Group Life Insurance

Combined Product Disclosure Statement and Policy Document

Issue Date: 1 December 2021

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

MetLife

Life, inspired by you.

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

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.

Contents

About this document

How to read this booklet

This booklet contains the Product Disclosure Statement (PDS) and the policy document for MetLife Group Life 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 Life Insurance Ordinary?

MetLife Group Life Insurance Ordinary (Non-Superannuation) provides death (including *terminal illness)* and *total and permanent disablement* 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 Life 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* 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 **15. 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 Life 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, family history 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 doctors' reports, blood tests and/or medical examinations.

When *we* underwrite a person for cover and *we* have received all the information *we* reasonably 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, honesty 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.

Other information

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 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 *eligible person's* 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 *eligible person's* 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 the *eligible person's* 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 **10. Premiums** of the policy document.

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

(a) the amount and type of cover that will be provided;

(b) the demographics of the *insured persons* (e.g. age, occupation, and gender distributions); and

(c) *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 life 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 Life Insurance pays *you* a lump sum benefit in the event of the death, *terminal illness* or *total and permanent disablement* of an *insured person* subject to the terms and conditions of *your* policy.

Cover and limitations

Minimum number of *insured persons*	25	
Who can own the policy?	*You* must be an Australian entity with at least 20 direct employees to be the *policy owner*.	
Who can obtain cover?	Generally Australian residents or holders of a temporary work visa approved by *us* aged up to 66^ for *TPD* cover and 69^ for death (including *terminal illness*) cover. The person will also need to satisfy any other *eligibility conditions* chosen by *you* and agreed to by *us*.	
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 *premium guarantee period*.	
	Death cover (including terminal illness)	**Total and permanent disablement (TPD) cover**
Maximum benefit	No maximum*	$5 million
Minimum entry age	15	15
Maximum entry age	69^	66**^
Maximum *cover cessation age*	70	70**
Exclusions	Exclusions and limitations apply which means that there will be situations where *we* will not pay a benefit. Refer to the terms and conditions in the policy document for further information.	

*Must be financially justified and subject to conditions.

**A restricted TPD definition may apply from age 65. The *policy schedule* will state this if this is the case.

^Entry age may be lower if the *cover cessation age* that applies to *your* policy is lower.

Features and benefits

Feature/Benefit	Description	Policy Document Page
Death benefit	Provides a benefit if an *insured person* dies.	2
Terminal illness benefit*	Provides a benefit if an *insured person* becomes *terminally ill*.	2
TPD benefit	Provides a benefit if an *insured person* becomes *totally and permanently disabled*.	2
Standard cover	Available to all persons who satisfy the *eligibility conditions* chosen by *you* and agreed to by *us*. To get *standard cover* each person must be disclosed to *us* within 30 days of the next *annual review date* after they first satisfy the *eligibility conditions*.	3
No *TPD* tapering (optional)	*We* may agree to not taper an *insured person's TPD* cover. This may be at an additional cost to *you*.	6
24-hour worldwide cover	*We'll* provide cover for an *insured person* 24 hours a day while they are overseas. Some conditions apply.	7
Cover while on leave without pay	*We'll* continue to provide cover while an *insured person* is on approved leave.	7
Continuation option (optional)	An *insured person* may be able to continue their cover once their *employment* ceases with *you*. This may be at an additional cost to *you*.	8
Interim accident cover	Provides interim cover for up to 90 days while an *insured person* or *eligible person* is being underwritten.	9
Extended cover	Provides cover for up to 60 days after an *insured person* leaves *your employment* and ceases to be eligible for cover under the policy.	11
Bundled policy discount	*We* may provide a discount when *you* take out both a Group Life Policy and Group Income Protection Policy with *us*. When *we* provide a discount, it will apply to the policy with the lowest premium.	13
Waiver of underwriting loadings	Where a premium loading is recorded for an *insured person*, *we* will not charge the extra premium for the loading except if the *insured person* exercises a continuation option. This is only applicable where the policy covers 50 or more *insured persons*.	
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.	

*The *terminal illness* benefit is provided as an advancement of the death benefit. So unless the policy indicates otherwise, any reference to death cover also applies to *terminal illness*.

TPD definitions

There are two *TPD* definitions available in this policy described as Definition 1 or Definition 2.

