Flexible Lifetime® – **Protection**
A safety net for living

Plan Rules

BUSINESS OVERHEADS INSURANCE

Keep this document it is part of your contract with AMP
Issued by AMP Life Limited ABN 84 079 300 379

This document

Please read this document. With the **Certificate of Insurance**, it forms your contract with us. We suggest you keep them together and in a safe place.

This document is in two parts:

- A brief introduction that covers the purpose of the plan, whom we pay, and who is insured. It starts on the next page.
- The rules of your contract with us. A table of contents for the rules starts on page 2.

If there is something you do not understand, please contact your financial planner or us.

DEFINITIONS

Some words and phrases used in **Business Overheads Insurance** have special meanings. These meanings are defined in rule 34 which starts on page 22.

Each time a defined word is used, it appears in type **like this**. Also, we list the defined words used on each page in a box at the bottom left-hand corner of the page.

The box looks like this:

THESE WORDS AND PHRASES ARE DEFINED:
- **ELIGIBLE BUSINESS OVERHEADS**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Introduction

PURPOSE

Business Overheads Insurance helps a business survive.

Its purpose is to pay an amount to reimburse **eligible business overheads** while the insured person is so ill or injured that they are **totally disabled**. However if the business appoints a locum while the insured person is **totally disabled**, we may not pay unless the business runs at a loss. The overheads we pay for are listed in rule 5.1.

We only start to pay after a certain period which we call the **"waiting period"**.

WHOM WE PAY

We pay the person who owns the plan – the plan owner. We call the plan owner "you".

INSURED PERSON

The person whose illness or injury will cause us to pay is called the "insured person".

We usually require you and the insured person to be the same person. However, for some business arrangements, you can take out Business Overheads Insurance to cover someone else. That is why we talk about "you" and the "insured person" as different people.

CHANGING THE PLAN

Once the plan has started, you can change it. For some changes, all you need to do is tell us in writing. For others, you may have to supply more information for us to consider. You should contact your financial planner or us, to discuss this.

THE RULES

The rules describing Business Overheads Insurance in full are set out on the following pages. These rules and the **Certificate of Insurance** we sent you with these rules, together form the contract and plan with us. The plan also includes your Annual Statements and any documents we send to you recording a change to the plan.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **ELIGIBLE BUSINESS OVERHEADS**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Table of contents

If the insured person is totally disabled

1.

WHAT HAS TO HAPPEN FOR US TO PAY

We pay you if the insured person is **totally disabled**. The insured person is **totally disable**d if:

- they are so ill or injured that they can't do their usual occupation; and
- they are under the ongoing care of their **doctor** for that illness or injury; and
- they do not do any **remunerative work.**

To help you understand our approach, when we assess the insured person's ability to do their usual occupation under the first dot point above, the assessment is based on their capacity to carry out any one duty or combination of duties, which is critical to the proper performance of their usual occupation.

2.

WHAT WE PAY

Each **month**, we pay an amount to help the plan owner pay **eligible business overheads**. Please note, we only pay for up to 12 **months**.

However, if we have been paying you for a period of 12 **months**, we will extend the period we pay you if the total amount we have paid is less than 12 times the **maximum monthly benefit**.

We will extend the period:

1. by six **months**; or
2. until the amount we have paid equals 12 times the **maximum monthly benefit**; or
3. until the insured person is **able to work**; or
4. until the plan ends

whichever comes first.

3.

HOW OFTEN WE PAY

We pay you once each **month** in arrears.

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **DOCTOR**
- **ELIGIBLE BUSINESS OVERHEADS**
- **MONTHS**
- **MAXIMUM MONTHLY BENEFIT**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

4.

WHEN WE START TO PAY

We start to pay after the insured person has been **totally disabled** for the **waiting period.** It starts on the date the insured person became **totally disabled**. Because we pay in arrears, we make the first payment one **month** after the **waiting period** ends. The length of the **waiting period** is shown in the **Certificate of Insurance**.

Example:

Stephen has a plan with a four week waiting period. He falls off a horse and is badly injured. He is **totally disabled** for three months. We pay him as shown below:

Accident on 1 March

1 March is the date Stephen becomes totally disabled. So that is when his waiting period starts. Remember, he has a four week waiting period.

