ZURICH

Corporate Care
Group Income Protection

Product Disclosure Statement
and Policy Terms

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About Zurich

Zurich is a leading insurer that offers multiple products to customers across the world. With about 55,000 employees, it provides a wide range of property and casualty, life insurance products and services in more than 215 countries and territories. In Australia, group life insurance solutions are provided by Zurich Australia Limited (Zurich) ABN 92 000 010 195 AFSL 232510 as part of the Zurich Financial Services Australia Group.

The ultimate holding company of the group, Zurich Insurance Group Ltd, is listed on the SIX Swiss Exchange.

Our industry code is our promise to you and insured members

We are committed to following the Life Insurance Code of Practice (Life Code)

The Life Code sets out insurers' obligations to consumers throughout the life insurance process, including when:

- you buy a policy, make a claim or deal with us
- we deal with claims, complaints and requests for information
- we help you if you experience financial hardship or need extra support.

Our key Life Code promises

As a subscriber to the Life Code, we make several key promises to consumers, including commitments to be honest, respectful and clear in all our interactions and communications. The Code also requires us to be fair, timely, transparent and accountable when providing services.

1. We will be honest, fair, respectful, transparent, and timely when we communicate with you, and we will use plain language unless medical or other technical terminology is needed.
2. We will ensure our staff and Authorised Representatives use appropriate sales and retention practices.
3. We will offer extra support if you have trouble with the process of buying insurance or claiming.
4. If we find that a sale was made using unacceptable sales practices, we will fix it, for example by issuing a refund or replacement policy.
5. When you make a claim, we will explain the process and keep you informed about our progress assessing it.
6. We will decide on your claim within the Life Code's timeframes. But if we cannot, we will explain why and tell you how to make a complaint.
7. If we decline your claim, we will explain why in writing and let you know what to do if you disagree.
8. We will restrict the use of investigators and surveillance to preserve your right to privacy.
9. The independent Life Code Compliance Committee (Life CCC) will monitor our compliance with the Code.
10. We will be accountable for Life Code requirements, and the Life CCC can sanction us.

You can get a copy of the Life Code

To find out more about the Life Code, visit our website.

Contents

About Zurich 2

Our industry code is our promise to you and insured members 3

- Our key Life Code promises 3

About this PDS and Policy 6

- Zurich Australia Limited issues Zurich Corporate Care Group Income Protection insurance 6
- Information in this PDS and Policy may change 6
- How to read this PDS and Policy 6
- Zurich Corporate Care Group Income Protection insurance is designed for consumers with certain objectives and needs 6
- Setting up the policy 7
- To find out more 7

Part 1: Product Disclosure Statement 8

- Zurich Corporate Care Group Income Protection insurance provides financial support if insured members are injured or sick 8
- You can hold Zurich Corporate Care Group Income Protection insurance in superannuation 14
- Internationally mobile employees 15
- You have a Duty to Take Reasonable Care Not to Make a Misrepresentation 15
- How we calculate premiums 16
- Your broker or financial adviser may receive commission payments from us 16
- How we assess underwriting applications 17
- How you can make a claim 17
- The rehabilitation services we offer 17
- How we manage privacy 17
- We welcome enquiries and complaints 18

Part 2: Policy terms 20

1. TERMS OF THE POLICY 20

- 1.1 When the policy starts and ends 20
- 1.2 How we send notices to you, and you to us 20
- 1.3 We guarantee continuing cover 20
- 1.4 How to vary the policy 20
- 1.5 What we may do if your risk profile changes 20
- 1.6 What currency we use 20

2. ELIGIBILITY AND PERIOD OF COVER 21

- 2.1 Eligible persons must meet certain criteria to be insured 21
- 2.2 How we accept insured members 21
- 2.3 Where we provide cover under automatic acceptance terms 21
- 2.4 Cover under group transfer terms 23
- 2.5 How we consider applications for cover 24
- 2.6 We may agree to a forward underwriting limit 24
- 2.7 When and how Interim Accident Cover applies 24
- 2.8 Rules may vary between member categories 25
- 2.9 Worldwide cover, round the clock 25
- 2.10 Cover for insured members working outside Australia 25
- 2.11 Cover during employer-approved leave 25
- 2.12 Extended cover 25
- 2.13 Ending cover for insured members 26
- 2.14 Members can apply for a Continuation Option 26

3. BENEFITS AND FEATURES BUILT INTO THE POLICY 28

- 3.1 A waiting period applies to disability benefits 28
- 3.2 Total Disability Benefit 28
- 3.3 Partial Disability Benefit 28
- 3.4 Enhanced Bereavement Benefit 29
- 3.5 Specific Injury Benefit 29
- 3.6 Early Notification Incentive Benefit 30
- 3.7 Return-to-work assistance 30
- 3.8 Recurring disability 30
- 3.9 Workplace modification assistance 30
- 3.10 Emergency Domestic Travel Benefit 30
- 3.11 Grief support 31
- 3.12 Practical Support Benefit 31

4. OPTIONAL BENEFITS 32

- 4.1 Superannuation Contribution Benefit 32
- 4.2 Escalation Benefit 32
- 4.3 Nurse Care Benefit 32
- 4.4 Recovery Assistance Benefit 32
- 4.5 Enhanced Recovery Assistance Benefit 33
- 4.6 Trauma Recovery Benefit 33
- 4.7 Enhanced Trauma Recovery Benefit 35
- 4.8 Immediate Family Member Benefit 35
- 4.9 Relocation Benefit 36
- 4.10 Alternative Benefit Expiry Age Benefit 36
- 4.11 Specific Trauma Recovery Benefit 36
- 4.12 Women's Health Benefit 37

5. LIMITATIONS TO BENEFITS 38

5.1 Exclusions apply in some cases 38
5.2 Pre-existing conditions are not covered in certain circumstances 38
5.3 Limitations in the policy schedule and decision notes 38
5.4 Benefit periods for casual employees and insured members working less than 14 hours per week 38
5.5 We cannot reimburse some expenses 38
5.6 Certain factors reduce the benefit payable 38
5.7 Incorrectly paid benefits must be repaid 39
5.8 Being overseas for over a year will stop benefits 39
5.9 One monthly benefit at a time 39
5.10 We may decline transactions that could be against the law 40

6. CLAIMS 41

6.1 When to notify us of a claim 41
6.2 How to make a claim 41
6.3 Before we pay a claim 41
6.4 Payment for claim costs outside Australia 41

7. COSTS YOU PAY 42

7.1 Where to find premium rates 42
7.2 What minimum annual premium applies 42
7.3 How we calculate premiums 42
7.4 How we manage over or under payments 42
7.5 When premiums are due 42
7.6 We guarantee premium rates 42
7.7 We can change premium rates or the minimum annual premium 42
7.8 We can adjust premiums or benefits if age is wrong 43
7.9 You may need to pay stamp duty, taxes and expenses 43
7.10 We may charge interest 43
7.11 We offer discounts or can provide lower premiums in some cases 43
7.12 We waive individual member premiums in specific cases 43

8. KEEPING US INFORMED 44

8.1 Tell us when members change 44
8.2 Tell us if other information changes 44
8.3 Keep records 44
8.4 We can carry out audits 44

9. GENERAL CONDITIONS 45

9.1 Cooling-off period for policy 45
9.2 Cooling-off period for members of a superannuation fund 45
9.3 Terminating the policy 45
9.4 Governing law for the policy 45
9.5 Statutory fund for the policy 45

10. DEFINITIONS 46

- Trauma Recovery Events 55
- Specific Trauma Recovery Events 61
- Women's Health Conditions 62

About this PDS and Policy

This document is a combined Product Disclosure Statement and Policy Terms (PDS and Policy). It sets out the benefits, features, options and risks of Zurich Corporate Care Group Income Protection insurance.

The information in this PDS and Policy will help you to decide if this product is suitable for you. It can help you compare products you may be considering from other life insurers. Read this PDS and Policy carefully and keep it in a safe place.

If you apply for Zurich Corporate Care Group Income Protection insurance and we accept your application, we will issue you a ***policy schedule*** that sets out the benefits, features and options that apply to your specific ***policy***. It will also include any additional or amended terms and conditions that apply. Read this PDS and Policy together with the ***policy schedule*** to understand the benefits that apply to you.

The information in this PDS and Policy, including tax information, is based on the continuation of present laws and our interpretation of those laws.

Zurich Australia Limited issues Zurich Corporate Care Group Income Protection insurance

Zurich Australia Limited (Zurich) is the issuer of Zurich Corporate Care Group Income Protection insurance.

We invite you to apply for this product if you are receiving this PDS and Policy in Australia. We do not offer the product to people in other countries.

Information in this PDS and Policy may change

The information in this PDS and Policy is up-to-date when it was written – see the date at the front of the document.

If the information changes over time, you can get updated information online or email us at group.risk@zurich.com.au.

If the change is materially adverse, we will issue a supplementary or replacement PDS and Policy.

We also reserve the right to change matters which do not form part of the PDS and Policy, including administrative matters.

How to read this PDS and Policy

The following sections explain the terms and conditions, how you can apply and how and when you can claim benefits.

Part 1: Product Disclosure Statement

Part 2: Policy Terms

Throughout this PDS and Policy, the following words will have the meanings set out in the table below:

Words we use in the policy	What the words mean
we, our, us, Zurich	Zurich Australia Limited (Zurich) ABN 92 000 010 195 AFSL 232510 and any properly appointed delegates.
you, your	The applicants for Zurich Corporate Care Group Income Protection insurance, or the ***policy owner*** and its delegates. If the ***policy owner*** is the trustee of a superannuation fund, 'you' and 'your' also mean the members' employer.
a *policy*, the *policy*	The documents we issue you. Please refer to the definition of ***policy*** in **10 Definitions** of **Part 2: Policy terms** for the documents that make up the ***policy***.
PDS and Policy	This document, made up of the Zurich Corporate Care Group Income Protection insurance Product Disclosure Statement and Policy Terms.

Other expressions and words throughout this PDS and Policy, and the ***proposal form***, also have special meanings. These words and expressions are shown in ***bold italic*** type and are defined in **10 Definitions** of **Part 2: Policy terms**. Other words and expressions with special meanings will be defined in the ***policy schedule***, which we will issue you if you buy this product.

If the ***policy schedule*** and **10 Definitions** of **Part 2: Policy terms** define a term differently, the meaning in the ***policy schedule*** will apply unless we agree otherwise.

We have used headings to help you use this document, but they are not part of how you should interpret the PDS and Policy.

Any words indicating the singular can also mean the plural, and vice versa.

If special terms or conditions apply to the benefits provided to ***insured members*** generally, we show them in the ***policy schedule***.

If we accept an ***insured member*** for cover on special conditions specific to that ***insured member***, we will notify you in our ***decision note***.

Zurich Corporate Care Group Income Protection insurance is designed for consumers with certain objectives and needs

We have designed the product for consumers with certain objectives, financial situations and needs. Not all products are suitable for all consumers and you need to consider, with the help of any financial adviser advising you, whether the product is right for you. The information in this PDS and Policy is general information only, not personal advice. It does not take into account your personal circumstances, financial situation or needs.

We have created a target market determination (TMD) for the product in this document. The TMD sets out:

- key attributes of the product
- the needs and objectives it is intended to address
- eligibility requirements
- financial capacity expectations
- some key exclusions, and
- how the product is to be sold.

Download our TMD (PDF)

Setting up the policy

It is important you read and understand the information in this PDS and Policy before applying.

Step 1 – You request a quote

To set up a ***policy***, start by asking one of our Partnership Managers for a quote for Zurich Corporate Care Group Income Protection insurance. You will need to decide:

- what level of ***monthly benefit*** to provide ***insured members***
- when the ***policy*** should start
- what the ***waiting period*** should be
- what the ***benefit period*** should be, and
- what optional benefits should apply.

We will then issue you a ***quotation summary*** with our offer of cover. Our ***quotation summary*** expires 90 days after we issue it unless we agree with you to change this period.

Step 2 – You accept our quote

Tell us if you accept our quote before it expires.

We will need the following to set up the ***policy***:

- a completed ***proposal form*** you have signed
- ***member information***, which includes details of all proposed ***insured members*** who have been seconded overseas by their employer to work. To help you provide the ***member information***, we may give you a specific form or allow you to provide the ***member information*** electronically or in some other way
- Information on transfer terms, if relevant (refer to **2.4 Cover under group transfer terms** of **Part 2: Policy terms** for information on transfer terms), and
- the first annual premium or deposit premium we need you to pay.

Please post or email your documents to:

Group Insurance Administration
GPO Box 4129
Sydney NSW 2001

Email Group Insurance Administration at group.risk@zurich.com.au

Please pay any premium or deposit premium by electronic fund transfer. You will find our bank account details on our invoice.

Step 3 – We issue the policy

This PDS and Policy is not a contract. A contract between you and us is only formed when we:

- accept your ***proposal form***
- we issue an 'on-risk' letter, and
- you pay the premium or deposit premium due.

Once all our requirements are met, we will issue you with a ***policy schedule***.

To find out more

If you want to know more about requesting a quote for Zurich Corporate Care Group Income Protection insurance, our dedicated Partnership Managers can help you. Visit our website or email us at group.risk@zurich.com.au.

Part 1: Product Disclosure Statement

Part 1 summarises key points about Zurich Corporate Care Group Income Protection insurance to help you decide if the product is for you.

Zurich Corporate Care Group Income Protection insurance provides financial support if insured members are injured or sick

Zurich Corporate Care Group Income Protection insurance can be a great way to add value to employees' remuneration packages or offer competitive insurance through a superannuation fund.

One contract – owned by an employer or superannuation fund trustee – can provide cover for a group of employees or members of a superannuation fund.

Zurich Corporate Care Group Income Protection insurance pays a benefit of up to 75% of an ***insured member's salary*** if they are unable to work due to illness or injury. The flexible nature of the insurance allows you to tailor the insurance cover for your group.

Please read **Part 2: Policy terms** for full details of when we pay any benefit, feature or option.

Summary of benefits and features we have built in

All ***insured members*** have access to these benefits and features.

For illness and injury

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Total Disability Benefit	If an ***insured member*** is unable to work due to illness or injury, we will pay you the ***monthly benefit*** while the ***insured member*** remains ***disabled***. We stop paying at the end of the ***benefit period*** even if the ***insured member*** continues to be ***disabled***. The maximum ***monthly benefit*** is generally 75% of the ***insured member's monthly salary***. You also have the option to choose: • a different ***monthly benefit***, where we generally pay you 75% of the ***insured member's monthly salary*** for the first 24 consecutive months of the benefit period, and 50% after that. If you choose this option, our Total Disability and Partial Disability definitions and rehabilitation requirements may be different from usual, but we will tell you in the ***policy schedule***, or • a definition of ***totally disabled*** where we assess the ***insured member's*** ability to do: – their own occupation for the first 24 consecutive months of the ***benefit period***, and – any occupation within their education, training or experience after that. If the ***insured member*** receives ***other payments*** or income, we may reduce the benefits payable as set out in **5.6.2 Reduction of the Total Disability Benefit by other payments**.	✓	28
Partial Disability Benefit	We will pay you part of the ***monthly benefit*** if an ***insured member*** returns to work or can return to work after a period of ***total disability***, but at reduced capacity. We stop paying at the end of the ***benefit period*** even if the ***insured member*** continues to be ***disabled*** or has reduced working capacity. If the ***insured member*** receives ***other payments*** or income we may reduce the benefits payable as set out in **5.6.3 Reduction of the Partial Disability Benefit by other payments**.	✓	28
Specific Injury Benefit	We will pay you a ***monthly benefit*** if an ***insured member*** is diagnosed with a specific injury within 180 days of the event that caused it, whether or not they are ***totally disabled***. Benefits start as soon as the ***insured member*** is diagnosed with the specific injury and continue for the nominated payment period for that specific injury.	✗	29

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Recurring disability	We will waive the ***waiting period*** if an ***insured member*** has a relapse of their illness or injury within 6 months of their claim ending. We will consider the relapse to be a continuance of the earlier period of ***disability*** and restrict ***disability*** benefits to the remainder of the ***benefit period*** (if any).	✓	30

For bereavement and grief

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Enhanced Bereavement Benefit	We will pay you 3 times the ***insured member's monthly benefit*** as a lump sum if an ***insured member*** dies or is diagnosed with a ***terminal illness***. We pay up to $60,000.	✓	29
Grief support	We will offer an ***insured member*** and their ***immediate family members*** access to our Grief Support Program at no extra cost if the ***insured member*** is diagnosed with a ***terminal illness***.	✓	31

For transport and practical support

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Emergency Domestic Travel Benefit	We will reimburse up to $1,000 for ***emergency transportation*** (excluding ambulance transport) of an ***insured member*** if: • they are receiving a Total Disability Benefit • they require ***emergency transportation*** within Australia, and • the transport is to a hospital.	✗	30
Practical Support Benefit	We will reimburse an ***insured member*** up to $500 for practical support, for example: • cleaning • meal preparation • transport for medical appointments • goal-related activities to improve health or wellness. We will pay this benefit during the first 12 months the ***insured member*** is ***on claim***. Additionally, if an ***insured member*** is ***on claim*** for a Total Disability Benefit or a Partial Disability Benefit and they are experiencing family and domestic violence, we will reimburse up to $1,000 for costs associated with securing emergency accommodation. This additional payment is payable at any time during the period that the ***insured member*** is ***on claim*** for a Total Disability Benefit or a Partial Disability Benefit.	✗	31
Return-to-work assistance	We may pay the appropriate service provider some or all of the costs an ***insured member*** incurs for participating in a rehabilitation or return-to-work program. We will only pay for costs if we agree such a program may help them return to work. Please refer to **page 17** or more information about the rehabilitation service we offer.	✓	30
Workplace modification assistance	We may pay some or all of the expenses required to modify an ***insured member's*** place of employment if we agree the modification is needed for them to return to work.	✓	30

For when an insured member is overseas or on employer-approved leave

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Worldwide cover	We provide worldwide cover, although some restrictions apply if the ***insured member*** is not an ***Australian resident*** and is working outside Australia.	✓	25
Cover while working outside Australia	We automatically cover ***Australian residents*** working outside Australia for you or a ***participating employer*** for any length of time. We cover ***insured members*** who are not ***Australian residents*** for up to 3 years while they are working outside Australia.	✓	25
Cover during employer-approved leave	We provide cover for up to 24 months if an ***insured member*** is on ***employer-approved leave***.	✓	25

For the interim and in changed circumstances

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Extended Cover	We provide cover for up to 60 days if an ***insured member*** stops meeting the ***eligibility criteria***. However, this Extended Cover is not available under superannuation policies in certain instances where the ***eligibility criteria*** stop being met.	✓	25
Continuation Option	An ***insured member's*** cover will end if you or a ***participating employer*** stop employing them. If this happens, they may be able to apply for an individual policy that provides ***disability*** benefits without having to undergo medical ***underwriting***.	✓	26
Interim Accident Cover	We provide cover for a ***disability*** that results from an ***accident*** while we consider a person's application to become an ***insured member***. This cover is only for up to 90 days.	✓	24

Incentives and discounts for you

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Early Notification Incentive Benefit	We will pay you 25% of the first month's ***disability*** benefit if: • you notify us of a claim within 30 days of the event that causes the claim, and • we accept a claim for a Total Disability Benefit or Partial Disability Benefit. This benefit is not payable where we pay the Specific Injury Benefit, Trauma Recovery Benefit, Enhanced Trauma Recovery Benefit, Specific Trauma Recovery Benefit or Women's Health Benefit under this ***policy***.	✓	30
Group transfer terms	We may agree to take over the level of insurance benefits provided by your previous insurer and provide equivalent benefits.	✓	23
Premium waiver	You do not have to pay premiums for ***insured members*** who are ***on claim***.	✓	43
Discounts and lower premiums	We will discount your premium if you buy Zurich Corporate Care Group Life insurance at the same time as Zurich Corporate Care Group Income Protection insurance, and both policies have the same ***policy start date*** and ***review date***. We will also be able to provide you with lower premiums if you pay annually in advance and pay by the due date, as we will not apply loadings that would apply for payments by instalment.	✓	43
Guaranteed continuing cover	The ***policy*** will continue as long as premiums are paid and other terms of the ***policy*** are satisfied, regardless of changes to the health of ***insured members***.	✓	20

Optional benefits

You can choose from the following benefits and features at extra cost.

Additional payments

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Superannuation Contribution Benefit	You can insure an extra amount of your ***insured members' salary*** as a Superannuation Contribution Benefit.	✓	32
Alternative Benefit Expiry Age Benefit	We provide ***insured members*** with cover up to age 67 or 70, subject to conditions.	✓	36
Escalation Benefit	We increase an ***insured member's monthly benefit*** each year while a claim is being paid. The increase will be the lower of: • the annual ***CPI*** increase, and • the selected ***escalation factor***.	✓	32

Care and support

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Nurse Care Benefit	We will pay a benefit if an ***insured member*** is: • ***totally disabled*** during the ***waiting period*** • confined to bed, and • receiving full-time nursing care. We will pay 1/30 of the ***monthly benefit*** each day, after the first 3 consecutive days that the ***insured member*** meets all of the above conditions, for up to 30 days or until the end of the ***waiting period***, whichever comes first.	✗	32

<table>
<tr><th>Benefit or feature</th><th>What it means for you</th><th>Available in superannuation?</th><th>Refer to page</th></tr>
<tr><td>Recovery Assistance Benefit</td><td>We will pay a lump sum if an insured member is receiving a Total Disability Benefit and becomes totally and permanently disabled within 12 months of the date of disability.

