ZURICH

Corporate Care Group Life Insurance

Product Disclosure Statement and Policy Terms

Issue date: 16 September 2024

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 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 Life 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 Life 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 Life insurance

Zurich Australia Limited (Zurich) is the issuer of Zurich Corporate Care Group Life 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 Life 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 **9 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 Life 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 **9 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 **9 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 Life 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 Life insurance. You will need to decide:

- what benefit and level of benefit to provide ***insured members***, and
- when the ***policy*** should start.

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 Life 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 Life insurance to help you decide if the product is for you.

Zurich Corporate Care Group Life insurance provides financial support if insured members become totally and permanently disabled, terminally ill or die

Zurich Corporate Care Group Life 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 Life insurance pays a lump sum benefit if an ***insured member*** dies, has a ***terminal illness*** or is ***totally and permanently disabled*** (***TPD***). 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 death, terminal illness and total and permanent disablement

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Death Cover	We will pay you a lump-sum benefit if an ***insured member*** dies.	✓	25
Terminal Illness Cover	We will pay you a lump-sum benefit if an ***insured member*** is diagnosed with an illness that is likely to lead to their death within 12 months.	✓	25
Total and Permanent Disablement (TPD) Cover	We will pay you a lump-sum benefit if an ***insured member*** meets the conditions of the ***TPD*** definition that applies.	✓	25

For bereavement and grief

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
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***.	✓	26
Return to wellness support	We may offer extra rehabilitation, retraining support, or both, if we decline an ***insured member's TPD*** claim and there is evidence that they could return to work within their education, training and experience. We will only pay for costs we have agreed to in advance, and we will pay the service provider directly.	✓	26

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.	✓	22
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. If an ***insured member*** goes ***on claim*** whilst they are overseas, we may require them to return to Australia to enable us to assess their claim.	✓	22
Cover during employer-approved leave	We provide cover for up to 24 months if the ***insured member*** is on ***employer-approved leave***.	✓	22

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.	✓	22
Death Cover 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 Death Cover without having to undergo medical ***underwriting***.	✓	23
Interim Accident Cover	We provide cover for death and ***TPD*** that result from an ***accident*** while we consider a person's application to become an ***insured member***. This cover is only for up to 90 days and excludes applications for Life Events Cover or ***transferred cover***.	✓	21

Incentives and discounts for you

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Group transfer terms	We may agree to take over the level of insurance benefits provided by your previous insurer and provide equivalent benefits.	✓	19
Discounts and lower premiums	We will discount your premium if you buy Zurich Corporate Care Income Protection insurance at the same time as Zurich Corporate Care Group Life 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.	✓	31
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***.	✓	16

Optional benefits

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

Benefit or feature	What it means for you	Available in superannuation?	Refer to page
Life Events Cover	An ***insured member*** under the age of 55 can apply to increase their ***insured benefit*** when ***specific life events*** occur, like getting married or welcoming a child. We do not require medical evidence, but we will require evidence to establish the occurrence of the ***specific life event***. We will only increase a benefit once in 12 months, up to a total of 3 times.	✓	20
TPD Cover Continuation option	An ***insured member's*** TPD Cover will end if you or a ***participating employer*** stop employing them. If this happens, they may apply for an individual policy that provides TPD Cover without having to undergo medical ***underwriting***.	✓	24
Non-standard TPD definitions	This option allows alternative ***TPD*** definitions. Some ***TPD*** definitions are not available for a ***policy*** issued to the trustee of a superannuation fund.	✓	25
Terminal Illness enhanced definition	You can choose to extend the certification period for ***terminal illness*** from 12 to 24 months.	✓	25

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.	✗	11

What cover is available

The table below sets out the general limits and options available under Zurich Corporate Care Group Life 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 (including stamp duty)	$15,000
Maximum benefit level	Death Cover – unlimited Terminal Illness Cover – $3 million TPD Cover – $5 million
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 death, ***terminal illness*** or ***TPD*** (as applicable) 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 death, ***terminal illness*** or ***TPD*** (as applicable) 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 Life insurance in superannuation

You can own Zurich Corporate Care Group Life 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**
- **2.13 Extended cover**
- **2.14 Ending cover for insured members**
- **2.15 Members can apply for a Continuation Option**
- **2.16 Members can apply to transfer individual cover**
- **4.5.2 Superannuation benefit is transferred to another fund**, and
- **8.2 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 Life 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 (inclusive of 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 **6 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 Life 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 **5 Claims** of **Part 2: Policy terms** or contact us.

Website: zurich.com.au/group-insurance

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 Life 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 **8.3 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 **6.2 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 **2.10 Worldwide cover, round the clock** and **2.11 Cover for insured members working outside Australia**)
- is employed with you or a ***participating employer***, 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**, 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 for total and permanent disablement or terminal illness from any source 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 ***insured 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 benefit levels*** for death and ***TPD***.

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 Transfer terms for Death Cover

We will provide ***standard cover*** for the same amount of Death Cover provided under the previous policy from the ***transfer date*** for all transferring members who:

- were insured under the previous policy on the day before the ***transfer date***, and
- are ***eligible persons*** on and from the ***transfer date***.

2.4.3 Transfer terms for TPD Cover

We will provide ***standard cover*** for the same amount of TPD Cover provided under the previous policy from the ***transfer date*** for all transferring members who:

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

2.4.4 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:

- Death Cover that is ***standard cover*** for the same amount of Death Cover provided under the previous policy, and
- TPD Cover that is ***limited cover*** only for the same amount of TPD Cover 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 TPD Cover 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.

