover available under the Life Protection Plan: Death cover, Total and Permanent Disablement (TPD) cover and Trauma cover.

You can apply for one or more of the covers under one plan as well as the Children's Trauma cover option (see page 24).

Death cover or Death and TPD cover are also available through the AMP Superannuation Savings Trust.

Type of cover	Why do I need it?	Key benefits payable
Death cover	You may want to take out Death cover to ensure that, if you die, your mortgage and other debts are paid off and your loved ones are provided with the income they need to continue their lifestyle.	A lump sum is payable if the insured person dies. We will advance the Death cover insured amount if the insured person is diagnosed as being terminally ill.
Total and Permanent Disablement (TPD) cover	Money is the last thing you would want to think about when faced with a life long disability. An emotional strain can be placed on a family to provide support to someone who may need full-time care and may never be able to work again.	A lump sum is payable if the insured person becomes totally and permanently disabled.
Trauma cover	Nobody likes to think about the possibility of experiencing a serious illness or injury in the future. You can't foresee this happening, but you can make plans to help support yourself should the unexpected happen. Trauma cover can help you make the adjustments to your lifestyle that you may need to make after experiencing a serious illness or injury.	A lump sum is payable if the insured person experiences a specified trauma condition, or undergoes a specified medical procedure, and survives 14 days.

Income Protection Plan see page 34

Type of cover	Why do I need it?	Key benefits payable?
Income Protection	Income protection can help you continue paying your day-to-day living expenses while you are too ill or injured to go to work.	A monthly benefit is payable while the insured person is totally or partially disabled due to an illness or injury.

Business Overheads Insurance Plan see page 51

Type of cover	Why do I need it?	Key benefits payable
Business Overheads Insurance	Business Overheads Insurance can help keep your business going while you are too ill or injured to go to work.	Reimbursement of eligible business expenses while the insured person is totally or partially disabled due to an illness or injury.

The above gives you a general idea about what each cover is designed to do. However, it is important that you read on so that you understand all of the terms and conditions of the cover.

As Flexible Lifetime – Protection is not a savings product, if you end a plan at any time after the 28 day money back guarantee period (see page 5), you won't receive any money back (except in the limited circumstances set out on page 61 – Refund of premiums). Your plan does not entitle you to share in any profits of AMP Life.

Types of claims paid by AMP in 2012

In 2012, we paid more than $726 million in claims across our entire policy range – trauma, death, terminal illness, total and permanent disability and income protection

Our claims philosophy

Our service is fair, ethical and transparent. We have a duty to you and each of our clients to thoroughly assess each claim application based on the terms and conditions of their policy and on thoughtful and reasonable assessment of the evidence presented on acceptance of insurance cover and at time of claim.

Death claims

Accidents	6.8%
Cancer	28.2%
Central Nervous System Disease	1.1%
Heart Attack	5.0%
Heart Disease	8.3%
Other and Natural Causes	36.1%
Other Disease of the Digestive tract	1.8%
Respiratory System Disease	6.5%
Stroke	1.9%
Suicide	4.3%

Trauma claims

Accidents	1.0%
Bowel Cancer	7.0%
Breast Cancer	22.9%
Other Cancers	30.7%
Central Nervous System Disease	4.5%
Heart Attack	9.8%
Heart Disease	8.5%
Prostate Cancer	6.8%
Stroke	3.8%
Other	5.1%

Total and Permanent Disablement claims

Accidents	25.0%
Breast Cancer	1.3%
Other Cancers	10.9%
Central Nervous System Disease	14.1%
Heart Disease	3.2%
Mental Illness	10.3%
Musculoskeletal	12.2%
Prostate Cancer	1.3%
Stroke	7.7%
Other	14.0%

Income Protection and Business Overheads Insurance claims

Accidents	27.3%
Bowel Cancer	1.3%
Breast Cancer	1.3%
Other Cancers	7.0%
Central Nervous System Disease	2.8%
Heart Attack	1.6%
Heart Disease	2.5%
Mental Illness	14.4%
Musculoskeletal	18.7%
Prostate Cancer	1.7%
Respiratory System Disease	1.3%
Stroke	1.6%
Other	18.5%

The 5 steps to applying for Flexible Lifetime – Protection

Step 1

Making an informed decision

This document sets out important information that you should know about Flexible Lifetime – Protection, including the benefits, features and options available under each plan. You should consider this document before applying for a plan.

The information in this document doesn't take into account your personal objectives, financial situation and needs. We encourage you to speak with your financial planner to help you decide which plan, and which insurance options within a plan, are suited to your circumstances and needs. If you are applying for cover as the trustee of a Self-Managed Superannuation Fund or small APRA fund, you should be aware of some important information which is set out on page 33.

Step 2

Finding out how much your insurance will cost

You can obtain an individual premium quote from your financial planner or by calling AMP on 1300 360 838.

Step 3

Completing your application for insurance

To apply for insurance we require you to complete an application. We also require a personal statement for each insured person. **Before you apply for cover, it is important that you understand your Duty of Disclosure (see page 64)**.

We provide the following flexible options for you to complete the application and personal statement:

Electronic	Telephone	Paper
You can complete and lodge your application and personal statement electronically with your financial planner.	Your financial planner can lodge your application and arrange for AMP to call you so that you can complete your personal statement over the phone at a time convenient to you.	An application form and a personal statement are included at the back of this document. You can complete them in writing and send them to us.

Step 4

The underwriting process

The process of underwriting takes place after you have submitted your application. Underwriting ensures that everyone insured with AMP pays an appropriate premium. To properly assess your application AMP may obtain information from a range of sources such as your doctor or may require you to have a medical examination or blood tests. In some cases we may offer insurance that is different to what you applied for or we may decline your application for insurance.

Interim Cover while we assess your application. We provide you with Interim cover at no extra cost, while your application is being assessed (see page 75).

Step 5

The Certificate of Insurance

If we agree to issue a plan, we will issue a Certificate of Insurance. The Certificate of Insurance, together with this document, is the contract of insurance between you and us. This document will set out the insured persons, the type of cover for each insured person, the insured amounts, the options selected and other important information about the plan.

Our commitment to you

Know exactly what you're getting	We have included the plan rules in this document so that you know the exact terms of the insurance before you apply.
28 day money back period	If we accept your application for insurance cover, we will send you a Certificate of Insurance. You have 28 days to check that the insurance meets your needs. If it doesn't, simply write to us requesting that your plan be cancelled and return the Certificate of Insurance. Your premium will be refunded in full. You cannot return your plan if you have exercised any rights or powers available under it. If insurance cover is acquired through the AMP Superannuation Savings Trust, the refund must be paid to another complying superannuation fund (see page 61 for more information).
Keeping you informed	Each year, we will send you an Annual Statement advising you about your insurance, fees and premiums for the next year. If you have changed occupation, ceased smoking or have experienced an improvement in health this may be an opportunity to be re-assessed and obtain a premium reduction. You can also get up-to-date information about your plan online. To register, visit **amp.com.au** and select 'My Portfolio' from the online services menu.
Automatic plan enhancements	Our products are reviewed on a regular basis to ensure you receive competitive cover. If we enhance your plan without changing premium rates, we will automatically provide you the enhancements for which you are eligible at no extra charge.
Feel secure – anywhere in the world	An insured person is covered worldwide, 24 hours a day, 7 days a week. For Income Protection and Business Overheads Insurance, benefit payments may stop after 3 months unless the insured person returns to Australia or New Zealand (see pages 40 and 54).
Guaranteed renewable cover	As long as you pay premiums when they are due, we guarantee to continue cover until the cover ends, regardless of changes to the insured person's health, occupation or pastimes. Different rules apply to Income Protection Basic plans (see page 50).
Supportive claims service	We are committed to paying all genuine claims in a professional empathetic manner and providing a supportive claims service. If you need to make a claim we have specially trained claims staff who will be ready to assist you. Either you or an authorised representative can call your financial planner or call us, to begin this process. See 'Claiming a benefit' on page 63.
Customer satisfaction	If you have a question, please contact us. Our details are on the back cover. We aim to provide products and services that exceed your expectations. If we don't meet your expectations, please tell us. We hope that we can resolve the issue when you contact us. If we can't, we'll aim to give you a response within 10 working days. We will keep you advised at regular intervals of the status of your complaint. If we can't resolve your complaint to your satisfaction within 45 days, then you may have the right to lodge a complaint with the Financial Ombudsman Service: GPO Box 3, Melbourne Victoria 3001. Phone: 1300 78 08 08 Fax: 03 9613 6399 Email: info@fos.org.au Website: **fos.org.au** If you have a plan acquired through the AMP Superannuation Savings Trust, please see page 31 for information about the Trustee's complaints process.
Respecting your privacy	Your privacy is important to us. See page 64 for information about how we handle your personal information.

About the Life Protection Plan

The Life Protection Plan offers flexible solutions to provide insurance that secures your tomorrow by protecting what you have today. You can structure your plan to meet your needs and help you build a secure future.

Flexibility to tailor a plan that meets your needs

The Life Protection Plan gives you choices – so you have the flexibility to tailor a plan that suits your needs. This section sets out the choices available to you. Cover is subject to us accepting your application for insurance.

What cover suits your needs?

There are 3 types of cover available under the Life Protection Plan. You can include any one or more of the following types of cover under the one Life Protection Plan:

Death cover	Total and Permanent Disablement (TPD) cover	Trauma cover	
(see page 9)	(see page 12)	**Standard** (see page 17)	**Optimum** (see page 18)

If the Life Protection Plan is acquired through the AMP Superannuation Savings Trust, the plan must include Death cover, and may also include TPD cover. Trauma cover is not available through the AMP Superannuation Savings Trust.

Who can own the plan?

The Life Protection Plan can be owned by:

An individual	Two individuals (as joint tenants)	A company

If you want a benefit paid under the Life Protection Plan to form part of your superannuation, you can select a superannuation trustee to own the plan. The trustee can be:

AMP Superannuation Limited, the trustee of the AMP Superannuation Savings Trust	A trustee of a Self-Managed Superannuation Fund or a small APRA superannuation fund

If you choose AMP Superannuation Limited to be the owner of the Life Protection Plan, you must first become a member of the AMP Superannuation Savings Trust (see page 27).

If you choose the trustee of a Self-Managed Superannuation Fund or a small APRA superannuation fund to be the owner of the Life Protection Plan, please read the important information on page 33.

Who can be an insured person?

The 'insured person' is the person whose life is covered under the Life Protection Plan. There can be more than one insured person under the Life Protection Plan (up to a maximum of 19 covers).

If the Life Protection Plan is acquired through the AMP Superannuation Savings Trust, there can only be one insured person.

The insured person must be within the ages set out in the table on page 8 when you apply for cover.

How do you want to structure your plan?

If you select more than one type of cover for the same insured person under the Life Protection Plan, you can choose to make the covers either Stand Alone or Linked. Stand alone cover generally has a higher premium than Linked cover.

Stand alone	Linked
If we pay a benefit under one type of cover (for example Trauma cover), it does not reduce the insured amount of any other cover (for example Death cover) for the insured person under the Life Protection Plan.	If we pay under one type of cover (for example Trauma cover), the insured amount of each remaining type of cover (for example Death cover) is reduced by the amount we pay.

How much cover can you apply for?

The maximum insured amount that you can currently apply for is:

Death cover	TPD cover	Trauma cover
No maximum	$5 million	$2 million

The above amounts are inclusive of all cover you may have with any insurer at the time you apply for cover or an increase in cover. The insured amounts may increase above these maximums during the term of your plan under the Indexation feature (see page 22).

Minimum insured amounts

The minimum insured Trauma cover amount that you can currently apply for is $10,000. There is no minimum insured amount for Death cover or TPD cover.

What type of premium works for you?

You can choose either a Stepped premium or Level premium (see page 61).

If you choose a Level premium, the premium will automatically change to Stepped from the plan anniversary after the insured person turns 64.

Do any optional benefits and features suit your needs?

Additional premium options can be added to your plan. The optional benefits and features available under each type of cover are set out as follows:

- Death cover – page 9
- TPD cover – page 12
- Trauma cover – page 16.

Life Protection Plan Snapshot

Features and benefits	Death cover	Death cover acquired through the AMP Superannuation Savings Trust	TPD cover	TPD cover acquired through the AMP Superannuation Savings Trust	Trauma cover
Death benefit	✓	✓			
Terminal Illness benefit	✓	✓			
Funeral benefit	✓				
Nomination of beneficiaries	✓	✓			
TPD benefit			✓	✓	
TPD Partial benefit			✓		
TPD Plus option (i)			✓	✓	
Own Occupation option (i)			✓	✓	
Trauma benefit					✓
Partials Package option (i)					✓
Optimum Trauma Reinstatement option (i)					✓
Optimum Buy Back option (i)					✓
Financial Planning benefit	✓		✓		✓
Guaranteed Future Insurability feature	✓	✓	✓	✓	✓
Indexation feature	✓	✓	✓	✓	✓
Business Safeguard option (i)	✓		✓		
Waiver of Premium option (i)	✓	✓	✓	✓	✓
Accommodation benefit	✓		✓		✓
Death benefit feature			✓	✓	✓
Children's Trauma cover option (i)	✓		✓		✓

(i) This is an additional premium option. It only applies if it is shown in the Certificate of Insurance for the insured person.

Life Protection Plan – Facts

Entry ages and cover expiry age

Cover type	Entry age of the insured person		Expires on the plan anniversary after the insured person turns
	Stepped premiums	Level premiums	
Death cover	10–74	10–59	99
Death cover through the AMP Superannuation Savings Trust	10–64	10–59	74
TPD cover	15–59		99
TPD cover through the AMP Superannuation Savings Trust	15–59		74
Trauma cover Standard	13–59		74
Trauma cover Optimum	13–59		99

Option	Entry age of insured person	Expires on the plan anniversary after the insured person turns
Children's Trauma cover option	1–12	16 (ii)
Business Safeguard option (i) (with Death cover)	15–59	65
Business Safeguard option (i) (with TPD cover)	15–54	65
Waiver of Premium option	10–54	59 (iii)
Waiver of Premium option through the AMP Superannuation Savings Trust	15–54	59 (iii)
TPD Plus option	15–59	64
Partials Package option (with Trauma cover Standard)	13–59	64
Partials Package option (with Trauma cover Optimum)	13–59	69
Optimum Buy Back option	13–59	64
Optimum Trauma Reinstatement option	13–59	64

The entry ages also apply to increases in cover and additions to existing plans.

(i) The Business Safeguard option is only available if the insured person's Death cover and/or TPD cover insured amount is $500,000 or more. This option is not available for an insured person with a premium loading or exclusion for health reasons.

(ii) The Children's Trauma cover option will convert to Death cover with linked Trauma cover Standard at expiry age (see page 25).

(iii) If we are waiving premiums for an insured person at the plan anniversary after their 59th birthday, we will continue to waive premiums until the plan anniversary after their 70th birthday, as long as they remain totally disabled (see page 23).

Taxation information

Are premium payments deductible?	Are benefit payments assessable for income tax?
Generally, Life Protection Plan premiums are not tax deductible. However, where a business arranges the Life Protection Plan to cover loss of revenue (profits), should an employee be covered under the plan, premiums may be tax deductible.	Generally, payment of the Death cover, TPD cover or Trauma cover insured amount will not attract income tax or capital gains tax (CGT). However: – when we pay the Death cover amount, CGT may apply if the plan owner is not the same person or entity as the plan owner when the Life Protection Plan began, – CGT applies to TPD cover and Trauma cover amounts we pay if the plan owner is not the insured person, or a relative (as defined for taxation purposes) of the insured person, – where a business arranges the Life Protection Plan to cover loss of revenue (profits), should an employee be covered under the plan, the amounts we pay will attract income tax.

Please see page 30 for information about the tax laws that apply to cover acquired through the AMP Superannuation Savings Trust.
We recommend that you speak to your accountant or tax adviser about your personal tax circumstances.

Plan Rules – Death cover

Benefits and features at a glance

The benefits and features of Death cover are listed below and are explained in detail on the pages listed below.

In-built benefits and features are shown below like this:	
Additional premium options can be added to Death cover. These options will only apply if they are shown in the Certificate of Insurance for the insured person, and are shown below like this:	
Some benefits and features do not apply if Death cover is acquired through the AMP Superannuation Savings Trust. These benefits and features are shown below like this:	⊘

Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see pages 65 to 74).

Key benefit

Death benefit
(see page 10)

Advanced payment benefits

We may advance payment of the Death cover insured amount under these benefits:

Terminal illness benefit (see page 10)	**Funeral benefit** (see page 10) ⊘

Additional benefits

The Financial Planning benefit and Accommodation benefit are in-built benefits and may be paid in addition to the above benefits. They are not available if the plan owner is the trustee of a self-managed or small APRA superannuation fund.

The Children's Trauma cover option is an additional premium option which can be added to Death cover, TPD cover or Trauma cover under a Life Protection Plan.

Financial Planning benefit (see page 21) ⊘	**Children's Trauma cover option** (see page 24) ⊘	**Accommodation benefit** (see page 23) ⊘

Features

Increasing cover features

These features allow the Death cover insured amount to be increased without providing evidence of the insured person's health or pastimes.

Indexation feature (see page 22)	**Guaranteed Future Insurability feature** (see page 21)	**Business Safeguard option** (see page 22) ⊘

Other features

Nomination of beneficiaries (see page 10)	**Waiver of Premium option** (see page 23)

24 hour, worldwide cover

Each insured person with Death cover is covered worldwide, 24 hours a day, 7 days a week.

Guaranteed renewable cover

As long as you pay premiums when they are due, we guarantee to continue Death cover until the cover ends (see page 11), regardless of changes in the insured person's health, occupation and pastimes.

⊘ Does not apply if cover is acquired through the AMP Superannuation Savings Trust.

Benefits and features explained

When we pay

We only pay a benefit under Death cover if the insured event happens after cover starts and before cover ends (see page 11).

We won't pay a benefit under Death cover in some circumstances (see 'When we won't pay' on page 11). Also, you must satisfy our claim requirements before we pay a benefit (see page 63).

Otherwise, we will pay a benefit under Death cover in the circumstances set out in this section and page 21.

Death benefit

We pay the Death cover insured amount if the insured person dies.

Terminal Illness benefit

We advance payment of the Death cover insured amount if the insured person, after the cover starts and before the cover ends, becomes terminally ill.

Terminally ill means that, as a direct result of any condition caused by an illness or injury, the insured person has a life expectancy of 12 months or less.

The prognosis must be:

- based on clinical findings and reports,
- provided in writing by an appropriately qualified doctor who is approved by us, and
- supported by additional evidence that we may require to agree with the prognosis.

We may also require you to give us information from medical advisers we choose.

The amount we pay under the Terminal Illness benefit is the Death cover insured amount on the date we agree with the doctor's prognosis. No Terminal Illness benefit will be paid if the Death cover has lapsed, been cancelled, or is otherwise not in force prior to this date.

On payment of the Terminal Illness benefit, Death cover for the insured person under the Life Protection Plan will end. If you have linked TPD cover and/or Trauma cover for the insured person, their TPD cover and/or Trauma cover insured amount/s will be reduced by the amount of the Terminal Illness benefit payable. You don't have to pay any more premiums for an insured person under the Life Protection Plan if we have paid the Terminal Illness benefit for that insured person.

Funeral benefit ⊘

We pay $20,000 (or the Death cover insured amount, if less) if:

- the Funeral benefit is claimed, and
- we receive a certified copy of the insured person's death certificate.

The Death cover insured amount reduces by the amount we pay under the Funeral benefit. We pay the balance of the Death cover insured amount (if any) if we accept the claim for the Death benefit.

We pay the Funeral benefit to:

- you, or
- if you have died, to your estate or to any person we are permitted to pay under the **Life Insurance Act** (which currently includes your spouse, defacto, child, parent or sibling, or a person who satisfies us that they are entitled to obtain probate of your Will).

Nomination of beneficiaries

If you are both the sole plan owner and sole insured person of the Life Protection Plan, you can nominate one or more beneficiaries to receive the Death benefit under the Life Protection Plan.

Your nomination will automatically be revoked if:

- you cease to be the sole plan owner or the sole insured person of the Life Protection Plan, or
- a nominated beneficiary dies before you (even if there are other surviving beneficiaries).

You can cancel your nomination at any time by writing to us.

If Death cover is acquired through the AMP Superannuation Savings Trust, we pay the Death Benefit to the Trustee. However, you can make a binding nomination or non-binding nomination through the AMP Superannuation Savings Trust. See page 28 for further information about who the Trustee will pay your Death benefit to.

Who we pay

Plan owner	Who we pay
Sole plan owner with no nominated beneficiary	If you are alive, we pay the Terminal Illness benefit or Death benefit to you. If you have died, we pay the Death benefit to your estate.
Sole plan owner with a nominated beneficiary(ies).	We pay the Terminal Illness benefit to you. We pay the Death benefit to your nominated beneficiary(ies).
Two individuals as joint tenants	If both plan owners are alive, we pay the Terminal Illness benefit or Death benefit to the joint plan owners. If an owner has died, we pay the Terminal Illness benefit or Death benefit to the surviving owner.
Trustee	The Trustee.

⊘ Does not apply if cover is acquired through the AMP Superannuation Savings Trust.

When we won't pay

Unless Death cover is Replacement cover (see below), we won't pay a benefit under Death cover for an insured person if the insured person dies, or becomes terminally ill, by their own hand (whether sane or insane at the time) within 13 months of the date the Death cover starts or the date the Death cover was last reinstated.

Also, if we increased the Death cover insured amount for the insured person because you asked us to, we won't pay the increased portion of the Death cover insured amount if the insured person dies, or becomes terminally ill, by their own hand (whether sane or insane at the time) within 13 months of the date of the increase. This does not apply to increases under the Indexation feature.

Replacement cover

If Death cover replaces Death cover issued by us, or another insurer, the 13 month period will not apply (but only up to the insured amount under the previous cover) if:

- you would have been entitled to claim under the previous cover had it not been replaced,
- the previous cover was in place at the time we issued the Death cover, and
- the previous cover was in place for a continuous period of at least 13 months.

For this exception to apply, we will require satisfactory evidence of the above at the time of any claim.

When Death cover ends

The Death cover under your Life Protection Plan for an insured person ends when one of the following happens:

- the insured person dies,
- we receive your written request to cancel the Death cover for that insured person,
- the insured person's Death cover reduces to nil because another benefit (for example, the Terminal Illness benefit or other linked benefits) becomes payable,
- the end date for the insured person's Death cover shown on the Certificate of Insurance,
- the plan anniversary after the insured person's 99th birthday, or if cover is acquired through the AMP Superannuation Savings Trust, the plan anniversary after the insured person's 74th birthday, or
- your Life Protection Plan ends (see page 26).

Plan Rules – Total and Permanent Disablement (TPD) cover

Benefits and features at a glance

The benefits and features of TPD cover are listed below and are explained in detail on the pages listed below.

In-built benefits and features are shown below like this:	
Additional premium options can be added to TPD cover. These options will only apply if they are shown in the Certificate of Insurance for the insured person, and are shown below like this:	
Some benefits and features do not apply if TPD cover is acquired through the AMP Superannuation Savings Trust. These benefits and features are shown below like this:	

Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see pages 65 to 74).

Key benefits

TPD benefit (see page 13)	**TPD Partial benefit** (see page 15)

Additional benefits

The Financial Planning benefit and Accommodation benefit are in-built benefits and may be paid in addition to the above benefits. They are not available if the plan owner is the trustee of a self managed or small APRA superannuation fund.

The Death benefit feature is an in-built feature.

The Children's Trauma cover option is an additional premium option which can be added to Death cover, TPD cover or Trauma cover under a Life Protection Plan.

Financial Planning benefit (see page 21)	**Children's Trauma cover option** (see page 24)
Accommodation benefit (see page 23)	**Death benefit feature** (see page 23)

Features

Increasing cover features

These features allow the TPD cover insured amount to be increased without providing evidence of the insured person's health or pastimes.

Indexation feature (see page 22)	**Guaranteed Future Insurability feature** (see page 21)	**Business Safeguard option** (see page 22)

Other features

TPD Plus option (see page 15)	**Own Occupation option** (see page 15)	**Waiver of Premium option** (see page 23)

24 hour, worldwide cover

Each insured person with TPD cover is covered worldwide, 24 hours a day, 7 days a week.

Guaranteed renewable cover

As long as you pay premiums when they are due, we guarantee to continue TPD cover until the cover ends (see page 15), regardless of changes to the insured person's health, occupation and pastimes.

Does not apply if cover is acquired through the AMP Superannuation Savings Trust.

Benefits and features explained

When we pay

We only pay a benefit under TPD cover if the insured event happens after cover starts and before cover ends (see page 15).

