Contact AMP

AMP Customer Service Centre

You can call or fax a Customer Service Officer on

Phone
131 267

Fax
1300 301 267

Address – Enquiries and Claims

Customer Service
AMP Life Limited
PO Box 300
PARRAMATTA NSW 2124

Or visit our website on
www.amp.com.au
or email us on polinfo@amp.com.au

If you have any enquiries or complaints please remember to mention your plan number.

Where to send Application Forms – New Business

AMP Operations Centre
Reply Paid 62990
PARRAMATTA NSW 2150

New business enquiries

Phone
1300 360 838

advice
investments
banking
retirement income
superannuation
insurance

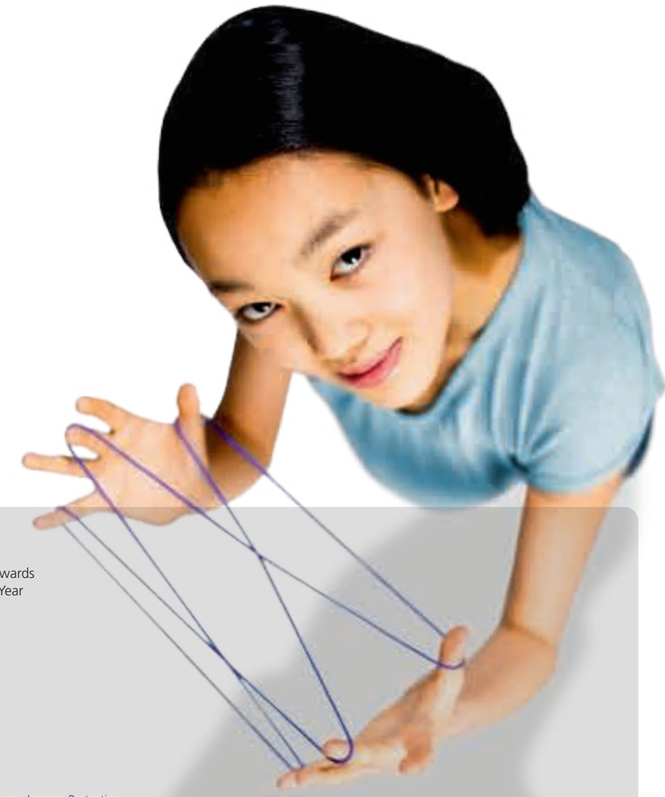
Contact your adviser or financial planner

Phone 138 888
Internet www.amp.com.au
Email askamp@amp.com.au

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

905614 1/07

A safety net for living



Asset INNOVATION awards 2007

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

Product Disclosure Statement

ISSUE DATE 24 NOVEMBER 2007

Flexible Lifetime – Protection Death, Total and Permanent Disablement, Trauma, Income Protection and Business Overheads Insurance are issued by AMP Life Limited ABN 84 079 300 379, AFSL No. 233671. Flexible Lifetime – Protection (Superannuation) Death, Total and Permanent Disablement is issued by AMP Superannuation Limited ABN 31 008 414 104, AFSL No. 233060, RSE Licence No. L0000550 the trustee of the AMP Personal Superannuation Fund RSE Registration No. R1001662.

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This Product Disclosure Statement ("PDS") is an important document. You should read all of it so you can understand how Flexible Lifetime – Protection works. This document describes the benefits, options and features that are available in Flexible Lifetime – Protection.

This PDS is issued by AMP Life Limited for Flexible Lifetime – Protection Death, Total and Permanent Disablement, Trauma, Income Protection and Business Overheads Insurance and AMP Superannuation Limited (ASL) for Flexible Lifetime – Protection (Superannuation) Death and Total and Permanent Disablement.

Both AMP Life Limited and ASL take full responsibility for the whole of the PDS. No other company in the AMP Group is responsible for any statements or representations made in this PDS. No other company in the AMP Group guarantees the performance of AMP Life Limited or ASL's obligations to customers or assumes any liability to customers in connection with Flexible Lifetime – Protection.

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

The information contained in this PDS is of a general nature only. It isn't based on your personal objectives, financial situation and needs.

You are encouraged to consult a financial planner before making any decision as to how appropriate Flexible Lifetime – Protection is to your objectives, financial situation and needs. If you don't have a financial planner you can contact AMP on 1300 360 838 to obtain a copy of our premium rates or a premium quote.

Changes to this PDS

As the information in this PDS may change from time to time, you can obtain updated information simply:
- by asking your financial planner (if applicable), or
- by visiting www.amp.com.au/pdsupdates, or
- by calling us on 133 888 to request a free paper copy of the updated information.

Secured by our Australian No. 1 Statutory Fund

Your plan is backed by our Australian No. 1 Statutory Fund. As at 31 December 2006 the assets available in our Australian No. 1 Statutory Fund were more than 50% higher than the solvency reserve required under the Life Insurance Act.

About AMP and your plan

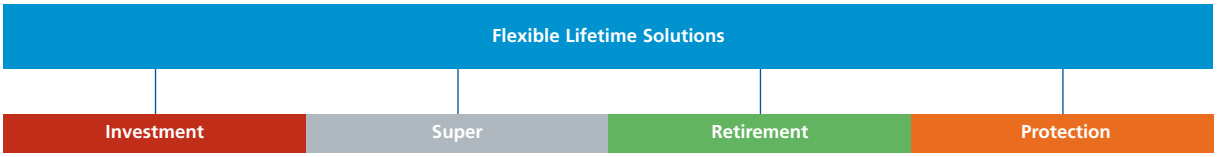
About AMP

The AMP group is a leading financial solutions provider and one of the leading investment managers in Australia. The AMP group provides investment, insurance, superannuation and retirement solutions to more than 3 million Australians and manages over $110 billion.

For over 150 years, AMP has helped generations of Australian families, individuals and business enterprises safeguard and build their financial future. AMP Life was formed in 1998.

About Flexible Lifetime Solutions

Flexible Lifetime – Protection is part of the Flexible Lifetime Solutions range and is designed to help you accumulate and have more throughout your life.



Flexible investment choice and a range of features

Simple, easy to understand product features and pricing structure.

Contemporary product features, designed to meet a broad range of individual financial needs.

Consistent service delivery and compatible product features and pricing across the range.

Value for money through competitive pricing, taking into account the features and investment choice available.

Talk to your financial planner today about how the Flexible Lifetime Solutions range can help you get more out of life.

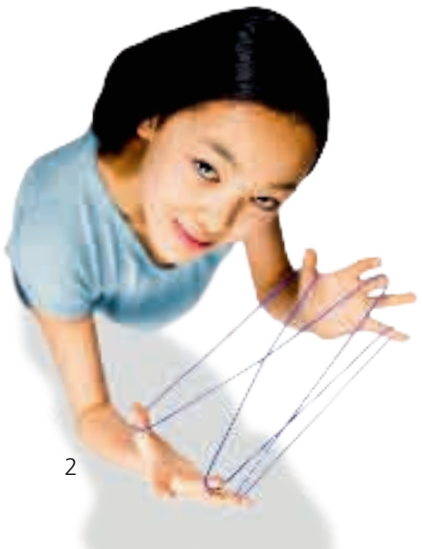
About Flexible Lifetime – Protection

Flexible Lifetime – Protection offers protection solutions to help protect your lifestyle and provide for your dependants.

You can choose:

- a non-superannuation plan, which offers you a range of insurance options including Death cover, Total and Permanent Disablement (TPD) cover, Trauma cover, Income Protection and Business Overheads Insurance to provide you with peace of mind, or
- a superannuation plan, which offers you Death cover and TPD cover within superannuation, where you may be eligible to take advantage of the benefits that superannuation can provide.

We encourage you to speak with your financial planner to help you decide which product, and which insurance options within the products, are suited to your circumstances and needs.



Who is Flexible Lifetime – Protection designed for?

Flexible Lifetime – Protection is designed to provide a financial safety net, so that if something unexpected were to happen you are able to cope financially.

Personal

As you go through life and your circumstances change so too does your financial situation. It's important at these times to ensure you are adequately protected.

- Young adults – while you are working to accumulate assets your priority may be to protect your lifestyle expenses.
- Adults – as you start to acquire significant debt, perhaps with the purchase of a home or starting a family, your needs change to ensure you have adequate insurance to be able to protect yourself and your family.
- Approaching retirement – you may still be paying off debt or concerned with health issues. Continuing your insurance provides a safety net that if something happens your savings can stay on track for retirement.

Business

Flexible Lifetime – Protection also provides solutions for people in business.

- Partnership or share purchase protection – protects a business owner in the event they suffer an illness or die. A lump sum payment provides the remaining partners the ability to purchase that share of the business.
- Key person protection – protects a business in the event of the loss of a person who makes a significant contribution towards the profitability and capital value of the business.
- Business Overheads insurance – covers a business for their overheads while the insured person is unable to work.

Self-managed superannuation fund

Flexible Lifetime – Protection is suitable to be owned by self-managed superannuation funds.

Why choose Flexible Lifetime – Protection?

Flexibility from the start

- Flexible ownership: there are many ownership options for your Death, TPD and Trauma cover – allowing you to structure your insurance according to your needs.
- Tailored plans: you can tailor the cover to your needs by selecting how much cover and the type of cover as well as additional options you may wish to add to your plan.

Remaining contemporary as your needs change

- When we enhance our product definitions without changing premiums these are automatically applied to your plan.
- Guaranteed future insurability allows you to increase Death, TPD, Trauma and Income Protection cover when you have a change in circumstances, without providing any information on your health status.

Support at claim time

- Financial planning benefit up to $1,500 is reimbursed to you for professional financial advice to support you if you receive a Death, TPD or Trauma benefit (not available for superannuation plans).
- Funeral benefit can help take the financial worry away from families planning a funeral (not available for superannuation plans).
- If you choose Income Protection, rehabilitation support allows you to focus on a speedy recovery by reimbursing approved rehabilitation expenses and programs – available with Advanced cover.
- Work during the waiting period – you can work up to 5 days in a row during the waiting period without the waiting period starting again. The waiting period is over when the number of days you have been unable to work equals the number of days in the waiting period.
- Ancillary benefits – if you choose Advanced cover there are also many ancillary benefits available that provide you with additional support at claim time.

Understanding terms in this PDS

Throughout this document:

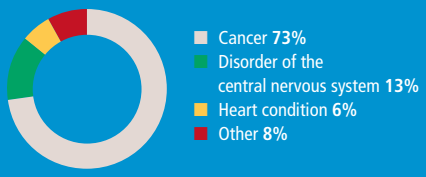
- **AMP** means the AMP Group (the AMP Group is made up of several entities, which include AMP Superannuation Limited and AMP Life Limited).
- **We**, **us** and **our**, in relation to Flexible Lifetime – Protection (Superannuation) Death, Total and Permanent Disablement means AMP Superannuation Limited, and means AMP Life Limited, for all other types of cover in this PDS.
- **You**, **your** and **yourself**, in relation to Flexible Lifetime – Protection (Superannuation) Death, Total and Permanent Disablement means the insured person, and means the plan owner, for all other types of cover in this PDS.
- **Insured person(s)** is the person(s) insured under the plan.
- **AMP Life** means AMP Life Limited.
- **Trustee** means AMP Superannuation Limited.
- **plan**, in relation to Flexible Lifetime – Protection (Superannuation) Death, Total and Permanent Disablement means your interest in the AMP Personal Superannuation Fund, and means the policy of insurance issued by AMP Life, for all other types of cover in this PDS.
- **The Fund** means the AMP Personal Superannuation Fund.

1. Death, Total and Permanent Disablement and Trauma cover

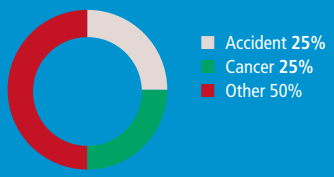
Death and TPD – non-superannuation or superannuation plans

Trauma – non-superannuation plans

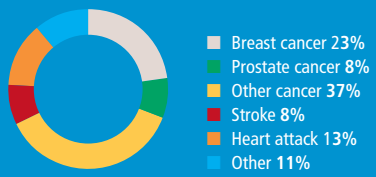
Death claims paid in 2006



TPD claims paid in 2006



Trauma claims paid in 2006



An AMP customer's story

In his late 50s, Kevin* was diagnosed with prostate cancer. Thankfully his Trauma cover meant he could focus on his recovery…

In his mid 40s, Kevin started thinking about the health problems that could affect him later in life. After discussing his options with his financial planner, Kevin decided to take out Trauma insurance. "It just seemed like a very good thing to do and it was going to give me a lot more security. If I did become ill, I wouldn't worry so much because there would be some protection for Lisa. That was my main concern and that's why I took it out."

When results from a routine health checkup revealed that Kevin had prostate cancer he had to undergo treatment immediately. "It was an absolute fluke that I found out about my problem. My doctor gave me a blood test and it showed up there. The scary thing was that I had no symptoms."

In a short space of time Kevin was suddenly faced with a major life changing event.

He was off work, undergoing treatment and having to come to terms with his condition. His wife, Lisa, was also at home providing Kevin with full-time care. At least they didn't have to worry about money, Kevin and Lisa received the money from Kevin's trauma benefit which helped them pay off outstanding bills, reduce their debts and cover the extra medical bills from Kevin's treatment. And they still had some left over to keep planning for their retirement. "It has helped ease the pressure tremendously. Once the bills were cleared, it was a big relief. It took a lot of worry away and I've been able to concentrate on my recovery and focus on going back to work."

* Details of person have been changed to protect privacy.

Your **Plan** at a glance

Purpose of Death, Total and Permanent Disablement and Trauma cover

This plan provides you with a specified lump sum if you:

- Have selected Death cover, and the insured person has less than 12 months to live due to a terminal illness, or dies.
- 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. Trauma cover is not available in a superannuation plan.

You can select one, or any combination of the types of cover available, subject to our approval and limitations that apply to cover taken as superannuation.

You can choose to have Death and TPD cover as non-superannuation or superannuation cover. If you choose a superannuation plan, you must have Death cover to add TPD cover.

If more than one type of cover applies to an insured person, you will need to decide whether the covers are taken as Stand alone or Linked. See page 16.

There may be additional options for you to choose with these benefits as well as in-built benefits. Your Certificate of Insurance (issued when your application is accepted) will tell you which cover and options have been included on your plan.

See page 8

Who can own the plan?

Non-superannuation: The plan can be owned by an individual, a company, the trustee of a trust – including trustees of superannuation funds (subject to legislative restrictions) or by multiple persons (as joint tenants only).

Superannuation: Your plan is owned by AMP Superannuation Limited, the Trustee, as an asset of the AMP Personal Superannuation Fund.

Your financial planner can help you decide the plan ownership that best suits your circumstances.

Who can be insured and for how much?

Non-superannuation: The plan can be taken out to insure one person or multiple persons. For example one plan may cover all family members, or business partners. You can insure more than one person (including children) on the same plan.

Superannuation: Only one person can be insured under a superannuation plan.

You can apply for cover within the entry age ranges shown in the table below. The age at which cover expires and maximum insured amounts are also shown in the table. The insured person's occupation, pastimes and health may restrict their available options. This will be determined when your application is being considered.

Type of cover	Entry age ranges of the insured person	Expiry age of cover (at plan anniversary)	Maximum sum insured
Death (non-superannuation)	10 to 69	99	No limit (subject to conditions)
Death (superannuation)	10 to 64	74	No limit (subject to conditions)
TPD (non-superannuation)	15 to 59	99	$3 million
TPD (superannuation)	15 to 59	74	$3 million
Business Safeguard	15 to 59 (Death) 15 to 54 (TPD)	65	N/A
Trauma	15 to 59	74 (Standard) or 99 (Premier)	$2 million
Children's Trauma cover with inbuilt Death cover	1 to 12	16	$50,000
Waiver of Premium (non-superannuation)	10 to 54	60	N/A
Waiver of Premium (superannuation)	15 to 54	60	N/A

This table applies to new business, and to increases and additions to existing plans.

Premiums and fees

The premium you pay depends on a number of factors including a plan fee. If you are applying for a superannuation plan your contributions will be credited as premium payments to a life insurance policy with AMP Life to secure your benefits. You must satisfy the contribution rules to remain in the AMP Personal Superannuation Fund. See page 39.

The current minimum premium is:

- $250 pa for the first adult insured person, and
- $200 pa for each subsequent adult insured person.

These amounts include the annual plan fee.

See page 44

Nominating a beneficiary

You may nominate one or more beneficiaries to receive the death benefit from your plan when you die.

See page 9 for further details of nominating a beneficiary for a non-superannuation plan or for details on nominating a beneficiary for a superannuation plan.

Taxation

Taxation laws vary depending on the type of plan you select. How taxation laws apply to you depends on your circumstances and we recommend you consult a tax adviser.

See page 17

Risks in taking out insurance

There are risks in taking out this insurance such as selecting a product or level of cover that does not give you the type or level of protection you need, or not complying with your duty of disclosure.

See page 48

Interim accident cover

While your application is being considered, AMP Life will provide you with Interim accident cover at no extra cost. Interim accident cover is different to the insurance being applied for.

See page 59

Cooling off

If you aren't satisfied with your plan, you can return it within the 14 day cooling off period and receive a refund of the premiums you have paid on this plan.

See page 49

Complaints

We have internal processes to manage complaints. However, if we are unable to resolve the complaint to your satisfaction, then you may be able to refer the matter to the Financial Industry Complaints Service (FICS).

If you have a superannuation plan you can refer the matter to the Superannuation Complaints Tribunal, or in certain circumstances FICS.

See page 51

This table describes the inbuilt features and options available in Flexible Lifetime – Protection Death, Total and Permanent Disablement and Trauma cover

Inbuilt features					
	Death cover (non-superannuation)	**Death cover (superannuation)**	**TPD cover (non-superannuation)**	**TPD cover (superannuation)**	**Trauma cover**
24 hour, worldwide cover	✓	✓	✓	✓	✓
Financial planning benefit	✓	✗	✓	✗	✓
Funeral benefit	✓	✗	✗	✗	✗
Guaranteed Future Insurability	✓	✓	✓	✓	✓
Indexation feature	✓	✓	✓	✓	✓
Interim accident cover	✓	✓	✓	✓	✓
Large sum insured discount	✓	✓	✓	✓	✓
Linked or stand alone cover	✓	✓	✓	✓ (must have Death cover)	✓
Nominating a beneficiary to receive your benefits on death	✓	✓	✗	✗	✗
Terminal Illness benefit	✓	✓	✗	✗	✗
Extra cost options					
	Death cover (non-superannuation)	**Death cover (superannuation)**	**TPD cover (non-superannuation)**	**TPD cover (superannuation)**	**Trauma cover**
Business Safeguard option	✓	✗	✓	✗	✗
Own occupation option in TPD	✗	✗	✓	✓	✗
Trauma cover Premier Partials Plus option	✗	✗	✗	✗	✓
Trauma cover Premier Buy back option	✗	✗	✗	✗	✓
Trauma cover Premier Trauma Reinstatement option	✗	✗	✗	✗	✓
Waiver of Premium option	✓	✓	✓	✓	✓

Death **cover**

Death cover pays a specified lump sum to the plan owner(s) or nominated beneficiaries if an insured person dies.

This cover expires on the plan anniversary after the insured person turns 99 for non-superannuation plans or 74 for superannuation plans.

Death cover automatically includes Terminal illness cover at no additional cost.

For non-superannuation plans, Funeral benefit is also included at no additional cost.

Terminal illness cover

If an insured person is diagnosed as having less than 12 months to live, and we agree with the diagnosis, we will advance up to 100% of the Death cover.

The maximum we'll pay in advance for an insured person (under all plans held with AMP) is $2 million. If there is a balance of Death cover we will pay this if the insured person dies.

For superannuation plans, we will only pay you when permitted by superannuation law. See page 41.

Funeral benefit

Only available for non-superannuation plans

We will advance up to $10,000 on the death of an insured person while the claim is being assessed, to cover funeral expenses. The death benefit payable will be reduced by the amount of the advance.

Nominating a beneficiary

You may nominate one or more beneficiaries to whom payment of the Death cover is made in the event of your death.

For superannuation plans

If your plan is owned by AMP Superannuation Limited you can nominate beneficiaries, however, your nomination is non-binding. See page 40 for the implications of a non-binding nomination.

Rules apply to who can be a nominated beneficiary on a superannuation plan (see page 40).

This nomination can be cancelled at any time in writing to us.

If no nomination is made or if the nomination is cancelled AMP Superannuation Limited will pay the estate.

For non-superannuation plans

To make a nomination, there must be only one plan owner and they must be the sole insured person.

This nomination can be cancelled at any time in writing to us. If no nomination is made or if the nomination is cancelled we will pay the estate of the plan owner.

If there is a change in plan ownership, any nomination will be automatically revoked.

Total and Permanent Disablement **cover**

Total and Permanent Disablement (TPD) cover pays a specified lump sum to the plan owner(s) if an insured person becomes totally and permanently disabled before the plan anniversary after they turn 99 for non-superannuation plans or 74 for superannuation plans.

If you choose TPD cover, you can also select the own occupation option.

The insured person will 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 activities of daily living, or
- suffer loss of cognitive functioning

as described in the definition of totally and permanently disabled.

From age 65 a modified definition of TPD applies. The insured person will be totally and permanently disabled if they:

- suffer loss of use of limbs and/or sight, or
- suffer loss of the ability to perform activities of daily living, or
- suffer loss of cognitive functioning

as described in the definition of totally and permanently disabled.

See page 11 for the definition of "Totally and permanently disabled".

Own occupation option

If you select this option a modified definition of totally and permanently disabled will be applied to the nominated insured person(s) if they are unable to work.

Under this definition, we will pay you a lump sum where we consider the insured person is unlikely ever to work in their primary full-time occupation.

This option is only available to certain occupations which include professional and white collar workers. Your financial planner can advise if the insured person is eligible for own occupation option.

Business safeguard **option**

Only available for non-superannuation plans

If Death and/or TPD cover is taken up, you can also choose Business safeguard to apply to the insured person(s) who you nominate.

This option can be used for business purposes such as:

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

It allows you to increase the level of Death cover and/or TPD cover for the nominated insured person(s), without providing further evidence of health. This gives you the flexibility to structure your insurance in line with your growing business.

