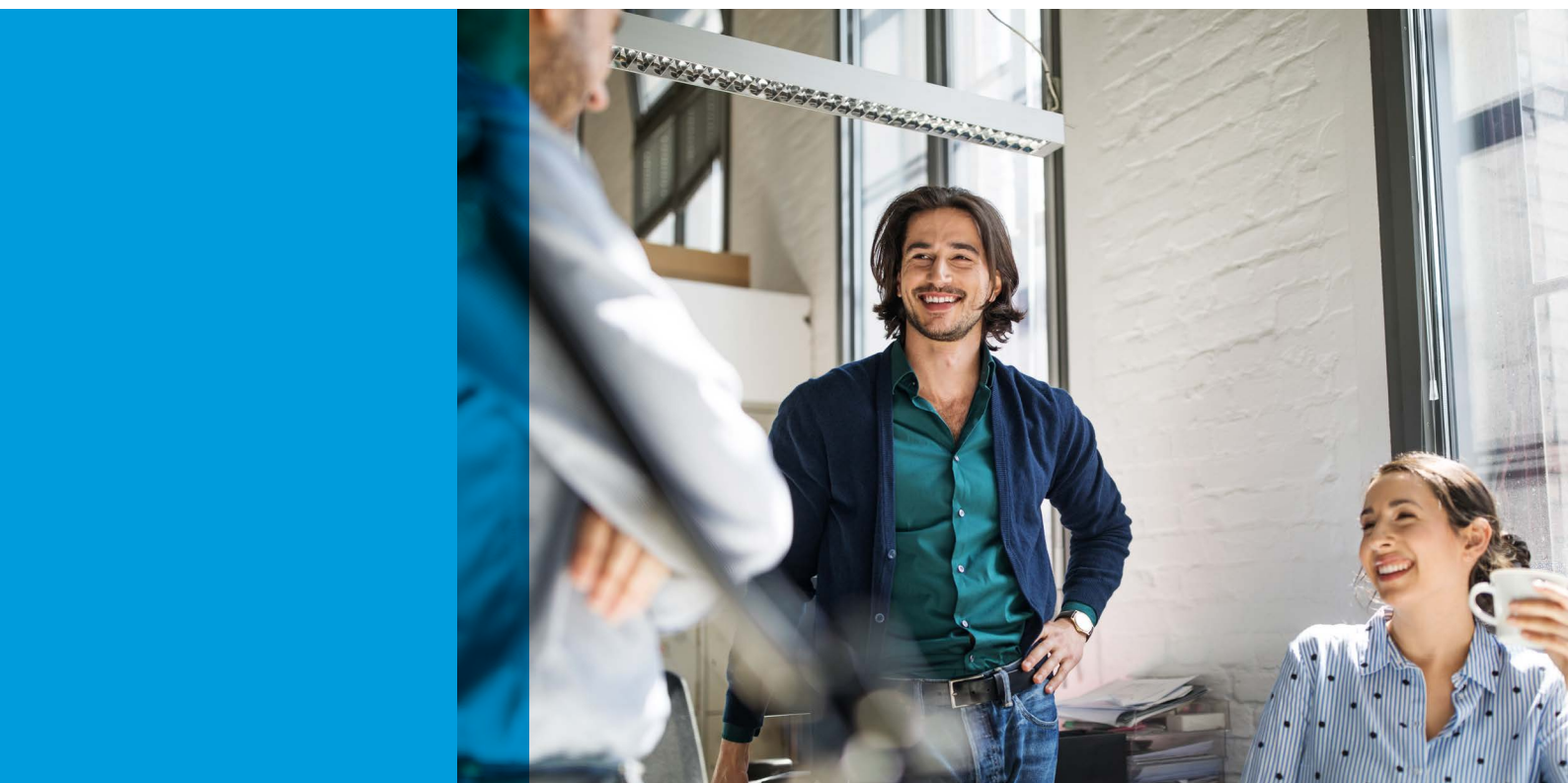


Group Income Protection Insurance

Combined Product Disclosure Statement and Policy Document

Issue Date: 1 December 2021

Group Income Protection Insurance is issued by MetLife Insurance Limited (MetLife)
ABN 75 004 274 882 AFSL No. 238096



About MetLife

In Australia, MetLife provides group insurance and individual life insurance products, specialising in death, total and permanent disability, and income protection insurance. Since its entry into the Australian market in 2005, MetLife has grown its group insurance market share significantly through partnering with superannuation funds, employers, brokers and advisers.

With over 150 years of experience, MetLife globally has established a strong presence in more than 40 markets reaching nearly 100 million customers.

This product is issued and underwritten by MetLife Insurance Limited.

The other companies within the MetLife group do not issue, guarantee or underwrite this product.

Which group insurance products are described in this document?

This booklet only covers MetLife Group Income Protection Insurance for ordinary (non-superannuation) arrangements. This booklet will not apply to *you* if *you* are the trustee of a superannuation fund and are looking to provide insurance for *your* members.

There are separate booklets containing the Product Disclosure Statements and/or policy documents for the following group insurance products issued by MetLife:

- MetLife Income Protection Insurance for superannuation arrangements (for policy documents only)
- MetLife Group Life Insurance for ordinary (non-superannuation) arrangements
- MetLife Group Life Insurance for superannuation arrangements (for policy documents only)

You can contact *us* on 1300 555 625 for a copy of these documents. *You* should consider these documents in deciding whether to acquire these other products.

MetLife 360Health - Virtual Care

When *you* purchase the policy, all *insured persons* under the policy will automatically have access to MetLife 360Health and the Virtual Care program.

MetLife 360Health Virtual Care is a service that gives an *insured person*, their partner and their children access to expert medical support and guidance from the comfort of their own home.

When someone is facing a health problem they need clear, definitive answers and reassurance that the support they are getting is the best available. *We* help where there is uncertainty by providing an *insured person* (and their partner and children) with easy access to leading general practitioners, specialists and mental health clinicians via Virtual Care which is provided through our partner Teladoc Health.

The services available include Mental Health Assist, Expert Medical Opinion, GP online and Nutrition Consultation. These services are designed to provide support for the *insured person* (and their partner and children) and are completely confidential.

For more information on this service, please contact *us*. *Our* contact details can be found below in the PDS.

Further details, including instructions on how to access the service, are also provided in *your* welcome pack when *you* purchase the policy.

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About this document

How to read this booklet

This booklet contains the Product Disclosure Statement (PDS) and the policy document for MetLife Group Income Protection Insurance for ordinary (non-superannuation) arrangements.

In this booklet:

- *we, our, us* and *MetLife* refer to MetLife Insurance Limited,
- *you, your* and *policy owner* refer to the applicant for this product and, if a policy is issued, the *policy owner* as set out in the *policy schedule*,
- headings are intended as a guide only and are not to be used to interpret the policy conditions, and
- as the context allows, plurals can be read as the singular and the singular as plurals.

What documents make up your policy?

The documents issued by *us* that make up *your* contract of insurance with *MetLife* (policy) are:

- the policy document section of this booklet,
- the *policy schedule* issued and signed by *us*, and
- any addendums issued and signed by *us*.

Please keep these documents in a safe place.

What is MetLife Group Income Protection Insurance Ordinary?

MetLife Group Income Protection Insurance Ordinary (Non-Superannuation) provides income protection cover in relation to a group of people who share a commonality, such as employees of the same employer. As a result, there will be a single MetLife Group Income Protection Insurance policy between *you* and *us*, but the policy provides cover in relation to a group of *eligible persons*.

As the insurance is provided on a group basis, *we* will pay the insured benefits to *you* (except where *your* policy expressly states otherwise such as in the case of a *superannuation contribution benefit* or a *retraining expenses benefit*) and *you* will pay the premiums collectively to *us*.

Understanding your insurance

Insurance can be complex, but it's important that *you* can understand how *your* insurance works. So we've tried to keep the language in this document as clear and straightforward as possible but some expressions that are used in this booklet do have a special meaning. Where these expressions are used they appear in italics. The meaning of all the defined terms are above (see **How to read this booklet**) and in the section headed **16. Definitions** in the policy document section of this booklet.

This booklet is only available to persons receiving the offer and making an application in Australia. It is not an offer, invitation or recommendation by *MetLife*. Applications from outside Australia will not be accepted. *MetLife* is also not bound to accept any application.

This booklet has been designed to help *you* decide if MetLife Group Income Protection insurance is right for *you*. Any advice given in the booklet is general advice only and does not take into account *your* objectives, financial situation or needs. As a result, before acting on this information, *you* should consider the appropriateness of the information having regard to *your* objectives, financial situation and needs.

This booklet contains important information about:

- significant features and benefits of this product,
- *your* Duty of Disclosure when applying for this product,
- *our* internal and external dispute resolution procedures, and
- *your* cooling off rights when purchasing this product.

Please note that, in addition to the summary of the significant features and benefits of this product, *you* must also read the policy document (which forms part of this booklet) as it contains the specific terms and conditions to understand the insurance provided (including the terms, exclusions and limitations that may apply to *your* cover).

Updating this PDS

The information contained in this PDS is current at the time of issue. From time to time *we* may change or update information that is not materially adverse by providing a notice of changes on *our* website www.metlife.com.au. *You* can also obtain a paper copy of the updated information without charge by calling *us* on 1300 555 625.

If there is a materially significant change or omission to this PDS which affects *your* policy, *we* will issue *you* with a notice of the changes.

About this document

Applying for cover

After consultation with *you*, we will provide a quote summary which should be considered in conjunction with this booklet. If *you* would like to go ahead with the application for cover, we would require *you* or *your* adviser to accept the quote summary by email and to advise *us* of the date *you* would like *us* to assume risk from. When we receive this information we will assist *you* in the application process which will include the completion of an application form. Please note, we do not generally assume risk that commences from a date before *you* accept the quote, unless we specifically agree to do so.

Neither this booklet nor the quote summary constitute a legally binding contract of insurance with *MetLife*. A contract is only formed when:

- we accept *your* application for this product and issue a *policy schedule* to *you* which confirms *your* cover and contains the specific benefits that apply to *your* policy. We may also require *you* to accept the policy by signing the *policy schedule* or by another means agreed by *us*,
- we issue an 'on-risk' letter confirming the issue of the policy, and
- *you* have paid the premium we advise *you* is due and payable for the cover.

If we agree to change any of the terms or conditions of the policy, we will do this by adding an addendum to *your* policy.

Other information

Automatic acceptance

We may offer *standard cover* up to an agreed amount (referred to as an *automatic acceptance limit*) without the need for medical or other evidence, if the following criteria are satisfied:

- at least 75% of the people that meet the *eligibility conditions* become an *insured person*, and
- the conditions that you set for people to be covered under this policy does not allow them to directly or indirectly choose their own level of cover outside of those conditions without *our* consent. For example, the amount of cover a person can obtain is based on a set formula which applies to all persons who meet the conditions, and
- at each *annual review date*, you provide us with the relevant details of every person who satisfies the *eligibility conditions* as at the *annual review date*. If a person satisfies the *eligibility conditions*, but you do not provide their details at the next *annual review date* after they become an *eligible person*, we may require that person to apply for cover and their application will be subject to acceptance by us. Unless we agree otherwise with you, we will require medical or other evidence as per *our* normal underwriting process as part of the person's application.

Underwriting

Underwriting is the process of assessing a person's insurability by obtaining information about their personal and family medical history, occupation, pastimes and any other information we may reasonably require that is considered relevant.

There may be situations where the *insured person* must obtain cover through underwriting. For example, an *insured person* is seeking cover above the *automatic acceptance limit*. Where underwriting is required we will need the *insured person* to complete a personal statement (application form) provided by us so we can assess their request. This means that acceptance for cover will be at *our* discretion and on such terms and conditions we determine, which will be based on *our* assessment of any information that we may reasonably require, including medical information such as doctor's reports, blood tests and/or medical examinations.

When we underwrite a person for cover, and we have received all the information we require, we will decide to:

- (a) accept on standard terms,
- (b) accept with an exclusion (e.g. of a specific condition),
- (c) accept with a loading (e.g. +50% of the standard premium),
- (d) accept with a combination of an exclusion and a loading, or

- (e) decline cover.

Where the policy covers 50 or more *insured persons*, any loading will be recorded but not charged by us unless the *insured person* chooses to continue cover under a continuation option.

We will only ask for personal information that we are permitted to ask for by law and *our* relevant industry Code of Practice, and which we believe is necessary for *our* underwriting purposes.

Duty to take care not to make a misrepresentation - Persons being underwritten

Care must be taken to answer all questions we ask as part of an *eligible person's* insurance application honestly and accurately.

Otherwise, the *eligible person* may not be able to rely on the insurance when it's needed most.

When an *eligible person* applies for life insurance, we will ask them a number of questions.

Our questions will be clear and specific. They will be about things such as the *eligible person's* health and medical history, occupation, income, lifestyle, pastimes, and other insurance.

The answers given in response to *our* questions are very important. We use them to decide if we can provide cover to the *eligible person* and, if we can, the terms of the cover and the premium we will charge.

The duty to take reasonable care

When applying for insurance, there is a duty to take reasonable care not to make a misrepresentation. A misrepresentation could be made if an answer is given that is false, only partially true, or that does not fairly reflect the truth.

This means when answering *our* questions, the *eligible person* should respond fully, honestly and accurately.

The duty to take reasonable care not to make a misrepresentation applies any time an *eligible person* answers *our* questions as part of an initial application for insurance, an application to extend or make changes to existing insurance, or an application to reinstate insurance.

The *eligible person* is responsible for all answers given, even if someone assists them with their application. We may later investigate the answers given in the *eligible person's* application, including at the time of a claim.

Consequences of not complying with the duty

If there is a failure to comply with the duty to take reasonable care not to make a misrepresentation, it can have serious

Other information

consequences for the *eligible person's* insurance, such as those explained below:

Potential consequences	Additional explanation	Impact on claims
The cover being avoided	This means the <i>eligible person's</i> cover will be treated as if it never existed	Any claim that has been made will not be payable
The amount of cover being changed	The <i>eligible person's</i> cover level could be reduced	If a claim has been made, a lower benefit may be payable
The terms of the cover being changed	We could, for example, add an exclusion to <i>eligible person's</i> cover meaning claims for certain events will not be payable	If a claim has been made for an event that is now excluded, it will not be payable

If we believe there has been a breach of the duty to take reasonable care not to make a misrepresentation, we will let the *eligible person* know our reasons and the information we rely on and give the *eligible person* an opportunity to provide an explanation.

In determining if there has been a breach of the duty, we will consider all relevant circumstances.

The rights we have if there has been a failure to comply with the duty will depend on factors such as what we would have done had a misrepresentation not been made during the *eligible person's* application process and whether or not the misrepresentation was fraudulently made.

If we decide to take some action on the *eligible person's* cover, we will advise you or the *eligible person* of our decision and the process to have this reviewed or make a complaint if you or the *eligible person* disagree with our decision.

