Westpac Protection Plans

Product Disclosure Statement and Policy Document (‘PDS’)

Westpac Term Life
Westpac Term Life as Superannuation
Westpac Standalone Living Insurance
Westpac Standalone Total and Permanent Disablement
Westpac Income Protection
Westpac Income Protection Plus
Westpac Business Overheads

This PDS is dated 1 December 2008

Westpac
Your future is our future

Welcome. This document sets out the conditions of the Westpac Protection Plan policies. Please contact our Customer Relations Centre on 131 817 if you have any questions about your Policy/ies.

Issued by:

- For all products except Westpac Term Life as Superannuation, Westpac Life Insurance Services Limited ('Westpac Life') ABN 31 003 149 157, Australian Financial Services Licence Number 233728.
- For Westpac Term Life as Superannuation, Westpac Securities Administration Limited ('WSAL') ABN 77 000 049 472, Australian Financial Services Licence Number 233731, RSE Licence Number, L0001083, the Trustee of Westpac Term Life as Superannuation, which is part of the Superannuation Division of the Westpac MasterTrust SFN 281412, SPIN WFS0112AU, RSE Licence Number R1003970, ABN 81 236 903 448.

Contact Us

131 817

8.00am to 6.30pm (Sydney time) Monday to Friday

Send your applications to:
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275 Kent Street
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Westpac Life and WSAL take full responsibility for the whole of this PDS. Westpac Term Life, Westpac Standalone Total and Permanent Disablement and the insurance policy issued by Westpac Life to WSAL under Westpac Term Life as Superannuation are included in the Westpac Life No. 1 Statutory Fund. All other Westpac Protection Plan products in this Policy are included in the Westpac Life No. 4 Statutory Fund.

Westpac Term Life as Superannuation is issued by WSAL. WSAL is a wholly owned subsidiary of Westpac Banking Corporation ABN 33 007 457 141 ('Bank'). Westpac Term Life as Superannuation is not a deposit or other liability of the Bank. The Bank does not guarantee the benefits payable in relation to the product.

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SECTION A:

Important Information for all Westpac Protection Plans

Welcome to Westpac Life

Westpac Life has over 357,000 customers[1] with premiums in-force of $267 million, and a total sum insured of $90.2 billion.

Financial advice

Achieving your goals starts with a good financial plan – the roadmap outlining where you want to be, what you want to be doing, when you want to do it, and how you want to get there. A professional financial planner can make a detailed assessment of your financial situation, help define your goals, and select products that suit your needs.

Westpac Protection Plans Overview

The Westpac Protection Plan range comprises the following products:

Product	Who needs this?	How does this help you?	For more information go to page
Westpac Term Life	People who want to protect their beneficiaries and cover their debt.	A benefit payable on death or terminal illness, with options for additional protection: ■ on Total and Permanent Disability; or ■ on suffering a specified serious medical condition or injury or undergoing specified surgery.	8
Westpac Term Life as Superannuation	People who want to protect their beneficiaries and cover their debt via superannuation.	A benefit payable on death or terminal illness, with an option for additional protection on Total and Permanent Disability.	9
Westpac Standalone Living Insurance	Anyone who is concerned about protecting themselves.	A benefit payable on suffering a specified serious medical condition or injury or undergoing specified surgery.	28
Westpac Standalone Total and Permanent Disablement	People who are concerned about their debt and loss of income.	A benefit payable on becoming Totally and Permanently Disabled.	39
Westpac Income Protection	Anyone who needs to replace their income if they are not working.	A regular monthly income if you become disabled because of Sickness or Injury and are unable to work.	44
Westpac Income Protection Plus	Anyone who needs to replace their income if they are not working.	A regular monthly income if you become disabled because of Sickness or Injury and are unable to work, together with a number of additional benefits.	44
Westpac Business Overheads	People who play a major part in their business.	Pays a monthly benefit for the day to day costs of running your business if you are disabled because of Sickness or Injury and are unable to work in your business.	58

1. Figure at 1 September 2007 and excludes consumer credit and group life customers.

Things to Read First

1. About this PDS

(a) The Westpac Protection Plans

This document contains important information about the following products, which are collectively referred to as the 'Westpac Protection Plans':

- Westpac Term Life
- Westpac Term Life as Superannuation
- Westpac Standalone Living Insurance
- Westpac Standalone Total and Permanent Disablement
- Westpac Income Protection
- Westpac Income Protection Plus
- Westpac Business Overheads

(b) Keep this booklet safe

For Westpac Protection Plans:

You will be forwarded a 'Policy Schedule' once your application has been approved. Your Policy Schedule sets out the details of the insurance we provide you. This PDS contains important information about the Westpac Protection Plans. This PDS and Policy Schedule are evidence of your contract with us ('Policy'). You should keep this PDS and Policy Schedule in a safe place. You should read this PDS and Policy Schedule carefully.

For Westpac Term Life as Superannuation:

This PDS combined with the Trust Deed and the Trustee's Policy Document with Westpac Life contain the full terms and conditions of this product. You can request a free copy of the Trust Deed and Policy Document by contacting us. You will be forwarded a membership certificate once your application has been approved. These are all important documents which should be read carefully and kept in a safe place.

(c) Contact us

If there is something that you don't understand, please call us or speak to your financial planner.

2. Changes to this PDS

(a) Supplementary PDS

The information in this PDS may change from time to time. When such change is materially adverse, we will issue a supplementary or replacement PDS.

Any other changes to the information in this PDS will be available to you at any time on our website. You can ask for a paper copy of such information free of charge by contacting us.

(b) No financial advice

The information in this PDS does not take account of your financial situation, objectives or needs. Before acting on any information in this PDS, you should consider whether it is appropriate to your financial situation, objectives or needs.

The offer made in this PDS is available only to persons receiving this PDS in Australia.

3. Definitions – who is the insured and who do we pay

For all Westpac Protection Plans apart from Westpac Term Life as Superannuation:

- the person whose life is insured is called the 'Insured Person'. There may be up to 5 insured people. The name of each Insured Person is in the Policy Schedule under the heading, Insured Person.
- the person to whom the benefit is paid is called the 'Policy Owner' and is referred to as 'you'. The name of the Policy Owner is on the Policy Schedule under the heading, Policy Owner. The Insured Person need not be the Policy Owner.
- 'we', 'us' and 'our' refer to Westpac Life.
- 'Review Date' is the anniversary of the date your insurance cover started.

For Westpac Term Life as Superannuation:

- 'you' and 'your' refer to the Insured Person.
- the Policy Owner is the Trustee.
- 'Review Date' is the anniversary of the date your insurance cover started.
- 'we', 'us' and 'our' refer to Westpac Life.

4. How to apply

(a) Application form

You can apply for a Westpac Protection Plan product by completing the application form attached to this PDS, or by completing an online form with your financial planner. You can lodge the application through your financial planner.

(b) Personal statement

The Insured Person will need to complete and lodge a personal statement, which asks questions about their health and medical history, occupation, financial information, pursuits, pastimes and other details we require to assess an insurance application. In some cases, we may require further information – for example a medical examination, blood tests or more detailed financial information. Privacy legislation protects all personal information and gives you and each Insured Person rights in regard to the way we handle that information. Full information on Privacy can be found on page 70.

When completing the application form and personal statement or providing us with any other information you and each Insured Person must comply with the duty of disclosure as outlined in section 5.

Important Information for all Westpac Protection Plans

5. Information you must provide – your duty of disclosure

(a) What your duty requires

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

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

(b) What your duty does not require

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 its business, ought to know;
- as to which compliance with your duty is waived by the insurer.

Your duty of disclosure extends beyond the time of your completion of the application up until the insurer accepts the application and issues a Policy.

(c) This Policy is based on the fact that you and each Insured Person:

- filled in the application form, the personal statement and any other form or information we requested, completely and accurately; and
- read and understood the material on these forms. This is very important.

This will help us determine:

- whether to provide the insurance;
- how much to charge for it; and
- whether any special conditions apply.

If you and any Insured Person complete an application online with your financial planner, you and each Insured Person must ensure that the information provided on the online application form, personal statement(s) and any other form is true and correct and that you and each Insured Person have not withheld any information material to the application. You and each Insured Person must read, check and understand the information submitted to us.

If the health, occupation or pastimes of any Insured Person has changed between the time you and that Insured Person filled in any of the forms that we required, and the time we issue your Policy Schedule to you, you must tell us. If you have not already told us, you must do so now.

(d) What happens if you or any Insured Person does not follow these instructions

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

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

So, if you think that either you, or any Insured Person, may not have followed the instructions, please tell us now.

(e) For Westpac Term Life as Superannuation

If you are applying for Westpac Term Life as Superannuation, the insurance policy is issued by Westpac Life to WSAL for your benefit. In these circumstances, WSAL has a duty of disclosure (as explained above) to the insurer, Westpac Life. To enable WSAL to comply with its duty of disclosure, you must disclose to WSAL and Westpac Life every matter that you know, or could reasonably be expected to know, is relevant to Westpac Life's decision whether to accept the risk of the insurance and, if so, on what terms. The consequences of non-disclosure are the same as described above.

6. Assessing your application

(a) What happens after we assess your application

Once we have received all the required information your application will be assessed.

We may offer to provide insurance that is different to what you applied for. For example, we may offer insurance for a lower amount, at a higher premium or with an exclusion applying for certain types of claims. When this happens, we will write to you requesting your agreement to proceed with the application on these terms. In some cases we will not be able to accept your application for cover. We will write and tell you if this occurs.

(b) Interim accident cover

After we have received a fully completed application form and personal statement and while we are assessing your application, we will provide you with interim accident cover. Full details of this cover is provided in the Interim Accident Cover Certificate on page 72.

7. When this Policy starts and your Review Date

Your insurance cover commences once we accept your application and issue you a Policy Schedule (or Policy information statement, membership certificate and the latest Fund annual report for Westpac Term Life as Superannuation). The Policy Commencement Date is listed in the Policy Schedule.

Once each year we review the premium that you pay. We call this the 'Review Date'. This is the anniversary of the date your Policy started and is shown in the Policy Schedule.

8. Cooling off period

(a) Cancelling your insurance

When you receive your insurance documents, please read these carefully. If you are not completely satisfied you may cancel your insurance. You have until the earlier of:

- 19 days from the day your insurance commenced; or
- 14 days after you receive your insurance documents.

If you would like to cancel your insurance within this cooling off period, please contact us. When we receive your advice to cancel, we will cancel the insurance from the Commencement Date and refund any payments you have made (less any tax that may apply to your premium).

Please note that you cannot exercise the right of cooling off if you have already made a claim under the insurance Policy.

(b) Cancelling your Westpac Term Life as Superannuation Policy

In addition to paragraph (a), for Westpac Term Life as Superannuation, if your payment includes amounts which superannuation laws do not permit you to take as cash, you will need to transfer these amounts to another superannuation or rollover fund. You must advise us, within one month, of the name and details of the superannuation or rollover fund that you want your monies to be transferred to. If we do not receive these details within one month after you tell us you want to cancel your insurance you will lose your right to cancel the insurance during the cooling off period.

9. Protection against inflation

(a) The Consumer Price Index (CPI)

To protect the value of your benefits against being eroded by inflation, we will automatically index the amount of your benefits each year on your Review Date in line with increases in the CPI. The increase we make to your benefits will normally be based on the weighted average CPI of eight capital cities combined, published by the Australian Bureau of Statistics or its successor over the 12 month period ending 31 March each year. It will apply for the next year starting 1 October.

Benefits under Term Life, Term Life as Superannuation, Standalone Living Insurance and Standalone Total and Permanent Disablement are subject to a minimum CPI increase of 3% a year. Where the CPI is less than 3%, the minimum 3% indexation increase will apply.

(b) Declining the CPI increase

You may decline this increase by advising us in writing within 30 days of the Review Date. You may also request in writing that indexation increases never apply again. In this case, we may agree to a subsequent request to restart indexation increases, but we may ask you for information on the Insured Person's health, occupation or pastimes. If any of these have changed, we may not restart CPI indexation.

10. Where we put your money

Westpac Term Life, Westpac Standalone Total and Permanent Disablement and the insurance policy issued by Westpac Life to WSAL under Westpac Term Life as Superannuation are included in Westpac Life No. 1 Statutory Fund. All other Westpac Protection Plan products in this Policy are included in the Westpac Life No. 4 Statutory Fund. We pay your benefits from these funds. The money in the funds is protected under the Life Insurance Act 1995.

11. This Policy has no cash value

None of the products in the Westpac Protection Plans allow you to share in any profit or surplus and your Policy does not have a surrender or cash value. If you cancel your insurance at any time except within the cooling off period, you will not be entitled to any payment.

Westpac Protection Plans Product Range

Westpac Term Life and Westpac Term Life as Superannuation

A snapshot of Westpac Term Life Cover in action*

Geoffrey was a small business owner who banked with Westpac. 12 years ago he took out a Westpac Term Life policy for $1,000,000, nominating his wife, Vesna, as sole beneficiary. Geoffrey's cover was automatically indexed to the Consumer Price Index (CPI) so that the sum insured would keep pace with inflation.

Geoffrey died after becoming ill with Melanoma. Vesna lodged a claim with Westpac Life and a payment of $1,163,775 was made (given that the rest of the policy terms and conditions were satisfied). The automatic CPI increase to Geoffrey's sum insured saw his cover increase by $163,775 over the life of his policy.

As Geoffrey had nominated his wife as his sole beneficiary, Westpac Life was able to pay the claim in a timely fashion, protecting Vesna from financial stress during a time of great grief.

Some examples of Term Life cover claims paid:

Cause	Skull fractures	Cardio/respiratory failure	Industrial accident
Occupation	Tree Surgeon	Accountant	Chemist
Age at claim	34	65	40
Years in force	4 years	8 years 6 months	13 years
Amount paid	$365,115	$852,061	$374,178

(Source: Claims data from Westpac Life Insurance Services Limited.)

*For illustrative purposes only. The above is a case study of a real life example (names have been altered) and demonstrates how Westpac Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

1. Introduction

1.1 Westpac Term Life

Westpac Term Life pays a benefit if the Insured Person dies or suffers a terminal illness. It can insure the lives of up to five people. Under this Policy we will pay you (or your Beneficiaries – see section 2.4) a benefit if any Insured Person dies. We call this a Death Benefit. We may also pay you a benefit if any Insured Person suffers a terminal illness.

For an additional cost, optional benefits such as a Disability Benefit can be added to the Policy. These are set out in the table on this page.

1.2 Westpac Term Life as Superannuation

Westpac Term Life as Superannuation offers the same benefits as Westpac Term Life, except that only one life can be insured and you may be able to benefit from the tax concessions available through superannuation. You must be eligible to make contributions to a superannuation fund (see section 3.5).

1.3 Summary table

Standard Benefits	Description	Term Life	Term Life as Superannuation	For full details see page
Death	Pays a benefit if the Insured Person dies before the Death Benefit ends.	✓	✓	12
Terminal Illness	Pays a benefit if the Insured Person suffers a terminal illness or condition and is not expected to live more than 12 months.	✓	✓	12
Future Insurability	Allows you to increase your Death Benefit without further health evidence when a special event occurs.	✓	✓	13
Financial Planning	Reimburses up to $1,500 (in addition to your Death Benefit) to cover the cost of obtaining financial advice following an eligible claim.	✓	✗	15
Funeral Advancement	Advances you up to $10,000 of the Death Benefit to cover funeral expenses and immediate costs following the Insured Person's death.	✓	✗	15
Optional Benefits (available at additional cost)				
Disability	Pays a benefit if the Insured Person becomes Totally and Permanently Disabled (TPD). A benefit may also be payable on partial disability (not available in Term Life as Superannuation).	✓	✓	16
	Waiver of Life Premium Benefit: Waives all premiums payable on a Westpac Term Life policy if the Insured Person is Totally and Temporarily Disabled.	✓	✗	19
Living	Pays a benefit if the Insured Person suffers a specified serious medical condition or injury or undergoes specified surgery. You are automatically entitled to buy back your Death Benefit one year after a Living Benefit payment.	✓	✗	19
Buying Back your Benefits	Allows you to buy back some of your benefits in a variety of ways. NOTE: Buying back your Death Benefit following a Disability Benefit payment is available under Term Life as Superannuation.	✓	✗	22
Multi-link	This benefit is suitable for the purposes of business loan protection for two or more business owners. It enables each business owner to be insured for the full amount of a business loan.	✓	✗	24

2. How Westpac Term Life works

2.1 Eligibility

Age Limits*		
Benefit	**Entry Age**	**Expiry Age**
Death	15–69	99
Terminal illness	15–69	99
Future insurability	15–54	55
Disability	15–59	At age 65, cover reverts to the 'General' definition. 'General' cover ceases at age 99.
Living^	15–59	65

*Entry age is the Insured Person's current age. Expiry age is the age as at the Review Date immediately before the Insured Person's birthday.

^This benefit is not available under Term Life as Superannuation.

2.2 Who is the Insured Person and who is the Policy Owner

You can apply for a Westpac Term Life Policy on your own life, in which case you are the Insured Person as well as the Policy Owner. You can also apply for a Westpac Term Life Policy on someone else's life (for example your spouse or partner), in which case the other person is the Insured Person and you are the Policy Owner.

Up to a maximum of five people can own the Policy and each Policy Owner will own the Policy jointly. The Policy Owner(s) pay premiums that are due under the Policy. When a Policy Owner dies, ownership of the Policy automatically goes to the surviving Policy Owners. If all Policy Owners have died, and the Policy has not ended (see section 14), the Policy Owner is the estate of the last surviving Policy Owner.

For each Insured Person, you apply for the amount of Death Benefit you wish to insure this person for. You can also apply for increased protection with a Disability Benefit and/or a Living Benefit. The amount you apply to insure for under each of these benefits can be different to, but no more than, the Death Benefit amount.

2.3 Who receives any benefits payable

The Policy Owner(s) will receive any benefits that become payable, except for a Death Benefit when there is a nominated Beneficiary. A 'Beneficiary' is a person who is paid a Death Benefit or share of a Death Benefit at your direction.

If there is no nomination of Beneficiaries and the Insured Person dies, the Death Benefit is paid equally between the surviving Policy Owners. If there are no surviving Policy Owners, and the Policy has not ended (see section 14), the benefit goes to the estate of the last surviving Policy Owner.

2.4 Nominating a Beneficiary

You may nominate up to five Beneficiaries to receive a Death Benefit subject to the following rules:

- a nominated Beneficiary can be a natural person, corporation or trust;
- if a nominated Beneficiary dies or the corporation or trust ceases to exist before a claim is made under the Policy and no change in nomination has been made, then any money otherwise payable to that Beneficiary will be paid to the Policy Owner or their estate;
- if ownership of the Policy is assigned or transferred to another person or entity, then any previous nomination becomes invalid. If your nomination has lapsed in whole or in part the Death Benefit or relevant share of the Death Benefit will be paid to you or your estate;
- you can change your nomination at any time before the Death Benefit becomes payable by sending us written notice of the change.

3. How Westpac Term Life as Superannuation works

3.1 Eligibility

To be eligible for Westpac Term Life as Superannuation, in addition to those matters set out in section 2.1, you must also be eligible to contribute to a superannuation fund or have contributions made to superannuation on your behalf. Please see section 3.5 below for more information about your eligibility to contribute to superannuation.

3.2 Applying

When you apply for Westpac Term Life as Superannuation, you will become a member of the Westpac MasterTrust ('Fund'). The Trustee of the Fund is Westpac Securities Administration Limited ('Trustee'). For more information on the Fund see page 25.

Provided you are eligible to contribute to superannuation, membership of the Fund is immediate from the date we receive your application. However insurance cover only commences on the date we accept your application. The Trustee has been issued with a group life insurance policy by Westpac Life and, if you are accepted for insurance, you become an Insured Person under the policy. You can only apply for Westpac Term Life as Superannuation on your own life.

Your only benefit as a member of the Fund is an interest in the life insurance policy issued by Westpac Life to the Trustee for your benefit.

You apply for the amount of Death Benefit you wish to insure yourself for. You can also apply for increased protection with a Disability Benefit. The amount you apply to insure for under the Disability Benefit can be different to, but no more than, the Death Benefit amount.

3.3 Tax File Numbers (TFNs) and contributions

While you are not required by law to supply the Trustee with your TFN, you will be ineligible to apply for Westpac Term Life as Superannuation if you have not provided us with your TFN.

Due to Government legislation, the Trustee is unable to accept non-concessional contributions (generally after-tax contributions made by you, or on your behalf, other than employer contributions) from you if you have not provided them with your TFN. The Trustee has further determined that the Fund will not accept any contributions made by you or on your behalf unless your TFN has been provided to them. Please read the Tax File Number Notification in the Application Form at the back of this PDS for further details relating to the quoting of your TFN.

3.4 Membership of the Fund

As a member of the Fund with insurance, you pay contributions to the Fund to cover the premiums that are due under the insurance policy (throughout this document, we use the term 'premiums' instead of 'contributions').

To be a member of the Fund with insurance you must be eligible to contribute to superannuation or have contributions made to superannuation on your behalf. Please note that the eligibility criteria to make contributions may change from time to time as required by law.

3.5 Eligibility to contribute to Superannuation

The rules that apply to superannuation contributions generally depend on your age and/or employment status. These rules are outlined below.

Age	When contributions can be made
If you're aged under 65 years	You can make contributions to superannuation or have contributions made on your behalf at any time. You don't need to be employed or meet any other eligibility rules.
If you're aged between 65 and 74 years	You can make contributions, or have them made on your behalf (except for spouse contributions) if you have been gainfully employed for at least 40 hours in a period of not more than 30 consecutive days in the financial year in which you wish to make the contributions or have contributions made on your behalf. You must make a new employment declaration for each financial year. Spouse contributions can only be made on your behalf if you meet the work test described above and you are under 70 years of age. Superannuation Guarantee contributions (SG) are only required to be made until age 70.
If you're aged 75 years and over	Only mandated employer contributions (award or certified agreement but not SG) are allowed.

3.6 Contributions accepted into Westpac Term Life as Superannuation

The following contributions can be accepted:

Contributions made by	Description
Your employer	■ Your employer can make mandated or voluntary employer contributions. ■ You may be able to arrange salary sacrifice contributions with your employer. These are additional employer contributions made from your pre-tax salary.
You	You can make your own personal contributions to superannuation from your after tax income. In some cases you may be able to claim a personal tax deduction for these contributions (refer to 'Tax concessions on contributions' in section C.5.1).
Your spouse (includes a de facto spouse where the couple is living together, but not same-sex couples)	Your spouse may make contributions to your superannuation, as long as the contribution is paid from an account in the name of the contributing spouse or a joint account where the contributing spouse is an account holder.

The following contributions cannot be accepted:

Contributions made by	Description
Government	Subject to eligibility criteria, each year the Government will contribute up to $1.50 for each dollar of personal after tax contributions you make. Personal contributions made to Term Life as Superannuation may qualify you for Government co-contributions, but the Fund is unable to accept these co-contributions. You must nominate another superannuation account to accept these contributions.

3.7 Contributions caps

The Government has set caps on the amount of contributions which can be made each year on a concessional basis. Additional tax applies to contributions in excess of the relevant cap.

These caps depend on whether the contributions are classified as concessional or non-concessional contributions, or are being made as a result of the sale of a qualifying small business. The caps apply to all contributions you make to any superannuation fund, including the Fund, as they apply on a per person basis. The table below outlines the types of contributions that may count towards your contributions caps.

Concessional contributions cap	This cap includes the following types of contributions: ▪ Employer contributions (including salary sacrifice) ▪ After tax contributions for which you claim a personal tax deduction ▪ Untaxed elements of the taxable component of directed termination payments over $1m contributed under the transitional rules for employment termination payments*	The cap is $50,000 per member for the 2008/09 financial year, and will be indexed to Average Weekly Ordinary Time earnings (AWOTE), rounded down to the nearest $5,000 in subsequent years. For those aged 50 or over at any time in a transitional financial year, a transitional cap of $100,000 (not indexed) will apply. Transitional financial years are the years between 2007/08 and 2011/12 inclusive. Concessional contributions in excess of the relevant cap will be subject to additional tax (refer to 'Taxation treatment of Westpac Term Life as Superannuation' on page 67).
Non-concessional contributions cap	This cap includes the following types of contributions: ▪ After tax contributions for which no tax deduction is claimed (including spouse contributions) ▪ Amounts transferred from overseas super funds (excluding the taxable amount of such transfers)* ▪ Amounts in excess of the CGT cap* ▪ Amounts of concessional contributions in excess of the concessional contributions cap	The cap is $150,000 per member for the 2008/09 financial year. This will not be separately indexed, but will remain fixed at three times the concessional contributions cap (currently $50,000). People under age 65 will be able to 'bring forward' future entitlements to two years' worth of non-concessional contributions, allowing up to $450,000 over a three year period to be contributed without an additional tax liability. There is no indexation during the three year period. Non-concessional contributions in excess of the relevant cap will be subject to additional tax (refer to 'Taxation treatment of Westpac Term Life as Superannuation' on page 67).
CGT cap	Contributions made from certain amounts arising from the disposal of qualifying small business assets, provided that a tax deduction is not claimed for the contribution*	A lifetime cap of $1.045 million (indexed) is available, provided that this is a personal contribution for which no deduction is claimed.