You can apply for this option for an insured person(s) who is up to age 59 for Death cover and 54 for TPD cover. The option is only available when the sum insured for Death and/or TPD cover for the insured person is greater than $500,000. If both Death and TPD covers are selected each level of cover must exceed $500,000. It isn't available if the insured person's plan has a premium loading or exclusion for health reasons.

If this plan forms part of a written buy/sell, share purchase or business continuation agreement, you can apply to increase the cover under this option by the actual increase in the value of the insured person's interest in the business since the latter of the last time the option was exercised and the start of the option.

If the insured person is a key person to the business, you can apply to increase the cover under this option by 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 start of the option.

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.

This option ceases when any of the following occurs:

- you don't exercise the option for 5 years, or
- The Death cover reaches $15 million or the TPD cover reaches $2.5 million, or
- the Death or TPD cover is 5 times the original amount, or
- after 10 years from the start of the option, or
- the insured person turns 65, 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.

If increased cover is provided under this option, your premium will increase in line with the higher level of cover.

Definition of Total and Permanent Disablement†

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 **regular 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 2 limbs, or – the sight of both eyes, or – the use of one limb and the sight of one eye where a limb means the whole hand below the wrist or the whole foot below the ankle. The loss must be unable to be remedied 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.

* See page 58 for the definition of activities of daily living.
† For the definition of terms in **bold**, see "Other definitions and descriptions" on page 58.

Trauma **cover**

Only available for non-superannuation plans

Trauma cover for adults

Trauma cover pays a specified lump sum to the plan owner(s) if the insured person suffers one of the trauma conditions we cover (see page 14) and survives for 14 days.

The conditions the insured person is covered for depends on the level of Trauma cover chosen. You can choose between 2 levels of Trauma cover, being Standard and Premier.

Standard covers 15 trauma conditions. Premier covers 50 conditions, including 3 partial benefits, and as a result is more expensive.

We have specific definitions for each of the trauma conditions and the insured person must survive 14 days. See "Trauma definitions and descriptions" from page 52.

If we are paying for one of the 3 partial benefits covered under Premier we will only pay the higher of $10,000 or 10% of the sum insured (to a maximum of $25,000). If we pay a partial benefit 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. We only pay for a partial benefit once for each condition. Your premium is also reduced accordingly.

Most trauma conditions are covered immediately. However:

- Cover for certain trauma conditions is delayed for a period of 3 months from the commencement or recommencement of this cover.
- If you increase the amount of cover, we won't cover the amount of the increase for these trauma conditions for a period of 3 months from the date of the increase.
- If the insured person suffers one of these trauma conditions within the 3 month period we will never pay for that condition, even if they suffer the same trauma condition again later.

See page 14 for more details of when cover starts for each trauma condition.

Cover continues until the plan anniversary after the insured person turns:

- 74 for Standard, and
- 99 for Premier.

From the plan anniversary after the insured person's 64th birthday for Standard, and 69th birthday for Premier, cover is restricted to the trauma conditions:

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

Premier Trauma Reinstatement option

If you choose Premier cover, you can select the Trauma Reinstatement option to apply to your plan.

This option allows you to choose to restore the Trauma benefit amount we have paid after a Trauma claim, without having to provide additional evidence of health, the insured person's occupation or pastimes.

This option becomes available one year after we pay the full Trauma cover claim, and is exercisable for 30 days. The cost of the restored Trauma cover will be based on our Trauma cover Premier rates applicable at the time of exercising this option 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.

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

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

- the insured person was diagnosed or suffered symptoms leading to diagnosis of the 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 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 condition is directly or indirectly related to the treatment used for the original trauma condition, or
- the insured person meets the definition of kidney failure or a heart condition*, and the original trauma claim was for systemic lupus erythematosus, or
- the insured person suffers a heart condition*, or a stroke, or paralysis** directly or indirectly resulting from a stroke, and the original trauma claim 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 of the following definitions: diplegia, hemiplegia, paraplegia, quadriplegia, tetraplegia.

This option to reinstate the cover will cease on the earlier of:

- the plan anniversary after the insured person's 64th birthday and,
- thirteen months after the date of the original Trauma claim.

If the Premier with Buy back option (see page 13) applies to your plan, you must restore the Death cover on your plan at the same time you restore your Trauma cover otherwise you lose the option to restore your Death cover under the Premier with Buy back option at a future date.

The Indexation feature and Guaranteed future insurability are not available on the reinstated cover.

Premier Partials Plus option

If you choose Premier cover, you can select the Partials Plus option to apply to your plan.

This option provides you with additional trauma cover for 5 conditions as well as the trauma conditions covered under Trauma Premier cover.

We pay the higher of $10,000 or 10% of the Trauma Premier sum insured (to a maximum of $25,000) to the plan owner(s) if the insured person suffers one of the partial trauma conditions we cover (see page 14) and survives for 14 days. If we pay a partial benefit 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. We only pay for a partial benefit once for each condition. Your premium is also reduced accordingly.

This option will cease on the plan anniversary after the insured person's 69th birthday.

Premier Buy back option

If you choose Premier Linked with Death cover, you can select the Premier with Buy back option. See page 16 for further details on Linked cover.

This option allows you to choose to restore Death cover by the amount it was reduced after payment of your claim for Trauma cover.

This option becomes available one year after we pay the Trauma cover claim, and is exercisable for 30 days.

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

We will base the premium for the restored cover on our normal Death cover rates and the insured person's age at the time, taking into account the benefit amount and any special conditions or premium loadings applying to the original Death cover.

This option will cease on the plan anniversary after the insured person's 64th birthday.

Children's Trauma cover

Only available for non-superannuation plans.

Children's Trauma cover is an optional cover available when a child (or children) is included as an insured person on an adult Flexible Lifetime – Protection plan.

Children's Trauma cover covers 15 child specific trauma conditions and has in-built Death cover.

We pay a lump sum of:

- $50,000 (plus CPI indexation increases) if, before the plan anniversary after the insured person's 16th birthday, they suffer one of the trauma conditions for which they are covered and survive 14 days, or
- $10,000 if an insured person dies after age 2 but before the plan anniversary after the insured person's 16th birthday.

On the plan anniversary after the insured persons 16th birthday their Children's Trauma cover will automatically be converted at that date to Death cover.

We have specific definitions for each of the trauma conditions, see page 52.

Most trauma conditions are covered immediately, however, cover for certain trauma conditions is delayed. If the insured person suffers a trauma condition within this period or before age 10 (whichever is relevant) we will never pay for that condition, even if they suffer the same trauma condition again later.

See page 14 for more details on when cover starts for each trauma condition.

Once we have paid a claim, the Children's Trauma cover applying to that insured person will end.

Replacement trauma cover

If your plan replaces a previous plan issued by us or another insurer, the delay in cover for some trauma conditions for 3 months 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 3 months.

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

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 3 months
Alzheimers disease and other dementias Aplastic anaemia Blindness Cardiomyopathy Coma Encephalitis HIV/AIDs – medically acquired HIV/AIDS – occupationally acquired Intensive care Kidney failure Liver failure Loss of hearing Loss of independent living Loss of speech Loss of use of limbs and/or sight Lung failure Major head trauma Major organ transplant Motor neurone disease	Multiple sclerosis Muscular dystrophy Myelodysplasia Myelofibrosis Paralysis that is one of: • diplegia • hemiplegia • paraplegia • quadriplegia • tetraplegia Parkinsons disease Peripheral blood stem cell or bone marrow transplant Peripheral neuropathy Primary pulmonary hypertension Severe burns Systemic sclerosis	Aortic surgery Benign tumour of the brain or spinal cord Cancer Coronary artery angioplasty – triple vessel Coronary artery surgery Heart attack – myocardial infarction Heart attack – out of hospital cardiac arrest Heart valve surgery Open heart surgery Pneumonectomy Severe rheumatoid arthritis Stroke Systemic lupus erythematosus **Partial benefit only:** Cancer (Partial) Coronary artery angioplasty (Partial) Parkinsons disease (Partial)

Premier Partials Plus option. Partials Plus option covers the following conditions for adults

Cover for the conditions in this column starts immediately	Cover for the conditions in this column is delayed for 3 months
Partial blindness	Melanoma Prostate cancer Severe inflammatory bowel disease Severe osteoporosis

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 3 months
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

Children's Trauma Cover covers the following trauma conditions for children

There is no cover if the child is less than 10 for the conditions in this column. For children 10 and older cover starts immediately	Cover for the conditions in this column is delayed for 3 months
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

See "Trauma definitions and descriptions" from page 52.

Waiver of Premium option

Waiver of Premium is an option you can choose along with Death, TPD and/or Trauma covers.

Under this option, we will waive premiums that fall due under this plan if the insured person is "totally disabled" for a period of more than 6 months.

Upon admittance of your claim, we will refund any premiums paid for the insured person, falling due during this 6 month period. If you have a superannuation plan this refund will be paid into an account in the AMP Eligible Rollover Fund on your behalf, or a similar complying superannuation fund that you nominate.

Our definition of "totally disabled" is different from the definition of totally and permanently disabled. See page 58.

You can choose from 2 types of Waiver of Premium:

- Individual life (only available for non-superannuation plans) – we waive the premium and plan fee for a particular insured person should they become totally disabled, or
- Nominated life – we waive the premium and plan fee payable for all insured persons if the nominated person is totally disabled.

Your financial planner can help you decide which type is more appropriate to your circumstances.

Waiver of Premium continues until the plan anniversary immediately before the insured person turns 60.

However, if we are waiving your premium under this benefit when the insured person turns 60, we will continue to waive your premium until they turn 70, provided they remain totally disabled.

Information applicable to Death, Total and Permanent Disablement and Trauma cover

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.

* For the definition of "carer", see page 58.

You must apply for the increase within 12 months of the date the event occurs. You must provide appropriate proof of that 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 the lower of 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 lower of:

- the initial amount of Death cover under the plan (excluding CPI increases and increases effected under this feature), and
- $1,000,000.

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

- the initial amount of the TPD and/or Trauma cover under the plan (excluding CPI increases and increases effected under this feature), 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.

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.

Financial planning benefit

Only available for non-superannuation plans

We will pay up to $1,500 to reimburse you for the cost of financial planning advice after a claim has been paid on this plan.

This benefit is payable only once for each insured person on this plan, and must be claimed within 12 months of the claim being paid. This benefit is automatically included in your plan. There is no additional cost for it.

Stand alone or Linked cover

If you select more than one type of cover for the same insured person, you need to decide whether:

- you want their remaining cover to stay the same after we pay a claim (we call this Stand alone), or
- you want their remaining cover to reduce after we pay a claim (we call this Linked).

For example, an insured person is covered for:

- TPD cover of $250,000.
- Trauma cover of $200,000, and
- Death cover of $400,000.

The insured person suffers kidney failure and we pay a $200,000 trauma claim. On payment of this claim their Trauma cover will cease.

If you had chosen Stand alone cover:

- Their TPD and Death covers would continue unchanged at $250,000 and $400,000 respectively.

However, if Linked cover had been chosen:

- The remaining cover would reduce by the $200,000 we had paid. That is, their TPD cover would reduce to $50,000 and their Death Cover to $200,000.

You can see in this example that the maximum we could pay with Linked cover is $400,000. But potentially, with Stand alone cover, we could pay $850,000.

Stand alone cover is more expensive than Linked cover. The decision between choosing Stand alone and Linked is an important one which your financial planner can help you make.

Automatic increases to your cover amount – the Indexation feature

Each year, unless otherwise agreed, the amount of cover you have is increased by any increase in the Consumer Price Index (CPI) or 5%, whichever is higher. If you don't want this increase, in full or in part, then you need to tell us.

The maximum age at which automatic increases apply for each insured person is:

- 74 for Death, TPD and Trauma cover
- 16 for Children's Trauma cover.

Please note that we don't increase the $10,000 death cover under Children's Trauma cover.

24 hours a day worldwide cover

The insured person(s) is covered worldwide, 24 hours a day, 7 days a week.

Taxation

As at the preparation date of this PDS, our understanding of taxation law and how it is interpreted for Death, TPD and Trauma cover is described below.

How taxation law applies to you depends on your circumstances and we recommend you consult your tax adviser.

For non-superannuation plans

Generally premiums aren't tax deductible and payment of the Death, TPD and/or Trauma cover sum insured won't attract income tax or capital gains tax (CGT).

However:

- When we pay the Death cover amount, CGT may apply if the plan owner isn't the same person or entity as the plan owner when the plan began.
- CGT also applies to TPD cover and Trauma cover amounts we pay if the plan owner isn't the insured person, or a relative (as defined for taxation purposes) of the insured person.
- Where a business arranges the plan to cover loss of revenue (profits) should a key employee suffer a trauma condition, be totally and permanently disabled, become terminally ill or die, premiums may be tax deductible and the amounts we pay will attract income tax.

For superannuation plans

There may be some tax concessions that apply to contributions that fund premiums. See page 39.

Amounts we pay may be taxable in accordance with superannuation taxation rules. See page 41.

When we won't pay

We won't pay the Death cover or any increase in the Death cover if the insured person dies (or becomes terminally ill) by their own hand within one year and 30 days of the date the cover, or the increase in cover, starts or restarts (respectively).

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 we issued your 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 exception to apply.

We won't pay if the total and permanent disablement, total disablement or trauma condition was caused directly or indirectly by an intentional or deliberate act by you or the insured person.

We won't pay for a trauma condition if the insured person dies within 14 days of the trauma.

We won't pay where an insured child's trauma condition is caused by any congenital condition. Also we won't pay where the trauma condition or death is caused by alcohol or drugs, or by someone connected to the child, or either of their parents, or a de facto spouse of either of their parents.

When Death cover stops

Death cover for an insured person stops when one of the following occurs:

- the plan anniversary after the insured person's 99th birthday for non-superannuation plans or 74th birthday for superannuation plans, or
- we pay a death benefit for the insured person, or
- we pay a terminal illness claim for the whole amount of the Death cover, or
- we pay a TPD and/or trauma claim for amounts equal to or greater than the Death cover, where the covers are Linked, and the Buy back option doesn't apply, or
- you write to us and ask to cancel this cover, or
- your plan ends for any of the reasons set out under the heading "When your plan stops".

When TPD cover stops

The TPD cover for an insured person will stop when one of the following occurs:

- the plan anniversary after the insured person's 99th birthday for non-superannuation plans or 74th birthday for superannuation plans, or
- we pay the TPD benefit for the insured person, or
- the insured person dies, or
- we pay a trauma or terminal illness claim for an amount equal to or greater than the level of TPD cover where the covers are Linked (see page 16), or
- you have a superannuation plan and you cancel your Death cover or we pay you a terminal illness claim for the full Death cover (TPD cover can only be held with Death cover on a superannuation plan), or
- you write to us and ask to cancel this cover, or
- your plan ends for any of the reasons set out under the heading "When your plan stops".

When Trauma cover for adults stops

The Trauma cover for an insured person will stop when one of the following occurs:

- the plan anniversary after the insured person's 74th birthday for Standard, and 99th birthday for Premier, or
- we pay a trauma benefit for the insured person with the exception of a payment under a trauma partial benefit, or
- the insured person dies, or
- we pay a TPD or terminal illness claim for an amount equal to or greater than the level of Trauma cover and covers are Linked (refer to page 16 for details about Linked cover), or
- you write to us and ask to cancel this cover, or
- your plan ends for any of the reasons set out under the heading "When your plan stops".

When Children's Trauma cover stops

Children's Trauma cover will stop when one of the following occurs:

- we pay the trauma benefit for the insured child, or
- the insured child dies, or
- on the plan anniversary after the insured child's 16th birthday (the cover then converts to Death cover), or
- you write to us and ask to cancel this cover, or
- your plan ends for any of the reasons set out below under the heading "When your plan stops".

When your plan stops

Your plan will stop when one of the following occurs:

- the last insured person under the plan dies, or
- all the cover(s) for the last insured person under the plan ends, or
- you write to us and ask to cancel your plan, or
- we cancel your plan because you haven't paid your premium or any other amount payable under the plan (see page 46), or
- you have a superannuation plan and you are no longer eligible to contribute, or have others contribute, to your plan. When this happens you can apply to transfer your plan to a non-superannuation plan (see below for details on a replacement option), or
- your plan is cancelled by us for reasons permitted by law.

Replacement option

There are rules on when you can contribute to a superannuation plan (see page 39).

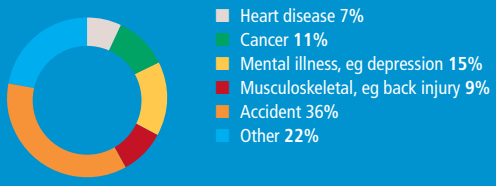
If you wish to continue your Death and/or TPD cover after you are unable to make contributions, you can apply for a current AMP non-superannuation plan without providing any evidence of health. The new plan will be dependant on the terms and conditions applicable at the time.

You must apply within 60 days of cancellation of your superannuation cover.

You can't take up this option if you're eligible to make a terminal illness or TPD claim under this plan.

2. Income Protection

Total income protection claims paid in 2006



One AMP customer's story

When John suffered an unexpected injury, his income protection plan helped to ease some of his financial worries…

John* 46 has always enjoyed outdoor activities, maintained a healthy lifestyle and successfully managed his own business.

When John started feeling pain in his left wrist he initially dismissed the pain as arthritic. He went to the doctor's only when it became more severe and was found to have a fractured left wrist, caused by gradual deterioration of the joint. John underwent surgery to fuse his left wrist with plates and screws, and for a bone graft. Further examination revealed a similar condition in his right wrist and as a result, he required ongoing treatment and extensive rehabilitation for both of his wrists.

John submitted his income protection claim and the monthly benefit helped John pay his rent, household bills and medical expenses. Without the regular income John would have had to rely on a government pension and social benefits, which wouldn't have allowed him to maintain his previous lifestyle.

To help John re-enter the workforce, AMP paid for courses for John so he could obtain new skills. John's story would have been very different if he didn't have income protection. "The fact is, I wouldn't be where I am today if I didn't have the insurance policy. The stress and pressure of not having an income really affected my emotional wellbeing. I'm going back to work and will start making a better income again for a better way of life."

* Details of person have been changed to protect privacy.

Your **Plan** at a glance

Purpose of Income Protection

This plan provides you with a regular income while you are totally disabled and unable to work due to illness or injury. We will pay you an income for a period you select. We also pay if you are partially disabled, that is, after being unable to work, you return to work but earn less due to illness or injury.

See page 23

Choosing your plan

This insurance is flexible and can be tailored to your circumstances. The amount we pay will depend upon whether you select Agreed value or Indemnity.

After you have selected whether you want Agreed value or Indemnity, you may select:

- How long you want to be paid for (the benefit period).
- How long you must have been totally disabled before we start paying you (the waiting period).
- The level of cover you want – Advanced, Standard or Basic.
- The type of premium you want to pay – Stepped or Level.

Your occupation, pastimes and health may restrict your available options. This will be determined when your application is being considered. Your Certificate of Insurance (issued when your application is accepted) will tell you which cover and options have been included on your plan.

Who can be insured?

Only one person can be insured under each plan and the plan owner must be the insured person. When this insurance starts, you must be at least 19 years old.

We only insure certain types of occupations and you must be working at least 25 hours per week.

How much can you be insured for?

You can choose a maximum monthly benefit up to 75% of your monthly earned income. The minimum monthly benefit is currently $1,250.

See page 22

Premiums and fees

The premium you pay depends on a number of factors including a plan fee.

See page 45

How long will your plan last?

Your plan will end in the circumstances listed on page 25. Under a basic plan, cover is variable and cancellable by us after we have paid a claim.

See page 25

Taxation

Generally income protection plans are tax deductible and the amount we pay you is subject to tax. How taxation laws apply to you depends on your circumstances and we recommend you consult a tax adviser.

See page 25

Risks in taking out insurance

There are risks in taking out this insurance such as selecting a product or level of cover that does not give you the type or level of protection you need, or not complying with your duty of disclosure.

See page 48

The table below shows the differences in features between Advanced, Standard and Basic plans

Features offered under these plans are	Advanced	Standard	Basic
Agreed value or Indemnity	✓	✓	✓
Automatic CPI increase in benefit while not on claim	✓	✓	✓
Automatic CPI increase in benefit while on claim	✓	Opt	Opt
Choice of waiting period	✓	✓	✓
Partial disability payment	✓	✓	✓
Choice of benefit period	✓	✓	✓
Continuous cover to age 60 or 65	✓	✓	✗
Guaranteed future insurability	✓	✓	✓
Superannuation contribution option	Opt	Opt	Opt
Rehabilitation costs feature	✓	✓	✓
Rehabilitation bonus	✓	✓	✓
Cover guaranteed to continue after a claim has been paid	✓	✓	✗
14 day cooling off period	✓	✓	✓
24 hour cover worldwide	✓	✓	✓
Up to 3 months payment while overseas	✓	✓	✓
Trauma feature	✓	✗	✗
Bedcare feature	✓	✗	✗
Major fracture or loss feature	✓	✗	✗
Domestic transport benefit	✓	✗	✗
Accommodation benefit	✓	✗	✗
Family support benefit	✓	✗	✗
Death feature	✓	✓	✗
Chronic condition option	Opt	✗	✗
Day 1 accident option	Opt	Opt	✗
Premiums	**Advanced**	**Standard**	**Basic**
Non-smoker discount	✓	✓	✓
Tax deductible premiums	✓	✓	✓
Choice of level or stepped premiums	✓	✓	✗
Pay no premium while we pay you*	✓	✓	✓
AIDS exclusion option	✓	✓	✓
Choice of yearly, half yearly or monthly premiums	✓	✓	✓

✓ Built-in feature ✗ Not applicable **Opt** Optional (at extra cost).
* We will reimburse your premiums upon acceptance of your claim.

Interim accident cover

While your application is being considered, we will provide you with Interim accident cover at no extra cost. Interim cover is different to the insurance being applied for.

See page 59

Cooling off

If you aren't satisfied with your plan, you can return it within the 14 day cooling off period and receive a refund of the premiums you have paid on this plan.