Waiting period ends on 28 March

Stephen becomes entitled to be paid from 29 March. Because we pay monthly in arrears, we send the first cheque one month later.

29 April

Stephen gives us the details of the business' eligible business overheads for April. We send the first cheque.

29 May

We send the second cheque.

I June

Stephen returns to work. We send a cheque for three days payment for 29, 30, and 31 May. Because Stephen is now able to work again, we stop paying.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **MONTH**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 34.

4.1

INSURED PERSON IS ABLE TO WORK DURING THE WAITING PERIOD

If the insured person is **able to work** during the **waiting period** but then suffers a **relapse** and is again **totally disabled**, the following rules apply.

Able to work for five days (or less) in a row

If the insured person is able to work for five days (or less) in a row before the **relapse** the **waiting period** continues – that is, it does not start again. We only start to pay when the insured person has been **totally disabled** for the total number of days of the **waiting period**.

That is so even if the insured person is **able to work** more than once during the **waiting period** and suffers more than one **relapse**. The **waiting period** only ends when all the number of days the insured person has been **totally disabled**, when added together, equal the **waiting period**.

Able to work for more than five days in a row

If the insured person is able to work for more than five days in a row during the **waiting period** before they suffer a **relapse**, the **waiting period** starts all over again. And we don't count any days the insured person was **totally disabled** before the **relapse**.

Example:

Let's use the same example we used above about Stephen who fell off the horse. But let's change it slightly and say that two weeks after the accident, he went back to work for three days.

Accident on 1 March

That is the date Stephen becomes totally disabled. So that is when his waiting period starts. Remember, he has a four week waiting period.

On 14 March

Stephen returns to work. But after three days he suffers a relapse and is totally disabled.

Waiting period ends on 31 March

Stephen's waiting period ends four weeks and three days after it started. So the waiting period ends on 31 March, when he has been totally disabled for a total of four weeks.

1 May

Stephen gives us details of the business' eligible business overheads for April. We send the first cheque.

1 June

We send the second cheque. Because Stephen is now able to work again, we stop paying.

THESE WORDS AND PHRASES ARE DEFINED:

- **ABLE TO WORK**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 34.

5.
HOW MUCH WE PAY

We aim to help you cope with peaks and troughs in your **eligible business overheads** from **month** to **month**. Therefore, when working out how much to pay in a particular **month**, we base our calculations on the entire period we have been paying. The rules about this are quite complicated. To make it clearer, we have set out an example about Maria the surveyor. It helps if you read the example first – it's on the next page.

1. To work out how much to pay each **month** we calculate two amounts.

2. The first amount we calculate each **month** is:

   - the total amount of **eligible business overheads** the business has actually paid since the end of the **waiting period**,

   reduced by:

   - any amount you, the business, or the insured person, have received (since the end of the waiting period) from AMP under a plan that is different from this one, or any other insurance company as reimbursement of the **eligible business overheads**,

   and reduced by:

   - 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.

3. The second amount we calculate is:

   - the **maximum monthly benefit** multiplied by the number of **months** since the end of the **waiting period**.

4. We take the lower of the two amounts and subtract the total amount we have paid you since the end of the **waiting period**. We pay you the total after that subtraction.

5. We deduct any taxes or government charges:

   - which the law requires us to deduct; or

   - which have to be paid and which we decide to deduct.

The eligible business overheads we include are listed in rule 5.1. Some of the overheads we don't include are listed in rule 5.2.

THESE WORDS AND PHRASES ARE DEFINED:
- **ELIGIBLE BUSINESS OVERHEADS**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Example:

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

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

In January, Maria's eligible business costs are $1,800. We pay her that amount, and carry the left over $200 into February.

In February, Maria's business has an expensive month – her insurance, rates, and electricity bills arrive. Maria's eligible business costs are $2,350. We pay Maria the monthly benefit, $2,000 plus the $200 left over from January.
And we carry the $150 of unpaid overheads into the next month, March.

In March, Maria's eligible business costs are $750. We add the $150 from February to the $750 for March, and pay Maria $900.

5.1 ELIGIBLE BUSINESS OVERHEADS WE INCLUDE

"Eligible business overheads" include:

- salaries of non-income producing staff – including family members who have been employed for more than three 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; and
- accountants' and auditors' fees.

