ZURICH

Zurich Active

Product Disclosure Statement
and policy conditions

Issue Date: 1 October 2024

Thank you for considering Zurich Active

This document explains Zurich Active insurance policies

This document is a product disclosure statement or PDS. It explains how Zurich Active works and what it does and doesn't cover.

Please read this document carefully to decide if Zurich Active is right for you before you apply for a policy.

Zurich Active policies are:

- Zurich Active Cover
- Zurich Income Safeguard
- Zurich Child Cover.

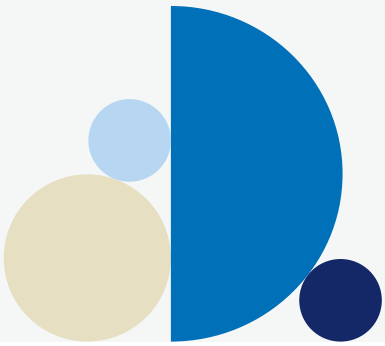
If we issue a policy to you, this document will become your policy conditions

If we issue a Zurich Active policy to you, we'll send you a policy schedule which will confirm the details of your cover and this document will become your copy of the policy conditions. Please store both documents together in a safe place.

We've divided this document into logical sections

Zurich Active policies are comprehensive and this document contains a lot of information. To help you find what you're looking for, we've divided the content into logical sections.

Contents



Here's how to read this document

This document contains information about Zurich Active policies, as well as the policy conditions.

We've italicised defined terms

In this document, all terms appearing in *italics* are defined terms with special meanings which are explained in the 'Definitions' section, starting on page 84. Some definitions are explained in the product section for Zurich Income Safeguard, for easier referencing.

'We' are Zurich Australia Limited

'Zurich', 'us', 'our' and 'we' means Zurich Australia Limited ABN 92 000 010 195, AFSL 232510. Our contact details are on the inside back cover of this document.

Zurich is the issuer of this document and the issuer of the insurance policies described in it.

'You' normally means the person applying for insurance

In this document, 'you' means the person making the insurance decisions and applying for cover. This is usually the policy owner. However, if you take out insurance as a member of a superannuation fund, the policy owner will be the trustee of the superannuation fund. In this case, 'you' means the life insured as the person making the insurance decisions and applying for cover.

This document contains general information only

The information in this document is general information only and doesn't consider your individual objectives, financial situation, or specific needs. Please carefully consider these factors when you decide whether each policy is appropriate for you personally.

We recommend getting specialist advice before you purchase Zurich Active policies

For example, professional financial advice and taxation advice will help you make informed decisions regarding these policies.

Zurich Active has been designed for consumers with certain needs and objectives

Each product explained in this document has been designed 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.

We've made a target market determination for each product in this document. The determination 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 it is to be sold. You can find these documents on our website at zurich.com.au/tmd.

We'll post changes which affect this document on our website

The information in this document is up to date when issued but some information can change. For example, we changed our registered address in late 2020. Changes like this, that are not materially adverse, will be posted on our website in the section: zurich.com.au/lifepds. You can also request a paper or electronic copy of any updated information without charge.

If there is a materially adverse change to the information in this document, we'll issue a supplementary or replacement document.

How to contact us

In this document we explain that there are times when you need to contact us to keep your insurance aligned with your situation. You're also welcome to contact us any time if you have questions. Our contact details are on the inside back cover of this document.

View and update your details any time

You can view your policy information, or update your payment or contact details, 24/7 online. Simply login or register with My Zurich (zurich.com.au/myzurich).

Life Insurance Code of Practice (Code)

We are committed to following the Life Insurance Code of Practice (the Code) and have adopted all of its requirements.

The Code sets out insurers' obligations to consumers during all stages of the life insurance process including:

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

As a subscriber to the Code, we make a number of 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.

If you would like more information about the Code, please visit our website at zurich.com.au/licop.

We can help if you need support

We recognise that some customers need more help than others. For example, customers who are from a non-English speaking background. Your financial adviser can help you through the process at the time when you apply for a policy. They can also help if you make a change to your policy, if you make a claim or if you want to make a complaint. If you contact us and we identify that you need more support or that you're experiencing financial hardship, we'll do our best to help. This could involve helping you to understand how your policy works or explaining the options available under your policy.

Customer concerns

We value your feedback and we're committed to ensuring we work with you to resolve your concerns.

Our Customer Care team is your first point of contact for raising complaints or providing feedback. You can contact us directly via phone, email or in writing and we'll do our best to resolve your issue fairly, respectfully and efficiently, and will keep you informed of our progress.

Our contact details are as follows:

131 551

Monday to Thursday 8.30am – 7.00pm AEST
Friday 8.30am – 5.30pm AEST

client.service@zurich.com.au

Zurich Customer Care
Locked Bag 994
North Sydney NSW 2059

If you're not satisfied with our response to your complaint, your concerns will be escalated to our Dispute Resolution Team. Our specialists will work closely with you to find a solution quickly and amicably.

Further help

If you're not satisfied with our response to your complaint, you can have your complaint reviewed free of charge by the Australian Financial Complaints Authority (AFCA), which is an external dispute resolution scheme.

Before AFCA can investigate your complaint, they generally require you to have first given us the opportunity to resolve it. AFCA provides a fair and independent complaint resolution service.

Contact details for AFCA are as follows:

1800 931 678

info@afca.org.au

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

afca.org.au

Please note there are time limits for lodging a dispute with AFCA, which are available by contacting AFCA.

What is Zurich Active?

Zurich Active is insurance you can tailor to meet your needs

Zurich Active is a flexible suite of life insurance policies. This document explains each of the policies, so that you can select a combination of insurances and ownership structures to meet your needs. Your financial adviser can help you with this process.

The table below shows the main benefits. Each policy offers a range of in-built benefits, as well as a number of optional benefits which allow you to tailor cover. The choices you make about each policy will affect the breadth and the cost of your cover.

You'll find the policy conditions applying to each type of insurance in the next sections of this document.

Choose cover that suits you best

Zurich Active Cover

Active is a package of insurance designed to provide long term protection against the financial impact of severe illness.

Active Cover pays on 170 health events. A higher proportion of benefit is paid for more severe events and you can make multiple claims over time. This recognises that if you survive a severe health event, financial protection against further health events is an ongoing, long-term need.

After we pay you a benefit for a health event, the maximum amount you can then claim reduces. However, unless the total we pay you reaches the health event policy limit, your policy can continue to cover you for:

- later health events which are entirely unrelated to the first claim
- later health events which are related to a previously claimed condition, if the later health event is more severe than the first
- death and *terminal illness*.

We only cover health events at the level of severity described in our definitions. While we don't have a definition for every health event that could possibly happen, there is a safety-net in place. The safety-net defines *occupational impairment* and functional incapacity of a high severity, without naming a specific condition. This means that if you're impacted by a medical condition that isn't one of our named specific health events, we may still pay a claim under the safety-net definitions.

Active Cover includes:

- a claim protector feature, which keeps a specified minimum amount of cover in place until age 65
- death cover, which we'll pay in advance for *terminal illness*.

Zurich Income Safeguard

Income protection provides a monthly benefit if the life insured is disabled due to *sickness* or *injury* and is unable to work. If the life insured is still working, but in a reduced capacity due to *sickness* or *injury*, income protection can pay a part-benefit to help with the resulting reduction in income. You select how quickly benefits are first payable after the life insured is disabled, as well as the maximum period of time that benefits are payable for each claim.

Income protection can financially support the life insured's recovery and return to work.

Zurich Child Cover

Child cover provides a lump sum payment if the insured child suffers a trauma condition which is covered by the policy and meets our specific definition of that condition.

Child cover also includes a death and terminal illness benefit as well as a carer benefit, which can provide financial support if the insured child suffers a health condition which isn't a covered trauma condition.

Child cover can minimise the financial impact of severe child illness or injury.

These features apply to all of the policies explained in this document

Interim cover starts as soon as you apply
Temporary accident cover is in place as soon as you apply. You can find the policy conditions in the 'Interim cover' section, starting on page 73.

Your cover will increase to help you keep up with cost of living
Cover will increase every year without health assessment to help allow for increases in the cost of living. You can decline increases when they're offered if you don't need more cover. This is explained in each of the policy sections of this document.

You can suspend your cover if you're finding it hard to pay premiums
The cover suspension feature allows up to 12 months break in cover to ease financial pressure. This feature isn't available on policies that are funded by a platform account. Information about the cover suspension feature can be found on page 72.

If you have existing insurance cover

If you indicate or agree, as part of your application, that any existing insurance for the life insured will be replaced by cover under this policy, then this policy is subject to a special condition that any benefit we pay under this policy will be reduced by any benefit payable under the existing insurance. This condition is limited to the extent to which the total benefit payable for the life insured exceeds our underwriting limits for that cover type. This may result in no reduction of benefits if limits were not exceeded at the time of application. The limits may depend on the life insured's particular circumstances. Contact us or your financial adviser for more information about limits that may apply to each cover type.

Where to find useful policy parameters

The section 'Useful parameters for each policy are summarised here', starts on page 62. In this section you'll find a snapshot of each policy, including entry ages, end ages, cover limits, and a list of benefits and features.

You can select the most appropriate policy owner

You can tailor Zurich Active policies to suit your individual needs.

Benefits under life insurance policies are usually payable on an event like death or *injury* happening to the life insured but payable to the policy owner. You can have a single policy owner or joint policy owners, for example, husband and wife, family trust trustees, business partners or self-managed superannuation fund (SMSF) trustees.

Your financial adviser can provide you with more information on policy structures for your individual situation.

If you don't want to hold any of your insurance in superannuation, then you can select from the full range of policies and available ownership structures shown in the tables on the next page.

When you apply for cover outside of superannuation, the policy is issued directly to you as the policy owner.

Some policies, like income protection are generally only available on your own life.

You can apply for other policies on your own life or the life of another person. For example, you could take out a policy with your *partner* as the life insured, as their death or severe health event would impact your financial situation.

Where multiple individuals are policy owners, each will own the policy as joint tenants. This means that on the death of a policy owner, their share passes to the surviving joint tenants. If we agree to a different arrangement, we'll document it on your policy schedule.

If a benefit becomes payable, the benefit is generally paid to the policy owner. If the life insured and policy owner are the same, the amount payable on the death of the life insured is generally paid to the life insured's legal personal representative or nominated beneficiaries.

If you hold your cover in superannuation, your cover choices are restricted

Zurich Active Cover and Zurich Income Safeguard can be held in superannuation. One way to set this up is for your own SMSF trustee to own the policy. Alternatively, you can become a member of a superannuation fund which offers Zurich Active.

An advantage of holding cover in superannuation is that premiums can be funded by superannuation investments and contributions. A disadvantage of holding cover in superannuation is that some benefits aren't available or are restricted. For example, some health events cover can't be held in superannuation because those events wouldn't meet a condition of release under superannuation law.

Under superannuation ownership, the trustee is the policy owner and we pay any insurance benefits under the policy to the trustee. If your insurance is owned by an *eligible superannuation fund*, we may agree with the trustee to pay income protection benefits to the life insured directly, to avoid delays.

Where you take out Zurich Active as a member of a superannuation fund, the trustee may only release benefits to you if the trustee is satisfied that you meet a condition of release under superannuation law.

As some benefits can't be held in superannuation, our superannuation optimiser solution will split cover into superannuation and non-superannuation components. We'll issue some cover to a superannuation trustee and some cover to you individually.

Superannuation optimiser automatically applies if you select Zurich Active Cover in superannuation, as not all health events cover can be held in superannuation.

Superannuation ownership, superannuation optimiser and superannuation platforms, are explained in the section 'Holding this insurance in superannuation', starting on page 55.

Available ownership structures are shown here

Policies available outside of superannuation	Policy owner	Life insured	Benefits payable to
• Zurich Active Cover • Zurich Income Safeguard • Zurich Child Cover	**You** as an individual (can be via a platform)	**You** or another individual	**You** or Nominated beneficiary (for death benefits if you're the only policy owner and the life insured)
	You as a corporation	Individual	Policy owner

Policies available in superannuation	Policy owner	Life insured	Benefits payable to
• Zurich Active Cover (using superannuation optimiser) • Zurich Income Safeguard (benefits adjusted to comply with superannuation laws)	You as SMSF trustee or trustees (individual or corporation) (can be via a platform)	SMSF member	SMSF trustee or trustees
	Trustee of an *eligible superannuation fund* (can be via a platform)	**You** (applying for cover through your superannuation fund)	Policy owner (trustee)

The policies are guaranteed to continue provided you pay premiums

Provided you pay premiums, these policies are guaranteed to continue up until the end date of the benefits you've chosen, regardless of any changes in your health or pastimes.

These policies cover you 24 hours a day, seven days a week, worldwide, which means you remain protected during holidays and overseas work assignments.

However, residency can affect how the policies work.

If you're thinking about moving overseas, read the 'Making changes to your policy' section, starting on page 71.

Your policy has a guaranteed upgrade of benefits

If we improve the terms of the benefits described in this document without any change in the standard premium rates, we'll incorporate the improvement in your policy.

Any improvements will apply to future claims only and not to past or current claims. The improvements won't apply to claims arising from conditions which first occur, are first diagnosed, or which first become reasonably apparent, before the improvement effective date.

Your cover won't be reduced because of the guaranteed upgrade. If you are inadvertently disadvantaged in any way, the previous policy wording will apply.

We'll let you know about any benefit upgrades that affect your policy via the policy anniversary notice that we send you every year. We'll also include information about any policy upgrades on our website at:

zurich.com.au/existingcustomers.

There are risks that come with holding these policies

Risks which come with holding Zurich Active policies include:

- the insurance you've chosen might be inadequate to fully protect your financial needs based on your circumstances now or in the future
- if premiums aren't paid when due, the policy will be cancelled, the life insured will no longer be covered, and you can't make a claim
- if you don't comply with your duty to take reasonable care not to make a misrepresentation, 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. The duty to take reasonable care not to make a misrepresentation is explained in the 'Applying for cover' section, starting on page 59.

Zurich Active Cover

Zurich Active Cover can provide cover for health events, death and terminal illness

This package of cover will provide a lump sum payment if the life insured suffers one or more of the listed health events or is diagnosed with a *terminal illness*. It can also provide a lump sum payment to your estate or nominated beneficiary if the life insured dies.

The policy conditions for Zurich Active Cover are set out in this section.

This is how cover for health events works

We'll pay a lump sum if the life insured meets one of our covered health event definitions. Covered health events include *heart attack*, *stroke*, *cancer*, and many others, as shown on pages 15 to 24. The definitions for each health event are set out in the 'Definitions' section, starting on page 84, and detail the severity requirements that need to be met for a benefit to be paid.

Health events cover continues until the policy anniversary when the life insured is 70.

Generally, the more severe the health event, the higher percentage of the amount of cover is payable. Each defined health event is matched to a benefit category reflecting its severity.

After a health event claim, cover will remain in place, allowing multiple claims over the life of the policy, but with lower maximum benefit amounts.

Depending on the remaining cover, for further claims that meet a health event definition, we'll pay either the:

- difference in benefit category percentage for unrelated conditions that occur in the first 12 months after a claim. This period applies because complications from a medical condition or its treatment can arise and should be treated as the one event
- difference in benefit category percentage where health deteriorates, and we pay a claim for the same condition at a more severe level
- full amount of the benefit for unrelated conditions that occur more than 12 months after the earlier claim.

While claims affect the maximum amount payable for later claims, some lower-severity health events will continue to pay the same percentage of the initial amount of cover.

Here's an example to demonstrate

Here is a simple example which shows how health events cover is structured when a policy starts, and then after claims are made. In this example, the policy begins with $500,000 of health events cover. $300,000 is paid over two separate health events, and the policy continues to provide up to $200,000 of health events cover for further events. The maximum amount payable at each health event benefit category would have indexed over time if inflation protection increases were accepted.

Cover when the policy starts	
Health event benefit category	**Maximum amount payable**
A	$500,000
B	$325,000
C	$200,000
D	$100,000
E	$25,000

Category D health event claim paid: $100,000
Category A is reduced

Cover after the first claim is paid	
Health event benefit category	**Maximum amount payable**
A	$400,000
B	$325,000
C	$200,000
D	$100,000
E	$25,000

Category C health event claim paid: $200,000
Categories A, B and C are reduced (the benefit categories continue to reflect their percentage of the initial amount of cover but are capped at the reduced benefit category A amount)

Cover after the second claim is paid	
Health event benefit category	**Maximum amount payable**
A	$200,000
B	$200,000
C	$200,000
D	$100,000
E	$25,000

Premiums for the life of the policy are based on the initial amount of cover

The premiums for Zurich Active Cover are structured to reflect it being a long-term protection package. As multiple claims can be made over the life of the policy and cover remains in place, the premiums are based on the amount that can be claimed over the life of the policy.

Premiums therefore continue to be based on the amount selected as the initial amount of cover even after benefits are paid.

Zurich Active Cover policy conditions

The information below forms part of the Zurich Active Cover policy conditions. Words or expressions shown in *italics* have their meaning explained in the 'Definitions' section, starting on page 84.

When we accept your application, we'll issue a policy schedule. The policy schedule shows:

- the life insured covered under the policy
- the initial amount of cover for each benefit at the start of the policy
- any extra-cost optional benefits selected
- whether your premiums are variable age-stepped or variable premiums
- benefit end dates
- any special conditions that apply to your policy specifically.

The life insured is only covered for the benefits and amounts shown on the policy schedule. Each benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefits end' on page 32.

Cover is automatically increased each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 27.

