Plan Rules

Income Protection
Business Overheads Insurance

Keep this document it is part of your contract with AMP

Issued by AMP Life Limited ABN 84 079 300 379

Important information about this document

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

This document sets out terms and conditions that apply to your **Plan**, including definitions and eligibility requirements for claims.

For further information about the claim process, and examples of what we may pay you, you can ask for a copy of *"FLP in action!"* - available online at www.amp.com.au/flpfacts, or from your financial planner or AMP Customer Service.

Definitions

Some words and phrases used in this document are defined. These are defined in the glossary on pages 23-28. Each time one of these definitions is used, it will appear in type **like this.**

Throughout this document:

- AMP means the AMP Group (the AMP Group is made up of several entities, including AMP Life Limited).
- You, your and yourself means the **Plan** Owner named in the **Certificate of Insurance**.
- AMP Life, we, us, and our means AMP Life Limited.
- **Insured Person** means the person insured under the **Plan** as identified on the **Certificate of Insurance**.
- **Plan** Owner means the owner of the Plan as identified on the **Certificate of Insurance**.

Other expressions used in this document have the meanings attributed to them in the **Certificate of Insurance**.

All references to dollar amounts in this **Plan** Rules are references to Australian currency. All payments to and from us must be in Australian Dollars.

Introduction

Purpose of your Plan

INCOME PROTECTION	BUSINESS OVERHEADS INSURANCE
Income Protection helps maintain people's lifestyles. It does this by paying you a monthly amount while the **insured person** is so ill or injured that they are unable to work.	Business Overheads Insurance helps a business survive. It does this by paying you a monthly amount to reimburse **eligible business overheads** while the **insured person** is so ill or injured that they are unable to work.

Governing Law

This Plan is governed by the Life Insurance Act 1995, the Corporations Act 2001, and the Insurance Contracts Act 1984.

Our liability is limited

The assets of our No. 1 Statutory Fund - or any other statutory fund of which this **Plan** forms part at the time - are the only assets we will use to pay you under this **Plan**.

This **Plan** does not entitle you to share in any profits of AMP Life.

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When the Plan and cover start and end

When the Plan and cover start

Your **Plan** starts on the **Plan** start date shown in the **Certificate of Insurance**.

To keep your **Plan**, you will need to pay premiums as they become due.

We can end the **Plan** if you don't do this. However, if you don't pay on time, we will write and remind you and you will have 30 days to pay before we take steps to end the **Plan**.

When the Plan and cover end

Your **Plan** ends when cover for the last remaining **insured person** ends.

The **Certificate of Insurance** shows the expiry date for each cover.

Guaranteed continuation of cover

If you continue to ensure the premium payable under the **Plan** is paid, we guarantee to keep the cover going until the cover ends.

If you have the Basic level of cover, we can cancel the **Plan** when we have finished paying a claim (as explained on page 9 under "Income Protection Basic **Plans**").

24 hours a day worldwide cover

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

Restarting the Plan

You may apply to have your **Plan** reinstated should the **Plan** have been cancelled by us for non-payment of premiums. You must apply within 3 **months** after the due date of the premium you didn't pay. Reinstatement will be on such terms as we determine to impose at the time.

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**. You must tell us in writing if you want to put your **Plan** "on hold".

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**:

- (for Income Protection) starts **remunerative work** again, or
- (for Business Overheads insurance) starts **remunerative work** in a business that would suffer while they were **totally disabled**

and you tell us in writing that you wish to take the **Plan** "off hold".

We will take the **Plan** "off hold" in these circumstances without you having to give us any more information about the **insured person's**:

- (for Income Protection) health, pastimes or occupation, or
- (for Business Overheads Insurance) health, pastimes or occupation - other than telling us that they are involved in a business again.

Your premium once your **Plan** ceases to be "on hold" is no longer reduced. The premium when the **insured person** starts **remunerative work** again will be based on our premium rates at that time.