The amount paid as a lump sum will depend on the person's age:

<table><tr><th>Age on the day the insured member ceased work</th><th>Amount we pay</th></tr><tr><td>Age 55 or younger</td><td>$50,000</td></tr><tr><td>56</td><td>$45,000</td></tr><tr><td>57</td><td>$40,000</td></tr><tr><td>58</td><td>$35,000</td></tr><tr><td>59</td><td>$30,000</td></tr><tr><td>60</td><td>$25,000</td></tr><tr><td>61</td><td>$20,000</td></tr><tr><td>62</td><td>$15,000</td></tr><tr><td>63</td><td>$10,000</td></tr><tr><td>64</td><td>$5,000</td></tr><tr><td>65 and older</td><td>$0</td></tr></table>
You can choose this option or the Enhanced Recovery Assistance Benefit, but not both.</td><td>✗</td><td>32</td></tr>
<tr><td>Enhanced Recovery Assistance Benefit</td><td>We will pay you a lump sum if the insured member is totally and permanently disabled at the end of the 5, 7 or 10 year benefit period (as applicable). The lump sum will be equal to an insured member's salary, up to a maximum of $100,000.

You can choose this option or the Recovery Assistance Benefit but not both.</td><td>✗</td><td>33</td></tr>
<tr><td>Trauma Recovery Benefit</td><td>We will pay an insured member's monthly benefit for up to 6 months if they suffer any of the trauma recovery events (as defined in 10 Definitions of Part 2: Policy terms). We will commence paying this during the waiting period.

This benefit is payable once ever for an insured member while they are insured under the policy.

The maximum period we will pay a Total Disability Benefit or Partial Disability Benefit for an insured member who has been paid the Trauma Recovery Benefit will be reduced by the number of months for which we paid the Trauma Recovery Benefit, if the applicable benefit period is 2, 5, 7 or 10 years.

If you choose this option you cannot choose the Enhanced Trauma Recovery Benefit or the Specific Trauma Recovery Benefit.</td><td>✗</td><td>33</td></tr>
<tr><td>Enhanced Trauma Recovery Benefit</td><td>We will pay an insured member's monthly benefit for up to 6 months if they suffer any of the trauma recovery events (as defined in 10 Definitions of Part 2: Policy terms). We will commence paying this during the waiting period.

This benefit is payable once every 3 consecutive years, but only once ever for any of the trauma recovery events, or a related trauma recovery event.

If you choose this option you cannot choose the Trauma Recovery Benefit or the Specific Trauma Recovery Benefit.</td><td>✗</td><td>35</td></tr>
</table>

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Immediate Family Member Benefit	We will pay up to an extra $3,000 per month if an ***insured member*** is confined to bed and requires care from an ***immediate family member***. We will only pay this benefit: • while we are paying a Total Disability Benefit in respect of an ***insured member***, and • for up to 3 months.	✗	35
Relocation Benefit	We will reimburse the cost of a single standard economy airfare if the ***insured member*** returns to Australia while ***totally disabled*** or ***partially disabled***. The maximum we will reimburse is up to 3 times the ***insured member's monthly benefit***.	✗	36
Specific Trauma Recovery Benefit	We will pay you an ***insured member's monthly benefit***, up to $12,500 per month, for up to 2 months if they suffer any of the specific trauma recovery events (as defined in **10 Definitions** of **Part 2: Policy terms**). We will commence paying this during the ***waiting period***. This benefit is payable once every 3 consecutive years, but only once ever for any of the trauma recovery events, or a related trauma recovery event. If you choose this option you cannot choose the Trauma Recovery Benefit or the Enhanced Trauma Recovery Benefit.	✗	36
Women's Health Benefit	We will pay you an ***insured member's monthly benefit***, up to maximum of $12,500, if they suffer any of the women's health conditions (as defined in **10 Definitions** of **Part 2: Policy terms**). This benefit is payable once every 3 consecutive years, but only once ever for each of the women's health conditions, or a related women's health condition.	✗	37

Special cover

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Internationally mobile employees	We may provide cover to internationally mobile employees who might otherwise not be able to obtain cover. Please ask us if you are interested. If we accept your application, we will issue a separate ***policy schedule*** for those employees to be insured on amended terms.	✗	15
Tailored Package	We can create a tailored package of benefits for you. Ask one of our dedicated Partnership Managers about our options.	✓	N/A

What cover is available

The table below sets out the general limits and options available under Zurich Corporate Care Group Income Protection insurance. We will confirm the limits and options that apply to your ***policy*** in the ***policy schedule***.

Minimum entry age	15 years
Maximum entry age	64 years for 'to age 65' and 'to age 67' cover 69 years for 'to age 70' cover
Benefit expiry age	65, 67 or 70 years, as applicable
Minimum number of persons to be insured to start a policy	20
Minimum annual premium (excluding stamp duty)	$15,000
Maximum monthly benefit level	$30,000
Maximum percentage of salary/*maximum replacement ratio* we insure	75% of the ***insured member's salary***
Maximum Superannuation Contribution Benefit	12% of the ***insured member's salary***
Waiting periods you can choose from	30, 60, 90, 180 and 365 days
Benefit periods you can choose from	***Benefit periods*** based on fixed terms – 2, 5, 7 or 10 years ***Benefit periods*** based on age – To age 65, 67 or 70 Where we have agreed to cover ***casual employees*** or members working less than 14 hours per week under the plan, their ***benefit period*** will be limited to a maximum of 2 years.
Frequency of premium payments	Yearly, half-yearly, quarterly or monthly

Please refer to **3 Benefits and features built into the policy** of **Part 2: Policy terms** for more details on the benefits.

Insurance carries certain risks

We are not bound to accept your ***proposal form***. You should also be aware that:

- the maximum amount of the insurance cover you select may not provide adequate insurance cover for an ***insured member*** if they get ill or are injured.
- if we do not receive your premium by the due date, we will give you at least 30 days' written notice before we cancel or terminate your ***policy*** – we are entitled to interest on any amount due. We may not accept an ***insured member's*** claim that arises after the premium due date until outstanding premiums have been paid.
- if you or an ***insured member*** do not comply with the Duty to Take Reasonable Care Not to Make a Misrepresentation (see below), we may avoid the ***policy***, or the ***insured member's*** cover, and treat it as though it never existed. We may otherwise vary the amount or terms of the cover, resulting in an ***insured member's*** claim being declined, or a benefit being reduced.
- if an ***insured member*** is insured for ***new events cover***, we will not pay any benefit for a ***disability*** occurring as a result (in whole or part), directly or indirectly, of a ***pre-existing condition***.
- if an ***insured member*** is insured for ***limited cover***, we will not pay any benefit for a ***disability*** caused by an illness or injury that caused the transferring member to be not ***at work*** on the last ***normal business day*** before the ***transfer date*** – whether the illness or injury directly or indirectly caused the absence.

You can hold Zurich Corporate Care Group Income Protection insurance in superannuation

You can own Zurich Corporate Care Group Income Protection insurance through superannuation.

Note, however, that superannuation law limits the circumstances when superannuation funds can pay benefits. This means that if the ***policy*** is owned by a superannuation fund trustee, it must meet requirements that allow benefits to be released under superannuation law.

We recommend you get independent expert advice if you are a superannuation fund trustee who wants to hold the ***policy*** for superannuation fund members to confirm ***insured benefits*** under the ***policy*** can be paid from the fund.

You also need to know that when a superannuation fund trustee owns a ***policy***:

- additional eligibility requirements apply
- certain benefits and features may not be available to ***insured members***, and
- cover for an ***insured member*** may also stop in certain additional circumstances.

You can find more details under **Summary of benefits and features we have built in** on **page 8** and in:

- **2.3.4 Extra requirements for superannuation members to get cover under automatic acceptance terms**
- **2.5 How we consider applications for cover**
- **2.12 Extended cover**
- **2.13 Ending cover for insured members**
- **2.14 Members can apply for a Continuation Option**, and
- **9.2 Cooling-off period for members of a superannuation fund**

of **Part 2: Policy terms.**

Internationally mobile employees

You can apply for cover for employees of an Australian company that operates internationally. This provides cover for both ***Australian residents*** and non-***Australian residents*** who live and work outside of Australia for the Australian company.

If we accept your application, we will provide you with a separate ***policy schedule***, setting out specific terms for those to be insured.

This cover is optional and at an additional cost. It is only available to persons receiving the PDS and Policy in Australia. It is not available:

- directly or indirectly, to persons in any other country, or
- if you are the trustee of a superannuation fund.

Ask one of our dedicated Partnership Managers about if you would like to know more about, or apply for this optional cover.

You have a Duty to Take Reasonable Care Not to Make a Misrepresentation

When applying for insurance, there is a legal duty under a consumer insurance contract to take reasonable care not to make a misrepresentation to the insurer.

We give notice to any applicant for Zurich Corporate Care Group Income Protection insurance that a ***policy*** issued under this PDS and Policy will be a consumer insurance contract. To meet this duty you must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

Failing to meet your duty can seriously affect your insurance

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

You are responsible for the information you provide to us. When answering our questions, you should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask us before you respond
- answer every question
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume we will ask others such as your broker
- review your application carefully. If someone else helped prepare your application (for example, your broker), please check every answer (and if necessary, make any corrections).

Tell us if something changes before your cover starts

Before your cover starts, please tell us about any changes that mean you would now answer our questions differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Tell us if you think you have not been accurate

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we will let you know whether it has any impact on the cover.

Take reasonable care on the phone too

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

Ask us for help if you need it

It's important that you understand this information and the questions we ask. Ask us for help if you have difficulty answering our questions or understanding the application process.

If you are having difficulty due to a disability, understanding English or for any other reason, we are here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

We can take action if you do not meet your duty

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether we can exercise one of these remedies depends on a number of factors, including all of the following:

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was
- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- how long it has been since the cover started, in some cases.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

How we calculate premiums

Your premium – what you pay for the ***insured members*** in your plan – includes:

- the cost of the ***policy***
- the cost of any optional benefits selected, and
- any government charges that apply.

Your annual premium will be at least the minimum annual premium (excluding stamp duty) shown in the ***policy schedule***. You need to pay the premium for an ***insured member*** from the start of their cover under the ***policy*** to the end of it.

We consider a range of factors when calculating your premium, such as the:

- number of ***insured members*** covered under the ***policy*** at the ***review date*** – if the number changes between review dates, we will recalculate at the next ***review date***
- type of benefits provided
- sum insured – the larger the sum insured, the larger the premium
- age demographic of ***insured members*** – premiums generally increase with age
- gender demographic of ***insured members***
- occupation of ***insured members*** – premiums are generally higher for occupations with hazardous duties or higher risks
- industry-related loadings or discounts
- grouping of policies
- payment frequency – whether premiums are paid annually or by instalment (premiums are higher if they are not paid in advance each year)
- claims history of your plan, and
- applicable commission you agreed with your intermediary.

Other factors that can affect premiums are changes to:

- our cost of providing cover – for example, the cost of claims we pay
- capital and regulatory requirements
- expected policyholder behaviour – including how long cover is held, and
- economic factors – including interest and inflation rates, levels of employment and market returns.

We generally guarantee premium rates from the ***policy start date*** to the end of the ***premium rate guarantee period***. We can change the premium rate at the end of the ***premium rate guarantee period***, or during the ***premium rate guarantee period*** in limited circumstances.

To find out more

For more details on the cost of cover, please refer to **7 Costs you pay** of **Part 2: Policy terms.**

Your broker or financial adviser may receive commission payments from us

If you purchase the ***policy*** through a broker or financial adviser, they may receive commission payments from us. Your broker or financial adviser can also charge you a fee for service directly. They may choose to use both options.

The premium you pay includes the amount of the commission payments we make to your broker or financial adviser, plus GST where applicable. Your premium may be reduced or increased by the amount or percentage negotiated between you and them in relation to the commission payments.

The percentage of the premium required for these payments is set out in the ***quotation summary***.

We pay your broker or financial adviser from the premium payments until they instruct us to stop.

Please talk to your broker or financial adviser for more information about this.

How we assess underwriting applications

We have standard requirements for assessing applications for Zurich Corporate Care Group Income Protection insurance, which we outline in our Underwriting Guide. You can get a copy by emailing us at group.risk@zurich.com.au.

Part of our process is getting a Group Risk Personal Statement from you. You can download the statement from our website, or here:

Group Risk Personal Statement (PDF)

Once you have completed it, post or email it to:

Group Insurance Underwriting
GPO Box 4129
Sydney NSW 2001

Email: group.risk.uw@zurich.com.au

Sometimes we need to ask ***insured members*** for extra information, such as additional medical, personal, or financial information.

How you can make a claim

We understand that when an ***insured member*** needs to claim, they may be experiencing a very difficult and emotional time, so we make the claim process as straightforward as possible. Please tell us about any event that could result in a claim as soon as you can.

Contact us to claim

The first step in making a claim is to contact us to notify us of the claim. Depending on the type of claim you are making, we will try to obtain all of the medical and other information we require to assess the claim from you or the ***insured member*** directly. We will send you or the ***insured member*** a claim form to complete. We may also collect information over the phone, or through our electronic lodgement service, where available.

Provide supporting documents

Before we can pay a claim, we must have evidence that the relevant policy terms and conditions have been fully met. The ***insured member*** and you are responsible for providing all supporting documents for the claim. If the ***insured member*** or you withhold information that we reasonably require to make this assessment, that may delay the claim, and could affect our decision on the claim.

The ***insured member*** may already have most of the supporting medical and financial information, but may need to pay for additional supporting documents, including medical reports.

Supporting documents should be legible, unaltered and include evidence to support the claim. If we cannot use them for any reason, we will tell you why and discuss what other documents you can provide. Any missing documents may delay the claim process.

To find out more

For more information about making a claim, refer to **6 Claims** of **Part 2: Policy terms** or contact us.

Website: zurich.com.au/group-insurance

The rehabilitation services we offer

Our rehabilitation takes a holistic and collaborative approach to return to work. Our multi-disciplinary rehabilitation team has qualifications in rehabilitation counselling, occupational therapy, psychology and exercise physiology. They have extensive experience in rehabilitation and have managed psychological and physical conditions across corporate organisations and diverse industries including construction, education, finance and defence.

We provide a range of services to suit the ***insured members'*** individual return-to-work goals.

Initial needs assessment

This assessment explores medical and work (vocational) factors to identify and access the right rehabilitation services for the ***insured member***.

Work readiness

If the ***insured member*** is not quite ready to return to work, we help them prepare by developing a daily structure that involves exercise, goal setting, and re-engagement in the community.

Return-to-work plan

We work with the ***insured member*** and their employer (if applicable) to build up their work capacity and endurance. This may involve returning to work initially on reduced hours or duties, and gradually increasing hours and duties as the ***insured member's*** condition improves. Workstation modifications and aids may also make returning to work easier.

Career counselling and business coaching

If the ***insured member*** cannot return to the same role, we assess their education, employment history and transferrable skills to identify suitable alternative employment or retraining options.

If the ***insured member*** would like to set up their own business, we can talk to them about whether business coaching would be worthwhile.

Preparing for job seeking

We help the ***insured member*** build confidence to look for jobs by helping them prepare their resume, find job leads and develop skills for successful interviews.

To find out more

If you have questions please contact us.

Email our Rehabilitation Team at claims.rehabilitation@zurich.com.au

How we manage privacy

We are bound by the *Privacy Act 1988* (Cth). Read the information below before you give us any personal or sensitive information, so you understand what we will do with your information. If others provide information, they need to know our approach too – for example, ***insured members*** and applicants for cover under this PDS and Policy.

We collect and use personal information to manage your insurance

We collect, use, process and store personal information (sometimes sensitive information) about you for several purposes, including to:

- comply with our legal obligations
- assess your application for insurance
- manage the insurance
- improve customer service or products
- manage claims, and
- deal with potential misrepresentation.

If you do not give us the information, we may not be able to process your application, manage your cover or assess your claims.

We may also collect personal information about you from government offices and third parties to assess an application or a claim.

By giving us or your broker or financial adviser your information, you consent to our use of your information, including us sharing your information with other parties for the purposes above, where relevant. Those other parties can include:

- the ***policy owner***
- your broker or financial adviser
- affiliates of the Zurich Insurance Group Ltd
- other insurers and reinsurers
- our service providers
- our banking gateway providers and credit card transaction processors
- our business partners.

We may use your personal information (but not sensitive information) to tell you about our other products and services. If you do not want your personal information to be used in this way, please contact us.

We may also use or disclose your information as authorised or required by Australian or overseas law

These following Australian laws may apply:

- *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*
- *Australian Securities and Investments Commission Act 2001*
- *Corporations Act 2001*
- *Income Tax Assessment Act 1997*
- *Insurance Contracts Act 1984*
- *Life Insurance Act 1995*
- *Taxation Administration Act 1953*.

We must comply with updates to these laws and any associated regulations, and any future legislation passed to replace or enhance any matter addressed by these laws and associated regulations. Other acts may also require or authorise us to collect your personal information.

If you want to know more

We can provide:

- a list of service providers and business partners that we typically may share your information with
- a list of countries where recipients of your information are likely to be located
- details of how to access or correct the information we hold about you
- information about how to make a complaint.

For further information about our approach to privacy, visit our website or email us at privacy.officer@zurich.com.au.

Our data commitment

We understand that data security is an important concern. You can rest assured that we are committed to:

- keeping your data safe
- putting data to work so we can better protect you
- never selling personal data
- not sharing personal data without being transparent about it.

We welcome enquiries and complaints

Our customer service team is your first point of contact for any enquiries, concerns and feedback. This is how you can get in touch:

Customer Service
GPO Box 4148
Sydney NSW 2001

Email: client.service@zurich.com.au

Phone: 132 062

We will give you extra support if you need it

We understand some people need extra help, for example when they want us to explain their policy or want to make a complaint. They might be experiencing financial hardship, managing a disability or mental health condition, experiencing family violence or come from a non-English speaking background or indigenous community. Tell us if you or the ***insured member*** needs extra support so we can ensure you get the service you need. We will work with you or your representative to identify how best to provide support. Feel free to ask someone to speak on your behalf, such as a relative, friend or legal representative. We can speak with them where we have your consent.

If you have a hearing or speech difficulty, contact us through the National Relay Service on 1300 555 727.

If you need translation help, contact the Translating and Interpreting Service on 131 450 and ask them to contact us on your behalf.

If you require further support, various organisations are available to help, such as Beyond Blue if you need mental health support.

Visit Beyond Blue's website.

You can make a complaint in several ways

Tell us if you are not satisfied with our products, information, service or response so we can put things right.

You and your representatives are welcome to use our internal dispute resolution procedures. This service is free.

We have dedicated people who will listen carefully and try to resolve your complaint as quickly as possible. Please tell us the following so we can help you better:

- Your name
- Your ***policy*** number (if applicable)
- Your contact details
- What we have not done so well, and
- How you would like us to resolve the problem.

We will respond to your complaint

We will confirm that we have received your complaint within one business day (or as soon as practicable). We will assign a contact person to your case, who will update you regularly on progress and work with you to resolve your complaint.

If we need more than 5 days to resolve your concerns, we will refer you to our Dispute Resolution Team for further investigation. When we have completed our investigation, we will discuss the outcome with you. We will write to you where required, to tell you how we will resolve your complaint. This will usually be within 30 calendar days. If we need longer, we will write to tell you.

You can have our complaint decision reviewed

If you are not satisfied with our response, you can have your complaint reviewed by an external dispute resolution scheme such as the Australian Financial Complaints Authority (AFCA) or the Office of the Australian Information Commissioner (OAIC).

Both organisations have time limits for lodging disputes – please contact them to find out the limits.

AFCA

AFCA is an external dispute resolution scheme that provides a free, fair and independent complaint resolution procedure. You can contact them for most matters.

Visit AFCA's website

Phone: 1800 931 678 (free call)
Email: info@afca.org.au

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

AFCA decisions you accept are binding for us. However, if you are not satisfied with AFCA's decision, you may seek another course of action.

OAIC

You can contact the OAIC about privacy matters.

Visit OAIC's website

Phone: 1300 363 992

Office of the Australian Information Commissioner
GPO Box 5218
Sydney NSW 2001

Part 2: Policy terms

Part 2: Policy terms sets out:

- the terms and conditions of the insurance, including who is eligible for cover, how they can be covered and when the cover ends
- the benefits we may pay in the event of a claim and the features of the product, and
- the rights and obligations that you and we must observe.

1. Terms of the policy

The ***policy*** is made up of:

- the ***policy schedule*** we issue to you – which contains information on limits, conditions and options selected
- the whole of **Part 2: Policy terms** (as updated or supplemented from time to time)
- the sections of this PDS and Policy titled **Zurich Australia Limited issues Zurich Corporate Care Group Income Protection insurance** and **How to read this PDS and Policy**
- any notices we issue or receive under the ***policy***
- any ***decision notes***, and
- any written changes to the ***policy***.

