Trauma Insurance Plus Plan

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A Important information

Keep this booklet safe

1 Please keep all the plan documents in a safe place. You will need them when you make a claim. You may also want to check something in them from time to time. In addition to these documents, we will send to you a notice at least once a year setting out your premium and charges.

If there is something in these documents that you don't understand, please speak to your adviser or call our representative on 132 987.

In this document, general information and definitions are found in Parts B and H.

You may be entitled to a benefit under the plan in the circumstances set out in Part C.

There are some circumstances in which we won't pay you the Benefit. Those are set out in Part D.

The procedure for you to make a claim is described in Part E.

Information about premiums and charges is set out in Part F.

The way the plan can be brought to an end is described in Part G.

This plan is not a savings plan

2 This is not a savings plan. It has no 'cash' value. This means you are not entitled to:

- any payment if you end the plan; or
- share in any of our profit or surplus.

Changing your mind and withdrawing in the first 14 days

3 Once you have received the plan document from us, you have 14 days to check that the plan meets your needs. This is known as the cooling off period. Within this period you may cancel the plan and get your money back. Your request must be in writing.

Changing to a new plan may be bad for you

4 If you are not satisfied with the plan, please tell us. It is possible we will be able to change the plan to satisfy you. Changing to a new plan may require a reassessment of the person insured's health, occupation, pastimes and place of residence. It is usually better to modify your plan rather than to end it and start a new one.

Where we put your money

5 We pay your premiums into a fund called Statutory Fund No. 1. The fund is protected under the Life Insurance Act 1995.

Legislation

6 The plan is issued subject to the Life Insurance Act 1995, the Insurance Contracts Act 1984, the Income Tax Assessment Act 1936, the Income Tax Assessment Act 1997 and any other Act of Parliament controlling the terms of insurance contracts.

Warning

7 The plan is provided on the understanding that your Application form was filled in completely and accurately. It is also based on the fact that you read and understood the material on the Application form about what you and the person insured must tell us. That is very important. For your convenience, we repeat that information here. Please read it again.

Your duty of disclosure

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

You have the same duty to disclose those matters to the insurer before you renew, extend, vary, or reinstate a contract of life insurance. Your duty, however, does not require disclosure of a matter:

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

Non-disclosure

9 If you fail to comply with your duty of disclosure (or make a misrepresentation to us) and the insurer would not have entered into the contract on any terms if the failure (or misrepresentation) had not occurred, the insurer may avoid the contract within three years of the commencement date. If your non-disclosure (or misrepresentation) is fraudulent, the insurer may avoid the contract at any time.

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

What we do for you

10 As long as you pay the premiums on time and comply with the plan we will:

- pay you benefits when you are entitled to them
- continue the plan until the plan ends or the Expiry date, as set out in the Schedule, and
- not place any further conditions on the plan.

Plan fee waiver on additional plans

11 Subject to agreement with us, if you have other plan(s) with us we may waive the plan fee on the second and subsequent plan(s). There are limitations on which plans this applies to. Please contact AXA for full details.

Your Schedule shows which plan is a primary plan and which plan(s) have had the plan fees waived.

How to deal with any concerns you may have

12 If the person insured has an inquiry or complaint about the plan or benefit entitlement, please contact our Customer Service Centre on the toll free number 132 987. Alternatively, the person insured may wish to write to:

AXA
PO BOX 14330
Melbourne VIC 8001

We will acknowledge inquiries and written complaints in writing within 10 days of receipt. We will provide the same acknowledgment for complaints received over the telephone, unless they can be resolved in a timely manner. Your complaint will be considered by us and a response will be provided within 45 days after receipt of the complaint.

If, after 45 days, you are not satisfied with the way your inquiry or complaint was handled or with our response, you can seek assistance from the Financial Ombudsman Service (FOS). This service has been set up by the Investment and Financial Services Association (IFSA) as an independent party to hear unresolved complaints.