If Definition 1 applies, that definition has two parts:

- Part A (Standard), and
- Part B (Restricted).

The Part that will apply in the event of a claim will depend on the age of the *insured person* at the time of disablement.

The table below provides a general overview for when Part A (Standard) or Part B (Restricted) will be applied to an *insured person*.

***Insured Person,* at the *date of disablement* is...**	**Definition**
age 64 or under	*TPD* Part A (Standard)
age 65 or older*	*TPD* Part B (Restricted)

*Where *TPD* cover does not cease on the person's 65th birthday.

If Definition 2 applies, that definition only has Part A (Standard).

Group Life Insurance (Ordinary)

Policy Document

MetLife

Life, inspired by you.

About this policy document

This is *your* Group Life 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 **15 Definitions**.

There is also a section **13.9 Interpretation** that contains some rules that explain how the policy is intended to be read.

Contents

1. Benefits

1.1 Types of benefits

There are three benefits available under this policy. The benefits that apply to *you* will be specified in the *policy schedule*.

Death	Terminal Illness*	Total and Permanent Disablement (TPD)
We'll pay *you* a benefit if an *insured person* dies.	*We'll* pay *you* a benefit if an *insured person* becomes *terminally ill*, provided the *date of certification* occurs whilst the person is an *insured person*.	*We'll* pay *you* a benefit if an *insured person* becomes *totally and permanently disabled*, provided the *date of disablement* occurs whilst the person is an *insured person.*

*The *terminal illness* benefit is provided as part of the death cover. So unless the policy indicates otherwise, any reference to death cover also applies to *terminal illness.*

1.2 What we pay

Benefit type	Amount we pay
Death	*We'll* pay *you* the amount of the *insured person's* cover for death, at the *insured person's* date of death.
Terminal illness	*We'll* pay *you* the *insured person's* cover for death, at the *insured person's date of certification*.
Total and permanent disablement	*We'll* pay *you* the amount of the *insured person's* cover for *TPD*, at the *insured person's date of disablement*.

One person, one benefit

If an *insured person* claims more than one benefit (for example, both *terminal illness* and *TPD*), *we* will only consider the claim that occurs first (for example, the earlier of the *insured person's date of certification* and their *date of disablement*).

1.3 Maximum benefits

The benefit payable under this policy for an *insured person* will not exceed the *maximum benefit*.

2. Getting cover

2.1 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 **8.1 When cover will end for an insured person**).

2.2 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 **2.3 Standard cover**.

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

2.3 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 **3.2 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 2.3.

2.4 Underwritten cover

An *eligible person* who:

- is not permitted to obtain *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 *eligible person* for cover under this policy.	Accept the *eligible person* 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.

2.5 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:

- *we* will provide cover and determine *our* liability for claims made in respect of the transferred cover 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,
- 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,

- *we* will provide these takeover terms for each person for the same type of cover they had under the *previous policy*. For example, if a person only had death cover under the *previous policy*, *we* will only provide *takeover cover* terms on death cover under this policy, even if they are eligible for other cover types. 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.

3. When cover starts and its conditions

3.1 When cover starts

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

Cover type	Cover starts...
Standard cover	For a person who obtains *standard cover* by way of automatic acceptance, cover starts from the: • date they first become an *eligible person* if this happens on or after the *commencement date*, or • *commencement date* if they first became an *eligible person* before the *commencement date* and remain so on the *commencement date*.
Underwritten cover	For a person who obtains *underwritten cover*, cover starts when *we* accept the *eligible person* for cover.
Takeover cover	For a person who obtains *takeover cover*, cover starts on the *commencement date*, or on a later date *we* have agreed with *you* and this is specified in the *policy schedule*.

