

Policy document

Group Salary Continuance

Employer non-superannuation



redefining / insurance

DRAFT ONLY

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1 *Important information about this policy*

1.1 *Introduction*

We issue this *policy* to *you*.

We pay *your* premiums into a fund called Statutory Fund No 1 (Non-superannuation), which is protected under the Life Insurance Act 1995. This does not grant *you* or any *person insured* access to ownership or any rights of the assets of that fund.

This *policy* has no cash surrender value and does not participate in any profits or surpluses.

This *policy* participates in the Insurope multinational pooling arrangement, if the words 'Insurope participating' appear in the additional options section of the *schedule*.

1.2 *Policy commencement*

This *policy* begins from the *policy commencement date*.

1.3 *Interpreting the policy and special conditions*

Headings have been included in this document for *your* convenience. The headings do not alter how this *policy* is to be interpreted. Any words indicating singular can also be taken to mean plural and vice versa.

Some words or expressions in this *policy* have a particular meaning, which is explained in Part 8. These words or expressions are shown in italics.

Any special conditions (if applicable) inconsistent with the terms of this *policy* will prevail to the extent of the inconsistency.

1.4 *Legal interpretation*

This *policy* is to be interpreted under the law as it applies in Victoria.

Any references to dollar amounts in this *policy* are to Australian currency.

Any payments to or from *us* are payable in Australian currency.

1.5 *Policy changes*

This *policy*, with respect to *you* or a *person insured* may be varied by written agreement between *you* and *us*.

Only *our* authorised officers can agree to alter a term of this *policy* and only if it is in writing.

1.6 *Notices*

Any notice *we* give *you*, or *you* give to *us*, must be in writing.

We will send notices to *you*, or someone else nominated by *you*, to the last address provided to *us*.

You should post notices to *us* at *our* head office or send by facsimile to Melbourne on (03) 9618 5483 (or as advised by *us* from time to time).

1.7 *Audit*

You must keep accurate records necessary for *us* and *you* to be able to operate this *policy* effectively.

We may conduct an audit from time to time of any records *you* have which are connected with this *policy*. If *we* do this, *we* must give *you* reasonable notice of *our* intention to conduct an audit and the audit must be conducted in normal office hours.

You, *your* agents and/or administrator/s must provide reasonable access to *us*, *our* auditors and/or any government body having the right to do so under the *applicable laws*, to all records held by *you*, *your* agents and/or administrator/s, relevant to this *policy*.

We will try to minimise any inconvenience to *your* operations in conducting any audit.

1.8 *World wide cover*

Subject to the terms of the *policy*, *we* will provide cover for a *person insured*, 24 hours a day, anywhere in the world. Refer to clause 2.6 for further explanation.

1.9 Insurance cover and categories

Under this *policy*, we will pay you a *benefit* if a *person insured* suffers:

- *total disablement* (see clause 3.3),
- a listed specific sickness or specific injury (see clause 3.16).

We may also pay you for other reasons. These are explained in Part 3 of this *policy*.

When an *eligible person* becomes a *person insured*, cover commences as explained in Part 2 of the *policy*. Cover for each *person insured* is subject to this *policy* remaining in force and the premium in respect of that *person insured* being paid. For this *policy* to remain in force you must pay the applicable premiums on time, provide the required information in accordance with Parts 5 and 6 of this *policy* and observe all the terms and conditions of this *policy*.

There may be different categories of *persons insured* under this *policy*. If there are different categories, these will be described in the *schedule* along with the *eligibility criteria* and the *benefit formula* applying to each *person insured* in that category along with other important details. Only a person who meets the *eligibility criteria* can become a *person insured* in that category or categories.

In the event of a claim being submitted for a *person insured*, we will assess the claim based on the category or categories of *persons insured* that applied to the *person insured*, immediately prior to the injury or sickness.

1.10 Benefits

The circumstances in which a *benefit* becomes payable under this *policy* are explained in Part 3. We rely on the *benefit formula* to calculate the amount of the *benefit* for a *person insured*. Provided our claims requirements are met (Part 7), *benefits* are payable to you unless instructed otherwise by you in writing and agreed to by us in writing.

We will reduce or not pay a *benefit* in some circumstances, as explained in Part 4.

Our liability to pay a *benefit* is to you as the policy owner only.

1.11 Renewal guarantee

We guarantee to renew this *policy* annually, subject to:

- the *minimum number of persons insured* and the *minimum annual premium*, that we advise from time to time being met, and
- any premium that is due being paid to us on time, in accordance with Part 5 of this *policy*, and
- you abiding by the terms and conditions of this *policy*.

1.12 Cooling-off period

Once you have received this *policy* from us, you have 21 days to check that the *policy* meets your needs. This is known as the cooling-off period. Within this period you may cancel this *policy*, from the *policy commencement date* and we will refund your premiums and any fees paid, less any tax we are, or have been required to pay, which has not been refunded to us.

Neither you nor any other person has any right to lodge a claim under this *policy* if this *policy* is cancelled pursuant to this clause 1.12.

1.13 Privacy

When you collect personal information in respect of an *eligible person* or *person insured* for us, you must make the relevant person concerned aware:

- that the information will be disclosed to us, and
- of the uses to which that information will be put to by us, and
- of the entities to which we may disclose that information.

You must advise the relevant person that:

- they are entitled to request reasonable access to information we have about them, and
- we reserve the right to charge an administration fee for collating the information they request.

AXA Australia's policy on Privacy can be obtained via www.axa.com.au.

2 Eligibility and acceptance

2.1 Who can become a person insured

Part A

An *eligible person* is a person who satisfies the conditions of Part B below and is:

- employed by the *employer* on a permanent basis, works at least 15 hours per week and receives paid leave (including, without limitation, paid sick leave and paid holiday leave) as a condition of employment; or
- a *contractor*.

Part B

The person must also:

- meet the *eligibility criteria* as set out in the *schedule*;
- be aged 15 years or older, but less than the *cover expiry age*, on the day he or she was first eligible for cover in accordance with the *eligibility criteria*; and
- be an *Australian resident*.

An *eligible person* will become a *person insured* through the application of either:

1. the *Automatic acceptance* terms (clause 2.2);
2. the *Transfer* terms (clause 2.3); or
3. the *Underwriting terms* (clause 2.4).

2.2 Automatic acceptance terms

Automatic acceptance as a person insured

An *eligible person* may be granted cover under automatic acceptance (without the need for medical or other evidence) provided all of the following terms are satisfied:

- the *eligible person* was *at work* on the *policy commencement date* or on the day *eligibility criteria* was first met, or at some other time *we advise you* in writing;
- the *eligible person* became a *person insured* under this *policy*, from the day *eligibility criteria* was first met;
- the amount specified for the *automatic acceptance limit* in the *schedule* is anything other than “nil”;
- there are at least 15 *persons insured* in the applicable category of *persons insured*;
- AXA is the only provider of insurance under *automatic acceptance* for the risk covered by this *policy* under the plan;
- at least 75 per cent of *eligible persons* are covered under this *policy* at all times; and
- any other terms that *we* specify in writing have been met and agreed by *us*.

Provided all of the terms above are met, an *eligible person* becomes a *person insured* and cover commences under *automatic acceptance*:

- on the *policy commencement date* provided the *person insured* was *at work*;
- on the day he or she first meets the *eligibility criteria* provided the *person insured* was *at work*; or
- at some other time *we* agree in writing with *you*.

Automatic acceptance of changes in the benefit amount for a person insured

The amount of the *benefit* for a *person insured* is calculated using the *benefit formula* and will change without the need for medical or other evidence if all of the conditions listed in clause 2.2 are met up to the lesser of:

1. the *automatic acceptance limit*, and
2. a maximum increase of 30 per cent in any 12 month period.

We will apply *underwriting terms* (clause 2.4) to the portion of the *benefit* which:

- has exceeded the *automatic acceptance limit*, or

- increased the *benefit* by more than 30 per cent in a 12 month period.

If the *person insured* does not comply with underwriting requirements (refer to clause 2.4), the *person insured's benefit* shall be no greater than:

- the *automatic acceptance limit*; or
- an increase of 30 per cent,

until such time as he or she complies with *our* underwriting requirements.

