St.George Protection Plans

Product Disclosure Statement and Policy Document (PDS)

Effective date: 1 April 2019

st.george

Contents

Your duty of disclosure

Life insurance is designed to cover you for the unexpected. So if you have any pre-existing health conditions at the time your Policy commences, you need to tell us about them so that we can decide whether or not to cover them. If you don't tell us about them, you may not be covered for them by this Policy. Please read the following information on your duty of disclosure carefully.

You have a duty, under the Insurance Contracts Act 1984, to tell us every matter that you know, or could reasonably be expected to know, is relevant to the decision whether to insure you and, if so, on what terms.

Every person to be insured under your Policy has the same duty of disclosure. If they fail to comply with their duty, their failure to disclose any relevant matter may be treated as a failure by you to comply with your duty of disclosure.

The duty of disclosure applies before you enter into, extend, vary or reinstate a Policy, and applies until the time when we issue a *policy schedule, membership certificate* or other written confirmation of the issue, extension, variation or reinstatement.

If any information provided to us changes (including any change to an Insured Person's health, occupation or pastimes) before we send the *policy schedule, membership certificate* or other written confirmation of cover to you, you must tell us.

The duty does not require disclosure of any matter:

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

Non-disclosure

If you fail to comply with your duty and the Policy would not have been entered into if the failure had not occurred:

- the Policy may be varied to reduce the sum insured or to reflect the terms that would have applied if you had complied with your duty; or
- the Policy may be treated as never having existed if it is within 3 years of entering into the policy or your non-disclosure was fraudulent.

Who plays a part in your journey?

You	• Discuss your protection needs with your financial adviser regularly to ensure your cover continues to be suitable as your life changes.
Your Adviser	• Your adviser can help you to determine the right type and level of insurance for you. • In addition, they will assist with your application, and help you monitor and retain the right insurance as your life changes.
Your Insurer	• The *Insurer* is responsible for managing your policy and for being there to pay claims if the unexpected happens. • The *Insurer* is Westpac Life Insurance Services Limited ABN 31 003 149 157, AFSL Number 233728.
Your Trustee	• You can take out a St.George Protection Plans Policy through superannuation. • The trustee of the superannuation fund is responsible for managing the fund in compliance with superannuation law. • The *Insurer* has a current arrangement with Westpac Securities Administration Limited ABN 77 000 049 472, AFSL Number 233731, RSE Licence L0001083 (*WSAL*) to provide insurance benefits for its members.

St.George Protection Plans

The *Insurer* of St.George Protection Plans has been protecting Australians and their families since 1987.

As we move through life, find a partner, raise a family, and maybe start a business, the importance of insurance keeps changing. That's because insurance is all about providing a financial safety net that helps you to take care of yourself and those you love when you need it the most.

What do you want to protect?

Your home

- ✓ Mortgage repayments
- ✓ Rent

Your income

- ✓ Salary
- ✓ Superannuation contributions
- ✓ Income from business

Your family and lifestyle

- ✓ Everyday costs
- ✓ Bills
- ✓ Children's education
- ✓ Estate planning

Your business

- ✓ Business income
- ✓ Business expenses
- ✓ Key people
- ✓ Business succession

St.George Protection Plans offer you a comprehensive and flexible range of personal and business life insurance solutions, designed to help protect you and your loved ones should the unexpected happen. Having the right amounts and types of life insurance in place can provide valuable financial support in your time of need.

Award winning life insurance solutions

At St.George, we are committed to delivering the best life insurance solutions to our customers. The breadth of our customer and industry recognition highlights our continued commitment to innovation, service excellence and helping our customers protect their financial future.

AFA/Beddoes Consumer Choice Awards 2018

Best in Return to Health and Wellness

Best Focus on Early Intervention

CANSTAR Innovation Excellence Awards 2018

Claims Medical e-Certificates

Excellence and Innovation in Return to Work 2018

Claims Cancer Assistance Program

SMSFAdviser Awards 2018

SMSF Insurance Provider

Australian Insurance Awards 2016 and 2017

Life Insurance Company of the Year

Best Claims Outcome and Customer Experience

World Finance Global Insurance Awards 2015, 2016 and 2017

Best Life Insurance Company, Australia

Chapter 1: Introduction

About this PDS

Please read this PDS to understand the Protection Plans policy features, benefits, limitations and exclusions. The terms and conditions of this PDS will form a part of your contract with us.

In this PDS, you will notice the use of terms and expressions which have a particular meaning as set out below.

Term	Meaning
'We', 'us', and 'our'	The *Insurer*.
Policy Owner	The person (or entity) shown as the Policy Owner in the *policy schedule* or *membership certificate*. For Policies held through *Westpac MasterTrust*, the Policy Owner is the *trustee*.
Insured Person	The person whose life is insured, or the life to be insured. The name of each Insured Person is set out in the *policy schedule* or *membership certificate* under the heading, Insured Person.
Insured Child	The child to be insured for the Children's Benefit being the child named on the *policy schedule* or *membership certificate* under the heading, Insured Child.
'You' and 'your'	The Insured Person for Term Life as Superannuation and Income Protection as Superannuation, and for all other Policies means the Policy Owner.
Policy	For Policies held through *Westpac MasterTrust*, the cover as provided under the contract of insurance between us and *WSAL*, and for all other cover, the contract of insurance with us.

Other important things to note

As you read through this PDS, you will notice that some words are in italics. These words have a particular meaning which can be found in chapter 8, comprising the defined term in bold followed by the definitional wording.

As you would expect in an insurance document, you'll also find quite a few medical terms. These are explained in chapter 7.

There are certain restrictions on the type of Policies and benefits that can be held inside superannuation. In this PDS, these are denoted as:

NS not available for Policies and benefits held inside superannuation.

S+ not available for Policies and benefits held inside superannuation. If you wish to access these benefits, you must hold a Flexible Linking Plus or Income Linking Plus Policy in addition to your Policies held inside superannuation.

For more information

To find out about St.George and the Life Insurance Code of Practice, please visit stgeorge.com.au.

Types of cover available in St.George Protection Plans

Below is a summary of the types of cover available and examples of what it could protect. Your financial adviser can help you to understand the types of cover which are right for you.

Types of cover	What it could protect			
	Your home	Your income	Your family and lifestyle	Your business
Term Life *Terminal illness* or death of the Insured Person.	✓	✓	✓	✓
Total and Permanent Disablement (TPD) The Insured Person being unlikely to ever again be able to either: • work; • perform household duties; or • perform activities of daily living, depending on the definition selected.	✓	✓	✓	✓
Living Insurance The Insured Person has a *specified medical event* (a specified *sickness*, *injury* or surgery).	✓	✓	✓	✓
Income protection The Insured Person is, due to *sickness* or *injury*, unable to: • work; • perform household duties; or • perform activities of daily living, depending on the definition selected.	✓	✓	✓	
Business Overheads The Insured Person is unable to work due to *sickness* or *injury*.				✓
Key Person Income The Insured Person is unable to work due to *sickness* or *injury*.		✓		✓
Needlestick Benefit The Insured Person contracts occupationally acquired HIV, hepatitis B or hepatitis C.		✓	✓	✓
Children's Benefit The Insured Child dies or has a *specified children's event* (a specified *sickness*, *injury* or surgery).			✓	

Applying for St.George Protection Plans

St.George Protection Plans offer cover for a diverse range of customers.

Your adviser can help you determine the right insurance for you, including the amount of cover, how to structure your policies, and the premium and payment option most suitable for you. They can also assist with your application and provide you with a quote for your cover.

To apply for cover or find out more:

- talk to your financial adviser; or
- contact us:
  - 1300 366 416, Monday to Friday 8.00am – 6.30pm (Sydney time)
  - GPO Box 4582, Sydney, NSW 2001
  - stgeorge.com.au

Below is a summary of the types of cover available for different age groups. For details of the eligibility and expiry ages for each cover type and premium structure, see chapters 2 and 3.

Who can apply?	Types of cover
Entry ages: 2 to 14	Children's Benefit
Entry ages: 15 to 17	Term Life TPD Living Insurance Needlestick Benefit
Entry ages: 17 to 59	Term Life TPD Living Insurance Needlestick Benefit Income protection Business Overheads Key Person Income
Entry ages: 59 to 69	Term Life Income Protection General Cover

Interim Accident and Sickness Cover

While we are considering your application, we provide you with free Interim Accident and Sickness Cover. For more information, see chapter 4.

Your Policy starts

If we accept your application for cover, we will issue you a *policy schedule* or *membership certificate*. Your cover starts on the 'Policy Risk Commencement Date' shown in your *policy schedule* or *membership certificate*.

Cooling off period

If you change your mind you can cancel your Policy and receive a refund of your premium within the cooling off period. For more information, see chapter 6, section 1.

We're here when you need it

St.George has helped thousands of Australians

In 2018 we provided customers and their families with more than $381 million in financial assistance, at a time when they needed it most.

The benefits included payments of:

- over $148 million to help families cope with losing a loved one;
- almost $150 million in Living Benefits and Total and Permanent Disablement payments to help those who were sick or injured; and
- almost $83 million paid in monthly income protection installments to help customers who were unable to work, due to sickness or injury.[1]

If you need to make a claim

We believe every customer and claims circumstance is unique. We understand that to manage claims effectively for our customers' benefit we need to treat people with empathy and consider their situation holistically. We will always seek to pay genuine claims promptly and we believe that transparency leads to better claims outcomes. We also understand that we are dealing with private information and we commit to maintaining the privacy, accuracy and security of personal information.

Please contact us as soon as you become aware that you need to make a claim. Our Customer Relations Consultants will arrange for you to receive any information or forms you need.

Before we can pay a benefit, you must provide satisfactory evidence and the authority for us to obtain further information which we consider to be relevant to your claim. Depending on the type of insurance, we will request medical and/or financial evidence, and proof of the Insured Person's age. We may also require the Insured Person to undergo medical examinations or tests as part of the assessment.

For more information about making a claim, see chapter 5.

1 Claims statistics cited are from the period between 1 October 2017 and 30 September 2018 inclusive, and pertain to Westpac Life Insurance Services Limited ABN 31 003 149 157 (WLISL) and St.George Life Limited ABN 88 076 763 936.

Features of your Policy

Guaranteed renewable

We won't cancel your insurance before the end of the term specified provided you keep paying the premiums when they are due – even if there is a change in the Insured Person's health, occupation or pastimes.

Guaranteed upgrades

Should better features and benefits become available in the future which don't result in an increase in premium, we will automatically upgrade your Policy. At claim time, we will always give you the best terms applicable to your Policy, from the time of commencement to the date of a *sickness* or *injury*.

Worldwide cover — 24 hours a day

We will provide you with full coverage anytime, anywhere in the world.

Loyalty Benefit

To reward your loyalty, after you have held your Policy for 3 years (from the *commencement date*), we will add an extra 5% of your sum insured to any Death Benefit, TPD Benefit, Living Benefit or Children's Benefit amount payable at the time of claim, without additional charge.

For income protection, Business Overheads and Key Person Income, after you have held your Policy for 3 years (from the *commencement date*), we will add a Death Benefit of $50,000 to your Policy without additional charge.

For more information see chapter 2, section 7 and chapter 3, section 14.

Premium Holiday

If your Policy has been in force and the premiums paid for at least 6 months, we will allow you to suspend your Policy for up to 12 months in certain circumstances of financial hardship. For more information see chapter 2, section 8 and chapter 3, section 15.

CPI increases

To help the value of your benefits keep up with the cost of living, we will automatically increase the amount of certain benefits each year on your *review date* in line with *CPI*.

Policy type	CPI increase
Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone TPD and Children's Benefit	*CPI* with a minimum of 3%
Income protection Policies with *own occupation IP* definition[1], Business Overheads and Key Person Income	*CPI* with a minimum of 3% Note: While you are receiving a monthly benefit from us, the *insured monthly benefit* will only be increased by the *CPI* on each *review date*
Income protection Policies with *home duties IP* and *general cover IP* definitions[1]	*CPI*

You may decline a *CPI* increase in any year by advising us within 30 days of the *review date*. You may also request that *CPI* increases never apply again.

If you wish to restart the *CPI* increases at a later date, please contact us.

Multi-Policy discount

If the Insured Person is covered by multiple eligible St.George Protection Plans Policies, you will receive a multi-policy premium discount of 5% on all Protection Plans premiums applicable to the Insured Person (excluding policy fee and stamp duty).

The eligible Policies are Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone TPD, Business Overheads, Key Person Income and income protection.

1 For more information on the *own occupation IP*, *home duties IP* and *general cover IP* definitions, please see chapter 3.

Paying for your insurance

The cost of your insurance includes the premium and other fees and charges, such as the policy fee and stamp duty.

Below is a summary of the premium structure and payment options available to you. For more information on your premiums, fees and charges, please see the 'Premiums and charges' section in chapter 6.

Your premium options

You are able to choose between stepped premium and level premium. A summary of each premium structure is set out below.

Stepped premium

Your premium is calculated each year, and will change based on the Insured Person's age and the sum insured at the *review date*. The premium will generally increase every year.

Level premium

Your premium for the time period specified (eg to age 55 for a 'Level 55' premium structure or to age 65 for a 'Level 65' premium structure) is calculated based upon the Insured Person's age at the commencement of the cover. From commencement to the end of the time period specified, the premium will generally remain unchanged for the amount of cover applied for.

Sometimes we may need to make changes to our rates as part of a review of our pricing. This may result in a change to your level premium rates. Further detail on when level premiums may change can be found below in the 'When your premium will change' section.

If there is an increase to your sum insured due to *CPI* increases or because you have requested to change your sum insured, the premium for the increased portion of cover will be calculated based on the Insured Person's age at the time of the increase. Your premium may also be recalculated based on the Insured Person's current age if you request a variation to your Policy.

When the specified period of time has elapsed, the premium will revert to a stepped premium structure.

When your premium will change

For new policies, your premium rates are guaranteed for at least two (2) years from the 'Policy Risk Commencement Date' for the initial sum insured, subject to the conditions outlined below.

For both stepped and level premiums, including within the first two (2) years of cover, your premiums will change if:

- there is a change to your sum insured due to *CPI* increases, or because you have requested to change your sum insured;
- there is a change due to an increase in your age (for level premiums, this relates to *CPI* increases only);
- there is a change to the premium discounts and/or loadings on your Policy; or
- you vary your Policy, including changing your premium frequency.

If you make amendments to your existing policy, including increasing or decreasing your sum insured, the rate guarantee will continue to apply to your new premium as per the conditions above, but only for the remainder of the two (2) year period starting from the policy's original 'Policy Risk Commencement Date'.

After your 2nd *review date* we may change the premium rates or discount factors applicable to your Policy, for both stepped and level premiums. These premium rate changes will not apply to a specific individual Policy, rather, a change would relate to an entire group based on pricing factors (such as occupation category) or a class of products.

You will be provided at least 30 days notice prior to an increase to your premium rates. You will be notified of any other changes to your premium in accordance with the law. In the event of war or invasion involving Australia, we may give immediate notice of premium change.

You can contact us to request information on your premium, or to request a quote for the premium that will apply after a variation to your Policy.

Your payment options

For all Policies, the Policy Owner is responsible for paying the premiums.

St.George Protection Plans provide flexibility through a number of different premium payment options, as shown in the table below. The ownership structure you have selected will determine the payment options available to you.

Payment options	Frequency	
	Yearly	Half-yearly/ Quarterly/ Monthly
Direct debit	✓	✓
Credit card	✓	✓
Cheque	✓	✗
Partial rollover	✓	✗

Please note:

- Payment by partial rollover is only available for eligible superannuation funds and products.
- Credit card payments can only be made from an accepted credit card.

Ownership options

This section explains the ownership options available under St.George Protection Plans.

St.George Protection Plans Policies can be held inside or outside superannuation.

The following table outlines the ownership options available.

Ownership option	Term Life	Standalone TPD	Standalone Living Insurance	Income Protection and Income Protection Plus	Business Overheads and Key Person Income	Children's Benefit and Needlestick Benefit
Outside superannuation • Self owned • Another individual • Trustee of a trust or a business entity	✓	✓	✓	✓[1]	✓[1]	✓
Inside superannuation Trustee of: • *SMSF* • *Westpac MasterTrust*	✓	✓[2]	✗	✓[3]	✗	✗

1 Income Protection and Business Overheads Policies must be owned by the Insured Person or a trust/business entity that the Insured Person has direct control of (eg the Insured Person is the trustee of the trust, or the partner or director of a business entity). A Key Person Income Policy must be owned by the business entity of which the key person has a share of ownership, or is employed by.

2 Standalone TPD is not available through *Westpac MasterTrust*.

3 If Income Protection Plus is selected, the core benefits which are consistent with a superannuation condition of release will be held under a policy inside superannuation, and the other benefits under an Income Linking Plus policy held outside superannuation (see 'Super Plus IP Benefit', chapter 3, section 30). *General cover IP* is only available in Policies held through an *SMSF* if the Insured Person is *gainfully employed* at the time you apply for cover. *General cover IP* is not available through *Westpac MasterTrust*.

Please note:

- We allow up to five Policy Owners on Term Life, Standalone TPD and Standalone Living Insurance Policies held outside superannuation. Each Policy Owner will jointly own the Policy. In the event a Policy Owner of a Policy with joint ownership dies, the ownership of the Policy automatically goes to the surviving Policy Owners. If all Policy Owners have died, the owner of the Policy will become the estate of the last surviving Policy Owner.
- TPD and/or Living benefits may be structured as additional benefits under a Term Life or Term Life as Superannuation Policy. This may be under the same or different ownership option. Please refer to page 12 for further information.
- If Income Linking Plus has been selected together with Income Protection you will have equivalent cover to that provided by Income Protection Plus.
- Policies held through *Westpac MasterTrust* are called Term Life as Superannuation and Income Protection as Superannuation.

There are restrictions and limitations on the type of cover that can be held inside superannuation, and on the terms and conditions of those Policies, as the payment of insurance benefits from a superannuation fund is governed by superannuation law.

The trustee of the superannuation fund can only provide a benefit to the Insured Person if the insured event is consistent with a condition of release under superannuation law. In the event of a claim, the trustee can only release benefits to the Insured Person if they meet a superannuation condition of release.

For more information on the superannuation conditions of release, see chapter 6, section 9.

Policy structures

This section explains the Policy structures available under St.George Protection Plans.

You can structure cover for an Insured Person in the following ways:

1. Stand-alone or individual Policies

The benefits paid will not affect the sum insured under any other Policy (unless we have stated otherwise).

2. Additional benefits under the same Policy

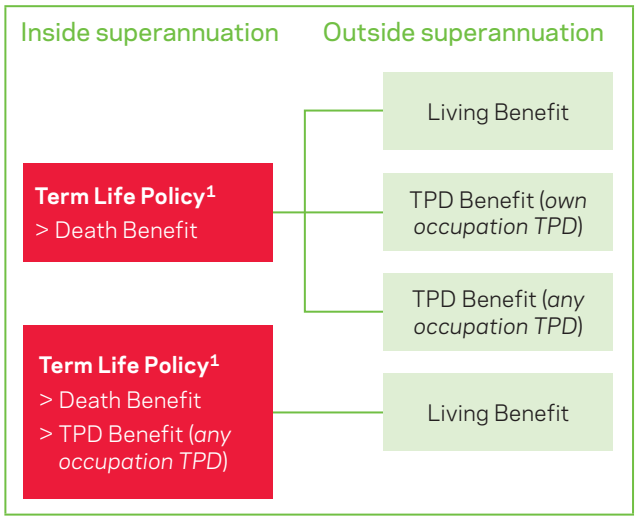
TPD and Living Benefits can be structured as additional benefits under a Term Life or Term Life as Superannuation Policy. The benefits paid will reduce the sum insured of all benefits held under the same Policy, and all benefits held under a linked Flexible Linking Plus Policy.

3. Linked Policies inside and outside superannuation

Flexible Linking Plus and Income Linking Plus allows you to link benefits under two Policies held inside and outside superannuation. The benefits (or the portion of a benefit) which are consistent with the superannuation conditions of release will be held under a Policy with ownership inside superannuation. The remaining benefits (or the remaining portion of a benefit) will be held outside superannuation under the Flexible Linking Plus or Income Linking Plus Policy.

Flexible Linking Plus

Benefits which are not consistent with a superannuation condition of release (such as TPD Benefit with *own occupation TPD* definition and Living Benefit) will be held under a Policy outside superannuation (referred to as the Flexible Linking Plus Policy) and linked to a Policy inside superannuation. The following diagram is an example of how you can link TPD and/or Living Benefits under a Flexible Linking Plus Policy held outside superannuation, to a Term Life Policy inside superannuation.

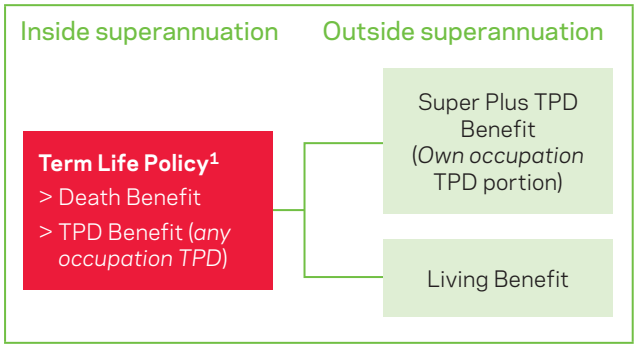


1 Benefits which are not consistent with a superannuation condition of release, such as the Financial Planning Benefit and Counselling Benefit, will be held under the Flexible Linking Plus Policy.

You can apply to add a Needlestick Benefit Policy and/or Children's Benefit Policy, held outside superannuation, to the above policy structures.

Super Plus TPD Benefit

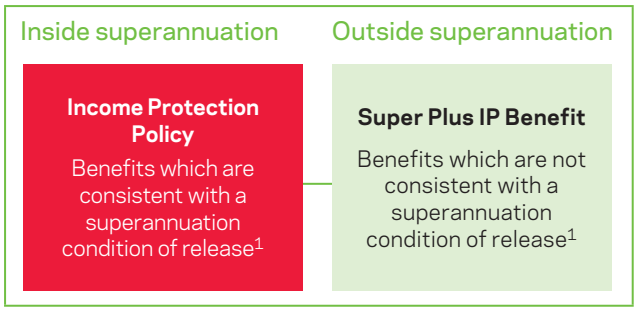
The Super Plus TPD benefit allows *own occupation TPD* to be held outside superannuation. The portion of the TPD Benefit which is consistent with a superannuation condition of release is held under a Policy inside superannuation, and the remainder of the TPD Benefit is held under a Policy outside superannuation. For more information on the Super Plus TPD Benefit, see chapter 2, section 22. The following diagram is an example of how Flexible Linking Plus can be used to link a Super Plus TPD Benefit and a Living Benefit under a Flexible Linking Plus Policy to a Term Life Policy held inside superannuation.



1 Benefits which are not consistent with a superannuation condition of release, such as the Financial Planning Benefit and Counselling Benefit, will be held under the Flexible Linking Plus Policy.

Income Linking Plus

Access benefits offered under an Income Protection Plus Policy inside and outside superannuation. The benefits which are consistent with a superannuation condition of release are held inside superannuation, and the remaining benefits are held outside superannuation. For more information on the Super Plus IP Benefit, see chapter 3, section 30. The diagram below is an example of how the Super Plus IP Benefit works in conjunction with an Income Protection Policy, to provide the benefits offered under an Income Protection Plus Policy.



1 Benefits offered under an Income Protection Plus Policy which are not consistent with a superannuation condition of release (such as the Crisis Benefit, Specified Injury Benefit, Counselling Benefit and Nursing Care Benefit), will be held outside superannuation under the Income Linking Plus Policy.

For more information on the superannuation conditions of release, please see chapter 6, section 9.

About your Policy

Once your cover is in place, it's important to maintain your Policy and review it on a regular basis to ensure you continue to have the right level and type of cover to suit your needs.

How to apply for a variation to your Policy?

Throughout this PDS, we make reference to applying for changes to your Policy in writing. We may agree to accept amendments by other means. Please contact us if you want to make changes to your Policy. If we agree to the variation, we will issue an update to your *policy schedule* or *membership certificate* to confirm the variation has been applied to your Policy.

Who receives the benefits of the Policy?

The Policy Owner is entitled to receive any benefits that are payable on a Policy.

If the Policy Owner has a valid *beneficiary* nomination on a Term Life Policy, then any benefit payable on death (Death Benefit, Funeral Advancement Benefit, Financial Planning Benefit or Counselling Benefit) will be paid to the *beneficiary*. For more information about *beneficiaries*, see 'Making a Claim' in chapter 5.

For a Term Life as Superannuation or Income Protection as Superannuation Policy, any benefits payable will be paid to the Policy Owner. If a valid *beneficiary* nomination has been made for a Term Life as Superannuation Policy, benefits may be payable to the *beneficiary*. Please refer to chapter 6, section 8 'Understanding *Westpac MasterTrust*' for further information.

For Standalone TPD, Standalone Living Insurance, Income Protection, Income Protection Plus and Business Overheads Policies, if the Insured Person and the Policy Owner is the same person, any benefit payable on death will be paid to their estate.

When does my Policy end?

To understand when your Policy will end, please see chapter 2, section 30 for Term Life, Term Life as Superannuation, Standalone TPD, Standalone Living Insurance, Needlestick Benefit, Children's Benefit and Flexible Linking Policies.

For Income Protection, Income Protection Plus, Income Protection as Superannuation, Business Overheads, Key Person Income and Income Linking Plus Policies, please see chapter 3, section 35.

Cover continuation

Term Life as Superannuation and Income Protection as Superannuation

If the Insured Person is no longer eligible to contribute to superannuation, or is no longer eligible to have contributions made on their behalf, the Insured Person can apply to transfer their current level of insurance under a Term Life as Superannuation Policy to a Term Life Policy, and/or an Income Protection as Superannuation Policy to an Income Protection Policy, without any further *underwriting*.

Any exclusions or special conditions applicable to the Policy will be maintained under the new Term Life and/or Income Protection Policy.

For more information on eligibility rules for contribution to superannuation, please see chapter 6, section 8 'Understanding *Westpac MasterTrust*'.

How to make a complaint?

We want you to be satisfied with your insurance, now and in the future. Our Customer Relations Centre is just a telephone call away should you have any inquiries or complaints:

- 1300 366 416, 8.00 am to 6.30 pm (Sydney time) Monday to Friday.

For more information on making a complaint, please see chapter 6, section 6.

Chapter 2: Term Life, TPD and Living Insurance

Term Life

Term Life insurance pays a benefit if the Insured Person dies or has a *terminal illness*. Term Life insurance can be used to help your family pay outstanding debts and to cover the costs of their future financial needs such as funding your children's education. This is available under a Term Life Policy or Term Life as Superannuation Policy.

Term Life and Term Life as Superannuation	
Entry ages (Based on premium option selected)	Policies with stepped premium: age 15–69
	Policies with 'Level 65' premium: age 15–59
	Policies with 'Level 55' premium: age 15–49
Expiry age (Some of the benefits may have an earlier expiry age)	*Review date* on or following the Insured Person's 99th birthday.

Included and optional benefits

The cover under a Term Life or Term Life as Superannuation Policy contains a number of included benefits and optional benefits, and a summary of these is set out in the following tables. The terms and conditions of each benefit are located in the 'Term Life, TPD and Living Insurance benefit specifics' section on pages 22 to 37.

You can apply for optional benefits. Unless we have stated otherwise, the optional benefits will require an additional cost. If we have accepted the application for an optional benefit for an Insured Person, it will be shown on your *policy schedule*, *membership certificate* or *renewal summary*. If we have accepted the application for an optional benefit after the commencement of your Policy, we will issue an update to your *policy schedule* or *membership certificate*.

Included benefits	Summary	Page
Death Benefit	Pays a benefit in the event of the Insured Person's death.	22
Terminal Illness Benefit	Pays a benefit, equal to the amount of the Death Benefit at that time if the Insured Person has a *terminal illness*.	22
Future Insurability Benefit	Allows you to increase the Death Benefit, TPD Benefit, and Living Benefit sum insured on the occurrence of one of the specified personal or business events without further medical *underwriting*.	22
Financial Planning Benefit S+	Reimbursement up to a value of $5,000 in total for the preparation of a financial plan following the payment of a Death Benefit, Terminal Illness Benefit, TPD Benefit or Living Benefit. This benefit is paid once for each Insured Person.	25
Funeral Advancement Benefit S+	Advances 10% of the Death Benefit up to a maximum of $25,000 to reimburse the immediate costs of the Insured Person's funeral. This benefit is paid once for each Insured Person.	25
Counselling Benefit S+	Reimbursement up to a value of $5,000 in total for a maximum of 10 counselling sessions following the payment of a Death Benefit, Terminal Illness Benefit, TPD Benefit or Living Benefit. This benefit is paid once for each Insured Person.	25

Optional benefits	Summary	Page
TPD Benefit	Pays a benefit in the event that the Insured Person becomes *totally and permanently disabled*.	26
Living Benefit S+	Pays a benefit if the Insured Person has a *specified medical event* (as listed in the '*Specified medical events* (full payment)' table on page 20) and meets our definition of the *specified medical event*.	28
Business Cover Benefit	This benefit is available for Policies taken out for business purposes, and allows you to increase your cover if a specified event occurs, to help match the growth of your business without the need for additional medical *underwriting*.	31
Multi-link Benefit NS	Available when two or more Insured Persons are applying for Term Life cover with the intent of covering their liability under a business loan. In the event a claim payment is made under a Death Benefit, TPD Benefit, Living Benefit or Terminal Illness Benefit, the sum insured of every benefit for all Insured Person(s) under the Policy will be reduced by the amount paid. There is no additional cost for this option.	32

You can apply to add the following Policies to a Term Life Policy or Term Life as Superannuation Policy:

- Needlestick Benefit S+
- Children's Benefit S+

The terms and conditions for the Needlestick Benefit and Children's Benefit Policies are located in the 'Term Life, TPD and Living Insurance benefit specifics' section on pages 33 to 34.

Total and Permanent Disablement

Total and Permanent Disablement (TPD) insurance pays a benefit if the Insured Person becomes *totally and permanently disabled*. It may assist with medical and rehabilitation costs, and provide a level of financial security for your family. This is available under a Standalone TPD Policy, as an additional benefit on a Term Life Policy or Term Life as Superannuation Policy, or under a Flexible Linking Plus Policy.

Total and Permanent Disablement		
Entry ages (Based on premium option selected)	Policies with stepped premium:	age 15–59
	Policies with 'Level 65' premium:	age 15–59
	Policies with 'Level 55' premium:	age 15–49
Expiry age (Some of the benefits may have an earlier expiry age)	*Review date* on or following the Insured Person's 99th birthday.	

The TPD Benefit with *own occupation TPD* definition is only available for Policies held outside superannuation.

Included and optional benefits

The TPD insurance cover under a Term Life, Term Life as Superannuation, Flexible Linking Plus or Standalone TPD Policy contains a number of included and optional benefits, and a summary of these is set out in the following tables. The terms and conditions of each benefit are located in the 'Term Life, TPD and Living Insurance benefit specifics' section on pages 22 to 37.

You can apply for optional benefits. Unless we have stated otherwise, the optional benefits will require an additional cost. If we have accepted the application for an optional benefit for an Insured Person, it will be shown on your *policy schedule, membership certificate* or *renewal summary*. If we have accepted the application for an optional benefit after the commencement of your Policy, we will issue an update to your *policy schedule* or *membership certificate*.

Included benefits	Summary	TPD as an additional benefit to Term Life	Standalone TPD	Page
TPD Benefit	Pays a benefit in the event that the Insured Person becomes *totally and permanently disabled*.	✓	✓	26
TPD Partial Benefit[#] S+	Pays a partial benefit if the Insured Person is *partially and permanently disabled*.	✓	✓	27
TPD Continuation Benefit	You may be able to continue your TPD Benefit on an *any occupation TPD* definition after the Insured Person's 65th birthday, subject to entry requirements and work arrangements.	✓	✓	27
Future Insurability Benefit	Allows you to increase the TPD Benefit on the occurrence of one of the specified personal or business events without further medical *underwriting*.	✓	✓	22
Financial Planning Benefit S+	Reimbursement up to a value of $5,000 in total for the preparation of a financial plan following the payment of a TPD Benefit. This benefit is paid once for each Insured Person.	✓	✓	25
Counselling Benefit S+	Reimbursement up to a value of $5,000 in total for a maximum of 10 counselling sessions following the payment of a TPD Benefit. This benefit is paid once for each Insured Person.	✓	✓	25
TPD Death Benefit	Pays a benefit of $10,000 if the Insured Person dies and the TPD Benefit has not been paid.	✗	✓	27

[#] Payment of this benefit will reduce the amount of the TPD Benefit or TPD Partial Benefit should they become payable subsequently while the Policy is in force.

Optional benefits	Summary	TPD as an additional benefit to Term Life	Standalone TPD	Page
Super Plus TPD S+	When Flexible Linking Plus is selected to split TPD inside and outside superannuation, the Super Plus TPD Benefit is the portion of *own occupation TPD* cover which is held under the Flexible Linking Plus Policy outside superannuation.	✓	✓	34
Business Cover Benefit	This benefit is available for Policies taken out for business purposes, and allows you to increase your cover if a specified event occurs, to help match the growth of your business without the need for additional medical *underwriting*.	✓	✗	31
TPD Buy Back Benefit*	Allows you to reinstate the Death Benefit after the Insured Person becomes *totally and permanently disabled*, by the amount of the TPD Benefit that was paid.	✓	✗	35
Double TPD Benefit*	Allows you to reinstate the Death Benefit after the Insured Person becomes *totally and permanently disabled*, by the amount of the TPD Benefit that was paid. In addition, premiums payable on the reinstated amount of the Death Benefit will be waived for the life of the Policy.	✓	✗	35
Waiver of Life Premium Benefit NS	Waives all premiums payable on the Policy if the Insured Person has been *totally and temporarily disabled* for at least 6 consecutive months. Premiums are waived for as long as the Insured Person remains *totally and temporarily disabled*.	✓	✗	35
Multi-link Benefit NS	Available when two or more Insured Persons are applying for TPD cover with the intent of covering their liability under a business loan. In the event a claim payment is made under a Death Benefit, TPD Benefit, Living Benefit or Terminal Illness Benefit, the sum insured of every benefit for all Insured Persons under the Policy will be reduced by the amount paid. There is no additional cost for this option.	✓	✗	32

* Not available if Multi-link Benefit is selected.

You can apply to add the following Policies to a Standalone TPD Policy or a Term Life Policy with an additional TPD Benefit:

- Needlestick Benefit S+
- Children's Benefit S+

The terms and conditions for the Needlestick Benefit and Children's Benefit Policies are located in the 'Term Life, TPD and Living Insurance benefit specifics' section on pages 33 to 34.

TPD definitions

We offer four types of TPD cover, which we call TPD definitions. Each TPD definition (*own occupation TPD, any occupation TPD, home duties TPD* and *general cover TPD*) offers cover for a different purpose. Your financial adviser will be able to help you choose the TPD definition suitable for your individual needs.

Each TPD definition has a different set of criteria that will need to be satisfied at the time of claim to be eligible for a TPD Benefit payment. The criteria which applies for each TPD definition is set out in the definition of *total and permanent disability* in chapter 8 'Definitions'.

