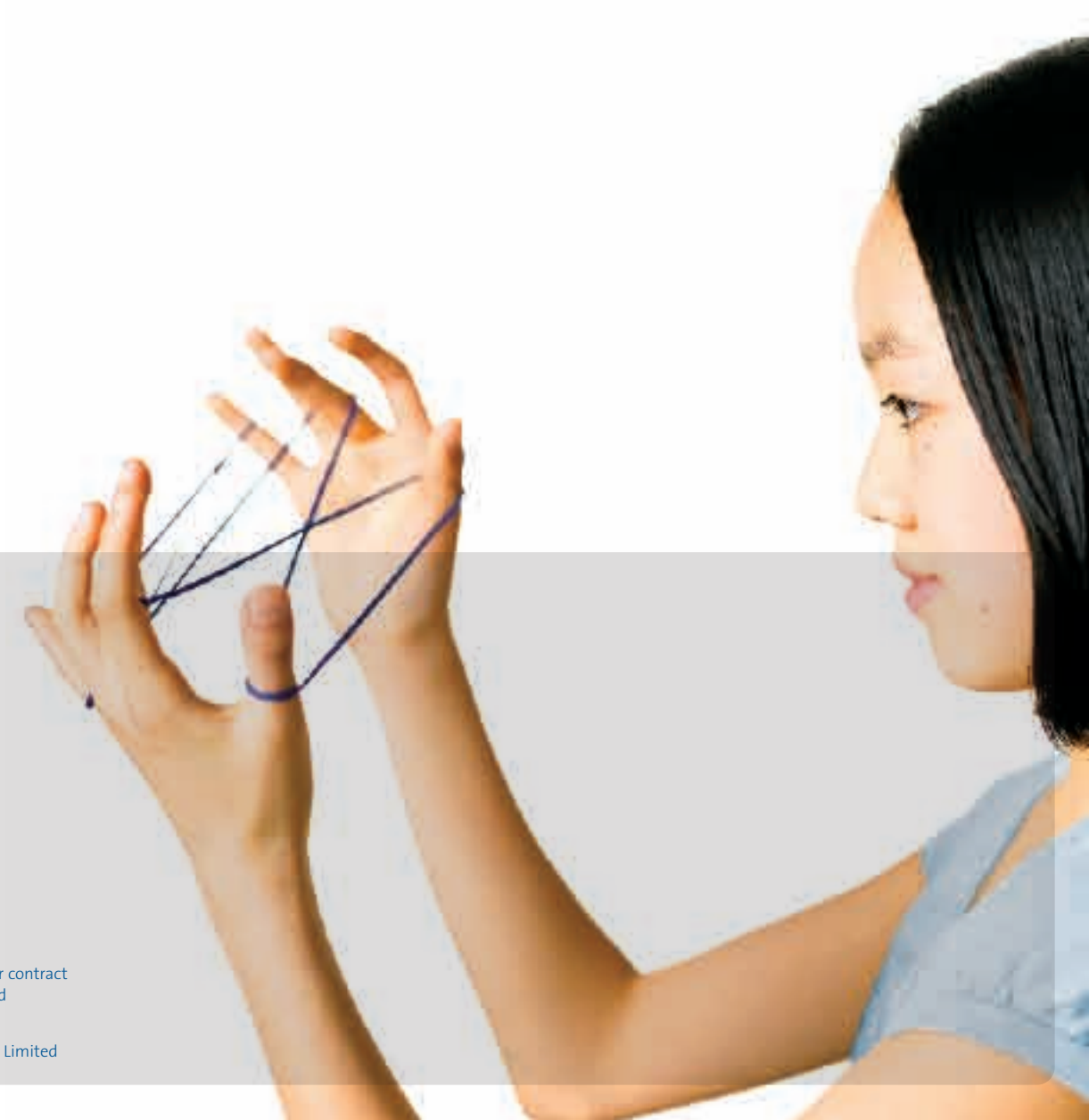
Flexible Lifetime® – **Protection**
A safety net for living

Plan Rules

INCOME PROTECTION



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

This document

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

This document is in two parts:

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

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

DEFINITIONS

Some words and phrases used in this document have special meanings.

These meanings are defined in rule 68 which starts on page 62.

Each time a defined word is used, it appears in type **like this**.

Also, we list the defined words used on each page in a box at the bottom left-hand corner of the page.

Introduction

PURPOSE

Income Protection helps maintain people's lifestyles.

Its purpose is to pay a monthly amount while the **insured person** is so ill or injured that they are unable to work.

We pay a reduced amount while they are **able to work** but – because of the illness or injury – earn less than they did before they became unable to work.

Please note, under most features we only start to pay after a certain period which we call the **waiting period**.

WHOM WE PAY

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

INSURED PERSON

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

TWO TYPES OF COVER TO CHOOSE FROM

You choose an **Agreed value or Indemnity plan**.

THREE LEVELS OF COVER TO CHOOSE FROM

You may choose from three levels of cover:

- *Advanced*, or
- *Standard*, or
- *Basic*.

The differences between these levels of cover were described in the Product Disclosure Statement you received when you applied for this plan. The actual cover you have is shown on the ***Certificate of Insurance***. That information is updated each year in your Annual Statement.

CHANGING THE PLAN

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

THE RULES

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

THESE WORDS AND PHRASES ARE DEFINED:

- **ABLE TO WORK**
- **AGREED VALUE**
- **CERTIFICATE OF INSURANCE**
- **INDEMNITY**
- **INSURED PERSON**
- **CERTIFICATE OF INSURANCE**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Table of contents

Reasons we pay

1.

REASONS WE PAY

The reasons we pay under an Income Protection plan are:

Reason we pay	Level of cover applicable	Rule number
The **insured person is totally disabled**	*Advanced*, *Standard*, and *Basic*	3
Partially disabled – when the **insured person** resumes work after a period of being totally disabled and earns less	*Advanced*, *Standard*, and *Basic*	9
Rehabilitation costs feature – reimbursing costs of rehabilitation equipment, program or works	*Advanced*, *Standard*, and *Basic*	14
Rehabilitation bonus feature – the **insured person** participates in an approved rehabilitation program	*Advanced*, *Standard*, and *Basic*	14.1
Day 1 accident option – if you select this option and the **insured person** suffers an **accident**	*Advanced*, *Standard*, and *Basic*	38.4
Chronic condition option – If you select this option, and the **insured person** has a **chronic condition** and they earn less	*Advanced*	16
Bedcare feature – the **insured person** is bedridden for more than 3 days	*Advanced*	21
Family support benefit – the **insured person** is **totally disabled** and requires full-time assistance	*Advanced*	22
Accommodation benefit – a family member accompanies the **insured person** who is eligible under the Bedcare feature and is disabled over 100km away from home	*Advanced*	24
Transport benefit – the **insured person** becomes **totally disabled** and requires transport	*Advanced*	34
Major fracture or loss feature – the **insured person** suffers a **major fracture or loss**	*Advanced*	25
Trauma feature – the **insured person** suffers a **trauma condition**	*Advanced*	31
Death feature – the **insured person** dies while we are paying	*Advanced* and *Standard*	37

2.

WE ONLY PAY FOR ONE REASON AT A TIME

For Income Protection *Advanced, Standard* and *Basic* plans, except for the Bedcare feature, *Rehabilitation costs feature*, *Rehabilitation bonus feature*, *Family support benefit*, *Accommodation benefit* and *Transport benefit*, we only pay for one reason at a time.

THESE WORDS AND PHRASES ARE DEFINED:

- **CHRONIC CONDITION**
- **INSURED PERSON**
- **MAJOR FRACTURE OR LOSS**
- **PARTIALLY DISABLED**
- **TOTALLY DISABLED**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 68.

If the insured person is totally disabled

3.
WHAT HAS TO HAPPEN FOR US TO PAY

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

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

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

4.
HOW OFTEN WE PAY

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

5.
WHEN WE START TO PAY

We start to pay after the **insured person** has been **totally disabled** for the **waiting period**.

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

Example

Stephen has an *Advanced* plan with a four week **waiting period**. He falls off a horse and is badly injured. He is **totally disabled** for 3 **months**. We pay him as shown below:

Accident on 1 March
1 March is the date Stephen becomes **totally disabled**. So that is when his **waiting period** starts.

Waiting period ends on 28 March
Stephen becomes entitled to be paid from 29 March. Because we pay monthly in arrears, we send the first cheque one **month** later.

29 April
We send the first cheque.

29 May
We send the second cheque.

I June
Stephen returns to work. We send a cheque for 3 days payment for 29, 30, and 31 May. Because Stephen is now **able to work** again, we stop paying.

THESE WORDS AND PHRASES ARE DEFINED:

- **ABLE TO WORK**
- **CERTIFICATE OF INSURANCE**
- **DOCTOR**
- **INSURED PERSON**
- **MONTH**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

5.1
INSURED PERSON IS ABLE TO WORK DURING THE WAITING PERIOD

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

Able to work for 5 days (or less) in a row

If the **insured person** is **able to work** for 5 days (or less) in a row before the **relapse**, the **waiting period** continues – that is, it does not start again. We only start to pay when the **insured person** has been **totally disabled** for the total number of days of the **waiting period**. That is so even if the **insured person** is **able to work** more than once during the waiting period and suffers more than one **relapse**. The **waiting period** only ends when the total number of days the **insured person** has been **totally disabled**, when added together, equal the **waiting period**.

Able to work for more than 5 days in a row

If the **insured person** is **able to work** for more than 5 days in a row during the **waiting period** before they suffer a **relapse**, the **waiting period** starts all over again. And we don't count any days the **insured person** was **totally disabled** before the **relapse**.

Example

Let's use the same example we used about Stephen who fell off the horse. But let's change it slightly and say that 2 weeks after the accident, he went back to work for 3 days.