We may in some cases waive the restriction on increases of 30 per cent or more.

Changes in the *automatic acceptance limit*

We may change the *automatic acceptance limit* without *your* consent. Where there is a change in the *automatic acceptance limit*, we will notify *you* in writing of the effective date of this change.

A change in the *automatic acceptance limit* will have the following effects on existing *persons insured* from the effective date of the change:

- for *persons insured* who have previously been accepted for cover via *underwriting terms*, any acceptance decision including any relevant conditions such as a premium loading, exclusion, restriction, *further underwriting limit* or other special conditions on the accepted amount of the *benefit* will remain unchanged regardless of any change to the *automatic acceptance limit*, even if the new *automatic acceptance limit* is higher than his or her *further underwriting limit*,
- for *persons insured* who are *at work* on the effective date of an increase in the *automatic acceptance limit*, other than for *persons insured* with a *further underwriting limit*, this new *automatic acceptance limit* will apply from the effective date,
- for *persons insured* who are not *at work* on the effective date of an increase in the *automatic acceptance limit*, this new *automatic acceptance limit* will apply from the date he or she is *at work*,
- where the *automatic acceptance limit* decreases, other than for *persons insured* with a *further underwriting limit*, this new *automatic acceptance limit* will apply for all *persons insured* from the effective date, regardless of *at work* status, and
- for *persons insured* with an amount of *benefit* higher than the new *automatic acceptance limit*, should his or her amount of *benefit* subsequently increase, this increased amount of *benefit* will be subject to *underwriting terms*. Where the increase in the amount of *benefit* is accepted, a *further underwriting limit* may be granted and the *person insured* will not generally be required to be re-underwritten for subsequent increases in the amount of *benefit* until his or her amount of *benefit* exceeds this *further underwriting limit*.

For *eligible persons* who meet the *automatic acceptance* terms (as described above) and who become a *person insured* on, or after the effective date of a change in the *automatic acceptance limit*, this new *automatic acceptance limit* will apply from the date he or she first commences cover.

2.3 Transfer terms

If all of the following apply, then we may, at *our* discretion, offer transfer terms:

- This *policy* replaces a *previous policy* issued by an insurer other than *us*.
- The *previous policy* is a *group insurance policy*.
- The *previous policy*, in *our* opinion, confirmed in writing, provides insurance for similar insured events.
- *You* provide all the information we request about the operation and terms of the *previous policy* (including underwriting decisions of the insurer of the *previous policy*) within 90 days of the *policy commencement date*.
- Under the *previous policy*, there are at least 15 people with insurance for similar insured events under each category of *persons insured* (if applicable).
- We are satisfied we have been provided with adequate information to assess whether we wish to offer transfer terms.

You will be notified in writing if transfer terms are offered by *us*.

If transfer terms are offered by us, the following applies.

1. Persons at work on the day before the *policy commencement date*

An *eligible person* who is *at work* on the day immediately preceding the *policy commencement date* will be provided, under this *policy*, with cover for a *benefit* amount, from the *policy commencement date* equal to the insured amount which would have been payable under the *previous policy* on the day immediately before the *policy commencement date* in the event he or she was *totally disabled*, as defined under the *previous policy* ('The Previous Policy Cover') if, and only if:

- a) this *policy* provides cover in respect of the *eligible person* in the event of his or her *total disablement*, and
- b) the *eligible person* was eligible, under the *previous policy*, to receive an income replacement payment if they had become *totally disabled*, as defined under the *previous policy*, on the day immediately before the *policy commencement date*, and
- c) all conditions of this *policy* have been complied with (for example, the payment of premium).

2. Persons not at work on the day before the *policy commencement date*

An *eligible person* who is not *at work* on the day immediately preceding the *policy commencement date*, because of sickness or injury, will be provided under this *policy* with cover from the *policy commencement date*, but only for *new events* cover up to the amount of The Previous Policy Cover. This restricted cover will apply in respect of the *eligible person* until the day he or she returns to be *at work* on or after the *policy commencement date*. At that time, the commencement of cover will apply, as described in condition 1 above titled 'Persons at work on the day before the *policy commencement date*.'

If The Previous Policy Cover is less than the proposed *benefit* amount under this *policy*, but more than the *automatic acceptance limit*, *underwriting terms* apply to the part of the proposed *benefit* amount which exceeds the *automatic acceptance limit*.

The amount of *benefit* payable in the event of the *person insured's total disablement* under this *policy* will not at any time exceed the *maximum benefit amount*.

If the insurer of the *previous policy* had approved future increases in the amount of The Previous Policy Cover for an *eligible person*, then *underwriting terms* as explained in clause 2.4 will not apply to increases under this *policy*, up to the level approved by the insurer of the *previous policy*, and in accordance with the *benefit formula*, except that no such increase can exceed 30 per cent in any 12 month period, unless previously agreed to in writing by us.

We may choose to provide cover as a result of future increases approved by the insurer of the *previous policy*, on the same or similar terms (as notified to you in writing by us), including applying any premium loading, exclusions or any other conditions which the insurer of the *previous policy* placed on The Previous Policy Cover of the *person insured*.

2.4 Underwriting terms

Underwriting terms apply when *automatic acceptance* terms and transfer terms do not apply.

If *underwriting terms* apply, we will only agree to provide the cover which is subject to *underwriting terms* if the *eligible person* completes the underwriting forms we supply, and he or she satisfies our underwriting requirements. We will notify you of the date when the cover commences and of any *further underwriting limit*.

We will notify you of our decision in writing, including any relevant conditions such as a premium loading, exclusion, restriction or other special conditions on the cover that is subject to *underwriting terms*. In some circumstances, we may decline to provide cover that is subject to *underwriting terms*.

2.5 Unpaid leave

If a *person insured* takes unpaid leave - for reasons other than of injury or sickness - approved in writing by his or her employer, before he or she commences the period of unpaid leave, we will continue to provide cover under this *policy* for the *person insured* for a period up to 12 months, provided we continue to receive premiums in respect of that *person insured*.

If a *person insured* takes unpaid leave for a period longer than 12 months - for reasons other than of injury or sickness - we must be notified in writing before he or she commences the period of unpaid leave and have given our

written approval to provide cover under this *policy* to the *person insured*. We must continue to receive premiums in respect of that *person insured* during the period of unpaid leave.

In the event that a *person insured* sustains *total disability* or *partial disability* during the period of *unpaid leave*:

- we may require a *person insured* who is overseas to return to Australia at his or her expense, where necessary, for medical treatment or assessment and we may not pay a *benefit* if the *person insured* does not return to Australia;
- the *waiting period* will commence on the date we receive a medical certificate from a *medical practitioner* stating that the *person insured* is unable to work due to sickness or injury; and
- *benefit* payments will not commence until after the specified return date that was approved by the *employer*, or where applicable, *us*, prior to the commencement of unpaid leave. The *employer* must keep appropriate records of the proposed date of return to work in this regard and provide such documents to *us*, upon *our* request.

If cover under this *policy* for a *person insured* ceases under clause 2.7 before the end of the proposed period of unpaid leave, cover will cease in respect of that *person insured*, and we will refund *you* any portion of premium overpaid.

2.6 Cover during overseas employment

We will provide cover for a *person insured* who is an *Australian resident* up to the next *premium guarantee date*, while he or she is outside of Australia for the purposes of the *employer*, provided any details regarding the *person insured's* temporary overseas arrangements we require are made available to *us* when we request them.

We may approve longer periods of cover under this *policy*, provided that we are told in advance and approve in writing the overseas employment related travel. We may apply a loading to the premium or conditions to the cover for the *person insured*.

We may require the *person insured* to return to Australia at his or her expense, where necessary, for medical treatment or assessment and we may not pay a *benefit* if the *person insured* does not return to Australia.