2.4.5 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 TPD Cover 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.

2.4.6 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.

2.4.7 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***.

2.4.8 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 **2.4.6 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***
- an ***insured member*** wants to keep the same amount of ***insured benefit*** after transferring some or all of their ***superannuation account balance*** to another superannuation fund under ***portability legislation***. If they do not apply and their ***insured benefit*** has a component based on a ***superannuation account balance***, the ***insured benefit*** will be reduced under **4.5.2 Superannuation benefit is transferred to another fund**.

An application can only be made for cover up to the ***maximum 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 **2.8 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 benefit level*** (as outlined in the ***quotation summary*** or ***policy schedule***).

2.7 Life Events Cover for specific events

An ***insured member*** can apply for an increase in cover for 4 ***specific life events*** without full ***underwriting***:

- marriage, or the second anniversary of establishing an ***interdependent relationship***
- a dependent child starting secondary school
- the ***insured member*** or their spouse giving birth or adopting a child, and
- taking out or increasing a mortgage on their ***home***.

You will find Life Events Cover in the ***policy schedule*** if the cover applies to the ***policy***.

2.7.1 Conditions for applying

Insured members who qualify for this benefit may apply to us to increase their ***insured benefit***. They do not need to supply medical evidence, but all of the following must be satisfied:

- the ***specific life event*** occurs after the ***insured member's*** cover starts under the ***policy***
- the ***insured member*** is below the age of 55 at the date of the ***specific life event***
- the ***insured member***, when they apply, must not have made a claim under any life insurance policy, nor be entitled to make a claim, whether the policy is issued by us or by another insurer
- we have not declined the ***insured member's*** application for additional cover under **2.5 How we consider applications for cover**
- the ***policy*** is still in force and cover for the ***insured member*** has not ended, and
- their application must be made within 90 days of the ***specific life event***.

If the ***specific life event*** is a mortgage, the mortgage must be with an accredited mortgage provider, either:

- an authorised deposit-taking institution (as defined in the *Banking Act 1959*), or
- a reputable financial services business, program or trustee that provides mortgage loans as part of its ordinary business activities and is accredited with the Mortgage and Finance Industry of Australia.

Taking out or increasing a mortgage excludes redrawing and refinancing mortgages.

2.7.2 Evidence we need

To increase an ***insured member's insured benefit*** for a ***specific life event***, we will need a completed application form and evidence as set out below:

- for marriage – a copy of the ***insured member's*** marriage certificate for a marriage recognised under the *Marriage Act 1961* (Cth)
- for an ***interdependent relationship*** – a copy of evidence that the relationship has existed for at least 2 years
- for a dependent child starting secondary school – a copy of a letter of admission from the child's school
- for the birth of a child – a copy of the birth certificate
- for adoption – a copy of the adoption document
- for a new mortgage – written confirmation from the accredited mortgage providers of the amount and effective date of the mortgage
- for an increased mortgage – written confirmation from the accredited mortgage providers of the amount of the mortgage immediately before the increase, the effective date of the increase and the amount of the increased mortgage.

2.7.3 Increasing the member's benefit

The increase in the ***insured benefit*** depends on the ***insured member's*** type of cover. The increase will be:

- one unit of cover – if they have ***unit-based cover***, or
- a ***fixed-dollar cover*** amount equal to 25% of the ***insured member's*** cover (on the date they apply for additional cover) – if they have ***fixed-dollar cover*** or ***formula-based cover***.

However, the increase cannot exceed $250,000 or cause the ***insured member's insured benefit*** to exceed the ***maximum benefit level***.

If we accept an ***insured member's*** application for Life Events Cover:

- the increase in cover will be on the same terms and conditions as the current acceptance terms for the ***insured member's*** cover under the ***policy***, including any loadings or exclusions
- we will issue a ***decision note*** to you on their cover, and
- Life Events Cover will start on the date we accept their application.

2.7.4 Limitations that apply

We only approve one application for each ***insured member*** for marriage or for the second anniversary of an ***interdependent relationship***.

We only pay the increased amount during the first 6 months of increase in the ***insured benefit*** due to a ***specific life event*** if the ***insured member's*** death or ***total and permanent disablement*** is caused by an ***accident***. After the 6 months, the ***insured member's*** Life Events Cover will no longer be limited to ***accidents*** only.

An ***insured member*** can apply for Life Events Cover once in 12 months, but only up to 3 times in total.

2.8 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**. We do not provide it for applications for Life Events Cover or ***transferred cover***.

2.8.1 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 **2.14 Ending cover for insured members**, and
- the date the application is cancelled or withdrawn.

2.8.2 When we pay a benefit

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

2.8.3 How much we pay

The Interim Accident Cover Benefit is the lowest of:

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

2.9 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.

2.10 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 **2.11 Cover for insured members working outside Australia** and **2.12 Cover during employer-approved leave**.

2.11 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***.

2.12 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 ***event date***.

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 **2.14 Ending cover for insured members**.

2.13 Extended cover

We will provide Death Cover and TPD Cover (if applicable) 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 **2.15 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.