1.1 When the policy starts and ends

The ***policy*** starts on the ***policy start date*** and continues until the earlier of the:

- policy expiry date in the ***policy schedule***, and
- date the ***policy*** is terminated under **9.3 Terminating the policy**.

1.2 How we send notices to you, and you to us

Notices under the ***policy*** must be in writing and can be delivered by post or email.

When we write to you, we will use the postal or email address you last advised us.

When you write to us, you can post your letter to our ***principal office*** in Sydney or email us.

Post: 118 Mount Street
North Sydney NSW 2060

Email: group.risk@zurich.com.au

1.3 We guarantee continuing cover

The ***policy*** will continue as described in **1.1 When the policy starts and ends,** regardless of changes in the health of your ***insured members***.

1.4 How to vary the policy

You may apply to us in writing to change the terms of the ***policy***. We must approve your application in writing for it to be effective. We will confirm any variation by issuing a new ***policy schedule***.

We will also issue a new ***policy schedule*** when the ***premium rate guarantee period*** expires.

Any insurance already in place will be unaffected by your application until the variation starts.

1.5 What we may do if your risk profile changes

We may write to you during the ***premium rate guarantee period*** if your risk profile changes, to advise that we will do one or more of the following:

- stop accepting new ***insured members***
- increase the premium rate (including during the ***premium rate guarantee period***)
- vary the ***automatic acceptance terms***
- vary or remove the ***AAL***
- require you to pay the minimum annual premium as outlined in **7.2 What minimum annual premium applies.**

We may take those steps if, compared to the start of the latest ***premium rate guarantee period***:

- the number of ***insured members*** changes by more than 25%
- the number of ***insured members*** changes (such as due to mergers or takeovers), and that change leads to an increase in premiums by 5% or more, simultaneously
- the number of ***insured members*** covered under the ***policy*** falls below 75% of persons eligible for cover based on the ***eligibility criteria***, or
- any other aspect of the risk profile of ***insured members*** changes in a way that increases the risk under the ***policy***, for example:
  - changes in age, sex, occupations or locations ***insured members*** work or live
  - changes to the ***policy owner's*** or the ***participating employer's*** business activity
  - changes in any government legislation.

1.6 What currency we use

All payments to, or from, us are to be made in Australian currency.

If the ***insured member*** is working outside Australia, you must tell us their ***salary*** in Australian currency. We will take no responsibility for foreign exchange risk.

2. Eligibility and period of cover

We only provide cover to ***eligible persons*** under the ***policy*** who meet the rules to become an ***insured member***. Their cover will depend on the terms of the ***policy***.

2.1 Eligible persons must meet certain criteria to be insured

Only an ***eligible person*** can become an ***insured member*** under the ***policy***. An ***eligible person*** is someone who:

- satisfies the eligibility rules in the ***policy schedule***
- is an ***Australian resident*** or holds a ***visa***
- lives in Australia (unless the person is outside Australia as set out in **2.9 Worldwide cover, round the clock** and **2.10 Cover for insured members working outside Australia**)
- is employed with you or a ***participating employer***, and working at least the ***required hours*** in the ***policy schedule***, and
- is aged at least the minimum benefit entry age and not more than the ***maximum benefit entry age*** on the day they are first eligible for cover or if they are required to apply for cover, the day they apply for cover.

We cover an ***eligible person*** for the benefits described in **3 Benefits and features built into the policy** and **4 Optional benefits** (where applicable), provided:

- we accept them as an ***insured member*** under **2.2 How we accept insured members**, and
- they continue to meet the ***eligibility criteria***.

2.2 How we accept insured members

An ***eligible person can*** become an ***insured member*** in one of these ways:

- through ***automatic acceptance terms*** in **2.3 Where we provide cover under automatic acceptance terms**
- through transfer terms in **2.4 Cover under group transfer terms**, or
- by applying to us online or in writing as set out in **2.5 How we consider applications for cover**.

We will provide cover to an ***eligible person*** if the following conditions are met:

- premiums are received by us within 30 days after the ***policy start date*** or the ***review date*** after the person first satisfies the ***eligibility criteria***, and
- all ***member information*** is received by us within 90 days after the ***policy start date***, or any other time we agree to in writing.

We may give you a specific form for the ***member information*** or allow you to provide the information electronically. ***Member information*** must be provided for all ***eligible persons***. If you have difficulty providing this information, please contact us and we will work with you to make alternative arrangements where available.

2.3 Where we provide cover under automatic acceptance terms

We may agree to automatically cover ***eligible persons***, as described in this section.

2.3.1 Conditions for providing an automatic acceptance level

We may agree to an ***automatic acceptance level*** (***AAL***) when you set up the ***policy***. An ***AAL*** is the maximum amount of cover we provide without ***eligible persons*** needing to give us any evidence of good health. We will only agree to an ***AAL*** if all of the following conditions are met:

- the eligibility rules agreed by you and us are clearly defined as set out in the ***policy schedule***
- you have at least 20 ***insured members*** at the ***policy start date*** and at each annual ***review date*** (unless we agree otherwise in writing)
- we are your sole insurer for this type of insurance, and
- at least 75% of all ***eligible persons*** (or as we otherwise agree in writing) become ***insured members*** at the ***policy start date***.

2.3.2 Conditions for providing an eligible person with cover under automatic acceptance terms

We will automatically accept an ***eligible person*** for cover under the ***policy*** up to the ***AAL***, provided all these conditions are met:

- the ***AAL*** shown in the ***policy schedule*** is not 'nil'
- the ***eligible person*** must not be entitled to payment of any insurance benefit from any source for an illness or injury or be in a waiting period for such a benefit
- the ***eligible person*** must not have previously been accepted for cover under your plan by ***automatic acceptance terms*** unless they were previously accepted under ***automatic acceptance terms*** and:
  - the cover provided at that time under the ***policy*** ceased only because they stopped being employed by you or a ***participating employer*** and the ***eligible person*** has recommenced employment with you or a ***participating employer*** who they had previously been employed by, or
  - the cover provided at that time under the ***policy*** ceased only because they stopped meeting one or more of the eligibility rules for cover, or a particular category of cover (for reasons other than illness or injury), but the ***insured member*** has:
    - remained employed by you or a ***participating employer***
    - not opted out of cover under the ***policy***, and
    - recommenced meeting the eligibility rules for cover or a particular category of cover.

  In either of these cases, the requirement to give us evidence of good health will not apply to the ***eligible person***.
- the requirements in **2.3.4 Extra requirements for superannuation members to get cover under automatic acceptance terms**, if the ***policy owner*** is the trustee of a superannuation fund, and
- the ***eligible person*** satisfies any other terms as agreed to by you.

2.3.3 Standard or new events cover may apply

If an ***eligible person*** receives cover under **2.3.2 Conditions for providing an eligible person with cover under automatic acceptance terms,** they will have ***standard cover*** if they were ***at work*** with you or a ***participating employer*** on:

- the ***policy start date*** (or, if not a ***normal business day***, then the last ***normal business day*** before the ***policy start date***), or
- the day they first satisfy the ***eligibility criteria*** (if they are an ***eligible person*** who first meets the ***eligibility criteria*** after the ***policy start date***), or the date they recommence meeting the ***eligibility criteria*** as set out in **2.3.2 Conditions for providing an eligible person with cover under automatic acceptance terms**.

Otherwise, the ***insured member*** will have ***new events cover***. When the ***insured member*** returns to the pre-disability duties (working the same hours and in the same capacity without limitation) they performed when they were last ***at work***, their ***new events cover*** will be replaced with ***standard cover*** from that date.

2.3.4 Extra requirements for superannuation members to get cover under automatic acceptance terms

If the ***policy owner*** is the trustee of a superannuation fund, an ***eligible person*** must also meet one of following criteria, in addition to the eligibility requirements under **2.3.2 Conditions for providing an eligible person with cover under automatic acceptance terms** to be automatically accepted up to the ***AAL***:

- meet the ***PMIF threshold***
- give you a ***PMIF member election*** within 120 days of the date of their welcome letter from the ***policy owner*** as trustee of the superannuation fund, or
- be a ***PMIF-exempt member***.

The ***insured member's*** cover will depend on how they become eligible for cover under ***automatic acceptance terms***.

How they became eligible	What cover they get
They meet the ***PMIF threshold*** after becoming a ***member***	They will become an ***insured member*** for ***standard cover*** if they were ***at work*** for 60 consecutive days immediately before meeting the ***PMIF threshold***. They will become an ***insured member*** for ***new events cover*** only if they have not been ***at work*** for 60 consecutive days immediately before meeting the ***PMIF threshold***. If they are subsequently ***at work*** for 30 consecutive days, on or after 12 months from the date their cover started under the ***policy***, we will replace ***new events cover*** with ***standard cover*** from the 31st consecutive day.
They give you a ***PMIF member election***	They will become an ***insured member*** for ***new events cover*** only. If they are subsequently ***at work*** for 30 consecutive days, on or after the day their cover started under the ***policy*** we will replace ***new events cover*** with ***standard cover*** from the 31st consecutive day.
They are a ***PMIF-exempt member***	They will become an ***insured member*** for ***standard cover*** if they were ***at work*** on the date they become a ***PMIF-exempt member***. They will become an ***insured member*** for ***new events cover*** only if they are not ***at work*** on the date they become a ***PMIF-exempt member***. When the ***insured member*** returns to the pre-disability duties (working the same hours and in the same capacity without limitation) they performed when they were last ***at work***, their ***new events cover*** will be replaced with ***standard cover*** from that date.

2.3.5 When cover starts under automatic acceptance terms

When cover under ***automatic acceptance terms*** starts for an ***insured member*** also depends on how they became eligible for cover.

How they became eligible	When their cover starts
They meet the ***PMIF threshold*** after becoming a ***member***	Cover starts the date you receive the first mandated employer superannuation contribution for the ***insured member*** after they first meet the ***PMIF threshold***.
They give you a ***PMIF member election***	Cover starts the date you receive the ***eligible person's PMIF member election***.
They are a ***PMIF-exempt member***	Cover starts the later of: • the ***policy start date***, and • when they first become a ***PMIF-exempt member***.
They meet the criteria another way	Cover starts the later of: • the ***policy start date***, and • the date the ***eligible person*** first meets the ***eligibility criteria***, or the date they recommence meeting the ***eligibility criteria*** as set out in **2.3.2 Conditions for providing an eligible person with cover under automatic acceptance terms.**

2.3.6 The amount we cover

An ***insured member*** is covered for the lower of:

- the ***AAL***, and
- the ***monthly benefit***.

If an ***insured member*** would like cover above the ***AAL***, they will need to apply as set out in **2.5 How we consider applications for cover.** We may agree to a ***forward underwriting limit.*** If we accept the application, cover will start on the date we accept the application in writing. We will specify any terms of acceptance in the ***decision note***.

2.3.7 Variation in automatic acceptance terms and AAL

We may agree with you to make changes to the ***automatic acceptance terms***, including the ***AAL***. We will outline any agreed variation to the ***automatic acceptance terms*** in a revised ***policy schedule***.

We may remove the ***AAL*** after consulting with you if the number of ***insured members*** covered under the ***policy*** falls below 75% of persons eligible for cover based on the ***eligibility criteria*** (or the figure we agree to in writing). Removing the ***AAL*** will not affect the cover for those who are ***insured members*** on the date the ***AAL*** is removed.

When an ***AAL*** increases, the higher ***AAL*** may apply to all existing ***insured members*** who are eligible for cover under ***automatic acceptance terms***. Whether they have been declined cover, excluded or loaded for cover above the previous lower ***AAL*** does not matter. Any previous loading, limitation or exclusion will only apply above the new higher ***AAL***. We will advise you in writing if we agree to increase the ***AAL***, and tell you when the change becomes effective.

2.4 Cover under group transfer terms

You can transfer your cover with another insurer to us if:

- we are satisfied with the previous insurer's underwriting standards, and
- we write to you to notify our agreement to offer transfer terms.

Transfer terms will only apply to persons who were insured under your previous policy on the day before the ***transfer date***.

We will cover all transferring members for an ***insured benefit*** on underwriting terms no less favourable than those provided by the previous insurer. This means that we will apply the same underwriting terms or rules that applied to individual ***insured members*** under the previous policy, including:

- forward underwriting limits
- premium loadings
- restrictions
- exclusions, and
- any limitations.

We will tell you about any exceptions.

Transfer terms are subject to all of the following conditions:

- you meet any specific terms in our agreement to offer transfer terms
- you give us all the information we reasonably require about the operation and terms of the previous policy in writing, within 90 days of the ***transfer date*** – including individual names, date of birth, and level and type of insured benefits. If you provide this information late, it may cause delays in the assessment and payment of a claim
- you pay premiums by the due date for all transferring members we agree to cover
- we provide cover in accordance with our ***quotation summary*** including our ***maximum monthly benefit level***.

2.4.1 Cover under transfer terms

We will provide ***standard cover*** for the same amount of ***insured benefit*** provided under the previous policy from the ***transfer date*** for ***eligible persons*** who were:

- insured under the previous policy on the day before the ***transfer date***, and
- ***at work*** *on the last* ***normal business day*** *immediately before the* ***transfer date***.

2.4.2 If a transferring member is not at work due to illness or injury

If transferring members insured under the previous policy are not ***at work*** on the last ***normal business day*** immediately before the ***transfer date*** due to illness or injury, we will give them ***limited cover*** only, for the same amount of ***insured benefit*** provided under the previous policy from the ***transfer date***.

Limited cover will end, and we will provide the ***insured member*** with ***standard cover*** for the same amount of ***insured benefit*** provided under the previous policy, when they return to their pre-disability duties (working the same hours and in the same capacity without limitation) they last performed when they were ***at work***, provided they are not entitled to a benefit under the previous policy.

2.4.3 If a transferring member is not at work for other reasons

If transferring members insured under the previous policy are not ***at work*** on the last ***normal business day*** immediately before the ***transfer date*** for reasons other than illness or injury, we will give them ***standard cover*** for the same amount of ***insured benefit*** provided under the previous policy, provided that the ***insured member*** was capable of performing the usual duties and hours of their usual occupation on that date.

2.4.4 We may provide special transfer terms

We may negotiate with you special transfer terms for transferring members. These terms will only apply if we notify you in writing.

2.4.5 If we apply a higher AAL to the transferring plan

When a plan is transferred to us and we apply a higher ***AAL***, the higher ***AAL*** may apply to all transferred ***insured members*** who held cover under the previous insurer's automatic acceptance limit including either:

- those who were declined cover above the previous insurer's automatic acceptance limit, or
- those who had loadings or exclusions applied to their cover above the previous insurer's automatic acceptance limit.

We will advise you in writing if we agree to do this.

Any loading or exclusions that previously applied to the cover above the previous insurer's automatic acceptance level will only apply above the higher ***AAL***.

2.4.6 Industry guidance

We will comply with the ***FSC Guidance Note*** as amended, substituted or replaced from time to time, to the extent of any inconsistency with the ***policy*** except where special terms are negotiated under **2.4.4 We may provide special transfer terms**. Refer to our website for further details.

2.5 How we consider applications for cover

We require a written application for all or part of the cover for an ***eligible person*** or ***insured member*** in each of these cases:

- ***automatic acceptance terms*** do not apply or we do not automatically accept an ***eligible person***, or transfer terms do not apply
- an ***eligible person*** requires cover above the ***AAL*** or their ***forward underwriting limit*** (if applicable)
- an ***insured member's*** cover stops under the ***policy*** for any reason other than those described in **2.3.2 Conditions for providing an eligible person with cover under automatic acceptance terms**
- an ***insured member*** wants to replace ***new events cover*** with ***standard cover***
- where an ***eligible person*** joins the plan after their 65th birthday, unless we agree to offer an ***AAL*** to members aged 65 or older as set out in **5.6.6 Cover after age 65 may be limited or reduced**.

An application can only be made for cover up to the ***maximum monthly benefit level***.

We may request medical and other information from the ***eligible person*** or ***insured member*** when we are considering an application. We can accept or decline an application, or accept an application subject to exclusions, a premium loading or other conditions we consider appropriate.

Until we accept or reject the application, Interim Accident Cover may apply as set out in **2.7 When and how Interim Accident Cover applies**.

If we accept an application, we will issue a ***decision note***. The terms in the ***decision note*** override any inconsistent terms in the ***policy*** (including the ***policy schedule***).

You will need to pay premiums from the effective date of any cover we approve.

2.6 We may agree to a forward underwriting limit

If an ***insured member*** has been forward ***underwritten*** to a ***forward underwriting limit***, we may agree to accept increases in the ***insured member's insured benefit*** up to the ***forward underwriting limit***. We will not require further medical evidence. However, the increase must be calculated by applying the formula used to calculate ***insured benefits***.

We will only agree to a ***forward underwriting limit*** for an ***insured member*** when we have:

- ***underwritten*** and approved the ***insured member's*** application for cover or increased cover, and
- notified you in writing of the ***forward underwriting limit***, which may be up to a ***maximum monthly benefit level*** (as outlined in the ***quotation summary*** or ***policy schedule***).

2.7 When and how Interim Accident Cover applies

We provide Interim Accident Cover for all cover that we require an application for under **2.5 How we consider applications for cover.**

Interim Accident Cover provides an Interim Accident Cover Benefit, which covers an ***insured member*** for a Total Disability Benefit or Partial Disability Benefit only. It does not cover the ***insured member*** or ***eligible person*** for a Specific Injury Benefit, any other built-in benefits or features, or any optional benefits.

2.7.1 When interim cover starts and ends

Interim Accident Cover starts when we receive an application for cover or increase in the ***insured benefit***. It ends on the earliest of:

- the date we write to notify you or the ***insured member*** of the result of your application
- 90 days after Interim Accident Cover starts
- the date that cover otherwise stops under **2.13 Ending cover for insured members**, and
- the date the application is cancelled or withdrawn.

2.7.2 When we pay a benefit

We will pay the Interim Accident Cover Benefit if an ***insured member*** or ***eligible person*** suffers ***disability*** as the result of an ***accident*** while Interim Accident Cover applies.

We pay the Interim Accident Cover Benefit each month after the ***waiting period*** while the ***insured member*** or ***eligible person*** remains ***disabled***. Payment stops when the ***insured member*** is no longer ***disabled*** or when the ***benefit period*** expires, whichever comes first.

2.7.3 How much we pay

The Interim Accident Cover Benefit is the lowest of:

- the ***monthly benefit*** amount applied for
- the difference between the level of increased cover applied for and the current level of cover, and
- the ***maximum monthly benefit level***.

2.8 Rules may vary between member categories

The eligibility rules may refer to different categories of ***insured members***. The cover and benefits that an ***insured member*** gets under the ***policy*** can depend on the category we accept them in. If a plan has different categories, this will be shown in the ***policy schedule*** with the terms that apply to each category.

2.9 Worldwide cover, round the clock

We will provide worldwide, 24-hour cover for an ***insured member*** regardless of whether they are away on business or holiday, subject to **2.10 Cover for insured members working outside Australia** and **2.11 Cover during employer-approved leave**.

2.10 Cover for insured members working outside Australia

An ***insured member*** who is an ***Australian resident*** and is working outside Australia for you or a ***participating employer*** will be covered while they are working outside Australia. You do not need to tell us about their travel beforehand.

If an ***insured member*** is not an ***Australian resident*** but is working outside Australia for you or a ***participating employer***, we will cover them for up to 3 years while they are working outside Australia if they:

- hold a ***visa***, and
- remain eligible to work in Australia.

If more than 3 years of cover is needed for an ***insured member*** who is not an ***Australian resident*** working outside of Australia, apply to us in writing before the end of that time. We may accept or decline that application.

Cover is subject to these conditions:

- the premium for the ***insured member*** must continue to be paid
- we reserve the right to impose conditions on the cover, and review cover in accordance with the ***policy***, at the end of the ***premium rate guarantee period*** (or if there is no ***premium rate guarantee period***, at the ***review date***) – if we apply such conditions, we will give you notice in writing, and
- you must give us any details about the location of ***insured members*** outside Australia within a reasonable time when we ask and at least annually with the ***member information*** at the ***review date***.

So that we can review cover in accordance with the terms of the ***policy***, you must keep records of the following:

- duration that ***insured members*** are working outside Australia
- number of ***insured members*** working outside Australia, and
- location of those ***insured members***.

2.11 Cover during employer-approved leave

An ***insured member*** is covered under the ***policy*** for up to 24 months while on ***employer-approved leave*** (including ***parental leave***). However, they must meet all the following conditions:

- their premium must continue to be paid
- their employer must approve the leave before it starts (except for approved sick leave or leave taken for reasons related to illness or injury)
- you must give us the names and number of ***insured members*** on ***employer-approved leave*** within a reasonable time when we ask, and at least annually with the ***member information***, and
- their employer must hold appropriate leave records for them including the start and end dates of the ***employer-approved leave*** in order for us to review cover under the ***policy***.

You do not need to tell us about the leave beforehand.

If more than 24 months of cover is needed for ***employer-approved leave***, you may apply to us in writing before the end of that time to extend cover. We may accept or decline that application.