3.2 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*:

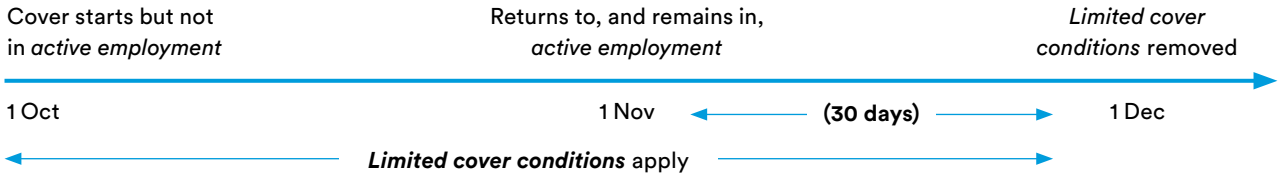
- is first given advice, care or treatment or recommended that they seek advice, care or treatment for the illness or injury, by a *medical practitioner*, or
- first had any symptom of the illness or injury for which a reasonable person in the same circumstances would have sought advice, care or treatment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

When limited cover applies

Limited cover conditions apply as follows:

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

Example



4. Cover amounts

4.1 Amount of cover

The amount of death (including *terminal illness*) cover and *total and permanent disablement* cover that applies to an *eligible person* will be determined as follows:

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

4.2 Automatic changes to cover

Where the *policy schedule* shows that the *insured cover* that applies to an *insured person* is calculated using a formula, the amount of cover for them will automatically change (increase or decrease) in line with the formula up to the amount 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 by more than the greater of:

- 25%, or
- $75,000,

since the last *annual review date*.

4.3 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.

4.4 Tapering of TPD cover

For *total and permanent disablement* cover, if the *insured cover* does not contain a method to reduce the *TPD* sum insured to nil at the *cover cessation age* (for example, as is the case for a fixed benefit amount or multiple of salary), *we* will reduce the *total and permanent disablement* cover each year from the *insured person's* 61st birthday to be nil at the *cover cessation age*. This is called *TPD* tapering.

We may agree to non-tapering of the *total and permanent disablement* cover. If *we* agree to this it will be stated in the *policy schedule*.

The table below shows the percentage in which the *insured person's TPD* cover will reduce from the *insured person's* 61st birthday as well as an example of how that reduction works

	Percentage reduction of TPD cover		**Example $500,000 TPD sum insured**	
Age last birthday	**Cover cessation age - 65**	**Cover cessation age - 70**	**Cover cessation age - 65**	**Cover cessation age - 70**
Up to 60	Nil	Nil	$500,000	$500,000
61	20%	10%	$400,000	$450,000
62	40%	20%	$300,000	$400,000
63	60%	30%	$200,000	$350,000
64	80%	40%	$100,000	$300,000
65	100%	50%	Nil	$250,000
66		60%		$200,000
67		70%		$150,000
68		80%		$100,000
69		90%		$50,000
70		100%		Nil

5. Extent of cover

5.1 TPD definition

There are two *TPD* definitions available in this policy described as *TPD Definition 1* or *TPD Definition 2*. Whether *TPD Definition 1* or *TPD Definition 2* applies to *your* policy will be stated in the *policy schedule*.

TPD Definition 1 has two parts:

- Part A (Standard), and
- Part B (Restricted).

TPD Definition 2 only has Part A (Standard).

When *TPD Definition 1* applies the table below sets out when Part A (Standard) or Part B (Restricted) of the definition will be applied to an *insured person*.

Insured Person	**TPD Definition**
is age 64 or younger on their *date of disablement*	*TPD Part A* (*Standard*)
is age 65 or older on their *date of disablement**	*TPD Part B (Restricted)*

*Where the *cover cessation age* is greater than 65.

If *we* agree to use other *TPD* definitions, this will be stated in the *policy schedule*.

5.2 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 in the case of a *total and permanent disablement* or *terminal illness* claim. If they do not return to Australia within 6 months of the date of any reasonable request, they may not be entitled to claim, or continue any claim, unless *we* otherwise agree.

5.3 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.

6. 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 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.

7. Interim accident cover

7.1 What is interim accident cover?

If an *eligible person* applies for *underwritten cover*, *we* will cover them for the types of cover that they have applied for (other than *terminal illness*) while *we* are considering the application. This cover is only provided where their death or *TPD* occurs as a direct result of an *accident*.

Accidental death cover	Accidental TPD cover
We pay a benefit if a person who has applied for death cover dies as a direct result of an *accident* that occurs during the *interim accident cover* period defined in section **7.2 When interim accident cover starts and stops.** The death as a result of the *accident* must occur during the *interim accident cover* period for this benefit to be paid.	*We* pay a benefit if a person who has applied for *TPD* cover becomes *totally and permanently disabled* as a direct result of an *accident* that occurs during the *interim accident cover* period defined in section **7.2 When interim accident cover starts and stops.** The *accident* and resulting *date of disablement* must occur during the *interim accident cover* period for this benefit to be paid.