Guidance for answering our questions

When answering our questions, the *eligible person* should:

- Think carefully about each question before they answer. If they are unsure of the meaning of any question, they should ask us before they respond,
- Answer every question that we ask,
- Not assume that we will contact the *eligible person's* doctor for any medical information,
- Answer truthfully, accurately and completely. If they are

unsure about whether they should include information, they should include it or check with us,

- Review their application carefully. If someone else helped prepare their application (for example, their adviser), they should check every answer (and make corrections if needed) before the application is submitted.

Other important information

An *eligible person's* application for cover will be treated as if they are applying for an individual 'consumer insurance contract'. For this reason, the duty to take reasonable care not to make a misrepresentation applies.

Before the *eligible person's* cover starts, we may ask about any changes that mean they would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if the *eligible person* lets us know about any changes when they happen.

If after the cover starts, the *eligible person* thinks they may not have met their duty, they should contact us immediately and we'll let them know whether it has any impact on the cover.

Forward underwriting limits

When we accept a person's application after being underwritten, we may offer a *forward underwriting limit* for cover above the *automatic acceptance limit*. The amount of an *insured person's forward underwriting limit* will be advised by us. A *forward underwriting limit* will only be available where the policy has a standard formula for calculating the *insured cover* and may require the provision of additional mandatory information such as doctor's reports, blood tests and/or medical examinations.

Premiums and charges

The amount of the premium is the total cost of cover for all *insured persons* during the relevant period based on the *premium rates* (which may include an admin fee and broker commission) for that period including any premium loadings. The premium amount also includes any government levies, taxes or charges not included in the *premium rates*. Further information on premiums can be found in the section titled **11. Premiums** of the policy document.

Your *premium rate* will mainly depend on factors impacting on the level of insurance risk such as:

- the amount and type of cover that will be provided;
- the demographics of the *insured persons* (e.g. age, occupation, and gender distributions); and
- your history of claims.

General information

Your duty of disclosure - Applying for this policy

Before you enter into a life insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to insure you and on what terms. You have this duty until we agree to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell us anything that:

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

If the insurance is for the life of another person and that person does not tell us everything he or she should have, this may be treated as a failure by you to tell us something that you must tell us.

If you do not tell us something

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

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the contract within 3 years of entering into it.

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

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

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

Our Privacy Statement

We collect, use and retain personal information in accordance with the Privacy Act 1988 (Cth). We collect, use, process and store personal information and, in some cases, sensitive information (including health information) about you and the individuals covered under your policy, in order to comply with our legal obligations, to assess your application for insurance cover, to administer the insurance cover provided, to enhance customer service or products and to manage claims. If you do not agree to provide us with the information, we may not be able to process your application, administer your cover or assess your claims.

In dealing with us, you agree to us using and disclosing your personal information as set out in this section and in our Privacy Policy.

For further information about how we handle your personal information, the entities we often disclose personal information to (including overseas recipients), details of how you can access or correct the information we hold about you or make a complaint, you can access our Privacy Policy at www.metlife.com.au/privacy or contact us on 1300 555 625.

Tax and stamp duty

Goods and Services Tax (GST) currently does not apply to life insurance premiums. Premiums are inclusive of stamp duty where applicable. The rate of duty will differ depending on which state or territory the insured person resides in and that rate may also vary from time to time.

This information is based on our current interpretation of the tax laws. Should changes in the law result in any new or additional taxes, duties or charges in relation to this policy, these amounts may be added to the premium or charged to the policy owner.

The way your insurance benefits and premiums are taxed will depend on your individual circumstances. We recommend that you consult a professional tax adviser for advice regarding your circumstances.

Commissions

When you purchase a group insurance policy from us, the premium is paid to us. When an adviser is involved, they may request that a commission be applied to the premium for their services. This commission rate, which can be up to 30% of the annual premium plus GST, will be added to the premiums due to us under the policy and we will then pay the commission to the adviser. It is the responsibility of the adviser to advise you if there is any commission being applied under the policy for their service. Any commissions will be included in the cost of the premiums that you pay.

General information

Commissions cannot be applied to a policy where the *policy owner* is a trustee of a complying superannuation fund.

Cooling off period

You have 14 days after your cover commences to cancel the policy. This is known as the cooling off period. The 14 days commences on the earlier of:

- 5 days after we issue the policy to you, and
- the date you receive our 'on-risk letter' confirming the issue of the policy.

If you cancel the policy within the cooling off period we will:

- refund your premium less the reasonable administrative and transaction costs (including taxes and duties) we have incurred in setting up the policy; and
- terminate the policy effective from the *commencement date*. Note, this means that we will not pay any benefits under the policy.

If you cancel the policy after the cooling off period or if you have exercised rights or powers under the policy (for example, if you have made a claim), we will retain the portion of premium which relates to the cover that was provided before we received your written notice.

Life Insurance Code of Practice

MetLife is proud to have adopted the Life Insurance Code of Practice – an industry code introduced by the Financial Services Council (FSC) to ensure a consistently high level of product and service standards for all Australians. You can find information about the Code at the Life Insurance Code of Practice link at the bottom of each page on our website www.metlife.com.au

Our contact details

How to contact us

MetLife Insurance Limited
GPO Box 3319, Sydney NSW 2001
Telephone: 1300 555 625 Monday to Friday (except public holidays) 8:00 am to 5:00 pm (AEST)
Email: auservices@metlife.com
Website: www.metlife.com.au

Complaints resolution

It is *our* commitment that we will always attempt to satisfactorily answer any questions and resolve any problems or complaints *you* may have regarding the policy or *our* services.

If *you* wish to make a complaint about this product or *our* services, please contact *us* on:

Telephone: 1300 555 625
Email: aucomplaints@metlife.com

or write to:

Dispute Resolution Officer
MetLife Insurance Limited
Reply Paid 3319, SYDNEY NSW 2001

You may contact the Australian Financial Complaints Authority (AFCA) if *you* are not satisfied with how *we* respond to *your* complaint. AFCA is an independent body whose services are available to *you* at no cost. They can be contacted by:

Telephone: 1800 931 678
Email: info@afca.org.au

or write to:

Australian Financial Complaints Authority
GPO Box 3, MELBOURNE VIC 3001

Time limits may apply for *you* to take *your* complaint to AFCA. *You* should consult the AFCA website (www.afca.org.au) to find out the time limit that applies to *your* complaint.

Group income protection insurance: a snapshot

The information in this section is a summary only and should be read in conjunction with the information provided in the policy document.

Features at a glance: benefits and options

MetLife Group Income Protection Insurance pays you a benefit if an *insured person* is *partially disabled* or *totally disabled* subject to the terms and conditions of *your* policy.

Cover and limitations

Minimum number of <i>insured persons</i>	25
Who can own the policy?	You must be an Australian entity with at least 20 direct employees to be the <i>policy owner</i> .
Who can obtain cover?	Generally <i>Australian residents</i> or holders of a temporary work visa approved by us aged up to 64. The person will also need to satisfy any other <i>eligibility conditions</i> chosen by you and agreed to by us.
Minimum entry age	15
Maximum entry age	64
Maximum cover cessation age	70*
Waiting period options	30, 60 and 90 days.
Benefit period options	2 years, 5 years and To Age 65. 2 year top up benefit expiry option (only available with the To Age 65 <i>benefit period</i>). The following persons can only have a 2 year <i>benefit period</i> : <ul style="list-style-type: none"> • <i>contractors</i> engaged by the <i>employer</i> for a period of less than 12 consecutive months, and • <i>casual employees</i>.
Maximum monthly benefit (includes the <i>superannuation contribution benefit</i> , if applicable)**	\$30,000 (equivalent to 75% of first \$480,000 of annual income) Where an <i>insured person</i> is 65 or older, the <i>maximum monthly benefit</i> we'll pay will not exceed \$10,000.
Premium frequency	Yearly unless other frequency requested (at additional cost of 3%).
Minimum premium (excluding any commissions, third party administration fees and government charges, taxes and levies)	\$10,000 per annum. We may change the minimum premium amount (increase or decrease) at the end of the <i>premium guarantee period</i> .
Insured percentage	Up to 75% of <i>income</i> .
Superannuation contribution benefit (SCB)**	Up to 12% of <i>income</i> .
Exclusions	Exclusions and limitations apply which means that there will be situations where we will not pay a benefit. Refer to the terms in the policy document for further information.

*As agreed by us. Cover cessation age applicable to your policy may be lower.

**The SCB is an optional benefit.

Standard features

Feature/Benefit	Description	Policy Document Page
Total disability benefit	Provides a benefit if an <i>insured person</i> is <i>totally disabled</i> .	2
Partial disability benefit	Provides a benefit if an <i>insured person</i> is <i>partially disabled</i> .	2
Death benefit	Provides an additional lump sum benefit if an <i>insured person</i> dies while we are paying them a <i>disability benefit</i> .	3
Retraining expense benefit	We may cover the cost incurred by the <i>insured person</i> while receiving a <i>disability benefit</i> if they undergo a retraining program that we have approved.	4
Increasing benefits (Escalation benefit)	We may increase the <i>disability benefits</i> paid to an <i>insured person</i> to keep up with inflation every 12 months.	4
Recurrent disability	No further <i>waiting period</i> will apply if an <i>insured person</i> has a relapse of the same sickness or injury within 6 months of receiving a <i>disability benefit</i> .	3
Standard cover	Available to all persons who satisfy the <i>eligibility conditions</i> chosen by <i>you</i> and agreed to by <i>us</i> . To get <i>standard cover</i> each person must be disclosed to <i>us</i> within 30 days of the next <i>annual review date</i> after they first satisfy the <i>eligibility conditions</i> .	10
24-hour worldwide cover	We'll provide cover for an <i>insured person</i> 24 hours a day while they are overseas. Some conditions apply.	14
Cover while on leave without pay	We'll continue to provide cover while an <i>insured person</i> is on approved leave.	14
Interim accident cover	Provides interim cover for up to 90 days while an <i>insured person</i> or <i>eligible person</i> is being underwritten.	17
Extended cover	Provides cover for up to 60 days where an <i>insured person</i> leaves <i>your employment</i> and ceases to be eligible for cover under the policy.	19
Waiver of premium	Premiums are waived while an <i>insured person</i> is receiving a benefit.	21
Return to work during the waiting period	For <i>total disability</i> , an <i>insured person</i> is permitted to return to work once, performing their usual duties without the <i>waiting period</i> restarting again.	30
Bundled policy discount	We may provide a discount when <i>you</i> take out both a Group Life Policy and Group Income Protection Policy with <i>us</i> . When we provide a discount, it will apply to the policy with the lowest premium.	21
Waiver of underwriting loadings	Where a premium loading is recorded for an <i>insured person</i> , we will not charge the extra premium for the loading except if the <i>insured person</i> exercises a continuation option. This is only applicable where the policy covers 50 or more <i>insured persons</i> .	
Guaranteed renewable	We'll guarantee to renew the policy each year provided the premiums are paid and the terms and conditions of the policy are met.	

Optional features at an additional cost

Feature/Benefit	Description	Page
Superannuation contribution benefit	Provides a benefit to cover the cost of employer superannuation guarantee contributions while an <i>insured person</i> is receiving a <i>disability benefit</i> .	5
Crisis benefit	Provides a lump sum benefit if an <i>insured person</i> suffers one of the 35 listed <i>crisis benefit medical conditions</i> .	6
Specific injury benefit	Provides a benefit if an <i>insured person</i> suffers one of the <i>specific injury events</i> .	7
Nursing care benefit	Provides a benefit to help with nursing expenses where the <i>insured person</i> requires the continuous full-time care of a <i>registered nurse</i> .	8
Family care benefit	Provides a benefit to help cover some of the lost income of an <i>insured person's direct family member</i> who has stopped working to care for the <i>insured person</i> .	8
Accommodation benefit	Provides a benefit to help cover some of the cost of accommodation for an <i>insured person's direct family member</i> while the <i>insured person</i> requires the continuous full-time care of a <i>registered nurse</i> .	9
Return to work benefit	Provides a benefit when an <i>insured person</i> returns to work performing their pre- <i>disability</i> hours after completing a <i>return to work program</i> , and they remain at work for 6 consecutive months.	9
Life recovery benefit	Provides a benefit to help with the recovery of an <i>insured person</i> who is <i>totally disabled</i> and has an unplanned emergency hospital admission.	9
Enhanced death benefit	Provides a lump sum benefit if an <i>insured person</i> dies or becomes <i>terminally ill</i> while they are insured under the policy even if we are not paying them a <i>disability benefit</i> .	10
Cover beyond age 65	Provides cover beyond age 65 up to a maximum age of 70. Some conditions apply.	14
Continuation option	An <i>insured person</i> may be able to continue their cover once their <i>employment</i> ceases with you.	16

Disability definitions

There are two *total disability* (and *partial disability*) definitions available under the policy for you to choose from. The definitions are as follows:

Definition 1	“Own occupation” definition applicable for the entire duration of the <i>benefit period</i> .
Definition 2	“Own occupation” definition applicable for the first 2 years of the <i>benefit period</i> . “Any occupation” definition applicable for each month of the <i>benefit period</i> after 2 years.

Definition 2 is generally cheaper than Definition 1 where the *benefit period* that applies to your policy (or a particular category of *insured persons* under the policy) is greater than 2 years.

The definition that applies to your policy will be stated in your *policy schedule*.

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Group Income Protection Insurance (Ordinary)

Policy Document

About this policy document

This is *your* Group Income Protection Policy Document, which sets out the details of the cover provided to *insured persons*.

In this policy:

- *we, us* and *our* refer to MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096,
- *you* and *your* refer to the *policy owner*.

Understanding your policy

Insurance can be complex, but it's important that *you* and the people that are insured under this policy can understand how *your* insurance works. *We* have tried to keep the language in this document as clear and straightforward as possible but some expressions that are used in the policy do have a special meaning.

Where these expressions are used they appear in italics. The meaning of all the defined terms is in section **16 Definitions**.

There is also a section **14.10 Interpretation** that contains some rules that explain how the policy is intended to be read.

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1. Benefits

1.1 Main benefits

There are two main benefits available under this policy. These benefits are payable in the circumstances described in the policy:

Total Disability Benefit	Partial Disability Benefit
We'll pay you a benefit if an <i>insured person</i> is <i>totally disabled</i> , provided their <i>date of disablement</i> occurs whilst they are an <i>insured person</i> .	We'll pay you a benefit if an <i>insured person</i> is <i>partially disabled</i> , provided their <i>date of disablement</i> occurs whilst they are an <i>insured person</i> .

1.2 What we pay

The amount of the benefit we'll pay you is as follows.

Benefit type	Amount we pay
Total disability benefit	We'll pay you the amount of the <i>insured person's</i> <i>monthly benefit</i> . The amount we pay will be reduced by any amount of <i>other disability income</i> in accordance with section 1.5 When we reduce benefits .
Partial disability benefit	We'll pay you the amount determined by the formula below: $\frac{\text{pre-disability income} - \text{return to employment income}}{\text{pre-disability income}} \times \text{monthly benefit}$ The amount we pay will be reduced by any amount of <i>other disability income</i> in accordance with section 1.5 When we reduce benefits .