Keeping you informed - we send you an Annual Statement

Each year, we will send you an Annual Statement setting out the current details of your **Plan**, including the premium and plan fee for the following year.

Automatic Plan enhancements

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

We will write to you and advise you of the changes should automatic enhancements be made on your **Plan anniversary**.

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

Cooling off period

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

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

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

The indexation feature - increasing maximum monthly benefit

While we aren't paying a monthly benefit

Each year (unless otherwise agreed), on the **Plan anniversary**, we will increase the **maximum monthly benefit** under the **Plan**.

The amount we will increase the **maximum monthly benefit** by will be the percentage change in the **CPI** since the last **Plan anniversary** (or since the **Plan** commencement date if this is the first **Plan anniversary** under the **Plan**).

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

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

If you do not want this increase, in full or in part, then you need to tell us.

While we are paying a monthly benefit

For Income Protection Advanced **Plans**, we continue to increase the **maximum monthly benefit** on the same basis as mentioned.

For other **Income Protection Plans**, we will only increase the **maximum monthly benefit** where you have selected the Claim Escalation option (see page 18 under "Claim escalation option") and on the terms set out for that option.

No indexation is available on Business Overheads Insurance while we are paying a monthly benefit.

Premiums - what you have to pay

Both the initial premium you are required to pay and when it is due, are stated in your **Certificate of Insurance**.

Your initial premium includes a plan fee and any government taxes, duties, or charges relating to the **Plan**. Each year, on the **Plan anniversary** date, we may increase the plan fee by any increase in the **Consumer Price Index** since the last **Plan anniversary** date and will pass on any new or change to a tax, duty, or charge relating to the **Plan**.

Changes to premiums

Each year premiums are recalculated.

This is based on the current age of each **insured person** (except where a level premium option has been selected for the **insured person's** cover), the **monthly benefit**, any increase to the **monthly benefit** due to the indexation feature, any change to **premium rates**, any increase of the annual plan fee due to indexation, any premium frequency fee, and any government charges (eg **stamp duty**) that apply at that time.

We guarantee not to increase premiums at other times unless the government introduces a new tax, duty or charge, or changes an existing one.

Keeping the premium the same

If you do not want to have your premium increase at any **Plan anniversary**, you need to write to us before the **Plan anniversary** to let us know. As we will do this by reducing the **maximum monthly benefit**, you must also at that time let us know if you want to remove any options on your plan.

Premium rates are not guaranteed.

The **premium rates** for this **Plan** are not guaranteed and are regularly reviewed and may be changed. However, if we increase **premium rates** for this **Plan**, it will apply to all **Plans** that are considered by us to be similar to this one, and we will write to you to advise the amount of the new premium before this increase applies.

If we reduce our **premium rates** or we increase any discounts, we may keep your premium the same by increasing the **maximum monthly benefit** under your **Plan**. If we do that, we will tell you in writing before doing so.

Stepped and Level premiums

If you choose a Stepped premium, the **insured person's** current age will determine the premium payable each year.

You can choose a Level premium structure so that the **premium rate** doesn't increase each year just because the **insured person** gets older. A Level premium will continue to be based on the **insured person's** age when you started the cover.

Premium frequency fee

If you pay more often than yearly, any extra fee is included in your premium. It is a percentage of the annual premium payable. We can change this percentage at any **Plan anniversary** and we will tell you of the change before it applies.

When premiums don't need to be paid

You don't have to pay any premium if we are paying a benefit under this **Plan**.

For Income Protection 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 **totally disabled**, your **Plan** continues until the **insured person** turns 60 and you do not have to pay the premium while the **insured person** continues to be **totally disabled**.

When we determine whether the **insured person** is **totally disabled**, once the **benefit period** ends, we assess their ability to do any **remunerative work** for which they are reasonably suited by education, training or experience.

Refund of premiums

If you end the **Plan** during a period for which you have already paid the premium, we will refund the premium less the plan fee, **stamp duty** and government charges - for any unused complete **months**. We do not refund premiums if the **Plan** ends for any other reason.