See page 49

Complaints

We have internal processes to manage complaints. However, if we are unable to resolve the complaint to your satisfaction, then you may be able to refer the matter to the Financial Industry Complaints Service.

See page 51

Your plan options

How long we pay – the benefit period	The oldest you can be when you apply		Expires when you turn	Waiting periods available (weeks)
	Level premium*	Stepped premium*		
Advanced and Standard cover				
Until you turn 65	59	54	65	2, 4, 8, 13, 26, 52, 104
Until you turn 60	54	49	60	2, 4, 8, 13, 26, 52, 104
For 5 years	54	49	60	2, 4, 8
For 2 years	54	49	60	2, 4
For 1 year	N/A	49	60	4
Basic cover				
For 5 years	N/A	49	60	2, 4, 8
For 1 or 2 years	N/A	49	60	2, 4

* For a description of terms see "Level or Stepped premium on Advanced and Standard covers" on this page. Availability of cover depends on satisfying underwriting criteria.

This table applies to new business and increases to existing plans.

Your occupation

Based on the duties of your occupation, we allocate you an occupation category. We use the following codes to describe occupation categories: 4A, 3A, 2A, A, B, C or E.

Category	Description
4A	Qualified professional, eg accountant.
3A	Medical profession.
2A	White collar occupation – office environment only, sedentary.
A	White collar occupation – travel or work outside the office environment or are not primarily sedentary in nature within the office environment eg sales representative.
B	Skilled craftspeople or tradespeople in non-hazardous industries. Also those involved in supervision of manual workers. The occupation must require technical or trade qualifications and relevant licence (if required), eg mechanic.
C	Blue collar occupations involved in either heavy manual work, or do not require any level of trade qualification. A degree of skill is still required, eg bricklayer.
E	Selected hazardous or heavy manual occupations. Generally unskilled or unqualified. Should have a minimum of 3 years experience, eg bulldozer operator.

Your occupation category will affect the premium you pay and the type of plan you can apply for. Your financial planner can tell you which category your occupation belongs to. Your occupation category will be shown in your premium quote.

Level or Stepped premium on Advanced and Standard covers

With Advanced and Standard levels of cover you can choose a level premium structure so that the premium rate doesn't increase each year just because you get older. A level premium will continue to be based on your age when you started the cover.

If you choose a stepped premium, your current age will determine the premium payable each year.

In the early years of the plan, the level method is more expensive than the stepped method. However, if you keep the plan for many years, the level method is likely to be cheaper than the stepped method. Your financial planner can explain the difference in more detail.

Please note that with both level and stepped methods, the premium will rise when the maximum monthly benefit increases. This can occur when we increase it because you ask us to and when we do so each year by any increase in the CPI.

How much you can insure

You can choose to insure up to 75% of your monthly earned income from your own efforts. The percentage is lower if you earn in excess of $250,000 per annum. Your financial planner can help explain this to you. If you don't have a financial planner, you can contact AMP on 133 888.

The minimum monthly benefit is currently $1,250 for new plans and $250 for increases to existing plans.

If you are employed the amount you can insure will be determined from your total remuneration package, including regular overtime and fringe benefits. Any regular bonuses and/or commission payments must be specified in the application and will be considered on a case by case basis.

For self-employed persons, the amount you can insure will be determined from gross earnings of the business less business expenses at the time of application or prior to application.

Employer superannuation contributions can be covered under the Superannuation Contribution option (see page 29). Employee contributions arranged through salary sacrifice can be insured as income.

How much we pay

The amount we pay won't exceed the maximum monthly benefit that applies at the time of the claim.

The maximum monthly benefit is the amount you nominate in your application and which we agree to insure you for, subject to changes for CPI, and changes you request and which we agree to.

Your maximum monthly benefit will be displayed on your Certificate of Insurance, and subsequent annual statements and confirmation letters following an agreed change to the maximum monthly benefit.

How we decide if you are totally disabled

We will pay if you are so ill or injured that you can't do your usual occupation. You must remain under the ongoing care and attention of your doctor and not do any remunerative work.

To help you understand our approach, when we assess your ability to do your usual occupation, the assessment is based on your capacity to carry out any one duty, or combination of duties, which are critical to the proper performance of your usual occupation.

Partial disability

Where having been totally disabled, you start work again, and because of your illness or injury you earn less, you are partially disabled.

To qualify for payment under Partial disability, you must have been totally disabled for at least 7 days.

Decide whether you want Agreed value or Indemnity

You may choose an Agreed value or Indemnity plan. A lower premium is charged for Indemnity plans. Your choice will be shown on your Certificate of Insurance.

The amount we pay may be different under Agreed value and Indemnity.

When we determine what we pay under Agreed value, we base it on the maximum monthly benefit. Maximum monthly benefit is defined on page 58.

When we determine what we pay under Indemnity, we base it on your "income" in the 12 months immediately before you became unable to work. Income (as it applies to an employee or self-employed person) is explained on page 58.

What we pay you

When you are totally disabled

When you are eligible to claim, if you aren't receiving regular income from other sources (explained below) then:

- we will pay you the maximum monthly benefit if you have chosen Agreed value, or
- if you have chosen Indemnity we will pay you a benefit which is 75% of your income in the 12 months immediately before you became unable to work.

However, we won't pay more than the maximum monthly benefit.

You pay no premiums when we agree to pay your claim.

When you are partially disabled

If you are partially disabled we pay the amount we would pay if you were totally disabled, reduced by a percentage to reflect what you are earning.

When we work out how much to pay we use the following formula:

$$\frac{(A - B)}{A} \times C = \text{your monthly partial benefit}$$

Where

A = Your monthly "pre-disability income".

B = The current monthly amount you earn from working.

C = The monthly benefit we pay if you are totally disabled.

"Pre-disability income" is explained on page 58.

If you receive income from other sources

If you receive regular income amounts from "other sources" while we pay you, we will reduce what we pay you.

We reduce the amount so that you don't receive more than 75% of your "pre-disability income" while you are totally disabled, or more than 100% of your "pre-disability income" if you are partially disabled. "Pre-disability income" is explained on page 58.

"Other sources" we take into consideration are payments because you are ill or injured from:

- any workers compensation, accident compensation or public liability scheme, or
- any insurance plans that you did not tell us about, or obtained after you applied for Income Protection.

Automatic increases to your cover amount – the Indexation feature

Each year, unless otherwise agreed, we increase the maximum monthly benefit by any annual increase in the Consumer Price Index (CPI).

If you don't want the annual CPI increase, in full or in part, you need to tell us at the time.

Claim escalation

For Advanced plans, we continue to make CPI increases while we are paying a claim. While we are paying a claim, we automatically increase it on the plan anniversary by any increase in the CPI.

For Standard and Basic plans, we only do that if you have added the Claim escalation option at an additional cost.

Under this option, when we pay a monthly amount, we automatically increase it on the claim anniversary each year by any increase in the CPI. But after we have stopped paying under a Standard or Basic plan, the maximum monthly benefit reduces to what it was when you became unable to work and made a claim.

When we pay

We start paying when you have been totally disabled or partially disabled (after you have been totally disabled for 7 days) for a specified period. We call this the "waiting period".

You choose the length of the waiting period when you apply for this insurance. You can choose a waiting period of 2, 4, 8, 13, 26, 52 or 104 weeks (depending on what type of plan you have chosen, refer to table on page 22). Your financial planner will be able to help you decide what waiting period would be suitable for you.

Because we pay in arrears, we make the first payment one month after the waiting period ends.

Ability to work during the waiting period

You may work during the waiting period for 5 days (or less) in a row without the waiting period starting again. The waiting period will end when the number of days you have been totally disabled, or partially disabled after you have been totally disabled for 7 days, equals the waiting period.

If you work for more than 5 days in a row during the waiting period, that waiting period stops and must restart if you are again totally disabled or partially disabled.

How long we pay

When you apply for this insurance, you choose how long you want us to pay while you are unable to work. We call this the "benefit period".

You can choose from a range of benefit periods (refer to the table on page 22). We stop paying when the benefit period ends – even if you are still unable to work.

We stop paying for Partial disability when the benefit period ends, or you earn your full income again. For Standard and Basic plans, when we are paying under Partial disability, the longest we will pay is 2 years.

What happens when the benefit period ends?

For plans with benefit periods to age 60 and 65

Once the benefit period ends, your plan ends.

For plans with benefit periods of 1, 2 or 5 years

Once the benefit period ends your plan continues until you turn 60. If you are still totally disabled once the benefit period ends, we will waive the premiums for this cover until you are able to work again.

When we determine whether you are totally disabled, once the benefit period ends, we assess your ability to do any remunerative work for which you are reasonably suited by education, training or experience.

What happens if you suffer a relapse?

A "relapse" occurs when you suffer the same illness or injury as previously, and the illness or injury arises from the same or a related cause. What happens when a relapse occurs depends on the type of plan chosen.

For plans with benefit periods to age 60 and 65

If you suffer a relapse within 12 months after we stopped paying, we treat the claim as a continuation of a previous claim. The waiting period won't be applied again.

For plans with benefit periods of 1, 2 or 5 years

If we previously paid for the full benefit period, we treat a relapse as a new claim only where you have worked in your usual occupation for at least 6 months in a row since we stopped paying. In these circumstances both the waiting period and benefit period start again.

If we haven't previously paid for the full benefit period, and you suffer a relapse within 6 months of us stopping payments, the claim will be treated as a continuation of the previous claim. The waiting period and benefit period don't start again. We will add up all the periods we pay you and treat them as one benefit period.

If we haven't previously paid for the full benefit period, and the relapse is suffered more than 6 months after we stopped paying we treat the relapse as a new claim, and both the waiting period and benefit period start again.

For Partial Disability on Standard and Basic plans

If we are paying under Partial Disability, we add up all the periods we pay you for that claim when we calculate the 2 year limit that applies (refer to "How long we pay" on page 24).

When your plan stops

Your plan will stop when one of the following occurs:

- plan expiry age (refer to the table on page 22), or
- you write to us and ask to cancel your plan, or
- we cancel your plan because you haven't paid your premiums or any other amount that relates to the plan, or
- you die, or
- your plan is cancelled by us for reasons permitted by law, or
- your plan is a Basic plan and it is cancelled after a claim (see page 28), or
- you leave work permanently for reasons other than illness or injury.

We continue to provide cover for 12 months after you temporarily stop working for reasons other than illness or injury. Then the cover changes. See "What happens if you temporarily leave work?" below.

What happens if you temporarily leave work?

If you suffer an illness or injury more than 12 months after temporarily leaving remunerative work, we only pay if, due to your illness or injury, you can't do any remunerative work for which you are reasonably suited by your education, training or experience.

You must remain under the ongoing care and attention of your doctor and not do any remunerative work.

Note: We don't consider maternity or paternity leave as temporarily leaving remunerative work.

On hold option

You can ask us to put the plan "on hold" within the first 12 months after you stop remunerative work.

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

You must tell us when you want to take the plan "off hold". When the plan goes off hold the premium will then be based on our premium rates which apply at the time. However, if you leave the workforce permanently for reasons other than illness or injury, the cover ends as soon as you leave work.

When we won't pay

We won't pay if you injure yourself directly or indirectly by your intentional or deliberate act, or if your illness or injury was caused by war.

We don't regard pregnancy or childbirth as either an illness or an injury, so we don't pay for this condition. However, we will pay if you are unable to work because you suffer complications during pregnancy or while giving birth.

How often you can claim

Provided that you meet the relevant benefit definitions and conditions described in this PDS, there are generally no limits on the number of times that you can claim.

We will have the option of cancelling your plan after a claim if you have selected Basic cover. See page 28.

Taxation

As at the preparation date of this document, our understanding of taxation law and how it is interpreted for Income Protection insurance is that generally:

- premiums are tax deductible, and
- the amounts we pay attract income tax.

This means that you may have to pay tax on this amount and should include it in your tax return. We do not deduct any tax from the monthly benefit that we pay.

How taxation law applies to you depends on your circumstances. We recommend you consult your tax adviser.

Automatic inclusions with Advanced, Standard and Basic plans

24 hours a day worldwide cover

You are covered worldwide, 24 hours a day, 7 days a week. However, if we are paying while you are outside Australia or New Zealand, payment beyond 3 months is at our discretion.

If you have been outside of Australia for more than 30 days and you become unable to work for at least 14 days, we will assist your return to Australia. We will reimburse your out of pocket costs up to the cost of a single economy airfare.

Rehabilitation costs feature

We reimburse rehabilitation costs that are approved by us, for equipment or programs, such as:

- wheelchairs, home and motor car modifications
- prosthetic devices (for example, artificial limbs), and
- rehabilitation program fees.

We do this while you are unable to work, both during the waiting period and while we are paying under this plan.

Your doctor must certify that the expense is necessary for your rehabilitation and we may reduce what we pay by amounts you receive from other sources.

We will pay up to 12 times the monthly benefit.

Rehabilitation bonus

We will pay an additional one-third of the maximum monthly benefit we would pay if you are totally disabled for up to 12 months while you participate in a rehabilitation program approved by us. Before you start the program, we must have approved it in writing.

We do this while you are totally disabled, both during the waiting period, and while we are paying under this plan.

We may continue this benefit for up to 3 months after your return to continuous full time work.

Guaranteed future insurability

You may increase your monthly benefit without providing any evidence of health when your income increases.

You may apply for the increase once every 12 months, and provide us with appropriate proof of your increase in income.

Each time, the maximum you may increase your monthly benefit is by the lower of: 10% of the original monthly amount, or $1,000, per month (above the amount of increase for CPI, if any), across all plans.

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

- you are older than 55 years of age, or
- your plan has a premium loading or special terms, or
- you are eligible to make a claim, or have made a claim, for income protection under any plan you hold with us.

Advanced cover

Advanced is our most comprehensive level of cover. It includes the following features, which Basic and Standard don't have.

Trauma feature

We pay you for 6 months if you suffer any one of the following trauma conditions:

- Aortic surgery
- Cancer
- Coma
- Coronary artery surgery
- Heart attack – myocardial infarction
- Heart attack – out of hospital cardiac arrest
- Heart valve surgery
- Intensive care
- Kidney failure
- Major head trauma
- Major organ transplant
- Open heart surgery
- Peripheral blood stem cell or bone marrow transplant
- Severe burns
- Stroke.

Full definitions are set out in "Trauma definitions and descriptions". See page 52. The Cancer (Partial) definition doesn't apply to this feature.

We pay even if you don't stop work.

We pay the monthly benefit under this feature one month after you suffer the trauma condition and then each month after that for 6 months, or earlier if the plan ends for any reason.

Cover starts 3 months after your plan starts. We pay only once for each condition.

When we pay under this feature we won't reduce the amount we pay by any other income you receive.

Bedcare feature

We pay you a benefit if you are totally disabled and your doctor requires you to be under the full-time care of a registered nurse, for 3 or more consecutive days during the waiting period.

We pay one-thirtieth of the monthly benefit for each day that you are bedridden, up to the end of the waiting period.

We will pay for a maximum of 180 days. We pay the benefit until the first of the following occurs:

- at the end of the waiting period, or
- the 180 days ends, or
- you are no longer bedridden.

Major fracture or loss feature

If you suffer certain fractures or losses we pay your monthly benefit for the specified number of months (up to your benefit period).

We pay even if you don't stop work.

We pay the monthly benefit under this feature one month after you suffer the fracture or loss and then each month after that until the payment period expires, or earlier if the plan ends for any reason.

The fractures and losses we cover and the period we pay are shown in the table below.

Fractures covered

We cover fracture of	Payment period
The spine causing paraplegia or quadriplegia	60 months
Thigh	3 months
Pelvis	3 months
Leg between the knee and foot	2 months
Kneecap	2 months
Ankle	2 months
Upper arm	2 months
Shoulder blade	2 months
Hand (requiring a plaster cast or surgery)	1 month
Forearm above the wrist	1 month
Wrist	1 month
Collar bone	1 month

These fractures are described in the Plan Rules.

Losses covered

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

These losses are described in the Plan Rules.

Domestic transport benefit

If you are in Australia but more than 100km from your usual residence when you become totally disabled and require emergency transportation within Australia, we will reimburse costs directly arising from your transportation other than:

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

This benefit is payable only once in any 12 month period and will be limited to an amount equivalent to 3 times the maximum monthly benefit payable.

Accommodation benefit

We will reimburse the reasonable accommodation expenses of an immediate family member who accompanies you if:

- you are eligible for a Bedcare benefit, and
- you became totally disabled and remain over 100km away from home.

We will pay up to $250 per day for a maximum period of 60 days. This benefit is only payable once in any 12 month period.

Family support benefit

We will pay an additional amount while you are totally disabled if:

- we have been paying you the monthly benefit under this plan for more than one month, and
- you require the full-time assistance of either:
  - a registered nurse (not being your immediate family member), or
  - an immediate family member who was in full-time paid employment when you became totally disabled but who stops all paid employment to look after you.

Under this benefit we will pay the lesser of $150 per day or 1/30 of the maximum monthly benefit payable for a maximum period of 6 months on any one claim.

Advanced and Standard cover

Death feature

The Death feature is automatically included with Advanced and Standard plans. Basic plans don't have the Death feature.

If you die while we are paying monthly benefits to you, we will pay an additional amount equal to 6 times the monthly benefit that would be payable if you were totally disabled.

We won't pay this amount where you die during the waiting period or where you are over 65 at the time of death.

The maximum we will pay as a death benefit under all income protection plans with us is $60,000.

Basic cover – Variable and cancellable after we have paid a claim

For Basic plans if you pay the premium on time and we haven't paid any claims under the plan we will keep the plan going on the same terms each year and won't cancel it or any part of it. However, we can cancel the plan after we have finished paying a claim.

When we have finished paying a claim we have the choice of:

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

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

If we don't cancel the plan after a claim, we will keep the plan going each year on the terms we set out when the claim was finished. We will do this as long as you pay the premium on time – until we finish paying any other claim under the plan. When we finish paying any other claim, we can again change the terms of the plan or cancel it.

Optional features

Optional features available with Advanced, Standard and Basic plans

AIDS exclusion option – premiums are reduced if you choose this option

If you choose this option no benefit will be paid for disability arising from the presence of HIV in the insured person's body, or AIDS or any AIDS-related illness.

We can change or withdraw this premium reduction at any time. If we do that, we will tell you in your Annual Statement.

Superannuation Contribution option

If you apply to include this option, we will pay you an extra amount if you are unable to work.

The additional amount is 12% of the monthly benefit that we pay you, and must be paid directly into a complying superannuation fund (as defined by legislation) or to you to be paid into a complying superannuation fund.

We also pay you an extra amount if we are paying you under partial disability feature or the Chronic condition option if you selected it.

If you select the Superannuation Contribution option, we automatically increase the maximum monthly benefit set out in your plan to take account of the maximum additional amount we pay under this optional benefit.

The amounts paid under this option are assessable income and are classified as personal non-concessional contributions made into the superannuation fund.

Optional features available with Advanced and Standard plans

Day 1 accident option

Day 1 accident option is available for Advanced and Standard plans.

If you choose this option a different waiting period will apply if you are totally disabled as a result of an accident.

If you are totally disabled for at least 3 days in a row due to an accident, we start to pay you from the day you were totally disabled. This means you do not have to wait for the waiting period to end to be eligible for payment.

This benefit is payable until the end of your waiting period or for 30 days, whichever occurs first. We pay monthly in arrears.

We pay one-thirtieth of the monthly benefit for each day that you are totally disabled.

We will not pay under this option if we are paying under the Trauma feature or Major Fracture or loss feature.

Optional features available with Advanced plans

Chronic condition option (not available for Indemnity plans)

Chronic condition option is available under Advanced plans with a benefit period to age 60 or 65.

Chronic condition option is intended to insure you against a situation where you suffer some progressive deterioration in health due to a chronic incurable physical condition which leads to an inability to work full-time.

You have a chronic condition if:

- you have an illness or injury which is constantly present for life, and for which there is no known cure, and
- both your income from work and your normal work hours reduce by more than 25% for at least 3 consecutive months and this reduction continues.

We start to pay you on the later of:

- when you lodge your claim, or
- you have satisfied the above requirements.

You don't need to meet your waiting period. We pay so that the total you earn from work plus what we pay equals the amount we would pay if you were totally disabled.

We base our calculation on your highest income for any 12 consecutive months between 2 years before the plan started and the date you claimed.

We don't pay for conditions that are non-physical, psychosomatic or psychiatric in nature.

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3. Business Overheads Insurance

Total business overheads insurance claims paid in 2006

- Mental illness, eg depression 14%
- Cancer **18**%
- Heart condition 18%
- Accident 36%
- Other 14%

Your **Plan** at a glance

Purpose of Business Overheads Insurance

This plan reimburses eligible business overheads for up to one year with a possible extension period of up to 6 months, while the insured person is totally disabled because they are ill or injured. We start to pay after the insured person has been totally disabled for either 2 or 4 weeks – the waiting period.

Only one person can be insured under each plan. This plan can be owned by the person or business entity that incurs the overhead costs of the business.

Who can be insured?

When this insurance starts the insured person must be at least age 19. You can apply for this insurance up to the age of 59.

The insured person's occupation, pastimes and health may restrict their available options. This will be determined when the application is being considered. Your Certificate of Insurance (issued when your application is accepted) will tell you the cover and options that have been included on your plan.

How much can you be insured for?

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

See page 33

Premiums and fees

The premium you pay depends on a number of factors including a plan fee.

See page 45

How long will your plan last?

The plan will end in the circumstances listed.

See page 35

Taxation

Generally Business Overheads Insurance plans are tax deductible and the amount we pay you is subject to tax. How taxation laws apply to you depends on your circumstances and we recommend you consult a tax adviser.

See page 34

Risks in taking out insurance

There are risks in taking out this insurance such as selecting a product or level of cover that does not give you the type or level of protection you need, or not complying with your duty of disclosure.

See page 48

Interim accident cover

While your application is being considered, we will provide you with Interim accident cover at no extra cost. Interim accident cover is different to the insurance being applied for.

See page 59

Cooling off

If you aren't satisfied with your plan, you can return it within the 14 day cooling off period and receive a refund of the premiums you have paid on this plan.

See page 49

Complaints

We have internal processes to manage complaints. However, if we are unable to resolve your complaint to your satisfaction, then you may be able to refer the matter to the Financial Industry Complaints Service.