Accident on 1 March
That is the date Stephen becomes **totally disabled**. So that is when his **waiting period** starts. Remember, he has a 4 week **waiting period**.

On 14 March
Stephen returns to work. But after 3 days he suffers a **relapse** and is **totally disabled**.

Waiting period ends on 31 March
Stephen's **waiting period** ends 4 weeks and 3 days after it started. So the **waiting period** ends on 31 March, when he has been **totally disabled** for a total of 4 weeks.

1 May
Because we pay monthly in arrears, we send the first cheque one **month** later.

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

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **INSURED PERSON**
- **MONTH**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

6.
WHEN WE STOP PAYING

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

- the **insured person** is **able to work**, or
- the **insured person** does any **remunerative work**. However we may keep paying a reduced amount if the **insured person's** illness or injury means that they earn less than they did before they became **totally disabled**. We explain this in rule 9, or
- all the periods we have paid because of one claim add up to the **benefit period**. The length of the **benefit period** is shown in the ***Certificate of Insurance***, or
- the plan ends, or
- the **insured person** dies.

7.

This rule has been removed.

8.
HOW MUCH WE PAY

This rule sets out how we calculate the amount we pay while the **insured person** is **totally disabled.** How much we pay depends on whether you have selected **Agreed value** or **Indemnity**. We call the amount we pay the **monthly benefit**.

Maximum monthly benefit is explained in rule 8.1.

Agreed value
If you selected this cover it is set out in the ***Certificate of Insurance*** we issued when the plan began. While the **insured person** is **totally disabled** we will pay the **maximum monthly benefit**.

However, if the **insured person** is **totally disabled** and receiving other payments (described in rule 8.2), then we will reduce what we pay so that we pay a **monthly benefit** that when added to these other payments is not more than 75% of the **insured person's pre-disability income** (determined in rule 8.3).

Note: *we won't pay more than the* ***maximum monthly benefit.***

Indemnity option
If you selected this cover it is set out in the ***Certificate of Insurance*** we issued when the plan began. While the **insured person** is **totally disabled** we will pay a **monthly benefit** based on 75% of their **income** in the 12 **months** immediately before they became **totally disabled**. We divide the **income** amount by 12 to get their monthly income.

If the **insured person** is **totally disabled** and receiving other payments (described in rule 8.2), then we will reduce what we pay so that we pay a **monthly benefit** that when added to these other payments is not more than 75% of the **insured person's pre-disability income** (determined in rule 8.3).

Note: *we won't pay more than the* ***maximum monthly benefit.***

Note:
- If you have selected the *Superannuation Contribution option*, we will calculate the amount under this option and include it in the **maximum monthly benefit**. The Superannuation Contribution option is described in rule 38.

We show examples following rule 8.3, of how the calculation works when the insured person is **totally disabled**. An example of how the calculation works for the Superannuation Contribution option amount is shown after rule 38.3.

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **AGREED VALUE**
- **BENEFIT PERIOD**
- **CERTIFICATE OF INSURANCE**
- **INCOME**
- **INDEMNITY OPTION**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **MONTHLY BENEFIT**
- **PRE-DISABILITY INCOME**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

8.1 AMOUNT OF MAXIMUM MONTHLY BENEFIT

The amount of the **maximum monthly benefit** which applies when the plan starts is shown in the ***Certificate of Insurance***. It may change after the plan starts in any of the following ways:

- it can increase each year by any increase in the **CPI**. Each year, we will set out the current amount in the *Annual Statement*, and
- it can change when you ask us to change it. If it has changed in this way, the new amount will be shown in the **Memorandum of Alteration** we sent you to record the change, and
- it will change if the plan is *Standard* with *Claim escalation option*, or *Basic* with *Claim escalation option*, and we have stopped paying a claim. When we stop paying, the **maximum monthly benefit** reduces to what it was when we started paying.

Please note, if you have selected an Income Protection plan with *Superannuation Contribution option* the **maximum monthly benefit** includes the amount that we will pay in respect of this option.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **CPI**
- **MAXIMUM MONTHLY BENEFIT**
- **MEMORANDUM OF ALTERATION**

THE DEFINITIONS ARE SET OUT IN RULE 68.

8.2 OTHER INCOME WE INCLUDE WHILE THE INSURED PERSON IS TOTALLY DISABLED OR HAS A CHRONIC CONDITION

When we work out whether to pay the **maximum monthly benefit** – or a reduced amount – we take account of the following amounts for the period the **insured person** is **totally disabled**:

- regular payments from any workers compensation, accident compensation or public liability scheme, payable because the **insured person** is ill or injured, and
- regular payments from any insurance plan payable because the **insured person** is ill or injured.

If any of these regular payments are paid other than monthly, we will convert them to monthly payments for our calculation. If the payment is from a lump sum then only that part of the payment that relates to compensation for loss of wages or earning capacity will be taken into consideration.

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

8.2.1 WE CAN RECALCULATE INCOME PROTECTION PAYMENTS

We can recalculate how much we pay, or have paid, if we did not include payments of the type listed in rule 8.2.

You must return any amount we have overpaid. We can choose either to reduce any amounts we pay in the future to cover those overpayments, or we can recover from you any amounts you owe us.

If we have underpaid, we will pay you the amount we owe.

THESE WORDS AND PHRASES ARE DEFINED:

- **INCOME**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

8.3 INCOME JUST BEFORE THE INSURED PERSON WAS TOTALLY DISABLED OR HAS A CHRONIC CONDITION

If you selected **Agreed value**:

If the **insured person** is **totally disabled** or has a **chronic condition**, when we calculate what we pay, we base it on their highest **income** in 12 consecutive **months** from 2 years before the plan started up until immediately before they became **totally disabled** or lodged a claim under the ***Chronic condition*** option. We divide that amount by 12 to get their monthly **income**.

If you selected **Indemnity**:

If the **insured person** is **totally disabled**, when we calculate what we pay, we base it on their **income** in the 12 months immediately before they become **totally disabled**. We divide the income amount by 12 to get their monthly **income**.

8.3.1 CPI INCREASES

Each year, we increase the monthly **income** referred to in rule 8 and 8.3, by the **CPI** if you have:

- Income Protection *Advanced*, or
- Income Protection *Standard* with *Claim escalation option*, or
- Income Protection *Basic* with *Claim escalation option*.

This is explained in rule 42.

When we calculate the **monthly benefit**, we will rely on the **insured person's income** tax returns, assessment notices, and any relevant books, of account. It is important that you take care in choosing the **maximum monthly benefit** when you apply for this insurance.

You should also make sure that if the **income** changes significantly, you change the **maximum monthly benefit**.

Your financial planner can help you with these choices.

THESE WORDS AND PHRASES ARE DEFINED:

- **AGREED VALUE**
- **CHRONIC CONDITION**
- **CPI**
- **INCOME**
- **INDEMNITY OPTION**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

EXAMPLES

The examples are designed to highlight the different ways we would calculate the **monthly benefit** payable depending on whether the owner selected **Agreed value** or **Indemnity** and the impact on the **monthly benefit** if income from other sources is received while the **insured person** is **totally disabled**.

Example 1 – Background facts

Phillip is a plumber. He has an Income Protection *Advanced* plan.

At the time Phillip commenced his plan on 1 January 2004 he was earning $80,000 per annum. The **maximum monthly benefit** when the plan commenced was $5,000 per month.

Since the plan started CPI increases have been applied and as at 1 January 2009 the **maximum monthly benefit** was $5,500.

Phillip has a car accident and is severely injured. On 1 January 2009 he is **totally disabled**.

Scenario One

Phillip earned $85,000 between 1 January 2008 and 1 January 2009. This is the highest amount of **income** he earned in any 12 **month** period from 1 January 2002 (2 years before his plan commenced) to immediately prior to becoming **totally disabled** on 1 January 2009. Phillip does not receive any other income while he is **totally disabled**.

How the monthly benefit is calculated if Phillip has chosen Agreed value

When we calculate what we pay, we base it on the **maximum monthly benefit**. So the amount we pay Phillip is $5,500 per **month**.

How the monthly benefit is calculated if Phillip has chosen Indemnity

When we calculate what we pay, we base it on his **income** in the 12 months immediately before he became **totally disabled**.

Phillip's income for the period 1 January 2008 and 1 January 2009 was $85,000 ($7,083.33 per **month**). 75% of this income is $5,312 per **month**.

We pay an amount up to the **maximum monthly benefit**. The **maximum monthly benefit** of $5,500 is more than 75% of his determined income ($5,312), so the amount we would pay Phillip is $5,312 per **month**.

Scenario Two

Let's consider the outcome if Phillip's income was only $50,000 ($4,166.67 per **month**) in the period 1 January 2008 to January 2009.

If Phillip had chosen **Agreed value** we would pay $5,500 as we base what we pay on the **maximum monthly benefit**.

If he had chosen **Indemnity** he would be paid $3,125 per **month** as we pay a **monthly benefit** based on 75% of his **income** in the 12 **months** immediately before he became **totally disabled**. 75% of $4,166.67 is $3,125.

THESE WORDS AND PHRASES ARE DEFINED:

- **AGREED VALUE**
- **INCOME**
- **INDEMNITY**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Example 2 – Background facts

Andrea is an accountant. She has a Income Protection *Standard* plan. She took out the plan on 1 January 2002 when her salary was $68,000 per annum. She is severely injured in a car accident on 1 January 2009 and is **totally disabled**. Her **maximum monthly benefit** is $5,000 per **month** on 1 January 2009 and she earned $75,000 per annum from 1 January 2008 to 1 January 2009.

From 1 January 2004 to 1 January 2005 she earned $120,000.

Andrea receives other payments while she is **totally disabled**. She receives $3,000 per **month** from a compensation scheme. Remember from rule 8.2 we take payments from compensation schemes into account when calculating how much we pay.