The exclusions, limitations, restrictions and claim procedures under this policy also apply to *interim accident cover*.

7.2 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.

7.3 What we'll pay

The benefit *we* will pay for accidental death or accidental *TPD* will be the lesser of:

- the amount of cover or additional cover applied for, or
- $2,000,000.

We will pay this benefit in addition to any amount paid from other cover that applies to the *eligible person* under this policy subject to section **1.3 Maximum benefits**.

7.4 What happens if we pay an interim accident benefit?

If *we* pay an *interim accident benefit*, the application for *underwritten cover* will be cancelled. *You* will be unable to apply for any further cover for that person under this policy. Any existing cover for that person under this policy will also be cancelled.

8. Ending and reinstating cover

8.1 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 *insured person*...	Cover ends on...
is paid under the policy: • a *terminal illness* benefit, • a *total and permanent disablement* benefit, • a death benefit, or • an *interim accident benefit*	the date the benefit becomes payable.
reaches the *cover cessation age*	the date they reach the *cover cessation age.*
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 *policy owner*	the date determined under section **4.3 Reducing or cancelling cover**.
is no longer an *insured person* because the policy is terminated	the date the policy is terminated subject to section **8.2 What happens if this policy ends?**
is no longer an *Australian Resident* 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 *Australian Resident* or no longer permanently in Australia or eligible to work in Australia.
ceases to be engaged by the *employer*	for an employee, the date they cease to be *employed* by the *employer*. for anyone else, the date they cease to be engaged by the *employer*. *We* will however extend cover from this date for up to 60 days (see section **8.4 Extended cover**).
ceases to meet the *eligibility conditions* (excludes ceasing to meet the *maximum entry age* if lower than the *cover cessation age*)	the date they cease to meet the *eligibility conditions*.
no longer meets the conditions under section **5.2 Worldwide cover** for cover while temporarily *employed* overseas	the date the person no longer meets the conditions for cover to continue while *employed* overseas under section **5.2 Worldwide cover**.
no longer meets the conditions under section **5.3 Leave without pay** for cover during *unpaid leave*	the date the person no longer meets the conditions for cover to continue when on *unpaid leave* under section **5.3 Leave without pay**.
has not had the outstanding premium owing for their cover paid to *us* within 30 days of the *premium due date*	the date premiums have been paid up to for the *insured person's* 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.

8.2 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.

8.3 Reinstating cover

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

8.4 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 **8.1 When cover will end for an insured person** (excluding when the person ceases to meet the *eligibility conditions*).

9. Claims

9.1 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.

9.2 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.

Apart from any medical examinations 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 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 and tests. However, unless *we* agree otherwise in writing, *we* will not pay any other costs related to the *insured person's* attendance for these investigations, including costs of travelling to an appointment or for non-attendance at an appointed examination.

9.3 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.

9.4 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. Premiums

10.1 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*.

10.2 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:

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

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.

10.3 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.

10.4 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.

10.5 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.

10.6 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.

10.7 Premium discount for bundled policies

If the *policy owner* has an active Group Income Protection Policy with *us*, *we* may provide a discount on whichever policy (either this policy or the Group Income Protection 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 Income Protection Policy with *us*, *we* will stop providing the discount.

11. 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).

11.1 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.

11.2 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.

11.3 War in Australia

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

12. Exclusions

12.1 Acts of war

We will not pay a benefit for an *insured person* if their death, *terminal illness* or *TPD* is caused directly or indirectly by an act of *war*.

While acts of *war* are excluded, if an *insured person* dies while on service with the Australian Armed Forces Reserve they will still be covered.

12.2 Suicide or self-inflicted injury

Where cover for an *insured person* is

- not *standard cover* or *takeover cover*,
- increased cover that is not increased as a result of a standard formula under the *insured cover*, or
- reinstated cover,

we will not pay a benefit if:

- their death, *terminal illness* or *TPD* is directly or indirectly caused by or attributed to:
  - suicide or attempted suicide, or
  - an intentional self-inflicted injury or infection, and
- this takes place within the first 13 months of the relevant cover starting, increasing or recommencing.