2.14 Ending cover for insured members

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

2.14.1 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 **6.5 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
- the ***event date***, where we accept a ***TPD*** claim and pay a ***TPD benefit*** under the ***policy*** in respect of an ***insured member***, except where the ***insured member*** holds Death Cover that is more than the amount of the ***TPD benefit***, in which case the remaining amount of Death Cover will continue
- the date of the latest ***written certification***, where we accept a ***terminal illness*** claim and pay a ***terminal illness benefit*** which is equal to the amount of the Death Cover under the ***policy*** for that ***insured member***. To avoid doubt, if the amount of the Death Cover is more than the amount of the ***terminal illness benefit*** paid or payable the remaining amount of Death Cover will continue
- they permanently retire (TPD Cover only, but Death Cover may continue)
- they stop meeting the ***eligibility criteria***, or the date their Extended Cover under **2.13 Extended cover** ends (if applicable)
- they are on leave for longer than we have agreed to provide cover for under **2.12 Cover during employer-approved leave**
- they are working outside Australia for longer than we have agreed to provide cover for under **2.11 Cover for insured members working outside Australia**
- the ***policy*** ends or is terminated, except to the extent discussed in **2.14.2 Our ongoing obligation to pay a terminal illness benefit or TPD 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.

2.14.2 Our ongoing obligation to pay a terminal illness benefit or TPD benefit where the policy transfers to another insurer

If the ***policy*** terminates and ***takeover terms*** apply, our ongoing liability to pay a ***terminal illness benefit*** or a ***TPD 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 **2.4.8 Industry guidance** or refer to our website for further details).

2.15 Members can apply for a Continuation Option

2.15.1 Death Cover 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 with us for Death Cover that is the same or less than the ***death benefit*** under the ***policy***.

2.15.2 Eligibility to apply for Death Cover Continuation Option

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 living in Australia (unless we agree otherwise)
- provide any non-medical information we consider relevant, and
- acknowledge that any restrictions, limitations or loadings that apply to their cover under the ***policy*** will apply to the new individual policy.

In addition, you, another person or another entity must not have received (or be eligible to receive) ***terminal illness benefit*** or ***TPD benefit*** for the ***insured member*** under the ***policy*** or any other policy issued by an insurer.

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 **2.13 Extended cover**.

2.15.3 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.

2.15.4 TPD Cover Continuation Option

The ***policy schedule*** will show if a TPD Cover Continuation Option applies. It is not a standard feature of the ***policy***.

If a TPD Continuation Option is available, and 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 with us for TPD Cover that is the same or less than the ***TPD benefit*** under the ***policy***.

To exercise the TPD Cover Continuation Option, a person must:

- meet the conditions for the Death Cover Continuation Option in and **2.15.2 Eligibility to apply for Death Cover Continuation Option** and **2.15.3 Medical evidence is not required but we consider some factors**, above
- exercise the Death Cover Continuation Option at the same time
- be engaged in an occupation that is not an excluded occupation under the individual policy, and
- be working the minimum hours required under the individual policy.

2.15.5 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***.

2.16 Members can apply to transfer individual cover

An ***insured member*** can apply for additional cover by transferring a ***previous life policy***. They can apply if, on the date we accept their application, they:

- have death only cover or have both death and TPD Cover under a ***previous life policy*** with another insurer through a superannuation fund (***previous cover***) and wish to transfer that ***previous cover*** into the ***policy***
- are not eligible for a benefit under the ***previous cover***, have not made a claim or are not entitled to make one, and
- do not have their ***previous cover*** through a self-managed superannuation fund.

2.16.1 How to apply for transfer

To transfer their ***previous cover***, an ***insured member*** must complete an application form, and answer all questions fully, including questions relating to their health. The ***insured member*** must provide us with all the information, including any supporting information we reasonably require to assess the application and verify the ***previous cover***, including its validity and currency.

If we accept the application, we will issue a ***decision note*** for the ***insured member***.

2.16.2 Conditions of transferred cover

Transferred cover starts on the date we accept the application. We will provide ***transferred cover*** in addition to ***existing cover***, and on the terms and conditions of the ***policy***.

The person's ***previous cover*** must be cancelled when we accept the application. If we accept a claim for death, ***terminal illness*** or ***total and permanent disablement*** for the ***insured member***, and the ***previous cover*** has not been cancelled, we will reduce any benefit by the amount they could receive under their ***previous cover***.

We accept the type and amount of ***transferred cover*** for the ***insured member*** that is at least as much, and as close as possible, to their ***previous cover***. However:

- we will round the amount up to the closest $1,000, if it is not already a multiple of $1,000
- the ***transferred cover*** cannot exceed $1 million even if the ***previous cover*** was higher, and
- the ***transferred cover*** and ***existing cover*** together cannot exceed the ***maximum benefit level***.

If the ***insured member's existing cover*** under this ***policy*** is subject to ***special acceptance terms*** on the date we accept the application, those terms will:

- not apply to the ***transferred cover*** unless we advise you in writing, and
- continue to apply to the insured amount of ***existing cover*** under this ***policy***.

If the ***insured member's previous cover*** is subject to special conditions, a premium loading or an exclusion (***previous cover terms***), we may either:

- accept the application subject to ***special acceptance terms***, or
- decline the application.

If we accept the application subject to ***special acceptance terms***, those ***special acceptance terms*** will not apply to the ***insured member's existing cover***.

The amount of ***transferred cover*** does not count towards any ***AAL*** that may apply for the ***insured member***.

3. Benefits and features built into the policy

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

3.1 Death benefit

We will pay you the ***death benefit*** if an ***insured member*** with Death Cover dies, provided their Death Cover did not end before their death.