Living Insurance

Living Insurance pays a benefit if the Insured Person has a *specified medical event* (such as cancer, stroke or heart attack) and their condition meets our definition of the relevant *specified medical event*. Living Insurance can help with major expenses, providing financial peace of mind during your recovery. This is available as an additional benefit on a Term Life Policy, a Flexible Linking Plus Policy or as a Standalone Living Insurance Policy.

Living Insurance	
Entry ages (Based on premium option selected)	Policies with stepped premium: age 15–59
	Policies with 'Level 65' premium: age 15–59
	Policies with 'Level 55' premium: age 15–49
Expiry age (Some benefits may have an earlier expiry age)	*Review date* on or following the Insured Person's 75th birthday.

We offer two levels of Living Insurance:

- **Living Benefit** – the *specified medical events* covered under this benefit are available under every Living Insurance Policy.
- **Living Benefit Plus** – covers a more comprehensive list of the *specified medical events*, in addition to those covered under the Living Benefit.

The *specified medical events* covered under the Living Benefit and Living Benefit Plus are listed on pages 20 and 21.

Included and optional benefits

The Living Insurance cover under a Term Life, Flexible Linking Plus, or Standalone Living Policy contains a number of included and optional benefits, and a summary of these is set out in the following tables. The terms and conditions of each benefit are located in the 'Term Life, TPD and Living Insurance benefit specifics' section on pages 22 to 37.

You can apply for optional benefits. Unless we have stated otherwise, the optional benefits will require an additional cost. If we have accepted the application for an optional benefit for an Insured Person, it will be shown on your *policy schedule* or *renewal summary*. If we have accepted the application for an optional benefit after the commencement of your Policy, we will issue an update to your *policy schedule*.

Included benefits	Summary	Living Insurance as an additional benefit to Term Life S+	Standalone Living NS	Page
Living Benefit and Living Benefit Plus	Pays a benefit if the Insured Person has a *specified medical event* (as listed in the '*Specified medical events* (full payment)' table on page 20).	✓	✓	28
Advancement Benefit#	Pays a partial benefit if the Insured Person has a *specified medical event* (as listed in the '*Specified medical events* (partial payment)' table on page 21).	✓	✓	29
Future Insurability Benefit	Allows you to increase the Living Benefit on the occurrence of one of the specified personal or business events without further medical *underwriting*.	✓	✓	22
Financial Planning Benefit	Reimbursement up to a value of $5,000 in total for the preparation of a financial plan following the payment of a Living Benefit. This benefit is paid once for each Insured Person.	✓	✓	25
Counselling Benefit	Reimbursement up to a value of $5,000 in total for a maximum of 10 counselling sessions following the payment of a Living Benefit. This benefit is paid once for each Insured Person.	✓	✓	25
Child Support Benefit	Pays a benefit of $10,000 if an eligible *dependant child* dies or has a *specified children's event*.	✓	✓	30
Living Buy Back Benefit*	Allows you to reinstate the Death Benefit after the Insured Person has a *specified medical event* (as listed in the '*Specified medical events* (full payment)' table on page 20), by the amount of the Living Benefit that was paid.	✓	✗	31
Living Insurance Death Benefit	Pays a benefit of $10,000 if the Insured Person has a *specified medical event*, but does not live 14 days.	✗	✓	31

\# Payment of this benefit will reduce any benefit payable if a *specified medical event* occurs subsequently while the Policy is in force.
* Not available if Multi-link Benefit is selected.

Optional benefits	Summary	Living Insurance as an additional benefit to Term Life S+	Standalone Living NS	Page
Business Cover Benefit	This benefit is available for Policies taken out for business purposes, and allows you to increase your cover if a specified event occurs, to help match the growth of your business without the need for additional medical *underwriting*.	✓	✗	31
Living Reinstatement Benefit*	Allows you to reinstate the Living Benefit after the Insured Person has a *specified medical event* (as listed in the '*Specified medical events* (full payment)' table on page 20) by the amount of the Living Benefit that was paid.	✓	✓	36
Double Living Benefit*	Allows you to reinstate the Death Benefit after the Insured Person has a *specified medical event* (as listed in the '*Specified medical events* (full payment)' table on page 20) by the amount of the Living Benefit that was paid. In addition, premiums payable on the reinstated amount of the Death Benefit will be waived for the life of the Policy.	✓	✗	37
Multi-link Benefit NS	Available when two or more Insured Persons are applying for Living Insurance cover with the intent of covering their liability under a business loan. In the event a claim payment is made under a Death Benefit, TPD Benefit, Living Benefit or Terminal Illness Benefit, the sum insured of every benefit for all Insured Persons under the Policy will be reduced by the amount paid. There is no additional cost for this option.	✓	✗	32

* Not available if Multi-link Benefit is selected.

You can apply to add the following Policies to a Standalone Living Insurance Policy or a Term Life Policy with additional Living Insurance:

- Needlestick Benefit S+
- Children's Benefit S+

The terms and conditions for the Needlestick Benefit and Children's Benefit Policies are located in the 'Term Life, TPD and Living Insurance benefit specifics' section on pages 33 to 34.

Specified medical events

We will pay the Living Benefit, or Advancement Benefit if:

- an Insured Person has a *specified medical event* listed in the relevant tables on pages 20 and 21 for the Living Insurance cover (ie Living Benefit or Living Benefit Plus) applicable for your Policy; and
- a *doctor* approved by us provides the medical evidence to support the claim.

We will only pay a benefit when we are satisfied that the Insured Person meets the full definition of the relevant *specified medical event*, as defined in chapter 7 'Medical glossary' and chapter 8 'Definitions'.

For example, the criteria for the *specified medical event* 'Coma – with specified criteria' can be found in chapter 7 'Medical glossary'.

The tables on pages 20 and 21 set out the list of *specified medical events* covered under Living Benefit, and the list of *specified medical events* covered under Living Benefit Plus.

Living Benefit and Living Benefit Plus (full payment)

We will pay the Living Benefit sum insured if the Insured Person has one of the *specified medical events* listed in the table below.

For full details of the Living Benefit and Living Benefit Plus, please see section 13 'Living Benefit' in this chapter.

Specified medical events (full payment)	Living Benefit	Living Benefit Plus
Cancer		
Cancer – excluding specified early stage cancers[1]	✓	✓
Prostate cancer – with major treatment[1]	✗	✓
Heart disorders		
Angioplasty – triple vessel[1]	✓	✓
Aortic surgery – excluding less invasive surgeries	✗	✓
Cardiac arrest – occurs out of hospital and of specified severity	✓	✓
Cardiomyopathy – resulting in significant permanent impairment	✗	✓
Coronary artery bypass surgery – excluding less invasive procedures[1]	✓	✓
Heart attack – of specified severity[1]	✓	✓
Heart valve replacement or repair	✓	✓
Idiopathic pulmonary arterial hypertension – resulting in significant permanent impairment	✗	✓
Open heart surgery[1]	✓	✓
Nervous system disorders		
Alzheimer's disease and other dementias – permanent and irreversible and of specified severity	✗	✓
Motor neurone disease	✗	✓
Multiple sclerosis	✗	✓
Muscular dystrophy	✗	✓
Parkinson's disease – resulting in permanent symptoms	✗	✓
Accidents		
Burns (severe) – covering specified surface area	✓	✓
Coma – with specified criteria	✓	✓
Head trauma (major) – resulting in significant permanent impairment	✓	✓
Paralysis	✗	✓
Body organ disorders		
Kidney failure – requiring permanent dialysis or transplantation	✓	✓
Liver failure (severe) – of specified severity	✗	✓
Loss of sight (both eyes) – of specified severity	✗	✓
Lung disease – requiring permanent oxygen therapy	✗	✓
Organ transplant (major) – from another donor	✓	✓
Blood disorders		
Aplastic anaemia – of specified severity	✓	✓
HIV – medically acquired	✗	✓
HIV – occupationally acquired	✗	✓
Other events		
Brain or spinal cord tumour (benign) – resulting in significant permanent impairment or requiring radical treatment	✓	✓
Deafness (both ears) – permanent and irreparable	✗	✓
Diabetes (severe) – of specified severity	✗	✓
Encephalitis – resulting in significant impairment	✗	✓
Intensive care – requiring continuous mechanical ventilation for 10 days	✗	✓
Loss of independent existence – with a specified level of impairment	✗	✓
Loss of limbs – complete and irrecoverable	✗	✓
Loss of single limb – complete and irrecoverable	✗	✓
Loss of speech – complete and irrecoverable	✗	✓
Meningitis (bacterial) – resulting in permanent impairment	✗	✓
Meningococcal septicaemia – resulting in permanent impairment	✗	✓
Osteoporosis (severe, before age 50) – with specified fractures	✗	✓
Pneumonectomy – removal of a complete lung	✗	✓
Rheumatoid arthritis (severe) – of specified severity	✗	✓
Stroke – of specified severity[1]	✓	✓

1 A three month exclusion applies for these *specified medical events*. For more details of the exclusion, please see section 13 in this chapter.

Advancement Benefit (partial payment)

We will pay an Advancement Benefit if the Insured Person has one of the *specified medical events* listed in the table below.

The payment of an Advancement Benefit will reduce any benefit payable if a *specified medical event* occurs subsequently while the Policy is in force.

For full details of the Advancement Benefit, please see section 14 'Advancement Benefit' in this chapter.

Specified medical events (partial payment)	Living Benefit	Living Benefit Plus	What we will pay
Angioplasty – single or double vessel[1]	✓	✓ (multi-payment)	25% of the Insured Person's Living Benefit sum insured up to a maximum of $50,000.
Aortic surgery – intra-arterial procedures	✓	✓	25% of the Insured Person's Living Benefit sum insured up to a maximum of $100,000.
Carcinoma in situ of female organs[1]	✓	✓	
Carcinoma in situ of the perineum, penis or testicle[1]	✗	✓	
Deafness (one ear) – permanent and irreparable	✗	✓	
Melanoma (early stage) – of specified severity[1]	✓	✓	
Loss of sight (single eye) – of specified severity	✗	✓	
Loss of single limb – complete and irrecoverable	✓	✗	
Prostate cancer – early stage[1]	✓	✓	
Systemic lupus erythematosus (SLE) with lupus nephritis – of specified severity	✗	✓	
Diabetes (Type 1 insulin dependent) – of specified severity	✗	✓	40% of the Insured Person's Living Benefit sum insured up to a maximum of $200,000.

1 A three month exclusion applies for these *specified medical events*. For more details of the exclusion, please see section 14 in this chapter.

Term Life, TPD and Living Insurance benefit specifics

Please take the time to read the details about the benefits your Policy provides. This section will provide you with the terms and conditions of each benefit in your Policy and is an important part of this PDS. Please speak to your financial adviser or contact us if you would like any of the details explained to you.

Please use the coloured icons below to assist you in understanding which benefits are available on your cover.

TL	**Term Life**
TLS	**Term Life as Superannuation**
TPD STANDALONE	**Standalone TPD**
LI STANDALONE	**Standalone Living Insurance**
+TPD	**TPD Benefit** (as an additional benefit to a Term Life or Term Life as Superannuation Policy, unless specified otherwise)
+LI	**Living Benefit** (as an additional benefit to a Term Life or Term Life as Superannuation Policy, unless specified otherwise)
NB	**Needlestick Benefit**
CB	**Children's Benefit**

1. Death Benefit

TL TLS

1.1 The Death Benefit will be paid to you, or the *beneficiary* if one has been nominated, if the Insured Person dies while your Policy is in force.

If you do not nominate any *beneficiaries* and the Insured Person dies, the Death Benefit will be paid equally between the surviving Policy Owners. If there are no surviving Policy Owners, the benefit will be paid to the estate of the last surviving Policy Owner.

1.2 We will pay the amount of the Death Benefit for the Insured Person as shown in the most recent *policy schedule*, *membership certificate* or *renewal summary*.

1.3 **Exclusions**

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

- the *commencement date*;
- for an increase in the Death Benefit for the Insured Person other than *CPI* or Loyalty Benefit increases, the date we increase the Death Benefit (applicable to the amount of the Death Benefit that was increased); and
- the date the Policy was last reinstated.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all of the following apply:

- We were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy.
- The sum insured of the Death Benefit being issued by us is the same as, or less than, the existing cover being replaced.[1]
- The other policy and equivalent sum insured were continuously in force for at least 13 months immediately prior to the issue of this Policy.
- The other policy was cancelled immediately after the issue of this Policy.
- No claim is pending or payable under the other policy.

2. Terminal Illness Benefit

TL TLS

2.1 The Terminal Illness Benefit will be paid to you if the Insured Person has a *terminal illness* while your Policy is in force.

2.2 We will pay the amount of the Death Benefit for the Insured Person as shown in the most recent *policy schedule*, *membership certificate* or *renewal summary*.

3. Future Insurability Benefit

TL TLS +TPD TPD STANDALONE +LI LI STANDALONE

3.1 The Future Insurability Benefit enables you to increase the Death Benefit, TPD Benefit and Living Benefit sum insured for an Insured Person without providing further health evidence when a specified personal event set out in the table in section 3.3, or business event set out in the table in section 3.4 occurs.

3.2 You may only apply for an increase in writing within 30 days of a personal event or business event (excluding the 'periodic increase' event), or within 30 days of the *review date* immediately following the 'periodic increase' event.

If you wish to increase your benefits, contact us and we will forward you the relevant forms to complete and advise you of the evidence we require. The evidence must be satisfactory to us, and demonstrate that the personal event or business event has occurred.

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

The minimum increase per personal event or business event is $25,000.

1 Where the sum insured of the Death Benefit being issued under this Policy exceeds that of the other policy, this exclusion will apply to the sum insured in excess of the sum insured in the other policy.

For Future Insurability Benefit increases under Term Life and Term Life as Superannuation, the increase to the Death Benefit must be the same amount as, or more than, any increase in the TPD Benefit or Living Benefit sum insured.

3.3 You can apply to increase the Death Benefit, TPD Benefit and Living Benefit for the following personal events:

Personal events		Maximum increase per event
Marriage	The Insured Person marries (which is recognised by Australian law).	The lesser of: • $250,000; and • 25% of the original Death Benefit, TPD Benefit, or Living Benefit sum insured.
A de facto *spouse*	The first anniversary of the Insured Person living with another person as de facto *spouse* on a continuous and bona fide domestic basis.	
Birth or adoption	The Insured Person or their *spouse* gives birth to or adopts a child.	
Post-Graduate degree	The Insured Person completes a post graduate degree at a university accredited by the appropriate local state or territory authority.	
Change in tax dependency status	The Insured Person ceases to have any tax dependants. A dependant for tax purposes includes the Insured Person's *spouse* or former *spouse*, their children under 18, a person who is wholly or substantially financially dependent on the Insured Person, and any person the Insured Person is in an *interdependency relationship* with. This event is restricted to Death Benefit increases for any Policies held inside superannuation. This event will only apply once for an Insured Person under all Policies with us.	
Becoming a *carer*	The Insured Person becomes a *carer* for the first time and is financially responsible for provision of such care, and/or is physically providing such care.	
Secondary school	A *dependant child* of the Insured Person starts secondary school.	
Divorce	The Insured Person gets a divorce (which is recognised by Australian law).	
Death of a *spouse*	The Insured Person's *spouse* dies.	
Periodic increase	The Policy Owner has not exercised the Future Insurability Benefit for any reason, and has not had an increase in the Insured Person's sum insured (excluding *CPI* increases and Loyalty Benefit increases) for a period of 3 consecutive years.	
Mortgage	The Insured Person takes out a *mortgage*, or increases the original amount borrowed under an existing *mortgage*, to buy or improve their home.	The lesser of: • $250,000; • 50% of the original Death Benefit, TPD Benefit, or Living Benefit sum insured; and • the amount of the new *mortgage* or increase in the original amount borrowed under an existing *mortgage*, as applicable.
Salary increase	The Insured Person's annual salary package increases by at least $10,000 within a 12 month period. The salary package does not include irregular payments such as bonuses or commissions that may not continue to be made in future.	The lesser of: • $250,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit; and • five times the annual amount of salary package increase.

For all personal event increases applied for under the Future Insurability Benefit, the maximum amount that you can increase the Death Benefit, TPD Benefit or Living Benefit by, over the life of the Policy (under all Policies with us), cannot exceed the lesser of $1 million and the initial sum insured of the Death Benefit, TPD Benefit or Living Benefit (as applicable) at the commencement of your Policy. Any increase over this amount under the Future Insurability Benefit (other than *CPI* and Loyalty Benefit increases) will be subject to *underwriting*.

3.4 You can apply to increase the Death Benefit, TPD Benefit and Living Benefit for the following business events:

Business events		Maximum increase per event
Value of the key person in the business increases	The Insured Person is a key person in the business and their value to the business increases. The Insured Person's value to the business is their remuneration package, excluding discretionary benefits, plus their share of net profits of the business distributed in the 12 months immediately before the event occurs.	The lesser of: • $500,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit sum insured; • an increase which is proportionate to the increase in the Insured Person's value to the business; and • five times the average annual increase in the gross remuneration package of the Insured Person over the 3 years immediately before the event.
The net value of the Insured Person's financial interest in the business increases	The Insured Person is a partner, shareholder, unit holder or similar principal in a business. The insurance was purchased in relation to a written share purchase or business succession agreement and the net value of the Insured Person's financial interest in the business increases. The net value of their financial interest in the business is their share of the value of the business, after deducting liabilities of the business, as determined by a valuation method that is acceptable to us.	The lesser of: • $500,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit sum insured; • an increase which is proportionate to the increase in the net value of the Insured Person's financial interest in the business; and • the average annual increase in the net value of the Insured Person's financial interest in the business over the 3 years immediately before the event.
The value of the Insured Person's loan increases	The Insured Person is the borrower for a business loan that the Death Benefit is intended by the Policy Owner to cover, and the value of the loan increases.	The lesser of: • $500,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit sum insured; and • an amount which is proportionate to the increase in the value of the Insured Person's loan.
Periodic increase	The Policy Owner has not exercised the Future Insurability Benefit for any reason, and has not had an increase in the Insured Person's sum insured (excluding *CPI* increases and Loyalty Benefit increases) for a period of 3 consecutive years.	The lesser of: • $250,000; and • 25% of the original Death Benefit, TPD Benefit or Living Benefit sum insured.

For all business event increases applied for under the Future Insurability Benefit, the maximum amount that you can increase the Death Benefit, TPD Benefit or Living Benefit by, over the life of the Policy (under all Policies with us), cannot exceed the lesser of $2 million and the initial sum insured of the Death Benefit, TPD Benefit or Living Benefit (as applicable) at the commencement of your Policy. Any increase over this amount under the Future Insurability Benefit (other than *CPI* and Loyalty Benefit increases) will be subject to *underwriting*.

3.5 You cannot apply for a Future Insurability Benefit increase for an Insured Person:
- after the *review date* on, or immediately following the Insured Person's 65th birthday;
- if you have had an increase under this benefit in the last 12 months;
- if you have the Business Cover Benefit on your Policy for the Insured Person;
- if a person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any Policy issued by us;
- on a benefit where a premium loading has been applied; or
- for salary increases, if the Insured Person is self-employed, a controlling director of the employer or a holding company of the employer, or is able to (directly or indirectly) make or control a decision on the amount of the Insured Person's salary package.

3.6 For 6 months immediately after the commencement of an increase under the Future Insurability Benefit, the increased amount:
- will only be payable in the event of an *accident*; and
- will not be payable for a *terminal illness* which arises during this period.

These conditions do not apply to increases under the 'birth or adoption' personal event.

3.7 Any exclusions that apply to the Death Benefit, TPD Benefit and Living Benefit will also apply to any increase in the Death Benefit, TPD Benefit and Living Benefit.

4. Financial Planning Benefit S+

TL | TLS WITH FLEXIBLE LINKING PLUS | +TPD | TPD STANDALONE | +LI | LI STANDALONE

4.1 If we pay a Death Benefit, Terminal Illness Benefit, or the entire sum insured of the TPD Benefit or Living Benefit, we will pay the Financial Planning Benefit to the recipient of the relevant benefit. Under the Financial Planning Benefit, we will reimburse the recipient of the benefit for the cost of obtaining financial advice.

4.2 We will pay the cost of obtaining financial advice, up to a maximum of $5,000.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the benefit so the total amount payable does not exceed $5,000.

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

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

- The financial plan must be provided by an authorised financial adviser that is acceptable to us.
- We will only reimburse amounts relating to the preparation and presentation of the plan and not amounts relating to the implementation of the plan, or commission paid to a financial adviser.
- The Financial Planning Benefit must be claimed within 12 months from the date the Death Benefit, Terminal Illness Benefit, TPD Benefit or Living Benefit was paid.
- The recipient must be able to provide a copy of the invoice showing a breakdown of the services provided, and a receipt showing the amount paid.

5. Funeral Advancement Benefit S+

TL | TLS WITH FLEXIBLE LINKING PLUS

5.1 We will reimburse funeral and related expenses and costs following the Insured Person's death. This benefit is only payable once for each Insured Person across all Policies issued by us.

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

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

5.2 We will pay 10% of the Death Benefit, up to a maximum $25,000.

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

5.3 **Exclusions**

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

- the *commencement date*; and
- the date the Policy was last reinstated.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all of the following apply:

- We were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy.
- The sum insured of the Death Benefit being issued by us is the same as, or less than, the existing cover being replaced.[1]
- The other policy and the equivalent sum insured were continuously in force for at least 13 months immediately prior to the issue of this Policy.
- The other policy was cancelled immediately after the issue of this Policy.
- No claim is pending or payable under the other policy.

6. Counselling Benefit S+

TL | TLS WITH FLEXIBLE LINKING PLUS | +TPD | TPD STANDALONE | +LI | LI STANDALONE

6.1 If we pay a Death Benefit, Terminal Illness Benefit, or the entire amount of the TPD Benefit or Living Benefit, we will also pay the recipient of the benefit a Counselling Benefit. Under the Counselling Benefit, we will reimburse the cost of up to 10 counselling sessions for you, the Insured Person or an *immediate family member* of the Insured Person.

6.2 We will reimburse the cost of the counselling sessions, up to a maximum of $5,000.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the Counselling Benefit, so the total amount payable does not exceed $5,000.

The Counselling Benefit will only be paid once per Insured Person across all Policies issued by us in respect of that Insured Person.

6.3 The following conditions must be met for the Counselling Benefit to be paid:

- The counselling session must be provided by an accredited counsellor approved by us.
- We will only reimburse amounts incurred by the recipient.
- The Counselling Benefit must be claimed within 12 months of receiving the benefit.
- The recipient must be able to provide a copy of the invoice showing a breakdown of the services provided and the amount paid, and/or a receipt showing the amount paid.

1 Where the sum insured of the Death Benefit being issued under this Policy exceeds that of the other policy, this exclusion will apply to the sum insured in excess of the sum insured in the other policy.

6.4 We will not pay for any expense to the extent that such payment is prohibited by health insurance law. Under current health insurance laws, we cannot pay for counselling sessions which are:

- provided by a medical practitioner and a Medicare benefit or pharmaceutical benefit is payable for any part of the service provided;
- provided in, or associated with, a hospital;
- would amount to carrying on a health insurance business in contravention of the Private Health Insurance Act 2007 (Cth); or
- which would be considered to be treatment that is intended to manage or prevent a disease, injury or condition.

7. Loyalty Benefit

7.1 The Loyalty Benefit will apply when the Policy has been in force for three years from the *commencement date*. The Loyalty Benefit amount will be listed on the most recent *renewal summary*.

7.2 The amount of the Loyalty Benefit will be 5% of any Death Benefit, TPD Benefit, Living Benefit or Children's Benefit.

7.3 The Loyalty Benefit will be taken into account when calculating a TPD Partial Benefit, Advancement Benefit, and any other benefit which is paid as a proportion of the total benefit.

7.4 You are not entitled to reinstate the amount of any Loyalty Benefit for the purposes of the Living Buy Back Benefit, TPD Buy Back Benefit, Double Living Benefit, Double TPD Benefit and Living Reinstatement Benefit.

7.5 The terms and conditions that apply to the payment of the Loyalty Benefit will be the same as those applying to the Death Benefit, TPD Benefit, Living Benefit or Children's Benefit (as applicable).

8. Premium Holiday

8.1 If your Policy has been in force and the premiums paid for at least 6 months, we will allow you to suspend your Policy once in any 12 month period for a maximum of 12 months in total over the duration of the Policy. You can stop the Premium Holiday at any time within the relevant period.

For Policies held outside superannuation, this benefit only applies if the Policy Owner is also an Insured Person.

8.2 Application for this benefit is subject to you submitting an application for Premium Holiday along with evidence that during the relevant period the Insured Person is experiencing financial hardship due to:

- being unemployed;
- being on sabbatical, maternity, paternity or long term leave from work; or
- the Insured Person's household income for the last three months reducing by 30% or more (as compared to the household income over the preceding three month period).

8.3 The following conditions apply to the Premium Holiday:

- During the period your Policy is on Premium Holiday, you will not have to pay premiums. However, you will not be eligible to claim for any *sickness*, *injury*, *specified medical event*, death or any other event that happens during this period. A *sickness*, *injury* or *specified medical event* is taken to have happened when:
  - a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the *sickness*, *injury* or *specified medical event*; or
  - the Insured Person first had any *symptom* of the *sickness*, *injury*, or *specified medical event* for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor*.
- Where there is more than one Policy Owner, all Policy Owners must provide us with their agreement to exercise the Premium Holiday.
- Acceptance of your application for a Premium Holiday will mean that your entire Policy and any linked Flexible Linking Plus Policy will be suspended.

9. TPD Benefit

9.1 **When we will pay**

We will pay a benefit if the Insured Person becomes *totally and permanently disabled* while the Policy is in force.

There are four definitions of *total and permanent disability*:

- *own occupation TPD*;
- *any occupation TPD*;
- *home duties TPD*; and
- *general cover TPD*.

The definition of *total and permanent disability* which applies to the Insured Person will be shown on the most recent *policy schedule*, *membership certificate* or *renewal summary*. If you do not qualify for the TPD Continuation Benefit (see section 11), from the *review date* on or following the Insured Person's 65th birthday, we will only pay the TPD Benefit if the Insured Person meets the *general cover TPD* definition.

If your TPD Benefit is made up of more than one definition of *total and permanent disability*, each definition will be considered as a separate benefit for the purposes of calculating the premium amount.

9.2 **What we will pay**

For *total and permanent disability*, the amount we will pay is the TPD Benefit shown in the most recent *policy schedule*, *membership certificate* or *renewal summary* for the Insured Person as at the *date of disablement*.

The maximum benefit payable from the *review date* on or following the Insured Person's 65th birthday is $1 million (plus the Loyalty Benefit) which can only be increased by the *CPI* after this time.

9.3 **What happens after we pay**

If the TPD Benefit is held under a Term Life Policy or Term Life as Superannuation Policy, after we pay the TPD Benefit, we will reduce the sum insured of every other benefit for the Insured Person under the same Policy and every benefit under a linked Flexible Linking Plus Policy, by the amount we paid.

If the TPD Benefit is held under a Flexible Linking Plus Policy, we will also reduce the sum insured of every other benefit for the Insured Person held under the Flexible Linking Plus Policy, and under the linked Term Life or Term Life as Superannuation Policy, by the amount we paid.

If we pay the entire sum insured of the TPD Benefit or it is reduced to nil, the TPD Benefit in respect of that Insured Person ends.

For Term Life and Term Life as Superannuation, if the Death Benefit sum insured for the Insured Person is reduced to zero because we have paid the entire sum insured of the TPD Benefit, the Policy will end.

9.4 **Exclusions**

We will not pay a TPD Benefit if the *sickness* or *injury* giving rise to the claim was caused by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

10. TPD Partial Benefit S+

+TPD TPD STANDALONE

10.1 **When we will pay**

We will pay a TPD Partial Benefit if an Insured Person suffers a *partial and permanent disability* while the Policy is in force.

10.2 **What will we pay**

For *partial and permanent disability*, we will pay the TPD Partial Benefit which is equal to 25% of the TPD Benefit (including the Loyalty Benefit) for the Insured Person at that time, up to a maximum of $500,000.

10.3 **What happens after we pay**

After we pay TPD Partial Benefit, we will reduce the sum insured of the TPD Benefit for the Insured Person by the amount we paid.

If the TPD Benefit is held under a Term Life or Term Life as Superannuation Policy, we will also reduce the sum insured of every other benefit for the Insured Person under the Policy, and under a linked Flexible Linking Plus Policy, by the amount we paid.

If the TPD Benefit is held under a Flexible Linking Plus Policy, we will reduce the sum insured of every other benefit for the Insured Person held under the Flexible Linking Policy, and under the linked Term Life or Term Life as Superannuation Policy, by the amount we paid.

10.4 **Exclusions**

We will not pay a TPD Partial Benefit if the *sickness* or *injury* giving rise to the claim was caused by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

11. TPD Continuation Benefit

+TPD TPD STANDALONE

At the *review date* on or following the Insured Person's 65th birthday, we may allow you to continue a TPD Benefit and TPD Partial Benefit (please see sections 9 and 10) under an *any occupation TPD* definition, up until the *review date* on or following the Insured Person's 70th birthday.

11.1 To be eligible for continuation, the Insured Person must meet the following eligibility criteria:

- The Insured Person's occupation class for the TPD Benefit must be shown as 'A' in the most recent *policy schedule*, *membership certificate* or *renewal summary*; and
- The Insured Person:
  - is actively working on a full time basis;
  - is not planning to cease work in the next 12 months; and
  - has not made a claim, or is not eligible to make a claim for any benefit under any insurance cover issued by us.

11.2 This option will only apply if:

- the Insured Person meets the eligibility criteria set out in section 11.1;
- we have accepted the application for this benefit for an Insured Person; and
- the Insured Person continues to actively work on a full time basis.

You must notify us of any changes to your employment status. If you are not eligible for the TPD Continuation Benefit, then you will be assessed under the *general cover TPD* definition.

11.3 You must continue to pay premiums for the TPD Benefit.

11.4 **Limits on your cover**

At the *review date* on or following the Insured Person's 65th birthday, the maximum sum insured is the lesser of:

- five times the Insured Person's annual *earnings* at that time; and
- $1 million.

However, if at the *review date* on or following the Insured Person's 65th birthday their annual *earnings* result in a reduced sum insured which will be less than $1 million, the difference up to $1 million can be held under a *general cover TPD* definition.

12. TPD Death Benefit

TPD STANDALONE

12.1 We will pay a TPD Death Benefit of $10,000 if the Insured Person dies while the Policy is in force and the TPD Benefit (including the TPD Partial Benefit) has not been paid.

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

- *commencement date* of this Policy; and
- date this Policy was last reinstated.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all of the following apply:

- We were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy.
- The amount of the TPD Death Benefit being issued by us is the same as, or less than, the existing cover being replaced.[1]
- The other policy and equivalent sum insured were continuously in force for at least 13 months immediately prior to the issue of this Policy.
- The other policy was cancelled immediately after the issue of this Policy.
- No claim is pending or payable under the other policy.

13. Living Benefit S+

+LI LI

STANDALONE

13.1 When we will pay

We will pay a Living Benefit and Living Benefit Plus if:

- an Insured Person has a *specified medical event* listed with a tick (✓) in the '*Specified medical event* (full payment)' table on page 20 while the Policy is in force; and
- a *doctor* approved by us provides the medical evidence to support the claim.

We will only pay a benefit if we are satisfied that the Insured Person meets the full definition of the relevant *specified medical event*, as defined in chapter 7 'Medical glossary' and chapter 8 'Definitions'. The *specified medical events* covered under the Living Benefit and Living Benefit Plus are listed in the '*Specified medical events* (full payment)' table on page 20 as indicated.

If the Living Benefit is held under a Standalone Living Insurance Policy, the Living Benefit and Living Benefit Plus will only be paid if the Insured Person subsequently lives for at least 14 days.

13.2 What we will pay

The amount we will pay is the Living Benefit shown in the most recent *policy schedule* or *renewal summary* for that Insured Person.

13.3 What happens after we pay

If the Living Benefit is held under a Term Life Policy, after we pay the Living Benefit, we will reduce the sum insured of every other benefit for the Insured Person under the same Policy, and under a linked Flexible Linking Plus Policy, by the amount we paid.

If the Living Benefit is held under a Flexible Linking Plus Policy, we will also reduce the sum insured of every other benefit for the Insured Person held under the Flexible Linking Plus Policy, and under the linked Term Life or Term Life as Superannuation Policy, by the amount we paid.

If we pay the entire sum insured of the Living Benefit, the Living Benefit in respect of that Insured Person ends.

For Term Life and Term Life as Superannuation, if the Death Benefit sum insured for the Insured Person is reduced to zero because we have paid the entire sum insured of the Living Benefit, the Policy will end.

13.4 Exclusions

- **Self-inflicted *injury* or attempted suicide**

  We will not pay you a benefit if the *specified medical event* giving rise to the claim is caused directly or indirectly by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

- **3 month exclusion**

  For the following *specified medical events*:
  - Cancer – excluding specified early stage cancers
  - Prostate cancer – with major treatment
  - Angioplasty – triple vessel
  - Coronary artery bypass surgery – excluding less invasive procedures
  - Heart attack – of specified severity
  - Open heart surgery
  - Stroke – of specified severity

  the benefit for the Insured Person is only payable if the *specified medical event* (and any treatment, *symptoms* or surgery that is attributable to the *specified medical event* including treatment that is a *specified medical event* in itself), occurs at least 3 months after the latest of the date we receive the completed application form and personal statement (including all required medical and financial information) for the Policy or the last reinstatement of the Policy.

  If any of the above conditions occur within 3 months of any increase to the benefit for the Insured Person (excluding *CPI* and Loyalty Benefit increases), the increased benefit amount will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

  This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all of the following apply:
  - We were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy.
  - The sum insured of the Living Benefit being issued by us is the same as, or less than, the existing cover being replaced.[2]
  - The other policy and equivalent sum insured were continuously in force for at least 3 months immediately prior to the issue of this Policy.

1 Where the amount of the TPD Death Benefit being issued under this Policy exceeds that of the other policy, this exclusion will apply to the sum insured in excess of the sum insured in the other policy.

2 Where the sum insured of the Living Benefit being issued under this Policy exceeds that of the other policy, this exclusion will apply to the sum insured in excess of the sum insured in the other policy.

- The other policy was cancelled immediately after the issue of this Policy.
- No claim is pending or payable under the other policy.

14. Advancement Benefit S+

+LI LI STANDALONE

14.1 When we will pay

We will pay an Advancement Benefit if:

- an Insured Person has a *specified medical event* listed with a tick (✓) in the '*Specified medical event* (partial payment)' table on page 21 while the Policy is in force; and
- a *doctor* approved by us provides the medical evidence to support the claim.

We will only pay a benefit if we are satisfied that the Insured Person meets the full definition of the relevant *specified medical event*, as defined in chapter 7 'Medical glossary' and chapter 8 'Definitions'.

If the Advancement Benefit is held under a Standalone Living Insurance Policy, the Living Benefit and Living Benefit Plus will only be paid if the Insured Person subsequently lives for at least 14 days.

Payment of an Advancement Benefit will reduce any benefit payable if a *specified medical event* occurs subsequently while the Policy is in force.

14.2 What we will pay

The *specified medical events* that apply to your Policy depend on whether you have selected Living or Living Benefit Plus. Please see the '*Specified medical event* (partial payment)' table on page 21 to see the *specified medical events* that apply for Living and Living Benefit Plus.