We won't pay a benefit under TPD cover in some circumstances (see 'When we won't pay' on page 15). Also, you must satisfy our claim requirements before we pay a benefit (see page 63).

Otherwise, we will pay a benefit under TPD cover in the circumstances set out in this section and page 23.

TPD benefit

When we pay

We pay you the TPD benefit if the insured person becomes totally and permanently disabled. The insured person must survive for 8 days from the occurrence of the illness or injury that directly or indirectly caused them to become totally and permanently disabled.

What does 'totally and permanently disabled' mean?

An insured person is totally and permanently disabled if they satisfy one of the parts of the definition of totally and permanently disabled in the table on page 14. However:

- part 1a of the definition of totally and permanently disabled does not apply to TPD cover acquired through the AMP Superannuation Savings Trust, and
- part 2 of the definition of totally and permanently disabled only applies if own occupation option is shown in the Certificate of Insurance for the insured person, and
- on and from the plan anniversary after the insured person's 64th birthday, the insured person is only totally and permanently disabled if they satisfy part 4, 5 or 6 of the definition of totally and permanently disabled.

Amount we pay

If we accept the claim because the insured person has satisfied Part 1a, 1b, 2 or 3 of the definition of 'totally and permanently disabled'	The TPD benefit we pay is a lump sum equal to the TPD cover insured amount that applies on the date 3 months after the insured person stopped performing home duties, regular remunerative work or their own occupation (as applicable).
If we accept the claim because the insured person has satisfied Part 4, 5, 6 or 7 of the definition of 'totally and permanently disabled'	The TPD benefit we pay is a lump sum equal to the TPD cover insured amount that applies on the date the insured person satisfies Part 4, 5, 6 or 7 of the definition of 'totally and permanently disabled' (as applicable).

We only pay the TPD cover insured amount once in respect of an insured person, even if the insured person satisfies two or more Parts in the definition of totally and permanently disabled.

If you have linked Death and/or Trauma cover for the insured person, their Death and/or Trauma cover insured amount(s) will be reduced by the amount of the TPD benefit payable and your premium will be reduced having regard to the reduced insured amount(s).

If you have any combination of linked Death, TPD and Trauma cover for the insured person and you are eligible for a benefit under two or all three types of cover at the same time for the same condition, we only pay a benefit under one type of cover. If the insured amounts are not equal, we pay a benefit under the cover which has the highest insured amount.

Totally and permanently disabled

Part 1a Unable to work

The insured person is totally and permanently disabled if:
- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in regular remunerative work for at least 3 months(i) in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in regular remunerative work:
  - for which they are reasonably fitted by education, training or experience, and
  - which allows them to earn greater than 25% of their pre-disability income.

(Regular remunerative work is defined on page 74).

(i) Upon admittance of your claim, we will refund any premiums falling due during this 3 month period that have been paid for the insured person.

Part 1b Unable to work

The insured person is totally and permanently disabled if:
- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in regular remunerative work for at least 3 months(i) in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in regular remunerative work for which they are reasonably fitted by education, training or experience. (Regular remunerative work is defined on page 74).

(i) Upon admittance of your claim, we will refund any premiums falling due during this 3 month period that have been paid for the insured person.

Part 2 Unable to work – Own occupation

Part 2 only applies if Own Occupation option is shown in the Certificate of Insurance for the insured person

The insured person is totally and permanently disabled if:
- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in their own occupation for at least 3 months(i) in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in their own occupation. (Own occupation is defined on page 73).

(i) Upon admittance of your claim, we will refund any premiums falling due during this 3 month period that have been paid for the insured person.

Part 3 Home Duties

The insured person is totally and permanently disabled if:
- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in their home duties for at least 3 months(i) in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever:
  a. engage in their home duties; or
  b. work in any occupation for which they are reasonably fitted by education, training or experience.

(Home duties is defined on page 73).

(i) Upon admittance of your claim, we will refund any premiums falling due during this 3 month period that have been paid for the insured person.

Part 4 Loss of use of limbs and/or sight

The insured person is totally and permanently disabled if they suffer from the total and irrecoverable loss of:
- the use of 2 limbs, or
- the sight of both eyes, or
- the use of one limb and the sight of one eye,

where a limb means the whole hand below the wrist or the whole foot below the ankle.

The loss must be unable to be remedied.

Part 5 Loss of independent living

The insured person is totally and permanently disabled if they become totally and permanently unable to perform at least 2 of the activities of daily living without assistance from someone else. ('Activities of daily living' is defined on page 72).

We will not pay for loss of independent living caused directly by alcohol or drug abuse.

Part 6 Loss of cognitive functioning

The insured person is totally and permanently disabled if they:
- suffer significant and permanent cognitive impairment with a loss of intellectual capacity, and
- are required to be under the continuous care and supervision of someone else.

Part 7 Day 1 TPD

If the insured person satisfied the definition in Part 1a, 1b, 2 or 3 as a result of one of the defined Listed medical conditions, we will waive the 3 month qualifying period.

The Listed medical conditions are:
- Alzheimer's disease and other dementias
- blindness
- cardiomyopathy
- paralysis – diplegia
- paralysis – hemiplegia
- paralysis – paraplegia
- paralysis – quadriplegia
- paralysis – tetraplegia
- loss of hearing
- loss of speech
- lung disease
- major head trauma
- motor neurone disease
- multiple sclerosis
- muscular dystrophy
- Parkinson's disease (advanced)
- primary pulmonary hypertension
- severe rheumatoid arthritis

Each of the Listed medical conditions are defined in the Trauma definitions section from page 65.

Does not apply if cover is acquired through the AMP Superannuation Savings Trust.

TPD Partial benefit

When we pay

We pay you the TPD Partial benefit for an insured person if they suffer total and irrecoverable loss of:

- the use of one limb (where a limb means the whole hand below the wrist or the whole foot below the ankle), or
- the sight of one eye, where visual acuity has reduced to 6/60 or less and the loss is unable to be corrected by glasses or any other means.

The loss must be unable to be remedied and the insured person must survive for 8 days after the loss.

We only pay the TPD Partial benefit once for each insured person. If the insured person's loss satisfies the conditions of both the TPD benefit and the TPD Partial benefit, we only pay you the TPD benefit.

Amount we pay

The TPD Partial benefit we pay is a lump sum equal to 25% of the TPD cover insured amount (up to a maximum of $500,000).

If the TPD Partial benefit is payable:

- the TPD cover insured amount for the insured person, and
- the insured amount(s) under any linked Death cover and/or Trauma cover,

will be reduced by the TPD Partial benefit payable, and your premium will be reduced having regard to the reduced insured amount(s).

TPD Plus option

This is an additional premium option which is available if the insured person's TPD cover is linked to Death cover. It only applies if it is shown in the Certificate of Insurance for the insured person.

Under this option, we will automatically restore the Death cover insured amount for an insured person to the amount that it was before it was reduced by payment of the TPD benefit. This option does not restore an insured amount because of a payment of the TPD Partial benefit.

You will not pay a premium for the restored amount for the remaining term of your Life Protection Plan, from the date we make the TPD benefit payment. However, you must still pay the premium for any amount of Death cover that exceeds the TPD amount.

We do not restore the Death cover insured amount if:

- the insured person dies within 8 days after we pay the TPD benefit, or
- we have paid a Terminal Illness benefit for the insured person.

The option ceases to apply on the plan anniversary after the insured person's 64th birthday.

Own Occupation option

This is an additional premium option. It only applies if it is shown in the Certificate of Insurance for the insured person.

This option is only available to certain occupations which include professional, white collar workers and light blue collar (trade and light manual) workers.

Under this option, you can claim the TPD cover insured amount if the insured person meets Part 2 in the definition of 'totally and permanently disabled' (see page 14).

When we won't pay

We will not pay a claim if the insured person's:

- total and permanent disablement (for a TPD benefit), or
- total and irrecoverable loss of the use of a limb or the sight of an eye (for a TPD Partial benefit),

was caused directly or indirectly by an intentional or deliberate act by you or the insured person.

If cover is acquired through the AMP Superannuation Savings Trust conditions may apply to when a claim may be paid directly to you (see Payment rules for Terminal Illness and TPD benefits on page 29).

When TPD cover ends

The TPD cover under your Life Protection Plan for an insured person ends when one of the following happens:

- the insured person dies,
- the TPD benefit for the insured person becomes payable,
- we receive your written request to cancel the TPD cover for the insured person,
- the insured person's TPD cover reduces to nil because another linked benefit becomes payable,
- the end date for that insured person's TPD cover shown on the Certificate of Insurance,
- the plan anniversary after the insured person's 99th birthday, or if cover is acquired through the AMP Superannuation Savings Trust, the insured person's 74th birthday,
- if you have acquired the TPD cover through the AMP Superannuation Savings Trust, the date your Death cover ends, or
- your Life Protection Plan ends (see page 26).

Does not apply if cover is acquired through the AMP Superannuation Savings Trust.

Plan Rules – Trauma cover

Benefits and features at a glance

The benefits and features of Trauma cover are listed below.

In-built benefits and features are shown below like this:

Additional premium options can be added to Trauma cover. These options will only apply if they are shown in the Certificate of Insurance for the insured person, and are shown below like this:

The benefits and features of Trauma cover are explained in detail on the pages listed below.

Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see page 65 to 74).

Key benefits

Trauma benefit (see page 17)	**Partials Package option** (see page 18)

Additional benefits

The Financial Planning benefit and Accommodation benefit are in-built benefits and may be paid in addition to the above benefits. They are not available if the plan owner is the trustee of a self managed or small APRA superannuation fund.

The Death benefit feature is an in-built feature.

The Children's Trauma cover option is an additional premium option which can be added to Death cover, TPD cover or Trauma cover under a Life Protection Plan.

Financial Planning benefit (see page 21)	**Children's Trauma cover option** (see page 24)
Accommodation benefit (see page 23)	**Death benefit feature** (see page 23)

Features

Increasing cover features

These features allow the Trauma cover insured amount to be increased without providing evidence of the insured person's health or pastimes.

Indexation feature (see page 22)	**Guaranteed Future Insurability feature** (see page 21)

Other features

Optimum Trauma Reinstatement option (Trauma cover Optimum only) (see page 19)	**Optimum Buyback option** (Trauma cover Optimum only) (see page 20)	**Waiver of Premium option** (see page 23)

24 hour, worldwide cover

Each insured person with Trauma cover is covered worldwide, 24 hours a day, 7 days a week.

Guaranteed renewable

As long as you pay premiums when they are due, we guarantee to continue Trauma cover until the cover ends (see page 20).

Not available through the AMP Superannuation Savings Trust

Benefits and features explained

When we pay

We only pay a benefit under Trauma cover if the insured event happens after cover starts and before cover ends (see page 20).

We won't pay a benefit under Trauma cover in some circumstances (see 'When we won't pay' on page 20). Also, you must satisfy our claim requirements before we pay a benefit (see page 63).

Otherwise, we will pay a benefit under Trauma cover in the circumstances set out in this section and page 23.

Trauma benefit

When we pay

We pay you the Trauma benefit if, after the cover starts and before the cover ends, the insured person:

- experiences a listed trauma condition or undergoes a listed medical procedure, and
- survives for 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure.

If the relevant trauma condition is coma, the insured person must survive for the additional period included within the definition of this condition (see page 67).

The trauma conditions and medical procedures covered differ depending on whether you have Trauma cover Standard or Trauma cover Optimum for the insured person:

- Trauma cover Standard covers 15 trauma conditions and medical procedures (see the table on this page). and
- Trauma cover Optimum covers 50 trauma conditions and medical procedures (see page 18).

The trauma conditions and medical procedures are defined on pages 65 to 72.

Amount we pay

The Trauma benefit we pay is a lump sum equal to the Trauma cover insured amount that applies on the date that the definition of the trauma condition or medical procedure is met.

We only pay the Trauma cover insured amount once in respect of an insured person, even if the insured person satisfies the definition of two or more trauma conditions (unless the Optimum Trauma Reinstatement option is exercised and the Trauma benefit again becomes payable – see page 19).

If you have linked Death and/or TPD cover for the insured person, the Death and/or TPD cover insured amount(s) for that insured person will be reduced by the amount of the Trauma benefit payable and your premium will be reduced having regard to the reduced insured amount(s).

If you have any combination of linked Death, TPD and Trauma cover for the insured person and you are eligible for a benefit under 2 or all 3 types of cover at the same time for the same condition, we only pay a benefit under one type of cover. If the insured amounts are not equal, we pay a benefit under the cover which has the highest insured amount (although, for the purposes of the Optimum Trauma Reinstatement option and the Optimum Buy Back option, if applicable, we will treat you as having been paid the Trauma benefit).

Trauma cover Standard

Trauma cover Standard covers the following trauma conditions and medical procedures:	
Cover for the trauma conditions and medical procedures in this column starts immediately	**Cover for the trauma conditions and medical procedures in this column is delayed for 3 months (as set out on page 20)**
Kidney failure	Aortic surgery
Major organ transplant	Cancer
Paralysis that is one of: – Diplegia – Hemiplegia – Paraplegia – Quadriplegia – Tetraplegia	Coronary artery surgery Heart attack – myocardial infarction Heart attack – out of hospital cardiac arrest Heart valve surgery Stroke
Peripheral blood stem cell or bone marrow transplant	
Under Trauma cover Standard, on and from the plan anniversary following the insured person's 64th birthday, the trauma conditions and medical procedures above will cease to be covered and will be replaced by: – loss of independent living, and – loss of use of limbs and/or sight.	

Trauma cover Optimum

Trauma cover Optimum covers the following trauma conditions and medical procedures:

Cover for the trauma conditions and medical procedures in this column starts immediately	Cover for the trauma conditions and medical procedures in this column is delayed for 3 months (as set out on page 20)
Alzheimer's disease and other dementias	Aortic surgery
Aplastic anaemia	Bacterial meningitis and meningococcal disease
Blindness	Benign tumour of the brain or spinal cord
Cardiomyopathy	Cancer
Coma	Coronary artery angioplasty – triple vessel
Diabetes	Coronary artery surgery
Encephalitis	Heart attack – myocardial infarction
Hepatitis B or C – occupationally acquired	Heart attack – out of hospital cardiac arrest
HIV/AIDS – medically acquired	Heart valve surgery
HIV/AIDS – occupationally acquired	Open heart surgery
Intensive care	Pneumonectomy
Kidney failure	Severe rheumatoid arthritis
Liver failure	Stroke
Loss of hearing	Systemic lupus erythematosus
Loss of independent living	
Loss of speech	
Loss of use of limbs and/or sight	
Lung disease	
Major head trauma	
Major organ transplant	
Motor neurone disease	
Multiple sclerosis	
Muscular dystrophy	
Myelodysplasia	
Myelofibrosis	
Paralysis that is one of: – Diplegia – Hemiplegia – Paraplegia – Quadriplegia – Tetraplegia	
Parkinson's disease (advanced)	
Peripheral blood stem cell or bone marrow transplant	
Peripheral neuropathy	
Primary pulmonary hypertension	
Severe burns	
Systemic sclerosis	

Under Trauma cover Optimum, on and from the plan anniversary following the insured person's 69th birthday, the only trauma conditions covered are:

- loss of independent living, and
- loss of use of limbs and/or sight.

At this time, cover for all other trauma conditions and medical procedures ends.

Partials package option

This is an additional premium option. It only applies if it is shown in the Certificate of Insurance for the insured person and the insured person's Trauma cover insured amount is at least $40,000.

We pay under the Partials package if the insured person:

- experiences a listed trauma condition or undergoes a listed medical procedure, and
- survives for 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure.

The Partial package covers the following trauma conditions and medical procedures:

Aortic surgery by minimal invasive techniques
Carcinoma in situ of breast
Carcinoma in situ of cervix uteri
Carcinoma in situ of fallopian tubes
Carcinoma in situ of ovary
Carcinoma in situ of penis
Carcinoma in situ of perineum
Carcinoma in situ of testes
Carcinoma in situ of uterus
Carcinoma in situ of vagina
Carcinoma in situ of vulva
Complications of pregnancy
Coronary artery angioplasty
Heart attack – partial payment
Heart valve surgery by minimal invasive techniques
Loss of use of one limb
Melanoma
Parkinson's disease
Partial blindness
Partial loss of hearing
Prostate cancer
Severe inflammatory bowel disease
Severe osteoporosis
Temporal arteritis
Type 1 Diabetes

Cover for Partial blindness, Partial loss of hearing and Loss of use of one limb commences immediately. However, cover for the other trauma conditions and medical procedures is delayed for 3 months (see page 20).

We may pay more than once under the Partials package option, although:

- for Coronary artery angioplasty, we only pay more than once where the procedure is at least 6 months after the previous Coronary artery angioplasty procedure, and
- otherwise, we will not pay more than once for a same specific trauma condition or medical procedure.

Amount we pay

Subject to the maximums below, the amount we pay under the Partials package for a trauma condition or a medical procedure is 25% of the Trauma cover insured amount.

The maximum amount we pay under the Partials package for a trauma condition or a medical procedure is:

For the following conditions: – Carcinoma in situ of uterus – Carcinoma in situ of fallopian tubes – Carcinoma in situ of vagina – Carcinoma in situ of vulva	25% of the Trauma cover insured amount
For Coronary artery angioplasty:	$50,000 per procedure
For Heart attack – partial payment	$50,000
For all other trauma conditions and medical procedures under the Partials package:	$25,000

If a benefit is payable under the Partials package:

– the Trauma cover insured amount for the insured person, and
– the insured amount(s) under any linked Death cover and/or TPD cover,

will be reduced by the benefit payable, and your premium will be reduced having regard to the reduced insured amount(s).

When cover under this option ends

Cover for an insured person under the Partials package ends when one of the following happens:

– the plan anniversary after the insured person reaches age:
  – 64, if you have Trauma cover Standard, or
  – 69, if you have Trauma cover Optimum
– the Trauma cover insured amount reduces to less than $40,000.

Optimum Trauma Reinstatement option (Trauma cover Optimum only)

This is an additional premium option. It only applies if it is shown in your Certificate of Insurance for the insured person.

This option allows you to restore Trauma cover after we have paid the Trauma benefit, without providing evidence of the insured person's health, occupation or pastimes. This option does not allow you to restore a benefit amount paid under the Partials package.

This option becomes exercisable one year after we pay the Trauma benefit. You must exercise the option within 30 days of the claim anniversary, by completing the relevant application form. We will send you notification when this option has become exercisable.

The premium for the reinstated Trauma cover will be based on our Trauma cover premium rates, and the insured person's age, applicable at the time of exercising this option, and taking into account any special conditions or premium loadings applying to the original Trauma cover.

We will not pay a claim under the reinstated Trauma cover if:

– the insured person experiences a trauma condition or undergoes a medical procedure for which we have already paid a Trauma benefit, or
– the insured person was diagnosed with, or experienced symptoms leading to diagnosis of:
  – a trauma condition, or
  – a medical condition,

  that became apparent between the date that we paid the Trauma benefit and the date Trauma cover is reinstated under the Optimum Trauma Reinstatement option, or
– a new trauma condition, or medical condition that a new medical procedure is intended to address, is directly or indirectly caused by or related to a trauma condition or medical procedure for which we have already paid a Trauma benefit, or
– the new trauma condition, or the new medical procedure, is directly or indirectly related to:
  – the treatment used for a previous trauma condition, or
  – a previous medical procedure, or
– the new trauma condition is for kidney failure or a heart condition and a previous Trauma cover payment was for systemic lupus erythematosus, or
– the new trauma condition is:
  – a heart condition
  – a stroke, or
  – paralysis (directly or indirectly resulting from a stroke),

  and previous Trauma cover payment was for a heart condition.

Please refer to page 73 for the definition of heart condition, page 73 for the definition of paralysis and page 71 for the definition of stroke.

When this feature ends

The Optimum Trauma Reinstatement option will end on the earlier of:

– the date the option is exercised
– the plan anniversary after the insured person turns 64, and
– the Optimum Trauma Reinstatement option end date shown in the Certificate of Insurance.

Optimum Buy Back option (Trauma cover Optimum only)

This is an additional premium option which is available if the insured person's Trauma cover is linked to Death cover. It only applies if it is shown in the Certificate of Insurance for the insured person.

This option allows you to restore Death cover for an insured person by the amount it was reduced after payment of the Trauma Benefit, without providing evidence of the insured person's health, occupation or pastimes. This option does not allow you to restore an insured amount because of a payment under the Partials package option.

This option becomes exercisable one year after we pay the Trauma benefit. You must exercise the option within 30 days of the claim anniversary by completing the relevant application form.

The premium for the restored Death cover will be based on our Death cover premium rates, and the insured person's age, applicable at the time of exercising this option, taking into account any special conditions or premium loadings applying to the original Death cover.

When this feature ends

The Optimum Buy Back option will end when one of the following happens:

- the plan anniversary after the insured person turns 64
- death cover for the insured person ends; or
- the Optimum Buy Back option end date shown in the Certificate of Insurance.

When we won't pay

We will not pay if the trauma condition, or if the purpose for the medical procedure, was caused directly or indirectly by an intentional or deliberate act by you or the insured person.

Delayed cover for some trauma conditions and medical procedures

Unless Trauma cover is Replacement Cover (see below), cover does not start for those trauma conditions and medical procedures which are expressed to be 'delayed for 3 months' until 3 months after:

- the Trauma cover start date
- an increase to the Trauma cover insured amount (other than an increase under the Indexation feature) in respect of the increased portion only
- the most recent reinstatement of Trauma cover.

This means that for those trauma conditions and medical procedures which are expressed to be 'delayed for 3 months':

- the trauma condition, or
- the medical condition which the medical procedure is intended to address,

must be diagnosed at least 3 months after the Trauma cover start date.

If the diagnosis occurs during this 3 months, we will never pay for that trauma condition or medical procedure under the Life Protection Plan, even if the insured person experiences the same trauma condition again or undergoes the same medical procedure again.

Replacement cover

If Trauma cover replaces trauma cover issued by us, or another insurer, the 3 month delayed start date will not apply (but only up to the insured amount under the previous cover) if:

- you would have been entitled to claim under the previous cover for the same trauma condition or medical procedure had it not been replaced
- the previous cover was in force at the time we issued the Trauma cover, and
- the previous cover was in place for a continuous period of at least 3 months.

We will require satisfactory evidence of the above points at the time of any claim for this exception to apply.

When Trauma cover ends

The Trauma cover under your Life Protection Plan for an insured person ends when one of the following happens:

- the insured person dies
- a Trauma benefit for the insured person becomes payable
- we receive your written request to cancel the Trauma cover for the insured person
- the insured person's Trauma cover reduces to nil because another linked benefit becomes payable
- the end date for that insured person's Trauma cover shown on the Certificate of Insurance
- the plan anniversary after the insured person's 74th birthday for Trauma cover Standard or the insured person's 99th birthday for Trauma cover Optimum, or
- your Life Protection Plan ends (see page 26).

Plan Rules – Additional benefits, features and options under the Life Protection Plan

Financial Planning benefit

We will reimburse the cost of financial planning advice up to $2,000 (in addition to the amount of the benefit we paid) if you are eligible for a benefit under the Life Protection Plan. Evidence of this expense must be produced in a form we accept and the financial advice must come from a suitable and qualified person we accept.

If there is more than one recipient of a benefit, we divide the Financial Planning benefit equally between the recipients.

This benefit is payable only once for each insured person under all plans with AMP and must be claimed within 12 months of the claim being paid.

Guaranteed Future Insurability feature

You can increase the Death cover and/or TPD cover and/or Trauma cover insured amount for an insured person without providing evidence of the insured person's health, occupation or pastimes when one of the following happens:

- the insured person marries, registers a de facto relationship or enters into a de facto agreement
- the insured person divorces, legally separates, registers a separation from a marriage or registered de facto relationship or cancels a de facto agreement
- the death of the insured person's spouse or registered de facto partner or a de facto partner who has entered into a de facto agreement with the insured person
- the insured person's child is born or they legally adopt a child
- the insured person's child starts school
- the insured person is granted a housing loan by a financial institution to buy their first home
- the insured person increases their mortgage for their primary place of residence
- the insured person completes their first undergraduate degree at a recognised Australian university
- the insured person is promoted or commences a new employment arrangement and as a result has an annual income increase of at least $10,000 and 10%
- the insured person becomes a carer for the first time
- the insured person increases their financial interest in a business for which they are a working partner or a working director, and the Life Protection Plan forms part of a buy/sell, share protection or business succession agreement
- where the insured person is a key person in a business, the business owns the plan, which was written for the purpose of key person protection, and their value as a key person to that business increases, or
- the insured person takes out or increases a loan secured over the business for which the insured person is the primary guarantor and the Life Protection Plan was written for loan protection.