1.3 When we pay

Disability benefits will begin to accrue from the day after the *waiting period* has ended. Unless we agree otherwise, benefits will be paid monthly in arrears, immediately following the month they relate to, until we cease to be liable. If a *disability benefit* is payable for less than a whole month, we will pay a portion of the *monthly benefit* based on the number of days in the month in which the benefit is payable. For example, if the *monthly benefit* starts to accrue on 16th February (outside of a leap year), we will pay 13/28th of the *monthly benefit* for February representing the 13 days of the month of February where benefits are payable.

1.4 When we stop paying

We will pay *disability benefits* until the earliest of the:

- end of the *benefit period* that applies*,
- date the *insured person* is no longer *disabled*,
- death of the *insured person*,
- date the *insured person* reaches the *cover cessation age*,
- date the *insured person* is not an *Australian resident*, is no longer permanently in Australia or not eligible to work in Australia, and
- date benefits stop under section **6.3 Cover beyond age 65** if the *insured person's* *cover cessation age* is greater than age 65.

We may also cease to pay *disability benefits* where the *insured person* refuses to undergo or continue a *return to work program* as reasonably required by us.

***Important Note: Benefit period for contractors and casual employees**

Contractors engaged by the *employer* for a period of less than 12 consecutive months and *casual employees* will have a two year *benefit period*.

1.5 When we reduce benefits

Total disability benefit

The *monthly benefit* will be reduced by *other disability income* if:

- the *monthly benefit*, plus
- the *other disability income*,

exceeds 75% of the *insured person's pre-disability income* (which includes any indexation to the *pre-disability income* figure as described in this section 1.5) but only to the extent that it exceeds 75% of that *pre-disability income* figure.

Partial disability benefit

The *partial disability benefit* will be reduced by *other disability income* if:

- the *partial disability benefit* payable, plus
- the *other disability income*, plus
- the *return to employment income*,

exceeds 100% of the *insured person's pre-disability income* (which includes any indexation to the *pre-disability income* figure as described in this section 1.5) but only to the extent that it exceeds 100% of that *pre-disability income* figure.

Indexation of pre-disability income

For the purpose of calculating the reduction under this section 1.5 (and the reduction under section **2.1 Superannuation contribution benefit**, if applicable), the *pre-disability income* figure we use will be increased by the lower of 5% and the most recently published *consumer price index (CPI)* increase. We will only do this where we have been paying the *disability benefit* for an *insured person* for a continuous 12 month period. If an increase is applicable, it will be applied at the end of each continuous 12 month period.

For the avoidance of doubt, indexation to the *pre-disability income* (as described above) will only occur for the purpose of calculating the reduction that applies under this section 1.5 (and the reduction under section **2.1 Superannuation contribution benefit**, if applicable), and does **not** apply when calculating the *disability benefit*. See section **1.9 Escalation benefit** for details on increases to the *disability benefit*.

1.6 Recurrent disability

If *disability* recurs within six months from the date the *insured person* ceased to be *disabled* from the same or related illness or injury, we will treat the recurrent *disability* as a continuation of the original claim.

This means we will:

- not apply a *waiting period* for the recurrent *disability*, and
- add together all periods of *disability* in determining when the *benefit period* ends.

If *total disability* or *partial disability* recurs six months or greater from the date the *insured person* ceased to be *disabled* from the same or related illness or injury, and cover has not otherwise ceased, we will still add together all periods of *disability* in determining when the *benefit period* ends. We will also apply a *waiting period* for the recurrent *disability*.

Maximum benefit per disability

The maximum period we will pay for a *disability* due to the same or related illness or injury is the *benefit period*. This is regardless of how often the *insured person* is *disabled* due to this illness or injury. For example, if an *insured person* with a 2 year *benefit period* is paid for 16 months for a back injury, returns to work for several years and then suffers the same or related injury again, the most we will pay for the second claim is 8 months.

1.7 Death benefit

If an *insured person* dies while entitled to receive a:

- *disability benefit*,
- *nursing care benefit*,
- *specific injury benefit*, or

- *life recovery benefit*

we'll pay you a one off amount of three times the *insured person's monthly benefit* and *superannuation contribution monthly benefit* (if it applies). If the *insured person's* death is on or after their 65th birthday, this benefit cannot exceed \$30,000.

Exclusions – when we will not pay a death benefit

We will not pay this benefit if:

- the *insured person* dies within 3 months of a *crisis benefit* being payable, or
- a benefit is paid or payable under section **2.9 Enhanced death benefit**.

1.8 Retraining expense benefit

When an *insured person* is *disabled*, and not required to participate in a *return to work program* by us, however a *medical practitioner* certifies that a rehabilitation program (other than an *excluded rehabilitation program*) would assist in their return to work, we will pay the costs for this, provided that:

- we approve the expenditure in writing before they are incurred,
- the expenses are incurred to directly assist the *insured person* to return to work in a gainful occupation or to undertake a vocational retraining program,
- we pay the costs directly to the provider of the applicable service, and
- the maximum amount we will pay for any one *disability* is the lesser of the:
 - expenses, and
 - amount we pre-approve.

We will not pay any expenses incurred for non-attendance or non-participation during the rehabilitation program by the *insured person*.

1.9 Escalation benefit

We will increase the *disability benefit* or *specific injury benefit* payable to an *insured person* by the lower of 5% and the most recently published *consumer price index (CPI)* increase. We will only do this where we have been paying the *disability benefit* or *specific injury benefit* for an *insured person* for a continuous 12 month period. If an increase is applicable, it will be applied at the end of each continuous 12 month period.

Where the *consumer price index (CPI)* is less than 0% we will apply a rate of 0%.

Any increase to the *disability benefit* or *specific injury benefit* cannot exceed the *maximum monthly benefit*.

1.10 Reduced or nil payments

If the *insured person* is *disabled* but the amount of *disability benefit* payable by us for a period is reduced or becomes zero under any condition of this policy, we will still consider that we have made a benefit payment for that period and count that period as part of the *benefit period*.

2. Optional benefits

The following optional benefits are also available under this policy:

- *superannuation contribution benefit,*
- *crisis benefit,*
- *specific injury benefit,*
- *nursing care benefit,*
- *family care benefit,*
- *accommodation benefit,*
- *return to work benefit,*
- *life recovery benefit,* and
- *enhanced death benefit.*

These benefits are payable in the circumstances described in the policy only when the *policy schedule* specifies that the benefit applies.

2.1 Superannuation contribution benefit

Where we are paying you a *disability benefit* for an *insured person*, we'll pay an amount equal to the *superannuation contribution monthly benefit* or *superannuation contribution partial monthly benefit* (as applicable).

Payment of this benefit will:

- be paid monthly in arrears and into the *insured person's* complying superannuation fund, and
- stop when the *insured person* ceases to be entitled to a *disability benefit*.

Reductions and limitations

The benefit payable under this section will be reduced by the amounts below:

- the amount of any *employer* superannuation contributions paid to an *insured person's* superannuation account for any period of *disability* (this does not include *employer* superannuation contributions paid to an *insured person's* superannuation account that relates to *return to employment income*), and
- the amount of any benefits payable under any other income protection policy where that benefit payable is designed to replace in whole or in part the compulsory employer superannuation entitlements the *insured person* would have benefited from if they were not *disabled*,

but only if the amounts above, when combined with the *superannuation contribution benefit*, exceeds the *superannuation contribution insured percentage* multiplied by the *pre-disability income*. The reduction will only apply to the extent that the combined amount exceeds the *superannuation contribution insured percentage* multiplied by the *pre-disability income*.

The *pre-disability income* figure we use for the above reduction will be increased in accordance with the terms outlined at section **1.5 When we reduce benefits** "Indexation of pre-disability income".

We can refuse to make a *superannuation contribution benefit* to anyone other than the trustee of a complying superannuation fund of which the *insured person* is a member at the time of payment.

Option - Converting monthly benefit to superannuation contribution monthly benefit

If the *superannuation contribution monthly benefit* payable is less than the *superannuation contribution insured percentage* multiplied by the *pre-disability income*, the *insured person* can choose to have a portion of their *monthly benefit* paid as a *superannuation contribution monthly benefit* instead. The *insured person* must tell us in writing before the relevant *disability benefit* is paid if they wish to exercise this option.

The total amount of *superannuation contribution monthly benefit* cannot exceed an amount equal to the *superannuation contribution insured percentage* multiplied by the *pre-disability income*.

2.2 Crisis benefit

How the crisis benefit works

We will pay this benefit if the *insured person* first satisfies one of the *crisis benefit medical conditions* while covered under this policy. The *crisis benefit medical conditions* are listed in the table below.

How you are paid for a crisis benefit

The amount we pay varies with age, and will be:

- if the *insured person* is under age 65, three times the *monthly benefit* plus the *superannuation contribution monthly benefit* (if applicable)
- if the *insured person* is age 65 or over, three times the lesser of:
 - the *monthly benefit*, plus the *superannuation contribution monthly benefit* (if applicable), and
 - \$10,000 per month.

The medical conditions we cover

The table below lists the medical conditions covered. The specific definition of each medical condition that an *insured person* needs to satisfy can be found in Appendix B. The definitions use medical terms because they are necessary to describe the precise symptoms, procedures and/or diagnosis.

Crisis Benefit Medical Condition	
Accidental HIV Infection*	Loss of Limbs
Alzheimer's Disease	Loss of Limbs and Sight of One Eye
Aplastic Anaemia	Loss of Speech
Bacterial Meningitis	Major Head Trauma
Benign Brain Tumour*	Major Organ Transplant*
Blindness	Motor Neurone Disease
Cancer*	Multiple Sclerosis
Cardiomyopathy	Muscular Dystrophy
Chronic Liver Failure	Occupationally Acquired Hepatitis B or Hepatitis C Infection*
Chronic Renal Failure	Parkinson's Disease
Chronic Respiratory Failure	Pneumonectomy (Removal of the lung)
Coma	Primary Pulmonary Hypertension *
Coronary Artery Angioplasty Multiple Vessel* (or Triple Vessel Coronary Artery Angioplasty)	Severe Burns
Coronary Artery Bypass Surgery*	Stroke*
Heart Attack*	Surgery to Aorta*
Heart Valve Surgery*	Terminal Illness*
Loss of Hearing	Viral Encephalitis
Loss of Independence	

*the *insured person* is not covered for that condition if it occurs in the first 90 days after the *insured person's* cover starts, is increased or reinstated.

Exclusions – when we will not pay a crisis benefit

We will not pay this benefit if the *insured person*:

- had symptoms directly related to, or had been diagnosed with, the condition that they are claiming before cover started for them under this policy. However, if the *insured person* is claiming under *takeover cover*, we will not apply this exclusion where a “crisis benefit” (or a similar benefit payable for specified medical conditions) would have been payable in relation to them under the *previous policy* if that policy had remained in force,
- suffers the condition identified with an * in the above table in the first 90 days after cover starts for them under this policy. However, if the *insured person* is claiming under *takeover cover*, we will not apply this exclusion where a “crisis benefit” (or a similar benefit payable for specified medical conditions) would have been payable in relation to them under the *previous policy* if that policy had remained in force,
- has been paid a *crisis benefit* within the previous 12 months while covered under this policy,
- has been paid two *crisis benefits* while covered under this policy or any other policy issued by us for which this policy is a replacement,
- is receiving the *specific injury benefit* for the same period, or
- dies within 14 days of satisfying the *crisis benefit medical condition*.

2.3 Specific injury benefit

If an *insured person* suffers one of the events listed below as a result of an *accident* that first occurs on or after the start of an *insured person’s* cover, we will pay a benefit for the period identified in the “Payment Period” column. We will only pay this benefit once under this policy for each *insured person*.

Specific Injury Event	Payment Period
<i>Paraplegia</i>	60 months
<i>Quadriplegia</i>	60 months
Total and permanent loss of use of:	
Both hands or both feet or sight in both eyes	24 months
One hand and one foot	24 months
One hand and sight in one eye	24 months
One foot and sight in one eye	24 months
One arm or one leg	18 months
One hand or one foot or sight in one eye	12 months
Thumb and index finger from the same hand	6 months

Fracture requiring a plaster cast or other immobilising device of the following bones:	Payment Period
Thigh (shaft)	3 Months
Pelvis (except coccyx)*	3 Months
Skull (except bones of the face or nose)*	2 Months
Arm, between elbow and shoulder (shaft only)	2 Months
Shoulder blade	2 Months
Leg (above the foot)	2 Months
Kneecap	2 Months
Elbow	2 Months
Forearm, between wrist and elbow (shaft only)	2 Months
Collarbone	1.5 Months

*plaster cast or other immobilising device not required for these fractures.

The amount of the *specific injury benefit* will be equal to the sum of the *total disability benefit* and the *superannuation contribution monthly benefit* (if applicable). It is also paid from the date the *specific injury event* occurs and can be paid during the *waiting period*.

We will cease to pay this benefit for the *insured person* if:

- it has been paid for the payment period corresponding to the *specific injury event*,
- they reach the *cover cessation age*, or
- they die.

This benefit will:

- not be paid where the *insured person* is also receiving a *crisis benefit* for the same period, and
- be paid instead of, and not in addition to, any *disability benefit* for the same period.

If an *accident* results in more than one *specific injury event*, we will only pay one *specific injury benefit* and it will be for the *specific injury event* with the longest payment period.

2.4 Nursing care benefit

We will pay a benefit if an *insured person* is *confined to bed* for three or more consecutive days during the *waiting period*.

This benefit starts after the *insured person* has been *confined to bed* for three successive days and will be paid for each successive day that the *insured person* is *confined to bed* for a maximum of 30 days. The benefit is paid monthly in arrears.

The daily amount of this benefit will be equal to the lesser of:

- 1/30 of the *total disability benefit* and the *superannuation contribution benefit*; and
- \$150.00.

We will cease to pay this benefit for an *insured person* if:

- it has been paid for 30 days or they have completed the *waiting period* (whichever happens first),
- they are no longer *confined to bed*,
- they reach the *cover cessation age*, or
- they die.

This benefit will not be paid where the *insured person* is also receiving the *disability benefit*, *accommodation benefit*, *specific injury benefit*, *family care benefit* or *life recovery benefit* for the same period.

2.5 Family care benefit

We will pay a benefit if an *insured person* is *totally disabled* and is receiving *family care* for at least three consecutive days.

This benefit starts after the *insured person* has received *family care* for three consecutive days and will continue to be paid each day that they are *totally disabled* and receiving *family care* for up to a maximum period of six months.

The monthly amount of this benefit will be equal to the lesser of:

- \$2,000,
- 50% of the *total disability benefit* and the *superannuation contribution benefit*, and
- the amount we consider is the monthly income lost by the *direct family member* directly resulting from the *direct family member's* provision of *family care*.