You can contact the Financial Ombudsman Service on 1300 780 808 or write to:

Financial Ombudsman Service
GPO Box 3
Melbourne VIC 3001

Fax: (03) 9613 6399
E-mail: info@fos.org.au

All correspondence to FOS should include the reference A-164.

B General

This is a trauma insurance plan

13 The plan document, the Application form, the Schedule and any options you choose make up your Trauma Insurance Plus Plan and are all evidence of your contract with us.

The plan is issued by The National Mutual Life Association of Australasia Limited (ABN 72 004 020 437), trading as AXA, referred to in the plan as 'us', 'we' and like words.

In the plan, the following terms refer to information set out in the Schedule:

- benefit
- commencement date
- expiry date
- premium structure, and
- renewal date.

Some words in the plan have a particular meaning. These are shown in ***bold italics*** and the meaning is explained in Part H.

The plan starts on the Commencement date, and ends on the Expiry date, unless it is ended by you or us before then.

Notices

14 Any notice we give each other must be in writing. It can be given in any way allowed by law. Any notice we give to you by post will be at the last address you gave us.

Who is insured?

15 Normally, the person who is insured and the person to whom we pay the Benefit are the same person. However, sometimes they are different. In the plan:

- the person who is insured is called 'the person insured' and is named in the Schedule; and
- the person who is paid the Benefit is called 'the plan owner' and is referred to as 'you'.

You can only transfer your rights under the plan to someone else if you get our written consent first.

Upgrade of benefits

16 If we make any future improvements to this Trauma Insurance Plus Plan, without any increase in our standard premium rates, we may choose to pass these changes on to you without you having to provide us with any medical evidence, or evidence regarding your occupation, pastimes or place of residence.

If you are suffering a pre-existing condition at the time the improvement is provided, the improvement will not apply when assessing any claim affected by that pre-existing condition.

C Circumstances in which we will pay you

Financial Plan Benefit

17 In the instance that you receive the total Benefit payable under this plan from us because the person insured has suffered a ***trauma event*** and you obtain a financial plan from a licensed financial adviser within 6 months of receiving the total Benefit from us, we will pay to the licensed financial adviser the lower of $2,000 and the actual cost incurred by you in obtaining the financial plan.

We will only pay the Financial Plan Benefit once from all plans or options held with us for which the person insured is covered. The payment of the Financial Plan Benefit will not reduce any other Benefit payable under this plan.

If the person insured suffers a ***trauma event***

18 If the person insured suffers one of the ***trauma events*** listed below, we will pay you the Benefit. The ***trauma event*** (except Loss of Capacity for Independent Living) must have occurred after the Commencement date and before the Expiry date, and before the first Renewal date after the person insured turns 70, whichever happens first.

The person insured may be covered for Loss of Capacity for Independent Living which occurred after the Commencement date and before the Expiry date, and before the person insured turns 99, whichever happens first.

Where the ***trauma event*** definition refers to a diagnosis, the diagnosis must be based on clinical, radiological, histological and laboratory evidence which is acceptable to us. A suitable ***medical practitioner*** must make the diagnosis.

Where the ***trauma event*** definition refers to a 25 per cent impairment of whole body function, we will place reliance on the latest published edition of American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment at the time of claim. Assessment must be carried out by a ***medical practitioner*** accredited in the evaluation of permanent impairment.

How much will we pay you?

Adult Insulin Dependent Diabetes

In the case of Adult Insulin Dependent Diabetes, we will pay you the lowest of:

- 10 per cent of the Benefit, or
- $25,000.

Angioplasty

We will only pay you for Angioplasty if the Benefit is $100,000 or more. We will pay you a benefit for Angioplasty on more than one occasion provided that the procedures occur at least six months apart. In the event that a payment is made, the total sum insured will be reduced by the benefit amount.

In the case of Angioplasty we will pay you the lowest of:

- 10 per cent of the Benefit, or
- $100,000.

Medical Condition Requiring Life Support

In the case of a Medical Condition Requiring Life Support, we will pay you the lowest of:

- 10 per cent of the Benefit, or
- $25,000.