If an ***insured member*** becomes ***disabled*** while they are covered under the ***policy*** whilst on ***employer-approved leave***, the ***waiting period*** starts on the ***date of disability***.

Any change in employment status during periods of ***employer-approved leave*** will not affect any entitlements to cover, provided that the ***insured member*** continues to meet the ***eligibility criteria*** and cover has not otherwise ended in accordance with **2.13 Ending cover for insured members**.

2.12 Extended cover

We will provide cover to an ***insured member*** for up to 60 days after the date they stop meeting the ***eligibility criteria***, if the following conditions are met:

- they had never received a benefit under the ***policy*** as at the date they stopped meeting the ***eligibility criteria***, and
- they were not entitled to receive a benefit under the ***policy***, nor were they in a ***waiting period*** to receive one, as at the date they stopped meeting the ***eligibility criteria***.

Cover under this clause (Extended Cover) will stop on the earlier of:

- the date they reach the ***benefit expiry age***
- 60 days after the date they stop meeting the ***eligibility criteria***
- the date their cover starts under a retail policy of insurance we issue under **2.14 Members can apply for a Continuation Option**, or another policy of insurance providing similar cover taken out by the ***insured member*** or on their behalf after they stopped meeting the ***eligibility criteria*** under the ***policy***, and
- the date they are ***gainfully working***.

In addition, if the ***policy owner*** is the trustee of a superannuation fund, we will not provide cover under this clause for an ***insured member*** who stops meeting the ***eligibility criteria***:

- at 11.59pm on the last day of the ***inactivity period***, unless the ***insured member*** is a ***PYS-exempt member*** at that time, or
- because they stop being a ***PMIF-exempt member***, and had not made a ***PMIF member election*** or otherwise met the ***PMIF threshold*** at that time.

2.13 Ending cover for insured members

This section outlines when cover for an ***insured member*** ends, and what happens at that time.

2.13.1 Cover ends when certain events occur or when the policy is terminated

An ***insured member's*** cover will end on the earliest of these dates:

- we receive their written notification to cancel their cover, or the date specified in their request to cancel the cover, whichever is later
- they are not an ***Australian resident*** and become ineligible to work in Australia (whether that is because they no longer hold a ***visa*** or for any other reason)
- they reach the ***benefit expiry age***
- we cancel or avoid the ***policy***, or the cover for the ***insured member***, in accordance with our legal rights
- we cancel or avoid the ***policy***, or the cover for the ***insured member***, because you have not paid the premium when due under **7.5 When premiums are due**. We will give you at least 30 days' written notice before cancelling your ***policy*** due to non-payment of premiums
- they start ***active service*** with the armed forces of any country, unless they are a member of the Australian Defence Force Reserves – in that case, cover for all benefits only ends when the reservist receives a call-out order under the *Defence Act 1903* (Cth)
- they die
- they permanently retire
- they stop meeting the ***eligibility criteria***, or the date their Extended Cover under **2.12 Extended cover** ends (if applicable)
- they are on leave for longer than we have agreed to provide cover for under **2.11 Cover during employer-approved leave**
- they are working outside Australia for longer than we have agreed to provide cover for under **2.10 Cover for insured members working outside Australia**
- the ***policy*** ends or is terminated, except to the extent discussed in **2.13.2 Our ongoing obligation to pay a disability benefit where the policy transfers to another insurer,** and
- if the ***policy owner*** is the trustee of a superannuation fund:
  - at 11.59pm on the last day of the ***inactivity period*** (unless the ***insured member*** is a ***PYS-exempt member*** at that time), and
  - immediately, if the ***insured member*** stops being a ***PMIF-exempt member*** and has not made a ***PMIF member election*** or otherwise met the ***PMIF threshold*** at that time.

2.13.2 Our ongoing obligation to pay a disability benefit where the policy transfers to another insurer

If the ***policy*** terminates and ***takeover terms*** apply, our ongoing liability to pay a ***disability*** benefit to a person who was an ***insured member*** on the date of termination will be determined in accordance with the ***FSC Guidance Note*** as amended, substituted or replaced from time to time (see **2.4.6 Industry guidance** or refer to our website for further details).

2.14 Members can apply for a Continuation Option

If an ***insured member's*** cover ends because they stop being an ***eligible person*** due to no longer being employed by you or a ***participating employer***, they can apply for an individual policy on their life.

The individual policy will have a benefit period and waiting period similar to what they had under the ***policy***. The individual policy will have the same amount of cover, subject to **2.14.1 The amount of cover.**

2.14.1 The amount of cover

The amount of cover under the individual policy will be limited to the applicable percentage of the ***insured member's*** new monthly salary from their gainful occupation. The monthly benefit at claim time is generally based on the lower of:

- the average monthly earnings for the 12 months immediately before the claim, and
- the nominated insured amount.

2.14.2 Eligibility to apply

The person must complete a written application for the individual policy and meet these conditions:

- be less than 61 years of age on the day they apply for the Continuation Option
- apply within 90 days of the date they first stop meeting the ***eligibility criteria*** because they are no longer employed by you or a ***participating employer***
- be an ***Australian resident*** or otherwise eligible under the residency requirements for the individual policy applicable at the time of application
- be a ***permanent employee*** or ***contractor*** working at least 14 hours per week. ***Casual employees*** and ***insured members*** working less than 14 hours per week are not eligible to apply for a Continuation Option
- be living in Australia (unless we agree otherwise)
- provide any non-medical information we consider relevant
- acknowledge that any restrictions, limitations or loadings that apply to their cover under the ***policy*** will apply to the new individual policy, and
- have not been eligible in the last 2 years to receive ***disability*** benefits under the ***policy*** or any other policy issued by an insurer.

In addition, you, another person or another entity must not be receiving (or be eligible to receive) a benefit payment for the ***insured member*** under the ***policy***.

A Continuation Option will not be available to any ***insured member*** if the ***policy*** terminates or cover is transferred to another insurer. If the ***policy*** is issued to a superannuation fund, this also applies when the ***policy*** is terminated and replaced as a result of a successor fund transfer.

If we accept the application, we will not cover the person under the ***policy*** for the period between when their cover ended under the ***policy*** and their cover starting under the individual policy, unless they are covered under Extended Cover as set out in **2.12 Extended cover.**

2.14.3 Medical evidence is not required but we consider some factors

We will not require the person to provide medical evidence. However, our assessment of their application will consider other factors, including:

- overseas travel and residence
- existing insurance
- occupation and duties
- income and working hours
- pastimes and interests, and
- smoking.

2.14.4 Conditions for the individual policy

If we accept the application, cover under the individual policy will commence in accordance with the terms of that policy. The individual policy issued will be the one that is available at the time the individual policy commences and will provide cover that is similar to this ***policy***.

Any restrictions, limitations and premium loadings that applied under the ***policy*** will apply to the individual policy.

The premium rate will be based on the applicable rates for the individual policy when we accept the person's application, and may be more than under the ***policy***.

3. Benefits and features built into the policy

In this section we describe the benefits for ***insured members***.

Benefits paid under the ***policy*** are monthly benefits, and are paid:

- monthly in arrears from the end of the ***waiting period***, or
- in 2 equal payments per month, paid on the 15th day and the 30th day after the end of the ***waiting period*** (if agreed by us and shown in the ***policy schedule***).

To be eligible for benefits under the ***policy***, an ***insured member*** must, as at the ***date of disability***, have been ***gainfully working*** for an average of at least the ***required hours*** specified in the ***policy schedule*** for:

- the 6 months immediately before the ***date of disability***, or
- the period since they started work with you or the ***participating employer***, if less than 6 months.

3.1 A waiting period applies to disability benefits

We will pay a ***disability*** benefit only after the end of the ***waiting period***. The ***waiting period*** starts on the ***date of disability***.

The ***insured member*** may return to work once during the ***waiting period***, for up to 5 consecutive days, to perform the usual hours and duties of their occupation, without having to restart the ***waiting period***. If that happens, we will extend the ***waiting period*** by the number of days worked. If they return to work more than once during the ***waiting period***, the ***waiting period*** starts again.

A new ***waiting period*** applies for each separate illness or injury that causes a ***disability*** that the ***insured member*** can claim under the ***policy***, unless the ***insured member*** is claiming under the provisions of recurring disability (see **3.8 Recurring disability**).

3.2 Total Disability Benefit

We will pay the ***monthly benefit*** during the ***benefit period*** when an ***insured member*** is ***totally disabled*** immediately after the ***waiting period*** ends, or after a period of ***partial disability***. To be eligible for the Total Disability Benefit, the ***insured member*** must have been:

- ***totally disabled*** for at least 7 out of the first 12 consecutive days of the ***waiting period***
- continuously ***disabled*** for the rest of the ***waiting period***, and
- ***totally disabled*** after the end of the ***waiting period***.

The Total Disability Benefit starts to accrue the first day after the end of the ***waiting period*** on which the ***insured member*** is ***totally disabled***.

Payment stops at the earliest of these events:

- the ***benefit period*** ends
- the ***insured member*** reaches the ***benefit expiry age***
- the ***insured member*** dies
- the ***insured member*** is no longer ***totally disabled***
- for an ***insured member*** on a ***visa***, the date their employment contract and/or ***visa*** expires or is otherwise terminated, or the date they permanently leave Australia, and
- the date the ***insured member*** has been receiving benefits for longer than 12 consecutive months while living outside Australia, in accordance with **5.8 Being overseas for over a year will stop benefits**.

If the ***insured member's*** Total Disability Benefit ceases part way through a month, we will calculate the Total Disability Benefit payable for the period on a pro-rata basis for the number of days the ***insured member*** is entitled to the Total Disability Benefit, divided by the total number of days in that month.

3.3 Partial Disability Benefit

We will pay a proportion of the ***monthly benefit*** during the ***benefit period*** when an ***insured member*** is ***partially disabled*** immediately after the ***waiting period*** ends, or after a period of Total Disability Benefits being paid. To be eligible for the Partial Disability Benefit, the ***insured member*** must have been:

- ***totally disabled*** for at least 7 out of the first 12 consecutive days of the ***waiting period***
- continuously ***disabled*** for the rest of the ***waiting period***, and
- continuously ***disabled*** after the ***waiting period*** ends.

We calculate the proportion of the ***monthly benefit*** as follows:

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

where:

A is the ***insured member's*** total monthly ***salary***.

B is the monthly income the ***insured member*** receives, or is capable of earning, for the month they are ***partially disabled***. B must be less than the A. If B is negative, we will treat B as zero that month. If the ***insured member*** is working below their assessed capacity, B will be what they could expect to earn if they were working at their assessed capacity. When we assess capacity, we consider medical evidence and other factors related to the ***insured member's*** condition.

C is the ***monthly benefit***.

The Partial Disability Benefit starts to accrue if the ***insured member*** is ***partially disabled*** after the ***waiting period***. It is payable monthly in arrears (unless otherwise specified in the ***policy schedule***).

Payment stops being paid at the earliest of these events:

- the ***benefit period*** ends
- the ***insured member*** reaches the ***benefit expiry age***
- the ***insured member*** dies
- the ***insured member*** is no longer ***partially disabled***
- the ***insured member*** receives, or becomes capable of earning, a monthly income equal to or greater than their ***monthly salary*** for 2 consecutive months
- for an ***insured member*** on a ***visa***, the date their employment contract and/or ***visa*** expires or is otherwise terminated, or the date they permanently leave Australia, and

- the ***insured member*** has been receiving benefits for longer than 12 consecutive months while living outside Australia, in accordance with **5.8 Being overseas for over a year will stop benefits**.

If the ***insured member's*** Partial Disability Benefit ceases part way through a month, we will calculate the Partial Disability Benefit payable for the period on a pro-rata basis for the number of days the ***insured member*** is entitled to the Partial Disability Benefit, divided by the total number of days in that month.

3.4 Enhanced Bereavement Benefit

We will pay 3 times the ***monthly benefit*** amount as a lump sum, up to $60,000, if an ***insured member*** dies or is diagnosed with a ***terminal illness***.

We only make one payment for an ***insured member*** under this clause. If we pay the Enhanced Bereavement Benefit for ***terminal illness***, we will not pay it when the ***insured member*** dies.

3.5 Specific Injury Benefit

This benefit is not included in policies issued to trustees of superannuation funds.

We will pay the ***monthly benefit*** for the relevant payment period if an ***insured member*** is diagnosed with a specific injury (as set out in the table below). The specific injury must occur within 180 days of the event that caused it.

Payments will end on the earlier of:

- the end of the relevant payment period for the specific injury, specified in the table below
- the date the ***benefit period*** ends, and
- the date the ***insured member*** reaches the ***benefit expiry age***.

We will pay this benefit whether or not the ***insured member*** is ***disabled***, and whether or not the ***insured member*** is still in the ***waiting period***. The benefit is payable:

- only once in any 3 consecutive years for an ***insured member***
- only once for any specific injury in the table below, or for a related specific injury
- only for one specific injury at a time – if an ***insured member*** has more than one injury at a time, we will pay for the injury with the longest payment period, and
- instead of, not in addition to, a Total Disability Benefit or a Partial Disability Benefit.

The maximum period for which we will pay a Total Disability Benefit and/or a Partial Disability Benefit is reduced by the number of months for which we pay the Specific Injury Benefit, if the ***benefit period*** is 2, 5, 7 or 10 years.

If the ***insured member*** dies during the period for which a Specific Injury Benefit is payable, we will pay you (as a lump sum) the greater of:

- the total of remaining ***monthly benefits*** payable under this clause, and
- the Enhanced Bereavement Benefit as set out in **3.4 Enhanced Bereavement Benefit**.

Specific injuries we cover

Specific injuries covered under the policy	How long we pay
Paralysis (the total and permanent loss of function of 2 or more limbs)	60 months (24 months if you have selected a 2-year benefit period)
Loss‡ of both feet or both hands	24 months
Loss‡ of any combination of 2 of: • a hand • a foot • sight in one eye	24 months
Loss‡ of one leg or one arm	12 months
Loss‡ of one foot or one hand or sight in one eye	12 months
Loss‡ of thumb and index finger of the same hand	6 months
Fracture of the skull (except bones of the nose or face)	2 months
Fractures of the following types that require a pin, traction, plaster cast or other immobilising structure:	
• pelvis or thigh bone (femur)	3 months
• lower leg (between and including ankle joints), or kneecap	2 months
• upper arm (humerus)	2 months
• lower arm (including wrist but excluding the elbow, hand and fingers)	1.5 months
• jaw	1.5 months
• collarbone	1.5 months

‡ Loss means any one of these:
- total and permanent loss of the use and control of the hand from the wrist, or the foot from the ankle joint
- complete severance of the thumb and index finger from the first phalangeal joint
- irrecoverable total loss of an eye or the sight in an eye.

The diagnosis of the specific injury must be made by a treating ***specialist medical practitioner***. We may reasonably require another ***specialist medical practitioner*** to confirm the diagnosis and certification, but we will pay for the cost of that ***specialist medical practitioner*** and reasonable travel costs.

If the ***insured member*** is ***disabled*** at the end of the payment period during which we paid a Specific Injury Benefit, we will waive the ***waiting period*** for a Total Disability Benefit or Partial Disability Benefit. We will only do this if the ***benefit period*** has not ended. We will pay the ***disability*** benefit for the rest of the ***benefit period*** while the ***insured member*** is still ***disabled***.

If the Escalation Benefit applies to the ***policy***, the Specific Injury Benefit will also be subject to the terms of **4.2 Escalation Benefit**.

3.6 Early Notification Incentive Benefit

We will pay you the Early Notification Incentive Benefit if we accept a claim for a Total Disability Benefit or Partial Disability Benefit for an ***insured member***. We will only pay this benefit if you do the following within 30 days of ***date of disability***:

- tell us the ***insured member*** plans to claim a Total Disability Benefit or Partial Disability Benefit under the ***policy***, and
- give us the information we need to confirm that the illness or injury occurred.

We will pay 25% of the amount payable for their ***disability*** for the first month. If the amount payable for the ***insured member's*** disability is for less than one month, we will pay a pro-rata amount for each day they are ***disabled***.

We pay the benefit in addition to any Total Disability Benefit or Partial Disability Benefit that becomes payable. We only pay the Early Notification Incentive Benefit after the ***waiting period*** ends.

The Early Notification Incentive Benefit does not apply if we pay the Specific Injury Benefit, Trauma Recovery Benefit, Enhanced Trauma Recovery Benefit, Specific Trauma Recovery Benefit or Women's Health Benefit, even if the ***insured member*** remains ***disabled*** at the end of the payment period for that benefit and a Total Disability Benefit or Partial Disability Benefit becomes payable.

3.7 Return-to-work assistance

If we agree that taking part in rehabilitation or a return-to-work program may help an ***insured member*** return to work, and we agree to pay for some or all of the costs of a program, we will pay the appropriate service provider directly. Please contact us before the ***insured member*** engages in such a program to check what we will pay.

3.8 Recurring disability

We will treat a recurrent claim as a continuation of the original claim and waive the ***waiting period*** if:

- An ***insured member*** was previously ***on claim*** for an illness or injury (original claim), which stopped because they were no longer ***disabled***
- The ***insured member*** becomes ***disabled*** from the same or related illness or injury (recurrent claim) within 6 months of the original claim ending, and
- the ***policy*** and the ***insured member's*** cover are still in force, subject to **2.4.6 Industry guidance.**

This means the recurrent claim is part of the same ***benefit period*** as the original claim. We will only pay ***disability*** benefits for the remaining ***benefit period***, which is shortened by the original claim.

We will not make further payments under the recurrent claim if we paid the original claim for the whole ***benefit period***.

We will consider an ***insured member*** to be suffering from a separate illness or injury if a claim is made more than 6 months after the original claim ended. A new ***waiting period*** and ***benefit period*** will apply.

3.9 Workplace modification assistance

We will pay for some or all of the expenses to modify a place of employment if:

- an ***insured member*** is receiving a Total Disability Benefit or Partial Disability Benefit, and
- we agree that their place of employment requires modification for their return to work.

We will pay up to 3 times the ***insured member's monthly benefit***, and we will pay the service provider directly.

Please contact us before the workplace modification is carried out, to check what we will pay.

We will only make one payment under this clause for each ***insured member***.

3.10 Emergency Domestic Travel Benefit

This benefit is not included in policies issued to trustees of superannuation funds.

We will reimburse expenses for an ***insured member's emergency transportation*** if:

- we are paying benefits under the ***policy*** because the ***insured member*** is ***totally disabled***, and
- the ***insured member*** requires ***emergency transportation*** within Australia to a hospital to treat that medical condition we are paying benefits for.

The amount we will reimburse is the lowest of:

- the expenses incurred for the ***emergency transportation***
- the ***insured member's monthly benefit***, and
- $1,000.

The ***insured member*** must tell us if they have the right to apply for, or have received, a similar benefit from any other source. We may not pay the benefit if they refuse to tell us. If they have recovered the cost of the ***emergency transportation***, or are able to do so, we will reduce our payment by that amount.

We will pay this benefit:

- only once for each claim of ***total disability*** for an ***insured member***, and
- in addition to any other benefit that becomes payable.

We will not pay this benefit:

- during the ***waiting period***, or
- for ambulance transport.

3.11 Grief support

We will offer an ***insured member*** and their ***immediate family members*** access to our Grief Support Program at no extra cost if an ***insured member*** is diagnosed with a ***terminal illness***.

This benefit will only be available once for each ***insured member***.

3.12 Practical Support Benefit

This benefit is not included in policies issued to trustees of superannuation funds.

3.12.1 Practical support and health and wellness

We will pay up to a total of $500 to reimburse an ***insured member*** for practical support, such as:

- cleaning
- meal preparation
- transport for medical appointments
- activities to improve their health or wellness.

We will reimburse eligible expenses incurred by the ***insured member*** during the ***waiting period*** and in the first 12 months of being ***on claim***.

We will pay this benefit:

- after the ***waiting period*** ends
- only if the ***insured member*** receives a Total Disability Benefit or Partial Disability Benefit under the ***policy***, and
- only once per claim.

3.12.2 Family and domestic violence practical support

We will pay up to a total of $1,000 to reimburse an ***insured member*** who is experiencing family and domestic violence, for emergency accommodation and associated expenses.

We will reimburse eligible expenses incurred by the ***insured member*** during the ***waiting period*** and at any other time they are ***on claim*** for a Total Disability Benefit or a Partial Disability Benefit.

We will pay this benefit:

- in addition to the amount in **3.12.1 Practical support and health and wellness**
- after the ***waiting period*** ends
- only if the ***insured member*** receives a Total Disability Benefit or Partial Disability Benefit under the ***policy***, and
- only once per claim.

4. Optional benefits

Some optional benefits are available under the ***policy*** for an additional cost. Cover for optional benefits only applies in respect of an ***insured member***, or a category of ***insured members***, when you choose and pay for them.

You will find all optional benefits (if any) and any non-standard terms in the ***policy schedule***.

4.1 Superannuation Contribution Benefit

We will pay a Superannuation Contribution Benefit (if applicable) when we pay an ***insured member*** a Total Disability Benefit or Partial Disability Benefit. We pay this benefit in addition to the Total Disability Benefit or Partial Disability Benefit, and at the same time as that payment.