Example

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

This right is in addition to any "cooling off" rights you have under this **Plan**.

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:

PHONE	FAX	MAIL	EMAIL
131 AMP (131 267)	1300 301 267	AMP Life Limited PO Box 300 PARRAMATTA NSW 2124	polinfo@amp.com.au

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 as possible.

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

- acknowledge that we received it and ensure an appropriate person properly considers the complaint, and
- respond to you as soon as we can and keep you informed of the progress, and
- aim to respond to your complaint within 10 working days (if we can't resolve it at first contact).

If your complaint is not resolved within 10 working days, then we will keep you informed of its status at regular intervals.

If we can't resolve your complaint to your satisfaction within 45 days, then you may have the right to lodge a complaint with the Financial Ombudsman Service (FOS) on:

PHONE	FAX	MAIL	EMAIL
1300 780 808	03 9613 6399	GPO Box 3 MELBOURNE VIC 3001	info@fos.org.au

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

Managing your Plan

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. 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 the **Plan** to anyone.

If your Income Protection Plan is owned by the Trustee of a self-managed superannuation fund or a small APRA fund because you are a member of the fund:

The trustee of that fund is solely responsible for ensuring that they have received independent financial and taxation advice about their ability to purchase one of the AMP products. AMP will make all payments to the trustee of the superannuation fund.

We strongly recommend that the trustee specifically requests advice in relation to the tax deductibility of premiums, the impact of the sole purpose test requirements of the Superannuation Industry (Supervision) Act 1993 (SIS) on the purchase of income protection and information regarding the release of any insurance payments received by the trustee from the insurer.

Benefits paid into the fund under the policy may be assessable income of the fund. The payment of the proceeds out of the fund to the member is not tax deductible. The amount is assessable as **income** to the member and taxed at their marginal rate of tax. This is because the benefits replace **income** that would be assessable income.

Changing the Plan

You may apply to change your **Plan** by writing to us. If we agree to those changes, we will write to you to confirm the changes and issue you a new **Certificate of Insurance**.

Guaranteed Future Insurability

*(Income Protection **Plans** only)*

You may increase the **maximum monthly benefit** without providing any evidence of health when the **insured person's income** increases. You may apply for the increase every 12 **months**, and provide us with appropriate proof of this increase in **income**.

Premiums will be based on the premium rates applicable at the time of exercising this feature.

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

- 10% of the **maximum monthly benefit**, 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.

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 remove this feature from your **Plan** 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.

What you need to know if you need to make a claim

How to make a claim - what to do

To make a claim you must contact us and we will send you a claim form to fill in and return to us. You must give us any documents and information we reasonably require to consider your claim.

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 and give us information about the circumstances surrounding their health.
- 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.

If any cost is incurred while you are getting this information, the cost will be yours. However, we will pay the costs of getting information from medical advisers we choose.

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.

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.

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 the **insured person** is 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.

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 **totally disabled**	Within one **month** of the **insured person** becoming **totally disabled**
The **insured person** is **partially disabled**	Within one **month** of **the insured person** returning to **remunerative work**
Rehabilitations 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

Late claims and responses

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

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**.

Income Protection Basic Plans

Following payment of a claim for Income Protection *Basic* **Plans**, we can elect by notice in writing to you to cancel the **Plan**. We may also elect to keep the **Plan** going on different terms.

Benefits - Income Protection Insurance

Your **Certificate of Insurance** will show the cover that has been selected for the **insured person**, the cover type (Advanced, Standard or Basic) and when the cover starts and ends.

Who we pay

We pay you.

What has to happen for us to pay

We pay you if the **insured person** is **totally disabled** or **partially disabled**. The amount we pay will differ depending on whether the **insured person** is **totally** or **partially disabled**.

Where the **insured person** is **totally disabled** or **partially disabled**, we may also pay you other amounts as more fully described below.

When we start to pay and how often

All benefits are paid monthly in arrears.

