ClearView

ClearView **LifeSolutions**

Policy Document

16 April 2012

Contents

Your policy

Your policy is a contract

Your policy is a contract that consists of:

- this policy document
- any other documents we issue which varies your policy
- the latest policy certificate (**Policy Certificate**) we have issued in relation to your policy.

The Policy Certificate states the effective date which is the date from which the Policy Certificate applies. These documents are important and you should read them carefully and keep them in a safe place.

Policy terms

Your policy sets out the terms of your ClearView LifeSolutions cover or ClearView LifeSolutions Super cover (as applicable). Your policy is not a legal contract with us unless:

- we accept your application for cover and issue a Policy Certificate to the policy owner, and
- the policy owner has paid the initial premium required by the policy.

If there is any inconsistency between the Product Disclosure Statement you considered before applying for cover and the policy we issue you, the terms contained in the policy will prevail to the extent of the inconsistency.

Policy Certificate

The Policy Certificate states the details that apply to (and the extent to which this policy document is varied for) a policy owner's policy, including: person insured; benefit amount or monthly benefit amount; cover start date; premium type; additional options that have been selected; any premium loading, exclusions or varied terms that apply; and any children insured and their benefit amount. The Policy Certificate determines the parts of this policy document that apply to the particular policy (ie. parts of this document that state they apply when indicated on the Policy Certificate, only apply where so indicated).

The policy owner may be issued with a new Policy Certificate. From the effective date stated on a new Policy Certificate (that will not be earlier than the time that the new Policy Certificate is issued), it replaces your existing Policy Certificate.

Issuer

ClearView LifeSolutions is issued by ClearView Life Assurance Limited (**ClearView**): ABN 12 000 021 581, AFS Licence No.227682. 'We/us/our' refers to ClearView as the issuer of this policy.

Policy owner and person insured

The operation of this policy and the parties involved with the policy, depends on the type of policy it is and the owner(s) of the policy. The policy may operate under one of three type and ownership structures:

- A policy owned by a person or company (that is not the trustee of a superannuation fund) (see 'Non-Superannuation Policy – ClearView LifeSolutions below)
- A policy owned by a person or company that is the trustee of a self managed superannuation fund (**SMSF**) (see 'Superannuation Policy – ClearView LifeSolutions' below), or
- A policy owned by ClearView Life Nominees Pty Limited (**CLN**) (see 'Superannuation Policy – ClearView LifeSolutions Super below).

How the policy operates and is interpreted in each of these cases is outlined below.

Non-Superannuation Policy – ClearView LifeSolutions

This is a policy that is issued by ClearView to a person or company that is not the trustee of a superannuation fund and is referred to as a *non-superannuation policy*. In this case your Policy Certificate will indicate that it is a 'ClearView LifeSolutions' policy and this policy document is interpreted and applies as follows:

- 'you' refers to the policy owner and is the person or company who is named on the Policy Certificate as the owner of the policy. If there is more than one policy owner of a policy, they own the policy as joint tenants (ie on the death of one of the policy owners, their share passes to the surviving joint tenant).
- The person insured is the person named as the person insured on the Policy Certificate. In the case of Child Cover, the child insured is the child named as the child insured on the Policy Certificate. A child insured is not a person insured within the meaning of this policy.
- You are responsible for paying the premiums for the policy.

Superannuation Policy – ClearView LifeSolutions

Where the policy is issued to the trustee of a SMSF, the policy is referred to as a *superannuation policy*. In this document, cover under a *superannuation policy* is also described as cover held inside superannuation. Your Policy Certificate will indicate that it is a 'ClearView LifeSolutions' policy and this policy document is interpreted and applies as follows:

- 'you' refers to the policy owner and is the trustee named on the Policy Certificate as the owner of the policy.

- The person insured is the member of the SMSF and is the person named as the person insured on the Policy Certificate.
- You, as trustee of the SMSF, are responsible for paying the premiums for the policy.

You are responsible for ensuring that your policy is consistent with superannuation and other laws and the governing rules of your SMSF. You are also responsible for collecting contributions to pay the premiums for this policy, procuring any action by the person insured that is required under this policy, and operating the SMSF in accordance with superannuation and other applicable laws and the governing rules of the SMSF.

Superannuation Policy – ClearView LifeSolutions Super

This is a policy that is issued by ClearView to CLN as trustee of the superannuation fund known as the ClearView Retirement Plan (**Plan**). The person insured under the policy has been admitted as a member of the Plan by CLN and is not the policy owner of the policy. However, CLN holds the policy in relation to the person insured's membership of the Plan. This policy is referred to as a *superannuation policy*. In this document, cover under a *superannuation policy* is also described as cover held inside superannuation.

In this case the Policy Certificate will indicate that it is a 'ClearView LifeSolutions Super' policy and this policy document sets out the terms of the policy issued by ClearView to CLN, and is interpreted and applies as follows:

- 'you' refers to CLN as the policy owner (and CLN is named on the Policy Certificate as the policy owner).
- The person insured is the member of the Plan and is the person named as the person insured on the Policy Certificate.

IMPORTANT NOTICE TO MEMBERS OF THE CLEARVIEW RETIREMENT PLAN

Superannuation Policy – ClearView LifeSolutions Super

Any benefits paid under the policy will be paid to CLN and premiums paid for the policy are paid by CLN after it receives a sufficient contribution from, or a rollover in respect of the member. This policy does not govern the member's membership of the Plan. Matters relating to the member's membership of the Plan, for example, any restrictions on the member's entitlement to:

- be paid a benefit received by CLN under the policy, and
- paying contributions or rollover amounts to CLN for CLN to pay premiums for the policy,are governed by the Plan's trust deed and superannuation laws.

It is important for the person insured (and member) to note that at the time of issue of this policy, Government legislation restricts the payment of certain benefits (including preserved benefits) out of a superannuation fund unless the superannuation fund member has satisfied certain conditions. These restrictions apply to all non-death related benefits paid to CLN under this policy.

This means that CLN may not pass the preserved portion of the benefit that it receives from ClearView under the policy to the member until CLN has proof satisfactory to it that the member has satisfied one of a number of conditions that allows CLN to pay a benefit to them, including:

- for permanent incapacity, CLN must be satisfied that as a result of ill-health (whether physical or mental), the member is unlikely to ever again engage in gainful employment for which they are reasonably qualified by way of education, experience or training, and
- for temporary incapacity, CLN must be satisfied that the member has ceased to be gainfully employed (for example ceasing temporarily to receive any gain or reward under a continuing arrangement to be gainfully employed) due to ill-health (whether physical or mental) but which does not constitute permanent incapacity.

If the member cannot provide the required proof, the portion of the benefit that CLN receives from ClearView must remain in the Plan until such time as CLN is permitted under the Plan's trust deed and superannuation law to pay the benefit or the member requests CLN to transfer the benefit to a superannuation entity of their choice. If the member provides satisfactory proof that they have satisfied a condition that allows CLN to pay them a benefit then they may ask CLN to pay the benefit to them.

The superannuation laws and various benefit rules and restrictions under them may change over the life of this policy. The rules and laws applicable at the time a benefit is payable are the relevant rules and laws.

CLN (as the policy owner) can exercise all of the rights of a policy owner, subject to its duties as the trustee of the Plan. For example, CLN may cancel all or any part of this policy if it considers it to be necessary to comply with the law. The member (and person insured) may request CLN to exercise certain rights it has as the policy owner under the policy. In some limited circumstances, the member (and person insured) may be able to enforce the policy against ClearView.

Relevant law

This policy is subject to and governed by the laws of New South Wales.

Defined terms and interpretation

Definitions

Some of the terms used in the policy have a specific meaning. These terms are either defined above or shown in italics and defined in the Dictionary starting on page 49.

Interpretation

In this policy document:

(a) Singular and plural: The singular includes the plural and the plural includes the singular.

(b) Grammatical extension: Other parts of speech and grammatical forms of a word or phrase defined in this agreement have a corresponding meaning.

(c) Inclusions and examples: Specifying anything after the words 'include' or 'for example' does not limit what else is included.

(d) Person: A reference to a person includes any company or other body corporate as well as an individual.

(e) Legislation: A reference to any legislation includes all delegated legislation made under it and amendments, consolidations, replacements or re enactments of any of them.

Worldwide cover

The person insured and any child insured is fully covered, 24 hours per day, anywhere in the world under this policy, unless there are any varied terms (which are agreed by you and us) which state otherwise and are shown on the Policy Certificate.

Guaranteed renewable

We guarantee to renew your policy each year up until the policy expiry, so long as your premiums continue to be paid when due. This means that we cannot cancel your cover, place any new restrictions on your cover or increase your individual premium (before applicable discounts) because of the number of claims made under this policy or any change in the person insured's health, occupation or pastimes.

Guaranteed upgrade of benefits to your cover

We will automatically pass on any future product enhancements to your policy in respect of the relevant covers, provided they do not result in an increase in premium and you accept those enhancements by continuing to pay premiums. Where they do result in an increase in premium, you will have the option to not take up the offer of the upgrade.

Any enhancements will apply to future claims. The enhancements will not apply to current claims or to any claims resulting from medical conditions, *sickness*, *injury* or *disability* which occurred before these enhancements came into effect.

Cooling off period

If for any reason you feel that your policy or individual cover under the policy does not meet your needs, you can cancel it by notifying us in writing and returning the Policy Certificate. You have a 30 day cooling off period starting on the earlier of:

- the date you receive your policy, or
- five business days after your policy start date.

We will cancel the policy or individual cover from the policy start date and refund any premiums you have paid in respect of the policy or individual cover (except any amounts of taxation or charges which we are unable to recover).

You will not be able to cancel your policy or any individual cover during the cooling off period if you have already made a claim under the policy.

For cover under ClearView LifeSolutions Super, CLN can exercise its cooling off rights during the cooling off period at the request of the member (and person insured). In this case, we will refund the premiums to CLN (except any amounts of taxation or charges which we are unable to recover) and CLN will return contributions or rollover amounts, subject to preservation requirements.

Currency

Premiums and any benefits are payable in Australia, in Australian dollars.

Statutory fund

All premiums received are paid into our No. 1 Statutory Fund, and all benefits are paid out of this fund.

Non-participating policy

This policy does not participate in distributions of profits or surplus of ClearView.

Waiver

No party to this policy may rely on the words or conduct of any other party as a waiver of any right unless the waiver is in writing and signed by the party granting the waiver. Unless expressly stated in the written waiver, the waiver by a party of a right will not operate as a waiver of any other right. The meanings of the terms used in this paragraph are set out in the table below.

Term	Meaning
conduct	includes delay in the exercise of a right.
right	any right arising under or in connection with this agreement and includes the right to rely on this clause.
waiver	includes an election between rights and remedies, and conduct which might otherwise give rise to an estoppel.

Invalidity and enforceability

If any provision of the policy is invalid under the law of any jurisdiction the provision is enforceable in that jurisdiction to the extent that it is not invalid, whether it is in severable terms or not. This does not apply where enforcement of the provision of the policy in accordance with previous sentence would materially affect the nature or effect of the parties' obligations under this agreement.

Continuation certificate

The continuation certificate is the notice we send you each year telling you the benefit amount or monthly benefit amount and the premium due for the year beginning on the next policy anniversary.

Notices

Any notice you give us under this policy must be given to us in writing and will be effective from the date on which we receive it. Any notice which we give you must also be in writing, and will be effective when delivered, emailed or faxed to, or five days after it is posted to, the address last known to us.

Variations to the policy

Subject to the following and the section 'Guaranteed upgrade of benefits to your cover' on page 4, any variation of this policy must be agreed to between the parties and any agreement by us must be in writing.

We may unilaterally vary this policy:

- as a result of any changes in the law, or
- if the variation is not prejudicial to you.

Any unilateral variation of this policy will apply to all ClearView LifeSolutions and ClearView LifeSolutions Super policies in a defined group and you will be given 30 days notice in writing of any new conditions.

Changing the policy owner – ClearView LifeSolutions

You may transfer the ownership of your policy to another person, subject to relevant law, including superannuation law, by completing a Memorandum of Transfer (which must be signed by you and the transferee) and sending it to us with your original policy to be registered.

Superannuation

If this policy is owned by the trustee of a SMSF, you agree to operate the superannuation fund at all times in accordance with the trust deed and rules of the fund and in a manner which ensures that it complies with the Superannuation Industry (Supervision) Act 1993 (**SIS Act**).

You must notify us if at any time the policy ceases to be an asset of the superannuation fund, or the fund ceases to be administered in accordance with its trust deed and rules, or if it ceases to comply with the SIS Act. Should any of these events happen we may terminate the policy and issue a replacement policy or make any changes to the terms of the policy as we consider appropriate.

There may be situations where, even though a claim is admitted by us and payment is made to the trustee of a complying superannuation fund, legislation or the rules of the fund may prevent the release of the benefit.

Disclosure obligations

If you or the person insured has not fully complied with their duty of disclosure stated on the application form or has made a misrepresentation, then we may elect not to pay a claim in full or in part.

Nominated beneficiary – non-superannuation policy only

A nominated beneficiary is a person(s) who has been nominated by you to receive part or all of the benefits payable in the event of the death of the person insured. The policy does not confer any other rights on a beneficiary.

For Life Cover and Accidental Death Cover under a *non-superannuation policy*, you are able to nominate up to five beneficiaries to receive the benefit amount if the person insured dies while this cover is in place, subject to the following rules:

- a nominated beneficiary must be a natural person, corporation or trustee
- a nominated beneficiary will receive the designated portion of any money payable under the relevant cover
- if a nominated beneficiary dies or the corporation or trustee ceases to exist before a claim is made under this policy and no change in nomination has been made, then any benefit that would have been payable to the nominated beneficiary will be paid to you or your estate

- if ownership of the policy is assigned or transferred to another person or entity, then any previous nomination of beneficiary becomes invalid, and
- you may change the nomination at any time prior to the death of the person insured by notifying us in writing.

You are the beneficiary in respect of a child insured. You may not nominate any other beneficiary to receive a Child Cover benefit.

When cover starts

Cover starts once your application has been approved and we have issued the policy (see the section 'Policy terms' on page 2). We will confirm this for the policy owner in writing and for ClearView LifeSolutions Super, we will also notify the person insured (and member). The cover start date is shown on your Policy Certificate.

When the policy ends

This policy terminates and all cover will end when the first of the following occurs:

- the death of the person insured
- the date on which all entitlements under the policy are paid
- the policy anniversary immediately after the expiry age of the last cover remaining on the policy
- we cancel your policy following your written request
- we cancel your policy because premiums are unpaid, as and when due; or
- we cancel your policy in accordance with our rights in relation to the duty of disclosure or a misrepresentation.

If there are two people insured under the policy and one dies, cover for the remaining person continues, but we may issue a new policy. Premiums will be reduced to reflect cover for one person and one benefit amount. If both people insured die as the result of the same event, we will pay the benefit amount for each person under the policy.

Payment of a benefit in respect of a child insured does not discontinue the policy for the person(s) insured or any remaining child insured on the policy.

Replacement cover

Where we determine that this policy or the cover issued under this policy replaces existing cover with us or another insurer we will provide documentation with your Policy Certificate that confirms this is replacement cover and the cover issued under this policy is conditional upon the existing cover being cancelled. If the cover under the existing policy is not cancelled prior to a claim arising under this policy, we will reduce any amount payable under this policy by the amount received under the policy that was to be replaced.

Structure of your cover

Cover may be structured in one of the following three ways and will be specified on your Policy Certificate.

Stand alone cover

Where cover under this policy is 'standalone cover' it operates independently of any other cover. When a benefit is paid under a standalone type of cover it does not reduce or impact the benefit amount for any other cover you hold in respect of the person insured.

Linked cover (under one policy)

Where cover is 'linked' to other cover(s) in respect of the same person insured (under the same policy), the cover interacts with other cover(s) to which it is linked. When a benefit is paid under one cover, all cover linked to it will be reduced by the benefit amount paid.

Flexi linking (two separate policies)

Flexi linking allows covers under two separate policies with different policy owners, on the same person insured, to be treated like linked cover under one policy. Where cover under this policy is 'flexi linked' to cover under another policy in respect of the same person insured, then when a benefit is paid under one policy in respect of the person insured, all cover flexi linked to it on the other policy will be reduced by the benefit amount paid and the premium payable for that cover will be accordingly reduced.

Flexi linking is only provided where one *superannuation policy* is owned via a trustee of a superannuation fund, and the other *non-superannuation policy* is owned by another policy owner.

Life Cover

Life Cover applies where the words 'Life Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Life Cover.

Life Cover Benefit

If the person insured dies or is diagnosed with a *terminal illness*, we will pay the Life Cover benefit amount stated on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

Funeral Advancement Benefit

Upon the production of the person insured's death certificate, or any other satisfactory evidence to us of the person insured's death, we will advance the lesser of $25,000 and the Life Cover benefit amount.

The Life Cover benefit amount will be reduced by the amount paid under this benefit.

Payment of this benefit is not an admission of our liability to pay a Life Cover claim. We reserve the right to recover the amount of the Funeral Advancement Benefit paid if a Life Cover claim is subsequently denied.

Limitations

This benefit is not available if Life Cover is held inside superannuation or if a trustee is a nominated beneficiary on the policy.

Grief Support Benefit

If we pay the Life Cover benefit amount we will reimburse the cost of up to four hours of grief counselling sessions for you, the person insured (on *terminal illness*) or an *immediate family member* of the person insured.

The maximum total amount we will reimburse under the Grief Counselling Benefit in respect of each person insured is $1,000.

Limitations

The Grief Support Benefit must be claimed within 12 months of payment of the Life Cover Benefit.

The counselling session must be provided by an accredited counsellor approved by us.

A copy of the invoice or receipt showing the amount paid and the services provided must be provided to us upon request.

This benefit is not available if Life Cover is held inside superannuation or if a trustee is a nominated beneficiary on the policy.

Life Cover Buy Back Benefit

This benefit applies if you have 'TPD Cover' and/or 'Trauma Cover' linked or flexi linked to your 'Life Cover'.

If the full Trauma Cover or TPD Cover benefit amount is paid, the linked or flexi linked Life Cover benefit amount will be reduced by the amount of the benefit paid. The Life Cover Buy Back Benefit will allow you to reinstate the Life Cover to the benefit amount applicable prior to the full payment of the linked or flexi linked Trauma Cover or TPD Cover benefit amount, without the need to provide further medical evidence for the person insured.

We will offer to reinstate your linked or flexi linked Life Cover benefit amount 12 months after the later of:

- the date we received your fully completed claim form in relation to which the full Trauma Cover or TPD Cover benefit amount is paid, or
- the date the person insured satisfied the trauma condition or TPD definition.

If you want to exercise this benefit, you must take up this offer within 30 days of our letter of offer.

Any premium loading, exclusions or varied terms which applied to the original Life Cover will apply to the reinstated Life Cover and the premiums will be based on those offered at the time of reinstatement.

The Indexation Benefit will apply to your reinstated Life Cover.

Limitations

The Future Increase Benefit and Business Guarantee Option are not available with the reinstated Life Cover.

This Life Cover Buy Back Benefit is not available if the Life Cover benefit amount has been reinstated under the Accelerated Life Cover Buy Back Option.