2.7 When cover under this policy for a person insured stops

Other than in the situation set out in clause 3.6, cover for a *person insured* will also stop as soon as one of the following happens:

- when the *person insured* reaches the *cover expiry age*;
- the *person insured* ceases to be employed by the *employer* on a permanent basis to work at least 15 hours per week;
- the *person insured* ceases to be a *contractor*;
- the *person insured* dies;
- when the *person insured* no longer meets the *eligibility criteria*;
- when *you* do not pay the premium for the *person insured*, unless *you* are being paid a *benefit* for the *person insured* and clause 5.5 applies;
- when the *person insured* is on unpaid leave or is overseas for the *employer* for longer than the period of time that we have agreed to provide cover under clause 2.5 and clause 2.6 respectively;
- if the *person insured* makes a fraudulent claim;
- the date the *policy* is terminated; or
- cover for all *persons insured* stops when the *policy* ends.

3 Benefits

3.1 General

We will pay you a *benefit* for a *person insured* if he or she is *totally disabled* (clause 3.3), *partially disabled* (clause 3.4) or suffers a listed specific sickness or specific injury (clause 3.16). Notwithstanding the below, the amount of the *benefit* will not be more than the *maximum benefit amount*.

If there are different categories of *persons insured*, a different *monthly benefit* and *employer superannuation benefit* (if any) may apply for each category.

The date at which the *benefit* is calculated is the *benefit calculation date*.

We will pay you at the end of each month in which you are entitled to be paid except for the *rehabilitation expenses* (if applicable) *benefit* as explained in clause 3.9 and workplace modification *benefit* as explained in clause 3.10. These will be paid as soon as is reasonably possible after the expenses are incurred.

For part of a month, we pay you 1/30th of the *benefit* for each day you are entitled to be paid the *benefit* under the *policy*.

In the event that we are by law required to pay any tax, duty or impost in connection with the *benefit* payable to you, we will deduct the amount concerned from the *benefit* and pay it to the proper authority.

To be eligible for a *benefit*, a *contractor* must have worked for the *employer* an average of 15 hours or more per week over a period of three consecutive months up to the date they became *totally disabled* (clause 3.3), *partially disabled* (clause 3.4) or suffered a listed specific sickness or specific injury (clause 3.16).

If the *contractor* has worked for the *employer* for a period of less than three consecutive months, the *contractor* will still be eligible for a *benefit* provided he or she has worked an average of 15 hours or more per week from the date the *person insured's* contract commenced to the date they became *totally disabled* (clause 3.3), *partially disabled* (clause 3.4) or suffered a listed specific sickness or specific injury (clause 3.16).

3.2 Interim cover

If *underwriting terms* (clause 2.4) apply to an *eligible person* or a *person insured* because:

- *automatic acceptance terms* do not apply, or
- cover exceeds the *automatic acceptance limit* or the *further underwriting limit*, or
- he or she has applied for voluntary cover or a voluntary increase to their cover,

then we will provide him or her with interim cover for *total disability* caused by *accidental injury* which lasts for at least the length of the *waiting period*.

Interim cover starts from the date we receive the written application, in the form approved by us, for all, or the relevant part of, the cover which is subject to *underwriting terms*, in respect of the *person insured* or *eligible person*.

The amount of cover provided is the amount of cover applied for up to a maximum amount of \$10,000 per month.

The maximum *benefit period* under this clause 3.2 for a *person insured*, is two years.

Interim cover automatically ends as soon as one of the following happens:

- we accept, limit or decline the application for the cover which is subject to *underwriting terms*, or
- you, the *person insured* or *eligible person* withdraws the application for the cover which is subject to *underwriting terms*, or
- 60 days pass from the date interim cover commenced, or
- cover stops under clause 2.7.

In all other ways, the conditions of the *policy* apply to interim cover, including the continued payment of premiums (Part 5).

3.3 Total disablement benefit

If a *person insured* is *totally disabled*, we will pay you a *benefit*. Other than where the *person insured* is a *contractor*, we will pay at the end of each month until the earliest of the events described in clause 3.5 occurs. In the case of a *contractor*, we will pay you a *benefit* at the end of each month until the earliest of:

- the occurrence of one of the events described in clause 3.5; and
- two years.

We don't start paying as soon as the *person insured* is *disabled*. You have to wait until the end of the *waiting period*.

The *waiting period* starts when a *medical practitioner*, after examining the *person insured* for the relevant sickness or injury, certifies that he or she is *totally disabled*. We do not pay a *benefit* for *total disability* for any period of time during the *waiting period*. The *benefit period* begins from the end of the *waiting period*.

The amount of the *benefit* will be:

- the *monthly benefit*, plus
- the *employer superannuation benefit* (if any), less
- any *offset* (clause 4.1).

The *benefit* will be subject to the *maximum benefit amount* and any *underwriting terms*, if applicable.

The meaning of *total disability* depends on which definition of *total disability* the *person insured* has under this *policy*, as set out in the *schedule*. The definition of *total disablement* may vary in respect of each particular category.

If the *waiting period* is 30 days or less, then if during the *waiting period* the *person insured* ceases to be *totally disabled* and:

- returns to his or her usual pre-disability duties and work hours for less than six consecutive working days, or
- participates no more than once in a *rehabilitation* program,

and then the *total disability* recurs for the same or related injury or sickness, the *waiting period* is extended by the number of days he or she returned to work, or participated in a *rehabilitation* program. The *waiting period* does not start again. If during the same *waiting period*, the *person insured* ceases to be *totally disabled* and returns to his or her usual pre-disability duties and work hours for six consecutive days or more, the *waiting period* starts again.

If the *waiting period* is 60 days or more, then if during the *waiting period* the *person insured* ceases to be *totally disabled* and:

- returns to his or her usual pre-disability duties and work hours for less than 10 consecutive working days, or
- participates only once in a *rehabilitation* program,

and then the *total disability* recurs for the same or related injury or sickness, the *waiting period* is extended by the number of days he or she returned to work, or participated in a *rehabilitation* program. The *waiting period* does not start again. If in the same *waiting period*, he or she ceases to be *totally disabled* and returns to his or her usual pre-disability duties and work hours for 10 consecutive days or more, the *waiting period* starts again.

3.4 Partial disablement benefit

If a *person insured* has been *totally disabled* for at least 14 consecutive days, even if during the *waiting period*, and then his or her health improves, but he or she is *partially disabled* after the *waiting period*, we will pay you a reduced amount of the *benefit*. However, we will not commence payments until the end of the *waiting period*. The *waiting period* starts when a *medical practitioner*, after examining the *person insured* for the relevant sickness or injury, certifies that he or she is *totally disabled*. We do not pay a *benefit* for *partial disability* for any period of time during the *waiting period*. We will pay at the end of each month until the earliest of the events described in clause 3.5 occurs.

The amount of the *benefit* for *partial disability* is based on the reduction in the *person insured's income* earned before *total disability* and the *disability income* earned whilst the *person insured* is *partially disabled*, as shown in the formula:

$$\left(\frac{A - B}{A} \times C \right) - \text{offset}$$

For the formula:

- A** equals the *person insured's income* as at the *benefit calculation date*.
- B** is the *person insured's actual disability income* (from any source) during the month in which he or she is *partially disabled*. If this amount is a loss, then B will equal zero.
- C** is the *benefit* amount which would otherwise be payable on *total disablement*, as may be varied in accordance with the *policy* provisions.

3.5 When benefits for a person insured stop

We stop paying a *benefit* for a *person insured* at the earliest of:

- the date the *person insured* ceases to be *totally disabled* or *partially disabled* (as applicable), or
- the date the *person insured* attains the *cover expiry age*, or
- the date the *person insured* commences a period of incarceration or is otherwise detained as a result of committing a criminal act, or
- when the *person insured* making a fraudulent claim, or
- the date the *benefit period* for the cause of the *disability* ends, or
- the *person insured* ceases being under *medical care*, or
- the *person insured* refuses to return to Australia from overseas for medical treatment or assessment, or
- for a *person insured* who is *totally disabled*, he or she refuses to undertake treatment or *rehabilitation* which could, in *our* opinion, be expected to assist his or her ability to return to 'any occupation' or his or her 'own occupation' on any basis, depending on the applicable definition of *total disablement* as described in the *schedule*, or
- for a *person insured* who is *partially disabled*, he or she refuses to undertake treatment or *rehabilitation* which could, in *our* opinion, be expected to assist his or her ability to return to 'any occupation', in an increased capacity or his or her 'own occupation', in an increased capacity, depending on the applicable definition of *total disablement*, as described in the *schedule*, or
- for a *person insured* who is *totally disabled*, where, in *our* opinion, he or she fails to take all steps to return to 'any occupation' or his or her 'own occupation' (as applicable) if he or she has the capacity to do so, or
- for a *person insured* who is *partially disabled*, where, in *our* opinion, he or she fails to take all the steps to return to 'any occupation' or his or her 'own occupation' (as applicable) in an increased capacity, or
- where *you* or the *person insured* fails to make available to *us* medical, financial or other evidence that *we* have requested in writing so to assess the claim, or
- the date the *person insured* dies.