Many other usual business overheads are also covered.

THESE WORDS AND PHRASES ARE DEFINED:
- **ELIGIBLE BUSINESS OVERHEAD**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Please 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**.

5.2 OVERHEADS WE WON'T PAY

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; – see rule 5.1
  - people who earn income for the business;
  - any member of the insured person's family who has been employed for less than three 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.

6. WHEN WE STOP PAYING

We stop paying as soon as any one of the following happens:

- the insured person is **able to work**; or
- the insured person does any **remunerative work**; or
- all the periods we have paid because of one claim add up to 12 **months**; or
- the plan ends; or
- the insured person dies.

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **ELIGIBLE BUSINESS OVERHEADS**
- **MONTHS**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

More than one claim

7. YOU CAN MAKE MORE THAN ONE CLAIM

We will pay a claim every time the insured person meets the rules set out in this plan. If we have already paid under the plan and the insured person suffers a new illness or injury after we stop paying, we will pay again. The **waiting period** and 12 **month** period both start again.

Rule 7.1 explains what happens if the insured person suffers a **relapse** after we stop paying.

7.1 RELAPSE

If the injured person suffers a **relapse** what happens depends on why we stopped paying.

If we stopped paying because we had paid for the full 12 **month** period, we will only pay for a **relapse** if the insured person has worked in their usual occupation for at least their usual **income** for at least six **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 12 **month** period start again.

The rest of rule 7.1 applies if:

- we have stopped paying; and
- we have not paid for the full 12 **month** period for this claim; and
- the insured person suffers a **relapse**.

If the insured person suffers the **relapse** at least six **months** after we stopped paying, then we treat it as a new claim and both the waiting period and 12 month period start again.

If the insured person suffers the relapse within six **months** after we stop paying, we treat the claim as the continuation of the previous claim.
The **waiting period** and the 12 **month** period do not start again. Instead, we add up all the periods we pay you for that claim and treat them as one 12 **month** period.

THESE WORDS AND PHRASES ARE DEFINED:
- **INCOME**
- **MONTH**
- **RELAPSE**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 34.

When we won't pay

8.
WAR

We won't pay if the insured person's injury, illness, or death was caused directly or indirectly by war – whether war was declared or not.

9.
ON PURPOSE

We won't pay if you do, or the insured person does, an intentional or deliberate act which directly or indirectly causes the insured person to be **totally disabled**.

9.1
PREGNANCY

We won't pay for normal and uncomplicated pregnancy or childbirth.

Locum and profitability	Please remember that if the business appoints a locum while the insured person is **totally disabled**, we may not pay unless the business runs at a loss.

Increasing maximum monthly benefit by the CPI

10.
WHILE WE AREN'T PAYING

Each year, on the **plan anniversary**, we will increase the amount of the **maximum monthly benefit** by any increase in the **CPI**. Usually, this will make the premium increase.

We won't reduce the **maximum monthly benefit** if the **CPI** is negative.

10.1
CPI INCREASES STOP AT A CERTAIN AGE

The last time we increase the insured person's **maximum monthly benefit** by any increase in the **CPI** is on the **plan anniversary** on, or before, the insured person turns 65.

You can decline CPI increases	We make the **CPI** increase automatically. However, you can ask us • to increase the **maximum monthly benefit** by only some of the increase in the **CPI**; or • not to increase the **maximum monthly benefit** at all; or • not to increase the **maximum monthly benefit** ever again. If you want us to do any of these things, you need to tell us in writing before you pay the premium due on the **plan anniversary** from which the **CPI** increase is to apply. You can subsequently ask us to start making **CPI** increases again. At that time we will consider your request.

THESE WORDS AND PHRASES ARE DEFINED:
- **CPI**
- **MAXIMUM MONTHLY BENEFIT**
- **PLAN ANNIVERSARY**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

When the plan and cover start and end

11.
WHEN THE PLAN AND COVER START

The plan starts when you and we agree that we will insure you.
That date is shown in the **Certificate of Insurance**.

The cover starts on the date the plan starts.

12.
WHEN THE PLAN AND COVER END

The insured person's cover ends when the plan ends.
The plan ends as soon as any one of the following happens:

- on the plan expiry date shown in the **Certificate of Insurance**; or
- you end it; or
- we end it under rule 12.1; or
- the insured person dies.