The Superannuation Contribution Benefit:

- is calculated based on 1/12th of the Superannuation Contribution Benefit percentage factor of the ***insured member's salary***, specified in the ***policy schedule***
- cannot, when combined with the ***insured member's monthly benefit***, be more than the ***AAL*** or any ***forward underwriting limit*** for that ***insured member***, and
- will be reduced proportionally if the ***insured member*** is entitled to a Partial Disability Benefit.

The terms that apply to paying ***disability*** benefits in the ***policy*** also apply to paying the Superannuation Contribution Benefit.

We do not pay the Superannuation Contribution Benefit during the ***waiting period***.

We will only pay this benefit when the relevant superannuation contribution and taxation laws allow. The superannuation provider must be a superannuation fund as defined in relevant superannuation and taxation laws.

We pay the benefit in one of these ways:

- to a superannuation provider you nominate
- to a superannuation provider the ***insured member*** nominates, or
- to you – but we may require evidence that you forward it to a superannuation provider for the ***insured member's*** benefit.

4.2 Escalation Benefit

If the Escalation Benefit applies, we will increase the ***monthly benefit*** and any Superannuation Contribution Benefit every 12 months after an ***insured member*** has continuously been ***on claim*** for a ***disability*** benefit or a Specific Injury Benefit. We will increase the ***monthly benefit*** by the lower of:

- the change in ***CPI*** during those 12 months, and
- the ***escalation factor***.

If the change in the ***CPI*** during that time is negative, the ***monthly benefit*** and any Superannuation Contribution Benefit will remain unchanged.

If we increase the ***monthly benefit*** by the Escalation Benefit, we will do so even if that means the ***monthly benefit*** exceeds the ***maximum monthly benefit level***, ***AAL*** or any ***forward underwriting limit*** for the ***insured member***. However, when the ***insured member*** is no longer ***on claim***, we will change the ***monthly benefit*** back to the amount before we applied the Escalation Benefit.

4.3 Nurse Care Benefit

This benefit is not available if the ***policy owner*** is the trustee of a superannuation fund.

If the Nurse Care Benefit applies, we will pay an amount equal to 1/30 of the ***monthly benefit*** for each day, after the first 3 consecutive days that an ***insured member*** is:

- ***totally disabled*** during the ***waiting period***
- confined to bed or hospitalised for more than 3 consecutive days on the advice of the ***insured member's medical practitioner***, and
- receiving full-time nursing care that the ***insured member's medical practitioner*** certifies as necessary for treating the ***insured member's disability***.

The nursing care must be performed by a registered and qualified nurse who does not normally reside in the same household and who is not a relative of the ***insured member***.

The Nurse Care Benefit is payable for up to 30 days, or until the ***waiting period*** ends, whichever occurs first.

We pay this benefit in addition to any other benefits paid during the ***waiting period***.

4.4 Recovery Assistance Benefit

This benefit is not available in either of these cases:

- if the ***policy owner*** is the trustee of a superannuation fund
- with the Enhanced Recovery Assistance Benefit.

We will pay you the Recovery Assistance Benefit (if applicable) set out in the table below if the ***insured member***:

- is receiving a Total Disability Benefit, and
- becomes ***totally and permanently disabled*** within 12 months of the ***date of disability*** for ***total disability***.

Recovery Assistance Benefit available under the policy

Age on the day the insured member ceased work	Recovery Assistance Benefit we pay
Age 55 or younger	$50,000
56	$45,000
57	$40,000
58	$35,000
59	$30,000
60	$25,000
61	$20,000
62	$15,000
63	$10,000
64	$5,000
65 and older	$0

The Recovery Assistance Benefit is payable in addition to any other benefits that may be payable under the ***policy***. We only pay one Recovery Assistance Benefit ever for each ***insured member***.

4.5 Enhanced Recovery Assistance Benefit

This benefit is not available in either of these cases:

- the ***policy owner*** is the trustee of a superannuation fund
- with the Recovery Assistance Benefit.

This benefit is only available for 5, 7 and 10 year ***benefit periods***.

If the Enhanced Recovery Assistance Benefit applies, we will pay you one times the ***insured member's salary***, up to $100,000, if the ***insured member***:

- has been ***on claim*** (including recurrent claims) and has received a Total Disability Benefit or Partial Disability Benefit for the whole ***benefit period***
- has done their best to take part in any return-to-work program recommended by us or their ***medical practitioner*** while on claim and that they have the capacity to undertake, and
- is ***totally and permanently disabled*** at the end of the ***benefit period***.

The Enhanced Recovery Assistance Benefit is payable in addition to any other benefits that may be payable under the ***policy***. We will only pay one Enhanced Recovery Assistance Benefit for each ***insured member***.

4.6 Trauma Recovery Benefit

This benefit is not available in either of these cases:

- the ***policy owner*** is the trustee of a superannuation fund
- with the Enhanced Trauma Recovery Benefit or the Specific Trauma Benefit.

If the Trauma Recovery Benefit applies, we will pay you the ***monthly benefit*** if a trauma recovery event first happens to the ***insured member*** while they are covered by the ***policy***. This benefit is payable whether or not the ***insured member*** is ***disabled***, and is payable during the ***waiting period***.

We will pay the ***insured member's monthly benefit*** in advance each month until the earliest of these events:

- the 6-month payment period for that trauma recovery event ends
- the ***insured member's*** cover ends under **2.13 Ending cover for insured members**, and
- the ***insured member*** dies.

We pay the Trauma Recovery Benefit on the following conditions:

- it is payable only once for an ***insured member***
- we will pay only one Trauma Recovery Benefit or Specific Injury Benefit at a time – if the ***insured member*** suffers either another trauma recovery event or a specific injury (see **3.5 Specific Injury Benefit**) while we are paying a Trauma Recovery Benefit, we will pay the one with the longer payment period, and
- we will not pay you any other benefits while we are paying the Trauma Recovery Benefit.

We will not pay a Trauma Recovery Benefit for certain trauma recovery events (marked in the table below) if they first happen, are first diagnosed, or symptoms leading to the trauma recovery event occurring or being diagnosed are ***reasonably apparent*** during the first 90 days of their cover under the ***policy*** starting.

We will pay a Total Disability Benefit or Partial Disability Benefit (as applicable) if the ***insured member*** is ***disabled*** at the end of the 6-month payment period because of the trauma recovery event that we have paid the Trauma Recovery Benefit for. We will pay from the later of:

- the end of the 6-month payment period for the trauma recovery event, and
- the end of the ***waiting period***.

The maximum period for which we will pay the Total Disability Benefits and/or Partial Disability Benefits is reduced by the number of months for which we pay the Trauma Recovery Benefit if the ***benefit period*** is 2, 5, 7 or 10 years.

The following trauma recovery events are included under the Trauma Recovery Benefit and are defined in **10 Definitions** of **Part 2: Policy terms**. Additional requirements apply to some of the trauma recovery events, as indicated in the table below.

Trauma recovery events	Benefit is not payable if the trauma recovery event first occurs or symptoms become reasonably apparent within 90 days of cover starting	Must be diagnosed and certified by a specialist medical practitioner
Angioplasty – triple vessel	✗	
aortic surgery	✗	
Aplastic anaemia (requiring treatment)		
benign brain lesion (permanent impairment or requiring surgical intervention)		✗
burns (severe)		
cancer (excluding early stage cancers)	✗	✗
cardiac arrest (out of hospital)	✗	✗
cardiomyopathy (permanent and irreversible)		
chronic kidney failure (end stage)		
chronic liver disease (end stage)		
chronic lung disease (end stage)		✗
cognitive loss (permanent)		
coma (of specified severity)		
coronary artery bypass surgery	✗	✗
dementia including Alzheimer's disease (diagnosed)		✗
diabetes (of specified severity)	✗	✗
head trauma (permanent and irreversible)		✗
heart attack (with cardiac impairment)	✗	✗
heart valve surgery	✗	
HIV (medically acquired)		
HIV (occupationally acquired)		
intensive care (prolonged)		
loss of independent existence (permanent)		
loss or paralysis of limb (permanent)		
meningitis and/or meningococcal disease (permanent and irreversible)		
motor neurone disease (diagnosed)		✗
multiple sclerosis (with impairment level)		✗
muscular dystrophy (with impairment level)		✗
organ transplant (major)		
Parkinson's disease (diagnosed)		✗
primary pulmonary hypertension (idiopathic pulmonary arterial hypertension with permanent impairment)		

Trauma recovery events	Benefit is not payable if the trauma recovery event first occurs or symptoms become reasonably apparent within 90 days of cover starting	Must be diagnosed and certified by a specialist medical practitioner
rheumatoid arthritis (severe)	✗	✗
specific loss – loss of either sight, hearing or speech		
stroke (diagnosed)	✗	✗
terminal illness		✗

4.7 Enhanced Trauma Recovery Benefit

This benefit is not available in either of these cases:

- the ***policy owner*** is the trustee of a superannuation fund
- with the Trauma Recovery Benefit or the Specific Trauma Recovery Benefit.

If the Enhanced Trauma Recovery Benefit applies, we will pay you the ***monthly benefit*** if a trauma recovery event first happens to the ***insured member*** while they are covered by the ***policy***. This benefit is payable whether or not the ***insured member*** is ***disabled***, and is payable during the ***waiting period***.

We will pay the ***insured member's monthly benefit*** in advance each month until the earliest of these events:

- the 6-month payment period for that trauma recovery event ends
- the ***insured member's*** cover ends under **2.13 Ending cover for insured members**, and
- the ***insured member*** dies.

We pay the Enhanced Trauma Recovery Benefit on the following conditions:

- it is payable only once for an ***insured member*** in any 3 consecutive years
- it is payable only once for an ***insured member*** for any of the trauma recovery events below, or for a related trauma recovery event
- we will pay only one Enhanced Trauma Recovery Benefit or Specific Injury Benefit at a time – if the ***insured member*** suffers either another trauma recovery event or a specific injury (see **3.5 Specific Injury Benefit**) while we are paying an Enhanced Trauma Recovery Benefit, we will pay the one with the longer payment period, and
- we will not pay you any other benefits while we are paying the Enhanced Trauma Recovery Benefit.

We will not pay an Enhanced Trauma Recovery Benefit for certain trauma recovery events (marked in the table above) if they first happen, are first diagnosed, or symptoms leading to the trauma recovery event occurring or being diagnosed are ***reasonably apparent*** during the first 90 days of their cover under the ***policy*** starting.

We will pay a Total Disability Benefit or Partial Disability Benefit (as applicable) if the ***insured member*** is ***disabled*** at the end of the 6-month payment period because of the trauma recovery event that we have paid the Enhanced Trauma Recovery Benefit for. We will pay from the later of:

- the end of the 6-month payment period for the trauma recovery event, and
- the end of the ***waiting period***.

The trauma recovery events included under the Enhanced Trauma Recovery Benefit are set out in the table in **4.6 Trauma Recovery Benefit** and are defined in **10 Definitions** of **Part 2: Policy terms**. Additional requirements apply to some of the trauma recovery events, as indicated in the table in **4.6 Trauma Recovery Benefit**.

4.8 Immediate Family Member Benefit

This benefit is not available if the ***policy owner*** is the trustee of a superannuation fund.

We will pay up to an additional 50% of the ***monthly benefit*** that an ***insured member*** is receiving, subject to a maximum payment of $3,000 per month, for a maximum of 3 months if:

- a ***medical practitioner*** certifies that the ***insured member*** is confined to bed due to illness or injury and they require care
- the ***insured member*** is receiving the Total Disability Benefit, and
- an ***immediate family member*** stops earning any income only because the ***insured member*** needs the ***immediate family member*** to care for them as a direct result of the ***insured member's*** illness or injury.

We will pay the Immediate Family Member Benefit when we receive all the required information. Payments will be made after the ***immediate family member*** provides the care, not before. We will pay it in addition to any other benefits that become payable but not during the ***waiting period***.

The ***immediate family member's*** employment must meet these conditions:

- they must not have been employed by the ***insured member***
- they must not be employed by an entity that the ***insured member*** controls or is a principal or director of, and
- they must provide evidence to confirm that they stopped earning any income only to care for the ***insured member***.

The evidence could be the ***immediate family member's*** pay slips, employment records or financial records. We may decline to make any payments if this evidence is not provided.

4.9 Relocation Benefit

This benefit is not available if the ***policy owner*** is the trustee of a superannuation fund.

We will pay the Relocation Benefit once while an ***insured member*** is ***on claim*** if the ***insured member***:

- becomes ***totally disabled*** while outside of Australia
- remains ***totally disabled*** for at least 30 days, and
- returns to Australia while ***totally disabled*** or ***partially disabled***.

This benefit is only payable once for each claim for ***total disability***.

This benefit is payable in addition to other benefits that become payable, whether or not the ***insured member*** is still in the ***waiting period***.

The amount we will reimburse is the lowest of:

- the cost of a single standard economy airfare for a scheduled commercial flight to the nearest Australian airport to where the ***insured member*** lives – the cost must be for the most direct route and must be reasonable in the circumstances
- expenses the ***insured member*** incurs in changing previous air travel arrangements, and
- 3 times the ***insured member's monthly benefit***.

We may decline to make a payment if you do not provide the following evidence:

- that no more than 15% of ***insured members*** work outside Australia at any one time, and
- ***member information*** including accurate details on the number of ***insured members*** working outside Australia and the countries they were in at the last ***review date***.

4.10 Alternative Benefit Expiry Age Benefit

You can request a ***benefit expiry age*** of over age 65 (Alternative Benefit Expiry Age) to apply to ***insured members*** under the ***policy***. If we agree to provide cover for ***insured members*** up to the Alternative Benefit Expiry Age, it will be shown on the ***policy schedule***. We will provide cover on these conditions:

- a specific category may have cover up to the Alternative Benefit Expiry Age if there are at least 20 ***insured members*** in that category (unless we agree otherwise), and
- the cover for an ***eligible person*** who joins the plan on or after their 65th birthday and who is below the Alternative Benefit Expiry Age will be capped at the lesser of:
  - $10,000, and
  - the ***AAL*** (if we have agreed to provide an ***AAL*** – refer to **5.6.6 Cover after age 65 may be limited or reduced**).

4.11 Specific Trauma Recovery Benefit

This benefit is not available in either of these cases:

- the ***policy owner*** is the trustee of a superannuation fund
- with the Trauma Recovery Benefit or the Enhanced Trauma Recovery Benefit.

We will pay you the ***insured member's monthly benefit*** if a specific trauma recovery event first happens to an ***insured member*** while they are covered under the ***policy***. This benefit is payable whether or not the ***insured member*** is ***disabled***, and is payable whether or not the ***insured member*** is still in the ***waiting period***.

We will pay the lower of:

- the ***insured member's monthly benefit***, and
- $12,500 per month

in advance each month until the earliest of these events:

- the 2-month payment period for that specific trauma recovery event ends
- the ***insured member's*** cover stops under the ***policy*** under **2.13 Ending cover for insured members**, or
- the ***insured member*** dies.

We pay the Specific Trauma Recovery Benefit on the following conditions:

- it is payable once for an ***insured member*** in any 3 consecutive years
- it is payable only once for an ***insured member*** for any of the specific trauma recovery events below or for a related specific trauma recovery event
- we will pay one benefit at a time – if the ***insured member*** suffers either another specific trauma recovery event, a trauma recovery event, an enhanced trauma recovery event or a specific injury (see **3.5 Specific Injury Benefit**) while we are paying a Specific Trauma Recovery Benefit, we will pay the benefit with the longest payment period, and
- we will not pay you any other benefits while we are paying the Specific Trauma Recovery Benefit.

We will pay a Total Disability Benefit or Partial Disability Benefit (as applicable) if the ***insured member*** is ***disabled*** at the end of the 2-month payment period because of the specific trauma recovery event that we have paid the Specific Trauma Recovery Benefit for. We will pay from the later of:

- the end of the 2-month payment period for the specific trauma recovery event, and
- the end of the ***waiting period***.

The following specific trauma recovery events are included under the Specific Trauma Recovery Benefit and are defined in **10 Definitions** of **Part 2: Policy terms**:

- ***bone marrow or stem cell transplant to treat a disease other than cancer***
- ***cardiac conditions***
- ***inflammatory bowel disease (requiring surgical intervention)***
- ***mental health condition (requiring hospitalisation)***.

4.12 Women's Health Benefit

This benefit is not available if the ***policy owner*** is the trustee of a superannuation fund.

We will pay you the Women's Health Benefit if the ***insured member*** is diagnosed with a women's health condition while they are covered under the ***policy***.

We will pay the lower of:

- 1 times the ***insured member's monthly benefit***, and
- $12,500.

We pay the Women's Health Benefit on the following conditions:

- it is payable once for an ***insured member*** in any 3 consecutive years
- it is payable only once for an ***insured member*** for any of the women's health conditions, or a related women's health condition
- we will pay one benefit at a time – if the ***insured member*** suffers either another women's health condition, a specific injury (see **3.5 Specific Injury Benefit**), a trauma recovery event, an enhanced trauma recovery event or a specific trauma recovery event while we are paying the Women's Health Benefit, we will pay the benefit with the longest payment period, and
- we will not pay the Women's Health Benefit while the ***insured member*** is ***on claim*** for a Total Disability Benefit or a Partial Disability Benefit.

The following women's health conditions are included under the Women's Health Benefit and are defined in **10 Definitions** of **Part 2: Policy terms**:

- ***ectopic pregnancy***
- ***endometriosis***
- ***hyperemesis gravidarum***
- ***menopause***
- ***neonatal mortality***
- ***premenstrual dysphoric disorder***
- ***preterm birth***
- ***stillbirth***.

5. Limitations to benefits

Benefits may be limited in some situations. This section explains what those are.

5.1 Exclusions apply in some cases

We will not pay a benefit under the ***policy*** if the event giving rise to the claim is caused directly or indirectly, fully or partly:

- by an ***insured member's*** involvement in ***war*** or ***war service*** – where the ***date of disability*** or date of death is during their most recent involvement in ***war*** or ***war service***, or within 5 years after the end of their most recent involvement
- by an ***insured member's*** intentional self-inflicted act, or
- by ***uncomplicated pregnancy or childbirth***.

In taking out the ***policy***, you acknowledge that a benefit may not be paid under the ***policy*** for an ***insured member*** who dies in ***war service***.

We may refuse to pay a benefit:

- if the claim arises directly or indirectly from an ***insured member*** participating in criminal activity
- while an ***insured member*** is imprisoned or on remand in a correctional or rehabilitation facility
- if an ***insured member*** unreasonably refuses to ***actively participate in a rehabilitation program*** that their ***medical practitioner*** has certified them as having capacity to take part in
- if an ***insured member*** unreasonably refuses to undergo medical treatment or rehabilitation that their ***medical practitioner*** recommends
- if you or an ***insured member*** do not comply with our reasonable claim requirements that are relevant to assessing whether an insured event has occurred
- where an ***insured member's*** reduced income or inability to work is caused by anything other than sickness or injury. For example, we will not pay a benefit if an ***insured member's*** professional qualification is restricted or revoked due to misconduct, or if their employer stops trading.

In addition, we will not pay any benefits for anything we have specifically excluded in the ***policy schedule*** or the ***decision note***.

5.2 Pre-existing conditions are not covered in certain circumstances

If an ***insured member*** is insured for ***new events cover***, we will not pay any benefit for a ***disability*** occurring as a result (in whole or part), directly or indirectly, of a ***pre-existing condition***.

If an ***insured member*** is insured for ***limited cover***, we will not pay any benefit for a ***disability*** caused by an illness or injury which directly or indirectly caused them to be not ***at work*** on the last ***normal business day*** before the ***transfer date***.

5.3 Limitations in the policy schedule and decision notes

The ***policy schedule***, or the ***decision note*** issued for an ***insured member***, may contain certain exclusions or limitations. We will not pay any benefits under the ***policy*** for anything we have specifically excluded in the ***policy schedule*** or ***decision note***. Payments will be subject to the limitations set out in those documents.

5.4 Benefit periods for casual employees and insured members working less than 14 hours per week

If we have agreed to cover ***casual employees*** or ***eligible persons*** who are working less than 14 hours per week as ***insured members*** under the ***policy***, the ***benefit period*** that applies to those ***insured members*** will be limited to a maximum of 2 years.

5.5 We cannot reimburse some expenses

We do not pay or reimburse the costs of:

- general medical consultations
- medical therapy consultations, including physiotherapy, psychotherapy and hydrotherapy.

We cannot reimburse any expenses that:

- the law does not allow us to reimburse, or
- the *National Health Act 1953* (Cth) or the *Private Health Insurance Act 2007* (Cth) regulates.

5.6 Certain factors reduce the benefit payable

Other payments will reduce the benefit payable, and the amount of an ***insured member's*** cover will be limited once they turn 65.

5.6.1 Other payments reduce some benefits

We will reduce the following benefits when the ***insured member*** receives ***other payments***:

- Total Disability Benefit
- Partial Disability Benefit
- Superannuation Contribution Benefit
- Specific Injury Benefit
- Trauma Recovery Benefit
- Enhanced Trauma Recovery Benefit, and
- Specific Trauma Recovery Benefit.

