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

Plan Rules

DEATH, TOTAL AND PERMANENT DISABLEMENT AND TRAUMA
DEATH, TOTAL AND PERMANENT DISABLEMENT (SUPERANNUATION)

Asset INNOVATION awards 2007

Winner of the Asset Innovation Awards
Trauma Insurance Product of the Year
Flexible Lifetime – Protection
Trauma cover Standard

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***. 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 **plan**. A table of contents for the rules starts on page 3.

If there is something you don't understand, please contact your financial planner or us.

UNDERSTANDING DEFINED TERMS IN THIS DOCUMENT

Throughout this document:

- AMP means the AMP Group (the AMP Group is made up of several entities, which include AMP Superannuation Limited and AMP Life Limited)
- you, your and yourself; in relation to Death, Total and Permanent Disablement (Superannuation) **plans** means the **insured person**; and means the **plan owner** in relation to Death, Total and Permanent Disablement, Trauma **plans**
- AMP Life, we, us, and our means AMP Life Limited
- The Fund means the AMP Personal Superannuation Fund
- **insured person(s)** means the person(s) insured under the **plan**. In relation to Death, Total and Permanent Disablement (Superannuation) **plans** the **insured person** is a member of the AMP Personal Superannuation Fund
- **plan owner** in relation to Death, Total and Permanent Disablement (Superannuation) **plans** means AMP Superannuation Limited, and means the owner of the **plan** for Death, Total and Permanent Disablement, Trauma **plans**
- non-superannuation plan means Death, Total and Permanent Disablement, Trauma plan under Flexible Lifetime – Protection. Your ***Certificate of Insurance*** will show if you have this **plan**
- superannuation plan means Death, Total and Permanent Disablement (Superannuation) **plan** under Flexible Lifetime – Protection (Superannuation). Your ***Certificate of Insurance*** will show if you have this **plan**.

In addition:

- rule 39 describes Trauma definitions used throughout this document, and
- rule 40 contains a 'Glossary of definitions' of other technical words used in this document.

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.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **PLAN**
- **PLAN OWNER**
- **TERMINAL ILLNESS**

THE DEFINITIONS ARE SET OUT IN RULE 40

Introduction

PURPOSE

For non-superannuation **plans**, this product provides you with a specified lump sum if you:

- have selected Death cover and the **insured person** dies or has less than 12 months to live due to a **terminal illness**
- have selected Total and Permanent Disablement (TPD) cover, and the **insured person** becomes **totally and permanently disabled**
- have selected Trauma cover and the **insured person** suffers one of the **trauma conditions** we cover.

For superannuation **plans**, this product provides a specified lump sum if you:

- die or have less than 12 months to live due to a **terminal illness**
- have selected Total and Permanent Disablement (TPD) cover, and become **totally and permanently disabled**.

You may have additional options on your plan.

The cover the **insured person** has is shown on the ***Certificate of Insurance***. That information is updated each year in the Annual Statement.

WHO WE PAY

For non-superannuation **plans**, we pay you.

For superannuation **plans**, we pay AMP Superannuation Ltd who will pay the benefit in accordance with the Trust Deed of the Fund.

INSURED PERSON

For non- superannuation plans more than one **insured person** can be covered under the plan. For example, you can ask us to insure your spouse, child, or business partner, as well as yourself. You can do that at any time – even after we have issued the **plan**.

You may insure a child (for Children's Trauma cover) when an adult is included as an **insured person** under the **plan**.

You can also be an **insured person** or you can own the **plan** but not be an **insured person**.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **PLAN**
- **PLAN OWNER**
- **TERMINAL ILLNESS**
- **TOTALLY AND PERMANENTLY DISABLED**
- **TRAUMA CONDITIONS**

THE DEFINITIONS ARE SET OUT IN RULE 40

CHANGING YOUR PLAN

Once the **plan** has started, you can apply to change it. For some changes, all you need to do is tell us by calling us or 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 your **plan** are set out on the following pages. When the **plan** starts, these rules and the ***Certificate of Insurance*** we sent you with these Plan Rules form the contract and plan with us.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **PLAN**

THE DEFINITIONS ARE SET OUT IN RULE 40

Table of contents

What has to happen for us to pay

1. REASONS WHY WE PAY A LUMP SUM

NON-SUPERANNUATION PLAN

There are three types of cover available in non-superannuation **plans**.

The three types of cover are:

1. Trauma cover – if the **insured person** suffers a **trauma condition**, and survives a specified number of days, we pay a lump sum – see rule 3. There are 2 levels of cover, Trauma cover Standard and Trauma cover Premier. Premier covers more **trauma conditions** than Standard.

   If a child is covered as an **insured person** under Children's Trauma cover, we pay a lump sum if they suffer a **trauma condition** or die – see rule 7.

2. Total and Permanent Disablement (TPD) cover – if the **insured person** becomes **totally and permanently disabled**, we pay a lump sum – see rule 4.

3. Death cover –

- Terminal illness benefit – if the **insured person** has less than 12 months to live, we pay the amount we would pay if they had died (up to $2,000,000). Upon death, we pay any remaining Death cover, if applicable – see rules 5 and 10.1.

- Death – if the **insured person** dies, we pay a lump sum.

SUPERANNUATION PLAN

There are two types of cover available in Superannuation **plans**.

The two types of cover are:

1. Total and Permanent Disablement (TPD) cover – if you become **totally and permanently disabled**, we pay a lump sum – see rule 4. Note, TPD cover can only be selected if Death cover is also selected.

2. Death cover –

- Terminal illness benefit – if you have less than 12 months to live, we pay the amount we would pay if you had died (up to $2,000,000). Upon death, we pay any remaining Death cover, if applicable – see rules 5 and 10.1.

- Death – if you die, we pay a lump sum.

The ***Certificate of Insurance*** shows the type, or types, of cover, which apply to the **insured person(s)**.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **PLAN**
- **TOTALLY AND PERMANENTLY DISABLED**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40

1.1

This rule has been removed

1.2

WAIVER OF PREMIUM OPTION

Under this option, we will waive **premiums** that fall due under your **plan** if the **insured person** is **totally disabled** for a period of more than 6 **months**. We may waive some or all of the **premiums** falling due under this option, depending on whether you have selected "Nominated life " or "Individual life ". See rule 29.

2.

STAND ALONE COVER OR LINKED COVER

If an **insured person** is covered for more than one type of cover, all their cover is either **Stand alone** or **Linked**:

- **Stand alone** means that each type of cover is completely independent of all other types of cover that apply to an **insured person** under this **plan**. If we pay under one type of cover, it doesn't affect the amount of any other cover for that **insured person**. The only time this doesn't apply is if we pay under Terminal Illness benefit, when we reduce the amount of the Death cover that applies to the **insured person** by the amount we pay.

- **Linked** means that each type of cover for an **insured person** is dependent on each other type of cover. If we pay under one type of cover, the amount of each remaining type of cover that applies to that **insured person** is reduced by the amount we pay. See Rule 11.

Note, if an **insured person** is covered for only one type of cover, it's treated as **Stand alone.**

Your ***Certificate of Insurance*** shows whether the cover that applies to an insured person is **Stand alone** or **Linked**.

EXAMPLE

Indira owns a Flexible Lifetime – Protection **plan** under which she is an **insured person**.

She has:

- Trauma cover of $200,000, and

- Death cover of $300,000.

If she chooses **Stand alone** cover and we pay her because she suffers a **trauma condition**, her Trauma cover would end but her Death cover would continue unchanged.

Instead if she chooses **Linked** cover and we pay her because she suffers a **trauma condition**, her Trauma cover would end and her Death cover would be reduced by $200,000. That is, her Death cover would be reduced to $100,000.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **LINKED**
- **MONTH**
- **PLAN**
- **PREMIUM**
- **STAND ALONE**
- **TOTALLY DISABLED**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

3.
TRAUMA COVER – ADULTS

AVAILABILITY

Not available to superannuation **plans**.

> Your ***Certificate of Insurance*** shows whether Trauma cover - adults applies to an **insured person**. The rule on Children's Trauma cover is set out in rule 7.

We pay if an **insured person** suffers a **trauma condition**, and survives for 14 days. Note, the **trauma condition** for Coma has a different survival period. See the description for Coma in rule 39.

The descriptions in rules 30, 31 and 39 set out the other requirements that must be met before we pay.

The number of **trauma conditions** an **insured person** is covered for depends on if you have selected:

- Trauma cover Standard, or
- Trauma cover Premier, or
- Trauma cover Premier with Partials Plus option.

Tables 1, 1.1 and 2 show which **trauma conditions** are covered under each of the cover types above.

For each **insured person** the ***Certificate of Insurance*** shows whether Standard, Premier, or Premier with Partials Plus option applies and when the cover starts and ends.