12.1
WHEN WE CAN END THE PLAN

To keep the plan going, you must pay the premium on time. We can end the plan if:

- you don't pay the premium on time. However, if you don't pay on time, you have an extra 30 days to pay before we take steps to end the plan. If you haven't paid on time, we will write and remind you; or
- the insured person leaves **remunerative work** and intends never to return to any **remunerative work**; or
- the insured person leaves **remunerative work** for more than 12 **months**, but you did not put the plan "on hold" – see rule 15.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **MONTH**
- **REMUNERATIVE WORK**

THE DEFINITIONS ARE SET OUT IN RULE 34

13. REFUND OF PREMIUMS

If you end the plan during a period for which you have already paid the premium, we refund the premium for any unused complete **months**. We do not refund premiums if the plan ends for any other reason.

Example:

If you have paid the yearly **base premium** of $1,200, and you end the plan nine **months** later, we refund $300.

Restarting the plan

If you end the plan, you can ask us to restart it. But you must ask us – in writing – within three **months** of it ending.

If we end the plan because you don't pay on time, you can ask us – in writing – to restart it. But you must ask us within three **months** of the date the premium you didn't pay was due.

To restart the plan, you must:

- pay us all the premiums you haven't paid; and
- give us any information we require about the insured person.

We will advise you if we agree to restart the plan.

14. LEAVING REMUNERATIVE WORK

If the insured person temporarily leaves **remunerative work**, the plan ends 12 **months** later. That means we won't pay for anything that happens to the insured person after that date.

However, the plan continues if they left **remunerative work** because of illness or injury.

Please note, you must tell us if the insured person is not doing **remunerative work**.

If the insured person will be out of **remunerative work** for more than 12 **months**, you can arrange to put the plan "on hold". This is explained in rule 15.

THESE WORDS AND PHRASES ARE DEFINED:
- **BASE PREMIUM**
- **MONTHS**
- **REMUNERATIVE WORK**

THE DEFINITIONS ARE SET OUT IN RULE 34

15. PUTTING THE PLAN "ON HOLD"

You can put the plan "on hold" while the insured person temporarily leaves **remunerative work**. However, you must put it "on hold" within 12 **months** after the insured person leaves **remunerative work**.

While the plan is "on hold" 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 plan "off hold" when the insured person again starts **remunerative work** in a business that would suffer while they were **totally disabled**. That means the insured person is covered again. And we guarantee to do this without you having to give us any more information about the insured person's health, pastimes or occupation – other than telling us that they are involved in a business again.

15.1 HOW TO PUT THE PLAN "ON HOLD"

To put the plan "on hold":

- you must tell us in writing that you want to; and
- you must keep paying the premium – however, while the plan is "on hold" the premium is reduced.

You can keep a plan "on hold" for as long as you want until the insured person again starts **remunerative work** in a business that would suffer while they were **totally disabled**.

15.2 HOW TO TAKE THE PLAN "OFF HOLD"

When the insured person again starts **remunerative work**, you, or we, can take the plan "off hold". You must tell us if the insured person does any **remunerative work** and is again involved in a business that would suffer while they were **totally disabled**.

When the plan is taken "off hold", the cover starts again. And the premium is no longer reduced. The premium when the insured person starts **remunerative work** again will be based on our **premium rates** at that time.

THESE WORDS AND PHRASES ARE DEFINED:

- **MONTHS**
- **PREMIUM RATES**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Guaranteed continuation of cover

16.
WE GUARANTEE TO CONTINUE YOUR PLAN

If you pay the premium on time and the plan is still current, we guarantee:

- to keep the cover going – on the same terms – each year; and
- not to cancel it – or any part of it.

Keeping you informed

17.
WE SEND YOU AN ANNUAL STATEMENT

Each year, we will send you an Annual Statement. It will set out:

- the amount of the **maximum monthly benefit** after any regular **CPI** increase; and
- the premium you have to pay to keep the plan going; and
- any material changes to information about the plan.

We will send the Annual Statement just before the **plan anniversary**.

This provides an opportunity for you to speak to your financial planner to review and update your insurance needs.

Premium – what you have to pay

18.
HOW MUCH AND WHEN

The amount of the premium when the plan starts, and when it is due, are both shown in the **Certificate of Insurance**.