How the monthly benefit is calculated if Andrea has chosen Agreed value

To work out how much we pay Andrea, we need to ensure that her **maximum monthly benefit**, when added to the other payments she receives while she is **totally disabled** is not more than 75% of her income as determined by rule 8.3. Her highest **income** was in 2004, when she earned $120,000, or $10,000 per month.

The total of Andrea's **maximum monthly benefit** ($5,000) and other income (from the compensation scheme) while she is **totally disabled** ($3,000) is $8,000.

$8,000 is more than $7,500 (being 75% of her monthly income as determined by rule 8.3 which was $10,000). We reduce the amount we pay until the total amounts she receives is $7,500.

The result is, we pay Andrea $4,500 each **month**. We pay her that amount because the $3,000 compensation plus $4,500 from us equals $7,500.

How the monthly benefit is calculated if Andrea has chosen Indemnity

To work out how much we pay Andrea, we base it on her **income** in the 12 months immediately before she became **totally disabled**. Her **monthly benefit**, when added to the other payments she receives while she is **totally disabled**, can't be more than 75% of her income as determined by rule 8.3.

Her income in the 12 months before she ceased work was $75,000, ($6,250 per month). 75% of this income is $4,687 per **month**.

We need to reduce the amount we pay her so that the total she receives is not more than $4,687 each **month**.

The result is we pay Andrea $1,687 each month. We pay her that because the $3,000 compensation plus the $1,687 she receives from us equals $4,687.

THESE WORDS AND PHRASES ARE DEFINED:

- **AGREED VALUE**
- **INCOME**
- **INDEMNITY**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

8.4 INCOME BEFORE PLAN STARTS OR CHANGES

When we determine the **insured person's income** before the plan starts (or when we last changed the **maximum monthly benefit** because you asked us to), we use the **income** in the last 12 months before the plan started, or before the **maximum monthly benefit** was increased.

We divide that amount by 12 to get their monthly **income**.

We may seek confirmation of the **insured person's income** at any time.

We don't take account of investment **income**.

THESE WORDS AND PHRASES ARE DEFINED:

- **INCOME**
- **INSURED PERSON**
- **MONTHLY BENEFIT**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Partial disability – when the insured person earns less

This feature helps when the **insured person** is getting better and starting to work again after they were **totally disabled**. For example, they might be working to reduced hours, or only doing some of their work.

9. PARTIAL DISABILITY

We pay if the **insured person** does any **remunerative work** but earns less than they did before they became **totally disabled**. We only pay if:

- the illness or injury which made them **totally disabled** causes them to earn less, and
- they were **totally disabled** for *at least* the first 7 days of the **waiting period**, and
- they have the approval of their **doctor** to work and we agree, and
- they remain under the ongoing care of their **doctor** for that illness or injury.

10. WHEN WE START TO PAY

If we were already paying, because the **insured person** was **totally disabled**, we keep paying on the same dates. (The **waiting period** does not apply again.)

If we are not already paying, we start to pay when the **waiting period** ends. Because we pay once a **month** in arrears, we make the first payment one **month** after the **waiting period** ends.

10.1 ABLE TO WORK DURING THE FIRST 7 DAYS

If we are not already paying and the **insured person** is **able to work** during the first 7 days of the **waiting period**, rule 5.1 applies. This applies no matter how long the **insured person's waiting period** is.

However, there is an exception to the way we apply rule 5.1:

- if the **insured person** is **able to work** during the **waiting period**, and
- the **waiting period** does not restart (see rule 5.1), then we don't count those days when they were **able to work** when we add up the 7 days.

This exception to rule 5.1 applies even if the **insured person** suffers more than one **relapse**.

THESE WORDS AND PHRASES ARE DEFINED:

- **ABLE TO WORK**
- **DOCTOR**
- **INSURED PERSON**
- **MONTH**
- **PARTIAL DISABILITY**
- **REMUNERATIVE WORK**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

10.2

This rule has been removed.

11.
HOW OFTEN WE PAY

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

12.
WHEN WE STOP PAYING

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

- the **insured person** becomes **totally disabled** again. (We start paying again under rule 3 and the **waiting period** does not apply again), or
- the illness or injury which made the **insured person totally disabled** no longer causes them to earn less, or
- the **insured person** no longer has the approval of their **doctor** to work. (If this means they are **totally disabled** we may keep paying under rule 3, and the **waiting period** does not apply again), or
- medical assessments indicate that they are **able to work**, or
- they are no longer under the ongoing care of their **doctor** for that illness or injury, or
- all the periods for which we have paid because of the one claim add up to the **benefit period**, or
- if the level of cover is *Standard* or *Basic*, all the periods for which we have paid because of the one claim under Partial disability is 2 years – even if the **benefit period** is longer than two years, or
- the plan ends, or
- the **insured person** turns 65, or
- the **insured person** dies.

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **BENEFIT PERIOD**
- **DOCTOR**
- **INCOME**
- **INSURED PERSON**
- **MONTH**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

13. HOW MUCH WE PAY

The way we work out how much we pay when the **insured person** returns to work is set out below.

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

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

Where

How we calculate this amount is set out in rule 13.2 and 8.3

A = the monthly **income** the **insured person** earned before they became **totally disabled (pre-disability income)**

How we calculate the insured income person's income when they earn less is explained in rule 13.1

B = the current monthly amount the **insured person** earned from working (where they are earning less)

C = the **monthly benefit** we pay

Remember, from rule 8, and rule 8.3.

If you selected **Agreed value**:

- If the **insured person** is **totally disabled** when we calculate what we pay, we base it on their highest income in 12 consecutive months from 2 years before the plan started up until immediately before they became **totally disabled**. We divide that amount by 12 to get their monthly **income**.

If you selected **Indemnity**:

- If the **insured person** is **totally disabled**, when we calculate what we pay, we base it on their income in the 12 months immediately before they become **totally disabled**. We divide the income amount by 12 to get their monthly **income**.

13.1 INCOME WHILE INSURED PERSON IS EARNING LESS

When we work out the **insured person's income** while they are doing any **remunerative work** but earning less than they did before they became **totally disabled**, we use their before tax **income** after deducting the tax deductible expenses of earning that **income**.

We only include **income** they earn because of their own efforts. We don't take account of investment **income**.

THESE WORDS AND PHRASES ARE DEFINED:

- **AGREED VALUE**
- **INCOME**
- **INSURED PERSON**
- **INDEMNITY**
- **MONTHLY BENEFIT**
- **PARTIAL DISABILITY**
- **PRE-DISABILITY INCOME**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

13.2
INCOME BEFORE THE INSURED PERSON WAS TOTALLY DISABLED

If the **insured person** is **partially disabled** and receiving any other payments as described in rule 8.2, then we will reduce what we pay so that we pay a **monthly benefit** that is not more than 100% of the **insured person's pre-disability income** (determined in rule 8.3).

Example

Albert has a *Standard* plan.

Albert is **totally disabled** for the **waiting period**. He then returns to work but is only able to earn less than he was earning before he became **totally disabled**. Albert's income as determined in Rule 8.3 is $10,000 a **month**.

He is now only earning $3,000 a **month**. Albert's **maximum monthly benefit** is $5,000.

He is not receiving any income from any source other than working.

We calculate what we pay as:

$$\frac{(10{,}000 - 3{,}000)}{10{,}000} \times 5{,}000 = \$3{,}500$$

Albert receives $3,000 because he works and $3,500 from us. That is a total of $6,500 a month. This is $1,500 more than we would pay if Albert did not work.

THESE WORDS AND PHRASES ARE DEFINED:
- **INCOME**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **MONTHLY BENEFIT**
- **PARTIALLY DISABILED**
- **PRE-DISABILITY INCOME**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Rehabilitation costs feature

14.
WHAT HAS TO HAPPEN FOR US TO PAY

We will reimburse the costs of any equipment, program or works which we agree the **insured person** needs for rehabilitation for up to 12 times the **maximum monthly benefit**.

We do this while the **insured person** is **totally disabled**, both during the **waiting period** and while we are paying under this plan.

For us to reimburse any costs:

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

14.1
REHABILITATION BONUS

We will pay an additional one-third of the **maximum monthly benefit** for up to 12 **months** while you participate in a rehabilitation program approved by AMP.

Before you commence the program, we must have approved it in writing.

We do this while the **insured person** is **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 the **insured person** returns to continuous full time work.

14.2
WHEN WE WON'T PAY

We won't pay if we disagree with the **doctor**.

We won't pay any part of the costs which you or the **insured person** can recover from anywhere else.

And we won't pay any costs after the **insured person** turns 65.

THESE WORDS AND PHRASES ARE DEFINED:

- **DOCTOR**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

More than one claim

15. YOU CAN MAKE MORE THAN ONE CLAIM

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

Rules 15.1 and 15.2 explain what happens if the **insured person** suffers a **relapse** after we stop paying.

Please remember that we will only pay for one reason at a time. This is explained in rule 2.

15.1 RELAPSE – BENEFIT PERIODS TO AGE 60 OR 65

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

If the **insured person** suffers the **relapse** within 12 **months** after we stopped paying, we treat the claim as a continuation of the previous claim. The **waiting period** does not start again. 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 to *Standard* and *Basic* plans. The limit is set out in rule 12.

15.2 RELAPSE – BENEFIT PERIODS ONE, TWO OR FIVE YEARS

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

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

The rest of rule 15.2 applies if:

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

If the **insured person** suffers the **relapse** at least 6 **months** after we stopped paying, then we treat it as a new claim and both the **waiting period** and **benefit period** start again.