You can apply to make changes to your policy. If you apply for optional benefits or increases to the benefit amounts after the policy starts, changes are only effective if we accept the application after assessing the life insured's health, occupation, and pastimes.

In some situations, we'll issue a policy which only includes death & terminal illness cover. If this is the case, it will be clearly shown on the policy schedule. This can happen if:

- your policy doesn't include cover for health events because we don't accept your application for health events cover
- you ask us to cancel the health events cover after the policy starts.

If cover is held in superannuation

Two related policies will be issued under superannuation optimiser. The policy schedule will show whether the policy is the superannuation policy or the non-superannuation policy. The section 'Holding this insurance in superannuation', starting on page 55, provides important information and terms for superannuation optimiser.

The related policies issued under a superannuation optimiser structure will both end automatically if either one of the policies ends. This happens because each policy contains only part of the cover and can't exist without the other part. If one of the policies is paid in advance, we'll refund any unused premiums. If we need to refund any contributions made to the superannuation policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

Benefits under the superannuation policy are subject to the superannuation restrictions and limitations described on page 56. Some benefits don't apply if the policy is issued to the trustee of a superannuation fund, but can be paid under the non-superannuation policy. These are clearly marked.

When a benefit is payable

A benefit is payable if the life insured:

- dies
- is diagnosed with a *terminal illness*
- suffers a health event covered under the policy, and the maximum amount payable for the relevant benefit category isn't nil. The maximum amount payable is explained on page 12.

We'll pay a benefit only for an event that occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 29.

Benefit name	What this benefit pays	Can it be held in superannuation?
Health events benefit	Pays a lump sum on diagnosis or occurrence of a covered health event. Multiple claims can be paid over the life of the policy. We don't cover all traumatic conditions. Our specific definition of the health event applies to any claim and describes a certain severity. The safety-net allows us to pay a benefit for severe events that aren't described specifically by any of our health event definitions but meet the safety-net definitions of *occupational impairment* or functional incapacity.	Yes, cover will be split across two policies under the superannuation optimiser structure. Benefits that don't meet the superannuation definition of permanent incapacity are excluded from the superannuation policy but will be held on a non-superannuation policy, as explained in the section 'Holding this insurance in superannuation' on page 55.
Death & terminal illness benefit	Pays a lump sum on death or *terminal illness*.	Yes
Advancement for funeral expenses	Advances up to $15,000 of the death benefit amount to reimburse funeral expenses.	No

What is a health event?

A health event is a *sickness* or *injury* or treatment for a *sickness* or *injury* that is listed in the section 'These are the health events and benefit categories' starting on page 15.

What is the safety-net?

If the life insured suffers a severe condition that isn't listed in our health events tables, it may be possible to meet our broader safety-net criteria. The safety-net considers the life insured's overall ability to perform an occupation or daily tasks. A benefit is payable if the life insured suffers severe functional capacity limitations arising from a *sickness* or *injury* at the severity described in the safety-net criteria in the table below.

Benefit category	Safety-net covered events
A	*occupational impairment*
	presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform four out of six *activities of daily living*
B	presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform three out of six *activities of daily living*
C	presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform two out of six *activities of daily living*

If our assessment is that the life insured's condition meets any of the health event definitions, we'll pay a benefit for that health event and no benefit will be paid under these safety-net definitions for the same condition.

You can't elect to claim under the safety net to access a higher benefit payment for a condition we've assessed as meeting a health event definition. However, you may be eligible to claim a further benefit under the safety-net if the life insured's condition worsens and there is no health event definition for the condition at a higher severity.

Further claims are subject to limits including the limited claim period and progressive condition rules. These rules are explained in the section 'Any claim we pay reduces the amount available for further claims' on page 32.

The safety-net ends on the policy anniversary when the life insured is 70.

What we'll pay for a health event claim

Several definitions are provided for each health event to describe different levels of severity. Benefits are intended to match the severity of any health event suffered, so each definition has been assigned a benefit category.

The benefit categories range from A to E, with A being the most severe.

Here are two definitions from the *cancer* health events list which demonstrate how this works:

Benefit category	Definition
B	Advanced *cancer* classified as stage 3 or above based on TNM classification
E	*carcinoma in situ*

When you apply for Zurich Active Cover, you select an initial amount of cover. The initial amount of cover increases over time if you accept increases, as explained in the section 'Inflation protection' on page 27. It will otherwise only change if you ask us to decease your cover, or if you apply to increase your cover and we agree to the increase.

The initial amount of cover is used to determine the premium you pay. It's also used to calculate the maximum benefit amount payable for a health event, death, or *terminal illness* claim. The table below shows the percentages that apply to each benefit category.

Benefit category	Percentage of the initial amount of cover payable
Death & terminal illness	100%
A	100%
B	65%
C	40%
D	20%
E	5% (the minimum benefit will be boosted to $10,000 if the initial amount of cover is less than $200,000 when the definition is met)

When you make your first claim

The first time a health event claim is made on the policy, the benefit payable is either 100%, 65%, 40%, 20% or 5% of the initial amount of cover as at the date the health event occurs. The amount payable is based on the definition met and the benefit category assigned to it.

As explained in the table above, the minimum amount payable is $10,000.

The amount paid for any claim reduces the benefit amount available for further claims. As multiple claims can be made on the policy, the premium payable after a claim continues to be based on the initial amount of cover.

If a claim is made for death or *terminal illness*, 100% of the initial amount of cover is paid, along with any additional death cover on the policy, and the policy ends.

The amount we'll advance for *terminal illness* is the maximum amount payable on the date the life insured's *terminal illness* is certified, even if we don't see the certifications until a later date.

Further claims

If a claim is made for death or *terminal illness*, 100% of the maximum amount payable is paid, along with any additional death cover on the policy, and the policy ends.

When a further health event claim is made, the amount payable is again based on the definition met and the benefit category assigned to it.

However, the benefit amount is reduced if any of the following apply:

- the new claim occurs in the first 12 months after a claim or if the new claim is a progressive condition
- the maximum amount payable for the relevant health event benefit category is reduced following an earlier claim
- the health event policy limit is reached.

Claims in the 12-month limited claim period and progressive claims

The limited claim period and progressive conditions are both explained on page 30.

Claims where the maximum amount payable is reduced following an earlier claim

The maximum amount payable for each health event benefit category is shown on your latest policy schedule and is updated each year in your policy anniversary notice.

Claims exceeding the health event policy limit

No further benefits are payable if the combined total payable reaches the policy limits shown in the table below.

Highest category health event claimed	Health events policy limits	
	for claims that are progressive conditions	for all other health event claims
A	$4 million	$6.6 million
B to E	$2.6 million	$5.2 million

The health events policy limits:

- include any benefits boosted by the extended care option
- apply across related policies if you select superannuation optimiser.

The maximum amount payable will change over time

The maximum amount payable refers to the highest amount we'll pay for each benefit category at any point in time.

When your policy starts, the maximum amount payable is shown on your policy schedule and the amounts for both death & terminal illness and category A health events will align with the initial amount of cover.

For example, a new policy would look like this:

Initial amount of cover: $500,000

Benefit category	Maximum amount payable
Death & terminal illness	$500,000
A health events	$500,000
B health events	$325,000
C health events	$200,000
D health events	$100,000
E health events	$25,000

After you make a claim, the maximum amount payable is reduced to show the amount of cover remaining on the policy.

For example, following a category D health event claim (which would pay $100,000), the same policy would look like this:

Initial amount of cover: $500,000

Benefit category	Maximum amount payable
Death & terminal illness	$400,000
A health events	$400,000
B health events	$325,000
C health events	$200,000
D health events	$100,000
E health events	$25,000

Situations when the maximum amount payable for each benefit category in this table will change include:

- after each claim, the amounts for death & terminal illness and benefit category A will be reduced by the claim amount paid. The amounts for the other benefit categories will continue to reflect their percentage of the initial amount of cover but are capped at the reduced benefit category A amount
- if you accept inflation protection increases, the amounts will be increased in line with that feature (see the section 'Inflation protection' on page 27)
- if you ask us to increase or decrease the initial amount of cover, the amount for each benefit category will be adjusted so that it retains the same proportion to the initial amount of cover as it did before the change.

We'll send you an updated policy schedule to reflect any claim payment, or if you ask us to increase or decrease your cover. Inflation protection increases will be reflected in the anniversary notice we send you each year.

You can reduce cover under your policy

If you ask us to reduce the initial amount of cover under your policy, the maximum amount payable and the protected amount will be adjusted accordingly.

The amount we'll pay for a claim may be reduced if you've already made a claim under your policy. This is explained in the section 'Further claims' on the previous page.

Cover changes when the life insured reaches 65 and 70

Occupational impairment cover ends when the life insured reaches 65

On the policy anniversary when the life insured is 65, cover for *occupational impairment* ends. The extended care option, if selected, also ends.

Health events cover and the safety-net end when the life insured reaches 70

From the policy anniversary when the life insured is 70, cover for all health events and remaining safety-net conditions ends and cover is only provided for death & *terminal illness*.

We'll remind you about these changes

We'll remind you about these changes when the life insured approaches 65 and 70 so that you have time to seek advice and decide whether to continue the cover.

Advancement for funeral expenses

We'll advance up to $15,000 of the death & terminal illness benefit amount to reimburse funeral expenses while a death benefit claim is being assessed.

The amount payable is the lower of:

- 10% of the maximum amount payable for death or *terminal illness*
- $15,000.

The maximum amount we'll pay under this benefit or any similar benefit is $15,000 across all *Zurich life insurance policies* for the life insured.

This benefit doesn't apply if the policy is issued to the trustee of a superannuation fund.

These are the health events and benefit categories

The benefit payable for any covered health event depends on the benefit category assigned to the definition. The categories range from A to E, with A being the most severe.

In this section, the following headings are used to group the covered health events definitions and benefit categories:

- cancer
- heart and artery
- brain and nerves
- digestive system
- kidneys and urogenital tract
- lungs
- musculoskeletal system
- severe burns
- hearing
- sight
- HIV/AIDS
- hospitalisation
- additional covered conditions.

We'll only pay a benefit for the covered health events set out in this section until the policy anniversary when the life insured is 70. See the section 'Health events cover and the safety-net end when the life insured reaches 70' on page 14.

Cancer	
A	Any metastatic *cancer* classified as stage 3 or above based on TNM classification where all non-palliative treatment modalities have failed and been exhausted
	Advanced lymphoma classified as Ann-Arbor stage 3 or above where all non-palliative treatment modalities have failed and been exhausted
	Malignant brain tumour classified as grade 2, 3 or 4 based on the WHO grading system for malignant tumours of the central nervous system where all non-palliative treatment modalities have failed and been exhausted
	Leukaemia where all non-palliative treatment modalities have failed and been exhausted and where there is resultant ongoing and continuous symptomatology
	Multiple myeloma where all non-palliative treatment modalities have failed and been exhausted and where there is resultant ongoing and continuous symptomatology
B	Advanced *cancer* classified as stage 3 or above based on TNM classification
	Lymphoma classified as Ann-Arbor stage 3 or above
	Malignant brain tumour classified as grade 3 or grade 4 based on the WHO grading system for malignant tumours of the central nervous system
	Malignant brain tumour classified as grade 2 based on the WHO grading system for malignant tumours of the central nervous system and which is treated with major interventionist treatment
	Acute myeloid leukaemia
	Advanced chronic lymphocytic leukaemia classified as Rai stage 3 or above
	Chronic myeloid leukaemia
	Acute lymphoblastic leukaemia
	aplastic anaemia (requiring treatment)
	bone marrow or stem cell transplant specifically to treat *cancer*
	transplant waiting list for the transplant of bone marrow specifically to treat *cancer*
	Multiple myeloma classified as stage 3 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy

Cancer (continued)	
C	Advanced *cancer* classified as stage 2 based on TNM classification
	Lymphoma classified as Ann-Arbor stage 2
	Malignant brain tumour classified as grade 2 based on the WHO grading system for malignant tumours of the central nervous system
	Chronic lymphocytic leukaemia classified as Rai stage 2
	Multiple myeloma classified as stage 2 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
	Total mastectomy (including nipple sparing mastectomy) for *cancer* or *carcinoma in situ* of the breast where the procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment by a *medical practitioner*
D	*cancer*
	prostate cancer requiring radiotherapy, brachytherapy or radical prostatectomy where the procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment by a *medical practitioner*
	prostate cancer where the tumour is described histologically as TNM classification T1 and has a Gleason score greater than 6
	Lymphoma classified as Ann-Arbor stage 1
	Brain tumour classified as grade 1 based on the WHO grading system for tumours of the central nervous system
	Chronic lymphocytic leukaemia classified as Rai stage 1
	Multiple myeloma classified as stage 1 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
E	*carcinoma in situ*
	The presence of one or more melanomas which are classified as melanoma in situ or stage T1aN0M0
	prostate cancer where the tumour is described histologically as TNM classification T1 and has a Gleason score of 6 or less
	Confirmed diagnosis of myelodysplastic syndrome or any myeloproliferative diseases (including polycythemia vera, essential thrombocythemia and myelofibrosis) requiring continuing active treatment and ongoing supportive care
	early stage chronic lymphocytic leukaemia

The 90-day elimination period applies to all ‘Cancer’ health events in this table. The elimination period is explained on page 29.

Heart and artery	
A	*heart attack* resulting in permanent and irreversible left ventricular ejection fraction of less than 30% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association functional classification system of cardiac impairment. Permanency will be established using three readings, three months apart
	cardiomyopathy resulting in permanent and irreversible left ventricular ejection fraction of less than 30% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association functional classification system of cardiac impairment. Permanency will be established using three readings, three months apart
	severe congestive cardiac failure with a permanent BNP level of greater than 500ng/l, whilst on ongoing optimal therapy for a minimum of six months where BNP lowering is specifically targeted as a treatment outcome measure (equivalent levels of proBNP will be accepted). Permanency will be established using three readings, three months apart
	severe peripheral vascular disease resulting in amputation of the leg or entire foot
B	*heart attack* resulting in permanent and irreversible left ventricular ejection fraction of 30 to 40% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association functional classification system of cardiac impairment. Permanency will be established using three readings, three months apart
	cardiomyopathy resulting in permanent and irreversible left ventricular ejection fraction of 30 to 40% whilst on ongoing optimal therapy for a minimum of six months, and significant and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association functional classification system of cardiac impairment. Permanency will be established using three readings, three months apart
	heart or heart and lung transplant
	transplant waiting list for the transplant of a heart or a heart and lung transplant
C	*heart attack*
	severe peripheral vascular disease with gangrene and amputation of more than one toe
	coronary artery bypass graft
	open aortic graft surgery – abdominal or thoracic
	open iliac or femoral artery aneurysm grafting
	surgical repair to correct structural lesions of the heart
	heart valve replacement or repair
	total pericardiectomy for constrictive pericarditis
	out of hospital cardiac arrest
D	*aortic surgery*

Heart and artery (continued)	
E	*percutaneous coronary angioplasty*
	endovascular heart valve repair or replacement
	endovascular or open carotid artery stenosis repair
	endovascular repair of an aortic aneurysm
	endovascular repair to correct structural lesions of the heart
	endovascular iliac or femoral artery aneurysm repair
	permanent cardiac defibrillator insertion

The 90-day elimination period applies to all 'Heart and artery' health events in this table. The elimination period is explained on page 29.

Brain and nerves	
A	Any *stroke* causing *permanent* and irreversible inability to perform four out of six *activities of daily living*[1]
	Any chronic neurological disease causing *permanent* and irreversible inability to perform four out of six *activities of daily living*[2]
	permanent unresponsive state[2]
	quadriplegia[2]
	paraplegia[2]
	A severe *new mental health condition*[2] measured by a trained psychiatric impairment assessor using the Psychiatric Impairment Rating Scale (PIRS), current at the time of testing, with a median test score of 5. The PIRS refers to the scale set out in the WorkCover NSW, Guides for the Evaluation of Permanent Impairment
	permanent total aphasia[2]
	diagnosis of motor neurone disease[2]
B	Any *stroke* causing *permanent* and irreversible inability to perform three out of *six activities of daily living*[1]
	Any chronic neurological disease causing *permanent* and irreversible inability to perform three out of six *activities of daily living*[2]
	severe epilepsy[2]
	A severe *new mental health condition*[2] measured by a trained psychiatric impairment assessor using the Psychiatric Impairment Rating Scale (PIRS), current at the time of testing, with a median test score of 4. The PIRS refers to the scale set out in the WorkCover NSW, Guides for the Evaluation of Permanent Impairment

Brain and nerves (continued)	
C	Any *stroke* causing *permanent* and irreversible inability to perform two out of *six activities of daily living*[1]
	Craniotomy to treat a cerebral arteriovenous malformation[3]
	Craniotomy to treat a cerebral aneurysm[3]
	Open surgery to remove a *benign central nervous system tumour*[3]
	Any chronic neurological disease causing *permanent* and irreversible inability to perform two out of six *activities of daily living*[2]
	diagnosis of bilateral hemianopia[2]
	coma
	encephalitis
D	A *new mental health condition*[2] resulting in ongoing medical treatment from a psychiatrist for more than two years and more than two in-patient admissions, each greater than one week, over a two-year period
	bacterial meningitis
E	*stroke*[1]
	Keyhole surgery to remove a *benign central nervous system tumour*[3]
	Endovascular treatment of a cerebral arteriovenous malformation[3]
	Endovascular treatment of a cerebral aneurysm[3]
	Endovascular treatment of a subarachnoid haemorrhage[3]
	Stereotactic brain surgery used for ablation, stimulation, implantation or radiotherapy[3]
	Shunt insertion for hydrocephalus[3]
	diagnosis of multiple sclerosis[2]
	diagnosis of parkinson's disease[2]
	diagnosis of parkinson-plus syndrome (specified)[2]
	diagnosis of muscular dystrophy[2]
	diagnosis of myasthenia gravis[2]
	diagnosis of cavernous sinus thrombosis[2]

1. The 90-day elimination period applies to all stroke-related 'Brain and nerves' health events in this table. The elimination period is explained on page 29.
2. The following are not covered:
   - any condition which is a result of drug or alcohol intake
   - any condition for which the life insured isn't following medical advice.
3. The following are not covered under surgery-related 'Brain and nerves' health events:
   - cysts, granulomas, abscesses, haematomas, trans-sphenoidal hypophysectomy, and biopsy procedures.