The ***death benefit*** becomes payable on the date of their death.

3.2 Terminal illness benefit

We will pay you a ***terminal illness benefit*** if an ***insured member*** with Death Cover has a ***terminal illness***. Their Death Cover must be in force on the date of the ***medical practitioner's*** latest ***written certification*** that we accept as evidence of ***terminal illness***.

The ***terminal illness benefit*** becomes payable on the date of that ***written certification***.

We will reduce the ***death benefit*** by the amount of ***terminal illness benefit*** we pay if the ***death benefit*** is higher than the ***terminal illness benefit***.

3.2.1 Standard and enhanced definitions of terminal illness

You can choose either of the following definitions of ***terminal illness*** for your plan:

- the standard definition, with a 12-month ***certification period***, or
- the enhanced definition, with a 24-month ***certification period*** – your ***policy schedule*** will show if it applies to your plan.

3.3 TPD benefit

We will pay you a ***TPD benefit*** if an ***insured member*** with TPD Cover becomes ***totally and permanently disabled***, provided their TPD Cover has not ended as at the ***event date***.

3.3.1 The TPD benefit decreases with age

An ***insured member's TPD benefit*** reduces with age as shown below, unless we agree otherwise in writing or unless their ***TPD benefit*** gradually drops to zero by the ***benefit expiry age***:

- 10% per year from their 61st birthday, if the ***benefit expiry age*** is 70
- 20% per year from their 61st birthday, if the ***benefit expiry age*** is 65
- 20% per year from their 63rd birthday, if the ***benefit expiry age*** is 67.

Where the ***benefit expiry age*** is not 65, 67 or 70, the amount by which the ***insured benefit*** reduces will be contained in the ***policy schedule***.

The following 2 examples illustrate the decrease in ***TPD benefit*** for the same amount of insurance but different ***benefit expiry ages***.

Example 1: Where the ***benefit expiry age*** is 70 and ***TPD benefit*** is $500,000

Person's age	TPD benefit	Percentage decrease
Up to 60	$500,000	0%
61	$450,000	10%
62	$400,000	20%
63	$350,000	30%
64	$300,000	40%
65	$250,000	50%
66	$200,000	60%
67	$150,000	70%
68	$100,000	80%
69	$50,000	90%
70	$0	100%

Example 2: Where the ***benefit expiry age*** is 67 and ***TPD benefit*** is $500,000

Person's age	TPD benefit	Percentage decrease
Up to 62	$500,000	0%
63	$400,000	20%
64	$300,000	40%
65	$200,000	60%
66	$100,000	80%
67	$0	100%

3.3.2 Standard and non-standard definitions of TPD

You can choose one of the following definitions of ***TPD*** for your plan.

- Standard ***TPD*** Definition – a key part of this definition is whether an ***insured member*** can return to work that they are reasonably suited to because of their education, training or their experience.
- Own Occupation ***TPD*** Definition – a key part of this definition is whether an ***insured member*** can specifically return to their ***own occupation***. This ***TPD*** definition is not available if you are the trustee of a superannuation fund.
- Non-standard ***TPD*** Definition – contact us if you would like to define ***TPD*** differently.

You will find which ***TPD*** definition applies to your plan in the ***policy schedule***.

The parts of the ***TPD*** definition applicable under each option are set out in the table below. **9 Definitions** of **Part 2: Policy terms** sets out the ***TPD*** definition, and definitions of Parts 1–5.

TPD Definition	Part 1 Any Occupation	Part 2 Own Occupation	Part 3 Activities of Daily Work	Part 4 Normal Domestic Duties	Part 5 Mental Health	Specific Medical Conditions
Standard TPD Definition	✓	✗	✓	✗	✓	✓
Own Occupation TPD Definition	✗	✓	✓	✗	✓	✓
Non-standard TPD Definition	*	*	*	*	*	*

(*This definition is available on request for the parts you select)

3.4 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***.

3.5 Return to wellness support

If we decline an ***insured member's TPD*** claim and there is evidence that they could return to work within their education, training or experience, we may offer to pay for the ***insured member*** to participate in a ***rehabilitation and retraining program*** through an appropriate service provider. Where we agree to pay some or all of the costs of that program, we will pay the appropriate service provider directly.

Where we agree to pay for some or all of the costs of that program, the following conditions apply:

- we will pay the appropriate service provider directly
- we will pay up to a maximum of $5,000, and
- this benefit is payable only once for an ***insured member*** under the ***policy***.

We will not:

- pay or reimburse any costs that we did not agree to pay prior to them being incurred, and
- pay or reimburse any costs that we are not permitted by law to pay or that are regulated by the *National Health Act 1953* (Cth) or the *Private Health Insurance Act 2007* (Cth).

4. Limitations to benefits

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

4.1 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 disablement*** 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.

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***.

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

4.2 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 death, ***terminal illness*** or ***TPD*** (as applicable) 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 death, ***terminal illness*** or ***TPD*** (as applicable) 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***.

4.3 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.

4.4 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.

4.5 We may reduce or refuse to pay the insured benefit in certain circumstances

The ***insured member's insured benefit*** may be reduced or refused in some cases.

4.5.1 The insured member is covered under another policy

We may reduce or refuse to pay an ***insured benefit*** if:

- an ***insured member*** becomes covered by similar benefits under another insurer's policy (the ***subsequent policy***) during Extended Cover (see **2.13 Extended cover**), and
- the death, ***terminal illness*** or ***total and permanent disablement*** arose or occurred during the period of Extended Cover.