Additional benefits

The following benefits are also provided under Life Cover. These are discussed in the policy document as indicated by the reference in the table below.

Additional benefit	Reference
Indexation Benefit	21
Future Increase Benefit	22
Accommodation Benefit	21
Financial Advice Benefit	23
Premium Freeze Benefit	21
Suspending Cover Benefit	22

Optional extras

The following options may apply to your Life Cover where you have selected one or more of these, pay the additional premiums and they are indicated on your Policy Certificate. These are discussed in the policy document as indicated by the reference in the table below.

Optional extra	Reference
Disability Premium Waiver Option	25
Business Guarantee Option	24

Life Cover exclusions

We will not pay any benefit under Life Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We will not pay any benefit under Life Cover if the person insured's death is caused directly or indirectly by suicide or any intentional self inflicted act within 13 months of:

- the cover start date
- an increase in the benefit amount (but only in respect of the increased amount and does not include an increase in cover as a result of the Indexation Benefit), or
- the date on which cover was last reinstated.

This 13 month suicide or any intentional self inflicted act exclusion will not apply if your Life Cover is replacing an existing life cover policy issued by us or another insurer if:

- the insurance under the policy to be replaced has been in place for a minimum of 13 consecutive months immediately prior to the commencement of this cover
- the policy to be replaced is cancelled immediately after the issue of this cover
- all similar exclusions have expired under the policy to be replaced (including exclusions which were applied to the policy after its commencement due to, for example, reinstatements or increases)
- the benefit amount under this cover being issued by us is the same or less than that under the policy that is being replaced*, and
- no claim is payable or pending under the policy to be replaced.

*Where the benefit amount under this cover being issued by us exceeds that of the policy that is being replaced, this exclusion will only apply to the excess benefit amount.

When Life Cover ends

Life Cover for the person insured will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid
- policy anniversary immediately after the person insured is age 99, or
- date on which the policy ends.

Accidental Death Cover

Accidental Death Cover applies where the words 'Accidental Death Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Accidental Death Cover.

Accidental Death Cover is not available inside superannuation.

Accidental Death Cover Benefit

If the person insured dies as a result of an *accident* and their death occurs within 90 days of the *accident*, we will pay the Accidental Death Cover benefit amount stated on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

Grief Support Benefit

If we pay the Accidental Death Cover benefit amount we will reimburse the cost of up to four hours of grief counselling sessions for you or an *immediate family member* of the person insured.

The maximum total amount we will reimburse under the Grief Counselling Benefit in respect of each person insured is $1,000.

Limitations

The Grief Support Benefit must be claimed within 12 months of payment of the Accidental Death Cover Benefit.

The counselling sessions must be provided by an accredited counsellor approved by us.

A copy of the invoice or receipt showing the amount paid and the services provided must be provided to us upon request.

Additional benefits

The following benefits are also provided under Accidental Death Cover. These are discussed in the policy document as indicated by the reference in the table below.

Additional benefit	Reference
Indexation Benefit	21
Financial Advice Benefit	23
Suspending Cover Benefit	22

Optional extras

The following option may apply to your Accidental Death Cover where you have selected this, pay the additional premium and it is indicated on your Policy Certificate. The option is discussed in the policy document as indicated by the reference in the table below.

Optional extra	Reference
Disability Premium Waiver Option	25

Accidental Death Cover exclusions

We will not pay any benefit under Accidental Death Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We will not pay any benefit under Accidental Death Cover if the person insured's death is caused directly or indirectly by:

- suicide or any intentional self inflicted act
- the person insured participating in criminal activity
- the person insured taking alcohol or drugs, other than a drug prescribed by a *medical practitioner* and taken as directed, or
- war or act of war (whether declared or not).

When Accidental Death Cover ends

Accidental Death Cover for the person insured will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid
- policy anniversary immediately after the person insured is age 99, or
- date on which the policy ends.

Total and Permanent Disability (TPD) Cover

TPD Cover applies where the words 'Total and Permanent Disability Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for TPD Cover.

TPD Cover Benefit

If the person insured suffers *total and permanent disability* while this cover is in place and meets the conditions of the TPD definition which applies (as shown on your Policy Certificate), we will pay the TPD Cover benefit amount stated on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

TPD definitions

The term *total and permanent disability* has a special meaning under this policy as set out below and will depend on the TPD definition which applies to your cover, as shown on your Policy Certificate (as varied by the terms of this policy document).

Any occupation TPD

As a result of *sickness or injury*, the person insured:

- has been absent from, and unable to work for three consecutive months, and
- is disabled at the end of the period of three consecutive months, to such an extent that the person insured is unlikely ever again to be able to engage in any occupation:
  - for which they are reasonably suited by education, training or experience, and
  - which is likely to generate average monthly earnings of at least 25% of the person insured's average *monthly earnings* in the 12 months prior to claim.

OR

- suffers at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 6th edition, or an equivalent guide to impairment approved by us, and
- is disabled to such an extent that, as a result, the person insured is unlikely ever again to be able to engage in any occupation:
  - for which they are reasonably suited by education, training or experience, and
  - which is likely to generate average monthly earnings of at least 25% of the person insured's average *monthly earnings* in the 12 months prior to claim.

OR

- satisfies the 'Non-working TPD' definition.

Own occupation TPD

As a result of *sickness* or *injury*, the person insured:

- has been absent from, and unable to work in, their *own occupation* for three consecutive months, and
- is disabled at the end of the period of three consecutive months, to such an extent that the person insured is unlikely ever again to be able to engage in his or her *own occupation*

OR

- suffer at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 6th edition, or an equivalent guide to impairment approved by us, and
- is disabled to such an extent that, as a result, the person insured is unlikely ever again to be able to engage in your *own occupation*

OR

- satisfies the non-working TPD definition.

Home duties TPD

As a result of *sickness* or *injury*, the person insured:

- has been unable to perform *home duties* for three consecutive months, and
- is disabled at the end of the period of three consecutive months, to such an extent that the person insured is unlikely ever again to be able to perform *home duties* or engage in any occupation for which they are reasonably suited by education, training or experience.

OR

- suffers at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 6th edition, or an equivalent guide to impairment approved by us, and
- is disabled to such an extent that, as a result, the person insured is unlikely ever again to be able to perform *home duties* or engage in any occupation for which they are reasonably suited by education, training or experience.

OR

- satisfies the 'Non-working TPD' definition.

Non-working TPD

As a result of *sickness* or *injury* the person insured has suffered:

- *Loss of Limbs or Sight* (as defined on page 56)
- *Loss of Independent Existence* (as defined on page 56), or
- *Cognitive Loss* (as defined on page 56).

When the TPD definition will change

On the policy anniversary immediately after the person insured is age 70, the TPD definition for all TPD cover will automatically convert to the 'Non-working TPD' definition.

The maximum TPD Cover and Trauma Cover available at age 70 is $3 million across all policies issued by us (and includes cover provided under TPD Cover, Accidental TPD Cover and Trauma Cover).

If the person insured is covered for more than $3 million at this age, we will reduce the aggregate benefit amounts. The premium will also be reduced accordingly to reflect the lower benefit amount.

The Indexation Benefit will continue to be available if the benefit amount is reduced to $3 million.

TPD Super Solutions

TPD Super Solutions applies when the words 'TPD Super Solutions' appear under the 'Benefit Type' section of your Policy Certificate. Where TPD Super Solutions applies, two policies will have been issued, this policy and another, with flexi linked TPD Cover.

Where this policy is owned by a trustee of a superannuation fund, then:

- the Policy Certificate will specify that the 'any occupation TPD' definition will apply, and
- the 'any occupation TPD' definition will be adopted under this cover, provided it satisfies a condition of release under SIS Act.

Where this policy is owned by a policy owner other than the trustee of a superannuation fund, then:

- the Policy Certificate will specify that the 'Own occupation TPD' definition will apply
- this policy is flexi linked to another policy owned by a trustee of a superannuation fund, and
- the 'Own occupation TPD' definition will be adopted under this cover (subject to the flexi linking offset as set out below).

Where this policy is owned by a policy owner other than the trustee of a superannuation fund:

- any TPD claim will first be assessed under the other flexi linked policy (owned by the trustee)
- if a benefit is paid under the other policy (to the trustee), the TPD Cover benefit amount under this policy will be correspondingly reduced, and
- if a benefit is not paid under the other policy (i.e. because the 'any occupation TPD' definition was not satisfied), the TPD claim will then be assessed under the 'Own occupation TPD' definition under this policy.

The TPD benefit amounts under this and the other flexi linked policy must always be the same and the total TPD benefits paid under the two policies in aggregate must not exceed the single benefit amount. The TPD benefit amounts under the two policies may only be increased or reduced together.

Once the full TPD benefit amount is paid under one policy, all TPD cover will cease under both policies.

Waiver of the qualifying period (Day 1 TPD)

If the person insured suffers one of the following defined trauma conditions (as defined in the 'Trauma Definitions' section starting on page 52), and meets all other requirements of the TPD definition shown on your Policy Certificate, we will waive the normal three month qualifying period.

- *Cardiomyopathy*
- *Primary Pulmonary Hypertension*
- *Motor Neurone Disease*
- *Multiple Sclerosis*
- *Muscular Dystrophy*
- *Parkinson's Disease*
- *Dementia including Alzheimer's Disease*
- *Paralysis*
- *Blindness*
- *Loss of Speech*
- *Loss of Hearing*
- *Chronic Lung Disease*
- *Severe Rheumatoid Arthritis*

Specific Loss Benefit

If the person insured suffers the '*Loss of One Limb* or *Partial Blindness*' (as defined in the 'Trauma Definitions' section starting on page 52) while TPD Cover applies, we will pay a partial TPD benefit of 25% of the TPD Cover benefit amount, subject to a maximum of $500,000.

The TPD Cover benefit amount will be reduced by the amount paid under this benefit.

Limitations

This benefit is not available if your TPD Cover is held inside superannuation.

Death Benefit

If the Policy Certificate specifies 'Stand alone TPD Cover' applies, then if the person insured dies and no TPD Cover benefit has been paid or is payable, we will pay a benefit of $10,000.

Limitations

This benefit will not apply where the person insured's death is caused directly or indirectly by suicide or any intentional self inflicted act of the person insured within 13 months of the:

- cover start date, or
- the date on which cover was last reinstated.

Additional benefits

The following benefits are also provided under TPD Cover. These are discussed in this document as indicated by the reference in the table below.

Additional benefit	Reference
Indexation Benefit	21
Future Increase Benefit	22
Accommodation Benefit	21
Financial Advice Benefit	23
Premium Freeze Benefit	21
Suspending Cover Benefit	22
Life Cover Buy Back Benefit	23

Optional extras

The following options may apply to your TPD Cover where you have selected one or more of these, pay the additional premiums and they are indicated on your Policy Certificate.

Accelerated Life Cover Buy Back Option

The Accelerated Life Cover Buy Back Option applies when the words 'Accelerated Life Cover Buy Back Option' appear under the 'Optional Extras' section of your Policy Certificate.

If we pay the full TPD Benefit, the linked or flexi linked Life Cover benefit amount that would have been reduced will be reinstated.

We will waive future premiums for the portion of the Life Cover benefit amount that is reinstated under this option up until the policy anniversary immediately after the person insured is age 65.

Limitations

This option cannot be exercised if:

- a benefit has been paid for *terminal illness*, we are in the process of assessing a *terminal illness* claim or you are eligible to make a claim for *terminal illness* in relation to the person insured
- the person insured does not survive for 14 days after suffering the *sickness* or *injury* that caused their *total and permanent disability*, or
- only a partial TPD payment was made under the Specific Loss Benefit (unless multiple payments have been made which total the full TPD Cover benefit amount).

The reinstated Life Cover benefit amount cannot be increased under the Indexation Benefit, Future Increase Benefit or the Business Guarantee Option (if applicable) once a TPD benefit is paid.

This option expires on the policy anniversary immediately when the person insured is age 65.

Life Cover Purchase Option

The Life Cover Purchase Option applies when the words 'Life Cover Purchase Option' appear under the 'Optional Extras' section of your Policy Certificate.

If we pay the full TPD Cover benefit amount, you may purchase Life Cover for the person insured under the TPD Cover up to the amount of the TPD benefit paid, without the need to supply further medical evidence in relation to the person insured.

If we paid the TPD benefit and the person insured satisfied the applicable TPD definition as a result of:

- *Dementia including Alzheimer's Disease*
- *Blindness*
- *Loss of Hearing*
- *Loss of Limbs or Sight*
- *Paralysis*
- *Multiple Sclerosis, or*
- *Parkinson's Disease*

we will offer the Life Cover Purchase Option six months after the later of:

- the date we received your fully completed claim form in relation to which we pay the full TPD Cover benefit amount, or
- the date the person insured satisfied the applicable TPD definition.

For all other TPD claims, we will offer the Life Cover Purchase Option 12 months after the later of:

- the date we received your fully completed claim form in relation to which we pay the full TPD Cover benefit amount , or
- the date the person insured satisfied the applicable TPD definition.

If you wish to exercise this option we must receive written acceptance from you within 60 days of our letter of offer.

The Indexation Benefit will apply to the new Life Cover.

Limitations

This option cannot be exercised if:

- a benefit has been paid for *terminal illness*, we are in the process of assessing a *terminal illness* claim or you are eligible to make a claim for *terminal illness* in relation to the person insured, or
- only a partial TPD payment was made (unless multiple payments have been made which total the full TPD Cover benefit amount).

Any premium loadings, exclusions or varied terms which applied to the original TPD Cover will also apply to the new Life Cover.

The Future Increase Benefit and Business Guarantee Option cannot be exercised under the new Life Cover.

Additional optional extras

The following options may apply to your TPD Cover where you have selected one or more of these, pay the additional premiums and they are indicated on your Policy Certificate. These options are discussed in the policy document as indicated by the reference in the table below.

Optional extra	Reference
Disability Premium Waiver Option	25
Business Guarantee Option	24

TPD Cover exclusions

We will not pay any benefit under TPD Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We will not pay any benefit under TPD Cover if the person insured's *total and permanent disability, sickness, injury* (or death) is caused directly or indirectly by any intentional self inflicted act.

When TPD Cover ends

TPD Cover for the person insured will end on the earlier of the:

- death of the person insured
- policy anniversary immediately after the person insured is age 99, or
- the date on which the policy ends.

Accidental Total and Permanent Disability (TPD) Cover

Accidental TPD Cover applies where the words 'Accidental Total and Permanent Disability Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Accidental TPD Cover.

Accidental TPD Cover is not available if cover is held inside superannuation.

Accidental TPD Cover Benefit

If the person insured is *totally and permanently disabled* because of an *accident* and their *total and permanent disability* occurs within 90 days of the *accident*, we will pay the Accidental TPD Cover benefit amount stated on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

TPD definitions

The term *total and permanent disability* has the meaning as set out on page 10 of this policy document under TPD Cover, except that the benefits payable under Accidental TPD Cover only relate to *total and permanent disability* caused by an *accident* (i.e. the person insured can only satisfy the relevant TPD definition if their *total and permanent disability* is the result of an *injury*. The *sickness* element of the TPD definition is not applicable in Accidental TPD Cover).

The specific TPD definition applicable also depends on the TPD definition which applies to your cover, as shown on your Policy Certificate (as varied by the terms of this policy document).

When the TPD definition will change

On the policy anniversary immediately after the person insured is age 70, the TPD definition for the cover will automatically convert to the 'Non-working TPD' definition set out on page 11 of this policy document, where their *total and permanent disability* is caused by an *accident* (i.e. the person insured can only satisfy the 'Non-working TPD' definition if their *total and permanent disability* is the result of an *injury*. The *sickness* element of the 'Non working TPD' definition is not applicable to Accidental TPD Cover).

The maximum Accidental TPD Cover (and TPD Cover and Trauma Cover if applicable) available at age 70 is $3 million across all policies issued by us (and includes cover provided under Accidental TPD Cover, TPD Cover and Trauma Cover). If the person insured is covered for more than $3 million at this age, we will reduce the aggregate benefit amounts.

The premium will also be reduced accordingly to reflect the reduced benefit amount.

The Indexation Benefit will continue to be available if the benefit amount has been reduced to $3 million.

Specific Loss Benefit

If the person insured suffers *'Loss of One Limb or Partial Blindness'* (as defined in the 'Trauma Definitions' section starting on page 52) as a result of an *accident* while this cover is in place, we will pay a partial TPD benefit of 25% of the Accidental TPD Cover benefit amount, subject to a maximum of $500,000.

The Accidental TPD Cover benefit amount will be reduced by the amount paid under this benefit.

Death Benefit

If the Policy Certificate specifies 'Stand alone Accidental TPD Cover' applies, then if the person insured dies as a result of an *accident* and their death occurs within 90 days of the *accident* and no Accidental TPD Cover benefit has been paid or is payable, we will pay a benefit of $10,000.

Additional benefits

The following benefits are also provided under Accidental TPD Cover. These are discussed in the policy document as indicated by the reference in the table below.

Additional benefit	Reference
Indexation Benefit	21
Accommodation Benefit	21
Financial Advice Benefit	23
Suspending Cover Benefit	22

Optional extras

The following option may apply to your Accidental TPD Cover where you have selected this, pay the additional premium and it is indicated on your Policy Certificate. The option is discussed in the policy document as indicated by the reference in the table below.

Optional extra	Reference
Disability Premium Waiver Option	25

Accidental TPD Cover exclusions

We will not pay any benefit under Accidental TPD Cover for anything we have specifically excluded, as stated on your Policy Certificate.

We will not pay any benefit under Accidental TPD Cover if the person insured's *total and permanent disability, injury* (or death) is caused directly or indirectly by:

- suicide or any intentional self-inflicted act of the person insured
- the person insured's participation in criminal activity
- the person insured taking alcohol or drugs, other than a drug prescribed by a medical practitioner and taken as directed, or
- war or act of war (whether declared or not).

When Accidental TPD Cover ends

Accidental TPD Cover for the person insured will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid,
- policy anniversary immediately after the person insured is age 99, or
- the date on which policy ends.

Trauma Cover

Trauma Cover applies where the words 'Trauma Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Trauma Cover.

Trauma Cover is not available if cover is held inside superannuation.

Trauma Cover Benefit

If the person insured suffers one of the 'Trauma conditions' listed immediately below and survives 14 days from:

- for an injury, the date the injury occurs
- for an illness, the date a *medical practitioner* diagnoses the illness, and
- for a treatment, the date the person insured undergoes the treatment,

we will pay the Trauma Cover benefit amount stated on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

Trauma conditions covered

Each of these trauma conditions has a specific meaning. Please refer to the 'Trauma Definitions' section starting on page 52. Those conditions marked with:

- ^ are subject to a 90 qualifying period as explained immediately below on page 16.
- * will only pay a partial benefit amount as explained below on page 17.

