Issue Date: 1 October 2016

ZURICH®

Zurich Active

Product Disclosure Statement

Contents

Issuer information

This Product Disclosure Statement (PDS) contains important information about insurance products issued by Zurich Australia Limited (Zurich).

This PDS has been prepared on 13 September 2016.

All of the information contained in this PDS is current at the time of preparation. Information contained in this PDS can change from time to time. If the change is not materially adverse, the updated information will be available on our website, zurich.com.au. A paper copy of any updated information will be given to you on request without charge.

The Zurich worldwide group of companies has obligations under various Australian and foreign laws. Despite anything to the contrary in this PDS or any other document related to the policies described in this PDS, the policies' terms will operate subject to all laws with which a Zurich worldwide company considers it must comply.

This offer is available only to persons receiving it (including electronically) within Australia. We cannot accept cash or applications signed and mailed from outside Australia.

Applications can be made via electronic application through the online insurance platform or using a current paper application form. It is important that you consider this PDS before completing the application form.

This PDS has been prepared by Zurich and does not take into account your objectives, financial situation or needs. Before acting on this PDS you should consider these factors and whether Zurich Active is appropriate to your situation. We recommend you obtain financial, legal and taxation advice before making any decisions relating to these policies.

The importance of insurance

Your life is full of promise and potential. All your hard work is building towards a bigger and brighter future for you and your family. It's a future that's worth protecting.

Life insurance helps you protect against the financial consequences of losing your most valuable asset – your health. It gives you the security of knowing that even if you get seriously ill or injured, you will have financial support to help you still achieve your long-term plans.

Zurich Active summary

Types of cover available

Zurich Active allows you to get more of the cover you need in one convenient package.

You can make multiple claims over the life of your Zurich Active policy and it provides broad coverage for a range of *Health Events*. Even if you suffer a medical condition that is not listed, you may be entitled to claim if the condition leads to a physical, mental or occupational impairment.

Active Cover (*Health Events*, *terminal illness*, and death cover)	We will pay a lump sum on the occurrence of covered *Health Events*, (such as heart attack, stroke, cancer, digestive conditions, psychiatric conditions and many others), *terminal illness*, and death. The amount for a *Health Event* depends on how serious the condition is. An important aspect of this cover is that we will pay a benefit if the *Health Event* meets the specific criteria set out under the policy and falls into one of the benefit categories. These benefit categories are found starting on page 44.
Income Cover (optional)	We will pay a monthly amount for the inability to work due to *illness* or injury that results in *disability* longer than the selected waiting period.
Child Cover (optional)	We will pay a lump sum if the insured child dies, is diagnosed with a *terminal illness* or suffers one of the covered *Child Cover Conditions*.

Cover for *Health Events*, *terminal illness* and death are automatically included in Zurich Active. You simply choose an *Initial Amount of Cover* based on how much insurance you need. Income Cover and Child Cover are optional. You can indicate whether you want to include these in your Zurich Active policy when you apply.

A claims approach that makes sense

If you are eligible to claim for a *Health Event* under your Zurich Active policy, the severity of your *illness* or injury will determine how much we pay. The more serious the *Health Event*, the larger the benefit, and if your health deteriorates further following a claim we may pay you another benefit.

Your Zurich Active policy will not cease after a *Health Event* claim and will remain in place (at a reduced level), allowing you to claim multiple times over the policy term subject to specified limits (see Claim Protector on page 11). For subsequent claims we will pay:

- the difference in benefit severity for a deterioration of a condition for which a claim has been paid (see Progressive Conditions on page 9)
- the difference in benefit severity for unrelated conditions that occur within the 12 month *Limited Claim Period* (see Limited Claim Period on page 10) or
- the full amount of the applicable benefit for unrelated conditions that occur outside the *Limited Claim Period*, subject to remaining levels of cover (see Subsequent claims under the policy on page 9).

Understanding your Zurich Active policy

Different terminology applies depending on how you are covered under a Zurich Active policy:

Policy owner	The person who is insured under the policy (insured person)	Terminology used in this document		
		"we", "our" or "us"	"you" or "your"	Policy is referred to as:
A person or company (that is not a trustee of a superannuation fund).	Either: • same person as the policy owner, or • a different person.	Zurich	The policy owner	Either: • being held outside superannuation, or • a non-superannuation policy.
A person or company who is a trustee of a self managed superannuation fund.	A member of the relevant self managed superannuation fund.	Zurich	The policy owner	Either: • being held within (or issued through) superannuation, or • a superannuation policy.
The trustee of an *eligible superannuation fund*.	A member of an *eligible superannuation fund*.	Zurich	A member of an *eligible superannuation fund*.	

Ownership and structure of your insurance

Ownership of your Zurich Active policy is an important consideration.

Your adviser will be able to recommend an appropriate ownership structure for you based on your personal circumstances. You can choose either non-superannuation ownership or superannuation ownership.

If you choose to hold your cover within superannuation, Superannuation Optimiser will apply.

Ownership	Description
Non-superannuation	The policy can be issued to an individual, a company, family trust, or other entity that is not a trustee of a superannuation fund. If a benefit becomes payable, the benefit is generally paid to the policy owner. If the insured person and policy owner are the same, the amount payable on the death of the insured person will be paid to their legal personal representative, unless any beneficiaries have been nominated under the policy, in which case it will be paid to the nominated beneficiaries.
Superannuation	The policy is issued to a trustee of a superannuation fund as policy owner and the insured person is a member of the superannuation fund. Some Active cover cannot be held within superannuation. If a benefit under the policy becomes payable, it will be paid to the trustee of the superannuation fund as policy owner, who must distribute the benefit in accordance with the governing rules of the superannuation plan and *superannuation law* current at the time of payment.

Superannuation Optimiser

Superannuation Optimiser allows you to split your cover so that it is held across two policies. One policy is issued to a trustee of a superannuation fund while the other is issued to the insured person (or other entity who is not a trustee of a superannuation fund). This enables you to hold those benefits that comply with a superannuation condition of release within superannuation and the remainder outside of superannuation.

For more information on how Superannuation Optimiser works refer to pages 29 to 31.

Zurich Active at a glance

Active Cover

Provides a lump sum if the insured person is diagnosed with a *terminal illness*, dies, or suffers a *Health Event* for which they are covered.

Entry ages	15–65 stepped premium 15–60 level premium	
Expiry age	99 for death, *terminal illness* and *Health Events* (the *Health Events* covered change between the ages 65 and 70)	
Amount of cover	For *Health Events* • minimum $100,000 • maximum $4 million For death and *terminal illness* • minimum is the *Health Events* sum insured • no maximum	
Included benefits and features	• *Health Events*, *terminal illness* and Death cover • Claim Protector (*Health Events*) feature • Financial Planning benefit • Funeral Assistance benefit • Indexation Increases feature • Future Increases feature	Page 6 Page 11 Page 12 Page 12 Page 12 Page 13
Available options	Additional Death Cover option Extended Care option	Page 14 Page 14

Optional Child Cover

Provides a lump sum payment if the insured child is diagnosed with a *terminal illness*, dies, or suffers a *Child Cover Condition* for which they are covered.

Entry ages	2–14	
Expiry age	21 (cover may be converted to a full policy prior to the child turning 21)	
Amount of cover	• minimum $10,000 • maximum $250,000	
Included benefits and features	• Indexation Increases feature • Continuation of Cover feature	Page 16 Page 16

Optional Income Cover

Provides a monthly benefit if the insured person is unable to work due to an *illness* or injury and is *totally disabled*, or *partially disabled*, in most cases, for longer than the specified waiting period.

Entry ages	17–60 (64, for to age 70 benefit period with stepped premiums)	
Expiry age	65 (70, for to age 70 benefit period)	
Monthly Amount of Cover	• minimum $1,250 per month • maximum $40,000 per month (for the first 24 months, then $30,000 per month for the remainder of the benefit period)	
Benefit type	• Income at Claim • Income at Application • Endorsed Income at Application	
Waiting periods available	• 30 days • 60 days • 90 days • 180 days • 1 year • 2 years	
Benefit periods available	• 2 years • 5 years • To age 65 • To age 70	
Included benefits and features	• Total Disability benefit • Partial Disability benefit • Specific Injury benefit • Death benefit • Indexation Increases feature • Premium Waiver feature • Involuntary Unemployment Premium Waiver feature • Recurrent Disability feature • Waiting Period Reduction feature • Medical Professionals feature	Page 20 Page 21 Page 21 Page 22 Page 22 Page 22 Page 22 Page 22 Page 23 Page 23
Available options	• Extra Benefits option – Health Event benefit – Bed Confinement benefit – Home Care benefit – Rehabilitation Expense benefit – Accommodation benefit – Future Increases feature – Cover Extension feature • Accident option • Claims Escalation option • Superannuation Cover option • Booster option	Page 23 Page 23 Page 23 Page 24 Page 24 Page 24 Page 24 Page 25 Page 25 Page 25 Page 25 Page 26

Active Cover

Active Cover provides a lump sum payment if you die, are diagnosed with a *terminal illness* or suffer one of the listed *Health Events*. The payment could be used by your family to pay down debts like your mortgage or credit cards, provide funds to cover unexpected expenses during your illness, or to help maintain your family's current lifestyle in the absence of your income.

Eligible entry ages	15 – 70 (stepped premiums) 15 – 60 (level premiums)
Expiry age	no expiry for death and *terminal illness* 99 for *Health Events*, the *Health Events* covered change between the ages 65 and 70
Minimum sum insured	$100,000
Maximum sum insured	$4 million (there is no maximum for the Additional Death Cover option, subject to financial justification and insurable interest)

The tables below summarise the benefits, features, and extra cost options that are available with Active Cover. Please refer to the relevant sections of this PDS for the complete terms and conditions.

Included benefits

Benefit name	Description	Page
Health Events, *terminal illness* and Death cover	Provides a lump sum payment if you die, are diagnosed with a *terminal illness*, or suffer one of the listed *Health Events*.	6
Funeral Assistance benefit	Advances a small portion of the *Initial Amount of Cover* so that immediate expenses can be met following the death of the insured person.	12
Financial Planning benefit	Reimburses up to $1,000 paid to a qualified financial adviser for the purpose of preparing a financial plan following the payment of a benefit category A or B claim.	12

Included features

Feature name	Description	Page
Claim Protector *(Health Events)* feature	Ensures 25% of the *Initial Amount of Cover* is retained on your policy so that funds will be available in the event that you suffer more than one claim over the life of the policy.	11
Indexation Increases feature	Increases the *Initial Amount of Cover* every year by the greater of 3% and the increase in the *consumer price index* so that cover retains its value against inflation.	12
Future Increases feature	Allows existing cover to be increased without further medical underwriting after the occurrence of a specified life event (eg the birth of a child).	13

Extra cost options

Option name	Description	Page
Additional Death Cover option	Pays an additional lump sum if the insured person dies or is diagnosed with a *terminal illness*.	14
Extended Care option	Pays an additional benefit amount if the insured person suffers a Category A *Health Event* that meets at least either 4 of the 6 *activities of daily living* or 60% *whole person impairment*.	14

The information provided in this section forms part of your *Health Events*, *terminal illness* and death cover terms and conditions. Words or expressions shown in *italics* have their meaning explained in the Glossary at the end of this PDS.

When a benefit is payable

Health Events, terminal illness and death cover

A benefit is payable if, during the *period of insurance* for *Health Events, terminal illness* and death cover, the insured person:

- dies
- is diagnosed with a *terminal illness*, or
- suffers a *Health Event* covered under the policy, and the *Maximum Amount Payable* for the benefit category under which the benefit is payable is not nil.

Whenever a benefit is paid for a *Health Event* and the policy has not ended, we will issue you with a replacement policy schedule that applies from the Schedule Date stated in the policy schedule which will reflect the date of the occurrence of the *Health Event* and state the *Remaining Amount of Cover* and *Maximum Amounts Payable* for each benefit category.

Where we do not accept your application for *Health Events* cover, we may choose to issue a policy with death and *terminal illness* cover only. In this situation, your policy schedule will show the *Maximum Amount Payable* for *Health Events* benefit categories as zero. Refer to the section titled 'Benefit categories' on page 7.

You may request the removal of the Health Events benefit from your policy. In which case we will reduce the *Initial Amount of Cover* on the corresponding benefit categories to zero. We will issue you with a replacement policy schedule that applies from the Schedule Date stated in the policy schedule, which will reflect the changes.

Where your policy schedule indicates that Superannuation Optimiser applies, your Active Cover will be held over two policies with a payment available under only one of these policies for any one *Health Event*. Please refer to the 'Superannuation Optimiser – Active Cover' section on page 29 for further information regarding the policy from which the benefit will be paid.

When cover changes

From the cover anniversary when the insured person turns age 65, cover for *occupational impairment* and cover under the Extended Care option, if applicable, ceases. From the cover anniversary when the insured person turns age 70, cover for all *Health Events* ceases and cover is only provided for:

- *loss of independent existence* (under benefit category A), and
- death and *terminal illness* (under benefit category AA).

From the cover anniversary when the insured person is aged 99, cover for *loss of independent existence* ceases and cover is only provided for death and *terminal illness* under benefit category AA.

Benefit categories

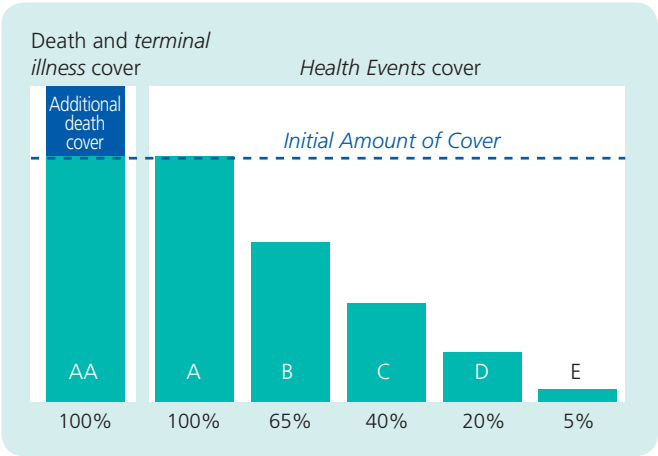
If you make a claim, the amount we will pay depends (in part) on the benefit category that your claim falls into, which is determined according to how serious the condition or event is. The highest benefit category is for death and *terminal illness* (benefit category AA) and the cover is based on the *Initial Amount of Cover* plus any additional death cover that you choose to include. After that, the *Health Event* benefit categories range from A through to E (from most serious to least serious), with the cover based on a percentage of the *Initial Amount of Cover*, as shown in the table below.

The list of *Health Events* covered by your Zurich Active policy and their corresponding benefit categories can be found in the section entitled 'Health Events' on page 44 of this PDS.

The amount we will pay may be reduced if it is not the first claim under the policy. See the section on 'How we calculate the amount we will pay' on page 8.

Benefit category	Type of cover	Percentage of the *Initial Amount of Cover*
AA	Death and *terminal illness*	100%, plus any additional death cover purchased
A	*Health Events*	100% *(Initial Amount of Cover)*
B	*Health Events*	65%
C	*Health Events*	40%
D	*Health Events*	20%
E	*Health Events*	5%[1]

1 If the *Initial Amount of Cover* is less than $200,000, benefit category E will be $10,000 and the percentage for benefit category E will be adjusted accordingly.

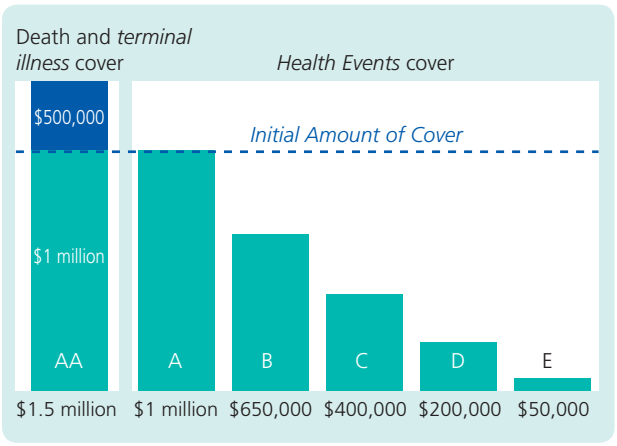


Examples

Throughout the PDS we will provide examples to show how Active cover works. These do not form part of your Zurich Active policy terms and conditions.

All examples are based on Active cover held by Michael, who is a 38 year old male.

Michael applied for an *Initial Amount of Cover* of $1 million plus $500,000 of additional death cover, which when issued provides the following levels of cover per benefit category:



In the examples throughout the PDS, cover has been assumed not to have been increased due to *indexation*.

How we calculate the amount we will pay

First claim under the policy

For a *Health Event*, the amount we will pay for the first claim under the policy is calculated in the following way:

1. Determine the benefit category and percentage that applies for the *Health Event*
2. Multiply the percentage by the *Initial Amount of Cover*

For death or *terminal illness*, we will pay the *Initial Amount of Cover* plus any additional death cover under benefit category AA.

Initial Amount of Cover

The *Initial Amount of Cover* is the amount originally issued, adjusted for Indexation Increases over time, plus any subsequent increases or decreases to the cover that you apply for and we accept. Refer to the Indexation Increases feature on page 12 for more information.

Remaining Amount of Cover

When your policy starts, the *Remaining Amount of Cover* under the policy is equal to the *Initial Amount of Cover.* When a *Health Event* claim is paid under the policy, the *Remaining Amount of Cover* under the policy is reduced by the amount paid for any *Health Event*.

Once the *Remaining Amount of Cover* has reduced to nil under the policy, there is no cover for *terminal illness* or death, unless additional death cover, which is not reduced by *Health Event* claims, has been included.

The Claim Protector feature included in your policy limits the extent to which the *Remaining Amount of Cover* for *Health Events* under benefit categories A to E will reduce. Refer to the Claim Protector feature section on page 11 for more information.

The *Remaining Amount of Cover* is adjusted for indexation increases in line with the *indexation* of the *Initial Amount of Cover.* Refer to Indexation Increases feature on page 12 for more information.

If you request a change to the *Initial Amount of Cover* under your policy, the *Remaining Amount of Cover* will be adjusted so that it retains the same proportion to the *Initial Amount of Cover* as it did before the requested change.

Maximum Amount Payable

The *Maximum Amount Payable* for each of the *Health Event* benefit categories A to E is calculated as the lesser of:

- the *Initial Amount of Cover* multiplied by the applicable percentage for the relevant benefit category, and
- the *Remaining Amount of Cover* under the policy.

If the *Initial Amount of Cover* is less than $200,000, the *Maximum Amount Payable* for benefit category E will be $10,000 and the percentage for benefit category E will be adjusted accordingly.

The *Maximum Amount Payable* for *terminal illness* and death under benefit category AA is the *Remaining Amount of Cover* under the policy plus any additional death cover.

Example: first claim

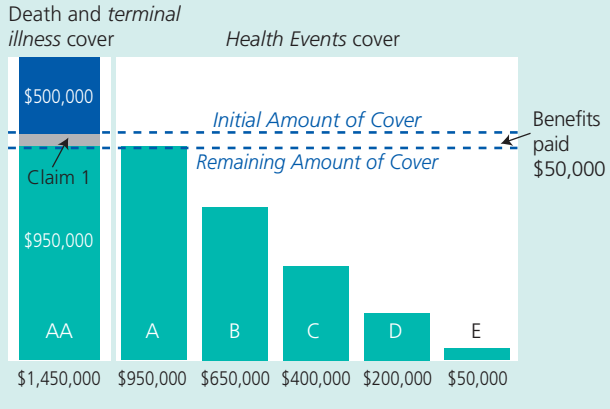
Michael is diagnosed with an early stage melanoma.

The depth and stage of the melanoma falls into the defined criteria for benefit category E under the *Health Event* category for solid tumour cancers, see the Cancer body system on page 44. For this claim, an amount of $50,000 is paid to Michael.

Following this claim, the *Remaining Amount of Cover* under the policy is reduced, resulting in the *Maximum Amount Payable* for each benefit category as shown below.

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,450,000
A	*Health Events*	$950,000
B	*Health Events*	$650,000
C	*Health Events*	$400,000
D	*Health Events*	$200,000
E	*Health Events*	$50,000

In the example, the claim for $50,000 reduces the *Maximum Amount Payable* for benefit categories AA and A as the *Remaining Amount of Cover* is less than the *Initial Amount of Cover* for these categories. For *Health Event* categories B to E there is no impact on the *Maximum Amount Payable.*



Subsequent claims under the policy

Multiple claims can be made under the policy. Any claims that are paid reduce the *Remaining Amount of Cover* available for subsequent claims.

For a subsequent *Health Event* claim, we will pay the *Maximum Amount Payable* applicable to the relevant benefit category for the claim, unless it is a *Progressive Condition* (see below) or falls within the *Limited Claim Period* (see page 10), in which case the amount we pay will be reduced.

For a subsequent claim under the policy that is for death or *terminal illness*, we will pay the *Maximum Amount Payable* under benefit category AA (which is based on the *Remaining Amount of Cover* plus any additional death cover).

Progressive Conditions

There are a number of medical conditions that we will treat as a progression of a prior condition when calculating how much we will pay.

A *Progressive Condition* is any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. For full details of *Health Events* we consider to be *Progressive Conditions*, refer to page 52.

If the condition has progressed in severity, we will pay the difference between the benefit category applicable to the current *Health Event* and the highest benefit category previously paid for the *Progressive Condition(s)*. If the benefit category for the current *Health Event* is the same as the highest benefit category previously paid for the *Progressive Condition(s)*, no benefit is payable.

The amount we will pay for a *Health Event* due to a condition that is a *Progressive Condition* to a claim that has previously been paid is calculated in the following way:

1. Determine the benefit category and percentage that applies for the *Health Event*
2. Deduct the percentage applicable to the benefit category paid for the prior claim that was the *Progressive Condition*[1]
3. Multiply the resulting percentage by the *Initial Amount of Cover*
4. The amount we will pay will be the lesser of the amount calculated above and the *Maximum Amount Payable* for the benefit category applicable to the *Health Event* being claimed.

Example: claim 2 – Progressive Condition

18 months after Michael's initial diagnosis of early stage melanoma, despite treatment, it has recurred and has been detected at a higher stage.

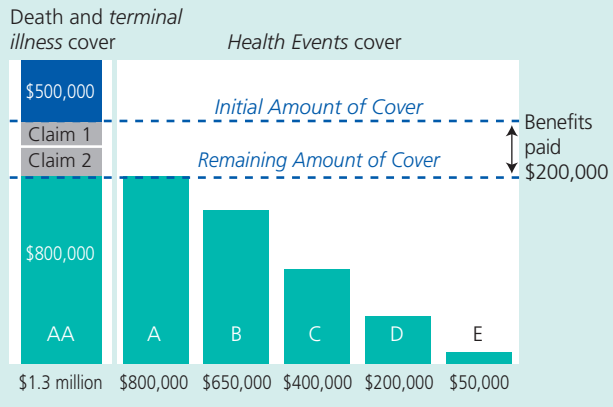
It now meets the defined criteria for benefit category D under the *Health Event* category for solid tumour cancers (see the Cancer body system on page 44).

As this recurrence of the melanoma is a *Progressive Condition* to the previous claim, we will pay the difference between the percentage payable for benefit category of the current claim and that of the previous claim.

In this case, the current benefit category of D provides a benefit of 20%, whilst the previous claim under benefit category E provided a benefit of 5%, therefore the amount payable is 15% of the *Initial Amount of Cover*, which is $150,000. This is the amount that will be paid, as it is not greater than the *Maximum Amount Payable* for benefit category D ($200,000). For this claim, an amount of $150,000 is paid to Michael.

Following this claim, the *Remaining Amount of Cover* under the policy is reduced, resulting in the *Maximum Amount Payable* for each benefit category as shown below.

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,300,000
A	*Health Events*	$800,000
B	*Health Events*	$650,000
C	*Health Events*	$400,000
D	*Health Events*	$200,000
E	*Health Events*	$50,000



1 The relevant percentage for the prior claim (ie the actual amount paid for the claim as a percentage of the *Initial Amount of Cover*) will be used if the prior claim was for the *Health Event angioplasty* or the benefit category E amount was set at $10,000 because the *Initial Amount of Cover* was less than $200,000.

Limited Claim Period

As complications from a medical condition, or its treatment, often arise within the months following a condition and it can be difficult to identify all of these complications, a *Limited Claim Period* applies for 12 months following a *Health Event* claim.

When a *Health Event* occurs, a *Limited Claim Period* starts and lasts for 12 months. If a subsequent *Health Event* occurs during this *Limited Claim Period*, any amounts already paid during the current *Limited Claim Period* will be deducted from the amount we will pay for the current claim. This may result in no benefit being payable for a subsequent condition that falls within the *Limited Claim Period.*

We will not deduct amounts paid for a prior claim for a *Health Event* within the *Limited Claim Period* where either the current claim or the prior claim is/was for a *Health Event* that is the result of an *accident*, unless the *Health Events* are directly or indirectly due to the same underlying cause or event.

Any *Health Event* that occurs during an existing *Limited Claim Period* will not start a new 12 month period. However, the next *Health Event* that occurs outside of a *Limited Claim Period* will start a new *Limited Claim Period.*

The 12 month period commences on the occurrence of each of the *Health Events* and not when the claim for that *Health Event* is paid.

The amount we will pay for a *Health Event* that falls during a *Limited Claim Period* is calculated in the following way.

1. Determine the benefit category and percentage that applies for the *Health Event.*

   If it is a *Progressive Condition* to a claim that occurred prior to the current *Limited Claim Period* apply the *Progressive Condition* reduction (see page 9).

2. Multiply the percentage by the *Initial Amount of Cover.*
3. Deduct all amounts that have been paid during the current *Limited Claim Period.*
4. The amount we will pay will be the lesser of the amount calculated above and the *Maximum Amount Payable* for the benefit category applicable to the *Health Event* being claimed.

Example: claim 3 – Limited Claim Period

Six months following his second claim, Michael has a heart attack.

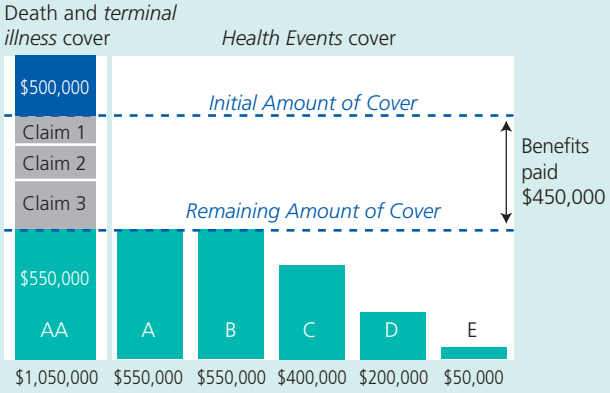
The severity of the heart attack meets the defined criteria for benefit category C under the *Health Event* category for heart attack, see the Heart and artery body system on page 46.

As this claim falls within the *Limited Claim Period* following the previous claim, we will only pay the difference between the amount payable for the current claim and the total of all other amounts paid during the current *Limited Claim Period.* This is calculated as $400,000 for the current benefit category C claim less the $150,000 already paid during the *Limited Claim Period.*

For this claim, an amount of $250,000 is paid to Michael.

Following this claim, the *Remaining Amount of Cover* under the policy is reduced, resulting in the *Maximum Amount Payable* for each benefit category as shown below.