The amount we will pay for an Advancement Benefit is a partial payment of your Living Benefit sum insured. This is explained in the '*Specified medical event* (partial payment)' table on page 21. Please note that the maximum amounts of $50,000, $100,000, and $200,000 in the '*Specified medical event* (partial payment)' table are not subject to *CPI* increases.

We will only pay once under each of the *specified medical events*.

The minimum benefit payable under the Advancement Benefit is $10,000.

If you have selected the Living Benefit Plus option for the Insured Person and it appears on the most recent *policy schedule* or *renewal summary* under that Insured Person, an Advancement Benefit for angioplasty – single or double vessel will be paid for the first and each subsequent time this *specified medical event* occurs.

14.3 What happens after we pay

After we pay an Advancement Benefit, we will reduce the sum insured of the Living Benefit or Living Benefit Plus for the Insured Person by the amount we paid.

If the Living Benefit or Living Benefit Plus is held under a Term Life Policy, we will also reduce the sum insured of every other benefit for the Insured Person under the same Policy, and under a linked Flexible Linking Plus Policy, by the amount we paid.

If the Living Benefit or Living Benefit Plus is held under a Flexible Linking Plus Policy, we will also reduce the sum insured of every other benefit for the Insured Person held under the Flexible Linking Plus Policy, and under the linked Term Life or Term Life as Superannuation Policy by the amount we paid.

If we pay the entire sum insured of the Living Benefit, the Living Benefit in respect of that Insured Person ends.

For Term Life and Term Life as Superannuation, if the Death Benefit sum insured for the Insured Person is reduced to zero because we have paid the entire sum insured of the Living Benefit, then the Policy will end.

14.4 Exclusions

- **Self-inflicted *injury* or attempted suicide**

  We will not pay you a benefit if the *specified medical event* giving rise to the claim is caused directly or indirectly by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

- **3 month exclusion**

  For the following *specified medical events*:
  - Angioplasty – single or double vessel
  - Carcinoma in situ of female organs
  - Carcinoma in situ or the perineum, penis or testicle
  - Melanoma (early stage) – of specified severity
  - Prostate cancer – early stage

  the benefit for the Insured Person is only payable if the *specified medical event* (and any treatment, *symptoms* or surgery that is attributable to the *specified medical event* including treatment that is a *specified medical event* in itself), occurs at least 3 months after the latest of the date we receive the completed application form and personal statement (including all required medical and financial information) for the Policy or the last reinstatement of the Policy.

  If any of the above conditions occur within 3 months of any increase to the sum insured for the Insured Person (excluding *CPI* and Loyalty Benefit increases), the increased sum insured will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all of the following apply:

- We were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy.
- The sum insured of the Living Benefit being issued by us is the same as, or less than, the existing cover being replaced.[1]
- The other policy and equivalent sum insured were continuously in force for at least 3 months immediately prior to the issue of this Policy.
- The other policy was cancelled immediately after the issue of this Policy.
- No claim is pending or payable under the other policy.

15. Child Support Benefit S+

+LI LI

STANDALONE

15.1 The Child Support Benefit in respect of each *dependant child* will commence on the later of the following:

- the *dependant child's* 2nd birthday; and
- the *commencement date* of the Living Benefit to which the Child Support Benefit is attached.

15.2 We will pay a Child Support Benefit if a *dependant child* has a *specified children's event* while the Policy is in force and a *doctor* approved by us provides the medical evidence to support the claim.

15.3 We will only pay a benefit of $10,000 if:

- the *dependant child* dies; or
- we are satisfied that the *dependant child* meets the full definition of the relevant *specified children's event*, as defined in chapter 7 'Medical glossary' and chapter 8 'Definitions'.

The *specified children's events* covered are:

- Aplastic anaemia – of specified severity
- Brain damage – resulting in permanent impairment
- Brain or spinal cord tumour (benign) – resulting in significant permanent impairment or requiring radical treatment
- Burns (severe) – covering specified surface area
- Cancer – excluding specified early stage cancers
- Cardiomyopathy – resulting in significant permanent impairment
- Coma – with specified criteria
- Deafness (both ears) – permanent and irreparable
- Encephalitis – resulting in significant impairment
- Head trauma (major) – resulting in significant permanent impairment
- Kidney failure – requiring permanent dialysis or transplantation
- Loss of limbs – complete and irrecoverable
- Loss of sight (both eyes) – of specified severity
- Loss of speech – complete and irrecoverable
- Meningitis (bacterial) – resulting in permanent impairment
- Meningococcal septicaemia – resulting in permanent impairment
- Organ transplant (major) – from another donor
- Paralysis
- Stroke – of specified severity
- *Terminal illness*

The definition of each *specified children's event* can be found in chapter 7 'Medical glossary' or in chapter 8 'Definitions'.

15.4 **Exclusions**

The Child Support Benefit will not be paid if the:

- *specified children's event* giving rise to the claim is directly or indirectly caused by a *congenital condition*; or
- *specified children's event* giving rise to the claim occurs within 3 months of the *commencement date* or last reinstatement of the Living Benefit.

15.5 The following conditions apply for the Child Support Benefit:

- The sum insured on the Insured Person's Living Benefit must be greater than or equal to $100,000 at the time of payment of the Child Support Benefit.
- Upon payment of the Child Support Benefit the cover for that *dependant child* will cease and no further benefit will be payable under the Child Support Benefit in respect of that *dependant child*.

15.6 The Child Support Benefit will end on the earliest of the:

- date the Child Support Benefit is paid in respect of that *dependant child*;
- *review date* on or following the *dependant child's* 18th birthday; and
- date the Living Benefit for the Insured Person ends for any reason.

1 Where the sum insured of the Living Benefit being issued under this Policy exceeds that of the other policy, this exclusion will apply to the sum insured in excess of the sum insured in the other policy.

16. Living Buy Back Benefit S+ +LI

16.1 After we have paid a Living Benefit, you are automatically entitled to reinstate the Death Benefit for the Insured Person by 100% of the Living Benefit paid. You can do this without having to provide any further information about the Insured Person.

This benefit may only be exercised by your request in writing, within 30 days from the first anniversary of the date we received notification of your claim, in relation to the *specified medical event* for which the Living Benefit was paid. If we do not receive a written request within this specified period, the offer lapses and will not be re-offered.

If the Living Benefit was an additional benefit on a Term Life or Term Life as Superannuation Policy, and this Policy is no longer available as the payment has reduced the Death Benefit to zero, and you seek to reinstate that Death Benefit for the Insured Person, we will issue a new Policy which we believe provides the same or similar death benefits.

16.2 The following conditions are placed on the Living Buy Back Benefit, and the Death Benefit that has been reinstated:

- You cannot buy back more than the Living Benefit we have paid.
- You can increase the reinstated Death Benefit with the *CPI*, provided we are still offering you *CPI* increases.
- The same *underwriting* assessment, such as premium loadings and exclusions, that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit.
- This benefit can only be exercised once.
- If the Double Living Benefit applies, the Living Buy Back Benefit is not available.
- The Insured Person must be alive at the time of the Living Buy Back Benefit application.
- This benefit ends on the *review date* on or following the Insured Person's 65th birthday.

17. Living Insurance Death Benefit NS LI

STANDALONE

17.1 We will pay a Living Insurance Death Benefit of $10,000 if the Insured Person:

- has a *specified medical event* before the Policy ends; and
- subsequently dies within 14 days of first diagnosis of that *specified medical event*.

17.2 A Living Insurance Death Benefit will not be paid if the *specified medical event* giving rise to the claim was caused directly or indirectly by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

18. Business Cover Benefit

TL TLS +TPD +LI

OPTIONAL OPTIONAL OPTIONAL OPTIONAL

18.1 The Business Cover Benefit enables you to increase the Death Benefit, TPD Benefit and Living Benefit for an Insured Person without providing further health evidence when a specified business cover event set out in the table in section 18.4 occurs.

18.2 You may only apply for the increase in writing within 30 days of the business cover event, or 30 days of the *review date* immediately following the specified event.

If you wish to increase your benefits, contact us and we will forward you the relevant forms to complete and advise you of the evidence we require. The evidence must be satisfactory to us, and demonstrate that the business cover event has occurred.

A business cover event is only applicable if the purpose of cover at the time of application is directly related to the business cover event.

The increased cover does not apply until we have confirmed it in writing, and your premium will increase to reflect the increase in cover. The minimum increase per business cover event is $25,000.

18.3 You can apply to increase the Death Benefit, TPD Benefit and Living Benefit up to the following maximums:

Maximums	Death Benefit	TPD Benefit	Living Benefit
Maximum increase per event	The lesser of: • $2,000,000; and • 50% of the original Death Benefit.	The lesser of: • $2,000,000; and • 50% of the original TPD Benefit.	The lesser of: • $2,000,000; and • 50% of the original Living Benefit.
Maximum total benefit after all Business Cover Benefit increases	The lesser of: • $10,000,000; and • 3 times the original Death Benefit.	The lesser of: • $3,000,000; and • 3 times the original TPD Benefit.	The lesser of: • $2,000,000; and • 3 times the original Living Benefit.

18.4 You can apply for an increase for the following business cover events:

Business cover events		Maximum Increase per event
Value of the key person in the business increases	The Insured Person is a key person in the business and their value to the business increases. The Insured Person's value to the business is their remuneration package, excluding discretionary benefits, plus their share of net profits of the business distributed in the 12 months immediately before the event occurs.	The lesser of: • the Death, TPD and Living Benefit limits in section 18.3; • an increase which is proportionate to the increase in the Insured Person's value to the business; and • five times the average annual increase in the gross remuneration package of the Insured Person over the 3 years immediately before the event.
The net value of the Insured Person's financial interest in the Business increases	The Insured Person is a partner, shareholder, unit holder or similar principal in a business. The insurance was purchased in relation to a written share purchase or business succession agreement and the net value of the Insured Person's financial interest in the business increases. The net value of their financial interest in the business is their share of the value of the business, after deducting liabilities of the business, as determined by a valuation method that is acceptable to us.	The lesser of: • the Death, TPD and Living Benefit limits in section 18.3; • an increase which is proportionate to the increase in the net value of the Insured Person's financial interest in the business; and • the average annual increase in the net value of the Insured Person's financial interest in the business over the 3 years immediately before the event.
The value of the Insured Person's loan increases	The Insured Person is the borrower for a business loan that the Death Benefit is intended by the Policy Owner to cover, and the value of the loan increases.	The lesser of: • the Death, TPD and Living Benefit limits in section 18.3; and • an increase which is proportionate to the increase in the value of the Insured Person's loan.

An increase under the Business Cover Benefit will not occur in relation to an Insured Person, if it would result in the total of all increases in Death Benefits, TPD Benefits or Living Benefits for an Insured Person (under all Policies with us) without health evidence (other than *CPI* and Loyalty Benefit increases) exceeding the 'maximum total benefit after all Business Cover Benefit increases' outlined in the table in section 18.3.

The Death Benefit may only be increased by the same amount as, or more than any increase in the TPD Benefit or Living Benefit sum insured, subject to the limits in the table in section 18.3.

18.5 You cannot apply for a Business Cover Benefit increase for an Insured Person:

- after the *review date* on or following the Insured Person's 65th birthday;
- if there has been an increase under this benefit in the last 12 months in respect of the Insured Person;
- if a person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any Policy issued by us;
- on a benefit where a premium loading has been applied; or
- for salary increases, if the Insured Person is self-employed, a controlling director of the employer or a holding company of the employer, or is able to (directly or indirectly) make or control a decision on the amount of the Insured Person's salary package.

Any exclusion that applies to the Death Benefit, TPD Benefit and Living Benefit will also apply to any increase in the Death Benefit, TPD Benefit and Living Benefit.

If the Business Cover Benefit has been selected for an Insured Person, the Future Insurability Benefit is not available for that Insured Person.

19. Multi-link Benefit NS

TL OPTIONAL +TPD OPTIONAL +LI OPTIONAL

19.1 The Multi-link Benefit is available when applying for a Term Life Policy for two or more Insured Persons, with the intent of covering their liability under a business loan.

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

If you choose the Multi-link Benefit, the TPD Buy Back Benefit, Living Buy Back Benefit, Double TPD Benefit, Double Living Benefit and Living Reinstatement Benefit are not available to you.

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

You can apply to continue the insurance cover (up to a maximum of the amount that applied immediately before the Policy ended) provided that, at the time of application, the Insured Person meets the entry age requirement for each benefit as set out on page 8. No additional medical evidence is required for the application however we will need financial information satisfactory to us before we will accept your application to continue the insurance cover. Any loadings, exclusions or special conditions will continue to apply.

20. Needlestick Benefit S+

NB

20.1 The Needlestick Benefit (under the optional Needlestick Benefit Policy) may be available with another St.George Protection Plans Policy, at an additional cost. The Needlestick Benefit is only available to certain medical professionals. Your financial adviser can help determine your eligibility to apply.

We will pay the amount of the Needlestick Benefit for the Insured Person as shown in the most recent *policy schedule* or *renewal summary*.

20.2 We will pay the Needlestick Benefit sum insured if the Insured Person is diagnosed with:

- HIV – occupationally acquired; or
- Hepatitis B or C – occupationally acquired,

as defined in the 'Medical glossary' in chapter 7.

20.3 The following conditions apply to the Needlestick Benefit:

- The Needlestick Benefit will only be paid if the Insured Person is infected whilst working in their *usual occupation* as a medical professional.
- *CPI*, Future Insurability Benefit, Business Cover Benefit and Loyalty Benefit increases do not apply to this option.
- If the Insured Person is eligible to claim on both the Needlestick Benefit and a Living Benefit for the same *sickness* or *injury*, then a maximum of $2,000,000 (plus any *CPI* increases on Living Benefit) will be paid in total.

20.4 **Exclusions**

No payment will be made where the:

- infection is as a result of an intentional self-inflicted *injury*;
- Insured Person is not working as a medical professional at the time of infection; or
- Insured Person had become positive to the hepatitis B surface antigen within six months from the *commencement date* of the benefit or within six months of the reinstatement of the benefit.

20.5 The Needlestick Benefit will end on the earliest of the:

- date the Needlestick Benefit is paid;
- *review date* on or following the Insured Person's 65th birthday;
- date the Policy to which the Needlestick Benefit is linked ends for any reason; and
- date we receive your written request to cancel the Policy.

21. Children's Benefit S+

CB

21.1 The Children's Benefit (under the optional Children's Benefit Policy) is available with another St.George Protection Plans Policy, at an additional cost.

21.2 We will pay a Children's Benefit if an Insured Child has a *specified children's event* and a *doctor* approved by us provides the medical evidence to support the claim.

21.3 We will only pay a benefit if:

- the Insured Child dies, or
- we are satisfied that the Insured Child meets the full definition of the relevant *specified children's event*, as defined in chapter 7 'Medical glossary' and chapter 8 'Definitions'.

The *specified children's events* covered are:

- Aplastic anaemia – of specified severity
- Brain damage – resulting in permanent impairment
- Brain or spinal cord tumour (benign) – resulting in significant permanent impairment or requiring radical treatment
- Burns (severe) – covering specified surface area
- Cancer – excluding specified early stage cancers
- Cardiomyopathy – resulting in significant permanent impairment
- Coma – with specified criteria
- Deafness (both ears) – permanent and irreparable
- Encephalitis – resulting in significant impairment
- Head trauma (major) – resulting in significant permanent impairment
- Kidney failure – requiring permanent dialysis or transplantation
- Loss of limbs – complete and irrecoverable
- Loss of sight (both eyes) – of specified severity
- Loss of speech – complete and irrecoverable
- Meningitis (bacterial)– resulting in permanent impairment
- Meningococcal septicaemia – resulting in permanent impairment
- Organ transplant (major) – from another donor
- Paralysis
- Stroke – of specified severity
- *Terminal illness*

We will pay the amount of the Children's Benefit for the Insured Child as shown in the most recent *policy schedule* or *renewal summary*.

21.4 **Exclusions**

The Children's Benefit will not be paid:

- if the *specified children's event* giving rise to the claim is directly or indirectly caused by a *congenital condition*; or
- for cancer and stroke, if the *specified children's event* giving rise to the claim occurs within 3 months of the *commencement date* or last reinstatement of the Policy.

21.5 The following conditions apply to the Children's Benefit:

- The benefit amount on your other St.George Protection Plans Policy must be greater than:
  - $50,000 for Term Life, Term Life as Superannuation, Standalone Living Insurance and Standalone Total and Permanent Disablement Policies; or
  - $1,000 per month for Income Protection, Income Protection Plus and Business Overheads Policies.
- You must be the natural parent or *legal guardian* of the Insured Child.
- We will only pay this benefit once for each Insured Child, and a child may only be named under one Policy.

21.6 The Children's Benefit will end on the earliest of the:

- date the Children's Benefit is paid;
- *review date* on or following the Insured Child's 16th birthday;
- date the Policy to which the Children's Benefit is linked ends for any reason; and
- date we receive your written request to cancel the Policy.

21.7 **Child Continuation Option**

At the *review date* on or following the Insured Child's 16th birthday, the Insured Child has the option of applying for a Term Life Policy with Living Benefit Plus.

The maximum benefit that is able to be applied for without medical and financial *underwriting* is the lesser of the current Children's Benefit amount or $200,000. Benefits over this amount, as well as optional benefits which are not available under the Children's Benefit, will be subject to medical and financial *underwriting*.

The Insured Child must be the Insured Person on the new Term Life Policy.

22. Super Plus TPD Benefit S+

+TPD WITH FLEXIBLE LINKING PLUS

TPD STANDALONE WITH FLEXIBLE LINKING PLUS

22.1 Flexible Linking Plus allows you to add a TPD Benefit with *own occupation TPD* definition to a Term Life as Superannuation, Term Life and Standalone TPD Policy held inside superannuation.

The Super Plus TPD Benefit is the *own occupation TPD* portion of the TPD Benefit which is not consistent with a superannuation condition of release, and is held under a Flexible Linking Plus Policy outside superannuation.

The Super Plus TPD Benefit is paid to the Policy Owner of the Flexible Linking Plus Policy.

For more information on how Flexible Linking Plus can be used to structure TPD inside and outside superannuation, please see the 'Linked Policies inside and outside superannuation' section under 'Policy Structures' on page 12.

22.2 The following conditions apply to the Super Plus TPD Benefit:

- In the event of a TPD claim, we will first assess your claim under the *any occupation TPD* definition. If your claim does not meet the *any occupation TPD* definition, we will then assess your claim under the *own occupation TPD* definition.
- There will only be one TPD Benefit payment under the Super Plus TPD Benefit (under the *own occupation TPD* definition) and the linked TPD Benefit (under the *any occupation TPD* definition). If the TPD Benefit is paid under the *any occupation TPD* definition, the linked Super Plus TPD Benefit ends. If the Super Plus TPD Benefit is paid in full under the *own occupation TPD* definition, the TPD Benefit ends.
- All other conditions applying to the payment of TPD Benefits (as per section 10) apply to the Super Plus TPD Benefit.

22.3 **Variation of benefits**

If the Insured Person receives a TPD Partial Benefit, the sum insured on both the Super Plus TPD Benefit and the linked TPD Benefit will be reduced by the amount paid.

Any variation to the TPD Benefit will also apply to the linked Super Plus TPD Benefit and vice versa. For example:

- if the TPD Benefit sum insured is reduced, the linked Super Plus TPD Benefit will be reduced.
- when the TPD Benefit ends, the linked Super Plus TPD Benefit will end.

For the purposes of Term Life and Term Life as Superannuation, the Super Plus TPD Benefit will be considered as part of the Policy for variation of benefits. Therefore, a payment of the Living Benefit under the Policy (including all benefits within the Flexible Linking Plus Policy) will result in a reduction of the Super Plus TPD Benefit. A payment of the Super Plus TPD Benefit will result in a reduction of the Death Benefit and Living Benefit.

23. TPD Buy Back Benefit

+TPD
OPTIONAL

23.1 Immediately after the later of the:

- Insured Person becoming *totally and permanently disabled*; and
- date we receive claim forms for the *total and permanent disability*,

if the Insured Person survives for 14 days from the later of the above dates, we will reinstate the Death Benefit for that Insured Person by 100% of the TPD Benefit we have paid. This will occur without you having to provide any further information about the Insured Person.

23.2 The following conditions apply to the TPD Buy Back Benefit, and the Death Benefit that has been reinstated:

- You cannot reinstate more than the TPD Benefit we have paid.
- The reinstated Death Benefit increases with the *CPI*, provided we are still offering you *CPI* increases.
- The same *underwriting* assessment, such as premium loadings and exclusions, that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit.
- The Death Benefit will be automatically reinstated once the Insured Person is eligible. You must decline the reinstatement in writing within 30 days of the reinstatement if you do not wish to have the Death Benefit reinstated.
- This benefit is not available to Insured Persons with a *general cover TPD* Benefit.
- This benefit is not available after the Death Benefit has been first reinstated under this benefit.
- If the Double TPD Benefit applies, the TPD Buy Back Benefit is not available.
- This benefit is not available if the Multi-link Benefit is selected.
- This benefit ends on the *review date* on or following the Insured Person's 65th birthday.

24. Double TPD Benefit

+TPD
OPTIONAL

24.1 Immediately after the later of the:

- Insured Person becoming *totally and permanently disabled*; and
- date we receive claim forms for the *total and permanent disability*,

if the Insured Person survives for 14 days from the later of the above dates, we will reinstate the Death Benefit for that Insured Person by 100% of the TPD Benefit we have paid. In addition, any premium payable on the reinstated Death Benefit will be waived for the life of the Policy. This will occur without you having to provide any further information about the Insured Person.

24.2 The following conditions apply to the Double TPD Benefit, and the Death Benefit that has been reinstated:

- You cannot reinstate more than the TPD Benefit we have paid.
- You cannot exercise this benefit if a claim for a Terminal Illness Benefit or Living Benefit (or similar benefit) has been paid, or is in progress for the Insured Person.
- The Future Insurability Benefit, Business Cover Benefit and *CPI* increases do not apply to the reinstated Death Benefit.
- The same *underwriting* assessment, such as premium loadings and exclusions, that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit.
- The Death Benefit will be automatically reinstated once the Insured Person is eligible. You must decline the reinstatement in writing within 30 days of the reinstatement if you do not wish to have the Death Benefit reinstated.
- This benefit is not available to Insured Persons with a *general cover TPD* Benefit.
- This benefit is not available if the Multi-link Benefit is selected.
- This benefit is not available after the Death Benefit has been first reinstated under this benefit.
- If the Double TPD Benefit applies, the TPD Buy Back Benefit is not available.
- This benefit ends on the *review date* on or following the Insured Person's 65th birthday.

25. Waiver of Life Premium Benefit NS

+TPD
OPTIONAL

25.1 We will waive payment of the entire premium payable under your Term Life Policy:

- if the Insured Person has been *totally and temporarily disabled* for a continuous period of 6 months; and
- for as long as the Insured Person is *totally and temporarily disabled*.

The premiums paid by you for the 6 months or more that the Insured Person was *totally and temporarily disabled* will be reimbursed.

25.2 If the Insured Person's *total and temporary disablement* recurs from the same or related cause within 6 months of you recommencing payment of the premium under the Policy, payment of the premium will be waived again without the Insured Person having to be *totally and temporarily disabled* for an additional continuous period of 6 months.

If there is more than 6 months between two periods of *total and temporary disablement*, payment of the premium under the Policy will not be waived again until the Insured Person has been *totally and temporarily disabled* for an additional continuous period of 6 months.

25.3 The following conditions apply to the Waiver of Life Premium Benefit:

- You are not entitled to apply for increases to the benefits payable in respect of any Insured Person on the Policy if the premium is being waived, except for increases in the Death Benefit under the Future Insurability Benefit (excluding the 'Periodic Increase' event).
- The benefits under your Policy will continue to be increased with the *CPI* if we are still offering you *CPI* increases.
- This option is only available while you have a TPD Benefit.
- This option is not available to Insured Persons with *general cover TPD*.
- This option is not available if the Super Plus TPD Benefit is selected.
- This benefit ends on the earlier of:
  - the date you are paid a TPD Benefit; and
  - the *review date* on or following the Insured Person's 65th birthday.

25.4 **Exclusions**

This option will not apply if the *total and temporary disability* giving rise to the claim was caused by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

26. Living Reinstatement Benefit S+

+LI OPTIONAL +LI OPTIONAL WITH STANDALONE

26.1 After we have paid the Living Benefit, you have the option to reinstate the Living Benefit, and for Term Life and Term Life as Superannuation reinstate the Death Benefit, for the Insured Person by 100% of the Living Benefit we have paid without having to provide any further information about the Insured Person.

This option can be exercised by your written request, within 30 days from the first anniversary of the date we received notification of your claim, in relation to the *specified medical event* for which the Living Benefit was paid. If we do not receive a written request within this specified period, the offer lapses and will not be re-offered.

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

26.2 The Policy Owner can exercise the option provided that:

- the Living Benefit payment was made before the *review date* on or following the Insured Person's 65th birthday; and
- a TPD Benefit (including TPD Partial Benefit and Super Plus TPD Benefit) has not been paid after the Living Benefit was paid under the Policy.

This option is not available for Policies with a Multi-link Benefit. This option is not available after you have exercised it once.

26.3 The reinstated Living Benefit and Death Benefit will be on the terms and conditions of the original Living Benefit and Death Benefit with the exception of the following:

- a further reinstatement option will not be available;
- *CPI* increases will not be available; and
- Future Insurability Benefit and Business Cover Benefit increases will not be available.

Any exclusions or special conditions applicable under your Policy will be maintained under the reinstated Living Benefit.

26.4 We will pay an amount of 10% of the Living Benefit, up to a maximum $50,000 for a claim under the reinstated cover if the *specified medical event* claimed:

- is the same as the original *specified medical event*;
- has occurred as a direct or indirect result of the original *specified medical event*;
- is a heart related condition and the original *specified medical event* was a heart related condition;
- is a lung related condition and the original *specified medical event* was a lung related condition;
- is a stroke – of specified severity and the original *specified medical event* was a heart related condition;
- is a heart related condition and the original *specified medical event* was a stroke – of specified severity;
- is a loss of independent existence – with a specified level of impairment; or
- is a cancer related condition and the original *specified medical event* was also a cancer related condition.

The Insured Person must satisfy the definition of the *specified medical event* again in order to claim on the reinstated cover. We will not pay a claim under the reinstated cover if the *specified medical event* occurred or was diagnosed, or the circumstances or *symptoms* leading to diagnosis were apparent before the Living Benefit was reinstated. The reinstated Living Benefit will be reduced by any amount payable under this section.

We will not pay a claim under the reinstated cover for an Advancement Benefit which is related to the original *specified medical event*. For an Advancement Benefit claim under the reinstated cover which is not related to the original *specified medical event*, we will pay the Advancement Benefit as per section 14.2.

27. Double Living Benefit S+ +LI OPTIONAL

27.1 Immediately after the later of the:

- Insured Person suffering a *specified medical event* (except for Advancement Benefit conditions); and
- date we receive claim forms in relation to the *specified medical event*,

if the Insured Person survives for 14 days from the later of the above dates, we will reinstate the Death Benefit for that Insured Person by 100% of the Living Benefit we have paid. In addition, any premium payable on the reinstated Death Benefit will be waived for the life of the Policy. This will occur without you having to provide any further information about the Insured Person.

27.2 The following conditions apply to the Double Living Benefit, and the Death Benefit that has been reinstated:

- You cannot reinstate more than the Living Benefit we have paid.
- You cannot exercise this benefit if a claim for a Terminal Illness Benefit, TPD Benefit, Super Plus TPD or Partial TPD Benefit has been paid, or is in progress for the Insured Person.
- The Future Insurability Benefit, Business Cover Benefit and *CPI* increases do not apply to the reinstated Death Benefit.
- The same *underwriting* assessments, such as premium loadings and exclusions, that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit.
- The Death Benefit sum insured will be automatically reinstated once the Insured Person is eligible. You must decline the reinstatement in writing within 30 days of the reinstatement if you do not wish to have the Death Benefit reinstated.
- This benefit is not available if the Multi-link Benefit is selected.
- This benefit is not available after the Death Benefit has been first reinstated under this benefit.
- If the Double Living Benefit applies, the Living Buy Back Benefit is not available.
- This benefit ends on the *review date* on or following the Insured Person's 65th birthday.

28. Exclusions

TL TLS +TPD TPD (STANDALONE) +LI LI (STANDALONE) NB CB

In addition to any other exclusions to the benefits described, we will not pay any benefit if the claim was caused directly or indirectly by an event or condition covered by any exclusion in your *policy schedule* or *membership certificate*.

29. When does my benefit end?

TL TLS +TPD TPD (STANDALONE) +LI LI (STANDALONE) NB CB

Your benefit under a Policy for an Insured Person continues until the earliest of:

- the date the Insured Person dies;
- the date we pay the entire benefit for the Insured Person;
- the *review date* on or following the date the Insured Person reaches the expiry age of the benefit;
- for Term Life and Term Life as Superannuation, the benefit amount for the Insured Person is reduced to zero because we have paid a TPD Benefit, Super Plus TPD Benefit, Living Benefit or Terminal Illness Benefit under the Policy or Flexible Linking Plus Policy;
- the date we receive your written request to cancel the benefit for the Insured Person; and
- the date your Policy ends.

30. When does my Policy end?

TL TLS +TPD TPD (STANDALONE) +LI LI (STANDALONE) NB CB

Your Policy will continue until the earliest of:

- the date the last Insured Person dies;
- the date all benefits for the last Insured Person end;
- the date we cancel your Policy because you have not paid your premiums or any other amounts which relate to your Policy;
- the date we cancel or avoid your Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you or an Insured Person prior to our acceptance of risk, or during the making of a claim; and
- the date we receive your written request to cancel your Policy.

When your Policy ends, any Policy which is linked through Flexible Linking Plus will also end.

Chapter 3: Income Products

Income protection for individuals – overview

Income protection provides a monthly benefit to replace a portion of the income lost when the Insured Person is unable to work at their full capacity due to *sickness* or *injury*.

St.George Protection Plans offer a comprehensive range of income protection products to help you and your family avoid financial stress if something unexpected were to happen. Alternatively, income protection can provide a benefit if the Insured Person is unable to carry out day to day household tasks, or in the event they are unable to perform the activities of daily living due to *sickness* or *injury*.

What types of Policies are available?

St.George Protection Plans offer the following types of income protection Policies:

- Income Protection – provides a monthly benefit while the Insured Person is *totally disabled* or *partially disabled*.
- Income Protection as Superannuation – Income Protection held through *Westpac MasterTrust*.
- Income Protection Plus – a more comprehensive level of income protection cover. In addition to the core benefits offered under an Income Protection Policy, a greater range of built-in support benefits are also available to provide financial assistance during your recovery.

Waiting and benefit periods

The *waiting period* and *benefit period* that apply to your Policy will determine when any benefit payments under the Policy will commence and the maximum length of time they can be paid for.

The *waiting period* and *benefit period* available to you will depend on the Policy you have selected, your income protection definition and the Insured Person's occupation. Your financial adviser can provide more details on the *waiting periods* and *benefit periods* available to you.

Waiting period

The *waiting period* is the amount of time from when the Insured Person becomes *totally disabled*, *severely disabled* or *partially disabled* to the date when your benefits begin to accrue.

The portion of any monthly benefit in excess of $30,000 is limited to a 2 years *benefit period* at application.

Payments are made monthly in arrears after the end of the *waiting period*.

Policy	*Waiting period* options					
	14 days	30 days	90 days	180 days	360 days	720 days
Income Protection Plus						
Own occupation IP	✓	✓	✓	✓	✓	✓
Home duties IP	✗	✗	✓	✓	✓	✓
Income Protection						
Own occupation IP	✓	✓	✓	✓	✓	✓
Home duties IP	✗	✗	✓	✓	✓	✓
General cover IP	✗	✗	✓	✓	✓	✓
Income Protection as Superannuation						
Own occupation IP	✓	✓	✓	✓	✓	✓

Benefit period

The *benefit period* is the maximum length of time you will be paid for in the event the Insured Person is *totally disabled*, *severely disabled* or *partially disabled*.

Policy	*Benefit period* options					
	2 years	5 years	To age 55	To age 65	To age 70	To age 80[1]
Income Protection Plus						
Own occupation IP	✓	✓	✓	✓	✓	✗
Home duties IP	✓	✗	✗	✗	✗	✗
Income Protection						
Own occupation IP	✓	✓	✓	✓	✓	✗
Home duties IP	✓	✗	✗	✗	✗	✗
General cover IP	✓	✓	✗	✓	✗	✓
Income Protection as Superannuation						
Own occupation IP	✓	✓	✓	✓	✓	✗

1 *Benefit period* to age 80 is not available under a Policy held inside superannuation.

What are the income protection definitions available?

St.George Protection Plans offer three types of income protection cover (we call these income protection definitions), each offering cover for different purposes. Each income protection definition (*own occupation IP*, *home duties IP* and *general cover IP*) offers cover for a different purpose. Your financial adviser can help you choose the definition suitable for your individual needs.

To qualify for an income protection benefit under each definition, the Insured Person must meet the applicable definition of *total disability*, *severe disability* or *partial disability*, as defined in chapter 8 'Definitions'.

Benefit type

The benefit type which applies to your Policy will determine the amount we will pay when the Insured Person is *totally disabled* or *partially disabled*. Your financial adviser can help you determine which of the following types of benefit are suitable for your needs:

- *Agreed value*
- *Endorsed agreed value*
- *Indemnity*.

What happens to the Policy while a claim is being paid?

Increasing claims benefit

If you are receiving a benefit payment, the amount of your monthly benefit will be increased on each *review date* by the *CPI*.

Premiums are waived while we pay you

You do not have to pay premiums, policy fees and stamp duty, for the period during which you are receiving a Total Disability Benefit, Severe Disability Benefit, Partial Disability Benefit, Crisis Benefit or Specified Injury Benefit payment.

For the avoidance of doubt, the premium waiver is applied pro-rata only for the period you are receiving a benefit.

Own Occupation Income Protection

Income Protection and Income Protection as Superannuation with an *own occupation IP* definition provides a monthly benefit if the Insured Person becomes disabled because of *sickness* or *injury*. Income Protection Plus with an *own occupation IP* definition offers more comprehensive cover by including a number of additional benefits.

Own occupation IP		
Entry ages (Based on premium option and *benefit period* selected)	Policies with stepped premium with *benefit periods* of 2 years, 5 years, to age 65, to age 70:	age 17–59
	Policies with stepped premium with *benefit period* to age 55:	age 17–49
	Policies with 'Level 65' premium:	age 17–59
	Policies with 'Level 55' premium:	age 17–49
Expiry age (Based on *benefit period* selected)	Policies with *benefit periods* of 2 years, 5 years, to age 65:	*Review date* on or following the Insured Person's 65th birthday.
	Policies with *benefit period* to age 55:	*Review date* on or following the Insured Person's 55th birthday.
	Policies with *benefit period* to age 70:	*Review date* on or following the Insured Person's 70th birthday.
Benefit type	*Agreed Value, Endorsed Agreed Value, Indemnity*	

Included and optional benefits

The *own occupation IP* cover in an Income Protection, Income Protection as Superannuation and Income Protection Plus Policy contains a number of included and optional benefits, a summary of these is set out in the following tables. The terms and conditions of each benefit are located in the 'Income product benefit specifics' section on pages 49 to 67.