Multiple Sclerosis Early Payment

In the case of Multiple Sclerosis Early Payment we will pay you the lowest of:

- 25 per cent of the Benefit, or
- $100,000.

- Muscular Dystrophy Early Payment

  In the case of Muscular Dystrophy Early Payment we will pay you the lowest of:

  - 25 per cent of the Benefit, or
  - $100,000.

In some cases a qualifying period applies

For the cancers listed below we won't pay you if the cancer occurs within 90 days of either of the following times:

- the Commencement date, or
- the date the plan is restored.

If the cancer occurs within 90 days from the date of any increase in the Benefit, not including any automatic CPI increases, the increase in benefit won't be included in the early payment.

Cancer Early Payment

In the case of one of the cancers listed below, we will pay you the greater of:

- 10 per cent of the Benefit, or
- $10,000.

The cancers covered under this early payment clause are:

- Prostate tumours classified as T1
- Malignant melanomas
- ***Carcinoma in situ*** of the breast, of the vulva, vagina or fallopian tube, or of the cervix.

In the case of all ***trauma events***, except those listed above, we will pay you the Benefit, as varied in any way. In the event that a payment is made under any of the above ***trauma events***, your plan will not end however the Benefit for any subsequent ***trauma event*** will be reduced by the amount we pay you. The maximum we will pay for the life of this plan is the total Benefit as it appears in the Schedule.

When will we pay you?

Subject to any qualifying period, we will pay you the Benefit as soon as possible after one of the ***trauma events*** occurs. We will deem the date the ***trauma event*** occurs to be the date we are satisfied that the ***trauma event*** is proved.

24 Hour Worldwide Cover

Subject to the terms and conditions of the plan, we will cover the person insured 24 hours a day and if the person insured travels overseas.

In some cases, a qualifying period applies

For the ***trauma events*** listed below under the heading '***Trauma events*** subject to a Qualifying Period, we won't pay you if the ***trauma event*** occurs within 90 days of either of the following times:

- the Commencement date, or
- the date the plan is restored.

If the ***trauma event*** occurs within 90 days from the date of any increase in the Benefit, not including any automatic CPI increases, we won't pay the amount of that increase.

Definitions of ***trauma events***

Trauma events subject to a Qualifying Period

Adult Insulin Dependent Diabetes

Adult insulin dependent diabetes means the diagnosis of type 1 insulin dependent diabetes mellitus (IDDM) by an appropriate consultant specialist after the age of 30.

Cancer

Cancer means the occurrence of an invasive malignant tumour that is confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion and destruction of normal tissue. The term cancer also refers to leukaemia, lymphoma and Hodgkin's disease unless excluded below.

The following cancers are excluded:

- other skin cancers unless there has been evidence of metastases;
- lymphocytic leukaemia less than Rai stage I;
- tumours that are a recurrence or metastases of a tumour that first occurred within the 90 day qualifying period.

The following are excluded from a full benefit payment. However, we will make an early payment of the greater of 10 per cent of the benefit or $10,000.

The cancers covered under early payment are:

- Prostate tumours classified as T1 (all categories) under the TNM classification system or of an equivalent classification where major interventionist therapy is not required;
- Malignant melanomas which are both less than Clark Level 3 and less than 1.5mm thickness as determined by histological examination;
- ***Carcinoma in situ*** of the breast where the tumour is classified as TNM stage TIS. There is no requirement for the breast to be removed;
- ***Carcinoma in situ*** of the vulva, vagina or fallopian tube where the tumour is classified as TNM stage Tis or FIGO Stage 0;
- ***Carcinoma in situ*** of the cervix that is at TNM stage Tis or CIN 3 grading.

If a prostate tumour classified as T1 (all categories) under the TNM classification system or of an equivalent classification is confirmed by histological examination and requires the person insured to undertake major interventionist therapy including radiotherapy, chemotherapy, biological response modifiers or any other major treatment, or if the tumour is completely untreatable, then 100% of the Benefit will be paid.