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,050,000
A	*Health Events*	$550,000
B	*Health Events*	$550,000
C	*Health Events*	$400,000
D	*Health Events*	$200,000
E	*Health Events*	$50,000



Michael received a benefit in this case because the heart attack fell within a higher benefit category than the previous melanoma claim that was paid in the same *Limited Claim Period.* Had there been two claims within the *Limited Claim Period* that were within the same benefit category, no further benefit would have been paid.

Claim Protector (*Health Events*) feature

The Claim Protector feature is an important part of your Active cover that applies up to age 65 to ensure that you will have cover for subsequent *Health Events* available, up to the maximums shown in the table below. Under this feature, 25% of the *Initial Amount of Cover* is protected (called the Protected Amount).

For the first 14 days following the occurrence of a *Health Event*, the Claim Protector will not apply and the *Maximum Amount Payable* will be limited to the *Remaining Amount of Cover* under the policy. 14 days after a *Health Event*, if the *Maximum Amount Payable* is less than the Protected Amount, the *Maximum Amount Payable* for benefit categories A to E is increased to the lesser of:

- the Protected Amount, and
- the *Initial Amount of Cover* multiplied by the applicable percentage for the relevant benefit category (refer to page 7 for the percentages that apply),

provided the total amount claimed for *Health Events* under your Active cover does not exceed the limits shown in the table below.

Highest benefit category for which a claim has been paid	Maximum combined total payable for claims that are *Progressive Conditions**	Maximum combined total payable for all *Health Event* claims*
A	$4 million	$6.6 million
B to E	$2.6 million	$5.2 million

* The maximum amount payable includes any amounts paid under the Extended Care option.

The Claim Protector feature does not apply to *terminal illness* or death cover provided under the policy, therefore your death and *terminal illness* cover under the policy may reduce to nil unless additional death cover is included.

Increases to the *Maximum Amount Payable* under the Claim Protector feature are not available:

- after age 65, or
- if a claim for a *terminal illness* under benefit category AA or a *Health Event* that is a *terminal illness* under benefit categories A to E has been paid.

The Protected Amount is adjusted for Indexation Increases in line with *indexation* of the *Initial Amount of Cover*. Refer to the Indexation Increases feature on page 12.

Example: claim 4 – Claim Protector

Five years later, Michael is in a car accident and suffers a back injury.

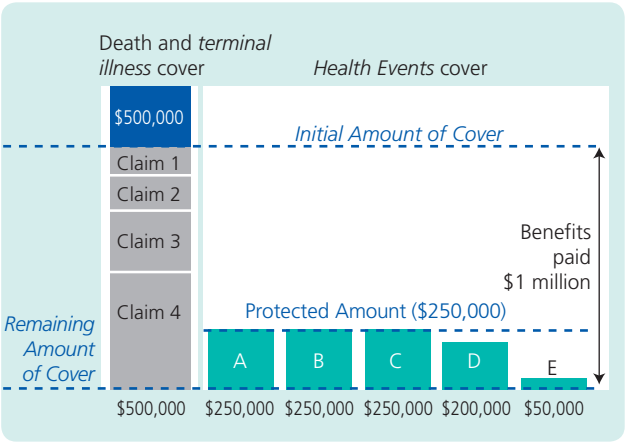
This injury meets the defined criteria for benefit category B under the *Health Event* category for back, limb and whole person impairment, see the Musculoskeletal body system on page 50.

This Health Event is not a *Progressive Condition* of any prior claim, nor has it fallen within a *Limited Claim Period*. Due to the previous claims paid under the policy, the *Maximum Amount Payable* for benefit category B is now $550,000 and this amount is paid to Michael. In total, $1 million has been paid to Michael for his *Health Events* claims.

This last claim has resulted in the *Remaining Amount of Cover* for the policy reducing to nil, making it less than the Protected Amount of $250,000 (25% of the *Initial Amount of Cover*). 14 days following the claim the Claim Protector applies and the *Maximum Amount Payable* for benefit categories A to D is increased as shown in the table below:

Benefit category	*Maximum Amount Payable* in the 14 days following the claim	*Maximum Amount Payable* 14 days after the claim
AA	$500,000	$500,000
A	$0	$250,000
B	$0	$250,000
C	$0	$250,000
D	$0	$200,000
E	$0	$50,000

Benefit categories A to C are increased to the Protected Amount. Benefit category D is increased to $200,000 based on 20% of the *Initial Amount of Cover* and benefit category E is increased to $50,000 based on 5% of the *Initial Amount of Cover.*



The automatic cover for *terminal illness* and death under Michael's policy has reduced to nil. However, because he chose to purchase additional death cover, he has $500,000 of cover remaining for death or *terminal illness*. The additional death cover is not reduced by claims for *Health Events* so will be available despite any future *Health Event* claims.

Financial Planning benefit

Under this feature, we will reimburse the cost of engaging a qualified financial adviser to prepare a financial plan following payment of a claim for *terminal illness,* death or a *Health Event* that falls within benefit category A or B.

The total amount payable under this benefit is the lesser of the actual fee paid for the financial planning advice (excluding any commissions received by the adviser) and $1,000. It is payable on receipt of evidence of:

- the financial advice provided
- the qualifications of the financial adviser, and
- the payment made for that advice.

This evidence must be received by us within 12 months of payment of the claim.

The benefit is payable to the person who receives the claim proceeds. If the claim proceeds are paid to more than one person, the maximum amount payable to each beneficiary for reimbursement of financial planning costs incurred by them will be split proportionally in line with the split of the benefit payment. The benefit is only payable once for the insured person across all cover with us. The financial adviser whose services are being reimbursed must be qualified and operating under an Australian Financial Services Licence.

This benefit is not available under a policy that is owned by the trustee of a superannuation fund.

Funeral Assistance benefit

Under this feature, part of the claim payment for death will be paid in advance so that immediate expenses can be met following your death.

The amount payable is the lesser of:

- 10% of the *Maximum Amount Payable* for benefit category AA, and
- $15,000.

The maximum amount we will pay under the Funeral Assistance benefit (or similar benefit) is $15,000 across all cover held with us for the insured person.

This benefit is not payable if:

- the insured person's death is the result of suicide within 13 months of *cover commencement*
- it is the result of anything that is excluded under the policy, or
- there is reasonable doubt about whether the death benefit will become payable.

Before this benefit becomes payable, we must receive medical evidence as to the cause and the date of death. If we agree this benefit is payable, it will be paid to the nominated beneficiary, the policy owner if different to the insured person, or the legal personal representative of the policy owner, within two business days of receipt of all of the required documents.

The death benefit that is paid will be reduced by the amount of the Funeral Assistance benefit.

The payment of a Funeral Assistance benefit is not an admission of liability and we reserve the right to recover the amount paid if the death benefit is subsequently not paid.

This benefit is not available under a policy that is owned by the trustee of a superannuation fund.

Indexation Increases feature

We will increase the *Initial Amount of Cover*, *Remaining Amount of Cover,* additional death cover and Protected Amount for benefit categories AA to E by the *indexation* rate on each cover anniversary before age 65, so that the policy retains its value over time in line with inflation.

We will tell you the proposed *indexation* increase before it applies and you can choose to decline the increase. If you decline an increase it will not affect future increase offers. To decline an increase, we must receive your notice of decline before the applicable cover anniversary. If you decline an *indexation* increase on the *Initial Amount of Cover*, the *Remaining Amount of Cover* and Protected Amount will also not be increased.

Under the Indexation Increases feature, the *Initial Amount of Cover* can increase above the maximum allowed at application.

Future Increases feature

Under this feature, after certain events for the insured person, you can apply to increase the *Initial Amount of Cover* until age 55, and we will accept the increase without the need for medical underwriting. However, satisfactory evidence of the event for which the increase is sought will be required. The application for an increase under this feature must be made on the appropriate form. The increase only takes effect from when we approve the application for the increase. The following table sets out the events and the maximum amounts by which you can apply to increase the *Initial Amount of Cover*.

The minimum increase to the *Initial Amount of Cover* under the Future Increases feature is $10,000. An increase under this feature cannot be made until 12 months after the cover start date for the applicable insurance cover.

The increase in cover must be requested in the six month period following the event and only one increase may be applied for in any 12 month period under this feature. The maximum amount by which the *Initial Amount of Cover* can be increased under this feature is $1 million.

The *Initial Amount of Cover* cannot be increased above the maximum amounts allowable, as stated on page 4. These maximum limits apply inclusive of all lump sum cover held with us or another insurer for the insured person.

Any premium adjustments, exclusions or special conditions which applied to the original cover will also apply to any increases made under this feature.

This feature is not available if:

- the policy was issued with a premium adjustment in the form of a medical loading of 75% or more, or
- a claim has been or can be made by you for lump sum cover under any policy provided by us.

If an event or condition giving rise to a claim occurs (or for a *Health Event*, the symptoms leading to the condition occurring or being diagnosed first became apparent) during the first six months after an increase in the *Initial Amount of Cover* under this feature, we will only pay a claim in respect of the increased cover if:

- the condition for which the claim is being made is due to an *accident,* and
- the *accident* occurs after the date of the increase.

If you increase your *Initial Amount of Cover,* you can also increase your additional death cover proportionately.

Events	Maximum increase
The insured person marries or registers a *partnership* The insured person or their *partner* gives birth to or adopts a child	The lesser of: • 25% of the *Initial Amount of Cover* when your policy started, and • $200,000.
The insured person takes out a new mortgage or increases an existing mortgage (excluding refinance or draw down)	The lowest of: • 25% of the *Initial Amount of Cover* when your policy started • $200,000, and • the increase in the size of the mortgage.
The *income* of the insured person increases by 15% or more in a 12 month period	The lowest of: • 25% of the *Initial Amount of Cover* when your policy started • $200,000, and • five times the increase in *income.*
The insured person becomes a *carer* for the first time	The lesser of: • 25% of the *Initial Amount of Cover* when your policy started, and • $200,000
The death of the insured person's *partner*	The lesser of: • 25% of the *Initial Amount of Cover* when your policy started, and • $200,000
The insured person divorces or de-registers a *partnership*	The lesser of: • 25% of the *Initial Amount of Cover* when your policy started, and • $200,000
A child of the insured person turns 18	The lesser of: • 25% of the *Initial Amount of Cover* when your policy started, and • $200,000

Additional Death Cover option

This is an option for which an additional premium is charged. Your policy will state whether additional death cover applies and, if so, the amount provided.

You can purchase an amount of additional death and *terminal illness* cover that will be paid if the insured person is diagnosed with a *terminal illness* or dies. The additional death and *terminal illness* cover is added to the *Remaining Amount of Cover* to derive the *Maximum Amount Payable* under benefit category AA. This option ensures you have an amount of death and *terminal illness* cover, separate from your *Health Events* cover, that is not affected by other claims under the policy.

Extended Care option

This is an option for which an additional premium is charged. Your policy schedule will state if the Extended Care option applies to your policy.

The Extended Care option is only available where the combined total of the *Initial Amount of Cover* plus the amount of cover provided under the Extended Care option (being an additional 50% of the *Initial Amount of Cover*) does not exceed $4 million at application.

Under this option, up until the cover anniversary when the insured person is aged 65, an additional amount of 50% of the *Initial Amount of Cover* will be paid if a claim has been paid for a *Health Event* under benefit category A, and the insured person either:

- has the presence of a medically recognised disease or disorder resulting in a *permanent* and irreversible inability to perform four out of six *activities of daily living*, or
- suffers *permanent* and irreversible *WPI* of at least 60%.

A benefit is only payable once under the Extended Care option.

The premium for this option will end on the earlier of the payment of a benefit under the Extended Care option or the cessation of cover for the Extended Care option on the policy cover anniversary when the insured person is aged 65.

The 'Other' body system *Health Event* categories safety net

Health Event claims will first be assessed against the relevant definitions for the affected body system. If in our opinion there is no assessment criteria relevant to your condition under the *Health Event* body system categories, we will assess you against the 'Other Body system' events of 'Inability to perform Activities of Daily Living (ADL)' and 'Occupational impairment'.

When cover is reduced

Cover provided under the policy will be reduced if you request a decrease in your Active cover.

If you request a change to the *Initial Amount of Cover* for *Health Events*, *terminal illness* and death cover under your policy, the *Remaining Amount of Cover* and the Protected Amount will be adjusted so that it retains the same proportion to the *Initial Amount of Cover* as it did before the requested change. The amount we will pay for a *Health Event*, *terminal illness* or death claim may be reduced if it is not the first claim under your policy. Refer to the 'How we calculate the amount we will pay' section on page 8.

When a benefit will not be paid

We will not pay a benefit under your Active cover if any of the following apply in respect of an insured person:

- for death and *terminal illness* (benefit category AA):
  - if the *terminal illness* or death occurs directly or indirectly as a result of an intentional self-inflicted act within 13 months of *cover commencement*. This exclusion will not apply if the *replacement cover waiver – death and terminal illness* applies.
- for *Health Events* cover (benefit categories A–E):
  - if the *Health Event* is caused directly or indirectly by an intentional self-inflicted act at any time
  - if the *Health Event* has a specified exclusion and the claim is for that excluded condition (see *Health Events* section starting on page 44), or
  - if the *Health Event* occurs in the 90 day period following the *application date* or the date any cover is reinstated and the *Health Event* has a 90 day exclusion specified (see *Health Events* section starting on page 44). This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.
  - if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent before the *application date* or the date any cover is reinstated.
- for all cover:
  - if death, *terminal illness*, or the *Health Event* is caused or contributed to by anything excluded under the policy as indicated on the policy schedule.

Optional Child Cover

Child Cover provides a lump sum payment if the insured child suffers one of the *Child Cover Conditions* covered by your policy. The payment could be used to cover additional unexpected expenses as a result of the injury or illness, or provide funds to allow you or your partner to take time off work to care for your child while they are unwell.

Eligible entry ages	2 – 14
Expiry age	21 (cover may be converted to an adult policy once the child is 15)
Minimum Amount of Cover	$10,000
Maximum Amount of Cover	$250,000
Other requirements	You must have, or be applying for, (as policy owner or insured person) Active Cover. The child(ren) to be insured must be your natural, step or adopted child or grandchild.

The tables below summarise the benefits and features available for Child Cover. Please refer to the relevant sections of this PDS for the complete terms and conditions.

Child Cover cannot be owned by a trustee of a superannuation fund.

Included benefits

Benefit name	Description	Page
Child Cover	Pays the Child Cover Amount of Cover if the insured child suffers one of the listed *Child Cover Conditions*.	16

Included features

Feature name	Description	Page
Indexation Increases feature	Increases the Amount of Cover every year by the greater of 3% and the increase in the *consumer price index* so that your cover retains its value against inflation.	16
Continuation of Cover feature	Allows you or the insured child to convert the Child Cover to an adult policy without the need for medical underwriting once they reach the age of 15.	16

The information provided below forms part of your Child Cover terms and conditions. Words or expressions shown in *italics* have their meaning explained in the Glossary at the end of this PDS. Any references to the 'insured person' include references to the 'insured child', where applicable.

Body system	Condition
Cancer of any body system	*aplastic anaemia* *cancer#*
Heart and artery	*cardiomyopathy* *heart attack#* *open heart surgery#* *out of hospital cardiac arrest#*
Brain and nerves	*bacterial meningitis or meningococcal septicaemia* *benign brain tumour with impairment level* *brain damage* *coma* *encephalitis* *major head trauma* *muscular dystrophy with impairment level* *paralysis* *stroke#*

Body system	Condition
Lungs	*chronic lung disease* *primary pulmonary hypertension*
Kidneys	*chronic kidney failure*
Ear, nose and throat	*loss of hearing* *loss of speech or total aphasia*
Eye	*loss of sight*
Musculo-skeletal	*loss of limbs* *severe burns*
Digestive system	*chronic liver disease*
Other	*child's loss of independent existence* *intensive care* *major organ transplant* *medically acquired HIV*

if the *Child Cover Condition* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent in the 90 day period following the *application date* or the date any cover is reinstated for the Child Cover, a benefit will not be paid for the *Child Cover Condition* at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events* and *Child Cover* applies.

When a benefit is payable

Your policy schedule will state if Child Cover applies. If your Zurich Active policy includes Child Cover a benefit equal to the Amount of Cover is payable if, during the *period of insurance*, an insured child:

- dies
- is diagnosed with a *terminal illness*, or
- suffers one of the *Child Cover Conditions* listed in the table on page 15.

We will only pay the Amount of Cover once under the policy for each insured child. Any amount we pay for Child Cover does not reduce the *Remaining Amount of Cover* under your Active cover.

The definitions for all the *Child Cover Conditions* can be found in the Glossary at the end of this PDS.

Indexation Increases feature

We will increase the Amount of Cover, by the *indexation* rate on each cover anniversary before Child Cover ends, so that it retains its value over time in line with inflation.

We will tell you the proposed Indexation Increase before it applies and you can choose to decline the increase. If you decline an increase it will not affect future increase offers. To decline an increase, we must receive your notice of decline before the applicable cover anniversary.

Under the Indexation Increases feature, the Amount of Cover can increase above the maximum allowed at application.

Continuation of Cover feature

This feature allows you or the insured child to commence a policy for the same or lesser amount as the Amount of Cover for the insured child under Child Cover, on any cover anniversary for the Child Cover that falls when the insured child is aged 15 to 21 inclusive, without the need for medical underwriting. Additional information from the insured child may be required at the time of conversion to establish the premium rate that will apply to the insurance.

Once this election is made, the Child Cover for that insured child is cancelled. The Continuation of Cover feature is not available if a claim has been paid or is payable for the insured child under any cover with us.

When a benefit will not be paid

A Child Cover benefit will not be paid in respect of an insured child if the *Child Cover Condition* (or where the *Child Cover Condition* involves surgery or a procedure, the disease or condition for which the surgery or procedure is undertaken):

- is a congenital condition
- is *intensive care* and the *illness* or injury that has caused this condition is as a result of drug or alcohol intake or self-inflicted means
- is caused by the intentional act or intentional omission of the policy owner or the insured child's parent, guardian or a person acting in a regular de facto role as a parent, or
- occurs in the 90 day period following the *application date* or the date any cover is reinstated and the *Child Cover Condition* has a 90 day exclusion specified). This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

A Child Cover benefit will not be paid if we do not receive consent to obtain medical records (past and present) of the insured child.

Optional Income Cover

Income Cover provides a monthly benefit if you are unable to work due to an *illness* or injury and are *totally* or *partially disabled* for longer than the waiting period. It contributes towards a replacement income so that you can concentrate on your recovery without having to worry about how to pay your ongoing expenses.

Eligible entry ages	17 – 60 17 – 64 for the 'to age 70' benefit period with stepped premiums
Expiry age	65, or 70 for the 'to age 70' benefit period
Minimum Monthly Amount of Cover	$1,250
Maximum Monthly Amount of Cover	$30,000 plus an additional $10,000 with a two year benefit period limited to the monthly equivalent of: • 75% of the first $320,000 of annual *income* • 50% of the next $240,000 of annual *income*, and • 20% of the balance of annual *income*.
Occupation requirement	The person to be insured must be *gainfully employed* for a minimum of 20 hours per week at the time of application.
Waiting periods	30 days, 60 days, 90 days, 180 days, 1 year and 2 years*
Benefit periods	2 years, 5 years, to age 65, to age 70#

Restricted to occupation classes 1E, 1L, 1M, and 1P. Subject to certain requirements.
* Not available with a 2 year or 5 year benefit period.

Pages 17 – 18 summarise the benefits, features, and extra cost options, as well as other important information about Income Cover. Please refer to the relevant sections of this PDS for the complete terms and conditions.

If Income Cover is to be held within superannuation, Superannuation Optimiser will apply.

Income Cover types	Description
Income Cover Plus	Available only to those working in occupations classed as 1, 1E, 1L, 1M or 1P.* It includes additional terms with respect to the waiting period requirements, *total disability* definition, and Premium Waiver feature.
Income Cover Standard	Available to all occupation classes.

* Your adviser will be able to assist you to determine your occupation class.

Included benefits	Description	Page
Total Disability benefit	Pays the *monthly benefit* if the insured person is *totally disabled* and unable to earn any income.	20
Partial Disability benefit	Pays part of the *monthly benefit* if the insured person is *disabled* but still earning some income.	21
Specific Injury benefit	Pays the *monthly benefit* for a set period of time if the insured person suffers one of a list of injuries, even if they return to work.	21
Death benefit	Pays up to four times the Monthly Amount of Cover if the insured person dies while receiving a benefit.	22

Included features	Description	Page
Indexation Increases feature	Increases the Monthly Amount of Cover each year by the increase in the *consumer price index* so that cover retains its value against inflation.	22
Involuntary Unemployment Waiver feature	Waives the premium if the insured person becomes *involuntarily unemployed*.	22
Premium Waiver feature	Waives the premium while a benefit is payable.	22
Recurrent Disability feature	Allows the insured person to continue with a previous claim without having to meet the waiting period requirements again if a recurrence of the same *disability* occurs within a certain period of time.	22
Waiting Period Reduction feature	Allows a one year or two year waiting period to be reduced if the insured person leaves an employer and existing salary continuance cover provided ceases.	23
Medical Professionals feature	Provides special terms for medical professionals who contract the Human Immunodeficiency Virus (HIV), Hepatitis B, or Hepatitis C and as a result have their occupational duties restricted.	23

Extra cost options	Description	Page
Extra Benefits option	Provides a comprehensive suite of additional benefits and features such as the Health Event benefit which pays the *monthly benefit* for six months if the insured person suffers a category A *Health Event*, even if they can return to work.	23
Accident option	Allows a benefit to be received during the waiting period if the insured person suffers an accident that causes them to be *totally disabled* for at least four consecutive days.	25
Claims Escalation option	Increases the *monthly benefit* each year by the *consumer price index* while receiving the Total Disability benefit or Partial Disability benefit.	25
Superannuation Cover option	Allows larger portion of *income* to be insured so that in the event of *disability*, a contribution can be made into superannuation.	25
Booster option	Increases the *monthly benefit* payable by 33% for 24 months if the insured person's *disability* meets the definition of a benefit category A *Health Event*.	26

Benefit types

The type of Income Cover chosen will determine how the benefit is calculated at claim time and the type of financial evidence that will need to be provided. Zurich Active Income Cover provides the following three options: Income at Claim, Income at Application, and Endorsed Income at Application.

For some occupations, Income Cover may only be available on an Income at Claim basis.

Benefit type	Description
Income at Claim	When cover is provided on an Income at Claim basis, the benefit payable in the event of a claim is based on the *income* you were earning prior to your *illness* or injury occurring. If your *income* reduces after applying for your policy, you may not receive the full amount for which you are insured. You will need to provide financial evidence at the time of claim to support the benefit being claimed before any benefit can be paid. Evidence of any *post-disability income* will also be required before payment of the Partial Disability benefit.
Income at Application and Endorsed Income at Application	When cover is provided on an Income at Application or Endorsed Income at Application basis, the benefit payable in the event of a claim will be based on your *income* at the time you applied for the cover up to a maximum of the Monthly Amount of Cover. If you elect Endorsed Income at Application, you will need to provide financial evidence at the time of application that supports the benefit for which you are applying. If you elect Income at Application cover, you will instead need to provide this financial evidence at the time of claim before any benefit can be paid. If you cannot substantiate the *income* disclosed at application then your benefit will be reduced accordingly. For both Income at Application and Endorsed Income at Application, you will need to provide evidence of any *post-disability income* before the Partial Disability benefit can be paid.

The waiting period and benefit period

Two important aspects of your Income Cover are your waiting period and benefit period.

Waiting period

This is the period of time before a benefit is payable on your policy. Generally, benefits are not payable during the waiting period.

Income Cover benefits are paid monthly in arrears. This means that if you qualify for a benefit your first payment will be made one month after the end of the waiting period.

For example, consider a policy with a 30 day waiting period. If the insured person suffered an injury on 1 April and as a result could not work at all, provided they meet the claim requirements and supply all the necessary evidence we request:

- the waiting period would end on 1 May (30 days after the injury) and
- the first payment would be paid on 1 June (covering the period from 1 May to 1 June).

Benefit period

This is the maximum period of time for which we will make payments for the same *disability*.

For some occupations certain benefit periods may not be available.

If payments have been made for the full duration of a '2 year' or '5 year' benefit period, new claims with a new benefit period can be considered but only after the insured person makes a successful return to *gainful employment* for at least 20 hours per week for six months before the *disability* recurs. This applies whether the new claim is as a result of a related or unrelated cause.

The information provided in this section forms part of your Income Cover terms and conditions. Words or expressions shown in italics have their meaning explained in the Glossary at the end of this PDS.

The *monthly benefit*

If you have Zurich Active Income Cover a Monthly Amount of Cover will be shown on your policy schedule.

To determine the amount payable each month during a claim, we first calculate the *monthly benefit*. The way your *monthly benefit* is calculated is determined by the benefit type as indicated on your policy schedule.

The Monthly Amount of Cover (plus any Indexation Increases that have been applied up until the date of disability) is the maximum amount that is payable for any given monthly period during a claim. However, where the Booster option applies, the monthly benefit may be higher. See the section entitled 'Booster option' on page 26 for further details.

The *monthly benefit* is calculated as follows:

Endorsed Income at Application

If the benefit type on your policy schedule is Endorsed Income at Application then the *monthly benefit* is your Monthly Amount of Cover as at the date of disability.

Income at Application or Income at Claim

If the benefit type on your policy schedule is Income at Application or Income at Claim then the *monthly benefit* is calculated as the lesser of your Monthly Amount of Cover as at the date of disability and the monthly equivalent of:

- 75% of the first $320,000 of *claimable income*,
- 50% of the next $240,000 of *claimable income*, and
- 20% of the balance of *claimable income*.

For both Income at Application and Income at Claim you will need to provide financial evidence satisfactory to us of *claimable income*.

If the Superannuation Cover option is indicated on your policy schedule, different limits will apply. Please see the section entitled Superannuation Cover option on page 25 for further details.

If the Claim Escalation option applies (see page 25 for more details), the monthly benefit may be increased at each cover anniversary occurring after the date of disability.

Different benefit types

If your policy schedule indicates that you have both Endorsed Income at Application and Income at Claim benefit portions then the *monthly benefit* will be the greater of:

- the Monthly Amount of Cover of the Endorsed Income at Application portion, and
- the *monthly benefit* calculated on the basis of the total of all Monthly Amounts of Cover being treated as Income at Claim.

Once calculated, the *monthly benefit* is used to determine the benefit payable from either the Total Disability benefit, Partial Disability benefit, Specific Injury benefit, or Health Events benefit (if the Extra Benefits option applies) depending on your *disability*. Please see the relevant sections of the PDS for further details of these benefits.

If the 'to age 70' benefit period has been selected, the *monthly benefit* will be calculated on an Income at Claim basis for any new claim where the waiting period commences on or after the cover anniversary when the insured person is 65.

If the policy schedule indicates that Superannuation Optimiser applies, please also refer to the section entitled 'Superannuation Optimiser – Income Cover' on page 29 for important information regarding how payments are made from the two linked policies under which your benefits are provided.

Claimable income

Claimable income is used to determine your *monthly benefit* if your benefit type is Income at Application or Income at Claim. You will need to provide evidence that is satisfactory to us of *claimable income* to support the Monthly Amount of Cover for which you applied before we will make any payments to you. If you are unable to provide financial evidence to support the Monthly Amount of Cover then your *monthly benefit* will be reduced accordingly.

IMPORTANT: the definition for *claimable income* is different for Income at Application and Income at Claim policies as detailed below.