We shall suspend the payment of *benefits* under the policy if the *person insured* refuses to attend a medical examination, *rehabilitation* or provide to *us* medical, financial or other evidence that *we* have requested in writing, to assess whether or not the *person insured* is entitled to *benefits* under this *policy*.

In addition to the above clauses, *we* will also stop paying a *benefit* for a *person insured*, where the words 'Benefits cease on total and permanent disablement' appear in the additional options section of the *schedule*, at the earliest of:

- where the *person insured* has received, or in *our* opinion, is entitled to receive a lump sum payment from *us* as a result of having become totally and permanently disabled as defined under a *group insurance policy* issued by *us*, or
- *you*, or the *person insured* fails to make available to *us* medical, financial or other evidence *we* have requested in writing, to assess whether or not the *person insured* is totally and permanently disabled.

When the reason for stopping payments no longer applies, payments will resume, provided that:

- the *person insured* continues to be *totally disabled* or *partially disabled* (as applicable), and
- cover has not stopped under clause 2.7 of the *policy*.

Where the *person insured* has remained *totally disabled* or *partially disabled* (as applicable) for the duration of the period for which payments were stopped, we will treat the resumption of payments as a continuation of the same *benefit period* where no *waiting period* applies. Back payment will not be made for the period in which payments stopped and the original *benefit period* end date will continue to apply.

3.6 Extended cover

If a *person insured* is no longer eligible for cover because the *person insured* has left the *employer* and:

- the *person insured* did not cease work with the *employer* for reasons of injury or sickness, and
- we are not paying *you*, or *you* are not entitled to a *benefit* under the *policy* for the *person insured*,

then we will automatically provide cover to the *person insured* for *total disablement*, *partial disablement* or a listed specific sickness or specific injury as described in clause 3.16 (if applicable) that is solely caused by accidental injury, free of charge.

Extended cover under this clause 3.6 stops on the earlier of;

- 60 days after cover would have otherwise stopped under clause 2.7, or
- the date the *person insured* attains the *cover expiry age*, or
- the date the *person insured* commences employment with a new employer, or
- the date a personal income protection plan issued under by *us* under a continuation option (as described in clause 3.13) commences in respect of the *person insured*.

We will not extend any cover described in the special conditions section of the *schedule* (if any).

3.7 Death benefit

If a *person insured* dies before the *cover expiry age* and we are paying *you* a *benefit* as at the date of death for that *person insured* because he or she is *totally disabled*, then subject to the terms of this *policy*, we will pay *you* a lump sum amount equal to three months *benefit* for *total disability*.

3.8 Recurrent disablement benefit

If none of the events described in clause 2.7 have occurred:

1. the *person insured* returns to performing all of his or her usual pre-disability duties and work hours for less than six months since we last paid *you* because he or she was *totally disabled* or *partially disabled* (as applicable), and
2. while the *person insured's* cover under this *policy* is still current, he or she has a recurrence of *total disability* or a recurrence of *partial disability* (as applicable) from the same cause or a related cause,

then we will treat it as a continuation of the same claim and no *waiting period* applies.

If this applies, we will add all periods of *total disability* or *partial disability* together, to determine when the *benefit period* ends.

However, if the *person insured* returns to properly performing all of his or her usual pre-disability duties and work hours (without limitation) of usual paid employment with the *employer* and is not in receipt of and/or entitled to claim income support benefits from any source including worker's compensation, statutory transport accident benefits or disability income benefits, for at least six months, the claim (from the same cause or a related cause) will be treated as a separate claim, and a new *waiting period* and *benefit period* will apply.

3.9 Rehabilitation expenses

If a *person insured* is *totally disabled* for at least the length of the *waiting period*, you can ask us to pay the *person insured's* *rehabilitation* expenses. These expenses may include for example buying goods such as equipment designed to assist the *person insured* re-enter the workforce, and the expense of any approved *rehabilitation* program. The most we will pay for each *person insured* under this *policy* is an amount equal to six payments of the *monthly benefit*.

We will only pay an amount for *rehabilitation* expenses which:

- we have approved in writing before you or the *person insured* incurs them, and
- a *medical practitioner* states in writing (and we agree) the *person insured* needs to spend as part of his or her *rehabilitation*, and
- cannot be reimbursed from any other source.

The payment by us of these expenses is done as part of the claims management process and any payment will be at our absolute discretion. Before we pay you this *benefit*, we must receive receipts for the *rehabilitation* expenses the *person insured* is claiming for.

This *benefit* is paid in addition to any other *benefit* for *total disability* or *partial disability*.

3.10 Workplace modification

If a *person insured's* workplace needs to be modified to allow him or her to return to paid work after being *totally disabled*, we may, at our absolute discretion, decide to pay you a *benefit* called the workplace modification *benefit*. However, we will only do this if the *person insured* has been *totally disabled* for at least the length of the *waiting period*. Also, we must approve in writing the costs of modifying the workplace before they are incurred.

We will pay you the lowest of:

- 2.5 times the *monthly benefit* for the *person insured*,
- the actual cost incurred in modifying the workplace, and
- \$5,000,

for any one *person insured*.

The amount that we will pay you will be reduced by any amount which is paid or required to be paid under legislation or award in order to modify the *person insured's* workplace to enable him or her to return to paid work.

The payment by us of these expenses, is done so as part of the claims management process and any payment will be at our absolute discretion. Before we pay you this *benefit*, we must receive receipts for the workplace modification expenses the *person insured* is claiming for.

This *benefit* is paid in addition to any *benefit* for *total disability* or *partial disability*.

3.11 Escalation benefit (if applicable)

This clause 3.11 only applies to this *policy* if the words 'Escalation benefit' appear in the additional options section of the *schedule* and the escalation percentage is other than "nil".

The escalation benefit described in this clause 3.11, will only be paid to you in respect of the relevant category of *persons insured* in the event of *total disablement*, *partial disablement* or listed specific sickness or specific injury (if applicable).

If we have been paying you a *benefit* for a *person insured* for 12 consecutive months, then, we will then increase the *benefit* paid to you by the lower of the annual percentage increase in the *CPI* and the *escalation percentage*. We will do this annually so long as we are still paying (without a break) the *benefit* because the *person insured* continues to be eligible for the *benefit*. However, we do not pay more than the *maximum monthly benefit*.

3.12 Employer superannuation contributions benefit (if applicable)

This clause 3.12 only applies to this *policy* if the words 'Employer superannuation contributions benefit' appear in the additional options section of the *schedule*.

The *employer superannuation contributions benefit* will be paid to *you* in respect of the relevant category of *persons insured* in the event of *total disablement*, *partial disablement* or a specific sickness or specific injury as described in clause 3.16 (if applicable).

The *employer superannuation benefit* is to cover the cost of employer superannuation contributions payable in respect of a *person insured* for who *we* are paying *you* a *benefit* for *total disability*, *partial disability* or a listed specific sickness or specific injury as set out in clause 3.16 (if applicable). Upon receipt of a *benefit*, *you* must ensure that the part of the *benefit* which comprises the *employer superannuation benefit*, if any, is paid by *you*, for the *person insured*, to a complying superannuation fund under the Superannuation Industry (Supervision) Act 1993 and regulations made thereunder, as amended.

The *person insured's benefit* in addition to the *employer superannuation benefit* cannot exceed the *maximum benefit amount*. *We* will cease paying the *employer superannuation benefit* as soon as the *person insured's* employment with his or her *employer* ceases or when the *person insured* is no longer a member of a complying superannuation fund under the Superannuation Industry (Supervision) Act 1993, as amended, whichever occurs first.

3.13 Continuation option benefit (if applicable)

This clause 3.13 only applies to this *policy* if the words 'Continuation Option' appear in the additional options section of the *schedule*.