Heart condition
*Heart Attack^*
*Out of Hospital Cardiac Arrest^*
*Coronary Artery Bypass Surgery^*
Coronary Artery Angioplasty^*
*Coronary Artery Angioplasty – Triple Vessel^*
Repair or Replacement of a Heart Valve
Surgery of the Aorta
Cardiomyopathy
Open Heart Surgery
Primary Pulmonary Hypertension
Nervous system condition
*Stroke^*
Major Head Trauma
Motor Neurone Disease
Multiple Sclerosis
Muscular Dystrophy
Paralysis
Dementia including Alzheimer's Disease
Coma
Encephalitis
Parkinson's Disease
Bacterial Meningitis and/or Meningococcal Septicaemia
Body organ condition
*Cancer^*
*Cancer of the Vulva or Perineum^*
Benign Brain Tumour or Spinal Cord Tumour
Blindness
Chronic Kidney Failure
Major Organ or Bone Marrow Transplant
Pneumonectomy
Severe Burns
Loss of Speech
Loss of Hearing
Chronic Liver Disease
Chronic Lung Disease
Severe Rheumatoid Arthritis
Blood condition
Occupationally Acquired HIV
Medically Acquired HIV
Aplastic Anaemia
Advanced Diabetes
Other condition
Intensive Care
Loss of Limbs or Sight
*Loss of One Limb**
Loss of Independent Existence
Cognitive Loss

90 day qualifying period

Unless we have agreed to waive the 90 day qualifying period in respect of replacement cover, no benefit will be paid under this cover for any of the trauma conditions marked with a ^ in the table above if the condition first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the first 90 days immediately following:

- the date we received your fully completed application for Trauma Cover
- an increase in the Trauma Cover benefit amount (but only in respect of the increased amount and does not include an increase in cover as a result of the Indexation Benefit), and
- the date this cover is last reinstated.

Where we have agreed to replace an existing trauma policy on the life of the person insured which is issued by us or another insurer, the 90 day qualifying period will not apply if:

- the insurance under the policy to be replaced has been in place for at least 90 consecutive days immediately prior to the commencement of this cover
- the policy to be replaced provided similar cover for the same trauma conditions or events that are subject to a 90 day qualifying period under this cover
- the benefit amount under this cover being issued by us is the same or less than that under the policy that is being replaced*
- the policy to be replaced is cancelled immediately after the issue of this cover
- all similar exclusions have expired under the policy to be replaced (including exclusions which were applied to the policy after its commencement due to, for example, reinstatements or increases), and
- no claim is payable or pending under the policy to be replaced.

*Where the benefit amount under this cover exceeds that of the policy that is being replaced, the 90 day qualifying period will apply to the excess benefit amount.

Partial trauma benefit payment

The benefit amount payable for:

- *Coronary Artery Angioplasty* is 25% of the Trauma Cover benefit amount subject to a maximum of $50,000 and a minimum of $10,000
- *Loss of One Limb* is 25% of the Trauma Cover benefit amount subject to a maximum of $100,000 and a minimum of $10,000.

Any partial benefit paid will reduce the Trauma Cover benefit amount.

Where a partial benefit payment would reduce the remaining Trauma Cover benefit amount to below $10,000, we will pay the entire benefit amount and your Trauma Cover will cease (subject to the Trauma Cover Reinstatement Benefit).

You can only claim for each type of trauma condition once, except for *Coronary Artery Angioplasty*. You may make multiple claims for this trauma condition provided that each of the procedures is at least six months apart. We will pay for such multiple trauma conditions until the full Trauma Cover benefit amount has been paid.

When the Trauma Cover changes

On the policy anniversary immediately after the person insured is age 70, we will only pay the Trauma Cover benefit if the person insured suffers *Loss of Independent Existence*, *Loss of Limbs or Sight*, or *Cognitive Loss*.

The maximum Trauma Cover and TPD Cover available at age 70 is $3 million across all policies issued by us (and includes cover provided under TPD Cover, Accidental TPD Cover and Trauma Cover). If the person insured is covered for more than $3 million at this age, we will reduce the aggregate benefit amounts. The Indexation Benefit will continue to be available if the benefit amount is reduced to $3 million.

Trauma Cover Reinstatement Benefit

If we pay a full or partial Trauma Cover benefit amount, you can reinstate your Trauma Cover for the amount of the trauma benefit paid, without having to supply further medical evidence.

We will offer the Trauma Cover Reinstatement Benefit 12 months after the later of:

- the date we received your fully completed claim form in relation to which we pay the full or partial Trauma Cover benefit amount, or
- the date the person insured satisfied the definition of the relevant trauma condition for which we paid the full or partial Trauma Cover benefit amount.

To exercise this benefit, you must take up this offer within 60 days of our letter of offer.

The premium for the reinstated Trauma Cover will be calculated based on the age of the person insured as at the time of the reinstatement (for both stepped and level premium types). Any premium loadings, exclusions or varied terms that applied to the original Trauma Cover will also apply to the reinstated Trauma Cover.

Limitations

This benefit is not available if:

- the Trauma Reinstatement Benefit has already been exercised in aggregate for the full original Trauma Cover benefit amount in relation to the person insured
- a TPD benefit or benefit for *terminal illness* has been paid, is being assessed or you are eligible to claim a TPD benefit or benefit for *terminal illness*, in relation to the person insured under linked or flexi linked cover, or
- a benefit has been paid for *Loss of Independent Existence* in relation to the person insured.

We will not pay a claim under reinstated Trauma Cover for:

- the same trauma condition for which we paid a claim under the original Trauma Cover
- a condition which is directly or indirectly related to a condition for which a claim has been previously paid under the original Trauma Cover (or treatment of that condition)
- a condition which first occurs or is first diagnosed, or symptoms leading to the condition occurring or being diagnosed first become reasonably apparent, before

the date of reinstatement of the Trauma Cover.

- *Stroke, Heart Attack, Out of Hospital Cardiac Arrest, Coronary Artery Bypass Surgery, Coronary Artery Angioplasty, Coronary Artery Angioplasty – Triple Vessel, Repair or Replacement of a Heart Valve, Surgery of the Aorta, Cardiomyopathy, Open Heart Surgery, Primary Pulmonary Hypertension* or *Chronic Kidney Failure* if a trauma benefit has been paid for any of these trauma conditions under the original Trauma Cover.
- *Paralysis* or *Loss of Sight* if the cause of the condition was the result of a *Stroke* and a trauma benefit has been paid for *Heart Attack, Out of Hospital Cardiac Arrest, Coronary Artery Bypass Surgery, Coronary Artery Angioplasty, Coronary Artery Angioplasty – Triple Vessel, Repair or Replacement of a Heart Valve, Surgery of the Aorta, Cardiomyopathy, Open Heart Surgery* or *Primary Pulmonary Hypertension* under the original Trauma Cover.
- *Cancer, Benign Brain Tumour or Spinal Cord Tumour, Cancer of the Vulva or Perineum, Breast Cancer with Surgery and Treatment, Carcinoma in situ (all sites), Early Stage Melanoma, Early Stage Prostate Cancer, Chronic Lymphocytic Leukaemia or Hydatidiform Mole* if a trauma benefit has been paid for any of these conditions under the original Trauma Cover.
- *Heart Attack* or *Stroke* if a trauma benefit has been paid for *Dementia including Alzheimer's Disease* under the original Trauma Cover.

The Future Increase Benefit and Business Guarantee Option are not available for the reinstated Trauma Cover.

Death Benefit

If the Policy Certificate specifies 'Stand alone Trauma Cover' applies, then if the person insured dies and no Trauma benefit is payable at the time of their death or has been paid under this policy, we will pay a benefit amount of $10,000.

Limitations

This benefit will not apply where the person insured's death is caused directly or indirectly by suicide or any intentional self inflicted act of the person insured within 13 months of the:

- cover start date, or
- the date on which cover was last reinstated.

Blood Borne Diseases Benefit

The Blood Borne Diseases Benefit applies where Trauma Cover applies and the person insured is classified by us as a *medical professional* at the time of application and is also such immediately prior to claiming this benefit.

If the person insured suffers *Occupationally Acquired Hepatitis B or C*, we will pay the Trauma Cover benefit.

Limitations

Any *accident* giving rise to a potential claim must be reported to us within 30 days of the *accident* and supported by a negative Hepatitis B or Hepatitis C test (as applicable) taken within seven days after the *accident*. We require access to all blood samples taken in order to facilitate independent testing, with the right to take additional samples as necessary.

The benefit will not be payable if:

- the Hepatitis B or Hepatitis C virus is caused by any other means, including sexual activity or recreational intravenous drug use
- in practicing their medical profession, the person insured has not made reasonable efforts to comply with relevant State and Commonwealth guidelines in relation to dealing with infection of health care workers
- the Australian Government or relevant government body has approved a medical treatment which renders the Hepatitis B or Hepatitis C virus (as applicable) inactive and non-infectious to others, or
- the person insured has not taken an approved vaccine that is recommended by the relevant government body for use in their occupation and is available prior to the accident which causes infection.

Additional benefits

The following benefits are also provided under Trauma Cover. These are discussed in the policy document as indicated by the reference in the table below.

Additional benefit	Reference
Indexation Benefit	21
Future Increase Benefit	22
Accommodation Benefit	21
Financial Advice Benefit	23
Premium Freeze Benefit	21
Suspending Cover Benefit	22
Life Cover Buy Back Benefit	23

Optional extras

The following options may apply to your Trauma Cover where you have selected one or more of these, pay the additional premiums and they are indicated on your Policy Certificate.

Trauma Plus Option

The Trauma Plus Option applies where the words 'Trauma Plus Option' appear under the 'Optional Extras' section of your Policy Certificate. The Trauma Plus Option provides cover for an extra 13 trauma conditions.

Each of these trauma conditions has a specific meaning. Please refer to the 'Trauma Definitions' section starting on page 52.

Those conditions marked with ^ are subject to a 90 qualifying period as explained on page 16.

Trauma Plus Condition
*Breast Cancer with Surgery and Treatment^*
*Carcinoma in situ^* • *Breast (excluding Breast Cancer with Surgery and Treatment)* • *Cervix – uteri (excluded are cervical intraepithelial neoplasia (CIN) classifications CIN-1 and CIN-2)* • *Fallopian tube (tubal mucosa only)* • *Ovary* • *Penis* • *Perineum* • *Prostate* • *Testicle* • *Vagina* • *Vulva*
*Early Stage Prostate Cancer^*
*Early Stage Melanoma^*
*Chronic Lymphocytic Leukaemia^*
*Hydatidiform Mole^*
*Diabetes Complication^*
Partial Loss of Hearing
Partial Blindness
Severe Osteoporosis
Severe Crohns Disease
Severe Ulcerative Colitis
Colostomy/ileostomy

The full Trauma Cover benefit amount is payable for Breast Cancer with Surgery and Treatment.

The benefit amount payable under the Trauma Plus Option for all other trauma conditions is 25% of the Trauma Cover benefit amount, subject to a maximum of $100,000 and a minimum of $10,000.

Any partial benefit paid will reduce the Trauma Cover benefit amount.

Accelerated Life Cover Buy Back Option

The Accelerated Life Cover Buy Back Option applies when the words 'Accelerated Life Cover Buy Back Option' appear under the 'Optional Extras' section of your Policy Certificate.

If we pay the full Trauma Cover benefit amount, the Life Cover benefit amount that would have been reduced under linked or flexi linked Life Cover will be reinstated.

We will waive future premiums for the portion of the Life Cover benefit amount that is reinstated under this option up until the policy anniversary immediately after the person insured is age 65.

Limitations

This option cannot be exercised if:

- a benefit has been paid for *terminal illness*, we are in the process of assessing a *terminal illness* claim or you are eligible to make a claim for *terminal illness* in relation to the person insured
- the person insured does not survive for 14 days after diagnosis (or occurrence) of the trauma condition, or
- only a partial trauma payment was made (unless multiple payments have been made which total the full Trauma Cover benefit amount).

The reinstated Life Cover benefit amount cannot be increased under the Indexation Benefit, Future Increase Benefit or the Business Guarantee Option (if applicable) once a trauma benefit is paid.

This option expires on the policy anniversary immediately after the person insured is age 65.

Life Cover Purchase Option

The Life Cover Purchase Option applies when the words 'Life Cover Purchase Option' appear under the 'Optional Extras' section of your Policy Certificate.

If we pay the full Trauma Cover benefit amount, you may purchase Life Cover for the person insured under the Trauma Cover up to the amount of the trauma benefit paid, without the need to supply further medical evidence for the person insured.

If we paid the trauma benefit as a result of:

- *Dementia including Alzheimer's Disease*
- *Blindness*
- *Loss of Hearing*
- *Loss of Limbs or Sight*
- *Paralysis*
- *Multiple Sclerosis*, or
- *Parkinson's Disease*

we will offer the Life Cover Purchase Option six months after the later of:

- the date we received your fully completed claim form in relation to which we pay the full Trauma Cover benefit amount, or
- the date the person insured satisfied the definition for the applicable trauma condition.

For all other trauma conditions, we will offer the Life Cover Purchase Option 12 months after the later of:

- the date we received your fully completed claim form in relation to which we pay the full Trauma Cover benefit amount, or
- the date the person insured satisfied the definition for the applicable trauma condition.

If you wish to exercise this option, we must receive written acceptance from you within 60 days of our letter of offer.

Any premium loadings, exclusions or varied terms which applied to the original Trauma Cover will apply to the new Life Cover.

The Indexation Benefit will apply to the new Life Cover.

Limitations

This option cannot be exercised if:

- a benefit has been paid for terminal illness, we are in the process of assessing a terminal illness claim or you are eligible to make a claim for terminal illness in relation to the person insured, or
- only a partial Trauma payment was made (unless multiple payments have been made which total the full Trauma Cover benefit amount).

The Future Increase Benefit and Business Guarantee Option cannot be exercised under the new Life Cover.

Additional optional extras

The following options may apply to your Trauma Cover where you have selected one or more of these, pay the additional premiums and they are indicated on your Policy Certificate. The options are discussed in the policy document as indicated by the reference in the table below.

Optional extra	Reference
Disability Premium Waiver Option	25
Business Guarantee Option	24

Trauma Cover exclusions

We will not pay any benefit under Trauma Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We will not pay any benefit under Trauma Cover if the person insured's trauma condition, *sickness, injury* (or death):

- is caused directly or indirectly by any intentional self inflicted act, or
- occurs within the 90 day qualifying period in respect of certain conditions as explained on page 16.

When Trauma Cover ends

Trauma Cover for the person insured will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid
- policy anniversary immediately after the person insured is age 80, or
- the date on which policy ends.

Additional benefits applicable to Life Cover, Accidental Death Cover, TPD Cover, Accidental TPD Cover and Trauma Cover

The following additional benefit provisions apply to Life, Accidental Death, TPD, Accidental TPD and Trauma Covers as indicated below (not all additional benefits apply to all Cover types).

Indexation Benefit

This benefit applies to cover if the words 'Indexation' are shown on your Policy Certificate.

If this benefit applies we will automatically increase the benefit amount at each policy anniversary. The rate of increase will be the greater of:

- 5%, and
- the percentage increase in the *Consumer Price Index (CPI)*.

You may choose not to accept this increase by notifying us 30 days prior to the relevant policy anniversary. If you decline an increase, you will not be excluded from being offered increases in future years.

The premium will be increased at the same time to reflect the increased benefit amount.

Limitations

The Indexation Benefit will not apply while premiums are being waived under the following options:

- Disability Premium Waiver Option, or
- Accelerated Life Buy Back Option.

The Indexation Benefit will not apply if the following benefits are being exercised:

- Premium Freeze Benefit, or
- Suspending Cover Benefit.

Accommodation Benefit

If we pay:

- a benefit for *terminal illness* and under advice from a *medical practitioner*, the person insured is confined to bed as a result of the *terminal illness*, or
- the full TPD Benefit amount, and under advice from a *medical practitioner*, the person insured is confined to bed as a result of the *total and permanent disability* for which we have paid the benefit, or
- the full Trauma Benefit amount and under advice from a *medical practitioner*, the person insured is confined to bed as a result of the trauma condition for which we have paid the Trauma Benefit,

AND

- an *immediate family member* is required to travel more than 100 kilometres from their place of residence to be with the person insured, or
- the person insured is more than 100 kilometres from their place of residence and requires an *immediate family member* to be with them,

we will reimburse you for the accommodation costs of the immediate family member of up to $250 per day, for each day the person insured remains confined to bed, for a maximum period of 30 days.

Limitations

This benefit must be claimed within 60 days of the *terminal illness*, TPD or trauma benefit being paid. This benefit is payable only once for any 12-month period in respect of each person insured.

A copy of the invoice or receipt for the accommodation must be provided to us upon request.

This benefit will cease to apply on the death of the person insured.

This benefit is not available if the Life Cover or TPD Cover is held inside superannuation.

This benefit does not apply to Accidental Death Cover or Accidental TPD Cover.

Premium Freeze Benefit

This benefit applies where the words 'Stepped Premium' appear under the 'Premium Type' section of your Policy Certificate.

If you choose to activate the Premium Freeze Benefit for your cover, the following will apply:

- the premium for your cover will be fixed (excluding the policy fee) at the level that applied prior to the next policy anniversary, and
- the benefit amount will reduce each year to an amount that could be purchased with the fixed premium and based on the premium rate that applies at the time.

The Premium Freeze Benefit may be activated at the start of your cover or within 30 days prior to any policy anniversary.

You may cancel the Premium Freeze Benefit by notifying us in writing within 30 days of the relevant policy anniversary, except where we are waiving premiums under the Disability Premium Waiver Option or the Accelerated Life Buy Back Option. The benefit amount will be the most recent benefit amount that applied immediately prior to you cancelling the premium freeze.

Limitations

The policy fee will not be fixed and will continue to be indexed in line with the *Consumer Price Index (CPI)* as described on page 46.

Premium rates may change in the future as described on page 47.

The Indexation Benefit, Future Increase Benefit and Business Guarantee Option (if applicable) cannot be exercised while the Premium Freeze Benefit is activated.

If the Life Cover, TPD Cover or Trauma Cover reduces to or below the minimum benefit amount of $50,000, the premium freeze benefit will cease.

This benefit does not apply to Accidental Death Cover or Accidental TPD Cover.

Suspending Cover Benefit

You may suspend all cover under your policy and premiums associated with your policy for up to 12 months. During this period, you will be unable to claim in respect of any event, *sickness* or *injury* that occurs during the suspension period.

You may activate the Suspending Cover Benefit by notifying us in writing within 30 days of the relevant premium due date (monthly or annually) from which you wish to suspend your cover.

To cancel the suspension of your policy, you must notify us in writing. All cover under the policy and premiums will resume as of the next premium due date after we received your notice.

Limitations

Your policy must have been in place for a continuous period of at least 12 consecutive months before you can exercise the Suspending Cover Benefit.

You may only exercise this benefit once in any 12 month period.

Your policy may be suspended under this benefit for a maximum of 12 months in total over the life of the policy. If you do not apply to cancel the Suspending Cover Benefit before the maximum period expires, your cover will be cancelled.

Future Increase Benefit

You may apply to us to increase the Life Cover, TPD Cover and Trauma Cover benefit amount when a specified personal, business or policy event occurs, without having to provide medical evidence for the person insured.

If TPD Cover and/or Trauma Cover are linked or flexi linked to Life Cover, the Life Cover benefit amount must always be greater than or equal to the higher of the TPD Cover and Trauma Cover benefit amount.