*These contribution types are not able to be made to Westpac Term Life as Superannuation. They are included to show you the main types of contributions that may count towards your contributions caps.

There are no caps on amounts contributed from certain payments for personal injury, provided that no deduction is claimed for the contribution.

In addition to the member caps described above, superannuation funds are generally unable to accept single non-concessional contributions in excess of $450,000 (or $150,000 if you are 65 or over on 1 July of the financial year in which you contribute) from a member in any financial year.

Please note that it is your responsibility to ensure contributions to superannuation are within your concessional and non-concessional contributions caps. The Trustee is required to reject certain single contributions which are in excess of the non-concessional contributions caps (as outlined above) but cannot monitor your overall position.

3.8 What if I am no longer eligible

If you require insurance after you are no longer eligible to contribute to superannuation or no longer eligible to have contributions made on your behalf, you can apply to transfer your insurance under Westpac Term Life as Superannuation to Westpac Term Life without further evidence of health on the same insurance conditions. Please speak to your financial planner if you are uncertain as to whether you are eligible to contribute to superannuation.

3.9 Who receives any benefits payable

Death Benefits that become payable are paid to the Trustee and will be paid to your estate or your nominated Beneficiary (see section 15.2).

Any other benefits that become payable from us will be paid to the Trustee. It is important to note that before you can access any benefits paid to the Fund you must meet a condition of release under government laws applying to superannuation funds, as well as the provisions of the Fund's Trust Deed. For more information see section 15.3.

Benefits

4. Death Benefit

4.1 Availability

You can apply to insure any person aged from 15 to 69.

4.2 When we will pay

We will pay a benefit if the Insured Person dies before the Death Benefit ends (see section 4.6).

4.3 What we will pay

We will pay the amount of the Death Benefit for the Insured Person as shown in the Policy Schedule:

- increased by Future Insurability Benefit increases (see section 6.1);
- increased by us if any CPI indexation has been applied (see section A.9);
- reduced by any Disability Benefit (including TPD Partial Benefit) or Living Benefit paid or payable under the Policy for that Insured Person; and
- increased by any Death Benefit increases following buy back (see section 11).

4.4 When we will not pay

We will not pay a Death Benefit if the Insured Person commits suicide (while sane or insane) within 13 months of the later of:

- the Death Benefit for the Insured Person starting under this Policy; or
- for an increase in the Death Benefit for the Insured Person, the date we increase the Death Benefit (other than a CPI increase under section A.9); or
- the date this Policy was last reinstated.

We will not pay a Death Benefit if death was caused by any event or condition covered by an exclusion shown in the Policy Schedule or membership certificate.

4.5 What happens after we pay

After we pay a Death Benefit, all benefits for that Insured Person end.

4.6 When this benefit ends

The Death Benefit for an Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 99th birthday;
- we pay the Death Benefit for the Insured Person;
- the Death Benefit amount for the Insured Person is reduced to zero because we have paid a Terminal Illness, Disability or Living Benefit;
- you write and ask us to cancel the Death Benefit for the Insured Person; or
- your insurance cover ends (see section 14).

5. Terminal Illness Benefit

5.1 Availability

The Terminal Illness Benefit is automatically included with a Death Benefit.

5.2 When we will pay

We will pay a benefit if the Insured Person suffers an illness or condition before this benefit ends (see section 5.7), and as a result of this he or she is not expected to live more than 12 months.

5.3 What we will pay

We will pay the amount of the Death Benefit for the Insured Person at that time.

5.4 What evidence we require

We will require the Insured Person's treating registered specialist medical practitioner to confirm in writing their opinion that the Insured Person has a terminal illness. You must pay for this report. We may require confirmation of the diagnosis by a registered medical practitioner of our choice and ask for any other medical reports we require. We will pay for these additional reports (see section C.3 – Making a claim for more details).

5.5 When we will not pay

A Terminal Illness Benefit will not be paid if the illness or condition giving rise to the claim was caused by an event or condition covered by an exclusion shown in your Policy Schedule or membership certificate.

5.6 What happens after we pay

After we pay a Terminal Illness Benefit, all benefits for that Insured Person end.

5.7 When this benefit ends

The Terminal Illness Benefit for an Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 99th birthday;
- we pay the Terminal Illness Benefit for the Insured Person;
- the Death Benefit amount for the Insured Person is reduced to zero because we have paid a Disability or Living Benefit;
- you write and ask us to cancel the Death Benefit for the Insured Person; or
- your insurance cover ends (see section 14).

6. Future Insurability Benefit

6.1 Availability

The Future Insurability Benefit enables you to increase the Death Benefit for an Insured Person without providing further health evidence when one of the special events listed in table 6.4 occurs.

The minimum increase per special event is $25,000 and the maximum increase per special event is listed in table 6.4.

6.2 Applying

You must apply for the increase in writing within 30 days of a personal event or within 30 days of the Review Date of the insurance cover immediately following a business event.

You must provide evidence of the event that is satisfactory to us.

There can only be one increase in an Insured Person's Death Benefit under the Future Insurability Benefit in any 12 month period.

Your premium will increase to reflect the increase in cover. The increased cover does not apply until we have confirmed it in writing.

6.3 Evidence required

You must provide copies of the following information with your application for a Future Insurability Benefit increase:

- Marriage or de facto relationship – for marriage – the marriage certificate, or for a de facto relationship – confirmation by way of a statutory declaration from the Insured Person and their de facto spouse that they have lived together on a bona fide domestic basis for 12 consecutive months, accompanied by notices issued by a local council, government agency or financial institution which support the statutory declaration.
- Birth or adoption – the birth certificate or adoption papers (as applicable), naming the Insured Person as a parent of the child.
- Mortgage – relevant loan and mortgage documents.
- Salary increase – written confirmation from the employer of the annual salary package of the Insured Person before and after the increase.
- Increase in value of key person – sufficient evidence of this, including details of the gross remuneration package of the Insured Person, the proportion of net profits of the business distributed to the Insured Person and the business results and financial statements, in each case for the previous 3 years.
- Increase in value of business interest – sufficient evidence of this, including details of the assets, liabilities and net value of the business, the Insured Person's interest in the business and the business results and financial statements, in each case for the previous 3 years.

For the increase in value of key person and business interest events, we may also request company minutes, audited accounts, tax returns and any other documents to substantiate the increase.

6.4 Maximum increase of Death Benefit for special events

Personal Events		Maximum Increase per Special Event
Marriage	The Insured Person marries (which is recognised by an Australian Court).	The lesser of: ■ $200,000; or ■ 25% of the original Death Benefit.
A de facto spouse	The first anniversary of the Insured Person living with another person (of the same or opposite sex) as de facto spouse on a continuous and bona fide domestic basis.	
Birth or adoption	The Insured Person or their spouse or de facto spouse gives birth to or adopts a child.	
Mortgage	The Insured Person takes out a Mortgage, or increases the original amount borrowed under an existing mortgage, to buy or improve their home. 'Mortgage' means a loan secured by a first mortgage over the Insured Person's principal place of residence. The Mortgage must be with an approved deposit-taking institution, credit union, building society or any other mortgage provider that we agree to.	The lesser of: ■ $200,000; ■ 50% of the original Death Benefit; or ■ the amount of the new Mortgage or increase in the original amount borrowed under an existing mortgage as applicable.
Salary Increase	The Insured Person's annual salary package increases by at least $10,000 a year. The salary package does not include irregular payments such as bonuses or commissions that may not continue to be made in future.	The lesser of: ■ $200,000; ■ 25% of the original Death Benefit; or ■ five times the annual amount of salary package increase.
Business Events		**Maximum Increase per Special Event**
Value of key person in your business increases	The Insured Person is a key person in their business and their value to the business increases. The Insured Person's value to the business is their remuneration package, excluding discretionary benefits, plus their share of net profits of the business distributed in the 12 months immediately before the event occurs.	The lesser of: ■ $200,000; ■ 25% of the original Death Benefit; ■ an increase which is proportionate to the increase in the Insured Person's value to the business; or ■ five times the average annual increase in the gross remuneration package of the Insured Person over the 3 years immediately before the event.
The net value of the Insured Person's financial interest in the business increases	The Insured Person is a partner, shareholder, unit holder or similar principal in a business. The insurance was purchased in accordance with a written share purchase or business succession agreement and the net value of the Insured Person's financial interest in the business increases. The net value of their financial interest in the business is their share of the value of the business, after deducting liabilities of the business, as determined by a valuation method that is acceptable to us.	The lesser of: ■ $200,000; ■ 25% of the original Death Benefit; ■ an increase which is proportionate to the increase in the net value of the Insured Person's financial interest in the business; or ■ the average annual increase in the net value of the Insured Person's financial interest in the business over the 3 years immediately before the event.
An increase under the Future Insurability Benefit will not occur if it would result in the total of all increases in Death Benefits for an Insured Person (under all policies with us) without health evidence (other than CPI increases) exceeding the lesser of $1 million and the original Death Benefit for the Insured Person.		

6.5 When you cannot apply

You cannot apply for a Future Insurability Benefit increase for an Insured Person under this insurance cover:

- after the Review Date of the insurance cover on or immediately before the Insured Person turns 55;
- if you have had an increase under this benefit in the last 12 months;
- if a person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any insurance cover issued by us;
- if we did not accept the Insured Person for the Death Benefit at standard premium rates; or
- for salary increases, if the Insured Person is self-employed, a controlling director of the employer or a holding company of the employer, or is able to (directly or indirectly) make or control a decision on the amount of the Insured Person's salary package.

6.6 Limits on increased cover

Any exclusions applying to the Insured Person's Death Benefit will also apply to an increase under the Future Insurability Benefit.

Except for the birth or adoption event, for 6 months immediately after the commencement date of an increase under the Future Insurability Benefit, the increased amount:

- will only be payable in the event of accidental death; and
- will not be payable for terminal illness which arises during this period.

'Accidental death' means death as a result of a single event that results in Bodily Injury that is unexpected. This does not include an event that results from sickness or disease. 'Bodily Injury' means physical damage to the body sustained as a result of an external traumatic occurrence.

7. Financial Planning Benefit (This benefit is not available under Westpac Term Life as Superannuation)

7.1 Availability

The Financial Planning Benefit is automatically included as part of your Wespac Term Life Policy, and is paid in addition to any Death Benefit.

7.2 Who we will pay

We will pay the benefit to either you or your Beneficiaries.

7.3 When we will pay

If we pay a Death Benefit, Terminal Illness Benefit, Disability Benefit (optional) or Living Benefit (optional), we will reimburse the recipient of the benefit for the cost of obtaining financial advice.

7.4 What we will pay

We will pay the cost of obtaining financial advice up to a maximum of $1,500.

We will only reimburse amounts relating to the preparation and presentation of the plan and not amounts relating to the implementation of the plan or commission paid to a financial planner.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the benefit so the total amount payable does not exceed $1,500.

The Financial Planning Benefit will only be paid once per policy per Insured Person across all policies issued by us in respect of that Insured Person.

7.5 Conditions

The following conditions must be met for the Financial Planning Benefit to be paid:

- the financial plan must be provided by an approved, accredited financial planner;
- the Financial Planning Benefit must be claimed within 12 months of receiving the Death, Terminal Illness, Disability or Living Benefit; and
- the recipient must be able to provide a copy of the invoice showing a breakdown of the services provided and a receipt showing the amount paid.

8. Funeral Advancement Benefit (This benefit is not available under Westpac Term Life as Superannuation)

8.1 Availability

The Funeral Advancement Benefit is a part of the Death Benefit.

8.2 Who we will pay

The benefit will be paid in accordance with the following order of priority:

- to the named Beneficiary;
- to the Policy Owner; or
- to the legal representative (either the executor where there is a will, or the administrator where there is not a will) of the Insured Person.

8.3 When we will pay

We will pay funeral expenses and other immediate costs upon the Insured Person's death. This benefit is only payable once for each Insured Person.

The payment of this benefit does not mean that any other benefit under the Policy will be admitted.

8.4 What we will pay

We will pay up to $10,000.

The Death Benefit will be reduced by the amount paid under the Funeral Advancement Benefit.

8.5 When we will not pay

The Funeral Advancement Benefit will not be paid if:

- the Insured Person commits suicide (while sane or insane) within 13 months of the later of the risk commencement date of the Death Benefit for the Insured Person, or the date the insurance was last reinstated; or
- death was caused by any event or condition covered by an exclusion shown in the Policy Schedule.

8.6 Evidence required

We will require a copy of the death certificate and invoice(s) showing the funeral and other related expenses paid (by whom and the amount paid) which are acceptable to us.

Optional Benefits

9. Disability Benefit

9.1 Availability

If you are applying for a Death Benefit for a person, or an Insured Person is covered for the Death Benefit, and the Insured Person is aged from 15 to 59, you can also apply to insure them for a Disability Benefit.

However, this benefit will not be available to people in certain occupations. Your financial planner can advise you in respect of your individual circumstances.

9.2 Types of Disability Benefits

Any Occupation	
Under Any Occupation, Total and Permanent Disability means:	■ An injury or sickness which has prevented the Insured Person from working for 3 consecutive months; and ■ the 3 month period has ended before the final Review Date before the Insured Person turns 65; and ■ in our opinion, the injury or sickness is likely to prevent the Insured Person from ever again being able to work in Any Occupation for which they are reasonably qualified because of education, training or experience, and which would pay remuneration at a rate greater than 25% of their earnings in the last 12 months of work. 'Earnings' is the income earned by the Insured Person's own personal exertion, after deduction of any expenses incurred in earning that income before tax; or ■ the Insured Person meets the 'General' cover meaning of 'Total and Permanent Disability' (see next page).
Additional information	'General' cover will apply if the Insured Person had permanently retired prior to the event.
Own Occupation	
Under Own Occupation, Total and Permanent Disability means:	■ An injury or sickness which has prevented the Insured Person from working for 3 consecutive months; and ■ the 3 month period has ended before the final Review Date before the Insured Person turns 65; and ■ in our opinion, the injury or sickness is likely to prevent the Insured Person from ever again being able to work in their Own Occupation. 'Own Occupation' is taken to mean the occupation that the Insured Person was last engaged in immediately prior to the event giving rise to a claim; or ■ the Insured Person meets the 'General' cover meaning of 'Total and Permanent Disability' (see next page).
Additional information	'General' cover will apply if the Insured Person had permanently retired prior to the event.

Home Duties	
Under Home Duties, Total and Permanent Disability means:	■ An injury or sickness which has prevented the Insured Person from carrying out all normal household duties for 3 consecutive months; and ■ the 3 month period has ended before the final Review Date before the Insured Person turns 65; and ■ in our opinion, the injury or sickness is likely to prevent the Insured Person from ever again being able to carry out all normal household duties. 'Normal household duties' means the duties normally performed by a person who remains at home and is not working in a regular occupation for income, including cleaning the house, washing, shopping for food, cooking meals and caring for minor children. For the avoidance of doubt, an Insured Person will not be considered to be unable to carry out all normal household duties if the Insured Person is able to perform any one or more of the listed duties; or ■ the Insured Person meets the 'General' cover meaning of 'Total and Permanent Disability' (see below).
'General' Cover	
Under 'General' cover, Total and Permanent Disability means:	The Insured Person has suffered either: ■ loss of independent existence, which means as a result of sickness or injury, the Insured Person: – has a permanent and irreversible inability to perform, without assistance, any two of the Activities of Daily Living (see page 38 for definitions); or – suffers cognitive impairment that requires permanent and constant supervision, which must be established and the diagnosis reaffirmed after a continuous period of at least 6 months of such impairment; or ■ total and permanent loss of use of two limbs, use of one limb and sight in one eye or sight in both eyes. 'Limb' means an arm or leg, including the whole hand or the whole foot.

9.3 Limits on Disability Benefit

You can choose from three different types of Disability Benefit depending on the level of protection required and the circumstances of the Insured Person. We call these 'Own Occupation', 'Any Occupation' and 'Home Duties' Disability Benefits.

'Own Occupation' cover is available, for additional cost, if the Insured Person is in a professional occupation such as medicine or law (your financial planner will be able to tell you which professional occupations are included).

You can apply to insure up to 100% of the Death Benefit for the Insured Person, up to a maximum amount.

The table below shows the maximum limits.

Type of Cover	Maximum Disability Benefit Amount
Any Occupation	$3 million
Own Occupation	$3 million
Home Duties	$750,000
'General' cover	$1 million

Whatever type of Disability Benefit you apply for, on the Review Date prior to the Insured Person turning 65, the Disability Benefit automatically becomes 'General' cover only. 'General' cover is subject to a maximum initial amount of $1 million and this amount can be indexed after that date (see section A.9 for details about indexation).

9.4 When this benefit applies

This benefit will only apply if:

- we have accepted your application for this benefit for an Insured Person;
- you continue to pay premiums for this benefit; and
- you continue to have a Death Benefit for that Insured Person.

9.5 When we will pay

We will pay a benefit if the Insured Person becomes Totally and Permanently Disabled before the Disability Benefit ends (see section 9.10).

9.6 What we will pay

The amount we will pay is:

- the Disability Benefit shown in the Policy Schedule for the Insured Person;
- increased by us if any CPI indexation has been applied (see section A.9); and

- reduced by any Living Benefit or TPD Partial Benefit paid or payable under the Policy for that Insured Person.

However, the maximum Disability Benefit on the Review Date immediately before the Insured Person turns age 65 is $1 million, which may be indexed after that date in accordance with section A.9.

9.7 When we will not pay

A Disability Benefit will not be paid if the injury or sickness giving rise to the claim:

- was caused by an intentional self-inflicted injury or attempted suicide (whether while sane or insane);
- was caused by any event or condition covered by an exclusion shown in your Policy Schedule or membership certificate; or
- happened before the Insured Person's benefit began (or before the benefit was last reinstated) and you or the Insured Person did not tell us about it.

If the injury or sickness giving rise to a claim happens before any increase to the benefit amount (excluding CPI indexation increases) and you or the Insured Person did not tell us about it, the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

9.8 When is the injury or sickness taken to have happened

An injury or sickness is taken to have happened when:

- a registered medical practitioner first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the injury or sickness; or
- the Insured Person first had symptoms of the injury or sickness for which a reasonable person in the same circumstances would have sought advice, care or treatment from a registered medical practitioner.

9.9 What happens after we pay

After we pay the full Disability Benefit we will reduce the amount of every other benefit for the Insured Person under this Policy by the amount paid, and the Disability Benefit for the Insured Person ends.

9.10 When this benefit ends

The Disability Benefit for an Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 99th birthday;
- we pay the Disability Benefit for the Insured Person;
- the Disability Benefit amount for the Insured Person is reduced to zero because we have paid a Terminal Illness or Living Benefit;
- you write and ask us to cancel the Disability Benefit for the Insured Person; or
- your insurance cover ends (see section 14).

9.11 TPD Partial Benefit (This benefit is not available under Westpac Term Life as Superannuation)

(a) When this benefit applies

The TPD Partial Benefit is automatically included as part of your Westpac Term Life Policy where you have a Disability Benefit.

(b) When we will pay

We will pay a benefit if the Insured Person has suffered the total and permanent loss of use of one limb or sight in one eye due to sickness or injury before the Disability Benefit ends (see section 9.10).

'Limb' means an arm or leg, including the whole hand or the whole foot.

(c) What we will pay

The amount we will pay is equal to 25% of the Disability Benefit for the Insured Person increased by us if any CPI indexation has been applied (see section A.9), up to a maximum of $250,000.

(d) What happens after we pay

After we pay the TPD Partial Benefit we will reduce the amount of every other benefit for the Insured Person under this Policy by the amount paid.

(e) When we will not pay

A TPD Partial Benefit will not be paid if the sickness or injury giving rise to the claim:

- was caused by an intentional self-inflicted injury or attempted suicide (whether while sane or insane);
- was caused by any event or condition covered by an exclusion shown in your Policy Schedule; or
- happened before the Insured Person's benefit began (or before the benefit was last reinstated) and you or the Insured Person did not tell us about it.

If the injury or sickness giving rise to a claim happens before any increase to the benefit amount (excluding CPI indexation increases) and you or the Insured Person did not tell us about it, the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

9.12 You can buy back the Death Benefit (optional)

Please see section 11.3.

9.13 Waiver of Life Premium Benefit (This benefit is not available under Westpac Term Life as Superannuation)

(a) Availability

If you are applying for a Disability Benefit for a Person or if the Insured Person is covered for the Disability Benefit, and is aged from 15 to 59, you can also apply to insure them for a Waiver of Life Premium Benefit.

This optional benefit can be taken out at any time before the Disability Benefit ends (see section 9.10, and subject to a maximum entry age of 59) but if it is not taken out at the same time as the Disability Benefit is taken out, the Insured Person may be subject to further underwriting assessment.

An additional premium will be charged for the Waiver of Life Premium Benefit.

(b) When this benefit applies

This benefit will only apply if:

- we have accepted your application for this benefit for an Insured Person;
- you continue to pay premiums for this benefit; and
- you continue to have a Disability Benefit for that Insured Person.

This benefit will not apply if the Total & Temporary Disability was caused by an exclusion outlined in Section 9.7.

(c) When we will waive the premium

We will waive payment of the entire premium payable under the Policy if the Insured Person has been Totally and Temporarily Disabled for a continuous period of 6 months and for as long as the Insured Person is Totally and Temporarily Disabled.

In addition, the premiums paid by you during the period the Insured Person was Totally and Temporarily Disabled will be reimbursed.

The Insured Person is considered Totally and Temporarily Disabled if:

- the Insured Person suffers a sickness or injury; and
- in our opinion, the Insured Person is unable to work because of that injury or sickness in Any Occupation for which the Insured Person is reasonably suited by education, training or experience. If the Insured Person's Disability Benefit is classed as Home Duties, the Insured Person is deemed to be unable to work if he or she is prevented from carrying out all normal household duties as described on page 17.

(d) Conditions

- Your benefits under the Policy will continue to be subject to CPI increases under section A.9.
- If the Insured Person's Total and Temporary Disablement recurs from the same or related cause within 6 months of the Policy Owner recommencing payment of the premium under the Policy, payment of the premium will be waived again without the Insured Person having to be Totally and Temporarily Disabled for an additional continuous period of 6 months.
- If there is more than 6 months between two periods of Total and Temporary Disablement, payment of the premium under the Policy will not be waived again until the Insured Person has been Totally and Temporarily Disabled for an additional continuous period of 6 months.
- You are not entitled to apply for increases to the benefits payable in respect of any Insured Person on the Policy if the premium is being waived (except for increases outlined in Section 6).

(e) When this benefit ends

The Waiver of Life Premium Benefit continues until the earliest of:

- the last Review Date before the Insured Person's 65th birthday;
- the date the Insured Person, in our opinion, meets the definition of Total and Permanent Disability applicable to the type of Disability Benefit chosen by you (see section 9.2);
- the Insured Person ceases to have the Disability Benefit; or
- you write and tell us to cancel this option.

10. Living Benefit (This benefit is not available under Westpac Term Life as Superannuation)

10.1 Availability

If you are applying for a Death Benefit for a person, or an Insured Person is covered for the Death Benefit, and they are aged from 15 to 59, you can also apply to insure them for a Living Benefit.

You can apply to insure up to 100% of the Death Benefit for the Insured Person, up to a maximum amount of $2 million.

10.2 When this benefit applies

This benefit will only apply if:

- we have accepted your application for this benefit for an Insured Person;
- you continue to pay premiums for this benefit; and
- you continue to have a Death Benefit for that Insured Person.

10.3 When we will pay

We will pay a Living Benefit (Full or Advancement) if:

- an Insured Person suffers a specified serious medical condition or injury or undergoes specified surgery, set out below; and
- a registered medical practitioner approved by us provides the medical evidence to support a claim see section C.3 – Making a claim – for more information.

We will only pay a benefit when we are satisfied that the Insured Person has satisfied the full definition of the relevant injury, condition or surgery. In addition, for the following conditions and surgery:

- Angioplasty
- Cancer
- Carcinoma in situ of female organs
- Coronary Artery Bypass Surgery
- Heart Attack
- Open Heart Surgery
- Prostate Cancer (stages T1a, T1b and T1c)
- Stroke,

the benefit for the Insured Person is only payable if the condition or surgery occurs at least 3 months after cover for the Insured Person begins or the last reinstatement of the Policy (if it had lapsed).