If:

- the *person insured*, within 60 days of the date cover ceases under this *policy* (had no extended cover applied under clause 3.6), applies for a personal income protection plan with *us*, and
- the *person insured* has stopped working for the *employer*, and
- the *person insured* is *at work* and permanently employed to work at least 25 hours per week at the time of applying for a personal income protection plan, and
- the amount of the cover applied for is not more than the amount of the *benefit* which applied to the *person insured* under this *policy*, immediately before cover stopped, and
- the *waiting period*, *benefit period* and *escalation percentage* (if any) under a personal income protection plan is the same as the *person insured's* under this *policy*, immediately before cover stopped,

then *we* guarantee that *we* will not ask for medical evidence as part of the application process for a personal income protection plan with *us* under this clause 3.13.

This clause 3.13 does not apply:

1. if the *person insured* has stopped working for the *employer* in any business, occupation or regular duties because of injury or sickness, or
2. if *we* are paying *you*, or *you* are entitled or become entitled to, a *benefit* under this *policy* for the *person insured*, or
3. if the *person insured* is aged 60 or greater, or
4. if the *person insured* has previously taken out a personal income protection plan with *us* under a continuation option, or
5. if the *person insured's* premium amount under the personal income protection plan applied for is less than the minimum premium *we* set for the purpose of this clause from time to time, or
6. to the amount of the *benefit* under this *policy* for the *person insured* which is more than the maximum amount *we* set for the purpose of this clause from time to time, or
7. if *we* have given written notice to *you* that this clause is to cease operating.

We reserve the right to:

- a) as part of the application process, ask questions and seek disclosure from the *person insured* for any information we consider relevant which does not relate to medical evidence in regards to the *person insured*, or
- b) refuse the application, or
- c) offer the personal income protection plan on any terms acceptable to us. This may include, but is not restricted to, premium loadings or equivalent special terms to those which applied under this *policy*.

3.14 Nursing care benefit (if applicable)

This clause 3.14 applies to this *policy* if the words 'Nursing care benefit' appear in the additional options section of the *schedule*.

If a *person insured* is *totally disabled*, we will pay you a daily amount for the length of the *waiting period*, subject to a maximum of 90 days, to help with nursing expenses. However, we will only do that if the *person insured* is *totally disabled*, continuously confined to bed and a *medical practitioner* certifies in writing that the *person insured* needs the continuous full-time care of a registered nurse for more than two consecutive days during the *waiting period*.

For each day (after the first two days) the *person insured* is continuously confined to bed and is under the full-time continuous care of a registered nurse during the *waiting period*, we will pay you 1/30th of the *monthly benefit*, up to a maximum of \$500 per day, for a maximum of 90 days.

The nurse cannot be you, your family member, business partner, employee or employer, nor can it be the *person insured* or his or her family member, business partner, employee or employer.

This *benefit* is paid in addition to any *benefit* for *total disability* or *partial disability*.

This *benefit* is not available if the person is receiving or has received a *benefit* as a result of a listed specific sickness or specific injury (clause 3.16).

3.15 Family carer benefit (if applicable)

This clause 3.15 applies to this *policy* if the words 'Family carer benefit' appear in the additional options section of the *schedule*.

If a *person insured's* family member stops earning all of his or her own income because he or she stops working in order to care for the *person insured* who is *totally disabled*, we will pay you a family carer *benefit*, however each of the following conditions must be met:

- we must have paid you the *monthly benefit* for more than 60 days because the *person insured* is *totally disabled*, and
- the *family member* must not have been an employee of the *person insured* or an employee of an entity which the *person insured* owns or owned, and
- the *family member* must have been earning income from permanent employment immediately before the *person insured* was *totally disabled*.

We will pay the family carer *benefit* for up to six months. Each month we will pay the lower of:

- the amount we estimate the *person insured's* family member would have earned if the *person insured* had not been *disabled*, or
- \$2,000.

This *benefit* is paid in addition to any *benefit* for *total disability*.

3.16 Trauma benefit (if applicable)

This clause 3.16 applies to this *policy* if the words 'Trauma benefit' appear in the additional options section of the *schedule*.

If the *person insured* suffers for the first time since cover commenced, a specific sickness or injury listed in either Table 1 or Table 2 (as applicable), we will pay you a trauma *benefit* for the period set out in the respective table, or the *benefit period*, whichever is the lesser. There is no *waiting period*. We will pay even if the *person insured* is not actually *totally disabled*. We will stop paying if the *person insured* dies or reaches the *cover expiry age*.

We won't pay you any other *benefit* under the *policy* while we are paying you the *benefit* for a specific sickness or injury (under this clause 3.16). If the *person insured* suffers from more than one of the specific sicknesses or specific injuries at the same time, we will only pay you for one specific sickness or one specific injury at a time. We will pay you for only one specific sickness or one specific injury, even if the sicknesses or injuries do not commence at the same time. We will pay you the *benefit* for the specific sickness or injury with the longest remaining payment period.

If, after the period in either Table 1 or Table 2 (as applicable) ends, the *person insured* is *disabled* because of the same specific sickness or injury, we will continue to pay you the appropriate *benefit* for disablement. You will be entitled to be paid from the end of the *waiting period*. We will stop paying if the *person insured* stops being entitled to *benefits* for being *totally disabled* or *partially disabled*.

For the purposes of this clause, the *waiting period* and *benefit period* start:

- from the date the specific sickness was diagnosed by a *medical practitioner*, or
- from the date the *person insured* attended a *medical practitioner*, after the specific injury happened.

Specific sickness trauma benefit

If the *waiting period* for a *person insured* is 90 days or less, and he or she suffers a specific sickness listed in Table 1 (as fully defined in Part 8), for the first time since cover commenced, we will pay you a trauma *benefit* monthly and in arrears for a fixed period. If the *waiting period* for a *person insured* is more than 90 days no *benefit* is payable for these specific sicknesses under this clause 3.16.

The fixed period we will pay you a *benefit* depends on the length of the *waiting period* which applies to the *person insured* as set out in Table 1 below.

Table 1

Specific sickness	
<ul style="list-style-type: none"> ▪ Cancer ▪ Chronic kidney failure ▪ Coronary artery surgery ▪ Heart attack ▪ Heart valve surgery ▪ Major transplant ▪ Severe Burns ▪ Stroke 	
Length of the <i>waiting period</i>	How long we pay for
30 days	6 months
60 days	4 months
90 days	3 months

Specific injury trauma benefit

If the *waiting period* for a *person insured* is 180 days or less, and he or she suffers a specific injury listed in Table 2 for the first time since cover commenced, we will pay you a trauma *benefit* monthly and in arrears for a fixed period. If the *waiting period* for a *person insured* is more than 180 days no *benefit* is payable for these specific injuries under this clause 3.16.

The fixed period we will pay you a *benefit* is set out in Table 2 below.

Table 2

Specific injury <i>benefit</i>	How long we pay you for
Total and permanent loss of use of:	
<ul style="list-style-type: none"> ▪ the <i>person insured's</i> arms and legs due to 	60 months

spinal cord injury or disease - quadriplegia	
▪ the <i>person insured's</i> legs due to spinal cord injury or disease – paraplegia	60 months
▪ both hands or both feet	24 months
▪ entire sight in both eyes	24 months
▪ one hand and one foot	24 months
▪ one hand and entire sight in one eye	24 months
▪ one foot and entire sight in one eye	24 months
▪ one arm or one leg	18 months
▪ one hand	12 months
▪ one foot	12 months
▪ entire sight in one eye	12 months
▪ thumb and index finger from same hand	6 months

Fracture – requiring a pin, traction, a plaster cast or other immobilising structure – of the <i>person insured's</i> :	
▪ thigh shaft	3 months
▪ pelvis except coccyx	3 months
▪ skull, except bones of nose or face	2 months
▪ upper arm, including elbow and shoulder	2 months
▪ shoulder blade	2 months
▪ lower leg, including ankle but excluding knee cap and foot	2 months
▪ knee cap	2 months
▪ collar bone	1.5 months
▪ hand, excluding fingers	1.5 months
▪ foot, excluding toes	1.5 months
▪ lower arm, including wrist but excluding elbow and hand	1.5 months

4 Limitations

4.1 We will reduce the disability benefit by other income received

We will reduce the *benefit* payable for a *person insured* by any *offset* amount which is paid (whether by lump sum, periodic payment or otherwise), or is required to be paid, to the *person insured* for whom *you* are claiming a *benefit* for under this *policy*. However, we won't reduce the *benefit* by any amount received as a lump sum total and permanent disablement payment or lump sum superannuation payment.