Income at Application

Claimable income is the highest of either the highest average monthly *income* for any 12 consecutive months in the 36 months preceding the start of the waiting period applying to the claim, and

- if the insured person is an Employee:
  - their *income* for the 12 months immediately prior to the application for cover (or approved increase)
- if the insured person is Self-Employed and their *income* in the 12 months prior to the application for cover (or approved increase) reduced by more, or increased by less, than 20% when compared to the *income* of same period 12 months earlier:
  - their *income* in the 12 months immediately prior to the application for cover (or approved increase)
- if the insured person is Self-Employed and the above does not apply:
  - the average of their *income* over the 24 months immediately prior to the application for cover (or approved increase).

The insured person's *income* prior to application will be increased by the increase in the *consumer price index* at each cover anniversary until the date of *disability*.

Income at Claim

Claimable income is the highest average monthly *income* for any 12 consecutive months in the 36 months preceding the start of the waiting period applying to the claim.

The benefit period

The benefit period is the maximum period for which a claim for *disability* is payable. The benefit period that applies is shown on your policy schedule.

The benefit period for a claim starts at the end of the waiting period and continues until the earlier of:

- the end of the selected benefit period (if the benefit period selected is 'to age 65' or 'to age 70', the benefit period ends at the cover anniversary when the insured person is aged 65 or 70, respectively), and
- the date when cover ends (see the section, 'When cover ends' on page 33).

If Superannuation Optimiser applies, the remaining benefit period for a two year or five year benefit period will also be reduced under a linked policy.

The waiting period

The waiting period is the period of time you must wait before a benefit is payable under your policy. The waiting period that applies is shown on your policy schedule.

The waiting period for a claim begins on the date of disability, which is the day the insured person is *disabled* due to *illness* or injury and has consulted a *medical practitioner* in relation to their *disability*.

On the basis of medical and other evidence acceptable to us, we may reduce the waiting period by up to seven days, determined by the number of continuous days for which the insured person was absent from *gainful employment* due to *illness* or injury prior to first consulting a *medical practitioner* in relation to their *disability*.

Return to work during the waiting period

The waiting period will restart if the insured person returns to work and is no longer *disabled*. However we will allow the insured person to return to work during the waiting period, without the waiting period restarting for up to:

- five consecutive days if the waiting period is 30 days
- 10 consecutive days if the waiting period is 60 days, 90 days, 180 days, 1 year or 2 years, and
- six consecutive months if the waiting period is 2 years and the insured person is also covered by a type of disability income insurance with a benefit period of two years provided through membership of a regulated superannuation scheme in Australia or provided through their employer.

The waiting period will be extended by the number of days worked while the insured person is not *disabled*.

Total Disability benefit

If you have Income Cover Standard as shown on your policy schedule, the Total Disability benefit is payable if, during the *period of insurance*, the insured person:

- has been continuously *disabled* during the waiting period and is *totally disabled* for at least five consecutive days during that time
- is *totally disabled* after the end of the waiting period, or after a period during which a Partial Disability benefit has been paid for the same *illness* or injury, and
- continues to be *totally disabled*.

If you have Income Cover Plus as shown on your policy schedule, the Total Disability benefit is payable if, during the *period of insurance*, the insured person:

- has been continuously *disabled* during the waiting period
- is *totally disabled* after the end of the waiting period, or after a period during which the Partial Disability benefit has been paid for the same *illness* or injury, and
- continues to be *totally disabled*.

Calculating the benefit payable

The Total Disability benefit payable is the *monthly benefit*, adjusted to take into account any:

- offsets which apply, as explained in the section titled 'When the *monthly benefit* is reduced' on page 27, and
- increases to the *monthly benefit* under the Claims Escalation option, if it applies, as explained on page 25.

The Total Disability benefit is payable monthly in arrears for each day of *total disability* after the end of the waiting period (1/30th of the Total Disability benefit payable per day if the benefit is only payable for part of a month), but not beyond the end of the benefit period for that *disability*.

Partial Disability benefit

If you have a Zurich Active Income Cover policy as shown on your policy schedule, the Partial Disability benefit is payable if, during the *period of insurance*, the insured person:

- has been continuously *disabled* during the waiting period
- is *partially disabled* after the end of the waiting period, or after a period during which the Total Disability benefit has been paid for the same *illness* or injury, and
- continues to be *partially disabled*.

Calculating the benefit payable

The Partial Disability benefit payable is a proportion of the *monthly benefit*, calculated as follows:

$$\frac{\textit{pre-disability income} - \textit{post-disability income}}{\textit{pre-disability income}} \times \textit{monthly benefit}$$

adjusted to take into account:

- the indexation of pre-disability income at each cover anniversary as explained on page 66, and
- increases to the *monthly benefit* under the Claims Escalation option, if it applies, as explained on page 25; and
- any offsets which apply, as explained in the section titled 'When the *monthly benefit* is reduced' on page 27.

The Partial Disability benefit is payable monthly in arrears for each day of *partial disability* after the end of the waiting period (1/30th of the Partial Disability benefit payable per day if the benefit is only for part of a month) but not beyond the end of the benefit period for that *disability*.

Specific Injury benefit

If you have a Zurich Active Income Cover policy as shown on your policy schedule, and the insured person suffers one of the injuries listed below during the *period of insurance*, we will pay the *monthly benefit* for the number of months indicated, regardless of whether the insured person is *totally disabled*.

Payments will be made during the waiting period.

Injury	Payment period
Paralysis	60 months*
Total and permanent loss of any two of: • the use of a foot from the ankle joint • the use of a hand from the wrist • the sight in an eye that is irreversible.	24 months
Total and permanent loss of any one of: • the use of a foot from the ankle joint • the use of a hand from the wrist • the sight in an eye that is irreversible.	12 months
Total and complete severance of the thumb and index finger from the phalangeal joint of the same hand.	6 months
Fracture of thigh or pelvis.	3 months
Fracture of the leg (between the knee and foot) or knee cap.	2 months
Fracture of the upper arm (including elbow and shoulder bone).	2 months
Fracture of the skull (except bones of the nose or face).	2 months
Fracture of the lower arm (including wrist, but excluding elbow, hands or fingers).	1 month
Fracture of the jaw or collarbone.	1 month

* If the benefit period is two years, the payment period for *paralysis* under this feature is 24 months.

If the benefit period is '2 years' or '5 years', the benefit period for *disability* due to, or related to, an injury for which we have paid the Specific Injury benefit is reduced by the number of months for which we have paid the Specific Injury benefit.

If the insured person suffers more than one specific injury at the same time, we will only pay for one specific injury, being the one with the longest payment period.

If we are paying benefits under the Specific Injury benefit, payments will cease if Income Cover ends, explained in the section titled 'When cover ends' on page 33.

The Specific Injury benefit is only available on cover held outside of superannuation. Refer to the section titled 'Policy ownership' on page 28.

Death benefit

If you have a Zurich Active Income Cover policy and the insured person dies while a benefit is being paid, we will continue to pay a monthly benefit equal to the Monthly Amount of Cover, for a period of four months from the date of death upon receipt of the death certificate.

The maximum combined benefit we will pay for the four months is $75,000. If you have the Extra Benefits option as shown on your policy schedule, the maximum amount we will pay for the four months is $150,000.

Indexation Increases feature

So that your cover retains its value over time in line with inflation, on each cover anniversary before the insured person reaches age 65, we will increase the Monthly Amount of Cover by the increase in the *consumer price index*. If the change in the *consumer price index* is zero or negative, the Monthly Amount of Cover will not change.

We will tell you the proposed indexation increase before it applies and you can choose not to accept the increase. If you decline an indexation increase it will not affect future Indexation Increases offers. To decline an indexation increase, we must receive your notice of decline before the applicable cover anniversary.

If your Zurich Active Income Cover policy provides cover on an Income at Claim basis, you should consider whether, by accepting an increase, your Monthly Amount of Cover will exceed the *monthly benefit*.

If your Zurich Active Income Cover policy provides cover on an Income at Application or Endorsed Income at Application basis, the indexation increases applied to the Monthly Amount of Cover will not need to be financially verified at time of claim.

Under the Indexation Increases feature, the Monthly Amount of Cover can increase above the maximum allowed at application.

Premium Waiver feature

We will waive the premium payable under your Zurich Active Income Cover policy while a benefit is payable under the policy. If the benefit otherwise payable is reduced to nil because benefit reductions apply (see the section entitled 'When the *monthly benefit* is reduced' on page 27) the premium will not be waived.

If you have Income Cover Plus as shown on your policy schedule, the premium will also be waived during the waiting period, if a benefit becomes payable under the policy.

Involuntary Unemployment Premium Waiver feature

We will waive the premium payable under your Zurich Active Income Cover policy for the period while the insured person is *involuntarily unemployed*, up to a maximum of three months, where the following conditions are met:

- at least six months has elapsed since the policy commenced or was last reinstated or last recommenced after a period of premium and policy suspension
- premiums due in that six month period have been paid in full
- the insured person is *involuntarily unemployed* for at least 10 consecutive working days, and
- during the period of *involuntary unemployment*, the insured person is registered with Centrelink or other government approved job placement agency as a job seeker.

The premium will be waived due to *involuntary unemployment* for a maximum of three months in any 12 month period and a total maximum of six months inclusive of all cover held with us for the insured person over the life of the policy. If the premium is paid on an annual basis, we will provide a pro rata refund of the premium that has already been paid for each month that you are eligible for the Involuntary Unemployment Premium Waiver.

This feature is not available if the insured person was self-employed immediately prior to *involuntary unemployment*.

Recurrent Disability feature

If the benefit period under your Zurich Active Income Cover policy is 'to age 65' or 'to age 70', any claim for *disability* arising from the same or a related cause as a previous claim that occurs within 12 months of the date to which benefits have been paid for the previous claim, will be treated as a continuation of the previous claim and the waiting period will be waived. If the claim is made more than 12 months after the previous claim ended it will be treated as a new claim and a new waiting period will apply.

If the benefit period under your Zurich Active Income Cover policy is '2 years' or '5 years', or this insurance has been extended beyond the cover anniversary when the insured person is aged 65 under the terms of the Cover Extension feature on page 25, any claim for *disability* arising from the same or a related cause as a previous claim that occurs within six months of the date to which benefits have been paid for the previous claim, will be treated as a continuation of the previous claim and the waiting period will be waived. If the claim is made more than six months after date to which benefits have been paid for the previous claim, a new waiting period will apply. A new benefit period will apply only if the insured person made a successful return to *gainful employment* of at least 20 hours per week for a continuous period of six months.

Waiting Period Reduction feature

If you have a Zurich Active Income Cover policy and the waiting period is '1 year' or '2 years' as shown on your policy schedule, the waiting period can be reduced without medical underwriting to '1 year' or '90 days' if the insured person also has salary continuance cover provided through their employer and that cover terminates because they leave their employer. This is not available if they:

- elect to take up any continuation of cover option on the salary continuance cover
- are on claim or eligible to claim (on either policy) at the time of applying to reduce the waiting period, or
- are not engaged in *gainful employment* of at least 20 hours per week with a new employer.

You must apply to change the waiting period within 30 days of the insured person ceasing employment with the employer through which the salary continuance cover was provided. Evidence of the cover, cessation of employment and other information necessary to assess eligibility is required at the time of applying to reduce the waiting period.

The premium will be adjusted accordingly for any change made to the waiting period under this feature.

Medical Professionals feature

If a medical professional contracts HIV, Hepatitis B or Hepatitis C, professional guidelines may restrict their ability to perform certain procedures and result in a reduction of income, well before the illness results in a physical inability to perform the duties of their occupation.

Under Zurich Active Income Cover, we will consider that a medical professional has satisfied the occupational duties component of the *total disability* or *partial disability* definition if the following apply:

- the occupation class shown on your policy schedule is 1M
- the insured person becomes infected with HIV, Hepatitis B or Hepatitis C as confirmed by documented proof of the infection
- at the time of infection, exposure-prone procedures, as defined by the relevant professional governing body, are at least one of the duties of the insured person's *usual occupation* necessary to produce *income*, and
- due to the insured person's HIV, Hepatitis B or Hepatitis C status, they are required to cease performing exposure prone procedures as a result of the guidelines of the professional governing body in their state.

The other components of the Total Disability benefit and Partial Disability benefit as applicable, must also be satisfied in order for a claim to be admitted.

The Medical Professionals feature will not apply if:

- a treatment is available which renders the HIV or Hepatitis B or Hepatitis C virus (as applicable) inactive and non-infectious, or
- the insured person has elected not to take an approved vaccine that is recommended by the relevant professional governing body for use in the insured person's occupation and which is available prior to the event which causes infection.

Extra Benefits option

This is an optional package of additional benefits and features for which an additional premium is charged. If the Extra Benefits option applies, it will be shown on your policy schedule.

The Extra Benefits option includes the following benefits and features:

- Health Events benefit
- Bed Confinement benefit
- Home Care benefit
- Rehabilitation Expenses benefit
- Accommodation benefit
- Future Increases feature
- Cover Extension feature.

Health Events benefit

If you have Income Cover with the Extra Benefits option and the insured person suffers a *Health Event* that meets benefit category A or B after the Health Events benefit starts and before Income Cover ends, we will pay the *monthly benefit* for six months, regardless of whether the insured person is *disabled*. Payments will be made during the waiting period.

For some *Health Events*, a 90 day exclusion applies, as explained in the *Health Events* section starting on page 44.

We will only pay once for each *Health Event* (and *Progressive Condition*) under this benefit.

If the benefit period is 2 years or 5 years, the benefit period for *disability* due or related to a condition for which we have paid the Health Event benefit is reduced by number of months for which we have paid the Health Events benefit.

If the insured person suffers more than one *Health Event*, we will only pay for one *Health Event* at a time.

If we are paying benefits under the Health Events benefit, payments will cease if Income Cover ends, explained in the section titled 'When cover ends' on page 33.

Bed Confinement benefit

If the insured person is *totally disabled*, confined to bed, as confirmed by a *medical practitioner*, and is under the care of a registered nurse for 72 hours or more during the waiting period, we will pay 1/30th of the *monthly benefit* for each day of such bed confinement during the waiting period.

The Bed Confinement benefit is payable for a maximum of 90 days.

Home Care benefit

If a Total Disability benefit has been paid for at least 30 days, and the insured person is confined to bed as a result of continuing *total disability*, as confirmed by a *medical practitioner*, we will increase the amount we will pay in a month to cover either:

- the forgone *income* of an *immediate family member* who provides satisfactory evidence to us that they were *gainfully employed* for at least 20 hours per week prior to the insured person suffering the *illness* or injury and have ceased to be *gainfully employed* to care for the insured person, or
- the cost of employing a registered nurse or housekeeper.

The additional amount we will pay each month is limited to the lesser of $5,000 or the amount equivalent to the *monthly benefit*, for a maximum of six months. This benefit starts to accrue on the first day all of the above requirements are met and is paid monthly in arrears.

This benefit is in addition to any benefit payable for the Total Disability benefit.

Rehabilitation Expenses benefit

If a Total Disability benefit is payable, we will increase the amount we will pay in a month to cover all or part of any rehabilitation expenses or costs associated with a rehabilitation programme for the insured person that we have approved in advance. A maximum payment of 12 times the *monthly benefit* applies under this benefit.

This benefit is in addition to any benefit payable for the Total Disability benefit or Partial Disability benefit.

Accommodation benefit

If the insured person is *totally disabled* and confined to bed, as confirmed by a *medical practitioner*, and an *immediate family member* requires accommodation at a location more than 100 kilometres from their home to be closer to the insured person, we will increase the amount we will pay in a month to cover the costs of accommodation up to $250 per day for a maximum of 30 days in any 12 month period.

The Accommodation benefit is payable during the waiting period. This benefit is in addition to any benefit payable for the Total Disability benefit.

Future Increases feature

Under this feature, you can apply to increase your Monthly Amount of Cover on each cover anniversary until the insured person turns 55, and we will accept the increase without the need for medical underwriting.

Only increases to the Monthly Amount of Cover above $500 are eligible for applications under the Future Increases feature.

The Monthly Amount of Cover cannot be increased under the Future Increases feature:

- by more than 15% at any cover anniversary, or
- above the monthly equivalent of a percentage of the annual *income* of the insured person, calculated as follows:
  - 75% of the first $320,000
  - 50% of the next $240,000, and
  - 20% of the balance,

  subject to a maximum Monthly Amount of Cover of:
  - $40,000 per month if the benefit period is '2 years', or
  - $30,000 per month for other benefit periods (plus an additional $10,000 per month for the first 24 months of the benefit period).

The combined total of all increases to the Monthly Amount of Cover made under this feature cannot exceed the Monthly Amount of Cover originally issued.

Financial evidence may be required to establish that the insured person's *income* supports the increase to the Monthly Amount of Cover.

The increase in cover must be requested in the 30 days prior to the applicable cover anniversary and must be made on the appropriate form. The increase only takes effect from when we approve the application for the increase.

Any premium adjustments, exclusions or special conditions which apply to the insurance will also apply to any increases made under this feature.

This feature is not available if:

- the policy was issued with a premium adjustment in the form of a medical loading of 75% or more, or
- a claim has or can be made for the insured person under any income replacement or business expenses policy provided by us.

Cover Extension feature

This feature applies if the occupation class shown on your policy schedule is 1E, 1L, 1M or 1P.

Under this feature we will offer to continue Income Cover beyond the cover anniversary when the insured person is aged 65, if the insured person is employed in an occupation which we insure under our standard underwriting guidelines at the time the offer is made.

This offer will not apply if:

- we originally offered cover with a limitation on the term of the policy so that cover expires earlier than the cover anniversary when the insured person is aged 65
- we originally offered cover with a premium adjustment due to medical reasons, or
- the insured person was eligible to receive a Total Disability benefit or Partial Disability benefit in the 12 month period preceding the date the offer would otherwise be available.

Cover under this feature will be provided on the following modified terms:

- on an Income at Claim basis
- a benefit period of 12 months
- benefits will only be payable for the Total Disability benefit, Partial Disability benefit and Death benefit
- the Extra Benefits option, Claims Escalation option, Accident option and Superannuation Cover option will not apply
- the Indexation Increases feature will not apply, and
- the maximum *monthly benefit* we will pay is $15,000.

Cover can continue on the modified basis until the earlier of:

- the cover anniversary when the insured person is aged 70, and
- the insured person has not been in *gainful employment* of at least 20 hours a week for six consecutive months.

Accident option

This is an option for which an additional premium is charged. If the Accident option applies, it will be shown on your policy schedule.

It is only available if a 30 day waiting period applies. For some occupations, the Accident option may not be available.

If the insured person is *totally disabled* for at least four consecutive days within 30 days of suffering an *accident* the *monthly benefit* for the Total Disability benefit will be payable during the waiting period.

The *monthly benefit* is payable in arrears for each day of *total disability* including the first four consecutive days (1/30th of the *monthly benefit* per day if the benefit is only payable for part of the month), but not beyond the end of the waiting period for that *illness* or injury.

Claims Escalation option

This is an option for which an additional premium is charged. If the Claims Escalation option applies, it will be shown on your policy schedule.

While the Total Disability benefit or Partial Disability benefit is being paid, we will increase the *monthly benefit* at each cover anniversary that occurs after the date of disability by any increase in the *consumer price index*.

Superannuation Cover option

The Superannuation Cover option allows you to insure a higher portion of your *income* so that you can continue to make superannuation contributions while you are *disabled*. It is not available where Superannuation Optimiser applies. Refer to the section titled 'Policy ownership' on page 28.

If the Superannuation Cover option applies, it will be shown on your policy schedule along with a percentage which is the proportion of the *monthly benefit* that will be paid to a nominated superannuation fund (after any adjustment for tax) while we are paying you a benefit under Income Cover.

The percentage is calculated at the time of application and is calculated by dividing the monthly superannuation contribution being insured by the Monthly Amount of Cover.

Effect on the *monthly benefit* calculation

If the Superannuation Cover option applies then the way in which your Income at Claim and Income at Application *monthly benefit* is calculated will be altered to be the monthly equivalent of:

- 100% of *claimable income* contributed to superannuation (to a maximum of 20% of *claimable income*)
- 75% of the next $320,000 of *claimable income*
- 50% of the next $240,000 of *claimable income*, and
- 20% of the balance of *claimable income*.

The *monthly benefit* calculated cannot exceed the Monthly Amount of Cover.

Example

An applicant earns an annual salary package of $110,000 (inclusive of $10,000 superannuation contributions).

	Superannuation Cover amount	Remainder of Income	Monthly Amount of Cover
Without Superannuation Cover option	Nil	75% x $110,000 = $82,500 / 12 = $6,875	$6,875
With Superannuation Cover option	100% x $10,000 = $10,000 / 12 = $833	75% x $100,000 = $75,000 / 12 = $6,250	$7,083

The percentage of any benefits paid to the nominated superannuation fund at the time of claim is 11.76% ($833 / $7,083).

Payment of the Superannuation Cover amount

You must provide us with the name and details of a nominated superannuation fund to which the Superannuation Cover portion of any benefits payable is to be paid. If you do not provide us with a direction at time of claim, we may not be able to pay the Superannuation Cover amount.

If the fund you nominate does not accept the Superannuation Cover amount from us, we will pay it to you subject to proof that the amount is subsequently forwarded to a superannuation provider for the insured person's benefit.

We will adjust the Superannuation Cover amount for the potential tax liability that may apply to this amount based on the marginal rate of tax that would otherwise have applied to the last dollar of the insured person's *pre-disability income*. The tax adjustment amount will be paid directly to you and the Superannuation Cover amount reduced by this tax adjustment amount before it is paid to the nominated superannuation fund.

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

Booster option

This is an option for which an additional premium is charged. If the Booster option applies, it will be shown on your policy schedule.

It is only available with a benefit period of 'to age 65' or 'to age 70' and where the Monthly Amount of Cover applied for at application, inclusive of any Superannuation Cover amount, is $30,000 per month or less.

Under this option, if the insured person is eligible for a *Health Event* claim under benefit category A, we will increase the *monthly benefit* by 33% under the Total Disability benefit, Specific Injury benefit or Health Event benefit for a maximum of 24 months for a claim for any *disability* arising from the same or a related cause.

Any benefits payable after the cover anniversary when the insured person is age 65 will not be subject to increases under this option. The Booster option does not apply to a claim for the Partial Disability benefit, Death benefit, Bed Confinement benefit, Home Care benefit, Rehabilitation benefit, Accommodation benefit or benefits payable under the Accident option.

The Indexation Increases feature and the Claims Escalation option will continue to apply.

If the Superannuation Cover option applies, the Superannuation Cover percentage will be applied to the increased benefit payable to determine the amount payable to the trustee of your nominated superannuation fund.

When the *monthly benefit* is reduced

The *monthly benefit* payable for the Total Disability benefit or Partial Disability benefit may be reduced by any of the following payments that are made or are payable in respect of the insured person:

- legislated compensation schemes and Workers' Compensation (unless your Zurich Active Income Cover policy schedule shows the insured person is categorised with an occupation class of 1E, 1L, 1M or 1P), and
- any other insurance that provides income payments due to *illness* or injury, which commenced prior to the commencement of the Zurich Active Income Cover policy unless we have expressly agreed in writing not to apply a reduction.

If a lump sum is paid by any of the above sources in respect of the insured person, we will convert that lump sum to a monthly payment at the rate of 1% of the lump sum paid per month for the first 100 months. Benefit reductions will only start once the lump sum has been paid.

The benefit we will pay will only be reduced to ensure that, when combined with the payments from any of the above sources and any *post-disability income*, it does not exceed the monthly equivalent of 75% of *pre-disability income* (100% of *pre-disability income* for the Partial Disability benefit or while the *monthly benefit* is increased under the Booster option).

One benefit payable

If the insured person is eligible for one or more benefit(s) payable for the Total Disability benefit, Partial Disability benefit, Specific Injury benefit, Health Events benefit, Bed Confinement benefit or Accident option at the same time, only one benefit will be payable, being the benefit which provides the highest payment.

When portions of the Monthly Amount of Cover are subject to different terms

Where we agree, your Zurich Active Income Cover policy may be set up so that separate portions of the Monthly Amount of Cover are subject to different waiting periods, benefit periods, types of cover and/or options. Details of each portion of the Monthly Amount of Cover, and the waiting periods, benefit periods, types of cover and options that apply to each portion, will be shown on the policy schedule issued to you.

In determining the *monthly benefit* to be used as the basis for the payment of any benefit(s) under the policy in any given month, we will consider the sum of only those portions of the Monthly Amount of Cover for which the particular benefit is payable, having regard to the waiting period, benefit period, type of cover and options that are applicable.

When we won't pay

A benefit will not be payable under Income Cover for a claim which is caused or contributed to by:

- an intentional self-inflicted act
- normal or uncomplicated pregnancy or childbirth
- war or an act of war
- anything excluded under the policy as indicated on the policy schedule
- elective surgery that occurs within six months of *cover commencement*
- for claims payable under the Health Events benefit on page 23, if the *Health Event* occurs in the 90 day period following the *application date* or the date any cover is reinstated and the *Health Event* has a 90 day exclusion specified (see *Health Events* section on page 44). This exclusion will not apply if the *replacement cover waiver – Income Cover Health Events benefit* applies.

We will not pay for any period while the insured person is in jail.

Benefits are only payable for up to six months while the insured person is outside Australia. In some circumstances, benefits may continue to be paid beyond six months if the insured person returns to Australia or attends a regional medical facility approved by us.

The payment of Income Cover benefits will end if the insured person unreasonably refuses to undergo the medical treatment including rehabilitation to treat their condition as recommended by their *medical practitioner.*

Policy ownership

You can structure your insurance with:

- **non-superannuation ownership**: where one or more individuals, a company, or a trust (ie an entity that is not a trustee of a superannuation fund) owns the insurance
- **superannuation ownership**: where a trustee of a superannuation fund (of which you are a member) owns the insurance. This can include:
  - the trustee of an *eligible superannuation fund*
  - a trustee of a self-managed superannuation fund (SMSF).

In some cases we allow insurance to be split across two policies, with different policy owners.

Non-superannuation ownership

When you apply for cover outside of superannuation, the policy is issued directly to you as policy owner. Any of the types of cover under Zurich Active can be held under a non-superannuation policy.

Where there are multiple owners of a single policy who are individual persons, each will own the policy as joint tenants (ie on the death of one of the policy owners, their share passes to the surviving joint tenants), unless they own the policy as trustees or we agree to a different arrangement which we will note on the policy.

If a benefit becomes payable, the benefit is generally paid to the policy owner. If the insured person and policy owner are the same, the amount payable on the death of the insured person will generally be paid to the legal personal representative, unless any beneficiaries have been nominated under the policy, in which case it will generally be paid to the nominated beneficiaries.

Nominating a beneficiary for death cover

If the policy owner is the same as the insured person, up to five beneficiaries can be nominated to receive the benefit payment if the insured person dies. If you do not nominate a beneficiary, the benefit will be paid to your legal personal representative or other person we are permitted to pay under the Life Insurance Act 1995 (Cth).

Each beneficiary you nominate must be a person, a company, a trust, or a legally recognised charity. You can change or cancel these nominations at any time in writing. A change in a nomination only takes effect when received by us. At time of claim, if part of a nomination is invalid or one of the nominated beneficiaries has predeceased the insured person, the proceeds in relation to that invalid part or predeceased nominated beneficiary will be paid to your legal personal representative.

If a nominated beneficiary is a minor, we will pay the proceeds in relation to that nominated beneficiary to their legal guardian or into a trust for which that minor is a beneficiary.