You can apply for optional benefits. Unless we have stated otherwise, the optional benefits will require an additional cost. If we have accepted the application for an optional benefit for an Insured Person, it will be shown on your *policy schedule, membership certificate* or *renewal summary*. If we have accepted the application for an optional benefit after the commencement of your Policy, we will issue an update to your *policy schedule* or *membership certificate*.

Included benefits	Summary	Income Protection & Income Protection as Superannuation	Income Protection Plus S+	Page
Total Disability Benefit	If the Insured Person is *totally disabled*, we will pay a monthly benefit after the end of your *waiting period*.	✓	✓	49
Partial Disability Benefit	If the Insured Person is *partially disabled*, we will pay a monthly benefit after the end of your *waiting period*.	✓	✓	51
Elective Surgery Benefit	Pays a monthly benefit if the Insured Person is *totally disabled* or *partially disabled* because of a transplant (where they are the donor) or cosmetic surgery.	✓	✓	53
Rehabilitation Expense Benefit S+	Pays a benefit to help meet certain approved rehabilitation costs which are incurred while the Insured Person is *totally disabled*.	✓	✓	54
Rehabilitation Program Benefit S+	Pays a benefit to help with approved costs of a rehabilitation program which are incurred while the Insured Person is *totally disabled*.	✓	✓	54
Return to Work Benefit S+	Provides a benefit after the Rehabilitation Expense Benefit or Rehabilitation Program Benefit has been paid, and the Insured Person has returned to work on a full time basis for 3 consecutive months.	✓	✓	54
Recurrent Disability Benefit	Allows the *waiting period* to be waived if the Insured Person becomes disabled within a certain period of time after we have paid a Totally Disability or Partial Disability Benefit due to the same *sickness* or *injury* for which the benefit was paid.	✓	✓	55

Included benefits	Summary	Income Protection & Income Protection as Superannuation	Income Protection Plus S+	Page
Death Benefit	Pays a benefit if the Insured Person dies while they are entitled to the payment of a Total Disability, Partial Disability, Crisis, Specified Injury or Nursing Care Benefit.	✓	✓	55
Change of Waiting Period Benefit	Allows you to reduce the *waiting period* without further health evidence if the Insured Person changes their employment status.	✓	✓	55
Future Insurability Benefit	Allows the Insured Person to increase their *insured monthly benefit* every 12 months without further health evidence.	✓	✓	56
IP Continuation Option	You may be able to continue cover at the expiry of the Policy if the Insured Person continues to work on a full time basis. The eligibility criteria include the Insured Person's occupation and working arrangements.	✓	✓	56
Extended Cover Benefit	You can apply to continue your cover on limited terms under the *general cover IP* definition at the expiry of the Policy.	✓	✓	57
Counselling Benefit S+	Reimbursement of up to $5,000 for a maximum of 10 counselling sessions following the payment of a Total Disability Benefit. This benefit is paid once for each Insured Person.	✗	✓	58
Nursing Care Benefit S+	Pays a benefit if the Insured Person is *confined to bed* for more than 3 consecutive days during the *waiting period*.	✗	✓	58
Specified Injury Benefit S+	Pays a monthly benefit for the *payment period* if the Insured Person suffers a specified injury, whether or not they are able to return to work. This benefit is not available for Policies with a 360 days or 720 days *waiting period*.	✗	✓	59
Crisis Benefit S+	Pays a monthly benefit for 6 months if the Insured Person suffers a specified crisis event, whether or not they are able to return to work.	✗	✓	59
Transport within Australia Benefit S+	Pays a benefit to enable the Insured Person to be transported within Australia if they become *totally disabled* in Australia; and: • are *confined to bed* more than 100 kilometres from their usual place of residence, or • it is considered medically necessary for the Insured Person to travel to a place more than 100 kilometres from their usual place of residence for reasons directly associated with the *sickness* or *injury* causing *total disability*.	✗	✓	60
Transport from Overseas Benefit S+	Pays a benefit to help the Insured Person to return to Australia if: • they become *totally disabled* whilst overseas; • they're *totally disabled* for more than 30 days; and • they choose to return to Australia while they are *totally disabled*.	✗	✓	61
Accommodation Benefit S+	If we have paid the Nursing Care Benefit and the Insured Person is *confined to bed* more than 100 kilometres away from their usual place of residence, we will pay a benefit to assist with the accommodation cost for an *immediate family member* who has to stay away from their usual residence to be with the Insured Person.	✗	✓	61
Family Care Benefit S+	If the Total Disability Benefit is payable and the Insured Person requires the full time care of an *immediate family member*, we will pay a monthly benefit to help cover the lost income of the *immediate family member* if they have to stop work to look after the Insured Person.	✗	✓	61

Included benefits	Summary	Income Protection & Income Protection as Superannuation	Income Protection Plus S+	Page
Home Care Benefit S+	Pays a monthly benefit to help cover the carer cost if: • the Total Disability Benefit is payable; • the Insured Person is *confined to bed* at home because of their *total disability*; and • in the opinion of a *doctor*, the Insured Person requires the care of a professional home carer.	✗	✓	61
Respite Care Benefit S+	Pays for the Insured Person to be placed into a respite care facility if the Insured Person is: • *totally disabled* for at least 24 continuous months; • living in their own home and require an *immediate family member* as a full time carer; and • permanently unable to perform, without assistance, any two activities of daily living (as defined in the 'Medical glossary' in chapter 7).	✗	✓	62
Child Care Benefit S+	Pays a benefit to help with approved additional child care costs which are incurred for an eligible child while the Insured Person is *totally disabled*.	✗	✓	62
Waiver of IP Premium S+	If you are paid a Total Disability Benefit, premium amounts payable during the *waiting period* will be refunded to you.	✗	✓	62

Optional benefits	Summary	Income Protection & Income Protection as Superannuation	Income Protection Plus S+	Page
Accident Benefit	Pays a benefit if the Insured Person is *totally disabled* for a specified number of days during the *waiting period* due to an *accidental injury*. This benefit is only available for Policies with a 14, 30 or 90 day *waiting period*.	✓	✓	62
Superannuation Contribution Option	Allows you to cover an additional portion of the Insured Person's *monthly earnings* to help with superannuation contributions in the event of *total disability*.	✓	✓	63
Super Plus IP Benefit S+	You can structure your income protection cover with the benefits offered under an Income Protection Plus Policy over two separate Policies with: • the benefits which are consistent with a superannuation condition of release under a Policy held inside superannuation; and • the other benefits under an Income Linking Plus Policy held outside superannuation.	✗	✓	63

You can apply to add the following Policies to an Income Protection Policy, Income Protection as Superannuation Policy or Income Protection Plus Policy:

- Needlestick Benefit S+
- Children's Benefit S+

The terms and conditions for the Needlestick Benefit and Children's Benefit Policies are located in the 'Term Life, TPD and Living Insurance benefit specifics' section in chapter 2, pages 33 to 34.

Options available if your Policy is approaching expiry

Cover under an *own occupation IP* definition may be available up until the *review date* on or following the Insured Person's 75th birthday, on a limited basis if the Insured Person's occupation class is AA, A, P or S and they are still working on a full-time basis past the expiry of their Income Protection or Income Protection Plus Policy. For more information on the IP Continuation Option, please see chapter 3, section 12.

You may also be eligible to apply to continue your cover until the *review date* on or following the Insured Person's 80th birthday, under a *general cover IP* definition and on a limited basis at the expiry on your Income Protection or Income Protection Plus Policy. For more information on the Extended Cover Benefit, please see chapter 3, section 13.

Home Duties Income Protection

Income Protection with a *home duties IP* definition provides a monthly benefit if the Insured Person becomes *severely disabled* because of *sickness* or *injury*, and is unable to perform *normal household duties*.

Income Protection Plus with a *home duties IP* definition provides more comprehensive cover by including a Crisis Benefit.

Home Duties IP	NS
Entry ages	Policies with stepped premium: age 17–59
	Policies with 'Level 65' premium: age 17–59
Expiry age	*Review date* on or following the Insured Person's 65th birthday.
Benefit type	*Agreed Value*

Included benefits

The *home duties IP* cover in an Income Protection and Income Protection Plus Policy contains a number of included benefits, and a summary of these is set out in the table below. The terms and conditions of each benefit are located in the 'Income product benefit specifics' section on pages 49 to 67.

Included benefits	Summary	Income Protection	Income Protection Plus	Page
Severe Disability Benefit	If the Insured Person is *severely disabled*, we will pay a monthly benefit after the end of your *waiting period*.	✓	✓	52
Recurrent Disability Benefit	Allows the *waiting period* to be waived if the Insured Person becomes disabled within a certain period of time after we have paid a Severe Disability Benefit due to the same *sickness* or *injury* for which the benefit was paid.	✓	✓	55
Death Benefit	Pays a benefit if the Insured Person dies while they are entitled to the payment of a Severe Disability or Crisis Benefit.	✓	✓	55
Extended Cover Benefit	You can apply to continue your cover on limited terms under the *general cover IP* definition at the expiry of the Policy.	✓	✓	57
Crisis Benefit	Pays a monthly benefit for 6 months if the Insured Person suffers a specified crisis event, whether or not they are able to perform *normal household duties*.	✗	✓	59

You can apply to add a Children's Benefit Policy to an Income Protection Policy or Income Protection Plus Policy.

The terms and conditions for the Children's Benefit Policy is located in the 'Term Life, TPD and Living Insurance benefit specifics' section in chapter 2, pages 33 to 34.

General Cover Income Protection

Income Protection with a *general cover IP* definition provides a monthly benefit if the Insured Person becomes *severely disabled* because of *sickness* or *injury*, and is unable to perform the activities of daily living (as defined in the 'Medical glossary' in chapter 7).

General cover IP		
Entry ages (Based on the Insured Person's employment status)	For a monthly benefit greater than $5,000 (the Insured Person must be *gainfully employed*):	Policies with stepped premium: age 17–59
		Policies with 'Level 65' premium: age 17–59
	For a monthly benefit of up to $5,000:	Policies with stepped premium: age 17–69
		Policies with 'Level 65' premium: age 17–59
Expiry age (Based on *benefit period* selected)	Policies with *benefit periods* of 2 years, 5 years, to age 65:	*Review date* on or following the Insured Person's 65th birthday.
	Policies with *benefit period* to age 80:	*Review date* on or following the Insured Person's 80th birthday.
Benefit type	*Agreed Value, Indemnity*	

General cover IP is only available in Policies held through an *SMSF* if the Insured Person is *gainfully employed* at the time you apply for cover.

Included benefits

The *general cover IP* cover in an Income Protection Policy contains a number of included benefits, and a summary of these is set out in the table below. The terms and conditions of each benefit are located in the 'Income product benefit specifics' section on pages 49 to 67.

Included benefits	Summary	Page
Severe Disability Benefit	If the Insured Person is *severely disabled*, we will pay a monthly benefit after the end of your *waiting period*.	52
Recurrent Disability Benefit	Allows the *waiting period* to be waived if the Insured Person becomes disabled again within a certain period of time after we have paid a Severe Disability Benefit due to the same *sickness* or *injury* for which the benefit was paid.	55
Death Benefit	Pays a benefit if the Insured Person dies while they are entitled to the payment of a Severe Disability Benefit.	55
Extended Cover Benefit	You can apply to continue your cover on limited terms under the *general cover IP* definition at the expiry of the Policy.	57

You can apply to add the following Policies to an Income Protection Policy:

- Needlestick Benefit S+
- Children's Benefit S+

The terms and conditions for the Needlestick Benefit and Children's Benefit Policies are located in the 'Term Life, TPD and Living Insurance benefit specifics' section in chapter 2, pages 33 to 34.

Income products for business protection – overview

St.George Protection Plans offer comprehensive solutions to help your business remain viable, by protecting your business expenses and business income, in the event of *sickness* or *injury* to an Insured Person.

Your financial adviser can assist with determining the right cover for your business needs.

Protecting your business expenses

If the Insured Person is unable to work due to *sickness* or *injury*, Business Overheads insurance can assist by providing a monthly benefit for the *allowable business expenses* which are incurred while the Insured Person is *totally disabled* or *partially disabled*.

Protecting your business income

Key Person Income insurance provides a monthly benefit to help the business remain viable if its owners and/or key income generating staff are unable to work due to *sickness* or *injury*. The benefit is paid to the business, which can be used to maintain the level of income to the business, assist with ongoing expenses and to fund the replacement and retraining of a staff member.

Waiting and benefit periods

The *waiting period* and *benefit period* that apply to your Policy will determine when a claim is payable and the maximum length of time it can be paid.

The *waiting period* is the amount of time from when the Insured Person becomes *totally disabled* or *partially disabled* to the date when your benefits begin to accrue. Payments are made monthly in arrears after the end of the *waiting period*.

The *benefit period* is the maximum length of time you will be paid for in the event the Insured Person is *totally disabled* or *partially disabled*.

The table below outlines the *waiting periods* and *benefit period* available under Business Overheads and Key Person Income. Your financial adviser can help you determine the suitable *waiting period* for your business needs.

Policy	*Waiting period* options	*Benefit period*
Business Overheads	14 days and 30 days	1 year
Key Person Income	30 days and 90 days	1 year

What happens to the Policy while a claim is being paid?

Increasing claims benefit

If you are receiving benefits, the monthly benefit will be increased on each *review date* by the *CPI*.

Premiums are waived while we pay you

You do not have to pay premiums, policy fees and stamp duty, for the period during which you are receiving a Total Disability Benefit or Partial Disability Benefit.

For the avoidance of doubt, the premium waiver is applied pro-rata only for the period you are receiving a benefit.

Business Overheads

Business Overheads pays a monthly benefit for the day to day costs of running a business if the Insured Person is disabled because of *sickness* or *injury* and is unable to work at their full capacity in their business.

The *allowable business expenses* that can be covered include rent, utility bills and salaries of non income producing employees. For a full list, please see the definition of *allowable business expenses* in chapter 8, page 96.

Business Overheads	NS	
Entry ages	Policies with stepped premium:	age 17–59
	Policies with 'Level 65' premium:	age 17–59
Expiry age	*Review date* on or following the Insured Person's 65th birthday.	

Included benefits

The Business Overheads cover contains a number of included benefits, and a summary of these is set out in the table below. The terms and conditions of each benefit are located in the 'Income product benefit specifics' section on pages 49 to 67.

Included benefits	Summary	Page
Total Disability Benefit	If the Insured Person is *totally disabled*, we will pay a monthly benefit after the end of your *waiting period*.	49
Partial Disability Benefit	If the Insured Person is *partially disabled*, we will pay a monthly benefit after the end of your *waiting period*.	51
Elective Surgery Benefit	Pays a monthly benefit if the Insured Person is *totally disabled* or *partially disabled* because of a transplant (where they are the donor) or cosmetic surgery.	53
Recurrent Disability Benefit	Allows the *waiting period* to be waived if the Insured Person becomes disabled again within a certain period of time after we have paid a Total Disability or Partial Disability Benefit due to the same *sickness* or *injury* for which the benefit was paid.	55
Death Benefit	Pays a benefit if the Insured Person dies while they are entitled to the payment of a Total Disability or Partial Disability Benefit.	55

You can apply to add the following Policies to a Business Overheads Policy:

- Needlestick Benefit S+
- Children's Benefit S+

The terms and conditions for the Needlestick Benefit and Children's Benefit Policies are located in the 'Term Life, TPD and Living Insurance benefit specifics' section in chapter 2, pages 33 to 34.

Key Person Income

Key Person Income pays a monthly benefit if the Insured Person is disabled because of *sickness* or *injury* and is unable to work at their full capacity in the *key person business*.

Key Person Income	NS	
Entry ages	Policies with stepped premium:	age 17–59
	Policies with 'Level 65' premium:	age 17–59
Expiry age	*Review date* on or following the Insured Person's 65th birthday.	
Benefit type (Based on employment status)	If the Insured Person is a *key person business owner*:	*Indemnity*
	If the Insured Person is a *key person employee*:	*Endorsed Agreed Value, Indemnity*

Included benefits

Key Person Income cover contains a number of included benefits, and a summary of these is set out in the table below. The terms and conditions of each benefit are located in the 'Income product benefit specifics' section on pages 49 to 67.

Included benefits	Summary	Page
Total Disability Benefit	If the Insured Person is *totally disabled*, we will pay a monthly benefit after the end of your *waiting period*.	49
Partial Disability Benefit	If the Insured Person is *partially disabled*, we will pay a monthly benefit after the end of your *waiting period*.	51
Elective Surgery Benefit	Pays a monthly benefit if the Insured Person is *totally disabled* or *partially disabled* because of a transplant (where they are the donor) or cosmetic surgery.	53
Recurrent Disability Benefit	Allows the *waiting period* to be waived if the Insured Person becomes disabled again within a certain period of time after we have paid a Total Disability or Partial Disability Benefit due to the same *sickness* or *injury* for which the benefit was paid.	55
Death Benefit	Pays a benefit if the Insured Person dies while they are entitled to the payment of a Total Disability or Partial Disability Benefit.	55

Income product benefit specifics

Please take the time to read the details about the benefits your Policy provides. This section will provide you with the terms and conditions of each benefit in your Policy and is an important part of this PDS.

Please speak to your financial adviser or contact us if you would like any of these details explained to you.
Please use the coloured icons below to assist you in understanding which benefits are available on your cover.

IP OWN	**Income Protection** with the *own occupation IP* definition	IPP OWN	**Income Protection Plus** with the *own occupation IP* definition
IP HOME	**Income Protection** with the *home duties IP* definition	IPP HOME	**Income Protection Plus** with the *home duties IP* definition
IP GENERAL	**Income Protection** with the *general cover IP* definition	BOH	**Business Overheads**
IPS OWN	**Income Protection as Superannuation** with the *own occupation IP* definition	KPI	**Key Person Income**

1. Total Disability Benefit

IP OWN IPS OWN IPP OWN BOH KPI

1.1 When we will pay

If the Insured Person is *totally disabled* while covered under the Policy, we will pay a monthly benefit after the end of your *waiting period*.

1.2 What we will pay

a. Income Protection, Income Protection as Superannuation and Income Protection Plus

The benefit paid will depend on whether you have chosen an *agreed value*, *endorsed agreed value*, or *indemnity* Policy:

Monthly benefit

If you have chosen an *agreed value* or *endorsed agreed value* Policy, the monthly Total Disability Benefit is the *insured monthly benefit*.

For an *agreed value* or *endorsed agreed value* Policy held inside superannuation that is not linked to an Income Linking Plus Policy, the amount of the Total Disability Benefit may be reduced at the time of claim so that it does not exceed the maximum permitted under superannuation law. For more information on the amount payable from Policies held inside superannuation, please see chapter 3, section 31.

The calculation below applies if you have chosen an *indemnity* Policy.

If you have chosen an *agreed value* Policy, and you overstated the *monthly earnings* of the Insured Person at application (or at the time when you applied for an increase to your monthly benefit), the following calculation also applies to your Policy.

The monthly Total Disability Benefit is calculated as follows:

The monthly Total Disability Benefit is the lesser of:

- the *insured monthly benefit*; and
- 75% of *pre-disability monthly earnings*.

If the *insured monthly benefit* with us at the time of application is greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $480,000, the monthly Total Disability Benefit is the lesser of:

- the *insured monthly benefit*; and
- a percentage of the *pre-disability monthly earnings*, where the percentage is;
  - 75% of the first $320,000 of annualised *pre-disability monthly earnings*;
  - 50% of the next $240,000 of annualised *pre-disability monthly earnings*; and
  - 20% of the remainder of annualised *pre-disability monthly earnings*.

Monthly benefit
If the Superannuation Contribution Option applies to the Policy, we will use the greater of the *income ratio* and 75% of *monthly earnings*. If the *insured monthly benefit* with us at the time of application is greater than $30,000 we will use the lesser of: • the *income ratio*; and • a percentage of *pre-disability monthly earnings*, where the percentage is; – 80% of the first $320,000 of annualised *pre-disability monthly earnings*; – 55% of the next $190,000 of annualised *pre-disability monthly earnings*; and – 20% of the remainder of annualised *pre-disability monthly earnings*.

For Policies with a 'to age 70' *benefit period* where the Insured Person becomes *totally disabled* after their 65th birthday, the monthly Total Disability Benefit will be calculated on an *indemnity* basis.

If the Insured Person:

- becomes unemployed; or
- takes paid or unpaid parental or sabbatical leave, or any other leave without pay,

cover under the Policy will continue, provided you pay premiums and any other amounts due.

If, for 12 months or more immediately before suffering *total disability*, the Insured Person:

- was unemployed for reasons other than *total disability*; or
- took paid or unpaid parental or sabbatical leave, or any other leave without pay,

they will only be considered *totally disabled* if, solely because of *sickness* or *injury*, they are:

- unable to perform any occupation for which they are reasonably suited by education, training or experience;
- not working; and
- under the *regular care of a doctor*.

b. Business Overheads

The amount of this benefit is the lesser of the *insured monthly benefit*, and the *allowable business expenses* actually incurred in the month the Insured Person is *totally disabled*.

c. Key Person Income

The benefit paid will depend on whether you have chosen an *endorsed agreed value* or *indemnity* Policy:

Benefit type	Monthly benefit
Endorsed agreed value	The monthly Total Disability Benefit is the *insured monthly benefit*.
Indemnity	The amount of the Total Disability Benefit is the lesser of: • the *insured monthly benefit*; and • the *pre-disability monthly business income*. The calculation of *pre-disability monthly business income* is applied differently depending on whether the Insured Person is a *key person business owner* or *key person employee*. If the Insured Person is a *key person business owner*, the *pre-disability monthly business income* is calculated based on: A x B = C where: A = a percentage being the lesser of: • the Insured Person's ownership percentage of the *key person business* as at the *date of disability*; • the average percentage of *gross profit* attributed to the Insured Person in the 12 months immediately preceding the commencement of *total disability* or *partial disability*; and • 50%. B = an amount which is the average monthly *gross profit* of the *key person business* for the 12 months immediately preceding the commencement of *total disability* or *partial disability*. This amount is increased by the *CPI* each *review date* since the *date of disability*. C = *pre-disability monthly business income*. If the Insured Person is a *key person employee*, the *pre-disability monthly business income* is calculated based on the Insured Person's *average monthly earnings* in the 12 months immediately preceding the commencement of *total disability* or *partial disability* multiplied by the *key person factor* (this is the percentage of *monthly earnings* we agree to replace at the time of claim, and is shown in the *policy schedule*).

1.3 How we will pay

The benefit accrues from the first day of *total disability* after the *waiting period* and is payable monthly in arrears.

If the Insured Person is *totally disabled* for less than the complete month after the *waiting period*, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *total disability*;
- the time when the aggregate of the period for which a Total Disability Benefit was payable to you and any period for which a Partial Disability Benefit was payable to you is equal to the *benefit period*; and
- your Policy ends.

For Business Overheads and Key Person Income, if at the end of the *benefit period* the Insured Person remains *totally disabled* and the total amount paid is less than 12 times the Total Disability Benefit, payments will continue until the earliest of the:

- payment of 12 times the Total Disability Benefit;
- expiry of a further 12 months;
- cessation of the *total disability*; and
- date the Policy ends.

1.4 Advanced partial payment

For Income Protection, Income Protection as Superannuation and Income Protection Plus Policies, we may make an advanced partial payment for your first monthly benefit. The advanced partial payment is payable a fortnight after the *waiting period* ends, and is payable in arrears. The amount of the advanced partial payment is calculated on a pro-rata basis based on a 30 day month.

If we have made an advanced partial payment on your Policy, the remainder of your monthly benefit will be payable at the end of the month. The amount payable will be your Total Disability Benefit, less the amount of the advanced partial payment.

1.5 Medical Professionals

The terms of this section 1.5 apply if the Insured Person is a medical professional who performs exposure prone procedures as the main and important part of their *usual occupation*.

If the Insured Person is diagnosed with Human Immunodeficiency Virus or hepatitis B or hepatitis C and, as a consequence of the diagnosis, they:

- are restricted as a regulatory requirement from performing exposure prone procedures; or
- experience a reduction in income due to loss of patients,

we will regard them as having satisfied the occupational duties component of the *total disability* definition due to *sickness* as follows. If the Insured Person is:

- not working, we will regard them as being unable to perform one or more of the *important income producing duties* of their *usual occupation*;
- not working for more than 10 hours per week in their *usual occupation* and not working in another occupation, we will regard them as being unable to perform the *important income producing duties* of their *usual occupation* for more than 10 hours per week.

The other requirements of the *total disability* definition set out in chapter 8 must be satisfied for the Insured Person to be deemed *totally disabled*.

The terms of this section 1.5 will not apply in the event that:

- any cure is found for AIDS or the effects of HIV, hepatitis B or hepatitis C (as applicable); or
- if the Insured Person had elected not to undertake medical treatment or vaccination that was available to the Insured Person and which results in the prevention of infection with HIV, or the occurrence of AIDS, hepatitis B, or hepatitis C, prior to the event giving rise to the claim.

1.6 Limitations

The amount of this benefit is reduced by any limitations on benefits (see chapter 3, sections 31 to 33).

2. Partial Disability Benefit

IP OWN IPS OWN IPP OWN BOH KPI

2.1 If the Insured Person is *partially disabled* while covered under the Policy, we will pay a monthly Partial Disability Benefit after the end of your *waiting period*.

2.2 What we will pay

a. Income Protection, Income Protection as Superannuation and Income Protection Plus

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

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

A = *Pre-disability monthly earnings*
B = *Post-disability monthly earnings*
C = the monthly Total Disability Benefit

For an *agreed value* or *endorsed agreed value* Policy held inside superannuation, which is not linked to an Income Linking Plus Policy, the amount of the Partial Disability Benefit may be reduced at the time of claim so that it does not exceed the maximum permitted under superannuation law. For more information on the amounts payable for Policies held inside superannuation, please see chapter 3, section 31.

For Policies with a 'to age 70' *benefit period* where the Insured Person becomes *partially disabled* after their 65th birthday, the Partial Disability Benefit will be calculated on an *indemnity basis*.

b. Business Overheads

The amount of this benefit is the lesser of the *insured monthly benefit* and the *allowable business expenses* actually incurred in the month the Insured Person is suffering *partial disability*.

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

c. Key Person Income

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

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

A = the lesser of:

- the number of hours worked by the Insured Person in the *key person business* prior to becoming *totally disabled* or *partially disabled*, based on the average number of hours worked in the three months immediately preceding the commencement of the *waiting period*; and
- 40 hours.

B = the hours worked by the Insured Person in the *key person business* after becoming *partially disabled*.

C = the monthly Total Disability Benefit.

2.3 How we will pay

The benefit accrues from the first day of *partial disability* after the *waiting period* and is payable monthly in arrears.

If the Insured Person is *partially disabled* in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month. They will still need to meet the *waiting period*.

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *partial disability*;
- the time when the aggregate of the period for which a Partial Disability Benefit was payable to you and any period for which a Total Disability Benefit was payable to you is equal to the *benefit period*; and
- the date your Policy ends.

2.4 Medical Professionals

The terms of this section 2.4 apply if the Insured Person is a medical professional who performs exposure prone procedures as the main and important part of their *usual occupation*.

If the Insured Person is diagnosed with Human Immunodeficiency Virus or hepatitis B or hepatitis C and, as a consequence of the diagnosis, they:

- are restricted as a regulatory requirement from performing exposure prone procedures; or
- experience a reduction in income due to loss of patients,

while working more than 10 hours per week in their *usual occupation* or working in another occupation, we will regard them as:

- working and able to perform one or more of the *important income producing duties* of their *usual occupation* but unable to perform all of them; and
- having satisfied the occupational duties component of the *partial disability* definition due to *sickness*.

The other requirements of the *partial disability* definition set out in chapter 8 must be satisfied for the Insured Person to be deemed *partially disabled*.

The terms of this section 2.4 will not apply in the event that:

- any cure is found for AIDS or the effects of HIV, hepatitis B or hepatitis C (as applicable); or
- if the Insured Person had elected not to undertake medical treatment or vaccination that was available to the Insured Person and which results in the prevention of infection with HIV, or the occurrence of AIDS, hepatitis B, or hepatitis C, prior to the event giving rise to the claim.

2.5 Limitations

The amount of this benefit is reduced by any limitations on benefits (see chapter 3, sections 31 to 33).

3. Severe Disability Benefit

IP HOME IP GENERAL IPP HOME

3.1 When we will pay

If the Insured Person is *severely disabled* while covered under the Policy, we will pay you a monthly Severe Disability Benefit after the end of the *waiting period*.

There are two definitions of *severe disability*:

- *home duties IP* NS ; and
- *general cover IP*.

The definition of *severe disability* which applies to the Insured Person will be shown on the *policy schedule*.

3.2 What we will pay

Definition	Benefit Payable
Home duties IP NS	The monthly Severe Disability Benefit is the *insured monthly benefit*.
General cover IP (The benefit is only available under a Policy held inside an *SMSF* if the Insured Person is *gainfully employed* at the time you apply for cover.)	*Agreed value* The monthly Severe Disability Benefit is the *insured monthly benefit*. For an *agreed value* Policy held inside superannuation that is not linked to an Income Linking Plus Policy, the amount of the Severe Disability Benefit may be reduced at the time of claim so that it does not exceed the maximum permitted under superannuation law. For more information on the amount payable from Policies held inside superannuation, please see chapter 3, section 31.
	Indemnity The monthly Severe Disability Benefit is the lesser of: • the *insured monthly benefit*; and • 75% of *pre-disability monthly earnings*. If the *insured monthly benefit* with us at the time of application is greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $480,000, the insured monthly Severe Disability Benefit amount is the lesser of: • the *insured monthly benefit*; and • a percentage of the *pre-disability monthly earnings*, where the percentage is: – 75% of the first $320,000 of annualised *pre-disability monthly earnings*; – 50% of the next $240,000 of annualised *pre-disability monthly earnings*; and – 20% of the remainder of annualised *pre-disability monthly earnings*.

If the Insured Person becomes unemployed (if applicable) or they take leave without pay, parental or sabbatical leave, cover under the Policy will continue, provided you have paid and continue to pay premiums and any other amounts due.

3.3 How we will pay

The benefit accrues from the first day of *severe disability* after the *waiting period* and is payable monthly in arrears. The benefit will continue to accrue until the earliest of the:

- date the Insured Person is no longer *severely disabled*;
- end of your *benefit period*; and
- date your Policy ends.

3.4 Limitations

The amount of this benefit is reduced by any limitations on benefits (see chapter 3, section 31).

4. Elective Surgery Benefit

IP OWN IPS OWN IPP OWN BOH KPI

4.1 When we will pay

We will regard the Insured Person as being *totally disabled* or *partially disabled*, as applicable, if:

- the Insured Person undergoes surgery by a *doctor* while covered under the Policy to:
  - transplant part of their body to another person; or
  - improve their appearance or to prevent their disfigurement; and
- as a consequence of the surgery, the Insured Person would be *totally disabled* or *partially disabled*.

4.2 How we will pay

The *waiting period* will commence from the day on which the Insured Person undergoes surgery.

The benefit accrues from the first day of *total disability* or *partial disability* as a result of the elective surgery after the *waiting period* and is payable monthly in arrears.

The benefit will continue to accrue until the earliest of the following:

- the Insured Person is well enough to return to work and earn their regular income;
- the end of the *benefit period*; and
- your Policy ends.

4.3 Exclusions

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

- the *commencement date*;
- the date we increase the *insured monthly benefit* (other than a *CPI* increase); and
- the date this Policy was last reinstated.

The above exclusion does not apply to the Policy if it replaces another similar income protection policy offering a benefit comparable to the Elective Surgery Benefit, issued by another insurer or another policy issued by us, and all of the following apply:

- we were specifically told about the intended replacement of the other policy and we agreed

to issue this Policy on the basis that it replaced the other policy;

- the *insured monthly benefit* being issued by us is the same as, or less than, the existing cover being replaced[1];
- the other policy and equivalent sum insured were continuously in force for at least 6 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.

5. Rehabilitation Expense Benefit S+

IP OWN IPP OWN

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

- the Insured Person has suffered *total disability* for a continuous period at least as long as the *waiting period*; and
- you or the Insured Person incur the cost of rehabilitation equipment or other capital expenses during the course of rehabilitation or engaging (or attempting to engage) in an occupation, which the Insured Person's *doctor* has certified as being necessary.

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

Examples of eligible expenses include the cost of a wheelchair, artificial limbs, re-education expenses and home or workplace modifications.

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

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

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

5.4 We will not pay for any expense to the extent such payment is prohibited by law. Under current health insurance laws, we cannot pay for rehabilitation expenses which:

- are incurred as part of treatment by a medical practitioner and a Medicare benefit or a pharmaceutical benefit is payable for any part of the service provided;
- are incurred as part of treatment provided in, or associated with, a hospital;
- would amount to carrying on a health insurance business in contravention of the Private Health Insurance Act 2007 (Cth); or
- would be considered to be treatment that is intended to manage or prevent a disease, injury or condition.

6. Rehabilitation Program Benefit S+

IP OWN IPP OWN

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

- the Insured Person has suffered a *total disability* for a continuous period at least as long as the *waiting period*; and
- you or the Insured Person incur the cost of a rehabilitation program during the course of rehabilitation or engaging (or attempting to engage) in an occupation, which the Insured Person's *doctor* has certified as being necessary.

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

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

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

6.3 The Insured Person must take part in the rehabilitation program to rehabilitate themselves because of the *total disability* you are claiming and not for any other reason.

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

6.5 We will not pay for any expense to the extent such payment is prohibited by law. Under current health insurance laws, we cannot pay for rehabilitation programs which:

- are provided by a medical practitioner, and a Medicare benefit or a pharmaceutical benefit is payable for any part of the service provided;
- are provided in, or associated with, a hospital;
- would amount to carrying on a health insurance business in contravention of the Private Health Insurance Act 2007 (Cth); or
- would be considered to be treatment that is intended to manage or prevent a disease, injury or condition.

7. Return to Work Benefit S+

IP OWN IPP OWN

7.1 We will pay the Return to Work Benefit if we have paid the Rehabilitation Program Benefit or Rehabilitation Expense Benefit and the Insured Person becomes *gainfully employed*, on a full time basis.

We will pay the equivalent of:

- one times the *insured monthly benefit* if the Insured Person becomes *gainfully employed*, on a full time basis for a minimum of 30 hours per week or more for three consecutive months; and

1 Where the *insured monthly benefit* being issued under this Policy exceeds that of the other policy, the above exclusion will continue to apply to the *insured monthly benefit* that is in excess of the sum insured of the other policy.

- a further two times the *insured monthly benefit* if the Insured Person becomes *gainfully employed*, on a full time basis for 30 hours per week or more for six consecutive months.

7.2 The Return to Work Benefit is paid in arrears and starts to accrue from the time when the Insured Person has been *gainfully employed* for a minimum of three consecutive months.

7.3 We will stop paying the Return to Work Benefit on the earlier of:

- the end of the Policy;
- the Insured Person no longer being *gainfully employed*, on a full time basis for at least 30 hours per week; and
- three times the *insured monthly benefit* being paid for any one *sickness* or *injury* under the Return to Work Benefit.

8. Recurrent Disability Benefit

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME | BOH | KPI

If the Insured Person suffers from the same or related *sickness* or *injury* that has previously resulted in a successful claim, we may not require the Insured Person to meet the *waiting period* again.