You can only increase the insured amount once under this feature in any 12 month period for each type of cover under the Life Protection Plan. You must apply for the increase within 12 months of the date the event occurs and provide appropriate proof of the event that we accept (such as certification of the event or a statutory declaration).

Maximum increases

You may increase the insured amount by up to 25% (up to a maximum of $250,000) at any one time. Premiums will be based on our premium rates, and the insured person's age, applicable at the time of exercising this feature.

The maximum amount by which you can increase an insured person's Death cover insured amount under this feature over the term of the Life Protection Plan is the original Death cover insured amount (to a maximum of $1,000,000).

The maximum amount by which you can increase an insured person's TPD cover insured amount under this feature over the term of the Life Protection Plan is the original TPD cover insured amount (to a maximum of $250,000). The maximum amount you can increase TPD cover to through this feature is $2.5 million.

The maximum amount by which you can increase an insured person's Trauma cover insured amount under this feature over the term of the Life Protection Plan is the original Trauma cover insured amount (to a maximum of $250,000). The maximum amount you can increase Trauma cover to through this feature is $2 million.

If you apply to increase Death, TPD and/or Trauma cover under this feature, as a result of an increase to the insured person's mortgage, the maximum increase will also be limited to the amount the mortgage is increased by.

If you apply to increase Death, TPD and/or Trauma cover under this feature, as a result of a promotion or commencement of a new employment arrangement, the maximum increase will also be limited to 10 times the salary increase.

Does not apply if cover is acquired through the AMP Superannuation Savings Trust or the Life Protection Plan is owned by a self-managed or small APRA superannuation fund.

When you can not take out this feature

You cannot take out this feature for an insured person if at the time of your request:

- the insured person is age 55 or more, or
- the insured person's cover has:
  - more than one exclusion, or
  - a premium loading of more than 50%, or
  - any other special terms, or
- the insured person's premiums are being waived under the Waiver of Premium option, or
- a person is eligible to make, or has made, a terminal illness, TPD or trauma claim under any AMP plan in relation to the insured person.

This feature does not apply to:

- the Children's Trauma cover option
- the Death cover insured amount restored after exercising the TPD Plus option
- the Death cover insured amount restored after exercising the Optimum Buy Back option, or
- the Trauma cover insured amount reinstated after exercising the Optimum Trauma Reinstatement option.

Indexation feature

Each year, unless otherwise agreed, on the plan anniversary we will increase the insured amounts for all insured persons under the Life Protection Plan by the higher of:

- the percentage increase in the CPI (see page 72) since the last plan anniversary (or since the plan start date if this is the first plan anniversary under the Life Protection Plan), and
- 5%.

We will notify you of the increase in the Annual Statement we send you each year. You must tell us if you do not want this increase, in full or in part.

The Indexation feature ceases to apply to an insured person on the plan anniversary after age 74 for Death cover, TPD cover and Trauma cover.

The Indexation feature does not apply to:

- the $25,000 Death cover insured amount under Children's Trauma cover option (see page 24),
- the Death cover insured amount restored as a result of exercising the TPD Plus option (see page 15),
- the Death cover insured amount restored as a result of exercising the Optimum Buy Back option (see page 20), or
- the Trauma cover insured amount reinstated as a result of exercising the Optimum Trauma Reinstatement option (see page 19).

Business Safeguard option

Business Safeguard option does not apply to Trauma cover.

This is an additional premium option. It only applies if it is shown in the Certificate of Insurance for the insured person.

This option is designed to be used for business purposes such as:

- business succession planning (buy/sell agreement)
- loan guarantor insurance, and
- key person insurance.

The option allows you to apply to increase the Death cover insured amount and/or TPD cover insured amount for an insured person, without providing evidence of the insured person's health or pastimes. You can apply to increase the insured amount for an insured person under this option by:

- if the insured person is a key person to the business – the actual increase in the value of the insured person to the business since the latter of the last time the option was exercised and the commencement of the option, or
- if the Life Protection Plan forms part of a written buy/sell, share purchase or business continuation agreement – the actual increase in the value of the insured person's interest in the business since the latter of last time the option was exercised and the commencement of the option.

This option is only available if the insured amount is $500,000 or more.

Before we increase the level of cover for an insured person under this option, we may require financial evidence of the increase in the value of the business from an appropriate person (eg an independent qualified accountant or business valuer) we approve.

If we increase the insured amount for an insured person under this option, your premium will increase in line with the higher level of cover.

When does the option end?

The Business Safeguard option for Death cover or TPD cover (as applicable) ends when one of the following happens:

- you do not exercise this option under Death cover or TPD cover (as applicable) for 5 years
- the 10th anniversary of the commencement of this option under Death cover or TPD cover (as applicable)
- the insured person turns 65
- for Death cover, the Death cover insured amount reaches 5 times the original insured amount (up to a maximum of $15 million)
- for TPD cover, the TPD cover insured amount reaches 5 times the original insured amount (up to a maximum of $2.5 million), or
- a person has made, or is eligible to make, a terminal illness, trauma or TPD claim in respect of the insured person under any plan with us.

Does not apply if cover is acquired through the AMP Superannuation Savings Trust.

Waiver of Premium option

This is an additional premium option. It only applies if it is shown in your Certificate of Insurance for the insured person.

You can choose one of the following 2 types of Waiver of Premium option:

- **Individual Life** – you do not have to pay the Life Protection Plan premium (including the plan fee) for a particular insured person if they become totally disabled before the plan anniversary after their 59th birthday and while they continue to remain totally disabled, or
- **Nominated Life** – you do not have to pay the Life Protection Plan premium (including the plan fee) for all insured persons if the nominated insured person is totally disabled before the plan anniversary after their 59th birthday and while they continue to remain totally disabled.

The option will cease to apply to your Life Protection Plan on the plan anniversary after the insured person's 59th birthday. However, if we are waiving premiums at that plan anniversary, we will continue to waive your premiums until the plan anniversary after the insured person's 70th birthday (providing they remain totally disabled).

What does 'totally disabled' mean?

An insured person is totally disabled if they are unable, due to injury or illness, to engage in any regular remunerative work for which they are reasonably fitted by their education, training or experience for a continuous period of more than 6 months. Please see page 74 for the meaning of 'regular remunerative work'.

Individual Life option

Under this option, the cover for the insured person continues, even though we waive the premiums for that insured person. Further, the premium you paid during the 6 months while we determined if the insured person was totally disabled will be refunded to you. However, if cover is acquired through the AMP Superannuation Savings Trust, the Trustee will pay this refund into a complying superannuation fund nominated by the member or an account in the AMP Eligible Rollover Fund established on behalf of the member.

You must restart paying the premium for the insured person when one of the following happens:

- as soon as the insured person stops being totally disabled
- the date Death cover ends for the insured person, or
- the plan anniversary after the insured person's 70th birthday.

Nominated Life option

Under this option, the cover for all the insured persons continues, even though we waive the premiums for all insured persons if the nominated insured person is totally disabled. Further, the premium you paid during the 6 months while we determined if the nominated insured person was totally disabled will be refunded to you.

You must restart paying your premium when one of the following happens:

- the nominated insured person is no longer totally disabled
- the date Death cover ends for the nominated insured person
- the plan anniversary after the nominated insured person's 70th birthday, or
- if the nominated insured person dies.

Accommodation benefit

We pay the Accommodation benefit to reimburse the reasonable accommodation expenses, once receipts are provided, of an immediate family member of the insured person who accompanies the insured person if the insured person:

- is eligible to claim a benefit under the Terminal Illness benefit, TPD benefit, TPD Partial benefit, Trauma benefit or Children's Trauma benefit option; and
- is bedridden; and
  - became totally disabled, and remains, over 100km away from their usual residence, or
  - the insured person needs to travel more than 100km from home for medical treatment, and
- requires an immediate family member to be with them.

We pay up to $250 per day for a maximum of 14 days.

This benefit is only payable once for each insured person under the Life Protection Plan and must be claimed within 6 weeks of the Terminal Illness, TPD or Trauma claim being paid.

Death benefit feature

This is an in-built feature of the Life Protection Plan with TPD or Trauma cover. This feature is only available if the insured person is not being provided with Death cover under this plan or any other plan where AMP Life is the insurer.

We pay under this Death benefit feature if the insured person dies while this plan is in force. We will pay $10,000 (or the TPD cover or Trauma cover sum insured if it is lower than $10,000) to you or the nominated beneficiary.

We will only pay once on the death of an insured person across all plans with AMP for that insured person. This feature must be claimed within 12 months of death.

This benefit is not payable if the insured person dies by their own hand within 13 months of the commencement or reinstatement of the Life Protection Plan, or if the insured person has made a claim under the Terminal illness benefit, TPD cover or Trauma cover.

Does not apply if cover is acquired through the AMP Superannuation Savings Trust or owned by a self-managed or small APRA superannuation fund.

Plan Rules – Children's Trauma cover option

This is an additional premium option. It only applies if it is shown in your Certificate of Insurance for the insured person. The insured person must be a child under the age of 16 years.

When we pay

We pay you a benefit under the Children's Trauma cover option if the insured person:

- experiences a listed trauma condition or undergoes a listed medical procedure, and
- survives for 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure.

We also pay a benefit under the Children's Trauma cover option if, after the cover starts and before the cover ends, the insured person dies or is terminally ill.

Terminally ill means:

- the insured person's doctor tells us in writing that they believe that the insured person has less than 12 months to live, and
- the doctor's prognosis is based on clinical findings and reports, and
- we agree with the doctor's prognosis.

We may also require you to give us information from medical advisers we choose.

The trauma conditions and medical procedures covered under Children's Trauma cover are set out in the table below.

Cover for the trauma conditions in the right hand column of the table is delayed for 3 months (as set out on page 20 under the heading 'Delayed cover for some trauma conditions and medical procedures').

Amount we pay

The amount we pay under the Children's Trauma cover option is:

- $100,000 (plus any increases under the Indexation feature) if the insured person experiences a listed trauma condition or undergoes a listed medical procedure and survives 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure, or
- $25,000 if the insured person dies or is terminally ill.

We only pay once under the Children's Trauma cover option, even if the insured person satisfies two or more definitions.

Children's trauma cover option covers the following trauma conditions and medical procedures	
Cover for the trauma conditions and medical procedures in this column starts immediately	**Cover for the trauma conditions in this column is delayed for 3 months (as set out on page 20)**
Benign tumour of the brain or spinal cord	Aplastic anaemia
Blindness	Bacterial meningitis and meningococcal disease
Coma	Cancer
Intensive care	Cardiomyopathy
Kidney failure	Leukaemia
Loss of hearing	Stroke
Loss of speech	Subacute sclerosing panencephalitis
Loss of use of limbs and/or sight	Viral encephalitis
Major head trauma	
Major organ transplant	
Paralysis that is one of: – Diplegia – Hemiplegia – Paraplegia – Quadriplegia – Tetraplegia	
Peripheral blood stem cell or bone marrow transplant	
Severe burns	

When we won't pay

We will not pay for a trauma condition or medical procedure for an insured person if:

- the insured person's trauma condition is caused directly or indirectly by, or the medical procedure is required directly or indirectly because of, any congenital condition, or
- the insured person's trauma condition, death or terminal illness is caused directly or indirectly by, or the medical procedure is required directly or indirectly because of:
  - alcohol or drugs, or
  - anybody who is connected to the insured person, or to either of their parents, or to a de facto spouse of either parent.

When Children's Trauma cover option ends

Cover for an insured person under the Children's Trauma cover option ends when one of the following happens:

- the first plan anniversary after the insured person's 16th birthday (see 'Conversion of cover' below)
- the insured person dies
- we receive your written request to cancel the Children's Trauma cover option for the insured person
- a benefit under the Children's Trauma cover option becomes payable for the insured person
- all cover for the last insured person under the Life Protection Plan (other than an insured person under this option) ends, or
- your Life Protection Plan ends (see page 26).

Conversion of cover

If cover for an insured person under the Children's Trauma cover option has not ended earlier, on the first plan anniversary after the insured person's 16th birthday, cover under the Children's Trauma cover option ceases and is then automatically converted to Death cover, with Linked Trauma cover Standard.

The Death cover and Trauma cover insured amount at that time will be equal to the Children's Trauma cover amount at the time of conversion (this includes any increases previously provided under the Indexation feature).

Any exclusions, loadings or other underwriting terms we have applied to the Children's Trauma cover option will continue on the converted cover.

General rules

Premiums and fees

See page 59.

When your plan and cover starts

Your Life Protection Plan starts on the date specified in the Certificate of Insurance. Your cover and any increase in the insured amount of your existing cover, starts on the date we notify you in writing.

When your plan ends

Your Life Protection Plan ends when one of the following happens:

- We receive your written request to cancel the Life Protection Plan,
- We cancel your Life Protection Plan because you have not paid your premium or any other amount payable under the plan,
- All covers for the last insured person end, or
- If you have a Life Protection Plan through the AMP Superannuation Savings Trust – you are no longer eligible to make superannuation contributions to the AMP Superannuation Savings Trust. (When this happens you can apply for a replacement option, as described under 'Replacement Option' on page 28).

We may also cancel your plan or cover for any reason the law permits. For example, if you do not comply with your duty of disclosure, we may cancel your plan or cover from the plan or cover start date and treat it as never having existed.

Reinstating the Plan

You may apply to have your plan reinstated if we cancel the plan because you have not paid your premium. You must apply within 12 months after the due date of the premium you did not pay.

We may reinstate your plan at our sole discretion and on any terms we determine at the time.

When you don't have to pay premiums

You don't have to pay premiums for an insured person under a Life Protection Plan if:

- we have paid the Terminal Illness benefit for that insured person, or
- your premiums are being waived under the Waiver of Premium option (see page 23).

You do not need to pay the premiums for Death cover for an insured person if their Death cover was reinstated as a result of exercising the TPD Plus option (see page 15).

Once we have accepted your claim for a benefit payment under the Life Protection Plan, we will refund any premiums for that cover that fell due since the date of the insured person's death or the date their injury or illness commenced.

Transfer of Ownership

You can transfer ownership of a Life Protection Plan that is not acquired through the AMP Superannuation Savings Trust.

To transfer ownership you must complete the transfer form on the last page of the Certificate of Insurance and send it to us, together with the Certificate of Insurance.

Ownership will transfer when we register the transfer. We will register the transfer if we have received all required information. After the transfer, we will only communicate with the new plan owner.

You can't transfer a Life Protection Plan acquired through the AMP Superannuation Savings Trust.

Life Protection Plan through the AMP Superannuation Savings Trust

What cover is available through the AMP Superannuation Savings Trust?

You can apply for Death cover only or Death and TPD cover through the AMP Superannuation Savings Trust under a Life Protection Plan. To have TPD cover, the Life Protection Plan must also have Death cover.

Any Death or TPD benefit you are eligible for under the Life Protection Plan is paid as a lump sum.

You must also become a member of the AMP Superannuation Savings Trust. AMP Superannuation Limited (Trustee), the trustee of the AMP Superannuation Savings Trust, will acquire the Life Protection Plan on your behalf and will be the owner of the plan. The Trustee is a wholly owned subsidiary of AMP Life Limited.

This section sets out:

- the types of contributions that can be made to pay the premium for your insurance cover
- when the Trustee will pay a benefit under the Life Protection Plan to you or a beneficiary
- information about nominating a beneficiary to receive a death benefit
- tax information
- what to do if you have a complaint, and
- general information about the Trustee.

Contributions

What contributions are accepted?

Having insurance in superannuation means that you have to satisfy superannuation contribution rules. The contributions that you make are used to pay the premium for your insurance cover. The following types of contributions can be made to the Fund:

Contribution type	Contribution description	You are under age 65	You are age 65 to under 70	You are age 70 to under 75
Member contributions	Contributions you as a member either pay from your after-tax income or which you personally claim as a tax deduction	At any time	Only if you are working at least on a part-time basis(i)	Only if you are working at least on a part-time basis(i)
Spouse contributions	Contributions your spouse pays into your plan. (Your spouse must not be entitled to a tax deduction for the contributions and must not live separately from you on a permanent basis).	At any time	Only if you are working at least on a part-time basis(i)	No spouse contributions accepted
Superannuation Guarantee (SG)(ii) and award/Industrial Agreement Employer contributions(iii)	Contributions an employer must pay under legislation, including contributions paid to comply with an award or industrial agreement.	At any time	At any time	Award/ Industrial Agreement Employer contributions at any time, and from 1 July 2013 SG contributions at any time.
Salary sacrifice and additional employer contributions	You may be able to arrange for your employer to make contributions to pay the premium for your insurance cover instead of paying you an equivalent amount of pre-tax salary. These 'salary sacrifice' contributions are treated as employer contributions. Your employer can also make employer contributions to your plan in addition to SG, Award/Industrial Agreement and Salary Sacrifice contributions.	At any time	Only if you are working at least on a part-time basis(i)(iii)	Only if you are working at least on a part-time basis(i)

(i) You are considered to be working on a part-time basis if, at the time the contribution is made, you have already worked at least 40 hours in a period of 30 consecutive days in that financial year.

(ii) Currently SG contributions end at age 70. However, from 1 July 2013, there will no longer be a maximum SG age limit.

(iii) The Life Protection Plan isn't designed to solely meet an employer's total SG obligations. Your employer may need to contribute to other superannuation products to meet their total SG obligations.

We do not accept transfers or rollovers from other superannuation funds as contributions.

Your contributions will be credited as premium payments to a life insurance policy with AMP Life to secure your benefits.

When contributions can be made

All types of contributions can be made into your plan if you are under age 65. From age 65, the contributions that can be made are set out in the table. If you don't satisfy these requirements the Trustee won't be able to accept your contributions. If the Trustee can't accept your contributions your cover will lapse, unless it is transferred to another AMP product.

Replacement option

You can continue your Death cover and/or TPD cover when you no longer can make contributions, by applying for a current Life Protection Plan or an equivalent plan without providing any evidence of health, occupation and pastimes. The new plan will be dependent on the terms and conditions applicable at the time.

Benefit payment rules

Who does the Trustee pay the Death benefit to?

You can nominate one or more beneficiary(ies) to receive your lump sum death benefit. Generally, all beneficiaries must be your dependants. A dependant includes:

- your spouse
- your child
- any person who is financially dependent on you, and
- any person with whom you have an interdependency relationship under law.

A spouse includes your husband or wife, another person whether of the same sex or different sex registered on the relationship registers of certain States or Territories (which at the date of this document are Victoria, Tasmania, the Australian Capital Territory, New South Wales and Queensland), or another person who, although not legally married to you, lives with you on a genuine domestic basis in a relationship as a couple. For tax purposes, a former spouse is also a dependant.

A child includes an adopted child, a stepchild or an ex-nuptial child, a child of your spouse, and someone who is your child within the meaning of the Family Law Act 1975 (for example, a child as a result of a Court Order giving effect to a surrogacy arrangement). For tax purposes, only a child under 18 years of age is a dependant unless a financial dependant.

You can also nominate your estate (referred to as 'legal personal representative').

A person must be a dependant on the date of your death to be a beneficiary.

What is an interdependency relationship?

Two persons (whether or not related by family) have an interdependency relationship if:

- they have a close personal relationship
- they live together
- one or each of them provides the other with financial support, and
- one or each of them provides the other with domestic support and personal care.

An interdependency relationship also includes two persons (whether or not related by family):

- who have a close personal relationship, and
- who do not meet the other 3 criteria listed in the paragraph above, because either or both of them have a physical, intellectual or psychiatric disability.

How can your Death benefit be paid?

You can choose how you would want the Death benefit paid.

There is a choice of:

Option 1 – Binding nomination.

Option 2 – Non-binding (or preferred) nomination, or

Option 3 – No nomination.

Before making a nomination, there are a number of factors that should be kept in mind, for example, the type of beneficiary nominated can have tax implications for dependant(s) when they receive the Death benefit.

For this reason, we strongly recommend that you discuss the nomination with a financial planner prior to filling in the application forms and personal statement.

Option 1 – Binding nomination

If the Trustee is provided with a binding nomination that satisfies all legal requirements, then the Trustee must pay the Death benefit to the beneficiaries nominated and in the proportions specified. However, the Trustee is not required to pay the Death benefit in accordance with the binding nomination if it's aware either:

- that doing so would breach a court order, or
- that the giving of, or failure to change, a nomination was a breach of a court order.

One of the legal requirements for a binding nomination is that it must be signed and dated in the presence of 2 witnesses over 18 who are not nominated beneficiaries. The Trustee will automatically treat the nomination as though it was non-binding if:

- the binding nomination does not satisfy this or other legal requirements, or
- it is not signed or correctly completed.

When the Trustee receives the nomination it will not check if the nominated beneficiaries on the nomination form are dependants or a legal personal representative

The binding nomination will normally become invalid when one of the following happens:

- 3 years have lapsed from the date the **Binding Nomination** form was signed (a new **Binding Nomination** form will need to be completed for there to be a binding nomination).
- Any nominated beneficiary dies before you die.
- Any nominated beneficiary (other than the legal personal representative) is not a dependant at the time of death.

– You marry or enter into a de facto relationship after signing the Binding Nomination Form.
– You get divorced or your de facto relationship ends after signing the Binding Nomination Form.
– A non-binding nomination is made (as described in Option 2 – Non-binding nomination).

If the binding nomination is no longer valid, then the Trustee will automatically treat the binding nomination as a non-binding nomination (see Option 2 – Non-binding nomination).

It is important that the binding nomination is regularly reviewed and updated:
– when your personal circumstances change, or
– if 3 years pass from the date of your last binding nomination.

The binding nomination can be cancelled or changed at any time. If the binding nomination is cancelled without making another nomination, then the Trustee must pay the Death benefit in accordance with Option 3 – No nomination.

Option 2 – Non-binding (or preferred) nomination

If a non-binding (or preferred) nomination is made or a binding nomination becomes a non-binding nomination (as described under Option 1 – Binding nomination), then the Trustee will decide which beneficiary will receive the Death benefit.

The Trustee will take into consideration your wishes that the death benefit be paid to the nominated beneficiary(ies), but depending on the circumstances at the time of death, the Trustee may decide to pay the Death benefit differently.

When the Trustee receives the nomination it will not check if:
– the nominated beneficiary(ies) on the nomination form are dependants or a legal personal representative, or
– the nomination form has been signed or correctly completed.

A non-binding nomination will continue to apply until it is cancelled or a new one is made. Therefore, it is important that a non-binding nomination is kept up-to-date in line with your personal circumstances. A non-binding nomination can be cancelled at any time or a new one can be made at any time.

If the non-binding nomination is cancelled without making another nomination, then the Trustee must pay the Death benefit in accordance with Option 3 – No nomination.

Option 3 – No nomination

If a nomination is not made, or your existing nomination is cancelled, and a new nomination is not made, then the Trustee must pay the Death benefit to your estate.

However, if the estate is insolvent or if a legal personal representative has not been appointed to manage the estate within a reasonable period of time, then the Trustee will decide:
– if there are dependants, which dependants will receive the Death benefit (and in what proportions), or
– if there are no dependants, which other persons will receive the Death benefit (and in what proportions).

This means that if there is neither a binding nor non-binding nomination, you should consider making a Will or altering your Will to cover the Death benefit.

Payment rules for Terminal Illness and TPD benefits

The Trustee can only pay the Terminal Illness benefit and TPD benefit in accordance with superannuation rules.

As the superannuation payment rules are different from the definition of 'terminal illness' and 'total and permanent disablement' under the plan, there may be some instances where the Trustee will not be able to pay a Terminal Illness benefit or TPD benefit directly to you.

For example, under superannuation law:

Superannuation Industry (Supervision) Act definition of Permanent Incapacity	Superannuation Industry (Supervision) Act definition of Terminal Medical Condition
'Permanent incapacity', in relation to a member, means ill-health (whether physical or mental), where the trustee is reasonably satisfied that the member is unlikely, because of the ill-health, to engage in gainful employment for which the member is reasonably qualified by education, training or experience. **The definition of 'permanent incapacity' under superannuation law differs from the definition of 'totally and permanently disabled' on page 14**. For example, AMP Life may pay the TPD benefit to the Trustee because you are a paraplegic, but the Trustee may not be able to release the benefit from the AMP Superannuation Savings Trust if you are still able to work.	A terminal medical condition exists in relation to a person at a particular time if the following circumstances exist: – Two registered medical practitioners have certified, jointly or separately, that the person suffers from an illness, or has incurred an injury, that is likely to result in the death of the person within a period (the certification period) that ends not more than 12 months after the date of the certification. – At least one of the registered medical practitioners is a specialist practising in an area related to the illness or injury suffered by the person. – For each of the certificates, the certification period has not ended. **The definition of 'terminal medical condition' under superannuation law differs from the definition of 'terminally ill' on page 10**. For example, AMP Life may pay the Terminal Illness benefit to the Trustee because your doctor tells us in writing that they believe you have less than 12 months to live. However, the Trustee may not be able to release this benefit to you unless two doctors tell us in writing that you have less than 12 months to live.