5.6.2 Reduction of the Total Disability Benefit by other payments

We will only reduce the Total Disability Benefit payable in the month so that the benefit paid by us, in combination with any ***other payments***, does not exceed the greater of:

- the Total Disability Benefit otherwise payable, and
- the ***maximum replacement ratio*** applicable to the ***insured member's*** cover, times the ***insured member's monthly salary***.

Notwithstanding the above, the amount we pay together with ***other payments*** cannot, in combination, exceed the ***maximum monthly benefit level*** under the ***policy***. We will reduce any Total Disability Payment to the extent that this happens.

5.6.3 Reduction of the Partial Disability Benefit by other payments

We will only reduce the Partial Disability Benefit payable in the month so that the benefit paid by us, in combination with any ***other payments***, does not exceed the greater of:

- the Partial Disability Benefit otherwise payable, and
- the ***maximum replacement ratio*** applicable to the ***insured member's*** cover, times the ***insured member's monthly salary***, less the income the ***insured member*** received for the month in which they were ***partially disabled***.

Notwithstanding the above, the amount we pay together with ***other payments*** cannot, in combination, exceed the ***maximum monthly benefit level*** under the ***policy***. We will reduce any Partial Disability Payment to the extent that this happens.

5.6.4 Reduction of the Superannuation Contribution Benefit, Specific Injury Benefit, Trauma Recovery, Enhanced Trauma Recovery and Specific Trauma Recovery Benefit

We will only reduce the Superannuation Contribution Benefit, Specific Injury Benefit, Trauma Recovery Benefit, Enhanced Trauma Recovery Benefit and Specific Trauma Recovery Benefit:

- by amounts the ***insured member*** receives or is eligible to receive that are of the same type that are payable under this ***policy***, and
- only to the extent that the benefit paid by us, in combination with ***other payments***, exceed the benefit otherwise payable.

5.6.5 Reduction of benefits when other payments are payable as a lump sum

Some ***other payments*** are payable as a lump sum. If some or all of that lump sum cannot be allocated to specific months, we will convert some or all of the lump sum (as applicable) to income on the basis of 1% for each month that we pay the ***monthly benefit***, for up to a maximum of 8 years. The balance of the lump sum, if any, will not be offset.

5.6.6 Cover after age 65 may be limited or reduced

An ***eligible person*** who joins the plan on or after their 65th birthday must apply to us in writing and we must accept the ***eligible person's*** application in order for them to be covered by:

- a ***benefit period*** that extends beyond age-65, or
- the Alternative Benefit Expiry Age Benefit in **4.10 Alternative Benefit Expiry Age Benefit**

unless we agree to offer an ***AAL*** for members who join the plan on or after their 65th birthday, and the ***eligible person*** is eligible for cover up to the ***AAL***.

If we agree to provide an ***AAL*** for members who join the plan on or after their 65th birthday, this will be shown in the ***policy schedule***.

Where a plan has a ***benefit expiry age*** of over age-65 or the Alternative Benefit Expiry Age Benefit applies, an ***insured member's*** maximum ***monthly benefit*** will be capped at $10,000 per month from their 65th birthday. This means that, if the ***insured member*** goes ***on claim*** and their ***date of disability*** is on or after their 65th birthday, benefits will be limited to a maximum of $10,000 per month, inclusive of any Superannuation Contribution Benefit (if applicable).

5.7 Incorrectly paid benefits must be repaid

You must repay any overpayment or incorrectly paid benefit either:

- to the extent we were entitled to reduce the benefit paid, but did not do so and we did not agree to waive, or
- to the extent that we paid a benefit for an ***insured member***, but we should not have paid some or all of the benefit under the terms of the ***policy***.

5.8 Being overseas for over a year will stop benefits

We will stop paying any benefits if an ***insured member*** travels or lives outside Australia for more than 12 consecutive months while ***on claim***.

We will start paying benefits again if they return to permanently live in Australia, remain eligible for cover and for benefits under the ***policy***, and give us evidence of their continuous ***disability***. If we recommence payments, we will not pay for a period where the ***insured member*** was not entitled to benefits under this clause.

5.9 One monthly benefit at a time

We pay one ***monthly benefit*** at a time, even if an ***insured member*** suffers more than one illness or injury. This limit applies to the following benefits:

- Total Disability Benefit
- Partial Disability Benefit
- Specific Injury Benefit
- Trauma Recovery Benefit
- Enhanced Trauma Recovery Benefit
- Specific Trauma Recovery Benefit, and
- Women's Health Benefit.

5.10 We may decline transactions that could be against the law

You agree that we may delay, block or refuse to process any transaction without incurring any liability if we reasonably suspect any of the following:

- the transaction may breach any laws or regulations in Australia or any other country
- the transaction involves any person (natural, corporate or governmental) that is itself sanctioned or is connected, directly or indirectly, to any person that is sanctioned under economic and trade sanctions imposed by the United States, the European Union or any country, or
- the transaction may directly or indirectly involve the proceeds of conduct which is unlawful in Australia or any other country, or be used for such purposes.

We may delay or withhold paying a benefit if we reasonably assess that payment may breach any law or regulation, including any sanctions regulations.

Before we take any of the above actions we will, where permitted, provide you with reasonable prior notice to respond to the issue.

You must provide all the information we reasonably require to manage our economic and trade sanctions risk, or to comply with any laws or regulations in Australia or any other country.

You agree that we may disclose any information about you or an ***insured member*** to any law enforcement, regulatory agency or court if we are legally required to in Australia or elsewhere.

6. Claims

If an ***insured member*** needs to make a claim, you or they can start by notifying us. When they make the claim, they will need to send us details, evidence and any extra information we need to assess the claim.

6.1 When to notify us of a claim

You or the ***insured member*** must advise us promptly about any claim or potential claim, otherwise it may affect our ability to obtain information and assess the claim. This may include you ensuring that ***insured members*** know they must advise you, or us, as soon as they become ***disabled***.

6.2 How to make a claim

Depending on the type of claim you are making, we will try to obtain all of the medical and other information we require to assess the claim from you or the ***insured member*** directly. We will send you or the ***insured member*** a claim form to complete, by email, or post if preferred. Sending a claim form does not mean we are liable for any claim lodged. Where possible, we will try to obtain relevant information over the phone, and you or the ***insured member*** may be able to submit documents and information through our electronic lodgement service, if available.

Our ability to obtain the information relevant to the claim event may be affected if a claim is not submitted, or if we are not notified of the death of an ***insured member***, promptly. This may delay the claim assessment.

6.3 Before we pay a claim

We will only pay a claim if we receive all the necessary evidence.

6.3.1 Evidence we need

We always need evidence of:

- the ***insured member's*** age
- all our requirements being met for providing cover under ***automatic acceptance terms***, or transfer terms, or for accepting the member for cover (or an increase in cover) through ***underwriting*** (as applicable)
- the ***insured member's disability*** or other entitlement to claim
- the ***insured member's*** income – ***salary*** or monthly income received from working whilst ***on claim***
- ***other payments*** received during the ***benefit period***, and
- the ***insured member*** being under the regular care of, and ***following the advice of a medical practitioner***.

You or the ***insured member*** need to give us the evidence and authorities required to assess the claim.

The type of evidence we need will depend on the type of claim, but we typically require evidence including the following:

- absence from work – for example, medical certificates, reports and copies of leave records from the ***insured member's*** employer, if appropriate
- details of the ***insured member's*** occupational and employment arrangements – including duties, responsibilities, hours and place of work
- other insurance cover for the ***insured member***
- any payments received while ***on claim***
- financial evidence of the ***insured member's*** income – including copies of personal and business tax returns, assessment notices and other financial evidence to prove their income
- medical reports from treating ***medical practitioners*** (at your expense, or at the ***insured member's*** expense), and
- investigations that support the claimable condition – for example, clinical, radiological, histological or laboratory evidence; copies of medical records; reports from a treating ***medical practitioner*** or an independent ***specialist medical practitioner***.

6.3.2 Extra assessments we may need

We may need the ***insured member*** to undergo reasonable examinations and tests conducted by a ***specialist medical practitioner*** or another appropriate ***medical practitioner***. If we request an examination or test by a ***specialist medical practitioner*** or another appropriate ***medical practitioner***, we will pay for it and for reasonable travel costs.

In addition, we may reasonably require the ***insured member*** to do the following at our expense:

- undergo an employability assessment
- be interviewed
- agree to an audit of their financial circumstances
- provide any other relevant information.

If the ***insured member*** fails to attend any pre-arranged consultation, they will have to pay any charges we incurred in arranging the consultation.

6.4 Payment for claim costs outside Australia

You or the ***insured member*** must pay any costs incurred outside Australia that relate to a claim for an ***insured member*** who is outside Australia in accordance with **2.9 Worldwide cover, round the clock, 2.10 Cover for insured members working outside Australia** or **2.11 Cover during employer-approved leave** unless we agree otherwise with you.

7. Costs you pay

This section outlines the premiums, taxes and expenses you pay, including how we calculate premiums and when you pay them.

7.1 Where to find premium rates

We will set out the premium rates in the ***policy schedule***.

7.2 What minimum annual premium applies

You must pay at least the minimum annual premium shown in the ***policy schedule***, plus stamp duty, even if we calculate a lower premium. If you do not, we may cancel or terminate the ***policy*** by giving you at least 30 days' written notice in accordance with **9.3 Terminating the policy.**

We may vary the minimum annual premium in accordance with **7.7 We can change premium rates or the minimum annual premium**.

7.3 How we calculate premiums

We calculate premiums based on the ***member information*** you give us. We will calculate the first premium from the ***policy start date*** to the first ***review date***. We will calculate subsequent premiums at each ***review date***, regardless of how often you make payments.

The premium is payable for an ***insured member*** from the date their cover starts until the date cover ends under **2.13 Ending cover for insured members**.

Our calculations consider:

- the number of ***insured members*** covered under the ***policy*** at the ***review date***
- the amount and type of benefits provided
- the sum insured – the larger the sum insured, the larger the premium
- age demographic of ***insured members*** – premiums generally increase with age
- gender demographic of ***insured members***
- the occupation of ***insured members*** – premiums are generally higher for occupations with hazardous duties or higher occupational risks
- industry related loadings or discounts
- grouping of policies – refer to **7.11 We offer discounts or can provide lower premiums in some cases**
- payment frequency – whether premiums are paid annually or by instalment (we apply a frequency loading if premiums are not paid annually in advance)
- claims history of your plan, and
- applicable commission you agreed with your intermediary.

We may also apply loadings to individual ***insured members*** based on our assessment of individual risks. Where we do this, we will notify you.

7.4 How we manage over or under payments

We calculate the premium based on the number of ***insured members*** covered under the ***policy*** at the ***review date*** and the amount and type of benefits provided. If this changes before the next ***review date***, we will recalculate the premium at that time to reflect the changes and:

- if you have paid too much, we will refund you any premium you have overpaid, or if you ask us to, we will apply the overpayment to reduce the next premium due, or
- if you have not paid enough, we will tell you of the additional premium you owe (the adjustment premium).

If the ***policy*** ends, any overpayment of premium is refunded or any adjustment premium is payable immediately (if applicable).

7.5 When premiums are due

You will need to pay premiums on these dates:

- the first premium – within 30 days of the ***policy start date*** or on the date specified if you have paid a deposit premium
- subsequent premiums – within 30 days of the ***review date***, or a later date as set out in the ***policy schedule***
- interim premium or adjustment premiums – as specified in our notice of the interim or adjustment premium.

If you do not pay any premium by the due date, we may not start the ***policy*** or we may cancel it. We will give you at least 30 days' notice and a chance to pay the overdue premium before we cancel the ***policy***. If a benefit is payable with a ***date of disability*** that occurs when the premium, interim premium or adjustment premium is overdue, we will not pay the benefit unless you pay us the overdue premium before we cancel the ***policy***.

7.6 We guarantee premium rates

Subject to **7.7 We can change premium rates or the minimum annual premium**, we will guarantee premium rates from the ***policy start date*** to the end of the ***premium rate guarantee period***.

7.7 We can change premium rates or the minimum annual premium

We calculate the premium using the premium rates shown in the ***premium rate schedule***. We can change the premium rates or the minimum annual premium at any of these times:

- when the ***premium rate guarantee period*** ends
- on or after the ***review date*** – provided a ***premium rate guarantee period*** is not in force
- if ***war*** occurs in Australia or New Zealand
- if **1.5 What we may do if your risk profile changes** applies, and
- if there is a change in any government charge, licence fee, tax or any other impost that is directly or indirectly attributable to the ***policy***.

We will give you at least 30 days' notice if we change the premium rates or the minimum annual premium. Refer to the section on **How we calculate premiums** in **Part 1: Product Disclosure Statement** for factors we take into account when determining any premium rate change.

7.8 We can adjust premiums or benefits if age is wrong

If an ***insured member's*** age is misstated, we reserve the right to adjust the premium or the ***insured benefit*** based on their correct age in accordance with the relevant laws.

7.9 You may need to pay stamp duty, taxes and expenses

The tax implications of insurance benefits and premiums under non-superannuation and superannuation policies depend on individual circumstances. It is important you get professional and independent tax advice on all potential tax implications before buying a Zurich Corporate Care Group Income Protection insurance product.

The following may apply to the ***policy***. We do not consider your specific circumstances when we provide this information.

7.9.1 Stamp duty

Stamp duty is payable in addition to the premium rates.

Each state and territory government charges stamp duty (except the Australian Capital Territory). We collect stamp duty and pass it on to the appropriate revenue office.

The amount payable depends on the information you provide regarding the ***insured member's*** state or territory of residence and may change from time to time.

Contact Group Insurance Administration on group.risk@zurich.com.au for an up-to-date listing of the duty percentage or dollar amount of duty that applies to premiums.

7.9.2 Goods and Services Tax (GST)

The ***policy*** is input taxed for GST purposes. GST does not apply to premiums, either for the ***policy*** or for specific benefit types. If this changes, we reserve the right to charge GST in addition to the premium which you are required to pay. We will notify you in writing if this happens.

7.9.3 Income Tax on benefits paid to insured members

Benefits are generally paid to you or a ***participating employer***. You or the ***participating employer*** will be responsible for deducting income tax from payments that you make to an ***insured member***, and for passing it onto the appropriate revenue office.

If you or a ***participating employer*** direct us to pay benefits directly to an ***insured member***, we may deduct income tax in accordance with the *Income Tax Assessment Act 1997* (Cth) from payments that we make to the ***insured member***, and pass it onto the appropriate revenue office. Where we deduct income tax from payments made to an ***insured member***, we will also arrange for a Pay As You Go (PAYG) summary to be issued to the ***insured member*** at the end of the relevant financial year.

7.9.4 Other expenses

In addition to the premium, you are required to pay:

- any other government charges like federal, state or territory taxes and charges – the premium rates do not include these, but references in the ***policy*** to payment of the premium do, and
- any expenses we incur in administering any function that a federal, state or territory government requires of us relating to the ***policy***.

We reserve the right to pass these charges to you in your premium and to increase your premium to cover any increase in these charges.

7.10 We may charge interest

We may charge you interest on any amount overdue for more than 30 days.

We will calculate interest based on the 5-year Australian government bond yield, as published in the *Australian Financial Review* on the date your premium was first due, plus 3% per year. If this rate is no longer published, interest will be calculated based on a comparable replacement rate.

7.11 We offer discounts or can provide lower premiums in some cases

We offer a combined plan discount. If the ***policy owner*** takes out both the ***policy*** and Zurich Corporate Care Group Life insurance and they have the same ***start date*** and annual ***review date***, we will reduce the annual premium for both policies by 2.5%. This discount only applies when both policies remain in force.

We will also be able to provide you with a lower premium if you pay annually in advance and pay by the due date as specified in **7.5 When premiums are due**, as we will not apply the non-annual payment loading that otherwise applies for payments by instalment. The non-annual payment loading will be set out in the ***policy schedule*** where it applies.

7.12 We waive individual member premiums in specific cases

You will not have to pay a premium for an ***insured member*** receiving any of these benefits:

- Total Disability Benefit
- Partial Disability Benefit
- Specific Injury Benefit
- Recovery Assistance Benefit
- Trauma Recovery Benefit
- Enhanced Trauma Recovery Benefit
- Specific Trauma Benefit
- Women's Health Benefit.

8. Keeping us informed

This section outlines information that we need from you, and that you will need to keep.

8.1 Tell us when members change

You must notify us when individual ***insured members*** join or leave so we can properly administer the ***policy***. Tell us at the ***review date*** or at any other intervals agreed between you and us.

8.2 Tell us if other information changes

You must notify us of any changes to ***member information*** or other information relevant to the ***policy*** within 30 days after the ***review date***, or as we otherwise agree in writing with you. If you have difficulty providing information, please contact us and we will work with you to make alternate arrangements where available.

We may pay a benefit based on the ***insured member's salary*** you previously told us if you do not:

- tell us of a change in an ***insured member's salary*** (or if included, performance-related annual bonuses and commissions) in accordance with this clause, and
- pay any additional premium.

8.3 Keep records

You must keep records of:

- ***member information***
- all relevant information relating to each claim – including the ***insured member's*** attendance record and duties (claims information), and
- duration of time ***insured members*** work outside Australia – including the number of people and their locations.

You must give us any ***member information*** or claims information we request.

8.4 We can carry out audits

You must give us or our nominated representative access to inspect, audit and take copies of information or records relevant to the ***policy***, including ***member information*** and claims information. You must instruct your agents or administrators to give us or our representative that access too.

We will conduct audits only during normal office hours and only after we have given you reasonable notice. We will take all reasonable steps to minimise any inconvenience to you.

9. General conditions

This section outlines rights, obligations and other general conditions for your insurance.

9.1 Cooling-off period for policy

You may cancel the ***policy*** during the cooling-off period. That means within 14 days of the earliest of:

- the date you receive the ***policy schedule***
- the date you receive an 'on-risk' letter confirming that we accept your application or ***proposal form***, and
- the end of the fifth day after the ***policy start date***.

To cancel the ***policy*** during the cooling-off period, give us notice in writing and return the ***policy schedule***. If you do this, we will terminate the ***policy*** and refund any money you have paid, except any tax that we cannot recover. You cannot exercise your right to cancel the ***policy*** or get a refund after an ***insured member*** has made a claim for benefits under the ***policy***.

9.2 Cooling-off period for members of a superannuation fund

We will refund all premiums for cover for an ***insured member*** if:

- the ***policy*** is issued to a superannuation fund trustee, and
- the ***insured member*** requests you to cancel their cover within 14 days of receiving your letter telling them of the cover.

We will cancel the cover from its start. We will not pay any claim that may arise in relation to the ***insured member*** during that 14-day period.

9.3 Terminating the policy

You can terminate the ***policy*** at any time by giving us at least 30 days' written notice.

We may only terminate the ***policy*** in the circumstances explained in **7.2 What minimum annual premium applies** and **7.5 When premiums are due** or in accordance with our legal rights. If we do, you must tell your ***insured members*** that we have given you notice. You are responsible for informing ***insured members*** of the termination of the ***policy***.

9.4 Governing law for the policy

The ***policy*** is governed by the law that applies in the state or territory of Australia where the ***policy*** is registered.

9.5 Statutory fund for the policy

We issue your ***policy*** from the statutory fund shown in the ***policy schedule***, but that does not give you any rights of ownership to the fund's assets.

The ***policy*** does not acquire a cash surrender value.

10. Definitions

Terms described in the ***policy schedule*** or ***decision note*** have the meaning shown in those documents.
The following terms in this PDS and Policy have these meanings:

The term we use	What we mean
Accident	An external event which was unexpected, unintended and causes death or injury of an ***insured member***. The following are not ***accidents***, and we exclude any claims arising from any of these situations: • illness, disease, allergy, or any gradual onset of a physical or mental infirmity contributing to death or injury of the ***insured member*** • injury or death, which was unintended and unexpected, from an intentional act or omission, or • injury or death as a result of an activity in which an ***insured member*** took risk or courted disaster – regardless of whether they intended injury or death.
Active service	An ***insured member's*** occupation as part of a military force (for example the army, the navy and the air force). ***Active service*** excludes reserve duty.
Actively participate in a rehabilitation program	An ***insured member*** actively engages in a ***rehabilitation program*** they have capacity to take part in, and that is designed to help them return to their ***usual occupation***. If the ***insured member*** stops participating in a ***rehabilitation program*** on the advice of their treating ***medical practitioner***, we will need written documentation from the treating ***medical practitioner*** explaining: • why they have advised the ***insured member*** to stop participating in the ***rehabilitation program*** • how long participation in the ***rehabilitation program*** is expected to pause • whether the ***rehabilitation program*** could be modified rather than paused, and • what medical information the treating ***medical practitioner*** used to form their opinion. If the ***insured member*** completes a ***rehabilitation program*** but does not return to their ***usual occupation***, we will work with the ***insured member*** to determine if additional ***rehabilitation program*** would help. We may stop, suspend, or reduce benefits if the ***insured member*** fails to commit to and take part in reasonable rehabilitation that they have capacity to take part in and that is expected to help them return to their ***usual occupation***.
At work	An ***insured member*** is: • actively performing all the duties of their occupation, free from any limitation due to illness or injury • working their usual hours free from any limitation due to illness or injury, and • not receiving or entitled to claim income support benefits from any source, for example workers' compensation benefits, statutory motor accident benefits or disability income benefits (including government income support benefits). An ***insured member*** who would have met these requirements except that they were not working for reasons other than illness or injury is also considered to be ***at work***. An ***insured member*** who does not meet these requirements is not ***at work***.
Australian resident	An Australian citizen, a New Zealand citizen or a permanent resident within the meaning of the *Migration Act 1958* (Cth).
Automatic acceptance level (AAL)	The automatic acceptance level shown in the ***policy schedule***.
Automatic acceptance terms	The meaning set out in **2.3 Where we provide cover under automatic acceptance terms**.
Benefit expiry age	The age at which cover ends, as set out in the ***policy schedule***.
Benefit period	The longest period we pay benefits for any one illness or injury if an ***insured member*** is ***disabled***.