We will cease to pay this benefit for an *insured person* if:

- they are no longer *totally disabled*,
- a *medical practitioner* no longer certifies the *insured person* requires *family care*,
- it has been paid for six months,
- they reach the *cover cessation age*, or
- they die.

This benefit will not be paid where the *insured person* is also receiving the *specific injury benefit* or *nursing care benefit* for the same period.

2.6 Accommodation benefit

We will pay a benefit where a *direct family member* has chosen to stay at a place near where the *insured person* is *confined to bed* (other than the *insured person's* home of residence) provided the *insured person*:

- is *totally disabled*,
- is *confined to bed* due to an injury or illness, and
- on the advice of a *medical practitioner* has been relocated to a place more than 100 kilometres from the *insured persons* place of residence.

The amount we will pay for this benefit will be the lesser of:

- the actual accommodation costs, and
- \$250 a day.

This benefit is payable once for up to 30 days in any 12 month period.

This benefit will not be paid where the *insured person* is also receiving the *nursing care benefit* or *specific injury benefit* for the same period.

2.7 Return to work benefit

We will pay a benefit if an *insured person* engages in a *return to work program* that we have requested whilst the *insured person* is *disabled*, and:

- we provide you or the *insured person* with confirmation in writing at the start of the *return to work program* that the program is a *qualifying program* for the purpose of the *return to work benefit*,
- either during, or immediately after completing the *return to work program*, the *insured person*:
 - ceases to be *disabled*, and
 - returns to work with their *employer*, and
 - returns to working at least the same hours they were performing immediately before their *date of disablement*, and
- the *insured person* continuously performs their full hours, and does not become *disabled* again, for 6 consecutive months.

When the *benefit period* applicable to an *insured person* is 2 years, the amount we will pay for this benefit will be the lesser of:

- the *monthly benefit* plus *superannuation contribution monthly benefit* (if applicable), and
- \$10,000

When the *benefit period* applicable to an *insured person* is greater than 2 years, the amount we will pay for this benefit will be the lesser of:

- three times *monthly benefit* plus *superannuation contribution monthly benefit* (if applicable), and
- \$20,000

This benefit is only payable once for an *insured person*.

2.8 Life recovery benefit

We will pay a benefit if an *insured person* is *totally disabled* and has an *unplanned hospital admission* during the *waiting period*.

This benefit starts after the *insured person* becomes *totally disabled* and has an *unplanned hospital admission* where the *insured person* is required to spend at least 24 hours in hospital. This benefit will be paid for each consecutive calendar day that the *insured person* remains in hospital up to a maximum of 5 calendar days.

The daily amount of this benefit will be \$300.

We will cease to pay this benefit for the *insured person* if:

- it has been paid for 5 days or they have completed the *waiting period* (whichever happens first),
- they are no longer *totally disabled*,
- they are discharged from hospital,
- they reach the *cover cessation age*, or
- they die.

This benefit will not be paid where the *insured person* is also receiving the *disability benefit*, *nursing care benefit*, *specific injury benefit* or *family care benefit* for the same period.

2.9 Enhanced death benefit

We will pay a benefit if an *insured person* dies or suffers a *terminal illness* whilst they are an *insured person*. This benefit will be paid regardless of whether the *insured person* is *disabled* at the date they become *terminally ill* or die.

The amount we will pay for this benefit will be three times the *monthly benefit* plus *superannuation contribution monthly benefit* (if applicable).

We will only pay this benefit once for an *insured person*. This means if we pay this benefit because the *insured person* suffers a *terminal illness*, we will not pay a second benefit when the person dies.

3. Getting cover

3.1 Eligibility

To be eligible for cover under this policy, a person must satisfy the *eligibility conditions* in the *policy schedule*.

Once a person receives cover under this policy, they will continue to hold that cover until it ends under the terms of the policy (see section **9.1 When cover will end for an insured person**).

3.2 Automatic acceptance

Automatic acceptance means that we will accept an *eligible person* for *insured cover* up to the *automatic acceptance limit* without the need for underwriting, subject to the terms of section **3.3 Standard cover**.

To be eligible for automatic acceptance at least 75% of the people that meet the *eligibility conditions* must be *insured persons*. If this condition is not met at any time, we may reduce the *automatic acceptance limits* and/or withdraw automatic acceptance for future *eligible persons*.

3.3 Standard cover

Where an *automatic acceptance limit* applies, a person who:

- is an *eligible person*,
- is at least 15 years of age and no older than the *maximum entry age*,
- has been notified to us, including all relevant details we require, within 30 days of the next *annual review date* after they first satisfy the *eligibility conditions* (or by another date we have agreed with you)*, and
- is not subject to *takeover cover*,

will have *standard cover* apply to them subject to the terms of this policy. There are circumstances where the cover an *insured person* obtains through automatic acceptance will be subject to *limited cover conditions*. See section **4.2 Limited cover** for details.

*If a benefit becomes payable under this policy for an *eligible person* after they have satisfied the *eligibility conditions*, but before the date that you are required to notify us of the *eligible person's* details, we will deem that *eligible person* to have been notified to us in accordance with this section 3.3.

3.4 Underwritten cover

An *eligible person* who:

- is not eligible for *standard cover* under automatic acceptance or *takeover cover*, or
- seeks cover above the *standard cover* they obtained under automatic acceptance or *takeover cover*,

must obtain cover through underwriting.

In order to consider the *eligible person's* application, we may require additional information on them, including medical and lifestyle information. We will only ask for personal information that we are permitted to ask for by law and our relevant industry Code of Practice, and which we believe is necessary for our underwriting purposes.

After considering an application for cover where we have received all the information we require, we will make one of the following decisions:

Accept cover	Accept with conditions	Refuse cover
Accept the <i>eligible person</i> for cover under this policy.	Accept the <i>eligible person</i> for cover on the conditions we consider appropriate. For example, placing an exclusion on the cover.	Refuse to provide cover under this policy.

Where we accept the application with conditions, or refuse the application, this will not affect any existing cover the *eligible person* may have. So if the *eligible person* already has *standard cover* under automatic acceptance the amount and conditions of that cover will not be changed by our underwriting decision.

3.5 Takeover cover

Where some or all of the cover available under this policy was held under a *previous policy* on the day before the *commencement date* (or a later date we have agreed with you), and we agree to takeover that cover, we will do so on the following basis:

- the *benefit period* that applies under the *previous policy* will continue to apply under this policy (unless we agree otherwise with you). If the same *benefit period* is not available under this policy, the *benefit period* that applies will be the next shortest *benefit period* available under this policy,
- where the *benefit period* was the same or longer under the *previous policy*, we will provide cover and determine our liability for claims made in respect of that person by applying *FSC Guidance Note 11* as the “incoming insurer.” If there is any inconsistency between the terms and conditions of this policy and *FSC Guidance Note 11*, the policy terms and conditions prevail to the extent of the inconsistency,
- where the *benefit period* was shorter under the *previous policy*, we will only apply *FSC Guidance Note 11* as the “incoming insurer” if we specifically agree to do so with the *policy owner*. If we do not agree to apply the terms of *FSC Guidance Note 11*, we may agree to apply alternative takeover terms,
- the *waiting period* that applied under the *previous policy* will continue to apply under this policy (unless we agree otherwise with you). If the same *waiting period* is not available under this policy, the *waiting period* that applies will be the next longest *waiting period* available under this policy,
- any individual conditions, exclusions or restrictions that applied to a person’s transferred cover under the *previous policy* on the day before the *commencement date* will continue to apply until they expire according to their terms. This includes any limited cover and exclusions. Similarly, if a person had no cover under the *previous policy* (because they had previously opted out, had cover cancelled or they were not eligible for cover after they joined the *employer*), they will not be provided cover under this policy, unless we agree otherwise with you, and
- we are accepting the *insured person's takeover cover* based on their representations that the information provided to the insurer of the *previous policy* was accurate and complete and that they complied with their ‘Duty of Disclosure’ or ‘Duty to take reasonable care not to make a misrepresentation’ (as applicable at the time they applied for their cover under the *previous policy*).

We may reduce the amount of insurance provided to an *insured person*, or treat the *takeover cover* for that person as not having commenced with us, if the person breached their ‘Duty of Disclosure’, or ‘Duty to take reasonable care not to make a misrepresentation’ (as applicable at the time they applied for their cover under the *previous policy*), or made misrepresentations in a way which would enable an insurer to exercise a remedy under the Insurance Contracts Act 1984 (Cth).

Before we provide *takeover cover*, we will require that all relevant information from the *previous policy*, including formulas, *automatic acceptance limits* and the details of any specific conditions that apply to a person, be supplied to us. Where we do not receive such information, we will not provide terms for taking over cover.

4. When cover starts and its conditions

4.1 When cover starts

The date cover starts will depend on the type of cover.

Cover type	Cover starts...
<i>Standard cover</i>	For a person who obtains <i>standard cover</i> by way of automatic acceptance, cover starts from the: <ul style="list-style-type: none"> • date they first become an <i>eligible person</i> if this happens on or after the <i>commencement date</i>, or • <i>commencement date</i> if they first became an <i>eligible person</i> before the <i>commencement date</i> and remain so on the <i>commencement date</i>.
<i>Underwritten cover</i>	For a person who obtains <i>underwritten cover</i> , cover starts when we accept the <i>eligible person</i> for cover.
<i>Takeover cover</i>	For a person who obtains <i>takeover cover</i> , cover starts on the <i>commencement date</i> , or on a later date we have agreed with you and this is specified in the <i>policy schedule</i> .

4.2 Limited cover

What's limited cover?

When the *limited cover conditions* apply, we will only pay a benefit for an illness or injury if it first becomes apparent or first occurs on or after the date the *insured person's* cover started or increased.

An illness or injury is considered to have first become apparent on the earlier of the day the *insured person*:

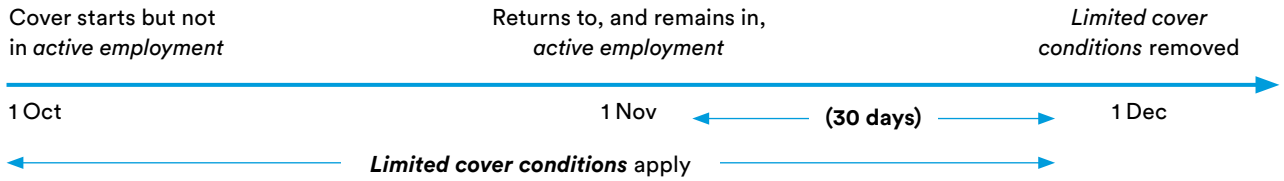
- is first given advice, care or treatment or recommended that they seek advice, care or treatment for the illness or injury, by a *medical practitioner*, and
- first had any symptom of the illness or injury for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *medical practitioner*.

When limited cover applies

Limited cover conditions apply as follows:

Cover type	Scenario	Limited cover conditions
<i>Standard cover</i>	The <i>insured person</i> is not in <i>active employment</i> on the date <i>standard cover</i> commences or the date their <i>standard cover</i> increases due to a change in the benefit design (including an increase to the <i>automatic acceptance limit</i>).	<i>Limited cover conditions</i> apply until they have returned to <i>active employment</i> for 30 consecutive days as also shown in the diagram below.

Example



5. Cover amounts

5.1 Amount of cover

The amount of income protection cover that applies to an *eligible person* will be determined as follows:

Cover type	Cover amount
Standard cover	The lesser of the <i>insured cover</i> and the <i>automatic acceptance limit</i> .
Underwritten cover	The amount of cover that has been accepted.
Takeover cover	The nearest amount of cover to the cover that applied under the <i>previous policy</i> (unless the <i>policy schedule</i> states otherwise), but not exceeding the <i>maximum monthly benefit</i> .

5.2 Automatic changes to cover

The amount of cover that applies to an *insured person* will automatically change (increase or decrease) in line with changes to an *insured person's monthly income* up to the amount of the cover that does not require written acceptance by us.

If there were less than 200 *insured persons* at the latest *annual review date*, any such change in cover cannot result in the amount of cover increasing for the *insured person* by more than the greater of:

- 25%, or
- \$1,000 per month,

since the last *annual review date*.

Any changes cannot increase cover above the *maximum monthly benefit*.

5.3 Reducing or cancelling cover

An *insured person* can apply to reduce or cancel their cover at any time.

The reduction or cancellation will take effect from the date you notify us in writing.

6. Extent of cover

6.1 Worldwide cover

Cover for an *insured person* applies worldwide. However, if an *insured person*:

- is not an *Australian Resident*, (including a holder of a temporary work visa approved by us), and
- is temporarily *employed overseas*,

they will only have cover for 90 days from the date they leave Australia.

Where an *insured person* who is an *Australian Resident* is temporarily *employed overseas*, cover will continue provided premiums continue to be paid by *you*.

We may require an *insured person* to return to Australia at their expense for assessment of a claim. There is also a maximum period for which we will pay benefits under this policy for an *insured person* who is overseas. The maximum periods are as follows:

- We will, at our discretion, pay a benefit if an *insured person* becomes *disabled* while they are outside Australia for a maximum period of 12 months.
- If the *insured person* is receiving benefits when they leave Australia, any ongoing entitlement to benefits is limited to 12 months from the date they leave Australia.

If an *insured person* returns to Australia and they are still *disabled*, benefits may be reinstated effective from the date they return subject to the other terms of this policy.

6.2 Leave without pay

If an *insured person* is given *unpaid leave*, we will continue to cover them for a period up to 24 months after the commencement of the leave if:

- the *employer* approves the period of *unpaid leave* in writing before the *insured person* goes on leave, and
- premiums continue to be paid for the *insured person* during their *unpaid leave*.

If the *insured person* will be on *unpaid leave* beyond the initial 24 month period, *you* may extend cover beyond the 24 month period by applying to us in writing before the 24 month period ends. Any extension will be at *our* discretion.

Cover for an *insured person* who is on *unpaid leave* will cease at the earliest of when the *insured person's*:

- *unpaid leave* ceases and they do not return to their *employment*,
- *unpaid leave* exceeds 24 months, or any extended period we have agreed to in writing, or
- cover otherwise ceases under this policy.

If an *insured person* is on *unpaid leave* and becomes eligible for a benefit we will pay this benefit at the later of the:

- date that has been agreed and documented by the *employer* and *insured person*, as the date the *insured person* will be returning to their *employment*, and
- day after the *waiting period* has ended.

6.3 Cover beyond age 65

If the *cover cessation age* stated in the *policy schedule* is greater than 65 years, the following will apply.