All nominations will automatically cease if ownership of the policy is transferred.

Ownership within superannuation

When you apply for cover within superannuation, the policy for cover on your life is issued to the trustee of the relevant superannuation fund as policy owner.

If you are the trustee of a self-managed superannuation fund, it is your responsibility as trustee to consider:

- the appropriateness of providing each type of insurance cover within superannuation and its potential implications for the complying status of your fund
- the taxation consequences of holding the cover, and
- *superannuation law* that operates to limit when benefits received by you as trustee can be paid out of the fund.

If a benefit becomes payable under a Zurich Active policy held within superannuation, it will be paid to the trustee, who must distribute the benefit in accordance with the governing rules of the superannuation plan and *superannuation law* current at the time of payment.

Restrictions on insurance held within superannuation

Superannuation law requires superannuation fund trustees to ensure insurance benefits they acquire from 1 July 2014 are aligned with the superannuation payment rules. We have applied restrictions to the insurance benefits we offer to superannuation fund trustees in accordance with these requirements.

See below for details of the terms that apply to Zurich Active cover held within superannuation. The 'Superannuation Optimiser – Income Cover' section on page 29 provides the terms that apply to Income Cover held within superannuation.

Zurich Active cover within superannuation

The Funeral Assistance benefit is not available if your insurance is held within superannuation.

All *Health Events* provided within superannuation are subject to the condition that, at the time of claim, the insured person also satisfies the definition of *permanent incapacity.*

Zurich Active cover within superannuation is subject to the Superannuation Optimiser structure, in which case benefits that do not meet *permanent incapacity* are excluded from the superannuation policy, but will be held on a non-superannuation policy.

The Financial Planning benefit is held under the non-superannuation policy where Superannuation Optimiser applies.

Superannuation Optimiser – Active cover

If you choose to hold part of your Zurich Active cover within superannuation, two policies will be issued under a structure called Superannuation Optimiser:

- a superannuation policy which will be owned by the trustee of a superannuation fund, and
- a separate non-superannuation policy which will provide the cover that cannot be issued under a superannuation policy.

The policy issued to the trustee of a superannuation fund will hold the cover for death and *terminal illness* and part of the cover for *Health Events*. The *Health Events* which are included are those covered under benefit category A and which also meet the definition of *permanent incapacity*. We refer to this policy as the 'superannuation policy'. The cover provided under this policy has been designed to align with the *superannuation law* payment rules.

The balance of the cover for *Health Events* not included under the superannuation policy will be held under a separate policy which we refer to as the 'non-superannuation policy'. The two policies will be linked together in a Superannuation Optimiser structure so that claims that are paid under one policy will reduce the *Remaining Amount of Cover* available under both policies. The effect of this structure is that the same amount of cover is provided, but split between two separate policies.

Superannuation policy	Non-superannuation policy
• Death • *Terminal illness* • *Health Events* covered under benefit category A (meeting the definition of *permanent incapacity)* • Extended Care option (meeting the definition of *permanent incapacity)*	• *Health Events* covered under benefit category A (not meeting the definition of *permanent incapacity*) • *Health Events* covered under benefit category B, C, D and E • Extended Care option (not meeting the definition of *permanent incapacity)*

Claims under the superannuation policy

Claims for death and *terminal illness* will be paid under the superannuation policy to the trustee as policy owner. Claims for *Health Events* will first be assessed under the superannuation policy to determine if the following requirements are satisfied:

- the definition of a *Health Event* covered under benefit category A, and
- the definition of *permanent incapacity*.

If both requirements are satisfied and a benefit is payable under the superannuation policy, the benefit will be paid to the trustee. The release of the benefit from the superannuation fund to the member or beneficiaries will then be subject to the governing rules of the superannuation fund and superannuation and related taxation laws current at the time of payment.

Claims under the non-superannuation policy

If no benefit is payable under the superannuation policy, the claim will then be assessed under the non-superannuation policy. If a benefit is payable under the non-superannuation policy, the benefit is paid to the policy owner of the non-superannuation policy (and hence is not subject to *superannuation law).*

Other conditions that apply to Superannuation Optimiser policies

The *Initial Amount of Cover* under each of the policies must always be the same. If you request a decrease to the *Initial Amount of Cover*, it will be applied to both policies. Similarly, if you apply to increase the *Initial Amount of Cover*, you must apply to increase both policies. In the event that the cover is cancelled under one of the policies, the cover under the other policy will immediately end.

We will take into account prior claims under both policies when determining whether a claim under either policy is for a *Progressive Condition* or is subject to a *Limited Claim Period.*

In the event of a *Health Event* claim, the premium payable under the superannuation policy is reduced in the same proportion as the reduction applied to the *Remaining Amount of Cover,* while the premium payable under the non-superannuation policy is increased by a corresponding amount so that the total premium payable across the two policies is unchanged (excluding other changes to the policies or indexation or age related increases). For more information on how we calculate premiums see 'The Premium' section on page 34.

Superannuation Optimiser – Income Cover

When you apply for Income Cover that is to be owned by a trustee of a superannuation fund, the cover is issued as two separate Income Cover policies linked to each other under the Superannuation Optimiser structure.

One policy will be owned by a trustee of a superannuation fund (referred to as the 'superannuation policy') and the cover it provides is known as the 'superannuation component'. The Income Cover benefits held under this policy are restricted by us. Our restrictions include rules to ensure any payments made under the superannuation policy as a result of a disability will be consistent with the *superannuation law.*

The remainder of the Income Cover benefits which would otherwise be available under Income Cover will be provided under a policy issued outside superannuation (referred to as the 'non-superannuation policy'). The Income Cover provided under this policy is called the 'non-superannuation component'.

The following conditions apply to Income Cover subject to Superannuation Optimiser:

- the Specific Injury benefit is not available under the superannuation policy (but will be available under the non-superannuation policy)

- the Extra Benefits option can only be included in the non-superannuation policy
- any injury or *illness* resulting in an entitlement under the Specific Injury benefit, Health Events benefit, or Bed Confinement benefit (which can only arise under the non-superannuation policy), is excluded from a benefit payment under the superannuation policy, but only for the period for which such benefit is payable under the non-superannuation policy
- the Death benefit is payable under the superannuation policy for amounts up to $75,000. If a Death benefit is payable in excess of $75,000 (only possible where the Extra Benefits option is selected), the portion above $75,000 will be paid from the non-superannuation policy.

The cover provided under each policy is summarised in the table below.

Superannuation component	Non-superannuation component
• Benefits that meet *temporary incapacity*, up to the *superannuation payment limit* for the: – Total Disability benefit, or – Partial Disability benefit. • Death benefit (up to $75,000). Benefits excluded: • Total Disability and Partial Disability for any injury or *illness* qualifying for payment under the Specific Injury benefit, Health Event benefit, or Bed Confinement benefit under the non-superannuation component. (But only for the period that such benefit is payable under the non-superannuation component.) • the portion of the Death benefit that exceeds $75,000.	• Benefits that do not meet *temporary incapacity* or, where the benefit meets *temporary incapacity*, any amount of the benefit that exceeds the *superannuation payment limit* for the: – Total Disability benefit, and – Partial Disability benefit. • Specific Injury benefit. • Any benefits payable under the Extra Benefits option (if selected) • Death benefit (only the portion of the benefit that exceeds $75,000 where Extra Benefits option has been selected). These benefit are not payable under the non-superannuation component: • the portion of the Death benefit that is up to $75,000.

The total benefits that are payable under the policies together will not exceed the amount that would otherwise be payable if the Income Cover policy had been issued to a single policyholder.

The 'non-superannuation component' only provides cover for a benefit also listed under the 'superannuation component' in any particular month where because of the Superannuation Optimiser restrictions, the 'superannuation component' cannot pay the benefits.

In any particular month, the Income Cover entitlements may be split across the two policies. For example, there may be instances when, in a particular month, the total benefit is payable under the 'superannuation component' or under the 'non-superannuation component'. There may also be instances where we pay a portion of the benefit payable under each of the linked Income Cover policies.

In the event of a claim we first consider the type of benefit to be assessed and the policy under which it is to be assessed. Claims will be assessed to determine whether they meet the requirements for a Specific Injury benefit. Similarly, if the Extra Benefits option applies, claims will be assessed to determine whether they meet the requirements of the Health Events benefit or the Bed Confinement benefit.

We will pay the benefit under the appropriate policy based on the information available to us at the time the decision is made by us.

Income Cover claims under the superannuation policy

Claims for the following benefits are considered under the superannuation policy:

- Total Disability benefit (including payments under the Accident option and the Booster option, where selected)
- Partial Disability benefit
- Death benefit.

In the event of a claim for either the Total Disability benefit or Partial Disability benefit, assessment will first be made under the superannuation policy to determine:

- if a benefit can be paid under the policy (because the insured person satisfies the requirements of *temporary incapacity*), and if so
- how much of the benefit that can be paid under the terms of the insurance can be paid under the superannuation policy (because the amount of payments must not exceed the *superannuation payment limit*).

No benefit will be paid from the superannuation policy for the same period for which a benefit has been paid or is payable from the non-superannuation policy under the Specific Injury benefit, Health Events benefit, or Bed Confinement benefit.

The amount of the benefit that can be paid is determined as the lesser of:

- the amount otherwise calculated under the terms of the insurance, and
- the *superannuation payment limit*.

The Death benefit is payable through superannuation up to the limit of $75,000.

If a benefit is payable under the superannuation policy, the benefit will be paid to the trustee of the superannuation fund. The release of the benefit from the superannuation fund to the member will be determined by the trustee, subject to the governing rules of the superannuation fund and *superannuation law* current at the time of payment.

Income Cover claims under the non-superannuation policy

In the event of a claim, the amount payable will be:

- any amount payable under the Specific Injury benefit or benefit payable under the Extra Benefits option
- any amount payable for the Total Disability benefit or Partial Disability benefit that cannot be paid under the superannuation policy because the insured person does not satisfy the requirements of *temporary incapacity*, and
- any amount payable under the Income Cover terms which exceeds the *superannuation payment limit* and could not be paid under the superannuation policy.

If the Extra benefits option applies and a Death benefit becomes payable, any portion payable in excess of $75,000, is payable under the non-superannuation policy.

Any benefit that becomes payable in respect of the non-superannuation component is paid to the policy owner of the non-superannuation policy and is not subject to *superannuation law*.

Restrictions to the Monthly Amount of Cover

The policy schedule will indicate if a policy is linked to another under Superannuation Optimiser and the policy number to which it is linked. If linked to another policy under this arrangement, the Monthly Amount of Cover under both policies must always be the same. If the Monthly Amount of Cover under either policy is altered, then the other will similarly be altered and the premium adjusted accordingly. If either policy is cancelled, then the other will also be cancelled.

Special conditions which apply to Income Cover policies linked by Superannuation Optimiser

The Monthly Amount of Cover, benefit type, benefit period and waiting period under each policy must be the same. If you request to change any of these under one policy, reduce the Monthly Amount of Cover or cancel one of the policies, the same changes will be made to the other policy to ensure that these policies continue to correspond with each other. If one policy is cancelled, the other policy will also be cancelled.

For the duration of a claim, each month we will determine, by applying the policy terms, whether a benefit is payable under the superannuation policy or the non-superannuation policy, or in some cases, by apportioning the total amount payable between the two policies so that benefits are payable under both policies. The payment of a benefit under one policy will also count towards the benefit period of the other policy.

If the requirements of the Premium Waiver feature are satisfied because a claim is payable under either or both of the policies under a Superannuation Optimiser structure, we will waive the premiums payable under both policies.

If the requirements of the Involuntary Unemployment Premium Waiver feature are satisfied, we will waive the premiums payable under both policies under a Superannuation Optimiser structure.

Ownership by the trustee of an *eligible superannuation fund*

You can apply for Zurich Active cover through superannuation if you are a member of an *eligible superannuation fund*.

Where the trustee of an *eligible superannuation fund* is the policy owner, all written notices regarding the policy, including, but not limited to, the policy document, renewal, dishonour and cancellation notices will be issued to the trustee of the *eligible superannuation fund*, as policy owner. The trustee is solely responsible for communicating with the member in regard to the policy and is responsible for payment of the premium in respect of the member by the due date.

In some circumstances, we may, by agreement with the trustee, send notices to the member directly.

Important information about applying for Zurich Active within superannuation through membership of an *eligible superannuation fund* can be found in the Product Disclosure Statement and/or other documents issued by the fund trustee.

Your policy

Terms of your policy

The terms of your policy are stated in the Zurich Active PDS (the date of which is stated in the policy schedule), and the most recent version of the policy schedule.

The policy schedule states the Schedule Date which is the date from which the policy schedule applies. The Schedule Date will reflect the date of the event that resulted in a change to the policy schedule. This may be earlier than when it is received.

When cover starts

Your Zurich Active cover starts from the Cover Start Date shown in the policy schedule that will be sent to you, subject to any special conditions that apply, or any other date applying under *cover commencement*.

As explained in the 'When a benefit will not be paid' sections of this PDS, qualifying periods may continue to apply for a period after *cover commencement* for some claims.

Zurich Active cover is referable to our No. 2 Statutory Fund and any claims paid under the policy will be paid from this fund.

Your Zurich Active cover is made up of the policy schedule and the terms and conditions contained in this PDS. We will send you the policy schedule for your Zurich Active cover. We recommend you keep your policy schedule in a safe place with your PDS.

The policy schedule

If we accept your application, we will issue a policy (or policies) detailing:

- Zurich Active policy number
- name(s) of the policy owner(s)
- name and personal details of the insured person
- *Initial Amount of Cover* provided
- *Remaining Amount of Cover* (if different from the *Initial Amount of Cover*)
- whether any additional death cover applies, and if so the amount provided
- *Maximum Amount Payable* under each of the benefit categories
- Protected Amount, which is a fixed proportion of the *Initial Amount of Cover*
- any options that apply
- whether the policy is part of a Superannuation Optimiser structure, and if so, whether the policy is the superannuation policy or the non-superannuation policy, and the other policy to which it is linked
- *application date*
- cover start date
- premium adjustments which apply, if any
- any special conditions which apply to you in addition to those outlined within this PDS
- amount of the Premium payable for the relevant period and whether it is payable monthly or annually,
- whether *occupational impairment* applies, and if so, the definition that is applicable.

If Child Cover applies it will be stated in the policy schedule. If it does, the policy schedule will also state the following details for that cover:

- Zurich Active Child Cover policy number
- names of the policy owner(s)
- names and dates of birth of each insured child
- Amount of Cover for each insured child
- cover start date
- cover anniversary
- premium adjustments which apply, if any
- special conditions which apply, if any, and
- amount of the premium payable, and whether it is payable monthly or annually.

If Income Cover applies it will be stated in the policy schedule. If it does, the policy schedule will also state the following details for that cover:

- Zurich Active policy number
- name(s) of the policy owner(s)
- name and personal details of the insured person
- Monthly Amount of Cover
- whether the cover is provided on an 'income at claim', 'income at application', or 'endorsed income at application' basis ('type of cover')
- waiting period
- benefit period
- any options that apply
- where cover is held within superannuation and Superannuation Optimiser applies, whether the cover provided is the 'superannuation component' or 'non-superannuation component'
- cover start date
- cover anniversary
- any premium adjustments which apply
- any special conditions which apply, and
- amount of the premium payable, and whether it is payable monthly or annually.

We may, when lawfully entitled to do so, avoid or adjust your cover if you have breached your duty of disclosure or you or the insured person have made a misrepresentation in your application for Zurich Active or when applying for an increase in cover.

When cover ends

Insurance cover provided under Zurich Active ends on the earliest of:

- the cover anniversary following the expiry age shown in the table following
- the death of the insured person
- the *Maximum Amount Payable* under benefit category AA reduces to nil (only in respect of cover for *terminal illness* and death)
- before age 65, the maximum combined total payable for all *Health Events* claims has been reached, as explained under the Claim Protector feature, see page 11 (only in respect of cover for *Health Events*)
- after age 65, the *Maximum Amount Payable* under benefit categories A to E reduces to nil (only in respect of cover for *Health Events*)
- cancellation of the cover upon written request of the policy owner
- cancellation of the cover upon the written request of the insured person where the policy is taken through an *eligible superannuation fund*
- cancellation of the cover by us due to non-payment of the premium when due
- cancellation of cover by us due to a fraudulent claim
- for Child Cover, the Continuation of Cover feature, as explained in this PDS, is exercised*
- any other date applied under a special condition shown in the policy schedule, or
- if you are a member of an *eligible superannuation fund,* 30 days after the insured person has left the *eligible superannuation fund* or becomes ineligible for membership of the *eligible superannuation fund* under law.

Cover type	Expiry age
Death and *terminal illness*	99
Health Events	99[1]
Income Cover with the following benefit periods: • 2 years • 5 years • 'to age 65'	65[2]
Income Cover with a 'to age 70' benefit period	70
Child Cover	21*

[1] The cover provided for *Health Events* changes at age 70. See page 6.

[2] Income Cover may be extended beyond the cover anniversary when you are aged 65 subject to the terms of the Cover Extension feature. See page 25.

* Child Cover ends only in respect of the insured child for whom the event has occurred.

Guaranteed upgrades

We will automatically provide any future improvements we make to your Zurich Active cover that you hold when they do not result in an increase in the premium rates. Where they do result in an increase in the premium rates, you will have the option to take up the offer of the upgrade.

Improvements will not apply to a claim resulting from an *illness* which first occurs (or symptoms leading to the condition occurring or being diagnosed first became reasonably apparent), or an injury or event which occurred, before these improvements took effect.

Guaranteed renewable

Provided the premiums continue to be paid when due, your Zurich Active policy is guaranteed renewable until the policy anniversary after the expiry age, shown in the table in the section titled 'When cover ends'. This means that we cannot cancel or alter the terms of the cover because of changes in the insured person's health, occupation or pastimes.

If you request to extend, vary or reinstate your cover, your duty of disclosure applies but only in respect of the cover that is being extended, varied or reinstated.

World wide cover

Your policy covers the insured person 24 hours a day, anywhere in the world.

Please refer to the 'When we won't pay' section in Income Cover for additional terms regarding claims while outside of Australia.

Keeping us informed

To ensure that our records are kept up to date and correct, we request that you advise us:

- of a change in your address or contact details, or
- of a change in banking or credit card details (that are relevant for the payment of premiums).

Keeping you informed

Where permitted by law, we may communicate with you regarding your policy via a number of different methods depending on the circumstances. These include (but are not limited to) post, telephone, fax, email, and SMS.

The premium

How the premium is calculated

The premium payable for your policy is calculated as at the cover start date and at each subsequent cover anniversary, by applying our premium rates to the cover amount for each benefit.

The factors on which the premium will depend include how much cover you have selected, the options which apply, the premium payment frequency, the premium type and the insured person's:

- age (premiums generally increase with age)
- gender
- general health
- smoking status (premiums are higher for smokers)
- recreational pursuits
- occupation, and
- state of residence.

The premiums for each type of insurance also depend on:

- whether the policy is structured under the Superannuation Optimiser structure (see page 29),
- for Income Cover, the waiting period, benefit period, whether the cover is provided on an Income at Claim or Income at Application basis, and whether Superannuation Optimiser applies.

For *Health Events*, *terminal illness* and death cover, the premium is based on the *Initial Amount of Cover* throughout the life of the policy. However, if the Extended Care option applies, the cost of this option included in the premium for the *Initial Amount of Cover* will end on the earlier of the payment of a benefit under the Extended Care option or the cessation of cover for the Extended Care option on the policy cover anniversary when the insured person is aged 65.

Generally, there are two premium types to choose from:

- **'Stepped' premium** – generally, the premium increases each year based on the insured person's age.
- **'Level' premium** – the premium remains the same until the cover anniversary when the insured person is aged 65, except for:
  - increases to your cover, including those made under Indexation Increases and Future Increases, and
  - increases we make to the underlying rates as explained on page 35 under 'Changes to the premium'.

  At the cover anniversary when the insured person is aged 65, the 'level' premium automatically converts to a 'stepped' premium.

Changes to the premium type will not be permitted while receiving Income Cover benefits or within six months of a claim ending.

If you request an increase or decrease in your cover, the premium will reflect the change. Before each cover anniversary, we will notify you of the premium for the period to the next cover anniversary.

As part of the application process, an indicative premium will be provided to you. You can also request a copy of our premium rates. The actual premium could increase if the person to be insured has a birthday after the indicative premium is provided and before the cover start date. We may also only be able to offer you cover if you agree to a higher premium.

Payment of the premium

Your premium is calculated on an annual basis and can be paid yearly or monthly in advance. If you choose to pay it yearly in advance, a discount of 6% will apply.

The premium can be paid from the following sources:

- credit card
- direct debit from an Australian bank account.

If you are paying your premiums on an annual basis, you may also pay via:

- BPAY®, or
- cheque made out to Zurich Australia Limited.

If you choose to pay premiums by cheque or BPAY®, Zurich will provide you with payment instructions once your policy is ready to receive premiums. We are not able to receive and hold payments before this time. We will also provide you with payment instructions on renewal.

You, or your adviser acting as your agent, must provide us with a valid premium deduction authority to enable us to deduct the premium when due for payment.

The premium payable for the first year is shown in the policy. If paid annually, we will deduct the premium on the cover anniversary each year or another date to which we agree.

If paid monthly, we will deduct the premium every month on the same day of the month as the cover anniversary or another day of the month to which we agree. If the date shown falls on a weekend or public holiday, the premium will be deducted on the next business day following the due date.

All payments to us must be in Australian dollars.

If you are a member of an *eligible superannuation fund*, please refer to the PDS for your fund for information about payment of premiums for Zurich Active.

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Non-payment of the premium

If a premium payment is not made, we will notify you advising the date on which the policy will end if the amount due is not paid. If a payment sufficient to meet the amount due is not made by that date, we will cancel the policy.

We will give at least 20 business days notice in writing before the policy is cancelled because of non-payment of premiums.

Premium and policy suspension

You may request for your Zurich Active policy to be suspended for a period you nominate where the following conditions are met:

- at least 12 months has elapsed since the policy commenced or was last reinstated or last recommenced after a previous period of premium and policy suspension
- premiums due in that 12 month period have been paid in full
- the period you nominate, when combined with the period of any previous suspensions is no more than 12 months, and
- you provide the request for suspension to us in writing, at least 30 days prior to the date that the suspension is to commence.

If your premium is paid on an annual basis, we will provide a pro rata refund of the premium that has already been paid for each whole month following the date of suspension.

During the suspension period you will not be required to pay your premium but you will be ineligible to claim any benefit under your policy. Indexation of the sum insured will not occur during the period of suspension.

In addition to the above, no claim will be payable on recommenced cover at any time for any:

- injury that first occurs during the period of suspension, or
- *illness* that first occurs or presents symptoms from the date of cover suspension until 90 days following cover recommencement.

Your policy will only recommence upon written confirmation from us following receipt of a written request from you prior to the date the suspension period is due to end and prior to the benefit expiry date. If no such recommencement request is received and subsequent written confirmation of recommencement issued by us, your policy will lapse and cover will end under the policy.

Premiums on recommenced cover will be payable from the date of recommencement based on premium rates applicable at that date and will be payable on the date specified in your policy schedule.

Following recommencement of cover, any benefit(s) paid due to an *illness* or injury that first occurs or symptoms leading to the condition occurring or being diagnosed first becoming apparent prior to the suspension period commencing, will be reduced by the premium that was not collected by us during the suspension period.

Changes to the premium

We can change the premium rates but only if we do this for all policies in a defined risk group.

Any changes to premium rates will come into effect for your policy on the next cover anniversary after we make the change.

If we increase premium rates we will provide 30 days prior notice of your new premium.

We reserve the right to pass on any government taxes and charges which may be introduced or increased during the life of your policy.

Surrender value

Your Zurich Active cover does not have a surrender value.

A pro-rata refund will be made where a premium is paid annually and cover is cancelled prior to the next cover anniversary.

Making a claim

Notifying us of a claim

Please contact us on 1800 208 130, or via email at life.claims@zurich.com.au, or via our website (zurich.com.au) if you think you are eligible to make a claim, or are unsure and would like some assistance. It is important that you notify us as soon as possible after any event that may lead to a claim. If you do not notify us within 30 days of an event, we may be able to adjust the benefit payable if we have been prejudiced by the delay.

We will send you a claim form and explain in detail our requirements and what the next steps are.

Assessing a claim

We will not determine liability on a claim until all of our claim requirements have been met. While assessing a claim we may, at our discretion, pay a benefit(s). This is not an admission of liability. To assess the claim, and ongoing payments in the case of Income Cover, we will require some or all of the following (to be provided at your expense), in a form that is satisfactory to us:

- a completed claim form
- your policy
- proof of age (unless previously provided)
- a certified copy of the death certificate (for death claims only)
- evidence of *terminal illness*, the *Health Event* or *disability,* whichever is applicable for the claim being made, including test results, investigations, and medical attendant statements (which we will send separately to the treating medical specialist)
- financial evidence including evidence of other insurance cover
- evidence of *claimable income*, *pre-disability income* and *post-disability income* and any payments received while Income Cover benefits are being paid by us, and
- evidence of *income* at time of application (and, if we have accepted an application for an increase in cover, *income* at the time you applied for the increase in cover) if Income Cover is provided on an 'income at application' basis, unless it has already been supplied.

We may also require further medical and occupational assessments and other information where relevant to assess or finalise payment of the claim. This may include assessment by a *medical practitioner* nominated by us. Reasonable co-operation from you and/or the claimant is required.

All claim payments may be subject to an appropriate specialist physician approved by us verifying the diagnosis.

Where we request an examination, assessment or financial audit by a person we nominate, we will meet the cost. Otherwise you must meet the cost of satisfying our claim requirements.

If the insured person dies while a *Health Event* or *terminal illness* claim is being assessed, we will finalise assessment of the claim in progress if we have sufficient evidence at the time of death to establish whether the insured person met the definition for which the original claim was being assessed. If we do not have sufficient evidence at that time to finalise assessment of the claim in progress, the claim will be assessed under the policy terms relating to death.

Health Event claims

An appropriate medical specialist or suitably qualified neuropsychologist or clinical psychologist will be required to confirm the diagnosis of the condition for any *Health Event* claim made under your Active cover.

In conjunction with the evidence provided and information from the treating medical specialist, we will determine the benefit category that applies to the condition for which you are making a claim. You cannot elect to have the claim assessed or paid under a lower benefit category.

Payment of a claim

We will pay the claim as soon as possible once it has been approved.

All claims will be paid in Australian dollars.

General information

Your adviser

This product is available through licensed intermediaries, who we refer to as 'your adviser'. This includes licensed financial advisers, who can assist you with advice in considering Zurich Active and help you determine the amount and type of cover you require considering your personal objectives, financial situation and needs. It also includes licensed distributors who may promote the product and make it available to you or assist you with an application.

Your adviser may act as your agent and lodge your application with us on your behalf.

Your adviser is your main point of contact for your insurance so please talk to them if you have any questions about your cover.

If your application is accepted, we may pay your adviser a commission for selling this product. The commission is paid by us and does not affect your premium. You can obtain details from your adviser of any commission paid.

How to apply

To apply for cover, you need to lodge an application with us, which your adviser can help you with. We will accept a paper application signed by you, or an online application lodged electronically by a financial adviser, where the adviser lodges the application as your agent. Generally the application will include an application for Zurich Active, a detailed personal statement and a number of declarations we will rely on in deciding whether or not to issue (and the terms on which we issue) the insurance being applied for, and to administer any policies we issue.