In that case, we may:

- refuse to pay any ***insured benefit*** that becomes payable under the ***policy***, or
- reduce any ***insured benefit*** by the amount the ***insured member*** receives or may receive under their ***subsequent policy***.

4.5.2 Superannuation benefit is transferred to another fund

We will reduce an ***insured member's insured benefit*** if their sum insured has a component based on a ***superannuation account balance*** and they transfer some or all of their superannuation benefit to another fund under ***portability legislation***. In that case, we will reduce their ***insured benefit*** by the amount of the ***superannuation account balance*** they transferred to the superannuation fund.

4.5.3 Other insurance is not cancelled as required

Sometimes we issue a ***policy***, or a cover under the ***policy***, on the condition that insurance with other insurers is cancelled. If the other insurance is still in place at the ***event date*** or the date the ***insured member*** dies (as applicable), we will reduce any benefits we pay by any benefits paid or payable under the other insurance. We will do this if the other insurance either:

- is not cancelled, or
- is cancelled but replaced with a policy issued by another insurer.

4.6 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***.

4.7 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.

5. 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.

5.1 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*** covered for a ***TPD benefit*** know that they must advise you, or us, of circumstances giving rise to a potential claim
- you or a representative acting on behalf of the ***insured member's*** estate notifying us of the death of the ***insured member*** as soon as reasonably possible.

5.2 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.

We generally ask for medical information and evidence to enable a claim for a ***TPD benefit*** or ***terminal illness benefit*** to be assessed.

During the course of a ***TPD*** claim, the ***insured member*** may be required to be interviewed, attend vocational assessments and rehabilitation, and provide us with all information required in order to determine their eligibility for benefits.

5.3 Before we pay a claim

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

5.3.1 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*** entitlement to claim the applicable ***insured benefit***, and
- the ***insured member*** being under the regular care of, and following the advice of a ***medical practitioner*** (for ***TPD*** claims).

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:

- an original or certified death certificate – if applicable. Where an ***insured member*** dies outside of Australia, we may require an original death certificate or copy certified by the Australian Embassy in the country of the ***insured member's*** death
- a birth certificate or other evidence of date of birth
- medical reports from treating ***medical practitioners*** (at your expense, or at the ***insured member's*** expense)
- 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***, and
- 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.

5.3.2 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.

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

5.4 Returning to Australia for claim assessment

We may require an ***insured member*** claiming a ***terminal illness benefit*** or ***TPD benefit*** while outside of Australia to return to Australia for claim assessment at their expense. We will require this if we cannot otherwise obtain the information we require under the ***policy*** to assess the claim. If they refuse to do so, we may refuse to pay a benefit.

5.5 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 **2.10 Worldwide cover, round the clock**, **2.11 Cover for insured members working outside Australia**, or **2.12 Cover during employer-approved leave**, unless we agree otherwise with you.

6. Costs you pay

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

6.1 Where to find premium rates

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

6.2 What minimum annual premium applies

You must pay at least the minimum annual premium shown in the ***policy schedule***, 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 **8.3 Terminating the policy**.

We may vary the minimum annual premium in accordance with **6.7 We can change premium rates or the minimum annual premium**.

6.3 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 **2.14 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 **6.11 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.

6.4 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).

6.5 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 an ***event date***, date of certification for ***terminal illness*** or date of death 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***.

6.6 We guarantee premium rates

Subject to **6.7 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***.

6.7 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.

6.8 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.

6.9 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 Life insurance product.

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

6.9.1 Stamp duty

Stamp duty is included in the premium rates.

6.9.2 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.

6.9.3 Tax on benefits paid to insured members

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

6.9.4 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.

6.10 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.

6.11 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 Income Protection 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 **6.5 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. Keeping us informed

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

7.1 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.

7.2 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.

7.3 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.

7.4 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.

8. General conditions

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

8.1 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***.

8.2 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.

8.3 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 **6.2 What minimum annual premium applies** and **6.5 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***.

8.4 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.

8.5 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.

9. 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.
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 bed, a chair or a wheelchair, or moving from place to place by walking, using a wheelchair or a walking aid.
Activity/Activities of daily work	The following activities: • bending – the ability to bend, kneel or squat to pick something up from the floor and straighten up again • communicating – the ability to: – clearly hear with or without a hearing aid or alternative aid if required – understand and clearly express themselves in speech or writing, or – interact with others by listening, understanding and speaking on a day-to-day basis and in a work environment. • reading (vision) – the ability to read, with correction with suitable lenses if required, to the extent that an ophthalmologist can certify that either: – visual acuity is at least 6/48 in both eyes – constriction is within or greater than 20 degrees of fixation in the eye with the better vision. • walking – the ability to walk more than 200m on a level surface without stopping from breathlessness, angina or severe pain elsewhere in the body • lifting – the ability to lift, carry or otherwise move objects weighing up to 5kg using one or both hands • having manual dexterity – being able to do these things with reasonable precision and success: – use at least one hand, its thumb and fingers, to pick up and manipulate small objects – use a keyboard.
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***.

The term we use	What we mean
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***.
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.
Date of disability/ date of disablement	A meaning that depends on the part of the ***TPD*** definition: • in Parts 1, 2, and 4 – the first day after the ***waiting period*** ends • in Parts 3 and 5 – the first day that all of the elements of the relevant definitions are satisfied.
Death benefit	The amount that applies to the ***insured member*** in the ***policy schedule*** or the ***decision note*** on the ***insured member's*** date of death.
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.
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***.
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).