For a 2 year or a 5 year Benefit Period

Where the *cover cessation age* is greater than 65, an *insured person* with a *benefit period* of 2 years or 5 years will have their cover continue after they turn age 65 up to the *cover cessation age* on the following basis:

Age at Disability	Cover conditions
If the <i>date of disablement</i> is before the <i>insured person's</i> 65 th birthday	The <i>disability benefit</i> will be paid for a period not exceeding the <i>benefit period</i> that applies to the <i>insured person</i> . The <i>disability benefit</i> plus <i>superannuation contribution benefit</i> (if applicable) that accrue and become payable after the <i>insured person's</i> 65 th birthday cannot exceed \$10,000 per month.
If the <i>date of disablement</i> is on or after the <i>insured person's</i> 65 th birthday	The <i>disability benefit</i> will be paid until the earliest of: <ul style="list-style-type: none"> • 2 years, or • the <i>insured person</i> reaching the <i>cover cessation age</i>* The <i>disability benefit</i> plus <i>superannuation contribution benefit</i> (if applicable) cannot exceed \$10,000 per month.

* Benefits may stop earlier under section 1.4 **When we stop paying**.

To Age 65 benefit period – Top up

An *insured person* with a To Age 65 *benefit period* will have their cover continue after they turn age 65 with a *benefit period* of 2 years if they have not previously claimed under this policy before their 63rd birthday. Cover will continue on the following basis:

Age at Disability	Cover conditions
If the <i>date of disablement</i> is before the <i>insured person's</i> 63 rd birthday	The <i>disability benefit</i> will be paid until the <i>insured person</i> turns age 65.* Note, cover will cease on the <i>insured person's</i> 65 th birthday (or earlier, subject to section 9.1 When cover will end for an insured person)
If the <i>date of disablement</i> is on or after the <i>insured person's</i> 63 rd birthday	The <i>disability benefit</i> will be paid until the earliest of: <ul style="list-style-type: none"> • 2 years, or • the <i>insured person</i> reaching the <i>cover cessation age</i>.* The <i>disability benefit</i> plus <i>superannuation contribution benefit</i> (if applicable) that accrue and become payable after the <i>insured person's</i> 65 th birthday cannot exceed \$10,000 per month.

* Benefits may stop earlier under section 1.4 **When we stop paying**.

7. Continuation option

If the *policy schedule* states that *your policy* has a Continuation Option and an *insured person's* cover ends under this policy because they cease to be engaged by the *employer*, they may apply to continue their cover with *us* through a new individual policy without having to provide medical evidence. To do so all the following requirements must be met.

The person must:

- be under age 60 when they apply for the Continuation Option,
- be an *Australian Resident* with a residential address in Australia,
- no longer be *employed* or engaged by the *employer*,
- not be leaving *employment* either directly or indirectly due to illness or injury,
- have been *employed* as either a *permanent employee*, a *franchisee* or a partner, and *at work* on the last day before their cover ends,
- not be joining any military forces (other than the Australian Armed Forces Reserve and is not on active duty outside Australia),
- not be entitled to any benefit under this policy or another policy issued by *us*,
- meet *our* standard minimum requirements for a new individual policy at that time including *our* occupation, travel and pastimes underwriting requirements, and
- provide *us*, within 60 days of cover ending under this policy, with the application for the Continuation Option and the correct premium for the cover being applied for.

In addition, this policy must still be in force and all premiums due for the person's cover under this policy must be up to date.

Where the above conditions are met, *we* will issue an individual policy to the person, subject to:

- the *waiting period* not being shorter, and the *benefit period* not being longer than those that applied when their cover ceased under this policy,
- the amount of cover under the individual policy is no more than the cover that applied when their cover ceased under this policy, and
- the individual policy having the same exclusions and loadings that applied when their cover ceased under this policy.

The person's cover will then be subject to the terms and conditions (including premium rates) applicable to the individual policy.

8. Interim accident cover

8.1 What is interim accident cover?

If an *eligible person* applies for *underwritten cover*, we will provide them with *interim accident cover*.

We will pay a *disability benefit* and a *superannuation contribution benefit* (if it applies) if the person suffers *disability* as a direct result of an *accident* that occurs during the *interim accident cover* period defined in section **8.2 When interim accident cover starts and stops**. The *accident* and the resulting *date of disablement* must occur during the *interim accident cover* period for this benefit to be paid.

8.2 When interim accident cover starts and stops

Interim accident cover starts on the date we receive the *eligible person's* application for *underwritten cover* and ends on the earliest of the date:

- the application is withdrawn,
- we accept the application,
- we reject the application,
- an *interim accident benefit* becomes payable,
- 90 days from the date we receive the application, and
- cover would otherwise cease under this policy for the person.

8.3 What we'll pay

If we pay a benefit for *interim accident cover*, the total benefit we'll pay for *interim accident cover* and any other cover available under this policy will be the lesser of:

- the total amount of cover the *eligible person* would have if their application for cover was accepted, subject to a maximum of \$20,000 per month above the existing cover,
- the *insured percentage* of the person's *pre-disability income* plus *superannuation contribution benefit* (if applicable), and
- the *maximum monthly benefit*,

less any amount of *other disability income* (as described in section **1.5 When we reduce benefits**) and *return to employment income* (as described in **1.2 What we pay**). The *benefit period* and *waiting period* that applies will be that specified in the *policy schedule*.

8.4 What happens if we pay an interim accident benefit?

If we pay an *interim accident benefit*, the application for *underwritten cover* will be cancelled.

9. Ending and reinstating cover

9.1 When cover will end for an insured person

Cover for an *insured person* under this policy will end on the earlier of the following:

When the <i>insured person</i> ...	Cover ends on...
reaches the <i>cover cessation age</i>	the date they reach the <i>cover cessation age</i> .
commences duty with the military services (other than the Australian Armed Forces Reserve and is not on active duty outside Australia) of any country	the date they commence duty with the military services.
dies	the date of death.
has their cover cancelled by the <i>policy owner</i>	the date determined under section 5.3 Reducing or cancelling cover .
is no longer an <i>insured person</i> because the policy is terminated	the date the policy is terminated subject to section 9.2 What happens if this policy ends?
is no longer an <i>Australian Resident</i> and does not hold a temporary work visa approved by us, is no longer permanently in Australia or is not eligible to work in Australia	the date the person is no longer an <i>Australian Resident</i> or no longer permanently in Australia or eligible to work in Australia.
ceases to be engaged by the <i>employer</i>	for an employee, the date they cease to be <i>employed</i> by the <i>employer</i> . for anyone else, the date they cease to be engaged by the <i>employer</i> . We will however extend cover from this date for up to 60 days (see section 9.4 Extended cover).
ceases to meet the <i>eligibility conditions</i> (excludes ceasing to meet the <i>maximum entry age</i> if lower than the <i>cover cessation age</i>)	the date they cease to meet the <i>eligibility conditions</i> .
no longer meets the conditions under section 6.1 Worldwide cover for cover while temporarily <i>employed overseas</i>	the date the person no longer meets the conditions for cover to continue while <i>employed overseas</i> under section 6.1 Worldwide cover .
no longer meets the conditions under section 6.2 Leave without pay for cover during <i>unpaid leave</i>	the date the person no longer meets the conditions for cover to continue when on <i>unpaid leave</i> under section 6.2 Leave without pay .
has not had the outstanding premium owing for their cover paid to us within 30 days of the <i>premium due date</i>	the date premiums have been paid up to for the <i>insured person's</i> cover.
ceases to hold a temporary work visa issued by the Australian Government and approved by us	the date the visa expires.
is accepted or rejected for a continuation option (for Extended Cover only)	the date the application for a continuation option is either accepted or rejected.

9.2 What happens if this policy ends?

Cover for all *insured persons* will end on the date this policy ends.

If you take out a policy with another insurer when this policy ends, we will use *FSC Guidance Note 11* to transfer the cover of all *insured persons* to the new policy. Where there are inconsistencies between *FSC Guidance Note 11* and this policy, this policy will prevail to the extent of the inconsistency.

9.3 Reinstating cover

Cover which has ceased can only be reinstated if we agree to reinstate the cover in writing.

9.4 Extended cover

If cover ends because the *insured person* ceases to be engaged by an *employer*, we will extend cover for up to 60 days from the date the cover ceased for that person. Premiums are not payable for this extension of cover.

The extended cover period ceases on the earlier of the following:

- 60 consecutive days have elapsed since their cover ceased,
- the date that an application for a continuation option has been accepted or declined by us,
- the date the person obtains insurance for the same or similar benefit provided under this policy with any other insurer as determined by us, or
- the date that cover would otherwise cease in accordance with any other condition in section 9.1 **When cover will end for an insured person** (excluding when the person ceases to meet the *eligibility conditions*).

10. Claims

10.1 When to tell us about a claim

You must tell us as soon as possible if you become aware of a claim or potential claim. If you or the *insured person* delay telling us and that prejudices our interests, we may reduce the benefit or not pay the claim. Our interests include the ability to obtain the evidence we require or would have obtained for the period of the illness or injury.

10.2 What we need to be told

Before we will pay a claim we will need you or the *insured person* to provide any evidence we believe necessary to make a decision about the claim. This may include regular monthly reports from the *insured person's* treating *medical practitioner* in our chosen form as well as documentary evidence of the *insured person's* income.

Apart from any medical examinations, *return to work program* and non-invasive tests that we may arrange, we will not pay for any costs incurred in providing evidence to support the claim, including any reports submitted to you from *medical practitioners* who have treated the *insured person*. Where we arrange for the *insured person* to undergo medical examinations, a *return to work program* or non-invasive tests that we believe are necessary, we:

- have the discretion to appoint a *medical practitioner* or other health professional of our choosing, and
- will pay the fees and the costs of those examinations, programs and tests. However, unless we agree otherwise in writing, we won't pay any other costs related to the *insured person's* attendance for these investigations and programs, including costs of travelling to an appointment or for non-attendance at an appointment.

We, or someone else on our behalf, may investigate an *insured person's* financial affairs where they are relevant to a claim. In this case, you and the *insured person* must cooperate fully in the investigation and provide access to all the evidence we reasonably consider necessary to the investigation.

10.3 Illegible and foreign language evidence

We require all evidence to be legible and in English.

Therefore, we may require you to have evidence:

- transcribed into a form in which can be comprehended in English, and
- appropriately certified to be a true copy of the original.

10.4 Confidentiality requirements

If we give you information that we obtain in the course of assessing a claim:

- you must deal with that information in accordance with the Privacy Act 1988, and keep that information confidential at all times, unless you have a legal obligation to disclose it, and
- any person you appoint to assist you to manage or assess claims must agree to be bound by these same confidentiality obligations.

10.5 Repayment of overpaid benefits

If we pay benefits that are more than the *insured person* is entitled to be paid under the terms of this policy, and the overpayment is as a result of a misrepresentation made by you or the *insured person*, you will repay to us the benefit amount that you received which was more than the correct benefit amount. We may reduce the benefit amount by any amount we deem reasonably necessary until the overpaid amount has been repaid in full.

11. Premiums

11.1 Amount and calculation of premiums

The amount of the premium is the total cost of cover for all *insured persons* during the relevant period. The premium amount also includes any government levies, taxes or charges not included in the *premium rates*. Premiums are calculated by applying the relevant *premium rate* (which may include commission and third party administration fees) as stated in the *policy schedule* to the amount of cover held by the *insured person*, and will include any loadings that apply to that *insured person*.

11.2 Adjustments in premiums

There are two methods available for adjustments in premiums. The method that applies to your policy will be stated in the *policy schedule*.

Method 1

Any adjustment premium for the previous year will be determined at each *annual review date* by taking:

- a proportion of the premium for any increase or decrease in an *insured person's* amount of cover from the date of the increase or decrease to the current *annual review date*.
- a proportion of the premium for new *insured persons* joining this policy during the previous year from the date of membership to the current *annual review date*.
- a proportion of the premium for *insured persons* leaving this policy during the previous year from the date of cessation of membership to the current *annual review date*.

Method 2

Any adjustment premium for the previous year shall be determined at each *annual review date* by application of the formula:

$$\text{Adjustment Premium} = \frac{1}{2}P \times \frac{(S2 - S1)}{S1}$$

When:

P is the total premium at the previous *annual review date*.

S1 is the amount of cover for all *insured persons* at the previous *annual review date*.

S2 is the amount of cover for all *insured persons* at the current *annual review date*.

Adjustment premiums shall be paid by or to us within 30 days of the completion of the annual review.

11.3 When premiums are due

Insurance premiums are payable to *us* annually in advance except where we agree to accept premiums by instalments. When premiums are payable by instalments an additional premium, as notified by *us*, will be payable.

If we do not receive the full premium, including any premium adjustments, within 30 days of the premium being due, we can give *you* written notice to terminate the policy. If a benefit is payable to *you* for a claim that occurs during a period where premiums are overdue, we will not pay the benefit until *you* pay *us* the overdue premium.

11.4 Minimum annual premium amount

We reserve the right to apply a minimum annual premium amount. If a minimum annual premium amount applies, this will be stated in the *policy schedule*. We may change the minimum annual premium amount by giving *you* 30 days written notice. Such minimum annual premium will become payable from the end of the *premium guarantee period* until we advise it is no longer payable.

11.5 Premium audit

From time to time we may audit *your* membership records to ensure the correct premium is being calculated and paid to *us*. We will give *you* reasonable notice if we propose to conduct an audit, and will only conduct an audit in normal office hours.

11.6 Premium corrections

If the age of an *insured person* has been incorrectly stated, *you* must advise *us* of the correct age as soon as it is reasonable for *you* to do so. We will adjust the premium and/or amount of cover for that *insured person*, as appropriate, based on the correct age.

11.7 Waiver of premiums while disabled

Premiums will be waived for an *insured person* whilst we are paying a benefit under this policy for them.

11.8 Premium discount for bundled policies

If the *policy owner* has an active Group Life Policy with *us*, we may provide a discount on whichever policy (either this policy or the Group Life Policy) has the lowest gross annual premium.

Where a discount is provided this will be detailed in the *policy schedule*, including the percentage amount of the discount. The discount will be applied to the final premium calculation at the *annual review date*.

If the *policy owner* cancels the Group Life Policy with *us*, we will stop providing the discount.

12. Varying the policy

This policy may be varied by written agreement between *you* and *us*. It may also be varied in the following circumstances.

If we vary the policy it must not prevent the policy from being treated as life insurance business under the Life Insurance Act 1995 (or any legislation that replaces it).

12.1 When we can vary the policy

We have the right to vary the *premium rates* or *automatic acceptance limit* at any time after the end of the *premium guarantee period*. We will give *you* 60 days written notice before we do this.

We may vary the terms and conditions (including the *premium rates*) with immediate effect and confirm that change in writing, even before the end of the *premium guarantee period*, if:

- the number of *insured persons* covered under this policy changes by more than 25% from the number of *insured persons* at the commencement of the previous *premium guarantee period*,
- the number of *insured persons* covered under this policy becomes less than 75% of *eligible persons*, or
- *your* business activity results in unusual changes in the number of *insured persons* (such as due to mergers or takeovers) which leads, in *our* opinion, to a major change in the risk insured by this policy.