We recalculate the premium each year. At that time, we base it on the age of the insured person and the **maximum monthly benefit**. We use the **premium rates**, loadings, discounts, plan fee, and stamp duty (and any other government charges) that apply at that time. We show the recalculated premium in the Annual Statement.
We send this just before the **plan anniversary**.

Whenever you change the plan, it is likely that the premium will change. After any change, we will tell you the amount of the new premium – in writing.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **CPI**
- **MAXIMUM MONTHLY BENEFIT**
- **PLAN ANNIVERSARY**
- **PREMIUM RATES**

THE DEFINITIONS ARE SET OUT IN RULE 34.

18.1
GOVERNMENT TAXES, DUTIES AND CHARGES

You have to pay any government taxes, duties, or charges relating to the plan. We will include these amounts in the premium when we tell you how much the premium is.

19.
PREMIUM GUARANTEE

We guarantee not to increase the premium between **plan anniversaries** unless:

- you change the plan in a way which increases the premium; or
- the government introduces a new tax, duty, or charge, or changes an existing one.

19.1
PREMIUM RATES AND DISCOUNTS ARE NOT GUARANTEED

We can change the **premium rates** and discounts, and withdraw discounts, in the future – they are not guaranteed. However, if we do that for this plan, it will apply to all Business Overheads Insurance plans that are similar to this one. And, any changes which apply to the insured person will apply to all people we insure under Business Overheads Insurance plans:

- who are in the same AMP Life rating and occupation category as that person at that time; or
- who have similar cover to that person.

However, if we have given you an individual discount on your premiums, we may remove this discount at any time.

If we do anything which changes the premium for this plan, we will tell you about the change – and the amount of the new premium – before it applies.

KEEPING THE PREMIUM THE SAME

Currently, if you want to keep the premium the same for the next 12 **months**, as it was for the last 12 **months**, we will do this.

You need to ask us to do this – in writing – before the **plan anniversary** from which you want the premium to stay the same. You must also tell us whether you want us to reduce the **maximum monthly benefit**, or change the cover in some other way, to keep the premium the same.

And you need to ask us to do this each year you want it to happen.

Please note, we may not agree to do this in the future – but you can always ask us to.

THESE WORDS AND PHRASES ARE DEFINED:
- **MAXIMUM MONTHLY BENEFIT**
- **MONTHS**
- **PLAN ANNIVERSARY**
- **PREMIUM RATES**

THE DEFINITIONS ARE SET OUT IN RULE 34.

20.

PLAN FEE

There is a plan fee included in your premium. Each year, we increase the plan fee by any increase in the **CPI**. However, we don't change it if the **CPI** is negative.

21.

PREMIUM FREQUENCY FEE

If you pay more often than yearly, we charge an extra fee. That fee is included in the premium. It is a percentage of the premium you would pay if you were paying yearly. We can change the percentage we use to calculate the increase at any **plan anniversary** in circumstances relating to the commercial operation of our business. We will tell you of any change before it applies.

22.

DISCOUNTS

We have a range of discounts which may apply to the plan. The premium shown in the **Certificate of Insurance** and Annual Statement is the premium after any discounts have been applied.

23.

WHEN PREMIUMS DON'T NEED TO BE PAID

You do not have to pay the premium while we are paying under the plan. You have to start paying the premium again when we stop paying.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **CPI**
- **PLAN ANNIVERSARY**

THE DEFINITIONS ARE SET OUT IN RULE 34.

How to make a claim

24.
WHAT TO DO

To make a claim you need to contact us. We will send you a claim form to fill in and return to us. You must also do each of the things set out in the rest of rule 24, and rule 25.

We can ask for the information described in those rules as often as we want:

- while we are dealing with the claim; and
- while we are paying.

We base our decision on whether to pay after reviewing all information, including the information in rules 24.1 to 24.5.

24.1
HEALTH

You must give us any information which we reasonably require about the insured person's health. For you to give us that information, we usually need the insured person to attend, and co-operate at, any assessments. Some of those assessments may be by medical advisers we choose. The insured person may also need to have medical tests.

You must pay the costs of getting information from the insured person's medical advisers. However, we will pay the costs of getting information from medical advisers we choose.

You must also give us information about the circumstances surrounding the insured person's health problems.