Where the cover for a person is for *interim accident cover*, *we* will not pay a benefit if their death, *terminal illness* or *TPD* is directly or indirectly caused by or attributed to:

- suicide or attempted suicide, or
- intentional self-inflicted injury or infection.

12.3 Previous terminal illness benefit

No benefit will be payable for *terminal illness* or death where a person has been paid or is eligible to be paid a *terminal illness* or similar benefit under the *previous policy*.

12.4 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. Policy owner information

13.1 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 **10.3 When premiums are due**.

13.2 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

13.3 Currency

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

13.4 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.

13.5 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.

13.6 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.

13.7 Non-assignment of policy

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

13.8 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.

13.9 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.

13.10 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.

14. 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
Write to: GPO Box 3, MELBOURNE VIC 3001
Email: info@afca.org.au
Online: www.afca.org.au

15. 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.
active employment	A person who in *our* 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 *policy schedule*.
at work	Actively performing all the duties of their occupation, 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 *Special Category Visa* while residing in Australia indefinitely.
automatic acceptance limit	The maximum amount determined by *us* and notified to *you* from time to time as stated in the *policy schedule* for which *we* may accept a person for *insured cover* without application.
basic work activities	Means any of the following six activities: **1. Mobility (walking or bending):** (a) Walk, with or without a walking aid*, more than 200m on a level surface without stopping; or (b) Bend, kneel or squat to pick something up from the floor from standing position and straighten up again. *Such as a walking stick, crutches or walking frames. **2. Vision (reading):** Read, with visual aids, to the extent that an Ophthalmologist can certify that: (a) visual acuity is equal to, or better than, 6/48 in both eyes; or (b) constriction is, within or greater than, 20 degrees of fixation in the eye with the better vision. **3. Lifting:** Using one or both hands to hold an object weighing at least 5kg above their own waist height continuously for 60 seconds. **4. Manual dexterity:** With at least one hand, without the use of aids: (a) type words using a computer keyboard; or (b) pick up a small object such as a coin or pen. **5. Hearing:** Clearly hear with or without an aid, where the inability to hear clearly must be due to permanent hearing loss of at least 90 dB in both ears, averaged over frequencies of 500Hz, 1000Hz and 2000Hz, as certified by an appropriate *medical specialist*. **6. Communicating (verbal or written):** Comprehend and express oneself through verbal or written language with clarity, where the inability to speak verbally or write with clarity must be due to dysfunction of the nervous system that is present on clinical examination, as certified by an appropriate *medical specialist*. Examples of dysfunction include dysarthria, aphasia and dysphasia.
care provider	A professional carer who is paid on a commercial basis.
casual employee	A person being engaged in *employment* of a temporary nature where: • continuity of *employment* is not guaranteed by the *employer*, regardless of hours worked or the period of *employment*, and • the person is not entitled to annual leave or sick leave.

commencement date	The "Commencement Date" stated in the *policy schedule*.
contractor	A person who is contracted for a fixed period of *employment* determined at the commencement of their *employment* 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 *insured cover* will cease, and they are no longer eligible for cover under this policy. The *cover cessation age* is shown in the *policy schedule*.
date of certification	The most recent date that two *medical practitioners*, one of whom is a *medical specialist* in the *insured person's* illness, certify that the illness will lead to the *insured person's* death within 12 months.
date of disablement	The later of, the date: • on which a *medical practitioner* examines and certifies in writing that the *insured person* is disabled, and • the *insured person* ceases all work.
eligibility conditions	"Eligibility Conditions" stated in the *policy schedule* that detail how a person can become eligible for *insured cover*.
eligible person	A person who meets the "Eligibility Conditions" stated in the *policy schedule*.
employed or employment	A person being engaged by the *employer*: • under a contract of employment and includes a: – *permanent employee* – *casual employee* – *contractor*, or • as a *franchisee*, or • as a partner (if the *employer* is a partnership).
employer	The "Employer" named in the *policy schedule* and any associated entity agreed to by *us*.
forward underwriting limits	The amount, determined by *us*, which an *insured person's insured cover* may increase to, in line with the calculation for *insured cover*, without the need for additional underwriting. This is only available where the policy has a standard formula for calculating the *insured cover*.
franchisee	An individual who has entered into a *franchise agreement* with *you*.
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 *insured person's employment* status and is stated in the *policy schedule*, and (b) any other component agreed to by *us* that would not otherwise be considered as income under **Appendix A**. Where the person is on *unpaid leave* and *we* continue to provide cover in respect of that *insured person* pursuant to section **5.3 Leave without pay**, income is the amount defined in (a) and (b), immediately before the start of the *unpaid leave*.
insured cover	The "Insured Cover" stated in the *policy schedule* which details the calculation of insurance cover for an *insured person*.
insured person	A person who has cover in force under this policy, other than *interim accident cover*.
interim accident benefit	The benefit payable for *interim accident cover* as described in section **7 Interim accident cover**.
interim accident cover	The cover provided under section **7 Interim accident cover** while a person is being assessed by *us* for additional cover that is not accepted under automatic acceptance.
limited cover conditions	The limitations on an *insured person's* cover as described in section **3.2 Limited cover**.
maximum benefit	The "Maximum Benefit" stated in the *policy schedule* which is the maximum sum insured that will be paid under this policy for an *insured person*.
maximum entry age	The maximum age a person can be to be eligible for *standard cover* as stated in the *policy schedule*.