As an alternative to completing the personal statement via a paper or online application, you may elect for the insured person to complete their personal statement via our TeleConnect interview service. If selected, we will set up a time to complete the interview over the telephone. Once the interview is completed, the application will be assessed and we inform your adviser of our decision.

If your adviser lodges an online application on your behalf, the adviser is required to confirm that he or she has your authorisation to act as your agent and that you have made a number of declarations and authorisations. It is your responsibility to ensure that the information provided to us by your adviser is accurate and complete. We will rely on the accuracy of the information provided to us via the online application, as we would if a paper application was signed and submitted by you. We may contact you to verify that the information we have received from your adviser is accurate and complete.

If you are the policy owner, but are not also the insured person under the policy we issue, it will be necessary for personal and health information to be collected from the insured person. This can be provided on a paper application submitted to us, and signed by the insured person. Alternatively, it may be supplied to us via the online application process described above. In these cases, the adviser will also be acting as the agent of the person to be insured in submitting the information.

After an online application is lodged electronically by you or your adviser or you have completed an interview with our TeleConnect service, you will receive a copy of the completed application relied upon by us in assessing the application. You must carefully review the information provided to ensure it is accurate and complete and notify us as soon as possible if any corrections are required. If a policy has already been issued and the corrected information would have been relevant in our assessment of the application, we may seek to enforce our remedies for non-disclosure and cancel or vary the insurance to take into account the corrected information.

If the person to be insured has a birthday after the application is submitted and before cover commences, the premium will be adjusted to reflect the rate applicable for your age at *cover commencement*. In these cases the premium may differ from any indicative quotes provided to you prior to the issue of the policy.

Risks of holding insurance

There are risks you should consider when deciding to purchase this policy, including:

- the insurance you have chosen might be inadequate to protect your circumstances now or in the future
- the insured person becomes ill but your policy does not pay a benefit for their specific condition
- the insured person may be unable to work for longer than the selected benefit period for Income Cover
- you elect to reject indexation increases to your policy and as a result cover does not maintain its value against inflation
- a claim is not paid and this policy cancelled if you fail to comply with the Duty of Disclosure set out on the next page
- your policy is cancelled because you become unable to pay your premiums by the due date as described on page 35
- the insurer becomes insolvent and is unable to meet liabilities that fall due under your policy.

Your duty of disclosure

To be read by each of the proposed policy owner and the person to be insured (if different people)

Before entering into a life insurance contract, we must be told anything that each of you as the proposed policy owner and the person to be insured (if a different person to the proposed policy owner) knows, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms.

The duty applies until we agree to provide the insurance. It also applies before the insurance contract is extended, varied or reinstated.

We do not need to be told anything that:

- reduces the risk we insure; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive the duty to tell us about.

If you are the person to be insured (but not also the proposed policy owner), you not telling us something that you know, or could reasonably be expected to know, that may affect our decision to provide the insurance and on what terms, may be treated as a failure by the proposed policy owner to tell us something that they must tell us with the following consequences for the proposed policy owner.

If we are not told something

In exercising the following rights, we may consider whether different types of cover can constitute separate contracts of life insurance. If they do, we may apply the following rights separately to each type of cover.

If we are not told anything that we are required to be told, and we would not have provided the insurance if we had been told, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if we had been told everything we should have been told. However, if the insurance contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the insurance contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if we had been told everything we should have been told. However, this right does not apply if the contract has a surrender value or provides cover on death.

If the failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

Underwriting

We will promptly notify you or your adviser of any additional information needed to underwrite your application.

We may contact the person to be insured for additional information about their medical and financial circumstances, as well as any hazardous pursuits or pastimes, occupational duties and other information that may assist with assessment of the application.

We may ask the person to be insured to undergo a medical examination and/or blood tests. This will usually be arranged through our nominated pathology provider, who may be able to arrange the services to be undertaken at their workplace or home or at medical centres across Australia. On request, we can send the medical examination and blood test results to a doctor nominated by them. We will cover the associated costs of any tests required.

The tests and requirements may vary depending on the person to be insured's age and occupation and the amount and type of cover applied for.

The application

In accepting an application of insurance, we will be relying on declarations and authorisations made by you, either directly or via your agent, relating to the following matters:

Your adviser

- you have appointed your adviser to act on your behalf in relation to this insurance and, if we receive online applications lodged by your adviser, you have appointed your adviser as your agent to complete and lodge an application for insurance as your agent,
- you have received a Zurich Active PDS and agree to be bound by it.

Disclosure obligations

- you and the person to be insured (if different) have read and understood the duty of disclosure as explained in this PDS and understand the duty continues until we have issued a contract of insurance
- you and the person to be insured (if different) confirm the information supplied in connection with the application is true and correct and no information material to the application has been withheld
- you acknowledge that we are entitled to rely on the information provided in the application, including online applications lodged on your behalf, in determining an application and assessing future claims, and that we may be entitled to vary or avoid the insurance if there has been non-disclosure, misrepresentation or fraud, and
- you and the person to be insured (if different) agree that you will review the information provided on an online application and agree to inform us immediately if there are any errors or omissions and understand that we may seek to vary or avoid the insurance if errors or omissions are identified.

Authorisations

- you and any person to be insured (if different) have read the Privacy Statement contained in the PDS and consent to the collection of personal information (including medical information) and its use by us as described.
- you authorise the collection of premiums from the account designated in the application.

Who should authorise the application

Both you as the policy owner and the person to be insured (if different) must authorise the application, payment authority and various other declarations and authorisations that are required to be completed for an application. As noted above, where an online application is lodged by your adviser electronically these authorisations will be provided to us by the adviser acting as your agent.

Cooling-off period

You have a 21 day cooling-off period after your Zurich Active cover commences during which time you can cancel your policy if you decide that the insurance cover does not meet your needs. You will be entitled to a refund of the premium that you have paid (but if you applied for cover within superannuation, the law may require your refund to be preserved within the superannuation system). If you wish to use the cooling-off period, you must not have made a claim and must notify us within 21 days of the earlier of:

- the date you receive your policy, or
- the end of the fifth business day after we issue the policy.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any personal or sensitive information ('Information'), you and the insured person (if different) should know the following.

We collect, use, process and store personal information and, in some cases, sensitive information about you and the insured person in order to comply with our legal obligations, to assess your application for insurance cover, to administer the insurance cover provided, to enhance customer service or products and to manage claims ('purposes'). If you or the insured person do not agree to provide us with the Information, we may not be able to process your application, administer your cover or assess your claims.

By providing us or your intermediary with Information, you and the insured person consent to our use of this Information which includes us disclosing the Information where relevant for the purposes, to the policy owner, your intermediary (including your adviser), affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our business partners or as required by law within Australia or overseas.

The Australian laws include:

- Australian Securities and Investment Commissions Act 2001
- Corporations Act 2001
- Insurance Contracts Act 1984
- Life Insurance Act 1995
- Anti Money Laundering and Counter Terrorism Financing Act 2006
- Anti Money Laundering and Counter Terrorism Financing Rules Instrument 2007 (No. 1)
- Income Tax Assessment Act 1997
- Taxation Administration Act 1953

as those acts are amended and any associated regulations. From time to time other acts may require, or authorise us to collect personal information from you or the insured person.

Zurich may also obtain Information from government offices and third parties to assess an application or a claim. We may use personal information (but not sensitive information) collected to notify you or the insured person of other products and services we offer. If you or the insured person does not want your personal information to be used in this way, please contact us.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your information to, a list of countries in which recipients of your information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 1800 005 057 or email us at privacy.officer@zurich.com.au

Residency and applicable laws

These policies are designed for customers who are resident in Australia. If you or the insured person moves to another country, your policy may no longer be suitable for your individual needs, and you may no longer be eligible to make payments into your policy. The local laws and regulations of the jurisdiction to which you or the insured person moves may affect our ability to continue to service your policy in accordance with its terms and conditions.

You need to tell us of any planned change in residency before the change happens.

We do not offer tax advice, so if you or the insured person decide to live outside Australia, we recommend obtaining advice on the tax consequences of changing your/the insured person's country of residence in relation to your policy. We will not be held liable for any adverse tax consequences that arise in respect of you or your policy as a result of such a change in residence.

A change in residency might require us to suspend or terminate your insurance accordingly.

We and other companies within the worldwide Zurich group of companies have obligations under Australian and foreign laws. Regardless of any other policy terms and conditions, we reserve the right to take any action (or not take any action) which could place us or another company within the group at risk of breaching Australian laws or laws in any other country.

All financial transactions, including acceptance of premium payments, claim payments and other reimbursements, are subject to compliance with applicable trade or economic sanctions laws and regulations.

We may terminate the policy if we consider you, the insured person, your directors and officers (if applicable), or beneficial owners as a sanctioned person, or you conduct an activity which is sanctioned, according to trade or economic sanctions laws and regulations. Further, we will not provide any cover, service or benefit to any party if we determine this places us at risk of breaching applicable trade or economic sanctions laws or regulations.

This policy is based on the legal and regulatory requirements applicable at the time the policy is issued. Should the legal and regulatory requirements change in a material way, Zurich is entitled to adapt the terms and conditions to the changed legal and regulatory requirements, provided the change is lawful.

Who to contact

We are here to help with any questions you have about your cover. Our contact details are:

General enquiries

Telephone: 1800 005 057

Email: life.insurance@zurich.com.au

Post: GPO Box 5216
Brisbane QLD 4001

Claims

Telephone: 1800 208 130

Email: life.claims@zurich.com.au

Post: Zurich Life Claims
GPO Box 4443
Sydney NSW 2001

You should be aware that we record all of our telephone conversations with you or your adviser relating to your policy.

Complaints resolution

If you have a complaint about Zurich Active, you should contact us on 1800 005 057 or via email at complaints.service@zurich.com.au. We will aim to acknowledge any complaint within 5 days and to resolve your complaint within 45 days.

If you are not satisfied with the response you receive from us, or we fail to resolve the complaint within 45 days, you can raise the matter with the Financial Ombudsman Service, GPO Box 3, Melbourne VIC 3001. The telephone number is: 1300 780 808 and the email address is: info@fos.org.au

If you are a member of an *eligible superannuation fund* please refer to the information about resolution of complaints in your fund's Product Disclosure Statement.

Tax

The information provided in this PDS is a guide only and is based on our understanding of the tax laws that were current at the date of this PDS. These laws can change, so we recommend you speak to your tax adviser regarding the tax consequences of insurance cover and policy ownership.

Where you are the policy owner

Any reference to 'you' in this section is in respect of your capacity as the policy owner (including circumstances in which you own the policy in your capacity as trustee of a self-managed superannuation fund).

Tax treatment of premiums

Non-superannuation

The premiums that you pay for a non-superannuation policy in respect of death, *terminal illness*, *Health Events* or Child Cover are generally not tax deductible to you. However, there are some circumstances where the premium, or part of the premium, may be claimed as a tax deduction. For example, this may be relevant in situations where an employer owns the policy or pays the premiums. There may be other tax consequences associated with this situation such as fringe benefits tax. We recommend you consult your tax adviser to discuss your particular circumstances.

The premiums that you pay for Income Cover are typically a tax deductible expense to you.

Within superannuation (as trustee of a self managed superannuation fund)

The premiums for an insurance policy held inside superannuation are generally tax deductible to the trustee depending on the extent to which they relate to the fund's liability to pay:

- a superannuation death benefit
- a superannuation benefit because of a terminal medical condition
- a disability superannuation benefit
- an income stream because of temporary incapacity.

We recommend you seek professional tax advice.

Tax treatment of benefits

Non-superannuation

The tax treatment of a benefit payable for death, *terminal illness*, *Health Events* or Child Cover can vary depending on the policy owner. There may be some cases where the benefit is taxable, such as where an employer owns the policy, and we recommend you discuss your particular circumstances with your tax adviser.

Benefits that are payable under Income Cover (including any Superannuation Cover and the Extra Benefits cover) are generally included in your assessable income and will be subject to tax at your marginal tax rate.

Within superannuation (as trustee of a self managed superannuation fund)

If you own a Zurich Active policy as the trustee of a self managed superannuation fund, the gross amount of any benefit that is payable under the cover will be paid by us to you in your capacity as the trustee. You are responsible for determining any tax liability in respect of a benefit that you receive or distribute from your self managed superannuation fund. The amounts received by the ultimate benefit recipients (for example, a member of the relevant superannuation fund) may have special tax treatment which does not necessarily depend on the nature of the original insurance claim payment. We recommend you seek professional tax advice.

Where you are a member of an *eligible superannuation fund*

Any reference to 'you' in this section is in respect of your capacity as a member of an *eligible superannuation fund*.

Tax treatment of premiums

The premiums for an insurance policy held within superannuation are generally tax deductible to the trustee depending on the extent to which they relate to the fund's liability to pay:

- a superannuation death benefit
- a superannuation benefit because of a terminal medical condition
- a disability superannuation benefit
- an income stream because of temporary incapacity.

Tax treatment of benefits

If an insured benefit becomes payable, Zurich pays the insurance proceeds to the trustee, who in turn is responsible for paying the benefit in accordance with the governing rules of the fund and *superannuation laws*.

Any insurance benefit that is payable through superannuation may be paid from the fund after allowance for any fund tax liability. Please refer to your fund's PDS for further information about tax in superannuation.

Interim cover

We provide you with interim cover for *accidental* injury or death while your application is being assessed, except where the insurance applied for will replace existing insurance in place with us or with another insurer.

Interim cover does not necessarily provide the same coverage as the policy or policies being applied for. The terms of interim cover are limited to those set out in this section. These terms cannot be varied or extended by any representation made by us or your financial adviser.

The person to be insured will be covered for *Health Events*, *terminal illness* and death that fall within benefit categories AA, A and B as the result of an *accident*, where the *accident* occurs during the period of interim cover and the condition occurs within three months of the *accident.* Only one benefit across the benefit categories AA, A and B will be payable during interim cover, being the one which pays the highest benefit.

If Income Cover is included in the application for cover, you will be covered for:

- the interim Total Disability benefit from the end of the waiting period applied for in the application, for up to a maximum of six months, if you are *totally disabled* as the result of an *accident* that occurs during the period of interim cover and *total disability* due to the *accident* starts within three months of the *accident,* and
- the interim death benefit, if you die as the result of an *accident* that occurs during the period of interim cover and death occurs within three months of the *accident*.

If Child Cover is included in the application, the child to be insured will be covered for death as the result of an *accident* and the *Child Cover Conditions* listed below as the result of an *accident,* where the *accident* occurs during the period of interim cover and the condition occurs within three months of the *accident:*

- *coma*
- *paralysis*
- *loss of hearing*
- *loss of limbs*
- *loss of sight*
- *major head trauma*
- *severe burns.*

When interim cover starts

Interim cover starts on the date an authorised application is received by us.

When interim cover ends

Interim cover will end on the earlier of:

- your application for cover is accepted and cover commences
- your application for cover is cancelled or withdrawn by you
- your application for cover is declined by us
- insurance cover commences under another contract of insurance (whether or not it is an interim contract of insurance) between you (or the trustee if you become a member of an *eligible superannuation fund*) and Zurich or or another insurer
- your interim cover is cancelled by us by providing you with at least 20 business days written notice, or
- 90 days from the date the interim cover started.

When interim cover is not payable

Nothing will be payable if the condition or event giving rise to the claim under interim cover was caused directly or indirectly by:

- an *accident* or injury that first occurred before interim cover started
- an *accident* or injury that would have been excluded by underwriting based on information existing on the day of the date of application
- an intentional self-inflicted act
- consumption of alcohol or drugs
- for Child Cover, an intentional act or intentional omission of the policy owner or the insured child's parent, guardian or a person acting in a regular de facto role as a parent, or
- the person to be insured engaging in any sport, pastime or occupation that we would not normally cover at standard rates.

When lawfully entitled to do so, we may avoid or adjust your interim cover if you have breached your duty of disclosure or you or the insured person have made a misrepresentation when applying for cover.

What we will pay

The maximum interim cover benefit that we will pay for each type of cover across all applications for the person to be insured is set out below:

In the case of interim cover for death, *terminal illness* and *Health Events*, the lesser of:

- the *Initial Amount of Cover* applied for to a maximum of:
  - Benefit category AA: $1 million
  - Benefit category A: $500,000
  - Benefit category B: $325,000
- the *Initial Amount of Cover* that we would offer under our usual underwriting rules based on the proposed premium.

In the case of interim cover for *total disability* under Income Cover, the lesser of:

- the Monthly Amount of Cover applied for
- $5,000 per month
- the monthly equivalent of 75% of first $320,000, 50% of the next $240,000 and 20% of the balance of the person to be insured's *pre-disability income*, adjusted for any reductions which apply, as explained in the section titled 'When the *monthly benefit* is reduced' on page 27, and
- the Monthly Amount of Cover that we would offer under our usual underwriting rules based on the proposed premium.

In the case of the interim death benefit under Income Cover, the lesser of:

- four times the Monthly Amount of Cover applied for
- $20,000
- four times the monthly equivalent of 75% of the first $320,000, 50% of the next $240,000 and 20% of the balance of the person to be insured's *claimable income*, and
- four times the Monthly Amount of Cover that we would offer under our usual underwriting rules based on the proposed premium.

In the case of interim Child Cover, the lesser of:

- the Amount of Cover applied for, subject to a maximum of $50,000, and
- the Amount of Cover that we would offer under our usual underwriting rules based on the proposed premium.

If multiple policies for the same person to be insured are applied for, and the maximum interim cover benefit payable for the person to be insured is less than the total of all amounts applied for, we will reduce the maximum interim cover benefit across the multiple applications in the same proportion.

If interim cover benefits are paid for the person to be insured by other insurers for an *accident,* we will reduce the amount we will pay for the same *accident* under the same or similar type of insurance so that the total paid across all insurers is no more than the maximum amount we otherwise would have paid.

We will only pay one amount under interim cover for *Health Events*, *terminal illness* and death cover, being whichever provides the greatest benefit.

Health Events

Benefit categories for Health Events

Benefit category	Health Events
Body system: Cancer	
Health Event category: Solid tumour cancers	
A	Any metastatic *cancer* classified as Stage III or above based on TNM classification where all treatment modalities have failed and been exhausted and where no other therapies are available and where progression of the cancer can be identified
B	Advanced *cancer* classified as Stage III or above based on TNM classification
C	Advanced *cancer* classified as Stage II based on TNM classification
D	*Cancer*
	Total mastectomy for *carcinoma in situ of breast* where the procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment by a *medical practitioner*
	Prostate cancer requiring radical prostatectomy where the procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment by a *medical practitioner*
	Prostate cancer where the tumour is described histologically as TNM Classification T1 and has a Gleason score greater than 6
E	*Carcinoma in situ*
	The presence of one or more melanomas which are classified as melanoma in situ or stage T1aN0M0.
	Prostate Cancer where the tumour is described histologically as TNM Classification T1 and has a Gleason score of 6 or less

The following are excluded under the 'solid tumour cancers' category:

- All hyperkeratoses, basal cell carcinomas, and squamous cell or intra-epidermal carcinomas of skin unless there has been a spread to other organs,
- pTa bladder tumours, and
- Stage 0 bowel cancer.

Health Event category: Lymphomas	
A	Advanced lymphoma classified as Ann-Arbor stage III or above where all treatment modalities have failed and been exhausted and where no other therapies are available and where progression of the cancer with resultant ongoing and continuous symptomatology can be identified
B	Hodgkin's Lymphoma classified as Ann-Arbor Stage III or above
	Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage III or above
C	Hodgkin's Lymphoma classified as Ann-Arbor Stage II
	Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage II
D	Hodgkin's Lymphoma classified as Ann-Arbor Stage I
	Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage I
Health Event category: Brain tumours	
A	Malignant brain tumour classified as Grade III or above based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system where all treatment modalities have failed and been exhausted and where no other therapies are available and where progression of the cancer can be identified
B	Malignant brain tumour classified as Grade III or above based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system
C	Malignant brain tumour classified as Grade II based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system
D	Malignant brain tumour classified as Grade I based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system

Benefit category	Health Events
Body system: Cancer	
Health Event category: Leukaemias	
A	Leukaemia where all treatment modalities have failed and been exhausted and where no other therapies are available, where progression of the cancer can be identified and where there is resultant ongoing and continuous symptomatology
B	Acute myeloid leukaemia
	Advanced chronic lymphocytic leukaemia classified as RAI Stage 3 or above
	Chronic myeloid leukaemia
	Acute lymphoblastic leukaemia
C	Chronic lymphocytic leukaemia classified as RAI Stage 2
D	Chronic lymphocytic leukaemia classified as RAI Stage 1
Health Event category: Other cancers	
A	Multiple myeloma where all treatment modalities have failed and been exhausted and where no other therapies are available, where progression of the cancer can be identified and where there is resultant ongoing and continuous symptomatology
B	*Aplastic anaemia*
	Bone marrow or stem cell transplant specifically to treat cancer
	Transplant waiting list for the transplant of bone marrow specifically to treat cancer
	Multiple myeloma classified as stage 3 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
C	Multiple myeloma classified as stage 2 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
D	Multiple myeloma classified as stage 1 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
E	Confirmed diagnosis of myelodysplastic syndrome requiring continuing and ongoing supportive care with regular transfusion of blood products, chemotherapy, or other equivalent treatments
	Bone marrow or stem cell transplant to treat a disease other than cancer

The following are excluded under the '*Cancer*' body system:

- any myeloproliferative diseases including polycythaemia rubera vera, essential thrombocytosis and myelofibrosis
- chronic lymphocytic leukaemia classified as RAI Stage 0
- if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent in the 90 day period following *the application date* or the date any cover is reinstated, a benefit will not be paid for the *Health Event* (or *Progressive Condition*) at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Benefit category	Health Events
Body system: Heart and Artery	
Health Event category: Heart attack	
A	*Heart attack* resulting in permanent* and irreversible left ventricular ejection fraction of less than 30% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
B	*Heart attack* resulting in permanent* and irreversible left ventricular ejection fraction of 30 to 40% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
C	*Heart attack*
Health Event category: Cardiomyopathy	
A	*Cardiomyopathy* resulting in permanent* and irreversible left ventricular ejection fraction of less than 30% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
B	*Cardiomyopathy* resulting in permanent* and irreversible left ventricular ejection fraction of 30 to 40% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
Health Event category: Other heart and artery conditions	
A	*Severe congestive cardiac failure* with a permanent* BNP level of greater than 500ng/l, whilst on ongoing optimal therapy for a minimum of six months where BNP lowering is specifically targeted as a treatment outcome measure (Equivalent levels of proBNP will be accepted.)
	Severe peripheral vascular disease resulting in amputation of the leg below the knee or higher
C	*Severe peripheral vascular disease* with gangrene and amputation of more than one toe
Health Event category: Heart transplant	
B	*Heart or heart and lung transplant*
	Transplant waiting list for the transplant of a heart or a heart and lung transplant
Health Event category: Surgical procedures	
C	*Coronary artery bypass graft*
	Open aortic graft surgery – abdominal or thoracic
	Open iliac or femoral artery aneurysm grafting
	Surgical repair to correct structural lesions of the heart
	Heart valve replacement or repair
	Total pericardiectomy for constrictive pericarditis
E	*Percutaneous coronary angioplasty***
	Endovascular heart valve repair or replacement
	Endovascular or open carotid artery stenosis repair
	Endovascular repair of an aortic aneurysm
	Endovascular repair to correct structural lesions of the heart
	Endovascular iliac or femoral artery aneurysm repair
	Permanent cardiac defibrillator insertion

* Permanency to be established by three readings, three months apart. ** The maximum benefit payment per claim is $40,000.

The following are excluded under the 'Heart and artery' body system:

- if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent in the 90 day period following *the application date* or the date any cover is reinstated, a benefit will not be paid for the *Health Event* (or *Progressive Condition*) at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events* and *Child Cover* applies.

Benefit category	Health Events
Body system: Brain and Nerves	
Health Event category: Stroke	
A	Any *stroke* causing *permanent* and irreversible inability to perform 4 out 6 *activities of daily living*
B	Any *stroke* causing *permanent* and irreversible inability to perform 3 out 6 *activities of daily living*
C	Any *stroke* causing *permanent* and irreversible inability to perform 2 out 6 *activities of daily living*
E	*Stroke*

The following are excluded under the 'Stroke' category:

- if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent in the 90 day period following the *application date* or the date any cover is reinstated, a benefit will not be paid for the *Health Event* (or *Progressive Condition*) at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Health Event category: Cognitive conditions	
A	*Severe cognitive impairment*
B	*Moderate cognitive impairment*
D	*Mild cognitive impairment*
Health Event category: Coma	
E	*Coma*
Health Event category: Surgical procedures and events	
C	Craniotomy to treat a cerebral arteriovenous malformation
	Craniotomy to treat a cerebral aneurysm
	Open surgery to remove a *benign central nervous system tumour*
E	Keyhole surgery to remove a *benign central nervous system tumour*
	Endovascular treatment of a cerebral arteriovenous malformation
	Endovascular treatment of a cerebral aneurysm
	Endovascular treatment of a subarachnoid haemorrhage
	Stereotactic brain surgery used for ablation, stimulation, implantation or radiotherapy
	Shunt insertion for hydrocephalus

The following are excluded under the 'surgical procedures and events' category:

- Cysts, granulomas, abscesses, haematomas, trans-sphenoidal hypophysectomy and biopsy procedures.

Health Event category: Other brain and nerve conditions	
A	Any chronic neurological disease causing *permanent* and irreversible inability to perform 4 out 6 *activities of daily living*
	Permanent vegetative state
	Quadriplegia
	Severe epilepsy
	Psychiatric condition resulting in: • *Permanent* and irreversible inability to perform 4 out 6 *activities of daily living*, or • *Permanently* placed under public guardianship by the Guardianship Board due to concern for their own safety or safety of others, or • *Total lack of social interaction*
	Permanent total aphasia
B	Any chronic neurological disease causing *permanent* and irreversible inability to perform 3 out 6 *activities of daily living*
	Diagnosis of motor neurone disease
	Paraplegia
C	Any chronic neurological disease causing *permanent* and irreversible inability to perform 2 out 6 *activities of daily living*
	Diagnosis of bilateral hemianopia

Benefit category	Health Events
Body system: Brain and Nerves	
Health Event category: Other brain and nerve conditions (continued)	
D	*Psychiatric condition*
E	*Diagnosis of multiple sclerosis*
	Diagnosis of Parkinson's disease
	Diagnosis of muscular dystrophy
	Diagnosis of myasthenia gravis
	Diagnosis of cavernous sinus thrombosis

The following are excluded under the 'Brain and nerves' body system:

- any psychiatric condition as a result of drug or alcohol intake.