We will start to pay any benefit where the **insured person** is **totally disabled** after the end of the **waiting period** for this cover. The length of the **waiting period** is shown in the **Certificate of Insurance**. Because we pay in arrears, we make the first payment one **month** after the **waiting period** ends.

If the **insured person** is **able to work** for 5 days (or less) in a row, 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**. 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**.

If the **insured person** works more than 5 consecutive days during the **waiting period**, the **waiting period** will then recommence should the **insured person** become **totally disabled** again from the same cause.

If the **insured person** becomes **partially disabled** immediately after we have been paying them a benefit for their total disablement, we will continue to make payment of the partial disablement benefit on the same date (ie the **waiting period** does not start again). Otherwise we will pay any benefit after the end of the **waiting period**.

How much we pay

The table below 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**.

AGREED VALUE	INDEMNITY
If you selected this type of 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 any **income**, then we will reduce what we pay so that we pay a **monthly benefit** that is not more than 75% of the **insured person's pre-disability income**.	If you selected this type of 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 any **income**, then we will reduce what we pay so that we pay a **monthly benefit** that is not more than 75% of the **insured person's pre-disability income**.

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 on page 17.

Income just before the insured person was totally disabled or suffered 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**.

If the insured person is partially disabled

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:

$$\frac{(A - B)}{A} \times C$$

Where:

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

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

C = the **monthly benefit** we pay if the **insured person** is **totally disabled**.

Income while the 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**.

Benefit offsets

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 **Plans** that you obtained after you applied for Income Protection, if either the insurer did not consider this Income Protection **Plan** in assessing the **insured person's** eligibility or if the **insured person's** total **income** from all insurance **Plans** exceeds 75% of their **pre-disability income**.

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.

We can recalculate Income Protection payments

We can recalculate how much we pay, or have paid, if we did not include **income** of the type listed in under "Benefit offsets".

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.

Leaving remunerative work

We will pay the benefit if the **insured person** suffers an illness or injury 12 **months** after temporarily leaving **remunerative work** and is **totally disabled**. However, the definition of **totally disabled** changes.

The change is that the first dot point:

- 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**.

Relapse

RELAPSE - BENEFIT PERIODS "TO AGE 60 OR 65"	RELAPSE - BENEFIT PERIODS 1, 2 OR 5 YEARS
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**.	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 following 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.

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.

When we won't pay

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.
- 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, or
- If the **insured person** at the time they became **totally disabled** or **partially disabled** had left, and never intends to return to, **remunerative work** for reasons other than illness or injury.

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

When we stop paying

IF THE INSURED PERSON IS TOTALLY DISABLED	IF THE INSURED PERSON IS PARTIALLY DISABLED
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**, or – all the periods we have paid add up to the **benefit period**, or – the **Plan** ends, or – the **insured person** dies.	We stop paying as soon as any one of the following happens: – the **insured person** becomes **totally disabled** again. (We start paying again 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 the benefit, 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 add up to the **benefit period**, or – the **Plan** ends, or – the **insured person** turns 65, or – the **insured person** dies.

Plan Features - Income Protection Plans

There are 3 types of cover available. Your **Certificate of Insurance** will show which one you have chosen.

1. Advanced.
2. Standard**.**
3. Basic.

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

FEATURES OFFERED UNDER THESE PLANS ARE	ADVANCED	STANDARD	BASIC	EXPLAINED ON PAGE
24 hour cover worldwide	✔	✔	✔	4
Cooling off period	✔	✔	✔	4
Agreed value or Indemnity	✔	✔	✔	10
Total disability payment	✔	✔	✔	10
Partial disability payment	✔	✔	✔	11
Up to 3 months payment while overseas	✔	✔	✔	9
Cover guaranteed to continue after a claim has been paid	✔	✔	✗	4
Automatic CPI increase in benefit while not on claim	✔	✔	✔	5
Automatic CPI increase in benefit while on claim (claim escalation option)	✔	Opt	Opt	5 and 18
Guaranteed future insurability	✔	✔	✔	8
Rehabilitation costs feature	✔	✔	✔	13
Rehabilitation bonus	✔	✔	✔	14
Trauma feature	✔	✗	✗	14
Bedcare feature	✔	✗	✗	14
Major facture or loss fracture	✔	✗	✗	15
Overseas transport benefit	✔	✔	✔	16
Domestic transport benefit	✔	✗	✗	16
Accommodation benefit	✔	✗	✗	16
Family support benefit	✔	✗	✗	16
Death feature	✔	✔	✗	16
Superannuation contribution option	Opt	Opt	Opt	17
Chronic condition option	Opt	✗	✗	17
Day 1 accident option	Opt	Opt	✗	18
AIDS exclusion option	Opt	Opt	Opt	18