Digestive system	
A	*gastrointestinal disease*, evidenced by endoscopy or gastroscopy, with all of the following: • persistent disturbance of bowel function at rest with severe persistent pain • complete limitation of activity with continued restriction of the diet and no response to medical therapy • constitutional symptoms – fever, weight loss or anaemia where there is no prolonged remission • at least four in-patient hospital admissions in a 12-month period
	permanent and ongoing inability to swallow requiring *permanent extraneous* feeding methods
	permanent ongoing faecal incontinence unresponsive to either medical or surgical therapy, including colostomy
	end stage liver disease
B	*liver transplant*
	pancreas transplant
	small bowel transplant
	transplant waiting list for the transplant of the liver, pancreas or small bowel
	gastrointestinal disease, evidenced by endoscopy or gastroscopy, with all of the following: • severe exacerbations of bowel dysfunction with disturbance of bowel function with continual pain • restriction of activity with continued restriction of the diet and no response to medical therapy • constitutional symptoms – fever, weight loss or anaemia • at least two in-patient hospital admissions in a 12-month period
C	*colectomy*
	colostomy/ileostomy
	severe crohn's disease
	Chronic inflammatory hepatitis resulting in a Knodell score of at least 13 out of 22, and showing abnormal LFT's including ALT, AST and GGT of more than three times the normal range continuously for at least one year (tested at least three times over this period)
E	Surgical repair of a tracheo-oesophageal fistula
	Chronic anal fistula requiring three or more in-patient surgical procedures
	portal vein thrombosis
	ulcerative colitis (severe)
	crohn's disease
	Partial hepatectomy (donors and liver biopsies excluded)

Liver conditions resulting from drug or alcohol intake aren't covered under any 'Digestive system' health event.

Kidneys and urogenital tract	
A	*chronic renal failure* where a renal physician has confirmed that on the basis of the life insured's medical condition, the life insured is permanently excluded from access to renal transplantation
B	*chronic renal failure*
	renal transplant
	transplant waiting list for the transplant of a kidney
	Total cystectomy requiring a urinary conduit
E	*acute renal failure*
	Nephrectomy (donors excluded)
	Bilateral orchidectomy due to disease
	Bladder fistula requiring a surgical procedure for closure of the fistula
	Vesico/recto-vaginal fistula requiring a surgical procedure for closure of the fistula

The following aren't covered under 'Kidneys and urogenital tract' health events:
- acute renal failure due to drug or alcohol intake
- transgender surgery.

Lungs	
A	End stage lung disease requiring *permanent* and continuous oxygen therapy (according to current Thoracic Society of Australia and New Zealand treatment guidelines) as prescribed by an appropriate registered *medical practitioner*
B	*chronic lung disease*
	lung or heart and lung transplant
	transplant waiting list for the transplant of a lung or a heart and lung transplant
C	*pneumonectomy* (excluding donors)
D	Lobectomy (excluding biopsy procedures and donors)
E	Lung abscess requiring surgical drainage through an open thoracotomy (simple percutaneous drainage procedures excluded)
	Chronic bronchopleural fistula requiring a surgical procedure for closure of the fistula through an open thoracotomy
	Chronic bronchiectasis requiring daily physiotherapy or postural drainage on instruction of a lung specialist for a period of more than three months and under the continuous care of a respiratory physician
	Multiple episodes of recurrent pulmonary emboli separated by a period of six months requiring insertion of a veno-caval filter

Musculoskeletal system	
A	Total and *permanent* loss of use of both the entire left leg and the entire right leg
	Spinal fusion at two or more levels in one area of the spine with associated *permanent neurological* deficit in an upper limb or lower limb including all of the following: • muscle weakness • sensory loss and reflex changes • *permanent* loss of use of bowel and bladder function
B	Total and *permanent* loss of use of the entire dominant arm
	Insertion of spinal cord stimulator for chronic pain
C	Total and *permanent* loss of use of the entire non-dominant arm
	Total and permanent loss of use of an entire leg
	severe osteoporosis before age 50
	Fracture or dislocation of the spine or a joint of the upper or lower limb resulting in *permanent* and irreversible inability to perform two out of six *activities of daily living*
D	Spinal fusion at two or more levels in one area of the spine without *permanent* neurological damage
	Total and *permanent* loss of use of one entire hand
E	Total and *permanent* loss of use of one entire foot
	Amputation of two or more fingers at the PIP or MCP joint, one of which must be either the index finger or thumb

Severe burns	
B	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns, where the third degree burns cover at least 20% of the body surface area as measured by the Rule of Nines or the Lund & Browder Body Surface Chart
C	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns, where the third degree burns cover at least 15% of the body surface area as measured by the Rule of Nines or the Lund & Browder Body Surface Chart
D	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns, where the third degree burns cover at least 10% of the body surface area as measured by the Rule of Nines or the Lund & Browder Body Surface Chart
E	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns, where the third degree burns cover at least 5% of the body surface area as measured by the Rule of Nines or the Lund & Browder Body Surface Chart

Hearing	
A	irreversible hearing loss in the better ear which even with amplification, results in an average hearing threshold of 91dB or greater as measured at 500, 1,000 and 1,500 Hz
B	*severe loss of binaural hearing*
E	irreversible hearing impairment in the worst ear which even with amplification, results in an average hearing threshold of 91dB or greater as measured at 500, 1,000 and 1,500 Hz
	inner ear or middle ear surgery
	radical or modified radical mastoidectomy where considered the appropriate and necessary treatment by a medical specialist

Sight	
A	*permanent* and irrecoverable loss of sight, to the extent that even when aided, eyesight is reduced in both eyes to 6/60 or worse of central visual acuity on the Snellen test chart
	permanent and irrecoverable loss of sight, to the extent that the degree of vision is less than or equal to 20 degrees of arc
C	*permanent* and irrecoverable loss of sight, to the extent that even when aided, eyesight is reduced in both eyes to 6/18 or worse of central visual acuity on the Snellen test chart
E	*permanent* and irrecoverable loss of sight in one eye, to the extent that even when aided, eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart or the degree of vision is less than or equal to 20 degrees of arc
	Surgical repair of a detached retina (laser surgery excluded)
	corneal transplant

HIV/AIDS	
A	*advanced AIDS*
B	*accidental HIV infection*

We won't pay a benefit if:
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious
- the life insured elected not to take an approved vaccine that is recommended by the relevant government body for use in the life insured's occupation and is available before the event which causes infection.

Hospitalisation	
D	*intensive care unit (ICU)* admission for at least seven days where ongoing assisted mechanical ventilation is required for at least three days
E	Hospital admission for at least three weeks after spending at least three days in *ICU*. Ongoing medical treatment is required in an acute healthcare setting or rehabilitation facility throughout this entire hospital admission period (i.e. over the minimum three week period)

Intensive care unit (ICU) admission resulting from drug or alcohol intake isn't covered under any 'Hospitalisation' health event.

Additional covered conditions	
C	*diabetes with severe life impact*
D	*severe rheumatoid arthritis with permanent daily life impact*
	diabetes (type 1) diagnosed after age 30
E	*bone marrow or stem cell transplant* to treat a disease other than *cancer*
	Le Fort 3 facial reconstruction surgery

When does a health event or safety-net condition occur?

The timing of a health event can affect the benefit that we'll pay.

Different criteria apply depending on the type of claim, as explained in the table below:

Type of claim	Type of event	Date the event occurs
Health event claims (not safety-net claims)	*sickness*	Date a *medical practitioner* first confirms diagnosis.
	injury	Date the *injury* occurs
	treatment	Date the life insured undergoes the treatment
Claims under the safety-net feature	Inability to perform *activities* of *daily living*	Date the life insured is permanently unable to perform the stated number of *activities of daily living*, as assessed by a medical specialist.
	Occupational impairment where the claim is based on irreversible *whole person impairment*	Date the life insured suffers *whole person impairment* of at least 25% due to *sickness* or *injury*, as assessed by a medical specialist.
	Occupational impairment where the claim isn't based on irreversible *whole person impairment*	Date the life insured first stopped work due to the disability that led to the claim. It isn't when evidence confirms that the disability is permanent.

Health events and safety-net conditions are only covered under the policy if the date the event occurs is after the benefit start date and before the first of:

- the health event benefit end date
- when the policy ends.

You can purchase optional benefits to boost your cover

You can select optional benefits when you apply for your policy and they will apply from the policy start date. You can also apply to add options after your policy starts.

Optional benefits only apply if they are shown on the policy schedule.

The optional benefits are summarised in this table, and the policy conditions for each are set out below.

Option name	What this option does	Can it be held in superannuation?
Extended care option	Boosts the health events benefit payable by 50% if the life insured suffers a category A health event which meets extra severity criteria.	Yes
Additional death cover option	Pays an extra lump sum on death or *terminal illness*.	Yes

Extended care

We'll boost the benefit we pay for category A health events if the life insured is severely disabled before the policy anniversary when they're 65.

We'll pay an extra 50% of the initial amount of cover if we pay a claim for a category A health event, and the life insured's condition meets a specific level of severity.

The extra benefit is only payable if the life insured suffers one of the following:

- a medically recognised disease or disorder resulting in a *permanent* and irreversible inability to perform at least four of the *activities of daily living*
- *permanent* and irreversible *whole person impairment* of at least 60%.

For example, if the initial amount of cover is $500,000 and the first claim on the policy is a category A claim which also meets one of the extended care option criteria, an extra $250,000 is payable, boosting the total benefit amount to $750,000.

This option isn't available if your initial amount of cover would exceed $4 million if boosted.

The extended care option ends on the first of:

- if we receive notification to cancel the option, the end of the period of the cover for this optional benefit you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the life insured is 65
- when the policy ends.

When the option ends, the premium paid for the option also ends.

Additional death cover

Active Cover automatically includes death & terminal illness cover. This option allows you to top-up the death & terminal illness cover with a separate benefit amount that isn't affected by other claims under the policy.

We'll pay the additional death benefit if the life insured dies. We'll advance the death benefit if the life insured is diagnosed with a *terminal illness*.

Your policy includes these features automatically

Your policy automatically includes the following features, regardless of the covers selected. Superannuation restrictions are shown where they apply.

Feature name	What this feature does	Does this feature apply to cover held in superannuation?
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 73.	Yes
Inflation protection	Increases cover every year, unless declined by you, without health assessment.	Yes
Claim protector	Protects 25% of the cover on the policy in case the life insured suffers more than one health event before age 65.	Yes
Future insurability	Allows an increase in cover without health assessment when certain life events happen, for example, marriage or birth of a child.	Yes
Financial planning advice	We'll reimburse up to $1,000 for financial advice following a claim payment under this policy for: • *terminal illness* • death • a category A or B health event.	No
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover and you can't make a claim. Up to 12 months of suspension can be taken over the life of the policy. Cover suspension is explained on page 72.	Yes, unless the policy is funded by a platform account.

Inflation protection

We'll increase your insurance cover each year to help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary until the policy anniversary when the life insured is 64. Inflation protection will continue to apply to cover at or above the maximum sum insured.

Inflation protection increases apply to each of the following amounts. Your anniversary notice will show them all separately, apart from the protected amount (which is 25% of the initial amount of cover):

- initial amount of cover
- maximum amount payable
- death & terminal illness cover
- additional death cover
- protected amount for benefit categories A to E.

The benefit amount is increased by the higher of:

- 5%
- any increase in *consumer price index* (CPI).

Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

You don't have to accept any increase we offer. You can:

- reject the increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

The claim protector keeps some cover in place

The claim protector is an important feature of the policy that protects 25% of the initial amount of cover for future health event claims. This 'protected amount' is shown on the policy schedule. The protected amount will increase if you accept inflation protection increases, as explained on this page.

In the first 14 days after a health event occurs, the maximum amount payable reduces to reflect the claim amount payable.

After 14 days, if the maximum amount payable after the reduction is less than the protected amount (which is 25% of the initial amount of cover), the maximum amount payable for all benefit categories is increased to the lower of the:

- protected amount
- initial amount of cover multiplied by the percentage for each benefit category.

The claim protector doesn't apply to death or terminal illness cover, which means death & terminal illness cover may reduce to nil unless additional death cover is included (as explained on page 25).

For example, if the maximum amount payable is $500,000, a category A health event claim will reduce the cover to nil, making it less than the protected amount of $125,000 (25% of the initial amount of cover).

14 days after the claim, the maximum amount payable for health events benefit categories will increase as follows:

Benefit category	Maximum amount payable
Death & terminal illness	nil
A health events	$125,000
B health events	$125,000
C health events	$125,000
D health events	$100,000
E health events	$25,000

Any further benefits for future claims are capped if the combined total payable reaches the health events policy limits in the section 'Further claims' on page 13.

The claim protector feature can be used more than once, but ends on the first of:

- the policy anniversary when the life insured is 65
- when a claim for *terminal illness* is paid.

Future insurability

You can increase the initial amount of cover without health assessment when any of the following covered events happen.

If the life insured:
- marries, registers a partnership, or begins co-habiting with a *partner*
- divorces, de-registers a partnership, or ends co-habiting with a *partner*
- becomes a parent following the birth or adoption of a child
- experiences a significant increase in salary (minimum 15%)
- takes out a new mortgage on their principal place of residence
- increases their mortgage on their principal place of residence
- takes out a new investment property loan
- becomes a full-time carer
- becomes a widow or widower, following the death of a *partner*.

If the life insured's child:
- starts secondary school
- turns 18.

You're eligible to make an increase if:
- you provide evidence of the event
- the benefit being increased has been in place for a minimum of 12 months
- the covered event happens before the life insured's 55th birthday
- the policy wasn't issued with a medical loading of 75% or more
- we haven't paid a benefit and there is no entitlement to a benefit under any Zurich policy for the life insured.

One increase can be made per policy year within 30 days of either the:
- date of any covered event
- policy anniversary after the date of any covered event.

The minimum increase amount is $10,000. The maximum increase available is 25% of the initial amount of cover on the policy start date, up to $200,000. Where the event is based on a mortgage or investment property loan, the increase can't exceed the new loan amount or increase in loan amount.

Any special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

Some limits apply to future insurability

The following limits apply to increases under this feature:
- the sum of all increases under this feature can't exceed $1 million over the life of the policy
- the initial amount of cover can't be increased to more than $4 million.

In the first six months after an increase, the extra benefit amount will only apply to events which are caused by *accidental death* or *accidental injury*. Only events that happen after the date of the increase are covered.

If you increase your initial amount of cover, you can also increase your additional death cover proportionately.

Financial planning advice

We'll reimburse up to $1,000 towards the cost of financial planning advice required as a result of a full benefit payment for *terminal illness*, death or a category A or B health event under this policy.

To claim this reimbursement, we'll need:
- a copy of the Statement of Advice which refers to the insurance claim
- your invoice, as proof of the expense.

This feature doesn't apply if the policy is issued to the trustee of a superannuation fund.

What this policy doesn't cover

Exclusions under death cover

We won't pay the death benefit for death caused by an event or condition specified as an exclusion on the policy schedule.

We won't pay the death benefit for death caused by suicide within 13 months of the:
- death benefit start date
- start date of any death benefit increase applied for (but only for the increase)
- most recent policy reinstatement.

We won't apply the suicide exclusion if, immediately before the death benefit started, the life insured held death cover for at least 13 consecutive months with us or another insurer, and we replaced it. We'll only waive the suicide exclusion on the amount of death cover we replaced.

Exclusions under health events cover

We won't pay a benefit if the health event is caused by either of the following:
- directly or indirectly by an intentional self-inflicted act or attempted suicide
- any event or medical condition specified as an exclusion on the policy schedule.

A 90-day elimination period applies to some health events

Some insured health events have a 90-day elimination period. The elimination period applies to the health events where shown on pages 15 to 24. The start of the elimination period can vary:

New cover

For new health events cover applications, the elimination period starts on the benefit start date for that cover. We won't ever pay a claim for those health events if during the elimination period any of the following happens:
- the condition occurs or is apparent. 'Apparent' means the life insured are aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended to the life insured.

Cover increases

For cover increases, the elimination period starts on the benefit start date of any increase in the health event benefit, and only applies to the increase portion of the cover. We won't ever pay a claim for those health events if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended to the life insured.

Reinstated cover or cover suspension

When there is a break in cover and the policy re-starts, the elimination period starts from the date the policy is reinstated or, if after cover suspension, from the cover suspension end date. We won't ever pay a claim for those health events if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended to the life insured.

We won't apply the 90-day elimination period if immediately before the health event cover started, the life insured held cover for the same health event with us or another insurer for more than 90 days, and we replaced it. We'll only waive the elimination period on the amount of cover we replaced. This waiver can also apply to any increases in the benefit that meet the same criteria.

Elective and donor transplant surgery isn't covered in the first six months

We won't pay a benefit for a health event that is due to elective or donor transplant surgery unless the elective or transplant surgery occurred at least six months after:
- the start of the policy
- if the policy is ever reinstated, the date of reinstatement
- for an increase in the benefit amount, the date of the increase.