Note, cover is delayed for three **months** for some **trauma conditions**. See Tables 1, 1.1 and 2.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **MONTHS**
- **PLAN**
- **TRAUMA CONDITIONS**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Table 1

Trauma cover Premier covers the following trauma conditions for adults*	
Cover for the conditions in this column starts immediately	**Cover for the conditions in this column is delayed for three months. See rules 3.1 and 3.2**
Alzheimer's disease and other dementias	Aortic surgery
Aplastic anaemia	Benign tumour of the brain or spinal cord
Blindness	Cancer
Cardiomyopathy	Coronary artery angioplasty– triple vessel
Coma	Coronary artery surgery
Encephalitis	Heart attack– myocardial infarction
HIV/AIDS – medically acquired	Heart attack– out of hospital cardiac arrest
HIV/AIDS – occupationally acquired	Heart valve surgery
Intensive care	Open heart surgery
Kidney failure	Pneumonectomy
Liver failure	Severe rheumatoid arthritis
Loss of hearing	Stroke
Loss of independent living	
Loss of speech	**Partial benefit only:**
Loss of use of limbs and/or sight	Cancer (Partial)
Lung failure	Coronary artery angioplasty (Partial)
Major head trauma	Parkinson's disease (Partial)
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	
Peripheral blood stem cell or bone marrow transplant	
Peripheral neuropathy	
Primary pulmonary hypertension	
Severe burns	
Systemic lupus erythematosus	
Systemic sclerosis	

* 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.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **PLAN**
- **TRAUMA CONDITIONS**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Table 1.1

The Partials Plus option covers the following trauma conditions for adults	
Cover for the conditions in this column starts immediately	**Cover for the conditions in this column is delayed for three months – see rules 3.1 and 3.2**
Partial blindness	Melanoma Prostate cancer Severe inflammatory bowel disease Severe osteoporosis

Table 2

Trauma cover Standard covers the following trauma conditions for adults*	
Cover for the conditions in this column starts immediately	**Cover for the conditions in this column is delayed for three months – see rules 3.1 and 3.2**
Kidney failure Major organ transplant Paralysis that is one of: – diplegia – hemiplegia – paraplegia – quadriplegia – tetraplegia Peripheral blood stem cell or bone marrow transplant	Aortic surgery Cancer Coronary artery surgery Heart attack – myocardial infarction Heart attack – out of hospital cardiac arrest Heart valve surgery Stroke

* From the **plan anniversary** following the **insured person's** 64th birthday, the only **trauma conditions** covered are Loss of independent living and Loss of use of limbs and/or sight.

3.1 COVER FOR SOME TRAUMA CONDITIONS IS DELAYED

For us to pay because an **insured person** suffers one of the **trauma conditions** listed in the right hand column of Table 1, Table 1.1 or Table 2, the **insured person** must suffer the **trauma condition** more than three **months** after the trauma cover for the **insured person** starts or restarts. That date is shown on the ***Certificate of Insurance*** or in the document in which we told you that we have restarted the trauma cover or **plan**.

Also, if we have increased the amount of the trauma cover for that **insured person** because you asked us to, and within three **months** after the increase that **insured person** suffers one of the **trauma conditions** in the right hand column of Table 1, Table 1.1 or Table 2, we pay the amount that applied before the increase. That three **month** period starts on the date from which the increase applies.

These restrictions do not apply to regular **CPI** increases.

If your **plan** replaces a previous **plan** issued by us or another insurer, the three **month** delay explained previously won't apply if you were eligible to claim for the same condition under the previous **plan** provided:

- the previous **plan** was in force at the time we issued your **plan**, and
- the previous **plan** was in place for at least three **months**.

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

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **CPI**
- **INSURED PERSON**
- **MONTHS**
- **PLAN**
- **PLAN ANNIVERSARY**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

3.2 TRAUMA CONDITIONS SUFFERED IN THREE MONTH PERIOD

If an **insured person** suffers a **trauma condition** in the right hand column of the Trauma cover tables within three **months** after the Trauma cover for that **insured person** starts, or restarts, we'll never pay for that condition, even if the **insured person** suffers it again later.

4. TOTAL AND PERMANENT DISABLEMENT (TPD) COVER

Your ***Certificate of Insurance*** shows whether TPD cover applies to an insured person

We pay if:

- an illness or injury which causes an **insured perso**n to become **totally and permanently disabled** happens while that **insured person** is covered by TPD cover, and
- they survive for six **months** after the date on which they stop performing (or would have stopped performing) **home duties, regular remunerative work**, or their **own occupation** because of their illness or injury.

However, if an **insured person** meets the definition of TPD because of either Loss of use of limbs and/or sight or Loss of independent living or Loss of cognitive functioning under the definition of **totally and permanently disabled**, they only need to survive for 14 days.

For superannuation **plans**, we pay AMP Superannuation Ltd who will pay the benefit to you in accordance with the Trust Deed of the Fund.

5. TERMINAL ILLNESS BENEFIT– ADULTS

This cover is built in to Death cover. If the Death cover applies to an **insured person**, that person is automatically covered for **terminal illness**. Your ***Certificate of Insurance*** shows whether Death cover applies to an **insured person**.

We pay if an **insured person** is diagnosed as having less than 12 **months** to live. For us to pay, the **insured person's doctor** must tell us in writing that they believe the **insured person** has less than 12 **months** to live. The **doctor's** belief must be based on clinical findings and reports. We will only pay if we agree with the **doctor**. We may also require you to give us information from medical advisers we choose.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **DOCTOR**
- **HOME DUTIES**
- **MONTH**
- **OWN OCCUPATION**
- **REGULAR REMUNERATIVE WORK**
- **TERMINAL ILLNESS**
- **TOTALLY & PERMANENTLY DISABLED**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40

6. DEATH COVER

Your ***Certificate of Insurance*** shows whether Death cover applies to an **insured person**.

We pay if the **insured person** dies.

6.1 FUNERAL BENEFIT

AVAILABILITY

Not applicable to superannuation **plans**.

WHAT HAS TO HAPPEN FOR US TO PAY

We will advance you, on your request, part of the Death cover amount on the production of the **insured person's** death certificate, while we are assessing the death claim.

The advance will be made to either:

- a surviving **plan owner**, or
- if the **plan owner** is deceased, and on completion of an indemnity and discharge in a form acceptable to us, to any person considered by us to be dependent on the **insured person** at the time of their death.

HOW MUCH WE PAY

We will advance up to $10,000. The Death cover amount on the **plan** will be reduced by the amount of the advance. The remainder of the Death cover will be payable upon acceptance of a death claim.

6.2 FINANCIAL PLANNING BENEFIT

AVAILABILITY

Not applicable to superannuation **plans**.

WHAT HAS TO HAPPEN FOR US TO PAY

We will reimburse you for the cost of financial planning advice after a benefit payment on this **plan**.

The financial advice must come from a suitably qualified person acceptable to us.

HOW MUCH WE PAY

We will reimburse you up to $1500, additional to the amount of the benefit paid.

WHEN WE PAY

We will reimburse you after the benefit has been paid and you produce evidence of this expense in a form acceptable to us.

HOW OFTEN WE PAY

This benefit is payable only once for each **insured person** on this **plan** and must be claimed within twelve **months** of the benefit being paid.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **MONTH**
- **PLAN**
- **PLAN OWNER**

THE DEFINITIONS ARE SET OUT IN RULE 40.

6.3

This rule has been removed

6.4
BUSINESS SAFEGUARD OPTION

AVAILABILITY

Not applicable to superannuation **plans**.

WHEN YOU CAN INCREASE YOUR DEATH OR TPD COVER

You may apply to increase the level of Death or TPD cover, or both Death and TPD covers without further medical evidence.

HOW MUCH YOU CAN INCREASE COVER BY

You can apply to increase the cover under this option:

- if this **plan** forms part of a written buy/sell, share purchase or business continuation agreement: by the actual increase in the value of your interest in the business since the latter of last time the option was exercised and the commencement of the option, or
- 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.

WHEN DOES THE OPTION END?

The option will cease when any of the following occurs:

- you don't exercise the option for five years.
- after 10 years from the commencement of the option
- the **insured person** turns 65
- the Death or TPD cover is five times the original amount
- the Death cover reaches $15,000,000 or the TPD cover reaches $2,500,000
- the **insured person** has received, or is eligible to receive, a benefit under this or another life insurance plan.

ELIGIBILITY TO INCREASE

You can't take up this option if at the time of your request the **insured person** has made or is eligible to make a **terminal illness**, trauma or TPD claim under any **plan** with us.

CONDITIONS OF INCREASE

We will require financial evidence of the increase in the value of the business from an independent qualified accountant, business valuer, or other appropriate person all of whom must be approved by us.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **PLAN**
- **TERMINAL ILLNESS**

THE DEFINITIONS ARE SET OUT IN RULE 40.

7. CHILDREN'S TRAUMA COVER

Not available to superannuation **plans**.

Your ***Certificate of Insurance*** shows whether it applies to an **insured person**.

7.1 THE TRAUMA CONDITIONS WE COVER

This rule applies to **insured persons** covered under Children's Trauma cover. See Rule 3 for **trauma conditions** covered under Trauma cover Standard, Trauma cover Premier and Trauma cover Premier with Partials Plus option.

We will pay if an **insured person** suffers a **trauma condition**, and survives for 14 days. The descriptions in rules 30, 31 and 39 set out the other requirements that must be met before we pay.

For some **trauma conditions**, cover is delayed for three **months**. For the others, cover only applies to an **insured person** who has turned 10. The ***Certificate of Insurance*** shows when Children's Trauma cover starts. The cover for **trauma conditions** under Children's Trauma cover ends after the **insured person** turns 16 and automatically converts to Death cover. See Rule 7.1.3.

Table 3

Children's Trauma cover covers the following trauma conditions for children	
Cover for the trauma conditions in this column starts immediately*	**Cover for the trauma conditions in this column is delayed for three months. See rules 7.1.1 and 7.1.2**
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	Aplastic anaemia Bacterial meningitis Cancer Leukaemia Subacute sclerosing panencephalitis Viral encephalitis

*If the child is under 10, cover is delayed until they turn 10.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **MONTH**
- **PLAN**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

7.1.1
COVER FOR SOME TRAUMA CONDITIONS IS DELAYED

For us to pay when an **insured person** suffers a **trauma condition** listed in the right hand column of Table 3, the **insured person** must suffer the **trauma condition** more than three **months** after the Children's Trauma Cover for that **insured person** starts or restarts. That date is shown in the ***Certificate of Insurance*** or in the document in which we told you that we have restarted the Children's Trauma cover or the **plan**.

Also, if we have increased the amount of the Children's Trauma cover because you asked us to, and within three **months** after the increase the **insured person** suffers one of the **trauma conditions** in the right hand column of Table 3 we pay the amount that applied before the increase. The three **month** period starts on the date from which the increase applies.

These restrictions do not apply to regular **CPI** increases.