The term we use	What we mean
Event date	The meaning depends on the part of the ***TPD*** definition: • in Parts 1 and 2 – the first day of the ***waiting period*** during which the ***insured member***, solely because of illness or injury, has not worked • in Part 3 – the first day that the ***insured member***, solely because of illness or injury, is totally unable to perform at least 3 ***activities of daily work*** • in Part 4 – the first day of the ***waiting period*** during which the ***insured member***, solely because of illness or injury, has been unable to perform ***normal domestic duties***, leave their ***home*** unaided and work in any occupation • in Part 5 – the first day of the 12-month period during which the ***insured member***, solely because of a mental health condition, has not worked.
Existing cover	Any insured amount of cover that the ***insured member*** held under the ***policy*** before we accepted their application for ***transferred cover***.
Fixed-dollar cover	The amount of the ***insured benefit*** for Death Cover or TPD Cover that is fixed at a specific amount. This is cover that we have agreed to provide because you, the ***insured member*** or the ***insured member's*** employer (if applicable) has requested it.
Formula-based cover	The amount of the ***insured benefit*** for Death Cover or TPD Cover calculated using a formula that you or the ***participating employer*** chose and that we agreed to.
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***.
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***.
Home	The ***insured member's*** main place of residence.
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***.

The term we use	What we mean
Insured benefit	Any benefit provided under the ***policy***, as the context requires, including the: • ***TPD benefit*** • ***terminal illness benefit*** • ***death 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.
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***.
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 • date the person first satisfied the ***eligibility criteria*** • sum insured (in Australian currency), and • formula for cover.
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.
Normal domestic duties	The tasks an ***insured member*** performs for themself or their family if their only occupation is to maintain their family ***home***. They must be able to perform these tasks unassisted: • cleaning – using domestic appliances and equipment to clean and maintain the ***home*** • cooking – using kitchen and cooking utensils, appliances and equipment to prepare more than the most basic meals • laundry – washing, drying and ironing clothes or linen to basic standards • shopping – buying and unpacking everyday household provisions, and • taking care of dependent children (if applicable). Normal domestic duties do not include duties performed outside the ***insured member's home*** for salary, reward or profit.
Other factors	All relevant information available to us in determining if an ***insured member*** satisfies the ***TPD*** definitions, for example: • information relevant to the ***insured member's*** future capability to return to work • full details of an ***insured member's*** previous gainful or non-gainful work, their past education, training or experience, and transferrable skills, irrespective of the date that the work, skills, training, education, or experience was obtained. We will not consider the ***insured member's*** previous status or seniority.
Own occupation	The ***insured member's*** occupation immediately before the ***event date***.
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.
Participating employer	Any participating employer mentioned in the ***policy schedule***.

The term we use	What we mean
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.
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 Life 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***.
Portability legislation	The provisions of: • the *Superannuation Industry (Supervision) Regulations 1994 (Cth)*, as amended from time to time, which regulate the transfer or rollover of superannuation benefits, or • any other relevant present or future law of the Commonwealth of Australia or any state or territory for the purposes of this definition.
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***.
Previous cover	Death-only cover, or death and total and permanent disablement cover, under a ***previous life policy*** with another insurer through a superannuation fund.
Previous cover terms	Any special condition, premium loading or exclusion that applies to the ***insured member's previous cover***.
Previous life policy	A life policy within the meaning of the *Life Insurance Act 1995* (Cth) that you held immediately before applying to transfer your ***previous cover*** to the ***policy***.
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 Life insurance from us.

The term we use	What we mean
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 Life insurance quotation we issue you that contains the draft ***premium rate schedule*** and our terms for cover for you.
Reasonable retraining or rehabilitation	Any further education, training, experience or rehabilitation that the ***insured member***: • has had since the ***event date***, or • has capacity to take part in, and can reasonably be expected to do so based on their previous education, training or experience.
Rehabilitation or retraining program	A program that: • includes job seeking, graduated return-to-work plans, retraining and other work readiness preparation • a ***specialist medical practitioner*** in the ***insured member's*** condition considers likely to result in them returning to paid work • is not eligible for a Medicare or pharmaceutical benefit for any part of the service provided, and • is 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***.
Special acceptance terms	Includes exclusions, premium loadings and other special conditions we apply to the ***insured member's*** cover.
Specialist medical practitioner	A ***medical practitioner*** who is a specialist practising in the relevant medical field of the ***insured member's*** illness or injury.
Specific life event	Refers to any of these dates for an ***insured member***: • they get married • the second anniversary of the establishment of an ***interdependent relationship*** • their dependent child starts secondary school • they or their spouse gives birth to or adopts a child • they take out or increase a mortgage on their main place of residence with an accredited mortgage provider (excludes redrawing and refinancing).