If a Heart Attack, Angioplasty, Open Heart Surgery, Coronary Artery Bypass Surgery, Cancer, Carcinoma in situ of female organs, Prostate Cancer (stages T1a, T1b and T1c) or Stroke occur within 3 months of any increase to the benefit for the Insured Person (excluding CPI indexation increases – see section A.9), the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

10.4 The medical conditions, injuries and surgery covered are:

Cancer
Cancer (malignant tumours)*
Carcinoma in situ of female organs*^
Prostate cancer (stages T1a, T1b and T1c)*^

Heart disorders
Angioplasty*^
Aortic surgery
Cardiomyopathy
Coronary artery bypass surgery*
Heart attack*
Heart valve surgery
Open heart surgery*
Out of hospital cardiac arrest
Pulmonary hypertension

Nervous system disorders^
Alzheimer's disease and other dementias
Motor neurone disease
Multiple sclerosis
Muscular dystrophy
Parkinson's disease

Accident
Coma
Major head trauma
Paralysis
Severe burns

Body organ disorders
Blindness
Chronic liver disease
Chronic lung disease
Kidney failure
Major organ transplant^

Blood disorders
Aplastic anaemia
Medically acquired HIV
Occupationally acquired HIV

Other events
Advanced diabetes
Benign brain tumour
Diabetes complication^
Encephalitis
Loss of hearing
Loss of independent existence
Loss of limbs
Loss of speech
Pneumonectomy
Severe rheumatoid arthritis
Stroke*

Important
Full definitions of each event are given in Living Benefit Definitions commencing on page 35. The Insured Person must satisfy the full definition of the appropriate event before we will pay a Living Benefit. Please read the full definitions.

*For these events, cover does not start until 3 months after the Insured Person's Living Benefit commences (or was last reinstated if it had been cancelled). This also applies to an increase in the amount of your Living Benefit (other than CPI indexation increases).

^For these events, an Advancement Benefit may be paid in certain specified circumstances. For more details, see section 10.5.b.

10.5 What we will pay

(a) Full Benefit payment

You are entitled to claim for a Full Benefit if you meet the definition of the event or condition as defined under Living Benefit Definitions commencing on page 35, except for the Advancement Benefit as outlined in section 10.5.b.

The amount we will pay ('the relevant amount') is:

- the Living Benefit shown in the Policy Schedule for that Insured Person;
- increased by us if any CPI indexation has been applied (see section A.9);
- reduced by any Disability Benefit (including TPD Partial Benefit) paid or payable under the Policy for that Insured Person;
- reduced by any Advancement Benefit we have previously paid you for that Insured Person under this Policy (see below).

(b) Advancement Benefit payment

We will pay an Advancement Benefit for the events listed in the following table:

<table>
<tr><th>Condition</th><th>When will we pay</th><th>What will be pay</th></tr>
<tr><td>Single or double vessel angioplasty</td><td>If an Insured Person has undergone this surgery.</td><td>We will pay 15% of the Living Benefit for that Insured Person at the date of the event, up to a maximum of $30,000.</td></tr>
<tr><td>Carcinoma in situ of female organs</td><td>When the Insured Person is diagnosed with carcinoma in situ of female organs.</td><td rowspan="2">We will pay 25% of the Living Benefit up to a maximum of $50,000.</td></tr>
<tr><td>Prostate cancer (stages T1a, T1b and T1c)</td><td>When the Insured Person is diagnosed with prostate cancer (stages T1a, T1b and T1c).</td></tr>
<tr><td>Alzheimer's disease and other dementias
Motor Neurone Disease
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease</td><td>When the Insured Person is diagnosed by a registered medical practitioner specialising in the field relevant to this condition, as suffering from the condition but the condition does not cause 25% permanent impairment of whole person function.</td><td rowspan="2">We will pay 25% of the Living Benefit up to a maximum of $50,000.

If the Insured Person subsequently meets the full definition of the condition (see page 35 – Living Benefit Definitions – for details), we will pay the balance of the Living Benefit.</td></tr>
<tr><td>Major organ transplant</td><td>When the Insured Person has been on a waiting list for at least 6 months to receive a major organ transplant and that procedure is unrelated to any previous procedure or surgery.

A waiting list means the Insured Person has been placed on an Australian waiting list, approved by us, for an organ transplant from a human donor that is listed in the major organ transplant definition and that is considered medically necessary.</td></tr>
<tr><td>Diabetes Complication</td><td>When the Insured Person is diagnosed with a Diabetes complication.</td><td>We will pay 40% of the Living Benefit for that Insured Person, up to a maximum of $200,000.</td></tr>
</table>

For Living Benefit definitions, please see page 35.

(c) Conditions on Advancement Benefit

Please note that the amounts of $200,000, $50,000 and $30,000 are not indexed by CPI under section A.9. In addition, the minimum benefit payable under the Advancement Benefit is $10,000.

We will only pay once under each of these group of events:

- Single or double vessel angioplasty; and
- Carcinoma in situ of female organs or Prostate cancer; and
- Alzheimer's disease and other dementias, Motor Neurone Disease, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease or Major organ transplant; and
- Diabetes complication.

10.6 When we will not pay

A Living Benefit will not be paid for any condition or injury that happened before the Insured Person's benefit began that you or the Insured Person did not tell us about. A condition or injury is taken to have happened when:

- a registered medical practitioner first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the condition or injury; or
- the Insured Person first had symptoms of the condition or injury for which a reasonable person in the circumstances would have sought advice, care or treatment from a registered medical practitioner.

We will not pay you a benefit if the condition, injury or surgery giving rise to the claim is caused directly or indirectly by:

- an intentional self-inflicted injury or attempted suicide (while sane or insane); or
- any other event or condition covered by an exclusion specified in the Policy Schedule.

10.7 What happens after we pay

After we pay a Living Benefit we will reduce every other benefit for the Insured Person under this Policy by the amount we paid and, unless the benefit was paid as an Advancement Benefit, the Living Benefit in respect of that Insured Person ends. If the Living Benefit was paid as an Advancement Benefit, we will also reduce the Living Benefit for the Insured Person by the amount we paid.

10.8 When this benefit ends

The Living Benefit for an Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- we pay the full Living Benefit for the Insured Person;
- the Living Benefit amount for the Insured Person is reduced to zero because we have paid a Terminal Illness or Disability Benefit;
- you write and ask us to cancel the Living Benefit for the Insured Person; or
- your insurance cover ends (see section 14).

10.9 Buying back your benefits

After we have paid a Living Benefit payment, you have the option of buying back your Death Benefit after 12 months. You may also be able to reinstate your Living Benefit if you elected this optional benefit at the time of your original application. Please see sections 11.2 and 11.4 below

11. Buying back your benefits (optional)

11.1 Introduction

After we have paid you either a Living Benefit or a Disability Benefit (and your Death Benefit has consequently been reduced), you may be able to buy back your Death Benefit. In the case of a Living Benefit payment, you simply exercise the option, which is automatically included as part of your Policy, in accordance with the conditions set out below. In the case of a Disability Benefit, you must have elected this option and paid additional premium, before you lodged your claim for the Disability Benefit.

In addition, after you have been paid a Living Benefit, you have the option of reinstating your Living Benefit after 12 months provided that you also reinstate your Death Benefit and you elected to include (and paid additional premium for) this option at the time of your original application.

11.2 Buying back your Death Benefit only following a Living Benefit payment ('Buy Back')

(a) When this benefit applies

This benefit is automatically included as part of your Policy. 12 months after we pay the Living Benefit for any condition, injury or surgery, except for an Advancement Benefit, you can increase the Death Benefit for the Insured Person by up to 100% of the Living Benefit you were paid. You can do this without having to provide further evidence of health, occupation or pastimes and the original rating for premiums and any exclusions will still apply.

If the Living Benefit reduces the Death Benefit to zero, and this Policy is no longer available when this benefit is exercised, we will issue an individual Policy available at the time which we believe provides the same or similar benefits.

(b) We place the following conditions on the Buy Back Benefit

- you cannot buy back more than the Living Benefit we have paid;
- you can index this Death Benefit, provided we are still offering you CPI indexation (see section A.9);

- the same underwriting assessment and exclusion clauses that we applied to the Insured Person's Death Benefit will apply to the Buy Back Benefit;
- you must continue to meet any minimum premium rules that we set;
- you must request the buy back in writing within 30 days from the first anniversary of the payment of the Living Benefit. The offer lapses and will not be re-offered if we do not receive a written request within 30 days from the first anniversary of the payment of the Living Benefit; and
- the Insured Person must be alive at the time of the Buy Back application.

(c) When this option ends

This option for the Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- the Living Benefit cover to which this option is attached ends for reasons other than Living Benefit payment;
- your insurance cover ends (see section 14); or
- you exercise the option.

11.3 Buying back your Death Benefit only following a Disability Benefit Payment ('Disability Buy Back')

(a) Availability

If the Insured Person is covered for the Disability Benefit, and they are aged from 15 to 59, you can also apply to insure them for a Disability Buy Back Benefit.

- This optional benefit can be taken out at any time, but if it is not taken out at the time of the original application you may be subject to further underwriting assessment; and
- an additional premium will be charged.

(b) When this benefit applies

14 days after we pay the Disability Benefit (except for a TPD Partial Benefit), you can increase the Death Benefit for that Insured Person by up to 100% of the Disability Benefit you were paid. You can do this without having to provide further evidence of health, occupation or pastimes and the original rating for premiums and any exclusions will still apply.

If the Disability Benefit reduces the Death Benefit to zero, and this Policy is no longer available when this benefit is exercised, we will issue an individual Policy available at the time which we believe provides the same or similar benefits.

(c) We place the following conditions on the Disability Buy Back Benefit

- you cannot buy back more than the Disability Benefit we have paid;
- you can index this Death Benefit, provided we are still offering you CPI indexation (see section A.9);
- the same underwriting assessment and exclusion clauses that we applied to the Insured Person's Death Benefit plus any additional underwriting assessment will apply to the Disability Buy Back Benefit;
- you must continue to meet any minimum premium rules that we set; and
- you must request the Disability Buy Back in writing within 30 days from the time you become eligible for this benefit (i.e. 14 days after we pay your Disability Benefit). The offer lapses and will not be re-offered if we do not receive a written request within this 30 day period.

(d) When this option ends

This option for the Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- The Disability Benefit cover to which this option is attached ends for reasons other than the Disability Benefit payment;
- you write and ask us to cancel the Disability Benefit or this option for the Insured Person;
- your insurance cover ends (see section 14); or
- you exercise the option.

11.4 Buying back your Death Benefit following a Living Benefit payment and reinstating your Living Benefit

(a) Availability

12 months after we pay the Living Benefit for any condition, injury or surgery, except for an Advancement Benefit, you have the option to increase the Death Benefit and reinstate the Living Benefit for the Insured Person by up to 100% of the Living Benefit you were paid without providing further evidence of health.

- This optional benefit must be taken out at the time of the original application; and
- an additional premium will be charged.

The Policy terms and conditions may no longer be available when this benefit is exercised. If so, we will issue a new Policy available at the time which we believe provides similar benefits.

(b) Conditions

The Policy Owner can exercise the option provided that:

- the buy back or reinstatement request is received in writing within 30 days from the first anniversary date of the Living Benefit payment. If your request for reinstatement is not received in this period the offer of reinstatement lapses and will not be re-offered;
- the Living Benefit payment was made before the Review Date preceding age 65; and
- a Disability Benefit, or Terminal Illness Benefit has not been paid.

The reinstated Living Benefit will be on the terms and conditions of the Living Benefit at the time of reinstatement with the exception of the following:

- a further reinstatement option will not be available;
- CPI indexation and future insurability increases will not be available; and
- any original exclusions or special conditions applicable under your Policy will be maintained.

(c) When we will not pay

We will not pay a claim under the reinstated cover if the specified condition claimed:

- is the same as the original condition event;
- has occurred as a direct or indirect result of the original specified condition event;
- is a heart related condition and the original specified condition event was also a heart related condition;
- is a lung related condition and the original specified condition event was a lung related condition;
- is a Stroke and the original specified condition event was a heart related condition;
- is a Loss of Independence;
- the specified condition occurred or was diagnosed, or the circumstances or symptoms leading to diagnosis were apparent before the Death and Living Benefit was reinstated; or
- was a cancer related condition and the original event was also a cancer related condition.

(d) When this option ends

This option for the Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- the Living Benefit cover to which this option is attached ends for reasons other than Living Benefit payment;
- you write and ask us to cancel the Living Benefit or this option for the Insured Person;
- your insurance cover ends (see section 14); or
- you exercise the option.

(e) When this option is unavailable

This option is not available for multi-link policies or "Key person" insurance. This option is not available after you have exercised it once.

12. 'Multi-link' Benefit (This benefit is not available under Westpac Term Life as Superannuation)

12.1 Availability

The 'Multi-link' Benefit is available when applying for business loan protection for two or more Insured Persons.

12.2 How the benefit works

If you choose the 'Multi-link' Benefit, then in the event we make a benefit payment being any Death, Disability (including TPD Partial Benefit), Living or Terminal Illness Benefit, including an Interim Accident Benefit, for an Insured Person, we will reduce the amount of every other benefit for all Insured Persons under this Policy. Each person's benefits will be reduced by the amount paid. If that amount exceeds an existing benefit for an Insured Person, then that benefit will be reduced to zero and will end.

12.3 Continuation option

If you choose the 'Multi-link' Benefit and the Policy ends because a benefit has been paid, you can apply to continue the insurance for the Insured Persons for whom the benefit was not paid. You must apply in writing within 30 days of the Policy ending.

You can apply to continue the insurance (up to a maximum of the amount that applied immediately before the Policy ended) provided that, at the time of application, the Insured Person is less than age 70 (for the Death Benefit) and age 60 (for the Disability and Living Benefits). No medical evidence is required however we will require financial information satisfactory to us before we will accept your application to continue the insurance. Any loadings, exclusions or special conditions will continue to apply.

12.4 No Buy Back Benefits

If you choose the 'Multi-Link' Benefit no buy back or reinstatement options are available to you.

13. We will not pay more than one benefit at a time

If an Insured Person suffers an injury or sickness or undergoes surgery that would make you eligible to claim for more than one benefit under this Policy, we will only pay one benefit for that injury, sickness or surgery.

14. When your Policy ends

Your Policy continues until the earliest of:

- the date you cease to be eligible to make contributions to superannuation or have contributions made to superannuation on your behalf (for Term Life as Superannuation);
- the last Insured Person dies;
- all benefits for the last Insured Person end;
- we cancel your Policy because you have not paid your premiums or any other amounts which relate to this Policy;
- we cancel or avoid the Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you prior to our acceptance of risk or during the making of a claim; or
- you write and ask us to cancel your Policy.

15. More about Westpac Term Life as Superannuation

The Westpac MasterTrust ('Fund')

15.1 Regulated superannuation fund

The Fund is a regulated superannuation fund under the Superannuation Industry (Supervision) Act 1993 and is a Registrable Super Entity (RSE) under the Act. Westpac Life is responsible for day-to-day management including the recording of contributions, administration and payment of benefits on behalf of the Trustee.

The operation of the Fund is governed by the Trust Deed. You can request a free copy of the Trust Deed by writing to us or calling 131 817.

The Trustee is indemnified for liability it incurs in respect of the insurance, unless the liability arises from fraud, a negligent act, default, omission, breach of duty or breach of trust, or such other act or omission specified by superannuation legislation.

15.2 Beneficiary Nomination Guidelines

(a) Payment in the event of your death

You can nominate one or more persons to receive the whole or a part of your benefit in the event of your death. If you do so, the nominated person will be paid the relevant share of your benefit on your death if at that time:

- the nominated person is a dependant or your legal personal representative ('LPR') (normally the executor of your will);
- you have not revoked the nomination; and
- your nomination is not invalid for any reason (see below).

For this purpose a dependant includes:

- your spouse or partner (but due to legislative restrictions not one of the same sex);
- any of your children (including adopted, step and adult children);
- any person with whom you are in an interdependency relationship at your death; and
- any other person who is financially dependent on you at the date of your death.

An interdependency relationship is a close personal relationship between two people who live together, where one or both of them provide for the financial and domestic support and personal care of the other. An interdependency relationship may still exist if there is a close personal relationship but the other requirements are not satisfied because of some physical, intellectual or psychiatric disability.

If you do not make a nomination, or the nomination you make is defective, your benefit will be paid to your LPR or, failing that, to one or more of your dependants as the Trustee determines.

(b) It is important to review your nomination regularly

You should review your nomination regularly to ensure that it continues to reflect your wishes. You can change your nomination at any time by completing the Nomination of Beneficiaries Form, obtainable by telephoning the Customer Relations Centre on 131 817. You can also revoke your nomination at any time without making a new one by writing to us.

Normally, after being notified of your death, the Trustee will consider whether to approve the last nomination received from you. Once the Trustee approves it, your nomination becomes valid and binding. But the Trustee will not approve a nomination if it has reason to believe that the nomination was invalid when you made it, or became invalid afterwards.

(c) Invalid nomination

Your nomination will be invalid when you make it if:

- it is unclear to the Trustee (e.g. because it is illegible or because the nominated proportions do not total 100%);
- the Trustee has actual knowledge that, when you made the nomination, you did not understand the consequences of making it; or
- you do not sign or date the form.

Your nomination may also become invalid after you make it if certain events occur, including marriage, divorce, and commencing or ceasing co-habitation with a person of either sex. At the date of your death, your nomination may have become invalid if a nominated person has either:

- died; or
- is no longer your dependant.

You should contact us to revise your nomination if any of these events occur.

(d) What if I don't make a nomination?

If you do not nominate any beneficiaries then your benefit will normally be payable to your estate.

(e) Professional estate and financial planning advice

Ordinarily, a valid nomination will be approved by the Trustee and so become binding. You should therefore take professional estate and financial planning advice before making one.

15.3 Conditions applying to payment of benefits under superannuation law

Superannuation law restricting payments from superannuation funds applies to all non-Death Benefits paid under the Policy. This means the Trustee can only release benefits to you if you meet a condition of release for superannuation law purposes.

Examples of some circumstances (referred to as 'conditions of release') in which the Trustee currently may be permitted to release preserved benefits are as follows:

- meeting the financial hardship conditions
- qualifying on compassionate grounds
- departing Australia permanently, having been a temporary resident of Australia (on a specified class of visa)
- having reached your preservation age and permanently retired from full or part-time employment
- having turned 60 and ceased employment with an employer on or after that age
- suffering from a terminal medical condition
- having turned 65
- becoming permanently incapacitated.

Preservation age is between age 55 and 60, depending on your date of birth:

Date of birth	Preservation Age
Before 1 July 1960	55
From 1 July 1960 to 30 June 1961	56
From 1 July 1961 to 30 June 1962	57
From 1 July 1962 to 30 June 1963	58
From 1 July 1963 to 30 June 1964	59
On or after 1 July 1964	60

If you do not satisfy a condition of release, the Trustee must preserve the benefit in the Fund until it is allowed to release it. Should this situation arise, the Trustee will write to you, explaining your options in relation to the preserved benefit. Please keep this in mind if you are eligible for a Terminal Illness or Total and Permanent Disablement Benefit.

15.4 Family law – treatment of superannuation on divorce

(a) Family Law Act 1975 ('FLA')

The FLA provides that any benefit that you may accrue in the Fund may be split with your spouse or former spouse on marriage breakdown. Alternatively a payment flag may be imposed on your benefit in the Fund. You only accrue a benefit in the Fund in the unfortunate event that you have a valid claim under the Westpac Term Life as Superannuation Policy. In this event, Westpac Life will deposit the relevant amount of insurance to your account with the Fund.

(b) Splitting your benefit

Where all requirements of the FLA have been satisfied, the Trustee is then required to split your benefit (if it is $5,000 or more) and your spouse or former spouse will be entitled to receive part or all of it. At the time of the split, the value of any benefit you may have in the Fund will reduce by the amount that is paid to, or for the benefit of, your spouse or former spouse.

You should seek professional advice as to the consequences of marriage breakdown on any benefit you may have in the Fund.

(c) Flagging your benefit

As an alternative to splitting, a payment flag may be placed on your account in the Fund in accordance with the procedures detailed in the FLA. While a payment flag is in place, the FLA requires that restrictions apply to how you may deal with any benefit that you may accrue in the Fund. In particular, you will not be able to cash, transfer or rollover your benefit while a payment flag is in place.

(d) Serving documents on the Trustee

Documents served on the Trustee for the purposes of the FLA can only be served at the following address:

Family Law and Superannuation Officer –
Legal Department
Westpac Securities Administration Limited
Westpac Place, 275 Kent St
SYDNEY NSW 2000

(e) Information about your superannuation interest

Where an eligible person under the FLA wishes to negotiate a superannuation agreement with you or facilitate the preparation of an order of the Family Court, they may apply to the Trustee to receive information about your benefit with the Fund. Where the application is made in accordance with the requirements of the FLA, the Trustee will be obliged to provide the requested information and will not be permitted to inform you about the application.

(f) Fees and expenses may apply

If your accrued benefit and/or account with the Fund becomes affected by the FLA and the Trustee is required to take certain action, you will be notified of any fees that may be charged by the Trustee for undertaking such action.

(g) Professional advice

If you believe your accrued benefit and/or account with the Fund will be affected by the FLA, you should consult your accountant, legal adviser and/or financial planner.

(h) Does not apply to de-facto relationships

Please note that the relevant sections of the FLA described above, currently only apply to legally married couples and do not apply to de-facto or same sex relationships.

Should you have any questions in relation to the above, please do not hesitate to call our Customer Relations Centre on 131 817, 8.00am to 6.30pm (Sydney time), Monday to Friday.

A snapshot of Westpac Standalone Living Insurance in action*

Nadia was self-employed, married and had two children. She decided to protect her family's financial position by taking out Westpac Standalone Living Insurance protection.

This insurance cover was in the form of three benefits:

(a) A Term Life policy which provides:
   – Death cover; and
   – Disability cover; and

(b) Cover for specific medical conditions, injuries and surgery.

A couple of years later, Nadia was diagnosed with a rare form of cancer. She lodged a claim against the Living Insurance benefit. The medical reports confirmed Nadia's medical condition, and as she satisfied all of the policy terms and conditions, she was paid in excess of $300,000.

Nadia's decision to cover herself against specific medical conditions gave her crucial financial flexibility at a time of great stress. She used the proceeds of her claim to meet the high costs of the latest cancer treatments. Her insurance payment also gave her the option to sell her business and work part time to give herself the best chance of recovery.

Some other examples of Living Insurance claims paid:

Cause	Breast cancer	Coronary artery surgery	Stomach cancer
Occupation	Computer consultant	Storeperson	Shop assistant
Age at claim	39	45	34
Years in force	7 years	10 years	4 years
Benefit	$294,830	$248,704	$172,369

(Source: Claims data from Westpac Life Insurance Services Limited.)

*For illustrative purposes only. The above is a case study of a real life example (names have been altered) and demonstrates how Westpac Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

1. Introduction

Westpac Standalone Living Insurance pays a benefit if the Insured Person suffers a specified serious medical condition or injury or undergoes specified surgery.

Standard Benefits	Description	For full details see page
Living	Pays a benefit if the Insured Person suffers a specified serious medical condition or injury or undergoes specified surgery, and subsequently survives 14 days.	29
Death	Pays $10,000 if the Insured Person suffers a specified serious medical condition or injury or undergoes specified surgery, and dies within 14 days.	33
Financial Planning	Reimburses up to $1,500 (in addition to your Living Benefit) to cover the cost of obtaining financial advice following an eligible claim.	33
Optional Benefits (available at additional cost)		
Reinstating your Living Benefit	Allows you to reinstate your Living Benefit without further health evidence 1 year after we have paid you a Living Benefit.	34

Important: The Death Benefit payable under Westpac Standalone Living Insurance is only payable in limited circumstances and provides a maximum payment of $10,000. If you require more comprehensive insurance for death in addition to serious medical conditions, both benefits are available in Westpac Term Life. Your financial planner can provide professional advice in relation to your individual circumstances.

2. How Westpac Standalone Living Insurance Works

2.1 Who can apply

You can apply for a Westpac Standalone Living Insurance Policy on your own life, in which case you are the Insured Person as well as the Policy Owner. You can also apply for a Westpac Standalone Living Insurance Policy on someone else's life (for example your spouse or partner), in which case the other person is the Insured Person and you are the Policy Owner. You can apply to insure more than one person under the one Policy (up to a maximum of five people).

You apply for the amount of Living Benefit which you wish to insure each person for.

2.2 Policy Ownership

More than one person can own the Policy, up to a maximum of 5 people and each Policy Owner will own the Policy jointly. The Policy Owner(s) pay premiums that are due under the Policy and when a Policy Owner dies, ownership of the Policy automatically goes to the surviving Policy Owners. If all Policy Owners have died, and the Policy has not ended (see section 7), the Policy Owner is the estate of the last surviving Policy Owner.