THESE WORDS AND PHRASES ARE DEFINED:

- **BENEFIT PERIOD**
- **INSURED PERSON**
- **MONTH**
- **PARTIAL DISABILITY**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

If the **insured person** suffers the **relapse** within 6 **months** after we stopped paying, we treat the claim as the continuation of the previous claim. The **waiting period** and the **benefit period** do not start again. Instead, we add up all the periods we pay you for that claim and treat them as one **benefit period**. And 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 to *Standard* and *Basic* plans. The limit is set out in rule 12.

Example

Michael has a *Standard* plan with an 8 week **waiting period** and a 5 year **benefit period**. He develops multiple sclerosis (known as MS) and over a 7 year period is on and off work a couple of times because of the MS. The following table shows when his **benefit period** starts and ends.

10 March 2005
Michael develops MS and is **totally disabled**.

5 May 2005
Michael's **waiting period** ends. We send him the first cheque one **month** later.

5 May 2007
Michael's MS eases and he returns to work. So we stop paying him. We have paid for 2 years.

20 September 2007
The MS gets worse again, Michael suffers a relapse and is again **totally disabled**. Because it is less than 6 months since we stopped paying, we start to pay him again and he doesn't have to wait the **waiting period**.

20 September 2010
We have paid Michael for another 3 years. The 2 periods we have paid him for because of his MS add up to his benefit period – 5 years. So we stop paying – even if he is still unable to work.

THESE WORDS AND PHRASES ARE DEFINED:
- **BENEFIT PERIOD**
- **MONTH**
- **PARTIAL DISABILITY**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Chronic condition option

16.
WHAT HAS TO HAPPEN FOR US TO PAY

This is an option available for Income Protection Advanced plans only. The ***Certificate of Insurance*** shows if it applies to your plan.

We pay you if the **insured person** has a **chronic condition**. The insured person has a **chronic condition**, if, as a result of a physical illness or injury, their ability to do their usual occupation has been, and continues to be, significantly reduced. This must be evidenced by:

- clinically significant test results showing their illness or injury is expected to be constantly present for life and there is no known cure, and
- their weekly hours of work being reduced on **doctor's** advice to less than 75% of the average normal weekly hours they worked in the 3 years before you lodged your claim, and this reduction continues for at least 3 consecutive **months** and subsequently while we are paying you, and
- their weekly **income** being reduced to less than 75% of their **income** as explained in rule 8.3, for the same period. We calculate their **income** in this instance, on a weekly basis.

16.1
WHAT CONDITIONS ARE NOT COVERED

Please note that conditions which are acute (that is, they are of short or relatively short duration with generally rapid onset and which are not chronic), are excluded. Because this option only covers conditions which result from physical illness or injury, we do not cover conditions that are psychosomatic or psychiatric in nature.

17.
HOW OFTEN WE PAY

We pay you once each **month** in arrears. This means we make the first payment one **month** after the date we start to pay in rule 18.

THESE WORDS AND PHRASES ARE DEFINED:
- **CHRONIC CONDITION**
- **DOCTOR**
- **INCOME**
- **INSURED PERSON**
- **MONTH**

THE DEFINITIONS ARE SET OUT IN RULE 68.

18.
WHEN WE START TO PAY

We start to pay from the later of:

- the date the **insured person** first meets the requirements of rule 16, and
- the date you lodge your claim.

We encourage you to lodge your claim once the **insured person's** hours of work and **income** start to reduce because of their **chronic condition**.

18.1
A DIFFERENT WAITING PERIOD APPLIES

The **waiting period** does not apply to this option but please note the 3 **month** requirement in rule 16.

19.
WHEN WE STOP PAYING

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

- the **insured person** becomes **totally disabled**. If this happens, we start paying immediately in terms of rule 3 and the **waiting period** does not apply, or
- the **insured person** recovers to the degree that their chronic illness or injury no longer meets the requirements of rule 16. (However, if the **insured person** has a **relapse** within 12 **months**, and they meet the requirements of rule 16, then we treat the claim as a continuation of the previous claim), or
- we ask for information to help us substantiate that we should continue to pay your claim, and you don't provide us with the information to our satisfaction, or
- the plan ends, or
- the **insured person** dies.

19.1
MORE THAN ONE CLAIM

If we have already paid you under this feature and the **insured person**:

- suffers a different **chronic condition**, or
- suffers the same **chronic condition** 12 **months** or more after we stopped paying, then we will pay again. But we treat it as a new claim and start to pay again in accordance with rule 18.

THESE WORDS AND PHRASES ARE DEFINED:
- **CHRONIC CONDITION**
- **INCOME**
- **INSURED PERSON**
- **MONTH**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

20.
HOW MUCH WE PAY

While the **insured person** has a **chronic condition**, the **monthly benefit** we pay, when added to **income** you or the **insured person** earns, equals the benefit we would pay if the **insured person** was **totally disabled** – see rule 8.

Under this option, when we calculate the benefit we would pay if the **insured person** was **totally disabled**, we use the highest **income** before you lodged a claim under the *Chronic condition option* – see rule 8.3.

We can take into account the **income** we consider they could earn if they were working to the capacity we think they could work at in their *usual occupation*.

Example

Sonya is a dentist. Her plan has the *Chronic condition* option included in it. On 1 February, she is diagnosed with arthritis in her hands. The arthritis condition is initially mild. Subsequently, the hours Sonya can work and her **income** are reduced, but not sufficiently so that she meets our **chronic condition** definition. But she still lodges her claim with us.

On 1 October, we receive information that her hours have reduced by 30% for the previous 3 consecutive months on **doctor's** advice, and her **income** has also reduced by 30% for the same months. This reduction in hours and **income** continues.

We agree with that information, and so we start paying her one **month** later on 1 November. Sonya, her doctor, and her accountant supply us with the following information:

- Her highest **income** before lodging her claim with us was $100,000 pa, and her **maximum monthly benefit** if she were **totally disabled** is $75,000 pa.
- Her **income** (and hours) now, because she has the **chronic condition**, have reduced by 30% to $70,000 pa, and we agree with this assessment of her reduced capacity.
- We top her earnings up so that the total she receives is equal to the amount we would pay if she was **totally disabled** (ie $75,000 pa).
- The amount we pay is $5,000 pa (ie $75,000 less $70,000 she is still earning).

We start paying $417 each **month** (ie $417 x 12 = $5,000).

THESE WORDS AND PHRASES ARE DEFINED:
- **CHRONIC CONDITION**
- **DOCTOR**
- **INCOME**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

We keep paying this until we ask for more information, or Sonya provides us with more information, and we are satisfied with that information, or the information results in us changing what we pay. We continue to pay her in the following **months** because her hours and **income** continue to be reduced.

On 1 January the following year, Sonya provides us with more information that her **income** is now reduced by 50% of the original $100,000, because her arthritis has worsened.

We agree with her information and so, we recalculate the **monthly** amount we are paying her as follows:

- Her **income** (and hours) now, because she has the **chronic condition**, have reduced by 50% to $50,000 pa and we agree with this assessment of her reduced capacity.
- We top her earnings up so that the total she receives is equal to the amount we would pay if she was **totally disabled** (ie $75,000 pa).
- The amount we pay is $25,000 pa (ie $75,000 less $50,000 she is still earning).

We start paying $2,083 each **month** (ie $2,083 x 12 = $25,000).

We keep paying this until we ask for more information, or Sonya provides us with more information, and we are satisfied with that information, or the information results in us changing what we pay.

After this, we read just the **monthly benefit** we pay Sonya periodically as her hours and **income** further reduce.

Some 3 years later, Sonya advises us she has had to stop work completely because of her condition. We stop paying her under the ***Chronic condition*** *option*, and start paying her under rules 3-8, because she is **totally disabled**.

Please note:

1. This example assumes that Sonya is not receiving income from other sources as described rule 8.2. If she was, that would reduce the **monthly benefit** we would pay.
2. Our example does not demonstrate how the **monthly benefit** we pay would alter each year because of **CPI** increases.

THESE WORDS AND PHRASES ARE DEFINED:
- **CHRONIC CONDITION**
- **CPI**
- **INCOME**
- **MONTH**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Bedcare feature

The bedcare feature applies to Income Protection Advanced plans only.

21.
WHAT HAS TO HAPPEN FOR US TO PAY

We pay if the **insured person** is bedridden for more than 3 days in a row during the **waiting period**. The **insured person** is bedridden if they are:

- **totally disabled**, and
- their **doctor** requires them to be – and they are – under the full-time care of a registered nurse. The nurse cannot be the **insured person**, you, or a member of the immediate family of either you or the **insured person**.

21.1
HOW MUCH WE PAY

For each day the **insured person** is bedridden, we pay one-thirtieth of the **monthly benefit** that we would pay if the **insured person** was **totally disabled**. We pay for each day they were bedridden until any one of the following happens:

- the **insured person** is no longer bedridden, or
- we have paid under the *Bedcare feature* for 180 days, or
- the **waiting period** ends, or
- the plan ends, or
- the **insured person** turns 65, or
- the **insured person** dies.

21.2
WHEN WE PAY

We pay as soon as you meet the conditions in rule 21.

21.3
BEDRIDDEN MORE THAN ONCE

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

THESE WORDS AND PHRASES ARE DEFINED:
- **DOCTOR**
- **INSURED PERSON**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Family support benefit

The Family support benefit applies to Income Protection Advanced plans only.

22.
WHAT HAS TO HAPPEN FOR US TO PAY

We will pay an additional amount while the **insured person** is **totally disabled** if:

- we have been paying the **insured person monthly** benefits for more than one **month**, and
- the **insured person** requires the full-time assistance of either:
  - a registered nurse (not being the **insured person**, you or a member of the immediate family of either you or the **insured person**), or
  - an immediate family member of the i**nsured person** who was in full-time paid employment when the **insured person** became **totally disabled** but who stops all paid employment to look after the **insured person**.