Personal events	The Life/TPD/Trauma benefit amount may be increased by up to the lesser of:
• The person insured's marriage • The person insured or their spouse gives birth or adopts a child • A dependent child of the person insured starts secondary school • The person insured completes an undergraduate degree at a government recognised Australian university • The person insured's divorce • The person insured's spouse dies • The person insured becomes a carer for the first time which includes being financially responsible for provision of such care and/or physically providing the care	• 25% of the benefit amount at the cover start date, and • $200,000.
• The person insured takes out or increases a mortgage on his or her principal place of residence with an accredited mortgage provider. This excludes re-draw and refinancing Accredited mortgage provider means an authorised deposit taking institution (ADI) or any other mortgage provider that we agree to.	• 50% of the Life Cover benefit amount at the cover start date and if applicable, 25% of the TPD Cover or Trauma Cover benefit amount at the cover start date • the amount of the mortgage, or increase to the mortgage, and • $200,000.
• A promotion or salary package increase of 15% or more for the person insured The salary package does not include irregular payments such as bonuses or commissions that may not continue in the future.	• 25% of the benefit amount at the cover start date • ten times the amount of the salary package increase, and • $200,000.
Business events	**The Life/TPD/Trauma benefit amount may be increased by up to the lesser of:**
• If the person insured is a partner, shareholder or similar principal in a business and the purpose of this cover supports a buy/sell, share purchase or business succession agreement and his or her value in the business increases	• 25% of the benefit amount at the cover start date • the increase in the value of your financial interest in the business, and • $200,000.

• If the person insured is responsible for a business loan and there is an increase in the loan liability for the business.	• 25% of the benefit amount at the cover start date • the increase in the value of the business loan, and • $200,000.
• If the person insured is a key person in a business and his or her value to the business increases.	• five times the average of the last three consecutive annual increases in the person insured's gross remuneration package • 25% of the benefit amount at the cover start date, and • $200,000.
Policy event	**The Life /TPD/Trauma benefit amount may be increased by up to the lesser of:**
Every third policy anniversary (if you have not increased the Life/TPD/Trauma benefit amount under the Future Increase Benefit in the previous three years)	• 25% of the benefit amount at the cover start date, and • $200,000.

To apply for an increase under this benefit, you must complete a 'Future Increase Benefit Application Form' and return it to us with any other information we have requested to demonstrate that the personal or business event has occurred.

Your application needs to be made:

- within 60 days of the occurrence of the personal, business or policy event, or
- within 60 days of the policy anniversary following the personal, business or policy event.

The increase in cover will take effect from the date we notify you in writing, which will be no later than 30 days from the date you satisfied our requirements.

Limitations

You may apply for an increase for only one personal, business or policy event per cover type in any 12 month period across all policies issued by us covering the person insured.

The increase benefit amount does not apply until we have confirmed it in writing and your premium will increase to reflect the increase in cover.

The premium for the increase benefit amount will be recalculated based on the age of the person insured at the time of the increase.

Within the first six months of an increase to a benefit amount, the increased benefit amount is only payable for death, *total and permanent disability* or a trauma condition (as applicable) which results from an *accident*.

Any increase under this benefit is subject to a minimum of $10,000.

The total increases under this benefit for each type of cover are subject to the lesser of:

- $2 million
- the original benefit amount for each type of cover at the cover start date, and

subject to the maximum benefit amount applicable for each cover.

This benefit is not available:

- from the policy anniversary immediately after the person insured is age 60
- if you have exercised the Business Guarantee Option on this cover for the same event
- if you or anyone else has made, or is eligible to make a claim in relation to the person insured for any benefit under this policy or any policy issued by us (including a claim to waive premiums under the Disability Premium Waiver Option), or
- if the original cover was issued by us with a medical loading greater than 100%, as shown on the Policy Certificate.

This benefit does not apply to Accidental Death cover or Accidental TPD Cover.

Financial Advice Benefit

If we pay the full Life Cover, Accidental Death Cover, TPD Cover, Accidental TPD Cover or Trauma Cover benefit amount, we will reimburse the cost of engaging a financial adviser who is operating under an Australian Financial Services Licence to prepare a financial plan(s) for you and/or any other beneficiaries under the policy.

The total amount payable under this benefit is the lesser of the actual fee charged by the financial adviser and $2,000.

You must be able to provide a copy of the invoice or receipt showing the amount paid and the services provided.

The financial plan must be provided within 12 months of receiving the full benefit amount.

This benefit will only be paid once for each person insured, regardless of how many life insurance policies they have with us.

This benefit is not available if cover is held inside superannuation.

Life Cover Buy Back Benefit

Please refer to page 7 for further details. This benefit only applies to Life Cover, TPD Cover and Trauma Cover. It does not apply to Accidental Death Cover or Accidental TPD Cover.

Optional extras applicable to Life Cover, Accidental Death Cover, TPD Cover, Accidental TPD Cover and Trauma Cover

The following options apply to Life, Accidental Death, TPD, Accidental TPD and Trauma Covers as indicated below (not all additional options apply to all Cover types).

Business Guarantee Option

The Business Guarantee Option applies when the words 'Business Guarantee Option' appear under the 'Optional Extras' section of your Policy Certificate.

If you have this option, you may apply to us to increase your benefit amount without having to provide further medical evidence for the person insured.

The application for increase must be in relation to an increase in the value associated with the 'business insurance purpose' which was nominated by you and agreed to by us at the time of application.

If TPD Cover and/or Trauma Cover are linked or flexi linked to Life Cover, the Life Cover benefit amount must always be greater than or equal to the higher of the TPD Cover and Trauma Cover benefit amount.

You may apply for one increase in any 12 month period under this option.

If exercising this option within three years of the commencement of this option, or within three years of the last increase under this option, the maximum individual and maximum total increase available is outlined in the table below.

Type of cover	Maximum individual increase#	Maximum total cover available under this option
Life Cover	• the increase in value of the 'business insurance purpose'	Lesser of: • three times the benefit amount at the cover start date, and • $15 million*
TPD Cover	• the increase in value of the 'business insurance purpose'	Lesser of: • three times the benefit amount at the cover start date, and • $5 million*
Trauma Cover	• the increase in value of the 'business insurance purpose'	Lesser of: • three times the benefit amount at the cover start date, and • $2 million*

#Any individual increase subject to the maximum total cover available under this option

*These amounts are the total to which your benefit amount may be increased and include all cover on the life of the person insured, including cover held inside superannuation and with other life insurance companies

If at any time you have not increased your cover under this option for more than three years, the maximum individual increase available for all cover types is the lesser of:

- the increase in value of the business insurance purpose
- three times the benefit amount at the cover start date
- $2 million and

subject to the maximum benefit amount applicable for each cover.

The benefit amount as a percentage of the person insured's share of the value associated with the business insurance purpose must never increase.

To apply for an increase under this option:

- you must complete a 'Business Guarantee Increase Application Form' and return it to us with any other information we have requested to demonstrate that the business event has occurred
- you need to provide relevant, current financial information appropriate to the business insurance purpose originally applied for, and any other evidence (other than medical evidence) that we may require, and
- the person insured must be actively at work in their usual occupation at the time of applying for the increase.

Your application needs to be made within 60 days of the date:

- the qualified accountant or valuer issues a written re-evaluation of the business (for buy/sell, share purchase or business succession business insurance purpose)
- the qualified accountant or valuer issues a written re-evaluation of the value of the person insured to the business (for key person business insurance purpose)
- of the increase in the amount of the business loan (for loan guarantee or debt protection business insurance purpose).

The increase in cover will take effect from the date we notify you in writing, which will be no later than 30 days from the date you satisfied our requirements.

Limitations

The increase benefit amount does not apply until we have confirmed it in writing and your premium will increase to reflect the increase in cover.

This option cannot be exercised if:

- you have exercised the Future Increase Benefit on this cover for the same business event
- you or anyone else has made, or is eligible to make a

claim in relation to the person insured for any benefit under this policy or any policy issued by us, (including a claim to waive premiums under the Disability Premium Waiver Option).

This option expires at the policy anniversary immediately after the person insured is age 60.

This option does not apply to Accidental Death Cover or Accidental TPD Cover.

Disability Premium Waiver Option

The Disability Premium Waiver Option applies when the words 'Disability Premium Waiver Option' appear under the 'Optional Extras' section of your Policy Certificate.

While the person insured is:

- *totally disabled* (as defined on page 30 of this policy document), and has been for a period longer than three consecutive months, or
- on claim under Income Protection Cover, Income Protection Plus Cover or Business Expense Cover,

we will waive the premiums for any Life Cover, TPD Cover and Trauma Cover (as applicable) up until the policy anniversary immediately after the person insured is age 65.

While the person insured is:

- *totally disabled* as a result of an *accident* where *total disability* occurs within 90 days of the *accident* (as defined on page 49 of this policy) and has been so disabled for a period longer than three consecutive months, or
- on claim under Accidental Income Protection Cover,

we will waive the premiums for any Accidental Death Cover or Accidental TPD Cover (as applicable) up until the policy anniversary immediately after the person insured is age 65.

If your policy includes Child Cover, we will also waive any premiums that become payable for the Child Cover while we are waiving premiums under this option.

Limitations

A waiver of premium under this option will not apply where the person insured's total disability is caused directly or indirectly by:

- any intentional self inflicted act
- war or act of war (whether declared or not), or
- for anything we have specifically excluded as shown on your Policy Certificate.

You cannot exercise this option:

- if there are any premiums owing on your policy. All outstanding premiums must be paid before we will waive the premium, or
- for premiums payable for Life Cover provided under the Life Cover Buy Back Benefit or the Life Cover Purchase Option or for premiums payable for Trauma Cover provided under the Trauma Cover Reinstatement Benefit.

The Indexation Benefit will not apply to covers for which the premiums are being waived.

You cannot increase your cover under the Future Increase Benefit or Business Guarantee Option (if applicable) where premiums are being waived.

This option expires at the policy anniversary immediately after the person insured is age 65.

Child Cover

Child Cover applies where the words 'Child Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Child Cover.

Child Cover is not available if cover is held inside superannuation.

Child Cover Benefit

The Child Cover benefit amount stated on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy) will be paid if the child insured:

- is diagnosed with or suffers one of the 'Trauma conditions' listed immediately below, and survives 14 days from
  - for an injury, the date the injury occurs
  - for an illness, the date a medical practitioner diagnoses the illness, and
  - for a treatment, the date the child insured undergoes the treatment
- is *terminally ill*, or
- dies.

Trauma conditions covered

Each of these trauma conditions has a specific meaning. Please refer to the 'Trauma Definitions' section starting on page 52. Those conditions marked with:

^ are subject to a 90 day qualifying period as explained immediately below on page 26.

* will only pay a partial trauma benefit amount as explained below on page 27.

Heart condition
*Heart Attack^*
*Out of Hospital Cardiac Arrest^*
*Coronary Artery By-pass Surgery^*
*Coronary Artery Angioplasty^**
*Coronary Artery Angioplasty – Triple Vessel^*
Repair and Replacement of a Heart Valve
Surgery of the Aorta
Cardiomyopathy
Open Heart Surgery
Primary Pulmonary Hypertension
Nervous system condition
*Stroke^*
Major Head Trauma
Multiple Sclerosis
Muscular Dystrophy
Paralysis
Coma
Encephalitis
Bacterial Meningitis and/or Meningococcal Septicaemia
Body organ condition
*Cancer^*
Benign Brain Tumour or Spinal Cord Tumour
Blindness
Chronic Kidney Failure
Major Organ or Bone Marrow Transplant
Pneumonectomy
Severe Burns
Loss of Speech
Loss of Hearing
Chronic Liver Disease
Chronic Lung Disease
Severe Rheumatoid Arthritis
Blood condition
Medically Acquired HIV
Aplastic Anaemia
Advanced Diabetes
Other condition
Intensive Care
Loss of Limbs or Sight
*Loss of One Limb**
Loss of Independent Existence
Cognitive Loss

90 day qualifying period

Unless we have agreed to waive the 90 day qualifying period, in respect of replacement cover, no benefit will be paid under this cover for any of the trauma conditions marked with a ^ if the condition first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the first 90 days immediately following:

- the date we received your fully completed application for Child Cover
- an increase in the Child Cover benefit amount (but only in respect of the increased amount and does not include an increase in cover as a result of the Indexation Benefit), and
- the date this cover is last reinstated.

Where we have agreed to replace an existing child cover policy on the life of the child insured which is issued by us or another insurer, the 90 day qualifying period will not apply if:

- the insurance under the policy to be replaced has been in place for at least 90 consecutive days immediately prior to the commencement of this cover
- the policy to be replaced provided similar cover for the same trauma conditions or events that are subject to a 90 day qualifying period under this cover

- the benefit amount under this cover being issued by us is the same or less than that under the policy that is being replaced*
- the policy to be replaced is cancelled immediately after the issue of this cover
- all similar exclusions have expired under the policy to be replaced (including exclusions which were applied to the policy after its commencement due to, for example, reinstatements or increases), and
- no claim is payable or pending under the policy to be replaced.

*Where the benefit amount under this cover exceeds that of the policy that is being replaced, the 90 day qualifying period will apply to the excess benefit amount.

Partial trauma benefit payment

The benefit amount payable for:

- *Coronary Artery Angioplasty*, and
- *Loss of One Limb*

is 25% of the Child Cover benefit amount subject to a maximum of $50,000 and a minimum of $10,000.

Any partial benefit paid will reduce the Child Cover benefit amount.

Where a partial benefit payment would reduce the remaining cover to below $10,000, we will pay the entire benefit amount and your Child Cover will cease.

You can only claim for each type of trauma condition once, except for *Coronary Artery Angioplasty*. You may make multiple claims for this trauma condition provided that each of the procedures is at least six months apart.

Accommodation Benefit

If we pay the Child Cover Benefit and under advice from a *medical practitioner*, the child insured is confined to bed as a result of the trauma condition or *terminal illness* for which we have paid the Child Cover Benefit and:

- an *immediate family member* is required to travel more than 100 kilometres from their place of residence to be with the child insured, or
- the child insured is more than 100 kilometres from their place of residence and requires an *immediate family member* to be with them,

we will reimburse you for the accommodation costs of the *immediate family member* of up to $250 per day, for each day the child insured remains confined to bed, for a maximum period of 30 days.

Limitations

This benefit must be claimed within 60 days of the Child Cover benefit being paid.

A copy of the invoice or receipt for the accommodation must be provided to us upon request.

This benefit will cease to apply on the death of the child insured.

Funeral Advancement Benefit

Upon the production of the child insured's death certificate, or any other satisfactory evidence to us of the child insured's death, we will advance the lesser of $25,000 and the Child Cover benefit amount.

The Child Cover benefit amount will be reduced by the amount paid under this benefit.

Payment of this benefit is not an admission of our liability to pay the Child Cover claim.

We reserve the right to recover the amount of the Funeral Advancement Benefit paid if the Child Cover claim is subsequently denied.

Continuation of Cover Benefit

If you or the adult person insured die or your policy ends because you have made a claim under your policy, the child's parent or guardian may continue the Child Cover on the child insured under a new policy without the need to provide further medical evidence in relation to the child insured.

Conversion of Child Cover Benefit

On the policy anniversary immediately after the child insured is age 21, we will give the child insured the option of converting the existing Child Cover to Life Cover, with the option to link or flexi link TPD and/or Trauma Cover, without having to reapply or supply further medical evidence.

The benefit amount may be up to the same amount of benefit that applied under Child Cover at the time it expired.

Any premium loadings, exclusions or varied terms that applied to the Child Cover will apply to the new Life Cover, Trauma Cover and/or TPD Cover.

The premium will be calculated based on the age of the child insured and the current premium rates at the time the new cover is issued.

This option must be exercised 60 days before the expiry of the Child Cover.

Additional benefits

The following benefits are also provided under Child Cover. The operation of these benefits are discussed in the policy document as indicated by the reference in the table below, except that references to 'person insured' in the relevant section is replaced by 'child insured', and reference in the table below, to 'Life Cover' is replaced with 'Child Cover' under the Grief Support Benefit, for the purpose of Child Cover.

Additional benefit	Reference
Indexation Benefit	21
Grief Support Benefit	7
Suspending Cover Benefit	22

Child Cover exclusions

We will not pay any benefit under Child Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We will not pay any benefit under Child Cover if the child insured's trauma condition giving rise to a claim or *terminal illness:*

- is caused directly or indirectly by an intentional self inflicted act or any attempt at suicide
- is the result of a malicious act of you, or the child insured's parent or guardian, or
- is excluded because of the 90 day qualifying period as explained on page 26.

We will not pay any benefit under Child Cover when the child insured commits suicide within 13 months of:

- the cover start date
- an increase in the benefit amount (but only in respect of the increased amount and does not include an increase in cover as a result of the Indexation Benefit), or
- the date cover is last reinstated.

When Child Cover ends

Child Cover for the child insured will end on the earlier of the:

- death of the child insured
- date on which all entitlements under the cover are paid
- policy anniversary immediately after the child insured is age 21, or
- the date on which the policy ends (subject to the Continuation of Cover benefit being exercised).

Income Protection Cover and Income Protection Plus Cover

Income Protection Cover applies if the words 'Income Protection Cover' appear in the 'Benefit Type' section of your Policy Certificate and you pay the premium for Income Protection Cover.

Income Protection Plus Cover applies if the words 'Income Protection Cover Plus' appear in the 'Benefit Type' section of your Policy Certificate and you pay the premium for Income Protection Plus Cover.

Benefit payment types

Indemnity benefit type

If the words 'Indemnity Benefit Type' appear on your Policy Certificate, the monthly benefit amount payable is the lesser of:

- 75% of the person insured's *pre-disability earnings* less *offsets*, and
- the monthly benefit amount insured for, as shown on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

Agreed value benefit type

If the words 'Agreed Value Benefit Type' appear on your Policy Certificate, the monthly benefit amount payable is the amount insured for, as shown on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy), regardless of any reduction in the person insured's income that may have occurred since the cover start date.

If financial evidence of the person insured's income supporting the monthly benefit amount was not provided at the time of application, then it may be required at the time of claim.

If you cannot satisfy this requirement, the monthly benefit amount will be the lesser of:

- 75% of the person insured's *pre-disability earnings* less *offsets*, and
- the monthly benefit amount insured, as shown on your Policy Certificate (including any increases or decreases that have been made under the terms of the cover).

Guaranteed agreed value benefit type

If the words 'Guaranteed Agreed Value Benefit Type' appear on your Policy Certificate, the monthly benefit amount if payable is the amount insured for, as shown on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy), regardless of any reduction in the person insured's income that may have occurred since the policy start date.

If you make a claim for a Partial Disability Benefit, financial evidence of your income at the time of claim will be required to determine the monthly benefit amount payable in that circumstance.

Waiting period

The waiting period is shown on your Policy Certificate.

The waiting period is the minimum period of time the person insured must be *totally disabled* or *partially disabled* as a result of the same *sickness* or *injury* before you are eligible to claim a *disability* benefit.

If the words 'Income Protection Cover' appear in the 'Benefit Type' section of your Policy Certificate, the person insured must be *totally disabled* for 14 days out of the first 19 consecutive days of the waiting period and *disabled* for the remainder of the waiting period, subject to the return to work rules outlined below.

If the words 'Income Protection Plus Cover' appear in the 'Benefit Type' section of your Policy Certificate, the person insured must be *totally disabled* or *partially disabled* throughout the waiting period , subject to the return to work rules outlined below.