2.3 Who receives any benefits payable

The Policy Owner(s) will receive any benefits that become payable. Benefits are divided equally between the surviving joint Policy Owners. If there are no surviving Policy Owners, and the Policy has not ended (see section 7) the benefit goes to the estate of the last surviving Policy Owner.

3. Living Benefit

3.1 Availability

You can apply to insure any person aged from 15 to 59. You can apply to insure up to a maximum amount of $2 million per Insured Person.

3.2 When we will pay

We will pay a Living Benefit (Full or Advancement) if:

- an Insured Person suffers a specified serious medical condition or injury or undergoes specified surgery (before the Living Benefit ends), set out in section 8 – Living Benefit Definitions;
- subsequently survives at least 14 days;
- our medical advisers support the occurrence of any condition or event you intend to claim on. We reserve the right to require the Insured Person to undergo medical examinations and other reasonable tests to confirm the condition or event;

- where we require the Insured Person to go to an appropriate medical specialist, they must be acceptable to us;
- where we have used standard classifications and measurements to determine an event or condition, we may use an appropriate equivalent standard acceptable to us if that classification is replaced or changes significantly; and
- we will only pay a benefit when we are satisfied that the Insured Person has satisfied the full definition of the relevant injury, condition or surgery.

3.3 Some conditions must occur at least 3 months after the commencement of cover

For the following conditions and surgery:

- Angioplasty
- Cancer
- Carcinoma in situ of female organs
- Coronary Artery Bypass Surgery
- Heart Attack
- Open Heart Surgery
- Prostate Cancer (stages T1a, T1b and T1c)
- Stroke,

the benefit for the Insured Person is only payable if the condition or surgery occurs at least 3 months after cover for the Insured Person begins or the last reinstatement of the Policy (if it had lapsed).

3.4 Restrictions on increases

If a Heart Attack, Angioplasty, Open Heart Surgery, Coronary Artery Bypass Surgery, Cancer, Carcinoma in situ of female organs, Prostate Cancer (stages T1a, T1b and T1c) or Stroke occur within 3 months of any increase to the benefit for the Insured Person (excluding CPI indexation increases – see section A.9), the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

3.5 The medical conditions, injuries and surgery covered are:

Cancer
Cancer (malignant tumours)*
Carcinoma in situ of female organs*^
Prostate cancer (stages T1a, T1b and T1c)*^

Heart disorders
Angioplasty*^
Aortic surgery
Cardiomyopathy
Coronary artery bypass surgery*
Heart attack*
Heart valve surgery
Open heart surgery*
Out of hospital cardiac arrest
Pulmonary hypertension

Nervous system disorders^
Alzheimer's disease and other dementias
Motor neurone disease
Multiple sclerosis
Muscular dystrophy
Parkinson's disease

Accident
Coma
Major head trauma
Paralysis
Severe burns

Body organ disorders
Blindness
Chronic liver disease
Chronic lung disease
Kidney failure
Major organ transplant^

Blood disorders
Aplastic anaemia
Medically acquired HIV
Occupationally acquired HIV

Other events
Advanced diabetes
Benign brain tumour
Diabetes complication^
Encephalitis
Loss of hearing
Loss of independent existence
Loss of limbs
Loss of speech
Pneumonectomy
Severe rheumatoid arthritis
Stroke*

Important
Full definitions of each event are given in Living Benefit Definitions commencing on page 35. The Insured Person must satisfy the full definition of the appropriate event before we will pay a Living Benefit. Please read the full definitions.

* For these events, cover does not start until 3 months after the Insured Person's Living Benefit commences (or was last reinstated if it had been cancelled). This also applies to an increase in the amount of your Living Benefit (other than CPI indexation increases).

^For these events, an Advancement Benefit may be paid in certain specified circumstances. For more details, see section 3.6.b.

3.6 What we will pay

(a) Full Benefit payment

You are entitled to claim for a Full Benefit if you meet the definition of the event or condition as defined in section 8, except for the Advancement Benefit as outlined in section 3.6.b.

The amount we will pay ('the relevant amount') is:

- the Living Benefit shown in the Policy Schedule for that Insured Person;
- increased by us if any CPI indexation has been applied (see section A.9);
- reduced by any Advancement Benefit we have previously paid you for that Insured Person under this Policy (see following section).

(b) Advancement Benefit payment

We will pay an Advancement Benefit for the events listed in the table below:

<table>
<tr><th>Condition</th><th>When will we pay</th><th>What will be pay</th></tr>
<tr><td>Single or double vessel angioplasty</td><td>If an Insured Person has undergone this surgery.</td><td>We will pay 15% of the Living Benefit for that Insured Person at the date of the event, up to a maximum of $30,000.</td></tr>
<tr><td>Carcinoma in situ of female organs</td><td>When the Insured Person is diagnosed with carcinoma in situ of female organs.</td><td rowspan="2">We will pay 25% of the Living Benefit up to a maximum of $50,000.</td></tr>
<tr><td>Prostate cancer (stages T1a, T1b and T1c)</td><td>When the Insured Person is diagnosed with prostate cancer (stages T1a, T1b and T1c).</td></tr>
<tr><td>Alzheimer's disease and other dementias
Motor Neurone Disease
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease</td><td>When the Insured Person is diagnosed by a registered medical practitioner specialising in the field relevant to this condition, as suffering from the condition but the condition does not cause 25% permanent impairment of whole person function.</td><td rowspan="2">We will pay 25% of the Living Benefit up to a maximum of $50,000.

If the Insured Person subsequently meet the full definition of the condition (see page 35 for details), we will pay the balance of Living Benefit.</td></tr>
<tr><td>Major organ transplant</td><td>When the Insured Person has been on a waiting list for at least 6 months to receive a major organ transplant and that procedure is unrelated to any previous procedure or surgery.

A waiting list means the Insured Person has been placed on an Australian waiting list, approved by us, for an organ transplant from a human donor that is listed in the major organ transplant definition and that is considered medically necessary.</td></tr>
<tr><td>Diabetes Complication</td><td>When the Insured Person is diagnosed with a Diabetes complication.</td><td>We will pay 40% of the Living Benefit for that Insured Person, up to a maximum of $200,000.</td></tr>
</table>

For Living Benefit definitions, please see page 35.

(c) Conditions on Advancement Benefit

Please note that the above amounts of $200,000, $50,000 and $30,000 are not indexed by CPI under section A.9. In addition, the minimum benefit payable under the advancement benefit is $10,000. We will only pay once under each of these groups of events:

- Single or double vessel angioplasty; and
- Carcinoma in situ of female organs or Prostate cancer; and
- Alzheimer's disease and other dementias, Motor Neurone Disease, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease or Major organ transplant; and
- Diabetes complication.

3.7 When we will not pay

(a) General

A Living Benefit will not be paid for any condition, injury or surgery that happened before the Insured Person's benefit began (or before the benefit was last reinstated), and you or the Insured Person did not tell us about it.

A condition or injury is taken to have happened when:

- a registered medical practitioner first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the condition or injury; or
- the Insured Person first had symptoms of the condition or injury for which a reasonable person in the circumstances would have sought advice, care or treatment from a registered medical practitioner.

(b) Other exclusions

We will not pay you a benefit if the condition, injury or surgery giving rise to the claim is caused directly or indirectly by:

- an intentional self-inflicted injury or attempted suicide (while sane or insane); or
- any other event or condition covered by an exclusion specified in the Policy Schedule.

3.8 What happens after we pay

After we pay a Living Benefit for the Insured Person under this Policy, the Living Benefit for the Insured Person ends. If the Living Benefit was paid as an Advancement Benefit, we will also reduce the Living Benefit for the Insured Person by the amount we paid.

3.9 When this benefit ends

The Living Benefit for an Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- we pay the full Living Benefit for that Insured Person;
- you write and ask us to cancel the Living Benefit for that Insured Person; or
- your Policy ends (see section 7).

3.10 Restrictions on increases

If the medical condition, injury or specified surgery giving rise to a claim happens before any increase to the benefit amount (excluding CPI indexation increases) and you did not tell us about it, the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

4. Death Benefit

4.1 Availability

The Death Benefit is automatically included with a Living Benefit.

4.2 When we will pay

We will pay a benefit if the Insured Person:

- suffers one of the specified serious medical conditions or injuries or undergoes specified surgery (see table 3.5) before the Policy ends (see section 7); and
- subsequently dies within 14 days.

4.3 What we will pay

We will pay a lump sum of $10,000. This amount is not indexed.

4.4 What happens after we pay

After we pay a Death Benefit, the Living Benefit for the Insured Person ends.

4.5 When we will not pay

A Living or Death Benefit will not be paid if the medical condition, injury or surgery giving rise to the claim:

- was caused directly or indirectly by an intentional self-inflicted injury or attempted suicide (whether while sane or insane);
- was caused directly or indirectly by an event or condition covered by an exclusion in your Policy Schedule; or
- happened (as per section 3.7.a) before the Insured Person's benefit began (or before the benefit was last reinstated) and you or the Insured Person did not tell us about it.

5. Financial Planning Benefit

5.1 Availability

The Financial Planning Benefit is automatically included with a Living Benefit, and is paid in addition to any Living Benefit.

5.2 Who we will pay

We will pay you the benefit.

5.3 When we will pay

If we pay a Living Benefit, we will reimburse the recipient of the benefit for the cost of obtaining financial advice.

5.4 What we will pay

We will pay the cost of obtaining financial advice up to a maximum of $1,500.

We will only reimburse amounts relating to the preparation and presentation of the plan and not amounts relating to the implementation of the plan or commission paid to a financial planner.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the benefit so the total amount payable does not exceed $1,500.

The Financial Planning Benefit will only be paid once per policy per Insured Person across all policies issued by us in respect of that Insured Person.

5.5 Conditions

The following conditions must be met for the Financial Planning Benefit to be paid:

- the financial plan must be provided by an approved, accredited financial planner;
- the Financial Planning Benefit must be claimed within 12 months of receiving the Living Benefit; and
- the recipient must be able to provide a copy of the invoice showing a breakdown of the services provided and a receipt showing the amount paid.

6. Reinstating your Living Benefit (optional)

6.1 Introduction

After we have paid you a Living Benefit, and if you elected this option at the time of your original application, you have the option of reinstating your Living Benefit in accordance with the terms and conditions set out below.

6.2 Availability

12 months after we pay the Living Benefit for any condition, injury or surgery, except for an Advancement Benefit, you have the option to reinstate the Living Benefit for the Insured Person by up to 100% of the Living Benefit you were paid without providing further evidence of health.

- This optional benefit must be taken out at the time of the original application; and
- an additional premium will be charged.

The Policy terms and conditions may no longer be available when this benefit is exercised. If so, we will issue a new Policy available at the time which we believe provides similar benefits.

6.3 Conditions

You can exercise the option provided that:

- the reinstatement request is received in writing within 30 days from the 12 month anniversary date of the Living Benefit payment. If your request for reinstatement is not received in this period the offer of reinstatement lapses and will not be re-offered;
- you do not reinstate more than the Living Benefit we have paid;
- you continue to meet any minimum premium rules that we set; and
- the Living Benefit payment was made before the Review Date preceding age 65.

The reinstated Living Benefit will be on the terms and conditions of the Living Benefit at the time of reinstatement with the exception of the following:

- the reinstatement option will not be available;
- CPI indexation and future insurability increases will not be available;
- any original exclusions or special conditions applicable under your policy will be maintained; and
- the Insured Person must be alive at the time we reinstate the benefit.

6.4 When we will not pay

We will not pay a claim under the reinstated cover if the specified condition claimed:

- is the same as the original specified condition event;
- has occurred as a direct or indirect result of the original specified condition event;
- is a heart related condition and the original specified condition event was also a heart related condition;
- is a lung related condition and the original specified condition event was a lung related condition;
- is a Stroke and the original specified condition event was a heart related condition;
- is a Loss of Independence;
- the specified condition occurred or was diagnosed, or the circumstances or symptoms leading to diagnosis were apparent before the Standalone Living Insurance Benefit was reinstated; or
- is a cancer related condition and the original specified event was a cancer related condition.

6.5 When this option ends

This option for the Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- you write and ask us to cancel your policy for the Insured Person;
- your insurance cover ends (see section 7); or
- you exercise the option.

7. When your Policy ends

Your Policy continues until the earliest of:

- the Living Benefit for the last Insured Person ends;
- the last Insured Person dies;
- we cancel your Policy because you have not paid your premiums, stamp duty or any other amounts which relate to this Policy;
- we cancel or avoid the Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you prior to our acceptance of risk or during the making of a claim; or
- you write and ask us to cancel your Policy.

8. Living Benefit Definitions

(a) Advanced diabetes

Severe diabetes mellitus, either Insulin or Non-Insulin dependent, as certified by a consultant endocrinologist and resulting in at least two of the following criteria:

(i) severe Diabetic Retinopathy resulting in visual acuity whether aided or unaided of 6/36 or less in both eyes;

(ii) severe Diabetic Neuropathy causing motor and/or autonomic impairment;

(iii) diabetic Gangrene leading to surgical intervention;

(iv) severe Diabetic Nephropathy causing chronic irreversible renal impairment (as measured by a corrected creatinine clearance below the laboratory's measured normal range); or

(v) persistent sensory neuropathy.

(b) Alzheimer's Disease and Other Dementias

Significant and permanent failure of brain function confirmed by a consultant neurologist. The dementia must also result in either:

(i) an inability to perform at least one of the Activities of Daily Living (see 'Activities of Daily Living' on page 38); or

(ii) a need for continual professional supervision as confirmed by the consultant neurologist.

Dementia resulting from alcohol or drug abuse is excluded.

(c) Angioplasty

Single or double vessel – Undergoing for the first time either angioplasty, cardiac keyhole surgery or stent insertion on one or two coronary arteries, as considered necessary by a cardiologist to treat coronary artery disease.

Triple Vessel – Undergoing for the first time either angioplasty, cardiac keyhole surgery or stent insertion on 3 or more coronary arteries in the same procedure, as considered necessary by a cardiologist to treat coronary artery disease.

Angiographic evidence is required to confirm the need for this procedure.

(d) Aortic Surgery

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

(e) Aplastic Anaemia

Permanent bone marrow failure, which results in anaemia, neutropenia and thrombocytopenia requiring treatment, with at least one of the following:

(i) permanent reliance on blood product transfusions;

(ii) marrow stimulating agents;

(iii) bone marrow transplantation; or

(iv) immunosuppressive agents.

(f) Benign Brain Tumour

Non-cancerous tumour in the brain or spinal cord which is histologically described and which produces neurological deficit causing permanent and significant functional impairment, as confirmed by a consultant neurologist and by imaging studies such as a CT or MRI scan or requires radical surgery for its removal.

The following are excluded:

(i) cysts, granulomas and cerebral abscesses;

(ii) malformations in, or of, the arteries or veins of the brain;

(iii) haematomas;

(iv) tumours in the pituitary gland; and

(v) acoustic neuroma and other cranial nerve tumours.

(g) Blindness

The permanent loss of sight of both eyes, whether aided or unaided, as a result of disease, illness or injury such that visual acuity is 6/60 or less in both eyes, or such that the visual field is reduced to 20 degrees or less of arc.

Blindness resulting from alcohol or drug abuse is excluded.

(h) Cancer

A malignant tumour pathologically confirmed and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue. Also included are Hodgkin's disease, lymphoma, colorectal cancer (from Dukes stage A) and leukaemia. The following are specifically excluded:

(i) all skin cancers except metastatic squamous cells carcinomas or melanomas of 1.5 millimetres or more in thickness or Clark Level 3 or more depth of invasion;

(ii) all tumours which are histologically described as micro-carcinoma, pre-malignant or showing the malignant changes of 'carcinoma in situ', including cervical dysplasia rated as CIN 1, 2 or 3 ('carcinoma in situ' of the breast is covered if it results directly in the removal of the entire breast. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment);

(iii) chronic lymphocytic leukaemia (less than RAI stage 1); and

(iv) prostatic tumours which are histologically described as TNM classification T1 (including T1a, T1b and T1c) or are of another equivalent or lesser classification (prostate cancer is covered if it results directly in total prostatectomy. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment).

(i) Carcinoma in situ of female organs

Carcinoma in situ means localised cancer characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and /or active destruction of normal tissue beyond the basement membrane.

Carcinoma in situ of the following sites is covered:

(i) **Cervix-uteri** – the tumor must be classified as TIS according to the TNM staging method or FIGO stage 0. (This excludes Cervical Intraepithelial (CIN) classifications CIN 1, CIN2 and CIN 3).

(ii) **Fallopian tube** – where the tumor must be limited to the tubal mucosa and classified as TIS according to the TNM staging method or FIGO stage 0.

(iii) **Vagina** – where the tumor must be classified as TIS according to the TNM staging method or FIGO stage 0.

(iv) **Vulva** – where the tumor must be classified as TIS according to the TNM staging method or FIGO stage 0.

(v) **Breast** – where the tumor must be classified as TIS according to the TNM staging method or FIGO stage 0.

FIGO refers to the staging method of the International Federation of Gynaecology.

(j) Cardiomyopathy

Impaired ventricular function of variable aetiology resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association (or equivalent) classification of cardiac impairment.

Cardiomyopathy resulting from alcohol or drug abuse is excluded.

(k) Chronic Liver Disease

End stage liver failure characterised by permanent jaundice, ascites and encephalopathy.

Disease resulting from alcohol or drug abuse is excluded.

(l) Chronic Lung Disease

End stage respiratory failure requiring permanent oxygen therapy, the diagnosis of which includes an FEV 1 test result of less than 1 litre.

(m) Coma

A state of unconsciousness with no reaction to external stimuli, persisting continuously and requiring the use of a life support system for a period of at least 3 consecutive days and resulting in neurological deficit, as confirmed by a consultant neurologist.

Coma resulting from alcohol or drug abuse is excluded.

(n) Coronary Artery Bypass Surgery

Coronary artery bypass surgery with the use of bypass graft(s) to one or more coronary arteries for treatment of coronary artery disease. The surgery must be the most appropriate treatment for the disease. All non-surgical procedures such as laser, angioplasty or other intra-arterial techniques are excluded.

(o) Diabetes complication

Type 1 insulin dependent diabetes mellitus, as certified by a consultant endocrinologist and resulting in at least two of the following criteria:

(i) urinary protein excretion of more than 300mg per day;

(ii) diabetic retinopathy with a minimum severity of at least exudates and/or dot-blot haemorrhages; or

(iii) persistent sensory neuropathy.

(p) Encephalitis

Severe inflammatory disease of the brain resulting in neurological deficit that causes at least 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist.

(q) Heart Attack

The occurrence of an acute myocardial infarction, which means the death of a portion of heart muscle due to inadequate blood supply as evidenced by:

- new electrocardiograph changes associated with myocardial infarction; and
- the elevation above the laboratory's upper limit of normal of the biochemical markers (such as troponin or cardiac enzymes) indicative of myocardial infarction.

If the above tests are inconclusive or superseded by technological advances, we will consider other appropriate and medically recognised tests in support of a diagnosis as confirmed by a consultant cardiologist.

Lesser acute coronary syndromes including unstable angina and acute coronary insufficiency are excluded as part of this definition.

(r) Heart Valve Surgery

Any surgery performed to repair or replace a cardiac valve as a consequence of a heart valve defect.

(s) Kidney Failure

End stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which permanent regular renal dialysis is instituted or renal transplantation undergone.

(t) Loss of Hearing

Total irreversible and irreparable loss of hearing, both natural and assisted, in both ears as a result of a disease, illness or injury as certified by an appropriate medical specialist.

(u) Loss of Independent Existence

As a result of sickness or injury, the Insured Person:

(i) has a permanent and irreversible inability to perform, without assistance, any two of the Activities of Daily Living (see section the Activities of Daily Living on page 38); or

(ii) suffers cognitive impairment that requires permanent and constant supervision, which must be established and the diagnosis reaffirmed after a continuous period of at least 6 months of such impairment.

(v) Loss of Limbs

The complete and irrecoverable loss of use of both hands or both feet, or one hand and one foot, as a result of disease, injury or illness.

(w) Loss of Speech

Complete and irrecoverable loss of speech as a result of disease, injury or illness as certified by a consultant neurologist.

(x) Major Head Trauma

Accidental head injury resulting in neurological deficit that:

(i) causes at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as certified by a consultant neurologist, or

(ii) results in a permanent and irreversible inability of the Insured Person, to perform, without the physical assistance of an adult, any one of the Activities of Daily Living.

(y) Major Organ Transplant

The medically necessary human to human transplant from a donor to the Insured Person of one or more of the following: a heart, lung, kidney, liver, pancreas or bone marrow.

(z) Medically Acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) that on the balance of probabilities arose from one of the following medical procedures performed in Australia by a registered health professional:

(i) blood or blood product transfusion;

(ii) organ transplant to the Insured Person;

(iii) assisted reproductive techniques; or

(iv) medical/dental procedure or operation.

This benefit will not apply in the event that any cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of infection with the HIV virus or the occurrence of AIDS prior to the making of a claim.

(aa) Motor Neurone Disease

Significant neurological deficit due to the unequivocal diagnosis of Motor Neurone Disease, that causes at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist.

(bb) Multiple Sclerosis

The definite diagnosis of Multiple Sclerosis with persisting neurological abnormalities that cause at least 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist.

(cc) Muscular Dystrophy

The definite diagnosis of Muscular Dystrophy, resulting in neurological deficit that causes at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist.

(dd) Occupationally Acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where the virus was acquired on the balance of probabilities as a result of an accident occurring during the course of the Insured Person's normal occupation. Sero-conversion of the HIV infection must occur within 6 months of the accident. HIV infection acquired by any other means including sexual activity or non-prescribed intravenous drug use is excluded.

Any accident giving rise to a potential claim must be reported to us within 7 days of the accident and supported by a negative HIV Antibody test taken after the accident. We must be given access to test independently all the blood samples used.

This benefit will not apply in the event that any cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of infection with the HIV virus or the occurrence of AIDS prior to the making of a claim.

(ee) Open Heart Surgery

Open chest surgery for the surgical treatment of a cardiac defect, cardiac aneurism or cardiac tumour.

(ff) Out of Hospital Cardiac Arrest

Cardiac arrest occuring out of hospital not associated with any medical procedure and documented by an ECG or ECG rhythm strip showing cardiac asystole or ventricular fibrillation.

(gg) Paralysis

The total and permanent loss of use through accident or disease of:

(i) both legs (paraplegia);
(ii) both arms and legs (quadriplegia);
(iii) one side of the body (hemiplegia); or
(iv) both sides of the body (diplegia).

(hh) Parkinson's Disease

The definite diagnosis of Parkinson's Disease with persisting neurological abnormalities that causes at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist.

Parkinson's Disease resulting from alcohol or drug abuse is excluded.

(ii) Pneumonectomy

The undergoing of surgery to remove an entire lung. This treatment must be deemed the most appropriate treatment and medically necessary by an appropriate medical specialist and supported by our medical advisers.

Pneumonectomy which is directly caused by smoking tobacco or use of other drugs not prescribed by a doctor is excluded.

(jj) Prostate Cancer (stages T1a, T1b and T1c)

The tumour is located within the prostate gland and is histologically described as TNM Classification T1a, T1b or T1c.

(kk) Pulmonary Hypertension

Primary pulmonary hypertension associated with right ventricular enlargement, established by cardiac catheterisation, resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment as confirmed by a cardiologist.

(ll) Severe Burns

Tissue injury caused by thermal, electrical or chemical agents causing third degree burns to:

(i) at least 20% of the body surface area as measured by the 'rule of 9' or the Lund & Browder Body Surface Chart (or equivalent classification);
(ii) both hands, requiring surgical debridement and/or grafting; or
(iii) the face, requiring surgical debridement and/or grafting.

(mm) Severe Rheumatoid Arthritis

The diagnosis of severe rheumatoid arthritis by a rheumatologist. The diagnosis must be supported and evidenced by, all of the following criteria:

(i) at least a 6 week history of severe rheumatoid arthritis which involves 3 or more of the following joint areas:
  a. proximal interphalangeal joints in the hands;
  b. metacarpophalangeal joints in the hands;
  c. metatarsophalangeal joints in the foot, or any joint of the wrist, elbow, knee or ankle;
(ii) simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone);
(iii) typical rheumatoid joint deformity; and
(iv) at least 2 of the following criteria:
  a. morning stiffness;
  b. rheumatoid nodules;
  c. erosions seen on x-ray imaging;
  d. the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of sever rheumatoid arthritis.

Degenerative osteoarthritis and all other arthridities are excluded.

(nn) Stroke

Any cerebrovascular accident or incident resulting in neurological deficit that last for at least 24 hours, as confirmed by a consultant neurologist. There must be clear evidence on a CT, MRI or similar scan that a stroke has occurred to our satisfaction.