AIDS and HIV infection have specific exclusions

The following exclusions apply to the insured health events *advanced AIDS* and *accidental HIV infection*.

A benefit isn't payable for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus if:
- the life insured elected not to take an approved vaccine that is recommended by the relevant government body for use in the life insured's occupation and is available before the event which causes infection
- a treatment is developed and approved which makes the HIV virus inactive and non-infectious.

There is a maximum benefit per claim for angioplasty

The maximum benefit payment per claim for *percutaneous coronary angioplasty* is $40,000.

Superannuation restrictions and limitations apply

If the policy is issued to a superannuation trustee, we'll only pay benefits that the trustee can release under superannuation law when the claim is assessed.

Benefits are only payable for *occupational impairment* if the life insured also meets the superannuation definition of permanent incapacity.

The limited claim period is the first 12 months after a claim

The limited claim period is the first 12 months after we pay you a benefit for a health event claim. The 12-month period starts when the health event occurs and not on the date the claim is paid.

If a health event occurs during a limited claim period, we'll deduct the original claim amount from the new claim amount. This may result in no benefit being payable for the second health event.

The limited claim period applies whether or not the second health event is a progressive condition. It can apply when complications from a medical condition or its treatment occur, for example, a situation where chemotherapy as a treatment is the cause of a new heart condition.

We won't apply a reduction if either of the health events is the result of an *accident* unless they have the same cause.

A health event occurring in a limited claim period won't start a new 12-month period. However, the next health event that occurs outside of a limited claim period will start a new limited claim period.

Here's what we mean by progressive conditions

A progressive condition is any condition or procedure that is related to the same underlying condition, medical cause, or pathology as an earlier claim. This includes any condition that is a recognised:

- outcome of an earlier claim
- complication of an earlier claim
- complication of any treatment for the earlier claim.

Two events don't have to be in the same health event grouping to be progressive conditions. For example, muscular dystrophy is in the grouping 'Brain and nerves' and the progressive condition *cardiomyopathy* is in the grouping 'Heart and artery'.

We'll only pay a progressive condition claim at a higher benefit category. This means that no benefit is payable for a progressive condition at a benefit category that is the same as, or lower than a previous claim.

If a health event is a progressive condition, we'll pay the difference between the benefit category that applies to the current health event and the highest benefit category already paid for the progressive condition.

For example, if we've paid a benefit for a category D health event (20%) and a new claim is made for a category B health event (65%), we'll pay the difference between them, which is 45% of the initial amount of cover.

Any two medical conditions that are both progressive conditions of a third medical condition, are treated as progressive conditions to each other for calculating any amount payable.

Examples of progressive conditions

The table below describes some progressive conditions. The table isn't exhaustive, meaning that even if a condition isn't listed here, it may still be treated as a progressive condition if supported by medical evidence.

The conditions named below are given their broad medical meaning and are not the defined health events as found in the 'Health events & benefit categories' and 'Definitions' sections of this document (see pages 15 and 84).

Claimed condition	Progressive conditions
Any arthritis, osteoporosis	Any arthritis, osteoporosis
Cancer	Cancer of the same cell type, including any treatment or disease for cancer of the same cell type
Cognitive conditions	Coma, Parkinson's disease, stroke
Multiple sclerosis	Any cognitive conditions
Muscular dystrophy	Cardiomyopathy
Parkinson's disease	Any cognitive conditions
Stroke	Cognitive conditions, Parkinson's disease
Any mental health condition	Any mental health condition

Claimed condition	Progressive conditions
Brain and neurological conditions, epilepsy	Brain and neurological conditions, coma, stroke, epilepsy.
Any other condition described by a neurologist to be a chronic neurological disease including but not limited to the following: permanent unresponsive state, profound short term memory loss, multiple sclerosis, dementia, epilepsy, myasthenia gravis, Alzheimer's disease, muscular dystrophy, motor neurone disease	Any other condition described by a neurologist to be a chronic neurological disease including but not limited to the following: permanent unresponsive state, profound short term memory loss, multiple sclerosis, dementia, epilepsy, myasthenia gravis, Alzheimer's disease, muscular dystrophy, motor neurone disease
Progressive systemic sclerosis, systemic lupus erythematosis, sarcoidosis, polyarteritis nodosa, giant cell arteritis, polymyositis, Wegener's granulomatosis, rheumatoid arthritis	Progressive systemic sclerosis, systemic lupus erythematosis, sarcoidosis, polyarteritis nodosa, giant cell arteritis, polymyositis, Wegener's granulomatosis, rheumatoid arthritis
Any cardiac condition or procedure	Any cardiac condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. In the case of angioplasty, an angioplasty procedure will not be considered a progressive condition to a prior angioplasty procedure and a subsequent claim for angioplasty will be paid if it occurs outside of the limited claim period
Any lung condition or procedure	Any lung condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim
Any kidney or urogenital tract condition or procedure	Any kidney or urogenital tract condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim
Any sight condition or procedure	Any sight condition or procedure
Any hearing condition or procedure	Any hearing condition or procedure
Any gastrointestinal disease or procedure	Any gastrointestinal disease or procedure
Any liver disease or procedure	Any liver disease or procedure
Diabetes, diabetes progression, complications of diabetes	Stroke, pancreas transplant, loss of vision, heart attack, cardiac bypass, cardiomyopathy, angioplasty, peripheral vascular disease, renal failure, kidney transplant
Any condition which is assessed on the basis of an inability to perform *activities of daily living*	Any condition which is assessed on the basis of an inability to perform *activities of daily living*

Any claim we pay reduces the amount available for further claims

When a benefit is paid under the policy, the maximum amount of cover is reduced as explained on page 13.

Benefit reductions also apply across two policies if one policy replaces the other or where the policies are related through superannuation optimiser.

When the benefits end

When the death benefits end

The death benefits end when one of the following happens:

- the maximum amount payable for death & *terminal illness* reduces to nil
- if we receive notification to cancel the death benefits, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the life insured is 99
- death of the life insured
- when the policy ends.

When the health events benefit and safety-net feature ends

The health events benefit and the safety-net feature end on the first of:

- the health event policy limit is reached before the life insured reaches 65
- after the life insured reaches 65, the maximum amount payable under benefit categories A to E reduces to nil
- if we receive notification to cancel the health events benefit, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the life insured is 70
- when the policy ends.

When the extended care option ends

The extended care option ends on the first of:

- if we receive notification to cancel the extended care option, the end of the period of cover for this optional benefit you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the life insured is 65
- when the policy ends.

When the policy ends

The policy ends when one of the following happens:

- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy
- the related policy ends (if superannuation optimiser applies)
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the life insured is 99
- payment of 100% of the death benefit
- death of the life insured.

Zurich Income Safeguard

Zurich Income Safeguard covers you for health events that prevent the life insured from working and earning income

Zurich Income Safeguard provides a monthly benefit if the life insured is unable to work solely due to *sickness* or *injury* for longer than the specified waiting period.

Income protection insurance replaces some lost income, so that the life insured can concentrate on recovery without having to worry about how to cover ongoing expenses.

When you need to claim under this policy, we want to partner with the life insured on their journey to recovery

When a *sickness* or *injury* occurs, we understand it can be a difficult and emotional time and we are here to help support the life insured on their return-to-health journey.

This is our commitment to the life insured

Being engaged in work is a benefit to you, your family and society and we want to help you make a safe return to health and work. We see it as part of our commitment to you when you have a policy with us.

While everyone is affected differently by sickness and injuries, there are expected recovery times for most sicknesses and injuries. We'll work with you and your *medical practitioner* to ensure you are getting the best treatment possible should your recovery be taking longer than expected.

Expectations during a claim

The claim process is explained in the 'Making a claim' section of this document, starting on page 76. To ensure transparency, the following sets out what we expect of you during a claim, and what you can expect from us.

What you can expect of us	Our expectations of you
We will: ✓ make payments for the duration of your claim in a timely way ✓ make the claims process as straightforward as we reasonably can ✓ work with you, your treating *medical practitioners* and where appropriate, our rehabilitation teams, to support you on your recovery journey. We'll support your return to your previous occupation, however, if evidence indicates that a return to your previous occupation is unlikely, we'll work with you, your treating *medical practitioners* and where appropriate our rehabilitation teams, to support your return to a suitable occupation based on your education, training, or experience ✓ provide access to and funding for appropriate rehabilitation or retraining programs, which may include job seeking, graduated return to work plans, reasonable retraining and other work readiness programs ✓ adhere to the Life Insurance Code of Practice and its principles of conduct such as being open, fair and honest.	You will: ✓ lodge your claim as soon as you can after a *sickness* or *injury* ✓ follow the advice of any treating *medical practitioner* on an ongoing basis, including recommended courses of treatment and rehabilitation to strive for maximum possible improvement ✓ co-operate in assessments of your capacity for work, rehabilitation progress or future employment prospects ✓ actively participate and co-operate in planning for your return to work, including attending reasonable retraining for other suitable employment ✓ make reasonable efforts to return to work in suitable employment.

Zurich Income Safeguard policy conditions

The information below forms part of the Zurich Income Safeguard policy conditions.

When we accept your application, we'll issue you with a policy schedule.

The policy schedule shows:
- the policy owner and the life insured covered under the policy
- the insured monthly benefit at the start of the policy
- the benefit period
- the waiting period
- any extra-cost optional benefits selected
- whether your premiums are variable age-stepped or variable premiums
- benefit end dates
- any special conditions that apply to your policy specifically.

The life insured is only covered for the benefits and amounts shown on the policy schedule. Each benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefits end' on page 44.

Cover is automatically increased each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 45.

You can apply to make changes to your policy. If you apply for optional benefits or to increase the benefit amount after the policy starts, changes are only effective if we accept the application after assessing the life insured's health, occupation, and pastimes.

The words or expressions shown in *italics* that are specific to this policy have their meaning explained on page 40 in the section 'What we mean by the terms we use'. Words or expressions that we use throughout this document, like *medical practitioner*, are explained in the 'Definitions' section, starting on page 84.

If cover is held in superannuation, restrictions apply

If the policy is issued to the trustee of a superannuation fund, we'll only pay benefits that the trustee can release under superannuation law when the claim is assessed.

Some benefits don't form part of the policy if the policy is issued to the trustee of a superannuation fund. These are clearly marked.

Monthly benefits are only payable under this policy if the life insured meets the superannuation definition of temporary incapacity.

Cover while unemployed in superannuation

The life insured won't meet the temporary incapacity definition and be eligible to receive monthly benefits if they're unemployed when *sickness* or *injury* occurs. You can only claim total or partial disability benefits under this policy during unemployment if *sickness* or *injury* is the reason the life insured is unemployed.

However, we provide complimentary cover if the life insured is totally or partially disabled due to *sickness* or *injury* while unemployed. Please see page 57 for further details on the eligibility conditions and an explanation of how this works.

Insured monthly benefit

The insured monthly benefit is the amount of monthly benefit shown on the policy schedule when your policy starts, plus any indexation, as explained in the section 'Inflation protection' on page 45. If you make a change to your policy and we issue a revised policy schedule, the insured monthly benefit will be updated on the revised policy schedule.

The insured monthly benefit is the maximum amount we'll pay for any month.

When you apply for cover, you can insure up to 70% of the life insured's annual income up to an annual income of $300,000. After that, a sliding scale applies. You can insure 50% of the next $200,000 of annual income and 25% of annual income above $500,000. When we say annual income, we mean the annual equivalent of (or 12-times) *monthly income*.

The maximum insured monthly benefit you can apply for is $30,000 per month, plus an additional amount up to $30,000 per month restricted to a 1-year or 2-year benefit period. If you separately insure your superannuation contributions using our super contributions option, explained on page 48, then these maximums include the super contributions monthly benefit amount. The overall maximum of $60,000 per month applies to income protection and business expenses cover combined.

This policy provides indemnity cover, which means that the monthly benefit payable if you make a claim is based on the life insured's annual income at the time of the claim. The monthly benefit we pay will be adjusted to reflect income the life insured receives or is entitled to receive as well as *other payments* received in the month because of *sickness* or *injury*, for example, sick leave benefits.

Benefit calculation examples are provided on page 43.

It's important to check your level of cover against your income to make sure it suits your needs. We don't refund premiums where your insured monthly benefit is higher than pre-claim earnings at claim time. If your income changes, you may need to adjust the insured monthly benefit to make sure you're not insured for more than you could receive or less than your *pre-claim earnings* would support. Your financial adviser can support you with this process.

Benefits payable under this policy

The benefits payable under this policy are summarised in the table below. A full explanation of each benefit follows the table.

We'll pay a benefit only if total or partial disability occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 49.

Benefit name	What this benefit pays
Total disability benefit	We'll pay a benefit if the life insured is totally disabled after the waiting period.
Partial disability benefit	We'll pay a benefit if the life insured is partially disabled after the waiting period.

What you need to know about how the claims journey works

The next few pages of this document provide guidance on what you can expect and important milestones when making a claim under your Zurich Income Safeguard policy. The waiting period and benefit period are important aspects of your cover and will be shown on your policy schedule.

How to qualify for a monthly benefit payment

To qualify for a monthly benefit, you must first satisfy the waiting period requirements. Once the waiting period requirements are met, we will calculate the benefit payable.

The waiting period

The waiting period is the period you must wait before the benefit period starts and you become eligible for a monthly benefit.

During the waiting period, you must follow the advice and recommended treatment of a *medical practitioner*. We may also provide you with rehabilitation support during the waiting period so we encourage you to tell us of your *sickness* or *injury* as soon as you can.

You must continue to pay premiums that fall due during the waiting period. If we accept your claim, these premiums will be refunded to you with the first benefit payment.

Choice of waiting periods

The waiting periods available are 30-days, 60-days, 90-days, 1-year, and 2-years.

The waiting period starts on medical consultation

The waiting period starts when the life insured consults a *medical practitioner* and receives advice confirming the total or partial disability.

The waiting period doesn't apply if the claim is a recurring claim. Recurring claims are explained on page 44.

Waiting period requirements

Solely due to *sickness* or *injury* the life insured must be all of the following:

- totally disabled for at least 7 out of 12 consecutive days during the waiting period
- totally or partially disabled for the remainder of the waiting period
- following the advice and recommended treatment of a *medical practitioner*.

Totally disabled during the waiting period means the life insured is both:

- unable to do each and every *important income-producing* duty of their *primary occupation*
- not working in their *primary occupation* or in any other *gainful occupation*.

Partially disabled during the waiting period means the life insured meets either of the following criteria:

- has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation*
- is unable to do each and every *important income-producing* duty of their *primary occupation* but does not meet the total disability definition.

The benefit period

The benefit period is the maximum period of time that we'll pay a monthly benefit.

The benefit period for any claim starts at the end of the waiting period.

A separate benefit period will apply to each claim for *sickness* or *injury*, except for certain recurring claim situations. See 'Recurring claims' on page 44.

All benefits end on the policy anniversary when the life insured is 65 unless the life insured has a 'special risk' or SR occupation. In this case, they end on the policy anniversary when the life insured is 60.

If your policy has a 1-year, 2-year or 5-year benefit period, then the benefit end date might be reached before the entire benefit period is paid. The cost of cover at older ages factors in shorter claim payment periods to allow for this outcome.

If the life insured is already covered by employment-related salary continuance with a 2-year benefit period, you might select a 2-year waiting period on your policy. In this case, if you need to claim, you'll be eligible for monthly benefits under the salary continuance cover first. Our waiting period may be served while you are receiving monthly benefits under the salary continuance cover.

Benefits are payable if the life insured is totally or partially disabled after the waiting period

The tables on this page and the next page explain how to qualify for a benefit, depending on the chosen benefit period and waiting period.

If the life insured has capacity to work (in their *primary occupation* or in another *gainful occupation*, as applicable), then they won't meet our definition of totally disabled. In this case we'll assess the claim under the partial disability definition and will use the partial disability calculation to work out the benefit amount payable.

For policies with waiting period of 30, 60 or 90 days and benefit period to age 65

During the first two years of a claim, the benefit payable will depend on the life insured's ability to work in their primary occupation after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled in the first two years of a claim	Qualifying for a benefit when the life insured is partially disabled in the first two years of a claim
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled in the first two years of a claim means the life insured meets all of the following criteria: • has no capacity to do each and every *important income-producing duty* of their *primary occupation* • is not working in their *primary occupation* or in any other *gainful occupation* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled in the first two years of a claim means both of the following: The life insured meets either of the following criteria: • has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation* • has no capacity to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

After we pay 24 months of total disability benefits, partial disability benefits or a combination of both, the occupation we use to assess working capacity changes. Instead of the life insured's *primary occupation*, we will consider any *gainful occupation* the life insured is suited for by education, training, or experience.

The 24-month period includes months when a monthly benefit is payable, even if the amount payable is reduced to nil because of *other payments*, *monthly income*, or *ongoing income*, or any combination of them.