If your **plan** replaces a previous **plan** issued by us or another insurer, the 3 **month** delay explained previously won't apply if you were eligible to claim for the same condition under the previous **plan** provided:

- the previous **plan** was in force at the time we issued your **plan**, and
- the previous **plan** was in place for at least three **months**.

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

7.1.2
TRAUMA CONDITIONS SUFFERED IN THREE MONTH PERIOD

If an **insured person** suffers:

- a **trauma condition** listed in the right hand column of Table 3 on page 15 within three **months** after the cover for that **insured person** starts, or restarts,
- a **trauma condition** listed in the left hand column of Table 3 on page 15 before they turn 10, we won't ever pay for that condition, even if the **insured person** suffers it again later.

7.1.3
CHILDREN'S TRAUMA COVER CHANGES TO DEATH COVER

At the **plan anniversary** on or before the insured child's 17th birthday, the Children's Trauma cover and its built in Death cover ends. However, at that date the amount of the Children's Trauma cover automatically changes to Death cover (which includes built-in terminal illness benefit, Guaranteed future insurability and Funeral benefit).

7.2
DEATH COVER PROVIDED UNDER CHILDREN'S TRAUMA COVER

Death cover (excluding the Terminal Illness benefit, Guaranteed future insurability and Funeral benefit) is built in to Children's Trauma cover.

We pay if an insured child dies while covered by Children's Trauma cover. We will pay $10,000.

Note, this Death cover ends if we pay because the **insured person** suffers one of the **trauma conditions** covered under Children's Trauma cover .

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **CPI**
- **INSURED PERSON**
- **MONTH**
- **PLAN**
- **PLAN ANNIVERSARY**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40

How much we pay

8.
WHAT WE PAY

We pay a lump sum.

9.
WHEN WE PAY

We will pay as soon as we have processed a claim which satisfies the rules of the **plan**.

10.
HOW MUCH WE PAY

Trauma cover – we pay the amount of the cover that applies on the date that the requirements of the **trauma condition** was met.

TPD cover – we pay the amount of cover that applies on the date six **months** after the **insured person** stopped performing (or would have stopped performing) **home duties**, **regular remunerative work** or their **own occupation**.

Terminal Illness benefit – we pay the amount of Death cover that applies on the date we agree with the **terminal illness** diagnosis. See rule 10.1.

Death cover – we pay the amount of cover that applies on the date listed in the death certificate (or on the date of death).

Note, if we have already paid you because of something that happened to that **insured person**, any remaining cover may have been reduced. See rule 11.

10.1
TERMINAL ILLNESS COVER – $2,000,000 LIMIT

If we pay because the **insured person** is **terminally ill**, we will advance you up to $2,000,000 of any Death cover amount. The most we will pay altogether under all AMP **plans** because an **insured person** is **terminally ill** is $2,000,000. If the $2,000,000 limit applies, we reduce the Death cover that applies to that **insured person** by the amount we pay, and later when they die, we pay any remaining death cover.

10.2
CHANGES TO THE AMOUNT OF COVER

After the **plan** starts, the amount of each cover for an **insured person** may change in any of the following ways:

- it can increase each year by any increase in the **CPI**. Each year, we will show the new amount in the Annual Statement, or
- it can change when you ask us to change it. If it has changed in this way, we will show the new amount in the document we send you to record the change, or
- it will reduce – perhaps to zero – for an **insured person** if we pay because something happens to that **insured person**. See rule 11.

10.3
TAXES OR CHARGES

We deduct any taxes or government charges from the amount we pay:

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

THESE WORDS AND PHRASES ARE DEFINED:
- **CPI**
- **HOME DUTIES**
- **INSURED PERSON**
- **MONTH**
- **OWN OCCUPATION**
- **PLAN**
- **REGULAR REMUNERATIVE WORK**
- **TERMINAL ILLNESS**
- **TERMINALLY ILL**
- **TRAUMA CONDITIONS**

THE DEFINITIONS ARE SET OUT IN RULE 40.

11.
COVER AMOUNTS MAY CHANGE AFTER WE PAY

If cover is Stand alone

If we pay a benefit for an **insured person** and the cover that applies to them is **Stand alone**:

- the cover for which we paid ends, and
- if we pay the Terminal illness benefit, the death cover for that **insured person** also ends. However, if the $2,000,000 limit in rule 10.1 applies, the death cover is only reduced by the amount we pay; and
- the amount of any other cover that continues for that **insured person** stays the same – that is, these amounts are not reduced. Note, if the **insured person** dies, all cover for that **insured person** ends.

The ***Certificate of Insurance*** shows if cover is **Stand alone**.

If cover is Linked

If we pay a benefit for an **insured person** and the cover that applies to them is **Linked**:

- the cover for which we paid ends, and
- we reduce some, or all, of any other cover for that **insured person** by the amount we paid, and
- some, or all, of any other cover for that **insured person** will end.

We explain the way covers are reduced in the example provided under Rule 2 on page 8.

The ***Certificate of Insurance*** shows if cover is **Linked**.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **LINKED**
- **STAND ALONE**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

11.1 CHILDREN'S TRAUMA COVER

If we pay because an **insured person** suffers a **trauma condition** under Children's Trauma cover or dies, all cover for that **insured person** ends.

11.2 TRAUMA PREMIER WITH BUY BACK OPTION

Your ***Certificate of Insurance*** shows if the **Buy back** option has been selected. The **Buy back** option is only available if you choose Death cover **linked** with your Trauma cover Premier. If you select the **Buy back** option, you will be able to restore the Death cover on the **plan** by the amount it was reduced upon a full Trauma cover claim. The option to restore the Death cover becomes available one year after we pay the full Trauma cover claim, and is exercisable for 30 days.

We will base the **premium** for the new cover on our normal Death cover **premium rates** and the **insured person's** age at the time, taking into account the cover amount, and any special conditions or **premium** loadings applying to your original cover. The **Buy back** option will cease on the **plan anniversary** following the **insured person's** 64th birthday.

The indexation feature and Guaranteed future insurability are not available on the restored Death cover.

EXAMPLE

Jenny owns a Flexible Lifetime – Protection **plan** under which she is an **insured person**.

She has:

Death cover of $300,000 **linked** with Trauma cover Premier of $200,000. She has also selected the **Buy back** option. If she suffers a **trauma condition**, we will pay her $200,000, and her Death cover amount will reduce to $100,000. One year after we pay the claim, Jenny can ask us to restore her Death cover amount back to $300,000.

THESE WORDS AND PHRASES ARE DEFINED:

- **BUY BACK**
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **LINKED**
- **PLAN ANNIVERSARY**
- **PREMIUM**
- **PREMIUM RATES**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

11.3

TRAUMA PREMIER REINSTATEMENT OPTION

Your ***Certificate of Insurance*** shows if the Trauma Reinstatement option has been selected.

The Trauma Reinstatement option can only be selected when you choose Trauma cover Premier.

This option allows you to choose to restore the full Trauma benefit amount we have paid after a full trauma claim, without having to provide additional evidence of health, details of the **insured person's** occupation or pastimes. The Trauma reinstatement option does not apply to any partial trauma benefits we pay.

This option becomes available one year after we pay the full Trauma cover claim, and is exercisable for 30 days, by completing the relevant application form. We will base the **premium** for the **Reinstated Trauma cover** on our Trauma cover rates applicable at the time and the **insured person's** age at the time, taking into account the sum insured and any special conditions or **premium** loadings applying to the original Trauma cover.

The option to reinstate the cover will cease on the earlier of the following:

- the date shown in the ***Certificate of Insurance,*** and
- 13 months after the date of the original full Trauma claim.

You can't exercise the Trauma reinstatement option if we have paid a trauma claim for any benefit that is a partial benefit (whether under Premier cover or the Premier Partials Plus option).

If the Premier with **Buy back** option applies to your **plan** (see Rule 11.2), you must restore the Death cover on your **plan** at the same time you restore your Trauma cover otherwise you lose the option restore to your Death cover at a future date. If the Premier with **Buy back** option does not apply to your **plan**, you do not have the option to restore any reduced or cancelled Death cover.

Reinstated Trauma cover

The Indexation feature and Guaranteed future insurability are not applicable on the **Reinstated Trauma cover**.

We will not pay a claim for the **Reinstated Trauma cover** if:

- the **insured person** was diagnosed or suffered symptoms leading to diagnosis of a new **trauma condition** that became apparent or occurred in the intervening 13 month period prior to the date of reinstatement of the Trauma cover (and we receive your completed application form and first **premium**), or
- the new **trauma condition** is the same as the original **trauma condition** or is directly or indirectly caused or related to the **trauma condition** for which the original trauma cover was paid, or
- the new **trauma condition** is directly or indirectly related to the treatment used for the original **trauma condition**, or

THESE WORDS AND PHRASES ARE DEFINED:
- **BUY BACK**
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **PLAN**
- **PREMIUM**
- **REINSTATED TRAUMA COVER**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

- the **trauma condition** is Kidney failure or a Heart condition* and the original trauma cover payment was for Systemic lupus erythematosus, or
- the **trauma condition** is a Heart condition* and the original trauma cover payment was also for a Heart condition*, or
- the **trauma condition** is a Stroke or Paralysis** (directly or indirectly resulting from a stroke) and the original trauma cover payment was for a Heart condition*.

* Heart condition means any of the following 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.

** Paralysis means any one of diplegia, hemiplegia, paraplegia, quadriplegia or tetraplegia.

We won't pay a benefit under the **Reinstated trauma cover** for a **trauma condition** for which we have already paid a trauma benefit.

We won't pay a benefit under the **Reinstated trauma cover** for a **trauma condition** unless acceptable evidence is provided that the new **trauma condition** is:

- independent of, and totally unrelated to the previously paid **trauma condition**, and
- totally unrelated to the treatment used for the original **trauma condition** for which we paid.

We won't pay a benefit under the **Reinstated trauma cover** for any conditions or symptoms that become apparent or are diagnosed before the date of reinstatement of the Trauma cover.

EXAMPLE

Michael owns a Flexible Lifetime – Protection plan under which he is an **insured person**.