It is recommended you discuss the differences in definitions with your financial planner.

If the Trustee is not able to pay a Terminal Illness benefit or TPD benefit directly to you, the Trustee will transfer the benefit to an account in the AMP Eligible Rollover Fund set up on your behalf, or to a similar complying superannuation fund nominated by you. Any such transferred benefits can only be subsequently released if you satisfy the superannuation payment rules (eg reaching age 65 or retiring after you have reached your preservation age).

Additional identification requirements

Before paying any benefit, the Trustee may need to verify the identity of:

- you
- any person(s), including the estate, selected to receive payments in the event of your death, and
- anyone acting on your behalf.

Verification generally involves checking the name and date of birth or address against a reliable independent document such as a passport or driver's licence, and may involve taking and retaining a copy of that document.

The Trustee may decide to delay or refuse any request or transaction, including benefit payments, if it is concerned that the request or transaction may breach any obligation of, or cause us to commit or participate in an offence under the Anti-Money Laundering and Counter Terrorism Financing Act 2006 (Cth). The Trustee is not liable for any loss or damage arising from any such delay.

Taxation

Outlined below is our general understanding of current legislation and rules as at the date of preparation of this document. Taxation laws and their interpretation may change from time to time. The Trustee will inform you of any changes that will affect your plan. We recommend that you consult your tax adviser.

Tax deductions for employers or self-employed individuals

There are tax deductions for contributions made by employers to fund insurance cover premiums for the benefit of their employees. Self-employed individuals may be able to claim a tax deduction for their personal contributions.

Contribution limits

There are limits that apply to contributions made to superannuation funds. Contributions above those limits (caps) are subject to 'excess contributions tax' of between 31.5% and 46.5%.

The cap amount and how much extra tax you pay once you exceed it depend upon whether the contributions are:

- concessional – which are generally made to a super fund for or by you in a financial year and are included in the assessable income of the super fund (for example, super guarantee, salary sacrificed amounts and any amount you are allowed as a personal super deduction in your income tax return), and
- non-concessional – which are generally made to a super fund by or for you in a financial year and are not included in the super fund's assessable income (for example, personal contributions you make from your after-tax income).

The contributions caps are:

Type of contribution	Cap	Other information
Concessional contributions cap	$25,000 pa(i)	The Government has announced that from 1 July 2014, the $50,000 pa concessional contributions cap will apply to people aged 50 and over whose account balances are less than $500,000. This has not yet been made law.
Non-concessional contributions cap(ii)	$150,000 pa	If under age 65, you can bring forward 2 years of caps. That is, you can make non-concessional contributions of up to $450,000 in one financial year. However, you will not be able to make any further non-concessional contributions for the next two years.

(i) Normally indexed annually in line with average weekly ordinary time earnings in increments of $5,000 (rounded down). However, indexation of the concessional contributions caps will be frozen at $25,000 pa, up to and including the 2013/2014 financial year.

(ii) This cap is also used to limit the amount of contributions a superannuation fund can accept in some circumstances.

Contributions in excess of the concessional contributions cap are taxed at a penalty rate of 31.5% in addition to any tax paid by the super fund. The 31.5% 'excess concessional contributions tax' may be paid personally, or if the individual elects, by debiting their superannuation account balance.

Note that the excess concessional contributions also count towards the non-concessional contributions cap.

Contributions in excess of the non-concessional caps are taxed at 46.5%. This is called the 'excess non-concessional contributions tax' and must be paid from your account balance.

The excess contributions tax rates are applied to the gross amount of the excess contribution or payment and there is no reduction for death and disability premiums, unlike the standard 15% contributions tax allowance on concessional contributions.

Eligible individuals will have the option to have excess concessional contributions taken out of their superannuation fund, and refunded, and assessed as income from their marginal tax rate, rather than incurring excess contributions tax. This measure will apply where an individual has made excess contributions of $10,000 or less in a particular year, and will only be available for the first breach in respect of the 2011/2012 or later years.

The Government intends to impose a further 15% charge on concessional contributions made by members from 1 July 2012 whose 'adjusted income' levels exceed $300,000 per annum. The adjusted income components are expected to include super contributions, rental losses, reportable fringe benefits and such. There is no law in place yet.

Other tax concessions

Contributions by employees on lower incomes and contributions made by a spouse may attract tax concessions. Your financial planner or tax adviser can provide more details about these concessions.

Tax on death claims

Death benefit lump sums paid to dependants, as defined for tax purposes (eg spouse, de facto spouse, your child under age 18, or people financially dependent on a person at the time of death or in an interdependent relationship) are generally tax free.

Where Death benefit lump sums are paid to a person who is not a tax dependant they are generally taxed at a rate of up to 15% (30% in certain circumstances) plus the Medicare levy.

Tax on Total and Permanent Disablement claims

Tax concessions apply if the total and permanent disablement results in you being unable to ever be gainfully employed.

Tax on Terminal Illness

Terminal Illness benefits are tax free if you meet the 'terminal medical condition' release set by superannuation rules (see page 29).

Collection of Tax File Numbers

The Trustee is required to disclose the following details before you provide your Tax File Number (TFN). The Trustee can collect your TFN under the Superannuation Industry (Supervision) Act 1993 (Cth).

You are under no obligation to disclose your TFN to the Trustee and it is not an offence to not quote your TFN. However, if you do not disclose your TFN to the Trustee, the Life Protection Plan cannot be acquired through the AMP Superannuation Savings Trust.

If the TFN is disclosed to the Trustee, the Trustee will treat it as confidential and use it only for lawful purposes, including:

- To find superannuation benefits
- To ensure you can continue to contribute to your account
- To calculate tax on any superannuation benefits you may be entitled to
- If the Trustee is paying unclaimed money, it must give the TFN to the Commissioner of Taxation
- The Trustee may also give the TFN to the Commissioner of Taxation if you receive a benefit, or for the purposes of the Lost Members' Register, and
- If you wish to transfer your benefits to another superannuation fund or retirement savings account, the Trustee would provide the TFN to the trustee of that other fund or retirement savings account provider. However, if you do not want the Trustee to do this, you can notify the Trustee in writing at the time not to do so.

These purposes may change in the future as a result of further legislative changes. More information about the use of Tax File Numbers and superannuation changes can be obtained from the Australian Taxation Office Superannuation Hotline 13 10 20.

Other important information

Complaints

The Trustee has established procedures to deal with any complaint. If you make a complaint, the Trustee will:

- acknowledge its receipt and ensure an appropriate person properly considers the complaint, and
- respond to you as soon as possible.

If your complaint cannot be resolved at first contact then the Trustee will keep you informed of the progress and aim to give you a response to your complaint within 10 working days. If the complaint is not resolved by that time, then the Trustee will keep you advised at regular intervals of the status of your complaint.

If the Trustee can't resolve your complaint to your satisfaction within 90 days, then you may have the right to lodge a complaint with the Superannuation Complaints Tribunal (SCT).

The SCT reviews the decisions of superannuation trustees as they affect an individual member. It is independent from the Trustee. Please try to resolve the complaint directly with the Trustee before contacting the SCT.

Superannuation Complaints Tribunal
Phone: 1300 884 114
Fax: 03 8635 5588
Email: info@sct.gov.au

or write to: Locked Bag 3060, MELBOURNE VIC 3001

Time limits on making complaints to the SCT

If you contact the SCT more than 12 months after the Trustee's decision or response, then the SCT may decide not to deal with your complaint. However, this general rule does not apply to a complaint about the denial of a TPD claim.

If the Trustee denies your TPD benefit claim, then you may be unable to make a complaint to the SCT if:

- you lodge a TPD benefit claim with the Trustee more than 2 years after you permanently stop working, or
- you complain to the SCT more than 2 years after the Trustee's first (original) decision to deny your TPD benefit claim.

Your beneficiaries have 28 days to lodge a complaint with the SCT in relation to a decision to pay the Death benefit. You should contact the SCT first to ensure that it can deal with your complaint.

The Trustee

Your Plan is part of the AMP Superannuation Savings Trust (schedule G of the fund). AMP Superannuation Limited is the trustee of the fund and is a wholly-owned subsidiary of AMP Life.

The Trustee:

- is responsible for all aspects of the operation of the your Life Protection Plan
- is responsible for ensuring that the AMP Superannuation Savings Trust is properly administered in accordance with the trust deed and policy documents, and
- ensures that the AMP Superannuation Savings Trust complies with relevant legislation, that all members' benefits are calculated correctly, and
- ensures that members are kept informed of the operations of the AMP Superannuation Savings Trust.

The Trustee has indemnity insurance.

The trust deed

The trust deed for the AMP Superannuation Savings Trust establishes the AMP Superannuation Savings Trust. It also contains:

- the members' rights and obligations relating to the AMP Superannuation Savings Trust, and
- the Trustee's rights and obligations as the trustee (for example, the right to charge fees, the right to be indemnified, the right to terminate the trust and the limits on our liability).

The rights and obligations of a trustee are also governed by laws affecting superannuation and general trust law.

You can contact us to get a copy of the trust deed (contact details are on the back cover).

Annual report

The Trustee will prepare an annual report of the AMP Superannuation Savings Trust each year. A copy can be obtained online at **amp.com.au** or by contacting AMP (our contact information is included on the back cover).

Complying Superannuation Fund Notice

This Complying Superannuation Fund Notice confirms that the AMP Superannuation Savings Trust:

- is a resident regulated superannuation fund within the meaning of the Superannuation Industry (Supervision) Act (SIS), and
- is not subject to a direction under section 63 of SIS.

Pursuant to section 25 of the Superannuation Guarantee (Administration) Act, a contribution made by an employer for the benefit of an employee to the AMP Superannuation Savings Trust is conclusively presumed, except in the limited circumstances set out in that section, to be a contribution to a complying superannuation fund if the employer receives a copy of this Complying Superannuation Fund Notice at or before the time that the contribution is made.

Self managed or small APRA superannuation fund trustee ownership

Self managed or small APRA superannuation fund trustee owners must read the following information.

The trustee of a self managed or small APRA superannuation fund is solely responsible for ensuring that they have received independent financial, legal and taxation advice about their ability to purchase one of these AMP products and the selection of options within them.

AMP will make all payments to the trustee of the superannuation fund. The distribution of benefits to a member of the self managed or small APRA superannuation fund is the responsibility of the trustee of that fund and they will be responsible to determine whether benefits can be distributed to members of the fund in conformity to the trust deed governing the fund and superannuation law, and for assessing the taxation implications of doing so.

All taxation information in this document is in respect of individuals and employers only. We strongly recommend that the trustee specifically requests advice in relation to the tax deductibility of premiums, the impact of the sole purpose test requirements of the Superannuation Industry (Supervision) Act 1993 (SIS), the release of any insurance payments received by the trustee under these products in light of the cashing restrictions under SIS, and the tax obligations in respect of the payments to the member by the trustee. Some benefits paid under the policy may need to be preserved by the trustee until there is a nil cashing restriction under SIS.

About the Income Protection Plan

Flexibility to tailor a plan that meets your needs

The Income Protection Plan gives you choices – so that you have the flexibility to tailor a plan that suits your needs. This section sets out the choices available to you. Cover is subject to our acceptance.

Who can own the plan?

The Income Protection Plan can be owned by:

An individual	A trustee of a self managed superannuation fund or small APRA superannuation fund

We pay a benefit under the Income Protection Plan to the plan owner.

If you choose the trustee of a self managed superannuation fund or a small APRA superannuation fund to be the owner of the Income Protection Plan, please read the important information on page 33.

Who can be an insured person?

The 'insured person' is the person whose life is covered under the Income Protection Plan. There can only be one insured person under an Income Protection Plan.

Unless the plan is owned by a trustee of a self managed superannuation fund or small APRA superannuation fund, the plan owner and the insured person must be the same person.

We only insure certain types of occupations. The insured person must be between the ages set out in the table on page 36 when you apply for this cover.

What plan type is right for you?

There are 3 plan types available under the Income Protection Plan:

Advanced plan	Standard plan	Basic plan

The benefits, features and options available under each plan are set out on pages 37 to 39.

What benefit type suits your needs?

You may choose an agreed value or indemnity plan. A lower premium is charged for indemnity plans.

Agreed value	Indemnity
The benefit we pay is based on the maximum monthly benefit, even if the insured person's income subsequently falls (see page 40).	The benefit we pay will be no more than 75% of the insured person's monthly income in the 12 months immediately before they became totally disabled or partially disabled(i). This may be less than the maximum monthly benefit (see page 40).

(i) A different definition of Indemnity applies if the insured person is taking or has taken maternity leave, paternity leave or leave without pay – see page 40.

How much cover do you need?

You can insure a percentage of the insured person's income (defined on page 73), as set out in the table below.

Income	Maximum % insured
The first $320,000	75%
The next $240,000	50%
Amounts over $560,000(i)	15%

(i) Limitations may apply for benefits in excess of these amounts.

The percentage may be higher if the Superannuation Contributions option applies to your plan (See page 45).

Currently, the minimum amount of cover is $1,250 per month ($250 per month for increases to existing plans excluding increases under the Guaranteed Future Insurability feature).

Not available through the AMP Superannuation Savings Trust

What length of benefit period and waiting period suits your needs?

The benefit period is the maximum period of time that we will pay some benefits. The premium is cheaper if you choose a shorter benefit period.

The waiting period is the period you must wait before you can become eligible for a Total Disability benefit or a Partial Disability benefit. The premium is cheaper if you choose a longer waiting period.

The following table shows the available benefit periods and waiting periods for each plan type:

Plan type	Benefit periods available				
	1 Year	2 Years	5 Years	To age 60	To age 65
	Waiting periods available (weeks)				
Advanced and Standard	4	2, 4	2, 4, 8	2, 4, 8, 13, 26, 52, 104	2, 4, 8, 13, 26, 52, 104
Basic	2, 4	2, 4	2, 4, 8	–	–

Do any optional benefits and features suit your needs?

The optional benefits and features available under the Income Protection Plan are set out on pages 37 to 39.

Income Protection Plan – Facts

Cover entry ages and expiry ages

Entry ages

Benefit period	Advanced plan and Standard plan		Basic plan
	Stepped Premium	Level Premium	
To age 65	19 to 59	19 to 59	–
To age 60	19 to 54	19 to 54	–
1, 2 or 5 years	19 to 49	19 to 54	19 to 49

The entry ages also apply to increases in cover and additions to existing plans.

	Plans with a benefit period of 1 year, 2 years, 5 years or 'To age 60'	Plans with a benefit period 'To age 65'
Expiry age	60	65

Taxation information

Are premium payments deductible?	Are benefit payments assessable for income tax?
Premium payments are generally tax deductible	Benefit payments are generally assessable for income tax and should be included in your tax return.

The above is our general understanding of current legislation and rules as at the date of preparation of this document. Taxation laws and their interpretation may change from time to time. We recommend that you speak to your accountant or tax adviser about your personal tax circumstances.

The insured person's occupation

Based on the duties of the insured person's occupation, we allocate an occupation category. We use the following codes to describe occupation categories: 4A, 3A, 2A, A, 4B, 3B, 2B, 1B or E.

The insured person's occupation category will affect the premium you pay and the type of plan you can apply for. Your financial planner can tell you which category the insured person's occupation belongs to. The following table provides a guide. The insured person's occupation category will be shown in your premium quote.

Category	Description
4A	Selected professional occupations (other than medical practitioners and dentists, but including surgeons) eg accountant, solicitor.
3A	Medical professional (other than surgeons), eg medical practitioner and dentists.
2A	White collar occupation – office environment only, sedentary, eg bank clerk, management consultant.
A	White collar occupation – travel or work outside the office environment or are not primarily sedentary in nature within the office environment, eg sales representative.
4B	Light/minimal manual work – supervision of manual work with up to 10% manual work being performed, eg building foreman, owner of café.
3B	Trade qualified – skilled craftspeople or tradespeople in non-hazardous industries. The occupation must require technical or trade qualifications and relevant licence (if required), eg mechanic, builder.
2B	Owner of businesses that involves manual work, however, trade qualifications are generally not required to perform the occupation. Also includes light manual occupations with limited skill required, eg greengrocer, blind and awning installers.
1B	Heavy manual – blue collar occupations involved in either heavy manual work, or do not require any level of trade qualification. A degree of skill is still required, eg bricklayer, local truck driver.
E	Selected hazardous or heavy manual occupations. Generally unskilled or unqualified. Should have a minimum of 3 years experience, eg bulldozer operator, roof plumber.

Income Protection Plan Snapshot

Features and benefits	Advanced plan	Standard plan	Basic plan
Total Disability benefit	✓	✓	✓
Partial Disability benefit	✓	✓	✓
Trauma feature	✓		
Major fracture or loss feature	✓		
Bedcare benefit	✓		
Day 1 Accident option (i)	✓	✓	
Death feature	✓	✓	
Superannuation Contribution option (i)	✓	✓	✓
Rehabilitation costs feature	✓	✓	✓
Rehabilitation bonus	✓	✓	✓
Overseas transport benefit	✓	✓	✓
Domestic transport benefit	✓		
Accommodation benefit	✓		
Family Support benefit	✓		
AIDS Exclusion option (ii)	✓	✓	✓
Indexation feature	✓	✓	✓
Guaranteed Future Insurability feature	✓	✓	✓
Claims Escalation option (iii)	✓	✓	✓
On Hold feature	✓	✓	✓
Change of employer feature	✓	✓	✓
Attempted return to work feature	✓	✓	✓
Relapse feature	✓	✓	✓
Return to work bonus	✓	✓	✓
Premium waiver	✓	✓	✓

(i) This is an additional premium option. It only applies if it is shown in the Certificate of Insurance.

(ii) This is an option for a discounted premium. It only applies if it is shown in the Certificate of Insurance.

(iii) This is an additional premium option on Standard and Basic plans. It only applies if it is shown in the Certificate of Insurance.

Plan Rules – Income Protection

Benefits and features at a glance

The benefits and features of the Income Protection Plan are listed below and are explained in detail on pages 40 to 50.

In-built benefits and features that apply to the **Advanced Plan**, **Standard Plan** and **Basic Plan**(i) are shown in this section like this:

(i) The Death feature does not apply to the Basic Plan.

In-built benefits and features that only apply to the **Advanced Plan** are shown in this section like this:

Additional premium options(ii) can be added to your Income Protection Plan. These options will only apply if they are shown in the Certificate of Insurance, and are shown in this section like this:

(ii) The AIDS Exclusion option is a discounted premium option.

Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see pages 65 to 74).

Income benefits

We will pay you one of the following income benefits at any one time – as long as you satisfy the conditions for payment:

Total Disability benefit (see page 41)	A waiting period applies before you become eligible for a payment under these benefits (unless the insured person has suffered a relapse).	However, you may be eligible for a payment under one of these benefits during the waiting period.	**Bedcare benefit** (see page 44)
Partial Disability benefit (see page 42)			**Day 1 Accident option** (Advanced and Standard plans only) (see page 44)
Major Fracture or Loss feature (see page 43)	A waiting period does not apply to these benefits. These benefits are payable for a specified period, even if the insured person can work.		
Trauma feature (see page 43)			
Death feature (Advanced plans and Standard plans only) (see page 45)	We may pay 6 extra payments equal to the Total Disability benefit (to a maximum of $60,000) if the insured person dies while they are totally disabled or partially disabled and we are paying you one of the above income benefits (although we don't pay under the death feature if the insured person dies during the waiting period).		

Additional benefits

These additional benefits may be paid in addition to one of the income benefits referred to on the previous page:

Superannuation Contribution option (see page 45)	**Superannuation** – With this additional premium option, contributions to the insured person's superannuation may continue to be made while you are receiving an income benefit.
Rehabilitation Costs feature (see page 46) **Rehabilitation bonus** (see page 46)	**Rehabilitation** – either or both of these rehabilitation benefits may be paid while the insured person is totally disabled, both during the waiting period and while we are paying an income benefit under the Income Protection plan (and the rehabilitation bonus may be paid up to 3 months after the insured person returns to continuous full-time work).
Accommodation benefit (see page 46) **Domestic Transport benefit** (see page 46) **Overseas Transport benefit** (see page 46)	**Disability away from home** – one of these benefits may be paid (which may be in addition to an income benefit) if the insured person becomes totally disabled more than 100 km away from home.
Family Support benefit (see page 47)	**Family Support** – We may pay this benefit (in addition to an income benefit) if the insured person is totally disabled and an immediate family member stops working to look after the insured person.
Return to work bonus (see page 47)	**Bonus on return to work** – We may pay this benefit (either in addition to a partial disability benefit or alone) if the insured person returns to work for at least 30 hours per week, after participating in an occupational rehabilitation programme, approved by us, for at least 3 months.

Features

The Income Protection Plan has the following features:

Indexation feature (see page 47)	**Increasing cover features** – These features allow your maximum monthly benefit to be increased without providing evidence of the insured person's health, occupation or pastimes.
Guaranteed Future Insurability feature (see page 47)	
Claims Escalation option (Standard plans and Basic plans only) (see page 48)	Claims escalation option is not available for Advanced plans because, under the Advanced plan, a similar feature is already included.
On Hold feature (see page 48) **Change of Employer feature** (see page 48)	**Employment event features** – These features give you choices if the insured person's employment circumstances change.
Attempted return to work feature (see page 48) **Relapse feature** (see page 49)	**Return to work features**
Premium Waiver (see page 49)	**Premium waiver and discount features**
AIDS Exclusion option (see page 47)	The AIDS Exclusion option is an option for discounted premiums.

24 hour, worldwide cover

The insured person is covered worldwide, 24 hours a day, 7 days a week (although benefit payments may stop after 3 months unless the insured person returns to Australia or New Zealand – see information on this page).

Guaranteed renewable

For Advanced plans and Standard plans, as long as you pay premiums when they are due, we guarantee to continue the Income Protection Plan until the plan ends (see page 50). Different rules apply to Basic plans (see page 50).

Understanding the waiting period, the benefit period and the monthly benefit

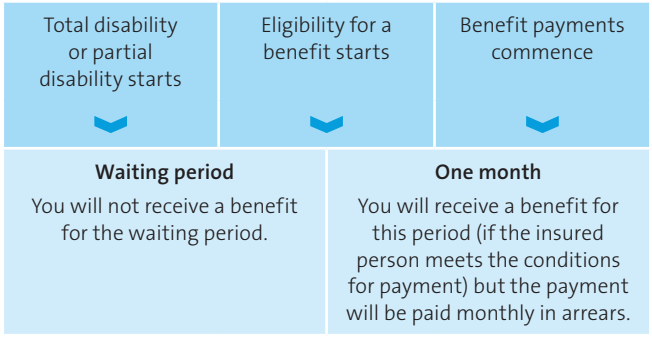
Waiting period

The waiting period is the period of time that you must wait before you become eligible for a Total Disability benefit or a Partial Disability benefit. The length of the waiting period you choose is shown in the Certificate of Insurance.

The waiting period starts on the date the insured person becomes totally disabled or partially disabled (as applicable). The waiting period only ends when the total number of consecutive days the insured person has been totally disabled or partially disabled (as applicable), when added together, equal the waiting period.

We treat days of total disability or partial disability as being consecutive even if those days are interrupted by a period of attempted return to work under the Attempted return to work feature (see page 48).

The following diagram illustrates how the waiting period and the timing of payments work.



Benefit period – how long we pay

The benefit period is the maximum period of time that we will pay the Total Disability benefit, and for Advanced plans and Standard plans, the Partial Disability benefit. The benefit period you choose is shown in the Certificate of Insurance. For Basic plans, the maximum period of time we will pay the Partial Disability benefit under one claim is 2 years, even if the benefit period is longer.

For the purposes of determining when the benefit period ends, you will be treated as being paid a benefit during any period that your benefit is reduced to nil under benefit offsets (see page 50).

When the insured person is outside Australia or New Zealand

We will pay for an illness or injury that happens anywhere in the world at any time. However, we may not pay for more than 3 months while the insured person is outside Australia or New Zealand (maximum overseas payment period).

We may agree to keep paying for more than 3 months while the insured person is outside Australia or New Zealand if you ask us to and you, and the insured person, agree to any conditions we set.

If we don't pay after the maximum overseas payment period, then, when the insured person returns to Australia or New Zealand, we will start paying again if you are still entitled to be paid under the Income Protection Plan. We will not pay you for any period before the insured person returns to Australia or New Zealand (other than the maximum overseas payment period).

If the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, then we may assist you with their return travel expenses (see Overseas Transport benefit on page 46).