The following are excluded:

(i) transient ischaemic attacks;
(ii) symptoms due to migraine;
(iii) vascular disease of the optic nerve;
(iv) physical head injury;
(v) reversible neurological deficit; and
(vi) any blood vessel incident outside the cranium, except embolism resulting in stroke.

Definition of Activities of Daily Living	
Bathing	The ability to shower or bathe.
Dressing	The ability to put on or take off clothing.
Toileting	The ability to use the toilet, including getting on or off.
Mobility	The ability to get in and out of bed and a chair.
Continence	The ability to control bladder and bowel function.
Feeding	The ability to get food from a plate into the mouth.

Westpac Standalone Total and Permanent Disablement

1. Introduction

Westpac Standalone Total and Permanent Disablement pays a benefit equal to the amount of the Disability Benefit to the Policy Owner(s) should an Insured Person(s) become Totally and Permanently Disabled. It may assist the Insured Person with the medical and rehabilitation costs and provide them and their family with financial security.

Standard Benefits	Description	For full details see page
Disability	Pays a benefit if the Insured Person becomes Totally and Permanently Disabled.	39
Limited death	Pays $10,000 if the Insured Person dies and the Disability Benefit has not been paid.	42
TPD Partial Benefit	Pays a partial benefit if the Insured Person suffers a partial disability.	43
Financial Planning	Reimburses up to $1,500 (in addition to your Disability Benefit) to cover the cost of obtaining financial advice following an eligible claim.	43

2. How Westpac Standalone Total and Permanent Disablement Works

2.1 When can you apply

You can apply for a Westpac Standalone Total and Permanent Disablement Policy on your own life, in which case you are the Insured Person as well as the Policy Owner. You can also apply for a Westpac Standalone Total and Permanent Disablement Policy on someone else's life (for example your spouse or partner), in which case the other person is the Insured Person and you are the Policy Owner. You can apply to insure more than one person under the one Policy (up to a maximum of five people).

2.2 Who can own this Policy

More than one person can own the Policy, up to a maximum of 5 people and each Policy Owner will own the Policy jointly. The Policy Owner(s) pay premiums that are due under the Policy and when a Policy Owner dies, ownership of the Policy automatically transfers to the surviving Policy Owners. If all Policy Owners have died, and the Policy has not ended (see section 7), the Policy Owner is the estate of the last surviving Policy Owner.

You apply for the amount of Disability Benefit you wish to insure each person for.

2.3 Who receives any benefits payable

The Policy Owner(s) will receive any benefits that become payable. Benefits are divided equally between the surviving joint Policy Owners. If there are no surviving Policy Owners, and the Policy has not ended (see section 7) the benefit goes to the estate of the last surviving Policy Owner.

3. Disability Benefit

3.1 Availability

You can apply to insure any person from 15 to 59. However, this benefit will not be available to people in certain occupations or if they are working a limited number of hours per week. Your financial planner can advise you on your individual circumstances.

3.2 Types of Disability Benefit

(a) Your choice

You can choose from three different types of Disability Benefit depending on the level of protection required and the circumstances of the Insured Person. We call these 'Own Occupation', 'Any Occupation' and 'Home Duties' Disability Benefits.

(b) Own Occupation

Own Occupation cover is available, for additional cost, if the Insured Person is in a professional occupation such as medicine or law (your financial planner will be able to tell you which professional occupations are included).

The table below shows the maximum limits.

Type of Cover	Maximum Disability Benefit Amount
Any Occupation	$3 million
Own Occupation	$3 million
Home Duties	$750,000
'General' cover	$1 million

(c) General Cover

Regardless of the type of Disability Benefit you have applied for, on the Review Date prior to the Insured Person turning 65, the Disability Benefit automatically becomes 'General' cover only. 'General' cover is subject to a maximum initial amount of $1 million and this amount can be indexed after that date (see section A.9 for details about indexation).

3.3 When we will pay

We will pay a benefit if the Insured Person becomes Totally and Permanently Disabled before the Disability Benefit ends (see section 7).

3.4 What we will pay

We will pay the amount of the Disability Benefit for the Insured Person at that time.

The amount we will pay is:

- the Disability Benefit shown in the Policy Schedule for the Insured Person; and
- increased by us if any CPI indexation has been applied (see section A.9).

However, the maximum Disability Benefit on the Review Date immediately before the Insured Person turns age 65 is $1 million, which may be indexed after that date in accordance with section A.9.

3.5 Definition of Total and Permanent Disability

The definition of Total and Permanent Disability cover depends on the age of the Insured Person and the type of disability cover we have agreed to provide for the Insured Person. Please see table 3.6 following for these definitions.

3.6 Types of Disability Benefits

<table>
<tr><th colspan="2">Any Occupation</th></tr>
<tr><td>Under Any Occupation, Total and Permanent Disability means:</td><td>An injury or sickness which has prevented the Insured Person from working for 3 consecutive months; and
the 3 month period has ended before the final Review Date before the Insured Person turns 65; and
in our opinion, the injury or sickness is likely to prevent the Insured Person from ever again being able to work in Any Occupation for which they are reasonably qualified because of education, training or experience, and which would pay remuneration at a rate greater than 25% of their earnings in the last 12 months of work.
'Earnings' is the income earned by the Insured Person's own personal exertion, after deduction of any expenses incurred in earning that income before tax;
or
the Insured Person meets the 'General' cover meaning of 'Total and Permanent Disability' (see next page).</td></tr>
<tr><td>Additional information</td><td>'General' cover will apply if the Insured Person had permanently retired prior to the event.</td></tr>
<tr><th colspan="2">Own Occupation</th></tr>
<tr><td>Under Own Occupation, Total and Permanent Disability means:</td><td>An injury or sickness which has prevented the Insured Person from working for 3 consecutive months; and
the 3 month period has ended before the final Review Date before the Insured Person turns 65; and
in our opinion, the injury or sickness is likely to prevent the Insured Person from ever again being able to work in their Own Occupation.
'Own Occupation' is taken to mean the occupation that the Insured Person was last engaged in immediately prior to the event giving rise to a claim;
or
the Insured Person meets the 'General' cover meaning of 'Total and Permanent Disability' (see next page).</td></tr>
<tr><td>Additional information</td><td>'General' cover will apply if the Insured Person had permanently retired prior to the event.</td></tr>
<tr><th colspan="2">Home Duties</th></tr>
<tr><td>Under Home Duties, Total and Permanent Disability means:</td><td>An injury or sickness which has prevented the Insured Person from carrying out all normal household duties for 3 consecutive months; and
the 3 month period has ended before the final Review Date before the Insured Person turns 65; and
in our opinion, the injury or sickness is likely to prevent the Insured Person from ever again being able to carry out all normal household duties.
'Normal household duties' means the duties normally performed by a person who remains at home and is not working in a regular occupation for income, including cleaning the house, washing, shopping for food, cooking meals and caring for minor children. For the avoidance of doubt, an Insured Person will not be considered to be unable to carry out all normal household duties if the Insured Person is able to perform any one or more of the listed duties;
or
the Insured Person meets the 'General' cover meaning of 'Total and Permanent Disability' (see next page).</td></tr>
</table>

'General' Cover	
Under 'General' cover, Total and Permanent Disability means:	The Insured Person has suffered either: ■ loss of independent existence, which means as a result of sickness or injury, the Insured Person: – has a permanent and irreversible inability to perform, without assistance, any two of the Activities of Daily Living (see page 38 for definitions); or – suffers cognitive impairment that requires permanent and constant supervision, which must be established and the diagnosis reaffirmed after a continuous period of at least 6 months of such impairment; or ■ total and permanent loss of use of two limbs, use of one limb and sight in one eye or sight in both eyes. 'Limb' means an arm or leg, including the whole hand or the whole foot. We will only consider the Insured Person to be Totally and Permanently Disabled under 'General' cover if the Insured Person survives at least 14 days after the date of loss of independent existence or total and permanent loss as described above.

3.7 When we will not pay

A Disability Benefit will not be paid if the injury or sickness giving rise to the claim:

- was caused by an intentional self-inflicted injury or attempted suicide (whether while sane or insane);
- was caused by an event or condition covered by an exclusion shown in your Policy Schedule; or
- happened before the Insured Person's benefit began (or before the benefit was last reinstated) and you or the Insured Person did not tell us about it.

If the injury or sickness giving rise to a claim happens before any increase to the benefit amount (excluding CPI indexation increases) and you did not tell us about it, the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

3.8 When is an injury or sickness taken to have happened

An injury or sickness is taken to have happened when:

- a registered medical practitioner first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the injury or sickness; or
- the Insured Person first had symptoms of the injury or sickness for which a reasonable person in the same circumstances would have sought advice, care or treatment from a registered medical practitioner.

3.9 When this benefit ends

The Disability Benefit for the Insured Person continues until the earliest of:

- the Review Date prior to the Insured Person's 99th birthday;
- we pay the full Disability Benefit for that Insured Person;
- you write and ask us to cancel the Disability Benefit for that Insured Person; or
- your Policy ends (see section 7).

4. Limited Death Benefit

4.1 Availability

The limited Death Benefit is automatically included in this Policy.

4.2 When we will pay

We will pay a limited Death Benefit if the Insured Person dies and the Disability Benefit has not been paid.

4.3 What we will pay

We will pay a lump sum of $10,000. This amount is not indexed by the CPI.

4.4 When we will not pay

A limited Death Benefit will not be paid if the Insured Person commits suicide (while sane or insane) within 13 months of the later of:

- the commencement date of this Policy; or
- the date this Policy was last reinstated.

5. TPD Partial Benefit

5.1 When this benefit applies

The TPD Partial Benefit is automatically included as part of your Westpac Standalone Total and Permanent Disablement Policy.

5.2 When we will pay

We will pay a benefit if the Insured Person has suffered the total and permanent loss of use of one limb or sight in one eye due to sickness or injury before the Disability Benefit ends.

'Limb' means an arm or leg, including the whole hand or the whole foot.

5.3 What we will pay

The amount we will pay is equal to 25% of the Disability Benefit for the Insured Person increased by us if any CPI indexation has been applied (see section A.9), up to a maximum of $250,000.

5.4 What happens after we pay

After we pay the TPD Partial Benefit, the Disability Benefit is reduced by the amount paid.

5.5 When we will not pay

A TPD Partial Benefit will not be paid if the sickness or injury giving rise to the claim:

- was caused by an intentional self-inflicted injury or attempted suicide (whether while sane or insane);
- was caused by any event or condition covered by an exclusion shown in your Policy Schedule; or
- happened before the Insured Person's Benefit began (or before the benefit was last reinstated) and you or the Insured Person did not tell us about it.

If the injury or sickness giving rise to a claim happens before any increase to the benefit amount (excluding CPI indexation increases) and you did not tell us about it, the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

6. Financial Planning Benefit

6.1 Availability

The Financial Planning Benefit is automatically included with a Disability Benefit, and is paid in addition to any Disability Benefit.

6.2 Who we will pay

We will pay you the benefit.

6.3 When we will pay

If we pay a Disability Benefit, we will reimburse the recipient of the benefit for the cost of obtaining financial advice.

6.4 What we will pay

We will pay the cost of obtaining financial advice up to a maximum of $1,500.

We will only reimburse amounts relating to the preparation and presentation of the plan and not amounts relating to the implementation of the plan or commission paid to a financial planner.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the benefit so the total amount payable does not exceed $1,500.

The Financial Planning Benefit will only be paid once per policy per Insured Person across all policies issued by us in respect of that Insured Person.

6.5 Conditions

The following conditions must be met for the Financial Planning Benefit to be paid:

- the financial plan must be provided by an approved, accredited financial planner;
- the Financial Planning Benefit must be claimed within 12 months of receiving the Disability Benefit; and
- the recipient must be able to provide a copy of the invoice showing a breakdown of the services provided and a receipt showing the amount paid.

7. When your Policy ends

Your Policy continues until the earliest of:

- the date we pay the Disability Benefit for the Insured Person;
- the last Insured Person dies;
- you write and ask us to cancel the Disability Benefit for the Insured Person;
- we cancel or avoid the Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you prior to our acceptance of the risk or during the making of a claim; or
- we cancel your Policy because you have not paid your premiums or any other amounts which relate to this Policy.

A snapshot of Westpac Income Protection in action*

Harry was a 35 year old married man with two young children. He worked as a project manager in the building industry.

Harry's family returned home from an overseas posting in the middle of Australia's property boom. As a result they took out a large mortgage to buy the family home.

Later Harry was diagnosed with a blood vessel malformation that put pressure on the lower spinal nerves and reduced his mobility. He required surgery and physiotherapy as well as a long period off work for rehabilitation.

Harry had taken out a Westpac Income Protection policy 3 years ago. He claimed against this policy, satisfied all of the policy terms and conditions, and as a result received a monthly benefit payment of $6,619. Westpac also paid nursing benefits for the period of his hospitalisation. Harry's family could then meet the mortgage costs and other expenses during his time off work.

Some other examples of Income Protection claims paid:

Cause	**Leukaemia**	**Stroke**	**Testicular cancer**
Occupation	Plumber	Lecturer	Quantity Surveyor
Age at claim	48	52	60
Years in force	8 years	3 years	1 year
Benefit	$5,451 per month	$3,319 per month	$2,295 per month

(Source: Claims data from Westpac Life Insurance Services Limited.)

*For illustrative purposes only. The above is a case study of a real life example (names have been altered) and demonstrates how Westpac Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

1. Introduction

Westpac Income Protection provides a regular monthly income if the Insured Person becomes disabled because of Sickness or Injury and is unable to work, while Westpac Income Protection Plus provides more comprehensive cover by including a number of additional benefits.

Standard Benefits	Description	Income Protection	Income Protection Plus	For full details see page
Total Disability	Pays a monthly benefit if the Insured Person is Totally Disabled because of Injury or Sickness and unable to work.	✓	✓	49
Partial Disability	Pays a monthly benefit if because of the Injury or Sickness the Insured Person is on reduced duties and earning less than before they became disabled.	✓	✓	49
Elective Surgery	Pays a monthly benefit if the Insured Person is disabled because of a transplant (where they are the donor) or cosmetic surgery.	✓	✓	50
Rehabilitation Expense	Pays a benefit to help meet rehabilitation costs incurred while the Insured Person is Totally Disabled.	✓	✓	50
Additional Benefits				
Change of Waiting Period	Allows you to reduce the Waiting Period without further health evidence if the Insured Person changes jobs.	✗	✓	51
Nursing Care	Pays a benefit if the Insured Person is confined to bed for more than 3 days during the Waiting Period.	✗	✓	51
Specified Injury	Pays a monthly benefit for a specified period if the Insured Person suffers certain serious injuries, whether or not they are able to return to work.	✗	✓	52
Crisis	Pays a monthly benefit for 6 months if the Insured Person suffers specified critical illnesses or undergo specified surgery, whether or not they are able to return to work.	✗	✓	53
Death	Pays a benefit if the Insured Person dies while they are entitled to monthly benefit payments.	✗	✓	53
Transport from Overseas	Pays a benefit to enable the Insured Person to return to Australia if they become Totally Disabled whilst overseas.	✗	✓	53
Accommodation	Pays a benefit to assist in the accommodation costs of a family member who has to travel from their usual residence to be with the Insured Person.	✗	✓	53
Family Care	Pays a monthly benefit to help cover the lost income of a family member if they have to stop work to look after the Insured Person.	✗	✓	54
Home Care	Pays a monthly benefit to help cover the cost of a professional home carer if required.	✗	✓	54
Future Insurability	Allows the Insured Person to increase their monthly benefit every 3 years without underwriting assessment.	✗	✓	54
Optional Benefit (available at additional cost)				
Accident	Pays a benefit if the Insured Person is totally disabled for more than 3 days during the waiting period due to an Injury.	✗	✓	54

2. Definitions

In this Policy some words and terms have special meanings:

(a) Benefit Period means the maximum period of time measured from the end of the Waiting Period for which a benefit entitlement in respect of any one Injury or Sickness may continue to accrue (subject to recurrent disability under section 8). Your Benefit Period is shown in the Policy Schedule.

(b) Confined to Bed means Totally Disabled and required by a Doctor to stay in bed under the full-time care of a registered nurse. The nurse cannot be you or a spouse, de facto partner (including a same sex partner), parent, child, sibling or business partner of you or the Insured Person.

(c) CPI Indexation Factor means the percentage increase in the Consumer Price Index ('weighted average of eight capital cities combined') as published by the Australian Bureau of Statistics or its successor over the 12 month period ending 31 March each year. The CPI Indexation Factor will apply for the subsequent year commencing 1 October.

If the Consumer Price Index is not published, or is considered by us to be inappropriate, the percentage increase shall be calculated by reference to such other index of inflation as, in our opinion, most nearly replaces it.

If the CPI Indexation Factor is negative, we will consider it to be zero.

(d) Doctor means a person who:

- is a registered medical practitioner in Australia or New Zealand (or is a medical practitioner of another country with qualifications acceptable to us); and
- is not:
  - you or the Insured Person; or
  - a spouse, de facto partner (including a same sex partner), parent, child, sibling or business partner of you or the Insured Person.

(e) Injury means an accidental bodily injury which is sustained by the Insured Person after the later of:

- the Commencement Date;
- for an increase in the Insured Monthly Disability Benefit, the date we increase the Insured Monthly Disability Benefit (other than a CPI increase (see section 22); or
- the date this Policy was last reinstated (see section C.1.5), but before this Policy ends.

Injury also means an accidental bodily injury which you and the Insured Person fully disclosed to us and we agreed to cover.

(f) Insured Monthly Disability Benefit is shown in the Policy Schedule.

(g) Monthly Earnings means:

- if the Insured Person is not self-employed, the normal monthly value of the remuneration package paid to the Insured Person by their employer, including salary, superannuation contributions, fees, commissions, regular overtime and bonus payments and packaged fringe benefits.

  'Remuneration package' does not include income which is not derived from the Insured Person's personal exertion or activities, such as interest or dividend payments; or
- if the Insured Person is self-employed:
  - the normal monthly income earned by the Insured Person's business, practice or partnership due to the Insured Person's personal exertion or activities, less
  - the Insured Person's share of the expenses of the business, practice or partnership that were necessarily incurred in producing the normal monthly income.

Monthly Earnings are calculated before deducting income tax.

(h) Partial Disability and **Partially Disabled** mean:

- the Insured Person is working and is able to perform:
  - one or more of the important income producing duties of their usual occupation, but is unable to perform all of them; or
  - all of the important income producing duties of their usual occupation, but in a reduced capacity; and
- the Monthly Earnings of the Insured Person are less than the amount of their Pre-disability Monthly Earnings; and
- the Insured Person is under the Regular Care of a Doctor.

(i) Partial Disability Benefit means the benefit provided under section 5 of this Policy.

(j) Post-disability Monthly Earnings means the Insured Person's Monthly Earnings after becoming Partially Disabled.

(k) Pre-disability Monthly Earnings means:

- if the monthly Benefit Type shown in the Policy Schedule is 'Indemnity', the Insured Person's highest average Monthly Earnings in any consecutive 12 month period in the 36 months immediately preceding the commencement of Total Disability, increased by the CPI Indexation Factor each Review Date since that date; or
- if the monthly Benefit Type shown in the Policy Schedule is 'Agreed Value', the Insured Person's highest average Monthly Earnings in any consecutive 12 month period between the 2 years prior to the Commencement Date and when the Waiting Period commences, increased by the CPI Indexation Factor each Review Date since that date.

(l) **Regular Care of a Doctor** means the Insured Person is:

- seeking advice, care and treatment from a Doctor in relation to their Injury or Sickness at such times as is reasonable in the circumstances;
- following the advice, care and treatment of the Doctor; and
- taking all other reasonable measures to avert or minimise any disabling Injury or Sickness.

(m) **Sickness** means a sickness or disease which first becomes apparent after the later of:

- the Commencement Date; or
- for an increase in the Insured Monthly Disability Benefit, the date we increase the Insured Monthly Disability Benefit (other than a CPI increase– see section 22); or
- the date this Policy was last reinstated (see section C.1.5), but before this Policy ends.

Sickness also means a sickness or disease which you and the Insured Person fully disclosed to us and we agreed to cover.

A Sickness is taken to have first become apparent when:

- a doctor first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the Sickness; or
- the Insured Person first had symptoms of the Sickness for which a reasonable person in the same circumstances would have sought advice, care or treatment from a doctor.

(n) **Total Disability** and **Totally Disabled** mean:

The Insured Person is, because of Injury or Sickness:

- unable to perform one or more of the important income producing duties of their usual occupation; and
- not working; and
- under the Regular Care of a Doctor.

This definition applies to occupation categories (as shown in the Policy Schedule) AA, A or BB during the life of a claim, and, only applies to occupation categories B or C for the first 2 years of a claim, after which, the Insured Person will need to demonstrate that they are, because of Injury or Sickness:

- unable to perform Any Occupation for which they are reasonably suited by education, training or experience; and
- not working; and
- under the Regular Care of a Doctor.

Important income producing duties mean those duties which could reasonably be considered primarily essential to producing your monthly income.

Usual occupation means the occupation in which the Insured Person was last engaged before becoming Totally or Partially Disabled.

(o) **Total Disability Benefit** means the benefit provided under section 4 of this Policy.

(p) **Waiting Period** means the minimum period of time which must elapse before any disability benefit entitlement may accrue. Your Waiting Period is shown in the Policy Schedule.

For the purposes of section 4 (Totally Disability Benefit), the Insured Person must be Totally Disabled throughout the Waiting Period in order to keep it running; if they cease to be Totally Disabled at any time the Waiting Period stops running; the Waiting Period will not start to run again unless the Insured Person again becomes Totally Disabled, and then it will do so from the beginning.

However, if the Insured Person returns to work for 5 consecutive days or less during the Waiting Period (10 consecutive days or less if the Waiting Period is 90 days or more), the Waiting Period does not stop running; instead those days will be added to (and count towards) the Waiting Period.

The table below shows the maximum number of consecutive days you can return to work during the Waiting Period.

Waiting Period	Maximum Number of Days
14 or 30 days	5
90, 180, 720 days	10

For the purposes of section 5 (Partial Disability Benefit):

- if the Insured Person returns to work other than in a partial capacity for 5 consecutive days or less during the Waiting Period (10 consecutive days or less if the Waiting Period is 90 days or more), the Waiting Period does not stop running; instead those days will be added to (and count towards) the Waiting Period. However, if the Insured Person returns to work in other than a partial capacity for more than 5 consecutive days during the Waiting Period (10 consecutive days if the Waiting Period is 90 days or more), the Waiting Period stops running; and
- for Westpac Income Protection Plus occupation categories AA, and A, it is enough that the Insured Person is Totally Disabled for at least 14 of the first 19 days of the Waiting Period and Partially Disabled for the balance of the Waiting Period or Partially Disabled for the entire Waiting Period; or
- for Westpac Income Protection Plus occupation categories BB, B and C, and for all occupation categories in Westpac Income Protection, it is enough that from the date of Total Disability the Insured Person is Totally Disabled for at least 14 of the first 19 days of the Waiting Period and Totally or Partially Disabled for the balance of the Waiting Period.

3. How Income Protection works

3.1 Who can apply

You generally apply for a Westpac Income Protection Plan on your own life, in which case you are the Insured Person as well as the Policy Owner.

3.2 Who can own this Policy

In some limited circumstances, the Insured Person can be different to the Policy Owner. See your financial planner for more information.

3.3 What you can apply for

You apply for the monthly benefit amount you wish to cover the Insured Person for. You can insure up to 75% of the Insured Person's regular Monthly Earnings. Depending on their occupation and income, there may be maximum monthly benefits for which you can insure.

3.4 Who receives any benefits payable

As Policy Owner you pay premiums that are due under the Policy and will generally receive any benefits that become payable. If you are both the Insured Peson and Policy Owner, the Death Benefit will be paid to your estate.

3.5 Options available when applying for a Westpac Income Protection Plan

(a) Waiting Period, Benefit Period and Agreed Value or Indemnity option

When you apply for a Westpac Income Protection Plan you will choose a Waiting Period, Benefit Period and either the Agreed Value or Indemnity option (refer to table below). The premium you need to pay will vary depending on your choices. Your financial planner can advise you on your individual circumstances.