8.1 ***Benefit periods* of 1, 2 or 5 years**

For *benefit periods* of 2 or 5 years (or 1 year for Business Overheads and Key Person Income), a new *waiting period* will not apply if, within 6 months after a Total Disability Benefit, Partial Disability Benefit or Severe Disability Benefit ceases to be payable, the Insured Person suffers *total disability*, *partial disability* or *severe disability* from the same or a related *sickness* or *injury*. The successive periods during which benefits were payable are added together to determine when the *benefit period* has expired.

For *benefit periods* of 1, 2 and 5 years, a new *waiting period* and a new *benefit period* will apply if:

- at least 6 months after a Total Disability Benefit, a Partial Disability Benefit or Severe Disability Benefit ceases to be payable, the Insured Person suffers *total disability*, *partial disability* or *severe disability* from the same or a related *sickness* or *injury*; and
- either:
  - the *benefit period* for the previous period of *total disability*, *partial disability* or *severe disability* had not ended; or
  - the Insured Person had returned to and performed the full duties of their *usual occupation* for their usual *monthly earnings* for at least 6 consecutive months after a Total Disability Benefit, Partial Disability Benefit or Severe Disability Benefit ceased to be payable.

Otherwise, no benefit is payable.

8.2 ***Benefit periods* to age 55, to age 65, to age 70 or to age 80**

For a *benefit period* to age 55, to age 65, to age 70, or to age 80, the *waiting period* will not apply if, within 12 months after a Total Disability Benefit, Partial Disability Benefit or a Severe Disability Benefit ceases to be payable, the Insured Person suffers *total disability*, *partial disability* or *severe disability* from the same or a related *sickness* or *injury*.

For *benefit periods* to age 55, to age 65, to age 70, or to age 80 a new *waiting period* will apply if at least 12 months after a Total Disability Benefit, a Partial Disability Benefit or a Severe Disability Benefit ceases to be payable, the Insured Person suffers *total disability*, *partial disability* or *severe disability* from the same or a related *sickness* or *injury*.

9. Death Benefit

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME | BOH | KPI

If the Insured Person dies while we are paying you a Total Disability Benefit, Partial Disability Benefit, Severe Disability Benefit, Crisis Benefit, Specified Injury Benefit or Nursing Care Benefit, a benefit equal to 6 times your monthly Total Disability Benefit or Severe Disability Benefit will be paid to either your estate (if you are both the Insured Person and the sole Policy Owner), or otherwise to the Policy Owner.

The Death Benefit will be reduced by any amount which has been paid in advance under a Crisis Benefit and/or Specified Injury Benefit and which relates to a period of time occurring after death of the Insured Person.

10. Change of Waiting Period Benefit

IP OWN | IPS OWN | IPP OWN

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

As shown in the table below, a *waiting period* in the first column can be reduced to the corresponding reduced *waiting period* in the second column.

Existing *waiting period* of:	Reduced to a *waiting period* of:
720 days	90, 180 or 360 days
360 days	90 or 180 days
180 days	90 days
90 days	30 days

Your premium will increase to reflect the shorter *waiting period*.

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

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

10.2 You can only shorten the *waiting period* without having to provide evidence of the Insured Person's health if:

- the Insured Person is not *totally disabled* or *partially disabled* at the time (either during the *waiting period* or while a benefit is payable), and is not eligible to claim any benefit under the Policy;
- the Insured Person was accepted for cover under this Policy without any loadings;
- you request the change in writing within 30 days of the Insured Person joining the new employer or the change in employment status occurring;
- the Insured Person provides us with written proof that the change of employment status has occurred;
- the Insured Person is not eligible, and will not become eligible, for income protection cover with the new employer through an insurance policy, superannuation or pension plan, and has no other income protection in force; and
- where a 720 day *waiting period* applies, you provide us with proof that the Insured Person was covered by an employer related income protection policy with a *benefit period* of 1 year or more while employed by the previous employer.

10.3 If the Insured Person suffers a *sickness* or *injury* prior to you exercising this benefit, any claim in relation to that *sickness* or *injury* will be assessed against the *waiting period* that applied at the time the Insured Person first suffered that *sickness* or *injury*.

11. Future Insurability Benefit

IP OWN IPS OWN IPP OWN

11.1 You can apply to increase the *insured monthly benefit* by up to 15% once in every 12 months if the Insured Person's *monthly earnings* have increased without needing to provide medical evidence.

The *income ratio* which applies to your *insured monthly benefit* after the increase must not be greater than the *income ratio* at the commencement of your Policy, or since the most recent increase in the monthly benefit that you have applied for under the Policy.

11.2 You may only apply for an increase in writing within 30 days of the *review date* and we will require financial evidence to support the increase in the *insured monthly benefit*.

Your premium will increase to reflect any increase in the *insured monthly benefit*. The increase in your *insured monthly benefit* does not apply until we have confirmed it in writing.

11.3 The *insured monthly benefit* after the increase must not be greater than an amount which is equal to the sum of:

- 75% of $320,000 of annualised *monthly earnings*;
- 50% of the next $240,000 of annualised *monthly earnings*; and
- 20% of the remainder of annualised *monthly earnings*.

If the Superannuation Contribution Option is selected, the *insured monthly benefit* after the increase must not be greater than an amount which is equal to the sum of:

- 80% of the first $320,000 of annualised *monthly earnings*;
- 55% of the next $190,000 of annualised *monthly earnings*; and
- 20% of the remainder of annualised *monthly earnings*.

The total increase over the life of the Policy cannot exceed the *insured monthly benefit* at the commencement of this Policy (including any increases in the *insured monthly benefit* which we have underwritten and accepted).

The maximum benefit limits for Income Protection, Income Protection as Superannuation and Income Protection Plus Policy applies to the total amount of the *insured monthly benefit* after the increase under Future Insurability Benefit.

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

- after the *review date* on or immediately following the Insured Person's 55th birthday;
- if you have had an increase under this benefit within the previous 12 months;
- if any person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any insurance cover issued by us; or
- if we accepted the Insured Person with a loading.

Any exclusions which apply to the Insured Person's Income Protection, Income Protection as Superannuation and Income Protection Plus Policy will also apply to an increase in the *insured monthly benefit*.

12. IP Continuation Option

IP OWN IPS OWN IPP OWN

We may allow an Income Protection, Income Protection as Superannuation or Income Protection Plus Policy to continue under an *own occupation IP* definition past the expiry of the Policy, up until the *review date* on or following the Insured Person's 75th birthday, on a limited basis if the Insured Person is still working on a full-time basis, and their occupation class is AA, A, P or S as shown in the *policy schedule* or *membership certificate*. Please contact us or your financial adviser if you want to know which occupation class will apply for the Insured Person before applying for this Policy.

1 Specified Injury Benefit is not available for a Policy held inside superannuation unless Income Linking Plus has been selected.

The offer to continue the Policy may be issued at the expiry of the Policy (ie the *review date* on or following the Insured Person's 55th, 65th or 70th birthday, as applicable).

12.1 This option will only apply if:

- we have made the offer of continuation in respect of the Insured Person;
- the Insured Person provides a declaration within 30 days of each *review date* that they:
  - are actively working on a full time basis;
  - are not planning to cease work in the next 12 months; and
  - have not made a claim, are not eligible to make a claim, and are not on claim for any benefit under any insurance cover issued by us;
- we have accepted an application for this option for the Insured Person; and
- premiums continue to be paid for this Policy.

12.2 From the *review date* on or following the Insured Person's 55th, 65th or 70th birthday (as applicable) the Policy will only pay the following benefits if this option applies:

- Total Disability Benefit; and
- Specified Injury Benefit.[1]

12.3 The following conditions apply to cover provided under the IP Continuation Option:

- The *waiting period* for the IP Continuation Option is restricted to 90 days, the *benefit period* is 2 years, and the maximum *insured monthly benefit* is $20,000;
- The contract will be issued on an *indemnity* basis, and *pre-disability monthly earnings* will be taken as the Insured Person's *monthly earnings* in the 12 month period immediately preceding the commencement of *total disability*;
- The Insured Person will be required to sign a declaration in accordance with section 12.1 within 30 days of every *review date* on or following the Insured Person's 55th, 65th or 70th birthday (as applicable), and must make their declaration every year;
- The *benefit period* may extend beyond the *review date* (other than the *review date* following the Insured Person's 75th birthday) if the Insured Person is on claim, however the Policy will end following the completion of the *benefit period*;
- The IP Continuation Option is not guaranteed to be offered or re-offered, and may be withdrawn at any time; and
- The Policy will continue until the earliest of:
  - the *review date* that the Insured Person fails to meet the conditions of the annual declaration in accordance with section 12.1; or
  - the *review date* on or following the Insured Person's 75th birthday.

13. Extended Cover Benefit

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME

If you are not receiving a benefit, or not entitled to make a claim at the expiry of your Income Protection or Income Protection Plus Policy, you can apply to continue your cover under a *general cover IP* definition without medical *underwriting*.

We must receive your application to extend your cover 30 days prior to the *review date* on, or following, the Insured Person's 55th, 65th or 70th birthday (as applicable).

For Policies held within an *SMSF*, the Insured Person must be *gainfully employed* at the time of applying for this benefit.

13.1 From the *review date* on or following the Insured Person's 55th, 65th or 70th birthday (as applicable), the Policy will only pay the following benefits:

- Severe Disability Benefit (*general cover IP* definition); or
- the Death Benefit.

13.2 The following conditions apply to cover provided under the Extended Cover Benefit:

- *CPI* increases will not apply;
- the *benefit period* is limited to 2 years;
- the amount payable will be the lesser of the *insured monthly benefit* showing in the *policy schedule* and $5,000; and
- the Policy will end on the earlier of the:
  - death of the Insured Person;
  - *review date* on or following the Insured Person's 80th birthday; and
  - time when the aggregate of the *benefit period* for which a Severe Disability Benefit was payable to you is equal to the *benefit period*.

The *waiting period* options available at application for extended cover are outlined in the table below:

IP or IPP *waiting period* at Policy end date	Available *waiting period*
14 days	90, 360 or 720 days
30 days	90, 360 or 720 days
90 days	90, 360 or 720 days
180 days	90, 360 or 720 days
360 days	360 or 720 days
720 days	720 days

14. Loyalty Benefit

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME | BOH | KPI

14.1 The Loyalty Benefit will apply when the Policy has been in force for three years from the *commencement date*. The Loyalty Benefit amount will be listed on the most recent *renewal summary*.

14.2 We will pay an extra $50,000 should the Insured Person die while the Policy is in force.

14.3 The Loyalty Benefit is only paid once per Insured Person across any Income Protection, Income Protection as Superannuation, Income Protection Plus, Business Overheads or Key Person Income Policy.

15. Premium Holiday

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME | BOH | KPI

15.1 If your Policy has been in force and premiums paid for at least 6 months, we will allow you to suspend your Policy once in any 12 month period for a maximum of 12 months in total over the duration of the Policy. You can stop the Premium Holiday at any time within the relevant period.

15.2 **Income Protection, Income Protection as Superannuation, Income Protection Plus and Business Overheads**

For Policies held outside superannuation, this benefit only applies if the Policy Owner is also an Insured Person.

Application for this benefit is subject to you submitting an application for Premium Holiday along with evidence confirming that during the relevant period the Insured Person is experiencing financial hardship due to:

- being unemployed;
- being on sabbatical, maternity, paternity or long term leave from work; or
- the Insured Person's household income for the last three months reducing by 30% or more (as compared to the household income over the preceding three month period).

15.3 **Key Person Income**

Application for this benefit is subject to you submitting an application for a Premium Holiday along with evidence confirming that the Insured Person is absent from the *key person business* and is on sabbatical, maternity, paternity or long term leave, during the relevant period.

15.4 The following conditions apply to the Premium Holiday under sections 15.1 to 15.3 above:

- During the period your Policy is on Premium Holiday, you will not have to pay premiums. However, you will not be eligible to claim for any *sickness*, *injury*, death or any other event that happens during this period. A *sickness* or *injury* is taken to have happened when:
  - a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the *sickness* or *injury*; or
  - the Insured Person first had any *symptom* of the *sickness* or *injury* for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor*.
- Acceptance of your application for a Premium Holiday will mean that your entire Policy and any linked Income Linking Plus Policy will be suspended.

16. Counselling Benefit S+

IPP OWN

16.1 If we pay a Total Disability Benefit, we will pay you the Counselling Benefit. The Counselling Benefit provides the cost of up to 10 counselling sessions for you, the Insured Person or an *immediate family member*.

16.2 We will reimburse the cost of the counselling sessions, up to a maximum of $5,000.

The Counselling Benefit will only be paid once per Insured Person across all Policies issued by us in respect of that Insured Person.

16.3 The following conditions must be met for the Counselling Benefit to be paid:

- the counselling session must be provided by an accredited counsellor approved by us;
- we will only reimburse amounts incurred by you;
- the Counselling Benefit must be claimed within 12 months of receiving the benefit; and
- you must be able to provide a copy of the invoice showing a breakdown of the services provided and the amount paid, and/or a receipt showing the amount paid.

16.4 We will not pay for any expense to the extent that such payment is prohibited by health insurance law. Under current health insurance laws, we cannot pay for counselling sessions which are:

- provided by a medical practitioner and a Medicare benefit or pharmaceutical benefit is payable for any part of the service provided;
- provided in, or associated with, a hospital;
- would amount to carrying on a health insurance business in contravention of the Private Health Insurance Act 2007 (Cth); or
- which would be considered to be treatment that is intended to manage or prevent a disease, injury or condition.

17. Nursing Care Benefit S+

IPP OWN

17.1 If the Insured Person is *confined to bed* for more than 3 consecutive days during the *waiting period*, we will pay you a Nursing Care Benefit equal to 1/30th of the monthly Total Disability Benefit for each consecutive day of confinement.

17.2 We will stop paying the Nursing Care Benefit on the earliest of the following events:

- when the Insured Person is no longer *confined to bed*;
- at the end of the *waiting period*;
- after 90 days; and
- when your Policy ends.

17.3 **If confinement to bed recurs**

If, following a period when the Insured Person was *confined to bed*, and within 6 months (for *benefit periods* of 2 and 5 years), or within 12 months (for *benefit periods* to age 55, to age 65 and to age 70), the Insured Person again becomes *confined to bed* from the same or a related *sickness* or *injury*, the Nursing Care Benefit becomes immediately payable. The successive periods of being *confined to bed* are added together to

determine the duration of any Nursing Care Benefit that we will pay you.

18. Specified Injury Benefit S+

IPP OWN

18.1 If the Insured Person suffers any of the *injuries* set out in section 18.5 while covered under this Policy, we will pay you a benefit equal to the monthly Total Disability Benefit for the *payment period* from the date the specified injury occurred, even if the Insured Person is able to return to work during that period. We may choose to pay some or all of this benefit as a lump sum.

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

18.2 We will not pay a Specified Injury Benefit if your *waiting period* is 360 days or 720 days.

18.3 We stop paying you a Specified Injury Benefit on the earliest of the following events:

- we have paid you a Specified Injury Benefit for the *payment period*;
- your *benefit period* ends; and
- your Policy ends.

18.4 If, at the end of the *payment period*, the Insured Person is suffering *total disability* or *partial disability* as a result of the specified injury, and the payment period was:

- equal to or longer than the *waiting period*, you will be entitled to receive a Total Disability Benefit or Partial Disability Benefit (if eligible);
- less than the *waiting period*, the *waiting period* will be reduced by the *payment period*. You will be entitled to receive a Total Disability Benefit or Partial Disability Benefit (if eligible) once the balance of the remaining *waiting period* has been served after the end of the *payment period*.

The period of payment of the Specified Injury Benefit is included in determining whether the *benefit period* for Total Disability Benefit or Partial Disability Benefit has expired.

18.5 **Specified Injuries**

The specified injuries listed in the following tables are covered under the Specified Injury Benefit.

For these *injuries*	*Payment period* (months)
Total and permanent loss of use of:	
Both feet or both hands or sight of both eyes	24
Any combination of a hand, a foot, sight in one eye	24
One leg above the knee joint or one arm above the elbow	18
One hand or foot or sight in one eye	12
Thumb and index finger of same hand	6

For these *injuries*	*Payment period* (months)
***Fracture*[1] of:**	
Spine resulting in paraplegia or quadriplegia	60
A thigh	3
The pelvis	3
The skull (except bones of face or nose)	2
An upper arm	2
A shoulder bone	2
The jaw	2
A leg (below the knee and above the ankle)	2
A kneecap	2
An ankle	2
A wrist	1
A forearm (above wrist)	1
A collarbone	1

1 *Fracture* must require a pin, traction, a plaster cast or other immobilising structure for these *injuries*, except in the case of pelvis or skull where this treatment is not practical.

19. Crisis Benefit S+

IPP OWN IPP HOME

19.1 If the Insured Person suffers for the first time any of the 'crisis events' listed below while covered under this Policy, we will pay you a benefit equal to the monthly Total Disability Benefit or Severe Disability Benefit for 6 months from the date the crisis event occurred. We may choose to pay some or all of this benefit as a lump sum.

The 'crisis events' are:

- Alzheimer's disease and other dementias – permanent and irreversible and of specified severity
- Angioplasty – triple vessel
- Aortic surgery – excluding less invasive surgeries
- Aplastic anaemia – of specified severity
- Brain or spinal cord tumour (benign) – resulting in significant permanent impairment or requiring radical treatment
- Burns (severe) – covering specified surface area
- Cancer – excluding specified early stage cancers
- Cardiac arrest – occurs out of hospital and of specified severity
- Cardiomyopathy – resulting in significant permanent impairment
- Coma – with specified criteria
- Coronary artery bypass surgery – excluding less invasive procedures
- Deafness (both ears) – permanent and irreparable
- Diabetes (severe) – of specified severity
- Encephalitis – resulting in significant impairment
- Heart attack – of specified severity
- Heart valve replacement or repair
- Idiopathic pulmonary arterial hypertension – resulting in significant permanent impairment

- Intensive care – requiring continuous mechanical ventilation for 10 days
- Head trauma (major) – resulting in significant permanent impairment
- HIV – medically acquired
- HIV – occupationally acquired
- Kidney failure – requiring permanent dialysis or transplantation
- Liver failure (severe) – of specified severity
- Loss of independent existence – with a specified level of impairment
- Loss of limbs – complete and irrecoverable
- Loss of sight (both eyes) – of specified severity
- Loss of speech – complete and irrecoverable
- Lung disease – requiring permanent oxygen therapy
- Meningitis (bacterial)– resulting in permanent impairment
- Meningococcal septicaemia – resulting in permanent impairment
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Open heart surgery
- Organ transplant (major) – from another donor
- Paralysis
- Parkinson's disease – resulting in permanent symptoms
- Pneumonectomy – removal of a complete lung
- Rheumatoid arthritis (severe) – of specified severity
- Stroke – of specified severity.

19.2 We will stop paying you a Crisis Benefit on the earliest of the following events:

- we have paid you a Crisis Benefit for 6 months; and
- your Policy ends.

If, at the end of the 6 month period, the Insured Person is suffering *total disability*, *partial disability* or *severe disability* as a result of the crisis event you will be eligible to receive a Total Disability Benefit, Partial Disability Benefit or Severe Disability Benefit (as appropriate).

The period of payment of the Crisis Benefit is included in determining whether the *benefit period* for Total Disability Benefit, Partial Disability Benefit or Severe Disability Benefit has expired.

19.3 **Exclusions**

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

- *commencement date*;
- date we increase the *insured monthly benefit* (other than a *CPI* increase) but only in respect of the increase; and
- date this Policy was last reinstated.

The above exclusion does not apply to the Policy if it replaces another similar income protection policy offering a benefit comparable to the Crisis Benefit, issued by another insurer, or another policy issued by us, and all of the following apply:

- we were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy;
- the *insured monthly benefit* being issued by us is the same as, or less than, the existing cover being replaced[1];
- the other policy and equivalent sum insured were continuously in force for at least 90 days 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.

We will not pay a Crisis Benefit if your *waiting period* is 360 days or 720 days.

19.4 **Crisis events**

Crisis events means the Insured Person has for the first time one of the listed 'crisis events' in 19.1 above. Each of the listed events are defined in the 'Medical glossary' in chapter 7. You must satisfy the full definition of the appropriate condition before we will pay this benefit and a *doctor* approved by us provides the medical evidence to support the claim.

20. Transport within Australia Benefit S+ IPP OWN

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

- becomes *totally disabled* in Australia; and
- is *confined to bed* more than 100 kilometres from their usual place of residence or it is considered medically necessary for the Insured Person to travel to a place more than 100 kilometres from their usual place of residence for reasons directly associated with the *sickness* or *injury* causing *total disability*.

20.2 We will pay a benefit equal to the lesser of:

- reimbursement of the actual, reasonable costs incurred by the Insured Person; and
- 2 times the monthly Total Disability Benefit.

20.3 **Exclusions**

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

We will pay this benefit once for any particular *sickness* or *injury*.

1 Where the *insured monthly benefit* being issued under this Policy exceeds that of the other policy, the exclusion will continue to apply to the *insured monthly benefit* that is in excess of the sum insured of the other policy.

21. Transport from Overseas Benefit S+

IPP

OWN

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

- becomes *totally disabled* while out of Australia;
- is *totally disabled* for more than 30 days; and
- chooses to return to Australia while *totally disabled*.

21.2 We will pay a benefit equal to the lesser of:

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

21.3 **Exclusions**

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

We will pay this benefit once for any particular *sickness* or *injury*.

22. Accommodation Benefit S+

IPP

OWN

22.1 We will pay you an Accommodation Benefit if:

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

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

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

23. Family Care Benefit S+

IPP

OWN

23.1 We will pay you a monthly Family Care Benefit if:

- a Total Disability Benefit is payable in respect of the Insured Person;
- as a result of the *total disability*, the Insured Person requires full time care from an *immediate family member*; and
- as a result, the *immediate family member* has had to cease *gainful employment*.

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

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

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

23.3 The benefit accrues from the first day of *total disability* after the *waiting period* and is payable monthly in arrears.

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *total disability*;
- we have paid you a Family Care Benefit for 6 months;
- your Policy ends;
- the Insured Person ceases to require full time care from the *immediate family member*; and
- the *immediate family member* recommences *gainful employment*.

24. Home Care Benefit S+

IPP

OWN

24.1 We will pay you a monthly Home Care Benefit if:

- a Total Disability Benefit is payable in respect of the Insured Person;
- as a result of the *total disability*, the Insured Person is *confined to bed* at home; and
- in the opinion of a *doctor*, the Insured Person requires the care of a paid professional home carer.

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

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

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

24.3 The benefit accrues from the first day of *total disability* after the *waiting period* and is payable monthly in arrears.

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *total disability*;
- we have paid you a Home Care Benefit for 6 months;
- your Policy ends; and
- the Insured Person ceases to require the care of a paid professional home carer.

24.4 **Exclusions**

We will not pay you the Home Care Benefit if the paid professional home carer is you, an *immediate family member*, or business partner of you or the Insured Person.

25. Respite Care Benefit S+

IPP OWN

25.1 We will pay you a Respite Care Benefit if:

- the Insured Person has been paid a Total Disability Benefit for a continuous period of at least 24 months;
- the Insured Person is living in their own home, and requiring an *immediate family member* as a full time carer; and
- the Insured Person has a permanent and irreversible inability to perform, without assistance, any two of the activities of daily living (as defined in the 'Medical glossary' in chapter 7).

25.2 We will pay the cost of respite care for a maximum of 2 weeks each year of claim after the first 24 months, if the respite care is provided outside the home in a registered respite care facility. The costs must be approved by us before the expenditure occurs.

The lump sum benefit is equal to reimbursement of the actual costs incurred, up to the lesser of:

- 2 times the monthly Total Disability Benefit; and
- $5,000 per year.

25.3 **Exclusions**

The benefit will not become payable for expenses that are reimbursable from any other source.

26. Child Care Benefit S+

IPP OWN

26.1 If the Insured Person is *totally disabled*, and requires additional childcare assistance solely as a result of their *total disability*, we will reimburse you the additional child care fees which cannot be recovered from another source.

26.2 This benefit is payable for a maximum of 6 months over the life of the Policy.

The amount we will reimburse per month is the lesser of:

- 5% of the Total Disability Benefit;
- $500 per month; and
- the actual additional child care cost incurred, less amounts reimbursed from other sources.

26.3 The following conditions apply to the Child Care Benefit:

- Each child must be under the age of 14 at the time when child care costs are incurred, unless the child has special needs which require additional assistance.
- The additional child care must be provided by a licensed external child care provider.
- The additional child care arrangement must be approved by us before the costs are incurred, and evidence satisfactory to us of the additional child care costs incurred must be provided to us each month.

27. Waiver of IP Premium S+

IPP OWN

If the Insured Person receives a Total Disability Benefit, the premiums paid on the Policy during the *waiting period* will be reimbursed to you.

You must recommence payment of premiums at the earliest of:

- the date the Insured Person stops being *totally disabled*;
- the end of the *benefit period*; and
- the *review date* on or following the Insured Person's:
  - 65th birthday for 2 year, 5 year or to age 65 *benefit period*; or
  - 70th birthday for to age 70 *benefit period*.

This benefit is not available if the *waiting period* is 180, 360 or 720 days.

28. Accident Benefit

IP OPTIONAL WITH OWN | IPS OPTIONAL WITH OWN | IPP OPTIONAL WITH OWN

28.1 This benefit will only apply if it appears on the *policy schedule* or *membership certificate* for the Insured Person, and is only available with a 14, 30 or 90 day *waiting period*.

28.2 We will pay you an Accident Benefit if, as a result of an *accidental injury*, the Insured Person is *totally disabled* for:

- more than 3 consecutive days during the *waiting period* for Policies with a 14 day or 30 day *waiting period*; or
- more than 30 consecutive days during the *waiting period* for Policies with a 90 day *waiting period*.

This benefit will be paid for the shorter of the *waiting period* and the period of *total disability*.

28.3 We will pay an amount that is 1/30th of the Insured Person's monthly Total Disability Benefit for each day that the Insured Person is *totally disabled* during the *waiting period*.

28.4 The benefit accrues from the date the Insured Person first seeks medical advice for the *injury* and has been certified as being *totally disabled*. The benefit is payable monthly in arrears. The benefit will continue to accrue until the earliest of:

- the end of the *waiting period*;
- the end of the Insured Person's *total disability*; and
- *review date* on or following the Insured Person's 65th birthday.

28.5 **Exclusions**

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

29. Superannuation Contribution Option

IP OPTIONAL WITH OWN | IPS OPTIONAL WITH OWN | IPP OPTIONAL WITH OWN

29.1 To help with superannuation contributions, this option allows you to have a monthly insured amount that is higher than is usually available under an Income Protection, Income Protection as Superannuation or Income Protection Plus Policy.

If the Total Disability Benefit is payable, the additional amount of your *insured monthly benefit* due to the Superannuation Contribution Option can be paid into a nominated superannuation fund.

29.2 Generally the *insured monthly benefit* can be up to 75% of the Insured Person's *monthly earnings*, however with this option you can insure up to 80% of the Insured Person's *monthly earnings*.

The *insured monthly benefit* as a percentage of *monthly earnings* is calculated at the time of application and is referred to as the *income ratio*. The *income ratio* will be shown on your *policy schedule* or *membership certificate*.

Example: Superannuation Contribution Option (for illustrative purposes only)

An Insured Person who has annual income of $100,000, and has superannuation contributions equating to $9,500. Their total annual *earnings* are therefore $109,500. The *insured monthly benefit* can be calculated as follows:

	Insured monthly benefit calculation	Additional superannuation amount	Maximum *insured monthly benefit*
Without Superannuation Contribution Option	75% × 109,500 = 82,125/12 = **$6,843.75**	0	= **$6,850***
With Superannuation Contribution Option	75% × 109,500 = 82,125/12 = **$6,843.75**	5% × 109,500 = 5,475/12 = **$456.25**	= **$7,300***
		Income ratio	= 7,300* x 12/109,500 = **80%**

* The *insured monthly benefit* is rounded up to the nearest ten dollars at the time of application.

29.3 The Superannuation Contribution Option is subject to the following conditions:

- the Total Disability Benefit, inclusive of any superannuation contribution amount, is payable to you; and
- by applying for this option, the Insured Person agrees to pay the additional benefit amount into their superannuation fund.

30. Super Plus IP Benefit S+

IPP WITH INCOME LINKING PLUS

30.1 Income Linking Plus allows the Insured Person to access benefits offered under an Income Protection Plus Policy over two separate Policies, inside and outside superannuation.

The Super Plus IP Benefit is any benefit offered under Income Protection Plus which is not consistent with a superannuation condition of release, and is held under an Income Linking Plus Policy outside superannuation. This may include any portion of the Total Disability Benefit or Partial Disability Benefit payable under the Policy, which is not consistent with a superannuation condition of release. This is explained in section 31.2(c) 'For all Policies held inside superannuation' in this chapter.

The Super Plus IP Benefit is paid to the Policy Owner of the Income Linking Plus Policy.

For more information on how Income Linking Plus can be used to structure your income protection, please see the 'Linked Policies inside and outside superannuation' section under 'Policy Structures' on page 12.

30.2 **Variation of benefits**

Any variation to the Super Plus IP Benefit will apply to both the linked Income Protection Policy, and the Super Plus IP Benefit under the Income Linking Plus Policy.

If the Income Linking Plus Policy ends, the linked Income Protection Policy will also end.

All other terms and conditions pertaining to the payment of Income Protection Plus benefits apply to the Super Plus IP Benefit.

31. Income Protection, Income Protection as Superannuation and Income Protection Plus Limitations

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME

This section applies to all benefits held under an Income Protection, Income Protection as Superannuation and Income Protection Plus Policy.

31.1 **For all benefits under an Income Protection, Income Protection as Superannuation and Income Protection Plus Policy:**

- no benefit will be payable for a particular *sickness* or *injury* after the *benefit period* has expired;
- all benefits cease to be payable when the Policy ends; and
- if *total disability*, *partial disability* or *severe disability* is caused by more than one *sickness* or *injury*, we will only pay benefits in respect of one *sickness* or *injury* at any one time.

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

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

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

For an Income Protection Policy held inside superannuation and an Income Protection as Superannuation Policy, benefits are only payable if they are consistent with a superannuation condition of release under superannuation law. If Income Linking Plus is selected, any benefit (or portion of a benefit) which does not meet a superannuation condition of release will be paid to the Policy Owner of the Income Linking Plus Policy through the Super Plus IP Benefit. For more information on the superannuation conditions of release, please see chapter 6, section 9.

31.2 **Total Disability Benefit and Partial Disability Benefit Offsets**

The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by the sources referred to below. These offsets are applied differently depending on the occupational category the Insured Person is in and where Policies are held inside superannuation. This will be shown on your *policy schedule* or *membership certificate*.

The amount of the Total Disability Benefit or Partial Disability Benefit may also be reduced or recovered in respect of the Insured Person for any offsets or limitations to your benefits which we have included in your *policy schedule* or *membership certificate*.

a. For all *endorsed agreed value* and *agreed value* Policies:

Occupation class	Offsets
AA, A, P and S	The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by regular payments from an insurance policy in an existing superannuation fund or from another existing insurance policy (including regular payments which are converted to a lump sum), made in respect of *sickness* or *injury*, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy.
BB, B and C	The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by the following sources; • workers or motor accident compensation or payments under common law relating to *sickness* or *injury*; or • regular payments from an insurance policy in an existing superannuation fund or another existing insurance policy (including regular payments which are converted to a lump sum), made in respect of *sickness* or *injury*, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy.

b. For all *indemnity* Policies:

Occupation class	Offsets
AA, P and S	The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by regular payments from an insurance policy in an existing superannuation fund or from another existing insurance policy (including regular payments which are converted to a lump sum), made in respect of *sickness* or *injury*, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy.
A	The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by the following sources: • workers or motor accident compensation or payments under common law relating to *sickness* or *injury*; or • regular payments from an insurance policy in an existing superannuation fund or another existing insurance policy (including regular payments which are converted to a lump sum), made in respect of *sickness* or *injury*, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy.
BB, B, C and E	The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by the following sources: • workers or motor accident compensation or payments under common law relating to *sickness* or *injury*; or • regular payments from an insurance policy in an existing superannuation fund or another existing insurance policy (including regular payments which are converted to a lump sum), made in respect of *sickness* or *injury*, but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy; or • the Insured Person's employer, partnership or business.

The reduction in benefit will be such that the reduced benefit that we pay, when combined with the income from the above sources (including the reduced *monthly earnings* for *partial disability*), does not exceed the following:

- 75%[1] of *pre-disability monthly earnings*; or
- 100% for *partial disability*.

If the *insured monthly benefit* with us at the time of application was greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $480,000, the amount should not exceed a percentage of the *pre-disability monthly earnings*, where the percentage is:

- 75%[1] of the first $320,000 of annualised *pre-disability monthly earnings*;
- 50%[1] of the next $240,000 of annualised *pre-disability monthly earnings*; and
- 20% of the remainder of annualised *pre-disability monthly earnings*.

If the *insured monthly benefit* with us at the time of application was greater than $30,000, the amount should not exceed a percentage of the *pre-disability monthly earnings*, where the percentage is:

- 80% of the first $320,000 of annualised *pre-disability monthly earnings*;
- 55% of the next $190,000 of annualised *pre-disability monthly earnings*; and
- 20% of the remainder of annualised *pre-disability monthly earnings*.

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

c. For all Policies held inside superannuation

The benefit we will pay, when combined with the income from other sources, must not exceed the Insured Person's highest average *monthly earnings* in any consecutive 12 month period in the 36 months immediately preceding the commencement of *total disability* or *partial disability*, increased by *CPI* each *review date* since that date.

For this purpose, income from other sources includes, but is not limited to, the following:

- workers or motor accident compensation or payments under common law relating to the *sickness* or *injury*;
- payments from the Insured Person's employer, partnership or business while being paid an insured benefit; and
- sick leave payments made to the Insured Person while being paid an insured benefit.

If Income Linking Plus is selected, the portion of the benefit which does not meet the condition above will be paid to the Policy Owner of the Income Linking Plus Policy through the Super Plus IP Benefit.

d. What we do not offset

We will not offset the following amounts:

- payments made as compensation for pain and suffering or the loss of use of part of the body;
- Total and Permanent Disablement, Living/Trauma or Terminal Illness payments;

1 Where the Superannuation Contribution Option is selected, the amount will not exceed the greater of the *income ratio* and 75%.

- payments made in respect of the *sickness* or *injury* from business expense insurance policies; or
- an entitlement to paid sick leave[1].

31.3 **Severe Disability Offsets**

The amount of the monthly Severe Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by the following sources:

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

The reduced benefit that we pay, when combined with the income from the above sources, must not exceed 75% of *pre-disability monthly earnings*.

If the *insured monthly benefit* with us at the time of application was greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $480,000, the amount should not exceed a percentage of the *pre-disability monthly earnings*, where the percentage is:

- 75% of the first $320,000 of annualised *pre-disability monthly earnings*;
- 50% of the next $240,000 of annualised *pre-disability monthly earnings*; and
- 20% of the remainder of annualised *pre-disability monthly earnings*.

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

The amount of the Severe Disability Benefit may be reduced or recovered in respect of the Insured Person for any offsets or limitations to your benefits which we have included in your *policy schedule*.

31.4 **For Policies held inside superannuation**

The Severe Disability Benefit that we will pay, when combined with the income from other sources, must not exceed the Insured Person's highest average *monthly earnings* in any consecutive 12 month period in the 36 months immediately preceding the commencement of *severe disability*.