12.2 Changes in the law and its interpretation

If there is a change to a law or the way a law is interpreted, we may also vary any of the terms and conditions of this policy (including the *premium rates*), with immediate effect, even before the end of a *premium guarantee period*.

We can do this when a change to a law or its interpretation means:

- it becomes impossible or impractical for *us* to carry out *our* obligations under the policy,
- how we or the policy is taxed changes,
- government charges, taxes or levies are imposed or changed, or
- the terms of the policy would become inconsistent with the law.

In this section, a “law” includes an industry code of practice that we are under a legal or contractual obligation to comply with.

12.3 War in Australia

If there is a *war* within Australia, we may vary the *premium rates* with immediate effect.

13. Exclusions

13.1 Acts of war

We will not pay a benefit for an *insured person* if their *disability* is caused directly or indirectly by an act of *war*.

13.2 Self-inflicted injury or attempted suicide

We will not pay a benefit in respect of an *insured person* if an illness, injury or medical condition is directly or indirectly caused by intentional self-inflicted injury or infection, suicide or attempt at suicide.

13.3 Normal pregnancy

We will not pay a benefit in respect of an *insured person* if their *disability* is directly or indirectly caused by normal and uncomplicated pregnancy, caesarean birth, threatened miscarriage, participating in in-vitro fertilisation or other medically assisted fertilisation techniques and normal discomforts of pregnancy, such as morning sickness, back ache, varicose veins, ankle swelling and bladder problems.

13.4 Health legislation

We will not make a payment under this policy if the payment would cause *us* to infringe any legislation in connection with health insurance, including the Private Health Insurance Act 2007 (Cth), Private Health Insurance (Prudential Supervision) Act 2015 (Cth), Health Insurance Act 1973 (Cth) or the National Health Act 1953 (Cth) or any succeeding legislation in connection with health insurance.

13.5 Sanctions

No benefit will be payable where the payment would expose *us*, *you* or the *insured person* (or an entity related to *us* or *you*) to any sanction, prohibition or restriction under the United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, Australia or United States of America.

13.6 Concurrent disabilities

We will only pay a *disability benefit* for an *insured person* for one *disability* at a time.

If a *disability benefit* is payable for a particular illness or injury, and the person subsequently suffers an unrelated illness or injury which also independently causes them to be *disabled* for the same period:

- no separate *disability benefit* will be payable for the subsequent illness or injury while a *disability benefit* is payable for the first illness or injury, and

- if the subsequent illness or injury becomes the sole condition causing *disability*, then that illness or injury will be treated as being “related” to the first illness or injury such that both periods of *disability* will be added together for the purposes of determining when the *benefit period* ends (see section **1.6 Recurrent disability**).

14. Policy owner information

14.1 Policy term

This policy commences on the *commencement date* and will end on the earliest of:

- the date we receive *your* written request to cancel this policy,
- a date we agree to in writing with *you*,
- the date cover ends for all *insured persons*, or
- a date we give *you* in writing if a premium is more than 30 days overdue. See section **11.3 When premiums are due**.

14.2 Payment of benefits

All payments connected to this policy will be paid to *you*, or a person nominated by *you* in writing, unless the terms of this policy specifically state otherwise.

14.3 Record keeping

You must keep accurate records necessary for the effective operation of this policy, in a format that is reasonably accessible by *us*.

The information *you* must provide includes information relevant to each claim including:

- salary,
- leave records, and
- *employment* duties.

Additionally, *you* must provide any records we are entitled to access under this policy to investigate the premiums owed to *us* during a relevant period, and the person’s eligibility to be covered under this policy.

14.4 Currency

All payments connected to this policy, whether to *us* or by *us*, must be made in Australia and in Australian currency.

14.5 Audit

We may conduct an audit of:

- any transaction,
- the performance of any obligation under this policy, or
- records *you* (or any person on *your* behalf) have,

which are connected with this policy.

We will give *you* reasonable notice if we propose to conduct an audit, and will only conduct an audit in normal office hours.

14.6 Notices

Notices must be in writing. We will send all notices to *you* at the address *you* last gave *us*, and *you* must send notices to *us* at the address we last gave *you*.

A notice which is delivered personally, by facsimile or email is treated as being given on the day it was received and a notice which is posted is treated as being given three days from the date of posting.

14.7 Waivers

If we do not exercise a power or right we have under this policy (or delay exercising it) this does not operate as a waiver of that power or right. We waive a power or right only where we say so in writing.

14.8 Non-assignment of policy

You may not assign this policy, unless we have previously given our written consent.

14.9 Statutory fund and surrender value

This policy:

- is issued in our No. 1 Statutory Fund,
- does not participate in our profits, and
- does not acquire a surrender value.

14.10 Interpretation

How to read this policy:

- headings are intended as a guide only and are not to be used to interpret the policy conditions, and
- as the context allows, plurals can be read as the singular and the singular read as plurals.

14.11 Governing law

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

15. Complaints

We will try to resolve any complaints and disputes promptly through our internal disputes resolution process.

But if we are unable to resolve a dispute to the *insured person's* satisfaction, the *insured person* may contact the Australian Financial Complaints Authority for help.

Australian Financial Complaints Authority

Phone: 1800 931 678

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16. Definitions

Words or expressions in italics throughout the policy document have meanings set out below:

accident	Bodily injury caused solely and directly by accidental, external and visible means, independent of any other cause.
accommodation benefit	A benefit payable as described in section 2.6 Accommodation benefit .
active employment	A person who in <i>our</i> opinion is capable of performing their identifiable duties, without restriction by any illness or injury, for at least 35 hours per week (whether or not they are actually working those hours).
annual review date	The “Annual Review Date” stated in the <i>policy schedule</i> .
at work	Actively performing all the duties of their <i>occupation</i> , working their usual hours free from any limitation due to illness or injury and not entitled to or receiving income support benefits of any kind.
Australian Resident	A person who (a) resides in Australia and is either an Australian citizen or the holder of a permanent visa as identified by the Australian Government; or (b) is a citizen of New Zealand and the holder of a <i>Special Category Visa</i> while residing in Australia indefinitely.
automatic acceptance limit	The maximum amount determined by <i>us</i> and notified to <i>you</i> from time to time as stated in the <i>policy schedule</i> for which <i>we</i> may accept a person for <i>insured cover</i> without underwriting.
benefit period	The maximum period for which <i>disability benefits</i> may be payable due to the same or related illness or injury and is identified in the <i>policy schedule</i> . The following persons can only have a 2 year <i>benefit period</i> : <ul style="list-style-type: none">• <i>contractors</i> engaged by the <i>employer</i> for a period of less than 12 consecutive months,• <i>casual employees</i>.
casual employee	A person being engaged in <i>employment</i> of a temporary nature where: <ul style="list-style-type: none">• continuity of <i>employment</i> is not guaranteed by the <i>employer</i>, regardless of hours worked or the period of <i>employment</i>, and• the person is not entitled to annual leave or sick leave.
commencement date	The “Commencement Date” stated in the <i>policy schedule</i> .
confined to bed	An <i>insured person</i> is <i>disabled</i> and a <i>medical practitioner</i> has certified that they require the continuous full time care of a <i>registered nurse</i> .
consumer price index or CPI	The consumer price index (weighted average of 8 capital cities combined) as published by the Australian Bureau of Statistics or its successor. If the Index is not published the increase shall be calculated by reference to such other retail price index which in <i>our</i> opinion most closely replaces it.
contractor	A person who is contracted for a fixed period of <i>employment</i> determined at the commencement of their <i>employment</i> and where that person is entitled to have benefits such as superannuation contributions and sick leave.
cover cessation age	The age at which a person’s <i>insured cover</i> will cease, and they are no longer eligible for cover under this policy. The <i>cover cessation age</i> is shown in the <i>policy schedule</i> .
crisis benefit	A benefit payable as described in section 2.2 Crisis benefit .
crisis benefit medical condition	A condition listed in Appendix B of this policy.
date of certification	The most recent date that two <i>medical practitioners</i> , one of whom is a <i>medical specialist</i> in the <i>insured person’s</i> illness, certify that the illness will lead to the <i>insured person’s</i> death within 12 months.
date of disablement	The later of, the: <ul style="list-style-type: none">• first date on which an <i>insured person</i> is unable to work due to illness or injury, and• date a <i>medical practitioner</i> certifies that an <i>insured person</i> is <i>totally disabled</i>.
death benefit	The benefit payable for death as described in section 1.7 Death benefit .

direct family member	An <i>insured person's</i> : <ul style="list-style-type: none"> • spouse or de-facto spouse, • parent or parent-in-law, • child who is at least 18 years of age, or • sibling who is at least 18 years of age.
disabled/disability	Either <i>partially disabled</i> or <i>totally disabled</i> as the context requires.
disability benefit	A benefit payable under this policy as a result of an <i>insured person</i> suffering <i>total disability</i> or <i>partial disability</i> (as applicable).
eligibility conditions	“Eligibility Conditions” stated in the <i>policy schedule</i> that detail how a person can become eligible for <i>insured cover</i> .
eligible person	A person who meets the “Eligibility Conditions” stated in the <i>policy schedule</i> .
employed or employment	A person being engaged by the <i>employer</i> : <ul style="list-style-type: none"> • under a contract of employment and includes a: <ul style="list-style-type: none"> – <i>permanent employee</i> – <i>casual employee</i> – <i>contractor</i>, or • as a <i>franchisee</i>, or • as a partner (if the <i>employer</i> is a partnership).
employer	The “Employer” named in the <i>policy schedule</i> and any associated entity agreed to by <i>us</i> .
enhanced death benefit	A benefit payable as described in section 2.9 Enhanced death benefit .
excluded rehabilitation program	Any program providing ‘hospital treatment’ or ‘general treatment’ within the meaning of the Private Health Insurance Act 2007 or any other program which might cause this policy to cease to be exempt from the National Health Act 1953, Health Insurance Act 1973 or Private Health Insurance Act 2007, Private Health Insurance (Prudential Supervision) Act 2015 or any succeeding legislation in connection with health insurance.
family care	Care provided by a <i>direct family member</i> to an <i>insured person</i> when: <ul style="list-style-type: none"> • a <i>medical practitioner</i> certifies that an <i>insured person</i> is <i>totally disabled</i> and requires care at home for 7 or more hours per day; • the <i>insured person</i> is not performing any work, • the <i>direct family member</i> providing the care was engaged in paid employment on a permanent basis for a minimum of 30 hours per week on the date the <i>insured person</i> became <i>totally disabled</i>, and • the <i>direct family member</i> can demonstrate to <i>our</i> satisfaction a reduction in their income as a result of providing this care to the <i>insured person</i>.
family care benefit	A benefit payable as described in section 2.5 Family care benefit .
forward underwriting limits	The amount, determined by <i>us</i> , which an <i>insured person's insured cover</i> may increase to, in line with the calculation for <i>insured cover</i> , without the need for additional underwriting. This is only available where the policy has a standard formula for calculating the <i>insured cover</i> .
franchisee	An individual who has entered into a <i>franchise agreement</i> with <i>you</i> .
franchise agreement	Has the meaning given to it in the Competition and Consumer (Industry Codes Franchising) Regulation 2014 (or any legislation that replaces it).
FSC Guidance Note 11	FSC Guidance Note No. 11 Group Insurance Takeover Terms as amended from time to time (the current version of which is dated 9 May 2013).
income	(a) As set out in Appendix A and the definition which applies will depend on the <i>insured person's employment</i> status and is stated in the <i>policy schedule</i> , and (b) any other component agreed to by <i>us</i> that would not otherwise be considered as income under Appendix A . Where the person is on <i>unpaid leave</i> , and <i>we</i> continue to provide cover in respect of that <i>insured person</i> pursuant to section 6.2 Leave without pay , <i>income</i> is the amount defined in (a) and (b), immediately before the start of the <i>unpaid leave</i> .
income producing duty	A duty of the <i>insured person's occupation</i> that generates at least 20% of the <i>insured person's pre-disability income</i> .

insured cover	The “Insured Cover” stated in the <i>policy schedule</i> which details the calculation of insurance cover for an <i>insured person</i> , plus the <i>superannuation contribution benefit</i> (if applicable).
insured percentage	The “Insured Percentage” stated under “Insured Cover” in the <i>policy schedule</i> .
insured person	A person who has cover in force under this policy, other than <i>interim accident cover</i> .
interim accident benefit	The benefit payable for <i>interim accident cover</i> as described in section 8 Interim accident cover .
interim accident cover	The cover provided under section 8 Interim accident cover while a person is being assessed by us for additional cover that is not accepted under automatic acceptance.
life recovery benefit	A benefit payable as described in section 2.8 Life recovery benefit .
limited cover conditions	The limitations on an <i>insured person’s</i> cover as described in section 4.2 Limited cover .
maximum entry age	The maximum age a person can be to be eligible for <i>standard cover</i> as stated in the <i>policy schedule</i> .
maximum monthly benefit	The maximum amount payable each month inclusive of any <i>superannuation contribution benefit</i> and any indexation, as identified in the <i>policy schedule</i> or otherwise stated in this policy.
medical practitioner	A person, accepted by us, who is registered and practising as a medical practitioner in Australia other than the: <ul style="list-style-type: none"> • <i>insured person</i>, or • <i>insured person’s</i> spouse or partner, parent, child or sibling. We may accept a similarly qualified person who is registered and practising as a medical practitioner in another country, on the basis their credentials are recognised by the Australian Medical Board.
medical specialist	A <i>medical practitioner</i> who is registered as a Specialist with the Australian Health Practitioner Regulation Agency (or any other body which replaces it).
monthly benefit	The lesser of the: <ul style="list-style-type: none"> • <i>insured percentage</i> multiplied by the <i>insured person’s pre-disability income</i>, • <i>automatic acceptance limit</i> or <i>forward underwriting limit</i> (as applicable to the <i>insured person</i>), and • <i>maximum monthly benefit</i>, subject to section 5.2 Automatic changes to cover .
monthly income	The <i>income</i> earned by the <i>insured person</i> in one calendar month.
nursing care benefit	A benefit payable as described in section 2.4 Nursing care benefit .
occupation	The <i>insured person’s</i> regular occupation that could be performed at any place of work.
other disability income	In respect of a month, any of the following benefits or entitlements which were received by an <i>insured person</i> during the month or which, though not actually received, we reasonably apportion to them for the month in question being any of the following: <ul style="list-style-type: none"> • the amount of any <i>income</i> that continues to be paid or continues to accrue (and is payable at a later date) whilst the person is <i>disabled</i> (this does not include <i>return to employment income</i>), • the amount of any income (other than benefits received under this Policy) and the commutation of income paid or payable in respect of an <i>insured person</i> as a result of <i>total disability</i> or <i>partial disability</i> or <i>interim accident cover</i>, • paid sick leave, paid annual leave or paid long service leave • any amounts payable in relation to a <i>disability</i>, injury or illness policy (other than lump sum TPD) • any amounts payable in respect of loss of income or loss of earning capacity (including an award of damages or a settlement of a claim for damages for personal injury under common law): <ul style="list-style-type: none"> – through workers compensation or any similar legislation (including any settlement under common law), or – under any statutory accident compensation scheme. Any amount which is in the form of a lump sum or is exchanged for a lump sum has a monthly income equivalent of 1/60th of the lump sum over a period of 60 months.
paraplegia	Total and permanent loss of the use of the lower limbs as a result of injury or disease.
partially disabled or partial disability	(refer to the <i>policy schedule</i> for the definition that applies to <i>your</i> policy) Definition 1 An <i>insured person</i> , solely as a result of illness or injury, is: <ul style="list-style-type: none"> • unable to work in their <i>occupation</i> at full capacity but is: <ul style="list-style-type: none"> – working in their <i>occupation</i> in a reduced capacity, or