Coronary Artery Bypass Surgery

Coronary artery bypass surgery means coronary artery bypass grafting surgery, which is considered medically necessary to treat coronary artery disease but does not include:

- angioplasty
- intra-arterial procedures
- laser techniques, or
- other non-surgical techniques.

Heart Attack

Heart Attack means the death of an area of heart muscle due to a sudden lack of adequate blood supply to the relevant area where:

- there are typical new ischaemic electrocardiographic (ECG) changes at the time of the heart attack, and
- there are diagnostic changes in relevant cardiac enzymes or markers in the days following the heart attack.

If the above criteria are not met, we will pay a claim based on satisfactory evidence that the life insured has unequivocally been diagnosed as having suffered a heart attack resulting in:

- a permanent reduction in the Left Ventricular Ejection Fraction to less than 50 per cent measured in the three months or more after the event, or
- new pathological Q waves.

Chest pain that does not meet the above diagnostic requirements is excluded.

Stroke

Stroke means the damage of brain tissue as a result of a cerebrovascular incident caused by haemorrhage, embolism, or thrombosis, associated with the sudden onset of objective neurological deficit.

The incident must be demonstrated by Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques approved by us.

Excluded:

- transient ischaemic attack
- cerebral symptoms associated with reversible neurological deficit
- cerebrovascular disorder of the eye or optic nerve
- symptoms due to migraine or headache, and
- brain tissue damage caused by head injury.

Trauma events **not subject to a Qualifying period**

Alzheimer's Disease and other Dementias

Alzheimer's Disease and Other Dementias means an unequivocal diagnosis of dementia including Alzheimer's Disease by a Consultant Neurologist where there is permanent irreversible failure of brain function resulting in significant cognitive impairment for which no other recognisable cause has been identified. Significant cognitive impairment is defined as a deterioration or loss of intellectual capacity as measured by clinical evidence and standardised testing, and which results in a requirement for continual supervision to protect the insured or others.

Angioplasty

The treatment of a coronary artery obstruction by balloon angioplasty, other catheter based techniques, or endoscopic surgery, where at least one of the following criteria have been met:

- the obstruction is giving rise to impairment of ventricular function
- the obstruction is giving rise to disabling symptoms, or
- the obstruction is associated with unstable angina pectoris or myocardial infarction.

Aplastic Anaemia

Aplastic anaemia means permanent bone marrow failure which results in anaemia, neutropaenia and thrombocytopaenia requiring treatment, with at least one of the following:

- blood product transfusions
- marrow stimulating agents
- bone marrow transplantation, or
- immunosuppressive agents.

Benign Brain Tumour

A non-cancerous tumour in the brain that gives rise to characteristic symptoms of increased intracranial pressure such as papilledema, mental symptoms, seizures and sensory impairment. The tumour must result in neurological deficit, resulting in:

a) at least 25 per cent permanent impairment of whole body function, or

b) the person insured being totally and permanently unable to perform at least one of the ***activities of daily living.***

The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI (Magnetic Resonance Imaging). The following are excluded:

- cysts,
- granulomas,
- malformations in or of the arteries or veins of the brain,
- haematomas, and
- tumours in the pituitary gland or spine.

Blindness

Blindness means the permanent loss of sight in both eyes as a result of disease, illness or injury to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that visual field is reduced to 10 degrees or less of arc irrespective of corrected visual acuity.

Cardiac Arrest

Cardiac Arrest that is the sudden breakdown of the heart's pumping function where it:

- is due to asystole or ventricular fibrillation, and
- is not associated with any clinical procedure, and
- is documented by electrocardiographic (ECG) changes, and
- occurs outside a hospital or other medical facility.

Cardiomyopathy

Cardiomyopathy means impairment of the ventricular function of variable aetiology resulting in significant and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Chronic Kidney Failure

Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

Chronic Liver Disease

Chronic Liver Disease means end stage liver failure resulting in:

- permanent jaundice, and
- ascites or encephalopathy.

Coma

Coma means the failure of cerebral function as shown by total unarousable unresponsiveness to all external stimuli persisting continuously with the use of a life support system for a period of at least three days. Coma directly resulting from alcohol or drug abuse is excluded.