See page 51

Plan **details**

Eligibility

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

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

This plan is particularly appropriate for:

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

Generally it won't be suitable for businesses where cashflow is earned from the sale of goods, eg retail shopkeepers.

Location of the business

The part of the business the insured person is involved in needs to be managed from Australia, and the business must be liable to submit a taxation return in Australia.

If the business doesn't meet these conditions, we may still agree to insure this person – but it is unlikely.

What we pay you

We pay you the lower of:

- the monthly cover you choose, increased by any increases in the CPI, and
- the eligible overheads the business has actually paid in the previous month.

What we pay may be reduced by:

- any amount the insured person or the business receives from any other business expense insurance they have, and
- any amount which the person who replaces the insured person generates over and above the costs of employing them.

You don't have to pay premiums on your plan while we are paying a benefit under it. We will reimburse your premiums when we agree to pay your claim.

The types of overheads we pay

Some examples of the eligible overheads we pay include:

- Salaries of most non-income producing staff.
- Workers compensation and superannuation costs.
- Rent and mortgage interest on business premises – unless the premises are also the insured person's residence.
- Property rates and property taxes.
- Leasing costs of office equipment and motor vehicles.
- Electricity, water, gas and telephone bills.
- Cleaning and laundry bills.
- General insurance premiums.
- Subscriptions to professional associations.
- Advertising costs.
- Accountants and auditors fees.

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

The types of overheads we won't pay

Some examples of the overheads that we won't pay include:

- the insured person's remuneration, or
- remuneration of people who earn income for the business (eg sales staff and locums), or
- remuneration of any member of the insured person's family who has been employed in the business for less than 3 months when the insured person becomes totally disabled, or
- the cost of stock, equipment or other assets of the business, or
- rent or mortgage on a private residence even if it is used for business purposes, or
- any tax the business has to pay, or
- depreciation, or
- expenses which the business doesn't incur regularly, and
- expenses which aren't normal and necessary for the business.

Coping with peaks and troughs

We aim to help you cope with peaks and troughs in the insured person's eligible business overheads from month to month, while the claim continues.

This means where:

- your eligible business overheads are higher than the maximum monthly benefit in a particular month, but
- we have paid less than the maximum monthly benefit multiplied by the number of months we have been paying for this claim, then we will pay any amounts that we haven't paid in earlier months up to the amount of your eligible business overheads for that month.

When we pay

We start paying when the insured person has been totally disabled for a specified period. We call this the "waiting period". You choose the length of the waiting period (2 weeks or 4 weeks) when you apply for this insurance.

Because we pay in arrears, we make the first payment one month after the waiting period ends.

Ability to work during the waiting period

You may work during the waiting period for 5 days (or less) in a row without the waiting period starting again. The waiting period will end when the number of days you have been totally disabled equals the waiting period.

If you work for more than 5 days in a row during the waiting period, that waiting period stops and must restart if you are again totally disabled.

How we decide whether the insured person is totally disabled

You can claim if the insured person is so ill or injured that they can't do their usual occupation. They must remain under the ongoing care of their doctor and must not do any remunerative work.

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

How long we pay

We pay for up to 12 months. This period is called the benefit period. If we have paid for the full 12 months we won't pay again unless:

- the insured person suffers a new illness or injury, or
- the insured person has worked in their usual occupation for their usual income for at least 6 months since we stopped paying.

If they suffer the same illness or injury, or one that arises from the same or a related cause, within 6 months after we stop paying, we will pay any remaining months of the 12 month period – the waiting period doesn't apply again.

Benefit period extension

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

The period of extension will be:

- six months, or
- until the total amount we have paid equals 12 times the maximum monthly benefit, or
- until the insured person is able to work, or
- until the plan ends

whichever comes first.

24 hours a day worldwide cover

You are covered worldwide, 24 hours a day, 7 days a week. However, if we are paying while you are outside Australia or New Zealand, payment beyond 3 months is at our discretion.

If you have been outside of Australia for more than 30 days and you become unable to work for at least 14 days, we will assist your return to Australia. We will reimburse your out of pocket costs up to the cost of a single economy airfare.

Taxation

As at the preparation date of this document, our understanding of taxation law and how it is interpreted for Business Overheads Insurance is that generally:

- premiums are tax deductible, and
- the amounts we pay attract income tax.

How taxation law applies to you depends on your circumstances. We recommend you consult your tax adviser.

Automatic increases to your cover amount – the Indexation feature

Each year, unless otherwise agreed, we increase the maximum monthly benefit by any increase in the CPI. If you don't want the annual CPI increase in full or in part, you need to tell us.

AIDS exclusion option – premiums are reduced if you choose this option

If you choose this option no benefit will be paid for disability arising from the presence of HIV in the insured person's body, or AIDS or any AIDS-related illness.

We can change or withdraw this premium reduction at any time. If we do that, we will tell you in your Annual Statement.

When your plan stops

Your plan will stop when any of the following occurs:

- the insured person's 65th birthday, or
- the insured person dies, or
- you write to us and ask us to cancel your plan, or
- we cancel your plan because you haven't paid your premiums or any other amount that relates to the plan, or
- your plan is cancelled by us for reasons permitted by law.

We continue to provide cover for 12 months after the insured person temporarily stops working for reasons other than illness or injury. Then the plan stops – that is, we won't pay for any illness or injury which the insured person suffers after that date.

On hold option

You can ask us to put the plan "on hold" within the first 12 months after the insured person stops remunerative work.

This means they won't be covered at this time, however, this guarantees their entitlement to cover when they return to work.

While the plan is "on hold", you pay a reduced premium. We won't pay in relation to any illness or injury which happens while the plan is "on hold".

You must tell us when the insured person returns to work and when they do return to work, the plan goes "off hold". Then the premium will be based on our premium rates which apply at the time. However, if the insured person leaves the workforce permanently for reasons other than illness or injury, the cover ends as soon as they leave work.

When we won't pay

We won't pay if you injure the insured person directly or indirectly by your intentional or deliberate act, or the insured person injures themselves directly or indirectly by their own intentional or deliberate act, or if the insured person's illness or injury was caused by war.

We don't regard pregnancy or childbirth as either an illness or an injury, so we won't pay for this condition. However, we will pay if the insured person is totally disabled because they suffer complications during pregnancy or while giving birth.

How often you can claim

Provided that you meet the relevant benefit definitions and conditions described in this PDS, there are generally no limits on the number of times that you can claim.

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4. This section contains the additional information relevant to Flexible Lifetime – Protection (Superannuation)

Please read this section together with Section 1 (from page 5) and information common to all products (from page 43) before completing the application form.

This section contains information that relates to superannuation plans where AMP Superannuation Limited is the owner.

The features and benefits available when AMP Superannuation Limited is the owner can be different to non-superannuation plans (not owned by AMP Superannuation Limited). The table below provides a comparison of the features available inside and outside of superannuation.

Feature	Non-superannuation	Superannuation
Death cover, including Terminal illness cover	✓	✓
Funeral benefit	✓	✗
Total and Permanent Disablement cover, including own occupation TPD.	✓	✓ only with Death cover
Business safeguard option for Death & TPD cover	✓	✗
Trauma cover	✓	✗
Financial planning benefit for Death, TPD and Trauma cover	✓	✗
Income Protection	✓	✗
Business Overheads Insurance	✓	✗
Guaranteed future insurability	✓	✓
Plan ownership for Death & TPD cover	Self or other individual, joint ownership, company, family trust or SMSF.	AMP Superannuation Limited
Death benefit beneficiary options	Beneficiaries can be nominated on a plan when the plan owner and insured person are the same. See page 9.	Superannuation rules restrict who can be nominated as a beneficiary (see page 40). Beneficiary nominations are not binding.
TPD benefit payments	Must meet the definition of the event.	Must meet the definition of the event and satisfy superannuation rules. See page 41.
Taxation concessions for Death and TPD premiums	Generally no taxation concessions apply except for certain business ownership arrangements. See page 17.	Contributions to fund premium payments may attract tax concessions. See page 39.
Taxation treatment of Death benefits	Generally no income tax or CGT applies. See page 17.	Nil tax if paid to a dependent as defined for tax purposes. See page 41.
Taxation treatment of TPD benefits	Generally no income tax or CGT applies. See page 17.	Concessional tax treatment may apply in certain circumstances. See page 41.
Cooling off period	14 days – refund in full to owner. See page 49.	14 days – refund payable to another superannuation fund or AMP Eligible Rollover Fund. See page 49.
Complaints resolution body	Financial Industry Complaints Service.	Superannuation Complaints Tribunal and in some cases the Financial Industry Complaints Service. See page 51.

Making **contributions**

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

Contribution type	Contribution description
Member contributions	Contributions you as a member either pay from your after-tax income or which you personally claim as a tax deduction.
Spouse contributions	Contributions your spouse pays into your plan. (Your spouse must not be entitled to a tax deduction for the contributions and must not live separately from you on a permanent basis.)
Superannuation Guarantee (SG) and Award/ Industrial Agreement Employer contributions*	Contributions an employer must pay under legislation, including contributions paid to comply with an award or industrial agreement.
Salary Sacrifice and Additional Employer contributions	You may be able to arrange for your employer to make contributions to your plan instead of paying you an equivalent amount of pre-tax salary. These "salary sacrifice" contributions are treated as employer contributions. Your employer can also make employer contributions to your plan in addition to SG, Award/Industrial Agreement and Salary Sacrifice contributions.

* This plan isn't designed to solely meet an employer's total SG obligations. Your employer may need to contribute to other superannuation products to meet their total SG obligations.

Certain contributions can't be accepted if we don't have your Tax File Number. See page 42.

When can contributions be made?

All types of contributions can be made into your plan if you are under age 65.

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

Type of contribution^	You are under age 65	You are age 65 to under 70	You are age 70 to under 75	You are age 75 or over
Member contributions*	At any time.	Only if you are working at least on a part-time basis**.	Only if you are working at least on a part-time basis**.	No Member contributions accepted.
Spouse contributions*	At any time.	Only if you are working at least on a part-time basis**.	No Spouse contributions accepted.	No Spouse contributions accepted.
Superannuation Guarantee (SG) and Award/Industrial Agreement Employer contributions***	At any time.	At any time.	Award/Industrial Agreement Employer contributions at any time (SG contributions end at age 70).	Award/Industrial Agreement Employer contributions at any time (SG contributions end at age 70).
Salary Sacrifice and Additional Employer contributions***	At any time.	Only if you are working at least on a part-time basis**.	Only if you are working at least on a part-time basis**.	No Salary Sacrifice or Additional Employer contributions accepted.

* Member and spouse contributions cannot be accepted if we don't have your tax file number.

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

*** If we don't have your TFN an additional tax called the "no-TFN tax" can be charged.

^ Different rules apply when claiming tax deductions for contributions (see page 41).

Nominating your beneficiaries

What happens if you die?

You can nominate one or more beneficiary(ies) to receive your death benefit. Generally, all beneficiaries must be your dependants. You can also nominate your estate (we call this your "legal personal representative").

Under superannuation law, you can't nominate anyone else as a beneficiary.

Who is a dependant?

A dependant includes:

- Your spouse (including a de facto spouse).
- Your children (including an adopted child, a step child or ex-nuptial child).
- Any person who is financially dependent on you, and
- Any person with whom you have an interdependency relationship (see below).

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

What is an interdependency relationship?

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

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

An interdependency relationship also includes 2 persons (whether or not related by family):

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

How can your death benefit be paid?

We allow you to choose how you would want your death benefit paid.

You have a choice of :

- Option 1 – Non-binding (or preferred) nomination
- Option 2 – No nomination.

They are discussed in the next column.

Option 1 – Non-binding (or preferred) nomination

If you make a non-binding (or preferred) death benefit nomination, then we will decide which of your beneficiaries will receive your benefit after your death.

We will generally pay your nomination beneficiary(ies), but depending on your circumstances at the time of your death, we may decide to pay your death benefit differently.

When you submit the nomination we won't check if:

- your nominated beneficiaries on the nomination form are your dependants or your legal personal representative, or
- you have signed or completed the nomination form correctly.

A non-binding nomination will continue to apply until you cancel an existing nomination or make a new one. Therefore, it is important that you keep your non-binding nomination up-to-date in line with your personal circumstances. You can cancel your non-binding nomination at any time or make a new one.

If you cancel your non-binding nomination without making another nomination, then we must pay your death benefit in accordance with Option 2 – No nomination.

Option 2 – No nomination

If you don't make a nomination or you cancel your existing nomination, and don't make a new nomination, then we must pay your death benefit to your estate.

However, if your estate is insolvent or if a legal personal representative hasn't been appointed to manage your estate within a reasonable period of time, then we will decide:

- if you have dependants, which of your dependants will receive your death benefit (and in what proportions), or
- if you have no dependants, which other person will receive your death benefit and in what proportions.

This means that if you don't have a non-binding nomination, you should consider making a Will or altering your Will to cover your Flexible Lifetime – Protection (Superannuation) benefit.

Taxation

We have outlined below our general understanding of current legislation and rules as at the date of preparation of this document. Taxation laws and their interpretation may change from time to time. We will keep you informed of any changes that could affect your plan. We recommend you consult your tax adviser.

Tax deductions for employers or self-employed individuals

There are concessional limits for contributions made by employers to fund insurance cover premiums for the benefit of their employees.

Self-employed individuals may be able to claim a tax deduction for their personal contributions up to the concessional limit.

Other tax concessions

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

Tax on death claims

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

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

Tax on Terminal Illness or Total and Permanent Disablement claims

Tax concessions apply if the total and permanent disablement results in your termination of employment.

Other **important** information

What has to happen before we pay?

We can only pay the Terminal Illness cover and TPD cover in accordance with superannuation rules.

So before we can pay you, those rules require that the trustee is reasonably satisfied you are unlikely, because of ill health, to engage in gainful employment for which you are reasonably qualified by education, training or experience.

As the superannuation rules are different from AMP Life's definition of "total and permanent disablement" there may be some instances where we won't be able to pay a TPD benefit directly to you.

In this case, we will transfer the benefit to an account in the AMP Eligible Rollover Fund set up on your behalf, or to a similar complying superannuation fund that you nominate. Any such transferred benefits can only be subsequently released if you are able to satisfy superannuation payment rules (eg retirement once your preservation age has been obtained).

Additional identification requirements

We are required to comply with the Anti-Money Laundering and Counter Terrorism Financing Act 2006.

In relation to Flexible Lifetime – Protection (Superannuation) Death, Total and Permanent Disablement we will need to monitor client transactions and report suspicious activity to the Australian Transaction Reports and Analysis Centre (AUSTRAC), a federal government body.

Also from 12 December 2007 before paying any claim, we may need to verify the identity of:

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

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

Further, if required by law or directed to do so by AUSTRAC, we may delay or refuse any request or transaction on this product, including benefit payments. We are not liable for any loss or damage arising from any such delay.

The trustee

Flexible Lifetime – Protection (Superannuation) Death, Total and Permanent Disablement is part of the AMP Personal Superannuation Fund ("PSF"). AMP Superannuation Limited is the Trustee of the PSF and is a wholly owned subsidiary of AMP Life Limited.

The Trustee has been granted a Registrable Superannuation Entity (RSE) licence by APRA on 1 February 2006. The RSE Licence number is L0000550.

The Trustee:

- Is responsible for all aspects of the operation of your plan.
- Is responsible for ensuring that the PSF is properly administered in accordance with the Trust Deed and policy documents, and
- Ensures that the PSF complies with relevant legislation, that all members' benefits are calculated correctly, and that members are kept informed of the operations of the PSF.

The Trustee has indemnity insurance.

What is the legal structure of Flexible Lifetime – Protection Superannuation)?

The trust deed establishes the Fund. It also contains:

- your rights and obligations relating to Flexible Lifetime – Protection (Superannuation), Death, Total and Permanent Disablement, and
- our rights and obligations as the trustee – for example, the right to charge fees, the right to be indemnified, the right to terminate the trust and the limits on our liability.

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

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

Collection of Tax File Numbers

We are required to tell you the following details before you provide your Tax File Number (TFN).

We can collect your TFN under the Superannuation Industry (Supervision) Act 1993. You are under no obligation to tell us your TFN, either now or later, and it is not an offence to not quote your TFN.

However, if you **don't** tell us your TFN:

- Any Employer Contributions will have the "no-TFN tax" applied at the rate of 31.5%. This is in addition to the current mandated contribution tax of 15%. The "no-TFN tax" may be refunded if the TFN is supplied within 4 years of the end of the financial year in which the contribution is made.
- We may have to withhold more tax than we would otherwise have to on your superannuation lump sum benefits if you do not provide your TFN. This additional tax may be able to be reclaimed in your next tax assessment with the Australian Taxation Office.
- We cannot accept personal contributions (non-concessional) and certain other types of contributions into your superannuation account.
- In the future, when we need to pay benefits to you, it may be more difficult for us to locate or amalgamate all the superannuation benefits you are entitled to.
- The consequences of not providing your TFN may change in the future as a result of further legislative changes.

If you do tell us your TFN, we will treat it as confidential and use it only for lawful purposes, including:

- To find your superannuation benefits, where other information is insufficient.
- To ensure you can continue to contribute to your account.
- To calculate tax on any superannuation benefits you may be entitled to.
- If we are paying unclaimed money, we must give your TFN to the Commissioner of Taxation.
- Also we may give your TFN to the Commissioner of Taxation if you receive a benefit, or for the purposes of the Lost Members' Register.
- If you wish to transfer benefits to another superannuation fund or Retirement Savings Account we would provide your TFN to the Trustee of that other fund or Retirement Savings Account provider. However, if you do not want us to do this, you can notify us in writing at the time not to do so.

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

Annual Report

We will send you a copy of the Annual Report of the Fund each year. You may also obtain a copy by contacting AMP Customer Service.

Regulated Superannuation Fund Certification (to be shown to any contributing employer)

AMP Superannuation Limited has a Registrable Superannuation Entity Licence issued on 1 February 2006. The RSE Licence number is L0000550.

AMP Superannuation Limited has registered the AMP Personal Superannuation Fund ("PSF") with the Australian Prudential Regulation Authority (APRA).

The registration number for the PSF is R1001662.

The AMP PSF is:

- A resident regulated superannuation fund within the meaning of the Superannuation Industry (Supervision) Act 1993 (SIS).
- Not subject to a direction under section 63 of SIS, and
- Has never previously been subject to a direction under section 63 of SIS.

AMP Superannuation Limited confirms that the PSF is a complying superannuation fund under Division 295 of the Income Tax Assessment Act 1997.

For and on behalf of
AMP Superannuation Limited

5. Information common to all products

Premiums and fees

Costs associated with your plan are comprised of premiums and fees. Both are described in this section.

How your premium is calculated

Your premium is calculated based on the insurance amount you have applied for (which may increase each year if you have the indexation feature) and additional options you may wish to add.

The method used in calculating your premium will vary depending on the type of cover you select. However, as a rough guide, in calculating the premium for each part of your insurance we use a base premium rate, dependant on your age, gender and smoking status. The base premium rate is then multiplied by the amount of insurance selected to give your base premium.

You can call us on 1300 360 838 to obtain a copy of our current premium rates.

Your premium rates whether stepped or level aren't guaranteed. Premium rates (including level premium rates) can vary at any time. Any consequent increase in your premium will apply at your next plan anniversary. You cannot be singled out for an individual premium variation.

The cost of insurance depends on a number of factors, such as the insurance amount you have applied for (which will increase each year with CPI if the indexation feature has been selected) and additional options you may want to add.

In calculating the premium for each part of your insurance, we use a base premium rate, which is dependant on your age, gender and smoking status. The base premium rate is then multiplied by the amount of insurance selected to give your base premium.

Base premium = **Base premium rate** X **Amount of insurance**

The base premium may then be increased or decreased using additional premium factors, for example, relating to your occupation, the state of your health, pastime pursuits and any optional extras. This calculation, sample premiums and the main premium factors that may be applicable are described in the following section.

Insurance premium = **Base premium** X **Premium factor to increase or decrease**

Sum insured discount

For Death, TPD and Trauma cover we apply discount or loadings to the premiums based upon the size of the cover selected. We can change discount rates at any time.

The table below shows some of the discounts and loadings applying at November 2007. Contact your financial planner for any changes to the discounts/loadings or call us on 1300 360 838. These discounts and loadings are not guaranteed.

The premium adjustment is effective on the full amount of the sum insured for each insured person. Each benefit is calculated separately. Due to the operation of the discount tables there will be instances where the premium for the same insured person may be less for a larger sum insured.

Discounts and loadings as at November 2007

Sum insured range	Premium load or (discount) percentage rate		
	Death	TPD	Trauma
0 – $99,999	0%	0%	7.5%
$100,000 – 149,999	0%	0%	0%
$150,000 – $249,999	(7.5%)	(2.5%)	0%
$250,000 – $499,999	(15.0%)	(10.0%)	0%
$500,000 – $999,999	(22.5%)	(17.5%)	(5%)
$1,000,000 – $1,999,999	(27.5%)	(22.5%)	(10%)
$2,000,000 and over	(30.0%)	(25.0%)	(10%)

Sample premiums

To give you an indication of how much the insurance in this product can cost, some premium examples are provided in this section.

However, you need to be aware that due to the number of premium factors involved in calculating the insurance premium, the exact insurance premium you are required to pay needs to be specifically tailored to you.

The various premium factors that may affect the calculation are described in the table on page 45.

You can obtain a tailored premium quote from your financial planner or you can call us on 1300 360 838.

If you have to pay more than the quote after we have assessed your personal circumstances, we will tell you of this by issuing an Advice of Revised Terms.