partially disabled or partial disability (continued)	<ul style="list-style-type: none"> – capable of working in that <i>occupation</i> in a reduced capacity (where such work is reasonably available), or – working in another occupation, • is earning or is reasonably capable of earning a <i>return to employment income</i> which is less than their <i>pre-disability income</i>, and • is under the regular care and following the advice of a <i>medical practitioner</i>. <p>Definition 2</p> <p><u>Own Occupation (applicable for the first 2 years of the <i>benefit period</i> only):</u></p> <p>An <i>insured person</i>, solely as a result of illness or injury, is:</p> <ul style="list-style-type: none"> • unable to work in their <i>occupation</i> at full capacity but is: <ul style="list-style-type: none"> – working in their <i>occupation</i> in a reduced capacity, or – capable of working in that <i>occupation</i> in a reduced capacity (where such work is reasonably available), or – working in another occupation, • is earning or is reasonably capable of earning a <i>return to employment income</i> which is less than their <i>pre-disability income</i>, and • is under the regular care and following the advice of a <i>medical practitioner</i>. <p><u>Any occupation (applicable for each month of the <i>benefit period</i> after 2 years):</u></p> <p>An <i>insured person</i>, solely as a result of illness or injury, is:</p> <ul style="list-style-type: none"> • unable to work at full capacity in their <i>occupation</i> or any other occupation they are suited to by reason of their education, training or experience but they are: <ul style="list-style-type: none"> – working in a reduced capacity in their <i>occupation</i> or another occupation they are suited to by education, training or experience, or – capable of working in a reduced capacity in their <i>occupation</i> or another occupation they are suited to by reason of education, training or experience (where such work is reasonably available), or – working in any other occupation, • is earning or is reasonably capable of earning a <i>return to employment income</i> which is less than their <i>pre-disability income</i>, and • is under the regular care and following the advice of a <i>medical practitioner</i>.
partial disability benefit	A benefit payable as described in section 1.2 What we pay .
permanent employee	Employment under an agreement or award in which a person works a minimum number of hours and is entitled to conditions and benefits normally associated with permanent employment such as annual leave and sick leave.
policy owner	The “Policy Owner” named in the <i>policy schedule</i> .
policy schedule	Any document issued to <i>you</i> which contains the specific terms and conditions that apply to this policy.
pre-disability income	The <i>insured person’s monthly income</i> immediately prior to their <i>date of disablement</i> .
premium due date	The “Premium Due Date” stated in the <i>policy schedule</i> .
premium guarantee period	The “Premium Guarantee Period” stated in the <i>policy schedule</i> .
premium rates	The rates stated in the <i>policy schedule</i> “Schedule 2”.
previous policy	The “Previous Policy” named in the <i>policy schedule</i> .
quadriplegia	Total and permanent loss of the use of both arms and both legs as a result of injury or disease.
qualifying program	<p>A <i>return to work program</i> that is:</p> <ul style="list-style-type: none"> • a comprehensive <i>return to work program</i> comprising of a range of tailored services with a goal of returning the <i>insured person</i> to their full duties and hours, • supported by evidence, including but not limited to the opinion of <i>medical practitioners</i>, <i>medical specialists</i> and occupational rehabilitation reports, indicating that the <i>return to work program</i> is necessary to facilitate a safe and sustainable return to full duties and hours, • supported by a documented return to work plan, agreed to in writing by the <i>employer</i>, the <i>insured person</i> and their <i>medical practitioner</i>, that consists of: <ul style="list-style-type: none"> – the anticipated timeframe for the <i>insured person</i> to return to their full hours and duties,

qualifying program (continued)	<ul style="list-style-type: none"> – actions required by the <i>employer</i>, the <i>insured person</i>, their <i>medical practitioner</i> and the occupational rehabilitation provider coordinating the <i>return to work program</i>, and – scheduled review points for the goals, anticipated timeframes and actions required. <p>For a <i>return to work program</i> to be considered a qualifying program, for the purposes of the <i>return to work benefit</i>, both the <i>employer</i> and the <i>insured person</i> must consistently participate in the documented actions required as part of the above mentioned return to work plan.</p> <p><i>Return to work programs</i> consisting of once-off single services such as health coaching, exercise programs and job seeking assistance are not considered to be qualifying programs for the purposes of the <i>return to work benefit</i>.</p>
registered nurse	<p>A person who is registered and practising as a nurse, other than:</p> <ul style="list-style-type: none"> • the <i>insured person</i>; • an <i>insured person's</i> parent, child or sibling; • an <i>insured person's</i> spouse or partner, as determined by <i>us</i> in <i>our</i> absolute discretion; or • an <i>insured person's</i> business partner, associate or employee.
retraining expenses	The cost of a retraining program (other than a retraining program providing 'hospital treatment' or 'general treatment' within the meaning of the Private Health Insurance Act 2007 (Cth) or any other program which might cause this policy to cease to be exempt from any legislation in connection with health insurance) which we have approved in writing prior to incurring such costs.
retraining expense benefit	A benefit payable as described in section 1.8 Retraining expense benefit .
return to employment income	The amount of income the <i>insured person</i> has received, or is capable of earning, during the month that <i>we</i> are paying a <i>partial disability benefit</i> .
return to work benefit	A benefit payable as described in section 2.7 Return to work benefit .
return to work program	<p>Any program or service which <i>we</i> reasonably consider would assist the <i>insured person</i> to carry out the duties of their <i>occupation</i> or any other occupation which may include (but not be limited to):</p> <ul style="list-style-type: none"> • training and education, • work or other experience or • employment assistance. <p>The cost of any <i>return to work program</i> <i>we</i> require an <i>insured person</i> to undertake will be met by <i>us</i>.</p>
special category visa	Has the meaning given to it in section 32 of the Migration Act 1958 (Cth).
specific injury benefit	A benefit payable under the circumstances described in section 2.3 Specific injury benefit .
specific injury event	An event listed in section 2.3 Specific injury benefit for which a <i>specific injury benefit</i> will be payable for.
standard cover	The acceptance of <i>insured cover</i> by <i>us</i> without the need for underwriting for an amount up to the <i>automatic acceptance limit</i> .
superannuation contribution benefit	A benefit payable as described in section 2.1 Superannuation contribution benefit .
superannuation contribution insured percentage	The "Superannuation Contribution Insured Percentage" stated in the <i>policy schedule</i> .
superannuation contribution monthly benefit	<p>The lesser of:</p> <ul style="list-style-type: none"> • the <i>superannuation contribution insured percentage</i> multiplied by <i>pre-disability income</i>; and • the <i>automatic acceptance limit</i> (or <i>forward underwriting limit</i>, if applicable) minus the <i>monthly benefit</i>.
superannuation contribution partial monthly benefit	A benefit payable in accordance with the following formula: $\frac{(\text{pre-disability income} - \text{return to employment income})}{\text{pre-disability income}} \times \text{superannuation contribution monthly benefit}$
takeover cover	The cover described in section 3.5 Takeover cover .
Terminal illness/terminally ill	<ol style="list-style-type: none"> a) an <i>insured person</i> suffering from an illness that despite reasonable medical treatment will lead to the <i>insured person's</i> death within 12 months of the <i>date of certification</i>, and b) <i>we</i> are satisfied, on medical or other evidence, that despite reasonable medical treatment the illness will lead to the <i>insured person's</i> death within 12 months of the <i>date of certification</i> referred to in paragraph (a). <p>The <i>date of certification</i> must be made while the <i>insured person</i> is covered under this policy</p>

totally disabled/total disability	<p>(refer to the <i>policy schedule</i> for the definition that applies to <i>your</i> policy)</p> <p>Definition 1</p> <p>The <i>insured person</i> solely as a result of illness or injury occurring while the policy is in force is:</p> <ul style="list-style-type: none"> • unable to perform at least one <i>income producing duty</i> of their <i>occupation</i>, • under the regular care and following the advice of a <i>medical practitioner</i>, and • not working or capable of working in their <i>occupation</i> in a reduced capacity (where such work is reasonably available) and is not working in any other occupation, whether paid or unpaid. <p>Definition 2</p> <p><u>Own Occupation (applicable for the first 2 years of the <i>benefit period</i> only):</u></p> <p>The <i>insured person</i> solely as a result of illness or injury occurring while the policy is in force is:</p> <ul style="list-style-type: none"> • unable to perform at least one <i>income producing duty</i> of their <i>occupation</i>, • under the regular care and following the advice of a <i>medical practitioner</i>, and • not working or capable of working in their <i>occupation</i> in a reduced capacity (where such work is reasonably available) and is not working in any other occupation, whether paid or unpaid. <p><u>Any occupation (applicable for each month of the <i>benefit period</i> after 2 years):</u></p> <p>The <i>insured person</i> solely as a result of illness or injury occurring while the policy is in force is:</p> <ul style="list-style-type: none"> • unable to perform at least one <i>income producing duty</i> of their <i>occupation</i> or any other occupation they are suited to by reason of their education, training or experience • under the regular care and following the advice of a <i>medical practitioner</i>, and • not working or capable of working in a reduced capacity in their <i>occupation</i> or any other occupation they are suited to by reason of their education, training or experience (where such work is reasonably available), whether paid or unpaid.
total disability benefit	The benefit payable as described in section 1.2 What we pay .
underwritten cover	Cover accepted by <i>our</i> underwriters following <i>our</i> assessment of any information that we may reasonably require, including information about the person's personal and family medical history.
unpaid leave	Any period of absence by the <i>insured person</i> from their <i>occupation</i> , unpaid by the <i>employer</i> , that has been approved by the <i>employer</i> in writing prior to such absence.
unplanned hospital admission	An <i>insured person</i> is under the care of, and following the advice of, a <i>medical practitioner</i> in hospital after an unplanned emergency admission.
waiting period	<p>The continuous period of days stated in the <i>policy schedule</i> starting from the <i>date of disablement</i> and during which an <i>insured person</i> has remained <i>totally disabled</i> or <i>partially disabled</i> in order to be entitled to a <i>disability benefit</i>.</p> <p>The following rules apply:</p> <ul style="list-style-type: none"> • the <i>insured person</i> must be <i>totally disabled</i> for at least 7 out of the first 12 consecutive days of the <i>waiting period</i> to qualify for a <i>disability benefit</i>, • if the <i>insured person</i> returns to work at full capacity during the <i>waiting period</i>: <ul style="list-style-type: none"> – where the <i>waiting period</i> is less than 60 days: if the <i>insured person</i> returns to work only once for a period of 5 consecutive days or less, the number of days worked will be added to the <i>waiting period</i>, or – where the <i>waiting period</i> is 60 days or more: if the <i>insured person</i> returns to work only once for a period of 10 consecutive days or less, the number of days worked will be added to the <i>waiting period</i>, otherwise the <i>waiting period</i> starts again.
war	Any act of war (whether declared or not), revolution, invasion, rebellion or civil unrest.
we/our/us	MetLife Insurance Limited ABN 75 004 274 882 AFSL No. 238096.
you/your	The <i>policy owner</i> .

Appendix A – Income Definitions

The definitions of *income* available in the policy will be based on the *insured person's employment* status as shown in the table below. The definition(s) which will apply to *your policy* will be stated in the *policy schedule*.

Definition	Employment Status	Income Definition
1(a).	<i>Employed – standard (excluding casual employees)</i>	The total regular income received by the <i>insured person</i> from the <i>employer</i> for personal exertion for their occupation including salary sacrifice amounts, but excluding overtime payments, profit distributions, director's fees and any other non-regular payments.
1(b).	<i>Employed – tailored components (excluding casual employees)</i>	The total regular income received by the <i>insured person</i> from the <i>employer</i> for personal exertion for their occupation including salary sacrifice amounts, SG contributions*, regular commission*, regular bonus* (but excluding overtime payments, profit distributions, director's fees and any other non-regular payments). Where this income includes commission and bonuses, these components will be averaged over a three year period. *The component(s) that apply to <i>you</i> will be specified in the <i>policy schedule</i> .
2.	<i>Casual employee</i>	The average of the regular income received by the <i>insured person</i> from the <i>employer</i> over the previous 12 months or the actual period of <i>employment</i> if less than 12 months, subject to a minimum average period of 3 months.
3.	Partner	The total regular income received by the <i>insured person</i> (after deduction of their share of business expenses) from the <i>employer</i> because of the personal exertion of the <i>insured person</i> , averaged over the previous 12 months (or lesser period if <i>employed</i> for less than 12 months). Income may include profit distribution that is connected to personal exertion. Profit distribution will be averaged over the previous 2 years (or lesser period if <i>employed</i> for less than 2 years). When calculating the average <i>income</i> , if the <i>insured person</i> has been <i>employed</i> for a period of 6 months or less, we will average over 6 months. Income will not include investment income or similar payments that may continue in the event of <i>disability</i> .
4.	Shareholders (<i>employed as a permanent employee</i>)	The total regular income received by the <i>insured person</i> from the <i>employer</i> for personal exertion for their occupation, including any income distributed to a spouse/partner and/or a child/children, (also including salary sacrifice amounts but excluding overtime payments, profit distributions, director's fees and any other non-regular payments). Where this income includes commission and bonuses these components will be averaged over a three year period.
5.	<i>Franchisee</i>	Income is the Gross Total Receivables Package less Ongoing Franchise Expenses. "Gross Total Receivable Package" means the total income received from the operation of the franchise and includes, but is not limited to, the following items: <ul style="list-style-type: none"> • Franchise income from all regular jobs, • Franchise income from all irregular jobs, • Mandated superannuation contributions, • Depreciation* of business equipment and motor vehicle(s), • The proportionate value of the motor vehicle. "Ongoing Franchise Expenses" means the total expenses that is necessarily incurred in the operation of the franchise and includes, but is not limited to, the following items: <ul style="list-style-type: none"> • Franchise fees, • Insurance, • Equipment and motor vehicle(s) maintenance costs, • Fuel, • Office supplies. *The maximum depreciation amount to be added back is the lesser of the actual depreciation, and 20% of net profit.