Working during the waiting period (return to work rules)

If you have a 14 or 30 day waiting period, the person insured can return to work at full capacity for up to five consecutive days during the waiting period without having to start the waiting period again. If your waiting period is more than 30 days, the person insured can return to work at full capacity for up to ten consecutive days. The days the person insured works will be added to the end of the waiting period.

The waiting period starts on the earlier of the following:

- when the person insured first consults a *medical practitioner* about the *sickness* or *injury* that is causing their *disability* and they are certified as *totally disabled* or *partially disabled* (as applicable), or
- when the person insured first stops working due to that *sickness* or *injury* (as long as they consult a *medical practitioner* within seven days and provide reasonable medical evidence about when the condition began).

Waiver of the waiting period for specific medical conditions

If the person insured is *totally disabled* as a result of suffering:

- *Cardiomyopathy*
- *Primary Pulmonary Hypertension*
- *Motor Neurone Disease*
- *Multiple Sclerosis*
- *Muscular Dystrophy*
- *Parkinson's Disease*
- *Dementia including Alzheimer's Disease*
- *Paralysis*
- *Loss of Independent Existence*
- *Loss of Speech*
- *Loss of Hearing*
- *Chronic Lung Disease*
- *Severe Rheumatoid Arthritis*

and is unlikely to ever engage in their full time occupation they were engaged in prior to disability, we will waive the waiting period.

Flexibility to Reduce Two Year Waiting Period

If you have selected a two year waiting period with a benefit period to age 60, age 65 or age 70 to complement an existing group superannuation income protection policy which provides a two year benefit period, we will allow you to reduce the waiting period, in the event that the group income protection cover over the person insured ceases, without the need to supply further medical evidence for the person insured.

You may apply to reduce the waiting period from 2 years to: 90 or 180 days or 1 year.

To reduce the waiting period under this benefit, you must apply in writing within 30 days of the group income protection cover ceasing and provide evidence that the group cover is no longer in force. The reduced waiting period and new increased premium will take effect from your next premium due date after we accept your change of the waiting period.

Limitations

This benefit is not available if the person insured is on claim or eligible to make a claim under the group superannuation income protection policy.

Benefit period

The benefit period is shown on your Policy Certificate.

The benefit period is the maximum amount of time we will pay the monthly benefit amount for in respect of any one continuous period of *disability*.

Subject to the rules on relapse of *sickness* or *injury* (set out under Relapse Benefit on page 31, a new benefit period will start at the end of each waiting period.

Total Disability Benefit

If the person insured is *totally disabled*, we will pay the monthly benefit amount.

Payment will begin to accrue from the first day after the end of the waiting period and will continue for as long as the person insured is *totally disabled*, to the end of the benefit period or the expiry of the policy, whichever occurs first.

We pay the Total Disability Benefit monthly in arrears.

If the person insured is *totally disabled* for part of the month, we will pay 1/30th of the monthly benefit amount for each day they are *totally disabled*.

Total disability

Total disability means:

Solely because of *sickness* or *injury*, the person insured is:

- unable to perform one or more *important income producing duties* of their *regular occupation*
- under the regular care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*, and
- not working.

OR

Solely because of *sickness* or *injury*, the person insured is:

- not working for more than ten hours* per week in their *regular occupation* and not working in any other *gainful employment*
- unable to perform the *important income producing duties* of their *regular occupation* for more than ten* hours per week, and
- under the regular care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*.

OR

Solely because of *sickness* or *injury*, the person insured is:

- working in their *regular occupation* or any other *gainful employment* but is unable to generate more than 20% of their *pre-disability earnings*, and
- under the regular care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*.

* If the person insured was working less than 20 hours per week in their *regular occupation* in the 12 consecutive months immediately prior to the cover start date and immediately prior to a *disability*, we will replace ten hours with five hours for the purposes of determining whether the person insured is *totally disabled*.

Partial Disability Benefit

If the person insured is *partially disabled*, we will pay you a proportion of the monthly benefit amount.

Payment will begin to accrue from the first day after the end of the waiting period and will continue for as long as the person insured is *partially disabled*, to the end of the benefit period or the expiry of the policy, whichever occurs first.

The Partial Disability Benefit amount we will pay is calculated as follows:

$$\text{monthly benefit amount} \times \frac{(A - B)}{A}$$

Where:

- A = person insured's *pre-disability earnings*, and
- B = person insured's *monthly earnings* for the month in which he or she is *partially disabled* and a partial disability benefit is claimed.

We pay the Partial Disability Benefit monthly in arrears. If the person insured is *partially disabled* for part of the month, we will pay 1/30th of the monthly partial disability benefit amount for each day they are *partially disabled*.

Partial disability

Partial disability means:

Solely because of *sickness* or *injury*, the person insured is unable to work in their *regular occupation* or any other *gainful employment* at full capacity and:

- they are working in their *regular occupation* in a reduced capacity, or any other *gainful employment*
- they are not *totally disabled*
- their *monthly earnings* are less than their *pre-disability earnings*, and
- they are under the care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*.

Relapse Benefit

Benefit period to age 60, 65 or 70

Where your policy has a benefit period to age 60, 65 or 70, if the person insured has returned to work on a full time basis after receiving a Total or Partial Disability Benefit and they suffer a relapse of the same or a related *sickness* or *injury* within 12 months of the previous claim ending, we will waive the waiting period and treat the relapse as a continuation of the original claim.

If the relapse occurs more than 12 months after the date we last paid a Total or Partial Disability Benefit, we will treat this as a new claim which means the waiting period will start again.

Benefit period of 1, 2 or 5 years

Where your policy has a benefit period of 1, 2 or 5 years, if the person insured has returned to work on a full time basis after receiving a Total or Partial Disability Benefit and they suffer a relapse of the same or a related *sickness* or *injury* within six months of the previous claim ending, we will waive the waiting period and treat the relapse as a continuation of the original claim.

If the relapse occurs more than six months after the date we last paid a Total or Partial Disability Benefit, we will treat this as a new claim which means the waiting period will start again.

Accommodation Benefit

If the person insured is *totally disabled* and under advice from a *medical practitioner* is confined continuously to bed and:

- an *immediate family member* is required to travel more than 100 kilometres from their place of residence to be with the person insured, or
- the person insured is more than 100 kilometres from their place of residence and requires an *immediate family member* to be with them,

we will reimburse you for the accommodation costs of the *immediate family member* of up to $250 per day, for each day the person insured remains confined to bed, for a maximum period of 30 days in any 12 month period.

This benefit is payable during the waiting period and in addition to any other benefit that becomes payable for *total disability*.

Limitations

This benefit is payable once in any 12 month period.

This benefit will cease to apply on the death of the person insured.

This benefit is not available if cover is held inside superannuation.

Medical Professionals Benefit

This benefit will apply if the person insured is classified by us as a *medical professional* at the time of application and immediately prior to claiming this benefit.

If the person insured suffers *Occupationally Acquired HIV* or *Occupationally Acquired Hepatitis B or C* and they:

- cease to perform or assist in exposure prone medical procedures as a result of their condition, and
- cease this part of their practice in compliance with their demonstrable professional obligations to the public and the demonstrable policies of the body that authorises them to practise their profession,

we will pay you a lump sum benefit amount once, which is the lesser of:

- 50 times the total *monthly benefit amount*, and
- $1,000,000.

Please refer to the 'Trauma Definitions' section starting on page 52 for the definition of *Occupationally Acquired HIV* and *Occupationally Acquired Hepatitis B or C*.

Any *accident* giving rise to a potential claim must be reported to us within 30 days of the *accident*, supported by a negative HIV, Hepatitis B or Hepatitis C test (as applicable) taken within seven days after the *accident*. We require access to all blood samples taken in order to facilitate independent testing, with the right to take additional samples as necessary.

Limitations

The benefit will not be payable if:

- the HIV, Hepatitis B or Hepatitis C virus is caused by any other means, including sexual activity or recreational intravenous drug use
- in practicing their medical profession, the person insured has not made reasonable efforts to comply with relevant State and Commonwealth guidelines in relation to dealing with infection of health care workers
- the Australian Government or relevant government body has approved a medical treatment which renders the Hepatitis B or Hepatitis C virus (as applicable) inactive and non-infectious to others
- a medical cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any Australian government approved treatment, which renders HIV inactive and non-infectious, or
- the person insured has not taken an approved vaccine that is recommended by the relevant government body for use in their occupation and is available prior to the accident which causes infection.

This benefit is not available if cover is held inside superannuation.

Rehabilitation Benefit

If we are paying a Total Disability Benefit or Partial Disability Benefit under this policy and the person insured participates in a rehabilitation program approved by us and/or incurs costs for equipment that we agree are needed for the person insured's rehabilitation, we will pay the Rehabilitation Benefit.

The maximum amount payable under this benefit over the life of the policy is 12 times the monthly benefit amount.

This benefit is payable in addition to any other benefit payable under this policy and is payable monthly in arrears.

Limitations

We must agree in writing before the person insured commences the rehabilitation program or purchases any equipment and we will not approve any expense that the person insured is entitled to have reimbursed by another source.

This benefit is not payable during the waiting period.

This benefit is not available if cover is held inside superannuation.

Waiver of Premium While on Claim Benefit

We will waive the premium (including the policy fee) payable for this cover in respect of the period while we are paying a *disability* benefit.

If we pay a disability benefit, we will refund any premiums (including the policy fee) in respect of the waiting period. For example, if you have paid an annual premium, we will refund a portion of the annual premium that relates to the waiting period and any subsequent period of *disability*.

Waiver of Premium While on Maternity Leave Benefit

If the person insured goes on maternity leave, after this cover has been in place for a continuous period of at least six consecutive months we will waive the premium for up to three months, while the person insured is on maternity leave.

For example, if you have paid an annual premium, we will refund a portion of the annual premium that relates to the period of maternity leave as described under this benefit.

Limitations

You must notify us in writing at least 30 days prior to the person insured commencing maternity leave and you must provide us with any information we have requested in relation to the person insured's maternity leave. Such information may include, but is not limited to a statement from the person insured's employer and *medical practitioner*.

We will waive premiums under this benefit for separate periods of maternity leave but we will only waive the premiums for a maximum of three months in total over the life of the policy.

Future Increase Benefit

If the person insured's income increases, this benefit allows you to increase the insured monthly benefit amount by up to 15%, without having to provide further medical evidence in relation to the person insured.

You may increase the insured monthly benefit amount on each policy anniversary, up until the policy anniversary immediately after the person insured turns age 55.

The increase allowed is the lesser of:

- 15% of the insured monthly benefit amount, and
- the actual increase in the person insured's monthly income.

This increase is in addition to any increase in cover under the Indexation Benefit.

Limitations

Any increase is subject to you providing financial evidence to support the increase and confirmation that the person insured is actively at work at the time of the increase. The total of all increases in the insured monthly benefit amount cannot exceed the original insured monthly benefit amount at the cover start date.

This benefit cannot be exercised if:

- a claim is being paid under this cover, a claim is being assessed or you are eligible to make a claim in relation to the person insured under this policy or another policy relating to the person insured, or
- cover was issued with a medical premium loading of greater than 100%.

Death Benefit

If the person insured dies while Income Protection Cover or Income Protection Plus Cover is in place, we will pay a lump sum benefit equal to six times the monthly benefit amount, subject to a maximum of $60,000 (across all ClearView income protection and business expense policies which cover the person insured). The person insured does not have to be claiming a *disability* benefit at the time of their death, to receive this benefit.

Extended Cover Benefit

The Extended Cover Benefit applies where the occupational category of the person insured is AAA, AA, A, AM or AL as shown on your Policy Certificate and the cover expiry date is age 65, as shown on your Policy Certificate.

If immediately prior to the cover expiry date the person insured is still working, we will offer to extend your cover beyond the policy expiry date, on modified terms.

Extended cover will be based on the following conditions, irrespective of what is shown on your Policy Certificate:

- the waiting period will be the greater of 30 days and the waiting period shown on your Policy Certificate
- the benefit period will be 1 year
- benefits will only be payable for *total disability*
- any Increasing Claim Option, Extras Package Option, Superannuation Contribution Option, Accident Option and TPD Lump Sum Option you have will cease to apply
- any benefit payable will be determined on an indemnity benefit type basis, and
- the maximum monthly benefit amount we will pay is $30,000.

Cover can continue under the extended cover modified basis until the earlier of:

- the policy anniversary immediately after the person insured is age 70, and
- when the person insured is no longer working in a gainful occupation of at least 20 hours per week for six consecutive months.

Limitations

This benefit is not available if:

- the original cover was issued with a medical premium loading or varied terms, or
- the person insured was on claim or eligible to make a claim during the 12 months prior to the cover expiry age as shown on the Policy Certificate.

Additional benefits

The following benefits are also provided under Income Protection Cover and Income Protection Plus Cover. The operation of these benefits is discussed in the policy document as indicated by the reference in the table below.

Additional benefit	Reference
Indexation Benefit	45
Suspending Cover Benefit	45

Optional extras

The following options may apply to your Income Protection Cover or Income Protection Plus Cover where you have selected one or more of these, pay the additional premiums and they are indicated on your Policy Certificate.

Increasing Claim Option

The Increasing Claim Option applies when the words 'Increasing Claim Option' appear under the 'Optional Extras' section of your Policy Certificate.

If we have paid a Total Disability Benefit or a Partial Disability Benefit for 12 months or more, we will increase the monthly benefit amount by the rate of the *Consumer Price Index (CPI)* on each yearly anniversary from when benefits first become payable for as long as we continue to pay a benefit.

When we stop paying the Total Disability Benefit or Partial Disability Benefit, we will increase your insured monthly benefit amount to be equal to the indexed monthly benefit amount applying immediately prior to the end of the Total Disability or Partial Disability claim.

Superannuation Contribution Option

The Superannuation Contribution Option applies when the words 'Superannuation Contribution Option' appear under the 'Optional Extras' section of your Policy Certificate.

Any time we pay a Total Disability Benefit or a Partial Disability Benefit, we will pay the superannuation contribution benefit or a proportion of that benefit (in the case of a Partial Disability Benefit, using the same proportion as applies for the Partial Disability Benefit) directly to the person insured's nominated complying superannuation fund.

The amount we pay to the person insured's superannuation fund is paid on their behalf as a personal contribution and subject to the standard superannuation rules relating to contributions, taxation and preservation.

The amount we pay is the lesser of the superannuation contributions insured for at the time of application and the actual average monthly superannuation contributions made by the person insured or their employer in the 12 months immediately prior to any claim.

If the Increasing Claim Option applies, we will also increase the superannuation contribution benefit.

Limitations

No benefit will be payable under this benefit if you have not nominated a complying superannuation fund and provided us with all necessary information in order for us to make the contribution on your behalf.

Accident Option

The Accident Option applies when the words 'Accident Option' appear under the 'Optional Extras' section of your Policy Certificate.

If the person insured is *totally disabled* as a result of an *accident* for a period of at least three consecutive days, we will pay 1/30th of the monthly benefit amount for each day the person insured is *totally disabled* during the waiting period.

This benefit will accrue from the first day that the person insured is *totally disabled* and will continue until the earlier of:

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

This benefit is not available if we are paying the Bed Confinement Benefit, Specific Injuries Benefit or Trauma Benefit under the Extras Package Option for the same period of *disability*.

Extras Package Option

The Extras Package Option applies when the words 'Extras Package Option' appear under the 'Optional Extras' section of your Policy Certificate.

This optional package of additional benefits includes:

- Specific Injuries Benefit
- Trauma Benefit
- Bed Confinement Benefit
- Overseas Assist Benefit
- Family Support Benefit
- Home Care Benefit

The Extras Package Option is not available if cover is held inside superannuation.

Specific Injuries Benefit

This benefit applies under Extras Package Option.

If the person insured suffers any of the specific injuries listed in the table below before the cover expiry, we will pay the monthly benefit amount for the period indicated regardless of whether or not the person insured is working. There is no waiting period.

You can choose to receive this benefit as either:

- a lump sum benefit, calculated by multiplying the monthly benefit amount by the specified payment period, or
- a monthly benefit amount payable monthly in advance for the specified number of months.

If the person insured is *disabled* as a result of the specific injury at the end of the payment period they may be assessed for a disability benefit (provided all other relevant conditions are met) and the Specific Injuries Benefit payment period may count towards the waiting period.

Specific injury	Payment period (months)
Total and permanent loss of use of:	
Both feet, both hands or sight in both eyes	24
Any combination of two of: A hand A foot Sight in one eye	24
One arm or one leg	18
One hand, one foot or sight in one eye	12
Thumb and index finger on the same hand at or above the first joint	6
Fracture requiring the application of a plaster, pin or other immobilising device of the following bones:	
Spine, resulting in *paralysis*	60*
Spine, not resulting in *paralysis*	3
Thigh	3

Pelvis	3
Skull (excluding bones of face or nose)	2
Upper arm	2
Shoulder bone	2
Jaw	2
Leg (excluding ankle)	2
Knee cap	2
Forearm (including the wrist)	1
Collarbone	1
Ankle	1

*If a 2 year benefit period applies, the payment period is reduced to 24 months.

Limitations

If the person insured suffers more than one specific injury at the same time or one of the specific medical conditions under the Trauma Benefit, we will pay for the one specific injury that has the longest payment period.

This benefit will be paid instead of the Total Disability Benefit, Partial Disability Benefit, Bed Confinement Benefit or any benefit payable under the Accident Option.

Trauma Benefit

This benefit applies under Extras Package Option.

If the person insured suffers any one of the specific medical conditions listed in the table below before the cover expiry date, we will pay a lump sum benefit equal to six times the monthly benefit amount, regardless of whether or not the person insured is working. There is no waiting period.

If at the end of the six month period, the person insured is *disabled* as a result of the same specific medical condition, they may be assessed for a *disability* benefit, subject to all terms of the policy being met and the payment period may count towards the waiting period.

Specific medical condition
Heart condition
*Heart Attack^*
*Out of Hospital Cardiac Arrest^*
*Coronary Artery By-pass Surgery^*
*Coronary Artery Angioplasty – Triple Vessel^*
Repair or Replacement of a Heart Valve
Surgery of the Aorta
Cardiomyopathy
Open Heart Surgery
Primary Pulmonary Hypertension
Nervous system condition
*Stroke^*
Major Head Trauma
Motor Neurone Disease
Multiple Sclerosis
Muscular Dystrophy
Dementia including Alzheimer's Disease
Parkinson's Disease
Paralysis
Coma
Encephalitis
Body organ condition
*Cancer^*
*Cancer of the Vulva or Perineum^*
Benign Brain Tumour or Spinal Cord Tumour
Blindness
Chronic Kidney Failure
Major Organ or Bone Marrow Transplant
Severe Burns
Loss of Speech
Loss of Hearing
Chronic Liver Disease
Chronic Lung Disease
Severe Rheumatoid Arthritis
Pneumonectomy
Blood condition
Occupationally Acquired HIV
Medically Acquired HIV
Aplastic Anaemia
Advanced Diabetes
Other condition
Intensive Care
Loss of Limbs or Sight
Loss of Independent Existence
Cognitive Loss

Limitations

No Trauma Benefit will be paid for any of the specific medical conditions marked with an ^, if the specific medical condition first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the 90 day qualifying period (as explained in on page 16 of this policy document).