The term we use	What we mean
Casual employee	A person who: • works on a temporary, as-required basis • is paid on an hourly basis for the period worked • does not accrue entitlements for sick leave and annual leave, and • is not otherwise a ***permanent employee***.
Certification period	The meaning given in the definition of ***terminal illness***.
Contractor	A person who: • performs all the normal duties of their work • is working at least the ***required hours***, and • is under a fixed term contract of at least one year.
Consumer Price Index (CPI)	The Consumer Price Index (all groups: all capital cities) published by the Australian Bureau of Statistics for the period in which the ***insured member's insured benefit*** becomes eligible for increase on this basis, or a replacement index we select.
Date of disability (for disability)	The first day, after ceasing working in their ***usual occupation***, that the ***insured member***: • attends a medical consultation with a ***medical practitioner***, and • is certified as having no capacity to perform one or more duties of their ***usual occupation*** necessary to produce ***salary***.
Date of disability (for TPD)	The first day after the ***TPD waiting period*** ends.
Decision note	The document we issue for an ***insured member*** when we have assessed their application for cover, increase in cover, or variation in cover. It sets out details of the following: • the type and level of ***insured benefits*** provided for that ***insured member*** (if any) • the date the cover starts or the increase in cover starts, and • any special conditions that apply.
Disability/Disabled	***Total disability*** or ***partial disability*** relating to an ***insured member*** (as applicable).
DSM	The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is no longer used or published, we will use a similar manual for diagnosis that the Royal Australian and New Zealand College of Psychiatrists selects.
Eligibility criteria	The rules for eligibility set out in **2.2 How we accept insured members** and the ***policy schedule***.
Eligible person	A person who meets the ***eligibility criteria***.
Emergency transportation	Emergency transport, that a ***medical practitioner*** believes an ***insured member*** requires because: • there is a serious threat to an ***insured member's*** life or health, and • they require immediate treatment. Ambulance transportation is excluded.
Employer-approved leave	An ***insured member*** who is: • employed by you or a ***participating employer*** – leave that you or the ***participating employer*** approved before it started (except for approved sick leave or leave taken for reasons related to illness or injury), or • self-employed – they are temporarily not working because they have taken a leave of absence (except for a leave of absence taken because of illness or injury, or the unavailability of work).
Escalation factor	As defined in the ***policy schedule***.

The term we use	What we mean
Event date	The first day of the ***TPD waiting period*** during which the ***insured member*** has not worked solely because of injury or illness.
Following the advice of a medical practitioner	The ***insured member*** is following the advice of the treating ***medical practitioner*** on an ongoing basis, including following recommended courses of treatment and rehabilitation.
Forward underwriting limit	The maximum amount to which we will accept future increases in the ***insured benefits*** without further application from an ***insured member***.
FSC Guidance Note	The Financial Services Council Guidance Note No. 11 Group Insurance Takeover Terms dated 9 May 2013.
Full-time	Working at least 30 hours per week.
Gainful employment	Any occupation or work for reward or financial benefit (or for the hope of reward or financial benefit), regardless of whether it is: • on a permanent or temporary basis • of a lower grade • of a lower status • for less remuneration, or • for fewer hours than the ***insured member's*** occupation(s) held prior to the ***event date*** (in relation to ***TPD***) or ***date of disability*** (in relation to ***disability***).
Gainfully working	An ***insured member*** who is either: • employed or self-employed for reward or financial benefit (or hope of reward or financial benefit) in any business, trade, profession, vocation, calling, occupation or employment, or • on ***employer-approved leave***.
Immediate family member	A person who is one of these: • the ***insured member's*** current spouse, or a person with whom the ***insured member*** is in an ***interdependent relationship***, or • the ***insured member's*** son, daughter, father, mother, brother, sister, father-in-law or mother-in-law.
Inactive	The meaning given to it in section 68AAA(3) of the *Superannuation Industry (Supervision) Act 1993* (Cth) when referring to a ***member's account***.
Inactivity period	The continuous period of 16 months ending at or after 11.59pm on 30 June 2019 during which a ***member's account*** has been ***inactive***.
Insured benefit	Any benefit provided under the ***policy***, as the context requires, including: • the Total Disability Benefit • the Partial Disability Benefit • the Specific Injury Benefit • any optional benefit as varied by any ***decision note*** on an individual ***insured member***.
Insured member	A person who is covered by the ***policy*** and is either: • an employee • a ***contractor*** of an employer • a partner in a partnership where the ***policy*** is employer owned, or • a member of a superannuation fund where the ***policy*** is owned by a trustee of a superannuation fund.

The term we use	What we mean
Interdependent relationship	A close personal relationship between 2 people who live together, where one or each of them provides the other with: • financial support, and • domestic support and care. You must provide us with evidence of established and ongoing interdependency. Your supporting evidence should be legible, unaltered and include evidence that supports your claim. If the information you provide to us is insufficient for any reason, we will let you know why and we will discuss with you what alternative documents may need to be provided.
Limited cover	Cover, other than cover for an illness or injury which directly or indirectly caused the transferring member to be not ***at work*** on the last ***normal business day*** immediately before the ***transfer date***.
Maximum benefit entry age	The maximum benefit entry age shown in the ***policy schedule***.
Maximum monthly benefit level	The maximum monthly benefit level shown in the ***policy schedule***.
Maximum replacement ratio	The maximum percentage of the ***insured member's monthly salary*** we will pay as a ***monthly benefit***. It is the lower of: • 75% of their ***monthly salary***, or • any other amount as set out in the ***policy schedule***, and • the maximum replacement ratio stated in the ***policy schedule***.
Medical practitioner	A medical practitioner who is either: • legally registered to practise in Australia, or • legally registered to practise in another country that has equivalent qualifications to a medical practitioner legally registered to practise in Australia. Medical practitioner generally includes the ***insured member's*** general practitioner and any treating specialists involved in diagnosing and managing their condition. For mental health claims, medical practitioner can include a treating psychiatrist. Medical practitioner does not include: • the ***insured member*** • the ***insured member's*** spouse or a person the ***insured member*** is in an ***interdependent relationship*** with • a relative, business partner, employer or employee of the ***insured member***, or • other para-medical professionals including psychologists, chiropractors, physiotherapists, optometrist or naturopaths.
Member	A member of the plan that the Trustee holds the ***policy*** for. Whether the member is currently insured or insurable under the ***policy*** does not matter.
Member's account	An account in the plan you hold for a ***member***, where we have issued the ***policy*** to the trustee of a superannuation fund.

The term we use	What we mean
Member information	All the information we need about an ***eligible person*** to administer the ***policy*** (including calculation of the premium and benefit amounts), and ask you for, for example: • name • date of birth • sex • occupation • state, territory and country of residence (including for persons who have been seconded overseas for work) • ***salary*** (in Australian currency) • whether the person is on ***employer-approved leave*** • date the person joined the company, and • date the person first satisfied the ***eligibility criteria***.
Monthly benefit	The amount shown in the ***policy schedule*** or a ***decision note***. If we have issued a ***decision note*** on an ***insured member***, the amount in the ***decision note*** applies.
Monthly salary	***Salary*** divided by 12.
New events cover	Cover where an ***insured member*** will only be covered for claims arising from an illness which first became apparent to the ***insured member***, or an injury which occurred to the ***insured member***, on or after the date that cover under the ***policy*** either: • commenced • recommenced, or • increased (as applicable). ***New events cover*** does not provide cover for ***pre-existing conditions***.
Normal business day	Any day that the applicable business normally operates.
On claim	The dates for which you are eligible to receive a benefit for the ***insured member*** under the ***policy***.

The term we use	What we mean
Other payments	Amounts payable to or for an ***insured member***: • paid through a statutory scheme, or a compulsory insurance scheme – one that pays amounts for loss of income or earning capacity (including amounts for past or future economic loss), or amounts calculated by reference to that loss of income or earning capacity. Examples of such schemes include workers' compensation and compulsory third-party motor vehicle insurance schemes • paid for or calculated based on loss of income or earning capacity (including amounts for past or future economic loss), whether or not the amount is payable under legislation • paid as damages under common law for, or calculated based on, loss of income or earning capacity (including amounts for past or future economic loss) • paid for or calculated based on paid ***parental leave***, where the ***insured member*** suffers ***disability*** during a period of ***parental leave***, and • paid under another disability, injury or illness insurance policy to replace or reimburse income or expenses or to cover the financial obligations that the ***insured member*** has to other parties. 'Amounts payable' includes commutation amounts, and settlement amounts, including but not limited to settlements made out of court for legal proceedings or contemplated legal proceedings. It does not include amounts for, or calculated based on: • annual leave • Disability Support Pension payable by Centrelink or its successors • investment income • long service leave entitlements • redundancy payments • sick leave • total and permanent disability benefits, trauma benefits or terminal illness benefits.
Parental leave	Includes maternity leave, paternity leave and adoption leave.
Part-time	Working at least 14 hours per week, but less than 30 hours per week.
Partial disability/ partially disabled (usual occupation)	An ***insured member*** is, only because of illness or injury: • capable of performing their ***usual occupation*** in a reduced capacity, and only has capacity to earn a monthly income that is less than their ***monthly salary***, or • incapable of performing one or more duties of their ***usual occupation*** necessary to produce salary, but is working and receiving monthly income that is less than their ***monthly salary***, and • ***following the advice of a medical practitioner*** in relation to their illness or injury they are claiming for. We will consider the ***insured member*** capable of performing their ***usual occupation*** in a reduced capacity even if that work is not made available to them.
Participating employer	Any participating employer mentioned in the ***policy schedule***.
Permanent employee	An ***eligible person*** working on a permanent basis and not as a ***casual employee***.
PMIF-exempt member	An ***eligible person*** that sections 68AAB and 68AAC of the *Superannuation Industry (Supervision) Act 1993* (Cth) do not prohibit you from providing insurance cover to. This excludes an ***eligible person*** who has made a ***PMIF member election*** or satisfies the ***PMIF threshold***.
PMIF member election	An election by the member under section 68AAB or 68AAC of the *Superannuation Industry (Supervision) Act 1993* (Cth).
PMIF threshold	The ***eligible person*** has a balance equal to or greater than $6,000 in their ***member's account***. If they became a member of the superannuation fund on or after 1 April 2020, they must be at least 25 years of age.

The term we use	What we mean
Policy	The documents issued by us to you, including: • the terms outlined in **Part 2: Policy terms** of this PDS and Policy (as updated or supplemented from time to time) • the sections titled **Zurich Australia Limited issues Zurich Corporate Care Group Income Protection insurance** and **How to read this PDS and Policy** of this PDS and Policy • the ***policy schedule*** • any notices we issue or receive under the ***policy*** • the ***decision note*** (if applicable), and • any written variations to the ***policy***.
Policy owner	The policy owner shown in the ***policy schedule***.
Policy schedule	The document we send you that sets out details of the ***policy***, including any special conditions, amendments or endorsements.
Policy start date	The policy start date shown in the ***policy schedule***.
Pre-existing condition	An injury that first occurred, or an illness that first became apparent to the ***insured member*** before the date that cover for that ***insured member*** either: • commenced • recommenced, or • increased (as applicable).
Premium rate guarantee period	The premium rate guarantee period shown in the ***policy schedule***.
Premium rate schedule	The premium rate table shown in the ***policy schedule***.
Principal office	Our office located at 118 Mount Street, North Sydney NSW 2060.
Proposal form	The application form we give you to complete, so you can buy Zurich Corporate Care Group Income Protection insurance from us.
PYS-exempt member	A member you are allowed to provide insurance cover to under section 68AAA of the *Superannuation Industry (Supervision) Act 1993* (Cth), despite the ***member's account*** being ***inactive*** for the ***inactivity period***.
Quotation summary	The Zurich Corporate Care Group Income Protection insurance quotation we issue you that contains the draft ***premium rate schedule*** and our terms for cover for you.
Reasonably apparent	A reasonable person in the circumstances could be expected to have been aware of the symptoms.
Rehabilitation program	A program that is: • developed by an accredited and appropriately qualified occupational or rehabilitation specialist • likely to result in a return to paid work in the ***insured member's*** previous occupation • not treatment eligible for a Medicare or pharmaceutical benefit for any part of the service provided, and • not part of treatment provided in, or associated with, a hospital.
Required hours	The required hours shown in the ***policy schedule***.
Review date	An annual date agreed to between you and us as shown in the ***policy schedule***.

The term we use	What we mean
Salary (for employees)	The annual cash salary remuneration that the ***insured member*** receives from their employer for the ***insured member's*** personal exertion immediately before becoming ***disabled***. The ***policy schedule*** will show if ***salary*** includes: • non-cash benefits or fringe benefits that directly substitute for ***salary***, or • performance-related commission and bonuses. The requirement that the ***salary*** must be received for the ***insured member's*** personal exertion will not apply if the ***insured member*** becomes ***disabled*** while on ***employer-approved leave***. In this case, we will calculate the ***insured member's monthly benefit*** based on the ***insured member's*** applicable ***salary*** immediately before they took ***employer-approved leave***. You will need to confirm their ***salary*** at claim time.
Salary (for casual employees)	The average of the cash salary remuneration that the ***insured member*** receives from their employer for the ***insured member's*** personal exertion in the 6 months immediately prior to becoming ***disabled***, or the actual period worked, if less. The requirement that the ***salary*** must be received for the ***insured member's*** personal exertion will not apply if the ***insured member*** becomes ***disabled*** while on ***employer-approved leave***. In this case, we will calculate the ***insured member's monthly benefit*** based on the ***insured member's*** applicable ***salary*** immediately before they took ***employer-approved leave***. You will need to confirm this at claim time.
Salary (for a business owner)	The gross amount the business earned in the 12 months immediately before the ***insured member*** became ***disabled***, as a direct result of the ***insured member's*** personal exertion or activities through their ***usual occupation***, after deducting the costs and expenses incurred in deriving that income. The requirement that the ***salary*** must be received for the ***insured member's*** personal exertion will not apply if the ***insured member*** becomes ***disabled*** while on ***employer-approved leave***. In this case, we will calculate the ***insured member's monthly benefit*** based on the ***insured member's salary*** in the 12 months immediately before they took ***employer-approved leave***. You will need to confirm this at claim time.
Specialist medical practitioner	A ***medical practitioner*** who is a specialist practising in the relevant medical field of the ***insured member's*** illness or injury.
Standard cover	Cover where the ***insured member*** will be covered for any illness or injury, regardless of whether it first occurred before or after the cover commenced, recommenced or increased (as applicable) under the ***policy***.
Takeover terms	The terms that apply to transferring cover under the ***policy*** to another insurer. This includes: • the terms that specify when the new or incoming insurer becomes responsible for claims • the acceptance terms on which the incoming insurer takes over the cover, and • the terms that specify when cover under the ***policy*** ends for transferring members.
Terminal illness	An illness or injury where all of the following apply: • 2 ***medical practitioners*** certify in writing (***written certification***) that the ***insured member*** suffers from an illness or has incurred an injury that, despite reasonable medical treatment, is likely to result in the ***insured member's*** death within 12 months from the date of ***written certification*** (***certification period***) • Medical evidence or other evidence confirms that the ***insured member*** will likely, despite reasonable medical treatment, die from the illness or injury within the ***certification period*** • At least one of the ***medical practitioners*** is a ***specialist medical practitioner*** • The ***certification period*** has not ended for any ***written certification***, and • The ***written certification*** by both ***medical practitioners*** must be dated while the ***insured member*** is insured under the ***policy***.

The term we use	What we mean
Total disability/ totally disabled (usual occupation)	An ***insured member*** is, only because of illness or injury: • medically certified as incapable of performing one or more duties of their ***usual occupation*** necessary to produce ***salary*** • not engaged in any occupation, and • ***following the advice of a medical practitioner*** about the illness or injury they are claiming for. We will not consider the ***insured member*** incapable of performing a duty of their ***usual occupation*** if they refuse to accept: • any reasonable omission, modification or substitution of that duty, or • the use of any appropriate assistive aids that would enable the ***insured member*** to perform that duty.
Totally and Permanently Disabled (TPD)	In relation to the optional Recovery Assistance Benefit and Enhanced Recovery Assistance Benefit, the ***insured member*** is ***gainfully working*** at the ***event date*** and based on relevant evidence, the ***insured member***, only because of that illness or injury: • has not worked during the entire ***TPD waiting period***, and • is unlikely ever – as at the ***date of disability***, to work in any ***gainful employment*** that they are reasonably suited by education, training or experience despite reasonable rehabilitation or retraining.
TPD waiting period	A period of 91 consecutive days commencing on the ***event date***.
Transfer date	The date the ***policy*** commenced with us.
Uncomplicated pregnancy or childbirth	Pregnancy, childbirth or termination that does not result in any serious medical complication. This definition includes: • participation in an IVF program or similar • normal discomforts such as morning sickness, backache, ankle swelling or bladder problems • giving birth • miscarriage, and • a termination Uncomplicated pregnancy also includes conditions that first appear during pregnancy and are recognised as pregnancy-related, temporary conditions, for example: • carpel tunnel syndrome • varicose veins, or • high blood pressure.
Underwritten/ underwriting	Our process to assess an ***eligible person's*** application for cover. It includes getting and considering information about their medical, health and employment status, and other information we require to make such an assessment.
Usual occupation	The occupation the ***insured member*** is regularly engaged in when they become ***disabled*** due to illness or injury.
Visa	A current and valid visa permitting residency (excluding a visa allowing permanent residency in Australia) or employment in Australia. It must be issued under the *Migration Act 1958* (Cth) or any amending or replacing Act that enables an ***eligible person*** or ***insured member*** to work in Australia.
Waiting period	The number of consecutive days that an ***insured member*** must be ***totally disabled*** or ***partially disabled*** (as applicable), before Total Disability Benefits or Partial Disability Benefits begin to accrue.
War	A state of armed conflict between different nations, states or armed groups using armed force to achieve economic, geographic, nationalistic, political, racial, religious or other ends.
War service	Includes participation in an action to: • defend a country or region from civil disturbance or insurrection, or • to maintain peace in a country or region.
Written certification	As defined in ***terminal illness***.

Trauma Recovery Events

The conditions included in the Trauma Recovery Benefit and Enhanced Trauma Recovery Benefit are listed in **4.6 Trauma Recovery Benefit** and **4.7 Enhanced Trauma Recovery Benefit.** The definitions that apply to each of the conditions are below. If a definition requires tests and the test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose the condition of the same degree of severity, or greater.