Body system: Digestive System	
Health Event category: Transplants	
B	*Liver transplant*
	Total pancreas transplant
	Small bowel transplant
	Transplant waiting list for the transplant of the liver, total pancreas or small bowel
Health Event category: Surgical procedures	
C	*Colectomy*
	Colostomy/Ileostomy
E	Surgical repair of a tracheo-oesophageal fistula
	Chronic anal fistula requiring three or more in-patient surgical procedures
Health Event category: Other digestive conditions	
A	Objective evidence of *gastrointestinal disease* with all of the following: • persistent disturbance of bowel function at rest with severe persistent pain • complete limitation of activity with continued restriction of the diet and no response to medical therapy • constitutional symptoms – fever, weight loss or anaemia where there is no prolonged remission, and • there have been at least 4 hospital admissions in a 12 month period
	Permanent and ongoing inability to swallow requiring *permanent* extraneous feeding methods
	Permanent ongoing faecal incontinence unresponsive to either medical or surgical therapy, including colostomy
B	Objective evidence of *gastrointestinal disease* with all of the following: • severe exacerbations of bowel dysfunction with disturbance of bowel function with continual pain • restriction of activity with continued restriction of the diet and no response to medical therapy • constitutional symptoms – fever, weight loss or anaemia, and • there have been at least two hospital admissions in a 12 month period
C	*Severe Crohn's disease*
E	*Portal vein thrombosis*
	Severe ulcerative colitis
	Crohn's disease
Health Event category: Liver conditions	
A	*End stage liver disease*
C	Chronic inflammatory hepatitis resulting in a Knodell score of at least 13 out of 22, and showing abnormal LFT's including ALT, AST and GGT of more than three times the normal range continuously for at least one year (tested at least three times over this period)
E	Partial hepatectomy (donors and liver biopsies excluded)

The following are excluded under the 'Digestive system' body system:

- any liver condition as a result of drug or alcohol intake.

Benefit category	Health Events
Body system: Kidneys and Urogenital Tract	
Health Event category: Renal failure	
A	*Chronic renal failure* where a renal physician has confirmed that on the basis of the insured person's medical condition, the insured person is *permanently* excluded from access to renal transplantation
B	*Chronic renal failure*
E	*Acute renal failure*
Health Event category: Kidney transplant	
B	*Renal transplant*
	Transplant waiting list for the transplant of a kidney
Health Event category: Surgical procedures	
C	Total cystectomy requiring a urinary conduit
E	Nephrectomy (donors excluded)
	Bilateral orchidectomy due to disease
	Bladder fistula requiring a surgical procedure for closure of the fistula
	Vesico/recto-vaginal fistula requiring a surgical procedure for closure of the fistula

The following are excluded under the 'Kidneys and urogenital tract' body system:

- acute renal failure as a result of drug or alcohol intake
- transgender surgery.

Body system: Lungs	
Health Event category: Diseases of the lung	
A	End stage lung disease requiring *permanent* and continuous oxygen therapy (according to current Thoracic Society of Australia and New Zealand treatment guidelines) as prescribed by an appropriate registered *medical practitioner*
B	*Chronic lung disease*
Health Event category: Surgical procedures	
C	*Pneumonectomy* (excluding donors)
D	Lobectomy (excluding biopsy procedures and donors)
Health Event category: Lung transplant	
B	*Lung or heart and lung transplant*
	Transplant waiting list for the transplant of a lung or a heart and lung transplant
Health Event category: Other lung conditions	
E	Lung abscess requiring surgical drainage through an open thoracotomy (simple percutaneous drainage procedures excluded)
	Chronic bronchopleural fistula requiring a surgical procedure for closure of the fistula through an open thoracotomy
	Chronic bronchiectasis requiring daily physiotherapy or postural drainage on instruction of a lung specialist for a period of more than three months and under the continuous care of a respiratory physician
	Multiple episodes of recurrent pulmonary emboli separated by a period of six months requiring insertion of a veno-caval filter

Benefit category	Health Events
Body system: Musculoskeletal System	
Health Event category: Burns	
B	*Severe burns* where the third degree burns cover at least 20% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
C	*Severe burns* where the third degree burns cover at least 15% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
D	*Severe burns* where the third degree burns cover at least 10% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
E	*Severe burns* where the third degree burns cover at least 5% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
Health Event category: Back, limb and whole person impairment	
A	*loss of musculoskeletal function,* that even with the use of appropriate assistive devices and workplace modifications, results in the *permanent* inability to: • perform two or more *occupational core duties*, where these duties require the use of the specific musculoskeletal function to complete at least 80% of the insured person's average weekly work hours, and • earn an *income* in any occupation which provides at least 75% of the insured person's *income* in the most recent 12 month period in which they were *gainfully employed*
	Permanent and irreversible *WPI* of at least 60%
B	*Permanent* and irreversible *loss of the use of two limbs*
C	*Permanent* and irreversible *WPI* of at least 40%
D	*Permanent* and irreversible *loss of use of one upper limb*
	Permanent and irreversible *WPI* of at least 25%
E	*Permanent* and irreversible *loss of use of one lower limb*
	Le Fort III facial reconstruction surgery
	Amputation of two or more fingers at the PIP or MCP joint, one of which must be either the index finger or thumb (must be due to either disease or *accident)*
	Severe osteoporosis
Body system: Ear	
Health Event category: Loss of hearing	
A	*Complete loss of hearing*
B	*Severe loss of binaural hearing*
E	*Complete loss of hearing in one ear*
Health Event category: Surgical procedures	
E	*Inner ear or middle ear surgery*
	Radical or modified radical mastoidectomy where considered the appropriate and necessary treatment by a medical specialist

Benefit category	Health Events
Body system: Eye	
Health Event category: Loss of sight	
A	*Permanent* and irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that eyesight is reduced in both eyes to 6/60 or less of central visual acuity on the Snellen test chart
	Permanent and irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that the degree of vision is less than or equal to 20 degrees of arc from the centre of the horizontal plane of the visual field
C	*Permanent* and irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that eyesight is reduced in both eyes to 6/18 or less of central visual acuity on the Snellen test chart
E	*Permanent* and irrecoverable loss of sight in one eye, with and without the use of an appropriate aid, to the extent that eyesight is reduced in that eye to 6/60 or less of central visual acuity on the Snellen test chart
Health Event category: Surgical procedures	
E	Surgical repair of a detached retina (laser surgery excluded)
	Corneal transplant
Body system: HIV/AIDS	
A	*Advanced AIDS*
B	*Accidental HIV infection*

The following are excluded under the 'HIV/AIDS' body system:

- If a treatment is developed and approved which renders the HIV virus inactive and non-infectious, or
- If the insured person has elected not to take an approved vaccine that is recommended by the relevant government body for use in the insured person's occupation and is available prior to the event which causes infection.

Body system: General	
Health Event category: Hospital admission	
D	*Intensive care unit (ICU)* admission for at least five weeks where ongoing assisted mechanical ventilation is required for at least three weeks
E	Hospital admission for at least four weeks after spending at least one week in *ICU.* Ongoing medical treatment is required in an acute healthcare setting or rehabilitation facility throughout this entire hospital admission period (ie over the minimum five week period)

The following are excluded under the 'General' body system:

- *Intensive care unit (ICU)* admission as a result of drug or alcohol intake.

Body system: Other	
Health Event category: Inability to perform Activities of Daily Living (ADL)*	
A	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 4 out of 6 *activities of daily living*
B	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 3 out of 6 *activities of daily living*
C	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 2 out of 6 *activities of daily living*
Health Event category: Occupational impairment*	
A	*occupational impairment*

* Unless specifically stated as a measurement tool for a *Health Event*, the use of the 'Other' Body System *Health Event* categories 'Inability to perform activities of daily living' and 'Occupational impairment' will only be applied to a condition for which we assess no benefit is payable and in our opinion there is no assessment criteria relevant to the condition under the *Health Event* categories of a different Body System.

Progressive Conditions

A *Progressive Condition* is any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. This includes any condition that is a recognised outcome and/or complication of a prior claim or a recognised complication of any treatment that might be administered in relation to the prior claim event.

Any two medical conditions that are both *Progressive Conditions* of a third medical condition, will be treated as *Progressive Conditions* to each other for calculating the amount payable.

The table below sets out the additional circumstances in which we will treat a condition as a *Progressive Condition.* This is relevant for determining the amount payable for any *Health Event* claim under the Zurich Active cover.

The terms used below are used in the broader medical meaning of the condition and not the defined *Health Events* as found in the *Health Events* tables in this section or in the defined terms in the Glossary.

Condition for which a claim has been paid:	Conditions which are considered to be *Progressive Conditions* to the condition for which a claim has been paid:
Any arthritis, osteoporosis	Any arthritis, osteoporosis.
Cancer	Cancer of the same cell type, including any treatment or disease for cancer of the same cell type.
Cognitive conditions	Coma, Parkinson's disease, stroke.
Multiple sclerosis	Any cognitive conditions.
Muscular dystrophy	Cardiomyopathy.
Parkinson's disease	Any cognitive conditions.
Stroke	Cognitive conditions, Parkinson's disease.
Any psychiatric condition	Any psychiatric condition.
Brain and neurological conditions, epilepsy	Brain and neurological conditions, coma, stroke, epilepsy.
Any other condition described by a neurologist to be a chronic neurological disease including but not limited to the following: permanent vegetative state, profound short term memory loss, multiple sclerosis, dementia, epilepsy, myasthenia gravis, Alzheimer's disease, muscular dystrophy, motor neurone disease.	Any other condition described by a neurologist to be a chronic neurological disease including but not limited to the following: permanent vegetative state, profound short term memory loss, multiple sclerosis, dementia, epilepsy, myasthenia gravis, Alzheimer's disease, muscular dystrophy, motor neurone disease.
Progressive systemic sclerosis, systemic lupus erythematosis, sarcoidosis, polyarteritis nodosa, giant cell arteritis, polymyositis, Wegener's granulomatosis, rheumatoid arthritis.	Progressive systemic sclerosis, systemic lupus erythematosis, sarcoidosis, polyarteritis nodosa, giant cell arteritis, polymyositis, Wegener's granulomatosis, rheumatoid arthritis.
Any cardiac condition or procedure	Any cardiac condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. In the case of angioplasty, an angioplasty procedure will not be considered a *Progressive Condition* to a prior angioplasty procedure and a subsequent claim for angioplasty will be paid if it occurs outside of the *Limited Claim Period*.
Any lung condition or procedure	Any lung condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim.
Any kidney or urogenital tract condition or procedure	Any kidney or urogenital tract condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim.
Any eye condition or procedure	Any eye condition or procedure.
Any ear condition or procedure	Any ear condition or procedure.
Any gastrointestinal disease or procedure	Any gastrointestinal disease or procedure.
Any liver disease or procedure	Any liver disease or procedure.
Diabetes, diabetes progression, complications of diabetes	Stroke, pancreas transplant, loss of vision, heart attack, cardiac bypass, cardiomyopathy, angioplasty, peripheral vascular disease, renal failure, kidney transplant.
Any condition which is assessed on the basis of an inability to perform *activities of daily living*	Any condition which is assessed on the basis of an inability to perform *activities of daily living.*

Glossary

Health Events

***Health Events* defined terms**	
permanent	Irreversible, present for a minimum of six months and expected to show no improvement or reversibility, while on optimal therapy, if appropriate (unless the *Health Event* specifically references an alternate timeframe over which the permanency will be measured).
transplant waiting list	Inclusion on an official transplant Australian waiting list, approved by us. The inclusion must be upon the advice of an appropriate medical specialist.
Body system: Cancer	
cancer	The presence of one or more malignant tumours, positively diagnosed with histological confirmation that are characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue. Any tumour described as early stage cancer, carcinoma in situ, premalignant, borderline malignant, non invasive, or of low malignant potential is excluded.
carcinoma in situ	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. Carcinoma in situ of the fallopian tube is limited to the tubal mucosa. Carcinoma in situ of the vulva also requires high grade dysplasia of the cervix at CIN III or above, confirmed histologically by biopsy.
prostate cancer	Localised prostate cancer characterised by focal autonomous new growth of cancer cells.
aplastic anaemia	Severe *permanent* and irrecoverable aplasia of bone marrow which results in anaemia, neutropenia and thrombocytopenia requiring at least one of the following treatments: • immunosuppressive agents • bone marrow transplant, or • peripheral blood stem cell transplant.
bone marrow or stem cell transplant	The insured person is the recipient of a bone marrow or stem cell transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner.*
FIGO	The staging method of the International Federation of Gynaecology and Obstetrics.
Body system: Heart and Artery	
heart attack	Myocardial infarction, characterised by the death of a portion of heart muscle due to inadequate blood supply. A rise and/or fall of cardiac enzymes, Troponin or other biochemical markers must be present and caused by myocardial infarction, with at least one value above generally accepted laboratory levels of normal. Furthermore, the clinical evidence and disease management pathway must be consistent with the diagnosis of acute myocardial infarction and confirmed as the hospital discharge diagnosis. If the above is inconclusive then we will consider a claim based on conclusive evidence that myocardial infarction has occurred.
New York Heart Association functional classification system	A scale used to assess cardiac impairment. I. No symptoms and no limitation in ordinary physical activity. II. Mild symptoms and slight limitation during ordinary activity and comfortable at rest. III. Marked limitation in activity due to symptoms, even during less-than-ordinary activity and comfortable only at rest. IV. Severe limitations and experiences symptoms even while at rest.
cardiomyopathy	Disease of the heart muscle causing it to enlarge and become weaker.
severe congestive cardiac failure	Failure of the functioning of the ventricles of the heart with poor cardiac output and congestion of the lungs or systemic veins.
severe peripheral vascular disease	Severe arterial insufficiency in vessels resulting in ischaemia of the limbs as a consequence of atherosclerosis.
heart or heart and lung transplant	The insured person is the recipient of a heart or heart and lung transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner.*
coronary artery bypass graft	The undergoing of coronary artery bypass grafting for the treatment of coronary artery disease that is considered the appropriate and necessary treatment by a *medical practitioner.* Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
open aortic graft surgery – abdominal or thoracic	Open surgery with aortic grafting that is considered the appropriate and necessary treatment by a *medical practitioner* to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.

***Health Events* defined terms**	
open iliac or femoral artery aneurysm grafting	Open surgery for the purposes of grafting the iliac or femoral artery vessels for the treatment of an aneurysm. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
surgical repair to correct structural lesions of the heart	The undergoing of a thoracotomy that is considered necessary to repair a structural lesion of the heart. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
heart valve replacement or repair	The undergoing of a thoracotomy that is considered necessary to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
total pericardiectomy for constrictive pericarditis	The undergoing of a thoracotomy with a total pericardiectomy for constrictive pericarditis.
percutaneous coronary angioplasty	The undergoing of percutaneous balloon dilatation, atherectomy or stent placement to correct a narrowing or blockage that is considered the appropriate and necessary treatment by a *medical practitioner* on the basis of angiographic evidence.
endovascular heart valve repair or replacement	Heart valve repair or replacement via percutaneous intravascular techniques not involving open thoracotomy.
endovascular or open carotid artery stenosis repair	The undergoing of percutaneous or open carotid artery stenosis repair.
endovascular repair of an aortic aneurysm	Abdominal or thoracic aneurysm repair or replacement via percutaneous techniques.
endovascular repair to correct structural lesions of the heart	Repair to correct structural lesions of the heart via percutaneous techniques.
endovascular iliac or femoral artery aneurysm repair	Iliac or femoral artery aneurysm repair or replacement via percutaneous techniques.
permanent cardiac defibrillator insertion	The insured person has a *permanent* cardiac defibrillator inserted. Cardiac pacemakers are specifically excluded.
Body system: Brain and nerves	
Stroke	A neurological event caused by a cerebrovascular incident. The stroke must: • be confirmed by an appropriate medical specialist • be evidenced by the acute onset of objective neurological signs and clinical symptoms, and • be evidenced by neuro-imaging. Transient ischaemic attacks, cerebral events due to reversible neurological deficits and migraine are excluded.
severe cognitive impairment	Total and *permanent* deterioration or loss of cognitive capacity supported by neuropsychometric testing, as set out in the Zurich Neuropsychometric Test* (as current at the time of testing) with test scores of 'below average', as defined in the test score criteria, in all of the following domains: • Intelligence • Memory • Visuo-spatial • Attention • Language • Executive functioning
moderate cognitive impairment	Total and *permanent* deterioration or loss of cognitive capacity supported by neuropsychometric testing, as set out in the Zurich Neuropsychometric Test* (as current at the time of testing) with test scores of 'below average', as defined in the test score criteria, in at least four of the following domains: • Intelligence • Memory • Visuo-spatial • Attention • Language • Executive functioning
Mild cognitive impairment	Total and *permanent* deterioration or loss of cognitive capacity supported by neuropsychometric testing, as set out in the Zurich Neuropsychometric Test* (as current at the time of testing) with test scores of 'below average', as defined in the test score criteria, in at least two of the following domains: • Intelligence • Memory • Visuo-spatial • Attention • Language • Executive functioning

*The Zurich Neuropsychometric Test, including scoring criteria, will be sent to the testing practitioner and is available on our website, zurich.com.au

***Health Events* defined terms**	
Coma	A state of total unconsciousness and unresponsiveness to all external stimuli, resulting in a score of 8 or less on the Glasgow Coma Scale, as outlined below, for a continuous period of at least three days. Glasgow Coma Scale is a scoring system used to measure the level of consciousness following traumatic brain injury. It is composed of three parameters as given below: **Best Eye Response (4)** 1. No eye opening 2. Eye opening to pain 3. Eye opening to verbal command 4. Eyes open spontaneously **Best Verbal Response (5)** 1. No verbal response 2. Incomprehensible sounds 3. Inappropriate words 4. Confused 5. Orientated **Best Motor Response (6)** 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localising pain 6. Obeys Commands A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 a moderate injury and 8 or less a severe brain injury.
benign central nervous system tumour	A non-malignant tumour of the central nervous system, including tumours of the brain and spinal cord, meningiomas, cranial nerve tumours and pituitary tumours treated by non-transphenoidal techniques. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.
permanent vegetative state	Persistent state of complete unresponsiveness to external stimuli associated with an incapacity to communicate or manage bodily functions for a continuous period of at least three months with no hope of recovery as confirmed by a medical specialist.
quadriplegia	total, *permanent* and irreversible loss of the use of all four limbs as a consequence of *illness* or injury, where a limb is defined as the shoulder down to the hand or the hip down to the foot.
severe epilepsy	Averaging more than two witnessed grand mal (tonic clonic) epileptic attacks per week over a six month period as documented by a neurologist despite optimal stabilised therapy, and under the control of a neurologist
total lack of social interaction	There is a *permanent* inability to carry out all of the following: • answering the telephone • holding a face to face conversation for at least five minutes and • travelling 50 metres outside using all available aids.
paraplegia	Total, *permanent* and irreversible loss of the use of two limbs as a consequence of *illness* or injury, where a limb is defined as the shoulder down to the hand or the hip down to the foot.
permanent total aphasia	Total and irreversible loss of speech with no intelligible vocalisation possible and incapacity to communicate in order to manage day-to-day activities. The loss must be confirmed to be total and irreversible at least three months after speech was first lost. Loss of speech due to psychological reasons and hysterical loss of speech are excluded.
psychiatric condition	A psychiatric condition resulting in ongoing medical treatment from a psychiatrist for more than two years and more than two-in patient admissions, each greater than one week, over a two year period.
diagnosis of motor neurone disease	Unequivocal diagnosis of motor neurone disease.
diagnosis of multiple sclerosis	Unequivocal diagnosis of multiple sclerosis, and evidenced by appropriate neuro-imaging and spinal fluid abnormalities.
diagnosis of Parkinson's disease	Unequivocal diagnosis of Parkinson's disease. Parkinson's disease as a result of medication or drugs is excluded.
diagnosis of muscular dystrophy	Unequivocal diagnosis of muscular dystrophy, which causes progressive and selective degeneration and weakness of voluntary muscles.
diagnosis of myasthenia gravis	Unequivocal diagnosis of myasthenia gravis.
diagnosis of cavernous sinus thrombosis	Unequivocal diagnosis of cavernous sinus thrombosis by a medical specialist via an MRI scan.
diagnosis of bilateral hemianopia	Unequivocal diagnosis of complete and *permanent* bilateral hemianopia as diagnosed by an appropriate medical specialist.

Health Events defined terms	
Body system: Digestive system	
liver transplant	The insured person is the recipient of a liver, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.
total pancreas transplant	The insured person is the recipient of a total pancreas, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.
small bowel transplant	The insured person is the recipient of a small bowel, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.
colectomy	Total colectomy requiring *permanent* colostomy or resulting in ileorectal anastomosis.
colostomy/ ileostomy	The creation of a *permanent* non-reversible opening, linking the colon and/or ileum to the external surface of the body.
gastrointestinal disease	Disease of the gastrointestinal system evidenced by organic pathology obtained by biopsy and present continuously for at least 12 months.
portal vein thrombosis	Isolated thrombosis of the portal vein.
severe Crohn's disease	Diagnosis of Crohn's disease with stricture formation, fistula formation and resection of the small bowel, that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.
Crohn's disease	Diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.
severe ulcerative colitis	Diagnosis of ulcerative colitis that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.
end stage liver disease	End stage liver failure defined by irreversible loss of liver biosynthetic function of the liver accompanied by a persistent coagulopathy and *permanent* jaundice, resulting in at least one of the following: • diuretic resistant refractory ascites • recurrent portal hypertensive bleeding • recurrent portal systemic encephalopathy • recurrent spontaneous bacterial peritonitis, • listing for liver transplantation.
Body system: Kidneys and urogenital tract	
chronic renal failure	Chronic irreversible failure of the function of both kidneys requiring *permanent* and ongoing haemodialysis or peritoneal dialysis. The insured person must be under the continuous care of a renal physician.
acute renal failure	Acute reversible failure of the function of both kidneys requiring admission to an ICU* or renal dialysis unit for temporary haemodialysis or haemofiltration treatment. *ICU must be an accredited Intensive Care Unit by the Australian Council on Healthcare Standards (ACHS)
renal transplant	The insured person is the recipient of a kidney transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.
Body system: Lungs	
chronic lung disease	End stage lung disease requiring a persistent FEV1 less than 30% predicted or DLCO less than 40% predicted (according to current Thoracic Society of Australia and New Zealand treatment guidelines) measured on at least three separate occasions more than three months apart whilst on optimal therapy.
pneumonectomy	Removal of an entire lung.
lung or heart and lung transplant	The insured person is the recipient of a lung or heart and lung transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.

***Health Events* defined terms**	
Body system: Musculoskeletal system	
severe burns	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns.
loss of musculoskeletal function	A condition affecting musculoskeletal function resulting in: a) loss of hand function where there is: • total and irreversible loss of muscle power resulting in the inability to grip any tool, utensil or assistive device, or • total and irreversible loss of the ability to use the hands and fingers with precision to perform activities such as picking up or manipulating small objects, manually operating a range of equipment or communicating through writing or typing, b) at least 80% *impairment of the upper limb*, or c) at least 50% *impairment of the lower limb*. The condition must be *permanent* and supported by appropriate radiological evidence.
impairment of the upper limb	*Permanent* and irreversible impairment of the hand based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols.
impairment of the lower limb	*Permanent* and irreversible impairment of the foot based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols.
occupational core duties	The primary *income* generating tasks being performed by the insured person in the occupation, business or employment in which they were *gainfully employed* at the time of the injury or *illness* (or if not *gainfully employed* at that time, the occupation, business or employment in which the insured person was most recently *gainfully employed*).
loss of the use of two limbs	The *permanent* and irreversible total loss of the use of two limbs, where 'limb' means the whole hand or whole foot.
loss of use of one upper limb	The *permanent* and irreversible total loss of the use of one whole hand.
loss of use of one lower limb	The *permanent* and irreversible total loss of the use of one whole foot.
whole person impairment (WPI)	Whole Person Impairment based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols.
severe osteoporosis	Before the age of 50, the insured person: • suffers at least two vertebral body fractures or a fracture of the neck or the femur, due to osteoporosis, and • has a bone mineral density reading with a T-score of less than -2.5 (ie 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).
Body system: Ear	
complete loss of hearing	The total and irreversible loss of more than 90% of binaural hearing as per the American Medical Association Guides to the Evaluation of Permanent Medical Impairment: 4th edition, with and without the use of an appropriate aid.
severe loss of binaural hearing	Total and irreversible loss of more than 75% of binaural hearing as per the American Medical Association Guides to the Evaluation of Permanent Medical Impairment: 4th edition, with and without the use of an appropriate aid.
complete loss of hearing in one ear	The total and irreversible loss of hearing in one ear, with and without the use of an appropriate aid.
inner ear or middle ear surgery	Surgery to the cochlear or middle ear bones, where the surgery is considered the appropriate and necessary treatment by a medical specialist.
radical or modified radical mastoidectomy	Removal of the mastoid bone and bones of the middle ear due to chronic disease.

Health Events defined terms	
Body system: Eye	
corneal transplant	The insured person is the recipient of a cornea, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner.*
Body system: HIV/AIDS	
advanced AIDS	HIV infection with a persistent CD4 cell count of less than 200/ul despite appropriate continuous antiretroviral therapy. There must be an associated AIDS defining illness with AIDS resulting in at least one of the following: • Kaposi's Sarcoma or Lymphoma • Pneumocystis Carinii infection, cryptoccal infection or any other opportunistic infection of the lungs or nervous system • Tuberculosis or other mycobacterium infection at any site • Progressive Multifocal Leukoencephalopathy • HIV Encephalopathy • HIV Wasting Syndrome characterised by more than 10% weight loss, chronic intractable diarrhoea and chronic candidiasis of the respiratory tract or gastrointestinal tract.
accidental HIV infection	*Accidental* infection with Human Immunodeficiency Virus (HIV) as the result of: • Transfusion of blood or blood products* • Organ transplantation* • *Accidental* incident occurring during the course of performing normal professional duties of the insured person's regular occupation with the requirement that appropriate care is being exercised**, or • Physical or sexual assault – a criminal case must be opened in addition to the insured person starting antiviral therapy**. The *accident* causing infection with HIV must have occurred after the date of policy commencement, or reinstatement, whichever is latest. HIV infection caused by any means other than those described above, including recreational intravenous drug use and sexual activity, other than assault as described is excluded. The incident must be reported to us within seven days of occurrence and we must be given access to test all blood tests and blood samples used. * The procedure must have been performed by a registered health professional and have occurred in Australia. 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. ** The incident must be reported to the appropriate authority and be supported by a negative HIV antibody test performed after the incident. The production and detection of HIV antibodies (sero-conversion) must be subsequently confirmed by way of a positive HIV antibody test within six months of the incident.
Body system: General	
intensive care unit (ICU)	An accredited Intensive Care Unit by the Australian Council on Healthcare Standards (ACHS)

Health Events defined terms

Body system: Other

activities of daily living (ADL)

There are six categories of ADLs. Each category is made up of a list of specific tasks. If the stated number of the specific tasks within a category cannot be performed, the whole category is scored as an inability to perform that ADL category.

The ability to perform the tasks of each ADL category must be assessed by a medical specialist, appropriate to the medical condition causing the impairment, using the Activities of Daily Living scoresheet provided by us.

When an insured person is being measured on their ability to perform any tasks of an ADL category:

- all tasks for which an impairment is present must be scored, irrespective of the medical condition(s) causing the impairment, and
- assistive devices must be used, where applicable.

Supporting objective medical evidence or investigations must be provided for each task of an ADL category scored. The ADL categories, specific tasks and required scores in order to be considered unable to perform the ADL category are detailed in the table below.