This benefit will be paid instead of any Total Disability Benefit, Partial Disability Benefit, Bed Confinement Benefit or any benefit payable under the Accident Option.

You can only claim a Trauma Benefit once in any 12 month period. You cannot claim a Specific Injuries Benefit at the same time as a Trauma Benefit (you will only be paid for the one with the longest payment period). For this purpose the Trauma Benefit will be considered a six month benefit payment.

Bed Confinement Benefit

This benefit applies under Extras Package Option.

If the person insured is *totally disabled* and under advice from a *medical practitioner* is confined continuously to bed for at least three consecutive days during the waiting period and a *medical practitioner* certifies that the continuous care of a registered nurse is required, they will qualify for this benefit. We will pay you 1/30th of the monthly benefit amount for each day the person insured continues to qualify for this benefit. This benefit is payable for a maximum of 90 days or until the end of the waiting period, whichever occurs first.

This benefit is not available if we are paying a Specific Injuries Benefit or Trauma Benefit.

Overseas Assist Benefit

This benefit applies under Extras Package Option.

If the person insured is *totally disabled* for at least one month while outside Australia and returns to Australia because of continuing *total disability*, we will reimburse the cost of a return economy airfare to Australia by the most direct route, including connecting flights, less any amounts that are reimbursed for the person insured from another source.

The maximum amount payable is three times the monthly benefit amount.

Family Support Benefit

This benefit applies under Extras Package Option.

If, due to *total disability*, the person insured is totally dependent on an *immediate family member* for essential everyday home care needs to enable the person insured to live at home (excluding nursing or similar services), and this causes a reduction in the income of the *immediate family member*, we will pay a benefit to you to subsidise his or her income.

We will pay the lesser of:

- the reduction in the income of the *immediate family member*, or
- 50% of the monthly benefit amount.

This benefit is payable monthly in arrears for up to three months.

This benefit is only payable while we are paying a Total Disability Benefit.

Home Care Benefit

This benefit applies under Extras Package Option.

If the person insured is *totally disabled* after the waiting period, and under advice from a *medical practitioner* is confined continuously to or near a bed (other than in a hospital or similar institution) and is totally dependent upon a paid professional housekeeper for essential everyday home care needs (excluding nursing and similar services), we will pay the lesser of:

- $150 a day, or
- 1/30th of the monthly benefit amount per day

for up to six months to help cover the cost provided the person insured continues to qualify for the benefit.

This benefit is not available if we are paying the Family Support Benefit or Accommodation Benefit.

Total and Permanent Disability (TPD) Lump Sum Option

The Total and Permanent Disability (TPD) Lump Sum Option applies when the words 'Total and Permanent Disability (TPD) Lump Sum Option' appear under the 'Optional Extras' section of your Policy Certificate.

If the person insured is *totally and permanently disabled* and meets the 'Own occupation TPD' definition as defined on page 10 of this policy document, we will offer you a choice of receiving a lump sum benefit amount under Income Protection Cover or Income Protection Plus Cover, in lieu of the regular monthly benefit amount. If we pay the lump sum benefit amount, no other disability benefits under 'to age 65' or 'to age 70' benefit period (as applicable) will be payable and your Income Protection Cover and Income Protection Plus Cover will end (subject to any other benefit period amounts being payable).

The lump sum benefit amount we pay is calculated as the lesser of:

- $5,000,000, and
- an amount equal to 'A' times the annualised monthly benefit, where:
  - the annualised monthly benefit amount is 12 times the total of your monthly benefit amount and any superannuation contribution benefit less any benefit reductions which would have applied to the monthly benefit amount had you not chosen to

receive a lump sum benefit amount, and

- 'A' is determined as:

Age*	Multiples to age 65 benefit period	Multiples to age 70 benefit period
39 or less	15	16
40 to 43	13	14
44 to 48	11	12
49 to 54	9	11
55 to 59	65 minus age next birthday	9
60 to 64	65 minus age next birthday	70 minus age next birthday
65 to 69	n/a	70 minus age next birthday

*Age refers to the age of the person insured at the time the lump sum benefit amount becomes payable, not when the request for the lump sum benefit amount is received.

Limitations

You cannot choose to receive a lump sum benefit if the person insured is *terminally ill*. This option cannot be cancelled.

When your monthly benefit amount may be reduced

The monthly benefit amount may be reduced if you or the person insured receive 'other payments' for disability which exceeds 10% of the person insured's *pre-disability earnings*. These 'other payments' will determine the amount of the *offset*. What is considered to be 'other payments' will depend on the type of cover.

If the words 'Income Protection Cover' appear under the 'Benefit Type' section of your Policy Certificate, then 'other payments' mean:

- any payment received as a result of a worker's compensation or motor accident claim, or any claim under similar state or federal legislation
- payments received from any other disability insurance that provides income payments due to *sickness* or *injury*, unless we have expressly agreed not to apply a reduction, and
- payments received from any social security benefits.

If the words 'Income Protection Cover Plus' appear under the 'Benefit Type' section of your Policy Certificate then 'other payments' mean:

- payments received from any other disability insurance that provides income payments due to *sickness* or *injury*, unless we have expressly agreed not to apply a reduction.

Any lump sum payment received will, for the purpose of the reduction, be treated as a series of 60 monthly payments with each monthly payment equal to 1/60th of the lump sum payment. We will only reduce the monthly benefit amount to ensure that, when combined with 'other payments' (and monthly earnings if the person insured is *partially disabled*) you do not receive more than:

- 75% of the person insured's *pre-disability earnings* or monthly benefit amount when the person insured is *totally disabled*, or
- 100% of the person insured's *pre-disability earnings* when the person insured is *partially disabled*.

We will not reduce the monthly benefit amount if you receive a payment for:

- work attributable to the person insured working ten hours (or five hours, if applicable) or less per week as described under the definition for *total disability*
- work attributable to the person insured working where earnings are less than 20% of *pre-disability earnings* as described under the 'income definition' for *total disability*
- a lump sum compensation payment for pain or suffering or loss of use of part of the body
- a lump sum trauma benefit or total and permanent disablement benefit paid under an insurance policy, or
- sick, long service or annual leave payments.

More than one benefit payable

Other than as specifically stated in this policy, if you are concurrently eligible for more than one benefit under Income Protection Cover or Income Protection Plus Cover, we will only pay one benefit and this will be the one which provides the highest payment.

Income Protection Cover exclusions

We will not pay a benefit under 'Income Protection Cover' or 'Income Protection Plus Cover' if the person insured's *disability* or death is caused directly or indirectly by:

- an intentional self inflicted act, suicide or any attempted suicide
- war or act of war (whether declared or not)
- normal or uncomplicated pregnancy or childbirth, or
- elective surgery or treatment which the person insured voluntarily undergoes within the first six months of:
  - the commencement of cover
  - an increase in the insured monthly benefit amount (but only in respect of the increased amount and does not include an increase in cover as a result of the Indexation Benefit), or
  - the date the cover is last reinstated.

If the person insured's condition is directly or indirectly related to pregnancy, childbirth or miscarriage complications (including post natal depression) a three month qualifying period applies. This means that if the person insured has been *totally disabled* for three months as a result of pregnancy, benefits will begin to accrue at

the end of this three month period or at the end of the waiting period, which ever is greater.

We will not pay any benefit under Income Protection Cover or Income Protection Plus Cover if the person insured's *disability* or death is caused directly or indirectly by anything we have specifically excluded, as shown on your Policy Certificate.

We cannot pay a benefit which we are not permitted by law to pay or reimburse any expenses which are regulated by the National Health Act 1953 or the Private Health Insurance Act 2007.

When Income Protection Cover or Income Protection Plus Cover ends

Income Protection Cover and Income Protection Plus Cover will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid
- the stated expiry date in the Policy Certificate (and not after the person insured is aged 70), or
- the date on which the policy ends.

Accidental Income Protection Cover

Accidental Income Protection Cover applies where the words 'Accidental Income Protection Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Accidental Income Protection Cover.

Accidental Income Protection benefit

If the person insured is *disabled* as a result of an *accident* for longer than the waiting period, we will pay you an ongoing monthly benefit amount for as long as the person insured is *disabled* or until the expiry of the benefit period, which ever comes first. The person insured's *disability* must occur within 90 days of the *accident*.

The definition of:

- *Total Disability* is as set out on page 30 of this policy document, and
- *Partial Disability* is as set out on page 31 of this policy document,

except that benefits payable under Accidental Income Protection Cover only relate to *disability* as a result of an *accident* (i.e. the person insured can only satisfy the relevant definition if their *disability* is caused by *injury*. The *sickness* element of the relevant definition is not applicable for Accidental Income Protection Cover).

The information in the sections referred to in the table below apply to Accidental Income Protection Cover, noting that a modified definition of *Total Disability* and *Partial Disability* apply.

Features under Income Protection Cover and Income Protection Plus Cover that apply to Accidental Income Protection Cover	Reference
Benefit payment types	29
Benefit period	30
Total Disability Benefit	30
Partial Disability Benefit	31

Waiting period

The waiting period is shown on your Policy Certificate.

The waiting period is the minimum period of time the person insured must be *totally disabled* or *partially disabled* as a result of the same *injury* before you are eligible to claim a *disability* benefit.

The person insured must be *totally disabled* for 14 days out of the first 19 consecutive days of the waiting period and *disabled* for the remainder of the waiting period, subject to the return to work rules outlined below.

Working during the waiting period (return to work rules)

If you have a 14 or 30 day waiting period, the person insured can return to work at full capacity for up to five consecutive days during the waiting period without having to start the waiting period again.

If your waiting period is more than 30 days, the person insured can return to work at full capacity for up to ten consecutive days.

The days the person insured works will be added to the end of the waiting period.

The waiting period starts on the earlier of the following:

- when the person insured first consults a *medical practitioner* about the *injury* that is causing their *disability* and they are certified as *totally disabled* or *partially disabled*, or
- when the person insured first stops working due to that *injury* (as long as they consult a *medical practitioner* within seven days and provide reasonable medical evidence about when the condition began).

Relapse Benefit

Benefit period to age 60, 65 or 70

If the person insured has returned to work on a full time basis after receiving a Total or Partial Disability Benefit and they suffer a relapse of the same or a related *injury* within 12 months of the previous claim ending, we will waive the waiting period and treat the relapse as a continuation of the original claim.

If the relapse occurs more than 12 months after the date we last paid a Total or Partial Disability Benefit, we will treat this as a new claim which means the waiting period will start again.

Benefit period of 1, 2 or 5 years

If the person insured has returned to work on a full time basis after receiving a Total or Partial Disability Benefit and they suffer a relapse of the same or a related *injury* within six months of the previous claim ending, we will waive the waiting period and treat the relapse as a continuation of the original claim.

If the relapse occurs more than six months after the date we last paid a Total or Partial Disability Benefit, we will treat this as a new claim which means the waiting period will start again.

Death Benefit

If the person insured dies as a result of an *accident* while this cover is in place and death occurs within 90 days of the *accident*, we will pay a lump sum benefit equal to six times the monthly benefit amount, subject to a maximum of $60,000 (across all ClearView income protection and business expense policies which cover the person insured). The person insured does not have to be claiming a *disability* benefit at the time of their death, to receive this benefit.

Additional built in benefits and optional extras

The additional built in benefits provided and optional extras are as described elsewhere in this policy document (see sections as indicated below), except that the additional built in benefits provided and optional extras payable under Accidental Income Protection Cover only relate to *disability* as a result of an *accident* (ie the person insured can only satisfy the relevant definition if their *disability* is caused by *injury*. The *sickness* element of the relevant definition is not applicable for Accidental Income Protection Cover) and the *disability* must occur within 90 days of the *accident*.

The optional extras may apply to your Accidental Income Protection Cover where you have selected one or more of these pay the additional premiums and they are indicated on your Policy Certificate.

Built in benefit	Reference
Flexibility to Reduce a Two Year Waiting Period Benefit	30
Indexation Benefit	45
Accommodation Benefit	31
Rehabilitation Benefit	32
Waiver of Premium While on Claim Benefit	32
Waiver of Premium While on Maternity Leave Benefit	32
Suspending Cover Benefit	45
Extended Cover Benefit	33
Medical Professionals Benefit	31
Optional extra	**Reference**
Increasing Claim Option	33
Accident Option	34
Superannuation Contribution Option	34
Extras Package Option	34

TPD Lump Sum Option

The Total and Permanent Disability (TPD) Lump Sum Option applies when the words 'Total and Permanent Disability (TPD) Lump Sum Option' appear under the 'Optional Extras' section of your Policy Certificate.

This option operates as set out on page 36 of this policy document, except that benefits payable under Accidental Income Protection Cover only relate to *disability* and *total and permanent disability* as a result of an *accident* (i.e. the person insured can only satisfy the relevant definition if their *disability* is caused by *injury*. The *sickness* element of the relevant definition is not applicable for Accidental Income Protection Cover).

When your monthly benefit amount may be reduced

The monthly benefit amount may be reduced if you or the person insured receive 'other payments' for disability which exceeds 10% of the person insured's *pre-disability earnings*. These 'other payments' will determine the amount of the *offset*.

'Other payments' mean:

- any payment received as a result of a worker's compensation or motor accident claim, or any claim under similar state or federal legislation
- payments received from any other disability insurance that provides income payments due to *sickness* or *injury*, unless we have expressly agreed not to apply a reduction, and
- payments received from any social security benefits.

Any lump sum payment received will, for the purpose of the reduction, be treated as a series of 60 monthly payments with each monthly payment equal to 1/60th of the lump sum payment.

We will only reduce the monthly benefit amount to ensure that, when combined with 'other payments' (and *monthly earnings* if the person insured is *partially disabled*) you do not receive more than:

- 75% of the person insured's *pre-disability earnings* or monthly benefit amount when the person insured is *totally disabled*, or
- 100% of the person insured's *pre-disability earnings* when the person insured is *partially disabled*.

We will not reduce the monthly benefit amount if you receive a payment for:

- work attributable to the person insured working ten hours (or five hours, if applicable) or less per week as described under the definition for *total disability*
- work attributable to the person insured working where earnings are less than 20% of *pre-disability earnings* as described under the 'income definition' for *total disability*
- a lump sum compensation payment for pain or suffering or loss of use of part of the body
- a lump sum trauma benefit or total and permanent disablement benefit paid under an insurance policy, or
- sick, long service or annual leave payments.

Accidental Income Protection Cover exclusions

We will not pay any benefit under Accidental Income Protection Cover if the person insured's *disability, injury* (or death) is caused directly or indirectly by:

- attempted suicide or any intentional self-inflicted act
- war or act of war (whether declared or not)
- the person insured's participation in criminal activity, or
- the person insured taking alcohol or drugs, other than a drug prescribed by a medical practitioner and taken as directed.

We will not pay any benefit under Accidental Income Protection Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We cannot pay a benefit which we are not permitted by law to pay or reimburse any expenses which are regulated by the National Health Act 1953 or the Private Health Insurance Act 2007.

When Accidental Income Protection Cover ends

Accidental Income Protection Cover will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid
- the stated expiry date in the Policy Certificate (and not after the person insured is aged 70), or
- the date on which the policy ends.

Business Expense Cover

Business Expense Cover applies where the words 'Business Expense Cover' appear under the 'Benefit Type' section of your Policy Certificate and you pay the premium for Business Expense Cover.

Business Expense Benefit

If the person insured is *disabled* for longer than the waiting period, we will pay you a monthly benefit amount for as long as the person insured is *disabled* or until the expiry of the benefit period, which ever comes first.

Indemnity benefit type

The monthly benefit amount payable is the lesser of:

- the person insured's share of actual *eligible business expenses* incurred while the person insured is *disabled* less *offsets*, and
- the monthly benefit amount insured for, as shown on your Policy Certificate (including any increases or decreases that have been made under the terms of the policy).

If more than one person is directly responsible for the generation of income in the person insured's business, we apportion the business expenses in the same proportion as the person insured's share of business income prior to the claim, between the person insured and the other person(s), to determine the person insured's share, unless we agree to divide the business expenses on a different basis. We only pay benefits if receipts are provided to us within 90 days after the date the business expenses were incurred.

Under the indemnity benefit payment type, we require you to provide satisfactory financial evidence for the purpose of determining the person insured's share of *eligible business expenses* at the time of claim, as well as the person insured's share of *pre-disability business income*.

Waiting period

The waiting period is shown on your Policy Certificate.

The waiting period is the minimum period of time the person insured must be *totally disabled* or *partially disabled* for as a result of the same sickness or injury before you are eligible to claim a *disability* benefit.

The person insured must be *totally disabled* for 14 days out of the first 19 consecutive days of the waiting period and *disabled* for the remainder of the waiting period, subject to the return to work rules outlined below.

If the person insured also has Income Protection Plus Cover, the person insured must be *totally disabled* or *partially disabled* throughout the waiting period, subject to the return to work rules outlined in the following paragraph.

Working during the waiting period (return to work rules)

If you have a 14 or 30 day waiting period, the person insured can return to work at full capacity for up to five consecutive days during the waiting period without having to start the waiting period again. If your waiting period is more than 30 days, the person insured can return to work at full capacity for up to ten consecutive days. The days the person insured works will be added to the end of the waiting period.

The waiting period starts on the earlier of the following:

- when the person insured first consults a *medical practitioner* about the *sickness* or *injury* that is causing their *disability* and they are certified as *totally disabled* or *partially disabled*, or
- when the person insured first stops working due to that *sickness* or *injury* (as long as they consult a *medical practitioner* within seven days and provide reasonable medical evidence about when the condition began).

Benefit period

The benefit period is shown on your Policy Certificate.

The benefit period is the maximum amount of time we will pay the monthly benefit amount for in respect of any one continuous period of *disability*.

The benefit period is 1 year but may be extended until 12 times the monthly benefit amount has been paid.

A new benefit period will start at the end of each waiting period.

Total Disability Benefit

If the person insured is *totally disabled*, we will pay the monthly benefit amount.

Payment will begin to accrue from the first day after the end of the waiting period and will continue for as long as the person insured is *totally disabled* or to the end of the benefit period, whichever occurs first.

We pay the Total Disability Benefit monthly in arrears.

If the person insured is *totally disabled* for part of the month, we will pay 1/30th of the monthly benefit amount for each day they are *totally disabled*.

Total disability

Total disability means:

Solely because of *sickness* or *injury*, the person insured is:

- unable to perform one or more *important income producing duties* of their regular occupation,
- under the regular care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*, and
- not working.

OR

Solely because of *sickness* or *injury*, the person insured is:

- not working for more than ten hours per week in their *regular occupation* and not working in any other *gainful employment*, and
- unable to perform the *important income producing duties* of their *regular occupation* for more than ten hours per week, and
- under the regular care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*.

*If the person insured was working less than 20 hours per week in their regular occupation in the 12 consecutive months immediately prior to the cover start date and immediately prior to a *disability*, we will replace ten hours with five hours for the purposes of determining whether the person insured is *totally disabled*.

OR

Solely because of *sickness* or *injury*, the person insured is:

- working in their *regular occupation* or any other *gainful employment* but is unable to generate more than 20% of the person insured's share of *pre-disability business income*, and
- under the regular care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*.