Monthly benefit

The amount we pay under most benefits under the Income Protection Plan is the Monthly Benefit or is calculated by reference to the Monthly Benefit. The meaning of Monthly Benefit differs depending on whether you have an Agreed Value Plan or an Indemnity Plan, which is shown in the Certificate of Insurance.

Agreed Value	Monthly benefit means the maximum monthly benefit, less any applicable Benefit Offsets (see page 50).
Indemnity	Monthly benefit means the lesser of: – the maximum monthly benefit, and – 75% of the insured person's monthly income in the 12 months immediately before the start of the waiting period (or the date you become eligible for the Major Fracture and Loss feature or the Trauma feature), less any applicable Benefit Offsets (see page 50).
Indemnity if the insured person is taking maternity leave, paternity leave or leave without pay, or has returned to work after taking maternity leave, paternity leave or leave without pay, but has been back for less than 12 months	Monthly benefit means the lesser of: – the maximum monthly benefit, and – 75% of the insured person's monthly income for the 12 months immediately before the start of the maternity leave, paternity leave, or leave without pay (or the date you become eligible for the Major Fracture and Loss feature or the Trauma feature), less any applicable Benefit Offsets (see page 50).

Maximum monthly benefit means the amount you apply for and we accept (as shown in the Certificate of Insurance), as varied in accordance with the terms of the Plan (for example, under the Indexation Feature) or by agreement.

Benefits and features explained

When we pay

We only pay a benefit under the Income Protection Plan if the insured event happens after cover starts and before cover ends (see page 50).

We won't pay a benefit under the Income Protection Plan in some circumstances (see 'When we won't pay' on page 50). Also, for some plans, we may reduce the amount we pay under a benefit if you receive payments from other sources (see 'Benefit Offsets' on page 50). You must satisfy our claim requirements before we pay a benefit (see page 63).

Otherwise, we will pay a benefit under the Income Protection Plan in the circumstances set out in this section.

Total Disability benefit

When we pay

We pay the Total Disability benefit if the insured person is totally disabled and has satisfied these conditions:

Advanced plan (white collar occupation)	Advanced plan (other than white collar occupations), Standard plan and Basic plan
– The insured person is totally or partially disabled for the whole waiting period, and – unless the insured person has experienced a relapse (see page 49), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.	– The insured person is totally disabled for at least 7 consecutive days during the waiting period (and totally disabled or partially disabled for the remainder of the waiting period), and – unless the insured person has experienced a relapse (see page 49), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Total Disability benefit monthly in arrears.

What does 'totally disabled' mean?

The meaning of 'totally disabled' will depend on whether you have an Advanced plan, Standard plan or Basic plan.

If you have an Advanced plan, the insured person will be considered totally disabled if they satisfy either the 'duties based' or 'hours based' definition of totally disabled below.

If you have a Standard plan or Basic plan, the insured person will be considered totally disabled if they satisfy the 'duties based' definition of totally disabled below.

Definition of Totally Disabled		
Duties based	The insured person is totally disabled if: – they are so ill or injured that they are unable to carry out any one duty, or combination of duties, which are critical to the proper performance of their usual occupation, and – they are under the ongoing care of a doctor for that illness or injury, and – they do not do any remunerative work (see page 74 for the meaning of 'remunerative work').	
Hours based	If the insured person is working more than 20 hours a week in the 12 months immediately preceding disability, the insured person is totally disabled if: – they are so ill or injured that they are unable to carry out the important income producing duties of their usual occupation for more than 10 hours a week, and – they are under the ongoing care of a doctor for that illness or injury, and – they are not working for more than 10 hours a week.	If the insured person is working 20 hours or less a week in the 12 months immediately preceding disability, the insured person is totally disabled if: – they are so ill or injured that they are unable to carry out the important income producing duties of their usual occupation for more than 5 hours a week, and – they are under the ongoing care of a doctor for that illness or injury, and – they are not working for more than 5 hours a week.
If the insured person experiences an illness or injury more than 12 consecutive months after temporarily leaving remunerative work (other than for maternity or paternity leave), we treat the insured person's usual occupation as being any occupation for which they are reasonably suited by education, training or experience.		

Amount we pay

The monthly amount we pay under the Total Disability benefit is the monthly benefit.

If, in any month, the insured person is totally disabled for less than the full month, the daily amount we pay is the monthly amount divided by the number of days in that month, for each day that the insured person is totally disabled.

When we stop paying

We stop paying the Total Disability benefit when one of the following happens:

– the insured person is no longer totally disabled,
– if you have a 1, 2 or 5 year benefit period, all periods that we have paid a benefit in relation to the one claim add up to the benefit period, or
– the Income Protection Plan ends (see page 50).

If we stop paying because the insured person is no longer totally disabled, you may be eligible to claim the Partial Disability benefit. If we accept your Partial Disability benefit claim, benefit payments will continue without a new waiting period applying.

Partial Disability benefit

When we pay

We pay the Partial Disability benefit if the insured person is partially disabled and has satisfied these conditions:

Advanced plan (white collar occupation)	Advanced plan (other than white collar occupations), Standard plan and Basic plan
– The insured person has been either totally disabled or partially disabled for the whole waiting period, and – unless the insured person experiences a relapse (see page 49), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.	– The insured person has been totally disabled for at least 7 consecutive days during the waiting period, and – the insured person has been totally disabled or partially disabled for the remainder of the waiting period, and – unless the insured person experiences a relapse (see page 49), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Partial Disability benefit monthly in arrears.

What does 'partially disabled' mean?

The insured person is 'partially disabled' if:

– they perform remunerative work but because they are so ill or injured they earn less than their pre-disability income, and
– they are under the ongoing care of a doctor for that illness or injury; and
– they are not totally disabled.

Amount we pay

The monthly amount we pay under the Partial Disability benefit is calculated using the following formula:

$$\frac{(A - B)}{A} \times C$$

Where:

A = Monthly pre-disability income.

B = The insured person's monthly income earned while partially disabled (if this amount is less than zero, we will treat it as zero).

C = Monthly benefit (see page 40).

If, in any month, the insured person is partially disabled for less than the full month, the daily amount we pay is the monthly amount divided by the number of days in that month, for each day that the insured person is partially disabled.

What does 'pre-disability income' mean?

– Agreed value plans

  If you have an agreed value plan, monthly 'pre-disability income' is 1/12 of the insured person's highest average income for any 12 consecutive months between 2 years before the Income Protection Plan started and the start of the waiting period.

– Indemnity plans

  If you have an indemnity plan, monthly 'pre-disability income' is 1/12 of the insured person's income in the 12 months immediately before the start of the waiting period.

  If the insured person is on or has returned from maternity leave, paternity leave or leave without pay within the prior 12 months, and you have an indemnity plan, monthly 'pre-disability income' is 1/12 of the highest average income for the consecutive 12 months before the start of the maternity leave, paternity leave or leave without pay.

If you have an Advanced plan and we have accepted your claim for a Partial Disability benefit, on each anniversary of the claim (ie the date you became eligible for a benefit under the Income Protection Plan), we will increase 'pre-disability income' by the percentage increase in the CPI since the date we commenced paying the benefit. If you have a Standard plan or Basic plan, we will only do this if the Claims Escalation option applies to your Income Protection Plan (see page 48).

When we stop paying

We stop paying the Partial Disability benefit when one of the following happens:

– The insured person is no longer partially disabled,
– If you have a Basic plan, the sum of all the periods for which we have paid the Partial Disability benefit under one claim is equal to 2 years – even if the benefit period is longer than 2 years,
– If you have a 1, 2 or 5 year benefit period, the sum of all the periods we have paid a benefit under the one claim is equal to the benefit period, or
– The Income Protection Plan ends (see page 50).

Trauma feature (Advanced plans only)

When we pay

We pay under the Trauma feature if the insured person experiences any of the trauma conditions or undergoes any of the medical procedures listed in the following table.

Trauma conditions and medical procedures covered
Aortic surgery
Cancer
Cardiomyopathy
Coma
Coronary artery angioplasty – triple vessel
Coronary artery surgery
Heart attack – myocardial infarction
Heart attack – out of hospital cardiac arrest
Heart valve surgery
Hepatitis B or C – occupationally acquired
HIV/AIDS – medically acquired
HIV/AIDS – occupationally acquired
Intensive care
Kidney failure
Major head trauma
Major organ transplant
Open heart surgery
Peripheral blood stem cell or bone marrow transplant
Pneumonectomy
Primary pulmonary hypertension
Severe burns
Stroke

Please refer to pages 65 to 72 for the definitions of these trauma conditions and medical procedures.

We pay even if the insured person does not stop working.

We only pay once for each trauma condition and medical procedure. You can make more than one claim under the Trauma feature as long as each claim is for a different trauma condition or medical procedure.

If the Trauma feature and Major Fracture or Loss feature are payable at the same time, the higher benefit, but not both, will be paid.

We pay under the Trauma feature monthly in arrears.

Amount we pay

The amount we pay under the Trauma feature is the monthly benefit each month for 6 months. If we paid you under another income benefit for the same claim before we accepted your claim under the Trauma feature, we can take this into account in determining when the 6 month period ends.

We do not take account of any income the insured person receives from remunerative work or any payments set out in Benefits Offsets on page 50.

When we stop paying

We stop paying under the Trauma feature when one of the following happens:

- we have paid under the Trauma feature for 6 months, or
- the Income Protection Plan ends (see page 50).

At the end of the 6 month period, you may be eligible for another benefit (for example, the Total Disability benefit or the Partial Disability benefit). The waiting period for the Total Disability benefit or the Partial Disability benefit can be satisfied while you are receiving a benefit under the Trauma feature.

When does cover start?

Cover does not start under the Trauma feature until 3 months after:

- the Income Protection Plan start date
- an increase to the maximum monthly benefit (other than an increase under the Indexation feature) in respect of the increased portion only
- the most recent reinstatement of the Income Protection Plan.

This means that:

- the trauma condition, or
- the medical condition which the medical procedure is intended to address,

must be diagnosed at least 3 months after the Trauma feature start date. If the diagnosis occurs before this time, we will never pay for that trauma condition or medical procedure under the Trauma feature, even if the insured person experiences the same trauma condition again or undergoes the same medical procedure again.

Major Fracture or Loss feature (Advanced plans only)

When we pay

We pay under the Major Fracture or Loss feature each time the insured person experiences one of the major fractures or losses in the following tables. We pay under the Major Fracture or Loss feature monthly in arrears. We pay even if the insured person does not stop working.

If the insured person experiences more than one fracture or loss resulting from the same incident, we pay for the one with the longest payment period.

If the Major Fracture or Loss feature and the Trauma feature are payable at the same time, the higher benefit, but not both, will be paid.

Amount we pay

The amount we pay under the Major Fracture or Loss feature is the monthly benefit each month of the payment period. However, if your benefit period is shorter than the payment period, we only pay for the benefit period.

If we paid you under another income benefit for the same claim before we accepted your claim under the Major Fracture or Loss feature, we can take this into account in determining

when the payment period ends. We do not take account of any income the insured person receives from remunerative work or any payments set out in 'Benefit offsets' on page 50.

When we stop paying

We stop paying under the Major Fracture or Loss feature when one of the following happens:

- We have paid for the payment period,
- If you have a 1, 2 or 5 year benefit period, the sum of all the periods that we have paid a benefit under the one claim is equal to the benefit period, or
- The Income Protection Plan ends (see page 50).

At the end of the payment period, you may be eligible for another benefit (for example, the Total Disability benefit or the Partial Disability benefit). The waiting period for the Total Disability benefit or the Partial Disability benefit can be satisfied while you are receiving a benefit under the Major Fracture or Loss feature.

Fractures covered

'Fracture' means the disruption in continuity of bone, with or without displacement. The fracture must be shown by radiographic or scanning techniques.

We cover fracture of:	Payment period (months)
The spine causing paraplegia or quadriplegia	60
A thigh	3
A pelvis	3
A leg between the knee and foot	2
A kneecap	2
An upper arm	2
A shoulder blade	2
An ankle	2
The skull (not bones of the nose or face)	2
The jaw	1
A hand (requiring a plaster cast or surgery)	1
A forearm above the wrist	1
A collar bone	1
A wrist	1

Losses covered

We cover permanent and irrecoverable loss of use of:	Payment period (months)
Both feet(i), or both hands(i)	24
The entire sight of both eyes	24
Any 2 of, a foot(i), a hand(i), and the entire sight of one eye	24
One leg at or above the knee	18
One arm at or above the elbow	18
One foot(i), or one hand(i), or the entire sight of one eye	12
The entire thumb, and index finger, of the same hand at or above the first joint	6

(i) A foot means the whole foot below the ankle and a hand means the whole hand below the wrist.

Bedcare benefit (Advanced plans only)

When we pay

We pay the Bedcare benefit if the insured person is bedridden for at least 3 days in a row during the waiting period.

We will not pay the Bedcare benefit for any period that you are entitled to a payment under the Day 1 Accident option, the Trauma feature or the Major Fracture or Loss feature.

The insured person is 'bedridden' if they are:

- totally disabled, and
- their doctor requires them to be, and they are, under the full-time care of a registered nurse. The nurse can't be you, or a member of your immediate family or of the insured person.

Amount we pay

The amount of the Bedcare benefit we pay is 1/30th of the monthly benefit for each day the insured person is bedridden during the waiting period.

When we stop paying

We stop paying the Bedcare benefit when one of the following happens:

- the insured person is no longer bedridden,
- the waiting period ends,
- we have paid the Bedcare benefit for 180 days, or
- the Income Protection Plan ends (see page 50).

If the insured person is bedridden more than once during one waiting period, we treat all of the days they were bedridden as one claim.

Day 1 Accident option (Advanced plans and Standard plans only)

This is an additional premium option. It only applies if it is shown in the Certificate of Insurance for the insured person.

When we pay

We pay under the Day 1 Accident option if the insured person is totally disabled for at least 3 days in a row during the waiting period due to an accident.

Accident means bodily injury caused directly and solely by violent, external and visible means and independent of all other causes. We pay under the Day 1 Accident option monthly in arrears. We will not pay under the Day 1 Accident option for any period that you are entitled to a payment under the Trauma feature or the Major Fracture or Loss feature.

Amount we pay

The amount we pay under the Day 1 Accident option is 1/30th of the monthly benefit for each day that the insured person is totally disabled during the waiting period due to an accident. This amount may be reduced (see benefit offsets on page 50).

When we stop paying

We stop paying under the Day 1 Accident option when one of the following happens:

- the insured person is no longer totally disabled,
- the waiting period ends,
- we have paid you under the Day 1 Accident option for 30 days, or
- the Income Protection Plan ends (see page 50).

Death feature (Advanced plans and Standard plans only)

We pay under the Death feature if the insured person dies while they are totally disabled or partially disabled and you are receiving an income benefit under this Income Protection Plan (although we don't pay under the death feature if the insured person dies during the waiting period).

We pay 6 extra payments, with each payment equal to the amount we would have paid each month if the insured person was totally disabled.

The maximum we will pay under this benefit under all AMP income protection plans is $60,000.

Superannuation Contribution option

This is an additional premium option. It only applies if it is shown in the Certificate of Insurance for the insured person.

If the insured person is an employee, their employer is obliged to make minimum contributions, to a superannuation account, on their behalf. These are known as Superannuation Guarantee (SG) contributions. The minimum will increase gradually, from 1 July 2013, according to the following scale:

Effective date	SG minimum percentage
Until 30 June 2013	9.00
1 July 2013 to 30 June 2014	9.25
1 July 2014 to 30 June 2015	9.50
1 July 2015 to 30 June 2016	10.00
1 July 2016 to 30 June 2017	10.50
1 July 2017 to 30 June 2018	11.00
1 July 2018 to 30 June 2019	11.50
From 1 July 2019	12.00

If the insured person becomes disabled, and is unable to earn an income, their employer may also stop making SG contributions.

The Superannuation Contribution option allows you to insure either:

- the insured person's compulsory SG contributions as at the time of your application; or
- a nominated percentage of annual income above the default minimum, but not more than 15%.

The percentage nominated is limited to the insured person's superannuation contribution percentage at the time of application.

When your plan starts, we will record the insured person's annual income. At each plan anniversary, we will increase this amount by the annual change in the CPI.

When we pay

We will pay under the Superannuation Contribution option if we are paying you under one of the following income benefits:

- Total Disability benefit
- Partial Disability benefit
- Major Fracture or Loss feature
- Trauma feature
- Bedcare benefit, or
- Day 1 Accident option.

The amount insured under the Superannuation Contribution option will be paid in addition to the income benefits listed above.

Amount we pay

The maximum monthly benefit in the Certificate of Insurance includes the Superannuation Contribution option. Under this option you can choose to insure either:

- the insured person's compulsory SG contributions at the time of your application (according to the table above), or
- a nominated percentage of annual income above the default minimum, but not more than 15%.

The percentage nominated is limited to the insured person's superannuation contribution percentage at the time of application.

If the Superannuation Contribution option applies to your plan, the insured person's SG contributions or nominated percentage can't be included as income when determining the maximum monthly benefit. Any contributions exceeding 15% of the insured person's annual income can be included as income for the purpose of calculating the monthly benefit. See page 73 for the definition of income.

Who we pay

If you are a trustee of a self managed or small APRA superannuation fund, we will pay the benefit to you. Otherwise, you must nominate a complying superannuation fund or retirement savings account, to which the benefit will be paid on your behalf.

The amount paid under either direction is assessable income and needs to be included in the insured person's tax return in the financial year it is received. The income tax payable on the amount paid will need to be paid from another source as the amount paid to the complying superannuation fund or retirement savings account can't be used to pay income tax because it is required to be preserved in accordance with legislation. Individuals and employers may be eligible for a tax deduction for the contribution.

When we stop paying

We stop paying under the Superannuation Contribution option when one of the following happens:

- we stop paying under the income benefits listed above, or
- the Income Protection Plan ends (see page 50).

Rehabilitation Costs feature

When we pay

We will pay the Rehabilitation Costs feature for the reimbursement of the costs of any equipment, vocational rehabilitation programs or works which we agree the insured person needs for rehabilitation when the insured person is totally disabled. We will not reimburse you for medical costs, treatment costs (such as physiotherapy) or any other costs which can only be reimbursed by a registered health insurer.

We do this while the insured person is totally disabled, both during the waiting period and while we are paying a benefit under the Income Protection Plan.

For us to reimburse any costs:

- we need the insured person's doctor to tell us in writing that the equipment, vocational rehabilitation programs or works are necessary for their rehabilitation,
- we need a written estimate of the costs, and
- we must agree in writing to pay the costs before you incur them.

Amount we pay

We pay under the Rehabilitation Costs feature up to 12 times the monthly benefit.

When we won't pay

We won't pay:

- if we disagree with the doctor,
- any part of the costs which you or the insured person can recover from anywhere else, or
- any costs incurred after the Income Protection Plan ends.

Rehabilitation bonus

We pay the Rehabilitation bonus for up to 12 months while the insured person participates in a rehabilitation program approved by us.

Before the insured person commences the program, we must have approved it in writing.

We pay while the insured person is totally disabled, both during the waiting period and while we are paying a benefit under the Income Protection Plan (and for up to 3 months after the insured person returns to continuous full-time remunerative work).

The amount we pay under the Rehabilitation bonus is an additional 1/3 of the monthly benefit.

Overseas Transport benefit

We pay the Overseas Transport benefit if the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, to assist with their return travel expenses to Australia.

We reimburse up to the cost of one single economy airfare for the insured person, by the most direct route available, less any amounts anyone else pays you or the insured person for this expense.

Domestic Transport benefit (Advanced plans only)

We pay the Domestic Transport benefit if the insured person is in Australia but more than 100km from their usual residence when they become totally disabled, and requires emergency transportation within Australia. This benefit reimburses costs directly arising from their transportation, other than:

- ambulance services, and
- costs reimbursed from other sources.

This benefit is payable only once in any 12 month period.

We pay up to 3 times the monthly benefit.

Accommodation benefit (Advanced plans only)

We pay the Accommodation benefit to reimburse the reasonable accommodation expenses, once receipts are provided, of an immediate family member of the insured person who accompanies the insured person if:

- you are eligible for a benefit under the Bedcare benefit, and
- the insured person became totally disabled, and remains, over 100km away from their usual residence.

We pay each time a new claim is made if the above requirements are met. This benefit is only payable once in any 12 month period.

- We pay up to $250 per day for a maximum period of 60 days.

Family Support benefit (Advanced plans only)

When we pay

We pay the Family Support benefit while the insured person is totally disabled if:

- we have been paying a benefit under the Income Protection Plan for more than one month, and
- the insured person requires the full-time assistance of an immediate family member who was in full-time paid employment when the insured person became totally disabled but who stops all paid employment to look after the insured person.

We pay each time a new claim is made if the above requirements are met.

Amount we pay

We pay 1/30th of the monthly benefit for each day that the conditions of payment are met (to a maximum of $150 per day).

When we stop paying

We stop paying the Family Support benefit when one of the following happens:

- you no longer satisfy the conditions for payment
- we have paid the Family Support benefit for 6 months, or
- the Income Protection Plan ends (see page 50).

Return to work bonus

When we pay

We pay under the Return to work bonus if the insured person has participated in an occupational rehabilitation programme (approved in writing by us) for at least 3 months, and has since returned to paid work for at least 30 hours per week.

Amount we pay

We will pay an additional benefit amount upon completion of one month, 3 months and 6 months of consecutive employment of at least 30 hours per week, as shown below.

After one month	One payment of half the monthly benefit you would have received had the insured person been totally disabled.
After three months	One payment of the full monthly benefit you would have received had the insured person been totally disabled.
After six months	One payment of 1.5 times the monthly benefit you would have received had the insured person been totally disabled.

The above amounts are limited to a total of 3 times the monthly benefit over the term of the Life Protection Plan. We will not pay the return to work bonus at the same time as the Rehabilitation bonus.

AIDS Exclusion option

This is an option for a discounted premium. It only applies if it is shown in the Certificate of Insurance for the insured person.

If the AIDS Exclusion option applies to your Income Protection Plan, we will not pay a benefit for disability arising from the presence of HIV in the insured person's body, or AIDS or any AIDS-related illness.

Indexation feature

On each plan anniversary, we will increase the maximum monthly benefit, unless you tell us not to.

If you have a Basic plan or Standard plan, we will not increase your maximum monthly benefit if we are paying you a benefit (although the maximum monthly benefit may be increased while on claim if the Claims Escalation option applies to your Income Protection Plan – see below).

The amount we will increase the maximum monthly benefit by will be the percentage increase in CPI since the last plan anniversary (or since the plan start date if this is the first plan anniversary under the Income Protection Plan). We won't reduce the maximum monthly benefit if the CPI is negative.

This increase will be clearly identified in the Annual Statement we send you each year. If you do not want this increase, in full or in part, then you need to tell us.

Guaranteed Future Insurability feature

You can increase the maximum monthly benefit without providing evidence of the insured person's health, occupation or pastimes when the insured person's income increases.

You may increase the maximum monthly benefit by up to 10% (to a maximum of $1,500 each year across all AMP Income Protection Plans). You cannot increase the monthly benefit above the maximum insured percentage or above $30,000. This increase is in addition to any increase to the maximum monthly benefit under the Indexation feature. Premiums will be based on the premium rates applicable at the time of exercising this feature.

You may only request an increase once in any 12 month period. You must provide us with appropriate proof of the insured person's increase in income.

You can't request an increase to the maximum monthly benefit under this feature if at the time of your request:

- the insured person is age 55 or more
- you are unable to provide proof of income to support the requested increase to your maximum monthly benefit
- your Income Protection Plan has:
  - more than one exclusion, or
  - a premium loading of more than 50%, or
  - any other special terms, or
- a person is eligible to make a claim, or is claiming a benefit, under any income protection plan with us.

Claim Escalation option

This is an additional premium option on Standard and Basic plans, and only applies if it is shown in the Certificate of Insurance for the insured person.

If the Claims Escalation option applies to your Income Protection Plan, we will increase benefit payments made to you under a claim by the percentage increase in the CPI 12 months after the end of the waiting period and every 12 months after that.

If the insured person experiences a relapse (see page 49), we add up all the periods we have paid when calculating the 12 month period.

When you have the Claims Escalation option and we stop paying a claim, the maximum monthly benefit is reduced to the amount it was when we started paying a benefit.

On Hold feature

You can put your Income Protection Plan 'on hold' within the first 12 months after the insured person temporarily leaves remunerative work. You must tell us in writing if you want to put your cover 'on hold'.

While the Income Protection Plan is 'on hold' a reduced premium is payable and there is no cover. This means, we won't pay for any illness or injury which happens while the Income Protection Plan is 'on hold'. You can leave your plan on hold indefinitely until the plan ends.