Deafness

The total, irreversible and irreparable loss of hearing, both natural and assisted, in both ears as a result of disease, illness or injury.

Diplegia

The total and permanent loss of the use of both sides of the body due to injury or sickness.

Encephalitis

Encephalitis means the severe inflammation of brain substance that results in significant and permanent neurological sequelae, with at least 25 per cent impairment of whole body function. Encephalitis as a result of HIV infection is excluded.

Heart Valve Surgery

The undergoing of heart surgery to replace or repair a heart valve as a consequence of a heart valve defect. Angioplasty, intra-arterial procedures and other non-surgical techniques are excluded.

Hemiplegia

Hemiplegia is the total and permanent loss of the use of one side of the body due to injury or sickness.

Loss of Capacity for Independent Living

Loss of capacity for independent living means that as a result of an injury or sickness, the person insured is permanently unable to perform at least two of the ***activities of daily living*** without assistance.

Loss of Limbs

The total and permanent loss of:

- the use of both hands
- the use of both feet, or
- the use of one hand and one foot.

Loss of Limbs and Sight

The total and permanent loss of:

- the use of one hand and the sight of one eye, or
- the use of one foot and the sight of one eye.

Loss of Speech

Total and permanent loss of the ability to produce intelligible speech as a result of permanent damage to the larynx or its nerve supply from the speech centres of the brain, whether caused by injury, tumour or sickness.

Lung Disease

Chronic lung disease requiring permanent supplementary oxygen. For the purposes of this definition, the criteria for requiring supplementary oxygen will be an arterial blood oxygen partial pressure of 55mmol/L or less, whilst breathing room air.

Major Head Injury

Major head injury means cerebral injury caused by external trauma which results in permanent neurological deficit and causes at least 25 per cent impairment of whole body function.

Major Organ Transplant

Major organ transplant means the receipt of a transplant of human bone marrow or one of the following whole human organs: heart, lung, liver, kidney, pancreas or small bowel.

Medical Condition Requiring Life Support

The occurrence of a medical condition that causes the need for continuous mechanical ventilation via tracheal intubation 24 hours per day for 10 consecutive days in an authorised intensive care unit of an acute care hospital.

Excluded:

- any medical condition resulting from alcohol or drug intake, or other self inflicted means.

Medically Acquired HIV infection

Medically Acquired HIV is the accidental infection with the Human Immunodeficiency Virus (HIV) after the start of this plan, which in our opinion arose from one of the following medically necessary events which must have occurred to the person insured while in Australia by a recognised and registered health professional:

- a blood transfusion
- transfusion with blood products
- organ transplant to the person insured
- assisted reproductive techniques, or
- a medical procedure or operation performed by a doctor.

Notification and proof of the incident will be required via a statement from the appropriate Statutory Health Authority that the infection is medically acquired. HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use is specifically excluded.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any treatment which renders the HIV inactive or non infectious.

All testing must be conducted by Australian Government approved specialist pathology laboratories. If required by us, we must be given access to all blood and body fluid samples tested and we must be allowed to independently test them. We may require that blood and body fluid collection and diagnostic testing be repeated. All evidence provided must be acceptable to us.

Motor Neurone Disease

Motor Neurone Disease means unequivocal diagnosis of Motor Neurone Disease by a consultant Neurologist and confirmed by neurological investigations.

Multiple Sclerosis

Multiple Sclerosis means unequivocal diagnosis of Multiple Sclerosis by a Consultant Neurologist where there has been more than one episode of well defined neurological deficit with persisting neurological abnormalities and with at least a 25 per cent impairment of whole body function that is permanent.

We will make an early payment of 25 per cent of the benefit, up to a maximum of $100,000, once only upon unequivocal diagnosis of Multiple Sclerosis by a Consultant Neurologist without requiring the person insured to have at least a 25 per cent impairment of whole body function that is permanent.