Partial Disability Benefit

If the person insured is *partially disabled*, we will pay you a proportion of the monthly benefit amount.

Payment will begin to accrue from the first day after the end of the waiting period and will continue for as long as the person insured is *partially disabled* or to the end of the benefit period, whichever occurs first.

The Partial Disability Benefit amount we will pay is calculated as follows:

$$\text{monthly benefit amount} \times \frac{(A - B)}{A}$$

Where:

- A = person insured's share of the *pre-disability business income*, and
- B = person insured's share of the *business income* for the month in which they are *partially disabled* and claiming a Partial Disability Benefit before any benefit is payable under the cover.

We pay the Partial Disability Benefit monthly in arrears. If the person insured is *partially disabled* for part of the month, we will pay 1/30th of the monthly Partial Disability Benefit amount for each day they are *partially disabled*.

Partial disability

Partial disability means:

Solely because of *sickness* or *injury*, the person insured is unable to work in their *regular occupation* or any other *gainful employment* at full capacity and:

- they are working in their *regular occupation* in a reduced capacity, or any other *gainful employment*
- they are not *totally disabled*
- the monthly *business income* is less than the person insured's share of the *pre-disability business income*, and
- they are under the care and following the advice of a *medical practitioner* in relation to that *sickness* or *injury*.

Future Increase Benefit

If the person insured's *eligible business expenses* increase, this benefit allows you to increase the insured monthly benefit amount by up to 15%, without having to provide further medical evidence in relation to the person insured.

You may increase the insured monthly benefit amount on each policy anniversary, up until the policy anniversary immediately after the person insured turns age 55.

The increase allowed is the lesser of:

- 15% of the insured monthly benefit amount, and
- the actual increase in the *eligible business expenses*.

This increase is in addition to any increase in cover under the Indexation Benefit.

Limitations

Any increase is subject to you providing financial evidence to support the increase and confirmation that the person insured is actively at work at the time of the increase. The total of all increases in the insured monthly benefit amount cannot exceed the original monthly benefit amount at the cover start date.

This benefit cannot be exercised if:

- a claim is being paid under this cover, a claim is being assessed or you are eligible to make a claim in relation to the person insured under this policy or another policy relating to the person insured, or
- cover was issued with a medical premium loading of greater than 100%.

Relapse Benefit

If the person insured has returned to work on a full time basis after receiving a Total or Partial Disability Benefit and they suffer a relapse of the same or a related *sickness* or *injury* within six months of the previous claim ending, we will waive the waiting period and treat the relapse as a continuation of the original claim.

If the relapse occurs more than six months after the date we last paid a Total or Partial Disability Benefit, we will treat this as a new claim which means the waiting period will start again.

Additional built in benefits and optional extras

The additional built in benefits provided and optional extras are as described in this policy document as indicated by the reference in the table below, except that where relevant, a reference to Income Protection Cover or Income Protection Plus Cover should be read as a reference to Business Expenses Cover.

The optional extra may apply to your Business Expense Cover where you have selected this option, pay the additional premium and it is indicated on your Policy Certificate.

Built in benefit	Reference
Indexation Benefit	45
Death Benefit	33
Waiver of Premium While on Claim Benefit	32
Suspending Cover Benefit	45
Extended Cover Benefit	33

Optional extra	Reference
Accident Option	34

When the Business Expense Cover monthly benefit will be reduced

Your monthly benefit amount may be reduced if you receive other business expense benefits from another insurance policy. We will only reduce the monthly benefit amount to ensure that, when combined with your other payments you do not receive more than 100% of your *eligible business expenses*.

Business Expense Cover exclusions

We will not pay any benefit under Business Expense Cover if the person insured's *disability, injury, sickness* (or death) is caused directly or indirectly by:

- an intentional self inflicted act or any attempt at suicide
- war or act of war (whether declared or not)
- normal or uncomplicated pregnancy or childbirth, or
- elective surgery or treatment which the person insured voluntarily undergoes within the first six months of:
  - the commencement of cover
  - an increase in the insured monthly benefit amount (but only in respect of the increased amount and does not include an increase in cover as a result of indexation), or
  - the date the cover is last reinstated.

If the person insured's condition is directly or indirectly related to pregnancy, childbirth or miscarriage (including post natal depression) a three month qualifying period applies. This means that if the person insured has been *totally disabled* for three months as a result of pregnancy, we will pay a benefit at the end of this three month period or at the end of your waiting period, which ever is greater.

We will not pay a benefit under Business Expense Cover for anything we have specifically excluded, as shown on your Policy Certificate.

We cannot pay any benefit which we are not permitted by law to pay or reimburse any expenses which are regulated by the National Health Act 1953 or the Private Health Insurance Act 2007.

When Business Expenses Cover ends

Business Expenses Cover will end on the earlier of the:

- death of the person insured
- date on which all entitlements under the cover are paid
- the stated expiry date in the Policy Certificate (and not after the person insured is aged 70), or
- the date on which the policy ends.

Additional benefits applicable to Income Protection Cover, Income Protection Plus Cover, Accidental Income Protection Cover and Business Expense Cover

The following additional benefit provisions apply to Income Protection Cover, Income Protection Plus Cover, Accidental Income Protection Cover and Business Expense Cover as indicated below.

Indexation Benefit

This benefit applies to cover if the words 'Indexation' are shown on your Policy Certificate.

If this benefit applies we will automatically increase the insured monthly benefit amount at each policy anniversary. The rate of increase will be the greater of:

- 5%, and
- the percentage increase in the *Consumer Price Index (CPI)*.

You may choose not to accept this increase by notifying us 30 days prior to the relevant policy anniversary. If you decline an increase, you will not be excluded from being offered increases in future years.

The premium will be increased at the same time to reflect the increased insured monthly benefit amount.

Limitations

The Indexation Benefit will not apply while we are paying a *disability* benefit under Income Protection Cover, Income Protection Plus Cover, Accidental Income Protection Cover or Business Expense Cover, unless the Increasing Claim Option applies, as explained on page 33 of this document.

The Indexation Benefit will not apply if the Suspending Cover Benefit is being exercised.

Suspending Cover Benefit

You may suspend all cover under your policy and premiums associated with your policy for up to 12 months. During this period, you will be unable to claim in respect of any *sickness* or *injury* that occurs during the suspension period.

You may activate the Suspending Cover Benefit by notifying us in writing within 30 days of the relevant premium due date (monthly or annually) from which you wish to suspend your cover.

To cancel the suspension of your policy, you must notify us in writing. All cover under the policy and premiums will resume as of the next premium due date after we received your notice.

Limitations

Your policy must have been in place for a continuous period of at least 12 consecutive months before you can exercise the Suspending Cover Benefit.

You may only exercise this benefit once in any 12 month period.

Your policy may be suspended under this benefit for a maximum of 12 months in total over the life of the policy. If you do not apply to cancel the Suspending Cover Benefit before the maximum period expires, your cover will be cancelled.

Premiums and other costs

Premium

You must pay the premiums as and when due under your policy to retain your cover and keep your policy in-force.

IMPORTANT INFORMATION FOR MEMBERS OF THE CLEARVIEW RETIREMENT PLAN

Superannuation Policy - ClearView LifeSolutions Super

For ClearView LifeSolutions Super, the member (and the person insured) is responsible for ensuring that they make contributions or rollovers to the ClearView Retirement Plan to fund the premiums payable by CLN. Government legislation, including taxation legislation, effects and restricts the circumstances when contributions can be made to a superannuation fund. If the member (and person insured) cannot or does not make such contributions or rollovers, CLN may not be able to pay the premiums to keep this policy in force. If the policy discontinues, the member's entitlement to benefits under ClearView LifeSolutions Super will also discontinue.

Premium type

Your premium type is specified on your Policy Certificate.

Stepped Premium

Where your premium type is specified as 'Stepped premium', your policy premiums are recalculated each year based on your changing benefit amounts and the increasing age of the person insured each year.

The policy fee, any taxes or monthly payment loading applicable, and any policy discounts you are eligible for, are then applied.

Level Premium

Where your premium type is specified as 'Level premium', your policy premiums are recalculated each year for changes in your benefit amount, but not for a change in the age of the person insured. The premium is calculated based on the age of the person insured at the date of the commencement of the relevant cover (including indexation of that cover amount). The premium for other increases in cover will be based on the age of the person insured at the time of commencement of the increased cover.

The policy fee, any taxes or monthly payment loading applicable, and any policy discounts you are eligible for, are then applied.

Level premiums are only available up to the policy anniversary immediately after the person insured is age 65. If you continue your policy past this age, your premium will convert to a stepped premium basis.

Policy fee

The premium includes a policy fee of $84 per year (or $7 per month if paying monthly, current as at 16 April 2012) for each person insured under your policy. Only one policy fee is payable on your cover across ClearView LifeSolutions and ClearView LifeSolutions Super per person insured. The policy fee will be indexed on 1 January each year in line with the *Consumer Price Index (CPI)*.

Government taxes and charges

The premium may include allowances for current government charges and taxes including stamp duty. Stamp duty is either incorporated into the base premium rate or is an additional charge. If it is an additional charge it will be shown on your annual statement.

We may pass on to you any applicable new or increased government taxes or charges.

Premium discounts and rewards

We may apply a premium discount to your premiums including a large policy discount, group discount, new cover reward and/or health maintenance reward as set out in the information provided to you by us. If a premium discount applies, the initial amount of the premium discount will be set out in the Policy Certificate.

The discounts available and the discounted scales adopted are not guaranteed and may be varied from time to time in our absolute discretion. A change in the premium discount we apply does not constitute a change in premium rate under this policy.

Paying your premium

You may pay your premiums monthly or annually.

If you pay your premium monthly, we may apply a monthly payment loading to your premium. Premiums which are paid monthly are installments of the annual premium. The policy continues to operate on an annual cycle.

If you stop paying your premiums

If you don't pay your premium within 30 days of the due date, we will write to you explaining that we will cancel your policy. If we cancel your policy all cover will cease and you will be unable to make a claim for an event which occurs after the date cover ceases.

Policy reinstatement

You may apply to us to reinstate your policy after it is cancelled, for non-payment of premium subject to our approval and payment of outstanding premiums. Please note that a declaration of good health may be required in order for us to consider reinstatement of your policy and we are under no obligation to reinstate your policy.

Cover recommences for *injuries*, *sicknesses* and events arising or occurring from the date of reinstatement.

Can premium rates and/or the policy fee change?

Premium rates and the policy fee are not guaranteed and we may review either or both up or down in the future, regardless of which premium type you select. Any change to the premium rates and/or policy fee will apply to all policies in a defined group. We will not single out an individual policy.

If we change the premium rates and/or policy fee (other than the annual indexation of the policy fee), we will give you at least 30 days notice in writing and the change will take effect from the next policy anniversary after the change is announced.

Claims

Making a claim

Claims should be made within 90 days after the insured event, or as soon as reasonably practical thereafter. If we are not notified within 90 days of an insured event, we may be able to adjust the benefit payable if we have been prejudiced by the delay.

A potential claim relating to *Occupationally Acquired HIV* or *Occupationally Acquired Hepatitis B or C* must be reported to us within 30 days of the relevant *accident* and supported by a negative HIV, Hepatitis B or Hepatitis C test (as applicable) taken within seven days after the *accident*.

Please contact our Customer Support team on **132 979** in order for us to send you the correct claim form, which will depend on the nature of your claim.

We will need all the evidence we reasonably regard as necessary to establish entitlement to a benefit. This includes the provision of relevant receipts and invoices where you are claims amounts in respect of costs or expenses incurred.

Claims requirements

We must be fully satisfied of our liability to pay a benefit under this policy, before any payment can be made.

To make a claim under the policy you must (at your own expense) provide us with:

- our claim form which has been fully completed
- the Policy Certificate
- proof of the age of the person insured, if not already provided and
- any other evidence we require to establish the circumstances of the claim, which may include the person insured providing us with an authority to obtain further medical information in connection with the claim.

If we require the person insured to undergo any medical examination (by a *medical practitioner* of our choice) or other examination, assessment or financial audit which we consider necessary, this will be at our expense. Otherwise the costs of medical or other information, which we may reasonably require to establish the validity of a claim, is your responsibility.

Note: In the case of ClearView LifeSolutions Super, the responsibility of CLN in this case is required to be satisfied by an equivalent responsibility of the member (and person insured) to CLN.

Dictionary

accident

Means an unintended or unexpected event, resulting in an *injury* which is independent of any other cause.

business expenses

Means regular or continuing fixed expenses incurred by the business whether the person insured is working or not and which are not a payment of capital or of a capital, private or domestic nature, and could not reasonably be considered to give a private benefit to the person insured, members of their family or any company, trust or other entity from which the person insured or their family derive a benefit. The person insured's share of these payments will be that which is apportionable to them in line with the usual manner that the profits and/or losses of the business are divided.

business income

Means the person insured's share of the gross income generated by the business before expenses and tax.

For the purpose of this definition business income will always have a minimum value of zero.

Consumer Price Index (CPI)

The weighted average of the 8 Australian capital cities combined, as published by the Australian Bureau of Statistics (or any body which succeeds it) for the 12 month period ending on 31 December each year.

disability

Refers to *total disability* or *partial disability*.

eligible business expenses

The person insured's share of the normal day to day fixed expenses of the person insured's business actually incurred by the person insured and include, but are not limited to:

- salaries or remuneration of employees who are not directly involved in generating sales, income or billings (including related costs such as superannuation contributions and pay roll tax)
- net costs of a locum (a person sourced external to the business and who is a direct replacement for the person insured whose gross sales, income or billings are less than the fees incurred for that locum)
- rent and regular principal and interest instalment repayments on business loans or mortgages (unless the business premises are also the person insured's principal residence)
- business property rates and taxes
- leasing costs for equipment and motor vehicles
- electricity, gas, water, telephone, laundry and cleaning
- business related insurance premiums (excluding premiums for this Business Expense Cover)
- contracted advertising costs
- subscriptions to professional associations;
- accounting and audit fees
- bank fees and charges, and
- any other *business expenses* we may agree to cover.

The following *business expenses* are specifically excluded:

- the person insured's personal salary, fees, drawings or any other remuneration
- salaries or remuneration for members of the person insured's family (unless they were employed at least 90 days before the date the person insured became *disabled*) or any person who is not an employee
- salaries or remuneration of employees who generate sales, income or billings (including related costs such as superannuation contributions and pay roll tax)
- cost of goods, fittings, equipment, implements or products used in the business
- depreciation
- premiums payable for Business Expense Cover under this policy.

exposure-prone medical procedures

Procedures where there is potential for contact between the skin (usually finger or thumb) of the healthcare worker or medical professional (as applicable) (the person insured) and sharp surgical instruments, needles or tissues (splinters/pieces of bone/ tooth) in body cavities or in poorly visualised or confined body sites including the mouth. Procedures which lack these characteristics do not constitute exposure-prone medical procedures because they are unlikely to pose a risk of transmission of blood-borne viruses from the infected healthcare worker or medical professional (as applicable) (the person insured) to a patient.

gainful employment

To be engaged in an occupation, business or employment for remuneration or reward.

home duties

This refers to the tasks performed by the person insured if the person insured's sole occupation is to maintain the family's usual place of residence (home) being:

- cleaning the family home
- shopping for food and groceries for the household
- preparing meals for the household
- performing laundry services for the household including washing and ironing, and
- caring for dependent children (where applicable).

For the avoidance of doubt, the person insured will not be

considered unable to perform home duties, if the person insured can perform at least one of these duties.

Home duties do not include duties performed outside of the person insured's home for salary, reward or profit.

immediate family member

Includes:

- spouse, child, sibling, parent, father in-law or mother in-law, or
- person in a bona fide domestic living arrangement and is financially interdependent.

important income producing duty

This is a duty of the person insured's occupation that we could consider primarily essential to producing their income.

injury

An *accidental* bodily injury.

medical practitioner

A medical practitioner who is legally qualified and registered to practise in Australia (or if outside Australia has the equivalent qualifications and is approved by us) that is not you, the person insured or an *immediate family member* or business partner of you or the person insured.

medical professional

For the purpose of this policy, the person insured will be considered a medical professional if:

- they have been classified as occupational category AM as shown on your Policy Certificate
- they are registered to practice in their medical profession and this registration is regulated by an Act of Parliament of a state or territory of the Commonwealth of Australia, and
- they have been performing or assisting in *exposure-prone medical procedures* as part of their *regular occupation* at least on a monthly basis.

monthly benefit amount

For:

- Income Protection Cover, Income Protection Plus Cover and Accidental Income Protection Cover under this policy, has the meaning set out on page 29, depending on the benefit payment type you have selected; and
- Business Expense Cover, has the meaning set out on page 42.

monthly earnings

If the person insured is self employed or a working director, monthly earnings is the gross monthly income generated by the business or professional practice as a result of the person insured's personal exertion less their share of the *eligible business expenses* necessarily incurred in generating that income, less any insured contributions under the Superannuation Contribution Option.

If the person insured is not self employed, monthly earnings is the gross monthly income earned from personal exertion by way of total remuneration package and includes salary, regular overtime, superannuation contributions, commissions, bonus payments and other fringe benefits, less any insured contributions under the Superannuation Contribution Option.

In each case, monthly earnings do not include income which is not derived from the person insured's personal exertion or activities, such as interest or dividend payments.

For the purpose of this definition monthly earnings will always have a minimum value of zero.

offsets

For:

- Income Protection Cover and Income Protection Plus Cover has the meaning as described on page 37 under 'When your monthly benefit amount may be reduced', and
- under Business Expense Cover, has the meaning as described on page 44 under 'When the Business Expense Cover monthly benefit will be reduced'.

own occupation (for TPD Cover and Accidental TPD Cover)

Means the most recent occupation the person insured was engaged in immediately prior to the date of their *total and permanent disability*.

partial disability

For:

- Income Protection Cover and Income Protection Plus Cover, has the meaning set out on page 31.
- Accidental Income Protection Cover, that definition is varied as set out on page 39.
- Business Expenses Cover, has the meaning set out on page 43.

pre-disability business income

The highest average monthly *business income* for any consecutive 12 month period in the three years immediately preceding the date of the person insured's *disability*. If they become *disabled* while on maternity, paternity, sabbatical or long service leave, then pre-disability business income will be based on their average monthly income during the 12 months before the period of leave commenced.

Pre-disability business income will be indexed while on total or partial disability claim.

pre-disability earnings

For agreed value and guaranteed agreed value benefit payments, pre-disability earnings are the person insured's highest average *monthly earnings* for any consecutive 12 month period between the period one year prior to the cover start date and the date of their *disability*.

For indemnity benefit payments, pre-disability earnings are the person insured's highest average *monthly earnings* for any consecutive 12 month period in the three years immediately preceding the date of their *disability*.

If they become disabled while on maternity, paternity, sabbatical or long service leave, then pre-disability earnings will be based on their average *monthly earnings* during the 12 months before the period of leave commenced.