Death, TPD, Trauma

Insured person's details	Insurance selected	Approximate yearly insurance premium payable
Example 1		
Age 39 Male Non-smoker Qualified accountant	Linked cover: > Death cover $300,000 >TPD cover $300,000 ("own occupation" option = No) > Trauma cover Premier $150,000	$762.12
Example 2		
Age 39 Female Non-smoker Qualified accountant	Linked cover: >Death cover $300,000 >TPD cover $300,000 ("own occupation" option = No) >Trauma cover Premier $150,000	$722.76

Income Protection

Insured person's details	Insurance selected	Approximate yearly insurance premium payable
Example 1		
Age 39 Male Non-smoker Qualified accountant	Income Protection – Advanced Agreed Value plan on stepped premiums Monthly benefit $4,500 AIDS cover and Claims escalation option included Waiting Period 4 weeks Benefit Period "to age 65"	$923.63
Example 2		
Age 39 Female Non-smoker Qualified accountant	Income Protection – Advanced Agreed Value plan on stepped premiums Monthly benefit $4,500 AIDS cover and Claims escalation option included Waiting Period 4 weeks Benefit Period "to age 65"	$1,447.44

The sample premiums provided are based on a person residing in New South Wales and are effective at the time this PDS was prepared. Please note we can vary premiums at any time. However, once your plan has started, you cannot be singled out for an individual premium variation.

We will notify you at least 30 days before any increase in your premium takes effect, unless it is a result of:

- an increase in the amount of insurance (for example, if you increase your insurance), or
- a change in Government stamp duty charges (see page 46).

Premium factors

The following table describes the various premium factors we consider and the order in which they may affect your insurance premium calculation.

Premium factor	How it affects your cover
Type of insurance	We apply different base premium rates to different benefits and options.
Age	Generally as you become older the cost of insurance increases.
Gender	As illness and life expectancy varies between men and women we charge different premium rates.
Smoking status	We charge more for smokers.
Amount of insurance (the "sum insured")	We can apply a discount to the base premium rate for larger sums insured (see page 44).
Agreed value or indemnity	We charge more for Agreed value plans.
Occupation	Generally occupations with hazardous duties or higher risks are charged more.
State of health	We charge different rates depending on your state of health and family medical history.
Waiting period and benefit period	For Income Protection we charge different rates depending on the benefit and waiting period selected.
Sports/recreational activities	We charge more for anyone engaged in activities we consider "high risk", eg scuba diving.
Optional extras	Adding options (eg Own occupation option) will increase the premium payable.
Stamp duty	Stamp duty is a Government levy payable on insurance (see Government duties on page 46).

Government duties

In addition to the premiums for any insurance cover Government stamp duty or a similar tax may also be payable.

Stamp duty is either incorporated into the base premium rates or is an additional charge.

Any additional stamp duty on insurance premiums will be deducted from your account when your insurance premium is deducted.

Your annual statement will show the amount of any additional stamp duty or tax deducted.

If a State or Territory stamp duty or tax applies to you, it will be based on the State or Territory we record as your address.

As stamp duty differs between States/Territories it is important that you inform us of any changes to the address of the first insured person on your plan.

Additional stamp duty charges currently vary between 1.5% and 11% of the cost of premiums, depending on the insurance benefits and/or options selected, and the State or Territory we record as the address of the first insured person on your plan. Additional stamp duty charges can change without notice (up and down) as governments introduce a new stamp duty or revise an existing one or as we change our address records.

AMP may also change the way we recover stamp duty, from incorporating it into the base premium rates to making it an additional charge.

If you stop paying premiums

If you don't pay each premium within 30 days of it being due, we will take steps to end the plan. We will remind you if we don't receive your premium.

Plan fee

The premium includes an annual plan fee to cover our costs. Each year, we may increase it by any increase in the CPI.

The plan fees for 2007 are:

- Death, Total and Permanent Disablement and Trauma:
  - $74.95 pa for the first insured person, and a further $14.99 pa for each subsequent insured person you include in the plan.
- Death, Total and Permanent Disablement (Superannuation) $74.95 pa.
- Income Protection and Business Overheads Insurance:
  - $74.95 pa for the first plan, and $14.99 pa for any other income protection plan or business overheads plan taken out at the same time to cover the same insured person.

The plan fees from 1 January 2008 will be available from your financial planner, and will be provided on your individual quote from 1 January 2008.

Payments to your financial planner

Standard commission

AMP Life will normally pay a standard commission to the financial planner for your plan. We pay this out of the insurance premiums – you don't pay this additional amount. If you do not have a financial planner, then the premium is still the same.

The standard commission on insurance is:

- 112.75% of the first year's premiums and 11% of premiums for that year and each subsequent year, or
- 55% of the first year's premiums and 22% of premiums for that year and each subsequent year, or
- 30.25% pa of premiums.

Your financial planner will notify us at the time of application which one of these options for standard commission on insurance they want to receive.

Rather than 112.75%, AMP Life pays commission of 130% of the first year's insurance premiums and 11% of premiums for that year and each subsequent year if the personal statement is completed using AMP's *easywrite* automated underwriting for insurance cover. This will only occur if the first of the standard commission options on insurance above is used.

Your premium will be the same whether or not *easywrite* automated underwriting is used by your planner to complete your personal statement.

All of the rates quoted above include 10% GST which your financial planner is required to pay to the Australian Taxation Office. These commission rates apply at November 2007. You can contact your financial planner or us for any changes to commission rates.

Alternative commission

You and your financial planner can agree to an alternative to the standard initial commission and ongoing service commission as well as the commission on insurance premiums. If lower commission on insurance is agreed between you and your financial planner, the cost of your insurance will be reduced.

Alternative Forms of Remuneration Register

AMP Life is required to comply with an industry code on alternative forms of remuneration. The code is the Investment and Financial Services Association and Financial Planning Association Industry Code of Practice on Alternative Forms of Remuneration ("the Code") in the wealth management industry.

The Code requires AMP Life to maintain a register that records any material forms of alternative remuneration, which it pays or receives. Registers are required to be maintained by investment managers, platform providers, representatives and licensees.

The register is publicly available for inspection by you and a copy of the register can be requested by contacting AMP on 131 267.

Premium payment options

You can pay premiums either yearly, half-yearly or monthly by direct debit. Direct debit payments can be from your bank, building society or credit union, or your credit card.

We accept Mastercard, Visa or American Express cards. You may also pay yearly or half-yearly by cheque, BPAY or Post Billpay.

The premium payment options are subject to change at our discretion.

Premium frequency fee

If you pay the premium more often than yearly, an extra fee is included in the premium because our costs are higher.

That fee is a percentage of the premium you would pay if you were paying yearly. For monthly payments it is 7.5% and for half yearly payments it is 3%. We can change these percentages at any plan anniversary in circumstances relating to the commercial operation of our business.

Direct debit service agreement

The following terms will apply to any direct debit that you, your spouse or your employer set up to make payments.

Before you request a direct debit arrangement you must check that the account you want to nominate can have direct debit (eg some passbook savings accounts cannot have direct debit). To find out if we can debit from your account, contact your financial institution.

Please double-check any account details you provide by comparing them with a recent statement from your financial institution.

This agreement allows AMP Customer Service to deduct from your nominated account the amount and frequency you request. If we want to change this agreement, we will notify you 14 days in advance unless it is specifically in relation to Government stamp duty. If you disagree with this change, please notify us within these 14 days.

Your financial institution account details will be kept confidential. However, these details will be disclosed:

- if you give permission
- if a court order applies
- to settle a claim
- if our financial institution needs information.

If the due date is on a weekend or public holiday, your payment will be processed on the next business day. You should make sure that sufficient cleared funds are available in your account on the due date for payment.

If there are not sufficient funds and your financial institution dishonours the payment, any charges incurred by:

- Your financial institution may be debited from your account.
- AMP may be debited from your plan or recovered in some other way.

If you want to change or cancel this agreement or dispute a debit, contact AMP Customer Service (contact details are on the inside back cover). In particular, if you want to:

- Change this agreement, eg the amount you pay, how often you pay, account number, deferring payment due to unforeseen circumstances, you need to contact us at least 3 days before the due date.
- Cancel this agreement or an individual payment, you need to contact us at least 3 days before the due date.
- Dispute a debit that has been made from your account.

AMP will respond to your initial dispute within 5 days. If you believe that a debit has not been correctly processed, you should contact us immediately on 131 267. You indemnify us against all losses, costs, damages and liabilities that we suffer as a result of you breaching this agreement, or providing us with an invalid or non-binding direct debit request addressed to us.

Ad-hoc direct debit

You, your spouse or your employer can request us to transfer ad-hoc amounts from your, your spouse's or your employer's bank account. Ad-hoc direct debits are not an automatic periodical deduction of a fixed amount. Debits from your, your spouse's or your employer's bank account will only occur each time you, your spouse or your employer instruct us by phone or in writing.

For Superannuation customers only

Your Direct Debit authority may not be created if a valid TFN has not been provided. If you have not provided a valid TFN your member or spouse (non-concessional) Direct Debit contributions request will be suspended until you provide a valid TFN. Your member or spouse (non- concessional) Direct Debit deductions will start effective on the date you provide a valid TFN. Any outstanding Direct Debit contributions will be deducted effective from the date you provide a valid TFN. If you wish to make a personal contribution on which you intend to claim a tax deduction you need to provide your TFN before making the contribution.

Note: In this agreement, we refer to AMP Life Customer Service Division as "AMP Customer Service", "we", "us" and "our".

How to apply

Before you apply you need to obtain your individual premium quote from your financial planner who can help you assess your needs and explain the details of the plan to you. If you don't have a financial planner, you can contact AMP on 1300 360 838 to obtain a premium quote.

The quote generally assumes that your health and pastimes indicate a standard insurance risk. We may increase the premium, restrict the available cover or decline cover altogether if our underwriting indicates that the insured person(s) is greater than a standard risk.

The only way to apply for these plans is to complete an application form, and generally, a Personal Statement. You can obtain these at the back of the PDS.

Your financial planner will assist you with the application process, or you can contact us on 1300 360 838. The information provided is used by our underwriters to assess whether to accept the risk, refuse the risk, apply a higher premium or apply an exclusion or restriction to the plan.

Depending on the insured person's age and the level and type of cover being applied for, and the information provided, we may ask the insured person to provide further information, undergo a medical test(s) and/or medical examination(s).

If the insured person has, or has had, a medical condition, their doctor may be asked to provide details of the insured person's medical history from their records or the insured person may be asked to undergo an up-to-date medical examination. We will generally pay for any medical consultation or medical test that we request for the insured person to undertake for the purposes of considering your application.

In some cases we may offer insurance that is different to what you applied for. We may offer insurance for a lower sum insured, at a higher premium or apply an additional exclusion. If this happens we will write to you requesting your agreement to proceed with the application on the revised terms. In some cases we won't be able to accept your application for cover and we will inform you of this.

Legislation ensures that personal information is protected. We have strict guidelines about how the information collected about you and the insured person is used, stored and accessed. This is set out in our Privacy Policy. After we have received a completed application and, either your first premium payment or valid direct debit details, we provide you with Interim accident cover. This cover is different to the cover you have applied for, see page 59.

When your insurance starts

Your plan will start when we accept your application. We will send you a Certificate of Insurance showing you the details of your insurance. The Certificate of Insurance will show the date your insurance starts.

Significant risks in taking out this insurance

Selection of a product that does not provide the type of cover you need

You may choose an insurance product that doesn't meet your needs. You should read the PDS carefully to prevent this. A financial planner can also assist you in the selection of the right product for you.

Inadequate amount of cover

You may select the correct insurance product for your needs, but you might not choose enough cover, the most suitable type of cover, waiting period or benefit period. This might cause you to still suffer financial hardship after receiving your benefit payment. You will need to assess your needs carefully to ensure that this doesn't occur. Again, a financial planner will be able to help you.

Inability to get cover or increases in cover

You may not be able to obtain the cover that you applied for because of your particular health or other circumstances, now or in the future. You should therefore not relinquish any existing cover you may have until new insurance cover is firmly in place.

You do not comply with your Duty of Disclosure

If you do not comply with your duty of disclosure, your insurer may not pay your claim, may pay only part of your claim, or cancel your plan. Please carefully read and ensure you understand and comply with your duty of disclosure.

Flexible Lifetime – Protection (Superannuation)

There is an additional risk that the Trustee may not be able to pay you the proceeds of a terminal illness or TPD claim. The trustee won't release funds if it is prevented from doing so by superannuation law which requires that the proceeds only be released where the trustee has been satisfied that the member has permanent or temporary incapacity. These are different from the definitions of disablement under this product.

How we handle insurance claims

Our aim is to provide timely financial assistance to insured person(s) who suffer an illness or injury (or death, if applicable) as per the insurance cover provided.

If you have the misfortune to need to make a claim we have specially trained claims staff who will be pleased to answer any questions and assist you with the completion of any necessary paperwork associated with your claim.

We aim to be proactive in our claims management. Our claims requirements will vary depending on the type of, and reason for, the claim you are making. Our claims requirements may include, but are not limited to:

- Completed claim forms.
- Certified copy of the death certificate (if applicable).
- Medical evidence (we may require the insured person to be examined by a doctor of our choice).
- Proof of diagnosis of condition or occurrence of the procedure for which the claim is being made, including copies of investigations performed by a specialist (eg clinical, histological and radiological evidence).
- Specific financial requirements (eg copies of taxation returns).

We pride ourselves on providing an excellent claims service and are committed to paying genuine claims.

We appreciate your feedback on the level of claims service we are providing.

How to claim

If you need to make a claim, AMP will assist you through the process. Either you or someone close to you can simply contact your financial planner or call us on 131 267. We will then advise you what to do next.

Claims should be made promptly after the event that entitles you to claim. Failure to do so may affect the amount payable to you.

Cooling off period (your right to return your plan)

We want this financial product to meet your needs. But if you no longer want it, you can return it. To do this you must tell us within 14 days, starting on the earlier of:

- the date you receive the Certificate of Insurance and Plan Rules, or
- 5 business days after the date of your Certificate of Insurance and Plan Rules.

However, you can't return your plan if you have exercised any rights or powers available under it.

For superannuation members the refund of any contributions under cooling off provisions can't be paid in cash, this refund must be paid to another superannuation fund on your behalf. If we aren't advised of an alternative superannuation plan within a month of your request to cancel your membership of Flexible Lifetime – Protection (Superannuation), we will make the payment to the AMP Eligible Rollover Fund.

We keep you informed

If we agree to issue the plan, we will send you a Certificate of Insurance and Plan Rules. These documents will set out the details of who owns the plan, who is insured, the amount of cover, options selected and other important information.

Please read these documents carefully to make sure the plan meets your needs.

Annual Statement

Each year, we will send you an Annual Statement advising you about your insurance, fees and your premium for the next year.

Get up-to-date information about your plan online. With My Portfolio you can access and keep track of your plan information online.

To register visit www.amp.com.au and select "online accounts: register".

Automatic plan enhancements

We review our insurance plans regularly. If we enhance our definitions or product features without changing the premium rates or existing premium discounts we will automatically provide you with the 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 on your plan anniversary.

AMP and your privacy

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it. We may also use this information for related purposes – for example, providing you with ongoing information about financial services that may be useful for your financial needs.

These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services, that may be made available by us, other members of the AMP group, or by your financial planner.

We usually disclose information of this kind:

- To other members of the AMP group.
- To your financial planner or broker (if any).
- If you are applying for a personal insurance product, to the owner of the plan.
- To external service suppliers who supply administrative, financial or other services to assist the AMP group in providing AMP financial services.
- To the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost superannuation.
- To anyone you have authorised or if required by law.

If health information is collected in relation to this financial product, then additional restrictions apply. The primary purpose for obtaining this health information is for the insurer, AMP Life, to assess your application for new or additional insurance. AMP Life may also use this information for directly related purposes – for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims.

AMP Life may disclose this type of health information to:

- The financial planner or broker responsible for the plan.
- The trustee.
- The owner of your personal insurance plan (if applicable).
- AMP Life's reinsurers.
- Medical practitioners.
- Any person AMP Life considers necessary to help either assess claims or resolve complaints.
- Anyone you have authorised or if required by law.

If you are an insured person, aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

Under the National Privacy Principles, you may generally access personal information about you held by the AMP group. Also, you may let us know if you think any of it is inaccurate, incomplete or out-of-date. The AMP Privacy Policy Statement sets out the AMP group's policy on management of personal information. You may obtain a copy by contacting us on 131 267 or visiting our website at www.amp.com.au.

Duty of Disclosure

Your Duty of Disclosure

Before you enter into a contract of life insurance, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or a resonable person in the circumstances could be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of life insurance.

Your duty however, doesn't require disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer.
- That is of common knowledge.
- That your insurer knows or, in the ordinary course of business, ought to know.
- As to which compliance with your duty is waived by the insurer.

Your Duty of Disclosure continues until you are informed that your application is accepted or declined.

Non-disclosure

If you fail to comply with your Duty of Disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If this failure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Death, Total and Permanent Disablement (Superannuation) cover

Before the trustee effects insurance cover with the insurer, the trustee has a duty of disclosure. It is a condition of your obtaining insurance cover that you have the same duty of disclosure to the trustee. Any reference to the "insurer" in the section headed "Your Duty of Disclosure" includes a reference to the "Trustee".

Enquiries and complaints process

If you need any additional information about the operation or management of your plan, or if you have a concern or complaint, then please contact your financial planner or contact AMP Customer Service.

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

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

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

If your complaint cannot be resolved at first contact, then we will keep you informed of the progress and aim to give you a response to your complaint within 10 working days.

If the complaint is not resolved by that time, then we will keep you advised at regular intervals of the status of your complaint.

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

This industry sponsored external service was established to help clients with complaints they cannot resolve directly with their company. It is independent and impartial.

Please try to resolve your complaint directly with us before contacting the FICS.

Financial Industry Complaints Service

Phone: 03 8623 2000 or 1300 780 808

Fax: 03 9621 2291

Email: fics@fics.asn.au

or write to:

PO Box 579, Collins St West
MELBOURNE VIC 8007

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

Phone: 1300 780 808

Fax: 03 8635 5588

Email: info@sct.gov.au

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.

Your beneficiaries have 28 days to lodge a complaint with the SCT in relation to a decision to pay your death benefit.

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

Trauma definitions and descriptions

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.

For specific information regarding claims requirements, please see the Plan Rules.

Please note that to satisfy the following descriptions the insured person must survive 14 days.

Alzheimer's disease and other dementias

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.

Aortic surgery

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.

Aplastic anaemia

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

Bacterial meningitis

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.

Benign tumour of the brain or spinal cord

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.

Blindness

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 10 degrees or less of arc. That loss must be irreversible and unable to be corrected by glasses or any other means.

Cancer

We will pay if an insured person suffers 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 1 or 2 if the insured 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.

Cancer (Partial)

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.

Cardiomyopathy

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.

Coma

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
- is the result of the insured person suffering another trauma condition for which we pay.

Coronary artery angioplasty (Partial)

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.

Coronary artery angioplasty – triple vessel

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.

Coronary artery surgery

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.

Encephalitis

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.

Heart attack – myocardial infarction

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, then 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.

Heart attack – Out of hospital cardiac arrest

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.

Heart valve surgery

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.

HIV/AIDS – medically acquired

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 occurred to the insured person in either Australia or New Zealand, and
- it occurred as a result of any one of the following procedures:
  - a blood transfusion
  - the transfusion with blood products
  - an organ transplant to the insured person
  - assisted reproductive techniques.

Before we will pay, we will require proof of the incident via a statement from a Statutory Health Authority that the infection was medically acquired.

We won't pay if the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection.

HIV/AIDS – occupationally acquired

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.

Intensive care

We will pay if the insured person has an accident or illness which requires them to have continuous mechanical ventilation by means of tracheal intubation. The tracheal intubation must need to continue for 10 consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital.

We won't pay where the accident or illness is a result of alcohol or drug use that isn't prescribed by a doctor.

Kidney failure

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.

Leukaemia

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

Liver failure

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

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

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.

See page 58 for the definition of activities of daily living.

Loss of speech

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

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

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

Major head trauma

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.

Major organ transplant

We will pay if an insured person requires a transplant from a donor of one of the following whole organs and is placed on a waiting list at an Australian hospital:

- kidney
- heart
- liver
- lung
- pancreas.

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

We won't pay in the event of a donation by the insured person of an organ for transplant.

Melanoma (Partial)

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

Motor neurone disease

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

Multiple sclerosis

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.

Muscular dystrophy

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

Myelodysplasia

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.

Myelofibrosis

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.

Open heart surgery

We will pay if an insured person has open heart surgery requiring diversion of the blood through a heart-lung machine, in order to have surgery to correct any heart defect including heart valve surgery. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We won't pay under this particular trauma condition for procedures such as valvotomy or coronary artery angioplasty which don't require open heart surgery.

Paralysis – diplegia

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.

Paralysis – hemiplegia

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.

Paralysis – paraplegia

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.

Paralysis – quadriplegia

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.

Paralysis – tetraplegia

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.

Parkinson's disease

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.

See page 58 for the definition of activities of daily living.

Parkinson's disease (Partial)

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

Parkinson's disease means the unequivocal diagnosis of idiopathic Parkinson's disease due to degeneration in the nigrostriatal area of the mid-brain and characterised clinically, by one or more of the following symptoms: rigidity, tremor, akinesia.

Other forms of Parkinsonism, whether related to medication, toxins or other neurogenerative conditions are specifically excluded.

Partial blindness

We will pay if an 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.

Peripheral blood stem cell or bone marrow transplant

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

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 result in the insured person not being able to do any one or more of the below activities without assistance from someone else:

- get in and out of a bed
- get on or off a chair/toilet
- move from place to place without using a wheelchair.

We won't pay if the peripheral neuropathy is directly caused by alcohol or related to use of other drugs not prescribed by a doctor.

We won't pay if this condition is contributed to or caused by HIV/AIDS related conditions.

Pneumonectomy

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

We will pay if the 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 of the New York Heart Association Classification of Cardiac Impairment.

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

Prostate cancer (Partial)

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.

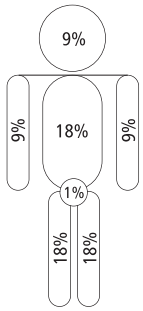
Severe burns

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 below.

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 (Partial)

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 indefinite second-line therapy.

Severe osteoporosis (Partial)

We will pay if an insured person suffers severe osteoporosis. Severe osteoporosis means the insured person before the age of 50, suffers at least 2 vertebral body fractures or a fracture of the neck or femur, due to osteoporosis and has bone mineral density reading with a T-score of less than –2.5 (ie 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least 2 sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis

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.