31.5 **Lump sums and non-monthly payments**

Any of the amounts referred to in this section which are paid as a lump sum will be converted to an equivalent monthly amount by dividing the lump sum by 60. Any regular amounts that are paid other than monthly will be converted to equivalent monthly amounts.

32. Business Overheads Limitations

BOH

32.1 **General**

No benefit will be payable for a particular *sickness* or *injury* after the *benefit period* has expired. However, we may be able to continue paying the Total Disability Benefit under certain circumstances past the *benefit period* expiry. These circumstances are outlined in section 1.3, chapter 3.

All benefits cease to be payable when the Policy ends.

If *total disability* or *partial disability* is caused by more than one *sickness* or *injury*, we will only pay benefits in respect of one *sickness* or *injury* at any one time.

32.2 **Total Disability Benefit and Partial Disability Benefit Offsets**

The amount of the Total Disability Benefit or Partial Disability Benefit will be reduced by any amounts paid or payable to you or the Insured Person under other business expenses insurance policies.

The amount of the Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person for any offsets or limitations to your benefits which we have included in your *policy schedule*.

33. Key Person Income Limitations

KPI

33.1 **General**

No benefit will be payable if the Insured Person:

- has not been generating income for the *key person business*; and/or
- has been on unpaid leave (including maternity and paternity leave if it is unpaid),

for more than 3 months immediately preceding the commencement of the *waiting period*.

No benefit will be payable for a particular *sickness* or *injury* after the *benefit period* has expired. However, we may be able to continue paying the Total Disability Benefit under certain circumstances past the *benefit period* expiry. These circumstances are outlined in section 1.3, chapter 3.

All benefits cease to be payable when the Policy ends.

1 For Policies held inside superannuation, sick leave payments made to the Insured Person are included in the total amount we will pay when combined with income from other sources in 31.2(c) above.

If *total disability* or *partial disability* is caused by more than one *sickness* or *injury*, we will only pay benefits in respect of one *sickness* or *injury* at any one time.

33.2 **Total Disability Benefit and Partial Disability Benefit Offsets**

The amount of the Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person if any amounts are paid by the sources referred to below. These offsets are applied differently depending on whether the Insured Person is a *key person business owner* or *key person employee* on the Policy.

Insured Person	Offsets
Key person business owner	The amount of the Total Disability Benefit or Partial Disability Benefit will be reduced or recovered if any amounts are paid by regular payments to the Policy Owner or Insured Person, in respect to the Insured Person, from another existing insurance policy for *sickness* or *injury* (including regular payments which are converted to a lump sum), but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy.
Key person employee	The amount of the Total Disability Benefit or Partial Disability Benefit will be reduced or recovered if any amounts are paid by regular payments to the Policy Owner, in respect to the Insured Person, from another existing insurance policy for *sickness* or *injury* (including regular payments which are converted to a lump sum), but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy.

The amount of the Total Disability Benefit or Partial Disability Benefit may be reduced or recovered in respect of the Insured Person for any offsets or limitations to your benefits which we have included in your *policy schedule*.

34. Exclusions

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME | BOH | KPI

In addition to any other exclusions to the benefits described, we addition to any other exclusions to the benefits described, we will not pay you a benefit:

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

35. When does my Policy end?

IP OWN | IP HOME | IP GENERAL | IPS OWN | IPP OWN | IPP HOME | BOH | KPI

Your Policy continues until the earliest of:

- the date we cancel your Policy because you have not paid your premiums or any other amounts which relate to your Policy;
- the date the Insured Person dies;
- the date we receive your written notice to end your Policy;
- the date we cancel or avoid the Policy as a result of an innocent or fraudulent nondisclosure and/or misrepresentation made by you or the Insured Person prior to our acceptance of risk or during the making of a claim;
- the *review date* on or following the Insured Person's birthday dependent on the *benefit period* shown in the table below:

Benefit period	Expiry age
To age 55	55
1 year	65
2 years, 5 years, to age 65	65
To age 70	70
To age 80	80

- for Key Person Income:
  - the date the Insured Person who is a *key person employee* permanently leaves the employment of the *key person business*;
  - the date the Insured Person who is a *key person business owner* ceases to retain a share in the ownership of the *key person business*;
  - the date the *key person business* ceases to operate in the same industry which was disclosed to us prior to our acceptance of risk. This does not apply if we were notified of the change in the operation of the *key person business* in writing and we have provided written confirmation of our continued acceptance of risk; and
  - the date an insolvency event happens to the *key person business*;
- for the IP Continuation Option:
  - the *review date* that the Insured Person fails to meet the conditions of the annual declaration; or
  - the *review date* on or following the Insured Person's 75th birthday; and
- for the Extended Cover Benefit:
  - the *review date* on or following the Insured Person's 80th birthday.

No benefit will be payable once a Policy has ended.

When your Policy ends, any Income Linking Plus Policy which is linked to it will also end.

Chapter 4: Interim Accident and Sickness Cover

From the moment we receive your completed application form and personal statement you are covered by Interim Accident and Sickness Cover, and you don't even need to pay any extra premium for this cover.

1. Definitions

The words in **bold** within chapter 4 have specific meanings for this chapter only. Please see below for the definitions of these words.

For the purposes of Interim Accident and Sickness Cover:

- **Sickness** means a sickness or disease which first becomes apparent after the earliest of the following:
  - the completed Interim Accident and Sickness Cover Certificate has been received by us;
  - the completed application form and personal statement has been received by us; or
  - the completed electronic application (including personal statement) has been submitted to us.

  For the avoidance of doubt, a sickness or disease is taken to have first become apparent when:
  - a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the sickness or disease; or
  - the Insured Person first had any *symptom* of the sickness or disease for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor*.
- **Pre-existing condition** means any **injury**, **sickness** or *symptom* that:
  a. you or the Insured Person were aware of, or a reasonable person should have been aware of;
  b. the Insured Person should have sought advice or treatment (conventional or alternative) from a *doctor* for (in circumstances where a reasonable person would have sought advice or treatment); or
  c. the Insured Person had a medical consultation for or was prescribed medication or therapy for.
- **Injury** means a bodily injury which is sustained by the Insured Person after the later of the following:
  - the completed Interim Accident and Sickness Cover Certificate has been received by us;
  - the completed application form and personal statement has been received by us; or
  - the completed electronic application (including personal statement) has been submitted to us.

2. Commencement of Interim Accident and Sickness Cover

Interim Accident and Sickness Cover commences when a fully completed:

- electronic application (including personal statement) has been submitted to us; or
- paper application form and personal statement has been received by us.

Applying for Interim Accident and Sickness Cover prior to completing your application for St.George Protection Plans

You can apply for Interim Accident and Sickness Cover prior to completing your application for St.George Protection Plans if you have read, accepted, signed and retained a copy of the Statement of Advice (SOA) in which your financial adviser recommends that you take out a St.George Protection Plans Policy. This provides you with cover while you are completing your application.

You must complete the Interim Accident and Sickness Cover Certificate (signed by you and your financial adviser) and send it to us to apply. In this case, Interim Accident and Sickness Cover commences on the date we receive your completed Interim Accident and Sickness Cover Certificate.

In the event that you make a claim under the Interim Accident and Sickness Cover Certificate, we will require a copy of the signed and dated SOA, in which your financial adviser has recommended St.George Protection Plans.

For more information on applying for cover under the Interim Accident and Sickness Cover Certificate, please contact your financial adviser.

3. Period of Interim Accident and Sickness Cover

Interim Accident and Sickness Cover will end on the earliest of the following:

- 90 days from the date Interim Accident and Sickness Cover commences;
- in respect of each interim benefit for each Insured Person, the 'Policy Risk Commencement Date' shown in your *policy schedule* or *membership certificate* for the equivalent benefit confirming the commencement of your St.George Protection Plans Policy, or the date you obtain alternative insurance in respect of the Insured Person;
- in respect of each interim benefit for each Insured Person, the date you withdraw your insurance application for the equivalent benefit under St.George Protection Plans;
- in respect of each interim benefit for each Insured Person, the date we decline the insurance application for the equivalent benefit under St.George Protection Plans; and
- the date we advise you that Interim Accident and Sickness Cover has ceased.

Interim Accident and Sickness Cover under an Interim Accident and Sickness Cover Certificate will end 10 days from the date we received the completed Interim Accident and Sickness Cover Certificate, unless we have received a completed application for St.George Protection Plans. Once we have received a completed application for St.George Protection Plans, the period of Interim Accident and Sickness Cover is as outlined above.

4. Interim benefits

Interim Death Benefit

This benefit is available to you if:

- you have applied for a Term Life or Term Life as Superannuation Policy; or
- a Death Benefit has been recommended in the SOA, and the amount of the Death Benefit is stated in the Interim Accident and Sickness Certificate which was submitted to us.

The lesser of:

- $1,000,000;
- the amount of the Death Benefit applied for in respect of the Insured Person if a completed application and personal statement has been submitted to us; and
- the Death Benefit amount recommended in the SOA if a completed Interim Accident and Sickness Certificate is submitted,

is payable should the Insured Person die (as a result of an *accident* or **sickness**) whilst the Interim Accident and Sickness Cover is in force.

Interim TPD Benefit

This benefit is available to you if:

- you have applied for a TPD Benefit as an additional benefit under a Term Life or Term Life as Superannuation Policy, Standalone TPD or Flexible Linking Plus Policy; or
- a TPD Benefit has been recommended in the SOA, and the amount of the TPD Benefit is stated in the Interim Accident and Sickness Certificate which was submitted to us.

The lesser of:

- $1,000,000;
- the TPD Benefit applied for in respect of the Insured Person if a completed application and personal statement has been submitted to us; and
- the TPD Benefit amount recommended in the SOA if a completed Interim Accident and Sickness Certificate is submitted,

is payable should the Insured Person become *totally and permanently disabled* as a result of an *accident* or **sickness** whilst the Interim Accident and Sickness Cover is in force.

The *total and permanent disability* definition (*own occupation TPD, any occupation TPD, home duties TPD*, or *general cover TPD*) that applies to the Interim TPD Benefit is the definition:

- nominated by you in your application; or
- recommended in the SOA if a completed Interim Accident and Sickness Certificate is submitted, and

we would normally offer to cover for the Insured Person's occupation under our normal *underwriting* rules at the time of application or submission of the certificate.

If the TPD definition nominated by you in your application, or recommended in the SOA, is not what we would normally offer to cover for the Insured Person's occupation, we will apply the TPD definition that we would normally offer for the Insured Person's occupation under our normal *underwriting* rules, to your Interim TPD Benefit. You can contact your financial adviser or us if you would like more information about the cover we would normally offer.

Interim Living Benefit

This benefit is available to you if:

- you have applied for a Living Benefit under a Term Life, Standalone Living or Flexible Linking Plus Policy; or
- a Living Benefit has been recommended in the SOA, and the amount of the Living Benefit is stated in the Interim Accident and Sickness Certificate which was submitted to us.

The lesser of:

- $1,000,000;
- the Living Benefit applied for in respect of the Insured Person if a completed application and personal statement has been submitted to us;
- the Living Benefit amount recommended in the SOA if a completed Interim Accident and Sickness Certificate is submitted, and
- the amount of Living Insurance we would normally offer to cover for the Insured Person under our normal *underwriting* rules (you can contact your financial adviser or us if you would like more information about the cover we would normally offer),

is payable if the Insured Person has a *specified medical event* as a result of an *accident* or **sickness** (unless we have stated otherwise below), whilst the Interim Accident and Sickness Cover is in force and the Insured Person subsequently survives for 14 days. The Interim Living Benefit is not payable for *specified medical events* listed under the Advancement Benefit.

We will only pay a benefit when we are satisfied that the Insured Person meets the full definition of the relevant *specified medical event*, as defined in chapter 7 'Medical glossary' and chapter 8 'Definitions'. We will not pay an Interim Living Benefit for any *specified medical event* for which a 3 month exclusion applies under the Living Benefit. Please refer to chapter 2, section 13.4 for the list of the conditions under the 3 month exclusion.

Interim Income Protection, Business Overheads and Key Person Income Benefit

This benefit is available to you if:

- you have applied for an Income Protection, Income Protection Plus, Business Overheads or Key Person Income Policy; or
- an Income Protection, Income Protection Plus, Business Overheads or Key Person Income Benefit has been recommended in the SOA, and the amount of the Protection, Income Protection Plus, Business Overheads or Key Person Income Benefit is stated in the Interim Accident and Sickness Certificate which was submitted to us.

The lesser of:

- $5,000 per month;
- the Total Disability Benefit or Severe Disability Benefit applied for under Income Protection, Income Protection as Superannuation, Income Protection Plus, Business Overheads or Key Person Income if a completed application and personal statement has been submitted to us;
- the Income Protection, Income Protection Plus, Business Overheads or Key Person Income Benefit recommended in the SOA if a completed Interim Accident and Sickness Certificate is submitted; and
- the maximum monthly benefit amount you can apply for under an Income Protection, Income Protection Plus, Business Overheads or Key Person Income Policy,

is payable should the Insured Person become *totally disabled* (applicable for *own occupation IP* under Income Protection or Income Protection Plus, and for Business Overheads and Key Person Income) or *severely disabled* (applicable for *home duties IP* and *general cover IP* under Income Protection and Income Protection Plus) as a result of an *accident* or **sickness**, whilst the Interim Accident and Sickness Cover is in force.

The income protection definition that applies to the Interim Income Protection Benefit is the definition:

- nominated by you in your application; or
- recommended in the SOA if a completed Interim Accident and Sickness Certificate is submitted, and

we would normally offer to cover for the Insured Person's occupation under our normal *underwriting* rules at the time of application or submission of the certificate.

If the income protection definition nominated by you in your application, or recommended in the SOA, is not what we would normally offer to cover for the Insured Person's occupation, we will apply the income protection definition that we would normally offer for the Insured Person's occupation under our normal *underwriting* rules, to your Interim Income Protection Benefit. You can contact your financial adviser or us if you would like more information about the cover we would normally offer.

The benefit accrues from the end of the *waiting period* applied for under the relevant Policy, or recommended in the SOA[1] if a completed Interim Accident and Sickness Certificate is submitted, and ceases to accrue at the earliest of either the date the Insured Person ceases to be *totally disabled, severely disabled* or 6 months from the end of the *waiting period*.

5. Exclusions

Any conditions, limitations and exclusions in the St. George Protection Plans Policy or Policies for which you have applied will apply to this cover.

A benefit will not be paid if the death, *total and permanent disability, specified medical event, accident*, **injury**, **sickness** or event giving rise to the claim is caused directly or indirectly by:

- an intentional, self-inflicted act or attempted suicide (whether sane or insane);
- an *accident* or **sickness** while the Insured Person is under the influence of alcohol or non-prescription drugs or drugs taken in excess of prescribed amounts;
- any act of war (whether declared or not) except where the Insured Person dies on war service;
- the Insured Person engaging in any sport, pastime or occupation that we would normally cover with a premium loading or exclusion, or would decline or defer cover; or
- a **pre-existing condition** that existed prior to, or at the time we received your completed application form or Interim Accident and Sickness Cover Certificate.

We will not pay a claim made under an Interim Accident and Sickness Cover Certificate if we are not in receipt of an SOA containing the St.George Protection Plans recommendation made by the financial adviser for the proposed life to be insured.

A benefit will not be paid if the Insured Person's occupation is one that we would not normally cover.

For information on the occupations, sports and pastimes for which we would normally:

- offer a Policy with a premium loading or exclusion, or
- decline the application; or
- defer the application,

please contact us or your financial adviser.

6. Claims

Only one Interim Accident and Sickness Benefit for an Insured Person will be paid in respect of any one *accident* or **sickness**. The cost of obtaining medical evidence that is required for the payment of an Interim Accident and Sickness Benefit claim is to be borne by you. The costs of further medical evidence may be borne by us, however this will be at our discretion.

If you are eligible to make a claim under this cover, it will not prevent your application for a St.George Protection Plans Policy continuing to be assessed. However, we will take into account the change in health of the Insured Person when assessing your application and we may decline your application or apply special loadings, conditions and exclusions.

If the Multi-link Benefit has been selected in the insurance application for a St.George Protection Plans Policy, then in the event we make a Death Benefit, TPD Benefit, Living Benefit or Terminal Illness Benefit payment for an Insured Person under Interim Accident and Sickness Cover, we will reduce the sum insured of every other benefit for all Insured Person(s) under the same Policy. The Interim Accident and Sickness Cover Benefit amount for each Insured Person will be reduced by the amount paid.

1 If alternative recommendations for the *waiting period* have been made in the SOA, the *waiting period* in the primary recommendation will be used.

Chapter 5: Making a claim

Who to contact

If you wish to make a claim, please contact our Customer Relations Consultants on:

- 1300 366 416, 8.00am to 6.30pm (Sydney time), Monday to Friday.

Our consultants will arrange for you to receive any information or forms you need.

How and when to make a claim

If you are making a claim under Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone TPD, Flexible Linking Plus, Needlestick Benefit or Children's Benefit, you need to tell us within 6 months of the *sickness*, *injury*, surgery or death occurring.

If you are making a claim under an Income Protection, Income Protection as Superannuation, Income Protection Plus, Income Linking Plus, Business Overheads or Key Person Income Policy, you need to write or call and tell us within 30 days of the *sickness* or *injury*. We ask that you return all claim forms within 60 days of receiving them. If you notify us of the *sickness* or *injury* more than 90 days after it occurs, and if we accept your claim, your payments may start from the later of the date on which we receive your notification and the end of your *waiting period*.

Evidence required

Before we will pay a benefit, you must provide satisfactory evidence and the authority for us to obtain further information which we deem relevant to the claim. This will include medical evidence from a specialist medical practitioner and in some circumstances also from a *doctor* acceptable to us. We may also require proof of the Insured Person's age, and if appropriate, proof of the Insured Person's *earnings*, business expenses or business income. You must provide this evidence at your own expense. Please note that we rely on the information that you provide during a claim. If either you or any Insured Person acts fraudulently, we may cancel the Policy or any of its benefits and not pay any benefits.

We may from time to time require you to provide reports or certificates from the *doctor* providing treatment to the Insured Person about the continuing *sickness* or *injury* of the Insured Person (if claims are based on overseas reports or certificates, they must be translated into English by a certified translator). You must do so at your own expense.

We may also require the Insured Person to undergo medical examinations or tests by a *doctor* whom we choose. The Insured Person must allow themselves to be examined at any reasonable time we request. We will pay the reasonable costs of such examinations or tests.

Proof of age

We can ask for proof of the Insured Person's age. You, or the Insured Person, must give us that information. If, when you applied for insurance, the Insured Person's age was lower than we were told it was, we will refund you any premium you have paid above what you should have paid, plus interest. If the Insured Person's age was higher than we were told it was, we will reduce your benefit to what it would have been if the premium you paid us was based on the Insured Person's true age.

Financial evidence

For Income Protection, Income Protection as Superannuation, Income Protection Plus and Income Linking Plus Policies, we may require you to provide proof of *pre-disability monthly earnings* and from time to time to provide proof of *post-disability monthly earnings* in a period for which you are claiming a benefit. The proof required may include income tax returns, accountant's statements or other proof which is acceptable to us.

For Business Overheads, we may require you to provide proof of *allowable business expenses* for any period for which you are claiming a benefit. We may also require you to provide proof of the normal basis of accounting for such expenses. The proof required may include bills, invoices or other proof which is acceptable to us.

For Key Person Income, we may require you to provide proof of the following:

- *pre-disability monthly business income*; and
- *business income* in a period for which you are claiming a benefit.

The proof required may include (but is not limited to) the business' tax returns, Profit & Loss Statements, Balance Sheets, accountant's statements or other proof which is acceptable to us.

Uses of personal information

We may request certain information from the Insured Person during the assessment of a claim. If this information is not provided, we may not be able to accept or continue the claim.

In addition, if you make a claim under the Policy, you agree that we will collect further personal information about the Insured Person. This includes health information which, for the purposes of assessing the claim, may be necessary to disclose to third parties, such as medical practitioners. You and the Insured Person agree that the necessary collections and disclosures of personal information will be a condition of making a claim.

What happens after you make your claim?

After you make a claim we will assess it, having regard to the information provided or obtained. We must act reasonably in doing this.

Payment of claims

For Income Protection, Income Protection as Superannuation, Income Protection Plus, Income Linking Plus, Business Overheads or Key Person Income Policies, we will start payment of any benefit (including any amounts that have accrued), after we have accepted liability to pay the claim. We will pay benefits to you monthly in arrears. All payments are made in Australian currency. Should we accept liability to pay a claim, this is not a representation by us that we will continue to accept liability for so long as the Insured Person is not working or working in a reduced capacity. We may cease payment of the benefit at any time where we are of the opinion that the Insured Person is not *totally disabled, partially disabled* or *severely disabled* as required by this Policy.

For the Waiver of Life Premium Benefit, we will start waiving premiums after we have accepted liability under the benefit. Should we accept liability under the Waiver of Life Premium Benefit, and therefore agree to waive premiums, this is not a representation by us that we will continue to agree to waive premiums for so long as the Insured Person is *totally and temporarily disabled*.

Nominating a beneficiary

Policies held outside superannuation

You are able to nominate up to five *beneficiaries* to receive a Death Benefit under a Term Life Policy, subject to the following rules:

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

We are obliged to comply with any nomination made so please review your nomination regularly, especially if there has been a change in your circumstances.

If there is no nomination of *beneficiaries* and the Insured Person dies, the Death Benefit is paid equally between the surviving Policy Owners. If there are no surviving Policy Owners, and the Policy has not ended, the benefit will be paid to the estate of the last surviving Policy Owner.

Policies paid for and held inside superannuation

There are specific rules about people that can be nominated as *beneficiaries* within Policies paid for and held inside superannuation.

For more information on *beneficiary* nominations for Term Life as Superannuation, see chapter 6, section 8.

Chapter 6: Other important information

1. Cooling off period

When you receive your insurance documents, please read them carefully.

If you are not completely satisfied you may cancel your insurance. You have until the earlier of:

- 28 days from the *commencement date*; and
- 23 days after you receive your insurance documents.

If you would like to cancel your insurance within this cooling off period, please contact us.

When we receive your advice to cancel under the cooling off provisions, we will cancel the insurance from the *commencement date* and refund any payments you have made (less any tax that may apply to your premium). You cannot exercise your rights under the cooling off period if you have already made a claim under the Policy.

Policies held through Westpac MasterTrust

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

2. Premiums and charges

For each Policy that you have, the premium and any other charges are the cost of your insurance cover. We calculate your premium when your insurance begins and at each *review date*. We will notify you of your premium in writing before each *review date*. We also recalculate your premium if you request any changes to your insurance (eg an increase in a benefit).

The premium depends on a number of variables, including, but not limited to, the premium option chosen, the type of insurance you have, any optional benefits, the amount of insurance you have for each benefit, the age, gender, smoking status, health, occupation and pursuits of each Insured Person, the frequency at which you choose to pay your premium and any loading specified in your *policy schedule* or *membership certificate*.

Calculating your premium

To calculate your premium, we add together the premium for each benefit for each Insured Person covered in a Policy and then add the policy fee. For each Policy, the minimum premium is $14 if paying monthly, $42 if paying quarterly, $84 if paying half-yearly, or $150 if paying annually, for each Insured Person plus the policy fee and stamp duty.

You can pay premiums monthly, quarterly, half-yearly or annually. Where premiums are not paid annually, your premium will be increased by 9%.

If you add an Insured Person to your Policy or increase an existing benefit for an Insured Person between *review dates* and you are paying annually, half-yearly or quarterly, the additional premium that you have to pay for that Insured Person will be the additional premium, multiplied by the number of months from the date this benefit or increase started to the next payment date, divided by the number of months in the payment period.

Example (for illustrative purposes only)

You add an Insured Person to your Policy three months before the next *review date*. The additional annual premium is $400. The additional premium you have to pay following that change is:

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

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

Paying your premium

You can choose the payment method that suits you. You can pay monthly, quarterly, half-yearly or yearly in advance by MasterCard, Visa, automatic debit from your bank account, or by any other method that we may make available. If you choose to pay by automatic debit from your bank account, then please take note of the conditions set out in the 'Direct Debit Request Service Agreement' in chapter 6, section 4. If you are paying yearly in advance, you may also pay by cheque.

For Term Life as Superannuation and Income Protection as Superannuation Policies, we will accept partial rollovers as a payment method for premiums paid yearly in advance. A partial rollover is a partial transfer of superannuation, from one complying superannuation fund to another.

Partial rollovers will be accepted only if the rollover amount matches exactly the rollover amount required for the Policy.

When you fund your Term Life as Superannuation and/or Income Protection as Superannuation annual premium by partial rollover from a taxed complying superannuation fund, a 15% tax rebate benefit is applied to your premium. This means you will only need to rollover 85% of your total annual premium. The benefit applies to policies held in *Westpac Mastertrust* where the annual premium for the policy is paid via rollover. This benefit may be withdrawn or changed at any time. We will notify you in advance if this occurs.

Before requesting a partial rollover, please check with the superannuation fund provider:

- that the balance of the superannuation account is sufficient to pay for the premiums, as well as to continue to meet any minimum balance requirements of the superannuation account;

- if they will accept our rollover authority form, as a superannuation fund provider may have additional requirements, such as proof of identification, or require the member to complete their own form;
- about any exit or withdrawal fees which may apply to the partial rollover; and
- if they will allow more than one partial rollover per year, in the case that premiums are paid with a partial rollover for more than one policy. Some superannuation funds have restrictions, such as only allowing one partial rollover each year.

Changing your premium

For new policies, your premium rates are guaranteed for at least two (2) years from the 'Policy Risk Commencement Date' for the initial sum insured, subject to the conditions outlined below.

For both stepped and level premiums, including within the first two (2) years of cover, your premiums will change if:

- there is a change to your sum insured due to *CPI* increases, or because you have requested to change your sum insured;
- there is a change due to an increase in your age (for level premiums, this relates to *CPI* increases only);
- there is a change to the premium discounts and/or loadings on your Policy; or
- you vary your Policy, including changing your premium frequency.

If you make amendments to your existing policy, including increasing or decreasing your sum insured, the rate guarantee will continue to apply to your new premium as per the conditions above, but only for the remainder of the two (2) year period starting from the policy's original 'Policy Risk Commencement Date'.

After your 2nd *review date* we may change the premium rates or discount factors applicable to your Policy, for both stepped and level premiums. These premium rate changes will not apply to a specific individual Policy, rather, a change would relate to an entire group based on pricing factors (such as occupation category) or a class of products.

You will be provided at least 30 days notice prior to an increase to your premium rates. You will be notified of any other changes to your premium in accordance with the law. In the event of war or invasion involving Australia, we may give immediate notice of premium change.

You can contact us to request information on your premium, or to request a quote for the premium that will apply after a variation to your Policy.

What if you don't pay?

If your premiums or other amounts are overdue, you will be notified. The time to pay this amount will be specified in the notice provided to you. If we don't receive your payment within that time, we will cancel your Policy. At our discretion, your Policy may be reinstated within a certain time if all outstanding amounts are received. We may also ask for more information about any Insured Person's health, income, occupation or pastimes before we do so. If an Insured Person's health, income, occupation or pastimes have changed, we may vary your benefits, charge additional premium or not let you reinstate the Policy.

Policy fee

A policy fee may apply for each standalone Policy, including Term Life, Term Life as Superannuation, Standalone TPD, Standalone Living Insurance, Income Protection, Income Protection as Superannuation, Income Protection Plus, Business Overheads, and Key Person Income. No additional policy fee is payable where a benefit (for example, a TPD and/or a Living Benefit) is added as an additional benefit to a Term Life or Term Life as Superannuation Policy.

At 1 October 2018, the policy fee is $93.60 per year, $50.99 per half-year, $25.50 per quarter, or $8.50 per month. The policy fee increases each year according to the *CPI*, and is updated on 1 October.

Periodic payments

We will recover other charges that we incur for periodic payments that you make. The maximum charge is currently 10 cents per payment and this may change without notice.

Stamp duty

Stamp duty, licence fees or similar charges that are payable in respect of your Policy must be paid in addition to your premium and the policy fee (where applicable). The rate of stamp duty, and the basis on which it is payable, varies for each state of Australia and can be changed without notice. We will recalculate the amount of stamp duty payable whenever your premium is recalculated. It will also vary if the rate of stamp duty, or the basis of calculating or charging stamp duty, on the Policy is altered.

Adviser Remuneration

We may pay commission, administration fees and other benefits to financial advisers and dealer groups. We pay these amounts out of the premium we receive from you, they are not an additional charge to you.

If you and your financial adviser agree on an advice service fee arrangement, we will debit the agreed fee from the account you choose. The amount of this fee is to be negotiated between you and your financial adviser – we will pass on the entire amount of this fee to your financial adviser.

If you have nominated an initial fee, this will be debited from your chosen account when your first Policy goes in force. If you have nominated an ongoing fee, this will be debited at the frequency you choose. The fee will be disclosed to you each year.

In addition to any payment for selling your Policy, we may make payments to financial services dealer groups based on commercial arrangements.

Your financial adviser will provide details of the benefits they will receive if we issue you with insurance in the Financial Services Guide and/or Statement of Advice that they will give to you.

The *Insurer* maintains an Alternative Forms of Remuneration Register (Register) in accordance with the Financial Services Council (FSC) and Financial Planning Association Industry Code of Practice on Alternative Forms of Remuneration in the Wealth Management Industry. The Register outlines the alternative forms of remuneration which are paid and received from givers and receivers of such remuneration. If you would like to view the Register, please contact us on 1300 366 416.

3. Other bits and pieces

Who's responsible for St.George Protection Plans?

The *Insurer* is Westpac Life Insurance Services Limited ABN 31 003 149 157, AFSL Number 233728.

The issuer for all the products described in this Product Disclosure Statement and Policy Document ('PDS'), except for Term Life as Superannuation (USI 81 236 903 448 001) and Income Protection as Superannuation (USI 81 236 903 448 004), is the *Insurer*. For Term Life as Superannuation and Income Protection as Superannuation (part of the *Westpac MasterTrust* ABN 81 236 903 448, SFN 281 412 940, SPIN WFS0341AU, RSE Registration R1003970), the issuer is Westpac Securities Administration Limited ABN 77 000 049 472, AFSL Number 233731, RSE Licence Number L0001083 (*WSAL*).

The trustee of *Westpac MasterTrust* is *WSAL*.

St.George Protection Plans are distributed by St.George Bank – A Division of Westpac Banking Corporation ABN 33 007 457 141 ('the Bank').

This PDS is issued by the *Insurer* and *WSAL*. The *Insurer* and *WSAL* take full responsibility for the whole of this PDS. The *Insurer* and *WSAL* are wholly owned subsidiaries of the Bank. Neither the St.George Protection Plans, nor an interest in the *Westpac MasterTrust* are an investment in, deposit with or other liability of the Bank. Neither the Bank nor any member of the *Westpac Group* (other than the *Insurer*) guarantees the benefits payable in relation to St.George Protection Plans.

Communication

We will send notices to the last address that you gave us and it is agreed that this will be valid notice to you. We say that you receive a notice on the date that you would have received it in the ordinary course of the mail. If you move, you need to tell us your new address.

Changing your Policy

We may *underwrite* any application for a variation to your Policy (including changes to any of the benefits or options, or addition of benefits or options). If we accept the application, we will send you written notice of the change.

If you add an Insured Person to your Policy or remove an Insured Person from your Policy, we will send you written notice of the change and the change will only be effective on provision of such written notice.

We will show the date that any change starts. Any notice we send you forms part of the *policy schedule* or *membership certificate* and the change will only be effective on provision of such written notice.

Changes to this PDS

The information in this PDS may change from time to time. When such change is materially adverse, we will issue a supplementary or replacement PDS. Any other changes to the information in this PDS will be available to you at any time on our website. You can ask for a paper copy of such information free of charge by contacting us.

Governing Law

This Policy is governed by the laws of New South Wales.

Currency

All dollar amounts are referred to in Australian currency. All claims will be paid in Australian dollars.

No financial advice

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

Availability

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

Where we put your money

Term Life, Standalone Total and Permanent Disablement, Flexible Linking Plus, Children's Benefit, Needlestick Benefit, and the insurance policy issued by the *Insurer* to *WSAL* under Term Life as Superannuation are included in the Westpac Life No. 1 Statutory Fund. All other Policies are included in the Westpac Life No. 2 Statutory Fund. We pay your benefits from these funds. The money in the funds is regulated under the Life Insurance Act 1995.

No cash value

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

4. Direct Debit Request Service Agreement

This agreement sets out the terms on which you have authorised the *Insurer* (Debit User ID No. 002631) under your Direct Debit Request to arrange for amounts that become payable in respect of your St.George Protection Plans Policy, to be made by deduction from your account at your financial institution (nominated account) using the direct debits payments system (also known as the Bulk Electronic Clearing System). The direct debits will be made at the rate and frequency specified in the most recent *policy schedule*, *membership certificate* or *renewal summary* or the latest notice that we have provided to you (whichever is later).

- We agree to be bound by this agreement when we receive your Direct Debit Request complete with the particulars we need to draw down an amount under it. Please ensure that you keep a copy of this agreement as it sets out certain rights you have against us and certain obligations you have to us in giving us your Direct Debit Request.
- You will need to:
  - complete a new Direct Debit Request for any other product you purchase from us, or if you move from one of our products to another; and
  - ask us to discontinue any Direct Debit Request that is in force if you cancel a product (debits may continue to be made to your nominated account until you do so).
  - Your Direct Debit Request authorises us to arrange for payment to us for the amounts, and at the times, required by the terms of your Policy and your instructions to us in relation to it. It also enables any changes in those amounts, and payment times, to occur automatically – you will not need to complete a new form.
- You can:
  - cancel, vary, defer or suspend the Direct Debit Request; or
  - stop or suspend an individual debit from taking place under it,

  by calling us on 1300 366 416, 8.00 am to 6.30 pm Sydney time, Monday to Friday (in some cases, we will need your written confirmation). You need to allow us 6 working days before the next drawing date to process your request, or the debit may still be made. (You may also be able to stop an individual debit by contacting your own financial institution. You may be liable for financial institution charges if you do this – your financial institution should have information on these).
- If a due date for a debit falls on a weekend or public holiday, the debit will be processed on the next business day. Please check with your financial institution if you are uncertain about when a debit will be processed to your nominated account.
- You must ensure that you have sufficient cleared funds available in the nominated account by the due date to permit the payments under the Direct Debit Request. Please check with us if you are uncertain about when debits will be processed to your nominated account.
- If a drawing is unsuccessful, we will not draw again until the next scheduled drawing date. If your drawing is to pay for insurance benefits, we will re-draw the missed payment as well as the current payment. Drawings will be suspended after two unsuccessful attempts. Your financial institution may charge you fees and interest for unsuccessful debits.
- You may pay us otherwise than by direct debit if the direct debit fails as follows:
  - online by visiting www.stgeorgelifeinsurancepayments.com.au to pay by credit card or debit card.*
  - by telephone on 1300 366 416 to arrange a payment by credit or debit card.*
- You should check your account: prior to the direct debit being applied to see if there are sufficient funds and after the direct debit is made to see that it has been correctly applied.
- Please contact our Customer Relations Centre on 1300 366 416 if you have any questions about your Direct Debit Request, such as concerns about a debit that we make under it. We investigate and deal with in good faith any dispute relating to an alleged incorrect or wrongful debit within 3 business days of receiving such a query, claim or complaint. This may include us and our bank reviewing our respective records. If necessary we will contact your financial institution to review its records. We will advise you as soon as practicable (generally within 5-10 days) depending on the nature and extent of the dispute, and the measures taken to resolve it. You may also dispute an amount we draw under your Direct Debit Request by contacting your financial institution.
- We can vary this Service Agreement at any time after giving you at least 14 days notice of the changes.
- We will keep information about your financial institution account details and records confidential, except:
  - to the extent necessary to resolve any claim you might make relating to a debit which you claim has been made incorrectly or is a wrongful debit (which includes the provision or disclosure of such information to Westpac Banking Corporation ABN 33 007 457 141, the sponsor of our use of the direct debits payment system);
  - if you consent to disclosure of such information; or
  - we are required to disclose such information by law.
- Direct debiting through the direct debit payments system is not available on all accounts provided by financial institutions. Please ensure that your financial institution allows direct debits on your nominated account before completing your Direct Debit Request. Also, before you complete your Direct Debit Request, it is your responsibility to check your nominated account details against a recent statement from your financial institution to ensure the details on your Direct Debit Request are completed correctly.
- We incur charges in relation to certain periodic payments we receive through the direct debit payments system. If a charge applies in respect of your payments, we will increase the amount deducted from your financial institution account to cover this expense. The maximum charge is currently 10 cents per payment. The amount of the charge, and the types of payments to which it applies may change without notice.