Qualifying for a benefit when the life insured is totally disabled after the first two years	Qualifying for a benefit when the life insured is partially disabled after the first two years
We'll continue to pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled after the first two years of a claim means the life insured meets all of the following criteria: • is not working • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll continue to pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled after the first two years of a claim means both of the following: The life insured meets either of the following criteria: • has capacity to work in any *gainful occupation* they are suited for by education, training, or experience, but earnings are reduced • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

For policies with a waiting period of 30, 60 or 90 days and benefit period of 1-year, 2-years or 5-years

Throughout the claim, the benefit payable will depend on the life insured's ability to work in their *primary occupation* after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled	Qualifying for a benefit when the life insured is partially disabled
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled means the life insured meets all of the following criteria: • has no capacity to do each and every *important income-producing duty* of their *primary occupation* • is not working in their *primary occupation* or in any other *gainful occupation* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled means both of the following: The life insured meets either of the following criteria: • has capacity to work reduced hours or to work the same hours but in a restricted capacity in their *primary occupation* • has no capacity to do each and every *important income-producing duty* of their *primary occupation* but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

For policies with a waiting period of 1-year or 2-years

The benefit payable will depend on the life insured's ability to work in any *gainful occupation* they are suited for by education, training, or experience, after satisfying the waiting period requirements.

Qualifying for a benefit when the life insured is totally disabled	Qualifying for a benefit when the life insured is partially disabled
We'll pay a total disability benefit if solely due to *sickness* or *injury* the life insured is totally disabled. Totally disabled means the life insured meets all of the following criteria: • is not working • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.	We'll pay a partial disability benefit if solely due to *sickness* or *injury* the life insured is partially disabled. Partially disabled means both of the following: The life insured meets either of the following criteria: • has capacity to work in any *gainful occupation* they are suited for by education, training, or experience, but earnings are reduced • has no capacity to do each and every *important income-producing duty* in any *gainful occupation* they are suited for by education, training, or experience but does not meet the total disability definition. And the life insured meets all of the following criteria: • has a *monthly income* that is at least 15% lower than *pre-claim earnings* • is following the advice and recommended treatment of a *medical practitioner* • is *actively participating in a rehabilitation or retraining program*.

What we mean by the terms we use

This is a selection of key words (defined terms) that are important to help you better understand how Zurich Income Safeguard works.

actively participating in a rehabilitation or retraining program means the life insured is actively engaged in a rehabilitation or retraining program they have the capacity to undertake, and which is designed to create a pathway for gainful employment.

The rehabilitation or retraining program should assist a return to their *primary occupation*. However, if they are unlikely to have capacity now or in the future to return to their *primary occupation*, the rehabilitation or retraining program can be one that will help them to return to alternate gainful employment using transferable skills from their education, training, or experience.

If the life insured stops participating in a rehabilitation or retraining program on the advice of their treating *medical practitioner*, we'll need written documentation from the treating *medical practitioner* explaining:

- the reasons that the life insured has been advised to stop participating in the rehabilitation or retraining program
- how long the rehabilitation or retraining program is expected to be paused
- whether the rehabilitation or retraining program could be modified rather than paused
- the medical information used by the treating *medical practitioner* in forming their opinion.

If the life insured completes a rehabilitation or retraining program but has not returned to a *gainful occupation*, we will work with the life insured to determine whether an additional rehabilitation or retraining program could assist.

gainful occupation means employed or self-employed for gain or reward. This includes any paid position of employment including the life insured's *primary occupation*.

important income-producing duty means each duty that is essential to the life insured's ability to produce *monthly income* from their *primary occupation* or a *gainful occupation* (as applicable).

injury means bodily injury caused by an accident. The accident must occur while the policy is in-force.

monthly income means either:

- if the life insured is self-employed or a working director, the total remuneration package before tax and excluding superannuation guarantee calculated monthly, and the life insured's share of the gross monthly income generated by the business after allowing for the expenses incurred in deriving that income. This also includes *ongoing income* in any form that the life insured or any related person or entity on the life insured's behalf, receive, derive or are entitled to receive from any nature or form of business which the life insured engaged in
- in all other circumstances, the life insured's total remuneration package before tax and excluding superannuation guarantee, and inclusive of regular bonuses, calculated monthly.

In both instances, monthly income does not include dividends, interest, rental income, proceeds from the sale of assets or royalties. For example, it does not include dividends from shares in a publicly listed bank.

ongoing income means any net profit (income less expenses), salary, payment, or income in any form that the life insured or any related person or entity on the life insured's behalf, receive, derive, or are entitled to receive from any nature or form of business which the life insured engaged in either before the claim or while on claim.

Ongoing income does not include dividends, interest, rental income, proceeds from the sale of assets or royalties. For example, it does not include dividends from shares in a publicly listed bank. It also does not include any superannuation payments as required to meet superannuation guarantee contribution requirements.

other payments are any of the following received because of the life insured's *sickness* or *injury*:

- payments from any other disability income, sickness or injury policies, including insurance provided by the life insured's employer or which forms part of the life insured's superannuation plan, that you didn't tell us about when you applied for cover, or that you told us you were replacing with this cover to the extent required to ensure the combined maximum amount paid in total does not exceed the life insured's *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 and the maximum monthly benefit payable
- payments from compulsory insurance schemes such as workers' compensation or accident compensation for loss of income
- paid leave from an employer, including sick leave, annual leave or long service leave
- common law settlements.

pre-claim earnings means the life insured's average *monthly income* for the 12 consecutive months immediately before the life insured's total or partial disability.

If *monthly income* reduces by 25% or more in the 12 consecutive months before the life insured's disability compared to the previous 12 consecutive months, other than as a result of unemployment or sabbatical leave, then pre-claim earnings is the higher of the average *monthly income* in the:

- 24 consecutive months before the life insured's total or partial disability
- financial year before the life insured's total or partial disability.

The definition changes if the life insured is on parental leave at the date of the total or partial disability or in the 12 months before the total or partial disability. In this case we will use the average *monthly income* for the 12 consecutive months before the period of leave started.

If a benefit is paid beyond 12 months, pre-claim earnings are increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before the anniversary of your claim. If there is no increase in CPI, then no increase will apply.

primary occupation means any type of business, profession, service, trade, or employment which encompasses the duties predominantly carried out by the life insured at the time of *sickness* or *injury*.

If the *sickness* or *injury* occurs while the life insured is unemployed, or on parental or sabbatical leave, primary occupation means any type of business, profession, service, trade, or employment which encompasses the duties predominantly carried out by the life insured at the last occupation they had before unemployment, parental leave, or sabbatical leave.

Primary occupation isn't specific to any place of employment, employer, or position.

sickness means sickness or disease including any pre-existing sickness or disease that the life insured told us about in the application that we agreed to cover.

How we calculate the monthly benefit payable

This policy covers the life insured for up to 70% of income prior to *sickness* or *injury*. Their *sickness* or *injury* and return to work journey may mean that they are either totally or partially disabled at various times. Totally disabled and partially disabled in this section means as defined in the tables on pages 37 to 39.

When you qualify for a benefit because the life insured is totally disabled, the amount you may receive in total from us and all other sources is 70%. However, when you qualify for a benefit because the life insured is partially disabled, the amount you may receive in total from us and all other sources can be higher to support and encourage an active return to *gainful employment*.

Total disability benefit

Each month you qualify for a benefit because the life insured is totally disabled, we pay the lower of the:

- insured monthly benefit reduced by *other payments* received in the month
- annual equivalent of (or 12-times) *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 to get a monthly amount. This amount is reduced by *other payments* received in the month and any *ongoing income*.

Partial disability benefit

Each month you qualify for a benefit because the life insured is partially disabled, we pay the lower of the:

- insured monthly benefit reduced by *other payments* received in the month
- annual equivalent of (or 12-times) *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 to get a monthly amount. This amount is reduced by *other payments* received in the month and 70% of *monthly income*. *Monthly income* is adjusted to the life insured's maximum earning potential if the life insured is not working at their full capacity. This is explained below.

If the life insured isn't working at their full capacity

If the life insured isn't working at their full capacity, we calculate *monthly income* as their maximum earning potential for the respective month. This is calculated as follows:

For policies with a to age 65 benefit period and a 30-day, 60-day or 90-day waiting period:

- during the first two years of a claim, we'll calculate *monthly income* based on what the life insured's maximum earning potential would reasonably be if they were working at capacity. Maximum earning potential will be based on the life insured's *primary occupation*.
- after two years on claim, we will base maximum earning potential on any *gainful occupation* the life insured is suited for by education, training, or experience.

For policies with a 1-year, 2-year or 5-year benefit period and a 30-day, 60-day or 90-day waiting period, we will calculate *monthly income* based on what the life insured's maximum earning potential would reasonable be if they were working at capacity. Maximum earning potential will be based on the life insured's *primary occupation*.

For policies with a 1-year or 2-year waiting period, we'll base maximum earning potential on any *gainful occupation* the life insured is suited for by education, training, or experience.

To determine maximum earning potential, we'll consider these three things:

- available medical evidence, including the opinion of the life insured's *medical practitioner*
- employability assessment
- any other relevant factors directly related to the life insured's medical condition, including information they provide to us.

Payments that impact the monthly benefit we pay

The monthly benefit amount we pay will be reduced by *other payments* received in the same month.

The monthly benefit will also be reduced by *monthly income* if you are partially disabled and *ongoing income* if you are totally disabled for the claim month.

If we are already paying benefits, we'll tell you 30 days before we adjust future payments because we change what we determine as the life insured's maximum earning potential.

If *monthly income* or *ongoing income* is negative in a month, we will treat the amount as zero.

We won't offset:

- business expenses benefits which reimburse actual business expenses
- total and permanent disability benefits, trauma benefits, terminal illness benefits or lump sum superannuation benefits
- sums awarded by a court for pain and suffering.

We'll convert lump sum payments to monthly amounts

Any *other payments*, *monthly income*, or *ongoing income* received as a lump sum compensation payment for loss of earnings that can't be allocated to specific months will be converted to a monthly amount.

We'll allocate 1% of the loss of earnings component of the lump sum to each month that we pay the total or partial disability benefit for up to five years.

We won't offset any remaining balance of the lump sum.

Benefits are paid monthly

The total disability benefit is paid 15 days after the waiting period ends, provided claim requirements are met, and monthly after that. Benefits for total disability are generally paid two weeks in arrears and two weeks in advance. Benefits for partial disability are generally paid entirely in arrears since we need evidence of income in the relevant month to work out the benefit amount.

If any claim ends part way through a month, we'll pay 1/30th of the monthly benefit for each day during this period.

We don't refund premiums where your insured monthly benefit is higher than *pre-claim earnings* at claim time.

Some claims may be paid in advance

If medical evidence supports the life insured's inability to work for three months or less, most often for *injury* claims, we may pay monthly benefits in advance. Each claim is different, and we can't always make advance payments for income protection claims. Eligibility depends on the life insured's occupation, the relevant *sickness* or *injury* and the waiting period. For example, if the life insured is a plumber and they break a leg, we know how long recovery is likely to take and may pay up to three months up-front.

Policies with a 1-year or 2-year waiting period are not eligible for payments in advance.

We'll only pay one or more monthly benefits in advance if a *medical practitioner* certifies that the life insured is totally disabled at the end of the waiting period and is likely to remain disabled for between one and three months.

If the life insured is still disabled at the end of the period paid in advance, the claim will continue on a regular monthly payment basis.

You must provide us with information on your earnings and income

We may require you or the life insured to provide us with timely financial information for the benefit payment period. Financial evidence may include submitted tax returns or other financial documentation which confirms the life insured's *monthly income* and *ongoing income* (if applicable).

We may adjust the monthly benefit over the claim period

We may calculate the amount of the total or partial disability benefit that we would otherwise have paid if the life insured's *monthly income* or *ongoing income* was averaged over the claim period, and either:

- recover any excess amount of monthly benefit paid
- reduce the amount of any future monthly benefits payable until the excess amount has been recovered
- pay any shortfall in monthly benefit.

Benefit calculation examples

Here are some examples which show how the amount payable will differ depending on whether the life insured is totally or partially disabled, and the income they have in the claim month.

In these examples, the life insured has *pre-claim earnings* of $10,000, an insured monthly benefit of $7,000 and receives $500 per month from a sports injury insurance claim during the claim period.

Total disability benefit calculation	
Lower of these two amounts:	
1. The insured monthly benefit **reduced by** *other payments* received in the month	$7,000 Less: *other payments* received: $500 = $6,500
2. The annual equivalent of *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12 **reduced by** *other payments* received in the month and *ongoing income*.	$7,000 Less: • *other payments* received: $500 • *ongoing income*: nil = $6,500
Monthly benefit payable is lower of 1 and 2	= $6,500 monthly benefit
Total income for the month from all sources	*Other payments* received: $500 Monthly benefit payable: $6,500 Total: $7,000

In the following partial disability examples, the first life insured is working at full capacity and has a *monthly income* of $2,000. The second life insured isn't working, however has maximum earning potential of $2,000.

Partial disability benefit calculations	Working at capacity	Not working at capacity
Lower of these two amounts:		
1. The insured monthly benefit **reduced by** *other payments* received in the month	$7,000 Less: *other payments* received: $500 = $6,500	$7,000 Less: *other payments* received: $500 = $6,500
2. The annual equivalent of *pre-claim earnings* capped at 70% of the first $300,000, 50% of the next $200,000 and 25% of the balance, divided by 12	$7,000	$7,000
If working at capacity reduced by *other payments* received in the month and 70% of *monthly income*.	Less: • *other payments* received: $500 • 70% of *monthly income:* $1,400 = $5,100	
If not working at capacity reduced by *other payments* received in the month and 70% of maximum earning potential.		Less: • *other payments* received: $500 • 70% of maximum earning potential: $1,400 = $5,100
Monthly benefit payable is lower of 1 and 2	$5,100 monthly benefit	$5,100 monthly benefit
Total income for the month from all sources	*Other payments* received: $500 *Monthly income:* $2,000 Monthly benefit payable: $5,100 Total: $7,600	*Other payments* received: $500 *Monthly income:* $0 Monthly benefit payable: $5,100 Total: $5,600

Recurring claims

This section explains what happens if you need to make a new claim because of a recurrence of a *sickness* or *injury* resulting in disability.

If the benefit period is to age 65, then no waiting period applies if a disability recurs from the same or related *sickness* or *injury* within 12 months of the original claim end date. A new waiting period will only apply if a disability recurs from the same or related *sickness* or *injury* after 12 months.

If the benefit period is 1-year, 2-years, or 5-years, whether the waiting period will apply and how long we will pay the claim for depends on the gap between claims and whether the life insured has fully recovered from the original claim. The table below shows how this works. For this purpose, fully recovered means the life insured has been employed in a *gainful occupation* and has been working without restriction for at least two consecutive years since they were last claiming a monthly benefit.

If a disability recurs from the same or related *sickness* or *injury* and the benefit period is 1-year, 2-years, or 5-years	
First 12 months from original claim end date	More than 12 months after original claim end date
No waiting period applies. The remaining benefit period will reduce by any previous claims. If we've already paid benefits for the full benefit period, no further benefit is payable.	**If the life insured has fully recovered** The waiting period applies. A new benefit period will begin for the new claim. **If the life insured has not fully recovered** The waiting period applies. The remaining benefit period will reduce by any previous claims. If we've already paid benefits for the full benefit period, no further benefit is payable.

When the benefits end

We stop paying the total disability benefit on the date the life insured stops being totally disabled. Totally disabled in this section means as defined in the tables on pages 37 to 39.

We also stop paying the total disability benefit (even if the life insured continues to be totally disabled) when any one of the following happens:

- the benefit end date
- the death of the life insured
- when the policy ends, as explained on page 49.

We stop paying the partial disability benefit on the date the life insured stops being partially disabled. Partially disabled in this section means as defined in the tables on pages 37 to 39.

We also stop paying the partial disability benefit (even if the life insured continues to be partially disabled) when any one of the following happens:

- the benefit end date
- where the claim has continued beyond two years, on the date when the life insured has capacity to either:
  - earn an annual income of $300,000 and is working at full capacity in any *gainful occupation*. Annual income is the annual equivalent of (or 12-times) *monthly income*
  - work at full capacity for 40 hours in their *primary occupation*
- the death of the life insured
- when the policy ends, as explained on page 49.

When the optional benefits end

Each optional benefit ends when one of the following happens:

- if we receive notification to cancel the option, the end of the period of cover for the optional benefit you have paid premiums for, adjusted for any premium refunds payable
- the optional benefit end date
- when the policy ends, as explained on page 49.

Some optional benefits don't have an end date shown on the policy schedule. In that case, the optional benefit ends when the policy ends, unless the benefit explanation specifies an earlier end date.

Your policy includes these features automatically

Your policy automatically includes the following features, regardless of the covers selected. Superannuation restrictions are shown where they apply.

Feature name	What this feature does
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 73.
Inflation protection	Increases cover every year, unless declined by you, without health assessment.
Waiver of premium	Premiums are waived while a monthly benefit is payable, even if the amount payable is reduced to nil.
Rehabilitation or retraining expenses (paid direct to provider)	If the monthly benefit is payable, we will also pay expenses for a reasonable rehabilitation or retraining program. This feature doesn't apply if the policy is issued to the trustee of a superannuation fund.
Waiting period reduction feature	Allows a 1-year or 2-year waiting period to be reduced to a 1-year or 90-day waiting period if the life insured leaves an employer and their salary continuance cover through their employer ends as a result.
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover, and you can't make a claim. Up to 12 months of cover suspension can be taken over the life of the policy. Cover suspension is explained on page 72. This feature isn't available if the cover is funded by a platform account.

Inflation protection

We'll increase your insurance cover each year to help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. Inflation protection will continue to apply to cover at or above the maximum sum insured.

The benefit amount is increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

If there is no increase in CPI, then no increase will be offered.