The term we use	What we mean
Activity/ Activities of daily living	The following activities: • bathing and/or showering • dressing and undressing • eating and drinking • using a toilet to maintain personal hygiene • getting in and out of a bed, a chair or a wheelchair, or moving from place to place by walking, using a wheelchair or a walking aid.
Angioplasty – triple vessel	The actual undergoing of angioplasty to 3 of the 4 main coronary arteries (left main, left anterior descending, circumflex and right coronary) or their branches within the same procedure or via 2 procedures no more than 3 months apart. Angiographic evidence showing obstruction is required to confirm that the procedure is medically necessary.
Aortic surgery	Surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta performed either by open surgery or by thoracoscopic or laparoscopic minimally invasive 'keyhole' techniques. Aortic surgery doesn't include percutaneous angioplasty or any other intravascular techniques.
Aplastic anaemia (requiring treatment)	Bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring one of the following treatments: • immunosuppressive agents • bone marrow transplantation • peripheral blood stem cell transplant.
Benign brain lesion (permanent impairment or requiring surgical intervention)	The diagnosis of a benign (non-malignant) lesion in the brain or an acoustic neuroma which results in the ***insured member***: • suffering at least 25% permanent whole person impairment as defined in the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment, or • being permanently unable to perform at least one of the ***activities of daily living*** without the physical assistance of another adult person, or • undergoing a craniotomy to remove the lesion. The following are excluded: • cysts, granuloma, abscesses, malformations in or of the arteries or veins of the brain and haematomas, • benign tumours of the pituitary gland removed by trans-sphenoidal surgery • tumors of the spine.
Burns (severe)	Tissue injury caused by thermal, electrical or chemical agents causing full thickness burns to either: • 20% or more of the body surface area as measured by the 'Rule of Nines' or the Lund and Browder Body Surface Chart • 50% or more of both hands, requiring surgical debridement and/or grafting • 50% or more of both feet, requiring surgical debridement and/or grafting • 50% or more of the face, requiring surgical debridement and/or grafting • the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

The term we use	What we mean
Cancer (excluding early-stage cancers)	The diagnosis of one or more malignant tumours including leukaemia, lymphoma and Hodgkin's disease characterised by the uncontrollable growth and spread of malignant cells and the invasion of normal tissue. Diagnosis must be supported by appropriate histology. • Melanomas are covered if they have a TNM classification of at least T1b • Prostatic cancer is covered if it is either: – a Gleason score of more than 6 – is required to have 'major interventionist treatment' to arrest the spread of malignancy. 'Major interventionist treatment' includes removal of the entire prostate, radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment. • Carcinoma in situ* of the breast is covered if either: – treatment requires the removal of the entire breast – treatment requires breast conserving surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy). • Carcinoma in situ* of the testicle is covered if treatment requires the removal of the testicle. *Carcinoma in situ is covered where the procedures are required to be performed specifically to arrest the spread of malignancy and are considered the appropriate and necessary treatment. The following are not covered: • all hyperkeratoses or basal cell carcinomas of the skin • all other melanomas (including T1a melanomas) • all other prostatic cancers • all squamous cell carcinomas of the skin unless there has been a spread to other organs • chronic lymphocytic leukaemia less than Rai Stage 1 • all other tumours showing the malignant changes of carcinoma in situ (Tis) or which are histologically described as pre-malignant, or which are classified as FIGO Stage 0. 'FIGO' refers to the staging method of the International Federation of Gynaecology and Obstetrics • Pituitary neuroendocrine tumours (PitNETs) are excluded unless: – there is evidence of metastatic spread, or – open craniotomy is required for removal.
Cardiac Arrest (out of hospital)	Cardiac arrest (cessation of cardiac function resulting in loss of consciousness, loss of respiratory effort and loss of signs of circulation) that occurs out of hospital. This should be supported by medical evidence such as but not limited to: • Electrocardiogram (ECG) showing asystole or ventricular fibrillation • ambulance or hospital medical records confirming cardiac arrest • the administration of Cardiopulmonary Resuscitation (CPR) by an attending ambulance officer or hospital clinical staff • Automated External Defibrillator (AED) data. Cardiac arrest related to alcohol, drug or medication abuse is excluded.
Cardiomyopathy (permanent and irreversible)	Impaired ventricular function resulting in significant impairment. The degree of permanent and irreversible impairment must be at least Class 3 of the New York Heart Association classification of cardiac impairment.
Chronic kidney failure (end stage)	End stage renal failure presenting as chronic irreversible failure of both kidneys to function. The condition must be evidenced by one of the following: • permanent regular renal dialysis • renal transplant.

The term we use	What we mean
Chronic liver disease (end stage)	Cirrhosis with a Child-Pugh score of greater than 9 as confirmed by a ***specialist medical practitioner***.
Chronic lung disease (end stage)	End stage lung disease requiring continuous supplementary oxygen therapy, as confirmed by a ***specialist medical practitioner***.
Cognitive loss (permanent)	A total and permanent deterioration or loss of intellectual capacity due to the loss of or damage to neurons in the brain (or through acquired brain injuries or progressive neurodegenerative disease) that has required the ***insured member*** to be under continuous care and supervision by another adult person for at least 6 consecutive months; that has been clinically observed and evidenced by accepted standardised testing, and that at the end of the 6-month period they are likely to require ongoing continuous care and assistance by another adult person to perform any of the ***activities of daily living*** in addition to a score of 15 or less out of 30 in a Mini Mental State Examination or equivalent evidence from an alternative neuro-psychometric test.
Coma (of specified severity)	A state of unconsciousness with no reaction to external stimuli or internal function. The coma must have a documented Glasgow Coma Scale of 8 or less and must continue for a continuous period of at least 72 hours. Coma (of specified severity) doesn't include coma resulting from drug or alcohol intake and or a coma that has been induced medically.
Coronary artery bypass surgery	The actual undergoing of coronary artery bypass surgery which is considered medically necessary to correct or treat coronary artery disease. Coronary artery bypass surgery doesn't include angioplasty, other intra-arterial procedures, or laser procedures.
Dementia including Alzheimer's disease (diagnosed)	Both of the following: • unequivocal diagnosis of permanent and irreversible dementia or Alzheimer's disease confirmed by a consultant neurologist or geriatrician • the ***insured member*** requires continual supervisory care as the result of cognitive impairment. The impairment must be evidenced by a Mini Mental State Examination score of 24 or less out of 30 or the results of another equivalent neuro-psychometric test.
Diabetes (of specified severity)	Severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist. The condition must be evidenced by at least 2 of the following: • severe diabetic retinopathy resulting in visual acuity (even with correction with suitable lenses) of 6/36 or worse in both eyes • severe diabetic neuropathy causing severe motor impairment, severe autonomic impairment or both severe motor and autonomic impairment • peripheral vascular disease leading to chronic infection and/or gangrene requiring surgery • severe diabetic nephropathy causing chronic irreversible renal impairment as measured by an eGFR of less than 30ml/min.
Head trauma (permanent and irreversible)	Cerebral injury resulting in permanent neurological deficit, as confirmed by a ***medical practitioner*** who is a consultant neurologist and/or a rehabilitation physician. The deficit causes either: • a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment, or • a total and irreversible inability to perform at least one ***activity of daily living*** without the assistance of another adult person.

The term we use	What we mean
Heart attack with cardiac impairment	The death of a portion of heart muscle arising from inadequate blood supply to the relevant area resulting in impairment of cardiac function evidenced by a left ventricular ejection fraction of less than 50% persisting for greater than 1 month after acute myocardial infarction. The diagnosis of heart attack must be supported by the following being present and consistent with acute myocardial infarction (and not due to medical intervention): • rise and/or fall of cardiac biomarkers (such as troponin or cardiac enzyme CK-MB), with at least one value above the 99th percentile of the upper reference range of laboratory normal, and • one of the following: – cardiac symptoms and signs consistent with acute myocardial infarction – new ECG changes (ST elevation, T wave changes, left bundle branch block (LBBB), or pathological Q waves). If the above test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose myocardial infarction of the same degree of severity, or greater. The following are not covered under this definition: • other acute coronary syndromes including but not limited to angina pectoris, where there is no biochemical evidence of myocardial injury • myocardial infarctions arising from elective percutaneous coronary interventions or coronary artery bypass grafting • elevations of troponins in the absence of an ischaemic cause (for example but not limited to, myocarditis, apical ballooning (Takotsubo cardiomyopathy), cardiac contusion, pulmonary embolism or drug toxicity).
Heart valve surgery	Surgery considered medically necessary to repair or replace cardiac valves due to heart valve defects or abnormalities that can't be corrected by non-surgical techniques. Heart valve surgery doesn't include angioplasty or intraarterial procedures.
HIV (medically acquired)	Infection with Human Immunodeficiency Virus (HIV) which on the balance of probabilities, arose from one of the following medically necessary events: • a blood transfusion • transfusion with blood products • organ transplant to the ***insured member*** • assisted reproductive techniques • a medical procedure or operation performed by a doctor or dentist. Only medical events performed in Australia by a recognised and registered health professional are covered. We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result. A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if a medical cure is developed that prevents AIDS occurring. "Cure" means any Australian Government approved treatment, which renders HIV inactive and non-infectious.
HIV (occupationally acquired)	Infection with Human Immunodeficiency Virus (HIV) due to an accident at work in the ***insured member's*** normal occupation. Any accident which may become a claim must be supported by a negative HIV antibody test taken after the accident. The infection must be evidenced by sero-conversion of the HIV infection within 6 months of the accident. We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result. A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if a medical cure is developed that prevents AIDS occurring. "Cure" means any Australian Government approved treatment, which renders HIV inactive and non-infectious.

The term we use	What we mean
Intensive care (prolonged)	Intensive care (prolonged) means severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days) which includes both of the following: • the ***insured member*** is admitted to an authorised intensive care unit of an acute care hospital due to accident or illness • while in intensive care, the ***insured member*** requires continuous mechanical ventilation by tracheal intubation for 10 consecutive days, 24 hours a day.
Loss of independent existence (permanent)	A condition whereby we have determined the ***insured member*** is totally and irreversibly unable to perform at least 2 of the 5 ***activities of daily living*** without the assistance of another adult person.
Loss or paralysis of limb (permanent)	The total and permanent loss of use of a whole hand or a whole foot as a result of illness or injury, or the total and permanent loss of the use of one arm or one leg as a result of paralysis.
Meningitis and/or meningococcal disease (permanent and irreversible)	All potential manifestations of bacterial meningitis or meningococcal septicaemia resulting in both of the following: • permanent and irreversible neurological deficit confirmed by a specialist physician • permanent and irreversible inability to perform at least one of the ***activities of daily living*** without the assistance of another adult person.
Motor neurone disease (diagnosed)	Unequivocal diagnosis of a progressive form of debilitating motor neurone disease, as confirmed by a ***medical practitioner*** who is a consultant neurologist.
Multiple sclerosis (with impairment level)	A disease characterised by demyelination in the brain and/or spinal cord that is disseminated in time and space. Multiple Sclerosis must be unequivocally diagnosed by a consultant neurologist. Diagnosis must be based on 2017 McDonald criteria or equivalent diagnostic guidelines and supported by neurological investigations such as CSF analysis, MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, and evoked auditory responses. There must be persistent neurological deficit despite appropriate treatment.
Muscular dystrophy (with impairment level)	The unequivocal diagnosis of muscular dystrophy, supported by both of the following: • evidence of permanent neurological deficit confirmed by a specialist physician as a definite result of the diagnosis of muscular dystrophy, and • a permanent and irreversible inability to perform at least one of the ***activities of daily living*** without the assistance of another adult person.
Organ transplant (major)	The ***insured member***: • undergoes human-to-human or animal-to-human organ transplant, or • has been placed on an Australian waiting list, or • undergoes permanent mechanical replacement for one or more of the following organs: – kidney – heart – lung – liver – pancreas – small bowel – the transplant of bone marrow (excluding autologous). Stem cell transplant performed to treat autoimmune disease or for cosmetic purposes is excluded from transplant. 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 specialist physician.

The term we use	What we mean
Parkinson's disease (diagnosed)	The unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of: • rigidity • tremor • bradykinesia and which requires treatment. All other types of parkinsonism, including secondary parkinsonism due to medication, are excluded.
Primary pulmonary hypertension (idiopathic pulmonary arterial hypertension with permanent impairment)	Primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation and resulting in significant and permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment. If the above test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose Idiopathic pulmonary arterial hypertension of the same degree of severity, or greater, as outlined above.
Rheumatoid arthritis (severe)	Diagnosis of rheumatoid arthritis by a rheumatologist using the 2010 American College of Rheumatology classification criteria (or the most recent update), which has failed to respond to conventional DMARDS including at least 2 biological agents administered over a period of at least 12 months.
Specific Loss – Loss of either sight, hearing or speech	***Loss of sight*** means permanent and irrecoverable loss of sight due to injury or illness, to the extent that one of the following applies: • eyesight is reduced in both eyes to 6/60 or worse of central visual acuity on the Snellen test chart (even with correction with suitable lenses) • the degree of vision is less than or equal to 20 degrees of arc. ***Loss of speech*** means the total loss of natural and assisted speech due to illness or injury. Loss of speech must have existed continuously for a period of at least 3 months and be permanent and irreversible. Loss of speech doesn't include loss of speech related to any psychological cause. ***Hearing loss*** (permanent in both ears) means due to illness or injury, the total and permanent loss of hearing in both ears to the extent that the loss is greater than 90 decibels across all frequencies. Deafness (permanent in both ears) does not cover the situation where an insured member can hear, either partially or fully, with the assistance of an aid (apart from a Cochlear implant).
Stroke (diagnosed)	The diagnosis of a stroke that meets all of the following: • cerebrovascular incident producing neurological deficits lasting more than 24 hours, and • evidenced by acute onset of new objective neurological signs and symptoms, and • evidenced by neuro-imaging changes consistent with the signs and symptoms, and • confirmed by a medical practitioner who is an appropriately qualified ***specialist medical practitioner***. Includes where there is infarction of brain tissue, intracranial or subarachnoid haemorrhage. Transient ischaemic attacks, migraine, vascular disease affecting the eye, optic nerve or vestibular functions, and incidental imaging findings (CT or MRI brain scan without clearly related clinical symptoms (silent stroke)), or as a result of hypoxia and trauma are excluded.

Specific Trauma Recovery Events

The conditions included in the Specific Trauma Recovery Benefit are listed in **4.11 Specific Trauma Recovery Benefit.** The definitions that apply to each of the conditions are below. If a definition requires tests and the test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose the condition of the same degree of severity, or greater.

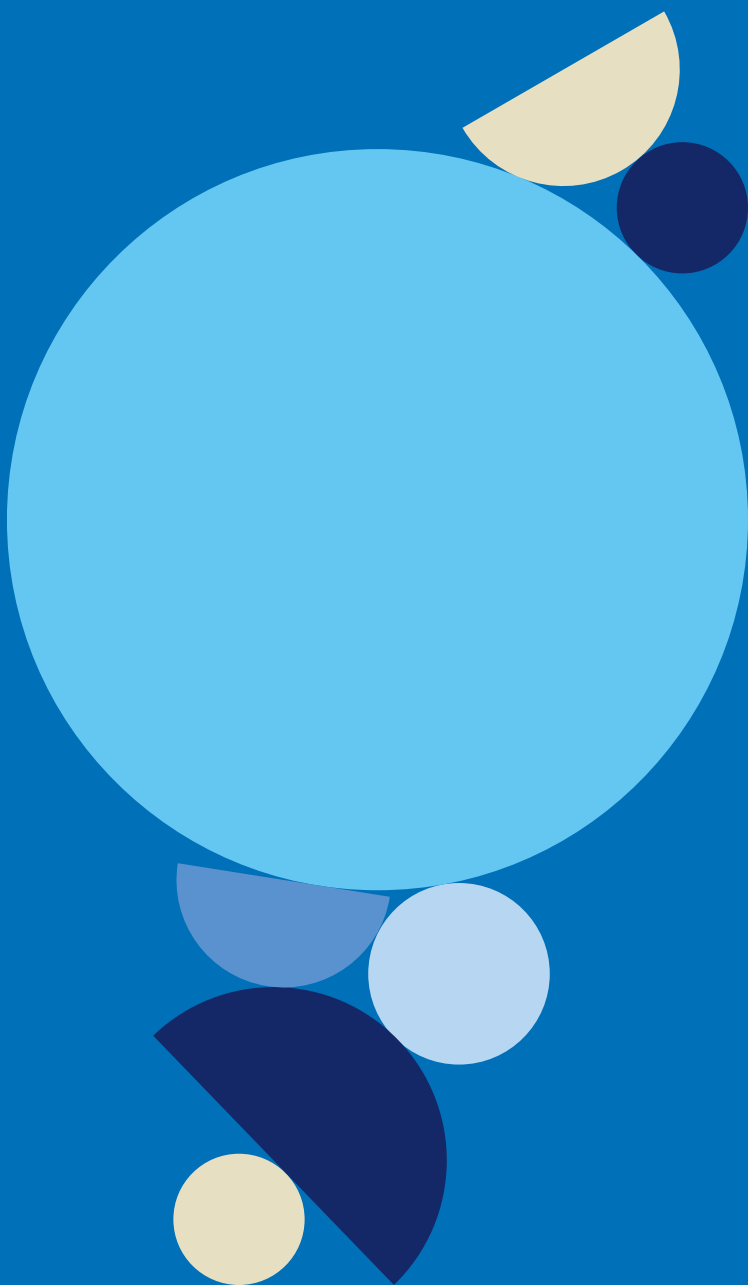
The term we use	What we mean
Inflammatory Bowel Disease (requiring surgical intervention)	The diagnosis of Crohn's disease or Ulcerative Colitis which requires the undergoing of invasive surgery (excluding endoscopic therapy) that is considered necessary for treatment where both: • standard therapy including steroids, immunosuppressants and biological treatment has failed to control symptoms, and • invasive surgery (excluding endoscopic therapy) is considered necessary for treatment.
Bone Marrow Transplant to treat disease other than cancer	The ***insured member*** is the recipient of a bone marrow or stem cell transplant to treat a disease other than cancer. The transplant must be performed in a registered hospital in Australia. Stem cell transplant for cosmetic purposes or experimental treatment is excluded.
Mental Health (Requiring Hospitalisation)	Hospital admission for 21 or more days under specialist psychiatric care for the treatment of a mental health disorder as defined by the most current ***DSM*** or any replacement or successor to ***DSM***. Admission for drug (including alcohol) detoxification or withdrawal is excluded.
Cardiac Conditions – Heart attack without cardiac impairment	The death of a portion of heart muscle arising from inadequate blood supply to the relevant area. The diagnosis must be supported by the following being present and consistent with acute myocardial infarction (and not due to medical intervention): • rise and/or fall of cardiac biomarkers (such as troponin or cardiac enzyme CK-MB), with at least one value above the 99th percentile of the upper reference range of laboratory normal, and • one of the following: – cardiac symptoms and signs consistent with acute myocardial infarction – new ECG changes (ST elevation, T wave changes, left bundle branch block (LBBB), or pathological Q waves). If the above test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose myocardial infarction. The following are not covered under this definition: • other acute coronary syndromes including but not limited to angina pectoris, where there is no biochemical evidence of myocardial injury • myocardial infarctions arising from elective percutaneous coronary interventions or coronary bypass grafting • elevations of troponins in the absence of an ischaemic cause (for example but not limited to, myocarditis, apical ballooning (Takotsubo cardiomyopathy), cardiac contusion, pulmonary embolism or drug toxicity).
Cardiac Conditions – Takotsubo syndrome	Hospital admission due to Takotsubo syndrome (Takotsubo cardiomyopathy) with evidence of myocardial damage. The diagnosis must be supported by the following being present and consistent with Takotsubo syndrome: • cardiac symptoms and signs consistent with Takotsubo syndrome, and • rise and/or fall of cardiac biomarkers (such as troponin or cardiac enzyme CK-MB), with at least one value above the 99th percentile of the upper reference range of laboratory normal, and • echocardiography or coronary angiography findings consistent with Takotsubo syndrome. The diagnosis must be confirmed by a consultant cardiologist.

The term we use	What we mean
Cardiac Conditions – Prolonged ventricular tachycardia (requiring emergency treatment)	Hospital admission due to sustained ventricular tachycardia (VT) requiring emergency DC cardioversion and the insertion of an implantable cardioverter-defibrillator (ICD) at the same admission. Sustained ventricular tachycardia occurring because of medication or medical procedures is excluded.

Women's Health Conditions

The conditions included in the Women's Health Benefit are listed in **4.12 Women's Health Benefit**. The definitions that apply to each of the conditions are below. If a definition requires tests and the test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose the condition of the same degree of severity, or greater.

The term we use	What we mean
Ectopic pregnancy	The diagnosis of ectopic pregnancy requiring surgery to treat.
Endometriosis (severe, requiring surgical intervention)	The diagnosis of endometriosis and both of the following: • classification as Stage 4 disease, with a score of more than 40 points, according to the American Society of Reproductive Medicine (ASRM) • requirement for surgery to treat disease. Stage 1, 2 and 3 endometriosis and adenomyosis are excluded.
Hyperemesis gravidarum	Diagnosis of hyperemesis gravidarum requiring hospital admission for 7 or more consecutive days.
Menopause	Perimenopause, menopause and post menopause diagnosed by an appropriately qualified ***medical practitioner***, where all of the following are satisfied: a. at initial diagnosis, the ***insured member*** is suffering from severe symptoms, with a Modified Greene Scale score of greater than 30, requiring reasonable and appropriate treatment recommended by the appropriately qualified ***medical practitioner*** in relation to their symptoms, for a minimum of 3 months b. the ***insured member*** continues to suffer from severe symptoms, with a Modified Greene Scale score of greater than 20, on reassessment by a ***medical practitioner***, despite completion of the period of reasonable and appropriate treatment referred to in a. above, and c. the ***insured member*** is ***totally disabled*** for at least 10 days in the 6 consecutive month period immediately following the assessment referred to in a. above. The 6 consecutive month period must start and end while the ***insured member*** is covered under the ***policy***.
Neonatal mortality	The death of a live born baby within 28 days after birth.
Premenstrual dysphoric disorder	Premenstrual dysphoric disorder (PMDD), where all of the following are satisfied: • the diagnosis of PMDD must be diagnosed by a psychiatrist using criteria outlined in the ***DSM***, whilst the ***insured member*** is covered under the ***policy*** • the ***insured member*** must be following the advice of an appropriate ***medical practitioner***, and receiving appropriate treatment in relation to the PMDD, and • the symptoms of PMDD cause the ***insured member*** to be ***totally disabled*** for at least 10 days in a 6 consecutive month period. The 6 consecutive month period must start and end while the ***insured member*** is covered under the ***policy***.
Preterm birth	The birth of live baby before 32 completed weeks of gestation.
Stillbirth	Fetal death prior to birth of a baby of 20 or more completed weeks of gestation or of 400 grams or more birthweight.



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