We guarantee to take the Income Protection Plan 'off hold' when the insured person starts remunerative work again and you tell us in writing that you wish to take the cover 'off hold'. We will take the Income Protection Plan 'off hold' in these circumstances without you having to provide evidence of the insured person's health, pastimes or occupation.

– Your premium, once your Income Protection Plan ceases to be 'on hold', is no longer reduced. The premium when the insured person starts remunerative work again will be based on our premium rates at that time.

Change of Employer feature

You can shorten the waiting period if the insured person changes employer:

– If the waiting period is 13 weeks or less, you can move to the next shortest waiting period, without providing evidence of the insured person's health, pastimes or occupation, or
– If you have a 104 week waiting period, and the insured person's superannuation plan with a 2 year benefit period was cancelled as a result of leaving employment, you can shorten your waiting period to 13, 26 or 52 weeks within 60 days of that superannuation cover ending.

You can only apply to shorten your waiting period once in any 12 month period.

You can't shorten the waiting period while we are paying a benefit under the Income Protection Plan (or during the waiting period). If you shorten the waiting period, the premium will increase.

When you ask us to shorten the waiting period, you need to provide us proof that the insured person has changed employer and that their superannuation cover has ended (if applicable). Usually, all we need is a letter from the insured person's new employer and a superannuation exit statement.

Attempted return to work feature

If the insured person returns to work during the waiting period (and is not totally disabled or partially disabled) for 5 days (or less) in a row, the waiting period does not start again. That is so, even if the insured person returns to work more than once during the waiting period. The days of attempted return to work are added to the waiting period for the purposes of determining when the waiting period ends.

Relapse feature

Benefit periods 'To age 60 or 65'

If the insured person experienced an illness or injury, and then they again experience the same illness or injury or one that arises from the same cause or a related cause **within 12 months after** we stopped paying the Total Disability benefit or the Partial Disability benefit, we treat the insured person as having experienced a relapse. We will recommence payment of the Total Disability benefit or Partial Disability benefit, as applicable, without applying a new waiting period.

If the insured person experienced an illness or injury, and then they again experience the same illness or injury or one that arises from the same cause or a related cause **at least 12 months after** we stopped paying the Total Disability benefit or the Partial Disability benefit, we will not treat the insured person as having experienced a relapse. We treat it as a new claim and the waiting period starts again.

Benefit periods of 1, 2 and 5 years

If the insured person experienced an illness or injury, and then they again experience the same illness or injury or one that arises from the same cause or a related cause, what happens depends on why we stopped paying.

If we stopped paying because we had paid for the full benefit period, we will only pay if the insured person has worked in their usual occupation for at least their usual income for at least 6 months in a row since we stopped paying. In that case, we treat the claim as a new claim and both the waiting period and benefit period start again.

Otherwise:

- If the insured person experiences the same illness or injury or one that arises from the same cause or a related cause **within 6 months** of when we stopped paying, then we treat the insured person as having experienced a relapse. We will treat the claim as a continuation of the previous claim and recommence payment of the Total Disability benefit or Partial Disability benefit (as applicable) without applying a new waiting period, or
- if the insured person experiences the same illness or injury or one that arises from the same cause or a related cause **at least 6 months** after we stopped paying, then we will not treat it as a relapse. We treat it as a new claim and the waiting period and benefit period start again.

Premium waiver – when you don't have to pay premiums

You don't have to pay premiums if we are paying an income benefit under the Income Protection Plan. This is so even if the benefit payable under the Income Protection Plan is reduced to nil due to benefit offsets (see page 50).

Once we have accepted your claim we will refund any premiums that fell due during the waiting period.

If we have paid until the benefit period ended and the insured person is still totally disabled or partially disabled, your Income Protection Plan still continues until the Income Protection Plan ends. You do not have to pay the premium while the insured person is totally disabled. However, for the purposes of determining whether this premium waiver will apply, we apply the duties based definition of 'totally disabled' on page 41 and the first bullet point of that definition becomes:

- they are so ill or injured that they are unable to do any remunerative work for which they are reasonably suited by their education, training or experience.

Specific rules for Basic plans

If you have a Basic plan, when we have finished paying a claim we have the choice of:

- keeping the cover going on the same terms as it had before the claim,
- at any time after the first plan anniversary, we can change the terms of the Income Protection Plan (for example we can charge extra premiums or add a specific rule to your Income Protection Plan), or
- at any time after the second plan anniversary, we can cancel the cover.

What we will do will depend on the circumstances of the claim.

If we don't cancel the Income Protection Plan after a claim, we will keep the Income Protection Plan going each year on the terms we set out when the claim was finished.

We will do this as long as you pay the premium on time – until we finish paying any other claim under the Income Protection Plan. When we finish paying any other claim, we can again change the terms of the cover or cancel it.

Benefit offsets

When we will reduce the amount we pay

Advanced Plan (White collar occupations)

We will not reduce an income benefit by payments you or the insured person receives from any other source.

Advanced Plan (other than White collar occupations), Standard Plan and Basic Plan

We will reduce the amount we pay under the Total Disability benefit, the Partial Disability benefit and the Day 1 Accident option, if you or the insured person receives any of the following payments:

- regular payments from any workers compensation, accident compensation or public liability scheme payable because the insured person is ill or injured, and
- regular payments from any insurance policy covering the insured person after you applied for the Income Protection Plan if the insurer did not consider this Income Protection Plan in assessing your eligibility.

If any of these payments are not paid monthly, we will convert them to monthly payments for our calculation. If the payment is a lump sum, we will only take into consideration that part of the payment that relates to compensation for loss of wages or earning capacity.

We ignore any other income or regular payments (including investment income and amounts paid as compensation because of the insured person's pain and suffering).

We can recalculate how much we pay, or have paid, if we did not include amounts listed above. You must return any amount we have overpaid. We may reduce any amounts we pay in the future to cover those overpayments.

Deducting taxes or charges

We can deduct from amounts we pay, any taxes or government charges that:

- the law requires us to deduct, or
- have to be paid and which we decide to deduct.

Premiums and fees

See page 59.

When we won't pay

We won't pay if the insured person's injury or illness was caused directly or indirectly by:

- war – whether war was declared or not, or
- your, or the insured person's, intentional or deliberate act.

We don't pay for normal and uncomplicated pregnancy or childbirth. However, we pay if the insured person is totally disabled or partially disabled because they experience complications during pregnancy or while giving birth.

When cover starts

Your Income Protection Plan starts on the date specified in the Certificate of Insurance. Any alteration to your cover, or increase in the maximum monthly benefit, starts on the date we notify you in writing.

When the Income Protection plan ends

Your Income Protection Plan ends when one of the following happens:

- the insured person turns 60 (if the benefit period is 1 year, 2 years, 5 years or 'to age 60'),
- the insured person turns 65 (if the benefit period is 'to age 65'),
- the insured person dies,
- the date we receive your written request to cancel the Income Protection Plan,
- we cancel your Income Protection Plan because you have not paid your premium or any other amount payable under the plan,
- the insured person leaves remunerative work and intends never to return to remunerative work, or
- if you have a Basic plan, we cancel the plan in the circumstances set out in the Specific rules for Basic plans on this page.

We may also cancel your Income Protection Plan for any reason the law permits. For example, if you do not comply with your duty of disclosure, we may cancel your plan from the plan start date and treat it as never having existed.

Reinstating the Plan

You may apply to have your Income Protection Plan reinstated if we cancel the plan because you have not paid your premium. You must apply within 3 months after the due date of the premium you did not pay.

We may reinstate your plan on any terms we determine at the time.

Transferring ownership

You can't transfer the ownership of the Income Protection Plan to anyone else. Also, you can't use the plan as security for any loan and the only person we will pay under the plan is you. That is so even if we receive notice of a trust, assignment, lien or charge related to an attempt to transfer any rights under the plan to anyone.

About the Business Overheads Insurance plan

Under a Business Overheads Insurance plan you can be reimbursed for eligible business overheads while the insured person is totally disabled or partially disabled due to illness or injury.

Is this plan right for you?

This cover is particularly appropriate for:

- Small businesses, partnerships with 5 or less partners and sole traders. Generally, it does not matter how the business is structured or who owns it.
- Businesses where the cashflow is earned as a result of services rendered (eg professionals or consultants).

Generally, this cover will not be suitable for businesses where cashflow is earned from the sale of goods (eg retail shopkeepers).

To be eligible for this cover, you need to show us that:

- the insured person's efforts are largely responsible for generating the business cash flow (or their share of its cash flow)
- if the insured person were unable to work, that cash flow would significantly decline, or even cease, and
- the insured person is responsible for the payment (or their share) of business expenses.

Flexibility to tailor a plan that meets your needs

The Business Overheads Insurance plan gives you choices – so that you have the flexibility to tailor a plan that suits your needs. This section sets out the choices available to you.

Who can own the plan?

The Business Overheads Insurance plan can be owned by:

An individual	A company

A Business Overheads Insurance plan can be owned by the individual or company that incurs the overhead costs of the business.

We pay a benefit under the Business Overheads Insurance plan to the plan owner.

Who can be an insured person?

The 'insured person' is the person whose life is covered under the Business Overheads Insurance plan. There can only be one insured person under a Business Overheads Insurance plan.

We only insure certain types of occupations. The person must be between the ages of 19 to 59 when you apply for cover. These entry age requirements apply to new business, as well as to increases and additions to existing plans.

How much cover do you need?

You can choose a maximum monthly benefit up to 100% of your monthly business expenses. The lowest maximum monthly benefit is currently $1,250.

How long is the benefit period and what waiting period suits your needs?

The benefit period is one year. This is the maximum period of time that we will pay most benefits. It can be extended by up to 6 months in some circumstances (see page 56).

The waiting period is the period you must wait before you can become eligible for a Total Disability benefit or a Partial Disability benefit.

You can have either a 2 week or 4 week waiting period. The premium is cheaper if you choose a longer waiting period.

Not available through the AMP Superannuation Savings Trust

Business Overheads Insurance Plan – Facts

Cover expiry age

Cover expires at age 65.

Taxation information

Are premium payments tax deductible?	Are benefit payments assessable for income tax?
Premium payments are generally tax deductible if incurred by a business.	Benefit payments are generally assessable for income tax and should be included in your business's tax return.

The above is our general understanding of the current legislation and rules as at the date of preparation of this document. Taxation laws and their interpretation may change from time to time. We recommend that you speak to your accountant or tax adviser about your personal tax circumstances.

Plan rules – Business Overheads Insurance

Benefits and features at a glance

The benefits and features of the Business Overheads Insurance Plan are listed below.

In-built benefits and features are shown below like this:	
An option for a discounted premium can be added to your Business Overheads Insurance Plan. This option will only apply if it is shown in your Certificate of Insurance, and is shown below like this:	

The benefits and features of the Business Overheads Insurance Plan are explained in detail on pages 53 to 57. Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see pages 65 to 74).

Key benefits

We will pay you one of the following business income benefits at any one time – as long as you satisfy the conditions for payment:

Total Disability benefit (see page 54)	**Partial Disability benefit** (see page 55)

Additional benefits

These additional benefits may be paid in addition to one of the business income benefits referred to above:

Cash Flow bonus (see page 56)	**Locum bonus** (see page 56)	**Overseas transport benefit** (see page 56)

Features

The Business Overheads Insurance Plan has the following features:

Indexation feature (see page 56)	**Attempted return to work feature** (see page 57)	**Relapse feature** (see page 57)
On Hold feature (see page 57)	**AIDS Exclusion option** (see page 56)	**Premium Waiver** (see page 57)

24 hour, worldwide cover

The insured person is covered worldwide, 24 hours a day, 7 days a week (although benefit payments may stop after 3 months unless the insured person returns to Australia or New Zealand – see page 54).

Guaranteed renewable

As long as you pay premiums when they are due, we guarantee to continue the Business Overheads Insurance plan until the plan ends (see page 58).

Understanding the Waiting Period, Benefit Period and the Maximum Monthly Benefit

Waiting period

The waiting period is the period of time you must wait before you become eligible for a Total Disability benefit or Partial Disability benefit. The length of the waiting period you choose is shown in the Certificate of Insurance.

The waiting period starts on the date the insured person becomes totally disabled.

The waiting period only ends when the total number of days the insured person has been totally disabled or partially disabled (as applicable) when added together, equal the waiting period.

The following diagram illustrates how the waiting period and the timing of payments work.

Total disability or partial disability starts	Eligibility for a benefit starts	Benefit payments commence
Waiting period You will not receive a benefit for the waiting period.	**One month** You will receive a benefit for this period (if the insured person meets the conditions for payment) but the payment will be paid monthly in arrears.	

Benefit period

The benefit period is 12 months. It is the maximum period of time that we will pay the Total Disability benefit and the Partial Disability benefit for one claim. We may extend the benefit period in some circumstances (see page 56).

When the insured person is outside Australia or New Zealand

We will pay for an illness or injury that happens anywhere in the world at any time. However, we may not pay for more than 3 months while the insured person is outside Australia or New Zealand (maximum overseas payment period).

We may agree to keep paying for more than 3 months while the insured person is outside Australia or New Zealand if you ask us to and you, and the insured person, agree to any conditions we set.

If we don't pay after the maximum overseas payment period, then, when the insured person returns to Australia or New Zealand, we will start paying again if you are still entitled to be paid under the Business Overheads Insurance plan. We will not pay you for any period before the insured person returns to Australia or New Zealand (other than the maximum overseas payment period).

If the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, then we may assist you with their return travel expenses (see 'Overseas Transport benefit' on page 56).

Maximum monthly benefit

The maximum monthly benefit is the amount you apply for, and we accept, as varied in accordance with the terms of the Business Overheads Insurance plan (for example, under the Indexation feature) or by agreement.

Benefits and features explained

When we pay

We only pay a benefit under the Business Overheads Insurance Plan if the insured event happens after cover starts and before cover ends (see page 58).

We won't pay a benefit under the Business Overheads Insurance Plan in some circumstances (see 'When we won't pay' on page 57). Also, we may reduce the amount we pay under a benefit if you receive payments from other sources (see 'Benefit Offsets' on page 57). You must satisfy our claim requirements before we pay a benefit (see page 63).

Other than that, we will pay a benefit under the Business Overheads Insurance Plan in the circumstances set out in this section.

Total Disability benefit

When we pay

We pay the Total Disability benefit if the insured person is totally disabled and has satisfied these conditions:

- the insured person has been totally disabled for the whole waiting period, and
- unless the insured person has experienced a relapse (see page 57) the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Total Disability benefit monthly in arrears.

What does 'totally disabled' mean?

The insured person is 'totally disabled' if:

- they are so ill or injured that they are unable to carry out any one duty, or combination of duties, which are critical to the proper performance of their usual occupation, and
- they are under the ongoing care of a doctor for that illness or injury, and
- they do not do any remunerative work (see page 74 for the meaning of 'remunerative work').

Amount we pay

We will reimburse the eligible business overheads (as defined on this page) incurred in a month, up to the maximum monthly benefit.

If, in any month, the insured person is totally disabled for less than a full month, we will pay a daily amount for each day that the insured person is totally disabled in that month. We calculate the daily amount by dividing the monthly amount by the number of days for that month.

We may reduce the amount of Total Disability benefit we pay by:

- benefit offsets (see page 57), and
- any amount which the person who replaces the insured person has generated (since the end of the waiting period) in excess of the amount they cost.

What are eligible business overheads?

Eligible business overheads include ongoing fixed costs which will continue to be payable while the insured person is disabled, such as:

- salaries of non-income producing staff – including family members who have been employed for more than 3 months in the business at the date the insured person became totally disabled. For example, we will pay salaries for secretaries, bookkeeping staff etc. We also pay costs directly relating to those salaries. For example, we pay workers compensation and superannuation costs,
- rent and mortgage interest payments for the business premises – unless they are also the insured person's residence,
- property rates and property taxes,
- leasing costs for office equipment and motor vehicles,
- electricity, water, heating and telephone bills,

- cleaning and laundry bills,
- general insurance premiums,
- subscriptions to professional associations,
- advertising costs,
- accountant's and auditor's fees, and
- any other business overheads we agree to cover.

Note: When the business employs someone to replace the insured person, if all the reasonable costs of employing that replacement person (eg salary, travel, accommodation, superannuation, etc) exceed the business income the replacement generates, then we treat that excess as an eligible business overhead.

What are not eligible business overheads?

The following costs are not eligible business overheads:

- any form of remuneration paid to:
  - The insured person.
  - Someone who is not a genuine employee adding value to the business.
  - The person who replaces the insured person – for example a locum.
  - People who earn income for the business, and
  - Any member of the insured person's family who has been employed for less than 3 months in the business at the date the insured person became totally disabled,
- the cost of stock, equipment, or other assets of the business,
- payments of the principal of any mortgage or debt,
- any rent or mortgage payments on the insured person's residential premises – even if the insured person uses those premises for their business,
- any tax the business has to pay,
- any depreciation,
- expenses which the business does not incur regularly, and
- expenses which are not normal and necessary for the business.

When we stop paying

We stop paying the Total Disability benefit when one of the following happens:

- the insured person is no longer totally disabled
- all the periods we have paid because of one claim add up to 12 months, unless the benefit period is extended (see page 56), or
- the Business Overheads Insurance plan ends (see page 58).

If we stop paying because the insured person is no longer totally disabled, you may be eligible for the Partial Disability benefit. If we accept your Partial Disability benefit claim, benefit payments will continue without a new waiting period applying.

Partial Disability benefit

When we pay

We pay the Partial Disability benefit if the insured person is partially disabled and satisfies these conditions:

- the insured person has been totally disabled for at least 7 consecutive days during the waiting period,
- the insured person has been totally disabled or partially disabled for the remainder of the waiting period, and
- unless the insured person has experienced a relapse (see page 57), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Partial Disability benefit monthly in arrears.

What does 'partially disabled' mean?

An insured person is 'partially disabled' if:

- they perform remunerative work but the illness or injury which made them totally disabled causes them to earn less than they did before they became totally disabled, and
- they are under the ongoing care of a doctor for that illness or injury.

Amount we pay

The monthly amount of the Partial Disability benefit we pay is calculated using the following formula:

$$\frac{(A - B)}{A} \times C$$

Where:

A = Pre-disability business income. This is 1/12 of the insured person's business income during the 12 months before the insured person became totally disabled.

B = The insured person's monthly business income while partially disabled. If this amount is less than zero, we will treat it as zero.

C = The amount we would have paid if the insured person was totally disabled.

We pay a daily amount if the insured person is partially disabled for less than a full month. The daily amount we pay is the monthly amount divided by the number of days in that month, for each day that the insured person is partially disabled.

We may reduce the amount of the Partial Disability benefit we pay by the benefit offsets (see page 57).

When we stop paying

We stop paying the Partial Disability benefit when one of the following happens:

- the insured person is no longer partially disabled
- all the periods we have paid because of one claim add up to 12 months, unless the benefit period is extended (see page 56), or
- the Business Overheads Insurance plan ends (see page 58).

When we extend the benefit period

We will extend the period we pay you if:

- we have been paying you for a period of 12 months, and
- the insured person continues to be totally disabled or partially disabled, and
- the total amount we have paid is less than 12 times the maximum monthly benefit.

We will continue to pay you until one of the following happens:

- the expiration of a further 6 months,
- the total amount we have paid you equals 12 times the maximum monthly benefit,
- the insured person ceases to be totally disabled or partially disabled, or
- the Business Overheads Insurance plan ends.

Locum bonus

Where we are paying a claim and you have employed a locum to the insured person's position, we pay a lump sum amount of $1,000 to help you meet the cost of this appointment. This amount does not increase with the Indexation feature.

This amount will only be paid once during the term of the plan.

Cash Flow bonus

We pay a Cash Flow bonus, in addition to the Total Disability benefit, to help you cope with the peaks and troughs in your eligible business overheads from month to month. The Cash Flow bonus is paid out of the 'benefits pool' or the 'expenses pool', as explained below:

What is the 'Benefits Pool'?	What is the 'Expenses Pool'?
If, in any month, we pay a Total Disability benefit which is less than the monthly benefit, we will allocate the difference to the benefits pool.	If, in any month, we pay a Total Disability benefit which equals the monthly benefit (but that amount is less than the eligible business overheads incurred) we will allocate unpaid eligible business overheads to the expenses pool.
The monthly benefit is the maximum monthly benefit less Benefit Offsets (see page 57).	

Amount we pay

The amount of Cash Flow bonus we pay is:

Negative cash flow situation	Positive cash flow situation
The amount by which your eligible business overheads (less benefit offsets) in a particular month exceeds your maximum monthly benefit (up to a maximum of the benefits pool).	The amount by which your eligible business overheads (less benefit offsets) in a particular month are less than your maximum monthly benefit (up to a maximum of the expenses pool).

Example

Maria is a surveyor in sole practice. She is injured in a car accident and can't work. She has a Business Overheads Insurance plan, so we start paying her eligible overheads. Her maximum monthly benefit is $2,000.

While she is totally disabled, she doesn't receive any reimbursement of overheads from anyone else and she doesn't appoint a locum.

In January, Maria's eligible business costs are $1,800. We pay her that amount, and we allocate the left over $200 to the benefits pool.

In February, Maria's business has an expensive month – her insurance, rates, and electricity bills arrive. Maria's eligible business costs are $2,350 and she is in a negative cash flow situation. We pay Maria the maximum monthly benefit, $2,000 plus the $200 from the benefits pool. We allocate the $150 of unpaid overheads ($2,350 – $2,200 paid to her) to the expenses pool.

In March, Maria is in a positive cash flow situation. Her eligible business costs are $750. We add the $150 from the expenses pool to the $750 for March, and pay Maria $900.

Overseas Transport benefit

We pay the Overseas Transport benefit if the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, to assist with their return travel expenses to Australia.

We reimburse up to the cost of one single economy airfare for the insured person, by the most direct route available, less any amounts anyone else pays you or the insured person for this expense.

AIDS Exclusion option

This is an option for a discounted premium. It only applies if it is shown in the Certificate of Insurance for the insured person.

If the AIDS Exclusion option applies, we will not pay a benefit for disability arising from the presence of HIV in the insured person's body, or AIDS or any AIDS-related illness.

Indexation feature

On each plan anniversary, we will increase the maximum monthly benefit by the percentage increase in the CPI since the last plan anniversary (or since the plan start date if this is the first plan anniversary under the Business Overheads Insurance plan). However, we will not do this if:

- you tell us not to, or
- we are paying you a benefit.

We will not reduce the maximum monthly benefit if the CPI is negative.

This increase will be clearly identified in the annual statement we send you each year.

If you do not want this increase, in full or in part, then you need to tell us.

Attempted return to work feature

If the insured person returns to work during the waiting period (and is not totally disabled or partially disabled) for 5 days (or less) in a row, the waiting period does not start again. That is so, even if the insured person returns to work more than once during the waiting period. The days of attempted return to work are added to the waiting period for the purposes of determining when the waiting period ends.

Relapse feature

If the insured person experienced an illness or injury, and then they again experience the same illness or injury or one that arises from the same or a related cause, what happens depends on why we stopped paying.

If we stopped paying because we had paid 12 times the monthly benefit, we will only pay if the insured person has worked in their usual occupation for at least their usual income for at least 6 months in a row since we stopped paying. In that case, we treat the claim as a new claim and both the waiting period and benefit period start again.

Otherwise:

- If the insured person experiences the same illness or injury or one that arises from the same cause or a related cause **at least 6 months after** we stopped paying, then we will not treat it as a relapse. We treat it as a new claim and both the waiting period and the benefit period start again.
- If the insured person experiences the same illness or injury or one that arises from the same cause or a related cause **within 6 months after** we stop paying, then we treat the insured person as having experienced a relapse. We will treat the claim as a continuation of the previous claim. The waiting period and the benefit period do not start again. Instead, we add up all the periods we pay you for that claim and treat them as one benefit period.

On Hold feature

You can put the Business Overheads Insurance plan 'on hold' within the first 12 months after the insured person temporarily leaves remunerative work. You must tell us in writing if you want to put your cover 'on hold'.

While the Business Overheads Insurance plan is 'on hold' a reduced premium is payable and there is no cover. That means, we won't pay for any illness or injury which happens while the plan is 'on hold'.

We guarantee to take the Business Overheads Insurance plan 'off hold' when the insured person starts remunerative work again and you tell us in writing that you wish to take the Business Overheads Insurance plan 'off hold'. We will take the Business Overheads Insurance plan 'off hold' in these circumstances without you having to provide evidence of the insured person's health, pastimes or occupation.

Your premium once your Business Overheads Insurance plan ceases to be 'on hold' is no longer reduced. The premium when the insured person starts remunerative work again will be based on our premium rates at that time.

Premium Waiver – when you don't have to pay premiums

You do not need to pay premiums under the Business Overheads Insurance plan if we are paying a benefit under the Business Overheads Insurance plan. This is so even if the benefit payable under the Business Overheads Insurance plan is reduced to nil due to benefit offsets (see information on this page).