You don't have to accept CPI increases. As income protection claims are based on the life insured's income, please take care to ensure that your insured monthly benefit remains aligned with income to avoid paying any unnecessary premium. If you don't want any increase we offer, you can:

- reject the increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection increases apply automatically during any claim that continues beyond a policy anniversary. This ensures that after the claim, the insured monthly benefit will be the same amount as it would have been if the claim had not occurred. The increase will be applied after the claim is finalised and won't apply to the calculation of benefits during a claim.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

Waiver of premium

We'll waive any premium due while a monthly benefit is payable, even if the amount payable is reduced to nil because of *other payments*, *monthly income*, and *ongoing income*. We'll also refund premium paid for the waiting period if a monthly benefit is payable.

If you have a 1-year or 2-year waiting period, we'll waive premiums due as you approach the policy end date, to reflect the fact that you won't be able to make a new claim. The policy will remain in-force so that you're still covered for a recurring claim or in case you have a waiting period underway. If you have a 1-year waiting period, we'll waive any premium due in the last 12-months of the policy and if you have a 2-year waiting period we'll waive any premium due in the last 24-months of the policy.

Rehabilitation or retraining expenses (paid direct to provider)

If a monthly benefit is payable, we will also pay expenses for a reasonable rehabilitation or retraining program for the life insured.

A reasonable rehabilitation or retraining program means a program that:

- may include job seeking, graduated return to work plans, retraining and other work readiness programs
- has been assessed by a specialist in the life insured's condition as likely to result in a return to remunerative work
- is not considered treatment that is eligible for a Medicare benefit or pharmaceutical benefit for any part of the service provided
- is not considered part of treatment provided in, or associated with, a hospital. We can't reimburse any expenses that we are not permitted by law to reimburse. We will not reimburse any expenses that are regulated by the National Health Act 1953 (Cth) or the Private Health Insurance Act 2007 (Cth)
- is not considered treatment that is entitled to be reimbursed from another source.

It's important that you let us know about your rehabilitation plans. We want to help the life insured to return to wellness and can meet rehabilitation or retraining expenses that will improve their ability to work. Make sure you check with us before you incur any expenses as not all expenses are covered. We'll review your plans and confirm what is covered as soon as we can.

The maximum amount payable under this feature is 24-times the insured monthly benefit.

Payments under this benefit will be made directly to the provider.

This feature doesn't apply if the policy is issued to the trustee of a superannuation fund.

Waiting period reduction feature

This feature is designed to provide flexibility to policies which have a waiting period of 1-year or 2-years because the life insured has salary continuance cover through their employer. We'll allow the waiting period to be reduced to 1-year or 90-days if the salary continuance cover ends because the life insured changes employer.

This feature isn't available if any of the following apply. If the life insured:

- elects to take up any continuation of cover option on the salary continuance cover
- is on claim or eligible to claim on either policy when you apply to reduce the waiting period
- isn't working in full-time paid employment with a new employer.

You must request a waiting period reduction within 30 days of the life insured ending employment with the employer who provided salary continuance cover.

You'll need to provide us with evidence to support your request, which means evidence of the salary continuance cover, and of the change in employment.

Your premium will be adjusted to reflect any change made to the waiting period under this feature.

You can purchase optional benefits to boost your cover

You can select optional benefits when you apply for your policy and they will apply from the policy start date.

You can also add options after your policy starts. Added optional benefits don't apply to any *sickness* or *injury* that occurs or is apparent within 90 days of the option being added. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

Optional benefits only apply if they are shown on the policy schedule.

The optional benefits are summarised in this table, and the policy conditions for each follow after the table.

The future insurability and super contributions options aren't available if the life insured has a high-risk occupation, which are occupations we describe on the policy schedule as 'special risk' or SR.

Option name	What this option does
Increasing claims option	Increases benefits annually with CPI while on claim.
Future insurability option	Allows an increase in cover without health assessment every year.
Super contributions option	Allows you to cover up to 100% of regular superannuation contributions in addition to the total or partial disability benefit, so that superannuation savings can continue while on claim.
Severity booster option	Increases the monthly benefit payable by 20% for specific conditions during the first six months on claim.

Increasing claims option

We'll index your claim payments. If the monthly benefit is paid beyond 12 months, the benefit is increased by any increase in *consumer price index* (CPI). Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before the anniversary of your claim. If there is no increase in CPI, then no increase will apply.

Future insurability option

The future insurability benefit allows you to increase the insured monthly benefit and any super contributions monthly benefit by up to 15% on every policy anniversary without any further health assessment. Cover can only be increased in line with an increase in income.

You'll need to provide evidence to show that you can support the increase. We must receive your request to apply an increase within 30 days of a policy anniversary.

You can't increase cover if:

- the request to increase is made after the policy anniversary when the life insured is 54
- we're paying benefits or have ever paid benefits under the policy
- the increase will result in the insured monthly benefit exceeding the monthly equivalent of our benefit limit, explained below
- the increase will result in a super contributions monthly benefit which is higher than the actual average monthly superannuation contributions the life insured or the life insured's employer made in the 12 months before the request to increase
- the insured monthly benefit has been issued with a medical loading (shown on the policy schedule).

Our benefit limit is based on annual income at the date when you apply for the increase:

- 70% of the first $300,000 of *pre-claim earnings*
- 50% of the next $200,000 of *pre-claim earnings*
- 25% of the balance of *pre-claim earnings*.

Annual income means the annual equivalent of (or 12-times) *monthly income*.

Any other special conditions, exclusions, or premium loading applied to the existing benefit, will also apply to the increased benefit.

The following limitations apply to increases under this benefit:

- the sum of all increases under this benefit can't exceed the insured monthly benefit amount on the benefit start date
- any increase under this benefit can't cause the insured monthly benefit amount to exceed $30,000, inclusive of any super contributions monthly benefit amount
- the insured monthly benefit can't be increased for any income changes until the future insurability option has been in-force for 12 months.

Super contributions option

We'll pay the super contributions monthly benefit when we pay a monthly benefit for total or partial disability.

The monthly benefit payable is a proportion of the insured amount, based on the amount we're paying as a monthly benefit for total or partial disability, as follows:

$$\frac{\text{monthly benefit payable}}{\text{insured monthly benefit}} \times \text{super contributions monthly benefit}$$

The maximum we pay each month is the lower of these two amounts:

- the average monthly superannuation contributions made by the life insured or on behalf of the life insured by an employer in the 12 months before the claim
- the super contributions monthly benefit amount.

Inflation protection, increasing claims option and future insurability option apply to the super contributions option.

If this benefit becomes payable, any super contributions monthly benefit is payable to a complying superannuation fund of your choice.

Severity booster option

We'll pay the severity booster if the life insured meets the conditions listed under either the 'Health event' or 'Hospitalised during the waiting period' headings below. Totally and partially disabled in this section means as defined in the table on page 37 to 39.

We'll only pay the severity booster benefit once, for the same period where it would otherwise be possible to qualify under both sections. This benefit is only available to policies with a 30-day waiting period.

This benefit does not increase any super contributions monthly benefit amount payable.

Health event

We'll boost the monthly benefit payable by 20% for the first six months on claim if the life insured suffers any one of the below health events and is totally or partially disabled when the waiting period ends:

- *severe burns*
- *invasive cancer (of stage 3 or 4)*
- *leukaemia, lymphoma, and blood related cancers (of stage 3 or 4).*

Each condition has an insurance definition which can be found in the 'Definitions' section, starting on page 84.

We won't pay a benefit if the life insured's condition doesn't meet our specific definition.

Hospitalised during the waiting period

If the life insured is hospitalised for at least 10 consecutive days for a *sickness* or *injury* during the waiting period and is totally or partially disabled after the waiting period ends, we'll boost the monthly benefit payable by 20% for the first month on claim.

If the life insured remains in hospital after the first month on claim, we'll boost the monthly benefit by 20% for each day the life insured is in hospital for up to five months. We'll pay 1/30th of the monthly benefit for each day during this period.

What this policy doesn't cover

Exclusions under income protection cover

We won't pay any benefits for *sickness* or *injury* occurring as a result of any event or medical condition specified as an exclusion on the policy schedule, or as a direct or indirect result of any of the following:

- an intentional self-inflicted act
- attempted suicide
- *illicit drug use*
- *uncomplicated pregnancy or childbirth*
- an act of war, whether declared or not. War doesn't include acts of terrorism.

We won't pay a benefit:

- that arises directly or indirectly from the life insured participating in criminal activity and for any period the life insured is incarcerated due to their participation in criminal activity
- if the life insured unreasonably refuses to undergo the medical treatment including rehabilitation to treat their condition as recommended by their *medical practitioner*
- for total or partial disability due to elective or donor transplant surgery unless the elective or transplant surgery occurred at least six months after:
  - the start of the policy
  - if the policy is ever reinstated, the date of reinstatement
  - for any increase in the insured monthly benefit, the date of the increase
- for a total or partial disability where reduced income or inability to work is caused by anything other than *sickness* or *injury*. For example, we won't pay a benefit if the life insured's professional qualification is restricted or revoked due to misconduct or if their employer stops trading.

We won't pay more than one benefit at a time

We'll only pay one benefit, being the highest, for the same period where it would otherwise be possible to qualify for a combination of both the total disability benefit and partial disability benefit.

If more than one separate and distinct *sickness* or *injury* results in a disability, payments will be based on the *sickness* or *injury* that provides the highest benefit.

When the policy ends

The policy ends when one of the following happens:

- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- death of the life insured.

Zurich Child Cover

Zurich Child Cover covers your children for certain health events

Child cover provides a lump sum payment if an insured child suffers one of the insured trauma conditions covered by your policy. The payment could be used to cover unexpected expenses resulting from your child's *sickness* or *injury*. Or it could allow you or your *partner* to take time off work to care for your child while they're unwell.

Multiple children can be covered under the one policy.

The policy conditions for Zurich Child Cover are set out in this section.

These benefits are payable under child cover

Benefit name	What this benefit pays
Trauma benefit	We'll pay the child cover benefit amount if an insured child suffers one of 18 covered conditions.
Injury advancement benefit	Advances $10,000 if an insured child suffers one of the following: • *loss of use of a hand or foot or sight in one eye* • *severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days).*
Carer benefit	We'll pay a monthly carer benefit of $5,000 if the policy owner or the policy owner's *partner* stops full-time paid work to care for an insured child at home (unless a trauma benefit is payable). This benefit only applies if the child cover benefit amount is $200,000 or more.
Death & terminal illness benefit	We'll pay a lump sum of up to $200,000 on death or *terminal illness*.

Zurich Child Cover policy conditions

The information below forms part of the Zurich Child Cover policy conditions. Words or expressions shown in *italics* have their meaning explained in the 'Definitions' section, starting on page 84.

When we accept your application, we'll issue a policy schedule. The policy schedule shows:

- each insured child covered under this policy
- the benefit amount that applies to each insured child at the start of the policy
- the benefit end date for each insured child
- any special conditions that apply to your policy specifically.

Each insured child is only covered for the amount shown on the policy schedule. The benefit is only 'in-force' from the benefit start date until the benefit ends, which can be earlier than the benefit end date shown on the policy schedule. See 'When the benefit ends' on page 54.

You can apply to make changes to your policy. If you apply to add an insured child or to increase the benefit amounts after the policy starts, changes are only effective if we accept your application after assessing the child's health.

Cover is automatically increased under the inflation protection feature each year unless you contact us with different instructions. Your options are explained in the section 'Inflation protection' on page 52.

This policy covers children for traumatic health events, terminal illness and death

This section explains when benefits become payable.

Benefits payable under child cover

The benefits payable under this policy are summarised on the previous page. A full explanation of each benefit follows below.

We'll pay a benefit only for an event that occurs while this benefit and the policy is in-force.

A benefit isn't payable if an exclusion applies. Exclusions are explained on page 53.

Trauma benefit

We'll pay the child cover benefit amount if the insured child is diagnosed with any one of the insured trauma conditions listed in the 'Insured trauma conditions for the child trauma benefit' table. Our insurance definition for each covered condition can be found in the section 'These definitions are specific to Child Cover', starting on page 94. The definitions describe health events at a specified severity. We won't pay a benefit if the insured child's condition doesn't meet our specific definition.

The amount payable is the child cover benefit amount on the date when the definition is met.

A 90-day exclusion period applies to trauma conditions in the list marked with an asterisk (*). The exclusion period applies when you apply for cover and if cover is ever reinstated. See 'What this policy doesn't cover' on page 53.

If the child cover benefit exceeds $200,000, the portion of cover which exceeds $200,000 is only payable if the insured child survives for at least 14 days after meeting the definition.

We'll only pay the trauma benefit for one insured trauma condition for each insured child.

Insured trauma conditions for the child trauma benefit

Cancers and tumours at the specified severity
benign tumour in the brain or spinal cord (with neurological deficit)
*cancer (excluding early stage cancers)**

Heart condition at the specified severity
cardiomyopathy (with significant permanent impairment)

Severe accident, loss of sight, hearing, speech, use of limbs, and paralysis
diplegia
hemiplegia
loss of use of hands, feet or sight
loss of hearing
loss of sight
loss of speech
major head trauma (with permanent neurological deficit)
paraplegia
quadriplegia
severe burns (of specified extent)

Neurological conditions at the specified severity
bacterial meningitis or meningococcal septicaemia (with severe life impact)
encephalitis (with permanent neurological deficit)
*stroke (of specified severity)**

Other covered conditions at the specified severity
chronic kidney failure (end stage)
major organ transplant (or waiting list)

Injury advancement benefit

We'll advance $10,000 if an insured child suffers one of the following that occurs while this benefit and the policy is in-force:

- *loss of use of a hand or foot or sight in one eye*
- *severe accident or illness requiring intensive care (with mechanical ventilation for 10 consecutive days).*

We'll only pay one injury advancement benefit for each insured child. The child cover benefit amount applying to an insured child is reduced by the amount advanced under this benefit.

Carer benefit

This benefit only applies if the child cover benefit amount is $200,000 or more.

We'll pay a monthly carer benefit of $5,000 if the policy owner or the policy owner's *partner* stops full-time paid employment to care for an insured child at home.

The carer benefit is only payable while the insured child is confined to bed and requires full-time care while this benefit and the policy is in-force.

The insured child must be confined to bed for a minimum of five consecutive days and must be following the advice and recommended treatment of a *medical practitioner*.

This benefit isn't payable if the trauma benefit has been paid or is payable. This benefit is payable in addition to an injury advancement benefit payment for the same insured child.

The carer benefit is paid for each complete month or 1/30th of the carer benefit is paid for each day this benefit is payable. The carer benefit is only payable for one carer, which can either be the policy owner or their *partner*.

A *medical practitioner* must confirm the insured child is confined to bed and requires full-time care. We'll require this certification each month that the claim continues.

The carer benefit is paid for a maximum of three months over the life of the policy.

Under this benefit, 'full-time paid employment' means working 20 hours or more per week in paid work.

Terminal illness benefit

We'll advance the death benefit if an insured child is diagnosed with a *terminal illness* while the policy is in-force.

The amount we'll advance is the death benefit amount on the date the insured child's *terminal illness* is certified, even if we don't see the certifications until a later date.

Death benefit

We'll pay the death benefit if an insured child dies while the policy is in-force.

The death benefit is the lower of:
- the child cover benefit amount for the insured child
- $200,000.

Your policy includes these features automatically

Your policy includes the following features.

Feature name	What this feature does
Interim cover	Puts some temporary accident cover in place as soon as you apply for cover. Interim cover is explained on page 73.
Inflation protection	Increases cover every year, unless declined by you, without health assessment.
Cover increase feature	Allows a $10,000 increase in cover without health assessment on the insured child's 6th, 10th, and 14th birthdays.
Continuation of cover	Allows the insured child to convert to an adult policy without health assessment once they reach age 15.
Cover suspension	Allows a break in cover to ease financial pressure. You can put your cover on hold for a chosen period, during which time there is no cover and you can't make a claim. Up to 12 months of suspension can be taken over the life of the policy. Cover suspension is explained on page 72.

Inflation protection

We'll increase your insurance cover each year to help protect the value of the cover from the impact of inflation. Increases are offered each year on the policy anniversary. Inflation protection will continue to apply to cover at or above the maximum sum insured.

The child cover benefit amount is increased by the higher of:
- 5%
- any increase in *consumer price index* (CPI).

Any increase in CPI is based on the annual percentage change in CPI published each quarter. We use the figure most recently published at least three months before your policy anniversary notice is sent. For example, if your policy anniversary is in September, we'll send your policy anniversary notice in August and the CPI increase on that notice will be based on the annual percentage change in CPI published for the March quarter.

You don't have to accept any increase we offer. You can:
- reject the increase. We'll still offer you increases in the following years
- agree a lower increase amount with us for the current policy anniversary
- reject the increase and all future increases. We won't offer you increases any more unless you ask us to start offering them again.

Contact us when you receive the offer if you want to make a change. If you don't contact us before the policy anniversary, the increase will be applied automatically.

Inflation protection doesn't apply to the amount payable for events which have already occurred when we offer it to you.

The child cover benefit amount will only be increased up to a maximum amount of $500,000.

Cover increase feature

You can increase the child cover benefit amount for each insured child by $10,000 on their 6th, 10th, and 14th birthdays, without health assessment.

This feature can be used provided:
- cover for the insured child won't exceed the maximum of $500,000
- we haven't paid a benefit and there is no entitlement to a benefit under this policy for the insured child.

The feature can only be used within 30 days of any of the specified birthdays.

Continuation of cover

An insured child can apply to continue cover under their own policy once they're 15 years old, without assessment of health.

Within 30 days of any policy anniversary after the insured child's 15th birthday, they can apply in writing for a new death and trauma cover policy for the same benefit amount. We'll ask if they're a smoker, so that we can charge the correct premium, but won't assess any other aspects of their health.