If *you* or the *person insured* receive any *offset* amounts or become entitled to receive any *offset* amounts *you* must promptly inform *us* in writing and provide *us* with full details of the amounts that have been received or are entitled to be receive.

We may also require *you* to sign a written undertaking, on such terms as we require, enabling *us* to recover any *offset* amounts.

If we reduce the *benefit* for a *person insured*, it will only be to the extent required to ensure that any *benefit* amounts payable under this *policy*, when added to other offsetable payments in respect of the *person insured*, does not exceed the *monthly benefit* plus the *employer superannuation benefit* (if any) for the *person insured* at the *benefit calculation date*.

If the *person insured* has a claim under this *policy*, his or her *benefit* may be reduced to nil because of the operation of the clause. In this case, we will be deemed to be paying *you* a *benefit*, even though the *person insured* receives no money. The *benefit period* and waiver of premium (if applicable) will continue.

If the *offset* amounts are payable as a lump sum, we will only reduce what we pay *you* by the portion of the lump sum relating to *income* for the same period.

If the *offset* amount relating to *income* is not readily ascertainable from the lump sum, we will agree an *offset* amount with *you*. If we cannot agree, we will determine the proportion of the lump sum relating to *income*. In this regard, the *offset* amount will be converted to an equivalent monthly amount of 1/60th of the lump sum *offset* amount over a period of 60 months, or the length of the *benefit period*, whichever is the lesser.

4.2 When cover is excluded

We will not pay a *benefit* if a *person insured's* total or partial disablement or listed specific sickness or specific injury as set out in clause 3.16 (if applicable) was caused by:

- pregnancy, childbirth or miscarriage, if they are uncomplicated, or
- the *person insured* (whether sane or insane) on purpose, or
- war, or
- the *person insured's* service in the armed services of any country or international organisation.

4.3 More than one benefit at a time

We will pay only one *benefit* for total disability, partial disability or a listed specific sickness or specific injury as set out in clause 3.16 (if applicable) at any one time. Therefore, if the *person insured* is totally disabled or partially disabled or suffers a listed specific sickness or specific injury (if applicable) because of more than one sickness or injury, or both, we will only pay a *benefit* for either one sickness or one injury. We will do this, even if the injuries or sicknesses are related. We will pay *you* the *benefit* in this manner, which result in the payment of the greatest amount.

If we have paid *benefits* for total disability, then subject to clause 3.8, the *person insured* must have returned to be at work before we will accept a subsequent claim for total disability.

Also, we will not pay the nursing care *benefit* at the same time as we are paying *you* for a specific sickness or specific injury (if applicable) for a *person insured*.

4.4 When incorrect information is given to us

We rely on the information provided to *us* to assess whether we will provide the cover for a *person insured*. If the information provided is not correct, in some circumstances we may be legally entitled not to pay a *benefit*.

We may also be legally entitled not to pay a *benefit* if *you* have not complied with *your* duty of disclosure. The duty of disclosure is set out in the Application form for this *policy* and in the forms completed when a *person insured* applies for cover. The duty of disclosure applies not only to *you* in respect of *your* completion of the Application form for this *policy* but also to any application to increase the cover for a *person insured*.

4.5 When we will decline to pay or reduce a benefit

We will decline to pay, or reduce a *benefit* which we may otherwise pay to *you*:

- where we have not received notice as soon as reasonably possible after the *person insured* first became *disabled*, in circumstances where such a delay has prejudiced *our* ability to assess and manage a claim, or
- if the *policy* claim requirements (Part 7) have not been complied with by *you*, an *employer* or a *person insured*, or
- if the *person insured* is in jail, or otherwise detained, as a result of a criminal act, or
- if the *person insured* makes a fraudulent claim, or
- if a premium due for all *persons insured* has not been paid by the *premium due date*.

5 Premiums

5.1 What you have to pay

You must pay the premium for all periods during which the *policy* has been in force, including any period of interim cover under clause 3.2, for *persons insured*.

The premium is due on the *premium due date*.

We may charge interest on any amount due to us outstanding more than 30 days.

In the event that we are by law required to pay any tax, duty or impost in connection with any premiums payable under this *policy*, we will increase your premium by the relevant amount and then pay the tax, duty or impost to the proper authority.

We will calculate the premium payable from the *policy commencement date* and on each *renewal date*. You must give us the information we request in order to calculate the premium.

We may otherwise agree that you will calculate the premium, in which case we will confirm the terms of this arrangement in writing.

The rates used to calculate the premium are set out in the *schedule*.

5.2 When we can change the premium

We can change the premium rates for all *persons insured* or for a particular category of *persons insured* by giving you written notice:

- at anytime after the *premium guarantee date*, or
- if Australia is involved in *war*, or
- if there has been a 25 per cent change in the total number of *persons insured* and/or total sum insured under the *policy* since the commencement of the *rate guarantee period*, or
- if there has been a significant change in the circumstances you advised and on which we relied in setting the premium rate for this *policy*, or
- if there is a change in federal, state or territory taxes or duties or other legislative changes that increase our costs under this *policy*.

5.3 How we calculate your premium

You must keep accurate records necessary for us to be able to calculate the premiums effectively and accurately and you must provide us with copies of these records within 45 days of us requesting it in writing.

At each *renewal date*, and on termination of the *policy*, we will calculate the premium to reflect changes in the number of *persons insured* and the cover provided over the period since the *policy* began, or since the last *renewal date*, as the case may be.

If, as a result of the recalculation of the premium, you have paid too much, we will pay you the over-payment or use it to *offset* the next premium due.

If, as a result of the recalculation of the premium, you have not paid enough, we will notify you (in writing) of the additional premium you owe. We refer to the additional premium in clause 5.4 as the *adjustment premium*.

Where we have agreed that you will calculate the premium, we will review your calculations by way of an audit at each *renewal date*.

If the *policy* ends, you will not be entitled to any refund of premium, in respect of a period of cover for which you have already paid premiums, except as explained in this clause 5.3.

5.4 When the premium must be paid

The premium is due on the *premium due date*.

The *adjustment premium* is due on the date indicated in the notice advising the *adjustment premium*.

5.5 Premiums waived during total disablement

You do not have to pay the portion of the premium which relates to a *person insured* who is *totally disabled* under this *policy*, and cover will continue for the *person insured*, if, on the *premium due date*, we are paying you a *benefit* for the *person insured* (except the nursing care *benefit* if applicable).

You must start paying premium for the *person insured* again on the first *premium due date* which falls after the date we stopped paying the *benefit* for the *person insured*.

6 *When this policy ends*

6.1 *You can end this policy*

You can end this *policy* by giving *us* one month's written notice, or *we* can agree on an earlier time in writing with *you*.

6.2 *We can end this policy*

We can end this *policy* or cover in respect of a *person insured* by giving *you* one month's written notice, as soon as any of the following happens:

- *your* annual premium falls below the *minimum annual premium*, or
- the number of *persons insured* falls below the *minimum number of persons insured*, or
- *you* do not provide *us*, within 30 days of *us* advising *you* in writing, with all of the information *we* need to verify the cover for a *person insured* and premiums paid or payable, or
- *you* do not pay the relevant premium or any *adjustment premium* within 45 days of the due date (see clause 5.4), or
- *you* do not provide any other information, which in *our* opinion is required to operate this *policy* effectively, or
- less than 75 per cent of *eligible persons* have cover under this *policy*.

You must inform *persons insured* of the notice to terminate as soon as possible, but in any event within 10 working days of receipt of *our* written notice to *you*.

7 Claims

7.1 How to make a claim

You must tell us (in writing), within 14 days – or as soon after that as possible - after the *person insured's* injury happens or disablement begins, that you will make a claim.