He has:

Trauma cover Premier of $400,000. He has also selected the Trauma Reinstatement option. If he suffers a **trauma condition**, we will pay him $400,000, and his Trauma cover will cease. One year after we pay the claim, Michael can exercise the Trauma Reinstatement option and have **Reinstated Trauma cover** of $400,000.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **REINSTATED TRAUMA COVER**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

When we won't pay

12.
ON PURPOSE

We won't pay if the **insured person's trauma condition** or the **insured person** becoming **totally and permanently disabled** or **totally disabled** was caused directly or indirectly by an intentional or deliberate act by you, or the **insured person**.

13.
DEATH – OR TERMINAL ILLNESS – BY OWN HAND

We won't pay if the **insured person** dies (or becomes **terminally ill**) by their own hand within one year and 30 days of the date the Death cover starts or restarts (respectively). That date is shown on the ***Certificate of Insurance*** or in the document in which we told you that we have restarted the Death cover or **plan**.

Also, if we have increased the amount of the Death cover for an **insured person** because you asked us to, and within one year and 30 days after the increase, that **insured person** dies – or becomes **terminally ill** – by their own hand, we pay the amount that applied before the increase. That one year and 30 day period starts on the date from which the increase applies. That date is shown in the document in which we told you that we have increased the Death cover.

If your **plan** replaces a previous **plan** issued by us, or another insurer, the one year and 30 day period won't apply. If you would have been entitled to claim under the previous **plan**, provided:

- the previous **plan** was in force at the time AMP issued this **plan**, and
- the previous **plan** was in place for at least one year and 30 days.

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

Note, it doesn't matter whether the **insured person** was sane or insane when they became **terminally ill** or died.

This restriction does not apply to regular **CPI** increases.

14.
CHILDREN'S TRAUMA COVER

We won't pay if an **insured person's trauma condition** is caused directly or indirectly by any congenital condition.

We won't pay if an **insured person's trauma condition** or death is caused directly or indirectly by:

- 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.

Rules 12 and 13 also apply to any claims under Children's Trauma cover.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **CPI**
- **INSURED PERSON**
- **PLAN**
- **TERMINALLY ILL**
- **TOTALLY AND PERMANENTLY DISABLED**
- **TOTALLY DISABLED**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Increasing benefits by the CPI

15.
INDEXATION FEATURE

Each year, on the **plan anniversary**, we will increase the amount of an **insured person's** cover by any increase in the **CPI** or 5%, whichever is higher, unless we agreed not to when that cover started.

These increases will be clearly identified in the Annual Statement we send you each year.

Increasing an **insured person's** cover makes the **premium** increase.

If you don't want this increase, in full or in part then you need to tell us.

Note: we don't increase the following:

- the $10,000 Death cover under Children's Trauma cover
- **reinstated trauma cover** issued as a result of exercising the Trauma reinstatement option (see Rule 11.3)
- death cover issued as a result of exercising the **Buy back** option (see Rule 11.2).

15.1
CPI INCREASES STOP AT A CERTAIN AGE

The last time we increase an **insured person's** cover by any increase in the **CPI** is on the **plan anniversary** on, or before, the **insured person** reaches the age shown in the table below.

Type of cover	Age limit
Trauma cover – adults	75
Terminal Illness benefit	75
Death cover	75
TPD cover	75

You can decline CPI increases

We make increases under the indexation feature automatically. However, you can ask us:

- to increase the amount of some or all of an **insured person's** cover by only some of the increase available under the indexation feature, or
- not to increase the amount of an **insured person's** cover at all, or
- not to increase the amount of an **insured person's** cover ever again.

If you want us to do any of these things, you need to tell us, in writing, before you pay the **premium** that falls due on the **plan anniversary** from which the increase under the indexation feature is to apply.

You can subsequently ask us to make increases under the indexation feature to that cover for that **insured person** again.

We may agree to do this.

THESE WORDS AND PHRASES ARE DEFINED:
- **BUY BACK**
- **CPI**
- **INSURED PERSON**
- **PLAN**
- **PLAN ANNIVERSARY**
- **REINSTATED TRAUMA COVER**

THE DEFINITIONS ARE SET OUT IN RULE 40.

When the plan and cover start and end

16.
WHEN THE PLAN AND COVER START

When we accept your application for insurance we will send you a ***Certificate of Insurance*** showing you the details of your insurance and the date your **plan** commenced.

While most cover for an **insured person** starts on the date shown in the ***Certificate of Insurance***, cover for some **trauma conditions** is delayed. This is explained in rule 3.1 for Trauma cover Premier and Standard and rule 7.1. for Children's Trauma cover.

The **Certificate of Insurance** shows the dates on which each type of cover for each **insured person** starts.

17.
WHEN THE PLAN AND COVER END

Each type of cover for an **insured person** ends on the first of the following dates:

- when we pay you for that **insured person** for that type of cover. This is explained in rule 11, or
- when we reduce the amount of that type of cover to zero for an **insured person** because we pay you under another type of cover. This is explained in rule 11, or
- on the date shown in the ***Certificate of Insurance*** for that **insured person** for that type of cover, or
- if you change your **plan** in a way that ends that type of cover for that **insured person**, or
- if the **insured person** dies, or
- when the **plan** ends.

Note, if an **insured person** who is covered by TPD cover stops performing **home duties**, or **regular remunerative work** or their **own occupation**, the circumstances in which we would pay under that type of cover are very narrow. This is explained in the definition of **totally and permanently disabled** in rule 40.

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

- all cover for the last remaining **insured person** ends, or
- you write to us and ask us to end the **plan**, or
- we end the **plan** under rule 17.1.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **HOME DUTIES**
- **INSURED PERSON**
- **OWN OCCUPATION**
- **PLAN**
- **REGULAR REMUNERATIVE WORK**
- **TOTALLY AND PERMANENTLY DISABLED**
- **TRAUMA CONDITIONS**

THE DEFINITIONS ARE SET OUT IN RULE 40.

17.1

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 do this. 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.

18.

REFUND OF PREMIUMS

If you end the **plan** during a period for which you have already paid the **premium**, we refund the **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.

EXAMPLE

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

For superannuation **plans** we will pay this refund into a similar complying superannuation fund that you nominate, or to an account in the AMP Eligible Rollover Fund (ERF) on your behalf.

RESTARTING THE PLAN

If you end the **plan**, you can ask us to restart it. But you must ask us in writing within 12 **months** of it ending.

If we end the **plan** because you don't pay on time, you can ask us to restart it. But you must ask us in writing within 12 **months** after the due date of the **premium** you didn't pay.

To restart the **plan**, you must:

- pay us one **premium**, and
- give us any information we require about any **insured person**.

We may then agree to restart the **plan**.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MONTHS**
- **PLAN**
- **PREMIUM**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Guaranteed continuation of cover

19.

WE GUARANTEE TO CONTINUE YOUR PLAN

If you pay your **premium** on time and the cover is still current, we guarantee:

- to keep the cover for each **insured person** going on the same rules each year, and
- not to cancel it – or any part of it.

Keeping you informed

20.

WE SEND YOU AN ANNUAL STATEMENT

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

- the name of each **insured person**, and
- the types of cover you have for each **insured person**, and
- the amount of cover after any regular increase under the indexation feature, and
- the **premium** you have to pay to keep the **plan** going.

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

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

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **PLAN**
- **PLAN ANNIVERSARY**
- **PREMIUM**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Changing your plan

21. YOU CAN CHANGE YOUR PLAN

You can change your **plan** in the following ways without needing to give us more details about the **insured person's** health, occupation, or pastimes. This applies even if the **insured person's** health gets worse, or they change their occupation, or pastimes.

For example you can:

- change the level of cover from Trauma cover Premier to Trauma cover Standard, or
- change an **insured person's** type of cover from **Stand alone** to **Linked**, or
- remove the **Buy back** option.

However:

- if you transfer a type of cover, we may require you to transfer all of that type of cover that applies to that **insured person** under this **plan** to the new **plan**. For **Linked** cover, we reduce the amount of any other remaining cover for that **insured person** by the amount you transferred, and
- the **insured person** must be under 70 when you make the change, and
- the new **premium**, the new amount of cover, and the **insured person's** age, must each meet any normal requirements we have (at the time you change) for the **plan** or cover which you change to.

Note, you can't make any of these changes if a **special rule** applies to that **insured person**.

> Note, you may be able to make other changes to the **plan**. For example, you can add an **insured person** to this **plan**, or increase a type of cover. However, we will need details about the **insured person's** health, occupation and pastimes. We suggest you speak to your financial planner, or us, about any changes you would like to make and what our requirements will be.

21.1 AUTOMATIC PLAN ENHANCEMENTS

We review our insurance **plans** regularly. If we enhance our definitions or product features without:

- changing the **premium rates** or
- changing existing **premium** discounts, or
- charging extra **premiums**,

we will automatically provide you enhancements for which you are eligible at no charge.

If we make a change that is not an enhancement these won't automatically apply to your **plan**.

We will write to you and advise you of the changes should automatic enhancements be made.

THESE WORDS AND PHRASES ARE DEFINED:
- **BUY BACK**
- **INSURED PERSON**
- **LINKED**
- **PLAN**
- **PREMIUM**
- **PREMIUM RATES**
- **SPECIAL RULE**
- **STAND ALONE**

THE DEFINITIONS ARE SET OUT IN RULE 40.

21.2 GUARANTEED FUTURE INSURABILITY

You may increase an **insured person's** Death cover and/or TPD cover and/or Trauma cover without providing any evidence of health if:

- the **insured person** marries, or
- the **insured person** divorces, or
- the **insured person's** child is born or they legally adopt a child, or
- the **insured person's** child starts school, or
- the **insured person** is granted a housing loan by a financial institution to buy their first home, or
- the **insured person** completes their first undergraduate degree at a recognised Australian university, or
- the **insured person** becomes a **carer** for the first time.