22.1
HOW OFTEN WE PAY

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

22.2
HOW MUCH WE PAY

We will pay the lesser of $150 per day or one-thirtieth of the **maximum monthly benefit** for a maximum period of 6 **months** on any one claim.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Accommodation benefit

The Accommodation benefit applies to Income Protection Advanced plans only.

23.
WHAT HAS TO HAPPEN FOR US TO PAY

We will reimburse the reasonable accommodation expenses, once receipts are provided, of an immediate family member who accompanies the **insured person** if:

- the **insured person** is eligible for a benefit under the *Bedcare feature*, and
- the **insured person** became **totally disabled**, and remains, over 100km away from home.

23.1
HOW OFTEN WE PAY

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

23.2
HOW MUCH WE PAY

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

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

THE DEFINITIONS ARE SET OUT IN RULE 68.

Transport Benefit

24.1
OVERSEAS TRANSPORT

The Transport benefit applies to Income Protection plans only.

WHAT HAS TO HAPPEN FOR US TO PAY

If the **insured person** has been outside Australia for more than 30 days, and they have been **totally disabled** for at least 14 days while they were overseas, then we will assist you with their return travel expenses.

HOW MUCH WE PAY

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

24.2
DOMESTIC TRANSPORT BENEFIT

This is an inbuilt feature of *Advanced* only.

WHAT HAS TO HAPPEN FOR US TO PAY

If the **insured person** is in Australia but more than 100km from their usual residence when they become **totally disabled** and require emergency transportation within Australia, the domestic transport benefit may be payable.

HOW MUCH WE PAY

We will reimburse costs directly arising from their transportation other than:

- ambulance services within the meaning of Section 67(4) of the *National Health Act* 1953 (Cth), 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**.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Major fracture or loss feature

The Major fracture or loss feature applies to Income Protection Advanced plans only.

25.
WHAT HAS TO HAPPEN FOR US TO PAY

We pay each time the **insured person** suffers one of the **major fractures or losses** in the tables on the next page.

26.
WHEN WE START TO PAY

We start to pay under this feature from the date the **insured person** suffers the specified fracture or loss. Because we pay in arrears, we make the first payment one **month** later.

27.
HOW OFTEN WE PAY

We pay you once each **month** in arrears. We pay for the length of the payment period. We continue to pay even if the **insured person** returns to work.

28.
HOW MUCH WE PAY

We pay the same amount that we would pay if the **insured person** was **totally disabled**.

The way this is calculated is set out in rule 8. However, we do not take account of any income they receive because they do **remunerative work**.

29.
WHEN WE STOP PAYING

We stop paying under the *Major fracture or loss feature* when any one of the following happens:

- we have paid for the payment period shown in the tables on the next page for the relevant **major fracture or loss**. However, if the **insured person** is **totally disabled**, or **partially disabled**, we may keep paying under rule 3 or 9 provided the **insured person** has met the **waiting period** from the date the **insured person** first became **totally disabled** (as determined in rule 5 and 5.1), or
- all the periods we have paid because of one claim add up to the **benefit period**, or
- the plan ends, or
- the **insured person** turns 65, or
- the **insured person** dies.

THESE WORDS AND PHRASES ARE DEFINED:
- **BENEFIT PERIOD**
- **INSURED PERSON**
- **MAJOR FRACTURE OR LOSS**
- **MONTH**
- **PARTIALLY DISABLED**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

30.

MORE THAN ONE FRACTURE OR LOSS

We pay each time the **insured person** suffers one of the major **fractures or losses**.

If they suffer more than one in the same incident, we pay for the one with the longest payment period.

Fractures covered

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

We cover fracture of:	**Payment period (months)**
The spine causing paraplegia or quadriplegia	60*
A thigh	3
A pelvis	3
A leg between the knee and foot	2
A kneecap	2
An upper arm	2
A shoulder blade	2
The ankle	2
A hand (requiring a plaster cast or surgery)	1
A forearm above the wrist	1
A collar bone	1
The wrist	1

Losses covered

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

* Please note if the **benefit period** is shorter than the payment period, we only pay for the **benefit period**.

\# A foot means the whole foot below the ankle and a hand means the whole hand below the wrist.

THESE WORDS AND PHRASES ARE DEFINED:

- **BENEFIT PERIOD**
- **INSURED PERSON**
- **MAJOR FRACTURE OR LOSS**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Trauma feature

The Trauma feature applies to Income Protection Advanced plans only.

31.
WHAT HAS TO HAPPEN FOR US TO PAY

We pay if the **insured person** suffers any 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.

We pay for 6 **months** under this feature. We pay once for each **trauma condition**. You can make more than one claim under the *Trauma feature* as long as each claim is for a different **trauma condition**.

We have detailed descriptions of each **trauma condition**. We only pay if the **insured person** meets our description in rule 67.

We pay under the *Trauma feature*, even if the **insured person** is **able to work** .

32.
WHEN WE START TO PAY

We start to pay from the date the **insured person** meets the definition for the specified **trauma condition**. Because we pay in arrears, we make the first payment one **month** later.

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **INSURED PERSON**
- **MONTH**
- **TRAUMA CONDITION**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

33.
WHEN COVER STARTS

For us to pay for a **trauma condition**, the **insured person** must suffer the **trauma condition** more than 3 **months** after the plan starts or restarts. The date cover for the *Trauma feature* starts is shown in the ***Certificate of Insurance***, unless we have restarted the plan.

If we have restarted it because you asked us to, the date the plan and *Trauma feature* restarts is shown in the document we sent you when we restart it.

Also, if we have increased the amount of the **maximum monthly benefit** because you asked us to, and within 3 **months** after the increase, the insured person suffers one of the **trauma conditions**, we use the amount of the **maximum monthly benefit** that applied before the increase when we calculate how much to pay. The 3 **month** period starts on the date from which the increase applies.

33.1
TRAUMA CONDITIONS SUFFERED IN 3 MONTH PERIOD

If the **insured person** suffers a **trauma condition** within **3 months** after cover for the *Trauma feature* starts or restarts, we won't ever pay for that condition (under the *Trauma feature*) – even if the **insured person** suffers it again later.

Please note, we may pay under rule 3 or 9 if the **trauma condition** causes the **insured person** to be **totally disabled**, or to earn less.

34.
HOW OFTEN WE PAY

We pay you once each **month** in arrears for 6 months.

35.
HOW MUCH WE PAY

Each **month**, we pay the same amount that we would pay if the **insured person** was **totally disabled**. However, we do not take account of any **income** they receive from **remunerative work** or any **income** described in Rule 8.2.

36.
WHEN WE STOP PAYING

We stop paying when any one of the following happens:

- we have paid for 6 **months**. However, if the **insured person** is **totally disabled**, or resumes work and earns less, we may keep paying under rule 3 or 9, or
- the plan ends, or
- the **insured person** turns 65, or
- the **insured person** dies.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **INCOME**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **REMUNERATIVE WORK**
- **TRAUMA CONDITION**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Death feature

The Death feature applies to Income Protection *Advanced and Standard* plans only.

37.
INSURED PERSON DIES

If the **insured person** dies while we are paying, we pay 6 extra payments. The amount of each extra payment is the amount we would have paid each **month** if the **insured person** was **totally disabled**.

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

Please note, we don't make those payments if the **insured person** dies during the **waiting period**.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MONTH**
- **WAITING PERIOD**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Superannuation Contribution option

38.
WHAT HAS TO HAPPEN FOR US TO PAY

If you have selected the *Superannuation Contribution option*, and we are paying because the **insured person** has a **chronic condition**, or is **totally disabled**, or is entitled under ***Partial disability***, we will pay an additional 12% of the amount which is not more than 75% of:

- their income as explained in rule 8.3, less
- any amounts as explained in rule 8.2.

This additional amount must then be directed towards the **insured person's** superannuation arrangements. Please note, that the **maximum monthly benefit** in the ***Certificate of Insurance*** already includes this 12% amount.

Before we are able to pay under this option, we need information that the **insured person**:

- is a member of a complying superannuation fund in terms of the *Superannuation Industry (Supervision) Act* 1993 (Cth) (the SIS Act), or any Act amending or replacing it, and is able to contribute to a complying superannuation fund according to the SIS regulations, or
- is an account holder of a Retirement Savings Account in terms of the Retirement Savings Account Act (the RSA Act), and is able to contribute to that account according to relevant legislation.

38.1
WHO WE PAY

You can choose to have the *Superannuation Contribution option* amount paid either:

- to you directly, or
- at your direction, to the complying superannuation fund or RSA you nominate, for the benefit of the **insured person**.

The amount paid under either direction is assessable income and needs to be included in the **insured person's** tax return in the financial year it is received.

The income tax payable on the amount paid will need to be paid from another source as the amount paid to the complying superannuation fund or RSA cannot be used to pay tax because it is required to be preserved in accordance with legislation.

THESE WORDS AND PHRASES ARE DEFINED:
- **CERTIFICATE OF INSURANCE**
- **CHRONIC CONDITION**
- **INCOME**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **PARTIAL DISABILITY**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

38.2
THE PROOF WE NEED

If we are paying you directly under this option, you need to provide us with proof that the amount we have paid, less tax payable, has been paid into a complying superannuation fund or RSA for the benefit of the **insured person**. If you do not provide the proof we need, we can stop paying under this option until you provide us with the proof we request.

38.3
WHEN WE STOP PAYING

We stop paying the *Superannuation Contributions* option when:

- we stop paying the **monthly benefit** because the **insured person** no longer has a **chronic condition**, is **able to work**, or we cease paying under ***Partial disability***, or
- you don't provide us with the proof we need – see rule 38.2, or
- the plan ends as described in rule 44.