medical practitioner	A person, accepted by *us*, who is registered and practising as a medical practitioner in Australia other than the: • *insured person*, or • *insured person's* 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 *medical practitioner* who is registered as a Specialist with the Australian Health Practitioner Regulation Agency (or any other body which replaces it).
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 *policy schedule*.
policy schedule	Any document issued to *you* which contains the specific terms and conditions that apply to this policy.
premium due date	The "Premium Due Date" stated in the *policy schedule*.
premium guarantee period	The "Premium Guarantee Period" stated in the *policy schedule*.
premium rates	The rates stated in the *policy schedule* "Schedule 2".
previous policy	The "Previous Policy" named in the *policy schedule*.
psychiatric treatment	Following the advice of a treating psychiatrist in accordance with an established treatment plan and expert guidelines for the treatment of psychiatric conditions (guidelines must be recognised in Australia).
Schizophrenia	Schizophrenia (Multiple Episodes or Continuous), diagnosed in accordance with Diagnostic and Statistical Manual of Mental Disorders (DSM) 5.
Schizophreniform Disorder	Schizophreniform Disorder (Multiple Episodes or Continuous), diagnosed in accordance with Diagnostic and Statistical Manual of Mental Disorders (DSM) 5.
special category visa	Has the meaning given to it in section 32 of the Migration Act 1958 (Cth).
standard cover	The acceptance of *insured cover* by *us* without the need for underwriting for an amount up to the *automatic acceptance limit*.
takeover cover	The cover described in section **2.5 Takeover cover**.
terminal illness / terminally ill	(a) an *insured person* suffering from an illness that despite reasonable medical treatment will lead to the *insured person's* death within 12 months of the *date of certification*, and (b) *we* are satisfied, on medical or other evidence, that despite reasonable medical treatment the illness will lead to the *insured person's* death within 12 months of the *date of certification* referred to in paragraph (a). The *date of certification* must be made while the *insured person* is covered under this policy.
total and permanent disablement (TPD)/ totally and permanently disabled	Has the meaning set out below and can be: • Definition 1, and/or • Definition 2, and/or • an alternative definition as agreed by *us*. The definition(s) which apply will be stated in *your policy schedule*. **Definition 1** Total and Permanent Disablement (TPD) means: **Part A (Standard):** For an *insured person* who is under the age of 65 immediately prior to their *date of disablement*: The *insured person* has been absent from their occupation with the *employer* through injury or illness for at least 3 consecutive months and has provided proof to *our* satisfaction that the *insured person* has become incapacitated to such an extent as to render the *insured person* unlikely ever to engage in or work for reward in any occupation or work for which he or she is reasonably qualified by reason of education, training or experience.

total and permanent disablement (TPD)/ totally and permanently disabled (continued)

Part B (Restricted):

For an *insured person* who is aged 65 or older immediately prior to their *date of disablement*:

The *insured person* satisfies either paragraphs (i), (ii), (iii) or (iv) and also satisfies paragraph (v):

i) the *insured person* suffering the permanent loss of use of 2 limbs or the sight of both eyes or the permanent loss of use of one limb and the sight of one eye (where limb is defined as the whole hand or the whole foot),

ii) solely because of injury or illness, and having provided proof to *our* satisfaction, the *insured person*:

(a) has been unable to perform at least two *basic work activities* for at least 3 consecutive months, and

(b) is unable to perform at least two *basic work activities* for the rest of their life, without the help of another person,

iii) all of the following are satisfied:

(a) the *insured person* has a psychiatric disorder which:

- has been diagnosed by a consultant psychiatrist and Fellow of RANZCP under the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association, and
- the *insured person* has been receiving *psychiatric treatment* for at least 12 months prior to the *insured person's* treating psychiatrist assessing the psychiatric disorder as chronic and unlikely to improve in the foreseeable future with or without further treatment, and

(b) *we* determine that solely because of their psychiatric disorder, the *insured person* has suffered from the following incapacity for at least 12 consecutive months, and is likely to continue to be so incapacitated for the rest of their life:

- has received an established diagnosis of *Schizophrenia* or *Schizophreniform Disorder* from their treating psychiatrist, or
- is unable to care for their dependent children in any capacity due to the unacceptable risk that the dependent(s) will be exposed to physical, emotional or psychological harm, requiring the dependent(s) to be removed from the *insured person's* care by Court order, or
- is unable to manage day-to-day financial affairs, including:
  - manage bank balance, or
  - pay bills on time without assistance

  requiring the appointment of a guardian to manage the *insured person's* financial affairs, where the appointment of a guardian must be made by Court or Tribunal order and the Court or Tribunal must be satisfied through its own independent medical review that the *insured person* is not capable of managing their day-to-day financial affairs as a result of their psychiatric disorder, or
- is unable to live independently, requiring a *care provider* to provide daily care and supervision to the *insured person*, or
- requires ongoing *psychiatric treatment* and full-time residential care in a mental health facility to protect them and/or others from serious physical harm. The mental health facility must be authorised by the relevant Australian government (state or federal) to provide treatment and care to persons who have a mental illness,

iv) the *insured person* through injury or illness, and having provided proof to *our* satisfaction, is suffering from the permanent deterioration or loss of intellectual capacity that has required the *insured person* to be under continuous care and supervision by another adult person for at least 3 consecutive months and this care is likely to be ongoing on a permanent daily basis,

v) the *insured person* has been absent from their occupation with the *employer* through injury or illness for at least 3 consecutive months and has provided proof to *our* satisfaction that the *insured person* has become incapacitated to such an extent as to render the *insured person* unlikely ever to engage in or work for reward in any occupation or work for which he or she is reasonably qualified by reason of education, training or experience.

total and permanent disablement (TPD)/ totally and permanently disabled (continued)	**Definition 2** Total and Permanent Disablement (TPD) means : **Part A (Standard):** The *insured person* has been absent from their occupation with the *employer* through injury or illness for at least 3 consecutive months and has provided proof to *our* satisfaction that the *insured person* has become incapacitated to such an extent as to render the *insured person* unlikely ever to engage in or work for reward in any occupation or work for which he or she is reasonably qualified by reason of education, training or experience.
underwritten cover	Cover accepted by *our* underwriters following *our* 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 *insured person* from their occupation, unpaid by the *employer*, that has been approved by the *employer* in writing prior to such absence.
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 *policy owner.*

Appendix A – Income Definitions

You can apply for the *insured cover* to be calculated using a formula which will be subject to *our* approval. If *we* approve the formula and *income* is used within that formula, 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).	*Employed* – standard (excluding *casual employees*)	The total regular income received by the *insured person* from the *employer* 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).	*Employed* – tailored components (excluding *casual employees*)	The total regular income received by the *insured person* from the *employer* 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 *you* will be specified in the *policy schedule*.
2.	*Casual employee*	The average of the regular income received by the *insured person* from the *employer* over the previous 12 months or the actual period if less, subject to a minimum average period of 3 months.
3.	Partner	The total regular income received by the *insured person* (after deduction of their share of business expenses) from the *employer* because of the personal exertion of the *insured person*, averaged over the previous 12 months (or lesser period if *employed* 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 *employed* for less than 2 years). When calculating the average *income*, if the *insured person* has been *employed* for 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 disability.
4.	Shareholders (*employed* as a *permanent employee*)	The total regular income received by the *insured person* from the *employer* 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.

Definition	Employment Status	Income Definition
5.	*Franchisee*	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: • 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: • 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.
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 *insured person's* 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 *disability*.

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