Once we have accepted your claim for a Total Disability benefit or Partial Disability benefit under the Business Overheads Insurance plan, we will refund any premiums that fell due during the waiting period.

If we have paid until the benefit period ended and the insured person is still totally disabled or partially disabled, your cover still continues until the Business Overheads Insurance plan ends. You do not have to pay the premium while the insured person is totally disabled. However, for the purpose of this premium waiver, the first bullet point in the definition of 'totally disabled' on page 54 becomes:

- they are so ill or injured that they are unable to carry out any remunerative work for which they are reasonably suited by their education, training or experience.

Continue cover

We can continue cover up to 12 months after the insured person temporarily stops working for reasons other than illness or injury.

Benefit offsets

When we will reduce the amount we pay

We will reduce the amount of the Total Disability benefit and Partial Disability benefit we pay if you, or the insured person, receives a business expense benefit from other insurance policies.

We deduct taxes and charges

We can deduct from amounts we pay, any taxes or government charges that:

- the law requires us to deduct, or
- have to be paid and which we decide to deduct.

Premiums and fees

See page 59.

When we won't pay

We will not pay if the insured person's injury or illness was caused directly or indirectly by:

- war – whether war was declared or not, or
- your, or the insured person's, intentional or deliberate act.

We do not pay for normal and uncomplicated pregnancy or childbirth. However, we will pay if the insured person is totally disabled or partially disabled because they experience complications during pregnancy or while giving birth.

When does your cover start?

Your Business Overheads Insurance Plan starts on the date specified in the Certificate of Insurance. Any alteration to your cover, or increase in the maximum monthly benefit, starts on the date we notify you in writing.

When the plan ends

Your Business Overheads Insurance plan ends when one of the following happens:

- the insured person turns 65,
- the insured person dies,
- we receive your written request to cancel the Business Overheads Insurance plan,
- we cancel your Business Overheads Insurance plan because you have not paid your premium or any other amount payable under the plan, or
- the insured person leaves remunerative work and intends never to return to remunerative work.

We may also cancel your Business Overheads Insurance plan for any reason the law permits. For example, if you do not comply with your duty of disclosure, we may cancel your plan from the plan start date and treat it as never having existed.

Reinstating the Plan

You may apply to have your plan reinstated if we cancel the plan because you have not paid your premium. You must apply within 3 months after the due date of the premium you did not pay. We may reinstate your plan on any terms we determine at the time.

Transferring ownership

You can't transfer the ownership of the Business Overheads Insurance plan to anyone else. Also, you can't use the plan as security for any loan and the only person we will pay under the plan is you. That is so even if we receive notice of a trust, assignment, lien or charge related to an attempt to transfer any rights under the plan to anyone.

Premiums and fees – facts

What is the premium?

The amount you pay for your plan is called a premium. Your premium includes a plan fee (which can increase each year by the CPI) and will usually change each year.

Before you apply for cover, you can obtain an individual premium quote from your financial planner or by calling AMP on 1300 360 838. Each year, AMP will send you an Annual Statement advising you about your premiums for the next year.

2012 Plan Fees		
Life Protection plan	$87.95 pa for the first insured person	$17.55 pa for any subsequent insured person(s)
Income Protection plan	$87.95 pa	$17.55 pa for any other Income Protection plan or Business Overheads Insurance plan taken out at the same time to cover the same insured person
Business Overheads Insurance plan	$87.95 pa	

Note: Only one person can be insured under an Income Protection plan or Business Overheads Insurance plan.

The minimum premium (including the plan fee) for a plan is $250 pa for the first insured person and $200 pa each for any other insured person(s).

Flexible payment options

You can pay premiums yearly, half-yearly or monthly by direct debit from your:

- bank account, building society account, or credit union account, or
- MasterCard, or
- VISA, or
- American Express card.

You can also pay yearly or half-yearly by cheque, BPAY® or Post Billpay.

These payment options are subject to change.

Factors that affect your premium

The following table describes the various premium factors we consider and how they may affect your premium.

We have separate premium rates for each type of plan, type of cover and optional benefit.

Premium Factor	How it affects your cover
Age	Generally, as you become older the cost of insurance increases.
Gender	As illness and life expectancy varies between men and women, we may charge different premium rates. Death cover and Trauma cover premiums are generally cheaper for females. TPD cover premiums are generally similar for males and females. Income Protection and Business Overheads Insurance premiums are generally cheaper for males.
Smoking status	We charge more for smokers.
Premium type	We apply different base premium rates depending on your choice of stepped or level premiums. If the premium type is stepped, premiums generally increase each year in line with the insured person's age. Stepped premiums are cheaper than level premiums in the early years of cover. If the premium type is level, premiums do not increase each year because of the insured person's age (but your premium can increase for other reasons). Level premiums are more expensive than stepped premiums in the early years of cover but will become cheaper than stepped premiums in the longer term.
State of health	We charge different rates depending on your state of health and family medical history.
Sports/ recreational activities	We charge more for anyone engaged in activities we consider 'high risk', eg scuba diving.
Stamp duty	Stamp duty is a Government levy payable on insurance (see Government duties below).
Payment frequency	If you pay more often than yearly, we may include an additional premium frequency loading in the premium.
Additional factor for TPD cover, Income Protection Plan and Business Overheads Insurance plan	
Occupation	Generally, occupations with hazardous duties or higher risks are charged more.

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Government duties

Your premium may also include government stamp duty or a similar tax.

Stamp duty is either incorporated into the base premium rate or is an additional charge. If it is an additional charge it will be shown on your annual statement. We may change the way we recover stamp duty, from incorporating it into base premium rates to making it an additional charge.

Currently, additional stamp duty charges vary between 1.5% and 11% of the cost of the base premium, depending on the plan, cover and/or options selected, and the State or Territory we record as the address of the first insured person on your plan.

As stamp duty differs between States and Territories it is important that you inform us of any changes to the address of the first insured person on your plan.

Discount and loadings

We apply discounts or loadings to the premiums for Life Protection Plans and Income Protection Plans, based on the size of the sum insured. These discounts and loadings are not guaranteed. The premium adjustment is effective on the full amount of the sum insured for each insured person. Each benefit is calculated separately. Due to the operation of the discount tables there will be instances where the premium for the same insured person may be less for a larger sum insured. The premium quote you receive will already take these discounts/loadings into account.

If you pay more often than yearly, we may include an additional premium frequency loading in the premium. This loading is a percentage of the yearly premium payable. We can change the percentage at any plan anniversary and we will inform you of any changes before it applies.

For monthly payments the loading is currently 7.52% and for half-yearly payments it is 3%.

Direct Debit Service Agreement

The following terms will apply to any direct debit that you, your spouse or your employer set up to make payments. These terms equally apply to members of the AMP Superannuation Savings Trust if the insurance is acquired through the AMP Superannuation Savings Trust. Here a reference to 'you' will also include a reference to a 'member'.

Before you request a direct debit arrangement you must check that the account you want to nominate can have direct debit (eg some passbook savings accounts cannot have direct debit). To find out if we can debit from your account, contact your financial institution.

Please double-check any account details you provide by comparing them with a recent statement from your financial institution.

This agreement allows AMP Life to deduct from your nominated account the amount and at the frequency shown on the certificate of insurance, or the amount as modified annually due to increases under the Indexation feature.

If we want to change this agreement, we will notify you 14 days in advance unless the change is specifically in relation to Government stamp duty. If you disagree with this change, please notify us within these 14 days.

AMP will keep your financial institution account details confidential. However, we will disclose these details:

- if you give permission
- if a court order applies
- to settle a claim, or
- if our financial institution needs information.

If the due date is on a weekend or public holiday, we will process your payment on the next business day.

You should make sure that sufficient cleared funds are available in your account on the due date for payment.

If there are not sufficient funds and your financial institution dishonours the payment, any charges incurred by:

- your financial institution may be debited from your account, and
- AMP may be debited from your Plan.

If you want to change or cancel this agreement or dispute a debit, contact our Customer Service area. In particular, if you want to:

- change this agreement (eg the amount you pay, how often you pay, account number, deferring payment due to unforeseen circumstances) – you need to contact us at least 3 days before the due date,
- cancel this agreement or an individual payment – you need to contact us at least 5 days before the due date, or
- dispute a debit that has been made from your account – AMP will respond to your initial dispute within 5 business days.

Cancellations and claims may also be made through your financial institution.

If you believe that a debit has not been correctly processed, you should contact us immediately on 131 267.

You indemnify us against all losses, costs, damages and liabilities that we suffer as a result of you breaching this agreement, or providing us with an invalid or non-binding direct debit request addressed to us.

Ad-hoc direct debit

You, your spouse or your employer can request us to transfer ad-hoc amounts from your, your spouse's or your employer's bank account. Ad-hoc direct debits are not an automatic periodic deduction of a fixed amount. Debits from your, your spouse's or your employer's bank account will only occur each time you, your spouse or your employer instruct us by phone or in writing.

Plan Rules – Premiums and fees

Both the initial premium you are required to pay and when it is due are stated in the Certificate of Insurance. Your initial premium consists of:

- the basic premium
- the plan fee, and
- government charges (eg Stamp Duty).

Premium types – stepped or level premiums

Stepped method

Under the stepped method, we will recalculate the basic premium for an insured person's cover on each plan anniversary, based on the insured person's age on that date. The premium will usually increase.

Level method

Under the level method, the premium for:

- an insured person's initial insured amount (for a Life Protection Plan) or maximum monthly benefit (for an Income Protection Plan), is based on the insured person's age at the plan start date, and
- any increase in the insured amount (for a Life Protection Plan) or the maximum monthly benefit (for an Income Protection Plan), is based on the insured person's age at the date of the increase.

If you choose a level premium for Death cover, TPD cover or Trauma cover the premium will automatically change to stepped from the plan anniversary after the insured person turns 64.

Changes to premium rates

Regardless of whether your premium type is stepped or level, the premium rates are not guaranteed. We may vary premium rates at any time. Any increase in your premium will apply at your next plan anniversary.

We can't single you out for an individual premium rate variation. If we increase premium rates we will apply the increase to all plans that we consider to be similar to your plan.

If we reduce our premium rates (or increase any discounts) for the Life Protection Plan we may keep your premium the same by increasing the insured amount under your plan. We will tell you in writing before we do this.

Keeping the premium the same

If you do not want your premium to increase on a plan anniversary, you need to write to us before the plan anniversary to let us know.

As we will reduce the insured amount (for a Life Protection Plan) or the maximum monthly benefit (for Income Protection Plans or Business Overheads Insurance Plans) to keep the premium the same, you must also tell us at the time the plan or cover that you want to reduce or cancel.

If you stop paying premiums

If you don't pay each premium as it becomes due, we can end your plan. If you don't pay on time, we will write and remind you and you will have 30 days to pay before we take steps to end your plan.

Refund of premiums

If you end your plan during a period that you have already paid the premium, we will refund the premium (or proportion of that premium) less the plan fee, stamp duty and Government charges, for any unused complete months.

We don't refund premiums if the plan ends for any other reason.

If cover under a Life Protection Plan is acquired through the AMP Superannuation Savings Trust, the Trustee will pay this refund into a similar complying superannuation fund nominated by the member, or to an account in the AMP Eligible Rollover Fund on behalf of the member.

This right is in addition to any 'cooling off' rights you have under a plan.

Statutory fund

Premiums are paid to, and benefit payments are made from (and are limited to), the assets of our No. 1 Statutory Fund.

Payments to your financial planner

If you purchase this plan, AMP Life may pay remuneration for the purchase to your financial planner. This remuneration may be in the form of commissions and/or other benefits.

Standard commission

AMP Life will normally pay a standard commission to the financial planner for your plan. We pay this out of the insurance premiums – you do not pay this additional amount.

The financial planner will notify us at the time of application of the required commission structure.

You can obtain details on commission rates from your financial planner or by contacting us on 131 267.

Alternative commission

You and your financial planner can agree to an alternative to the standard commission. If an alternative rate of commission is agreed between you and your financial planner, the cost of your insurance may be reduced.

Alternative forms of remuneration

AMP Life is required to comply with an industry code on alternative forms of remuneration. The code is the Financial Services Council and Financial Planning Association Industry Code of Practice on Alternative Forms of Remuneration in the Wealth Management Industry (the Code).

The Code requires AMP Life to maintain a register that records any material forms of alternative remuneration, which it pays or receives. Registers are required to be maintained by investment managers, platform providers, representatives and licensees.

The register is publicly available for inspection by you and a copy of the register can be requested by contacting AMP on 131 267.

Plan Rules – Claiming a benefit

How to claim

We aim to be proactive in our claims management. Our claim requirements vary depending on the type of, and reason for, the claim you are making. We pride ourselves on providing a supportive claims service and are committed to paying genuine claims. This includes the provision of a Claims Concierge Service and a specially trained and empathetic Claims team.

The 4 steps of the claims process:

Step 1 – You notifying AMP of your intention to claim.

Step 2 – You complete and return the claim paperwork.

Step 3 – AMP assesses your claim.

Step 4 – We assist you with your claim payment.

Notifying us of a claim

To notify us of your intention to claim a benefit, you or an authorised representative acting on your behalf can contact our Claims team on the following numbers:

Death claims **1300 373 654**

Disability claims **1300 366 214**

Disability claims include claims under the Terminal Illness benefit, Total and Permanent Disablement cover, Trauma cover, Income Protection and Business Overheads Insurance.

Information that you must provide to us

Upon this notification we will send claim forms for you to complete and return to us. These forms will be specific to the plan and benefit type under which you are claiming. Our initial claims requirements will be outlined in our letter to you, and may include, but are not limited to:

- Initial Claim Form.
- Certified copy of the death certificate (if applicable).
- Initial Medical Report, completed by the insured person's treating doctor.
- Medical evidence, including proof of diagnosis of the medical condition or occurrence of the medical procedure for which the claim is being made.
- Copies of any medical reports from relevant specialists, scans or test results (eg clinical, histological and radiological evidence) which will assist in the assessment of your claim.
- Any other evidence and history of the insured person's health
- Employer's statement (if applicable).
- Certified copy of yours and the insured person's proof of identity.

In addition, we will advise you of the direct contact details of our claims representative for your future reference.

You must also provide us with any other documents and information we reasonably require to consider your claim. For example, you must provide us any information which we reasonably require about:

- the insured person's income and expenses. For example, we will usually ask for the insured person's income tax returns, income tax assessment notices and any relevant books of account. We may ask you what the insured person's income and expenses:
  - were when the plan started, or you last changed it, and
  - were just before you became eligible for a benefit, and
  - are while we are paying, and
- any other information we believe is relevant in assessing your claim.

Medical assessments

We may also require the insured person to attend, and cooperate at, any assessments. Some of those assessments may be by medical advisers we choose. The insured person may also need to have medical tests.

We will pay the costs of obtaining information from medical advisers we choose. In all other cases, you must pay the costs of providing information in support of your claim.

Time limit

You must tell us you are going to claim a benefit as soon as practicable.

If you delay in making a claim or providing information:

- this may delay the payment of any benefits you receive from us, and
- we may reduce the amount we pay (which may be to nil) to the extent that we have been prejudiced by the delay.

When we pay

We will pay as soon as we have processed a claim that satisfies the rules of the plan.

Providing information to AMP

Your Privacy

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it. We may also use this information for related purposes – for example, enhancing customer service and product options and providing you with ongoing information about opportunities that may be useful for your financial needs. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services that may be made available by us, other members of the AMP Group, or by your financial planner. We usually disclose information of this kind:

- To other members of the AMP Group.
- To your financial planner or broker (if any).
- To the owner of the plan.
- To external service suppliers who supply administrative, financial or other services to assist the AMP Group in providing AMP Financial Services.
- To the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost superannuation.
- To anyone you have authorised or if required by law.

If health information is collected in relation to this financial product, then additional restrictions apply. AMP Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, AMP Life, to assess your application for new or additional insurance. AMP Life may also use this information for directly related purposes – for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims. AMP Life may disclose this type of health information to:

- The financial planner or broker responsible for the plan.
- The trustee.
- The owner of your personal insurance plan (if applicable).
- AMP Life's reinsurers.
- Medical practitioners.
- Any person AMP Life considers necessary to help either assess claims or resolve complaints.
- Anyone you have authorised or if required by law.

If you are an insured person, aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

If you are an insured person, AMP Life and/or their health screening provider may also speak to a third party for the sole purpose of arranging a health screening appointment. This third party may include a spouse, family member, personal assistant, financial planner or other relevant party.

Under the National Privacy Principles, you may generally access personal information about you held by the AMP Group. Also, you may let us know if you think any of it is inaccurate, incomplete or out-of-date. The AMP Privacy Policy Statement sets out the AMP Group's policy on management of personal information.

You may obtain a copy by contacting us on 131 267 or visiting our website at **amp.com.au**.

Your duty of disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of life insurance.

Your duty however does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of its business, ought to know
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it.

If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Plan Rules – Dictionary of defined terms

The terms defined in this Dictionary are separated into 2 categories:

- Trauma definitions – including AMP's Claims Guiding Statement (pages 65 to 72), and
- Other general definitions of terms used throughout this document (pages 72 to 74).

Trauma definitions

These definitions apply to trauma conditions and medical procedures covered under the Life Protection Plan and Income Protection Plan.

Claims guiding statement

Medical diagnoses and investigation methods used in many of the trauma conditions that we cover are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular trauma condition. Should the insured person be diagnosed with one of the trauma conditions, and the method(s) used to diagnose it isn't specified within our trauma definition, we may take that method(s) into consideration. This may assist in the assessment of your claim.

Alzheimer's disease and other dementias

The insured person receives an unequivocal diagnosis of dementia (including Alzheimer's disease) resulting in permanent and significant cognitive impairment with a Mini-Mental State Examination score of 24 or less.

Aortic surgery

The insured person has surgery performed to correct a structural abnormality of the aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We won't pay for surgery performed using intraluminal or laparoscopic techniques.

Aortic surgery by minimal invasive techniques

The insured person has keyhole surgery performed to correct a structural abnormality of the aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Aplastic anaemia

The insured person has severe aplasia of bone marrow as defined by an appropriate consultant medical specialist.

Bacterial meningitis and meningococcal disease

The insured person suffers bacterial meningitis or meningococcal septicaemia. The meningitis or septicaemia must produce neurological deficit causing permanent and significant functional impairment or the inability to perform any one of the activities of daily living without assistance from someone else.

Benign tumour of the brain or spinal cord

The insured person has a non-cancerous tumour in the brain or spinal cord which is histologically described and which produces neurological deficit:

- causing permanent and significant functional impairment, or
- resulting in the inability to perform any one of the activities of daily living without assistance from someone else, or
- requiring surgery for its removal.

We don't cover any of the following:

- cysts, granulomas and cerebral abscesses, or
- malformations in, or of, the arteries or veins of the brain, or
- haematomas, or
- tumours in the pituitary gland.

Blindness

The insured person loses the sight of both eyes to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 10 degrees or less of arc. That loss must be irreversible and unable to be corrected by glasses or any other means.

Cancer

We will pay	If an insured person suffers from a malignant tumour. This includes:
	– a malignant sarcoma,
	– Hodgkin's lymphoma,
	– non-Hodgkin's lymphoma,
	– a malignant bone marrow disorder,
	– leukaemia, including:
	  – acute leukaemia,
	  – chronic myelocytic leukaemia,
	  – chronic lymphocytic leukaemia where classified as Binet Stage B and C or Rai Stage I, II or III,
	– thrombocythemia,
	– polycythemia vera,
	– melanoma where the thickness is 1.0mm or more or the Clark level of invasion is Level 3 or more, or where the melanoma is showing signs of ulceration,
	– any other type of skin cancer that has metastasised,
	– a prostate tumour that is histologically described as having:
	  – a TNM Classification of T2, or
	  – a TNM Classification of T1 (or any equivalent classification) with a Gleason score of 6 or more, or
	  – a TNM Classification of T1 where removal of the entire prostate or radiotherapy is recommended, specifically to arrest the spread of malignancy, and the procedure is the appropriate and necessary treatment
	– tumours which are histologically described as pre-malignant or showing malignant changes of 'carcinoma in situ' requiring treatment similar in extent to that which would be undertaken for invasive carcinoma(i).

Payment conditions	The cancer must be: – confirmed by pathology tests, and – characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.
We won't pay	For all other types of skin cancer.

(i) Treatment in this instance is defined as surgery and adjuvant therapy (such as radiotherapy and/or chemo-therapy)

Carcinoma in situ of breast

The insured person suffers carcinoma in situ of the breast, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of cervix uteri

The insured person suffers carcinoma in situ of the cervix-uteri, where the tumour is classified as:

– CIN 3 grading, or

– tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of uterus

The insured person suffers carcinoma in situ of the uterus, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of fallopian tubes

The insured person suffers carcinoma in situ of the fallopian tubes, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of ovary

The insured person suffers carcinoma in situ of the ovary, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of penis

The insured person suffers carcinoma in situ of the penis, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of perineum

The insured person suffers carcinoma in situ of the perineum, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of testes

The insured person suffers carcinoma in situ of one or both testes, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of vagina

The insured person suffers carcinoma in situ of the vagina, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of vulva

The insured person suffers carcinoma in situ of the vulva, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Cardiomyopathy

The insured person's heart muscle fails to function properly resulting in permanent physical impairment to at least Class 3 of the New York Heart Association Classification of Cardiac Impairment.

Coma

The insured person is in a state of unconsciousness and doesn't react to external stimuli. The state of unconsciousness must be continuous for at least 72 hours.

Complications of pregnancy

The insured person experiences one of the following complications of pregnancy:

- Hydatidiform mole – the insured person suffers a molar pregnancy, characterised by the presence of a hydatidiform mole and confirmed by an appropriate consultant medical specialist.
- Neo-natal death – the insured person gives birth to a child of at least 20 weeks gestation that does not survive 30 days.
- Still birth (excluding elective pregnancy termination) – the insured person's child suffers foetal death in utero after at least 20 weeks gestation and confirmed by a death certificate.

Coronary artery angioplasty

The insured person undergoes angioplasty involving less than 3 coronary arteries during the same procedure (with or without the insertion of a stent, laser therapy or atherectomy).

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Coronary artery angioplasty – triple vessel

The insured person undergoes angioplasty of the coronary arteries (with or without the insertion of a stent, laser therapy or atherectomy) to 3 or more coronary arteries within the same surgical procedure.

Angiographic evidence, indicating obstruction of 3 or more coronary arteries, is required to confirm the need for this procedure.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Coronary artery surgery

The insured person has coronary artery disease and as a result has surgery involving bypass grafts to one or more coronary arteries. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We don't pay under this particular trauma condition for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.

Diabetes

The insured person is diagnosed with diabetes by an appropriate consultant medical specialist resulting in at least two of the following:

- severe diabetic retinopathy resulting in visual acuity (corrected or uncorrected) of 6/36 or worse in both eyes,
- severe diabetic neuropathy causing motor and/or autonomic impairment,
- diabetic gangrene leading to surgical intervention,
- severe diabetic nephropathy causing chronic irreversible kidney impairment and requiring regular dialysis or kidney treatment.

Encephalitis

The insured person is diagnosed as having encephalitis by an appropriate consultant medical specialist.

The insured person must have impaired brain function which causes permanent inability to perform any one of the activities of daily living without assistance from someone else, or causing at least 25% impairment of whole body function.

We won't pay for encephalitis caused directly or indirectly by HIV/AIDS.

To establish 25% impairment of whole body function we will rely on the latest published edition of American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment at the time of claim. Assessment must be carried out by a medical practitioner accredited in the evaluation of permanent impairment.

Heart attack – partial payment

The insured person suffers a heart attack resulting in the death of an area of the heart muscle due to a lack of adequate blood supply where, together with symptoms of ischaemia there are diagnostic changes in the relevant cardiac enzymes or biomarkers in the days following the heart attack.

A heart attack must be confirmed by diagnostic changes in relevant cardiac enzymes or biomarkers and there will be no need for typical new ischaemic changes (new ST-T) or new left bundle branch block (LBBB) in the electrocardiograph (ECG)

We won't pay for:

- non heart attack related causes of elevated cardiac enzymes or biomarkers, and
- other acute coronary syndromes including, but not limited to, angina pectoris.

Heart attack – myocardial infarction

The insured person suffers a heart attack resulting in the death of an area of heart muscle due to lack of adequate blood supply where:

- there are diagnostic changes in relevant cardiac enzymes or biomarkers in the days following the heart attack, and
- there are typical new ischemic changes in the electrocardiograph (ECG): new ST-T changes or new left bundle branch block (LBBB).