We will also stop paying the *Superannuation Contribution option* if SIS or any other laws change so that we can either, no longer pay the amount under the option to you directly, or pay the amount to a complying superannuation fund or RSA on your behalf.

Example

Craig has as an Advanced plan and has selected the *Superannuation Contribution option.*

Craig runs an advertising firm. He has a skiing accident and is **totally disabled**. Before he became **totally disabled** Craig was earning $10,000 a **month**.

Because Craig has chosen the *Superannuation Contribution option* his **maximum monthly benefit** is made up of 2 parts:

Part 1 – a **monthly** amount we pay to Craig.

Part 2 – an additional amount payable into a superannuation plan.

For Part 1, let's say the amount we are paying Craig because he is **totally disabled** is $7,500 as determined by rule 8.

For Part 2, the additional amount payable into a superannuation plan is 12% of the **monthly** amount which we pay directly to Craig, ie 12% of the amount worked out in Part 1.

Therefore the additional amount payable into a superannuation plan is:
12% x $7,500 = $900

Craig's **maximum monthly benefit** is: $8,400, ie $7,500 + $900 = $8,400.

Of the **maximum monthly benefit**, $7,500 is paid directly to Craig, and the other $900 is paid and administered as per rule 38.1 and 38.2.

THESE WORDS AND PHRASES ARE DEFINED:
- **ABLE TO WORK**
- **CHRONIC CONDITION**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTHLY BENEFIT**
- **MONTH**
- **PARTIAL DISABILITY**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Day 1 accident option

The Day 1 accident option applies to Income Protection Advanced and Standard plans only. The ***Certificate of Insurance*** shows if it applies to your plan.

38.4
WHAT HAS TO HAPPEN FOR US TO PAY

If you have selected this option, a benefit is only payable 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.

38.5
WHEN WE PAY

This benefit is payable:

- until you are no longer **totally disabled**
- until the end of the **waiting period**, or
- for 30 days,

whichever occurs first.

We pay each **month** in arrears.

38.6
HOW MUCH WE PAY

We pay one-thirtieth of the **monthly benefit** for each day that you are **totally disabled** as a result of an accident.

38.7
WHEN WE WON'T PAY

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

When we won't pay

39.
WAR

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

40.
ON PURPOSE

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

40.1
PREGNANCY

We won't pay for normal and uncomplicated pregnancy or childbirth. However, we will pay if the **insured person** is unable to work because they suffer complications during pregnancy or while giving birth.

THESE WORDS AND PHRASES ARE DEFINED:
- **ACCIDENT**
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **MONTH**
- **MONTHLY BENEFIT**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Increasing maximum monthly benefit by the CPI

This rule only applies while we are not paying you. To find out about **CPI** increases while we are paying you, read rule 42.

41.
WHILE WE AREN'T PAYING

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

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

41.1
CPI INCREASES STOP AT A CERTAIN AGE

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

You can decline CPI increases

We make the **CPI** increase automatically. However, you can ask us:

- to increase the **maximum monthly benefit** by only some of the increase in the CPI, or
- not to increase the **maximum monthly benefit** at all, or
- not to increase the **maximum monthly benefit** ever again.

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

You can subsequently ask us to start making **CPI** increases again. At that time we will consider your request.

THESE WORDS AND PHRASES ARE DEFINED:

- **CPI**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **PLAN ANNIVERSARY**

THE DEFINITIONS ARE SET OUT IN RULE 68.

42. WHILE WE ARE PAYING A MONTHLY BENEFIT

Income Protection Advanced plans include this feature automatically. This benefit is optional with *Income Protection Standard* or *Basic*. It is called the *Claim escalation option*. The ***Certificate of Insurance*** shows whether you added this to the plan.

While we are paying, we automatically increase the **maximum monthly benefit** by any increase in the **CPI**. We do this in the following way:

- we increase the **maximum monthly benefit** by the increase in the **CPI**, and
- we increase the **income** as described in rule 8.3, by the increase in the **CPI**, and
- we recalculate the amount we pay as described in rule 8.

42.1 WHEN WE INCREASE THE MONTHLY BENEFIT

For *Income Protection Advanced* plans, we increase the amount we pay on each plan anniversary.

For *Income Protection Standard* or *Basic* plans which have the "*Claim escalation option*", when we increase the amount we pay while we are paying, we do this 12 **months** after the end of the **waiting period** and every 12 **months** after that. If the **insured person** suffers a **relapse**, we add up all the periods we have paid when calculating the 12 **month** period.

42.2

This rule has been removed

42.3 AFTER WE STOP PAYING

If you have the *Claim escalation option* under *Income Protection Standard* or *Basic* and we stop paying a claim, the **maximum monthly benefit** is reduced to what it was when the **insured person** became **totally disabled**. (When we stop paying under *Advanced*, the **maximum monthly benefit** is not reduced.

After that, for *Income Protection Advanced*, *Standard*, and *Basic*, we will again increase the **maximum monthly benefit** in the same way that we were before the **insured person** became **totally disabled**. However, if **CPI** increases had stopped before the **insured person** became **totally disabled**, they don't start again after we stop paying.

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **CPI**
- **INCOME**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **MONTH**
- **RELAPSE**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

When the plan and cover start and end

43.
WHEN THE PLAN AND COVER START

The plan and cover starts on the date shown in the ***Certificate of Insurance***.

However, the cover for the *Trauma feature* under Income Protection *Advanced* is delayed until 3 **months** after the plan starts.

44.
WHEN THE PLAN AND COVER END

The **insured person's** cover ends when the plan ends.

The plan ends as soon as any one of the following happens:

- on the plan expiry date shown in the ***Certificate of Insurance***, or
- you end it, or
- we end it under rule 44.1, or
- the **insured person** dies.

44.1
WHEN WE CAN END THE PLAN

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

- you don't pay the premium on time. However, if you don't pay on time, you have an extra 30 days to pay before we take steps to end the plan. If you haven't paid on time, we will write and remind you, or
- the **insured person** leaves **remunerative work** and intends never to return to any **remunerative work**, or
- the plan has the *Income Protection Basic* level of cover and we end it under rule 49.1.

45.
REFUND OF PREMIUMS

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

Example

If you have paid the yearly **base premium** of $1,200, and you end the plan 9 **months** later, we refund $300.

Restarting the plan	If you end the plan, you can ask us to restart it. But you must ask us – in writing – within 3 **months** of ending. If we end the plan because you don't pay on time, you can ask us – in writing – to restart it. But you must ask us within 3 **months** of the date the premium you didn't pay was due. To restart the plan, you must: • pay us all the premiums you haven't paid, and • give us any information we require about the **insured person**. We will advise you if we agree to restart the plan.

THESE WORDS AND PHRASES ARE DEFINED:
- **BASE PREMIUM**
- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **MONTHS**
- **REMUNERATIVE WORK**

THE DEFINITIONS ARE SET OUT IN RULE 68.

46.
LEAVING REMUNERATIVE WORK

If the **insured person** suffers an illness or injury 12 **months** after temporarily leaving remunerative work and is **totally disabled** we will pay, however, the definition in rule 3 changes.

The change is that the first dot point at rule 3 becomes:

- they are so ill or injured that they can't do any **remunerative work** for which they are reasonably suited by their education, training, or experience.

If the **insured person** is on maternity or paternity leave we do not consider them to have left remunerative work.

47.
PUTTING THE PLAN "ON HOLD"

You can put the plan "on hold" within the first 12 **months** after the **insured person** temporarily leaves remunerative work.

While the plan is "on hold" the 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".

We guarantee to take the plan "off hold" when the **insured person** starts **remunerative work** again. That means the **insured person** is covered again.

We guarantee to do this without you having to give us any more information about the **insured person's** health, occupation, or pastimes.

47.1
HOW TO PUT THE PLAN "ON HOLD"

To put the plan "on hold":

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

You can keep a plan "on hold" for as long as you want until the **insured person** starts **remunerative work** again.

47.2
HOW TO TAKE THE PLAN "OFF HOLD"

When the **insured person** starts **remunerative work** again, you, or we, can take the plan "off hold". You must tell us if the **insured person** starts **remunerative work** again.

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

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MONTH**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Guaranteed continuation of cover

48.
WE GUARANTEE TO CONTINUE *ADVANCED* AND *STANDARD* PLANS

For *Advanced* and *Standard*, if you pay the premium on time and the plan is still current, we guarantee:

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

49.
BASIC PLAN – NO CLAIM PAID

For *Basic*, if you pay the premium on time, the plan is still current, and we have not paid any claims under the plan, we guarantee:

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

However, we can cancel the plan when we have finished paying a claim – see rule 49.1.

49.1
BASIC PLAN – CLAIM PAID

For *Basic*, when we have finished paying a claim:

- we can keep the plan on the same terms as it had before the claim, or
- after the first **plan anniversary**, we can change the terms of the plan. For example, we can charge extra premiums or add **special rules** to the plan, or
- after the second **plan anniversary**, we can cancel the plan.

What we will do depends on the circumstances of the claim – but it is our decision.

Once we make our decision, if we have not cancelled the plan, we will keep the plan going each year on the terms we set when the claim was finished. We guarantee to 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.

THESE WORDS AND PHRASES ARE DEFINED:
- **PLAN ANNIVERSARY**
- **REMUNERATIVE WORK**
- **SPECIAL RULES**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Keeping you informed

50.

WE SEND YOU AN *ANNUAL STATEMENT*

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

- the amount of the **maximum monthly benefit** after any regular **CPI** increase, and
- the premium you have to pay to keep the plan going.

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

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

THESE WORDS AND PHRASES ARE DEFINED:

- **CPI**
- **MAXIMUM MONTHLY BENEFIT**
- **PLAN ANNIVERSARY**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Premium – what you have to pay

51.
HOW MUCH AND WHEN

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

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

Whenever you change the plan, it is likely that the premium will change.