ADL category	Specific tasks		Scores required in order to be considered unable to perform the ADL category:
1. Self-care	• Bathing • Grooming • Dressing • Eating and feeding	• Bowel and bladder function • Mobility	• 'cannot' in at least one specific task, or • 'with help' in at least two specific tasks.
2. Communication	• Speaking • Reading	• Writing • Keyboard use	• 'cannot' in at least one specific task, or • 'minimal' in at least two specific tasks.
3. Physical activity	Intrinsic • Standing • Sitting • Reclining • Walking • Stooping • Squatting • Kneeling • Reaching • Bending • Twisting	Functional • Carrying • Lifting • Pushing • Pulling • Climbing • Exercising	• 'cannot' in at least three specific tasks, or • 'with help' in at least six specific tasks.
4. Sensory function	• Hearing • Seeing • Tactile sensation	• Tasting • Smelling	• 'cannot' in at least one specific task, or • 'minimal' in at least two specific tasks.
5. Hand functions	• Grasping • Holding • Pinching	• Percussive movements • Sensory discrimination	• 'cannot' in at least one specific task, or • 'minimal' in at least two specific tasks.
6. Advanced functions	• Travel (riding, driving) • Sexual function • Social interaction • Understand concepts • Memory	• Problem solving • Stress adaptation • Sleep pattern • Recreational/ social activities	• 'cannot' or 'poor' in at least four specific tasks.

ADL Scoring

The following scoring method is used to score the ADL Score Sheet:

- If a person is independent in performing that task, he is regarded as able to do that task (can), (normal) or (good).
- If a person makes use of assistive devices, or requires the supervision of another person in performing that task, he is regarded as requiring assistance to do the task (with help), (minimal) or (average). Examples of assistive devices are walking frames, raised toilet seats, shower or bath benches.
  Please note that glasses and hearing aids are not classified as assistive devices.
- If a person is completely dependent on another person(s) to perform a task, he is regarded as unable to do that task (cannot) or (poor). Poor means a rating of poor or below average as measured and evaluated by the relevant and appropriate neuropsychometric test(s).

***Health Events* defined terms**	
Occupational impairment	The relevant definition of occupational impairment that applies is shown on your policy. Before the anniversary when the insured person is aged 65: a) if the Own Occupation definition applies, due to injury or *illness*: • the insured person has been absent from their *own occupation* for a continuous period of at least three months, and in our opinion, is incapacitated to the extent that they are unlikely ever again to be able to engage in their *own occupation* OR • The insured person has suffered irreversible *whole person impairment* of at least 25% which shows no further chance of improvement, and in our opinion, is incapacitated to the extent that they are unlikely ever again to be able to engage in their *own occupation* b) if the Any Occupation definition applies, due to injury or *illness*: • the insured person has been absent from work for a continuous period of at least three months, and in our opinion, is incapacitated to the extent that they are unlikely ever again to be able to engage in *any occupation* OR • The insured person has suffered irreversible *whole person impairment* of at least 25% which shows no further chance of improvement, and in our opinion, is incapacitated to the extent that they are unlikely ever again to be able to engage in *any occupation* c) if the Domestic Duties definition applies, due to injury or *illness*: • the insured person has not performed *domestic duties* for a continuous period of at least three months and, in our opinion, is incapacitated to the extent that it is likely they will be able to perform neither *domestic duties* nor engage in *any occupation* ever again OR • the insured person has suffered irreversible *whole person impairment* of at least 25% which shows no further chance of improvement and, in our opinion, is incapacitated to the extent that it is likely they will be able to perform neither *domestic duties* nor engage in *any occupation* ever again d) if the occupational impairment definition shown in your policy is 'not applicable', then no occupational impairment cover applies. e) if the occupational impairment definition shown in your policy is 'definition assessment at claim', whether cover for occupational impairment is included and, if so, which definition of occupational impairment applies, will be determined by Zurich at the time of claim, based on the information provided to us during the application process and in accordance with the standard Active underwriting rules applying as at May 2012. f) if the occupational impairment definition shown in your policy is 'occupational underwriting at claim' and if the insured person provides satisfactory information to us at the time of claim regarding the duties performed and hours worked as at the date of application, whether cover for occupational impairment is included and, if so, which definition of occupational impairment applies, will be determined by Zurich at the time of claim in accordance with Zurich's standard Active underwriting rules applying as at May 2012.

Child Cover

Child Cover Conditions defined terms	
Child activities of daily living	1. Bathing and showering 2. Dressing and undressing 3. Eating and drinking 4. Using the toilet 5. Moving from place to place by walking, wheelchair or with assistance of a walking aid or getting in and out of bed, a chair or wheelchair.
Cancer	
cancer	The presence of one or more malignant tumours, including lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders, that are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. The following cancers are excluded: • tumours which are histologically described as premalignant or show the malignant changes of carcinoma in situ (including cervical dysplasia CIN-III and lower). 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 by a *medical practitioner* • melanomas which are less than stage T1bN0M0 • all hyperkeratoses and basal cell carcinomas, and squamous cell carcinomas of skin unless it has spread to other organs • chronic lymphocytic leukaemia less than Rai stage 1, and • prostatic cancers which are TNM Classification T1 or less and have a Gleason score of 6 or less. Prostatic cancer which is TNM classification T1 or less and which has a Gleason score of 6 or less is covered if it results in the entire removal of the prostate. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment by a *medical practitioner*.
aplastic anaemia	Severe aplasia of bone marrow which results in anaemia, neutropenia and thrombocytopenia requiring one of the following treatments: • immunosuppressive agents • bone marrow transplant, or • peripheral blood stem cell transplant.
Heart and artery	
cardiomyopathy	Disease of the heart muscle causing it to enlarge and become weaker, resulting in significant cardiac impairment to the degree of at least Class III of the *New York Heart Association functional classification system.*
heart attack	Myocardial infarction, characterised by death of a portion of heart muscle due to inadequate blood supply. The following clinical features must be present (and not caused by medical intervention): • new ECG changes, and • elevation of cardiac biomarkers with CK-MB above the upper limit of normal or Troponin I greater than 2.0ug/L or Troponin T greater than 0.6ug/L. If the above is inconclusive then we will consider a claim based on conclusive evidence that myocardial infarction has occurred, resulting in either one of the following: • new pathological Q-waves, • a permanent left ventricular ejection fraction of 50% or less, measured six weeks or more after the event.
open heart surgery	The undergoing of a thoracotomy for treatment of cardiac defect(s), cardiac aneurysm or benign cardiac tumour(s).
out of hospital cardiac arrest	Cardiac arrest that occurs outside of a hospital 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.

Child Cover Conditions defined terms

Brain and nerves

bacterial meningitis or meningococcal septicaemia	Bacterial meningitis or meningococcal septicaemia resulting in: • a permanent impairment of at least 25% whole person function, or • total and irreversible inability to perform at least one of the numbered *child activities of daily living*.
benign brain tumour	Non-malignant tumour in the brain, pituitary gland or spine, resulting in a neurological deficit causing: • a permanent impairment of at least 25% whole person function, or • total and irreversible inability to perform at least one of the numbered *child activities of daily living*. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI. Cysts, granulomas, aneurysms in or of the arteries or veins of the brain and haematomas are not covered.
brain damage	Brain damage, as confirmed by a *medical practitioner* who is a consultant neurologist, which results in a neurological deficit causing a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 5th edition, or an equivalent impairment approved by us.
coma	A state of total unconsciousness and unresponsiveness to all external stimuli, resulting in a score of 8 or less on the Glasgow Coma Scale, as outlined below, for a continuous period of at least three days. Glasgow Coma Scale is a scoring system used to measure the level of consciousness following traumatic brain injury. It is composed of three parameters as given below: **Best Eye Response (4)** 1. No eye opening 2. Eye opening to pain 3. Eye opening to verbal command 4. Eyes open spontaneously **Best Verbal Response (5)** 1. No verbal response 2. Incomprehensible sounds 3. Inappropriate words 4. Confused 5. Orientated **Best Motor Response (6)** 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localising pain 6. Obeys commands A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 a moderate injury and 8 or less a severe brain injury.
encephalitis	Acute inflammation of the brain caused by viral infection resulting in neurological deficit and leading to: • permanent impairment of at least 25% whole person function, or • total and irreversible inability to perform at least one of the numbered *child activities of daily living*.
major head trauma	*Accidental* head injury, leading to neurological deficit causing: • permanent impairment of at least 25% whole person function, or • total and irreversible inability to perform at least one of the numbered *child activities of daily living*.
muscular dystrophy with impairment level	Unequivocal diagnosis of muscular dystrophy, which causes progressive and selective degeneration and weakness of voluntary muscles resulting in: • permanent impairment of at least 25% whole person function, or • total and irreversible inability to perform at least one of the numbered *child activities of daily living*.
paralysis	The total and irreversible loss of the use of two limbs, where a limb is defined as the shoulder down to the hand or the hip down to the foot.
stroke	A neurological event caused by a cerebrovascular incident. The stroke must: • be confirmed by an appropriate medical specialist • be evidenced by the acute onset of objective neurological signs and clinical symptoms, and • be evidenced by neuro-imaging. Transient ischaemic attacks, cerebral events due to reversible neurological deficits, migraine, hypoxia or trauma, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Lungs

chronic lung disease	End stage lung disease requiring permanent and continuous oxygen therapy, a persistent FEV1 less than 30% predicted or DLCO less than 40% predicted (American Thoracic Society 2004).
primary pulmonary hypertension	Primary pulmonary hypertension characterised by enlargement of the right ventricle as a result of high pulmonary artery pressure. It must have resulted in significant cardiac and respiratory impairment leading to impairment equivalent to at least Class III of the *New York Heart Association functional classification system*.

Kidneys

chronic kidney failure	Chronic irreversible failure of the function of both kidneys requiring either regular renal dialysis or renal transplantation.

Child Cover Conditions defined terms	
Ear, nose and throat	
loss of hearing	The total and irreversible loss of hearing in both ears with and without the use of an appropriate aid.
loss of speech or total aphasia	Total and irreversible loss of speech. The loss must be confirmed to be total and irreversible at least three months after speech was first lost. Loss of speech or total aphasia due to psychological reasons is excluded.
Eye	
loss of sight	The irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that eyesight is reduced in both eyes to 6/60 or less of central visual acuity on the Snellen test chart or the degree of vision is less than or equal to 20 degrees of arc.
Musculoskeletal	
loss of limbs	The total and irreversible loss of the use of: • two limbs, or • sight in both eyes *(loss of sight),* • or the sight in one eye and one limb, where 'limb' means whole hand or whole foot and loss of sight in one eye means the irrecoverable loss of sight in one eye, with and without the use of an appropriate aid, to the extent that eyesight is reduced in that eye to 6/60 or less of central visual acuity on the Snellen test chart.
severe burns	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns to at least: • 20% of body surface as measured by the Rule of Nines or the Lund and Browder Body Surface Chart • the whole of both hands, requiring surgical debridement and/or grafting, or • the whole of the face, requiring surgical debridement and/or grafting.
Digestive system	
chronic liver disease	End stage liver failure resulting in permanent jaundice, bleeding varices, ascites or encephalopathy.
Other	
child's loss of independent existence	After reaching seven years of age, the total and irreversible inability to perform at least two of the numbered *child activities of daily living* without the assistance of another person.
intensive care	A sickness or injury has resulted in the insured person requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an authorised intensive care unit of an acute care hospital. No benefit shall be payable where the sickness or injury is as a result of drug or alcohol intake or other self-inflicted means.
major organ transplant	The insured person is the recipient of an organ transplant of one of the following organs: • heart • kidney • liver • lung • pancreas • small bowel, or • the transplantation of bone marrow. The transplant must be considered the appropriate and necessary treatment by a *medical practitioner.*
medically acquired HIV	The *accidental* infection with Human Immunodeficiency Virus (HIV), which on the balance of probabilities arose from one of the following medical procedures: • transfusion of blood or blood products • organ transplant • assisted reproduction techniques, or • other medical procedure or operation performed by a doctor or at a registered medical facility. The procedure must have been performed by a registered health professional and have occurred in Australia. 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. A claim for medically acquired HIV will not be payable if: • HIV infection is caused by any other means, including sexual activity or recreational intravenous drug use, or • a treatment is developed and approved which renders the HIV virus inactive and non-infectious.

Other defined terms

Other defined terms	
accident/accidental	A fortuitous and unforeseen event, resulting in an injury, which is not caused, or contributed to, by an intentional act of the insured person.
application date	The application date shown on your policy, which is the Zurich date stamp recorded on a paper application received by us or the date an electronic application is authorised via the website for: • a new type of cover with Zurich, or • an increase to existing cover (but only in respect of the increase).
any occupation	Any occupation, business or employment for which the insured person is suited by education, training or experience that would generate earnings greater than 25% of the insured person's earnings in the most recent period of 12 months in which he or she was *gainfully employed*.
carer	The insured person begins to provide unpaid care for the first time and that care is: • medically necessary due to disability, chronic illness or frail age • was not previously required • is likely to be required for a continuous period of at least six months The commencement of care for the first time must be evidenced by either a letter from a *medical practitioner* or evidence that the insured person is receiving a Centrelink carer benefit for providing that care.
Child Cover Condition	An injury, *illness* or treatment for an injury or *illness*, meeting the criteria as defined in the Child Cover Condition section starting on page 61. The date of occurrence of the Child Cover Condition is: • for an injury, the date the injury occurs • for an *illness*, the date a *medical practitioner* confirms diagnosis, or • for treatment, the date the insured person undergoes the treatment. In order to be eligible to claim, the occurrence of the Child Cover Condition as described above must occur after *cover commencement* and before cover ends.
claimable income	If the benefit type indicated on your policy schedule is Income at Claim then *claimable income* is the highest average monthly *income* for any 12 consecutive months in the 36 months preceding the start of the waiting period applying to the claim. If the benefit type indicated on your policy schedule is Income at Application then *claimable income* is the highest of either the highest average monthly *income* for any 12 consecutive months in the 36 months preceding the start of the waiting period applying to the claim, and • if the insured person is an Employee: – their *income* for the 12 months immediately prior to the application for cover (or approved increase) • if the insured person is Self-Employed and their *income* in the 12 months prior to the application for cover (or approved increase) reduced by more, or increased by less, than 20% when compared to the *income* of same period 12 months earlier: – their *income* in the 12 months immediately prior to the application for cover (or approved increase) • if the insured person is Self-Employed and the above does not apply: – the average of their *income* over the 24 months immediately prior to the application for cover (or approved increase). The insured person's *income* prior to application will be increased by the increase in the *consumer price index* at each cover anniversary until the date of *disability*.
consumer price index	The weighted average of the eight Australian capital cities combined, published by the Australian Bureau of Statistics or any body which succeeds it, in respect of the 12 month period finishing on or prior to 30th September. It will be determined at 31st December each year and applied at the cover anniversary on or following 1st March in the next year.
cover commencement	The latest of: • cover start date shown in your policy schedule • the date cover is reinstated (but only in respect of the reinstated cover), or • the date cover commences for any increases in cover that you applied for (but only in respect of the increase).
disability/disabled	*Total disability* or *partial disability*.
domestic duties	The tasks performed by an insured person whose sole occupation is to maintain the family home. These tasks include, unassisted by another person, cleaning of the home, cooking of meals for their family, doing the family laundry, shopping for the family's groceries and taking care of dependent children (where applicable). Domestic duties do not include duties performed outside the insured person's home for remuneration or reward.

Other defined terms	
eligible superannuation fund	A superannuation fund through which an arrangement exists between the trustee and Zurich for members of the fund to be able to obtain Zurich Active insurance.
fracture	Any break in the bone that requires a pin, traction, plaster or other immobilising structure.
gainful employment/ gainfully employed	The insured person is engaged in an occupation, business or employment for remuneration or reward.
Health Event	An injury, *illness* or treatment for an injury or *illness*, meeting the criteria as defined in the *Health Events* section starting on page 44. The date of occurrence of the Health Event is: • for an injury, the date the injury occurs • for an *illness,* the date a *medical practitioner* confirms diagnosis, or • for treatment, the date the insured person undergoes the treatment. In order to be eligible to claim, the occurrence of the Health Event as described above must occur after *cover commencement* and before cover ends.
illness	A pathological condition evidenced by medically recognised signs and symptoms.
immediate family member	A married or de facto partner, child, brother, sister or parent.
income	Income earned through personal exertion calculated: • after the deduction of expenses incurred in producing that income, and • before the deduction of income tax. It is based on the total remuneration package and includes salary, wages, packaged fringe benefits, regular commissions, regular bonuses, regular overtime payments and pre-tax superannuation contributions. For the self-employed it also includes that share of net income of the business directly generated by personal exertion after deduction of all business expenses but before the deduction of tax. Income does not include: • income that the insured person would continue to receive from his or her business even if unable to work, including any ongoing profit generated by other employees of the business, or • other unearned income such as dividends, interest or rental income.
indexation	The increase in consumer price index. For *Health Events, terminal illness* and death cover and Child Cover, the minimum indexation rate that will apply is 3%. The consumer price index is the weighted average of the eight Australian capital cities combined, published by the Australian Bureau of Statistics or any body which succeeds it, in respect of the 12 month period finishing on or prior to 30th September. It will be determined at 31 December each year and applied at the cover anniversary on or following 1 March in the next year.
Initial Amount of Cover	The Initial Amount of Cover is the amount originally issued, adjusted for Indexation Increases over time, plus any subsequent increases or decreases to the cover that you apply for and are accepted by us. Refer to page 12 for information about Indexation Increases.
involuntary unemployment/ involuntarily unemployed	A period during which the insured person is: • not working • is actively seeking employment, and • where becoming unemployed was a result of: – the termination of the insured person's *gainful employment* by their employer without the consent of the insured person, or – the insured person being made redundant from *gainful employment* by their employer. It does not include unemployment as a result of: • the insured person ceasing *gainful employment* of a casual, seasonal or temporary nature • the expiration of a fixed term employment contract or other specified period of work, or • the deliberate or serious misconduct of the insured person.

Other defined terms	
Limited Claim Period	As complications from a medical condition, or its treatment, often arise within the months following a condition and it can be difficult to identify all of these complications, a *Limited Claim Period* applies for 12 months following a *Health Event* claim. When a *Health Event* occurs, a *Limited Claim Period* starts and lasts for 12 months. If a subsequent *Health Event* occurs during this *Limited Claim Period*, any amounts already paid during the current *Limited Claim Period* will be deducted from the amount we will pay for the current claim. We will not deduct amounts paid for a prior claim for a *Health Event* within the *Limited Claim Period* where either the current claim or the prior claim is/was for a *Health Event* that is the result of *accident*, unless the *Health Events* are directly or indirectly due to the same underlying cause or event.
loss of independent existence	The total and irreversible inability to perform at least two of the tasks under the Self-care category of Activities of Daily Living. In order to be considered unable to perform two of the Self-care tasks, the person must score 'cannot' for at least two of the Self-care tasks.
Maximum Amount Payable	The Maximum Amount Payable for each of the Health Event benefit categories A to E is calculated as the lesser of: • the *Initial Amount of Cover* multiplied by the applicable percentage for the relevant benefit category, and • the *Remaining Amount of Cover* under the policy. If the *Initial Amount of Cover* is less than $200,000, the Maximum Amount Payable for benefit category E will be $10,000 and the percentage for benefit category E will be adjusted accordingly. The *Maximum Amount Payable* for *terminal illness* and death under benefit category AA is the *Remaining Amount of Cover* under the policy plus any additional death cover.
medical practitioner	A doctor who is legally qualified and registered to practise medicine in Australia (or if outside Australia, has equivalent qualifications and registration) not being you, the insured person, or a business partner or *immediate family member* of you or the insured person.
monthly benefit	The *monthly benefit* as described on page 19.
own occupation	The occupation, business or employment in which the insured person was *gainfully employed* at the time of the injury or *illness* for which the claim for *occupational impairment* is made (or, if not *gainfully employed* at that time, the occupation, business or employment in which the insured person was most recently *gainfully employed*).
partial disability/ partially disabled	The insured person is not totally disabled, and solely as a result of injury or *illness*: • is unable to perform at full capacity one or more of the duties their *usual occupation* necessary to produce income as confirmed by a *medical practitioner*, and • is *gainfully employed* but their *post-disability income* is less than *pre-disability income*, and is under the regular care and following the advice of a *medical practitioner*.
partner	A person with whom the insured person is legally married or in a *partnership*.
partnership	A prescribed relationship which is registered under State or Territory law for the purposes of the Acts Interpretation Act 1901.
period of insurance	Commences on *cover commencement* for each insurance cover, and continues until the insurance cover ends as explained in the section entitled 'When cover ends' on page 33 of this PDS. The *period of insurance* does not include any period during which the insurance cover is subject to premium and policy suspension (see the section entitled 'Premium and policy suspension' on page 35 for further details).
permanent incapacity	Permanent incapacity as defined by the *superannuation law*, as amended from time to time and applied as if Zurich was the trustee of the relevant superannuation fund and the insured person was a member of the fund.
pre-disability income	If the Income Cover is provided on an:

Income at Application or Endorsed Income at Application basis	Income at Claim basis
the highest average monthly *income* of the insured person for any 12 consecutive months in the period commencing 24 months before the cover start date until the start of the waiting period applying to the claim	the highest average monthly income of the insured person for 12 consecutive months in the 36 months preceding the start of the waiting period applying to the claim
For the purposes of calculating Partial Disability benefit payments, *pre-disability income* will be increased by the increase in the *consumer price index* at each cover anniversary occurring after the date of disability while the insured person remains on claim.	

Other defined terms	
Progressive Condition	There are a number of medical conditions that we will treat as a progression of a prior condition when calculating how much we will pay. A *Progressive Condition* is any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. For full details of *Health Events* we consider to be *Progressive Conditions,* refer to page 52.
post-disability income	The *income* earned in the month by the insured person from personal exertion following injury or *illness* while *partially disabled*.
Remaining Amount of Cover	When your policy starts, the *Remaining Amount of Cover* under the policy is equal to the *Initial Amount of Cover*. When a *Health Event* claim is paid under the policy, the *Remaining Amount of Cover* under the policy is reduced by the amount paid for the *Health Event*. Once the *Remaining Amount of Cover* has reduced to nil under the policy, there is no cover for t*erminal illness* or death, unless additional death cover, which is not reduced by *Health Event* claims, has been included.
replacement cover waiver – death and terminal illness	The specified exclusion will be waived and does not apply if the policy issued by us replaces other similar insurance under a policy or policies issued by us or another insurer (the other policy), and we agreed to issue this policy on the basis that it replaced the other policy (as shown in your policy) and the following conditions are also met: • the *Initial Amount of Cover* plus any additional death cover being issued by us is the same amount or less than that under the other policy. If the death and *terminal illness* cover (being the *Initial Amount of Cover* plus any additional death cover) under the policy being issued by us is higher than that under the other policy, the exclusion only applies to the portion of death and *terminal illness* cover in excess of the cover under the other policy • the other policy was continuously in force for 13 months immediately prior to the issue of this policy • the other policy was cancelled immediately after the issue of this policy, and • no claim is pending or payable under the other policy.
replacement cover waiver – Income Cover Health Event benefit	The specified exclusion will be waived and does not apply if the policy issued by us replaces other similar insurance under a policy or policies issued by us or another insurer (the other policy) and we agreed to issue this policy on the basis that it replaced the other policy (as shown in your policy document) and the following conditions are also met: • the Income Cover Monthly Amount of Cover under the policy being issued by us is the same amount or less than that under the other policy. If the monthly amount of cover under the policy being issued by us is higher than that under the other policy, the exclusion only applies to the portion of the Monthly Amount of Cover in excess of the cover under the other policy • the other policy was continuously in force for 90 days immediately prior to the issue of this policy • the other policy provided similar cover for the *Health Event* • the other policy was cancelled immediately after the issue of this policy, and • no claim is pending or payable under the other policy.
replacement cover waiver – Health Events and Child Cover	The specified exclusion does not apply to a *Health Event* or *Child Cover Condition*, as relevant, if the policy issued by us replaces other similar insurance under a policy or policies issued by us or another insurer (the other policy) and we agreed to issue this policy on the basis that it replaced the other policy (as shown in your policy) and the following conditions are also met: • the *Initial Amount of Cover* being issued for *Health Events* (or the Amount of Cover for Child Cover) by us is the same amount or less than that under the other policy. If the *Initial Amount of Cover* (or Amount of Cover) under the policy being issued by us is higher than that under the other policy, the exclusion only applies to the portion of the *Initial Amount of Cover* (or Amount of Cover) in excess of the cover under the other policy • the other policy was continuously in force for 90 days immediately prior to the issue of this policy • the other policy provided similar cover for the *Health Event* (or the *Child Cover Condition*) • the other policy was cancelled immediately after the issue of this policy, and • no claim is pending or payable under the other policy.
superannuation law	Superannuation law includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations as amended from time to time.

Other defined terms		
superannuation payment limit	The amount we determine in our absolute discretion as satisfying the requirements of the *superannuation law* in regard to the permissible insurance benefits payable in respect of a member of a superannuation fund and applied as if Zurich was the trustee of the relevant superannuation fund and the insured person was a member of the fund. In making the determination, it is recognised that Zurich may interpret the *superannuation law* in a particular manner which may change over time. We will make a determination in accordance with procedures maintained by us.	
temporary incapacity	Temporary incapacity as defined by the *superannuation law* and applied as if Zurich was the trustee of the relevant superannuation fund and the insured person was a member of the fund.	
terminal illness	The insured person is diagnosed with an *illness,* which reduces life expectancy to less than 12 months from the date of diagnosis, as confirmed by two *medical practitioners*, one of whom is a medical specialist approved by Zurich.	
total disability/totally disabled	Income Cover Plus	Solely as a result of injury or *illness,* the insured person is not *gainfully employed* in any capacity and is unable to perform one or more of the duties of their *usual occupation* necessary to produce income, as confirmed by a *medical practitioner.* If you also have Income Cover Plus as indicated on your policy schedule, for a maximum of twelve monthly payments per claim, *totally disabled* will also include: • solely as a result of injury or *illness,* the insured person is not *gainfully employed* for more than 10 hours** per week, is unable to work more than 10 hours** per week in their usual occupation, and has a post-disability income that is not more than 25% of their pre-disability income, or • solely as a result of injury or illness, the insured person is not gainfully employed for more than 20 hours*** per week, is unable to earn a *post-disability income* that is more than 20% of their *pre-disability income*, and has a *post-disability income* that is not more than 20% of their *pre-disability income.* In addition to the above, the insured person must be under the regular care and following the advice of a *medical practitioner.*
	Income Cover Standard	Solely as a result of injury or *illness*, the insured person is not *gainfully employed* in any capacity and is unable to perform one or more of the duties of their *usual occupation* necessary to produce income, as confirmed by a *medical practitioner.* In addition to the above, the insured person must be under the regular care and following the advice of a *medical practitioner.*
usual occupation	The occupation in which the insured person is regularly engaged at the time of the *illness* or injury giving rise to the claim, except: • if your policy shows that we classified the occupation of the insured person as occupation class 4, after 36 months of claim, usual occupation means any occupation which the insured person is reasonably capable of performing having regard to their education, training or experience, • if the insured person has been unemployed or on maternity, paternity or sabbatical leave for greater than 12 months at the time of *disability,* then usual occupation means any occupation which the insured person is reasonably capable of performing having regard to their education, training or experience.	
whole person impairment (WPI)	Whole Person Impairment based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols.	

** If the insured person was working less than 20 hours per week in their *usual occupation* in the 12 months immediately prior to the commencement of *disability,* the insured person must be unable to work more than five hours per week in their *usual occupation* and not be *gainfully employed* for more than five hours per week.

*** If the insured person was working less than 20 hours per week in their *usual occupation* in the 12 months immediately prior to the commencement of *disability,* then the insured must not be *gainfully employed* for more than 10 hours per week.