You must apply for the increase within 12 **months** of the date the event occurs. You must provide appropriate proof of the event, that is acceptable to us, such as certification of the event or a statutory declaration. **Premiums** will be based on the rates applicable at the time of exercising this feature.

You can only increase the insurance cover amount once under this feature in any 12 **month** period. Each time, you may increase the insurance cover amount by 25% of the original sum insured or $250,000, whichever is the lesser.

The maximum total amount by which you can increase the Death cover under this feature over the life of the **plan** is the lesser of:

- the initial amount of Death cover under the **plan** (excluding increases under the indexation feature and increases effected under Guaranteed Future Insurability), and
- $1,000,000.

The maximum total amount by which you can increase the TPD cover and/or Trauma cover under this feature over the life of the **plan** is the lesser of:

- the initial amount of TPD and/or Trauma cover under the **plan** (excluding increases under the indexation feature and increases effected under Guaranteed Future Insurability), and
- $250,000.

The maximum amount you can increase TPD cover to under this feature is $2.5 million. The maximum amount you can increase Trauma cover to under this feature is $2 million.

This feature is not available for Children's Trauma cover.

THESE WORDS AND PHRASES ARE DEFINED:
- **CARER**
- **INSURED PERSON**
- **MONTH**
- **PLAN**
- **PREMIUM**

THE DEFINITIONS ARE SET OUT IN RULE 40.

You can't exercise this feature if at the time of your request:

- the **insured person** is older than 55 years of age, or
- the **insured person's plan** has a **premium** loading or special terms, or
- the **insured person's premiums** are being waived under the waiver of premium option, or
- the **insured person** is eligible to make, or has made a **terminal illness**, TPD or trauma claim under any **plan** that the **insured person** holds with AMP.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **PLAN**
- **PREMIUM**
- **TERMINAL ILLNESS**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Premium – what you have to pay

22.
HOW MUCH AND WHEN

The amount of the **premium** when the **plan** starts, and when the **premium** falls 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 each **insured person** and the cover that applies to them. We use the **premium rates**, loadings, discounts, and plan fees (and any government charges like stamp duty) that apply at that time. We show you the recalculated **premium** in the Annual Statement. We send this just before the **plan anniversary**.

If you change the **plan**, it is likely that the **premium** will change. After any change, we will inform you of the change and the amount of the new **premium** in writing.

22.1
GOVERNMENT TAXES, DUTIES AND CHARGES

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

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **PLAN**
- **PLAN ANNIVERSARY**
- **PREMIUM**
- **PREMIUM RATES**

THE DEFINITIONS ARE SET OUT IN RULE 40.

23. PREMIUM GUARANTEE

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

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

23.1 PREMIUM RATES AND DISCOUNTS NOT GUARANTEED

We can change **premium rates** and discounts, and withdraw discounts and loadings, in the future, as they aren't guaranteed. However, if we do that for this **plan**, the changes will apply to all Flexible Lifetime – Protection **plans** that are similar to this one.

Additionally if we do that for an **insured person**, it will apply to all people we insure under Flexible Lifetime – Protection **plans** that are similar to this one, for example people:

- who are in the same AMP Life insurance rating category as that person at that time, or
- who have similar cover to that person, or
- who are part of a special arrangement we have established with their employer, professional affiliation, or similar type of association.

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 the **plan** or for an **insured person**, we will tell you about the change, and the amount of the new **premium**, before it applies.

KEEPING THE PREMIUM THE SAME	If you want to keep the **premium** the same for the next 12 **months** as it was for the last 12 **months**, 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 what cover you want reduced or cancelled, to keep the **premium** the same. You need to ask us to do this each year that you want it to happen. Note, we may not agree to do this in the future.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MONTHS**
- **PLAN**
- **PLAN ANNIVERSARY**
- **PREMIUM**
- **PREMIUM RATES**

THE DEFINITIONS ARE SET OUT IN RULE 40.

24.
IF WE REDUCE OUR PREMIUM RATES

If we reduce our **premium rates**, or we increase any discounts, we may keep your **premium** the same by increasing the amount of cover under the **plan**. If we do that, we will tell you in writing before the **plan anniversary** from which the change applies and you agree to the change when you pay the next **premium**.

If you don't want the change, please tell us in writing.

25.
PLAN FEE

There is a **plan** fee for each **insured person**. That fee is included in your **premium**. If there is more than one **insured person** under the **plan**, the **plan** fee is lower for the second and following **insured persons**.

Each year, we increase the **plan** fee by any increase in the **CPI**. However, it stays the same if the **CPI** is negative.

26.
PREMIUM FREQUENCY FEE

If you pay more often than yearly, we charge an extra fee. That fee is included in your **premium**. It is a percentage of your **premium**. We can change the percentage we use to calculate the increase at any **plan anniversary**.

27.
DISCOUNTS

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

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

THE DEFINITIONS ARE SET OUT IN RULE 40.

When you don't have to pay premiums

28.
IF WE PAY YOU

You do not have to pay the **premium** for an **insured person**:

- if we have paid because that **insured person** is **terminally ill**, or
- if you have the Waiver of Premium option – see rule 29.

29.
WAIVER OF PREMIUM

The ***Certificate of Insurance*** shows whether you have the Waiver of Premium option.

There are two types of Waiver of Premium available under this **plan**. However, you can add only one type to your **plan**.

The two types of Waiver of Premium available are:

Individual life

- you don't have to pay the **premium** for one or more **insured persons** while they are **totally disabled**. This is explained in rule 29.1, or

Nominated life (doesn't apply to Superannuation plans)

- you don't have to pay any **premium** under the **plan** while a particular **insured person** is **totally disabled**. This is explained in rule 29.2.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **PLAN**
- **PREMIUM**
- **TERMINALLY ILL**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 40.

29.1 WAIVER OF PREMIUM OPTION – INDIVIDUAL LIFE

If an **insured person** has been **totally disabled** for at least six **months** before they turn age 60, you don't have to pay any more **premiums** for that **insured person** and their cover continues. In addition, the **premium** you paid during the six **months** while we determined if the **insured person** was **totally disabled** will be refunded to you.

For Superannuation **plans** we will pay this refund into a similar complying superannuation fund that you nominate, or an account in the AMP Eligible Rollover Fund (ERF) on your behalf.

You have to start paying the **premium** for that **insured person** again on the first of the following dates:

- as soon as that **insured person** stops being **totally disabled**, or
- the date Death cover ceases for the **insured person**, or
- the **plan anniversary** on or after the **insured person's** 70th birthday, or
- the termination of the **plan**.

This type of option is available for one or more **insured persons** covered under this **plan**. If there is more than one **insured person**, we calculate the amount of the **plan** fee we will waive by dividing the total **plan** fee by the number of **insured persons**.

29.2 WAIVER OF PREMIUM OPTION – NOMINATED LIFE

This is not available in superannuation **plans**.
If you have selected this option only one "nominated" **insured person** is covered by the Waiver of Premium option. If that person has been **totally disabled** for at least six **months** before they turn age 60, you don't have to pay any more **premium** under this **plan** even if there are other **insured persons** on the plan and they are not **totally disabled**. In addition, the **premium** you paid during the six **months** while we determined if the **insured person** was **totally disabled** will be refunded to you.

You have to start paying the **premium** on the **plan** again on the first of the following dates:

- as soon as the nominated **insured person** stops being **totally disabled**, or
- the date Death cover ceases for the nominated **insured person**, or
- the **plan anniversary** on or after the nominated **insured person's** 70th birthday, or
- the termination of the **plan**, or
- if that **insured person** dies.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MONTH**
- **PLAN**
- **PLAN ANNIVERSARY**
- **PREMIUM**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 40.

How to make a claim

30.
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 rules 30.1 to 30.3.

We can ask for the information described in those rules:

- while we are assessing the claim, and
- while you are not paying the **premium** because we are waiving your **premium**. In that case, we can ask for it as often as we need it.

30.1
HEALTH AND OTHER INFORMATION

For you to give us that information, you must give us any documents and information which we reasonably require about:

- an **insured person's** health, and
- the circumstances surrounding their health problems, and
- anything else related to the claim.

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

An **insured person** suffers a **trauma condition** if they meet the description shown in rule 39. Usually, we will ask an appropriate consultant medical specialist who specialises in the diagnosis, rehabilitation or treatment of that **trauma condition** to confirm that the **insured person** meets that description. For example, we usually ask a neurologist to confirm that the **insured person** has suffered a stroke as described in rules 3 and 39.

30.2
AGE AND IDENTITY

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

THESE WORDS AND PHRASES ARE DEFINED:
- **DOCTOR**
- **INSURED PERSON**
- **PREMIUM**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

31.
TIME LIMITS

You must tell us that you are going to make a claim. You must do that within the relevant time period shown in the table below.

You must give us all information which we ask for within six **months** after you tell us in writing that you are going to make a claim.

However, we may extend those periods if you ask us.

Type of claim	How soon you must tell us that you are going to claim
An **insured person** suffers a **trauma condition**.	Within 12 **months** of the **insured person** suffering the **trauma condition**.
An **insured person** is **totally and permanently disabled**.	Within 12 **months** of the **insured person** suffering the illness or injury which causes you to make a claim because they are **totally and permanently disabled**.
An **insured person** is **totally disabled** and you want to make a claim under the Waiver of Premium option.	Within 12 **months** of the **insured person** being **totally disabled**.
An **insured person** is **terminally ill**.	No time limit – but the sooner you tell us, the sooner we can pay.
An **insured person** dies.	No time limit – but the sooner you tell us, the sooner we can pay.

32.
LATE CLAIMS AND RESPONSES

If you don't meet these time limits 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:
- **INSURED PERSON**
- **MONTH**
- **TERMINALLY ILL**
- **TOTALLY AND PERMANENTLY DISABLED**
- **TOTALLY DISABLED**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Miscellaneous

33.
OWNERSHIP AND TRANSFERS

You can transfer the ownership of the **plan** if it is a non-superannuation **plan**.