(b) Choices available to you

Waiting Period	The Waiting Period is the minimum length of time between when the Insured Person is disabled and when they become eligible for benefit payments. You can choose a waiting period of 14, 30, 90, 180 or 720 days (180 and 720 days are available only with the 'to age 65' benefit period).
Benefit Period	The Benefit Period is the maximum length of time for which benefits are payable for any one disability. You can choose a Benefit Period of 2 years, 5 years or to age 65.
Agreed Value or Indemnity option	The main difference between an Agreed Value Policy and an Indemnity Policy is what we will pay you if the Insured Person's earnings have reduced since taking out your insurance. **Agreed Value** Under the Agreed Value option, we will not reduce the amount you are paid when the Insured Person is disabled because their Monthly Earnings have reduced since taking out your insurance, provided income details were correctly disclosed at the time of application. **Indemnity** Under the Indemnity option, if the Insured Person's Monthly Earnings have reduced since taking out your insurance we may reduce the amount you are paid when they are disabled. The definition of Monthly Earnings, as well as how we allow for amounts you may be paid from other sources in relation to an Injury or Sickness are also different for the Agreed Value and Indemnity options. Full details are provided below.

3.6 Ages and occupations - when you can apply

You can apply if the Insured Person is aged from 17 to 54.

If the Insured Person works in professional, white collar or certain light manual occupations, you can apply up to the age of 59.

For people in certain occupations, there are limits on the Benefit Periods available for you to choose. In addition, Westpac Income Protection will not be available to people in certain occupations or if they are working a limited number of hours per week. Your financial planner can advise you on your individual circumstances.

4. Total Disability Benefit

4.1 When we will pay

If the Insured Person is Totally Disabled, we will pay you a monthly benefit after the end of your Waiting Period. The benefit will be payable monthly in arrears and you will continue to receive a monthly benefit payment until the earliest of the following events:

- the Insured Person is no longer Totally Disabled;
- the end of your Benefit Period; or
- when your Policy ends (see section 26 for details).

4.2 What we will pay

(a) Indemnity or Agreed Value

The benefit you receive will depend on whether you have chosen an Agreed Value or Indemnity Policy.

The amount of this benefit is reduced by any limitations on benefits (see section 20).

What we will pay when the Insured Person is Totally Disabled	
	Agreed Value
	The monthly Total Disability Benefit is the Insured Monthly Disability Benefit increased in accordance with section 22.
	Indemnity
	The monthly Total Disability Benefit is the lesser of: ■ the Insured Monthly Disability Benefit, increased in accordance with section A.9 and section 22; and ■ 75% of your Pre-disability Monthly Earnings.

(b) When does the benefit accrue

The benefit accrues from the first day of Total Disability after the Waiting Period and is payable monthly in arrears.

The benefit will continue to accrue until:

- the end of the Insured Person's Total Disability;
- the time when the aggregate of the period for which a Total Disability Benefit was payable to you and any period for which a Partial Disability Benefit was payable to you is equal to the Benefit Period; or
- your Policy ends (see section 26);

whichever occurs first.

(c) What if I am disabled for less than a month

If the Insured Person is Totally Disabled in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month. You will still need to meet the Waiting Period.

5. Partial Disability Benefit

5.1 When we will pay

We will pay you a monthly Partial Disability Benefit if the Insured Person is Partially Disabled and meets the Waiting Period.

5.2 What we will pay

(a) Formula

We will pay you a monthly Partial Disability Benefit, calculated as follows:

$$\text{The monthly Total Disability Benefit} \times \frac{(\text{Pre-disability Monthly Earnings} - \text{Post-disability Monthly Earnings})}{\text{Pre-disability Monthly Earnings}}$$

If the Insured Person is continuously disabled for the first 3 months immediately after the end of the Waiting Period, and the Post-disability Monthly Earnings while Partially Disabled is less than or equal to 20% of Pre-disability Monthly Earnings, we will pay the monthly Total Disability Benefit for the first 3 months.

The amount of this benefit is reduced by any limitations on benefits (see section 20).

(b) When does the benefit accrue

The benefit accrues from the first day of Partial Disability after the Waiting Period and is payable monthly in arrears. The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's Partial Disability;
- the time when the aggregate of the period for which a Partial Disability Benefit was payable to you and any period for which a Total Disability Benefit was payable to you is equal to the Benefit Period; or
- your Policy ends (see section 26);

whichever occurs first.

(c) What if I am Partially Disabled for less than a month

If the Insured Person is Partially Disabled in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month. You will still need to meet the Waiting Period.

6. Elective Surgery Benefit

6.1 When we will pay

We will regard the Insured Person as being Totally Disabled or Partially Disabled, as applicable, due to Sickness if:

- the Insured Person undergoes surgery by a Doctor while covered under this Policy to:
  - transplant part of their body to another person; or
  - improve their appearance or to prevent their disfigurement; and
- as a consequence of the surgery, the Insured Person would be Totally Disabled or Partially Disabled, except for the fact that their disability is caused by the surgery and not an Injury or Sickness.

The Waiting Period will commence from the day on which you undergo surgery.

The benefit will be payable monthly in arrears and you will continue to receive monthly payments until they are well enough to return to work and earn their regular income, the end of the benefit period or your Policy ends (see section 26), whichever is the earlier.

6.2 When we will not pay

This benefit will not apply to surgery that takes place within 6 months after the later of:

- the Commencement Date; or
- for an increase in the Insured Monthly Disability Benefit, the date we increase the Insured Monthly Disability Benefit (other than a CPI increase under section 22); or
- the date this Policy was last reinstated (see section C.1.5).

7. Rehabilitation Expense Benefit

7.1 When we will pay

(a) Conditions

We will pay you a Rehabilitation Expense Benefit, in addition to any other benefit under this Policy, if:

- the Insured Person has suffered Total Disability for a continuous period at least as long as the Waiting Period; and
- you or the Insured Person incurs the cost of a rehabilitation program or equipment or other capital expenses during the course of rehabilitation or engaging (or attempting to engage) in an occupation, which the Insured Person's Doctor has certified as being necessary.

(b) Costs must be approved

The costs must be approved by us before they are incurred.

(c) Examples of eligible expenses

Examples of eligible expenses include the cost of a wheelchair, artificial limbs, travelling expenses to attend an approved rehabilitation program, re-education expenses and home or workplace modifications.

7.2 What we will pay

We will reimburse the actual rehabilitation expenses incurred by you or the Insured Person up to a maximum amount, determined in accordance with your type of cover as set out below:

- for Westpac Income Protection, up to a maximum of 6 times the monthly Total Disability Benefit;
- for Westpac Income Protection Plus, up to a maximum of 12 times the monthly Total Disability Benefit.

7.3 When we will not pay

We will not pay you this benefit for expenses that are reimbursable from any other source.

8. Total or Partial Disability that recurs

8.1 When will a new Waiting Period or Benefit Period apply

(a) Benefit Periods of 2 and 5 years

For Benefit Periods of 2 and 5 years as shown in the Policy Schedule a new Waiting Period will not apply, if, within 6 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers Total Disability or Partial Disability from the same or a related Injury or Sickness. The successive periods during which benefits were payable are added together to determine when the Benefit Period has expired.

For Benefit Periods of 2 and 5 years as shown in the Policy Schedule, a new Waiting Period and a new Benefit Period will apply if:

- at least 6 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers Total Disability or Partial Disability from the same or a related Injury or Sickness, and
- either:
  - the Benefit Period for the previous period of Total Disability or Partial Disability had not ended; or
  - the Insured Person had returned to and performed the full duties of their usual occupation for their usual Monthly Earnings for at least 6 consecutive months after a Total Disability Benefit or a Partial Disability Benefit ceased to be payable.

Otherwise, no benefit is payable.

(b) Benefit Period to age 65

For a Benefit Period to age 65 as shown in the Policy Schedule, the Waiting Period will not apply, if within 12 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers Total Disability or Partial Disability from the same or a related Injury or Sickness.

For Benefit Period to age 65 as shown in the Policy Schedule, a new Waiting Period and a new Benefit Period will apply if:

- at least 12 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers Total Disability or Partial Disability from the same or a related Injury or Sickness, and
- either:
  - the Benefit Period for the previous period of Total Disability or Partial Disability had not ended; or
  - the Insured Person had returned to and performed the full duties of their usual occupation for their usual Monthly Earnings for at least 12 consecutive months after a Total Disability Benefit or a Partial Disability Benefit ceased to be payable.

Otherwise, no benefit is payable.

Additional benefits available if you choose Westpac Income Protection Plus ('IP Plus')

9. Change of Waiting Period Benefit (IP Plus only)

(a) Change in employment status

You can shorten the Waiting Period for the Insured Person if the Insured Person changes their employment status. You can do this without having to provide any evidence of the Insured Person's health.

As shown in the table below, a Waiting Period in the first column can be reduced to the corresponding Reduced Waiting Period in the second column.

Existing Waiting Period	Reduced to a Waiting Period
720 days	90 days or 180 days
180 days	90 days
90 days	30 days

Your premium will increase to reflect the shorter Waiting Period.

We consider that an Insured Person has changed their employment status if:

- they cease working for one employer and commence working for another unrelated employer; or
- they cease being self-employed and commence working for an unrelated employer.

(b) Conditions on shortening the Waiting Period

You can only shorten the Waiting Period without having to provide evidence of the Insured Person's health if:

- the Insured Person is not Totally Disabled or Partially Disabled at the time (either during the Waiting Period or while a benefit is payable);
- the Insured Person was accepted for cover under this Policy at our standard premium rates;
- the Insured Person provides us with written proof that the change of employment status has occurred;
- you request the change in writing within 30 days of the Insured Person joining the new employer;
- the Insured Person is not eligible, and will not become eligible, for income protection cover with the new employer through an insurance Policy, superannuation or pension plan; and
- where a 720 day Waiting Period applies, you provide us with proof that the Insured Person was covered by an employer related income protection policy with a waiting period of 1 year or less while employed by the previous employer.

The right to reduce the Waiting Period under this benefit is not guaranteed and can be withdrawn by us advising you in writing.

10. Nursing Care Benefit (IP Plus only)

10.1 When we will pay

If the Insured Person is Confined to Bed for more than 3 consecutive days during the Waiting Period, we will pay you a Nursing Care Benefit equal to 1/30th of the monthly Total Disability Benefit for each consecutive day of confinement.

10.2 How long we will pay

We will stop paying the Nursing Care Benefit:

- when the Insured Person is no longer Confined to Bed;
- at the end of the Waiting Period;
- after 90 days; or
- when your Policy ends (see section 26);

whichever first occurs.

10.3 If Confinement to Bed recurs

(a) For Benefit Periods of 2 and 5 years

If, following a period when the Insured Person was Confined to Bed, and within 6 months, the Insured Person again becomes Confined to Bed from the same or a related Injury or Sickness, the Nursing Care Benefit becomes immediately payable. The successive periods of being Confined to Bed are added together to determine the duration of any Nursing Care Benefit that we will pay you.

(b) For Benefit Period to age 65

If, following a period when the Insured Person was Confined to Bed, and within 12 months, the Insured Person again becomes Confined to Bed from the same or a related Injury or Sickness, the Nursing Care Benefit becomes immediately payable. The successive periods of being Confined to Bed are added together to determine the duration of any Nursing Care Benefit that we will pay you.

11. Specified Injury Benefit (IP Plus only)

11.1 When we will pay

If the Insured Person suffers any of the injuries, defined as a 'Specified Injury' in section 11.4, while covered under this Policy, we will pay you a benefit equal to the monthly Total Disability Benefit for the Specified Injury payment period from the date the Specified Injury occurred, even if the Insured Person is able to return to work during that period.

If the Insured Person suffers more than one Specified Injury at the same time, we will pay you a benefit for the injury with the longer payment period.

11.2 How long we will pay

We stop paying you a benefit when:

- we have paid you a Specified Injury Benefit for the payment period shown in section 11.4;
- your Benefit Period ends; or
- your Policy ends (see section 26);

whichever occurs first.

11.3 When you still receive a Total or Partial Benefit

If, at the end of the specified payment period, the Insured Person is suffering Total Disability or Partial Disability as a result of the Specified Injury:

- you will be entitled to receive a Total or Partial Disability Benefit (if eligible) if the specified payment period is equal to or longer than the Waiting Period; or
- otherwise, the Waiting Period will be reduced by the specified payment period and will start from the first day the Insured Person is Totally Disabled after the end of the specified payment period. You will be eligible to receive a Total or Partial Disability Benefit (as appropriate) from the first day of Total Disability or Partial Disability (as appropriate) after the balance of the Waiting Period has expired.

The period of payment of the Specified Injury Benefit is included in determining whether the Benefit Period has expired.

11.4 Specified Injuries

The following are covered:

For these Injuries	Payment Period (Months)
Total and permanent loss of use of:	
Both feet or both hands or sight of both eyes	24
Any combination of a hand, a foot, sight in one eye	24
One leg above the knee joint or one arm above the elbow	18
One hand or foot or sight in one eye	12
Thumb and index finger of same hand	6
Fracture of:	
Spine resulting in paraplegia or quadriplegia	60
A thigh	3
The pelvis	3
The skull (except bones of face or nose)	2
An upper arm	2
A shoulder bone	2
The jaw	2
A leg (excluding ankle)	2
A kneecap	2
A forearm (above wrist)	1
A collarbone	1
Fracture means the disruption in the continuity of the bone, with or without displacement, demonstrated by radiographic or scanning technique.	

11.5 When we will not pay

We will not pay a Specified Injury Benefit if your Waiting Period is 720 days.

If you are entitled to claim for both the Specified Injury Benefit and the Crisis Benefit as a result of the same event, we will only pay you for one of the benefits, being the benefit with the longest payment period.

12. Crisis Benefit (IP Plus only)

12.1 When we will pay

If the Insured Person suffers for the first time any of the conditions or undergoes for the first time any of the surgeries, defined as a 'Crisis' in section 12.4, while covered under this Policy, we will pay you a benefit equal to the monthly Total Disability Benefit for 6 months from the date the Crisis occurred, even if the Insured Person is able to work during that period.

12.2 For what period we will pay

We will stop paying you a benefit when:

- we have paid you a Crisis Benefit for 6 months; or
- your Policy ends (see section 26);

whichever occurs first.

If, at the end of the 6 month period, the Insured Person is suffering Total Disability or Partial Disability as a result of the Crisis you will be eligible to receive a Total or Partial Disability Benefit (as appropriate).

The period of payment of the Crisis Benefit is included in determining whether the Benefit Period has expired.

12.3 When we will not pay

We will not pay a Crisis Benefit if the condition first becomes apparent, or the surgery first occurs, within 90 days after the later of:

- the Policy Commencement Date; or
- for an increase in the Insured Monthly Disability Benefit, the date we increase the Insured Monthly Disability Benefit (other than a CPI increase see section 22); or
- the date this Policy was last reinstated (see section C.1.5).

We also will not pay a Crisis Benefit if your Waiting Period is 720 days.

If you are entitled to claim for both the Crisis Benefit and the Specified Injury Benefit as a result of the same event, we will only pay you for one of the benefits, being the benefit with the longest payment period.

12.4 Definition of Crisis

Crisis means suffering any of the conditions or undergoing any of the surgeries below for the first time, diagnosed by clinical findings and reports acceptable to us:

- Aortic surgery
- Cancer
- Coronary artery bypass surgery
- Heart attack
- Heart valve surgery
- Kidney failure
- Major organ transplant
- Stroke.

A full definition of each condition is given in Living Benefit Definitions commencing on page 35. You must satisfy the full definition of the appropriate condition before we will pay this benefit.

13. Death Benefit (IP Plus only)

If the Insured Person dies while we are paying you a Total Disability Benefit, Partial Disability Benefit, Crisis Benefit, Specified Injury Benefit or Nursing Care Benefit, a benefit equal to 6 times your monthly Total Disability Benefit will be paid to you.

If you are both the Insured Person and the Policy Owner, we will pay the Death Benefit to your estate.

14. Transport from Overseas Benefit (IP Plus only)

14.1 When we will pay

We will pay you a Transport from Overseas Benefit, in addition to any other benefits under this Policy, if the Insured Person:

- becomes Totally Disabled while out of Australia;
- is Totally Disabled for more than 30 days; and
- chooses to return to Australia while Totally Disabled.

14.2 What we will pay

We will pay a benefit equal to the lesser of:

- reimbursement of the actual costs incurred;
- a single standard economy airfare to Australia by the most direct and available route; and
- 3 times the monthly Total Disability Benefit.

14.3 When we will not pay

We will not pay you this benefit for expenses that are reimbursable from any other source.

We will only pay this benefit once for any particular Total Disability.

15. Accommodation Benefit (IP Plus only)

15.1 When we will pay

We will pay you an Accommodation Benefit if:

- the Nursing Care Benefit is also payable;
- the Insured Person is Confined to Bed more than 100 kilometres away from their usual residence; and
- an immediate family member has to stay away from their usual residence to be with the Insured Person.

15.2 What we will pay

We will pay a benefit equal to reimbursement of accommodation costs incurred in order for the family member to be with the Insured Person of up to $200 per day, for a maximum of 30 days in any 12 month period.

15.3 When we will not pay

We will not pay you this benefit for expenses that are reimbursable from any other source.

16. Family Care Benefit (IP Plus only)

16.1 When we will pay

We will pay you a monthly Family Care Benefit if:

- a Total Disability Benefit is payable in respect of the Insured Person;
- as a result of the disability, the Insured Person is totally dependent on an immediate family member; and
- as a result, the immediate family member has had to cease a paid full-time or permanent part-time occupation.

16.2 What we will pay

We will pay a monthly benefit which is the lesser of:

- the monthly Total Disability Benefit; and
- $2,000.

If the benefit is payable during a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

16.3 For what period we will pay

The benefit accrues from the first day of Total Disability after the Waiting Period and is payable monthly in arrears.

The benefit will continue to accrue until:

- the end of the Insured Person's Total Disability;
- we have paid you a Family Care Benefit for 6 months;
- your Policy ends (see section 26);
- the Insured Person ceases to be totally dependent on the immediate family member; or
- the immediate family member recommences gainful employment;

whichever occurs first.

17. Home Care Benefit (IP Plus only)

17.1 When we will pay

We will pay you a monthly Home Care Benefit if:

- a Total Disability Benefit is payable in respect of the Insured Person;
- as a result of the disability, the Insured Person is Confined to Bed at home; and
- in the opinion of a Doctor, the Insured Person is totally dependent upon the care of a paid professional home carer.

17.2 What we will pay

We will pay you a monthly benefit which is the lesser of:

- the monthly Total Disability Benefit; and
- $4,500.

If the benefit is payable in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

17.3 When we will not pay

We will not pay you if the paid professional home carer is you or a family member of the Insured Person.

17.4 For what period we will pay

The benefit accrues from the first day of Total Disability after the Waiting Period and is payable monthly in arrears.

The benefit will continue to accrue until:

- the end of the Insured Person's Total Disability;
- we have paid you a Home Care Benefit for 6 months;
- your Policy ends (see section 26); or
- the Insured Person ceases to be totally dependent upon the care of a paid professional home carer;

whichever occurs first.

18. Future Insurability (IP Plus Only)

18.1 Availability

The Future Insurability Benefit enables you to increase the Insured Monthly Disability Benefit for an Insured Person on the terms and conditions set out below without providing evidence of health.

18.2 Maximum amount of each increase

The Insured Monthly Disability Benefit may be increased up to 20% each time it is increased under this benefit.

Your premium will increase to reflect the increase in cover. The increased cover does not apply until we have confirmed it in writing.

18.3 Maximum number of increases

The maximum number of increases to the Insured Monthly Disability Benefit allowed during the term of the Policy is calculated as follows:

$$\text{Maximum number of increases} = \frac{(55 - A)}{3}$$

where A = the age of the Insured Person at the commencement date of the Policy.

18.4 When you can apply

You can apply for an increase in the Insured Monthly Disability Benefit in writing within 30 days of every third Review Date, subject to section 18.5 below, and provided that:

- you apply for the increase before the Review Date on or immediately before the Insured Person turns 54;
- you have not had an increase under this benefit in the previous 12 months;

- a person has not made, or is not eligible to make, a claim in relation to the Insured Person for any benefit under any insurance cover issued by us;
- the Insured Person does not have a medical loading on the Policy;
- the maximum number of increases permitted under section 18.3 has not been made;
- after the increase, the Insured Monthly Disability Benefit would not be more than 75% of the Insured Person's Pre-disability Monthly Earnings; or
- after the increase, the total amount of the Insured Monthly Disability Benefit would not be more than the maximum benefit limits available under Westpac Income Protection Plus.

18.5 Acceleration of increases

You can request that an increase in the Insured Monthly Disablility Benefit be brought forward up to 4 times during the term of the Policy provided that there is only one increase in any 12 month period.

18.6 Existing exclusions apply

Any exclusions which apply to the Insured Person's Westpac Income Protection Plus Policy will also apply to an increase in the Insured Monthly Disability Benefit.

19. Accident Benefit (Optional) (IP Plus only)

19.1 When this Benefit applies

This benefit is available at an additional cost. This option can be added after the policy commences and you may be subject to further underwriting assessment at that time. This benefit will only apply if:

- we have accepted your application for this benefit for an Insured Person;
- you continue to pay premiums for this benefit; and
- the Waiting Period for the Insured Person is either 14 or 30 days.

19.2 When we will pay

We will pay you an Accident Benefit if, as a result of an Injury, the Insured Person is Totally Disabled for more than 3 consecutive days during the Waiting Period.

This benefit will be paid for the shorter of the Waiting Period and the period of Total Disability.

19.3 What we will pay

We will pay an amount that is 1/30th of the Insured Person's monthly Total Disability Benefit for each day that the Insured Person is Totally Disabled during the Waiting Period.

19.4 When we will not pay

We will not pay this benefit if the Insured Person is eligible for the Specified Injury Benefit, Crisis Benefit or Nursing Care Benefit under this Policy.

19.5 For what period we will pay

The benefit accrues from the date the Insured Person first seeks medical advice for the Injury and has been certified as being Totally Disabled. The benefit is payable monthly in arrears. The benefit will continue to accrue until:

- the end of the Waiting Period;
- the end of the Insured Person's Total Disability; or
- your Policy ends (see section 26);

whichever occurs first.

20. We may limit the benefits we pay

20.1 General

- No benefit will be payable after the Benefit Period has expired.
- All benefits cease to be payable when the Policy ends (see section 26).
- If Total Disability or Partial Disability is caused by more than one Injury or Sickness, we will only pay Benefits in respect of one Injury or Sickness at any one time.

20.2 Total Disability Benefit and Partial Disability Benefit

(a) Offsets

The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the sources referred to below. These offsets are applied differently depending on the occupational category you are in. To find out which occupational category the Insured Person is in, please speak to your financial planner.

For occupational categories AA and A (for Income Protection and Income Protection Plus – Agreed Value only) the following applies:

The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the following sources:

- any common law payments relating to sickness or injury; or
- regular payments from an existing superannuation fund or another existing insurance policy, made in respect of Injury or Sickness, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum).

For all other occupational categories (regardless of whether it is Income Protection or Income Protection Plus – Agreed Value or Indemnity) the following applies:

The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the following sources:

- workers or motor accident compensation or under common law relating to sickness or injury; or
- regular payments from an existing superannuation fund or another existing insurance policy, made in respect of Injury or Sickness, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum).

(b) Further offsets for Indemnity policies

If the monthly Benefit Type in the Policy Schedule is 'Indemnity', the amount of the monthly Total Disability Benefit or Partial Disability Benefit may also be reduced if any amounts are paid from the following sources:

- under legislation, in respect of Injury or Sickness;
- the Insured Person's employer, partnership or business; or
- sick leave payments.

(c) Sources not included

The above sources do not include:

- payments made as compensation for pain and suffering or the loss of use of part of the body;
- lump sum Total and Permanent Disablement, trauma or terminal illness payments;
- payments made in respect of the injury or sickness from business expense insurance policies; or
- an entitlement to paid sick leave that is not taken.

The reduction in benefit will be such that the reduced benefit that we pay, when combined with the income from other sources (and the reduced Monthly Earnings for Partial Disability), does not exceed 75% of Pre-disability Monthly Earnings (100% for Partial Disability).

If the Insured Person receives any amount as outlined in this Section 20, that includes an amount for loss of income resulting from their disability for any period we have paid, or will pay, the Insured Person must, on demand by us, repay either the benefits we have paid them or the amount they have been awarded for loss of income, whichever is lower. We can also choose to reduce any amounts we pay in the future to cover such overpayments.

20.3 Lump sums and non-monthly payments

Any of the amounts referred to in this section which are paid as a lump sum, or at periods other than monthly, will be converted to an equivalent monthly amount of 1/60th of the lump sum over a period of 60 months.

20.4 We will only pay one benefit at a time

We will not pay the following benefits at the same time:

- Total Disability and Specified Injury;
- Partial Disability and Specified Injury;
- Total Disability and Crisis;
- Partial Disability and Crisis;
- Nursing Care and Crisis;
- Nursing Care and Specified Injury;
- Specified Injury and Crisis;
- Family Care and Home Care;
- Accident Benefit and Specified Injury;
- Accident Benefit and Crisis; or
- Accident Benefit and Nursing Care.