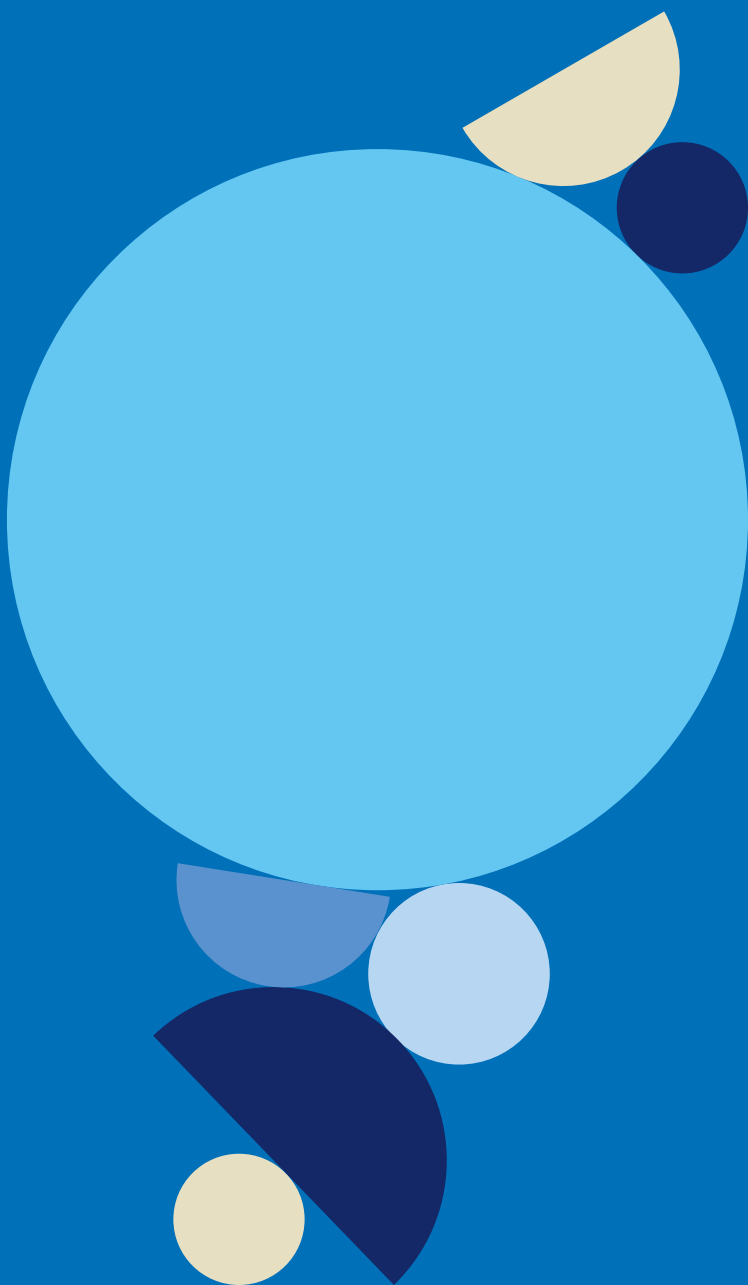
The term we use	What we mean
Specific Medical Condition	Any of the following conditions: 1. ***Cardiomyopathy* (permanent and irreversible)** means impaired ventricular function resulting in significant impairment. The degree of permanent and irreversible impairment must be at least Class 3 of the New York Heart Association classification of cardiac impairment. 2. ***Cognitive loss (permanent)*** means 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. 3. ***Dementia including Alzheimer's disease (diagnosed)*** means both of the following: • unequivocal diagnosis of permanent and irreversible dementia or Alzheimer's disease that is 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 by the results of an equivalent neuro-psychometric test. 4. ***Head trauma (permanent and irreversible)*** means cerebral injury resulting in permanent neurological deficit, as confirmed by a ***medical practitioner*** who is a consultant neurologist and/or an 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. 5. ***Loss or paralysis of limb (permanent)*** means the total and permanent loss of either the 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. 6. ***Motor neurone disease (diagnosed)*** means the unequivocal diagnosis of a progressive form of debilitating motor neurone disease, as confirmed by a ***medical practitioner*** who is a consultant neurologist. 7. ***Multiple sclerosis (with impairment level)*** means 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. 8. ***Muscular dystrophy (with impairment level)*** means 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.

The term we use	What we mean
	9. ***Parkinson's disease (diagnosed)*** means 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. 10. ***Primary pulmonary hypertension (idiopathic pulmonary arterial hypertension with permanent impairment)*** means primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation and resulting in significant 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 superseded by 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. 11. ***Specific Loss*** – Loss of either sight, hearing or speech. ***Loss of sight*** means permanent and irrecoverable loss of sight due to illness or injury, 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 at least 3 months and be permanent and irreversible. Loss of speech does not include loss of speech related to any psychological cause. ***Hearing loss (permanent in both ears)*** means the total and permanent loss of hearing in both ears greater than 90 decibels across all frequencies, due to illness or injury. 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).
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***.
Superannuation account balance	The dollar value of the accumulation fund maintained by you for of an ***insured member*** under your plan, where you are the trustee of a superannuation fund.
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/ Terminally ill (Standard definition)	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 for Death Cover under the ***policy***.