* Eftpos cards without a Visa or Mastercard number are not accepted. American Express is not accepted.

5. Protection of your privacy

Why we collect your personal information

We collect personal information, including sensitive information (eg health information) from you to process your application, provide you with your product or service, calculate your premium, assess any claims made by you and manage your product or service. We may also use your information to comply with legislative or regulatory requirements in any jurisdiction, prevent fraud, crime or other activity that may cause harm in relation to our products or services, and help us run our business. We may also use your information to tell you about products or services we think may interest you.

If you do not provide all the information we request, we may need to reject your application or claim, or we may no longer be able to provide a product or service to you.

Disclosing your personal information

We may disclose your personal information to *WSAL*, other members of the *Westpac Group*, anyone we engage to do something on our behalf, and other organisations that assist us with our business. We may also disclose your personal information to third parties such as your financial adviser and reinsurers.

We may disclose your personal information to an entity which is located outside Australia. Details of the countries where the overseas recipients are likely to be located are in the St.George Privacy Policy.

As a provider of financial services, we have obligations to disclose some personal information to government agencies and regulators in Australia, and in some cases offshore. We are not able to ensure that foreign government agencies or regulators will comply with Australian privacy laws, although they may have their own privacy laws. By using our products or services, you consent to these disclosures.

Other important information

We are authorised to collect personal information from you by certain laws. Details of these laws are in the St.George Privacy Policy.

The St.George Privacy Policy is available at stgeorge.com.au or by calling 1300 366 416. It covers:

- how you can access the personal information we hold about you and ask for it to be corrected;
- how you may complain about a breach of the Australian Privacy Principles, or a registered privacy code and how we will deal with your complaint; and
- how we collect, hold, use and disclose your personal information in more detail.

The St.George Privacy Policy will be updated from time to time.

Information about your nominated beneficiary and other individuals

You agree to ensure that any person you nominate as your *beneficiary* is made aware:

- you have nominated them as your *beneficiary*;
- we and other members of the *Westpac Group* hold their personal information;
- we and other members of the *Westpac Group* will use their personal information in determining to whom and in what proportion your benefits will be paid upon your death and, to the extent that such information is not provided, we may not be able to pay your death benefits according to your wishes;
- we and other members of the *Westpac Group* may disclose their personal information to each other and to third parties (including your financial adviser) that assist us in the administration of the Policies held through *Westpac MasterTrust* or when required or permitted by law to disclose their personal information; and
- they may contact us and request access to their personal information using the details provided above.

Where you have provided information about another individual, you must make them aware of that fact and the contents of this Privacy Statement.

We and the members of the *Westpac Group* will use or disclose your personal information to contact you or send you information about other products and services offered by the *Westpac Group* or its preferred suppliers. If you do not wish to receive marketing communications from us please call us on 1300 366 416.

Financial Crimes Monitoring

We are bound by laws about the prevention of money laundering and the financing of terrorism as well as sanctions obligations including but not limited to the Anti-Money Laundering and Counter-Terrorism Financing Act 2006.

By submitting an application for cover, you agree that:

- transactions may be delayed, blocked or refused where we have reasonable grounds to believe that they breach Australian law or the law of any other country; and
- we may from time to time require additional information from you to assist us in the above compliance process.

Where legally obliged to do so, we may disclose the information gathered to regulatory and/or law enforcement agencies.

You must not initiate, engage in or effect a transaction that may be in breach of Australian law (or the law of any other country).

Marketing Information

Members of the *Westpac Group* would like to be able to contact you, or send you information, regarding other products and services. If you do not wish to receive this information, please contact our Customer Relations Centre:

St.George Protection Plans
Post: Customer Relations
GPO Box 4582
Sydney NSW 2001
Phone: 1300 366 416, 8.00am to 6.30pm (Sydney time), Monday to Friday

You do not need to do this if you have already told us you do not wish to receive information of this sort.

6. Complaints

Contact Us

We want you to be totally satisfied with your insurance, now and in the future. If you have any enquiries or complaints about your insurance, please speak to us about it.

If you wish to make a formal enquiry or complaint, please contact our Customer Relations Centre:

St.George Protection Plans
Post: Customer Relations
GPO Box 4582
Sydney NSW 2001
Phone: 1300 366 416, 8.00am to 6.30pm (Sydney time), Monday to Friday

When we receive your written enquiry or complaint it will be recorded, investigated and acted upon. We will endeavour to respond to a complaint as soon as possible and within 45 days.

If you have a complaint about your Policy which is not answered to your satisfaction or within 45 days, you may raise the matter directly with the Australian Financial Complaints Authority (AFCA):

Australian Financial Complaints Authority
Post: GPO Box 3
Melbourne VIC 3001
Website: www.afca.org.au
Email: info@afca.org.au
Phone: 1800 931 678

AFCA provides fair and independent financial services complaint resolution that is free to consumers and will attempt to settle the matter by conciliation. It also has the power to arrange a formal hearing if the matter cannot be resolved.

Alternatively, before you go AFCA or take any other action you can refer your matter to the St.George Customer Advocate who is available to assist in some circumstances. The role of the Customer Advocate is to provide an objective review of the outcome of your complaint. The Customer Advocate's determinations are binding on us but it's up to you if you want to accept or reject the determination. Further details are available at https://www.stgeorge.com.au/contact-us/your-customer-advocate. The Customer Advocate can be contacted by email at: customeradvocate@stgeorge.com.au.

7. Understanding Tax

Goods and Services Tax (GST)

Under current legislation, GST is not levied on life insurance premiums and policy fees. This does not include the advice service fee.

Tax and other charges deducted from benefits

We will deduct from any benefit paid under your Policy, any tax, duties or levies we are required by law to deduct.

We may require you to pay tax and other charges

We may require you to pay any taxes, levies or duties which relate to your Policy. If the level of tax, duties or levies is varied or if additional tax, duties or levies are imposed, we may require you to pay this additional amount. We may cancel your Policy if you do not pay this amount.

Taxation treatment of your Policy (except Policies held inside superannuation)

The taxation information described in the table below is a general statement only, and is based on tax laws present at 1 April 2019 and our interpretation of those laws. Your individual situation may differ and you should seek independent professional tax advice.

Type of cover	Premium Impact	Benefit Impact
Term Life, TPD, Living Insurance, Needlestick Benefit and Children's Benefit	**For individuals**	
	Premiums are not tax deductible.	Generally, any benefits will not be treated as assessable income for tax purposes. However, there may be capital gains tax implications in certain circumstances.[1] We recommend you seek individual tax advice.
	For business	
	The deductibility of premiums will depend on the specific circumstances of each Policy. For example, if you take out a Term Life Policy and the objective of the Policy is to cover the loss of business revenue associated with the loss of a key employee, the premiums paid by the business may be an allowable tax deduction. There may be fringe benefits tax implications in respect of premiums, where benefits are derived by employees or their dependants.	The assessability of the benefit will depend on the specific circumstances of the Policy. For example, if you take out a Term Life Policy and the objective is to cover the loss of business revenue associated with the loss of a key employee, the benefit may be treated as assessable income. There may also be tax implications if a death benefit termination payment is made by the business to dependants or non-dependants of the deceased.
Income Protection (excluding *general cover IP* and *home duties IP*)[2], Business Overheads and Key Person Income	Premiums paid may be tax deductible.	Payments you receive may be assessable for tax purposes.

1 Such as when we pay a Death Benefit and the Policy Owner is not the original owner of the Policy and has acquired the Policy for consideration, or where we pay a Living Insurance or TPD Benefit and the Policy Owner is not the Insured Person or a relative (as defined for tax purposes).

2 If you have *general cover IP* and the Insured Person is not *gainfully employed*, or *home duties IP* we recommend you seek individual tax advice.

8. Understanding Westpac MasterTrust

Westpac MasterTrust

Westpac MasterTrust is a regulated superannuation fund under the Superannuation Industry (Supervision) Act 1993 and is a Registrable Super Entity (RSE) under that Act.

The *Insurer* is responsible for day-to-day management including the recording of contributions, administration and payment of benefits on behalf of *WSAL*.

The operation of *Westpac MasterTrust* is governed by the Trust Deed. You can request a free copy of the Trust Deed by writing to us or calling 1300 366 416.

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

Tax File Numbers (TFNs) and contributions

While you are not required by law to supply *WSAL* with your TFN, you will be ineligible to apply for Term Life as Superannuation and Income Protection as Superannuation if you have not provided us with your TFN.

Due to Government legislation, *WSAL* is unable to accept non-concessional contributions (generally after-tax contributions made by you, or on your behalf, other than employer contributions) from you if you have not provided your TFN. *WSAL* has further determined that *Westpac MasterTrust* will not accept any contributions made by you or on your behalf unless your TFN has been provided. Please read the Tax File Number Notification in the application form for further details relating to the quoting of your TFN.

Membership of Westpac MasterTrust

As a member of *Westpac MasterTrust* with insurance, you pay contributions or make rollovers to *Westpac MasterTrust* to cover the premiums that are due under the insurance Policy.

Eligibility to contribute to superannuation

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

The current rules are outlined in the table below.

Age	When contributions can be made
If you're aged under 65 years	You can make contributions to superannuation or have contributions made on your behalf at any time. You don't need to be employed or meet any other eligibility rules.
If you're aged between 65 and 74 years[1]	You may be able to make contributions, or have them made on your behalf (special rules apply for spouse contributions) if you have been *gainfully employed* for at least 40 hours over 30 consecutive days in the same financial year that you make the contributions. You must make a new employment declaration for each financial year. Spouse contributions can only be made on your behalf if you meet the work test described above and you are under 70 years of age. Mandated employer contributions can be made. These include Superannuation Guarantee (SG) and certain contributions made under an award or certified agreement.
If you're aged 75 years and over	Only mandated employer contributions can be made.

1 A work test exemption applies for recent retirees with total superannuation balances under $300,000, for contributions made from 1 July 2019.

Contributions into Policies held through Westpac MasterTrust

The following contributions can be accepted:

Contributions made by	When contributions can be made
Your employer	Your employer can make mandated or voluntary employer contributions. You may be able to arrange salary sacrifice contributions with your employer- these are additional employer contributions made from your pre-tax salary.
You	You can make your own personal contributions to superannuation from your after tax income. In some cases you may be able to claim a personal tax deduction for these contributions.[1]
Your *spouse*	Your *spouse* may make contributions to your superannuation, as long as the contribution is paid from an account in the name of the contributing *spouse* or a joint account where the contributing *spouse* is an account holder.

1 Individuals are able to claim a tax deduction on personal contributions to super, regardless of the proportion of income they derive from employment (assuming all other criteria are satisfied).

The following contributions cannot be accepted:

Contributions made by	When contributions can be made
Government	Subject to eligibility criteria, each year the Government can contribute an amount into your superannuation fund for personal before or after tax contributions you make, depending on your level of income. Personal contributions made to Term Life as Superannuation and Income Protection as Superannuation may qualify you for Government co-contributions or Low Income Super Tax Offsets, but *Westpac MasterTrust* is unable to accept these co-contributions or Low Income Super Tax Offsets. You must nominate another superannuation account to accept your co-contribution.

Contributions caps

The Government has set caps on the amount of contributions which can be made each year on a concessional basis.

Additional tax may apply to contributions in excess of the relevant cap.

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

Concessional contributions cap	This cap includes the following types of contributions: • Employer contributions (including salary sacrifice) • Personal contributions for which you claim a tax deduction	For the financial year (2018/19), the cap is $25,000 per member. This cap is indexed in line with average weekly ordinary time earnings (AWOTE), in increments of $2,500 (rounded down).[2] Concessional contributions in excess of the relevant cap will be subject to additional tax (refer to 'Taxation treatment of Term Life as Superannuation and Income Protection as Superannuation' on pages 85 and 86).
Non-concessional contributions cap	This cap includes the following types of contributions: • Personal contributions for which no tax deduction is claimed (including spouse contributions) • Amounts transferred from overseas super funds (excluding the taxable amount of such transfers)[1] • Amounts in excess of the CGT cap (refer to below)[1] • Amounts of concessional contributions in excess of the concessional contributions cap (that are not refunded)	The cap is $100,000 per member for the 2018/19 financial year.[3] This cap will not be separately indexed, but is fixed at four times the general concessional cap (2018/19). Persons under age 65 can 'bring forward' future entitlements to two years' worth of non-concessional contribution limits. If so, they may be able to make non-concessional contributions of up to three times the annual non-concessional contribution limit in a single year. Non-concessional contributions in excess of the relevant cap may be subject to tax (refer to 'Taxation treatment of Term Life as Superannuation and Income Protection as Superannuation' on pages 85 and 86).
CGT cap	Contributions made from certain amounts arising from the disposal of qualifying small business assets, provided that a tax deduction is not claimed for the contribution[1]	A lifetime cap of $1.48 million for the 2018/19 financial year (indexed) is available.

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

2 From 1 July 2018, individuals with a total super balance of less than $500,000 at the end of 30 June of the previous financial year, will be able to carry forward unused portions of the previous five year's concessional contributions caps.

3 An individual will only be eligible for a non-concessional contribution cap if their total superannuation balance is less than the general transfer balance cap ($1.6 million (2018/19)), on 30 June in the previous financial year.

There are no caps on amounts contributed from certain payments for personal injury, provided that no deduction is claimed for the contribution and the contribution is made within certain time limits. In addition, you may be able to make up to $300,000 of downsizer contributions to superannuation, from the proceeds of selling your home, without affecting the above caps. Neither personal injury or downsizer contributions can be made into *Westpac MasterTrust*.

Please note that it is your responsibility to ensure contributions to superannuation are within your concessional and non-concessional contributions caps. *WSAL* cannot monitor your overall position.

Taxation treatment of Term Life as Superannuation and Income Protection as Superannuation

a. Tax concessions on contributions

The information in this section gives a general overview of the taxation of super. As tax is complex, we always recommend you seek professional advice about how the rules might impact you or your *beneficiaries*.

The information and rates in this section can change from time-to-time. Please refer to the ATO website at ato.gov.au for the latest update.

Superannuation can be subject to tax on contributions, earning and withdrawals.

b. Tax payable on contributions

Contributions are generally subject to two types of taxation.

Contributions tax

Some, but not all, contributions are taxed, generally at a rate of 15%.

Contributions tax is deducted from:

- employer contributions, including SG, Award, salary sacrifice and voluntary employer contributions; and
- personal contributions for which you claim a tax deduction.

Contributions tax is not deducted from:

- personal contributions for which you do not claim a tax deduction; and
- spouse contributions.

High income earners 15% additional tax

If you are classified as a high income earner, you may need to pay an additional 15% tax on some or all of your contributions. Currently you are considered to be a high income earner if your 'income' is $250,000 or greater in a financial year 2018/19. The definition of 'income' for the purposes of this measure includes contributions which have had contributions tax applied to them, unless those contributions are excess concessional contributions. If you are liable for this tax the ATO will notify you after the end of the financial year. Further information on this tax is available on the ATO website at ato.gov.au.

Excess contributions tax – Additional tax on contributions that exceed a contributions cap

If you exceed the contribution caps, additional tax applies to the excess amount:

- Your total excess concessional contributions are taxed at your marginal tax rate, with an excess concessional contribution charge applying. This tax treatment applies regardless of whether excess concessional contributions are refunded or not. Refunded excess concessional contributions will not count towards the non-concessional cap, whereas excess concessional contributions retained in superannuation will.
- Excess non-concessional contributions that are not refunded are taxed at the top marginal tax rate. If excess non-concessional contributions are refunded, an associated earnings rate will apply on the excess contribution, and these earnings will be included in your assessable income.

Term Life as Superannuation and Income Protection as Superannuation will not be able to release amounts in relation to excess concessional or non-concessional contributions, to pay your tax liability as no account balance is maintained for you. For further information on the refund of excess concessional contributions refer to ato.gov.au.

c. Claiming tax deductions for your personal contributions

You must meet a number of conditions to be eligible to claim a tax deduction for your personal contributions to super. Your eligibility can be affected by your age and the level of any salary sacrifice and certain other employer contributions made for you.

You must notify us in an ATO approved format and within certain time frames (explained below) if you wish to claim a tax deduction for some or all of your personal contributions to *Westpac MasterTrust*.

If you have made personal contributions to *Westpac MasterTrust* we will remind you to complete a Personal Tax Deduction Notice if applicable to you.

Before you can claim a deduction in your tax return we need to accept your notice (if we're able to under tax law) and you need to receive an acknowledgement of your notice from us.

It's important to send us a Personal Tax Deduction Notice BEFORE the earlier of when:

- you lodge your tax return for the financial year in which the relevant contribution was made;
- 30 June of the financial year following the financial year in which the contribution was made (eg by 30 June 2020 for contributions made in the 2018/19 financial year);
- the date *WSAL* ceases to hold the contributions covered in the notice; and
- the date you cease to be a member of *Westpac MasterTrust* (generally the date your cover ceases).

You may vary an earlier notice in certain circumstances but only to reduce the amount you intend to claim as a tax deduction (including to nil). To vary an earlier notice, you will need to complete a new Personal Tax Deduction Notice form. It's important to note that a variation must generally be lodged within the same time frame as a deduction notice itself. We are unable to accept a variation to an earlier notice after any of the above events has occurred.

We suggest you obtain professional tax advice if you're considering claiming a deduction for your personal contributions.

d. Tax on superannuation lump sums

Taking a cash lump sum benefit

Any tax *WSAL* is required to deduct will depend on your age and the tax components within your benefit, as shown in the table below. Your preservation age can be determined using the following table:

Age	Tax treatment of taxable component (2018/19)	Tax treatment of tax-free component (2018/19)
Under Preservation age[1]	20% + Medicare levy	Nil
Preservation age to 59	Up to $205,000[1]: Nil Above $205,000[1]: 15% + Medicare levy	Nil
60 and over	Nil	Nil

1 This is the low rate cap for 2018/19 and will be indexed to AWOTE rounded down to the nearest $5,000 in subsequent years.

Preservation age is between age 55 and 60, depending on the member's date of birth. Your preservation age can be determined using the following table:

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

If you are under age 60 and the *trustee* does not hold your Tax File Number (TFN), it is required to deduct tax on the taxable component of a lump sum payment at the highest marginal tax rate plus the Medicare levy.

Taking a cash lump sum as a result of suffering from a terminal medical condition

Members who are suffering from a terminal medical condition will be able to receive a lump sum superannuation benefit that is exempt from tax. For *Westpac MasterTrust*, this would arise as a result of receiving a Terminal Illness Benefit. Refer to section 10 for the definition of terminal medical condition.

Term Life as Superannuation does not pay TPD or Terminal Illness Benefits Payments as pensions. The tax treatment of these benefits paid as an income stream is different to that outlined below. You should consult your financial adviser for advice.

e. Tax on superannuation death benefits

Death benefits paid as a lump sum to your dependants (for tax purposes) are tax-free. A dependant for tax purposes includes your *spouse* or former *spouse*, your children under 18, a person who was wholly or substantially financially dependent on you at the time of your death and a person with whom you were in an *interdependency relationship* at the time of your death.

Death benefits paid as a lump sum to a non-dependant for tax purposes will be taxed in the following manner:

Tax free component	Tax free
Taxable component (taxed element)	Taxed at 15% plus the Medicare levy
Taxable component (untaxed element)	Taxed at 30% plus the Medicare levy

An untaxed element will generally arise where the lump sum death benefit contains insurance proceeds. The amount of the untaxed element is calculated using a statutory formula. Tax on the untaxed element will only be payable, however, where the lump sum death benefit is paid to a non-dependant for tax purposes.

Death benefits paid as a lump sum to your estate are taxed within the estate depending on whether the *beneficiaries* are your dependants or non-dependants for tax purposes. The Medicare Levy is not payable by the estate.

f. Tax on superannuation income benefits

Income paid to you from Income Protection as Superannuation is generally assessable income for tax purposes. *WSAL* is required to withhold PAYG tax from income payments it makes to you. The amount of tax withheld will depend on the size of the income payments.

Beneficiary nomination guidelines for Term Life as Superannuation

Payment in the event of your death

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

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

For this purpose a dependant includes:

- your *spouse*;
- any of your children (including adopted, step and adult children);
- any person with whom you are in an *interdependency relationship* at the time of your death; and
- any other person who is financially dependent on you at the time of your death.

If you do not make a nomination, or the nomination you make is defective, your benefit will be paid to your legal personal representative or, failing that, to one or more of your dependants as *WSAL* determines. It is a non-binding nomination.

It is important to review your nomination regularly

You should review your nomination regularly to ensure that it continues to reflect your wishes. You can change your nomination at any time by completing the Nomination of Beneficiaries Form, obtainable by telephoning the Customer Relations Centre on 1300 366 416. You can also revoke your nomination at any time without making a new one by writing to us.

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

Invalid nomination

Your nomination will be invalid when you make it if:

- it is unclear to *WSAL* (eg because it is illegible or because the nominated proportions do not total 100%);
- *WSAL* has actual knowledge that, when you made the nomination, you did not understand the consequences of making it; or
- you do not sign or date the form or the signature has not been witnessed properly.

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

- has died; or
- is no longer your dependant.

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

What if I don't make a nomination?

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

Professional estate and financial planning advice

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

Family law – treatment of superannuation on divorce

Family Law Act 1975 (FLA)

Provisions of the FLA deal with the treatment of superannuation on relationship or marriage breakdown with a *spouse*. The FLA provides that a member's superannuation benefit may be split with the member's *spouse* or former *spouse* on marriage or relationship breakdown. Alternatively a payment flag may be imposed on your benefit in the *Westpac MasterTrust*.

In order for *WSAL*, to commence any payment split or impose a payment flag on your account, *WSAL* must have been served with either:

- a superannuation agreement, made between you and your *spouse* or former *spouse*, and in accordance with the requirements of the FLA; or
- an order of the Family Court of Australia, that specifies how your benefit is to be split with your *spouse* or former *spouse* or that a payment flag must be applied to your account.

The FLA also specifies that *WSAL* must be provided with certain evidence of marriage or relationship breakdown if you serve a superannuation agreement on *WSAL*. You and/or your *spouse* or former *spouse* may arrange for the required documents to be served on *WSAL*. Documents can only be served on *WSAL* for the purposes of the FLA at the following address:

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

All documents served on *WSAL* should be either an original or a certified copy.

If *WSAL* is required to effect a payment split on your benefit, the value of your account will reduce by the amount that is paid to, or for the benefit of, your *spouse* or former *spouse*.

Information about your superannuation benefit

Where an eligible person under the FLA wishes to negotiate a superannuation agreement with you (which may be before or during a relationship, or after relationship breakdown) or facilitate the preparation of an order of the Family Court, they may apply to *WSAL* to receive information about your benefit. Where the application is made in accordance with the requirements of the FLA, *WSAL* will be obliged to provide the requested information and will not be permitted to inform you about the application.

Fees and expenses may apply

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

Professional advice

The FLA involves many complex requirements in relation to splitting a superannuation benefit. It is recommended that, if you believe your benefit will be affected by the FLA, you should consult your legal adviser, financial adviser and/or accountant. Should you have any questions in relation to the above, please do not hesitate to call our Customer Relations Centre on 1300 366 416, 8.00am to 6.30pm (Sydney time), Monday to Friday.

9. Conditions applying to payment of benefits under superannuation law

Superannuation law applies to all benefits paid under a superannuation Policy, and may restrict payment. This means the trustee of a superannuation fund can only provide insurance benefits to a member if the benefit for the insured event is consistent with a condition of release for superannuation law purposes.

Benefits from Policies must be releasable from superannuation under one of the following conditions of release:

- temporary incapacity;
- permanent incapacity;
- terminal medical condition; or
- death.

Temporary incapacity

Under superannuation law, temporary incapacity, in relation to a member who has ceased to be gainfully employed (including a member who has ceased temporarily to receive any gain or reward under a continuing arrangement for the member to be gainfully employed), means ill-health (whether physical or mental) that caused the member to cease to be gainfully employed but does not constitute permanent incapacity. Therefore, if the member has ceased gainful employment prior to the *sickness* or *injury* that gave rise to the claim, benefits will not be payable from a superannuation policy under the temporary incapacity condition of release, but may be payable under an alternative condition of release, subject to trustee consent.

If the temporary incapacity condition of release is met, benefits including an Income Protection Policy held inside superannuation, including an Income as Superannuation Policy, may only be paid as a non-commutable income stream for the duration of the temporary incapacity. Benefits from an Income Protection Policy held inside superannuation, together with all earned income and replacement of earned income, cannot exceed income prior to temporary incapacity.

Permanent incapacity

A member is deemed to be suffering from permanent incapacity if the trustee is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience.

Terminal medical condition

A terminal medical condition exists at a particular time if two medical practitioners certify that the member is suffering from a sickness, or has incurred an injury, that is likely to result in death no more than 24 months from the date of the certification (the certification period). At least one of the medical practitioners must be a specialist in the area of the sickness or injury.

Chapter 7: Medical glossary

If the method for diagnosing one of the events in this Medical Glossary has been superseded due to medical improvements, we will consider other appropriate and medically recognised methods or tests that conclusively diagnose the event to at least the same severity.

Activities of daily living

The activities of daily living are:

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

Alzheimer's disease and other dementias – permanent and irreversible and of specified severity

The unequivocal diagnosis of Alzheimer's disease or other dementia, confirmed by a consultant neurologist or geriatrician. The diagnosis must confirm permanent and irreversible failure of the brain function with cognitive impairment for which no other recognisable cause has been identified. A Mini-Mental State Examination score of 24 or less is required.

Angioplasty – single or double vessel

Undergoing either angioplasty, cardiac keyhole surgery or stent insertion on one or two coronary arteries, as considered necessary by a cardiologist to treat coronary artery disease.

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

Angioplasty – triple vessel

Undergoing for the first time either angioplasty, cardiac keyhole surgery or stent insertion on 3 or more coronary arteries within a single procedure, or in two procedures no more than two months apart, as considered necessary by a cardiologist to treat coronary artery disease.

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

Aortic surgery – excluding less invasive surgeries

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

Aortic surgery – intra-arterial procedure

Intra-arterial procedure performed to correct a structural abnormality of the thoracic or abdominal aorta, but not its branches. This treatment must be deemed the most appropriate treatment and medically necessary by an appropriate medical specialist and supported by our medical advisers.

Aplastic anaemia – of specified severity

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

a. permanent reliance on blood product transfusions;
b. marrow stimulating agents;
c. bone marrow transplantation; or
d. immunosuppressive agents.

Brain or spinal cord tumour (benign) – resulting in significant permanent impairment or requiring radical treatment

Non-cancerous tumour in the brain or spinal cord which produces neurological deficit resulting in:

a. *significant functional impairment*; or
b. radical treatment which includes radiotherapy (eg gamma knife stereotactic radiosurgery), laser therapy, ultrasonic aspiration, or any other major invasive neurosurgical techniques necessary for the therapeutic management of the tumour.

The presence of the underlying tumour must be confirmed by a registered medical practitioner specialising in the field relevant to the condition and by imaging studies such as a CT or MRI scan.

The following are excluded:

- cysts, granulomas and cerebral abscesses;
- malformations in, or of, the arteries or veins of the brain;
- haematomas;
- tumours in the pituitary gland; and
- acoustic neuroma and other cranial nerve tumours.

Brain damage – resulting in permanent impairment

Brain damage, as confirmed by a medical practitioner who is a consultant neurologist, which results in neurological deficit causing at least a 25% permanent impairment of whole person function according to the 5th edition of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment', or an equivalent guide to impairment as approved by us.

Burns (severe) – covering specified surface area

Tissue *injury* caused by third degree or full thickness burns to:

a. at least 20% of the body surface area as measured by the 'Rule of Nines' or the Lund & Browder Body Surface Chart (or equivalent classification); or
b. at least 50% of both hands, requiring surgical debridement and/or grafting; or
c. at least 50% of both feet, requiring surgical debridement and/or grafting; or
d. the face, requiring surgical debridement and/or grafting.

Cancer – excluding specified early stage cancers

A malignant tumour pathologically confirmed and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue. Also included are:

- Hodgkin's disease, lymphoma, colorectal cancer (from Dukes stage A), myelofibrosis, myelodysplastic syndrome and leukaemia;
- essential thrombocythemia and polycythemia vera, where the Insured Person has developed uncontrolled symptoms associated with myeloproliferative neoplasms, which requires cytoreductive therapy or chemotherapy; and
- pseudomyxoma peritonei, where the diagnosis is confirmed by histological evidence, and which requires debulking surgery, aggressive cytoreduction or intraperitoneal chemotherapy.

The following are specifically excluded:

a. all skin cancers except:
   - melanomas of 1.0 millimetre or more Breslow thickness, or Clark Level 3 or more depth of invasion, or with evidence of ulceration; and
   - non-melanoma skin cancers that have spread to the bone, lymph node, or another distant organ;
b. all tumours which are histologically described as papillary microcarcinoma of the thyroid, pre-malignant or showing the malignant changes of 'carcinoma in situ', including cervical dysplasia rated as CIN 1, 2 or 3.

   'Carcinoma in situ' of the breast is not excluded 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; or
   - breast conserving surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy). The surgery and treatment must be undertaken specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment as confirmed by an appropriate specialist *doctor* acceptable to us. Chemotherapy means the use of drugs as prescribed by an appropriate specialist *doctor* specifically designed to kill or destroy cancer cells;
c. chronic lymphocytic leukaemia (less than RAI stage 1); and
d. prostatic tumours which are histologically described as TNM classification T1 (including T1a, T1b and T1c) with a Gleason score of 5 or less, or are of another equivalent or lesser classification.

   Prostate cancer is covered if it results directly in total prostatectomy. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment.

Carcinoma in situ of female organs

The Insured Person is confirmed by biopsy to have localised cancer characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues.

'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane.

Carcinoma in situ of the following sites is covered:

a. Cervix-uteri (the tumour must be classified as Tis according to the TNM staging method or CIN 3).
b. Corpus-uteri (the tumour must be classified as Tis according to the TNM staging method).
c. Fallopian tube (the tumour must be limited to the tubal mucosa and classified as Tis according to the TNM staging method).
d. Ovary (the tumour must be classified as Tis according to the TNM staging method).
e. Vagina (the tumour must be classified as Tis according to the TNM staging method).
f. Vulva (the tumour must be classified as Tis according to the TNM staging method).
g. Breast (the tumour must be classified as Tis according to the TNM staging method).

Carcinoma in situ of the perineum, penis or testicle

The Insured Person is confirmed by biopsy to have localised pre-invasive or low level cancer in one or more of the following sites: perineum, penis or testicle. The pre-invasive or low level cancer must have a TNM classification of Tis.

Cardiac arrest – occurs out of hospital and of specified severity

Cardiac arrest occurring out of hospital not associated with any medical procedure and documented by an ECG or ECG rhythm strip showing cardiac asystole or ventricular fibrillation. If an ECG is not available, we will consider other evidence acceptable to us that unequivocally confirms out of hospital cardiac arrest has occurred. Such evidence may include Automated External Defibrillator (AED) data, and ambulance and hospital medical reports confirming cardiac arrest.

Cardiomyopathy – resulting in significant permanent impairment

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

Coma – with specified criteria

A state of unconsciousness with no reaction to external stimuli, resulting in a Glasgow Coma Scale of 6 or less, persisting continuously and requiring the use of a life support system for a period of at least 3 consecutive days.

Coronary artery bypass surgery – excluding less invasive procedures

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

Deafness (both ears) – permanent and irreparable

Permanent and irreversible loss of hearing in both ears. Loss of hearing (both natural and assisted) must be across all frequencies at every decibel below 91dB as a result of *sickness* or *injury*, as certified by an appropriate medical specialist. For the purpose of this definition, hearing that has been treated by cochlear implant is not considered `assisted'.

Deafness (one ear) – permanent and irreparable

Permanent and irreversible loss of hearing in one ear. Loss of hearing (both natural and assisted) must be across all frequencies at every decibel below 91dB as a result of *sickness* or *injury,* as certified by an appropriate medical specialist. For the purpose of this definition, hearing that has been treated by cochlear implant is not considered `assisted'.

Diabetes (severe) – of specified severity

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

a. severe diabetic retinopathy resulting in visual acuity whether aided or unaided of 6/36 or less in both eyes;
b. severe diabetic neuropathy causing motor and/or autonomic impairment;
c. diabetic gangrene leading to surgical intervention;
d. severe diabetic nephropathy causing chronic irreversible renal impairment (as measured by a

corrected creatinine clearance below the laboratory's measured normal range); or

e. persistent sensory neuropathy.

Diabetes (Type 1 insulin dependent) – of specified severity

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

a. urinary protein excretion of more than 300mg per day;
b. diabetic retinopathy with a minimum severity of at least exudates and/or dot-blot haemorrhages; or
c. persistent sensory neuropathy.

Encephalitis – resulting in significant impairment

Severe inflammatory disease of the brain resulting in neurological deficit that causes either:

a. *significant functional impairment*, as confirmed by a consultant neurologist; or
b. an inability to perform at least one of the activities of daily living (as defined in this chapter).

Head trauma (major) – resulting in significant permanent impairment

Accidental head *injury* resulting in neurological deficit that causes either:

a. *significant functional impairment*, as certified by a consultant neurologist; or
b. a permanent and irreversible inability of the Insured Person, to perform, without the physical assistance of an adult, any one of the activities of daily living (as defined in this chapter).

Heart attack – of specified severity

Death of heart muscle caused by inadequate blood supply, evidenced by typical rise and/or fall of cardiac biomarker blood tests with at least one of the following:

a. Acute cardiac symptoms and signs consistent with a heart attack;
b. New serial electrocardiograph changes associated with myocardial infarction; or
c. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

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

The following are specifically excluded:

- other acute coronary syndromes, including but not limited to angina pectoris;
- injury not related to myocardial ischemia;
- acute heart failure;
- takotsubo cardiomyopathy; and
- any elective percutaneous procedure for coronary artery disease, which is the sole cause of a rise in cardiac biomarkers.