We will send you the necessary claim forms as soon as is reasonably possible. The *person insured* must submit a claim form of our choosing, fully completed and properly executed, to us before we can assess whether the *person insured* is entitled to any *benefits* under this *policy*.

Please ensure that the required forms are completed and return them to us within 30 days - or as soon as is reasonably possible - after the start of the period for which you are claiming the *benefit*.

A *medical practitioner* will need to fill in a section of the claim form for the *person insured*. We won't pay for any costs involved in getting the *medical practitioner* to do this.

If we do not have written notice of the *person insured's* claim within 60 days of the *person insured* ceasing work due to his or her injury or sickness, our right to properly assess the *person insured's* claim may be prejudiced. Therefore, we may refuse to pay you for any part of the *person insured's* claim which happened 60 days or more before we received your written notice.

At any time we, or our appointed representatives, may ask the *person insured* for more information, including information about his or her health, financial and business affairs, other insurance claims and any other matter which we consider relevant to the claim or application for insurance. The *person insured* must provide to us that information, and, if we request, allow himself or herself to be interviewed or examined.

We may choose one or more *medical practitioners* or other relevant professionals to examine the *person insured*. We will pay the costs of getting any additional medical information or having any medical examination that we request.

In this clause, information includes an authority to obtain and/or provide information from or to another source.

For *persons insured* who are residing or travelling overseas, in the event of a claim we may require them to return to Australia for medical treatment and assessment. We will not pay any costs relating to the *person insured's* return to Australia. See clauses 2.5 and 2.6 for details.

7.2 Misstatement of age

If a *person insured's* age is misstated, we reserve the right to adjust premiums or the *benefit* based on the correct age.

7.3 Claims after termination

If the *policy* or cover is terminated, (whether for all *persons insured* or any number of *persons insured*) we will only pay a claim if:

- the event on which the claim is payable (Part 3) occurred before the *policy* or cover for the *person insured* (as applicable) was terminated, and
- any premium arrears have been paid up to the date the *policy* or cover for the *person insured* (as applicable) is terminated.

If, after the *policy* ends, we have to continue paying you a *benefit*, the parts of this *policy* which specifically relate to those payments continue until we stop making payments.

8 Definitions

Unless otherwise apparent from the context, terms described in the *policy* have the meanings shown below:

Accidental injury means an injury to an *eligible person* or *person insured* which first occurred after cover for the *eligible person* or *person insured* began under this *policy*, including any interim cover, and is caused directly and solely because of an accidental event which was violent, external and visible and which was not caused by attempted suicide, or self-inflicted by the person on purpose.

Adjustment premium is as defined in clause 5.3.

Applicable laws means all laws, including legislation and any principle or common law or equity, relevant to this *policy*. A reference to 'legislation' includes regulations, orders and rules made under legislation as amended, modified or enacted from time to time, and policy statements, circulars, codes of practice or guidelines, however described, issued or adopted from time to time by the regulator under such legislation.

At work means the person was properly performing all his or her duties and work hours (without limitation) of usual paid employment with the *employer* and is not in receipt of and/or entitled to claim income support benefits from any source including worker's compensation, statutory transport accident or benefits disability income benefits; or

- is on *employer* approved leave for reasons other than sickness or injury, and
- was on the day immediately preceding the first day of *employer* approved leave properly performing all his or her duties and work hours (without limitation) of usual paid employment.

A *person insured* who does not meet this definition is correspondingly described as being not *at work*.

Australian resident means an *eligible person* or *person insured* who is legally permitted to reside and work for reward in Australia.

Automatic acceptance is described in clause 2.2.

Automatic acceptance limit means the *automatic acceptance limit* described in the *schedule*. The *automatic acceptance limit* may vary depending on the types and amount of cover.

Benefit calculation date means the date described in the *schedule*.

Benefit means the *monthly benefit* plus the *employer superannuation contributions benefit* (if any).

Benefit period means the period described in the *schedule*. The *benefit period* starts from the date *you* are first entitled to be paid the *benefit*.

Contractor means a person who:

- is not an employee of the *employer*,
- is performing work in connection with a contract entered into with the *employer*,
- is contracted to work at least 15 hours per week for a period of at least 12 months, and
- is personally performing all the normal and usual duties of his or her work

Cover expiry age means the age cover expires as described in the *schedule*.

CPI means the Australian National All Groups Consumer Price Index rated average of 8 capital cities combined. *We* use the last published Index for the 12 months ending 30 September each year. However, *we* may use the Index published for a more recent 12 month period and/or another rate index which *we* believe more fairly and accurately reflects changes in the cost of living.

Disability and disabled means *total disability* and/or *partial disability* as the context requires.

Disability income means the monthly amount earned by the *person insured* as a result of his or her own personal exertion (other than *benefits* received under this *policy*) from the same components of remuneration as described in the *income* definition during any period *we* are paying *you* or *you* are entitled to be a *benefit* for the *person insured* under this *policy*, and any amount which, in *our* opinion, the *person insured* could be reasonably expected to earn while *disabled*.

Eligibility criteria means the criteria described in the *schedule*.

Eligible person is a *person insured* who satisfies clause 2.1.

Employer means an *employer* participating in this *policy* as described in the *schedule* and, in relation to an *eligible person* or *person insured* means the *employer* employing that person. Where the owner of the *policy* is a partnership, the *employer* means the partners in that partnership.

Employer superannuation contributions benefit is as described in the *schedule* subject to such other limited benefit amount resulting from either clause 2.3 (transfer terms) or clause 2.4 (*underwriting terms*).

Escalation percentage means the percentage described in the *schedule*.

Family member means in relation to the *person insured*, his or her spouse (including legal spouse, de facto or same-sex partner), mother, father, mother-in-law, father-in-law, child (including adopted child, a step-child or an ex-nuptial child).

Further underwriting limit means in respect of a *person insured* the amount (if any) which *we* last notified *you* up to which *we* will accept future increase in the amount of the *benefit* in accordance with the *benefit formula*. *Underwriting terms* will not apply to these increases.

Group insurance policy is a policy of life insurance, the owner of which is a person ('the owner') who is not a *person insured*, which offers cover for more than one life.

Important duties means one or more duties which are important and essential in producing *income*.

Income:

1. in the case of a *person insured* who owns part, or all of a business, practice or partnership that is the *employer*, means:

the amount that is generated by the business due to the *person insured's* own personal exertion activity, after all expenses in earning that amount have been deducted and,

- for *persons insured* who have two consecutive years or more with the *employer*, the average of the last two years *we* have not been paying *you* a *benefit* under the *policy* for the *person insured*, and
- for *persons insured* who have less than two years with the *employer*, the average of the period *we* have not been paying *you* a *benefit* under the *policy* for the *person insured*,

but does not include any commissions, bonuses, investment and interest income and employer Superannuation Guarantee entitlements

or

2. in the case of a *person insured* who does not own part or all of a business, practice or partnership, means the total remuneration given to the *person insured* by the *employer* including fringe benefits, but excludes any commissions, bonuses, investment and interest income and employer Superannuation Guarantee entitlements.

Where the *benefit calculation date* is 'last day at work,' *income* is the *person insured's* monthly *income* earned from working for the *employer* immediately before a *benefit* became payable by *us* in respect of the *person insured*.

Where the *benefit calculation date* is 'last renewal date,' *income* is the *person insured's* monthly *income* earned from working for the *employer* at the most recent *renewal date* that we have confirmed in writing to you.

Maximum benefit amount is as described in the *schedule*.

Medical care means that the *person insured* must be receiving and following treatment or advice recommended by a *medical practitioner* who has personally assessed him or her and been provided with full clinical details of his or her case, and the *person insured* will continue to be reviewed in these circumstances on at least a monthly basis unless otherwise agreed by us.

Medical practitioner means a registered *medical practitioner* who is appropriately qualified to treat the *person insured* for his or her injury or sickness. The *medical practitioner* cannot be you or your family member, business partner, employee or employer nor can it be the *person insured* or his or her family member, business partner, employee or employer.

Minimum annual premium is as described in the *schedule*.

Minimum number of persons insured is as described in the *schedule*.

Monthly benefit is as described in the *schedule* subject to such other limited benefit amount resulting from either clause 2.3 (transfer terms) or clause 2.4 (*underwriting terms*).