The new policy will be the most comparable policy we offer when the insured child applies to continue cover. The premiums for the new policy will be those applying when it is issued. Any special conditions, exclusions, or premium loading that applied to the original policy may also apply to the new policy.

When the new policy is issued, all cover for the child under this policy will automatically end.

Continuation of cover is only available if we haven't paid a benefit under this policy for the insured child.

What this policy doesn't cover

Exclusions under child cover

We won't pay a benefit if the claim is caused by any event or medical condition specified as an exclusion on the policy schedule, or directly or indirectly by any of the following:
- an intentional self-inflicted act in the first 13 months
- attempted suicide in the first 13 months
- an act of the policy owner or person who will otherwise be entitled to the benefit payable, intending to harm the insured child.

A 90-day elimination period applies to some trauma conditions

Some insured trauma conditions have a 90-day elimination period. The elimination period applies to the trauma conditions on page 51 that are marked with an asterisk (*).

The start of the elimination period can vary:

New cover

For new child cover applications, the elimination period starts on the benefit start date for that cover. We won't ever pay a claim for those trauma conditions if during the elimination period any of the following happens:
- the condition occurs or is apparent. 'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended for the insured child.

Cover increases

For cover increases, the elimination period starts on the benefit start date of any increase in child cover benefit, and only applies to increase portion of the cover.

We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended for the insured child.

Reinstated cover or cover suspension

When there is a break in cover and the policy re-starts, the elimination period starts for reinstated cover, from the date the policy is reinstated or, if after cover suspension, from the cover suspension end date.

We won't ever pay a claim for those trauma conditions if during the elimination period, either of the following happens:
- the condition occurs or is apparent. 'Apparent' means you or the insured child are aware of symptoms or a diagnosis relating to the condition
- surgery for the condition is recommended for the insured child.

In all circumstances, we won't pay a benefit for any trauma condition that is directly or indirectly related to a condition that we won't pay a claim for in the elimination period.

We won't apply the 90-day elimination period if immediately before the child cover started, the insured child was covered under another policy for the same trauma condition with us or another insurer for more than 90 days, and we replaced it. We'll only waive the elimination period on the amount of benefit we replaced.

This waiver can also apply to any increases in the benefit that meet the same criteria.

Any claim we pay reduces the amount available for further claims

When a benefit is paid under the policy, the death and trauma benefits are reduced by the amount paid, and the premium is re-calculated. The new premium will be based on the reduced levels of cover from the next premium due date after payment of the relevant benefit.

Death cover benefit reductions

The death benefit amount is reduced by the amount paid or advanced, under any of the following:
- terminal illness benefit
- trauma benefit
- injury advancement benefit.

Trauma cover benefit reductions

The trauma benefit amount is reduced by the amount paid or advanced, under any of the following:
- terminal illness benefit
- injury advancement benefit.

When the benefit ends

The child cover benefit ends for each insured child when one of the following happens:
- payment of the child cover benefit amount
- if we receive notification to cancel the benefit, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- the child cover benefit end date shown on the policy schedule
- the policy anniversary when the insured child is 18
- the death of the insured child
- when the policy ends

When the policy ends

The policy ends when one of the following happens:
- the latest benefit end date shown on the policy schedule
- when we cancel the policy due to non-payment of any premium. We will write to you at least 30 days before and provide the opportunity to pay the overdue premium before we cancel the policy
- if we receive notification to cancel the policy, the end of the period of cover you have paid premiums for, adjusted for any premium refunds payable
- the policy anniversary when the last insured child is 18
- payment of 100% of the child cover benefit relating to the last insured child under the policy
- death of the last insured child covered under the policy.

Holding this insurance in superannuation

Holding insurance cover in superannuation can be tax effective

Holding insurance in superannuation can be a tax-effective strategy which doesn't affect your day-to-day cashflow.

If you use superannuation to fund insurance, then depending on the fund, you will generally be eligible for a 15% tax saving that the trustee can pass on to members.

However, using superannuation savings to fund insurance will reduce your retirement savings. You can discuss this option with your financial adviser to make sure that it is an appropriate option for you personally.

The owner of the policy is the trustee of the relevant fund

When you apply for cover within superannuation, the policy is issued to a trustee of the relevant superannuation fund as policy owner.

If a benefit becomes payable under a policy held within superannuation, we'll generally pay it to the trustee. The trustee must pay the benefit in line with the governing rules of the superannuation fund and superannuation law.

Self-managed superannuation funds

If you're the trustee of a self-managed superannuation fund, it's your responsibility as trustee to consider:

- the appropriateness of providing each type of insurance cover within superannuation and its potential implications for the complying status of your fund
- the taxation consequences of holding the cover
- superannuation law that limits when you can pay benefits out of the fund.

Eligible superannuation funds

If you don't have a self-managed superannuation fund, Zurich Active policies are also available through *eligible superannuation funds* where the trustee is the policy owner, and the life insured is a fund member. The trustee is solely responsible for paying the premium for the member by the due date from the member's account or contributions.

In this situation, we may agree with the trustee to send notices to the life insured directly, so that you receive up to date information about your insurance. We may also agree with the trustee to pay income protection benefits to the life insured directly, to avoid delays.

You can find more information about applying for insurance within superannuation through membership of an *eligible superannuation fund* in the PDS and other documents issued by the fund trustee.

Restrictions apply to insurance held in superannuation

Superannuation fund trustees must ensure that insurance benefits are aligned with the superannuation payment rules under superannuation law. We've applied restrictions to the insurance benefits we offer to superannuation fund trustees in line with these requirements.

The types of insurance that we allow to be held within superannuation are Active Cover (death cover and health events which meet the superannuation definition of permanent incapacity) and income protection.

The terms 'temporary incapacity' and 'permanent incapacity' have definitions under superannuation law which includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations. The term 'superannuation payment limit' is a term we use to describe cashing restrictions that apply to some superannuation benefits. We'll use these terms and apply the limit as if we're the trustee of the relevant superannuation fund and the life insured is a member of the fund.

Temporary incapacity is a term used in superannuation law which generally refers to situations when income protection benefits can be paid.

To meet the definition, the life insured must stop paid work (also defined in superannuation law) due to *sickness* or *injury* for a period of at least one full day during the waiting period.

Permanent incapacity is a term used in superannuation law which generally refers to situations when total and permanent disability benefits can be paid.

To meet the definition, the life insured must have all the necessary certifications required to establish permanency in superannuation law.

Superannuation payment limit is the maximum insurance benefit amount that can be paid to a member of a superannuation fund under superannuation law and applies to superannuation income protection benefits.

The limit is designed to make sure the life insured doesn't receive more in total during a claim (including all insurance benefits and income) than before a claim.

The benefit we pay under the policy for any month is capped to avoid this happening.

How superannuation restrictions affect Active Cover

If you apply for Active Cover in superannuation, we'll split your cover across two policies under the superannuation optimiser structure. Benefits that don't meet the superannuation definition of permanent incapacity are excluded from the superannuation policy but will be held on a non-superannuation policy.

If Active Cover is held in superannuation, two important restrictions apply:

- at the time of any health events claim, the life insured must also meet the superannuation definition of permanent incapacity
- the advancement for funeral expenses isn't available.

Cover is held across two policies

When superannuation optimiser applies and cover is held across two policies, one of the policies is issued to the trustee of a superannuation fund. This is the superannuation policy. The remainder of the cover is issued on a non-superannuation policy. We'll determine which policy will pay a benefit based on the information available when we assess your claim. The two policies are known as 'related' policies.

The cover under each related policy is explained in the table below.

Superannuation component	Non-superannuation component
This component pays benefits for: • death (including additional death cover) • *terminal illness* • category A health events which meet the superannuation definition of permanent incapacity • extended care option (if the health event meets the superannuation definition of permanent incapacity).	This component pays benefits for: • category A health events which don't meet the superannuation definition of permanent incapacity • category B, C, D and E health events • extended care option (if the health event doesn't meet the superannuation definition of permanent incapacity).

Claims under the superannuation policy

Claims for death and *terminal illness* will be paid under the superannuation policy to the trustee as policy owner.

If a health events claim is made, an assessment will first be made under the superannuation component to determine if the life insured meets the:

- definition of a category A health event
- superannuation definition of permanent incapacity.

If both requirements are met and a benefit is payable under the superannuation policy, we'll pay the benefit to the trustee of the superannuation fund. The trustee will release the benefit from the superannuation fund to the member, subject to the governing rules of the superannuation fund and superannuation law.

Claims under the non-superannuation policy

If both requirements aren't met, the claim will then be assessed under the non-superannuation component.

The life insured may meet the definition of a category A health event but not meet the superannuation definition of permanent incapacity. In this case, the benefit is paid directly to the policy owner of the non-superannuation policy and isn't subject to fund governing rules or superannuation law.

Where cover is split across policies, they must stay in step with each other

The initial amount of cover under each policy must always be equal.

If you request a decrease to the initial amount of cover, it will be applied to both policies. Similarly, if you apply to increase the cover, you must apply to increase the cover on both policies. If the cover is cancelled on one of the policies, the cover on the other policy will also end. If one of the policies is paid in advance, we'll refund any unused premiums. If cover suspension is taken, it will be applied to both policies at the same time.

Any links which apply between claims apply across both policies

Both related policies will work as one policy for the purpose of:

- progressive conditions
- limited claim periods
- health event policy limit.

How superannuation restrictions affect income protection

If income protection cover is held in superannuation, when you make a claim, the life insured must also meet the superannuation definition of temporary incapacity or permanent incapacity.

Income protection can be structured wholly within superannuation, with restrictions designed to meet superannuation law.

Benefits are capped at the superannuation payment limit.

Complimentary cover supplements income protection held in superannuation

If your policy is held in superannuation, and the life insured is unemployed when *sickness* or *injury* occurs, no benefit is payable under Zurich Income Safeguard.

However, we provide complimentary cover for this situation.

Complimentary Zurich Income Safeguard (complimentary cover) is provided to the life insured.

Complimentary cover is only provided to the life insured while the relevant Zurich Income Safeguard policy remains in force. No premiums are payable for complimentary cover and benefits are payable to the life insured directly.

The terms of the complimentary cover do not form part of the policy with the policy owner of the Zurich Income Safeguard policy.

How the complimentary cover works

Complimentary cover provides identical benefits and on the same terms as the Zurich Income Safeguard policy, including all the additional benefits, features and selected optional benefits, except that the complimentary cover doesn't exclude payment of a benefit because the life insured is unemployed when *sickness* or *injury* occurs.

Complimentary cover only applies in the event the life insured is unemployed at the time of *sickness* or *injury* and no benefit is payable under your Zurich Income Safeguard policy. Unemployed means that the life insured is not working for gain or reward.

Assessment of claims for a total or partial disability benefit

We will first assess a claim for the total or partial disability benefit against the Zurich Income Safeguard policy.

If the life insured is unemployed at the time of the *sickness* or *injury* and does not qualify for a benefit, we will assess a claim for a benefit under the complimentary cover.

We will only ever pay a monthly benefit under the complimentary cover if the life insured is unemployed at the time of *sickness* or *injury* and doesn't qualify for a benefit under Zurich Income Safeguard.

If we are paying under the complimentary cover, we will waive the premium for your Zurich Income Safeguard policy.

Certain features of both covers are the same

Under the complimentary cover, the following are the same as your Zurich Income Safeguard policy:

- the benefit payable, waiting period and benefit period
- the life insured
- extra-cost optional benefits.

If any of the above features under your Zurich Income Safeguard policy change, the complimentary cover will automatically change in the same way. For instance, if the insured monthly benefit amount is reduced or increased under your Zurich Income Safeguard policy, the insured monthly benefit amount on the complimentary cover will be reduced or increased (as applicable) by the same amount.

If a cover suspension is taken, it will be applied to both policies at the same time.

The taxation implications of a benefit payment will differ depending on whether we pay a benefit to the trustee of your superannuation fund or directly to the life insured under complimentary cover, or as a superannuation benefit you receive from the trustee of your superannuation fund. We recommend you seek advice from a tax adviser.

When complimentary cover ends

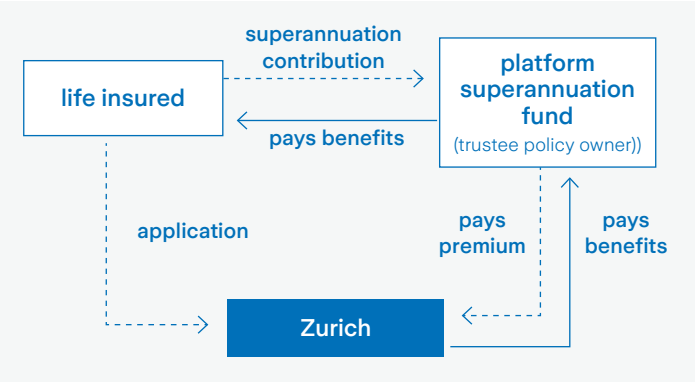
Complimentary cover and eligibility for any benefit under the complimentary cover ends when the Zurich Income Safeguard covering the life insured ends.

Some superannuation platforms offer our insurance

You can take Active Cover (death cover and health events cover) and income protection cover through selected superannuation platforms. Your financial adviser can tell you which platforms offer our insurance. Platforms offer the convenience of consolidated finances and reporting.

If you include Zurich insurance in your platform account, you'll pay premiums by automatic deduction from the platform account on the same day each month, quarter, half-year or year, depending on your chosen payment frequency. The available frequencies may vary by platform.

The diagram below shows how this works.



If premiums aren't paid in any month due to insufficient funds, then the outstanding premium will be deducted from the account in the following month, to bring premiums up to date.

The PDS prepared by the trustee of the platform superannuation fund will contain more information about how the platform works.

Superannuation restrictions apply to platform policies

Restrictions apply to the benefits which can be held in superannuation. In summary, the cover available via a superannuation platform is as follows:

- death cover
- health events cover which will meet the superannuation definition of permanent incapacity
- income protection cover which will meet the superannuation definition of temporary incapacity.

Benefits which aren't available with superannuation ownership are identified in the section 'Useful parameters for each policy are summarised here', starting on page 62.

Superannuation optimiser can be used to split cover between a superannuation platform policy and a second policy held outside superannuation. Superannuation optimiser is explained earlier in this section of the document.

Applying for cover

Here's how to apply for cover

Here is an easy step-by-step diagram which shows how to put Zurich Active cover in place, in this case with personal advice from your financial adviser.

Work out what you need	The first step involves a discussion with your financial adviser. They will help work out what types of cover you need, how much cover, the most appropriate ownership structure and any tailoring required for your situation. Once the details are agreed with you, you'll be given a personalised premium quote.
Make sure you understand what you're applying for	This document contains all the information you need to know about Zurich Active policies. Please read it carefully to make sure you understand the policy or policies you plan to apply for. If you're applying for cover through a superannuation fund, make sure you read the PDS issued by the trustee of that fund as well to understand the implications of taking insurance through superannuation.
Complete an application	We'll ask about the life insured's health, financial situation, lifestyle and pastimes. Your financial adviser will help you complete and submit the application electronically. If you elect to use our tele-interview service, then you can provide most of the details over the phone. If you don't want to share that information with your financial adviser, you can ask us to keep it private.
Up to 90 days of interim cover applies	As soon as you submit an application which includes valid payment details, we provide up to 90 days of interim cover. Interim cover is cover for *accidental death* and *accidental injury*, and the interim cover you have is based on the covers you apply for. Interim cover generally ends when we finish our assessment, which is when we issue a policy or we decline the application. Interim cover is temporary and has its own policy conditions which are set out in the 'Interim cover' section, starting on page 73.
We assess your application	We assess the information in the application. Any health condition the life insured tells us about will be covered under the policy unless we're unable to offer cover or specifically exclude the condition. Depending on factors including age, health, cover applied for and benefit amount we may need more information directly from the life insured, from the life insured's doctor or we may request a medical examination or test. Most applications are assessed without any medical testing. If any medical test we request as part of your application returns an abnormal result, we'll provide that result to the doctor identified in your application.
Any revised terms are agreed with you	If our application assessment results in a premium loading or special exclusion, then your financial adviser will be in touch with you to agree the revised terms. Any revised terms form part of your application and we'll only issue a policy if you agree to them. You can end the process here if you don't want to go ahead with the application on revised terms.
Policy is issued	Once we complete our assessment and accept your application, a policy schedule is created and sent to you. The policy schedule shows the details of the individual policy, including sums insured and cover start and end dates. Any special conditions and exclusions that have been agreed will be shown on the policy schedule.
Store your documents	This document contains the policy conditions. Please keep it together with your policy schedule so that you can find both documents easily if you need to make a claim. You'll also need your documents if you decide to change your cover.

The duty to take reasonable care not to make a misrepresentation

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into. To meet this duty, each person whose life is to be insured 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.

The duty applies to this contract as a consumer insurance contract.

If you do not meet your duty

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.

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance of each life to be insured. The information given to us in response to our questions is vital to our decision.

Guidance for answering our questions

You are responsible for the information provided to us. Each person answering our questions 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 doctor
- review your application carefully. If someone else helped prepare your application (for example, your financial adviser), please check every answer, and if necessary, make any corrections.

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer 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.

Notifying the insurer

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

If you need help

It's important that you and every person answering our questions understands this information and the questions we ask. Ask us or your financial adviser for help if you have difficulty answering our questions or understanding the application process.

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

What can we do if the duty is not met?

If a person who answers our questions does 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 the person who answered our questions 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
- in some cases, how long it has been since the cover started.

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.

If you have death cover, you can name beneficiaries

If your policy is held in superannuation, you can generally make death benefit nominations with the trustee. The PDS issued by the trustee of the fund will provide more information.