Heart valve replacement or repair

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

Hepatitis B or C – occupationally acquired

Occupationally acquired hepatitis B or hepatitis C where the virus was acquired due to an *accident* occurring while the Insured Person was engaging in their *usual occupation* as a medical professional and proof of sero-conversion from:

a. Hepatitis B surface antigen negative to hepatitis B surface antigen positive; or
b. Hepatitis C antibody negative to hepatitis C antibody positive,

being demonstrated by testing within six months of the *accident*. Hepatitis B or hepatitis C acquired in any other manner is excluded.

Any *accident* that potentially may give rise to a claim must be treated in accordance with the relevant infection control guidelines for the relevant practice body or state health service, including, at a minimum, baseline screening with regular screening at six weeks, 12 weeks and six months post event. This screening will require a supporting negative hepatitis B or hepatitis C test performed on material taken after the *accident* date. Blood product and all other blood samples used will need to be made available for independent testing.

The Insured Person will be deemed not to have Hepatitis B or C – occupationally acquired if:

- any cure is found for hepatitis B and/or hepatitis C; or
- the Insured Person had elected not to take a medical treatment that is available which results in the prevention of infection with hepatitis B and/or hepatitis C prior to the making of a claim.

HIV – medically acquired

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

a. blood or blood product transfusion;
b. organ transplant to the Insured Person;
c. assisted reproductive techniques; or
d. medical/dental procedure or operation.

The Insured Person will be deemed not to have HIV–medically acquired if:

- any cure is found for AIDS or the effects of HIV; or
- a medical treatment is developed that results in the prevention of infection with HIV or the occurrence of AIDS prior to the making of a claim.

A statement from the appropriate Statutory Health Authority must be provided, showing documented proof of the incident and confirming that the infection is medically acquired.

HIV – occupationally acquired

Infection with the Human Immunodeficiency Virus (HIV) where the virus was acquired due to an *accident* occurring while the Insured Person was engaging in their *usual occupation*. Sero-conversion of the HIV infection must occur within 6 months of the *accident*.

HIV infection acquired by any other means including sexual activity or non-prescribed intravenous drug use is excluded.

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

The Insured Person will be deemed not to have HIV-occupationally acquired if:

- any cure is found for AIDS or the effects of HIV; or
- a medical treatment is developed that results in the prevention of infection with HIV or the occurrence of AIDS prior to the making of a claim.

Idiopathic pulmonary arterial hypertension – resulting in significant permanent impairment

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

Intensive care – requiring continuous mechanical ventilation for 10 days

Sickness or *injury* that has for the first time resulted in the Insured Person requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital.

Intensive care as a result of drug or alcohol abuse is excluded.

Kidney failure – requiring permanent dialysis or transplantation

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

Liver failure (severe) – of specified severity

End stage liver failure characterised by:
a. permanent jaundice; and
b. ascites or encephalopathy.

Loss of independent existence – with a specified level of impairment

As a result of *sickness* or *injury*, the Insured Person:
a. has a permanent and irreversible inability to perform, without assistance, any two of the activities of daily living (as defined in this chapter); or
b. suffers *significant cognitive impairment*, which must be established and the diagnosis reaffirmed after a continuous period of at least 6 months of such impairment.

Loss of limbs – complete and irrecoverable

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

Loss of sight (both eyes) – of specified severity

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

Loss of sight (single eye) – of specified severity

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

Loss of single limb – complete and irrecoverable

The complete and irrecoverable loss of use of one hand or one foot as a result of *sickness* or *injury*.

Loss of speech – complete and irrecoverable

The complete and irrecoverable loss of speech as a result of *sickness* or *injury* as certified by a consultant neurologist.

Lung disease – requiring permanent oxygen therapy

Chronic lung disease requiring permanent supplementary oxygen. The requirement for supplementary oxygen will be an arterial blood oxygen partial pressure of 55 mmHg or less, while breathing room air.

Melanoma (early stage) – of specified severity

The presence of one or more malignant melanomas which are less than 1.0mm Breslow thickness and less than Clark level 3 depth of invasion, confirmed histologically by biopsy.

The malignancy must be characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

All tumours that are histologically described as melanoma in situ are excluded.

Meningitis (bacterial) – resulting in permanent impairment

Unequivocal diagnosis of bacterial meningitis by a consultant neurologist resulting in:
a. *significant functional impairment*; or
b. a permanent and irreversible inability to perform, without assistance, any one of the activities of daily living (as defined in this chapter).

Meningococcal septicaemia – resulting in permanent impairment

Unequivocal diagnosis of meningococcal septicaemia by a consultant neurologist resulting in:
a. *significant functional impairment*; or
b. a permanent and irreversible inability to perform, without assistance, any one of the activities of daily living (as defined in this chapter).

Motor neurone disease

The Insured Person is unequivocally diagnosed by a consultant neurologist, as suffering from motor neurone disease.

Multiple sclerosis

The unequivocal diagnosis of multiple sclerosis made by a medical practitioner who is a consultant neurologist on the basis of confirmatory neurological investigation. There must be at least one episode of confirmed neurological deficit to satisfy this definition.

Muscular dystrophy

The Insured Person is unequivocally diagnosed by a consultant neurologist, as suffering from muscular dystrophy, on the basis of confirmed neurological investigations.

Open heart surgery

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

Organ transplant (major) – from another donor

The medically necessary:
a. human to human transplant from a donor to the Insured Person (or Insured Child or *dependant child* if applicable); or
b. placement of the Insured Person (or Insured Child or *dependant child*) on a waiting list, to undergo organ transplant from a human donor,

for one or more of the following: a heart, lung, kidney, liver, pancreas or bone marrow.

A waiting list means the Insured Person (or Insured Child or *dependant child*) has been placed on an official Australian acute care hospital waiting list, approved by us.

Osteoporosis (severe, before age 50) – with specified fractures

Prior to the age of 50, the Insured Person is unequivocally diagnosed with osteoporosis and suffers at least two separate vertebral body fractures or a fracture of the neck of femur due to osteoporosis.

Paralysis

The total and permanent loss of use through *sickness* or *injury* of:

a. both legs (paraplegia);
b. both arms and legs (quadriplegia);
c. one side of the body (hemiplegia); or
d. both sides of the body (diplegia).

Parkinson's disease – resulting in permanent symptoms

Means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease confirmed by a consultant neurologist, as characterised by the clinical manifestation of one or more of the following:

- rigidity;
- tremor; and
- akinesia,

resulting in the degeneration of the nigrostriatal system.

All other types of Parkinsonism are excluded (for example, secondary to medication).

Pneumonectomy – removal of a complete lung

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

Prostate cancer – early stage

A tumour located within the prostate gland and histologically described as TNM classification T1 (including T1a, T1b and T1c) with a Gleason score of 5 or less.

Prostate cancer – with major treatment

Low level prostatic tumours:

- which are histologically described as TNM classification T1 (including T1a, T1b and T1c) or lesser classification;
- with a Gleason score of 5 or less; and
- where appropriate and necessary major treatment (includes radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment) has been performed specifically to arrest the spread of malignancy.

Rheumatoid arthritis (severe) – of specified severity

The diagnosis of severe rheumatoid arthritis by a rheumatologist, as evidenced by either of the following criteria.

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

OR

- The diagnosis must be supported and evidenced by all of the following criteria:
  a. diagnosis of Rheumatoid Arthritis as specified by the American College of Rheumatology and European League Against Rheumatism: 2010 Rheumatoid Arthritis Classification Criteria; and
  b. symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or 4 large joints (ankles, knees, hips, elbows, shoulders); and
  c. the Insured Person has failed at least 6 months of intensive treatment with two conventional disease-modifying antirheumatic drugs (DMARDs). This excludes corticosteroids and non-steroidal anti-inflammatories; and
  d. the disease must be progressive and non-responsive to all conventional therapy.

  Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for Rheumatoid Arthritis.

Degenerative osteoarthritis and all other arthridities are excluded.

Stroke – of specified severity

Any cerebrovascular accident (CVA) or incident resulting in neurological deficit. The stroke must:

a. be confirmed by a consultant neurologist; and
b. be evidenced by neuro-imaging (eg CT, MRI or similar scanning technique).

The following are specifically excluded:

- cerebral events with reversible neurological deficits, including but not limited to transient ischemic attack;
- cerebral symptoms due to migraine;
- cerebral injury resulting from head trauma or hypoxia; and
- neurovascular disease or incident affecting the eye, optic nerve or vestibular functions.

Systemic lupus erythematosus (SLE) with lupus nephritis – of specified severity

The unequivocal diagnosis of SLE according to the latest 'American College of Rheumatology revised criteria for the classification of SLE'.

In addition to the diagnosis of SLE, lupus nephritis must be confirmed by renal changes as measured by a renal biopsy that is grade three or more of the World Health Organisation classification of lupus nephritis and be associated with persisting proteinuria (more than 2+).

Chapter 8: Definitions

Each defined term is indicated by the use of italics throughout the PDS. Those italicised terms are subject to the definitional meanings set out in this chapter 8 ('this chapter'). Within this chapter, the corresponding defined term/s are indicated in bold, and given the meaning that is supplied by the wording which subsequently follows up until the start of the next defined term/s indicated in bold.

Accident and **accidental** means death, *total and permanent disability*, *sickness*, or *injury* as a result of a single event that results in a bodily *injury* sustained as a result of an external traumatic occurrence that is unexpected. This does not include an event that results from *sickness*.

Agreed value means that the amount of the Total Disability Benefit (which is relevant to calculating the benefit payable in the event of *total disability* and/or *partial disability*) or Severe Disability Benefit, being the *insured monthly benefit* amount stated in the most recent *policy schedule*, *membership certificate* or *renewal summary*, will not reduce when the Insured Person is disabled because their *monthly earnings* have reduced since taking out the insurance, provided income details were correctly disclosed at that time.

Allowable business expenses means the following items of expenditure provided they are incurred in the normal conduct and operation of the *Insured Person's business*:

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

Allowable business expenses do not include:

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

Any occupation TPD is a definition of *total and permanent disability*.

Beneficiary means a person to whom a Death Benefit, Funeral Advancement Benefit, Financial Planning Benefit or Counselling Benefit, or part of any of these benefits is paid at your direction or in accordance with superannuation law as relevant.

Benefit period means the maximum period of time measured from the end of the *waiting period* for which a benefit entitlement in respect of any one *sickness* or *injury* may continue to accrue (subject to recurrent disability). Your benefit period is shown in your *policy schedule* or *membership certificate*.

Business income means:

- For Business Overheads Policies, the gross income of the business before expenses and tax.
- For Key Person Income Policies, the [portion of the] *gross profit* of the *key person business* attributable to the Insured Person. Business income does not include any income which is not directly attributable to the Insured Person such as interest payments, sale of an asset and government subsidies.

Carer means:

- the primary caregiver who provides assistance with communication, mobility or self-care for more than 20 hours per week to a disabled or aged person, for more than 6 consecutive months, and is in receipt of an Australian Government Carer's Allowance; or
- the person financially responsible for providing assistance with communication, mobility or self- care for more than 20 hours per week to a disabled or aged person, for more than 6 consecutive months.

Commencement date means the date 'Policy Risk Commencement Date' shown on your *policy schedule* or *membership certificate*.

Confined to bed means *totally disabled* and required by a *doctor* to stay in bed under the full-time care of a registered nurse. The nurse cannot be you or a *spouse*, parent, child, sibling or business partner of you or the Insured Person.

Congenital condition means a condition present at birth as a result of either hereditary or environmental influences.

CPI means the percentage increase in the Consumer Price Index ('weighted average of eight capital cities combined') as published by the Australian Bureau of Statistics or its successor over the 12 month period ending 31 March each year. The CPI will apply for the subsequent year commencing 1 October. If the CPI is not published, or is considered by us to be inappropriate, the percentage increase shall be

calculated by reference to such other index of inflation as, in our opinion, most nearly replaces it. If the CPI is negative, we will consider it to be zero.

Date of disablement means:

- for *own occupation TPD* and *any occupation TPD*, 3 months after ceasing work due to *sickness* or *injury*;
- for *home duties TPD*, 3 months after ceasing home duties due to *sickness* or *injury*; and
- for *general cover TPD*, the date the Insured Person meets the *general cover TPD* definition.

Date of disability is the date *total disability* or *partial disability* commenced.

Dependant child means a natural child of the Insured Person, or a child for whom the Insured Person is a *legal guardian*.

Doctor means a person who:

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

Earnings means the income earned by the Insured Person's own personal exertion before tax, but after deduction of any expenses incurred in earning that income.

Endorsed agreed value means that the amount of the Total Disability Benefit (which is relevant to calculating the benefit payable in the event of *total disability* and/or *partial disability*) or Severe Disability Benefit will be subject to a guaranteed amount, being the *insured monthly benefit* amount stated in the most recent *policy schedule*, *membership certificate* or *renewal summary*.

Fracture means the disruption in the continuity of the bone, with or without displacement, demonstrated by radiographic or scanning technique.

Gainful employment and **gainfully employed** means:

- For employees, a person is working for salary, wages, or commission.
- For self-employed, a person is working in a business or professional practice and as a result of their personal exertion is generating an income from the business or professional practice.

General cover IP is a definition of Income Protection.

General cover TPD is a definition of *total and permanent disability*.

Gross profit is the *key person business* revenue minus its costs of goods sold, before deducting expenses and tax. Gross profit does not include any profit gained from the sale of assets, government subsidies or interest.

Home duties IP is a definition of Income Protection and Income Protection Plus.

Home duties TPD is a definition of *total and permanent disability*.

Immediate family member means a *spouse*, parent, child or sibling.

Important income producing duties means:

- For Income Protection, Income Protection as Superannuation, Income Protection Plus and Business Overheads, those duties which could reasonably be considered primarily essential to producing the Insured Person's monthly income.
- For Key Person Income, those duties which could reasonably be considered primarily essential to producing the *business income*.

Income ratio means the *insured monthly benefit* as a percentage of *monthly earnings*. It is calculated at the time of application.

Indemnity means:

- For Income Protection, Income Protection as Superannuation and Income Protection Plus:
  - The amount of the Total Disability Benefit (which is relevant to calculating the benefit payable in the event of *total disability* and/or *partial disability*) or Severe Disability Benefit, being the *insured monthly benefit* amount stated in the most recent *policy schedule*, *membership certificate* or *renewal summary*, may be reduced if the Insured Person's *monthly earnings* have reduced since your insurance commenced.
- For Key Person Income:
  - The Total Disability Benefit (which is relevant to calculating the benefit payable in the event of *total disability* and *partial disability*) is the lesser of the *insured monthly benefit* and the *pre-disability monthly business income*.

Injury means a bodily injury which is sustained by the Insured Person after the later of:

- the *commencement date*;
- for an increase in the sum insured for any benefit, the date we increase the benefit (other than a *CPI* or Loyalty Benefit increase); and
- the date your Policy was last reinstated, but before your Policy ends.

A bodily injury which was sustained prior to the *commencement date* or last reinstatement of your Policy, that you or the Insured Person fully disclosed to us and we agreed to cover is considered an injury for the purposes of this definition.

Insolvency event means any of the following events:

- The *key person business*:
  - has ceased trading;
  - is insolvent;
  - goes into liquidation or provisional liquidation;
  - has a receiver or other controller appointed to it or to any of its assets;
  - is wound up;
  - is dissolved; or
  - is deregistered as a business, company or trust.

OR

- Any lawful step is taken by a mortgagee to take possession of assets of the *key person business*.

Insured Child means the child to be insured for the Children's Benefit. The name of each Insured Child is set out in the *policy schedule* under the heading, Insured Child.

Insured monthly benefit means the amount shown in the most recent *policy schedule*, *membership certificate* or *renewal summary*.

Insured Person means the person whose life is insured, or the life to be insured. The name of each Insured Person is set out in the *policy schedule* or *membership certificate* under the heading, Insured Person.

Insured Person's business means the business, profession or occupation of the Insured Person.

Insurer means Westpac Life Insurance Services Limited ABN 31 003 149 157, AFSL 233728.

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

Key person business means the Policy Owner of a Key Person Income Policy.

Key person business owner means a person who is a shareholder, unitholder or partner of the *key person business* who works to generate income for the *key person business*, where the loss of that person would result in significant loss of profits during the continuation of business operations subsequent to the loss.

Key person employee means a person who is an employee of the *key person business* with specific skills or knowledge, where the loss of that person would result in significant loss of profits during the continuation of business operations subsequent to the loss.

Key person factor means the percentage of *monthly earnings* we agree to replace at the time of claim and is shown in the most recent *policy schedule*.

Key person means the *key person business owner* and/or the *key person employee*, who is the Insured Person under the Policy.

Legal guardian is a person who has been given the legal power to make important decisions on behalf of another person, such as where that person should live, or what care and services that person should have.

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

Membership certificate means the most recent document that we issue to you, which sets out the details of the insurance we provide you under Term Life as Superannuation or Income Protection as Superannuation.

Monthly earnings means:

For Income Protection, Income Protection as Superannuation and Income Protection Plus:

- if the Insured Person is not self-employed, the normal monthly value of the remuneration package paid to the Insured Person by their employer, including salary, superannuation contributions, fees, commissions, regular overtime and bonus payments and packaged fringe benefits. Remuneration package does not include income which is not derived from the Insured Person's personal exertion or activities, such as interest or dividend payments; or
- if the Insured Person is self-employed:
  - the normal monthly income earned by the *Insured Person's business*, practice or partnership due to the Insured Person's personal exertion or activities, less
  - the Insured Person's share of the expenses of the business, practice or partnership that were necessarily incurred in producing the normal monthly income.

  Monthly earnings are calculated as the amount before the deduction of income tax.

For Key Person Income:

- the normal monthly value of the remuneration package paid to the Insured Person by the *key person business*, including salary, superannuation contributions, fees, commissions, regular overtime and bonus payments and packaged fringe benefits.

  Monthly earnings are calculated as the amount before the deduction of income tax.

Mortgage means a loan secured by a first mortgage over the Insured Person's principal place of residence. The mortgage must be with an authorised deposit-taking institution (ADI), or any other mortgage provider that we agree to.

Normal household duties means the household duties normally performed by a person who remains at home and is not working in a regular occupation including part time and/or voluntary work, for income. Normal household duties include:

- Cooking and preparing meals – meaning the ability to prepare meals using basic ingredients and kitchen appliances;
- Cleaning the house – meaning the ability to carry out the basic internal household chores using various tools such as a mop or vacuum cleaner;
- Washing and drying clothes – meaning the ability to maintain the household's laundry by using the washing machine and being able to hang clothes on a washing line or clothes airer;
- Shopping for groceries – meaning the ability to physically purchase general household grocery items with the use of either a shopping basket or trolley;
- Looking after children – (if the Insured Person does this as part of their everyday activities at home) meaning the ability to care for and supervise children up to the age of 12 years old, including, the preparation of meals, bathing, dressing and getting the child to and from school by car or walking.

For the avoidance of doubt, an Insured Person will not be considered to be unable to carry out all normal household duties if the Insured Person is able to perform any one or more of the listed normal household duties.

Our means the *Insurer*.

Own occupation means the occupation that the Insured Person was engaged in immediately prior to the event giving rise to the claim.

If the Insured Person was unemployed immediately prior to the event given rise to the claim, own occupation refers to the occupation they were engaged in the last time they were *gainfully employed* prior to the event giving rise to the claim.

Own occupation IP is a definition of Income Protection, Income Protection as Superannuation and Income Protection Plus.

Own occupation TPD is a definition of *total and permanent disability*.

Partial and permanent disablement and **partially and permanently disabled** means the loss of use of one *limb* or sight in one eye due to *sickness* or *injury*.

Partial disability and **partially disabled** means:

a. for Income Protection, Income Protection as Superannuation and Income Protection Plus

- Due to *sickness* or *injury* the Insured Person:
  - while working and able to perform one or more of the *important income producing duties* of their *usual occupation*, is unable to perform all of them;
  - while working and able to perform all of the *important income producing duties* of their *usual occupation*, is only able to do so in a reduced capacity; or
  - is working in another occupation; and
- the *monthly earnings* of the Insured Person are less than the amount of their *pre-disability monthly earnings*; and
- the Insured Person is under the *regular care of a doctor*.

b. for Business Overheads
- Due to *sickness* or *injury* the Insured Person:
  - while working and able to perform one or more of the *important income producing duties* of their *usual occupation*, is unable to perform all of them;
  - while working and able to perform all of the *important income producing duties* of their *usual occupation*, is only able to do so in a reduced capacity; or
  - is working in another occupation; and
- the Insured Person is suffering a loss in *business income*; and
- the Insured Person is under the *regular care of a doctor*.

c. for Key Person Income
- Due to *sickness* or *injury* the Insured Person is:
  - while working and able to perform one or more of the *important income producing duties* of their *usual occupation* in the *key person business*, is unable to perform all of them; or
  - while working and able to perform all of the *important income producing duties* of their *usual occupation* in the *key person business*, is only able to do so in a reduced capacity; and
- the Insured Person is working for a lower number of hours than the average number of hours worked in the three months immediately preceding the commencement of the *waiting period*; and
- the Insured Person is under the *regular care of a doctor*.

Payment period means the period of time set out in the tables in chapter 3, section 18.5 that is used to determine the amount you will be paid after suffering a specified *injury* under the Specified Injury Benefit.

Policy means:
- for Policies held inside *Westpac MasterTrust*, the cover as provided under the contract of insurance between us and *WSAL*; and
- for all other cover, the contract of insurance with us.

Policy Owner means the person (or entity) shown as the Policy Owner in the *policy schedule* or *membership certificate*. For Policies held through *Westpac MasterTrust*, the Policy Owner is the *trustee*.

Policy schedule means the most recent document that we issue to you which sets out the details of the insurance we provide you, and forms part of your contract with the *Insurer*.

Pre-disability monthly earnings means:

For Income Protection and Income Protection Plus:
- if the monthly benefit type shown in the *policy schedule* or *membership certificate* is *indemnity*, the Insured Person's highest average *monthly earnings* in any consecutive 12 month period in the 36 months immediately preceding the commencement of *total disability* or *partial disability*, increased by the *CPI* each *review date* since that date; or
- if the monthly benefit type shown in the *policy schedule* or *membership certificate* is *endorsed agreed value* or *agreed value*, the Insured Person's highest average *monthly earnings* in any consecutive 12 month period between the date 2 years prior to the *commencement date* and the date that the *waiting period* commences, increased by the *CPI* each *review date* since that date.

For Policies with a 'to age 70' *benefit period*, and where the Insured Person becomes *totally disabled* or *partially disabled* after the *review date* following their 65th birthday:
- the Insured Person's highest average *monthly earnings* in any consecutive 12 month period in the 36 months immediately preceding the commencement of *total disability* or *partial disability*, increased by the *CPI* each *review date* since that date.

For the IP Continuation Option:
- the Insured Person's *monthly earnings* in the 12 month period immediately preceding the commencement of *total disability* or *partial disability*.

Pre-disability monthly business income means:

a. *Key person employee*

If the Insured Person is a *key person employee* and the monthly benefit type shown in the *policy schedule* is *indemnity*, the *key person factor* multiplied by the *key person employee's* average *monthly earnings* in the 12 months immediately preceding the commencement of *total disability* or *partial disability*, increased by the *CPI* each *review date* since the *date of disability*.

b. *Key person business owner*

The pre-disability monthly business income is calculated as follows:

A x B = C

A = a percentage being the lesser of the following:
- The Insured Person's ownership percentage of the *key person business* as at the *date of disability*;
- The average percentage of *gross profit* attributed to the Insured Person in the 12 months immediately preceding the commencement of *total disability* or *partial disability*; and
- 50%.

B = an amount which is the average monthly *gross profit* of the *key person business* for the 12 months immediately preceding the commencement of *total disability* or *partial disability*. This amount is increased by the *CPI* each *review date* since the *date of disability*.

C = *pre-disability monthly business income*.

Post-disability monthly business income means the monthly *business income* while the Insured Person is *partially disabled*. If this is a negative amount, we will use zero.

Post-disability monthly earnings means the Insured person's *monthly earnings* after becoming *partially disabled*.

Regular care of a doctor means the Insured Person:

- has sought advice, care, and treatment from a *doctor* in relation to the *sickness* or *injury* that you are claiming for and is continuing to do so at such times as is reasonable in the circumstances; and
- is following the advice, care and treatment of the *doctor*.

Renewal summary means the annual renewal notice sent to the Policy Owner or Insured Person.

Review date means the anniversary of your Policy *commencement date*, or if you have placed your Policy in a group of Policies (ie a portfolio) with a different review date, the review date of the portfolio.

Severe disability and **severely disabled** means:

a. for *home duties IP*

   The Insured Person is, because of *sickness* or *injury*, unable to perform the *normal household duties* and is under the *regular care of a doctor*.

b. for *general cover IP*

   The Insured Person, because of *sickness* or *injury*, is under the *regular care of a doctor*; and;

   - is unable to perform, without assistance, any two of the activities of daily living (as defined in the 'Medical glossary'); or
   - is suffering from *significant cognitive impairment*.

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

- the *commencement date*;
- for an increase in the sum insured for any benefit, the date we increase the benefit (other than a *CPI* or Loyalty Benefit increase); and
- the date your Policy was last reinstated, but before your Policy ends.

For the avoidance of doubt, a sickness or disease is taken to have first become apparent when:

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

A sickness or disease which first became apparent before the *commencement date*, increase in sum insured but only in respect of that increase, or last reinstatement of the Policy that you or the Insured Person fully disclosed to us and we agreed to cover is considered a sickness for the purposes of this definition.

Significant cognitive impairment means a deterioration or loss of intellectual capacity that results in a requirement for a full-time permanent caregiver.

Significant functional impairment means a permanent impairment of at least 25% of whole person function as defined in the most current edition of the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', or an equivalent guide to impairment approved by us.

SMSF means a self managed superannuation fund as defined by section 17A of the Superannuation Industry (Supervision) Act 1993 (Cth). With limited exceptions, self managed superannuation funds have less than five members, all of which are trustees or directors of the trustee company.

Specified children's event(s) means death and any of the *sickness*, *injuries* or surgeries covered under the Children's Benefit or Child Support Benefit. With the exception of death, each of the specified children's events is defined in chapter 7 'Medical glossary' or in this chapter.

A specified children's event does not include:

- any *sickness*, *injury* or surgery; or
- death as a result of a *sickness*, *injury* or surgery,

which is, or is related to, a pre-existing condition that existed prior to, or at the time of, application or, for increases in the sum insured, at the time of the application to increase cover.

Pre-existing condition is taken to mean any *injury*, *sickness* or *symptom* that:

- you, the Insured Person, the *dependant child* or the Insured Child were aware of, or a reasonable person should have been aware of;
- you, the Insured Person, the *dependant child* or the Insured Child should have sought advice or treatment (whether conventional or alternative), from a medical practitioner or other health professional for (in circumstances where a reasonable person would have sought advice or treatment); or
- you, the Insured Person, the *dependant child* or the Insured Child had a medical consultation for or were prescribed medication or therapy for.

Specified medical event(s) is a *sickness*, *injury* or surgery for which a Living Benefit, Living Benefit Plus and Advancement Benefit are payable as listed in the 'Specified medical events (full payment)' and 'Specified medical events (partial payment)' tables on pages 20 and 21.

Spouse means:

- the Insured Person's husband or wife via marriage; or
- the Insured Person's de facto partner or any other person with whom the Insured Person is in a relationship (provided that this relationship is registered under a state or territory law); or
- another person who, although not legally married to the Insured Person, lives with the Insured Person on a genuine domestic basis in a relationship as a couple.

Symptom means a departure from normal function or feeling which is noticed by the Insured Person, indicating the potential presence of *sickness* or abnormality. A symptom is taken to have existed when first noticed by the Insured Person.

Terminal illness means:

If the Policy is held inside superannuation:

- two registered medical practitioners have certified, jointly or separately, that the Insured Person has a *sickness* or *injury*, that in spite of any reasonable medical treatment, is likely to result in their death within a period (the certification period) that ends no more than 24 months after the date of the certification;

- at least one of the registered medical practitioners is the treating registered specialist medical practitioner, and
- for each of the certificates, the certification period has not ended.

This must be evidenced by a medical report from the treating registered specialist medical practitioner and, where required by us, confirmed by a registered medical practitioner of our choice.

If the Policy is held outside superannuation:

- the treating registered specialist medical practitioner has determined that:
  - the Insured Person has a *sickness* or *injury* that in spite of any reasonable medical treatment, is likely to result in the death of the Insured Person; and
  - the death is likely to occur within a period that ends no more than 24 months after the date of the determination.

This must be evidenced by a medical report from the treating registered specialist medical practitioner and, where required by us, confirmed by a registered medical practitioner of our choice.

Total and temporary disablement and **totally and temporarily disabled** means:

- the Insured Person has suffered a *sickness* or *injury*; and
- the Insured Person is unable to work because of that *sickness* or *injury* in any occupation for which the Insured Person is reasonably suited by education, training or experience. If the Insured Person's TPD Benefit is defined as *home duties TPD*, the Insured Person is deemed to be unable to work if the Insured Person is prevented from carrying out all *normal household duties*.

Total disability and **totally disabled** means:

a. For Income Protection, Income Protection Plus, Income Protection as Superannuation and Business Overheads:
   - the Insured Person is, because of *sickness* or *injury*:
     - unable to perform one or more of the *important income producing duties* of their *usual occupation*;
     - not working; and
     - under the *regular care of a doctor*, or
   - the Insured Person is, because of *sickness* or *injury*:
     - not working for more than 10 hours per week in their *usual occupation*, and not working in any other occupation;
     - unable to perform the *important income producing duties* of their *usual occupation* for more than 10 hours per week; and
     - under the *regular care of a doctor*, or
   - the Insured Person is continuously *partially disabled* after the end of the *waiting period*, and the *post disability monthly earnings* while *partially disabled* are less than or equal to 20% of *pre-disability monthly earnings*.

   The above definition applies to occupation categories (as shown in the *policy schedule* or *membership certificate*) AA, A, P, S, BB, B or C during the life of a claim and only applies to occupation category E for the first 2 years of a claim, after which, the Insured Person will need to demonstrate that they are, because of *sickness* or *injury*:
   - unable to perform any occupation for which they are reasonably suited by education, training or experience;
   - not working; and
   - under the *regular care of a doctor*.

b. For Key Person Income:
   - The Insured Person is, because of *sickness* or *injury*:
     - unable to perform one or more of the *important income producing duties* of their *usual occupation* in the *key person business*;
     - not working; and
     - under the *regular care of a doctor*, or
   - The Insured Person is, because of *sickness* or *injury*:
     - not working for more than 10 hours per week in their *usual occupation* in the *key person business*;
     - not performing any *important income producing duties*;
     - unable to work for more than 10 hours per week in their *usual occupation*;
     - not working in any other occupation; and
     - under the *regular care of a doctor*.

Total and permanent disability and **totally and permanently disabled** means:

a. For own occupation TPD
   - *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months;
   - the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
   - the *sickness* or *injury* makes it unlikely that the Insured Person will ever again be able to work in their *own occupation*.

   The Insured Person will also be considered to be totally and permanently disabled if the Insured Person meets the *general cover TPD* definition of total and permanent disability.

b. For any occupation TPD

   If the Policy is held outside superannuation:
   - *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months; and
   - the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and either:
     - the *sickness* or *injury* makes it unlikely that the Insured Person will ever again be able to work in any occupation for which they are reasonably qualified because of education, training or experience; or
     - if the Insured Person is able to work in any occupation for which they are reasonably qualified because of education, training or experience but the total remuneration for this occupation is less than 25% of the Insured Person's earnings in their last 12 months of work.

   The Insured Person will also be considered to be totally and permanently disabled if the Insured Person meets the *general cover TPD* definition of total and permanent disability.

   If the Policy is held inside superannuation:
   - *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months; and

- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* makes it unlikely that the Insured Person will ever again be able to work in any occupation for which they are reasonably qualified because of education, training or experience.

The Insured Person will also be considered to be totally and permanently disabled if the Insured Person meets the *general cover TPD* definition of total and permanent disability.

c. For home duties TPD

If the Policy is held outside superannuation:

- *sickness* or *injury* which has prevented the Insured Person from carrying out all *normal household duties* for at least 3 consecutive months;
- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* makes it unlikely that the Insured Person will ever again be able to carry out all *normal household duties*.

The Insured Person will also be considered to be totally and permanently disabled if the Insured Person meets the *general cover TPD* definition of total and permanent disability.

If the Policy is held inside superannuation:

- *sickness* or *injury* which has prevented the Insured Person from carrying out all *normal household duties* for at least 3 consecutive months;
- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* makes it unlikely that the Insured Person will ever again;
  - be able to carry out all *normal household duties*; and
  - be able to work in any occupation for which they are reasonably qualified because of education, training or experience.

The Insured Person will also be considered to be totally and permanently disabled if the Insured Person meets the *general cover TPD* definition of total and permanent disability.

d. For general cover TPD

If the Policy is held outside superannuation:

- the Insured Person has suffered either:
  - total and permanent loss of use of two *limbs*; loss of use of one *limb* and loss of sight in one eye; or loss of sight; or
  - a Loss of Independent Existence (as defined in the 'Medical glossary').

If the Policy is held inside superannuation:

- the Insured Person has suffered:
  - total and permanent loss of use of two *limbs*; loss of use of one *limb* and loss of sight in one eye; or loss of sight; or
  - the Insured Person has suffered a Loss of Independent Existence (as defined in the Medical Glossary); and
- the *sickness* or *injury* makes it unlikely that the Insured Person will ever again be able to work in any occupation for which they are reasonably qualified because of education, training or experience.

Trustee means Westpac Securities Administration Limited ABN 77 000 049 472, AFSL Number 233731, RSE Licence L0001083.

Underwrite or **underwriting** means our assessment of the Insured Person's health and other factors, which could include occupation and pastimes, depending on the cover applied for. Underwriting allows us to decide whether to accept the application and what the cost of cover will be for each individual.

Us means the *Insurer*.

Usual occupation means the occupation in which the Insured Person was last engaged before becoming *totally disabled* or *partially disabled*.

Waiting period means the minimum period of time which must elapse before any benefit entitlement under an Income Protection, Income Protection as Superannuation, Income Protection Plus, Business Overheads or Key Person Income Policy may accrue. Your waiting period is shown in the *policy schedule* or *membership certificate*.

For occupation categories AA, A, P, S, BB, B, or C:

- the Insured Person must be continuously *totally disabled* or *partially disabled* throughout the entire waiting period, and
- the waiting period will end if the Insured Person ceases to be *totally disabled* or *partially disabled* at any time during the waiting period. If the Insured Person becomes *totally disabled* or *partially disabled* again, the waiting period will start from the beginning.

For occupation category E:

- Total Disability Benefit: the Insured Person must be continuously *totally disabled* throughout the entire waiting period.
- Partial Disability Benefit: the Insured Person must be *totally disabled* for at least 14 of the first 19 days of the waiting period and *totally disabled* or *partially disabled* for the balance of the waiting period.

For the Severe Disability Benefit, the Insured Person must be *severely disabled* throughout the entire waiting period. The waiting period will end if the Insured Person ceases to be *severely disabled* at any time during the waiting period. If the Insured Person becomes *severely disabled* again, the waiting period will start from the beginning.

We means the *Insurer*.

Westpac Group means Westpac Banking Corporation ABN 33 007 457 141 and its related bodies corporate, which include the *Insurer* and *WSAL*.

Westpac MasterTrust means Westpac MasterTrust ABN 81 236 903 448, SFN 281 412 940, SPIN WFS0341AU, RSE Registration Number R1003970.

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