To transfer ownership:

- you must complete the transfer form on the last page of the ***Certificate of Insurance*** we sent you when the **plan** started and send it to us, and
- you must send us that ***Certificate of Insurance***, and
- we register the transfer.

After the transfer, we will communicate only with the new **plan owner**.

34.
GOVERNING LAW

This **plan** is governed by the Life Insurance Act 1995, and the Insurance Contracts Act 1984.

35.
AUSTRALIAN $

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

36.
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 you under this **plan**.

37.
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.

38.

This rule has been removed

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **PLAN**
- **PLAN OWNER**

THE DEFINITIONS ARE SET OUT IN RULE 40.

Trauma definitions and descriptions

39.
DESCRIPTIONS OF TRAUMA CONDITIONS

To satisfy these definitions and descriptions you must survive for 14 days.

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 you be diagnosed with one of the **trauma conditions**, and the diagnostic method(s) used isn't specified within the trauma definition, we may take the method(s) into consideration, which may assist you in the assessment of your claim.

Alzheimer's disease and other dementias

DESCRIPTION

We will pay if an insured person's brain function fails significantly and permanently. The failure must cause the insured person to:

- be unable to perform any one of the activities of daily living without assistance from someone else, or
- require daily care on an ongoing basis.

We won't pay if the dementia is directly caused by alcohol or drug abuse.

GLOSSARY OF TERMS

Activities of Daily Living – See rule 40 for the definition.

Dementia – Progressive mental deterioration due to organic disease of the brain.

THESE WORDS AND PHRASES ARE DEFINED:
• TRAUMA CONDITION
THE DEFINITIONS ARE SET OUT IN RULE 40.

Aortic surgery

DESCRIPTION

We will pay if an insured person has surgery performed to correct a structural abnormality of the thoracic or abdominal 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.

GLOSSARY OF TERMS

Aorta – The main artery arising from the heart with branches to every part of the body.

Intraluminal techniques – The treatment of internal abnormalities by means of a catheter inserted through a superficial blood vessel to apply certain techniques, and not involving an open surgical operation.

Catheter – A hollow tube.

Aplastic anaemia

DESCRIPTION

We will pay if an insured person has severe aplasia of bone marrow as defined by an appropriate consultant medical specialist.

GLOSSARY OF TERMS

Aplasia – Failure of the bone marrow to produce blood cells.

Aplastic anaemia – A severe form of anaemia caused by aplasia of the bone marrow.

Bacterial meningitis

DESCRIPTION

We will pay if an insured person suffers bacterial meningitis caused by a proven organism. The meningitis must produce neurological deficit causing permanent and significant functional impairment.

GLOSSARY OF TERMS

Meningitis – Inflammation of the covering of the brain and spinal cord.

Neurological deficit – Abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Benign tumour of the brain or spinal cord

DESCRIPTION

We will pay if an 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 requires radical 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.

GLOSSARY OF TERMS

Benign tumour – An enlargement or swelling due to overgrowth of tissue which pushes aside normal tissue but doesn't invade it.

Cerebral abscess – A localised collection of pus occurring in the brain.

Cyst – A sac or capsule containing liquid or semi-solid substance.

Granuloma – A mass of tissue occurring in reaction to the presence of, for example, a foreign body or bacterial infection.

Haematoma – A mass produced by a coagulation of blood in a tissue or cavity.

Histologically described – A conclusion reached after a microscopic examination of cells.

Neurological deficit – Abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Pituitary gland – The master gland of the endocrine system which controls hormone production of other endocrine glands.

Blindness

DESCRIPTION

We will pay if an 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 ten degrees or less of arc. That loss must be irreversible and unable to be corrected by glasses or any other means.

Cancer

DESCRIPTION

We will pay if an insured person suffers a malignant tumour, malignant sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorder or leukaemia with the exception of chronic lymphocytic leukaemia, Binet stages A and B or Rai stages 0, I and II. We only pay for chronic lymphocytic leukaemia Rai stages I or II if the insured person is diagnosed under the age of 45. 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 any of the following:

- skin cancers other than melanoma, or
- melanoma where the thickness is less than 1.5mm and the Clark level of invasion is Level 1 or 2, or
- prostatic tumours which are equivalent to or less than TNM Classification T1 and a Gleason score of less than 8 (note, we won't consider the Gleason score for prostatic tumours which are equivalent to or more than TNM Classification T2), or
- tumours which are histologically described as pre-malignant or showing malignant changes of "carcinoma in situ" and not requiring radical surgery, or
- HIV/AIDS related cancers.

GLOSSARY OF TERMS

Binet/Rai stages – Classification of chronic lymphocytic leukaemia which describes disease progression.

Bone marrow disorders – Life shortening disorder of bone marrow elements.

Carcinoma in situ – Cancer confined to its site of origin and readily curable.

Chronic lymphocytic leukaemia – A form of leukaemia that is usually only life threatening in its advanced stages.

Clark Level – A classification system describing the depth of invasion of a melanoma past the top layers of the skin. The classifications are from 1 to 5.

Gleason score – A grading method assigned to indicate how aggressive the tumour is.

Histologically described – A conclusion reached after a microscopic examination of cells.

Hodgkin's lymphoma and non-Hodgkin's lymphoma – Sometimes treatable malignant diseases causing enlargement of the lymph nodes and spleen.

Leukaemia – A malignant disease of the bone marrow, where there is impairment of formation of mature blood cells. This impairment can be manifested in bleeding and bruising, serious infection and symptoms of anaemia such as tiredness and fatigue.

Malignant bone marrow disorders – Malignant disease in the bone marrow due to tumour spread from other organs or due to tumours arising from the blood-forming cells resulting in life threatening effects on the mature blood cells.

Melanoma – A malignant tumour of the skin, usually developing from a mole.

Sarcoma – A malignant tumour of tissues such as bone, muscle or ligament.

TNM classification – A classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Cancer (Partial)

DESCRIPTION

We will pay if an insured person suffers carcinoma in situ of the vulva, vagina or fallopian tubes, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

GLOSSARY OF TERMS

Carcinoma in situ – Cancer confined to its site of origin and readily curable.

TNM classification – A classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Cardiomyopathy

DESCRIPTION

We will pay if an 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.

We won't pay for cardiomyopathy that is directly caused by alcohol, or related to drug use that is not prescribed by a doctor.

GLOSSARY OF TERMS

New York Heart Association Classification of Cardiac Impairment – A functional classification to assess cardiovascular disability.

Class 3 – Physical impairment constituted by a marked limitation of physical activity. The insured person will be comfortable at rest, but less while engaging in ordinary activity.

Coma

DESCRIPTION

We will pay if an insured person is in a state of unconsciousness and doesn't react to external stimuli. The state of unconsciousness must score 6 or less on the Glasgow Coma Scale.

The state of unconsciousness must either:

- be continuous for at least 4 days, followed by new functional impairment producing neurological signs which last at least a further 14 days. The signs must be demonstrated clinically and by a cerebral CT scan, angiogram, MRI, PET, or any other reliable imaging technique approved by AMP, or
- be continuous for at least 90 days.

In all circumstances, we won't pay for any coma that is:

- caused by the insured person's alcohol or drug abuse, or
- the result of the insured person suffering another trauma condition for which we pay.

GLOSSARY OF TERMS

Glasgow Coma Scale – Bedside assessment of levels of consciousness.

Coronary artery angioplasty (Partial)

DESCRIPTION

We will pay if an 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.

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

GLOSSARY OF TERMS

Angioplasty – The treatment of an internal abnormality by the inflation of a balloon catheter inserted through a superficial artery and not involving an open surgical operation.

Coronary artery – Vessel conveying blood to the heart muscle.

Coronary artery angioplasty – Triple vessel

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Angioplasty – The treatment of an internal abnormality by the inflation of a balloon catheter inserted through a superficial artery and not involving an open surgical operation.

Coronary artery – Vessel conveying blood to the heart muscle.

Coronary artery surgery

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Angioplasty – The treatment of an internal abnormality by the inflation of a balloon catheter inserted through a superficial blood vessel and not involving an open surgical operation.

Coronary artery – Vessel conveying blood to the heart muscle.

Coronary artery disease – Significant narrowing or blockage of the coronary arteries.

Encephalitis

DESCRIPTION

We will pay if an 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.

We won't pay for encephalitis caused directly or indirectly by HIV/AIDS.

GLOSSARY OF TERMS

Activities of Daily Living – See rule 40 for the definition.

Encephalitis – Infection of the brain causing inflammation.

Heart attack – myocardial infarction

DESCRIPTION

We will pay if part of an insured person's heart muscle dies as a result of inadequate blood supply to the relevant area. An appropriate consultant medical specialist must certify that a heart attack has occurred and provide confirmatory evidence of this by the following test results:

- new electrocardiographic changes consistent with myocardial infarction, and

  – abnormal biomarkers such as a cardiac enzyme rise above the upper limit of normal, or

  – a rise of Troponin I above 2.0 ng/ml or Troponin T above 0.6 ng/ml.

If on the above criteria, a heart attack is confirmed, but the results are below the limits indicated, the following will be considered as diagnostic evidence:

- abnormal wall motion as assessed by echocardiography, or
- reduction of left ventricular ejection fraction to 50%, or less

  where either of the above is confirmed at least 6 weeks after the cardiac event.

We won't pay for other causes of severe non-cardiac chest pain, heart failure or angina.

GLOSSARY OF TERMS

Abnormal wall motion – An area of dead heart muscle.

Cardiac enzymes – Damage to heart muscle can raise the level of these enzymes. This is shown in a blood test.

Echocardiography – The use of ultrasound to investigate the heart.

Electrocardiographic changes – A graph of electrical activity of the heart showing variation from the normal which is consistent with a heart attack.

Myocardial infarction – Heart attack.

Heart attack – out of hospital cardiac arrest

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Cardiac arrest – Sudden, and often unexpected, stoppage of effective heart action.