See page 58 for the definition of activities of daily living.

Stroke

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.

Subacute sclerosing panencephalitis

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

Systemic lupus erythematosus (SLE)

We will pay if an insured person suffers systemic lupus erythematosus where irreversible organ damage has occurred requiring intravenous immunosuppressive or cytotoxic therapy.

The organ damage includes lupus nephritis, cerebral lupus, cardiac disease specially related to SLE. An appropriate consultant medical specialist must confirm the diagnosis of SLE with pathological and other supporting evidence.

Systemic sclerosis

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. See page 58 for the definition of activities of daily living.

Viral encephalitis

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.

Other definitions and descriptions

Accident

Refers to bodily injury caused directly and solely by violent, external and visible means and independent of all other causes.

Activities of daily living:

1. Washing: the insured person can wash themself by some means.
2. Dressing: the insured person can put clothing on or take clothing off.
3. Feeding: the insured person can get food from a plate into their mouth.
4. Continence: the insured person can control both their bowel and bladder function.
5. Mobility: the insured person can:

   a) Get in and out of a bed.

   b) Get on or off a chair/toilet.

   c) Move from place to place without using a wheelchair.

Carer

The primary caregiver, who provides assistance with communication, mobility or self-care to a disabled or aged person, for more than 6 months.

CPI

The Consumer Price Index. An index of prices used to measure the change in the cost of basic goods and services.

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).

Income

For employed persons

The insured person's total package from employment, including commissions, regular bonuses, fringe benefits and any other items relating to their own efforts, less tax deductible expenses related to earning that income. We do not include superannuation contributions by the employer.

We include superannuation contributions made by an employer that are part of a salary sacrifice arrangement between the employee and employer. We do not include investment income.

For self-employed persons

Where the insured person owns (directly or indirectly) all or part of the business or practice, income means income earned by the business or practice as a result of the insured person's personal exertion or activities less their share of the business expenses incurred in earning that income. We do not include investment income.

Joint tenant

A type of ownership of property where 2 (or more) persons hold an interest in the same property, and where the interest automatically passes on the death of one to the survivor(s).

Maximum monthly benefit

The amount that we and you agree is the most we will pay each month if the insured person is totally disabled or has a chronic condition. We use that amount to calculate how much we will pay for any reason under the plan. The amount which applies when the plan starts is shown in the Certificate of Insurance. It may change after the plan starts.

It can:

- increase each year by any increase in the CPI, and
- change when you ask us to change it.

Own occupation

Own occupation means the primary full-time occupation which the insured person has performed immediately prior to becoming disabled.

Pre-disability income

For Agreed value

The highest average monthly income for any 12 consecutive months between 2 years before the plan started and the date the insured person became unable to work.

For Indemnity

Income in the 12 months immediately before the insured person became unable to work. We divide that amount by 12 to get the monthly income.

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.

Total and permanent disablement (TPD)

See page 11 for the definition of TPD.

Totally disabled (applicable to Income Protection and Business Overheads Insurance)

An insured person is totally disabled if they are so ill or injured they can't do their usual occupation. They must remain under the ongoing care and attention of a doctor and not do any remunerative work.

When we assess their ability to do their usual occupation, the assessment is based on their capacity to carry out any one duty, or combination of duties, which are critical to the proper performance of their usual occupation.

Totally disabled (applicable to Waiver of Premium option)

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 for a period of more than 6 months because they suffered an illness or injury.

Interim accident cover – Certificate

About Interim accident cover

While your application is being considered, we will provide you with Interim accident cover at no extra cost.

This cover is different to the insurance being applied for and is subject to the terms and conditions described below.

Interim accident cover is not available if either you or the insured person:

- have withdrawn an application, or
- have applied for a similar type of plan, and had the application declined, or
- are currently applying for similar cover outside of AMP
- are applying for this cover to replace an existing plan.

When cover commences

This cover will start when we receive your completed application form and either the first premium payment or valid direct debit details at an AMP registered office.

Cover is subject to the premium payment not being dishonoured.

This Certificate is for you to keep. It explains the terms and conditions of Interim accident cover.

When we will pay

If you applied for Death cover

We will pay if you have applied for Death cover and the insured person dies solely as a result of an accident during the Interim accident cover period.

If you applied for TPD cover

We will pay if you have applied for TPD cover and, solely as a result of an accident during the Interim accident cover period, the insured person suffers from the total and irrecoverable loss of:

- the use of 2 limbs, or
- the sight of both eyes, or
- the use of one limb and the sight of one eye,

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

The loss must be unable to be remedied and the insured person must survive at least 14 days after the loss.

If you applied for Trauma cover

We will pay if you have applied for Trauma cover and the insured person suffers one of the following trauma conditions during the Interim accident cover period, solely as a result of an accident:

- blindness*
- coma*
- diplegia
- hemiplegia
- intensive care*
- major head trauma*
- paraplegia
- quadriplegia
- severe burns*
- tetraplegia.

* If you applied for Trauma cover Standard these conditions are not covered under that plan and not covered under Interim accident cover.

The definitions of the above trauma conditions are set out in "Trauma definitions and descriptions". See page 52 of the Product Disclosure Statement.

If you applied for Income Protection

We will pay if you have applied for Income Protection cover and the insured person becomes unable to work solely as a result of an accident occurring during the Interim accident cover period.

This benefit is paid monthly while the insured person is unable to work, starting from the end of the waiting period selected, for a maximum of 12 months.

If you applied for Business Overheads Insurance

We will pay if you have applied for Business Overheads Insurance and the insured person becomes unable to work solely as a result of an accident occurring during the Interim accident cover period.

This benefit is paid monthly while the insured person is unable to work, starting from the end of the waiting period selected, for a maximum of 6 months.

How much we pay

We will only pay once for Interim accident cover under Flexible Lifetime – Protection Death, TPD, Trauma plans.

If you applied for Death cover

We will pay you a lump sum under Death cover.

We will pay the lesser of:

- $1,000,000, or
- the sum insured applied for.

If you applied for TPD and/or Trauma cover

We will pay you a lump sum under TPD and/or Trauma cover.

We will pay the lesser of:

- $600,000, or
- the sum insured applied for.

If you applied for Income Protection

We will pay you monthly benefits for a maximum of 12 months for Interim accident cover under Income Protection.

We will pay the lesser of:

- $5,000 per month, or
- the sum insured applied for.

If you applied for Business Overheads Insurance

We will pay you monthly benefits for a maximum of 6 months for Interim accident cover under Business Overheads Insurance.

We will pay the lesser of:

- $5,000 per month, or
- the sum insured applied for, or
- the insured person's share of the allowable business expenses actually incurred during the period for which they were unable to work.

When cover stops

Interim accident cover ceases on the earliest of:

- 90 days from the date this Interim accident cover starts, or
- the date your application is approved, declined, withdrawn, or
- the date we advise that your Interim accident cover is cancelled.

During consideration of your application, we may choose to modify the cover we offer. If this occurs, Interim accident cover will also be adjusted to incorporate the changed terms, including any adjustments to the premium.

Important note

When assessing your application for insurance, we will take into account any claims you have made on Interim Accident cover. We may impose special conditions or decline your application for insurance under these circumstances.

When we won't pay

We won't pay for intentional or self-inflicted injury or death.

We won't pay where, under our underwriting rules, we would have declined, or applied a loading or special terms to, the insurance applied for.

We won't pay where the accidental death or injury is caused by:

- any pre-existing medical condition you or the insured person were aware of at the time of applying for this cover, or
- engaging in any sport, pastime or occupation which would not normally be covered under our standard underwriting rules.

AMP

Office/Planner Use Only

Plan number

Multiple applications ☐

AMP Flexible Lifetime – Protection
Application

Before you sign this application form, be aware that AMP Life or your financial planner is obliged to provide you with a Product Disclosure Statement containing a summary of the important information in relation to these plans. This information will help you to understand the plan and decide whether it is appropriate to your needs.

It is essential to attach a copy of the quote(s) and other relevant materials to this application form.

Mark boxes with (✗) where appropriate, otherwise use block letters. Leave a box between words.

1 PLANS INCLUDED

DEATH, TPD AND TRAUMA COVER

All insured persons

☐ Superannuation **OR**
☐ Ordinary (includes self-managed superannuation funds)

Office/Planner Use Only

Request ID

Plan number

Type of application

☐ New business (including conversion/continuation)
☐ Increase to existing plan
☐ Addition of insured person to existing plan (ordinary only)
☐ Addition of new cover to existing plan

INCOME PROTECTION AND/OR BUSINESS OVERHEADS INSURANCE

Insured person 1

☐ Income protection
☐ Business overheads insurance

Office/Planner Use Only

Request ID

Plan number

Plan number

Type of application

☐ New business (including conversion/continuation)
☐ Increase
☐ Second plan discount

Flexible Lifetime – Super insurance application lodged: ☐ No ☐ Yes

Insured person 2

☐ Income protection
☐ Business overheads insurance

Office/Planner Use Only

Request ID

Plan number

Plan number

Type of application

☐ New business (including conversion/continuation)
☐ Increase
☐ Second plan discount

Flexible Lifetime – Super insurance application lodged: ☐ No ☐ Yes

If more than 2 insured persons are applying, please provide a separate application

2 INSURED PERSONS DETAILS

Insured person 1

Title | Surname

Given names | Previous surname

Date of birth | Sex ☐ Male ☐ Female | Country of birth

Marital Status ☐ married ☐ single ☐ widowed ☐ divorced ☐ de facto

Have you smoked tobacco or any other substance or used nicotine replacement products within the last 12 months? ☐ No ☐ Yes

Current occupation | Income pre-tax pa $

Your relationship to owner for Death, TPD and Trauma – Ordinary:

☐ self ☐ spouse/partner ☐ business partner ☐ employee ☐ dependant **Other:**

Residential address ☐ (✗) box if an overseas resident

Unit No.		Street No.		Street name			
Suburb					State		Postcode

Do you want AMP to change the address for other products you have? ☐ No ☐ Yes

Home phone number | Business phone number | Mobile phone number

Email address

Correspondence address (if same as above, leave blank)

PO box		Street No.		Street name			
Suburb					State		Postcode

Existing insurance details

Other than this/these applications, are you applying for or do you have any personal insurance with AMP? ☐ No ☐ Yes

If **"Yes"**, please provide details of other insurances, and current or prior proposals, insuring your life. If you are applying for other AMP insurance cover at the same time as this application and have completed the insurance details in the table below already, you do not have to complete again.

Name of insurer	Life cover	Total & Permanent Disablement cover	Trauma cover	Monthly disability (income) cover	Disability Type	Is this cover to be cancelled?†
AMP Life Limited	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	If Yes give policy No. ☐
Amount to Cancel	$	$	$	$		
	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	If Yes give policy No. ☐
Amount to Cancel	$	$	$	$		
	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	If Yes give policy No. ☐
Amount to Cancel	$	$	$	$		

* Temporary salary continuance cover ** Income protection cover *** Business overheads insurance cover

† **Important Note:** Your application will be considered on the understanding that if you intend to cancel any existing cover, that you will do so on acceptance of this application. Failure to do so may render invalid a claim on your AMP plan. If this application is to replace a current AMP plan, the plan to be replaced will cease and a new plan will start.

2 INSURED PERSONS DETAILS - CONTINUED

Insured person 1

Title | Surname

Given names | Previous surname

Date of birth | Sex ☐ Male ☐ Female | Country of birth

Marital Status ☐ married ☐ single ☐ widowed ☐ divorced ☐ de facto

Have you smoked tobacco or any other substance or used nicotine replacement products within the last 12 months? ☐ No ☐ Yes

Current occupation | Income pre-tax pa $

Your relationship to owner for Death, TPD and Trauma – Ordinary:

☐ self ☐ spouse/partner ☐ business partner ☐ employee ☐ dependant **Other:**

Residential address ☐ (✗) box if an overseas resident

Unit No.	Street No.	Street name
Suburb	State	Postcode

Do you want AMP to change the address for other products you have? ☐ No ☐ Yes

Home phone number | Business phone number | + | Mobile phone number

Email address

Correspondence address (if same as above, leave blank)

PO box	Street No.	Street name
Suburb	State	Postcode

Existing insurance details

Other than this/these applications, are you applying for or do you have any personal insurance with AMP? ☐ No ☐ Yes

If **"Yes"**, please provide details of other insurances, and current or prior proposals, insuring your life. If you are applying for other AMP insurance cover at the same time as this application and have completed the insurance details in the table below already, you do not have to complete again.

Name of insurer	Life cover	Total & Permanent Disablement cover	Trauma cover	Monthly disability (income) cover	Disability Type	Is this cover to be cancelled?†
AMP Life Limited	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	If Yes give policy No. ☐
Amount to Cancel	$	$	$	$		
	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	If Yes give policy No. ☐
Amount to Cancel	$	$	$	$		
	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	If Yes give policy No. ☐
Amount to Cancel	$	$	$	$		

* Temporary salary continuance cover ** Income protection cover *** Business overheads insurance cover

† **Important Note:** Your application will be considered on the understanding that if you intend to cancel any existing cover, that you will do so on acceptance of this application. Failure to do so may render invalid a claim on your AMP plan. If this application is to replace a current AMP plan, the plan to be replaced will cease and a new plan will start.

If Death, TPD and Trauma cover is not required, go to section 14 on page A8

Insured child 1 Note: Only applicable if there is an insured adult under Death, TPD and Trauma cover

Surname | Given names

Date of birth | Sex ☐ Male ☐ Female | Country of birth

Insured child 1 continued over page.

Residential address ☐ **(✗) box if an overseas resident**

Unit No.	Street No.	Street name	
Suburb		State	Postcode

Insured child 2

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

Country of birth

Residential address ☐ **(✗) box if an overseas resident**

Unit No.	Street No.	Street name	
Suburb		State	Postcode

If plan owner is same as insured person – or if superannuation insurance, go to section 6 on page A5

3 PLAN OWNERS (for Death, TPD and Trauma – Ordinary only)

Plan owner 1

Company Name

OR

Title

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

Address

Unit No.	Street No.	Street name	
Suburb		State	Postcode

Home phone number

Business phone number

Mobile phone number

Email address

Plan owner 2

Company Name

OR

Title

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

Address

Unit No.	Street No.	Street name	
Suburb		State	Postcode

Home phone number

Business phone number

Mobile phone number

Email address

4 ADDRESS FOR CORRESPONDENCE

Addressee

Address: (Indicate either one if same as section 3) ☐ Plan owner 1 ☐ Plan owner 2

PO box		Street No.		Street name	
Suburb			State		Postcode

5 REASON INSURANCE IS NEEDED

☐ family protection ☐ personal loan ☐ business loan ☐ buy/sell ☐ keyperson

Other:

6 NOMINATION OF BENEFICIARIES (Optional) – Death cover only

You must read this information before completing the beneficiary details below.

For Death cover – Ordinary

☐ You may (only) nominate beneficiaries if:

- there is only one insured person on this plan
- this person is also the sole owner of this plan (ie not a company or joint owner), and
- this person has applied for death cover.

Death benefit payments to beneficiaries are subject to terms and condition of the plan and limitations imposed by the law at the time of the claim payment. I understand that this nomination will be void if there is a change in plan ownership, or if insured person(s) are added to the plan.

For Death cover – Superannuation

☐ You may nominate beneficiaries if you have applied for Death cover. The person(s) you nominate must be dependent on you at the time of your death. If they aren't, or if a nomination has been made or becomes invalid, the Trustee will pay the total death benefit to your estate. The nomination that you make will replace any previous nomination, including any nominations for other plans that you may have in the AMP Personal Superannuation Fund.

I nominate the following beneficiaries to receive the specified proportion of the benefit payable at my death:

Given names — Surname

Relationship to applicant: ☐ spouse ☐ child ☐ financial dependant ☐ interdependency — Date of birth (of beneficiary)

Other

Sex ☐ Male ☐ Female — **Proportion of total benefit** ___ %

Given names — Surname

Relationship to applicant: ☐ spouse ☐ child ☐ financial dependant ☐ interdependency — Date of birth (of beneficiary)

Other

Sex ☐ Male ☐ Female — **Proportion of total benefit** ___ %

Given names — Surname

Relationship to applicant: ☐ spouse ☐ child ☐ financial dependant ☐ interdependency — Date of birth (of beneficiary)

Other

Sex ☐ Male ☐ Female — **Proportion of total benefit** ___ %

Given names — Surname

Relationship to applicant: ☐ spouse ☐ child ☐ financial dependant ☐ interdependency — Date of birth (of beneficiary)

Other

Sex ☐ Male ☐ Female — **Proportion of total benefit** ___ % — **Total** 100 %

If further beneficiaries are required, please attach a separate page to this form

7 DEATH, TPD AND TRAUMA COVER STRUCTURE

Insured person 1

Type of cover ☐ linked ☐ stand alone

Insured person 2

Type of cover ☐ linked ☐ stand alone

8 DEATH COVER

Insured person 1

Cover applied for $

Insured person 2

Cover applied for $

9 TOTAL AND PERMANENT DISABLEMENT COVER

Insured person 1

Cover applied for $

Own occupation definition to apply?* ☐ No ☐ Yes

Insured person 2

Cover applied for $

Own occupation definition to apply?* ☐ No ☐ Yes

10 TRAUMA COVER

Insured person 1

Cover applied for $

Trauma type ☐ Premier ☐ Standard

Trauma options (available for Trauma Premier only)

Buy back option ☐ No ☐ Yes

Trauma Reinstatement option ☐ No ☐ Yes

Partials Plus option ☐ No ☐ Yes

Insured person 2

Cover applied for $

Trauma type ☐ Premier ☐ Standard

Trauma options (available for Trauma Premier only)

Buy back option ☐ No ☐ Yes

Trauma Reinstatement option ☐ No ☐ Yes

Partials Plus option ☐ No ☐ Yes

Insured child 1

Children's trauma cover $50,000 (includes $10,000 death cover) ☐

Insured child 2

Children's trauma cover $50,000 (includes $10,000 death cover) ☐

11 COVER OPTIONS

Insured person 1

Waiver of premium* ☐ Individual life ☐ Nominated life

Business safeguard* ☐ No ☐ Yes

Indexation through CPI* is automatically included. If indexation is not required please mark the box below.

☐ No CPI

Insured person 2

Waiver of premium* ☐ Individual life ☐ Nominated life

Business safeguard* ☐ No ☐ Yes

Indexation through CPI* is automatically included. If indexation is not required please mark the box below.

☐ No CPI

* Refer to Product Disclosure Statement for details and availability.

TAX FILE NUMBER – for Superannuation only

See information on the collection of Tax File Numbers on page 42 of the Product Disclosure Statement.

Tax file number

12 PAYMENT DETAILS – Death, TPD and Trauma cover

Are the premiums paid by your employer? (For superannuation only) ☐ No ☐ Yes

Total premium $ per ☐ year ☐ half year ☐ month

Initial payment option ☐ credit card ☐ direct debit ☐ cheque

Regular payment option ☐ credit card ☐ direct debit (must be chosen if initial is direct debit)
☐ notice (not available for monthly payment)

Credit card debit authority

FORM OF REQUEST FOR DEBITING AMOUNTS TO ACCOUNTS BY THE DIRECT DEBIT SYSTEM – DDR

We will deduct your initial premium within 5 days of our acceptance of your application for insurance.

Type of credit card ☐ VISA ☐ MasterCard ☐ Amex

Credit card number Expiry date

Name on credit card

Direct debit authority

Name of financial institution (eg bank, credit union)

Account holder name

BSB number Account number Deduction date (eg 15th)

Branch location

I/We request AMP Life (user ID000103), until further notice in writing to debit my/our account/credit card, as outlined above any amounts which they may debit or charge me/us through the direct debit system. I/We have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement page 47. I/We understand that AMP or I/we may terminate this request at any time.

Signature(s) of account/cardholder(s)

Signature ✗ Signature ✗

Date Date

13 CONVERSION/CONTINUATION OPTION DETAILS

Complete this section only if you are transferring from an existing AMP plan and AMP has approved conversion.

I/We, as owner(s) of the plan below (the "old" plan):

Existing plan number(s)

Continuation option from an AMP Superannuation fund plan number

- Request that the old plan be converted effective from the issue date of the new plan being applied for.
- Acknowledge that all cover for the insured person under the old plan will end when the new plan is issued.
- Acknowledge that this new plan is issued on the basis that I/we complied with the Duty of Disclosure at the time of issue of the old plan and on the basis that any statements made by me/us and all insured persons under the old plan were true and complete.
- Acknowledge that any special conditions applying to the old plan will continue under the new plan.
- Understand that the provision in the new Plan Rules "When we won't pay" on death or terminal illness will not apply to my new plan for the same amount of cover, provided the one year and 30 day period under my old plan has finished.