Rehabilitation costs feature

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 **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.

We won't pay:

- if we disagree with the **doctor**
- any part of the costs which you or the **insured person** can recover from anywhere else
- any costs after the **insured person** turns 65.

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.

We won't pay:

- if we disagree with the **doctor**
- any part of the costs which you or the **insured person** can recover from anywhere else
- any costs after the **insured person** turns 65.

Trauma feature

*(Income Protection Advanced **Plans** only)*

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 start to pay from the date the **insured person** meets the definition for the specified **trauma condition** as described on pages 23-25.

We pay you once each **month** in arrears for 6 **months** under this feature, and the first payment will be made one **month** after the date the **insured person** meets the definition for the specified **trauma condition**.

Each **month**, we pay the same amount that we would pay if the **insured person** were **totally disabled**. However, we do not take account of any **income** they receive from **remunerative work** or any **income** described in benefit offsets on page 11.

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

Cover for some trauma conditions delayed

We will not pay for any **trauma conditions** that an **insured person** suffers within 3 **months** of either:

- the date this cover starts, or
- an increase to the sum insured (other than regular **CPI** increases) is confirmed by us in writing (in respect of the increased portion only), or
- the most recent reinstatement of the **Plan**.

If an **insured person** suffers one of the **trauma conditions** within one of the 3 **month** periods mentioned above, then we will never pay for that condition even if the **insured person** suffers it again.

Please note, we may pay the benefit if the **trauma condition** causes the **insured person** to be **totally disabled**, or to earn less as explained on pages 10-11.

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 **partially disabled**, we may keep paying, or
- the **Plan** ends, or
- the **insured person** turns 65, or
- the **insured person** dies.

Bedcare feature

*(Income Protection Advanced **Plans** only)*

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 you, or a member of your immediate family or of the **insured person**.

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.

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.

Major fracture or loss fracture

*(Income Protection Advanced **Plans** only)*

We pay each time the **insured person** suffers one of the **major fractures or losses** in the following tables, and if they suffer more than one in the same incident, we pay for the one with the longest payment period.

We pay the same amount that we would pay if the **insured person** were **totally disabled**, and we do not take account of any **income** they receive because they do **remunerative work**.

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
An ankle	1
A hand# (requiring a plaster cast or surgery)	1
A forearm above the wrist	1
A collar bone	1
A 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 2 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.

We start to pay under this feature from the date the **insured person** suffers the specified fracture or loss.

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

Because we pay in arrears, we make the first payment one **month** from the date the **insured person** suffers the specified fracture or loss.

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 this page for the relevant **major fracture or loss**. However, if the **insured person** is **totally disabled**, or **partially disabled**, we may keep paying the **monthly benefit** provided the **insured person** has met the **waiting period** from the date the **insured person** first became **totally disabled**, 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.

Overseas transport benefit

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.

Domestic transport benefit

*(Income Protection Advanced **Plans** only)*

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.

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

- ambulance services within the meaning of s67(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**.

Accommodation benefit

*(Income Protection Advanced **Plans** only)*

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.

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.

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

Family support benefit

*(Income Protection Advanced **Plans** only)*

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 **insured 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**.

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

Death feature

*(Income Protection Advanced and Standard **Plans** only)*

If the **insured person** dies while we are paying a benefit for total or partial disablement, 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**.