21 Exclusions

21.1 When we will not pay

We will not pay you a benefit:

- if the Injury or Sickness giving rise to the claim is caused by:
  - an act of war (whether declared or not). This exclusion does not apply to the Death Benefit where the Insured Person dies on war service;
  - intentional self-inflicted injury (while sane or insane);
  - attempted suicide (while sane or insane);
  - normal and uncomplicated pregnancy and childbirth; or
- for any other specific exclusions which we have included in the Policy Schedule.

21.2 What happens to this Policy if the Insured Person becomes unemployed or takes leave

If the Insured Person becomes unemployed for reasons other than Total Disability or takes leave without pay, parental leave or sabbatical leave, for 12 calendar months or more immediately before suffering Total Disability or Partial Disability, the Insured Person will only be considered to be Totally Disabled or Partially Disabled if, solely because of Sickness or Injury, the Insured Person is:

- unable to perform Any Occupation for which the Insured Person is reasonably suited by education, training or experience; and
- not working; and
- under the Regular Care of a Doctor.

22. Your monthly benefit payments are indexed

(a) Increasing the amount of the Benefits by the CPI

Without further evidence of the insurability of the Insured Person, we will, each year on the Review Date, increase the Insured Monthly Disability Benefit by the CPI Indexation Factor applying at that Review Date, subject to the following provisions:

- you may decide to reject some or all of an indexation increase in any one year. You must reject the increase in writing and we must receive it prior to the Review Date on which the increase was made. This does not affect future offers of indexation increases; and
- you may request in writing for indexation increases to never apply again under this Policy, which will apply from the date we receive your request. You may subsequently request that indexation increases recommence although we are not obliged to agree to this.

(b) Indexation while you are receiving a benefit

If you are receiving benefits on any Review Date, the Insured Monthly Disability Benefit will be indexed on each Review Date by the CPI Indexation Factor.

23. Other benefits

(a) Premiums waived while we pay you

You do not have to pay premiums for the period during which you are receiving a monthly Total Disability Benefit or Partial Disability Benefit payment.

(b) Cover can continue if you are unemployed

If the Insured Person is unemployed for reasons other than Total Disability or they take leave without pay, parental or sabbatical leave for 12 months or more immediately before suffering Total or Partial Disability, they will only be considered Totally or Partially Disabled if, solely because of Sickness or Injury they are:

- unable to perform Any Occupation for which they are reasonably suited by education, training or experience;
- not working; and
- under the Regular Care of a Doctor.

Cover under the Policy will continue, provided you pay premiums and any other amounts due. Unemployment does not include permanent retirement from the workforce.

24. General limitations

- If the Insured Person is disabled by more than one Sickness or Injury at the same time, you will receive benefits in relation to only one of these conditions.
- No benefit will be payable after your Benefit Period has expired.
- Only one benefit is payable at any time (except where a Rehabilitation Expense Benefit is payable).

25. No transfer of ownership

You cannot transfer ownership of this Policy unless we agree in writing to the transfer.

26. When your Policy ends

Your Policy continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- we cancel your Policy because you have not paid your premiums or any other amounts which relate to this Policy;
- the Insured Person dies;
- the Insured Person retires or ceases gainful employment (unless they intend to return to gainful employment) for any reason other than due to Total or Partial Disability;
- we receive your written notice to end this Policy;
- we cancel or avoid the Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you prior to our acceptance of risk or during making the claim.

No benefits will be payable following the ending of this Policy.

Westpac Business Overheads

1. Introduction

Westpac Business Overheads pays a monthly benefit for the day to day costs of running a business for up to 12 months if the Insured Person is disabled because of Sickness or Injury and is unable to work in their business. It could mean the difference between the business surviving or collapsing.

Standard benefits	Description	For full details see page
Total Disability	Pays a monthly benefit for the day to day costs of running a business if the Insured Person is Totally Disabled because of Injury or Sickness and is unable to work.	60
Partial Disability	Pays a monthly benefit if because of the Injury or Sickness the Insured Person is on reduced duties and earning less than before they became disabled.	61
Death	Pays a benefit if the Insured Person dies while they are entitled to benefit payments.	61
Elective surgery	Pays a monthly benefit for the day to day costs of running a business if the Insured Person is disabled because of a transplant (where they are the donor) or cosmetic surgery.	61

2. Definitions

2.1 Definitions

In this Policy some words have special meanings:

(a) **Allowable Business Expenses** means the following items of expenditure if they are incurred in the normal conduct and operation of the Insured Person's Business:

- Accountants' and auditors' fees
- Advertising
- Business insurance premiums
- Cleaning, electricity, gas, heating, laundry, telephone and water
- Leasing costs of equipment and vehicles
- Mortgage interest payments
- Property rates and taxes
- Rent
- Salaries of non income producing employees including related costs such as pay roll tax and superannuation
- Subscriptions to professional bodies and publications
- Other fixed expenses normally incurred in the conduct of the Insured Person's Business and which were identified in the application for this Policy and agreed to by us
- Any net costs associated with employing a locum after the Insured Person became Totally Disabled to perform the work normally performed by them. Net costs is treated as the total expense incurred with hiring the locum less the revenue generated by the locum.

Allowable Business expenses will not include:

- The cost of books, equipment, fittings, goods, implements or products used in the Insured Person's Business
- Depreciation of equipment and vehicles
- The salary and the salary-related costs of the Insured Person
- Repayment of mortgage or loan principal
- Salaries and related costs of income producing employees
- Salaries and related costs paid to any of the Insured Person's relatives, unless the relative has been a full-time employee of the Insured Person's Business for at least 6 months prior to the commencement of Total Disability
- Any share of the expenses of the Insured Person's Business which is not normally attributable to the Insured Person
- Expenses of a private or domestic nature

(b) **Benefit Period** means the maximum period of time measured from the end of the Waiting Period for which a benefit entitlement in respect of any one Injury or Sickness may continue to accrue (subject to recurrent disability – see section 8). Your Benefit Period is 1 year.

(c) **Business Income** means the gross income of the business before expenses and tax.

(d) **CPI Indexation Factor** means the percentage increase in the Consumer Price Index ('weighted average of eight capital cities combined') as published by the Australian Bureau of Statistics or its successor over the 12 month period ending 31 March each year. The CPI Indexation Factor will apply for the subsequent year commencing 1 October.

If the Consumer Price Index is not published, or is considered by us to be inappropriate, the percentage increase shall be calculated by reference to such other index of inflation as, in our opinion, most nearly replaces it.

If the CPI Indexation Factor is negative, we will consider it to be zero.

(e) Doctor means a person who:

- is a registered medical practitioner in Australia or New Zealand (or is a medical practitioner of another country with qualifications acceptable to us); and
- is not:
  - you or the Insured Person; or
  - a spouse, de facto partner (including a same sex partner), parent, child, sibling or business partner of you or the Insured Person.

(f) Elective Surgery Benefit means the benefit provided under section 7 of this Policy.

(g) Injury means an accidental bodily injury which is sustained by the Insured Person after the later of:

- the Commencement Date; or
- for an increase in the Insured Monthly Business Overheads Benefit, the date we increase the Insured Monthly Business Overheads Benefit (other than a CPI increase under section 11); or
- the date this Policy was last reinstated (see section C.1.5),

but before this Policy ends.

Injury also means an accidental bodily injury which you and the Insured Person fully disclosed to us and we agreed to cover.

(h) Insured Monthly Business Overheads Benefit means the amount shown in the Policy Schedule.

(i) Insured Person's Business means the business, profession or occupation of the Insured Person.

(j) Partial Disability and **Partially Disabled** mean:

- the Insured Person is able to perform:
  - one or more of the important income producing duties of their usual occupation, but is unable to perform all of them; or
  - all of the important income producing duties of their usual occupation, but in a reduced capacity; and
- the Insured Person is suffering a loss in Business Income, and
- the Insured Person is under the Regular Care of a Doctor.

If the Insured Person is Partially Disabled and not working, their monthly Business Income will be estimated based on what they could be reasonably expected to earn for performing their usual occupation having regard to their Injury or Sickness.

(k) Partial Disability Benefit means the benefit provided under section 5 of this Policy.

(l) Regular Care of a Doctor means the Insured Person is:

- seeking advice, care and treatment from a Doctor in relation to their Injury or Sickness at such times as is reasonable in the circumstances;
- following the advice, care and treatment of the Doctor; and
- taking all other reasonable measures to avert or minimise any disabling Injury or Sickness.

(m) Sickness means a sickness or disease which first becomes apparent after the later of:

- the Commencement Date; or
- for an increase in the Insured Monthly Business Overheads Benefit, the date we increase the Insured Monthly Business Overheads Benefit (other than a CPI increase under section 11); or
- the date this Policy was last reinstated (see section C.1.5), but before this Policy ends.

Sickness also means a sickness or disease which you and the Insured Person fully disclosed to us and we agreed to cover.

A Sickness is taken to have first become apparent when:

- a doctor first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the Sickness; or
- the Insured Person first had symptoms of the Sickness for which a reasonable person in the same circumstances would have sought advice, care or treatment from a doctor.

(n) Total Disability and **Totally Disabled** mean the Insured Person is, because of Injury or Sickness:

- unable to perform one or more of the important income producing duties of their usual occupation; and
- not working; and
- under the Regular Care of a Doctor.

Important income producing duties mean those duties which could reasonably be considered primarily essential to producing your monthly income.

Usual occupation means the occupation in which the Insured Person was last engaged before becoming Totally or Partially Disabled.

(o) Total Disability Benefit means the benefit provided under section 4 of this Policy.

(p) Waiting Period means the minimum period of time which must elapse from the commencement of Total Disability before any benefit entitlement may accrue. Your Waiting Period is shown in the Policy Schedule.

2.2 Waiting Period

In general, the Insured Person must be Totally Disabled throughout the Waiting Period in order to keep it running. If they cease to be Totally Disabled at any time the Waiting Period stops running, the Waiting Period will not start to run again unless the Insured Person again becomes Totally Disabled, and then it will do so from the beginning.

However, if the Insured Person returns to work for 5 consecutive days or less during the Waiting Period, the Waiting Period does not stop running; instead those days will be added to (and count towards) the Waiting Period.

2.3 Partial Disability Benefit

For the purposes of section 5 (Partial Disability Benefit):

- it is enough that from the date of Total Disability the Insured Person is Totally Disabled for at least 7 of the first 19 days of the Waiting Period and Totally or Partially Disabled for the balance of the Waiting Period; and
- if the Insured Person returns to work other than in a partial capacity for 5 consecutive days or less during the Waiting Period, the Waiting Period does not stop running; instead those days will be added to (and count towards) the Waiting Period. However, if the Insured Person returns to work in other than a partial capacity for more than 5 consecutive days during the Waiting Period, the Waiting Period stops running.

3. How Business Overheads works

3.1 When you can apply

You generally apply for a Westpac Business Overheads plan on your own life, in which case you are the 'Insured Person' as well as the Policy Owner.

3.2 Who can own this Policy

In some limited circumstances, the Insured Person can be different to the Policy Owner – see your financial planner for more information.

As Policy Owner you pay premiums that are due under the Policy and will receive any benefits that become payable.

3.3 What you can apply for

The monthly benefit amount can be up to 100% of the Insured Person's regular business expenses of the kind covered by the Policy. Depending on their occupation, there may be maximum monthly benefits for which you can insure.

3.4 Choices you make when applying

When you apply you will also choose a Waiting Period of either 14 or 30 days. The premium you need to pay will vary depending on your choice. Your financial planner can advise you on your individual circumstances.

3.5 Availability

You can apply if the Insured Person is aged from 17 to 54 and is the owner or part owner of a business for which they are liable for a share of that business' expenses. If they work in a professional, white collar or certain light manual occupations, you can apply up until age 59. This Policy will not be available to people in certain occupations. Your financial planner can advise you on your individual circumstances.

Benefits

4. Total Disability Benefit

4.1 When we will pay

We will pay you a monthly Total Disability Benefit if the Insured Person is Totally Disabled.

4.2 What we will pay

The amount of this benefit is the lesser of the Insured Monthly Business Overheads Benefit and the Allowable Business Expenses actually incurred in the month the Insured Person is suffering Total Disability.

The amount of this benefit is reduced by any limitation on benefits (see section 9).

4.3 When does my benefit accrue

The benefit accrues from the first day of Total Disability after the Waiting Period and is payable monthly in arrears.

The benefit will continue to accrue until:

- the end of the Insured Person's Total Disability;
- your Benefit Period ends (subject to our agreement to pay you 12 times the Insured Monthly Business Overheads Benefit over a period of 24 months from the first day of Total Disability);
- we have paid 12 times the Insured Monthly Business Overheads Benefit; or
- your Policy ends (see section 13);

whichever occurs first.

If the Insured Person is Totally Disabled in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

5. Partial Disability Benefit

5.1 When we will pay

We will pay you a monthly Partial Disability Benefit if the Insured Person is Partially Disabled.

5.2 What we will pay

The amount of this benefit is the lesser of the Insured Monthly Business Overheads Benefit and the Allowable Business expenses actually incurred in the month the Insured Person is suffering Partial Disability.

The amount earned by the Insured Person from personal exertion will be determined by us on the basis of the contribution of the Insured Person to the Business Income of the business.

The amount of this benefit is reduced by any limitation on benefits (see section 9).

5.3 When does my benefit accrue

The benefit accrues from the first day of Partial Disability after the Waiting Period and is payable monthly in arrears.

The benefit will continue to accrue until:

- the end of the Insured Person's Partial Disability;
- your Benefit Period ends; or
- your Policy ends (see section 13);

whichever occurs first.

If the Insured Person is Partially Disabled in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

6. Death Benefit

6.1 What we will pay

If the Insured Person dies while we are paying a Total Disability Benefit or a Partial Disability Benefit, a benefit equal to 6 times your monthly Total Disability Benefit will be paid to you.

6.2 Who we will pay

If you are both the Insured Person and the Policy Owner, we will pay the Death Benefit to your estate.

7. Elective Surgery Benefit

7.1 When we will pay

We will regard the Insured Person as being Totally Disabled or Partially Disabled due to Sickness if:

- the Insured Person undergoes surgery by a Doctor while covered under this Policy to:
  - transplant part of their body to another person; or
  - improve their appearance or to prevent their disfigurement; and
- as a consequence of the surgery, the Insured Person would be Totally Disabled or Partially Disabled, except for the fact that their disability is caused by the surgery and not an Injury or Sickness.

The Waiting Period will commence from the day on which the Insured Person undergoes surgery.

7.2 When we will not pay

This benefit will not apply to surgery that takes place within 6 months after the later of:

- the Commencement Date;
- for an increase in the Insured Monthly Business Overheads Benefit, the date we increase the Insured Monthly Business Overheads Benefit (other than a CPI increase under section 11); or
- the date this Policy was last reinstated (see section C.1.5).

8. Total or Partial Disability that recurs

8.1 Total or Partial Disability recurring within 6 months

If, within 6 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers Total Disability or Partial Disability from the same or a related Injury or Sickness, the Waiting Period does not apply. The successive periods when benefits were payable are added together to determine when the Benefit Period has expired.

8.2 Total or Partial Disability recurring after 6 months

A new Waiting Period and a new Benefit Period will apply if:

- at least 6 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers Total Disability or Partial Disability from the same or a related Injury or Sickness; and
- either:
  - the Benefit Period for the previous period of Total Disability or Partial Disability had not ended; or
  - the Insured Person had returned to their usual occupation for at least 6 consecutive months after a Total Disability Benefit or a Partial Disability Benefit ceased to be payable.

Otherwise, no benefit is payable.

9. We may limit the benefits we pay

9.1 General

- No benefit will be payable after the Benefit Period has expired.
- All benefits cease to be payable when the Policy ends (see section 13).
- If Total Disability or Partial Disability is caused by more than one Injury or Sickness, we will only pay benefits in respect of one Injury or Sickness at any one time.

9.2 Total Disability Benefit and Partial Disability Benefit

The amount of the Total Disability Benefit or Partial Disability Benefit will not exceed the Insured Monthly Business Overheads Benefit, increased in accordance with section 11, less:

- any amounts paid or payable to you or the Insured Person under other business expenses insurance policies; and
- any income before expenses and tax earned by you or the Insured Person (whether from personal exertion or otherwise) from the Insured Person's Business in excess of any salary and salary related costs of replacing the Insured Person.

10. When we will not pay you

We will not pay a benefit if the Injury or Sickness giving rise to the claim is caused by:

- an act of war (whether declared or not);
- intentional self-inflicted injury (whether while sane or insane);
- attempted suicide (whether while sane or insane);
- normal and uncomplicated pregnancy and childbirth; or
- an event or condition covered by an exclusion shown in your Policy Schedule.

If the Insured Person is disabled by more than one Sickness or Injury at the same time, you will receive payments in relation to only one of these conditions.

11. Your monthly benefit payments are indexed

(a) Increasing the amount of the Benefits by the CPI

Without further evidence of the insurability of the Insured Person, we will, each year on the Review Date, increase the Insured Monthly Business Overheads Benefit by the CPI Indexation Factor applying at that Review Date. Please see section A.9 for more information.

(b) Indexation while you are receiving a Benefit

If you are receiving Benefits on any Review Date, the Insured Monthly Business Overheads Benefit will be indexed on each Review Date by the CPI Indexation Factor.

12. No transfer of ownership

You cannot transfer ownership of this Policy unless we agree in writing to the transfer.

13. When your Policy ends

Your Policy continues until the earliest of:

- the Review Date prior to the Insured Person's 65th birthday;
- we cancel your Policy because you have not paid your premiums or any other amounts which relate to this Policy;
- the Insured Person dies;
- the Insured Person retires or ceases gainful employment for any reason other than Injury or Sickness;
- the date on which you cease to be liable for the expenses, or a portion of the expenses, of their business;
- we receive your written notice to end this Policy; or
- we cancel or avoid the Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you prior to our acceptance of risk or during making the claim.

No benefits will be payable following the ending of this Policy.

SECTION C:

Additional Information for all Westpac Protection Plans

1. Premiums and Charges

1.1 Introduction

This section applies to all Westpac Protection Plans.

1.2 Premiums

(a) Calculation of premiums

For each product that you have, the premium and any other charges (see section below) is the cost of your insurance cover.

The premium depends on a variety of factors, including:

- the type of insurance you have, including any optional benefits;
- the amount of insurance you have for each benefit (including CPI indexation increases);
- the age, gender, smoking status, health, occupation and pursuits of each Insured Person;
- how long you have had your insurance;
- the Policy fee;
- the frequency at which you choose to pay your premium;
- our standard scales of premium rates;
- any discount factors applying; and
- any loading specified in your Policy Schedule (or membership certificate for Westpac Term Life as Superannuation).

We calculate your premium when your insurance begins and at each Review Date. Your premium will generally increase with age. We will notify you of your new premium in writing before each anniversary. We also calculate your premium if you request any changes to your insurance (eg. an increase in a benefit). In this case, we will confirm your new premium in writing.

To calculate your premium, we add together the premium for each benefit for each Insured Person and then add the Policy fee (see below).

Copies of our standard premium rates for each type of insurance are available upon request. Your financial planner can give you an illustration of the cost of the insurance cover you might require.

(b) Policy fee

Each premium payment includes a policy fee. At 1 October 2008 this fee (per payment) is:

- $75.60; or
- $6.86 if you pay your premium monthly; or

The Policy fee increases each year according to the CPI (see section A.9 for details), and is updated on 1 October.

(c) Premium frequency and payment

You can pay premiums monthly or annually.

Where premiums are paid monthly, your premium will include an additional loading of 9% of the annual premium.

Premiums are payable annually or monthly at such time or times and in such manner as we may accept and you may choose.

(d) If you add an Insured Person to your Policy

If you add an Insured Person to your Policy or increase an existing benefit for an Insured Person between Review Dates and you are paying annually, the additional premium that you have to pay for that Insured Person will be the additional annual premium, multiplied by the number of months from the date this benefit or increase started to the next Review Date, divided by 12.

For example, you add an Insured Person to your Policy 3 months before the next Review Date. The additional annual premium is $400. The additional premium you have to pay following that change is:

$$\frac{400 \times 3}{12} = \$100.00$$

If you add an Insured Person to your Policy or increase an existing benefit for an Insured Person between Review Dates and you are paying monthly, your monthly premiums will increase from the next monthly premium that is payable after the benefit or increase started.

(e) Discounts for larger amounts of insurance

A discount applies for larger amounts of insurance cover.

The discounts that apply for different amounts of insurance cover are:

Westpac Term Life, Westpac Term Life as Superannuation – Death & TPD Benefits, Westpac Standalone Total and Permanent Disablement	
Amount of Insurance	**Discount**
$100,000 or less	0%
$250,000	15%
$500,000	25%
$1,000,000 or more	30%

Westpac Term Life – Living Benefit, Westpac Standalone Living Insurance	
Amount of Insurance	**Discount**
$100,000 or less	0%
$250,000	10%
$500,000	12.5%
$1,000,000 or more	15%

Westpac Income Protection, Westpac Income Protection Plus, Westpac Business Overheads	
Amount of Insurance	**Discount**
$2,000 per month or less	0%
$3,000 per month	7.5%
$8,000 per month or more	20%

Please note that we apply any discount to the premium before we add the Policy fee and stamp duty (if applicable). The discounts that apply for amounts of insurance between those shown in the above tables are determined on a pro-rata basis.

(f) Continuity discounts

You will receive a discount of 2% in the second year of your Policy and a further 2% each subsequent year up to a maximum of 10% in the sixth and subsequent years. We apply the discount to your premium before we add the Policy fee and stamp duty (if applicable).

(g) Premium payment methods

You can choose the payment method that suits you. You can pay monthly or yearly in advance by MasterCard, Visa, by automatic debit from your bank account, or by any other method that we may make available to you from time to time.

If you choose to pay by automatic debit from your bank account, then the terms that apply are set out in the Direct Debit Service Agreement (see section 6).

Please note that we do not accept rollovers.

(h) Minimum premium

For each product, the minimum premium is $14 if paying monthly or $150 if paying annually, for each person insured, plus the Policy fee and stamp duty (if applicable).

(i) Maintaining your insurance

All Westpac Protection Plans are guaranteed to continue for the term specified, which means that provided your premiums are paid when due we cannot cancel your insurance even if there is a change in an Insured Person's health, occupation or pastimes.

To maintain your insurance, you must pay premiums, and any other charges payable, when they are due. If your premiums or any other amounts payable are overdue we will write to you. Your insurance will be cancelled if you do not pay these amounts within the time specified in our notice.

Insurance that has been cancelled can only be reinstated if we agree to your request to do so. All premium arrears must be paid in full and we can request further medical evidence and impose further conditions before we decide whether we are prepared to agree to reinstate your Policy.

(j) Changes to premium rates

We can change the premium rates and discount factors. However, we can only do this by changing the premium rates and discount factors of all Policy Owners who have this version of the Policy. We will write and tell you if we do this. We usually give you 3 months notice before changing the premium rates and discount factors. In the event of war or invasion involving Australia, we may give immediate notice.

1.3 Other charges

(a) Periodic payments

We will recover other charges that we incur for periodic payments that you make. The maximum charge is currently 14 cents per payment and this may change without notice.

(b) Stamp duty

For Westpac Term Life and Westpac Term Life as Superannuation, any stamp duty is currently included in the premium.

For Westpac Standalone Living Insurance, Westpac Standalone Total and Permanent Disablement, Westpac Income Protection, Westpac Income Protection Plus and Westpac Business Overheads, stamp duty, licence fees or similar charges payable in respect of your Policy must be paid in addition to your premium. The rate of stamp duty varies for each state of Australia and can be changed without notice. We will recalculate the amount of stamp duty payable whenever your premium is recalculated. It will also vary if the basis of calculating or charging stamp duty on the Policy is altered.

(c) Commission

We pay commission and other benefits to financial planners. Your financial planner will provide details of the benefits he or she will receive if we issue you with insurance in the Financial Services Guide and, if applicable, the Statement of Advice that your financial planner will give to you. We pay these amounts out of the premium we receive from you – **they are not an additional charge to you.**

(d) Goods and Services Tax (GST)

Under current legislation, GST does not have an impact on life insurance premiums (including policy fees).

(e) We may require you to pay tax and other charges

We may require you to pay any taxes, levies or duties which relate to your Policy.

If the level of tax, duties or levies is varied or if additional tax, duties or levies are imposed, we may require you to pay this additional amount.

We may cancel your Policy in accordance with section 1.5 if you do not pay this amount.

(f) Tax and other charges deducted from benefits

We will deduct from any benefit paid under your Policy, any tax, duties or levies we are required by law to deduct.

1.4 Payment of premium while on claim

For Westpac Income Protection, Westpac Income Protection Plus, and Westpac Business Overheads we will waive the proportion of any premium, stamp duty or other amount that falls due during any period in which we are paying you a Total Disability Benefit or Partial Disability Benefit.