Cardiac asystole – Complete failure of contraction of the heart causing cardiac arrest.

Electrocardiogram – A graph of electrical activity of the heart.

Ventricular fibrillation – Heart abnormality with ineffective twitching of the heart chambers.

Heart valve surgery

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Intraluminal techniques – The treatment of internal abnormalities by means of a catheter inserted through a superficial blood vessel to apply certain techniques, and not involving an open surgical operation.

HIV/AIDS – medically acquired

DESCRIPTION

We will pay if 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 must have occurred to the insured person in either Australia or New Zealand, and
- it must have 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.

GLOSSARY OF TERMS

HIV – The Human Immunodeficiency Virus. As the name implies over time infection with HIV causes the immune system to become deficient, which can lead to the development of illnesses such as cancers.

HIV/AIDS – occupationally acquired

DESCRIPTION

We will pay if an 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
- to us within 14 days of its occurrence, and
- be 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.

GLOSSARY OF TERMS

HIV – The Human Immunodeficiency Virus. As the name implies, over time infection with HIV causes the immune system to become deficient, which can lead to the development of illnesses such as cancers.

Sero conversion – The documented change from the absence to the presence in the blood of antibodies to the HIV. These antibodies usually appear in the blood for the first time within 8 to 12 weeks of infection occurring but can appear later.

Intensive care

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Mechanical ventilation – Mechanically assisted movement of air into the lungs.

Tracheal intubation – Insertion of a tube into the trachea.

Kidney failure

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Kidney transplant – Transplantation of a donor kidney into another person's body.

Renal dialysis – The use of defined filtering techniques to remove waste products normally excreted by the kidney.

Leukaemia

DESCRIPTION

We will pay if an insured person is diagnosed with leukaemia.

GLOSSARY OF TERMS

Leukaemia – A malignant disease of the bone marrow, causing abnormalities in the blood, spleen and lymph nodes.

Liver failure

DESCRIPTION

We will pay if an insured person suffers irreversible failure of the liver and as a result the only effective treatment option is to receive a liver transplant. 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 if the liver failure is directly caused by alcohol or related to use of other drugs not prescribed by a doctor.

Loss of hearing

DESCRIPTION

We will pay if an 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

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Activities of Daily Living –

See rule 40 for the definition.

Loss of speech

DESCRIPTION

We will pay if an 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

DESCRIPTION

We will pay if the insured person, because of physical severance or permanent nerve damage, 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).

Lung failure

DESCRIPTION

We will pay if an insured person suffers irreversible failure of both lungs requiring continuous oxygen supply and with FEV1 test results of consistently less than one litre.

GLOSSARY OF TERMS

FEV1 –

Forced expiratory volume in one second.

Major head trauma

DESCRIPTION

We will pay if an insured person suffers an accidental head injury which produces neurological deficit causing significant functional impairment which, in the opinion of an appropriate consultant medical specialist, is likely to be permanent.

GLOSSARY OF TERMS

Neurological deficit –

Abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Functional impairment –

Abnormalities of the nervous system producing certain symptoms and resulting in some disorder of function.

Major organ transplant

DESCRIPTION

We will pay if an insured person requires a transplant from a human 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

DESCRIPTION

We will pay if the insured person has a malignant melanoma where the thickness is less than 1.5mm and the Clark level of invasion is Level 2. The melanoma 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 a melanoma where the thickness is less than 1.5mm and the Clark level of invasion is Level 1.

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

GLOSSARY OF TERMS

Clark Level – A classification system describing the depth of invasion of a melanoma past the top layers of the skin. The classifications are from 1 to 5.

Melanoma – A malignant tumour of the skin, usually developing from a mole.

Motor neurone disease

DESCRIPTION

We will pay if an insured person receives an unequivocal diagnosis of motor neurone disease by an appropriate consultant medical specialist.

GLOSSARY OF TERMS

Motor neurone disease – Disorders with progressive muscle weakness and wasting due to destruction of nerves.

Multiple sclerosis

DESCRIPTION

We will pay if an insured person receives an unequivocal diagnosis of advanced multiple sclerosis by an appropriate consultant medical specialist. There must be significant neurological deficit which causes permanent inability to perform any one of the activities of daily living without assistance of someone else.

GLOSSARY OF TERMS

Activities of Daily Living – See rule 40 for the definition.

Multiple sclerosis – A disease with abnormal nervous tissue in the brain and spinal cord which interferes with the normal function of the nerves.

Neurological deficit – Abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Muscular dystrophy

DESCRIPTION

We will pay if the insured person receives an unequivocal diagnosis of muscular dystrophy by an appropriate consultant medical specialist.

GLOSSARY OF TERMS

Muscular dystrophy – An inherited disease which results in the muscles failing to function.

Myelodysplasia

DESCRIPTION

We will pay if 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.

GLOSSARY OF TERMS

Myelodysplasia – A bone marrow disorder leading to significant impairment of normal blood formation which results in anaemia, reduced white blood cells and platelets.

Myelofibrosis

DESCRIPTION

We will pay if 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.

GLOSSARY OF TERMS

Myelofibrosis – A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen.

Open heart surgery

DESCRIPTION

We will pay if 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.

GLOSSARY OF TERMS

Coronary artery angioplasty – The treatment of an internal abnormality by the inflation of a balloon catheter inserted through a superficial blood vessel and not including an open surgical operation.

Valvotomy – Surgical widening of a narrowed heart valve.

Paralysis – diplegia

DESCRIPTION

We will pay if an insured person suffers total and permanent paralysis of both arms or both legs due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

GLOSSARY OF TERMS

Paralysis –

Complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – hemiplegia

DESCRIPTION

We will pay if an 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. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

GLOSSARY OF TERMS

Paralysis –

Complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – paraplegia

DESCRIPTION

We will pay if an insured person suffers total and permanent paralysis of both legs due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

GLOSSARY OF TERMS

Paralysis –

Complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – quadriplegia

DESCRIPTION

We will pay if an insured person suffers total and permanent paralysis of both arms and both legs due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

GLOSSARY OF TERMS

Paralysis –

Complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – tetraplegia

DESCRIPTION

We will pay if an 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. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

GLOSSARY OF TERMS

Paralysis – Complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Parkinson's disease

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Activities of daily living – See rule 40 for the definition.

Neurological deficit – Abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Parkinson's disease – A progressive disease of the brain with muscle stiffness and tremors.

Parkinson's disease (Partial)

DESCRIPTION

We will pay if the insured person receives an unequivocal diagnosis of Parkinson's disease as confirmed by an appropriate consultant medical specialist.

Parkinson's Disease means the unequivocal diagnosis of idiopathic Parkinson's Disease due to degeneration in the nigrostriatal area of the midbrain 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.

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

Akinesia – Absence, loss, or impairment of the power of voluntary movement.

Nigrostriatal system – An area deep within the brain.

Parkinson's disease – A progressive disease of the brain with muscle stiffness and tremors.

Partial blindness

DESCRIPTION

We will pay if 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.

We will pay:

• $10,000, or

• 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

Peripheral blood stem cell or bone marrow transplant

DESCRIPTION

We will pay if an insured person receives a bone marrow transplant, or peripheral blood stem cell transplant for the treatment of lymphoma or leukaemia. 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.

Peripheral neuropathy

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Peripheral neuropathy – A disease of the nerves which affects people's ability to use their arms, or hands or legs or feet.

Pneumonectomy

DESCRIPTION

We will pay if 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

DESCRIPTION

We will pay if an insured person suffers primary pulmonary hypertension associated with the right ventricle being enlarged and this:

- is established by cardiac catheterisation and/or echocardiography, and
- results in permanent physical impairment to at least Class 3 (marked limitation of activity by symptoms) of the New York Heart Association Classification of Cardiac Impairment.

We don't pay for any other causes of pulmonary hypertension.

GLOSSARY OF TERMS

Cardiac catheterisation – A tube inserted into the heart or coronary arteries.

Echocardiography – The use of ultrasound to investigate the heart.

New York Heart Association Classification of Cardiac Impairment – Is a functional classification to assess cardiovascular disability.

Class 3 – Physical impairment constituted by a marked limitation of physical activity. The insured person will be comfortable at rest, but less while engaging in ordinary activity.

Primary pulmonary hypertension – A condition, cause unknown, associated with increased pressure in the heart-lung circulation, and manifested by an enlarged right ventricle of the heart, as confirmed by chest X-ray, ECG, echocardiogram and cardiac catheter studies.

Right ventricle – One of the major lower chambers of the heart.

Prostate cancer

DESCRIPTION

We will pay if an insured person is diagnosed as having a prostate tumour equivalent to TNM Classification T1 and a Gleason score of less than 8. The tumour must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

GLOSSARY OF TERMS

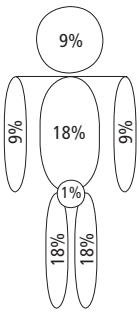
Gleason score – A grading method assigned to indicate how aggressive the tumour is.

TNM classification – A classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Severe burns

DESCRIPTION

We will pay if an insured person suffers third degree burns to 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart shown on this page.



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 if the insured person suffers third degree burns to the whole of both hands or the whole of the face where grafting is required.

Severe inflammatory bowel disease

DESCRIPTION

We will pay if an 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 indefinate second-line therapy.

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

GLOSSARY OF TERMS

Crohn's disease – A chronic inflammatory disease, primarily involving the small and large intestine, which can affect other parts of the digestive system.

Immunosuppressive – Capable of suppressing the immune response.

Ulcerative colitis – An inflammatory bowel disease that causes inflammation and sores (ulcers) in the lining of the large intestine.

Severe osteoporosis

DESCRIPTION

We will pay if an insured person suffers Severe osteoporosis. Severe osteoporosis means the insured person, before the age of 50, suffers at least two 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. This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

We will pay:

- $10,000, or
- 10% of the sum insured (subject to a maximum of $25,000),

whichever is higher.