Options

The following are options that you may select for your **Plan** if you have an Income Protection **Plan**. Some of the options are restricted to one or more types of Income Protection Plans. Your **Certificate of Insurance** will show if the option has been selected and when it starts and ends.

The options available for Income Protection **Plans** are:

Superannuation Contribution option

*(Available for all Income Protection **Plans**)*

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 **monthly benefit.**

This additional amount must then be directed towards the **insured person's** superannuation arrangements. Please note, the **maximum monthly benefit** in the **Certificate of Insurance** already includes this 12% amount if the *Superannuation Contribution option* applies to your **Plan**.

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.

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.

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.

When we stop paying

We stop paying the *Superannuation Contribution 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, or
- the **Plan** ends as described on page 4.

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.

Chronic condition option

*(Available for Income Protection Advanced **Plans** only)*

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 a **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 on pages 10-11, for the same period. We calculate their **income** in this instance, on a weekly basis.

While the **insured person** has a **chronic condition**, the **monthly benefit** we pay, when added to **income** the **insured person** earns, equals the benefit we would pay if the **insured person** was **totally disabled** - see page 10.

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 page 10.

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*.

When we start to pay and how often

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

We start to pay from the later of:

- the date the **insured person** first meets the requirements of **chronic condition** defined on the previous page, 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**.

This means we make the first payment one **month** after the date we start to pay in accordance to the terms described above.

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 the previously mentioned conditions.

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.

The **waiting period** does not apply to this option but please note the 3 **months** requirement as defined in this benefit section on page 14.

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 under the terms of being **totally disabled** 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 as described on page 17. (However, if the **insured person** has a **relapse** within 12 **months**, and they meet the requirements set on page 11, 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.

Day 1 Accident option

*(Available for Income Protection Advanced and Standard **Plans** only)*

If you have selected this option, a benefit is only payable if the **insured person** is **totally disabled** as a result of an **accident**.

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

This benefit is payable:

- until the insured person is no longer **totally disabled**, or
- until the end of the **waiting period**, or
- for 30 days,

whichever occurs first.

We pay each **month** in arrears and we pay one-thirtieth of the **monthly benefit** for each day that the **insured person** is **totally disabled** as a result of an **accident**.

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 Fracture*.

AIDS exclusion option - premiums are reduced if you have chosen this option

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

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

Claims escalation option

*(Available for Income Protection Standard and Basic **Plans**)*

If you choose this option, we will increase benefit payments made to you under a claim by the percentage change in the **CPI** 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.

Benefits - Business Overheads Insurance

Your **Certificate of Insurance** will show the cover that has been selected and when the cover starts and ends.

Who we pay

We pay you.

What has to happen for us to pay

We pay you if the **insured person** is **totally disabled** or **partially disabled**. The amount we pay will differ depending on whether the **insured person** is **totally disabled** or **partially disabled**.

When we start to pay and how often

All benefits are paid monthly in arrears.

We will start to pay any benefit where the **insured person** is **totally disabled** after the end of the **waiting period** for this cover. The length of the **waiting period** is shown in the **Certificate of Insurance**. Because we pay in arrears, we make the first payment one **month** after the **waiting period** ends.

If the **insured person** is **able to work** for 5 days (or less) in a row, 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. 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**.

If the **insured person** works more than 5 consecutive days during the **waiting period**, the **waiting period** will then recommence should the **insured person** become **totally disabled** again from the same cause.

If the **insured person** becomes **partially disabled** immediately after we have been paying them a benefit for their total disablement, we will continue to make payment of the partial disablement benefit on the same date (ie the **waiting period** does not start again). Otherwise we will pay any benefit after the end of the **waiting period**.

How long we will pay you

We generally only pay for up to 12 **months**.

However, if we have been paying you for a period of 12 **months**, and the **insured person** continues to be **totally disabled**, we will extend the period we pay you if the total amount we have paid is less than 12 times the **maximum monthly benefit**.