In the event that we make an advance early payment under this benefit, the plan will not end, however the amount of the benefit will be reduced by the amount we pay you for Multiple Sclerosis.

Muscular Dystrophy

Muscular Dystrophy means unequivocal diagnosis of Muscular Dystrophy by a Consultant Neurologist where there is associated neurological deficit with at least a 25 per cent impairment of whole body function that is permanent.

We will make an early payment of 25 per cent of the benefit, up to a maximum of $100,000, once only upon unequivocal diagnosis of Muscular Dystrophy by a Consultant Neurologist without requiring the person insured to have at least a 25 per cent impairment of whole body function that is permanent.

In the event that we make an early payment under this benefit, the plan will not end, however the amount of the benefit will be reduced by the amount we pay you for Muscular Dystrophy.

Occupationally Acquired HIV Infection

Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring whilst the person insured was carrying out the normal duties of his or her usual occupation. No payment will be made unless all the following are proven to our satisfaction:

- proof of the accident giving rise to the infection
- proof that the accident involved a definite source of the HIV infection, and
- proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident.

All testing must be conducted by Australian Government approved specialist pathology laboratories. If required by us, we must be given access to all blood and body fluid samples tested and we must be allowed to independently test them. We may require that blood and body fluid collection and diagnostic testing be repeated. All evidence provided must be acceptable to us.

HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any treatment which renders the HIV inactive or non infectious.

Paraplegia

The total and permanent loss of the use of the lower limbs due to spinal cord injury or disease.

Parkinson's Disease

Parkinson's Disease means an unequivocal diagnosis of Parkinson's Disease by a Consultant Neurologist and the condition must be unable to be controlled with medication and must show signs of progressive incapacity with at least a 25 per cent impairment of whole body function.

Pneumonectomy

The excision of an entire lung when deemed medically necessary by an appropriate specialist and supported by our medical advisers.

Primary Pulmonary Hypertension

Primary Pulmonary Hypertension means primary pulmonary hypertension with right ventricular enlargement established by investigations including cardiac catheterisation.

Quadriplegia

The total and permanent loss of the use of the upper and lower limbs due to spinal cord injury or disease.

Severe Burns

Severe burns means third degree burns to 20 per cent or more of the body surface, or to the whole of the face or the whole of both hands requiring surgical debridement and/or grafting.

Surgery of the Aorta

Surgery of the aorta means surgery performed to correct any narrowing, dissection, or aneurysm of the thoracic or abdominal aorta but does not include angioplasty, intra-arterial procedures or other non-surgical techniques.

Triple Vessel Angioplasty

Triple Vessel Angioplasty means the actual undergoing for the first time of coronary artery angioplasty to correct a narrowing or blockage of three or more coronary arteries within the same procedure. Angiographic evidence, of obstruction of three or more coronary arteries, is required to confirm the need for this procedure.

We will increase the Benefit by the increase in the Consumer Price Index

19 Each year on the Renewal date, we will increase the Benefit by the increase in the Consumer Price Index, known as the CPI. Your Premium will increase as a result of this increase in the Benefit. We will not increase the Benefit:

- after the person insured's 65th birthday
- by less than five per cent in any year, or
- by any amount which would cause the Benefit to exceed $1,500,000 inclusive of the total benefit amount under any other trauma plans or options held with us for which you are covered.

You don't have to accept the Benefit increases

You may decline this increase for any particular year or for all years by writing to us.

When the increase to your Benefit applies

The increase to your Benefit only applies to a claim you make under the plan that happens after the date of the increase.

The CPI information we use

The increase we make to your Benefit will normally be based on the Australian National All Groups Consumer Price Index weighted average of eight capital cities combined. We use the last published Index for the 12 months ending 30 September each year. Any increase will be applied on your next renewal date after 1 January the following year. However, we may use the Index published for a more recent 12 month period and/or another index or rate which we believe more fairly and accurately reflects changes in the cost of living.

D When we won't pay

If the *trauma event* results in the death of the person insured within 14 days

20 We will not pay the Benefit for a ***trauma event*** which results directly or indirectly in the death of the person insured within 14 days of the ***trauma event*** occurring.