Signature(s) of previous plan owner(s)

Signature ✗ Signature ✗

Date Date

Signature(s) of new plan owner(s)

Signature ✗ Signature ✗

Date Date

If income protection and/or business overheads insurance is not required, go to section 19 on page A11

14 INCOME PROTECTION INSURANCE

Insured person 1 and Plan owner

Type of cover ☐ Advanced ☐ Standard ☐ Basic

Benefit period ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 60 ☐ To age 65 ☐ Lifetime (for increases only)

Waiting period ☐ 2 weeks ☐ 4 weeks ☐ 8 weeks ☐ 12 weeks ☐ 26 weeks ☐ 52 weeks ☐ 104 weeks

Total maximum monthly benefit $

(Including 12% super contribution option amount)

For Standard and Basic cover:

claim escalation benefit ☐ No ☐ Yes

Superannuation contribution option: ☐ No ☐ Yes

Indemnity option ☐ No ☐ Yes

AIDS cover ☐ No ☐ Yes

Day 1 accident option ☐ No ☐ Yes

Chronic condition option

(Only available with Advanced 60 or 65) ☐ No ☐ Yes

Premium type ☐ Stepped ☐ Level

Insured person 2 and Plan owner

Type of cover ☐ Advanced ☐ Standard ☐ Basic

Benefit period ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 60 ☐ To age 65 ☐ Lifetime (for increases only)

Waiting period ☐ 2 weeks ☐ 4 weeks ☐ 8 weeks ☐ 12 weeks ☐ 26 weeks ☐ 52 weeks ☐ 104 weeks

Total maximum monthly benefit $

(Including 12% super contribution option amount)

For Standard and Basic cover:

claim escalation benefit ☐ No ☐ Yes

Superannuation contribution option: ☐ No ☐ Yes

Indemnity option ☐ No ☐ Yes

AIDS cover ☐ No ☐ Yes

Day 1 accident option ☐ No ☐ Yes

Chronic condition option

(Only available with Advanced 60 or 65) ☐ No ☐ Yes

Premium type ☐ Stepped ☐ Level

For Advanced and Standard cover with one year benefit period and conversion option, please specify details of conversion option

Insured person 1 and Plan owner

Maximum monthly benefit $

Waiting period ___ weeks

Benefit period

Premium type ☐ Stepped ☐ Level

AIDS cover ☐ No ☐ Yes

Insured person 2 and Plan owner

Maximum monthly benefit $

Waiting period ___ weeks

Benefit period

Premium type ☐ Stepped ☐ Level

AIDS cover ☐ No ☐ Yes

15 BUSINESS OVERHEADS INSURANCE – Income Protection and/or Business Overheads Insurance

Insured person 1

Benefit period ☒ 1 year

Waiting period ☐ 2 weeks ☐ 4 weeks

Maximum monthly benefit $

AIDS cover ☐ No ☐ Yes

Premium type ☒ Stepped

Insured person 2

Benefit period ☒ 1 year

Waiting period ☐ 2 weeks ☐ 4 weeks

Maximum monthly benefit $

AIDS cover ☐ No ☐ Yes

Premium type ☒ Stepped

Where the Business Overheads insurance plan owner is not the person insured, please enter details in the notes section on page A14.

16 PAYMENT DETAILS – Income Protection and/or Business Overheads Insurance

Insured person 1

Total premium $ ☐☐☐☐☐☐☐ per ☐ year ☐ half year ☐ month

Initial payment option ☐ credit card ☐ direct debit ☐ cheque

Regular payment option ☐ credit card ☐ direct debit (must be chosen if initial payment is direct debit)
☐ notice (not available for monthly payment)

If not paying by credit card or direct debit, go to section 18 on page A11

Credit card debit authority

FORM OF REQUEST FOR DEBITING AMOUNTS TO ACCOUNTS BY THE DIRECT DEBIT SYSTEM – DDR
We will deduct your initial premium within 5 days of our acceptance of your application for insurance.

Type of credit card	☐ VISA ☐ MasterCard ☐ Amex
Credit card number	
Expiry date	
Name on credit card	

Direct debit authority

Name of financial institution (eg bank, credit union)

Account holder name

BSB number

Account number

Branch location

I/We request AMP Life (user ID000103), until further notice in writing to debit my/our account/credit card, as outlined above any amounts which they may debit or charge me/us through the direct debit system. I/We have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement on page 47. I/We understand that AMP or I/we may terminate this request at any time.

Signature(s) of account/cardholder(s)

Signature

✗

Date

Signature

✗

Date

17 PAYMENT DETAILS – Income Protection and/or Business Overheads insurance

Insured person 2

Total premium $ ☐☐☐☐☐☐☐ per ☐ year ☐ half year ☐ month

Initial payment option ☐ credit card ☐ direct debit ☐ cheque

Regular payment option ☐ credit card ☐ direct debit (must be chosen if initial payment is direct debit)

☐ notice (not available for monthly payment)

Credit card debit authority

FORM OF REQUEST FOR DEBITING AMOUNTS TO ACCOUNTS BY THE DIRECT DEBIT SYSTEM – DDR

We will deduct your initial premium within 5 days of our acceptance of your application for insurance.

Type of credit card ☐ VISA ☐ MasterCard ☐ Amex

Credit card number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry date ☐☐☐☐

Name on credit card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Direct debit authority

Name of financial institution (eg bank, credit union) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account holder name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BSB number ☐☐☐☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Branch location ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I/We request AMP Life (user ID000103), until further notice in writing to debit my/our account/credit card, as outlined above any amounts which they may debit or charge me/us through the direct debit system. I/We have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement on page 47. I/We understand that AMP or I/we may terminate this request at any time.

Signature(s) of account/cardholder(s)

✗ ✗

Date ☐☐☐☐☐☐☐☐ Date ☐☐☐☐☐☐☐☐

18 CONVERSION/CONTINUATION OPTION DETAILS (- IP and/or BOI)

Complete this section ONLY if you are transferring from an existing AMP plan and AMP has approved conversion.
I/We, as owner(s) of the plan below (the "old" plan):

Insured person 1

Existing Income Protection plan number(s)

Existing Business Overheads plan number(s)

Insured person 2

Existing Income Protection plan number(s)

Existing Business Overheads plan number(s)

- Request that the old plan be converted effective from the issue date of the new plan being applied for.
- Acknowledge that all cover for the insured person under the old plan will end when the new plan is issued.
- Acknowledge that this new plan is issued on the basis that I/We complied with the Duty of Disclosure at the time of issue of the old plan and on the basis that any statements made by me/us and all insured persons under the old plan were true and complete.
- Acknowledge that any special conditions applying to the old plan will continue under the new plan.

Signature(s) of previous plan owner(s)

Signature

Date

Signature

Date

Signature(s) of new plan owner(s)

Signature

Date

Signature

Date

19 DUTY OF DISCLOSURE

Before you enter into a contract of life insurance, you have a Duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same Duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of life insurance.

Your Duty however doesn't require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of knowledge
- that your insurer knows or, in the ordinary course of business, ought to know
- as to which compliance with your duty is waived by the insurer.

Your Duty of Disclosure continues until you are informed that your application is accepted or declined.

Non-disclosure

If you fail to comply with your Duty of Disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Death, Total and Permanent Disablement (Superannuation) cover

Before the Trustee effects insurance cover with the insurer, the Trustee has a Duty of Disclosure. It is a condition of your obtaining insurance cover that you have the same Duty of Disclosure to the Trustee. Any reference to the "insurer" in the section headed "Your Duty of Disclosure" includes a reference to the "Trustee".

20 AGREEMENT AND DECLARATION – for all plans included in this application

I/We agree that:

1. I/We have received and read the Flexible Lifetime – Protection Product Disclosure Statement dated 24 November 2007 (and any applicable supplements).
2. My/our financial planner is authorised to use the information provided by me/us in this application and any other form relevant to AMP to complete and submit an electronic application on my/our behalf.
3. I/We have read the Duty of Disclosure on page A11. I/We understand that any insurance AMP issues will be based on the information given in this application and the personal statement(s), and that if I/we do not comply with the duty to disclose information, the insurance may be cancelled or altered.
4. I/We also understand that I/we need to tell AMP of any change to an insured person(s) health, occupation or pastimes, or other things relevant to the insurance application that happen to that person after I/we have completed this Application and the personal statement(s) that could alter AMP's decision to insure them, right up to the point that AMP issues the Certificate of Insurance and Plan Rules.
5. I/We understand that AMP may obtain information from any doctor or hospital used by the insured person(s).
6. I/We have read the Privacy information in my Product Disclosure Statement and agree to the various uses and exchanges of my personal information and acknowledge my right to access personal information held about me/us by the AMP Group.
7. I/We have read all the information provided in this application and believe it is complete and correct even if the information has been written by someone else.
8. For Income Protection & Business Overheads Insurance plans included in this application:

   Overseas

   I/We understand that, at AMP's discretion, insurance benefits may not be payable for more than three months in any one period that the insured person is unable to work unless they are continuously present in Australia or New Zealand.

   Income Protection Insurance – Basic cover:

   I/We understand that Income Protection Insurance – Basic cover plans (if included in this application) may be cancelled by AMP following a claim.
9. For plans providing Total & Permanent Disablement (TPD) and/or Trauma cover (if included in this application):
   - If Death cover has not been selected for an insured person, I/we acknowledge that AMP will not make any payment under that plan should that insured person die.
10. For plans applied for electronically: I/we understand that AMP may cancel my/our insurance contract issued and cover provided if AMP does not receive signed copies of the application form and personal statement(s) (if required) within 60 days of the insurance cover being issued.

Signatures of insured persons

Insured person 1

Signature

✗

Date

Insured person 2

Signature

✗

Date

FINANCIAL PLANNER AUTHORITY

I give my consent to my financial planner to provide information to AMP, on my behalf, concerning my health, pastimes, occupation and financial status, for the purpose of expediting the assessment of my application for insurance.

I give my consent to AMP to disclose to my financial planner any personal medical information or finding that results in my application for Insurance being accepted on non-standard or amended terms, or declined. I understand that AMP will not provide copies of medical or other reports regarding my application for insurance to my financial planner without first obtaining my specific consent to do so.

Insured person 1

Signature

✗

Date

Insured person 2

Signature

✗

Date

FOR PLAN OWNERS IF NOT AN INSURED PERSON

Signatures of insured persons

Plan owner 1

Signature

✗

Date

Signatures of insured persons

Plan owner 2

Signature

✗

Date

Notes: 1. Joint owners: If a Flexible Lifetime – Protection Ordinary plan has more than one plan owner, ownership is joint tenancy and, on death of an owner, ownership will pass to the surviving plan owner(s). 2. Register: Unless otherwise requested, Flexible Lifetime – Protection Ordinary plans will be registered in the State or Territory of the first plan owner's address. Other plans will be registered in the insured person's State or Territory of residence.

FURTHER DECLARATIONS FOR SUPERANNUATION INSURANCE

11. I am applying/have applied already to the Trustee of the AMP Personal Superannuation Fund, to be a member of that fund and agree to be bound by the provisions of the Trust Deed.
12. Where I am making an application with the assistance of a financial planner, my financial planner is authorised to use the information provided by me in this application and any other form to complete and submit an electronic application on my behalf.
13. If I have applied for TPD cover and my occupation is currently 'home duties', I acknowledge that I have previously been employed or self-employed for gain or reward.
14. If my employer is going to contribute to the AMP Personal Superannuation Fund to pay for my insurance premium:

    a) I confirm that any contributions made under an award or industrial agreement can legally be paid into the AMP Personal Superannuation Fund and

    b) I will write to advise the Trustee if my employer stops making these contributions.
15. I understand that I cannot receive a terminal illness benefit or a TPD benefit (including benefits paid under the "own occupation" or "home duties" provisions within the TPD definition) in cash unless I am able to access my superannuation benefit
16. I understand AMP can't refund premiums paid in cash, unless I meet a condition of release, and the refund must be paid to another superannuation fund at my direction or will be paid to the AMP Eligible Rollover Fund.

Signature of insured person

✘

Date

FINANCIAL PLANNER AND OFFICE USE ONLY

Planner number	Name	Initial income split (total 100%)	Servicing Planner (Tick one)

Insurance Commission

Please indicate the insurance commission type and level to apply. The commission amounts shown include GST.

Upfront*	Hybrid	Level
☐ 112.8% Initial, 11% Trail	☐ 55% Initial, 22% Trail	☐ 30.3% Level commission
☐ 90.2% Initial, 11% Trail	☐ 44% Initial, 22% Trail	☐ 24.2% Level commission
☐ 67.7% Initial, 11% Trail	☐ 33% Initial, 22% Trail	☐ 18.2% Level commission
☐ 45.1% Initial, 11% Trail	☐ 22% Initial, 22% Trail	☐ 12.1% Level commission
☐ 22.6% Initial, 11% Trail	☐ 11% Initial, 22% Trail	☐ 6.1% Level commission
☐ 0% Initial, 11% Trail	☐ 0% Initial, 22% Trail	
☐ 0% Initial, 0% Trail		

* All applications submitted using *easywrite* will result in a higher initial commission.

Notes:

AUTHORITY FOR MEDICAL REPORT To be completed and signed by the insured person

I _____ (full name of insured person) hereby authorise you to release at any time details of my personal and family medical history, including referrals to or treatment by other Practitioners, to AMP Life Limited ABN 84 079 300 379. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. A photocopy of this authorisation shall be as valid as the original. Under Government Privacy legislation, I may access a copy of your report from AMP. Furthermore, I have been advised by AMP of the ways this information may be used and to whom it may be disclosed, and approve those purposes.

Signature of insured person ✘ _____ Date _____

AUTHORITY FOR MEDICAL REPORT To be completed and signed by the insured person

I _____ (full name of insured person) hereby authorise you to release at any time details of my personal and family medical history, including referrals to or treatment by other Practitioners, to AMP Life Limited ABN 84 079 300 379. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. A photocopy of this authorisation shall be as valid as the original. Under Government Privacy legislation, I may access a copy of your report from AMP. Furthermore, I have been advised by AMP of the ways this information may be used and to whom it may be disclosed, and approve those purposes.

Signature of insured person ✘ _____ Date _____

FINANCIAL AUTHORITY (Authority to obtain personal information from accountant to be completed by insured person)

Only to be completed if you wish your accountant to release information to AMP

I _____ (full name of insured person) hereby authorise

my accountant, _____ (insert name and address of accountant) or any accountant, financial institution, or any other financial service provider that I currently or may in future use to release details of my financial history to AMP Life Limited ABN 84 079 300 379. The purpose is to allow AMP Life Limited to assess my application for insurance.

Signature of insured person ✘ _____ Date _____

AUTHORITY FOR PATHOLOGY TESTS

I have recently applied to AMP Life Ltd ABN 84 079 300 379 for Life Insurance/Income Continuation cover and, as part of their standard underwriting requirements, I am to undertake the following blood tests:

• Multiple Biochemical Analysis (MBA) • HDL/LDL Cholesterol • Hepatitis B & C serology • HIV Antibodies

As I am a non-smoker, a cotinine test result will also be required *(cross out this sentence if you are a smoker).*

I hereby provide authorisation for the above blood tests to be performed in connection with my insurance application and the results to be forwarded to: **The Chief Medical Officer, AMP Life Limited, PO Box 300, PARRAMATTA NSW 2124**

I also provide my consent and authorisation for the HIV antibodies test and in the event of a positive result, request that the following doctor be advised of the result, to enable appropriate counselling to be conducted:

Doctor's name _____

Doctor's address

Unit No.	Street No.	Street name	
Suburb		State	Postcode

Name of Insured Person _____

Signature of insured person ✘ _____ Date _____

AUTHORITY FOR PATHOLOGY TESTS

Instructions to the insured person when blood tests are required

You can choose from the following alternatives to get your blood tests done.

You must fast for 8 hours (you may drink water) before having blood tests done. An early morning appointment may help make fasting easier for you.

1. Via your own or usual doctor. You will need to take this tear-off form along to your doctor to ensure that the correct blood tests are completed.
2. Via a paramedical facility*. Your financial planner will contact one of these service providers who will then contact you to arrange an appointment at a time and place convenient for yourself for a nurse to visit you to take blood.
3. Via a local pathology collection centre*. As per your own or usual doctor, you will need to take this tear-off form along to the collection centre to ensure that the correct blood tests are completed.

* You will need to confirm your identification at the time of providing the blood sample for 2 or 3 above.

Instructions to the financial planner when blood tests are required

1. If your client chooses to attend their own or usual doctor to have the required blood tests done, you will need to ensure that they take this tear-off form with them.
2. If your client is comfortable using a paramedical facility, you will need to complete a 'Health Request' form for the particular provider to be able to follow up with your client. AMP's Paramedical service providers include:

Lifescreen	**Phone: 1800 686 000**	**Fax: 1800 804 758**
Symbion Health	**Phone: 1800 770 001**	**Fax: 1800 770 002**
Pathrec	**Phone: 1800 066 895**	**Fax: 1800 631 582**

   If you do not have one of these forms available, contact Lifescreen and they will immediately fax one to you. When you return this form to them, they will then look after everything for you.
3. If your client chooses to attend a local pathology collection centre, you will need to provide your client with the address and arrange an appointment accordingly.

You will need to ensure that your client takes this tear-off form to their appointment

Issued by AMP Life Limited ABN 84 079 300 379, AFSL No. 233671 and AMP Superannuation Limited ABN 31 008 414 104, AFSL No. 233060, RSE Licence No. L0000550 the trustee of the AMP Personal Superannuation Fund, RSE Registration No. R1001662.

AMP

Risk Products Personal Statement

Financial Planner & Office Use Only

Financial Planner number | Plan number

If there is more than one insured person, please provide a separate Personal Statement for each insured person.

Mark boxes with (✗) where appropriate, otherwise use block letters. Leave a box between words.

DETAILS

Title | Surname

Given names

Date of birth | Sex ☐ Male ☐ Female

May we phone or email you if we need to clarify any details contained in this statement? ☐ No ☐ Yes

If "Yes", please provide preferred contact details:

Phone number

Preferred contact time ☐ 8am – 10am ☐ 10am – 12pm ☐ 12pm – 2pm ☐ 2pm – 4pm ☐ 4pm – 6pm ☐ Any

Preferred contact day ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Any

Email address

Important Note

This Personal Statement must be complete and correct because it will be the basis on which AMP Life Limited (ABN 84 079 300 379) may agree to insure you. You must therefore read and understand your DUTY OF DISCLOSURE explained below.

If you are unsure of anything in the statement, please ask your Financial Planner or AMP to explain it.

If you require more room to provide your answers than has been allocated on this form, please provide a separate signed and dated page(s) and attach this page(s) to your application.

YOUR DUTY OF DISCLOSURE

What you must tell us

You must answer all the questions in the Personal Statement completely and accurately. This helps us to decide whether to provide the insurance, how much to charge and whether any special rules should apply. You must also tell us anything else you think may be relevant to our decision about insuring you, or anything a reasonable person in the circumstances could be expected to know would be relevant to our decision. This may include giving us information we do not specifically ask for, eg if you have a medical problem which your doctor cannot explain or diagnose; if you are involved in any criminal activity; if you are facing bankruptcy; etc.

This duty continues until we issue the Certificate of Insurance and Plan Rules to the plan owner(s), or Flexible Lifetime® – Super members, until we advise you that we have accepted your application for insurance. Therefore, you must tell us about any change in your health, occupation, pastimes or any other relevant matter which happens after this Personal Statement has been completed up until the time the plan owner(s) or superannuation member is sent the Certificate of Insurance and Plan Rules, for FLS members, up until we notify you that we have accepted your application for insurance.

If you don't tell us

If you don't tell us what we need to know to complete our assessment of the risk, we may be able to treat your cover as if it never existed and pay nothing, or keep your policy going but reduce the amount we pay.

1 RESIDENCE AND TRAVEL

a. Are you an Australian or New Zealand citizen, or do you have an Australian permanent residency visa? ☐ No ☐ Yes

If "No":

i) What is your country of birth?

ii) How long have you lived in Australia? ☐☐ years ☐☐ months

iii) What type of visa do you hold?

iv) Have you applied for an Australian permanent residency visa? ☐ No ☐ Yes

b. Do you have any definite plans to travel or reside overseas, other than New Zealand in the next 12 months? ☐ No ☐ Yes

If "Yes", to any of the above questions, please provide full details (including reason for visit, country, when and duration):

2 SPORTS ACTIVITIES

Do you currently participate, or intend to participate, in any hazardous activity, competitive sport, aviation or flying activity other than as a regular fare paying passenger? ☐ No ☐ Yes

If "Yes", please complete one of the supplementary questionnaires on page A12.