After any change, we will tell you the amount of the new premium in writing.

51.1
STEPPED AND LEVEL PREMIUMS

For *Advanced* and *Standard*, you can choose whether we will calculate the premium by the "stepped" method, or the "level" method. For *Basic* plans, we calculate the premium by the "stepped" method.

Stepped method

Under the stepped method, the **base premium** usually increases each year as the **insured person** gets older and as the **maximum monthly benefit** increases by the **CPI**. It may also increase or decrease if we change the **premium rates**.

Level method

Under the level method, the **base premium** does ***not*** increase just because the **insured person** gets older – but, it will increase as the **maximum monthly benefit** is increased by the **CPI**. And it may also increase or decrease if we change the **premium rates**, loadings, discounts and plan fee or if government charges (such as stamp duty or other charges) change.

In the early years, 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.

THESE WORDS AND PHRASES ARE DEFINED:

- **BASE PREMIUM**
- **CERTIFICATE OF INSURANCE**
- **CPI**
- **INSURED PERSON**
- **MAXIMUM MONTHLY BENEFIT**
- **PREMIUM RATES**
- **PLAN ANNIVERSARY**

THE DEFINITIONS ARE SET OUT IN RULE 68.

51.2 GOVERNMENT TAXES, DUTIES AND CHARGES

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

Stamp duty

The amount of stamp duty payable on your insurance will depend on the type of insurance cover you have and the State/Territory in which you live. We will charge any stamp duty amount payable on your insurance cover based on the address that we have on our records. It is your responsibility to inform us of any corrections or changes to your address.

Depending on the type of insurance cover you have and how stamp duty on that cover is treated in your State/Territory, you may be required to pay an additional amount on your insurance premiums. This will be shown in your ***Certificate of Insurance*** and *Annual Statements*.

52. PREMIUM GUARANTEE

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

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

52.1 PREMIUM RATES AND DISCOUNTS NOT GUARANTEED

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

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

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

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

KEEPING THE PREMIUM THE SAME

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

You need to ask us to do this – in writing – before the plan anniversary from which you want the premium to stay the same.

You must also tell us whether you want us to reduce the **maximum monthly benefit**, or change the cover in some other way, to keep the premium the same.

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

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

THESE WORDS AND PHRASES ARE DEFINED:

- **CERTIFICATE OF INSURANCE**
- **INSURED PERSON**
- **MONTH**
- **MAXIMUM MONTHLY BENEFIT**
- **PLAN ANNIVERSARY**
- **PREMIUM RATES**

THE DEFINITIONS ARE SET OUT IN RULE 68.

53.
PLAN FEE

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

54.
PREMIUM FREQUENCY FEE

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

55.
DISCOUNTS

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

56.
WHEN PREMIUMS DON'T NEED TO BE PAID

You do not have to pay the premium while we are paying under the plan.

Once we have started paying under the plan we will refund any premiums that fell due during the **waiting period**.

56.1
FOR PLANS WITH A 1, 2 OR 5 YEAR BENEFIT PERIOD

If we have paid until the **benefit period** ended and the **insured person** is still unable to work, you do not have to pay the premium while the **insured person** continues to be **totally disabled** as determined in rule 3. However, the definition in rule 3 changes. The change is that the first dot point at rule 3 becomes:

- they are so ill or injured that they can't do any **remunerative work** for which they are reasonably suited by their education, training, or experience.

THESE WORDS AND PHRASES ARE DEFINED:

- **BENEFIT PERIOD**
- **CERTIFICATE OF INSURANCE**
- **CPI**
- **INSURED PERSON**
- **PLAN ANNIVERSARY**
- **REMUNERATIVE WORK**
- **TOTALLY DISABLED**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

How to make a claim

57.
WHAT TO DO

To make a claim you need to contact us. We will send you a claim form to fill in and return to us. You must also do each of the things set out in the rest of rule 57 and rule 58.

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

- while we are assessing the claim, and
- while we are paying.

We base our decision on whether to pay after reviewing all information, including the information in rules 57.1 to 57.6.

57.1
HEALTH

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

The **insured person** may also need to have medical tests.

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

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

57.2
BEDCARE CLAIMS

If you make a claim under *Advanced* because the **insured person** has been bedridden:

- *in hospital*, you must give us evidence that the **insured person** has been in hospital, or
- *out of hospital*, you must give us evidence that a registered nurse looked after the **insured person** full-time while the **insured person** was bedridden. The registered nurse cannot be the **insured person**, you, or a member of the immediate family of either you or the **insured person**.

57.3
AGE AND IDENTITY

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

57.4
INCOME AND EXPENSES

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

We may ask you what the **insured person's income** and expenses:

- were when the plan started, or you last changed it, and
- were just before the insured person became unable to work, and
- are while we are paying.

You must pay any costs of getting this information.

THESE WORDS AND PHRASES ARE DEFINED:
- **INCOME**
- **INSURED PERSON**

THE DEFINITIONS ARE SET OUT IN RULE 68.

57.5
OTHER INFORMATION

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

57.6
WHEN THE INSURED PERSON IS OUTSIDE AUSTRALIA OR NEW ZEALAND

We will pay for an illness or injury that happens anywhere in the world at any time. We may not pay for more than 3 **months** while the **insured person** is outside Australia or New Zealand.

If we don't pay after the 3 **months** referred to above, then, when the **insured person** returns to Australia or New Zealand, we will start paying again if you are still entitled to be paid under the plan.

If the **insured person** has been outside Australia for more than 30 days, and they have been **totally disabled** for at least 14 days while they were overseas, then we will assist you with their return travel expenses. We will reimburse up to the cost of one single economy airfare for the **insured person**, by the most direct route available, less any amounts anyone else pays you or the **insured person** for this expense.

We may agree to keep paying for more than 3 **months** while the **insured person** is outside Australia or New Zealand if:

- you ask us to, and
- you, and the **insured person**, agree to any conditions we set.

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

THE DEFINITIONS ARE SET OUT IN RULE 68.

58.

TIME LIMITS

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

You must also give us any information we ask for within 2 **months** after we ask for it.

Type of claim	**How soon you must tell us that you are going to claim**
The **insured person** is unable to work	Within one **month** of the **insured person** becoming unable to work
Partially disabled – the **insured person** is earning less than they were before they became unable to work	Within one **month** of the **insured person** returning to **remunerative work**
Rehabilitation costs	Before you incur the costs
The **insured person** is bedridden	Within one **month** of the **insured person** becoming bedridden
The **insured person** has a **chronic condition**	Within one **month** of the **insured person** having a **chronic condition**
The **insured person** suffers a **major fracture or loss**	Within one **month** of the **insured person** suffering the **major fracture or loss**
The **insured person** suffers a **trauma condition**	Within one **month** of the **insured person** suffering the **trauma condition**
The **insured person** dies	No time limit – but the sooner you tell us, the sooner we can pay.

59.

LATE CLAIMS AND RESPONSES

If you don't meet the time limits in rule 58, and we have been prejudiced by the delay, we will reduce the amount we pay to compensate us for the prejudice we have suffered.

THESE WORDS AND PHRASES ARE DEFINED:

- **CHRONIC CONDITION**
- **MAJOR FRACTURE OR LOSS**
- **MONTHS**
- **INSURED PERSON**
- **PARTIALLY DISABLED**
- **REMUNERATIVE WORK**
- **TRAUMA CONDITION**

THE DEFINITIONS ARE SET OUT IN RULE 68.

Miscellaneous

60.
CHANGING THE WAITING PERIOD

You can ask us to change the **waiting period**. We may agree to the change.

However, you have the right to shorten the **waiting period** in the situation described in rule 60.1.

60.1
WHEN YOU CHANGE EMPLOYER

If the **waiting period** is 13 weeks or less and the **insured person** changes employer, you can shorten the **waiting period**. You can shorten it to the next shortest **waiting period** we have available at that time. However, you can do that only once in any 12 **month** period. And you can't shorten it either during the **waiting period**, or while we are paying.

If you shorten the **waiting period**, the premium will increase.

When you ask us to shorten the **waiting period**, you don't have to give us any more information about the **insured person's** health. But you need to show us that the **insured person** has changed employer. Usually, all we need is a letter from their new employer.

Please note, we can withdraw this feature at any time. If we do, we will let you know in writing before we do so.

If the **waiting period** has changed since the plan began, the new **waiting period** will be shown in the **Memorandum of Alteration** we sent you to confirm the change.

61.
AUTOMATIC PLAN ENHANCEMENTS

We review our *Income Protection* plans regularly. If we enhance our definitions or product features without changing the premium rates or existing premium discounts, or charging extra premiums, we will automatically provide you enhancements for which you are eligible at no charge.

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

We will write to you and advise you of the changes on your **plan anniversary**.

THESE WORDS AND PHRASES ARE DEFINED:
- **INSURED PERSON**
- **MEMORANDUM OF ALTERATION**
- **MONTH**
- **PLAN ANNIVERSARY**
- **WAITING PERIOD**

THE DEFINITIONS ARE SET OUT IN RULE 68.

61.1
GUARANTEED FUTURE INSURABILITY

You may increase the **maximum 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, you may increase the **maximum monthly benefit** above the amount of **CPI** increase (if applicable) by the lower of:

- 10% of the original monthly amount, or
- $1,000,

across all AMP Income Protection plans.

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

- you are older than 55 years of age, or
- you are unable to provide proof of **income** to support the requested increase to your **maximum monthly benefit,** or
- your plan has a premium loading or **special rule**, or
- you are eligible to make a claim, or are on a claim, for any plan you hold with us.

62.
OWNERSHIP AND DEALINGS

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

Please note, the only person we will pay under this plan is you. That is so even if we receive notice of a trust, assignment, lien, or charge related to an attempt to transfer any rights under this plan to anyone.