New events cover means cover for *total disablement* or a specific sickness or specific injury as set out in clause 3.16 (if applicable) other than a cause of *total disablement* or listed specific sickness or specific injury as set out in clause 3.16 (if applicable) in relation to the medical condition or any directly or indirectly related condition arising from sickness or injury which has caused the *person insured* either:

- to be not *at work* on the working day immediately preceding the *policy commencement date*, or
- in respect of a sickness or injury occurring in the period after the last day *at work* and prior to the *policy commencement date*, to be not *at work* or to be working in a reduced capacity on the *policy commencement date*.

Offset means:

1. amounts paid or payable in relation to the sickness or injury of the *person insured* including:
 - any amount which is paid under any other disablement, injury or sickness insurance policy you or the *person insured* holds with us or any other insurance company (except for lump sum total and permanent disablement payments or lump sum superannuation payment), and
 - any amount which is paid under common law actions for loss of earnings, past and future, and
 - worker's compensation or any other equivalent payments in respect of lost *income* (whether under legislation or not), and
 - statutory accident compensation scheme payments, and
 - any social security payments or entitlements, and
 - any Department of Veteran Affairs payments or entitlements,

plus

2. any sick leave received by the *person insured* at the same time as we are paying you a *benefit* in respect of the *person insured*,

plus

3. any other *income* received by the *person insured* from the *employer*, that is not as a result of the *person insured's* own personal exertion, at the same time as we are paying you a *benefit* in respect of the *person insured*, but excluding any investment income,

plus, if the words 'Employer superannuation contributions benefit' appear in the additional option section of the *schedule*:

4. any paid amount designed to replace in whole or part the compulsory employer Superannuation Guarantee, a *person insured* would have received had he or she not been *disabled*. This *offset* condition number 4 is applied to the *employer superannuation contributions benefit* (if applicable).

Partially disabled means the *person insured* is *partially disabled* if, immediately after being *totally disabled* for at least 14 days, he or she is not able to perform one or more of the *important duties* of his or her occupation and, because of the *disability*, the *person insured's income* for the work he or she does is less than the amount of his or her pre-disability *income*. The *person insured* must be under the regular care of a *medical practitioner*.

Partially disabled, partial disablement and partial disability shall have a corresponding meaning.

Person insured means an *eligible person* that we have agreed to provide cover under the terms and conditions of this *policy* and for whom you have paid all premiums due.

When referring in this document to the *policy*, we mean:

- this *policy*,
- the *schedule*,
- the Application form and any other associated papers,
- any special conditions, exclusions or endorsements to this *policy*,
- any notices issued or received by us under the *policy*,
- any individual applications for cover by an *eligible person*,

as the context requires.

Policy commencement date means the date described in the *schedule*.

Premium due date means the date described in the *schedule*.

Premium guarantee date means the date described in the *schedule*.

Previous policy means a *group insurance policy* providing Group Salary Continuation cover, that was in force on the day immediately preceding the *policy commencement date*, that this *policy* is replacing.

Rate guarantee period means the period of time from the date we notify you as the effective commencement date of the current premium rates until the *premium guarantee date*.

Rehabilitation means occupational *rehabilitation* for the purpose of returning the *person insured* to duties of employment. Occupational *rehabilitation* includes initial *rehabilitation* assessment, functional assessment, workplace assessment, vocational assessment and vocational retraining. Any occupational *rehabilitation* must be as part of a return to work program approved by us.

Renewal date means the date described in the *schedule*.

Schedule means the *schedule* attached to this *policy* and issued at the commencement of this *policy*, or as varied in accordance with the terms of this *policy*.

Total disablement means:

Where in the *schedule* the *total disablement* definition for the *person insured* is defined as ‘any occupation’:

The *person insured* is *totally disabled* if, because of injury or sickness:

- a) For the first two years of a claim, he or she is:
 - not capable of doing the *important duties* of his or her regular occupation, and
 - not working in any occupation (whether paid or unpaid), and
 - under *medical care*.
- b) After the first two years of a claim, because of the same injury or sickness, he or she is:
 - not capable of performing any occupation (whether paid or unpaid) for which he or she is reasonably suited by education, training or experience, and
 - not working in any occupation (whether paid or unpaid), and
 - under *medical care*.

Where in the *schedule* the *total disablement* definition for the *person insured* is defined as ‘own occupation’:

The *person insured* is *totally disabled* if, because of injury or sickness, he or she is:

- not capable of doing the *important duties* of his or her regular occupation, and
- not working in any occupation (whether paid or unpaid), and
- under *medical care*.

Total disablement, *total disability* and *totally disabled* shall have a corresponding meaning.

Underwriting terms means we will only agree to provide cover for an *eligible person* or an increase in the cover for a *person insured* when we are satisfied he or she has met *our* underwriting requirements. We may impose conditions on any cover or part of it that is subject to *underwriting terms*.

Waiting period means the number of consecutive days (shown in the *schedule*) for which a *person insured* must be *totally disabled* or *partially disabled*, as the case may be, before his or her *benefit* becomes payable under this *policy*.

If there is more than one category of *persons insured*, the *waiting period* for a *person insured* is that specified in the *schedule* for his or her category. The *waiting period* may be extended in certain circumstances as explained in clause 3.3.

War includes but is not limited to *war*, (declared or undeclared) or *war* related activities, revolution, invasion or rebellion or civil unrest.

We/our/us means The National Mutual Life Association of Australasia Limited ABN 72 004 020 437, located at 447 Collins St Melbourne Victoria 3000 (or some other location as advised from time to time).

You/your means the owner of this *policy* (as described in the *schedule*) and includes the owner's agents and representatives and any administrator appointed by *you*.

If trauma cover (clause 3.16) applies:

Cancer means the occurrence of an invasive malignant tumour that is confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion and destruction of normal tissue. The term cancer also refers to leukaemia, lymphoma and Hodgkin's disease unless excluded below.

The following are excluded:

- tumours classified as carcinoma in situ,

- malignant melanomas classified as Clark Level 1 or 2,
- malignant melanomas of less than 1.5mm Breslow thickness,
- other skin cancers,
- prostate tumours classified as T1 (all categories) under the TNM classification system and/or of an equivalent or lower classification,
- lymphocytic leukaemia Binet stages A and B or Rai stages O, I and II,
- tumours that are a recurrence or metastases of a tumour that first occurred within 90 days of cover commencing under the Policy, and
- Kaposi's Sarcoma and other tumours associated with HIV infection.

Chronic Kidney Failure means chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

Coronary Artery Surgery means coronary artery bypass grafting surgery performed via open chest surgery as a consequence of coronary artery disease.

Excluded:

Coronary artery surgery which is done using a technique which does not require open-chest surgery, for example:

- endoscopic intervention,
- angioplasty,
- laser techniques,
- other catheter techniques.

Heart attack means the death of an area of heart muscle due to a sudden lack of adequate blood supply to the relevant area, where:

- there are typical new electrocardiographic (ECG) changes at the time of the heart attack, and
- there are diagnostic changes in relevant cardiac enzymes or markers in the days following the heart attack.

Excluded:

- chest pain which does not meet the diagnostic requirements above,
- chest pain not related to a heart condition.

Heart Valve Surgery means the undergoing of open-heart surgery to replace or repair a heart valve as a consequence of a heart valve defect. Balloon or catheter techniques are excluded.

Major Organ Transplant means the receipt of human bone marrow or one of the following whole human organs: heart, lung, liver, kidney, pancreas.

Severe Burns means third degree burns to at least 20 per cent of the body surface area.

Stroke means the damage of brain tissue as a result of a cerebrovascular incident where:

- it is caused by haemorrhage, embolism or thrombosis, and
- it is associated with the sudden onset of objective neurological deficit, and
- the neurological deficit is likely to be permanent, and
- the haemorrhage, embolism or thrombosis has been demonstrated by Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques approved by us.

Excluded:

- Transient ischaemic attack,
- Reversible ischaemic neurological deficit,
- Cerebrovascular disorder of the eye or optic nerve,
- Symptoms due to migraine or headache,
- Brain tissue damage caused by head injury.

The National Mutual Life Association of Australasia Limited
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