24.2
AGE AND IDENTITY

You must prove the insured person's age and identity and your identity.

24.3
INCOME, EXPENSES AND OVERHEADS

You must give us any information we ask for about the insured person's **income** and expenses and about the business' **income** and expenses. For example, we will usually ask for receipts, income tax returns, assessment notices, and any relevant books of account.

We may ask you what the **income** and expenses:

- were when the plan started, or you last changed it; and
- were just before the insured person became **totally disabled**; and
- are while we are paying.

You must pay any costs of getting this information.

THESE WORDS AND PHRASES ARE DEFINED:
- **INCOME**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

24.4
OTHER INFORMATION

You must give us any documents and other information we ask for about anything related to the claim.

24.5
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.

We may not pay for more than three **months** while the insured person is outside Australia or New Zealand.

If we don't pay after the three **months** referred to above, 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 plan.

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 will assist you with their return travel expenses. We will 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.

We may agree to keep paying for more than three **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.

25.
TIME LIMITS

You must tell us that you are going to make a claim. You must do that within one **month** of the insured person becoming **totally disabled**.

You must also give us any information we ask for within two **months** after we ask for it.

However, we may extend the two **month** period if you ask us to do so.

26.
LATE CLAIMS AND RESPONSES

If you don't meet the time limits in rule 25, and we have been prejudiced by the delay, we will reduce the amount we pay to compensate us for the prejudice we have suffered.

THESE WORDS AND PHRASES ARE DEFINED:
- **MONTHS**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Miscellaneous

27.
AUTOMATIC PLAN ENHANCEMENTS

We review our Business Overheads Insurance plans regularly. If we enhance them without increasing the table of rates, reducing existing premium discounts or charging extra premiums, we will automatically offer you enhancements for which you are eligible at no charge. If we offer this on the **plan anniversary**, you accept the enhancement when you pay the premium.

28.
OWNERSHIP AND DEALINGS

You can't transfer the ownership of the plan to anyone else. Nor can you use the plan as security for any loan.

Please note, the only person we will pay under this 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 this plan to anyone.

29.
GOVERNING LAW

The plan is:

- governed by the Life Insurance Act 1995; and
- governed by the Insurance Contracts Act 1984.

30.
AUSTRALIAN $

All amounts under this plan must be paid in Australian dollars.

31.
OUR LIABILITY IS LIMITED

The assets of our No.1 Statutory Fund – or any other fund of which this plan forms part at the time – are the only assets we will use to pay the plan owner under this plan.

32.
NO SHARE OF PROFITS

This is a non-participating plan. That means it does not entitle you to share in any profits of AMP Life.

33.

Rule no longer used.

THESE WORDS AND PHRASES ARE DEFINED:
- **PLAN ANNIVERSARY**

THE DEFINITIONS ARE SET OUT IN RULE 34.

Definitions

34.
DEFINITIONS

AMP, AMP LIFE, OUR, US, AND WE

AMP, AMP Life, our, us, and **we** mean AMP Life Limited.

ABLE TO WORK

The insured person is **able to work** if they do not meet the definition of totally disabled.

BASE PREMIUM

Base premium is the amount of the premium we calculate from our **premium rates**. It includes the premium frequency fee. It does not include the plan fee, or any stamp duty, or other government fee, duty, tax, or charge.

CERTIFICATE OF INSURANCE

Certificate of Insurance is the Certificate we send you when the plan starts.

The Certificate sets out the details of who owns the plan, who is insured, the amount of cover, and other important information about the plan when it starts. The Certificate and the rules in this document form your contract with us.

The information in the Certificate can be updated in the following two ways:

- first, in the Annual Statement we send you each year.
- second, if you ask us to change the plan and we agree to it. We will send you a **Memorandum of Alteration** recording the change.

We suggest that you keep each Annual Statement and each **Memorandum of Alteration** with the **Certificate of Insurance**.

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 to the plan fee, or **maximum monthly benefit**, we use the annual percentage increase to the index relative to the September quarter in the previous calendar year.

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.

ELIGIBLE BUSINESS OVERHEADS

Eligible business overheads is the name we give to those overheads which we pay for under this plan. They are listed in rule 5.1. There is a list of overheads for which we don't pay in rule 5.2.