1.5 What happens if you don't pay your premiums when they are due

We will write and tell you if your premiums, stamp duty or any other amounts are overdue. We will give you the time specified in the notice to pay this amount. If we don't receive your payment within that time, we will cancel your Policy. We will not pay any benefits if your Policy is cancelled. We may let you reinstate the Policy within a certain time if you pay all outstanding amounts. We may also ask for more information about any Insured Person's health, occupation or pastimes before we do so. If an Insured Person's health, occupation or pastimes have changed, we may vary your benefits, charge additional premiums or not let you reinstate the Policy.

2. Further Information

2.1 Notices

We will send notices to the last address that you gave us. We say that you receive a notice on the date that you would have received it in the ordinary course of the mail. If you move, you need to tell us of your new address.

2.2 Changing your Policy

If you:

- add an Insured Person to your Policy;
- remove an Insured Person from your Policy; or
- change any of the insurance under this Policy,

we will send you written notice of the change.

We will show the date that any change starts. Any notice or endorsement we send you forms part of the Policy Schedule.

2.3 Governing Law

(a) Policy Governance

This Policy is governed by the laws of New South Wales.

(b) Legislative changes

The Australian Federal Government has recently introduced legislation aimed at reducing discrimination of same-sex couples in relation to Commonwealth laws including superannuation and taxation. The intention of this law reform is to ensure members of a same sex couple are treated in the same manner as a married or de facto couple in relation to superannuation and taxation matters.

The first piece of legislation introduced is intended to ensure that a member of a same sex relationship or a child of such a relationship are treated in the same manner in relation to superannuation and taxation law as a member of a married or de facto relationship or a child of a married or de facto relationship. Further changes are expected to be announced in the coming months, and these changes may affect some items set out in this PDS.

2.4 Currency

All dollar amounts are referred to in Australian currency. All claims will be paid in Australian dollars.

2.5 Worldwide cover – 24 hours a day

Full cover is provided at all times, anywhere in the world.

3. Making a claim

3.1 Who to contact

If you wish to make a claim, please contact our Customer Relations Consultants on:

131 817
8.00 am to 6.30 pm (Sydney time)
Monday to Friday.

Our consultants will arrange for you to receive any information or forms you need.

3.2 How and when to make a claim

(a) Claims under Westpac Income Protection, Westpac Income Protection Plus or Westpac Business Overheads

If you are making a claim under Westpac Income Protection, Westpac Income Protection Plus or Westpac Business Overheads, you must write and tell us within 30 days of your disability. We ask you to return all claim forms within 60 days of receiving them.

If you notify us of your disability more than 90 days after the disability occurs, once we accept your claim your payments may start from the later of the date on which we receive your notification and the end of your Waiting Period.

(b) Claims under Westpac Term Life, Westpac Term Life as Superannuation, Westpac Standalone Living Insurance or Westpac Standalone Total and Permanent Disablement

If you are making a claim under Westpac Term Life, Westpac Term Life as Superannuation, Westpac Standalone Living Insurance or Westpac Standalone Total and Permanent Disablement you must tell us within 6 months of the injury, sickness, condition, disability or death occurring.

3.3 Evidence required

(a) General

Before we will pay a benefit, you must provide satisfactory evidence and the authorities we require for us to obtain further information.

This will include medical evidence from a registered medical practitioner acceptable to us. We may also require proof of the Insured Person's age as well as, and if appropriate, proof of the Insured Person's earnings or business expenses. You must provide this evidence at your own expense.

(b) Medical Evidence

We may from time to time require you to provide reports or certificates from the Doctor providing treatment to the Insured Person about the continuing disability of the Insured Person (if claims are based on overseas reports or certificates, they must be translated into English by a certified translator). You must do so at your own expense.

We may also require the Insured Person to undergo medical examinations or tests by a Doctor whom we choose. The Insured Person must allow him or herself to be examined at any reasonable time we request. We will pay the reasonable costs of such examinations or tests.

(c) Proof of age

We can ask for proof of the Insured Person's age. You, or the Insured Person, must give us that information. If, when you applied for insurance:

- the Insured Person's age was lower than we were told it was, we will refund you any premium you have paid above what you should have paid plus interest; or
- the Insured Person's age was higher than we were told it was, we will reduce your benefit to what it would have been if the premium you paid us was based on their true age.

(d) Proof of earnings

We may require you to provide proof of Pre-disability Monthly Earnings and from time to time to provide proof of Post-disability Monthly Earnings in a period for which you are claiming a benefit. The proof required may include income tax returns, accountant's statements or other proof which is acceptable to us.

(e) Proof of Allowable Business Expenses

We may require you to provide proof of Allowable Business Expenses for any period for which you are claiming a benefit. We may also require you to provide proof of the normal basis of accounting for such expenses. The proof required may include bills, invoices or other proof which is acceptable to us.

(f) We rely on the information you provide

Please note that we rely on the information that you provide during a claim. If either you or any Insured Person acts fraudulently, we may be able to cancel the Policy or any of its benefits and not have to pay any benefits.

3.4 What happens after you make your claim?

For Westpac Term Life, Westpac Term Life as Superannuation, Westpac Standalone Total and Permanent Disablement, and Westpac Standalone Living Insurance, after you make a claim we will assess it having regard to the information provided or obtained. We must act reasonably in doing this. In assessing a claim for a Disability Benefit, we will assume that the Insured Person had taken or will take such measures as may have been or as may be or become reasonable to avert or minimise the injury, disease or sickness giving rise to the claim.

3.5 Payment of claims

For Westpac Income Protection, Westpac Income Protection Plus or Westpac Business Overheads, we will start payment of any benefit (including any amounts that have accrued), after we have accepted liability to pay the claim. We will pay benefits to you monthly in arrears. All payments are made in Australian currency. Should we accept liability to pay a claim, this is not a representation by us that we will continue to accept liability for so long as the Insured Person is not working. We may cease payment of the benefit at any time where we are of the opinion that the Insured Person is not Totally or Partially Disabled as required by this Policy. This right exists irrespective of whether the condition of the Insured Person has changed.

4. Taxation treatment of your Product (except Westpac Term Life as Superannuation)

4.1 Introduction

The taxation information described in this section is a general statement only, and is based on continuance of present tax laws at September 2008 and interpretation of those laws. Your individual situation may differ and you should seek independent professional tax advice.

4.2 Westpac Term Life, Westpac Standalone Living Insurance and Westpac Standalone Total and Permanent Disablement

(a) Premium impact

- For individuals: Premiums are not tax deductible.
- For Business: The deductibility of premiums will depend on the specific circumstances of each Policy. For example, if you take out Westpac Term Life and the objective of the Policy is to cover the loss of business revenue associated with the loss of a key employee, the premiums paid by the business may be an allowable tax deduction.

  There may be fringe benefits tax implications in respect of premiums, where benefits are to be applied for employees or their dependants.

(b) Benefit impact

- For individuals: Generally any benefits will not be treated as assessable income for tax purposes. However, there may be capital gains tax implications in certain circumstances*. We recommend you seek individual tax advice.
- For business: The assessability of the benefit will depend on the specific circumstances of the Policy.

  For example, if you take out Westpac Term Life and the objective of the Policy is to cover the loss of business revenue associated with the loss of a key employee, the benefit may be treated as assessable income.

  There may also be tax implications if a death benefit termination payment is made by the business to dependants or non-dependants of the deceased.

4.3 Westpac Income Protection, Westpac Income Protection Plus and Westpac Business Overheads

(a) Premium impact

Premiums paid are generally tax deductible.

(b) Benefit Impact

Payments you receive are generally assessable for tax purposes.

5. Taxation treatment of Westpac Term Life as Superannuation

5.1 Tax concessions on contributions

(a) Employer contributions

Employers can claim tax deductions on all contributions to superannuation on behalf of their employees, subject to the eligibility rules described in 'Eligibility to contribute'.

(b) Personal contributions

You may be eligible to claim a full tax deduction on your personal after tax contributions if you are self employed or substantially self employed. There are no limits on the amount you may claim as a deduction, but additional tax will apply on those contributions in excess of the concessional contributions cap (refer to 'Contributions caps').

*Such as when we pay a Death Benefit under a Term Life Policy and the Policy owner is not the original owner of the Policy, or where we pay a benefit under a Living Insurance or Standalone Total and Permanent Disablement Policy and the Policy owner is not the Insured Person or a relative (as defined for tax purposes).

To be able to claim the deduction, you will need to provide a valid personal tax deduction notice to the Trustee by the earlier of:

- the date you lodge your personal tax return in which you claim the deduction for the contributions,
- the end of the financial year following the financial year in which you made the contributions,
- the date the Trustee ceases to hold the contributions covered in the notice, and
- the date you cease to be a member of the Fund (generally the date your cover ceases).

(c) Spouse contributions

Your spouse may be able to claim a tax offset of up to $540 for contributions they make to your superannuation account. The maximum offset will be available if your income is below $10,800 pa and reduces to $0 once your income is $13,800 pa. Government eligibility rules apply.

5.2 Tax payable on contributions

(a) Concessional contributions

The following concessional contributions are subject to taxation at a maximum rate of 15% within Westpac Term Life as Superannuation:

- employer contributions;
- personal after tax contributions for which you claim a personal tax deduction.

(b) Excess concessional contributions

If contributions are made in excess of the relevant concessional cap (refer to 'Contributions caps'), those contributions are liable for additional tax at a rate of 31.5%. The Australian Taxation Office (ATO) will inform you of this liability and provide you with a Release Authority which will allow you to meet the liability by withdrawing amounts from a superannuation fund. Alternatively, you may pay the tax with your own money. Westpac Term Life as Superannuation will not be able to release amounts to pay your tax liability since no account balance is maintained for you.

(c) Non-concessional contributions

No tax is payable on the non-concessional contributions made to the Fund unless the relevant non-concessional cap (refer to 'Contributions caps') is exceeded.

(d) Excess non-concessional contributions

If your contributions are made in excess of the non-concessional cap, those contributions are liable for tax at a rate of 46.5% . The ATO will inform you of this liability and provide you with a Release Authority. You must withdraw the required amount from a superannuation fund to pay the tax, using the Release Authority. Westpac Term Life as Superannuation will not be able to release amounts to pay your tax liability since no account balance is maintained for you.

5.3 Tax on superannuation lump sums

(a) Taking a cash lump sum benefit

Any tax the Trustee is required to deduct will depend on your age and the tax components within your benefit, as shown in the table below:

Age	Taxable component	Tax-free component
Under 55	20% + Medicare levy	Tax-free
55–59	Up to the low rate cap*: Nil Above the low rate cap: 15% + Medicare levy	Tax-free
60 and over	Tax-free	Tax-free

*$145,000 for 2008/09. This amount will be indexed to Australian Weekly Ordinary Time Earnings (AWOTE) rounded down to the nearest $5,000 in subsequent years.

You may be entitled to a tax-free component calculated under the provisions of the Income Tax Assessment Act, 1997, potentially reducing the overall amount of tax you will pay.

If you are under age 60 and the Trustee does not hold your TFN, it is required to deduct tax on the taxable component at the highest marginal tax rate plus the Medicare levy.

(b) Taking a cash lump sum as a result of suffering from a terminal medical condition

Members who are suffering from a terminal medical condition will be able to receive a lump sum superannuation benefit that is exempt from tax. For this product, this may be the result of receiving either a Disability Benefit or Terminal Illness Benefit.

A member will be taken to be suffering from a terminal medical condition if two registered medical practitioners certify that the member suffers from an illness, or has incurred an injury that is likely to result in their death within a period of 12 months (the certification period). At least one of these certifying practioners must be a specialist practicing in an area related to the member's injury or illness.

5.4 Tax on death benefits

Death benefits paid as a lump sum to your dependants (for tax purposes) are tax-free. A dependant for tax purposes includes your spouse or former spouse (including de facto spouse), your children under 18, a person who was wholly or substantially financially dependent on you at the time of your death and a person with whom you were in an interdependency relationship* at the time of your death.

Death benefits paid as a lump sum to a non-dependant for tax purposes will be taxed in the following manner:

Tax-free component	Tax-free
Taxable component	Taxed at 15% plus the Medicare levy.
Taxable component (untaxed element)	Taxed at 30% plus the Medicare levy.

An untaxed element arises where the lump sum death benefit contains an insurance payout, where the benefit is paid to a non-dependant. The amount of the untaxed element is calculated by using a statutory formula.

Death benefits paid as a lump sum to your estate are taxed within the estate depending on whether your beneficiaries are your dependants or non-dependants for tax purposes.

Westpac Term Life as Superannuation does not pay death benefits as pensions. The tax treatment of death benefits paid as an income stream is different to that outlined above. You should consult your financial planner for advice.

6. Direct Debit Service Agreement

- This agreement sets out the terms on which you have authorised us, Westpac Life Insurance Services Limited and Westpac Securities Administration Limited, to arrange for amounts that become payable in respect of your Westpac Protection Plans product, to be made by deduction from your account at your financial institution.
- You will need to:
  - complete a new Direct Debit Request for any other product you purchase from us, or if you move from one of our products to another; and
  - ask us to discontinue any Direct Debit Request that is in force if you cancel a product (debits may continue to be made to your account until you do so).
- Your Direct Debit Request authorises us to arrange for payment to us for the amounts, and at the times, required by the terms of your product and your instructions to us in relation to it. It also enables any changes in those amounts, and payment times, to occur automatically – you will not need to complete a new form.
- You can:
  - cancel, vary, defer or suspend the Direct Debit Request; or
  - stop or suspend an individual debit from taking place under it,

  by calling us on 131 817, 8.00 am to 6.30 pm Sydney time, Monday to Friday (in some cases, we will need your written confirmation). You need to allow us 6 working days before the next drawing date to process your request, or the debit may still be made. (You may also be able to stop an individual debit by contacting your own financial institution. You may be liable for financial institution charges if you do this – your financial institution should have information on these).
- If a due date for a debit falls on a weekend or public holiday, the debit will be processed on the next business day.
- You must ensure that you have sufficient clear funds available in the nominated account by the due date to permit the payments under the Direct Debit Request. Please check with us if you are uncertain when debits will be processed to your account.
- If a drawing is unsuccessful, we will not draw again until the next Scheduled drawing date. If your drawing is to pay for insurance benefits, we will re-draw the missed payment as well as the current payment. Drawings will be suspended after two unsuccessful attempts.
- Please contact our Customer Relations Centre on 131 817 if you have any questions about your Direct Debit Request, such as concerns about a debit that we make under it. We will reply to you within 7 days.
- We can vary this Service Agreement at any time after giving you 14 days notice of the changes.
- We will keep information about your financial institution account confidential, except to the extent necessary to resolve any claim you might make relating to a debit which you claim has been made incorrectly.
- Direct debiting is not available on all accounts provided by financial institutions. Please ensure that your financial institution allows direct debits on your nominated account, before completing the Direct Debit Request.
- We incur charges in relation to certain periodic payments we receive through the Direct Debit payments system. If a charge applies in respect of your payments, we will increase the amount deducted from your financial institution account to cover this expense. The maximum charge is currently 14 cents per payment. The amount of the charge, and the types of payments to which it applies may change without notice.

*An interdependency relationship is a close personal relationship between two people who live together, where one or both of them provide for the financial and domestic support and personal care of the other. An interdependency relationship may still exist if there is a close personal relationship but the other requirements are not satisfied because of some physical, intellectual or psychiatric disability.

Additional Information for all Westpac Protection Plans

7. Privacy information and consents

7.1 Privacy

Privacy legislation protects your personal information and gives you rights in regard to the way we handle that information. The following privacy information and consents are for the Policy Owner. Additional information and consents for the Insured Person are set out in the personal statement.

By signing the application form, you agree to the following:

Westpac Life Insurance Services Limited ('Westpac Life'), Westpac Securities Administration Limited ('the Trustee') where the insurance is provided through a Westpac superannuation fund, any other member of the Westpac Group*, and third parties such as your financial planner and reinsurers ('the Parties') may exchange with each other any information about you including:

- any information provided by you in this application; and
- any other personal information you provide to any of them or which they otherwise lawfully obtain about you.

If you have identified any person as a Beneficiary, you agree to ensure that each such person is made aware that:

- you have nominated him/her as a Beneficiary of the Policy;
- Westpac Life and the Trustee hold a record of their personal information for this purpose; and
- he/she may contact the Westpac Group*, or request access to his/her information, by calling 131 817.

If Westpac Life or the Trustee engages anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then you agree Westpac Life or the Trustee and the Service Provider may exchange with each other any information referred to above.

Westpac Life or the Trustee might give any information referred to above to entities other than the Parties and the Service Providers where it is required or allowed by law or where you have otherwise consented.

You agree that any information referred to above can be used by the Parties and any Service Provider for assessing the application for this Policy and, if the application is accepted, to issue the Policy, for administration of the Policy, planning, product development and research purposes.

You can access most personal information that members of the Westpac Group* hold about you (sometimes there will be a reason why that is not possible, in which case you will be told why).

If you fail to provide any information requested in this form, or do not agree to any of the possible exchanges or uses detailed above, Westpac Life may be unable to accept the application. To find out what sort of personal information members of the Westpac Group* have about you, or to make a request for access, please telephone 131 817.

7.2 Financial Crimes Monitoring

To meet our regulatory and compliance obligations for anti-money laundering and counter financing of terrorism, we will be increasing the levels of control and monitoring we perform. You should be aware that:

- transactions may be delayed, blocked or refused where we have reasonable grounds to believe that they breach Australian law or the law of any other country; and
- we may from time to time require additional information from you to assist us in the above compliance process.

Where legally obliged to do so, we may disclose the information gathered to regulatory and/or law enforcement agencies.

You must not initiate, engage in or effect a transaction that may be in breach of Australian law (or the law of any other country).

Marketing Information: Members of the Westpac Group* would like to be able to contact you, or send you information, regarding other products and services. If you do not wish to receive this information, please:

- call us on 131 817; or
- write to Westpac Protection Plans
  Customer Relations Consultant
  GPO Box 524, Sydney,
  NSW 2001.

You do not need to do this if you have already told us you do not wish to receive information of this sort.

*The Westpac Group means Westpac Banking Corporation and its related bodies corporate which includes Westpac Life Insurance Services Limited and Westpac Securities Administration Limited.

8. Complaints

8.1 Contact Us

We want you to be totally satisfied with your insurance, now and in the future. If you have any inquiries or complaints about your insurance, please speak to us about it.

Our Customer Relations Centre is just a telephone call away on:

131 817
8.00 am to 6.30 pm (Sydney time)
Monday to Friday

If you wish to make a formal inquiry or complaint, please call our Customer Relations Centre or address it in writing to:

Westpac Protection Plans
Customer Relations Consultant
GPO Box 524
Sydney NSW 2001

When we receive your written enquiry or complaint it will be recorded, investigated and acted upon. We will endeavour to respond to a complaint as soon as possible and within 45 days.

8.2 Financial Ombudsman Service

If you have a complaint about your Policy (except Westpac Term Life as Superannuation, see below) which is not answered to your satisfaction or within 45 days, you may raise the matter directly with the:

Financial Ombudsman Service
GPO Box 3
Melbourne VIC 8007
Telephone 1300 780 808
Facsimile: (03) 9613 6399
Website: www.fos.org.au
Email: info@fos.org.au

The Service will attempt to settle the matter by conciliation. It also has the power to arrange a formal hearing if the matter cannot be resolved.

Before you ask the Service to help you, please try to resolve the issue with us. There are some circumstances where the Service cannot deal with your complaint. They can advise you of these circumstances.

8.3 Superannuation Complaints Tribunal

If you are not satisfied with the outcome of your complaint or the Trustee's decision in relation to Westpac Term Life as Superannuation, you may contact the Superannuation Complaints Tribunal. The Tribunal is an independent body set up by the Federal Government to assist members or beneficiaries to resolve certain types of complaints with fund trustees.

The Tribunal may be able to assist you to resolve your complaint, but only if you are not satisfied with the response received from our handling of your complaint. If the Tribunal agrees to consider your complaint, it will attempt to resolve the matter through enquiry and conciliation.

If conciliation fails the Tribunal may make a determination in relation to the dispute.

Your correspondence for the Tribunal should be addressed to:

The Superannuation Complaints Tribunal
Locked Bag 3060
GPO Melbourne
VIC 3001

The Tribunal may also be contacted on 1300 780 808.

Interim Accident Cover Certificate

1. Introduction

We provide Interim Accident Cover while we are considering your application for a Westpac Protection Plan policy or policies. We provide this cover on the terms and conditions set out in this certificate. You do not have to pay an extra premium for this cover. To the extent that they are relevant, the conditions in the Westpac Protection Plan policy or policies for which you have applied that relate to the payment of a claim apply to this cover. Unless otherwise stated, terms used in this Interim Accident Cover Certificate have the same meaning as in the relevant Policy for which you have applied.

2. Commencement of Cover

Cover commences when a fully completed application form and personal statement in respect of each Insured Person has been received by Westpac Life. Please note, if your application is submitted electronically by your financial planner, cover commences when the signed application is received by Westpac Life.

3. Period of cover

Cover will end on the earliest of the following:

(a) 60 days from the date this cover commences;

(b) in respect of each interim accident benefit for each Insured Person, the date Westpac Life accepts or declines the insurance application for that benefit under the Westpac Protection Plan(s);

(c) in respect of each interim accident benefit for each Insured Person, the date the Policy owner withdraws their insurance application for that benefit under the Westpac Protection Plan(s); or

(d) the date Westpac Life advises the Policy Owner that Interim Accident Cover has ceased.

4. Cover provided

(a) Accidental Death Benefit

The lesser of $1,000,000 and the amount of Death Benefit applied for in respect of the Insured Person, is payable should the person to be insured die as a result of an Accident whilst the Interim Accident Cover is in force.

(b) Accidental Total and Permanent Disability Benefit

The lesser of $1,000,000 and the Disability Benefit applied for in respect of the person to be insured, is payable should the Insured Person become Totally and Permanently Disabled as a result of an Accident whilst the Interim Accident Cover is in force.

The Total and Permanent Disablement (TPD) definition that applies is either 'Own Occupation', 'Any Occupation' or 'Home Duties', as nominated by you in your application form.

(c) Accidental Living Benefit

The lesser of $1,000,000 and the Living Benefit applied for in respect of the Insured Person, is payable should the Insured Person suffer a specified serious medical condition or injury or undergo specified surgery as a result of an Accident whilst the Interim Accident Cover is in force and the Insured Person subsequently survives for 14 days.

The specified serious medical conditions, injuries and surgery relevant to the Accidental Living Benefit are as defined in the Westpac Protection Plans Product Disclosure Statement and Policy Document.

(d) Accidental Income Protection benefit

The lesser of $5,000 per month and the Insured Monthly Disability Benefit applied for under Westpac Income Protection, Westpac Income Protection Plus or Westpac Business Overheads is payable should the Insured Person become Totally Disabled as a result of an Accident whilst the Interim Accident Cover is in force. The benefit accrues from the date of expiry of the Waiting Period applied under the relevant income protection policy and ceases to accrue at the earliest of either the date the Insured Person ceases to be Totally Disabled or 6 months from the end of the Waiting Period.

5. Accident and Bodily Injury

Accident and Bodily Injury have the following meanings:

- **Accident**

A single event that results in Bodily Injury that is unexpected. This does not include an event that results from sickness or disease.

- **Bodily Injury**

Physical damage to the body sustained as a result of an external traumatic occurrence.

6. Exclusions

A benefit will not be paid under this cover if the death, disablement or living benefit condition is caused directly or indirectly:

- by an intentional self-inflicted act or attempted suicide (whether sane or insane);
- by an accident while the Insured Person is under the influence of alcohol or non-prescription drugs or drugs taken in excess of prescribed amounts;
- by an act of war (whether declared or not) except where the Insured Person dies on war service;
- by the Insured Person engaging in any sport, pastime or occupation that we would not normally cover at standard rates; or
- by any condition that the Policy Owner or Insured Person knew about before applying for cover.

A benefit will not be paid if the proposed Insured Person's occupation is one that we would not normally cover.

7. Claims

Only one interim accident benefit for an Insured Person will be paid in respect of any one Accident. The cost of obtaining medical evidence that is required for the payment of an interim accident benefit claim is to be borne by the Policy Owner. At the discretion of Westpac Life, the costs of further medical evidence may be borne by Westpac Life.

If you are eligible to make a claim under this cover, it will not prevent your application for a Westpac Protection Plan policy will continue to be assessed. However we will take into account the change in health of the Insured Person(s) when assessing your application and we may decline your application or apply special loadings, conditions and exclusions.

Call 131 817

8.00am to 6.30pm (Sydney time) Monday to Friday

Visit westpac.com.au

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WFS772 (10/08) 142582