3 DOCTOR INFORMATION

Name of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw)

Address of your usual doctor

PO box		Street No.		Street name	
Suburb		State		Postcode	

Phone number

Have you been a patient of this doctor for less than 2 years? If less than 2 years, please provide details of the previous doctor. ☐ No ☐ Yes

Name of previous doctor

Address of previous doctor

PO box		Street No.		Street name	
Suburb		State		Postcode	

Date of last consultation with any doctor

Name of doctor that you saw (if same as above, write "As above")

Were you referred for further tests, investigations or to a specialist? ☐ No ☐ Yes

Please advise reason, result/outcome of your last consultation

4 INSURANCE DETAILS

Have you ever made a claim or received benefits in regard to any illness, injury, or condition? ☐ No ☐ Yes

If "Yes", please provide full details:

5 HABITS

a. Have you smoked tobacco or any other substance or used nicotine replacement products in the last 12 months? ☐ No ☐ Yes

If "Yes", please advise the type of product: **quantity per:** ☐☐ **day** ☐☐ **week** ☐☐ **month**

b. Do you consume alcohol? ☐ No ☐ Yes

If "Yes", please advise number of standard drinks* per: ☐☐ **day** ☐☐ **week** ☐☐ **month**

c. Have you ever used illegal or illicit drugs? ☐ No ☐ Yes

If "Yes", please advise details including type, frequency and date(s) of usage:

d. Have you ever received treatment or been recommended for treatment by a doctor or other medical facility for the use of drugs or alcohol? ☐ No ☐ Yes

If "Yes", please advise details including date(s) of treatment:

*A standard drink = 1 nip spirits, 1 wine glass of wine, sherry glass port/sherry, 10oz/285ml glass of beer

6 MEDICAL HISTORY

Height

☐ cm or ☐ ft ☐ ins

Weight

☐ kg or ☐ st ☐ lbs

- **If you answer "Yes" to any of the bold conditions, complete the relevant Medical Questionnaire on pages A7 to A11.**
- **If you answer "Yes" to conditions which are not bold, provide details in the Additional Information table below.**

Have you ever had symptoms of, been told you had, or received advice from any health professionals including but not limited to doctors, specialists, counsellors or chiropractors for any of the following:

a. High blood pressure, **chest pain**, high cholesterol, stroke or any **heart or vascular disorder**? ☐ No ☐ Yes

b. **Asthma, bronchitis or any other lung disorder?** ☐ No ☐ Yes

c. **Epilepsy**, seizure disorder, multiple sclerosis, paralysis, migraine, dizziness, neuritis or any other neurological disorder? ☐ No ☐ Yes

d. **Kidney stones**, nephritis, passing blood in the urine or any other kidney or bladder disorder? ☐ No ☐ Yes

e. Hepatitis, cirrhosis or any liver or gall bladder disorder? ☐ No ☐ Yes

f. **Diabetes**, sugar in urine, thyroid or pancreatic disorder? ☐ No ☐ Yes

g. Indigestion, reflux, **ulcer or hernia**? ☐ No ☐ Yes

h. Colitis, passing blood from the bowel or any other bowel disorder? ☐ No ☐ Yes

i. Anaemia, leukaemia, haemophilia, received a blood transfusion or any other blood disorder? ☐ No ☐ Yes

j. Cancer, tumour, **lump, cyst or skin lesion** of any kind? ☐ No ☐ Yes

k. **Back or neck pain, sciatica, whiplash or any other spinal disorder?** ☐ No ☐ Yes

l. Repetitive strain injury, chronic fatigue syndrome, fibromyalgia, or muscle strain? ☐ No ☐ Yes

m. **Arthritis, gout or any disorder of the joints?** ☐ No ☐ Yes

n. **Bipolar, manic or major depressive illness, schizophrenia** or any other **psychotic disorder**? ☐ No ☐ Yes

o. Any other **mental health condition**, including but not limited to **depression, anxiety, stress** or **personality disorder?** ☐ No ☐ Yes

p. **Psoriasis, eczema, dermatitis** or any other **skin condition?** ☐ No ☐ Yes

q. Sleep apnoea or any other sleep disorder? ☐ No ☐ Yes

r. Any impairment of sight not corrected by glasses or contact lenses? ☐ No ☐ Yes

s. Any ear disorder such as hearing loss or tinnitus? ☐ No ☐ Yes

t. Have you ever had an occupational needle stick injury? ☐ No ☐ Yes

u. i) Have you, or do you intend to participate in any activity that increases your chances of contracting the HIV virus? This would include things such as working or engaging in secular intercourse with a prostitute or intravenous drug user or someone you suspect or know to be HIV positive, or engaging in anal sexual intercourse. ☐ No ☐ Yes

ii) Are you suffering from AIDS, or infected with HIV, or are you carrying antibodies to the HIV virus? ☐ No ☐ Yes

If you have answered "Yes" to any of the above, AMP will contact you for further information.

v. Have you had any other disorder or impairment, taken ay medication or undergone any medical tests, including genetic tests not mentioned above? ☐ No ☐ Yes

w. Do you intend to seek, any medical advice, undergo any tests, including genetic tests or investigations in the future? ☐ No ☐ Yes

Males only

x. Any prostate disorder or abnormality? ☐ No ☐ Yes

Females only

y. Have you had an abnormal pap smear or any gynaecological condition? ☐ No ☐ Yes

z. i) Have you ever had a breast ultrasound or mammogram? ☐ No ☐ Yes

ii) Have you ever had a breast lump (even if you have not seen a doctor about it?) ☐ No ☐ Yes

iii) Are you currently pregnant? ☐ No ☐ Yes

If "Yes", expected date of delivery? ☐☐☐☐☐☐☐☐

iv) Have you ever had a complication with a past or current pregnancy? ☐ No ☐ Yes

ADDITIONAL INFORMATION (required if "Yes" answered for conditions not in bold)

Question letter	Condition/Test/ Reason	Date first started	Date of last symptoms	Have you completely recovered?	Full details of treatment	Full name and address of doctor or hospital
		/ /	/ /	Yes / No		
		/ /	/ /	Yes / No		
		/ /	/ /	Yes / No		
		/ /	/ /	Yes / No		

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

7 FAMILY HISTORY

Has any first degree blood related family member (father, mother, brother, sister) had diabetes, stroke, heart condition, familial polyposis, breast, ovarian, colon or bowel cancer, polycystic kidney disease, Huntington's chorea, motor neurone disease or muscular dystrophy? ☐ No ☐ Yes

If "Yes", please complete the table below:

Family member/ Relationship to you	List ALL conditions and cause of death if applicable (if cancer, please give type and site)	Age at onset

8 OCCUPATION AND INCOME DETAILS (This section must be completed for all applications)

a. What is your current occupation?

b. How many hours per week and weeks per year do you work in your main occupation? ☐ hours ☐ weeks

c. How many weeks per year do you work in your main occupation? ☐ weeks

d. Do you have any other occupation? ☐ No ☐ Yes

If "Yes", please provide details (including type of occupation, duties, number of hours worked per week and the income earned in the last 12 months):

e. Do you have any definite plans to change your occupation? ☐ No ☐ Yes

If "Yes", please provide details:

f. Have you or any business that you have ownership of, ever been made bankrupt, been liquidated or been placed under administration? ☐ No ☐ Yes

If "Yes", please provide details including when and date of discharge if applicable:

g. What is your current annual income? (income earned through personal exertion, less any expenses incurred whilst earning that income)?

$ ☐☐☐☐☐☐☐ +

9 ADDITIONAL OCCUPATION DETAILS

To be completed only if applying for Total and Permanent Disablement, Income Protection, Temporary Salary Continuance or Business Overheads Insurance

a. Name of your business or employer

b. Address of your business or employer

c. Do you hold any professional/trade qualifications? ☐ No ☐ Yes

If "Yes", give details:

Type Institution

d. What are the main duties of your occupation?

Duties (eg office work, sales, supervision, manual work, explosives handling)	% of time
	%
	%
	%
	%
	100%

Location (eg office, on-site, driving, underground, offshore, underwater, at heights or at home)	% of time
	%
	%
	%
	%
	100%

e. Has your main occupation and/or employment status changed in the last 3 years? ☐ No ☐ Yes

If "Yes", please provide details of your previous occupation, duties and dates of change:

Occupation	Employment status	Date from	Date to
		/	/
		/	/
		/	/

f. Do you have any definite plans to take extended leave (eg parental or study leave) in the near future? ☐ No ☐ Yes

If "Yes", please provide full details including type and length of leave and your intentions on returning to work:

g. Do you have definite plans to change your working arrangements to part-time, casual or self-employed? ☐ No ☐ Yes

If "Yes", please provide full details including current and future employment status:

h. Are you self-employed (including sole trader, in a partnership or employee of your own company or trust)? ☐ No ☐ Yes

If "Yes", please complete the questions for SELF-EMPLOYED (i to n)

If "No", please complete the questions for EMPLOYEE (o to p)

SELF-EMPLOYED – SOLE TRADER, PARTNERSHIP, EMPLOYEE OF OWN COMPANY OR TRUST

i. How long have you been self-employed? ☐☐ years ☐☐ months

j. Please select which of the following applies:

☐ sole trader ☐ in a partnership ☐ employee of your own company or trust

k. What is the percentage of the business that you own and how many employees do you have? ☐☐☐ % ☐☐☐ employees

l. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If "Yes", please provide for how long, and the source (eg salary, investment income, company profits):

m. Please indicate your share of the business income/expenses, etc for the last 2 financial years for which tax returns, assessment notices and accounts are available.

Tax year ending	Gross income	Expenses incurred	Net profit or loss before tax	Add back any salary, wages, director's fees, superannuation	Your total income
30/06/	$	$	$	$	$
30/06/	$	$	$	$	$

n. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If "Yes", please provide for how long, and the source (eg salary, investment income, company profits):

EMPLOYEE – WITH NO OWNERSHIP INTEREST IN YOUR EMPLOYER'S BUSINESS:

o. What is your base annual salary from your main occupation (including salary packaged items, but excluding compulsory government superannuation contributions)?

Current financial year	Previous financial year 30/06/20☐☐
$	$
$	$

p. Do you receive any:
Commission, bonuses or regular overtime ☐ No ☐ Yes

	Current financial year	Previous financial year 30/06/20☐☐
Commission	$	$
Bonuses	$	$
Regular overtime	$	$

q. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If "Yes", please provide for how long, and the source (eg salary, investment income, company profits):

10 AGREEMENT AND DECLARATION

I, the insured person, agree and declare that:

a. I have read my duty of disclosure. I have kept my duty of disclosure in mind when completing my Personal Statement, and I understand any plan issued by AMP will be based on information I give in my Personal Statement, any additional questionnaire(s), form(s) and statement(s), as well as telephone underwriting (if applicable).

b. I understand I must tell AMP of any change in my health, occupation or pastimes and of any other thing that happens to me which may in any way affect the risk of insuring me, where this change occurs after I have completed this Personal Statement right up to the time that AMP issues the plan.

c. All the information provided in my Personal Statement is complete and correct. If any information has been written by someone else, I have reviewed this information and confirm it is complete and correct. I understand that if I do not comply with my duty to disclose all information completely and accurately, the insurance might be cancelled or the terms may be altered by AMP.

d. I authorise any doctor, hospital or other health service provider that I have or may attend to release details of my personal and family medical history, including referrals to or treatment by other practitioners, to AMP. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. I understand that, under Government Privacy legislation, I may access a copy of these reports from AMP. I have been advised by AMP of the ways this information may be used, and to whom it may be disclosed, and approve those purposes.

e. I have read the Privacy Information on page A14 and agree to the various uses and exchanges of my personal information and acknowledge my right to access personal information held about me by the AMP Group.

f. I have read the HIV Antibodies Test Information on page A14 and I agree that if an HIV test is required to assess my application for insurance, that I consent to such a test being performed and that I will provide advice at the time of blood collection as to whom I wish to be notified in the event of a positive HIV antibody result.

IMPORTANT: This agreement and declaration must be signed after you have read your duty of disclosure and privacy information and completed your Personal Statement. Only sign this agreement and declaration if you agree to make the declaration.

My signature to this declaration confirms my agreement to all of the above

✘ Insured person

Date

Signature of my parent/guardian if I am under age 16

✘ Parent/guardian if applicable

Date

11 FINANCIAL PLANNER INFORMATION (To be completed by financial planner)

If this application has been discussed with an Underwriter prior to submission, provide the following:

Underwriter's name

Date

Pre-arranged medical tests

Doctor Medical Exam ☐ Paramedical Exam ☐ Blood Test ☐

Specialist Medical Exam ☐ Resting ECG ☐ Stress ECG ☐

Other (please specify)

Financial Planner notes

12 HEALTH QUESTIONNAIRES

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

MENTAL HEALTH CONDITION

Please indicate (✓ the appropriate box(es)) the mental health condition(s) you have had, or received treatment for:

- Anxiety (including generalised anxiety, panic or phobic disorder) ☐
- Eating disorder (including anorexia nervosa and bulimia) ☐
- Depression (including major depression and dysthymia) ☐
- Manic depressive illness, bi-polar disorder ☐
- Alcohol or other substance abuse or addiction ☐
- Post-traumatic stress ☐
- Schizophrenia or any other psychotic disorder ☐
- Stress, sleeplessness or chronic tiredness ☐

Other (please describe below)

Has the cause of your condition been identified? ☐ No ☐ Yes

If "Yes", please provide the details:

How often did you have symptoms? ☐ years ☐ months

Describe your symptoms?

Date your condition first began

Date of last symptoms

Have you ever been prescribed any medication? ☐ No ☐ Yes

If "Yes", please provide details including the name of all drugs, dosage and how frequently taken:

Medicine (eg Zoloft)	Dose	Frequency

Are you still taking medication for your condition? ☐ No ☐ Yes **If "No", date ceased?**

Have you ever been absent from work or had your lifestyle restricted in any way, as a result of this condition(s)? ☐ No ☐ Yes

If "Yes", please provide the details:

Have you or are you consulting any psychologist, psychiatrist, counsellor or any other therapist for this condition(s)? ☐ No ☐ Yes

If "Yes", please provide details including dates of your most recent visit:

Have you ever been hospitalised for this condition(s)? ☐ No ☐ Yes

If "Yes", please provide details including dates of hospitalisation and treatment:

Have you ever attempted suicide? ☐ No ☐ Yes

If "Yes", please provide the details:

Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to this condition:

Date	Medical provider	Address

GENERAL MEDICAL CONDITION

Name of condition

Cause if known

Date your condition first began

Date of last symptoms

How often do you have symptoms?

Describe your symptoms

Have you ever taken medication for this condition? ☐ No ☐ Yes

If "Yes", please provide details (including name, dose and frequency):

Are you still taking this medication? ☐ No ☐ Yes

Have you ever had any other treatment (eg physiotherapy, surgery, etc) or been in hospital or received emergency treatment for this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Are any tests, surgery or treatment planned or scheduled in relation to this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Are there any residual complications or disabilities resulting from this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Have you ever been absent from work or incapacitated as a result of this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Does your usual doctor have details of this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to this condition:

Date	Medical provider	Address
/ /		

ABNORMAL PAP SMEAR

Please indicate (✓ the appropriate box(es)) the condition(s) you have had, or received treatment for:

Carcinoma ☐

CIN3 ☐

CIN2 ☐

CIN1 ☐

Human Papilloma Virus ☐

Atypia or change (caused by infection or irritation) ☐

Other abnormality ☐

When was the condition diagnosed? Date

Has the abnormality been surgically removed? ☐ No ☐ Yes

If "Yes", please provide details for each abnormality you have selected, including dates:

Have you had a follow up pap smear? ☐ No ☐ Yes

If "Yes", please provide date and result:

Give details of your most recent visit to a doctor or hospital relating to this condition:

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application

RESPIRATORY DISORDERS (eg asthma, bronchitis etc)

Name of condition

How long has it been since you last experienced symptoms (including but not limited to, shortness of breath, coughing, chest tightness or wheezing)?

Do you use any inhalers? ☐ No ☐ Yes

If "Yes" how often to you take your medication?

Medicine (eg Ventolin)	Dose	Frequency

Have you ever required treatment with oral steroids, or been admitted to hospital in the past 12 months as a result of this condition? ☐ No ☐ Yes

If "Yes", how many times have you used oral steroids or been hospitalised for this condition?

Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to your condition:

Date	Medical provider	Address

BACK OR NECK OR OTHER MUSCULOSKELETAL DISORDER

Name of condition

What part of your back is affected (eg neck, upper, middle, lower and/or whole spine)?

What was the cause of this condition?

How long ago did this condition begin?

Are you still experiencing symptoms? ☐ No ☐ Yes

If "Yes", how frequently do you suffer symptoms?

If "No", when did you last suffer symptoms?

Do, or did your symptoms radiate to other areas (eg legs, arms or groin)? ☐ No ☐ Yes

If "Yes", please provide details:

Have you ever had to do or intend to have surgery for this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Have you ever had, or are you contemplating having investigations such as CT or MRI scans? ☐ No ☐ Yes

If "Yes", please provide details (doctor, date and result etc):

Have you ever been absent from work, incapacitated or had your lifestyle restricted as a result of this condition? ☐ No ☐ Yes

If "Yes", please provide details:

Please provide details of all treatment that you have had or may have in the future for this condition, eg physiotherapy, chiropractic treatment, and/or medications, including dates, name and address of doctors, chiropractors or physiotherapists ☐ No ☐ Yes

If "Yes", please provide details:

DIABETES

Which of the following best describes your condition:

Type 2 Diabetes (Non-Insulin Dependent)	☐	Diabetes Insipidus	☐
Type 1 Diabetes (Insulin Dependent)	☐	Insulin Resistant	☐
Gestational Diabetes	☐	Not sure	☐

How long ago were you diagnosed with this condition?

How is this condition treated?

- Diet ☐
- Oral medication ☐
- Insulin ☐
- Other ☐

Please advise details including name of medication, dosage used per day:

Do you have any complications as a result of your diabetes (eg eye, kidney or nerve problems, high blood pressure or vascular disease etc)? ☐ No ☐ Yes

If "Yes", please provide details:

Have you ever suffered from a diabetic or insulin coma, or required hospitalisation due to your diabetes or any related condition? ☐ No ☐ Yes

If "Yes", please provide details:

When did you last have this condition checked by a medical practitioner?

Please provide your doctor's details, including name and address:

Date	Medical provider	Address
/ /		

OCCUPATIONAL NEEDLE STICK INJURY

Have you had any tests performed due to this needle stick injury? ☐ No ☐ Yes

If "Yes", please advise details of test(s) performed and the results if known:

Are any tests pending due to your needle stick injury? ☐ No ☐ Yes

If "Yes", please advise what test(s) are to be performed and when this is to occur:

13 SPORTING ACTIVITIES QUESTIONNAIRES

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attached to your application

DIVING

Which of the following best describes your participation in this activity, please select all that apply:

Scuba ☐ Enriched Air ☐ Mixed Gases ☐

Snorkel ☐ Other diving activity ☐

Do you have recognised diving qualifications eg PADI, FAUI or NAUI and or relevant qualifications for mixed gases?

If "Yes", please provide details of all diving qualifications you have obtained:

How many dives do you perform per annum? ☐☐☐

What is the maximum depth to which you dive? (in metres) ☐☐☐

Do you dive:

In caves ☐ No ☐ Yes

In dams or lakes ☐ No ☐ Yes

In ice diving ☐ No ☐ Yes

At night ☐ No ☐ Yes

Potholing ☐ No ☐ Yes

Internal exploration of wrecks ☐ No ☐ Yes

If "Yes", please provide details including frequency:

Do you ever dive alone or participate in depth record attempts? ☐ No ☐ Yes

If "Yes", please provide details including number of dives and location of the dives:

MOTOR SPORT on land or on water

Are you a professional or sponsored driver? ☐ No ☐ Yes

Please indicate (✓ the appropriate box(es)) the activity(ies) you take part in:

Bicycles ☐ Jet ski racing ☐ Trucks ☐

Boats ☐ Karts/go karts ☐ Other (specify below) ☐

Car ☐ Motorcycles

Provide details of your involvement

Category		
Class		
Vehicle		
Fuel		
Engine capacity		
No. of events last 12 mths		
No. of events next 12 mths		
Maximum speed		
No. of vehicles per event		

Competition licence type ____ Issuing body ____ Years held ☐☐

Do you have definite plans to compete overseas? ☐ No ☐ Yes

If "Yes", please provide details:

Do you participate or intend to participate in record attempts, testing of prototypes or testing of vehicles? ☐ No ☐ Yes

If "Yes", please provide details:

Have you ever had a motor sport accident, or has your competition licence ever been suspended? ☐ No ☐ Yes

If "Yes", please provide details:

AVIATION

Please indicate the activity(ies) you take part in:

Type of flying*	Fixed wing or helicopter	No. of hours past 12 months	No. of hours next 12 months

*Type of flying as defined by the Aviation Authorities:
eg aerobatics; agricultural (including crop dusting and inspecting); airline operations; air racing; aircraft record attempts; ballooning; charter flying; commuter operations; competition flying; experimental flying; gliding; hang gliding; microlighting/ powered hang gliders; paragliding and parascending; private flying or business commuting; record attempts; stunt flying; test flying; training/instructing; other (specify)

Type of aircraft that you usually fly?

Licence type ☐ Years held ☐☐

Name of your pilot's club or association

Air Navigation Order under which your flying is controlled

Do you have any definite plans to upgrade or change your Licence? ☐ No ☐ Yes

Do you have any definite plans to fly outside of Australia, or take off or land from anywhere that is not a registered airfield? ☐ No ☐ Yes

If "Yes", please provide details:

Have you ever been involved in flying accidents, been grounded or had your licence revoked? ☐ No ☐ Yes

If "Yes", please provide details:

OTHER ACTIVITIES

Please indicate the activity(ies) you take part in:

Frequency of participation? ☐☐☐ per annum Duration of participation? ☐☐☐ years

Details of any licences or qualifications

Name of any club or organisation that you are a member of

Location(s) where you undertake or participate in this activity

Maximum altitude/depth or speed etc

Do you participate in competition? ☐ No ☐ Yes

If "Yes", please provide details:

Details of any injury(ies) as a result of participating in this activity

Details of any definite plans to change from what you stated above

Details of any other relevant features of your involvement in this activity

PRIVACY INFORMATION

Your privacy is important to us and further information about AMP's collection of personal information is provided in our Product Disclosure Statement.

Our primary purpose in collecting information about your health is to assess the application for new or additional insurance from AMP. We may also use this information for directly related purposes such as deciding whether we need more information from you; arranging reinsurance; assessing future applications for new or altered insurance; and assessing and administering claims.

We will generally collect health information from someone else, such as a doctor, with consent. We need this information to assess the insurance application and, if you choose not to provide such consent, we may not be able to process the application.

We need this information to assess the insurance application and, if you choose not to provide such consent, we may not be able to proceed with the application.

We may disclose this type of information to:

- If your insurance is part of a superannuation fund, the trustee of that fund.
- The Financial Planner or broker responsible for the plan, (if any).
- AMP's reinsurers.
- Medical practitioners.
- Any person AMP considers necessary to assist in either the assessment of claims under your plan or the resolution of complaints, and
- Anyone you have authorised.

Aspects of your health information may be provided to the owner of the Plan in resolving or explaining terms of acceptance or if the standard Plan Rules are varied. You have the right to access personal information held about you by the AMP group, as explained in your Product Disclosure Statement.

HIV ANTIBODIES TEST INFORMATION

For AMP Life to consider your insurance application, you may need to have a blood test for Human Immunodeficiency Virus (HIV) antibodies. Depending on the type of insurance you have applied for, the blood sample may also be used to determine other matters like your serum cholesterol and kidney and liver functions.

AIDS – Acquired Immune Deficiency Syndrome is the final stage of the illness caused by HIV. HIV destroys some of the defence mechanisms which protect us against infections and cancers. As a result, people infected with HIV may suffer severe infections and cancer as well as organ damage. The most recent evidence suggests that the virus stays in the body indefinitely and causes progressive damage. There is still no cure or vaccine for AIDS but in many cases those infected may survive 10 or more years.

A positive HIV antibody test can have major social, medical, psychological and legal consequences which you should consider before having this test done. These include:

- Possible ill-informed discrimination.
- Possible lawful exclusion from employment if you work in one of a very limited range of occupations where there is a risk of transmitting HIV.
- HIV and AIDS are notifiable to government authorities, but your identity would not be reported.
- As HIV positive people will develop AIDS and long term outlook is uncertain, life and disability insurance is not normally available to people with HIV.
- Some countries restrict the entry of people with HIV.
- It is an offence to knowingly transmit HIV or to put other people at risk of infection.

You may choose to not have the test done. If you decide not to have the test, AMP can't consider your application for insurance. You may choose to arrange your own HIV antibody test and have the results sent to AMP.

If you choose to have AMP arrange the test, the results will be sent under confidential cover to AMP's medical officer/chief underwriter to protect your privacy. In the event of a positive result, this will be communicated to you via the doctor you have specified in your authority for HIV test. Otherwise, acceptance of your insurance application will indicate that your HIV antibody test was negative.

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