INSURED PERSON

Insured person is explained under the heading "Insured person" on page 1.

MAXIMUM MONTHLY BENEFIT

The **maximum monthly benefit** is the amount that we and you agree is the most we will pay each month if the insured person is **totally disabled**.

We use that amount to help calculate how much we will pay under the plan.

The amount which applies when the plan starts is shown in the **Certificate of Insurance**. It can:

- increase each year by any increase in the **CPI**. The current maximum monthly benefit will be shown in the latest Annual Statement; and
- change when you ask us to change it. If it has changed in this way, the new amount will be shown in the latest **Memorandum of Alteration**.

MEMORANDUM OF ALTERATION

Memorandum of Alteration is a document we send you confirming a change to the plan.

MONTH

Month means calendar month.

PLAN

Plan is explained under the heading "The rules" on page 1.

PLAN ANNIVERSARY

The date of the **plan anniversary** for the plan is shown 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 **CPI** increase to the **maximum monthly benefit**.

When we recalculate the premium each year, the new amount applies for one year from the plan anniversary.

PLAN OWNER

Plan owner is explained under the heading "Whom we pay" on page 1.

PREMIUM RATES

Premium rates means the rates we use to calculate the **base premium**.
We set those rates. They depend on a range of things including: the insured person's age, sex, health, occupation, pastimes and smoking habits.

RELAPSE

An insured person suffers a **relapse** when they have earlier suffered an illness or injury, and then they again suffer the same illness or injury – or one that arises from the same cause or a related cause.

REMUNERATIVE WORK

An 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.

SPECIAL RULE

Special rule means any rule which we apply to a particular insured person or plan and which does not apply to all Business Overheads Insurance plans.

TOTALLY DISABLED

The definition of **"totally disabled"** is set out in rule 1. It is:

The insured person is totally disabled if:

- they are so ill or injured that they can't do their usual occupation; and
- they are under the ongoing care of their **doctor** for that illness or injury; and
- they do not do any **remunerative work**.

To help you understand our approach, when we assess the insured person's ability to do their usual occupation under the first dot point above, the assessment is based on their capacity to carry out any one duty or combination of duties, which is critical to the proper performance of their usual occupation.

WAITING PERIOD

Waiting period is the period for which the insured person must be **totally disabled** before we start to pay. The **Certificate of Insurance** shows the length of waiting period. The waiting period starts on the date the insured person becomes **totally disabled**.

What happens if the insured person returns to **remunerative work** during the waiting period is explained in rule 4.1.

Sometimes the waiting period does not apply if the insured person suffers a **relapse** – this is explained in rule 7.

YOU

You is explained under the heading "Whom we pay" on page 1.

Enquiries and complaints

CONTACT US

If you need any additional information about your plan, or if you have a concern or complaint, then please contact your financial planner or contact an AMP Customer Service Officer on 13 12 67.

If you want to write to us, our address is:

AMP Life Limited
PO Box 300
PARRAMATTA NSW 2124.

Our Customer Service Officers are available to answer your enquiries and complaints. We will try to resolve your enquiry or complaint as quickly as possible. To help us do this, please give us as much information about your complaint as possible.

We have established procedures to deal with any complaints. If you make a complaint, we will:

- acknowledge its receipt and ensure an appropriate person properly considers the complaint; and
- respond to you as soon as we can.

If your complaint cannot be resolved at first contact, then we 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 we will keep you advised at regular intervals of the status of your complaint.

If we cannot resolve your complaint to your satisfaction within 45 days, then you may have the right to lodge a complaint with the Financial Industry Complaints Service (FICS) (contact details listed below).

This industry sponsored external service was established to help clients with complaints they cannot resolve directly with their company. It is independent and impartial. Please try to resolve your complaint directly with us before contacting the FICS.

Financial Industry Complaints Service
Phone: 03 8623 2000 or 1300 780 808
Fax: 03 9621 2291
Email: fics@fics.asn.au

or write to

PO Box 579, Collins St West
MELBOURNE VIC 8007

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Customer Service Officer

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advice
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insurance

Contact your adviser or financial planner

telephone 131 267
web www.amp.com.au
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If you have any enquiries or complaints please mention your plan number

AMP Life Limited ABN 84 079 300 379
33 Alfred Street Sydney NSW 2000

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