If the person insured had a medical condition, injury or illness before the plan began and the person insured didn't tell us about it

21 We won't pay a benefit for a ***trauma event*** that occurred before the Commencement date unless you or the person insured told us in writing about the medical condition or illness when you or he or she applied for the plan or applied to have the plan increased or restored under clause 32, and we agreed to accept it.

For the purposes of this clause, the person insured had a medical condition or illness if:

- a 'medical practitioner' or 'other health professional' gave the person insured, or recommended that he or she receive advice, care or treatment, or
- the person insured had symptoms of a medical condition or illness for which a reasonable person would have tried to receive advice, care or treatment from a 'medical practitioner' or 'other health professional'.

'Medical practitioner' means a registered medical practitioner who is appropriately qualified to treat the person insured for injury or sickness. For the purposes of this clause only, the 'medical practitioner' can be you or your family member, business partner, employee or employer or the person insured or his or her family member, business partner, employee or employer. For all other clauses in this plan, the definition of medical practitioner is contained in clause 35.

'Other health professional' means a physiotherapist, chiropractor, occupational therapist, practitioner of Chinese medicine, herbal therapies or any other such person.

Other circumstances

22 We will not pay the Benefit if the person insured's ***trauma event*** was caused by the person insured or you on purpose.

E Making a claim

How to make a claim

23 You must send us written advice that you wish to make a claim as soon as possible after the person insured is diagnosed as suffering a ***trauma event***.

Complete forms and return to AXA

The necessary claim forms will be provided to you as soon as is reasonably possible. Please fully complete the forms and return them to us within six months after the person insured is diagnosed as suffering a ***trauma event***, or as soon as is reasonably possible.

We can ask for more information

When we receive the claim forms we may ask for more information. This may include proof of age, access to any medical records or other information which we consider relevant to the claim. We must receive this information before we can finalise the claim and we may choose a ***medical practitioner*** to examine the person insured. We will pay the costs of getting any additional medical information or having any examination that we request.

In this clause, 'information' includes an authority to obtain and/or provide information from, or to, another source.

F The premium and other amounts you have to pay

Premiums

24 You must pay your premium when it is due and in Australian dollars. The premium includes the cost of providing the insurance cover and all taxes, duties, charges and the plan fee. You can pay by instalments. We will calculate your premium on each Renewal date.

The cost of providing the insurance cover is based on:

- the amount of the Benefit, as varied in any way
- the person insured's age
- any special conditions that apply to the plan, and
- the standard premium table that applies at the time.

We can change your premium

25 The standard premium table for each Premium structure referred to below, shows factors and premium rates for each age, based on the person insured's sex, occupation and whether he or she smokes.

At any time we may change the standard premium tables so that the changes apply to all plans like this one. If we do this we may notify you in writing following the change.

You may choose a 'level' or 'yearly stepped' Premium structure

26 The Premium structure you choose will determine how often we refer to the standard premium table to obtain the premium rate for the person insured.

Level

Where the Premium structure is 'level', we will only obtain the premium rate at the Commencement date of the plan, except if:

- there are any increases in the Benefit, in which case we will obtain the premium rate for the increase at the date of the increase, or
- we change the standard premium table so that the changes apply to all plans like this one, in which case we will apply your new premium rates based on the new standard premium table at the date of the change.

If you have a 'level' Premium structure, your Premium will change

If you have a 'level' Premium structure, your Premium structure will change to 'yearly stepped' from the first Renewal date after the person insured turns 65.

Yearly Stepped

Where the Premium structure is 'yearly stepped', we obtain the premium rate every year on the Renewal date of the plan.

The cost of providing the insurance cover will normally increase as the person insured grows older.

If you prefer, you may choose to keep the cost of providing the insurance cover the same each year and decrease your Benefit. If you wish to do that, you must let us know in writing. If you do that, the Benefit will be reduced so that it matches the premium you are paying and any special conditions that apply.

What are the charges?