How to contact us

Enquiries and policy admin

We can answer enquiries relating to any of the products in this PDS, and if you take out a policy with us, we can help you to keep your policy details up to date.

We can also help you with basic alterations to your policy, to help keep cover in line with your needs – for example if you wish to exercise an option on your policy.

Please contact Zurich in the most convenient way for you:

General enquiries: 1800 005 057
Claims: 1800 208 130

life.insurance@zurich.com.au
life.claims@zurich.com.au

GPO Box 5216
Brisbane
QLD 4001

or

Zurich Life Claims
GPO Box 4443
Sydney NSW 2001

www.zurich.com.au

Financial advice

Your financial adviser should be your first point of contact for financial advice. Zurich can only provide you with factual information about these products and how they operate.

Zurich head office

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ZURICH

Insurance-only Division Membership

Product Disclosure Statement

Product Disclosure Statement issued by Macquarie Investment Management Limited ABN 66 002 867 003 AFSL 237492
RSE No. R1004496 RSE Licence No. L0001281

Contents

This Product Disclosure Statement (PDS) contains important information about the Insurance-only Division of the Macquarie Superannuation Plan ABN 65 508 799 106 (the Division). The trustee is Macquarie Investment Management Limited (the Trustee). The Division provides members with access to death and disablement cover through superannuation, and accepts contributions and rollovers only for the purposes of paying premiums for that cover. Members do not have an account balance in the Division.

Zurich Australia Limited ABN 92 000 010 195 AFSL 232510 (Zurich, the Insurer) is the provider of insurance to members of the Division. The Insurer has consented to be named in this PDS, but is not the issuer of the PDS. Further information about the insurance is in the separate PDSs issued by the Insurer. An application for insurance can be submitted electronically by your adviser acting on your behalf or on a current paper application form. Applications to the Trustee for membership of the Division are made along with the application for insurance. You should consider both the relevant PDS issued by the Insurer and this PDS before completing the application.

The information contained in this PDS is general information only. We have not taken into account your objectives, financial situation or needs. You should consider the appropriateness of the information in this PDS, taking into account your objectives, financial situation and needs, before acting on any information in this PDS. Information about tax provided in this PDS is a guide only and is based on the Trustee's understanding of the tax laws that were current at the date of the PDS. These laws can change and the Trustee recommends you speak to your tax adviser regarding the tax consequences of holding insurance cover through superannuation. References to *superannuation law* in this PDS include the *Superannuation Industry (Supervision) Act 1993* (Cth) and associated regulations as amended from time to time.

All of the information contained in this PDS is current at the time of issue. Information contained in this PDS can change from time to time. If the change is not materially adverse, the updated information will be available at zurich.com.au and macquarie.com.au/yourwrap. A paper copy of any updated information will be given to you on request without charge.

The Trustee is not an authorised deposit-taking institution for the purposes of the *Banking Act 1959* (Cth), and its obligations do not represent deposits or other liabilities of Macquarie Bank Limited ABN 46 008 583 542. Neither Macquarie Bank Limited, nor any other company in the Macquarie Group, guarantees or otherwise provides assurance in respect of the obligations of the Trustee.

Introducing the Insurance-only Division of the Macquarie Superannuation Plan

The Insurance-only Division of the Macquarie Superannuation Plan (the Division) provides members with life insurance cover within superannuation. It does not provide superannuation account balances or investment returns to members. Some of the key features of the Division are:

- The Division does not offer a superannuation savings facility and the Trustee will only accept contributions and rollovers to pay the premiums for insurance policies held through the Division
- The Trustee can claim a tax deduction for the premium it pays and it may offset this against the tax payable on any contributions made by your employer or contributions made by you that are tax deductible
- An amount will only be payable from the Division if the Insurer pays a benefit because an insured event happens under the policy. The Trustee will only pay the amount it is entitled to receive from the Insurer less any tax that must be withheld. All amounts are paid as superannuation benefits, in accordance with *superannuation law*, and applicable tax treatment.
- The Trustee will only accept your application for membership of the Division if your application for insurance is accepted by the Insurer.

The PDS provides important information that will help you understand the types of insurance benefits available through the Division and the tax treatment that may apply, your options for meeting the costs of the insurance, and the potential risks of holding insurance through the Division.

The insurance benefits available

Zurich (the Insurer) is the provider of life insurance cover to members of the Division. If your application for cover is accepted, the Insurer will issue a life insurance policy to the Trustee and you will be the insured person under the policy. The Division provides you with access to various types of insurance cover from which you may select. The insurance products offered through the Division are:

- **Zurich FutureWise** which provides the following types of insurance:
  - Life Insurance – providing cover for death and terminal illness
  - TPD Insurance – providing cover for total and permanent disablement or 'permanent incapacity'
  - Disability Income Insurance – providing cover for 'temporary incapacity' where you are unable to work to earn income due to illness or injury.
- **Zurich Active** which provides the following types of insurance:
  - Cover for death, terminal illness and a range of specified health events that result in 'permanent incapacity'.
  - Income Cover – providing cover for 'temporary incapacity' where you are unable to work to earn income due to illness or injury.

The terms and conditions of the insurance cover, including limitations and exclusions, are described in the PDS for the insurance you select. The amount of cover you select and any special conditions the Insurer applies to your cover, will be set out in a policy schedule. A copy of the policy schedule will be sent to you by the Insurer if your application is accepted.

You will only be entitled to a benefit from the Division if a benefit is paid by the Insurer because an insured event occurs while you are covered under the policy, and you have satisfied a condition of release under *superannuation law*. The insured events under the policies offered in the Division are consistent with the conditions of release. If a benefit is payable under a policy the Trustee will normally direct the Insurer to pay it to you or your beneficiaries as a superannuation benefit.

The cost of insurance

The cost of insurance is referred to as the premium and is determined by the Insurer. The Insurer may charge a policy fee as part of the premium. The Trustee pays the premium including any policy fee charged by the Insurer with amounts you contribute or rollover to the Division. The Trustee does not charge any additional management fees or costs to members of the Division.

The actual cost for you will depend on the insurance cover you select and a range of factors as explained in the Insurer's PDS. Your financial adviser can provide you with a quotation that will set out the indicative cost of your insurance for the first year of the policy.

Paying for insurance through superannuation

Premiums can be paid either by you or your employer making superannuation contributions to the Division or by rolling over benefits from another superannuation fund. Some conditions apply to the types of contributions and rollovers that can be accepted by the Trustee as explained below. The Trustee has arranged for the Insurer to accept contributions and rollovers to the Division on its behalf and then to immediately apply the amounts collected to pay premiums.

Making contributions to superannuation

Contributions can be paid either monthly or annually, and must be in Australian dollars. To pay by credit card or direct debit from an Australian bank account, you must provide a valid authority to enable the contribution to be deducted when due. You can authorise your adviser to do this for you. Any direct debit instruction you provide is subject to the terms of the Direct Debit Request Service Agreement as set out in the application form.

If you choose to pay the premium annually, contributions can also be made by BPAY® or cheque made out to the Insurer, Zurich Australia Limited. If you choose to make contributions by BPAY® or cheque, the Insurer will provide you with payment instructions once a policy has been issued and when the policy becomes due for renewal each year. Cheques cannot be accepted before a policy has been issued.

As the Division does not offer a superannuation savings facility, the Trustee cannot accept contributions in excess of the premiums due for insurance held in the Division. The Trustee is also unable to accept Government Contributions into the Division.

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Eligibility to contribute to superannuation

To make contributions to the Division, certain conditions must be met, depending on your age and who is making the contribution. Generally, you are eligible to contribute to superannuation (or have contributions made on your behalf) if you are under age 65, or aged 65 to 74 and have worked at least 40 hours in a period of not more than 30 consecutive days in the financial year in which contributions are made.

Limits on superannuation contributions made each financial year

Contribution caps limit the amount of contributions that can be paid into the superannuation system for you each financial year, whether they are made to one or more superannuation funds. It is your responsibility to ensure you do not exceed these caps. Penalties may apply where these caps are exceeded.

Tax on contributions

Generally the Trustee is required to pay tax of 15 per cent on concessional contributions (employer contributions and, if you are eligible, personal contributions that you advise the Trustee you intend to claim as a tax deduction). However, premiums paid are generally tax deductible to the Trustee, so that any tax payable on contributions will be offset by the amount of the tax deduction available.

An additional tax of 15 per cent applies to certain concessional contributions that do not exceed the concessional contributions cap, that, when added to an individual's taxable income and certain other amounts, exceed $300,000. The Government has proposed to reduce this threshold to $250,000 from 1 July 2017, but at the time of preparation of this PDS, legislation had not been passed to change the law. This additional tax is levied on the individual, not the superannuation fund, and cannot be offset by the tax deduction available to the Trustee.

If you pay premiums by making non-concessional contributions (for example, where you are not eligible to claim a tax deduction for personal contributions, or your spouse makes after tax contributions for you) the Trustee will not pass on to you the benefit of any tax deduction on premiums.

Paying premiums by rollover from another superannuation fund

If your premiums are paid annually, you may pay by rollover from another superannuation fund. If you choose this option, you must provide a valid authority that instructs the Trustee to request from your nominated fund the amount required. You may do this by providing an Enduring Rollover Authority, which allows the Trustee to request your nominated fund to roll over benefits each year until you revoke the instruction. Your nominated fund may apply limits or other conditions on rollovers, such as minimum withdrawals, and may charge fees for processing your request. You should check the terms and conditions with you nominated fund, and ensure there is a sufficient balance in your account to cover the rollover each year.

If you roll over from another complying taxed superannuation fund, the Trustee's current practice is to pass on the benefit of the tax deduction available for premiums, by reducing the rollover amount required to cover the premium due. For example, if the premium due is $1000 and the value of the tax deduction is $150, the portion of the premium to be paid by the rollover is reduced to $850. You will be notified of the reduced amount required before the rollover request is sent to your nominated fund. Any changes to this practice will be communicated to you with advance notice.

The Trustee is required to pay tax of 15 per cent on the untaxed element of an amount rolled over from another superannuation fund. This tax may also be offset by a tax deduction available to the Trustee on the premiums.

The Trustee is unable to accept rollovers that contain United Kingdom (UK) transfer or New Zealand KiwiSaver transfer amounts. The Trustee is also unable to accept rollovers that are not equal to the specific amount due. Rollovers that cannot be accepted will be returned to the transferring superannuation fund. If a rollover is returned, you will be requested to provide alternate instructions so that the premium can be paid.

Client Money

If the Trustee receives money before your application for membership is accepted, that money will be held in a non-interest bearing trust account with an Australian authorised deposit taking institution (currently Macquarie Bank) until your interest in the Division has been issued. If your interest is not issued within a period of one month of receipt of the money (or if this is not reasonably practicable, by the end of such longer period as is reasonable in the circumstances), the money will be returned.

Non-payment of premium

Contributions or rollovers must be received when the premium is due for payment. The Trustee has arranged for the Insurer to notify you directly of the premium obligations. If contributions or rollovers are not received by the Insurer when the premium is due, the Insurer will be entitled to cancel the insurance after giving notice to you. If a payment sufficient to meet the amount due is not made by the date notified, the Insurer will then cancel the insurance and you will cease to be a member of the Division.

Cooling-off period

You have a 21 day cooling-off period after your membership of the Division commences during which time you can cancel your insurance if you decide that it does not meet your needs. You will be entitled to a refund of the premium and any policy fee that you have paid but subject to tax and superannuation preservation rules imposed by the law. See the section below titled 'Refunds' for more information.

If you wish to use the cooling-off period, you must not have made a claim and must notify the Insurer within 21 days of the earlier of:

- the date you receive your copy of the policy schedule from the Insurer, or
- the end of the 5th day after the policy was issued, and your membership commenced.

Refunds

Superannuation contributions and rollovers received into the Division are subject to superannuation preservation rules. In cases where a premium is refunded by the Insurer to the Trustee (for example, a part refund of an annual premium where cover is cancelled before the next cover anniversary, or a full refund of the initial premium paid where cover is cancelled in the cooling off period), the refund must be rolled over to another complying superannuation fund. Any tax that would otherwise have been offset by a deduction available to the Trustee for insurance premiums will be deducted from the amount refunded and the balance transferred to the other fund.

The Super Safeguard Eligible Rollover Fund

The Trustee may transfer any refund of premiums to an Eligible Rollover Fund (ERF) if you do not nominate a superannuation fund for the transfer. The ERF presently nominated by the Trustee for this purpose is the Super Safeguard Eligible Rollover Fund, the trustee of which is Diversa Trustees Limited ABN 49 006 421 638 AFSL 235 153. The Australian Prudential Regulation Authority (APRA) has approved the Super Safeguard Eligible Rollover Fund to operate as an ERF. The Trustee reserves the right to change the chosen ERF without prior notice to you.

Should your superannuation benefit be transferred to the Super Safeguard Eligible Rollover Fund:

- your interest in (and membership of) the Division, including your insurance cover, will cease
- you will become a member of the Super Safeguard Eligible Rollover Fund and will be subject to its governing rules
- your account will be invested according to the investment strategy of the Super Safeguard Eligible Rollover Fund
- the Super Safeguard Eligible Rollover Fund may charge fees to your account
- you may not be offered insurance cover, and
- all subsequent enquiries relating to your benefit should be directed to:

Super Safeguard Eligible Rollover Fund

GPO Box 3426
Melbourne VIC 3001

Phone: 1300 135 181

Fax: 1300 135 191

Email: enquiries@supersafeguard.com.au

Website: supersafeguard.com.au

You should refer to the Product Disclosure Statement for the Super Safeguard Eligible Rollover Fund for more information.

Benefit payments and tax

The Insurer will not pay a benefit under an insurance policy held in the Division until the Trustee has determined to whom the benefit must be paid. This might be you, your legal personal representative or one or more of your dependants. Benefits paid from the Division are treated as superannuation benefits for tax purposes. Any tax payable on a benefit will be withheld before an amount is paid from the Division.

Death

Death benefits will be paid to either your legal personal representative (estate) or one or more of your dependants as defined under *superannuation law*. If the Trustee holds a valid non-lapsing death benefit nomination at the time of your death (see the section titled 'Death benefit nominations' on page 5), the Trustee will pay the benefit in accordance with your nomination. If there is no valid non-lapsing death benefit nomination, the Trustee will pay the benefit to your legal personal representative. If the Trustee has not been able to find a legal personal representative after making reasonable enquiries, payment may be made to another individual.

Death benefits can only be paid from the Division as a lump sum. However, certain beneficiaries may be eligible to receive your death benefit through a pension account established within the Macquarie Superannuation Plan. A lump sum benefit paid from the Division after your death is tax free when it is paid, either directly or via the estate, to one or more of your dependants as defined in tax law.

Terminal medical condition

Benefits for a terminal medical condition can only be paid from the Division as a lump sum. A lump sum benefit paid to you because of a terminal medical condition is generally tax free.

Permanent incapacity

Benefits for permanent incapacity can only be paid from the Division as a lump sum. A lump sum benefit paid because of your permanent incapacity may be taxable, but some concessions may apply.

Temporary incapacity

Benefits for temporary incapacity can only be paid from the Division as an income stream for the period of incapacity (restrictions apply) and cannot be converted to a lump sum. The Trustee will direct the Insurer to pay the income stream payments to you. An income stream paid from the Division for temporary incapacity will generally be taxed as ordinary income at your marginal tax rate. The Trustee may be required to withhold tax on any income stream benefits paid to you.

Death benefit nominations

You have the option of nominating to whom a death benefit from the Division will be paid. Where the Trustee has consented to your nomination, your benefit will be paid as a lump sum to the person that you have nominated as long as your nomination remains valid, and has been made in the prescribed manner.

A non-lapsing nomination can only be made by you. The Trustee will not accept a non-lapsing nomination made by an attorney or any other agent. The Trustee can only consent to a nomination if it is made in writing and signed by you in the presence of two witnesses who are over 18 years of age and not named as beneficiaries in your nomination. To make a nomination simply complete the death benefit nomination section of the application, or complete and return a death benefit nomination form.

The Trustee can only consent to a nomination in respect of one or more of your dependants (as defined in *superannuation law*) or a legal personal representative. To remain a valid nomination, a nominated beneficiary must still be a dependant at the time of death. If the Trustee has consented to your nomination and that nomination, or a part of it, is no longer valid at the time of payment, the Trustee will pay the non-valid portion of your death benefit to your legal personal representative. The Trustee will pay the valid portion of your death benefit in accordance with that part of your nomination which is valid.

A nomination applies across all death benefits with regard to any interest you hold in the Division with respect to a particular insurance product. Therefore if you hold multiple interests in the Division, each with respect to a different insurance product, any subsequent nomination in respect of an interest revokes a prior nomination in respect of that interest only. You may revoke or change your nomination at any time by completing a new non-lapsing death benefit nomination form. It will come into effect once the Trustee has consented to it.

Your benefit can only be paid as a pension if, at the time of death, the recipient is either a dependant of yours (as defined in *superannuation law*) who is not a child, or a child of yours who is less than age 18, or aged 18 to 24 inclusive and is financially dependent on you, or aged 18 or more and has a qualifying disability.

You should periodically review your nomination to ensure you still wish for the Trustee to pay the person(s) you have nominated, because it will not automatically become invalid after a fixed period of time, or in the event of marriage, divorce or any other life-changing event. Details of any nomination that the Trustee has consented to will be included in your annual statement.

Risks of holding insurance through superannuation

There are risks you should consider before deciding to hold insurance through superannuation, including:

- A benefit paid from the Division is a superannuation benefit for tax purposes and it may be subject to more tax than would otherwise apply if the benefit was paid from the same insurance held outside of superannuation.
- Limits apply to the amount you can contribute to superannuation each year. Any contributions you make to the Division in order to pay premiums will reduce the amount you may be able to contribute to other superannuation accounts you hold for retirement savings purposes.
- Where you choose to pay premiums by rollover from another superannuation fund, your retirement savings will be reduced so that you may have less available to you on retirement than otherwise may have been the case.
- Taxation or *superannuation law* may change in the future, altering the suitability of holding insurance in superannuation.

Your adviser and how to apply

This product is available through financial advisers, referred to in this PDS to as 'your adviser'. Your adviser may act as your agent and lodge on your behalf an application for membership of the Division. If your application is accepted, the Insurer may pay your adviser a commission for selling the insurance. You can obtain details from your adviser of any commission paid.

Your adviser can assist you to make an application for membership of the Division, along with an application for insurance. If your adviser lodges an online application on your behalf, the adviser is required to confirm that they have authorisation to act as your agent. It is your responsibility to ensure that the information provided to the Insurer and the Trustee by your adviser is accurate and complete. The Trustee will rely on the accuracy of the information provided via the online application as if a paper application was signed and submitted by you.

Applications for membership of the Division can only be accepted after the insurance application has been accepted by the Insurer. In accepting your application, the Trustee will rely on declarations and authorisations made by you, either directly or via your agent, relating to the following matters:

- You have appointed your adviser to act on your behalf in relation to the application and, if you choose to submit an online application, you have appointed your adviser to complete and lodge an application as your agent.
- You have received this PDS and the Insurer's PDS(s) for the insurance product(s) you have chosen to apply for.

- You confirm the information supplied in connection with the application is true and correct and no information material to the application has been withheld.
- You authorise the collection of premiums from the account designated in the application, and where you have designated a bank account, you confirm you have received a copy of the Direct Debit Request Service Agreement.
- You have read the Privacy Statement (see pages 6-7) and the anti-money laundering terms and conditions (see page 7) contained in the PDS.
- Where you have chosen to have premiums paid by making new contributions to superannuation, you are eligible to do so under *superannuation law*.
- You acknowledge that Macquarie Bank Limited has no obligations in respect of your membership of the Division or insurance policies issued to the Trustee.

Tax file number collection

Collection of tax file numbers (TFNs) is authorised under law. The Trustee will only use your TFN for purposes authorised by law. The purposes currently authorised include:

- taxing benefit payments at lower rates than may otherwise apply
- passing your TFN to the Australian Taxation Office
- allowing the Trustee to provide your TFN to the trustee of another superannuation fund or Retirement Savings Account if your benefit is transferred to that fund. However, the Trustee will not do so if you advise in writing that you do not want it to be passed on, and
- locating accounts in the Macquarie Superannuation Plan or consolidating certain accounts within the superannuation environment.

Declining to quote your TFN is not an offence, however, if you do not provide your TFN:

- the Trustee cannot accept contributions made by you or someone on your behalf (other than your employer)
- certain concessional contributions and other amounts may be subject to an additional no-TFN tax
- you may pay more tax on your superannuation benefits than you have to, and
- it may be more difficult to find your superannuation benefits if you lose contact with your superannuation fund.

As a consequence, the Trustee will not accept your application for membership of the Division until you provide your TFN.

Privacy

Your privacy is important to the Trustee. This statement explains how personal information can be used or disclosed and provides information about your privacy rights.

As the Trustee will own the insurance policy, all information provided in your insurance application to the Insurer may be shared with the Trustee. Similarly, information collected by the Insurer in assessing claims or managing the insurance may also be supplied to the Trustee.

By completing the application you agree to the Trustee collecting, using and disclosing your personal information to:

- communicate with you and your adviser about the application and any cover the Insurer provides for you
- monitor, audit, evaluate and otherwise administer your fund membership and insurance, and
- assess process and investigate any insurance claims.

Macquarie companies may contact you on an ongoing basis by telephone, electronic message (eg email or SMS), online and other means to offer other products or services which may be of interest to you, including offers of banking, financial, advisory, investment, and funds management services. If you do not wish that to occur please let Macquarie know by calling 1800 806 310 or visiting macquarie.com.au/optout-bfs

The Trustee collects personal information through our interactions with you, as well as from public sources, information brokers and the third parties described under 'Disclosure of personal information' below. The Trustee may take steps to verify information collected. If you do not supply the personal information requested, the Trustee may not be able offer membership of the fund to you.

The references in this Privacy Statement to personal information include sensitive information such as medical and health related details. If required to assess your application, administer your policy or process any claims, the Insurer and the Trustee may seek further information from any medical attendant consulted by the insured person.

You agree that the Trustee may disclose personal information about you to the Insurer and other companies in the Macquarie Group and external service providers (as described in Macquarie's Privacy Policy). Some of these third parties may be located outside of Australia (this includes locations in the Philippines, India, South Africa, and the United States of America). Where this occurs we take reasonable precautions to ensure your information is kept secure.

A current list of all locations to which your information may be sent and/or stored by Macquarie Group and its external service providers is available in our Privacy Policy, available at macquarie.com.au

The Trustee may also disclose your personal information:

- if acting in good faith, we believe that the law requires or permits the Trustee to do so
- if you consent, or
- to the doctor identified in your application in the event that any medical tests that the Insurer has requested return an abnormal result.

The personal information will also be provided to your adviser in connection with your application and ongoing management of your membership. This excludes the release of any reports sourced by the Insurer from any outside parties. You can instruct the Insurer not to supply your adviser with any medical information received in the declaration that forms part of your application.

We are required or authorised to collect certain personal information about you under the *Superannuation Industry (Supervision) Act 1993* (Cth) and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (Cth). Under the *Privacy Act 1998* (Cth), you may request access to your personal information held by the Trustee. You can contact the Trustee to make such a request or for any other reason relating to the privacy of your personal information. You may also request a copy of the Macquarie Group Privacy Policy available at macquarie.com.au which contains further information about our handling of personal information including procedures for accessing and correcting personal information and dealing with your concerns. Contact details are shown in the section titled 'Who to contact'.

Anti-money laundering and counter terrorism financing terms and conditions

As part of our commitment to international anti-money laundering standards, Macquarie is required to fulfil our legal obligation and internal policies and procedures as required.

You must not knowingly do anything to put Macquarie Group (Macquarie) in breach of the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (Cth) (AML/CTF Laws) and/or its internal policies and procedures, rules and other subordinate instruments. You undertake to notify Macquarie if you are aware of anything that would put Macquarie in breach of AML/CTF Laws.

If requested, you agree to provide additional information and assistance and comply with all reasonable requests to facilitate Macquarie's compliance with AML/CTF Laws in Australia or an equivalent law in an overseas jurisdiction and/or its internal policies and procedures.

You undertake that you are not aware and have no reason to suspect that:

- the money used to fund the insurance is derived from or related to money laundering, terrorism financing or similar activities (illegal activities), and
- proceeds of insurance made in connection with this product will fund illegal activities.

Macquarie is subject to AML/CTF Laws and/or its internal policies and procedures. In making an application pursuant to the PDS, you consent to Macquarie disclosing, in connection with AML/CTF Laws and/or its internal policies and procedures, any of your personal information as defined in the *Privacy Act 1988* (Cth) we have.

In certain circumstances, we may be obliged to freeze or block an account where it is used in connection with illegal activities or suspected illegal activities. Freezing or blocking can arise as a result of the account monitoring that is required by AML/CTF Laws and/or its internal policies and procedures. If this occurs, we are not liable to you for any consequences or losses whatsoever and you agree to indemnify Macquarie if we are found liable to a third party in connection with the freezing or blocking of your account.

Macquarie retains the right not to provide services to any applicant that Macquarie decides, in its sole discretion, that it does not wish to supply.

The Macquarie Superannuation Plan

The Macquarie Superannuation Plan (the Plan) is a resident, complying and regulated superannuation fund within the meaning of *superannuation law*. The Macquarie Superannuation Plan is not subject to a direction from APRA under Section 63 of the *Superannuation Industry (Supervision) Act 1993* (Cth). A direction under Section 63 would prohibit acceptance of any contributions made by an employer sponsor.

The Trust Deed and Rules of the Macquarie Superannuation Plan (the Plan) sets out the powers and duties of the Trustee and the rights and obligations of the members of the Plan. A copy of the Trust Deed and Rules is available at macquarie.com.au/yourwrap or a copy can be sent to you on request.

An annual report about the management and financial condition of the Macquarie Superannuation Plan for the period to 30 June is prepared each year. If you do not elect to receive a hard copy annual report you can view the annual report online at macquarie.com.au/yourwrap and we will not send you a copy. You may elect to have a hard copy of the annual report sent to you free of charge.

Who to contact

In the first instance, enquiries should be directed to the Insurer:

General enquiries

Telephone: 1800 005 057

Fax: 1800 812 175

Email: life.insurance@zurich.com.au

Post: Zurich Australia Limited
GPO Box 5216
Brisbane QLD 4001

Claims

Telephone: 1800 208 130

Email: life.claims@zurich.com.au

Post: Zurich Life Claims
GPO Box 4443
Sydney NSW 2001

You should be aware that all telephone conversations with you or your adviser are recorded.

What to do if you have a complaint

Superannuation law requires the Trustee to take all reasonable steps to ensure that complaints are properly considered and dealt with within 90 days. If you have a complaint:

- contact your adviser and discuss your enquiry or complaint with them
- if you are not satisfied with the result, you may telephone us on 1800 025 063, or
- it may then be necessary to write to us.

Complaints Officer
Macquarie Investment Management Limited
GPO Box 4045
SYDNEY NSW 2001

We will ordinarily respond to your written enquiry or complaint as soon as possible but within 45 days of receipt.

If you are still not satisfied with our response, after 90 days, you may wish to refer the matter to the Superannuation Complaints Tribunal (SCT), an independent body set up by the Federal Government to review trustee decisions relating to individual members.

You can contact the SCT on 1300 884 114 or info@sct.gov.au.

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Macquarie Investment Management Limited
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1 Shelley St Sydney NSW 2000

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The trademarks depicted are registered in the name of
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AWAS-011469-2016 ZU23279 V1 09/16