We will continue to pay you:

- for a period of 6 **months**, or
- until the total amount we have paid you equals 12 times the **maximum monthly benefit**
- until the **insured person** ceases to be **totally disabled**, or
- until the **Plan** ends,

whichever comes first.

What we pay

The insured person is totally disabled

Each **month**, we pay an amount equal to the **maximum monthly benefit** or the **eligible business overheads** for that month (if those overheads are lower than the **maximum monthly benefit**).

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

This rule sets out how we calculate the amount we pay while the **insured person** is **totally disabled**.

1. To work out how much to pay each month we calculate 2 amounts.
2. The first amount we calculate each **month** is:
   - the total amount of **eligible business overheads** the business has actually paid since the end of the **waiting period**,

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

     and reduced by:
   - any amount which the person who replaces the **insured person** has generated (since the end of the **waiting period**) in excess of the amount they cost.
3. The second amount we calculate is:
   - the **maximum monthly benefit** multiplied by the **number of months** since the end of the **waiting period**.
4. We take the lower of the 2 amounts and subtract the total amount we have paid you since the end of the **waiting period**. We pay you the total after that subtraction.
5. We deduct any taxes or government charges:
   - which the law requires us to deduct, or
   - which have to be paid and which we decide to deduct.

Example

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

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

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

In February, Maria's business has an expensive month - her insurance, rates, and electricity bills arrive. Maria's eligible business costs are $2,350. We pay Maria the **monthly benefit**, $2,000 plus the $200 left over from January.

And we carry the $150 of unpaid overheads into the next month, March.

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

If the insured person is partially disabled

Each month we pay an amount equal to:

$$\frac{(A - B)}{A} \times C$$

Where:

A = The **insured person's "pre-disability business income**" earned before they became **totally disabled**

B = The **insured person's** current monthly **business income** earned from working (where they are earning less)

C = The lower of:

- the **maximum monthly benefit**, or
- **eligible business overheads** for that **month**.

Eligible business overheads we include

"Eligible business overheads" include:

- Salaries of non-**income** producing staff - including family members who have been employed for more than 3 **months** in the business at the date the **insured person** became **totally disabled**. For example, we will pay salaries for secretaries, book-keeping staff, etc. We also pay costs directly relating to those salaries. For example, we pay workers compensation and superannuation costs.
- Rent and mortgage interest payments for the business premises - unless they are also the **insured person's** residence.
- Property rates and property taxes.
- Leasing costs for office equipment and motor vehicles.
- Electricity, water, heating, and telephone bills.
- Cleaning and laundry bills.
- General insurance premiums.
- Subscriptions to professional associations.
- Advertising costs.
- Accountants' and auditors' fees.

Many other usual business overheads are also covered.

Note: When the business employs someone to replace the **insured person**, if all the reasonable costs of employing that replacement person (eg salary, travel, accommodation, superannuation, etc) exceed the **business income** the replacement generates, then we treat that excess as an eligible business overhead.

Overheads we won't pay

The following costs are not **eligible business overheads**:

- Any form of remuneration paid to:
  - The **insured person.**
  - Someone who is not a genuine employee adding value to the business
  - The person who replaces the **insured person** - for example a locum
  - People who earn **income** for the business
  - Any member of the **insured person's** family who has been employed for less than 3 **months** in the business at the date the **insured person** became **totally disabled**.
- The cost of stock, equipment, or other assets of the business.
- Payments of the principal of any mortgage or debt.
- Any rent or mortgage payments on the **insured person's** residential premises - even if the **insured person** uses those premises for their business.
- Any tax the business has to pay.
- Any depreciation.
- Expenses which the business does not incur regularly, and
- Expenses which are not normal and necessary for the business.

Relapse

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 12 **month** period, we will only pay for a **relapse** if the **insured person** has worked in their usual occupation for at least their **usual income** for at least 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 12 **month benefit period** start again.