In each case, pre-disability earnings will be indexed while on total or partial disability claim.

regular occupation (for Income Protection Cover, Income Protection Plus Cover, Accidental Income Protection Cover and Business Expense Cover)

Means the occupation the person insured is regularly engaged in, except that:

- if the person insured is unemployed or on maternity, parental or sabbatical leave for greater than 12 months at the time of disability, then regular occupation will mean any occupation for which the person insured is reasonably suited having regard to their education, training and experience.

sickness

A sickness, disorder or disease.

terminal illness

Means the person insured is diagnosed with a *sickness* which reduces his or her life expectancy to less than 12 months from the date of claim, as confirmed by a medical specialist approved by us.

total and permanent disability

Has the meaning set out on page 10. However, for Accidental TPD Cover, the definition is varied as set out on page 14.

total disability

For:

- Income Protection Cover and Income Protection Plus Cover, has the meaning set out on page 30.
- Accidental Income Protection Cover, that definition is varied as set out on page 39.
- Business Expenses Cover, has the meaning set out on page 43.

Trauma Definitions

Heart Disorders

Heart Attack

The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following:

- signs and symptoms of ischaemia consistent with myocardial infarction or
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]) or
- development of pathological Q waves in the ECG or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive or our noted diagnostic techniques are impractical to apply or have been superseded, we will consider other appropriate and medically recognised tests.

A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease is excluded. Also excluded are other acute coronary syndromes including but not limited to angina pectoris.

Out of Hospital Cardiac Arrest

Cardiac arrest that occurs out of hospital and is due to:

- cardiac asystole, or
- ventricular fibrillation with or without ventricular tachycardia.

The cardiac arrest must not be related to any medical procedure and must be documented by an electrocardiogram.

Coronary Artery By-Pass Surgery

The undergoing of coronary artery by-pass surgery with the use of bypass graft to one or more coronary arteries for treatment of coronary artery disease. The surgery must be the most appropriate treatment for the disease as recommended by a cardiologist. All non-surgical procedures such as laser, angioplasty or other intra-arterial techniques are excluded.

Coronary Artery Angioplasty

The undergoing of coronary artery angioplasty, cardiac keyhole surgery or stent insertion on one or two coronary arteries to correct a narrowing or blockage. The procedure must be considered necessary by a cardiologist to treat coronary artery disease and supported by angiographic evidence.

Coronary Artery Angioplasty – Triple Vessel

Undergoing, in the same procedure, coronary artery angioplasty to three or more coronary arteries, where the procedure is considered necessary by a cardiologist to treat coronary artery disease.

Repair or Replacement of a Heart Valve

Surgery to replace or repair heart valves as a consequence of heart valve defects or abnormalities. Percutaneous intravascular procedures or other non-surgical procedures are excluded.

Surgery of the Aorta

Surgery to correct a narrowing, dissection or aneurysm of the thoracic or abdominal aorta but not its branches. Percutaneous intravascular procedures or other non-surgical procedures are excluded.

Cardiomyopathy

Condition of 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 classification of cardiac impairment.

Primary 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.

Open Heart Surgery

The undergoing of open heart surgery that is considered necessary to correct a cardiac defect, cardiac aneurysm or cardiac tumour.

Nervous System Disorders

Stroke

A neurological event caused by a cerebrovascular accident or incident. The stroke must:

- be confirmed by a consultant neurologist, and
- be evidenced by neuro-imaging.

Transient ischaemic attacks, cerebral events due to reversible neurological deficits, migraine, hypoxaemia or trauma and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Major Head Trauma

Accidental *injury* to the head resulting in neurological deficit causing:

- at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th edition, or an equivalent guide to impairment approved by us, or
- total and irreversible inability to perform without the assistance of another person at least one of the *Activities of Daily Living* (as defined on page 57 of this document), as certified by a consultant neurologist.

Motor Neurone Disease

The unequivocal diagnosis of Motor Neurone Disease by a consultant neurologist.

Multiple Sclerosis

The unequivocal diagnosis of Multiple Sclerosis by a consultant neurologist which is characterised by demyelination in the brain and spinal cord. There must have been more than one episode of well-defined neurological deficit with persisting clinical neurological abnormalities. Neurological investigations such as lumbar puncture, Magnetic Resonance Imaging (MRI), evidence of lesions in the central nervous system, evoked visual responses and evoked auditory responses are required to confirm diagnosis.

Muscular Dystrophy

The unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist.

Paralysis

As a result of *sickness* or *injury*, the total and permanent loss of the use of two limbs, where limb is defined as the shoulder down to the hand or the hip down to the foot.

Paraplegia, Quadriplegia, Tetraplegia, Diplegia and Hemiplegia are included in this definition.

Dementia including Alzheimer's Disease

Clinical diagnosis of Dementia (including Alzheimer's Disease) by a consultant neurologist, psycho-geriatrician, psychiatrist or geriatrician. The diagnosis must confirm permanent, irreversible failure of brain function resulting in significant cognitive impairment for which no other recognisable cause has been identified. Significant cognitive impairment in this definition means a deterioration in your Mini-Mental State Examination scores to 24 or less.

Coma

A state of total unconsciousness and unresponsiveness to all external stimuli, resulting in a Glasgow Coma Scale score of 6 or less and requiring continuous assisted ventilation to maintain life for at least 72 consecutive hours.

Encephalitis

The severe inflammation of brain substance caused by viral infection resulting in neurological deficit, causing:

- at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th edition, or an equivalent guide to impairment approved by us, or
- total and irreversible inability to perform without the assistance of another person at least one of the '*Activities of Daily Living*' (as defined under *Loss of Independent Existence*) as certified by a consultant neurologist.

Parkinson's Disease

The unequivocal diagnosis of Parkinson 's Disease by a consultant neurologist, which is characterised by irreversible neurological deficit.

Bacterial Meningitis

The unequivocal diagnosis of Bacterial Meningitis by a consultant neurologist, which is characterised by:

- at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th edition, or an equivalent guide to impairment approved by us, or
- total and irreversible inability to perform without the assistance of another person, at least one of the '*Activities of Daily Living*' (as defined under *Loss of Independent Existence*).

Meningococcal Septicaemia

The unequivocal diagnosis of Meningococcal Septicemia by a consultant neurologist which is characterised by:

- at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th edition, or an equivalent guide to impairment approved by us, or
- total and irreversible inability to perform without the assistance of another person, at least one of the '*Activities of Daily Living*' (as defined under *Loss of Independent Existence*).

Body Organ Disorders

Cancer

The presence of one or more malignant tumours (including leukaemia, lymphoma, hodgkin's disease and colorectal cancer from Dukes stage A) characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

The following cancers are excluded:

- Conditions classified by their clinical features, cytopathology and/or histopathology as tumours showing the malignant changes of 'carcinoma in situ' or which are histopathologically described as premalignant (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). Uterine cervical intraepithelial lesions, cervical dysplasias and cervical intraepithelial neoplasias, including those classified as CIN1, CIN2 and CIN3 are examples of tumours categorised as either being carcinoma in situ and/or premalignant and are excluded.
- All hyperkeratosis and basal cell carcinomas, and squamous cell carcinomas of skin unless there has been evidence of metastatic spread.
- Prostatic cancers which remain histopathologically classified as TNM stage T1a or T1b or are of another equivalent or lower classification and have a Gleason score of 6 or less, unless major interventionist treatment is required to arrest the spread of malignancy.
- Melanomas which have a depth of invasion of less than Clark Level 3 or less than 1.5mm in Breslow thickness, unless there is histological evidence of ulceration.
- Chronic Lymphocytic Leukaemia diagnosed as less than RAI Stage 1.

Cancer of the Vulva or Perineum

Any lesion described by a histopathologist as carcinoma of the vulva or perineum that meets the criteria of either Stage 3 or 4 (tumour of any size with contiguous invasion of local organs) of the 1988 International Federation of Gynecology and Obstetrics (FIGO) surgical staging system.

Benign Brain Tumour or Spinal Cord Tumour

A non-cancerous tumour in the brain, cranial nerve, meninges or spinal cord which is histologically described and which produces neurological damage and functional impairment which a consultant neurologist considers to be permanent:

- at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th edition, or an equivalent guide to impairment approved by us, or
- requires cranial surgery for its removal.

The presence of the underlying tumour must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland are excluded.

Blindness

The permanent loss of sight in both eyes, whether aided or unaided, due to *sickness* or *injury* to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 20 degrees or less of arc, as diagnosed by an ophthalmologist.

Chronic Kidney Failure

End stage renal failure presenting as chronic irreversible failure of both kidneys to function which requires permanent renal dialysis or renal transplantation.

Major Organ or Bone Marrow Transplant

Undergoing, or being placed on an official Australian waiting list approved by us for, a transplant from a human donor for bone marrow or one or more of the following organs:

- heart
- kidney
- liver
- lung
- pancreas, or
- small bowel.

This treatment must be considered medically necessary and deemed the most appropriate treatment.

Pneumonectomy

The undergoing of surgery to remove an entire lung. This treatment must be considered medically necessary and deemed the most appropriate treatment.

Severe Burns

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

- 20% or more of the body surface area as measured by the age-appropriate use of 'The Rule of Nines' or the Lund & Browder Body Surface Chart
- both hands, requiring surgical debridement and/or grafting, or
- the face, requiring surgical debridement and/or grafting.

Loss of Speech

The total and irrecoverable loss of the ability to produce intelligible speech as a result of *sickness* or *injury* which causes permanent damage to the larynx or its nerve supply or the speech centres of the brain, as certified by an appropriate medical specialist. Loss of speech due to psychological reasons is excluded.

Loss of Hearing

Complete and irrecoverable loss of hearing, both natural and assisted, from both ears as a result of sickness or injury, as certified by an appropriate medical specialist.

Chronic Liver Disease

End stage liver failure resulting in permanent jaundice, ascites or encephalopathy.

Chronic Lung Disease

End stage lung disease requiring continuous permanent oxygen therapy and FEV1 test results of consistently less than one litre.

Severe Rheumatoid Arthritis

The unequivocal diagnosis of severe rheumatoid arthritis by a Rheumatologist. The diagnosis must be supported by, with evidence of, all of the following criteria:

- at least a six-week history of Severe Rheumatoid Arthritis which involves three or more of the following joint areas:
  - proximal interphalangeal joints in the hands
  - metacarpophalangeal joints in the hands, or
  - metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle.
- simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone), and
- typical rheumatoid joint deformity and at least two of the following criteria:
  - morning stiffness
  - rheumatoid nodules
  - erosions seen on X-ray imaging, or
  - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of Severe Rheumatoid Arthritis.

Degenerative osteoarthritis and all other arthritidies are excluded.

Blood Disorders

Occupationally Acquired HIV

Infection with Human Immunodeficiency Virus (HIV) as the result of an accident occurring during the course of the person insured's regular occupation. The production and detection of HIV antibodies (sero-conversion) must be confirmed by way of a positive HIV antibody test within six months of the accident. Any accident giving rise to a potential claim must be reported to us within 30 days of the incident and supported by a negative HIV antibody test taken within seven days after the accident.

We require access to all blood samples taken in order to facilitate independent testing, with the right to take additional samples as necessary. The benefit will not be paid if:

- HIV Infection is caused by any other means, including sexual activity or recreational intravenous drug use
- in practicing their medical profession, the person insured has not made reasonable efforts to comply with relevant State and Commonwealth guidelines in relation to dealing with infection of health care workers
- the person insured has not taken an approved vaccine that is recommended by the relevant government body for use in the person insured's occupation and is available prior to the event which causes the infection, or
- a medical cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any Australian Government approved treatment, which renders HIV in-active and non-infectious.

Medically Acquired HIV

Accidental infection with Human Immunodeficiency Virus (HIV) which we believe, on the balance of probabilities, arose from one of the following medical procedures performed in Australia by a registered health professional:

- a transfusion of blood or blood products
- an organ transplant where the person insured was the recipient
- assisted reproductive techniques, or
- other medical procedure or operation performed by a medical/paramedical practitioner or dentist at a registered medical facility.

We require a statement from the appropriate Statutory Health Authority that provides documented proof of the incident and confirms that the infection is medically acquired.

We require access to all blood samples taken in order to facilitate independent testing, with the right to take additional samples as necessary.

The benefit will not be paid if:

- HIV Infection is caused by any other means, including sexual activity or recreational intravenous drug use; or
- a medical cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any Australian Government approved treatment, which renders HIV in-active and non-infectious.

Occupationally Acquired Hepatitis B or C

The contracting of Hepatitis B or Hepatitis C as the result of an *accident*, during the course of the person insured's regular occupation, resulting in the production of:

- Hepatitis B surface antigen or HBV DNA, demonstrated by way of a positive Hepatitis B surface antigen or HBV DNA test, or
- Hepatitis C antibodies, demonstrated by way of a positive Hepatitis C antibody test.

The production of antigens or antibodies must be confirmed within six months of the accident.

Aplastic Anaemia

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

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

Advanced Diabetes

Means that a consultant endocrinologist has confirmed that at least two of the following complications have occurred as a direct result of diabetes:

- retinopathy resulting in visual acuity uncorrected and corrected of 6/36 or worse in both eyes
- peripheral vascular disease leading to chronic infection or gangrene, requiring surgical intervention
- nephropathy causing chronic irreversible renal impairment as measured by a corrected creatinine clearance less than 28ml/min (CKD stage 4, International Chronic Kidney Disease classification), or
- neuropathy causing:
  - irreversible autonomic neuropathy resulting in severe postural hypotension, and/or motility problems in the gut with intractable diarrhea, or
  - polyneuropathy leading to significant mobility problems due to sensory and/or motor deficits.

Other Events

Intensive Care

A *sickness* or *injury* that has, for the first time, resulted in the person insured requiring continuous mechanical ventilation by means of tracheal intubation for ten consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital.

Sickness or *injury* as a result of alcohol or non-prescribed drug intake, or other self-inflicted means is excluded.

Cognitive Loss

A total and permanent deterioration or loss of intellectual capacity (supported by a score of 15 or less out of 30 in a Mini Mental State Examination or evidence from another neuropsychometric test that is acceptable to us) that has required the person insured to be under continuous care and supervision by another person for at least three consecutive months and at the end of that three month period the person insured is likely to require ongoing continuous care and supervision by another person.

Loss of Limbs or Sight

The person insured has sustained, as a direct result of *sickness* or *injury*, the complete and irreversible loss of use of:

- two limbs
- sight in both eyes (*Blindness* and *Partial Blindness*), or
- the sight in one eye (*Partial Blindness*) and one limb.

Where limb means the whole hand, whole foot, whole arm or whole leg.

Loss of One Limb

The person insured has sustained, as a direct result of *sickness* or *injury*, the complete and irrecoverable loss of use of a whole hand, whole foot, whole arm or whole leg.

Loss of Independent Existence

As a result of *sickness* or *injury*:

- there is permanent and irreversible inability to perform without the assistance of another person any two of the Activities of Daily Living or all of the Home Duties (defined below), or
- the person insured suffers cognitive impairment that results in the person insured requiring permanent and constant supervision for a continuous period of at least six months. The person insured's permanent and irreversible impairment must be established by a medical practitioner nominated by us.

Loss of Independent Existence as a result of alcohol or non-prescribed drug intake, or AIDS is excluded.

Activities of Daily Living

1. Dressing – putting on and taking off clothing.
2. Toileting – using the toilet, which includes getting on and off.
3. Mobilising – getting in and out of bed and a chair.
4. Maintaining continence – having good control of bowel and bladder function.
5. Feeding – getting food from a plate into the mouth.

Home Duties

This refers to the tasks performed by the person insured if the person insured's sole occupation is to maintain the family's usual place of residence (home) being:

- cleaning the family home
- shopping for food and groceries for the household
- preparing meals for the household
- performing laundry services for the household including washing and ironing, and
- caring for dependent children (where applicable).

For the avoidance of doubt, the person insured will not be considered unable to perform home duties, if the person insured can perform at least one of these duties.

Home duties do not include duties performed outside of the person insured's home for salary, reward or profit.

Carcinoma In Situ

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. The tumour must be classified as Tis according to the TNM staging method or FIGO Stage 0. Only carcinoma in situ of the following sites is covered:

- Breast (excluding Breast Cancer with Surgery and Treatment)
- Cervix – uteri (excluding cervical intraepithelial neoplasia (CIN) classifications CIN-1 and CIN-2)
- Fallopian tube (tumour must be limited to the tubal mucosa)
- Ovary
- Penis
- Perineum
- Prostate
- Testicle
- Vagina
- Vulva

FIGO refers to the staging method of the Federation Internationale de Gynecologie et d'Obstetrique.

Breast Cancer with Surgery and Treatment

Carcinoma in situ of the breast requiring breast conserving surgery followed by adjuvant therapy such as radiotherapy and/or chemotherapy, which is considered medically necessary and the most appropriate treatment.

For this purpose, chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells. Adjuvant endocrine manipulation therapy, hormonal manipulation therapy and non-endocrine adjuvant therapy are excluded.

Early Stage Prostate Cancer

Localised cancer characterised by focal autonomous new growth of cancer cells. The tumour must be described histologically as TNM Classification T1 and have a Gleeson score of 6 or less.

Early Stage Melanoma

The presence of one or more melanomas which are both less than 1.5mm, in Breslow thickness and less than Clark level 3 depth of invasion as determined by histological examination.

Chronic Lymphocytic Leukaemia

The presence of chronic lymphocytic leukaemia diagnosed as RAI Stage 0, which is defined to be in the blood and bone marrow only.

Hydatidiform Mole

The presence of a hydatidiform mole resulting in surgical removal as recommended and confirmed by a histopathologist.

Diabetes Complication

Means a consultant endocrinologist has confirmed that at least two of the following complications have occurred as a direct result of Type 1 Insulin dependent diabetes mellitus:

i. urinary protein excretion of more than 300mg per day
ii. creatinine clearance of 28-42ml/min (CKD stage 3b, International Chronic Kidney Disease Classification)
iii. retinopathy with a minimum severity of at least exudates and/or dot- blot haemorrhages, or
iv. persistent sensory neuropathy.

Partial Loss of Hearing

Complete and irrecoverable loss of hearing, both natural and assisted, from one ear as a result of sickness or injury, as certified by an appropriate medical specialist.

Partial Blindness

The permanent loss of sight in one eye, whether aided or unaided, due to sickness or injury to the extent that visual acuity is 6/60 or less in one eye, or to the extent that the visual field is reduced to 20 degrees or less of arc, as certified by an ophthalmologist.

Severe Osteoporosis

Before the age of 50, the person insured:

- suffers at least two vertebral body fractures or a fracture of the neck or femur, due to osteoporosis, and
- has a bone mineral density reading with a T-score of -2.5 or worse (i.e. 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least two sites by dual energy X-ray absorptiometry (DEXA).

Severe Crohns Disease

Unequivocal diagnosis of Crohns disease that has failed to be controlled by standard therapy including cortisone treatment and requires permanent immunosuppressive medication.

Severe Ulcerative Colitis

Unequivocal diagnosis of Ulcerative Colitis that has failed to be controlled by standard therapy including cortisone treatment and requires permanent immunosuppressive medication.

Colostomy/ileostomy

The creation of a permanent non-reversible opening, linking the colon and/or ileum to the external surface of the body.

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132 979

Issued by:
ClearView Life Assurance Limited
ABN 12 000 021 581
AFS Licence No. 227682

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CVLS_0086 10/05