THESE WORDS AND PHRASES ARE DEFINED:
- **CPI**
- **INCOME**
- **MAXIMUM MONTHLY BENEFIT**
- **SPECIAL RULE**

THE DEFINITIONS ARE SET OUT IN RULE 68.

63.
GOVERNING LAW

The plan is:

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

63.1
WE DEDUCT TAXES OR CHARGES

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

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

64.
AUSTRALIAN $

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

65.
OUR LIABILITY IS LIMITED

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

66.
NO SHARE OF PROFITS

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

Descriptions of trauma conditions

67.
DESCRIPTIONS OF TRAUMA CONDITIONS

This rule applies to *Advanced plans* only. The descriptions of the **trauma conditions** covered under the *Trauma feature* in the *Advanced* plan are:

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 will not pay for surgery performed using intraluminal or laparoscopic techniques.

Glossary of terms

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

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

Catheter – A hollow tube.

CANCER

We will pay if an **insured person** suffers a malignant tumour, malignant sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorders 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 person is diagnosed under the age of 45.

The cancer must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.

We will not 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
- AIDS or HIV related cancers.

*Your **Certificate of Insurance** shows if you are covered for AIDS*

Glossary of terms

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

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

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

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

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

THE DEFINITIONS ARE SET OUT IN RULE 68

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

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

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

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

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

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

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

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

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

COMA

We will pay if an insured person is in a state of unconsciousness and does not 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 other reliable imaging technique approved by AMP, or
- be continuous for at least 90 days.

In all circumstances, we will not 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.

Glossary of terms

Glasgow Coma Scale – Bedside assessment of levels of consciousness.

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 do not pay under this particular trauma condition for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.

Glossary of terms

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

Coronary artery – Vessel conveying blood to the heart muscle.

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

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.

Glossary of terms

Abnormal wall motion – an area of dead heart muscle.

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

Echocardiography – The use of ultrasound to investigate the heart.

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

Myocardial infarction – Heart attack.

HEART ATTACK –
OUT OF HOSPITAL CARDIAC ARREST

We will pay if an insured person suffers a cardiac arrest which:

- is not associated with any medical procedure, and
- is documented by an electrocardiogram, and
- occurs outside a hospital, and
- is due to either cardiac asystole or ventricular fibrillation.

Glossary of terms

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

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

Electrocardiogram – A graph of electrical activity of the heart.

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

HEART VALVE SURGERY

We will pay if an insured person has surgery to correct, or replace, a cardiac valve.

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

We won't pay for surgery performed using intraluminal or laparoscopic procedures.

Glossary of terms

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

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 will not pay where the accident or illness is a result of alcohol or drug use that is not prescribed by a doctor.

Glossary of terms

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

Tracheal intubation – Insertion of a tube into the trachea.

KIDNEY FAILURE

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 will not pay in the event of temporary renal dialysis for acute and reversible kidney failure.

Glossary of terms

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

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

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.

Glossary of terms

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

Functional impairment – abnormalities of the nervous system producing certain systems and resulting in some disorder of function.

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 will not pay in the event of a donation by the insured person of an organ for transplant.

OPEN HEART SURGERY

We will pay if the insured person has open heart surgery requiring diversion of the blood through a heart-lung machine, in order to have surgery to correct any heart defect including heart valve surgery.

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

We will not pay under this particular trauma condition for procedures such as valvotomy or coronary artery angioplasty which do not require open heart surgery.

Glossary of terms

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

Valvotomy – Surgical widening of a narrowed heart valve.

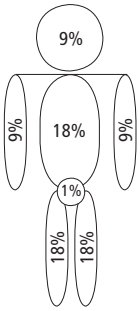
PERIPHERAL BLOOD STEM CELL OR BONE MARROW TRANSPLANT

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.

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.



Lund Browder Body Surface Chart

The burns can be caused by thermal, electrical or chemical agents.

The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and legs (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area.

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

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 will not pay for transient ischaemic attacks, reversible ischaemic neurological deficit, major head injuries or symptoms due to migraine or headache.

Glossary of terms

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

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

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

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

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

Definitions

68.

ACCIDENT

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

AMP, AMP LIFE, OUR, US AND WE

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

ABLE TO WORK

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

AGREED VALUE

Under **Agreed value** we will calculate how much to pay when the insured person is **totally disabled** on the basis of their **maximum monthly benefit**.

BASE PREMIUM

Base premium is the amount of the premium we calculate from our **premium rates**.

It includes the premium frequency fee. It does not include the plan fee, or any stamp duty, or other government fee, duty, tax, or charge.

BENEFIT PERIOD

The **benefit period** is the longest period of time for which we will pay any one claim. You choose the length of the benefit period when you apply for this insurance. The length of your benefit period is shown in the ***Certificate of Insurance***.

CERTIFICATE OF INSURANCE

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

The *Certificate* sets out the details of who owns the plan, who is insured, the amount of cover, and other important information about the plan when it starts.

The *Certificate* and the Plan Rules in this document form your contract with AMP.

The information in the *Certificate* can be updated in the following 2 ways:

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

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

CHRONIC CONDITION

See rule 16.

CPI

CPI means Consumer Price Index.

When we make a calculation using the increase in the CPI, we use the percentage annual increase in the Australian National All Groups Consumer Price Index published by the Australian Bureau of Statistics. We use the Index published for the most recent September quarter. However, if that index is abolished or changed, we may use another index which we believe fairly and accurately reflects changes in the cost of living.

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

DOCTOR

Doctor means a legally qualified medical practitioner registered to practice in Australia, New Zealand, the United Kingdom, the United States of America, or Canada.

That person may not be:

- you, your business partner, or a member of your immediate family, or
- the insured person, the insured person's business partner, or a member of the insured person's immediate family.

INCOME (EMPLOYED)

Income means 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.

INCOME (SELF-EMPLOYED)

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.

INDEMNITY OPTION

If **Indemnity** is selected we will calculate how much to pay when the insured person is **totally disabled** on the basis of their **income** in the 12 months immediately before becoming **totally disabled**.

INSURED PERSON

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

MAJOR FRACTURE OR LOSS

Major fracture or loss means a fracture or loss which we cover under rule 25.

MAXIMUM MONTHLY BENEFIT

The **maximum monthly benefit** is the amount that we and you agree is the most we will pay each **month** if the insured person is **totally disabled** 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**. The current **maximum monthly benefit** will be shown in the latest *Annual Statement*, and
- change when you ask us to change it. If it has changed in this way, the new amount will be shown in the latest ***Memorandum of Alteration***.

MEMORANDUM OF ALTERATION

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

MONTH

Month means calendar month.

MONTHLY BENEFIT

Monthly benefit is the amount that we actually pay you each month.

PARTIAL DISABILITY

The definition of Partial Disability is set out in rule 9. Partially disabled has a corresponding meaning.

The insured person is partially disabled if they do any **remunerative work** but earn less than they did before they became **totally disabled**. We only pay if:

- the illness or injury which made them **totally disabled** causes them to earn less, and
- they were **totally disabled** for at least the first 7 days of the waiting period, and
- they have the approval of their **doctor** to work and we agree, and
- they remain under the ongoing care of their **doctor** for that illness or injury.

PLAN

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

PLAN ANNIVERSARY

The date of the **plan anniversary** for the plan is shown in the ***Certificate of Insurance***. For most plans it will be the same date in each year as the date on which the plan starts. However, if you want it to be a different date, we may agree to make it a different date.

The plan anniversary is the date in each year on which we make any **CPI** increase to the **maximum monthly benefit**. When we recalculate the premium each year, the new amount applies for one year from the plan anniversary.

PLAN OWNER

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

PRE-DISABILITY INCOME (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 **totally disabled**. We divide that amount by 12 to get the monthly income.

PRE-DISABILITY INCOME (INDEMNITY)

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

PREMIUM RATES

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

RELAPSE

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

REMUNERATIVE WORK

An insured person is engaged in **remunerative work** if they are doing work in any employment, business, or occupation. They must be doing it for reward – or the hope of reward – of any type.

SPECIAL RULE

Special rule means any rule which we apply to the insured person or plan and which does not apply to all AMP *Income Protection* plans.

TRAUMA CONDITION

The **trauma conditions** which we cover are listed in rule 31. The full description of each of them is set out in rule 67.

TOTALLY DISABLED

The definition of "**totally disabled**" is set out in rule 3.

The insured person is totally disabled if:

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

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

WAITING PERIOD

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

What happens if the insured person returns to **remunerative work** during the waiting period is explained in rule 5.1. However, for claims under *Partial disability*, rule 9 and 10 apply and for the *Bedcare feature*, rule 24.1 applies. For claims under the Trauma feature or Major fracture or loss feature the waiting period does not apply.

Sometimes the waiting period does not apply if the insured person suffers a **relapse** – this is explained in rule 15.

Enquiries and complaints

CONTACT US

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

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

AMP Life Limited
PO Box 300
PARRAMATTA NSW 2124.

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

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

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

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

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

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

Financial Industry Complaints Service

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

or write to

PO Box 579, Collins Street West
MELBOURNE VIC 8007

This page has been left blank intentionally.

This page has been left blank intentionally.

Directory

AMP Life Limited

REGISTERED OFFICE
Level 24
AMP Building
33 Alfred Street
SYDNEY NSW 2000
Phone: 02 9257 5000
Fax: 02 9257 7886

AMP Customer Service Centre

PHONE
131 267
Monday to Friday

FAX
1300 301 267

ADDRESS
AMP Financial Services
Jessie Street Building
PO Box 300
PARRAMATTA NSW 2124

WEBSITE
www.amp.com.au

EMAIL
polinfo@amp.com.au

advice
investments
banking
retirement income
superannuation
insurance

Contact your adviser or financial planner

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

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

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

905048 11/07