The following rule applies if:

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

If the **insured person** suffers the **relapse** at least 6 **months** after we stopped paying, then we treat it as a new claim and both the **waiting period** and 12 **month** period start again.

If the **insured person** suffers the **relapse** within 6 **months** after we stop paying, we treat the claim as a continuation of the previous claim.

The **waiting period** and the 12 **month** period do not start again. Instead, we add up all the periods we pay you for that claim and treat them as one 12 **month** period.

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.

When we won't pay

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.
- 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.
- If the **insured person** at the time they became **totally disabled** or **partially disabled** had left, and never intends to return to, **remunerative work** for reasons other than illness or injury, or
- If the **insured person** becomes **totally disabled** or **partially disabled** more than 12 **months** from leaving r**emunerative work**.

We don't regard pregnancy or childbirth as either an illness or an injury, so we don't pay for this condition.

When we stop paying

IF THE INSURED PERSON IS TOTALLY DISABLED	IF THE INSURED PERSON IS PARTIALLY DISABLED
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**, or – all the periods we have paid because of one claim add up to 12 **months**ˆ, or – the **Plan** ends, or – the **insured person** dies.	We stop paying as soon as any one of the following happens: – the **insured person** becomes **totally disabled** again. (We start paying again 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 the benefit, 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 12 **months**ˆ, or – the **Plan** ends, or – the **insured person** turns 65, or – the **insured person** dies.

ˆ Payments may be made below this under certain circumstances (see page 19 - "How long we will pay you").

Locum bonus

Where we are paying a claim, and you have employed a locum to the **insured person's** position, we will pay you a lump sum amount of $1,000 to help you meet the cost of this appointment.

This bonus is payable once only during the term of the Business Overheads Insurance Plan. The Indexation feature does not apply to the $1,000 Locum bonus.

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

This is an option available to opt-out of AIDS cover. The **Certificate of Insurance** shows if it applies to your **Plan**.

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

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

Trauma definitions and descriptions

Aortic surgery

The **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

The **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
- AIDS or HIV related cancers, or
- tumours which are histologically described as pre-malignant or showing malignant changes of "carcinoma in situ" other than those requiring treatment similar in extent to that which would be undertaken for invasive carcinoma. Treatment in this instance is defined as surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy).

Glossary of terms

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

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

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

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

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

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

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

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

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

The **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

The **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

The **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

The **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

The **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

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

The **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

The **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

The **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

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

The **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

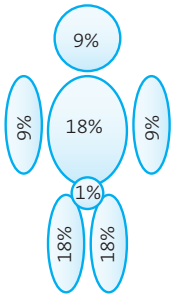
The **insured person** suffers third degree burns to 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart shown below.

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

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

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

Lund Browder Body Surface Chart



Stroke

The **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

Accident

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

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**.

Business income

The share of monthly **income** earned by the business as a result of the **insured person's** personal exertion or activities. We do not include investment income.

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 pages 17-18.

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.

Eligible business overheads

Eligible business overheads is the name we give to those overheads which we pay for under this **Plan**. They are listed on page 20. There is a list of overheads for which we don't pay on page 21.

Income

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**.

Major fracture or loss

Major fracture or loss means a fracture or loss which we cover as set out on page 15.

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**.

Partially Disabled

The **insured person** is **partially disabled** if they do 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.

Partially disabled has a corresponding meaning.

Plan

Plan is explained under the heading "Definitions" on the inside of the front cover.

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**.

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**.

Pre-disability business income

One-twelfth of the **insured person's** share of the **business income** during the 12 **months** before the **insured person** became **totally disabled**.

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**.

Stamp duty

This is a government tax. The amount of **stamp duty** payable on the insurance **Plan** will depend on the type of insurance cover and the State/Territory in which the **insured person** lives (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.

Trauma conditions

The **trauma conditions** which we cover are listed on page 14.

The full description of each of them is set out on pages 23-25.

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**.

Total disability has a corresponding meaning.

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**.

Contact your adviser or financial planner

Phone 133 888
Web www.amp.com.au

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

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