If the above criteria are not met, we will pay a claim based on satisfactory evidence that the insured person has unequivocally been diagnosed as having suffered a heart attack resulting in:

- a permanent reduction in the Left Ventricular Ejection Fraction to less than 50 per cent measured in the three months or more after the event, or
- new pathological Q waves.

We won't pay for other acute coronary syndromes including, but not limited to, angina pectoris.

Heart attack – out of hospital cardiac arrest

The insured person suffers a cardiac arrest which:

- isn't associated with any medical procedure, and
- is documented by an electrocardiogram, and
- occurs outside a hospital, and
- is due to either cardiac asystole or ventricular fibrillation.

Heart valve surgery

The insured person has surgery to correct, or replace, a cardiac valve. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We won't pay for surgery performed using intraluminal or laparoscopic procedures.

Heart valve surgery by minimal invasive techniques

The insured person has keyhole surgery performed to repair or replace a cardiac valve. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Hepatitis B or C – occupationally acquired

The insured person becomes infected with Hepatitis B or C, which is:

- acquired as a result of an accident occurring during the course of the insured person's normal occupation, and
- acquired while the insured person was carrying out their normal occupational duties, and
- documented by proof indicating:
  - Hepatitis B surface antigen negative to Hepatitis B surface antigen positive, or
  - Hepatitis C antibody negative to Hepatitis C antibody positive

within 6 months of the presumed causal event.

Any accident giving rise to a potential claim must be:

- reported to the relevant authority or employer, and
- reported to us within 14 days of its occurrence, and
- supported by a negative Hepatitis B or C test taken within 7 days of the accident.

We will only pay if we are able to:

- independently test all blood samples used, and
- take further samples, and
- obtain a copy of the report made to the relevant institution or employer, and
- obtain all evidence relating to the alleged source of infection.

We won't pay if the infection is acquired through any other cause including but not limited to sexual activity, recreational intravenous drug use or deliberate self-infection.

HIV/AIDS – medically acquired

The insured person acquires HIV through accidental infection as a result of a medical procedure. We will only pay if we believe on the balance of probabilities that the infection arose because of one of the medical events listed below.

The event must have been medically necessary and it was performed by or under the supervision of a medical doctor or a dentist, and:

- it occurred to the insured person in either Australia or New Zealand, and
- it occurred as a result of any one of the following procedures:
  - a blood transfusion
  - the transfusion with blood products
  - an organ transplant to the insured person
  - assisted reproductive techniques.

Before we will pay, we will require proof of the incident via a statement from a Statutory Health Authority that the infection was medically acquired.

We won't pay if the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection.

HIV/AIDS – occupationally acquired

The insured person becomes infected with HIV if:

- the virus is acquired as a result of an accident occurring during the course of the insured person's normal occupation, and
- the virus is acquired while the insured person was carrying out their normal occupational duties, and
- sero conversion to the HIV infection occurs within 6 months of that accident.

Any accident giving rise to a potential claim must be:

- reported to the relevant authority or employer, and
- reported to us within 14 days of its occurrence, and
- supported by a negative HIV antibody test taken after the accident.

We will only pay if we are able to:

- independently test all blood samples used
- take further samples
- obtain a copy of the report made to the relevant institution or employer, and
- obtain all evidence relating to the alleged source of infection.

We won't pay if:

– the HIV infection is acquired through any other cause including but not limited to sexual activity, recreational intravenous drug use or deliberate self-infection, or
– recommended precautionary measures aren't taken before or after the presumed causal event.

Intensive care

The insured person has an accident or illness which requires them to have continuous mechanical ventilation by means of tracheal intubation. The tracheal intubation must need to continue for 10 consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital.

We won't pay where the accident or illness is a result of alcohol or drug use that isn't prescribed by a doctor.

Kidney failure

The insured person suffers irreversible failure of both kidneys which requires either:

– continuing renal dialysis, or
– transplantation of a human kidney.

In the opinion of an appropriate consultant medical specialist, the dialysis or transplant must be required on medical grounds and must be the most appropriate treatment.

We won't pay in the event of temporary renal dialysis for acute and reversible kidney failure.

Leukaemia

The insured person is diagnosed with leukaemia.

Liver failure

The insured person suffers irreversible failure of the liver resulting in permanent jaundice, ascites and/or encephalopathy

Loss of hearing

The insured person suffers a total and permanent loss of hearing, both natural and assisted from both ears. A cochlear implant must be deemed necessary by an appropriate consultant medical specialist. This must be certified at least 3 months after the ability to hear was first lost.

Loss of independent living

The insured person suffers total and permanent inability to perform at least 2 of the activities of daily living without assistance from someone else.

We won't pay for loss of independent living caused directly by alcohol or drug abuse.

Loss of speech

The insured person totally loses the ability to speak due to organic brain disease or accidental injury. The loss must be irreversible. We won't pay for loss of speech which is due to any psychological cause.

Loss of use of limbs and/or sight

The insured person, because of irreversible functional impairment on either a neurological or musculoskeletal basis, totally and permanently loses the:

– use of both feet, or
– use of both hands, or
– use of one foot and one hand, or
– sight in both eyes (to the extent of 6/60 or less), or
– any combination of 2 of: a hand, a foot or sight in an eye (to the extent of 6/60 or less).

Loss of use of one limb

The insured person, because of irreversible functional impairment on either a neurological or musculoskeletal basis, totally and permanently loses the use of one foot or one hand.

Lung disease

The insured person suffers chronic lung disease and as a result requires permanent supplementary oxygen. The requirement for supplementary oxygen will be an arterial blood oxygen partial pressure of 55 mmol/L or less, while breathing room air.

Major head trauma

The insured person suffers an accidental head injury which produces neurological deficit:

– causing the inability to perform any one of the activities of daily living without assistance from someone else, or
– causing significant functional impairment,

which in the opinion of an appropriate consultant medical specialist, is likely to be permanent.

Major organ transplant

The insured person requires a transplant from a donor of one of the following whole organs and is placed on a waiting list at an Australian hospital:

– kidney
– heart
– liver
– lung
– pancreas.

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

We won't pay in the event of a donation by the insured person of an organ for transplant.

Melanoma

The insured person has a malignant melanoma where the thickness is less than 1.0mm and Clark level of invasion is less than 3. The melanoma must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.

Motor neurone disease

The insured person receives an unequivocal diagnosis of motor neurone disease by an appropriate consultant medical specialist.

Multiple sclerosis

The insured person receives an unequivocal diagnosis of multiple sclerosis with more than one episode of well defined neurological deficit with persisting neurological abnormalities by an appropriate consultant medical specialist.

Muscular dystrophy

The insured person receives an unequivocal diagnosis of muscular dystrophy by an appropriate consultant medical specialist.

Myelodysplasia

The insured person is diagnosed to have myelodysplasia by an appropriate consultant medical specialist. The condition must have progressed to the point that it is permanent and the severity is such that the insured person requires a blood transfusion at least monthly and/or admission to hospital due to complications of the disorder at least 4 times per year.

Myelofibrosis

The insured person is diagnosed to have myelofibrosis by an appropriate consultant medical specialist. The condition must have progressed to the point that it is permanent and the severity is such that the insured person requires a blood transfusion at least monthly.

Open heart surgery

The insured person has open heart surgery requiring diversion of the blood through a heart-lung machine, in order to have surgery to correct any heart defect including heart valve surgery. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We won't pay under this particular trauma condition for procedures such as valvotomy or coronary artery angioplasty which don't require open heart surgery.

Paralysis – diplegia

The insured person suffers total and permanent paralysis of both arms or both legs due to organic disease or accidental injury.

Paralysis – hemiplegia

The insured person suffers total and permanent paralysis of both the arm and the leg on the same side of the body due to organic disease or accidental injury.

Paralysis – paraplegia

The insured person suffers total and permanent paralysis of both legs due to organic disease or accidental injury.

Paralysis – quadriplegia

The insured person suffers total and permanent paralysis of both arms and both legs due to organic disease or accidental injury.

Paralysis – tetraplegia

The insured person suffers total and permanent paralysis of both arms and both legs, together with loss of head movement, due to organic disease or accidental injury.

Parkinson's disease (advanced)

The insured person receives an unequivocal diagnosis of advanced Parkinson's disease. There must be significant neurological deficit which causes permanent inability to perform any one of the activities of daily living without assistance from someone else.

Parkinson's disease

The insured person receives an unequivocal diagnosis of Parkinson's disease as confirmed by an appropriate consultant neurologist.

Parkinson's disease means the unequivocal diagnosis of idiopathic Parkinson's disease due to degeneration in the nigrostriatal area of the mid-brain and characterised clinically, by one or more of the following symptoms; rigidity, tremor, akinesia.

Other forms of Parkinsonism, whether related to medication, toxins or other neurodegenerative conditions are specifically excluded.

Partial blindness

The insured person:

- loses the sight in both eyes with irreversible eye damage to the extent of 6/24, or
- loses the sight in one eye where visual acuity has reduced to 6/60 or less in that one eye,

and the loss is unable to be corrected by glasses or any other means.

Partial loss of hearing

The insured person suffers a total and permanent loss of hearing, both natural and assisted in one ear. This must be certified at least 3 months after the ability to hear was first lost.

Peripheral blood stem cell or bone marrow transplant

The insured person receives a bone marrow transplant, or peripheral blood stem cell transplant for the treatment of a:

- malignant blood disorder, or
- metabolic disorder,

where transplant is required.

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

(No payment will be made where the insured person is a donor of an organ or stem cells for transplantation to another person.)

Peripheral neuropathy

The insured person is diagnosed to have peripheral neuropathy by an appropriate consultant medical specialist. The condition must have progressed to the point that it is permanent and results in the insured person not being able to do any one or more of the below activities without assistance from someone else:

- get in and out of a bed
- get on or off a chair/toilet
- move from place to place without using a wheelchair.

We won't pay if the peripheral neuropathy is directly caused by alcohol or related to use of other drugs not prescribed by a doctor. We won't pay if this condition is contributed to or caused by HIV/AIDS related conditions.

Pneumonectomy

The insured person undergoes surgical removal of an entire lung. In the opinion of an appropriate consultant medical specialist, the insured person must require the treatment on medical grounds and it must be the most appropriate treatment.

Primary pulmonary hypertension

The insured person suffers primary pulmonary hypertension with right ventricular enlargement established by investigations including cardiac catheterisation.

Prostate cancer

The insured person is diagnosed as having a prostate tumour equivalent to TNM Classification T1 and a Gleason score of 5 or less. The tumour must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.

Severe burns

The insured person suffers burns classified as deep dermal thickness or full thickness, to 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart.

The burns can be caused by thermal, electrical or chemical agents.

The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and legs (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area.

We will also pay, where grafting is required, if the insured person suffers full thickness burns to 50% of both hands or both feet or 50% of the face.

Severe inflammatory bowel disease

The insured person suffers severe inflammatory bowel disease. Severe inflammatory bowel disease means a diagnosis of Crohn's disease and/or ulcerative colitis that has failed surgical and conventional medical intervention and requires indefinite second-line therapy.

Severe osteoporosis

The insured person suffers severe osteoporosis. Severe osteoporosis means the insured person, before the age of 50, suffers at least 2 vertebral body fractures or a fracture of the neck or femur, due to osteoporosis and has bone mineral density reading with a T-score of less than -2.5 (ie 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least 2 sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis

The insured person is diagnosed as having severe rheumatoid arthritis, by an appropriate consultant medical specialist who has confirmed all of the following complications occurred as a direct result of the rheumatoid arthritis:

- at least a 6 week history of severe rheumatoid arthritis which involves 3 or more of the following joint areas:
  - proximal interphalangeal joints in the hands,
  - metacarpophalangeal joints in the hands,
  - metatarsophalangeal joints in the foot, wrist, elbow, knee or ankle,
- simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone)
- typical rheumatoid joint deformity and
- at least two of the following criteria:
  - morning stiffness,
  - rheumatoid nodules,
  - erosions seen on x-ray imaging,
  - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis.

We won't pay for any other form of arthritis.

Stroke

The insured person suffers a cerebrovascular episode producing neurological damage which lasts for more than 24 hours.

The damage must be evidenced clinically by:

- cerebral CT scan, or
- an angiogram, or
- an MRI or PET, or
- other reliable imaging techniques approved by AMP Life.

We won't pay for transient ischaemic attacks, reversible ischaemic neurological deficit, major head injuries or symptoms due to migraine or headache.

Subacute sclerosing panencephalitis

The insured person suffers subacute sclerosing panencephalitis.

Systemic lupus erythematosus (SLE)

The insured person suffers systemic lupus erythematosus where irreversible organ damage has occurred requiring intravenous immunosuppressive or cytotoxic therapy.

The organ damage includes lupus nephritis, cerebral lupus, cardiac disease specially related to SLE. An appropriate consultant medical specialist must confirm the diagnosis of SLE with pathological and other supporting evidence.

Systemic sclerosis

The insured person is diagnosed to have systemic sclerosis by an appropriate consultant medical specialist.

The condition must have progressed to the point that the insured person can't perform any one of the activities of daily living without assistance from someone else.

Temporal arteritis

The insured person is diagnosed with arteritis and, as a result, permanently loses sight in one eye.

Type 1 Diabetes

The insured person is diagnosed with Type 1 insulin dependent diabetes mellitus (IDDM) for the first time after the age of 30 by an appropriate consultant medical specialist.

Viral encephalitis

The insured person suffers encephalitis due to direct viral invasion of the central nervous system. The encephalitis must produce neurological deficit causing permanent and significant functional impairment.

General definitions

Activities of daily living

1. Washing: the insured person can wash themself by some means.
2. Dressing: the insured person can put clothing on or take clothing off.
3. Feeding: the insured person can get food from a plate into their mouth.
4. Continence: the insured person can control both their bowel and bladder function.
5. Mobility: the insured person can:
   a. get in and out of a bed;
   b. get on or off a chair/toilet; and
   c. move from place to place without using a wheelchair.

AMP Superannuation Savings Trust

AMP Superannuation Savings Trust (ABN 76 514 770 399).

AMP Life

AMP Life Limited.

Business Income

Gross monthly income earned by the business as a result of the insured person's personal exertion or activities. We do not include investment income.

Benefit period

For Income Protection

See page 40.

For Business Overheads Insurance

See page 51.

Carer

The primary caregiver, who provides assistance with communication, mobility or self-care to a disabled or aged person, for more than 6 months.

Certificate of Insurance

A reference to a Certificate of Insurance in this document means the Certificate of Insurance that we send you when your plan starts, as amended by:

- the Annual Statement we give you each year, and
- any notice we give you which records a change in the terms of your plan as agreed between you and us.

CPI

CPI means Consumer Price Index.

When we make a calculation using the increase in the CPI, we use the percentage annual increase in the Australian National All Groups Consumer Price Index published by the Australian Bureau of Statistics. We use the Index published for the most recent September quarter. However, if that index is abolished or changed, we may use another index which we believe fairly and accurately reflects changes in the cost of living. When calculating the increase, we use the annual percentage increase to the index relative to the September quarter in the previous calendar year.

De facto relationship

De facto relationship means:

- a relationship between two persons (whether of the same sex or different sexes) that is registered under a law of a State or Territory of Australia, or
- a relationship between two persons (whether of the same sex or different sexes) who, although not legally married to each other, live with each other on a genuine domestic basis in a relationship as a couple.

Doctor

Doctor means a legally qualified medical practitioner registered to practise in Australia, New Zealand, the United Kingdom, the United States of America, or Canada.

That person may not be:

- you, your business partner, or a member of your immediate family, or
- the insured person, the insured person's business partner, or a member of the insured person's immediate family.

Dollar (or $)

All references to dollar amounts in this document are references to Australian currency. All payments to and from us must be in Australian dollars.

Full-time occupation

The insured person is engaged in remunerative work for at least 20 hours per week, 40 weeks per year.

Heart condition

Heart condition means any of the following trauma definitions:

- aortic surgery
- cardiomyopathy
- coronary artery angioplasty – triple vessel
- coronary artery surgery
- heart attack – myocardial infarction
- heart attack – out of hospital cardiac arrest
- heart valve surgery
- major organ transplant (heart only)
- open heart surgery
- primary pulmonary hypertension.

Home duties

The insured person is engaged in home duties if they are doing at least 4 of the following duties related to running the family home:

- cleaning the family home
- shopping for food and household items
- meal preparation
- laundry services
- caring for a child or dependant (if applicable).

Income

For employed persons

The insured person's total package from employment, including commissions, regular bonuses, fringe benefits, employer superannuation contributions and any other items relating to their own efforts.

We include superannuation contributions made by an employer that are part of a salary sacrifice arrangement between the employee and employer. We do not include investment income.

If you choose the Superannuation Option, any superannuation contribution amount insured under that option will not be included in the calculation of income.

For self-employed persons

Where the insured person owns (directly or indirectly) all or part of the business or practice, income means income earned by the business or practice as a result of the insured person's personal exertion or activities less their share of the business expenses incurred in earning that income.

We do not include investment income.

Income benefit

Income benefit means one of the benefits listed on page 38.

Insured amount

Insured amount means the amount you apply for and we accept for a particular type of cover under the Life Protection Plan, as shown in the Certificate of Insurance and varied in accordance with the terms of the Plan (for example, under the Indexation Feature) or by agreement.

If there are multiple insured persons under the one Life Protection Plan, a reference to insured amount in this document means the insured amount referable to a particular insured person, as the context implies.

Insured person

The person(s) named as the 'insured person' in the Certificate of Insurance, before the plan ends.

Linked

See page 6.

Month

Calendar month.

Monthly benefit

See page 40.

Maximum monthly benefit

For Income Protection

See page 40.

For Business Overheads Insurance

See page 54.

Ongoing care

The insured person:

- has sought advice, care and treatment from a doctor in relation to their illness or injury and is continuing to do so at reasonable intervals in the circumstances, and
- is following the advice, care and treatment of the doctor, and
- is taking all other reasonable measures to minimise or avoid further illness or injury.

Own occupation

The primary full-time occupation the insured person has performed immediately prior to becoming disabled.

Paralysis

Paralysis means any of the following definitions:

- diplegia
- hemiplegia
- paraplegia
- quadriplegia
- tetraplegia.

Partially disabled

For Income Protection

See page 42.

For Business Overheads Insurance

See page 55.

Plan anniversary

The date of the Plan anniversary for the Plan appears in the Certificate of Insurance. For most Plans, it will be the same date in each year as the date on which the Plan starts. However, if you want it to be a different date, we may agree to make it a different date.

The Plan anniversary is the date in each year on which we make any increase under the Indexation feature. When we recalculate the premium each year, the new amount applies for one year from the Plan anniversary.

Pre-disability income

For TPD cover

Remuneration received in the last 12 consecutive months of regular remunerative work before the insured person became unable to work due to illness or injury.

For Income Protection

See page 42.

Regular remunerative work

The insured person is engaged in regular remunerative work if they are doing work in any employment, business, or occupation for at least 10 hours per week. They must be doing it for reward, or the hope of reward, of any type.

Relapse

For Income Protection

See page 49.

For Business Overheads Insurance

See page 57.

Remunerative work

The insured person is engaged in remunerative work if they are doing work in any employment, business, or occupation. They must be doing it for reward – or the hope of reward – of any type.

Significant impairment/significant functional impairment

Abnormalities of the nervous system that result in some disorder of function and produce symptoms which may include, but are not restricted to:

- any disability requiring daily assistance with any of the activities of daily living, or
- Impaired speech, vision, hearing, cognitive or motor function.

Special terms

Any terms which we apply to the insured person or the plan and which does not apply to all Flexible Lifetime – Protection plans.

Stand Alone

See page 6.

Terminal Illness

See page 10.

Totally disabled

For Waiver of Premium

See page 23.

For Income Protection

See page 41.

For Business Overheads Insurance

See page 54.

Waiting period

For Income Protection

See page 40.

For Business Overheads Insurance

See page 53.

We, us, our

AMP Life Limited.

White collar

The insured person's occupation is 'white collar' if the Certificate of Insurance shows their occupation category as 'White collar', '4A', '3A', '2A' or 'A'.

You

The plan owner (or, where cover is acquired through the AMP Superannuation Savings Trust, the insured person, except that AMP Life will pay any benefit to the Trustee).

Interim cover – Certificate

About Interim cover

While your application is being considered, we will provide you with Interim cover at no extra cost.

This cover is different to the insurance being applied for and is subject to the terms and conditions set out below.

Interim cover is not available if either you or the insured person:

- have withdrawn an application, or
- have applied for a similar type of plan, and had the application declined or deferred, or
- are currently applying for similar cover outside of AMP, or
- are applying for this cover to replace an existing plan.

Any special terms that we would apply under our underwriting rules to the cover you apply for, will also apply to this Interim cover.

The term 'accident' as used in this certificate, means bodily injury caused directly and solely by violent, external and visible means and independent of all other causes.

When cover starts

This cover will start when we receive your completed application and personal statement and either the first premium payment or valid direct debit details at an AMP registered office.

Cover is subject to the premium payment not being dishonoured.

This certificate is for you to keep. It explains the terms and conditions of Interim cover.

When we will pay

If you applied for Death cover

We will pay if you have applied for Death cover for an insured person, and they die during the Interim cover period.

If you applied for TPD cover

We will pay if you have applied for TPD cover for an insured person, and solely as a result of an accident during the Interim cover period, they satisfy one of the following parts of the definition of totally and permanently disabled on page 14 of the PDS.

- Part 1a (other than cover through the AMP Superannuation Savings Trust),
- Part 1b,
- Part 4,
- Part 5 or,
- Part 6.

If you applied for Trauma cover

We will pay if you have applied for Trauma cover for an insured person, and they experience one of the following trauma conditions or undergo one of the following medical procedures during the Interim cover period, solely as a result of an accident:

- blindness[1]
- coma[1]
- diplegia
- hemiplegia
- intensive care[1]
- loss of independent living[1]
- major head trauma[1]
- paraplegia
- quadriplegia
- severe burns[1]
- tetraplegia.

1 If you applied for Trauma cover Standard these conditions are not covered under that plan and not covered under Interim cover.

The definitions of the above trauma conditions and medical procedures are set out on pages 65 to 72.

If you applied for an Income Protection Plan

We will pay if you have applied for an Income Protection Plan for an insured person, and they become totally disabled during the Interim cover period. The total disability must be caused by an injury which occurs after Interim cover starts, or by an illness which is contracted and/or commences more than 30 days after the Interim cover starts.

This benefit is paid monthly while the insured person is totally disabled, starting from the end of the waiting period selected, for a maximum of 12 months.

If you applied for Business Overheads Insurance

We will pay if you have applied for a Business Overheads Insurance Plan for an insured person and they become totally disabled solely as a result of an accident occurring during the Interim cover period.

This benefit is paid monthly while the insured person is totally disabled, starting from the end of the waiting period selected, for a maximum of 6 months.

How much we pay

We will only pay once for Interim cover for Life Protection Plans with Death cover, TPD cover or Trauma cover.

For Death cover under a Life Protection Plan

We will pay you a lump sum under Death cover under a Life Protection Plan.

We will pay the lesser of:

- $1,000,000, or
- the insured amount applied for.

For TPD cover and/or Trauma cover under a Life Protection Plan

We will pay you a lump sum under TPD cover and/or Trauma cover under a Life Protection Plan.

We will pay the lesser of:

- $600,000, or
- the insured amount applied for.

For Income Protection Plan

We will pay you monthly benefits for a maximum of 12 months for Interim cover under Income Protection Plans.

We will pay the lesser of:

- $10,000 per month, or
- the maximum monthly benefit applied for.

The amount we pay may be reduced by Benefit Offsets (see page 50).

For Business Overheads Insurance Plans

We will pay you monthly benefits for a maximum of 6 months for Interim cover under Business Overheads Insurance Plans.

We will pay the lowest of:

- $5,000 per month, or
- the maximum monthly benefit applied for, or
- the insured person's share of the allowable business expenses actually incurred during the period for which they are totally disabled.

The amount we pay may be reduced by the Benefit Offsets (see page 57).

When cover stops

Interim cover ceases when one of the following happens:

- 90 days from the date this Interim cover starts, or
- the date your application is approved, declined, deferred or withdrawn, or
- the date we advise that your Interim cover is cancelled.

When we won't pay

We will not pay for intentional or self-inflicted injury or death.

We will not pay where, under our underwriting rules, we would have declined or deferred the insurance applied for.

We will not pay where eligibility for the Interim cover claim is caused by:

- any pre-existing medical condition you or the insured person were aware of at the time of applying for this cover, or
- engaging in any sport, pastime or occupation which would not normally be covered under our standard underwriting rules.

Contact your adviser or financial planner

Need more information?

Everyone has different financial needs. And to find the best solution, you may need professional financial advice. Talk to your financial planner or an AMP Customer Service Officer:

phone 133 888
web amp.com.au

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