27 All the charges (other than the cost of providing the insurance cover) for the plan are fully described in this section. We will not apply any other charges without your consent.

Plan Fee

The plan fee helps pay for the establishment and administration of the plan. The current plan fee for each payment method and frequency is outlined below:

Payment Method	Payment Frequency	Plan Fee per payment
Direct eg: cheque, cash BPAY® (Bank Account Debit only)	Yearly	$57.00
	Half Yearly	$30.00
	Quarterly	$15.00
Bank Account Debit eg: Bankcard, MasterCard or Visa card	Yearly	$57.00
	Half Yearly	$30.00
	Quarterly	$15.00
	Monthly	$5.00
	Fortnightly	$2.50

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In certain circumstances only one plan fee will be applicable. The conditions for this are outlined in clause 11.

The plan fee may be increased to take account of the effects of inflation. We will use the Consumer Price Index as outlined in clause 19 for any increase.

Instalment Fee

An instalment fee applies if you choose to pay more frequently than annually. The loading is three and a half per cent of the annual premium for half yearly cases and seven per cent for all other premium frequencies.

Government Stamp Duty

A government stamp duty is charged on this plan, and any options that have been attached to this plan, based on the state in which the person insured lives.

The stamp duty rates and how they are charged vary from state to state and depend on the type of insurance cover that has been purchased.

The stamp duty will be included in, or in addition to, the insurance premium. If the stamp duty is charged in addition to the insurance premium, it will be shown as a separate item on the Schedule.

State governments may change the rate of stamp duty from time to time, and any change may affect the amount you pay.

Variations

We can change the fees or charges which apply to the plan. If we change the fees or charges we will tell you in writing at least three months prior to the change occurring.

Taxation

28 We can change the standard premium tables, fees or charges at any time to take account of any change to taxation or revenue laws.

G Ending the plan

You can end the plan

29 You can end the plan at any time. If you cancel it in the first 14 days from the date your plan document is first received, you get your money back. If you cancel it after the first 14 days, you don't get your money back.

The plan ends on the date we receive your notice.

When the plan ends, you can no longer make a claim under the plan and we do not have to pay you any benefits. We will not refund you any premiums, except if the plan ends within the 14 day cooling off period.

When the plan will end

30 The plan automatically ends as soon as one of the following happens:

- when we have paid the Benefit in full, or
- the person insured dies, or
- on the Expiry date.

Other circumstances where the plan will end

31 We can also end the plan if:

- your premium is more than 30 days late. However, we will give you 28 days written notice before we end it for this reason, or
- you make a fraudulent claim.

When the plan ends, you can no longer make a claim under the plan and we do not have to pay you any benefits or refund you any premiums.

Restoring the plan

32 If the plan ends because your premium is more than 30 days late you have six months in which to ask us to restore it. When we are deciding whether or not to restore the plan, we may ask you for more information. You have to pay the premium and any premium owing. The plan is restored when we tell you that in writing.

We can set conditions

We can restore the plan on certain conditions. If we restore it on a condition that is inconsistent with the plan, that new condition takes priority.

What is covered?

If we restore the plan, it only applies in relation to a ***trauma event*** which occurs after it is restored.

H Meaning of words used in the plan

33 ***activities of daily living*** are the total inability to perform the following:

- bathing/showering
- dressing/undressing
- eating/drinking
- using the toilet to maintain personal hygiene, and
- getting in and out of bed, a chair or wheelchair or moving from place to place by walking, a wheelchair or with a walking aid.

34 ***carcinoma in situ*** means focal new growth of malignant cells that have not yet invaded normal tissues and have been diagnosed by biopsy.

35 ***medical practitioner*** means a registered medical practitioner who is appropriately qualified to treat the person insured for injury or sickness. The medical practitioner cannot be you or a family member, business partner, employee or employer, nor can it be the person insured or his or her family member, business partner, employee or employer.

36 ***trauma event(s)*** means one of the medical conditions as defined in this document in clause 18.

Issued by The National Mutual Life Association of Australasia Limited (ABN 72 004 020 437)