The term we use	What we mean
Terminal illness/ Terminally ill (Enhanced definition)	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 24 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 for Death Cover under the ***policy***.
Terminal illness benefit	The of lower of: • the ***death benefit*** on the date of the latest ***written certification***, and • $3 million.
Total and Permanent Disablement/Totally and Permanently Disabled (TPD)	The meaning depends on the ***TPD*** definition that has been chosen and its parts. **Specific Medical Conditions** For all parts with a ***waiting period***, we may waive ***waiting periods*** and provide immediate assessment where: • an ***insured member*** is suffering from a ***specific medical condition***, and • we have received all claim requirements. **Part 1 – Any occupation** An ***insured member*** satisfies all of the following: • They were ***gainfully working*** on the day immediately before either: – the ***event date*** – the date the ***employer-approved leave*** begins if the ***event date*** occurs during ***employer-approved leave***. • They were ***gainfully working*** for an average of at least the ***required hours*** for: – at least 6 consecutive months immediately before the ***event date*** or the date the ***employer-approved leave*** begins, or – the period since their cover started under the ***policy***, if less than 6 months. • They are following a ***medical practitioner's*** advice on the illness or injury they are claiming for. The ***insured member*** must be at a stage where, despite any further treatment, their illness or injury is not expected to improve enough to enable a return to ***gainful employment*** within their education, training or experience, and • Based on medical or other relevant evidence and ***other factors***, and solely because of injury or illness, the ***insured member***: – has not worked at any time during the ***waiting period***, and – at the ***date of disablement***, is unlikely ever to be able to return to work in any ***gainful employment*** that: – they are reasonably suited to by education, training or experience, or – they may become reasonably suited to, with ***reasonable retraining or rehabilitation***.

The term we use	What we mean
	Part 2 – Own occupation The ***insured member*** satisfies all of the following: • They were ***gainfully working*** on the day immediately before either: – the ***event date*** – the date the ***employer-approved leave*** begins if the ***event date*** occurs during ***employer-approved leave***. • They were ***gainfully working*** for an average of at least the ***required hours*** for: – at least 6 consecutive months immediately before the ***event date*** or the date the ***employer-approved leave*** begins, or – the period since their cover started under the ***policy***, if less than 6 months. • They are following a ***medical practitioner's*** advice on the illness or injury they are claiming for. The ***insured member*** must be at a stage where, despite any further treatment, their illness or injury is not expected to improve enough to enable a return to ***gainful employment*** in their ***own occupation***, and • Based on medical or other relevant evidence and ***other factors***, and solely because of illness or injury, the ***insured member***: – has not worked at any time during the ***waiting period***, and – at the ***date of disablement***, is unlikely ever to be able to return to work in their ***own occupation*** following ***reasonable retraining or rehabilitation***. **Part 3 – Activities of daily work** The ***insured member*** satisfies all of the following: • They are totally and irreversibly unable to perform at least 3 ***activities of daily work*** solely because of illness or injury. • They are following a ***medical practitioner's*** advice on the illness or injury they are claiming for. The ***insured member*** must be at a stage where, despite any further treatment, their illness or injury is not expected to improve enough to enable a return to ***gainful employment*** within their education, training or experience, and • Based on medical or other relevant evidence and ***other factors***, and solely because of illness or injury, at the ***date of disablement***, the ***insured member*** is incapable of ever working in any ***gainful employment*** for which: – they are reasonably suited to by education, training or experience, or – they may become reasonably suited to, with ***reasonable retraining or rehabilitation***. **Part 4 – Normal domestic duties** The ***insured member*** satisfies all of the following: • They are following a ***medical practitioner's*** advice on the illness or injury they are claiming for. The ***insured member*** must be at a stage where, despite any further treatment, their illness or injury is not expected to improve enough to enable a return to ***gainful employment*** within their education, training or experience, and • Based on medical or other relevant evidence and ***other factors***, and solely because of illness or injury, the ***insured member***: – has been unable to perform ***normal domestic duties***, leave their ***home*** unaided and work in any occupation during the ***waiting period*** – as at the ***date of disablement***, is unlikely ever to be able to perform ***normal domestic duties***, and – as at the ***date of disablement***, is unlikely to work in any ***gainful employment*** for which: – they are reasonably suited to by education, training or experience, or – they may become reasonably suited to, with ***reasonable retraining or rehabilitation***.

The term we use	What we mean
	Part 5 – Mental health The ***insured member*** satisfies all of the following: • They have a mental health condition which has been diagnosed by a psychiatrist using criteria outlined in the ***DSM***. • They have been assessed as having an impairment of 19% or above on the Psychiatric Impairment Rating Scale, by an appropriately qualified psychiatrist. • They have been under the regular ongoing and appropriate care of a psychiatrist for at least 12 months (unless we agree a shorter period). The psychiatrist must consider that the ***insured member*** has exhausted all reasonable and appropriate treatment options. • They have not worked at any time for 12 consecutive months from the ***event date*** due to the mental health condition – However, the 12 months does not apply where the person is suffering one or more of the ***specific medical conditions***, and • Based on medical or other relevant evidence and ***other factors***, and solely because of the mental health condition, the ***insured member*** is incapable of ever working in any ***gainful employment*** for which: – they are reasonably suited to by education, training or experience, or – they may become reasonably suited to, with ***reasonable retraining or rehabilitation***.
Total and Permanent Disablement benefit/ TPD benefit	The amount specified in the ***policy schedule*** for the ***insured member*** on the ***event date***, as varied by any ***decision note*** on an individual ***insured member***.
Transfer date	The date the ***policy*** commenced with us.
Transferred cover	Cover that the ***insured member*** wishes to transfer into the ***policy***, and that we accept, under **2.16 Members can apply to transfer individual cover**.
Unit-based cover	Cover that is based on a number of units, where one unit represents a set amount at a certain age.
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.
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	A 91 consecutive day period.
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***.



Group Insurance Administration
Email group.risk@zurich.com.au
Address GPO Box 4129 Sydney NSW 2001

Zurich Australia Limited
ABN 92 000 010 195
AFSL 232510

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