Definition	Employment Status	Income Definition
6.	Self -employed (Executive Director)	For a self-employed person, or an executive director, and who owns (directly or indirectly) all or part of the business, including all or part ownership through another legal entity, the regular income earned in the 12 months immediately prior from the <i>insured person's</i> personal exertion after the deduction of their share of business expenses incurred in earning the income excluding investment income, profit distributions or similar payments that may continue in the event of <i>disability</i> .

Appendix B – Crisis Medical Conditions

Medical Condition	Definition
Accidental HIV Infection	Infection with the Human Immunodeficiency Virus (HIV) where it was acquired as a result of an accident and seroconversion to HIV infection occurs within six months of the accident. Any accident giving rise to a potential claim must be reported to us and supported by a negative HIV Antibody test taken after the accident. This does not include any disease or injury associated with AIDS or HIV virus acquired as a result of sexual activity or recreational intravenous drug use.
Alzheimer's Disease	The unequivocal diagnosis of Alzheimer's (pre-senile dementia) Disease by a consultant neurologist or geriatrician confirming Alzheimer's due to failure of brain function with significant cognitive impairment for which no other recognisable cause has been identified.
Aplastic Anaemia	Acquired permanent bone marrow failure that results in anaemia, neutropenia and thrombocytopenia requiring treatment by at least one of the following: <ul style="list-style-type: none"> • blood production transfusion, • marrow stimulating agents, • immunosuppressive agents, or • bone marrow transplantation.
Bacterial Meningitis	The diagnosis of the <i>insured person</i> with Bacterial Meningitis. The meningitis must produce neurological deficit causing permanent and significant functional impairment, meaning either; <ul style="list-style-type: none"> • at least a 25% impairment of whole person function as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association, or • totally and irreversibly unable to perform at least two of the five Activities of Daily Living. Diagnosis must be confirmed by a consultant neurologist. Bacterial Meningitis in the presence of HIV is excluded. All other forms of meningitis including viral, are excluded.
Benign Brain Tumour	The diagnosis of a non-malignant tumour of the brain or spinal cord. Confirmed by appropriate specialist (neurologist or neurosurgeon) and imaging studies such as CT or MRI scans. Resulting in permanent symptoms or signs leading to either: <ul style="list-style-type: none"> • at least a 25% impairment of whole person function as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association, or • totally and irreversibly unable to perform at least two of the five Activities of Daily Living. Cysts, granulomas, cholesteatomas, malfunctions in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are excluded.
Blindness	As a result of disease or accident the permanent loss of the sight in both eyes such that the: <ol style="list-style-type: none"> a) visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes, or b) field of vision is constricted to 20 degrees or less of arc around central fixation in the better eye irrespective of corrected visual activity (equivalent to 1/100 white test object).
Cancer (excluding specified early stage cancers)	The presence of one or more malignant tumours including Hodgkin's disease, leukaemia and other malignant bone marrow disorders, and is characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue of different histological type. The following classifications are not covered under this definition: <ul style="list-style-type: none"> • pre-malignant, • non-invasive, • high-grade dysplasia, • carcinoma in situ, • having borderline malignancy or low potential, • all non-melanoma skin cancers unless having spread to the bone, lymph node, or another distant organ, or • all melanoma skin cancers unless having progressed to at least TNM classification T2bNOM0.

Cancer (excluding specified early stage cancers) - continued	<p>The following classifications are covered under this definition:</p> <ul style="list-style-type: none"> • Malignant tumours of the prostate with any one of the following characteristics: <ul style="list-style-type: none"> - a Gleason score of at least 7, or - having progressed to at least TNM classification T2, or - having progressed to at least TNM classification T1 and where prostatectomy is considered medically necessary to arrest malignancy; and • Carcinoma in situ of the breast where a mastectomy (removal of the entire breast with or without nipple and skin sparing surgery) is required and considered medically necessary.
Cardiomyopathy	Permanent and irreversible impairment of ventricular function as confirmed by a cardiologist to the degree of the New York Heart Association classification of at least Class III or equivalent classification of cardiac impairment.
Chronic Liver Failure	End stage liver failure, together with two of the following conditions: <ul style="list-style-type: none"> • permanent jaundice, • ascites, or • hepatic encephalopathy.
Chronic Renal Failure	End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is instituted.
Chronic Respiratory Failure	End stage lung disease with a consistent pulmonary function test result of FEV1 less than 40% predicted and requiring permanent oxygen therapy.
Coma	A state of unconsciousness with no reaction to external stimuli or internal needs, resulting in a documented Glasgow Coma Scale of 6 or less with the use of a life support system, for a continuous period of at least 96 hours.
Coronary Artery Angioplasty Multiple Vessel (or Triple Vessel Coronary Artery Angioplasty)	<p>Angioplasty of the coronary arteries (with or without the insertion of a stent, laser therapy or atherectomy) to three or more coronary arteries within the same surgical procedure or within two procedures done no more than two months apart.</p> <p>Angiographic evidence, indicating at least 50% obstruction of three or more coronary arteries, is required to confirm the need for this procedure. In the opinion of an appropriate consultant <i>medical specialist</i>, the treatment must be required on medical grounds and must be the most appropriate treatment.</p>
Coronary Artery Bypass Surgery	Coronary artery bypass graft surgery performed in an open heart operation or by key-hole surgical technique for coronary artery disease causing inadequate myocardial blood supply but does not include laser therapy, angioplasty or any other intra-arterial procedure.
Heart Attack (with evidence of severe heart muscle damage)	<p>The death of a portion of the heart muscle as a result of inadequate blood supply.</p> <p>The diagnosis must be confirmed by a cardiologist and evidenced by typical rise and/or fall of cardiac biomarker blood test with at least one level above the 99th percentile of the upper reference limit plus any one of the following:</p> <ul style="list-style-type: none"> • acute cardiac symptoms and signs consistent with myocardial infarction (e.g. chest pain); • new serial ECG changes with the development of any of the following: <ul style="list-style-type: none"> – ST elevation or depression, – T wave inversion, – pathological Q waves, or – left bundle branch block (LBBB); or • imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. <p>If the above is inconclusive then if three months after the heart attack is diagnosed the <i>insured person's</i> left ventricular ejection fraction is less than 50%, then the definition will be met.</p> <p>The following are not covered:</p> <ul style="list-style-type: none"> • a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease, • other acute coronary syndromes including but not limited to angina pectoris, and • viral myocarditis.

Heart Valve Surgery	The actual undergoing of a procedure to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities. Valvotomy is specifically excluded.
Loss of Hearing	Complete and permanent loss of hearing in both ears which cannot be corrected or improved with treatment or assistive devices, as a result of injury or sickness the loss is at least 90 dB in both ears, averaged over frequencies of 500Hz, 1000Hz and 2000Hz, as certified by an appropriate <i>medical specialist</i> .
Loss of Independence	<ol style="list-style-type: none"> 1. A condition as a result of injury or sickness, where the <i>insured person</i> is totally and irreversibly unable to perform at least two of the five Activities of Daily Living without the assistance of another person. <p>or</p> <ol style="list-style-type: none"> 2. Cognitive impairment, meaning a deterioration or loss in the <i>insured person's</i> intellectual capacity which requires another person's assistance or verbal cueing to perform any of the Activities of Daily Living. <p>or</p> <ol style="list-style-type: none"> 3. Loss of Limb/s and Sight of One Eye. The <i>insured person</i> would be required to be under continuous care and supervision by another adult person for at least six consecutive months. At the end of that six month period, the <i>insured person</i> must, in <i>our</i> opinion on the basis of medical evidence, require ongoing continuous care and supervision by another adult person. <p>The loss of independence should be confirmed by a consultant physician.</p>
Loss of Limbs	The total and permanent loss of the use of two limbs as a result of injury or disease.
Loss of Limb/s and Sight of One Eye	The total and irrecoverable loss by the <i>insured person</i> of the: <ul style="list-style-type: none"> • use of both hands, or • use of both feet, or • use of one hand and one foot, or • use of one hand and the sight of one eye, or • use of one foot and the sight of one eye.
Loss of Speech	The total and permanent loss of the ability to produce intelligible speech, as a result of permanent damage to the larynx or its nerve supply or to the speech centres of the brain, whether caused by injury, tumour or sickness. The loss must be certified as being total and permanent by an appropriate <i>medical specialist</i> .
Major Head Trauma	As a result of an Accident, a traumatic brain injury resulting in permanent neurological deficit, causing either; <ul style="list-style-type: none"> • at least 25% impairment of whole person function (lasting more than six weeks from the date of the trauma) as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Diagnosis must be certified by a consultant neurologist, or • totally and irreversibly unable to perform at least two of the five Activities of Daily Living. <p>An Accident means a physical injury which occurs while the policy is in force that is caused solely and directly by violent, visible, external and unexpected means that is not traceable, even indirectly, to any pre-existing mental or physical condition.</p>
Major Organ Transplant	The human to human organ transplant from a donor to that person of one or more of the following organs: <ul style="list-style-type: none"> • kidney, • heart, • lung, • liver, • pancreas, • small bowel or • the transplantation of bone marrow.

Major Organ Transplant - continued	<p>This treatment must be considered medically necessary and the condition affecting the organ deemed untreatable by any other means other than organ transplant, as confirmed by a <i>medical specialist</i>.</p> <p>The transplantation of any other organ, only part of an organ, or any other tissue transplants is excluded from this definition.</p>
Motor Neurone Disease	The unequivocal diagnosis of progressive form of Motor Neurone Disease, certified by a consultant neurologist.
Multiple Sclerosis	<p>The unequivocal diagnosis of a disease characterised by demyelination of nervous tissue. The diagnosis has to be made by a consultant neurologist confirming permanent impairment of at least 25% of function although the person suffering the disease need not necessarily be confined to a wheelchair.</p> <p>The diagnosis will be based on confirmatory neurological investigations, e.g. lumbar puncture, evoked visual responses, evoked auditory responses and MRI (Magnetic Resonance Imaging) evidence of lesions of the central-nervous system.</p>
Muscular Dystrophy	The unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist resulting in at least 25% impairment of whole person function, as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association.
Occupationally Acquired Hepatitis B or Hepatitis C Infection	<p>The <i>insured person</i> is infected with Hepatitis B or Hepatitis C as a result of an Occupational Accident.</p> <p>An Occupational Accident means an accident that happens whilst the <i>insured person</i> is performing the usual duties of their normal occupation and involves contact with a bodily substance which puts the <i>insured person</i> at risk of transmission of the infections.</p> <p>This benefit will only be paid if all the following conditions for payment are satisfied. We require that:</p> <ul style="list-style-type: none"> • the <i>insured person</i> reports the accident to us within 48 hours after it happens, • the <i>insured person</i> is tested for infections within 48 hours after the accident and the results are negative, • the <i>insured person</i> has a positive anti-HCV screening tests (enzyme immunoassay) 10 weeks after infection, • a <i>medical practitioner</i> diagnoses the <i>insured person</i> to be: <ul style="list-style-type: none"> – positive to Hepatitis C within 180 days after the accident; or – positive to Hepatitis B within 180 days after the accident and still be positive within 180 days after the first diagnosis; • the <i>insured person</i> complies with all infection control precautions that apply, • the <i>insured person</i> is vaccinated or immunised for the infections as required by us, and • all tests be carried out according to the procedures we specify.
Parkinson's Disease	<p>The unequivocal diagnosis by a consultant neurologist of idiopathic Parkinson's Disease (paralysis agitans) which is of a permanent nature.</p> <p>All other types of Parkinsonism are excluded.</p>
Pneumonectomy (Removal of the lung)	Undergoing a surgical procedure in which an entire lung is removed due to underlying lung disease or disorder.
Primary Pulmonary Hypertension	Primary pulmonary hypertension with right ventricular enlargement established by investigations including cardiac catheterisation, resulting in a significant permanent physical impairment to the degree of at least Class III of the New York Heart Association classification of Cardiac Impairment.
Severe Burns	<p>Tissue injury caused by thermal, electrical or chemical agents causing full thickness to any of the following:</p> <ul style="list-style-type: none"> • 20% or more of the Body Surface as measured by the 'Rule of 9' or the Lund and Browder Body Surface Chart, • whole of both hands, requiring surgical debridement and/or grafting, or • whole of the head requiring surgical debridement and/or grafting.

<p>Stroke (in the brain resulting in specified permanent impairment)</p>	<p>Death of brain tissue caused by one of the following:</p> <ul style="list-style-type: none"> • ischaemic infarction of brain tissue, or • intracranial haemorrhage (cerebral, intraventricular or subarachnoid). <p>The diagnosis must be supported by both of the following:</p> <ul style="list-style-type: none"> • evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event, and • findings on MRI, CT or other reliable imaging evidence consistent with the diagnosis of a new stroke. <p>The following are not covered:</p> <ul style="list-style-type: none"> • transient ischaemic attacks, • cerebral symptoms due to migraine, and • vascular disease affecting the eye or optic nerve. <p>Permanent neurological deficit with persisting symptoms means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the <i>insured person's</i> life. It includes outcomes such as numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function. It does not mean:</p> <ul style="list-style-type: none"> • an abnormality seen on brain or other scans without definite related clinical symptoms, • neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms, and • symptoms of psychological or psychiatric origin.
<p>Surgery to the Aorta</p>	<p>Surgical repair to the aorta to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta but does not include angioplasty, intra arterial procedures or other non surgical techniques.</p>
<p>Terminal Illness</p>	<p>The diagnosis of the <i>insured person</i> with an illness which, in the opinion of an appropriate <i>medical specialist(s)</i> approved by us, will result in the death of the <i>insured person</i> within 12 months of the diagnosis regardless of any treatment that may be undertaken.</p>
<p>Viral Encephalitis</p>	<p>Severe inflammation of brain tissue which results in significant and permanent neurological impairment as certified by a consulting neurologist. Significant neurological impairment means at least 25% impairment of whole person function as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association.</p> <p>Diagnosis as certified by a consultant neurologist.</p> <p>Encephalitis as a result of HIV infection is excluded.</p>
<p>Activities of Daily Living</p>	<p>Activities of Daily Living means:</p> <ul style="list-style-type: none"> • Bathing: the ability to wash themselves either in the bath or shower or by sponge bath without the assistance of another person. The <i>insured person</i> will be considered to be able to bathe themselves even if the above tasks can only be performed by using equipment or adaptive devices. • Dressing: the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten and unfasten them without the assistance of another person. The <i>insured person</i> will be considered able to dress themselves even if the above tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls. • Eating: the ability to feed themselves once food has been prepared and made available, without the assistance of another person. • Toileting: the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing without the assistance of another person. The <i>insured person</i> will be considered able to toilet themselves even if he or she has an ostomy pouch/bag and is able to empty it himself or herself, or if the <i>insured person</i> uses a commode, bedpan or urinal, and is able to empty and clean it without the assistance of another person. • Transferring: the ability to move in and out of a chair or bed without the assistance of another person. The <i>insured person</i> will be considered able to transfer themselves even if equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorised devices is used.

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