If we pay under this particular trauma condition, the cover for other trauma conditions the insured person has on this plan continues, but the continuing amount of cover is reduced by what we paid under this condition. Your premium is also reduced accordingly.

We pay under this definition only once.

GLOSSARY OF TERMS

Osteoporosis – A softening of the bones that gradually increases and makes them more fragile.

T-score of less than -2.5 – 2.5 standard deviations below the young adult mean for bone density.

Dual energy X-ray absorptiometry (DEXA) – An imaging test that measures bone density by passing x-rays with two different energy levels through the bone.

Severe rheumatoid arthritis

DESCRIPTION

We will pay if an insured person is diagnosed as having severe rheumatoid arthritis, by an appropriate consultant medical specialist who recommends reconstructive surgery as part of the most appropriate treatment, where response to conventional disease modifying therapy has failed and the condition has progressed to the point that the insured person can't perform any one of the activities of daily living without assistance from someone else.

We won't pay for any other form of arthritis.

GLOSSARY OF TERMS

Activities of daily living – See rule 40 for the definition.

Severe rheumatoid arthritis – Chronic active arthritis with no complete freedom from pain and moderate or marked deformities with serious restrictions of movement and impairment of function.

Stroke

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Cerebrovascular episode – An event where the blood supply to part of the brain is impaired.

CT scan, angiogram, MRI or PET – Variety of tests which provide images of an organ such as the brain. These tests are used to define abnormalities such as tumour or damage to an organ from impaired blood supply or injury.

Neurological damage – Damage to the brain, spinal cord or nerves where the normal structure and function has been affected resulting in symptoms such as impaired vision, speech or paralysis.

Transient ischaemic attack – An event where there is temporary interruption of the normal blood flow to the brain, resulting in temporary abnormalities of brain function and leading to symptoms such as impairment of balance, vision, speech or co-ordination which aren't permanent. Recovery of normal function occurs within 24 hours.

Reversible ischaemic neurological deficit – Abnormality of neurological function which lasts for 24 hours but which is reversible.

Subacute sclerosing panencephalitis

DESCRIPTION

We will pay if an insured person suffers subacute sclerosing panencephalitis.

GLOSSARY OF TERMS

Subacute sclerosing panencephalitis – A progressive and fatal disease of the brain suspected to be of viral origin.

Systemic lupus erythematosus

DESCRIPTION

We will pay if an insured person suffers Systemic lupus erythematosus (SLE) 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.

GLOSSARY OF TERMS

Cerebral lupus – A chronic autoimmune disease characterised by inflammation in the brain.

Cytotoxic therapy – A process that kills cells.

Immunosuppressive – Capable of suppressing the immune response.

Lupus nephritis – A kidney disease that occurs with SLE and often leads to renal failure.

Systemic lupus erythematosus – A chronic inflammatory condition affecting the internal organs, caused by an autoimmune disease.

Systemic sclerosis

DESCRIPTION

We will pay if an 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.

GLOSSARY

Activities of daily living – See rule 40 for the definition.

Systemic sclerosis – A progressive skin disorder which is characterised by thickening and tightening of the skin affecting the face and hands. The disease also affects internal organs.

Viral encephalitis

DESCRIPTION

We will pay if an 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.

GLOSSARY OF TERMS

Encephalitis – Inflammation of the brain.

Neurological deficit – Abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Glossary of definitions

40.
GLOSSARY OF DEFINITIONS

ACTIVITIES OF DAILY LIVING

1. Washing: the **insured person** can wash themselves 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 their 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.

BUY BACK

See Rule 11.2

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

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 Plan Rules in this document form your contract with AMP.

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

- first, in the Annual Statement we send you each year, and
- 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 increase in the Australian National All Groups Consumer Price Index published by the Australian Bureau of Statistics. 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 the amount of cover, we use the annual percentage increase to the index for 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.

HOME DUTIES

An **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).

INSURED PERSON

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

LINKED

Linked cover means that each type of cover for an **insured person** is dependent on each other type. If we pay under one type of cover, the amount of each remaining type of cover that applies to an **insured person** is reduced by the amount we pay.

MEMORANDUM OF ALTERATION

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

MONTH

Month means calendar month.

OWN OCCUPATION

Your **Own Occupation** is the primary full-time occupation you have performed immediately prior to becoming disabled. This option is only available to class A occupations which include professional and white collar workers.

PLAN

Plan means the rules in this document, the ***Certificate of Insurance***, your Annual Statements and any documents we send you recording a change to your **plan**.

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 **CPI** increase to the types of cover. When we recalculate the premium each year, the new amount applies for one year from the **plan anniversary**.

PLAN OWNER

Plan owner is the person who owns the **plan** and whom we pay. We call that person "you". More than one person may own the **plan**. If it is a superannuation plan, it is owned by AMP Superannuation Limited.

PREMIUM

The **premium** is the amount payable for your **plan**, calculated from our **premium rates**. It includes the plan fee, premium frequency fee, any discounts or loadings and any government fees, duties or charges.

PREMIUM RATES

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

REGULAR REMUNERATIVE WORK

An **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.

REINSTATED TRAUMA COVER

See Rule 11.3.

SPECIAL RULE

Special rule means any rule which we apply to a particular **insured person** and which doesn't necessarily apply to all other Flexible Lifetime – Protection plans.

STAND ALONE

Stand alone cover means that each type of cover is completely independent of all other types of cover that apply to an **insured person** under this **plan**. If we pay under one type of cover, it does not affect the amount of any other cover for that **insured person**. The only time this doesn't apply is if we pay under Terminal Illness benefit, when we reduce the amount of the Death cover that applies to the **insured person** by the amount we pay.

TERMINALLY ILL AND TERMINAL ILLNESS

An **insured person** is **terminally ill** if they are diagnosed as having less than 12 months to live. **Terminal illness** has a corresponding meaning.

TOTALLY AND PERMANENTLY DISABLED

An **insured person** can be **totally and permanently disabled** if they:

- are unable to work, or
- are unable to perform specified **home duties**, or
- suffer loss of use of limbs and/or sight, or
- suffer loss of the ability to perform the **activities of daily living**, or
- suffer loss of cognitive function,

and meet the definitions of any of the above as described in the TPD table on page 68.

TOTALLY DISABLED

An **insured person** is **totally disabled** while they are unable to engage in any **regular remunerative work** for which they are reasonably fitted by their education, training or experience. They must be unable to do that because they have suffered an illness or injury.

TRAUMA CONDITION

The **trauma conditions** covered under Trauma cover Standard, Trauma cover Premier and the Partials Plus option are listed in Rule 3.

The **trauma conditions** covered under Children's Trauma cover are listed in Rule 7.1.

The full description of each **trauma condition** is set out in Rule 39.

YOU, YOUR

You and **your** and **yourself** in relation to superannuation **plans** means the **insured person**; and means the **plan owner** in relation to Death, Total and Permanent Disablement, Trauma plans.

Definition of Totally and Permanently Disabled

Definition	The insured person is totally and permanently disabled if they:
Part 1 Unable to work	• suffer an illness or injury, and • the illness or injury wholly prevents them from engaging in **regular remunerative work** for at least 6 **months** 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 r**egular remunerative work** for which they are reasonably fitted by education, training or experience. The **insured person** must also survive 6 **months**. Upon admittance of your claim, we will refund any premiums falling due during this 6 **month** period, that have been paid for the **insured person**.
Part 2 Unable to work – **Own occupation** (Part 2 is only applicable to **insured persons** who have selected the **own occupation** option)	• suffer an illness or injury, and • the illness or injury wholly prevents them from engaging in their **own occupation** for at least 6 **months** 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**. The **insured person** must also survive 6 **months**. Upon admittance of your claim, we will refund any premiums falling due during this 6 **month** period, that have been paid for the **insured person**.
Part 3 **Home duties**	• suffer an illness or injury, and • the illness or injury wholly prevents them from engaging in **home duties** for at least 6 **months** 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 attend to **home duties**. The **insured person** must also survive 6 **months**. Upon admittance of your claim, we will refund any premiums falling due during this 6 **month** period, that have been paid for the **insured person**.
Part 4 Loss of use of limbs and/or sight	• suffer from the total and irrecoverable loss of: – the use of two 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 and the **insured person** must survive for 14 days after the loss.
Part 5 Loss of independent living	• become totally and permanently unable to perform at least 2 of the **activities of daily living** without assistance from someone else. We will not pay for loss of independent living caused directly by alcohol or drug abuse. The **insured person** must survive for 14 days after the loss.
Part 6 Loss of cognitive functioning	• suffer significant and permanent cognitive impairment with a loss of intellectual capacity, and • they are required to be under the continuous care and supervision of someone else. The **insured person** must survive for 14 days after the loss.

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 AMP Customer Service 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
Telephone: (03) 8623 2000 or 1300 780 808
Fax: (03) 9621 2291
Email: fics@fics.asn.au
or write to
PO Box 579, Collins Street West
Melbourne VIC 8007

Additionally, for Flexible Lifetime – Protection (Superannuation) members, if we cannot 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) (contact details listed below).

The SCT reviews the decisions of superannuation trustees as they affect an individual member. It is independent from us. Even so, please try to resolve your complaint directly with us before contacting the SCT.

Superannuation Complaints Tribunal
Telephone: 1300 780 808
or write to
Locked Bag 3060,
GPO Melbourne VIC 3001

TIME LIMITS ON MAKING COMPLAINTS TO THE SCT

If you contact the SCT more than 12 months after our 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 total and permanent disablement (TPD) claim (see below).

If we deny your total and permanent disablement (TPD) claim, then you may be unable to make a complaint to the SCT:

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

You should contact the SCT first to ensure that it can deal with your complaint.

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Directory

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advice
investments
banking
retirement income
superannuation
insurance

Contact your adviser or financial planner

telephone 131 267
web www.amp.com.au
email polinfo@amp.com.au

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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