If you are the only policy owner and the life insured, you can nominate beneficiaries to receive the death benefit. You can't nominate beneficiaries if your policy has joint owners, as death benefits are paid to the surviving owner if one owner dies.

The following rules apply to beneficiary nominations:

- you must be the only policy owner and the life insured to make a valid nomination
- a beneficiary must be an individual, corporation or trust
- you can't make contingent nominations which are nominations that provide for multiple scenarios
- a nomination must be properly executed in the form we specify before we can accept it
- you can change or revoke a nomination any time but the change is only effective when receive and accept it
- you can only have one nomination in-force at any time and can't supplement a nomination. To add beneficiaries, you must replace the nomination by making a new one
- an attempt at making a new nomination received by us revokes past nominations even if the attempt at making the nomination is defective
- if ownership of the policy is assigned to another person or entity, then any previous nomination is automatically revoked
- payment of the death benefit will be made using the latest unrevoked valid nomination
- if a beneficiary dies before you, we'll pay the portion of the death benefit for that beneficiary to your legal personal representative
- if a beneficiary is alive when you die, but we're notified of their death before we can pay the death benefit, then we'll pay the entitlement to the deceased beneficiary's legal personal representative
- a beneficiary has no rights under the policy, other than to receive policy proceeds after a claim has been admitted by us. They can't authorise or initiate any policy transaction
- we may delay payment if the nomination or nominations become the subject of legal proceedings or external dispute resolution processes
- a court order or decision of an external dispute resolution process relating to a nomination overrides the nomination.

Only Australian residents can apply for Zurich Active policies

These policies are only available to people located in Australia when they apply for cover. We can't accept applications signed and submitted from outside Australia.

Cover is available to Australian residents and people who are in the process of applying for permanent residency and are living in Australia. All parties to any policy issued must be Australian residents, including policy owners, lives insured and the person, company or fund that is paying the premium. The policies are designed for Australian residents and their operation and your rights may be restricted if you or the life insured becomes a resident of another country.

You have a 30-day cooling-off period

You have 30 days from when your policy starts to check that your policy meets your needs. In the 30-day cooling-off period, you can cancel the policy for any reason and receive a full refund of any premiums paid, provided you haven't made a claim. Your right to cancel the policy and receive a refund ends if you make a claim or make use of any other rights under your policy in the 30 days.

If your policy has superannuation ownership and we need to refund any contributions made to the policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

How to cancel your policy

To cancel your policy during the cooling-off period or any time after that, choose the most convenient option for you:

- over the phone, provided you are the only policy owner or if the policy owner is the trustee of an *eligible superannuation fund*
- in writing as a letter sent by post
- in writing as an email attachment.

Our contact details are on the inside back cover of this document.

Useful parameters for each policy are summarised here

Zurich Active Cover

Health events, death & terminal illness cover		
Provides a lump sum payment if the life insured suffers one or more covered health event, dies or is diagnosed with a terminal illness.		
Entry ages	15 – 65	
End age (policy anniversary when the life insured is the age shown)	65 for *occupational impairment* 70 for health events 99 for death & terminal illness cover	
Minimum initial amount of cover	$100,000 (health events, death & terminal illness)	
Maximum initial amount of cover	$4 million (health events, death & terminal illness) If you select the extended care option, then this is the maximum boosted amount (the maximum boosted amount is 150% of the initial amount of cover for certain category A health events, see page 25)	
Increasing cover after the policy begins	You can apply for a cover increase until the policy anniversary when the life insured is 69	
	non-superannuation ownership	**superannuation ownership**
Benefits and features	• health events benefit • death & terminal illness benefit • inflation protection • claim protector • advancement for funeral expenses • future insurability • financial planning advice	• health events benefit (category A health events which meet the definition of permanent incapacity) • death & terminal illness benefit • inflation protection • claim protector • future insurability
Optional benefits	• extended care option • additional death cover option	• extended care option • additional death cover option
Automatic inclusions	• interim cover • cover suspension (not available if funded by platform)	• interim cover • cover suspension (not available if funded by platform)

Zurich Income Safeguard

Income protection		
Income protection provides a monthly benefit if the life insured is unable to work due to a sickness or injury that causes ongoing restricted capacity for longer than the specified waiting period. **Cover restrictions that apply to some occupations are outlined on the next page.**		
Entry ages	19 – 60	
End age (policy anniversary when the life insured is the age shown)	65	
Eligibility The life insured must be in paid work	Full-time and part-time permanent employees or self-employed workers: minimum 20 hours per week Fixed-term contractors and casual workers: minimum 24 hours per week Minimum hours are a guideline only, based on the life insured's current situation. We'll ask about working history as part of the application process.	
Minimum insured amount	$1,500 per month	
Maximum insured amount	$30,000 per month, plus up to $30,000 per month restricted to a 1-year or 2-year benefit period If you separately insure your superannuation contributions using our super contributions option, explained on page 48, then these maximums include the super contributions monthly benefit amount. The overall maximum of $60,000 per month applies to income protection and business expenses cover combined	
Increasing cover after the policy begins	You can apply for a cover increase until the policy ends	
Waiting periods available	• 30-days • 60-days • 90-days • 1-year • 2-years	
Benefit periods available	• 1-year • 2-years • 5-years • to age 65	
	non-superannuation ownership	**superannuation ownership**
Benefits and features	• total disability benefit • partial disability benefit • inflation protection • waiver of premium • rehabilitation or retraining expenses (paid direct to provider) • waiting period reduction feature	• total disability benefit • partial disability benefit • inflation protection • waiver of premium • waiting period reduction feature • complimentary cover if unemployed at time of sickness or injury
Optional benefits	• increasing claims option • future insurability option • super contributions option • severity booster option	• increasing claims option • future insurability option • super contributions option • severity booster option
Automatic inclusions	• interim cover • cover suspension (not available if funded by platform)	• interim cover • cover suspension (not available if funded by platform)

Income protection cover restrictions for some occupations

Some restrictions apply to occupations which we class as 'special risk' or SR. Your financial adviser can tell you if your occupation is in this group, and your occupation class will be shown on the policy schedule. SR means that your day-to-day duties make you more likely to claim for sickness or injury than most people.

SR restrictions are summarised in this table.

Entry ages	19 – 53
End age (policy anniversary when the life insured is the age shown)	60
Waiting periods available	• 30-days • 60-days • 90-days
Benefit periods available	• 1-year • 2-years • 5-years
Maximum insured amount	$10,000 per month
Optional benefits available	• increasing claims option • severity booster option

Zurich Child Cover

Child cover	
Child cover provides death, terminal illness and limited trauma benefits for children, as well as a carer benefit for parents.	
Entry ages	2 – 17
End age (policy anniversary when the insured child is the age shown)	18
Minimum benefit amount	$10,000
Maximum benefit amount	$500,000 Maximum applies to all child trauma cover combined across all insurers. Death & terminal illness benefit is capped at $200,000.
Increasing cover after the policy begins	You can apply for a cover increase until the policy anniversary when the insured child is 17
Benefits and features	• trauma benefit • injury advancement benefit • carer benefit • death & terminal illness benefit • inflation protection • cover increase feature • continuation of cover
Automatic inclusions	• interim cover • cover suspension

Calculation of premiums and payment information

The premium is the amount you pay for your insurance cover

It includes the cost of the policy and any optional benefits selected, as well as any government charges that apply.

The following terms in this part of the PDS form part of all policies.

We calculate your initial premium based on the life insured and the cover you select

We calculate premiums based on:

- the amount of cover
- any optional benefits you choose
- whether your premiums are variable age-stepped or variable premiums
- the benefit period and waiting period (for income benefits only)
- the frequency of your premium payments
- the life insured's gender and current age
- whether or not the life insured is a smoker
- the life insured's occupation and employment arrangement
- the life insured's current and past health
- any pastimes the life insured participates in
- whether you or the life insured qualify for a discount
- the period of time since health, financial, and occupational assessment (for income benefits on variable age-stepped only).

A number of factors affect the cost of your cover

The cost of your cover is generally higher if:

- the period of time that has passed since the health, financial and occupational assessment is longer (for income benefit on variable age-stepped only)
- you select a higher benefit amount
- you include more optional benefits
- you pay premiums half-yearly, quarterly or monthly
- you select a longer benefit period or a shorter waiting period (for income benefits only)
- the life insured is older
- the life insured is male (for death cover) or female (for health events cover and income benefits)
- the life insured is a smoker
- the life insured's occupation includes hazardous duties or higher occupational risk
- the life insured isn't in good health or has underlying heath issues
- the life insured participates in hazardous pastimes.

The cost of your cover is generally lower if:

- the life insured's health, financial and occupational assessment has been recently completed (for income benefit on variable age-stepped only)
- you select a lower benefit amount
- you include fewer or no optional benefits
- you pay premiums yearly
- you select a shorter benefit period or a longer waiting period (for income benefits only)
- the life insured is younger
- the life insured is female (for death cover) or male (for health events cover and income benefits)
- the life insured is a non-smoker who has not smoked tobacco, e-cigarettes (vaping) or any other substance and has not used a nicotine product in the past 12 months
- the life insured is a salary-based employee (for income benefits only)
- policy discounts apply.

The cost of cover will vary over time

The premium payable from the start of the policy to the first policy anniversary is shown on the policy schedule.

For health events, death & terminal illness cover, the premium is based on the initial amount of cover throughout the life of the policy. However, the cost of your cover will still change.

The cost of your cover will vary over time depending on:

- whether your premiums are variable age-stepped or variable premiums
- the period of time since health, financial, and occupational assessment (for income benefits on variable age-stepped only)
- whether you or the life insured qualify for a discount under the terms of any special program we offer
- whether you accept inflation protection offers
- whether we change premium rates. Such changes would apply to all policies in the same category.

Here are the reasons why premiums can vary

Some of the factors used in calculating a premium change from year to year:

- variable age-stepped premiums are generally lower than variable premiums at the start of the policy, but variable age-stepped premiums generally increase each year as the life insured gets older whereas variable premiums do not
- variable age-stepped premiums may be lower at the start of the policy, on the basis that the life insured's health has been recently assessed (for income benefits on variable age-stepped only)
- discounts under any special program we offer will have their own terms that allow for changes
- inflation protection increases are extra amounts of cover added to your policy if you accept them a policy anniversary
- we may make changes to premium rates for all policies in the same category if the cost of providing cover increases.

Factors which can result in changes to premium rates include changes in:

- costs we incur in providing Zurich Active, for example, claim cost. The amount we pay in claims could be higher than expected if we pay more claims than

expected, if we pay higher benefit amounts than expected, if we pay benefits for longer periods than expected, and if emerging industry experience and trends show an increase in long term claims cost
- commission costs
- the cost of reinsurance
- capital requirements
- expected policyholder behaviour across the portfolio, including how long Zurich Active is held
- economic factors such as interest rates, inflation rates, employment level and market returns
- tax, government, or other mandatory charges
- operating expenses
- other factors affecting our ability to continue providing cover and meeting claims under this product.

These factors can be higher or lower than expected over time.

When inflation protection increases are offered, we calculate variable age-stepped and variable premiums for the new cover based on:
- the same factors shown on the previous page for initial premium calculation, except that we don't review the life insured's health, occupation, employment arrangement, and pastimes
- any premium loading already applying to the existing cover, which will also apply to the increase amount
- the life insured's age at the policy anniversary.

The difference between variable age-stepped and variable premiums

Life insurance is long-term cover, which makes it different to other types of insurance like car insurance where the item being insured is re-valued each year. Unless you ask us to make changes, we only assess your medical and financial information at the start of the policy. When we calculate the premium each year, the change in your premium will depend on whether you've selected variable age-stepped or variable premiums.

Variable age-stepped premiums generally increase each year based on rates for the life insured's age. Variable premiums for the benefit amount at policy outset are based on the age of the life insured when cover begins. Variable premiums are 'averaged out' or smoothed, which means they are generally higher than variable age-stepped premiums during the initial years, but lower than variable age-stepped premiums in later years. If you plan to keep your policy for longer than 10-12 years, variable premiums may save you money over the life ofyour policy.

Both variable age-stepped and variable premiums can change as they aren't guaranteed or 'fixed'.

Variable age-stepped and variable premiums for any increase in cover, including inflation protection increases, are based on the age of the life insured at the date of the increase.

For Active Cover, variable premiums convert to variable age-stepped premiums on the policy anniversary when the life insured is 65. The reason for this is that variable premiums smooth the cost during the ages when most people have cover. If variable premiums were calculated over all ages, including older ages when people are more likely to claim, they would be less affordable. The impact of the change from variable to variable age-stepped is that the cost will increase substantially on the anniversary when the life insured is 65. This is because the variable age-stepped premium will then be based on age 65, 66, 67 and so on, unlike the smoothed premium for younger ages that applied previously.

We'll remind you about this change when the life insured approaches 65 so that you have time to seek advice and decide whether to continue the cover.

The cost of your cover will usually increase each year

Regardless of whether you choose variable age-stepped or variable premiums, the overall policy premium will increase:
- if the benefit amount increases, for example, when inflation protection increases are applied
- if the policy is impacted by any change in stamp duty
- if we change the premium rates for all policies in the same category.

Premium rates aren't guaranteed and can change

Whether variable age-stepped or variable premiums apply, premium rates for the policies explained in this document aren't guaranteed and can change. This will only occur following a review of our premium rates against the cost of providing cover, as explained earlier in this section.

Any change will affect all policies in the same category, not just your individual policy. We'll tell you about any changes to premium rates at least 30 days before the change takes effect.

The premium payable from the start of your policy is shown on your policy schedule. Each anniversary notice we send you will outline your premium for the next policy year. These premium amounts we tell you about won't change before the next policy anniversary unless you ask us to make a change to your policy. If you ask us to change your policy before your next policy anniversary and we have a premium increase underway, your policy will automatically attract the new premium rates at the time of the change which means they will apply earlier than they otherwise would.

We've changed premium rates for all policies in the same category in the past. You can find information about premium increases we have made in recent years on our website in the section: zurich.com.au/existingcustomers.

Choice of payment methods and timing

You can choose to pay premiums as shown in the table below. If you choose any frequency other than yearly, a frequency loading will apply.

Method of payment	First premium	Monthly	Quarterly	Half-yearly	Yearly
Direct debit	✓	✓	✓	✓	✓
Credit card	✓	✓ Direct debit	✓ Direct debit	✓	✓
BPAY®	×	×	×	✓	✓
Platform deduction	First month's premium is waived	✓	✓	✓	✓
Rollover from an *eligible superannuation fund*	✓	×	×	×	✓

Stamp duty

State governments impose stamp duty on life insurance policies and those duties vary from state to state.

Any stamp duty that applies is included in the cost of your policy, generally as a separately stated amount. If changes in the law or a change in the life insured's residency result in a higher rate of stamp duty, the extra duty will be added to your premium or deducted from insurance benefits.

Other charges may apply

Goods and Services Tax (GST) isn't currently payable on insurance premiums for the policies described in this PDS.

Direct debits from your financial institution may incur an extra fee, charged by your financial institution.

You can pay insurance premiums from a platform account

You can take Zurich Active Cover and Zurich Income Safeguard through selected platforms. Your financial adviser can tell you which platforms offer our insurance.

If you include Zurich insurance in your platform account, you'll pay premiums by automatic deduction from the platform account on the same day each month, quarter, half-year or year, depending on your chosen payment frequency. The available frequencies may vary by platform.

If premiums aren't paid in any month due to insufficient funds, then the outstanding premium will be deducted from the account in the following month, to bring premiums up to date.

The PDS prepared by the platform provider, or fund trustee for superannuation, will explain how the platform works.

Your financial adviser will explain the quoted premium

A premium illustration will be created for you

The illustration will show the cost of each cover and any optional benefits you select as well as the details of any stamp duty that may apply. Your financial adviser can explain the illustration and answer any questions you may have.

You can also contact us if you have questions about how premiums are calculated. The premium illustration created when you apply for cover is specifically tailored to you, but we can provide premium rates for the policies described in this document on request.

Your financial adviser may receive commission from us

The policies explained in this document can be tailored to meet your needs, which is why they are only available via financial advisers and certain other distributors. We pay commission to financial advisers and other distributors who choose to be remunerated that way. Your financial adviser or other distributor will tell you if they plan to receive commission. Commission amounts will be explained in the documents they give you which will include a Financial Services Guide and may also include a Statement of Advice. We pay commission out of the premiums you pay us. Commission is not an additional amount you have to pay.

Unpaid premiums will cause cover to be cancelled

The premium is payable on the due date shown on the policy schedule and any notices we send you after that. You must pay premiums to keep the policy in-force. We can only accept premiums paid in Australian dollars.

If you don't pay the premium on the due date, we may cancel your policy. If we decide to cancel your policy, we'll write to you at least 30 days before and provide you with the opportunity to pay the premium before we cancel. We won't cover any events that happen once your policy is cancelled.

You may be able to reinstate your cover after it is cancelled. You can find information about reinstatements in the 'Making changes to your policy' section, starting on page 71.

Refunds of premium when cover reduces or ends

If you pay your premium monthly and you make a change to your policy, we'll generally make the change effective on the next premium due date. This ensures you always have the cover you've paid for. If your change reduces the cost of your cover, no premium refund is due.

If you're paying premiums yearly, half-yearly or quarterly and the policy is cancelled, or changed so that the premium payable decreases, before the next annual, half-yearly or quarterly instalment is due, we will pay a pro-rata refund based on the number of whole months remaining in the period of cover you have paid premiums for.

If you make any other overpayment of premium, we'll only refund amounts which exceed $5.00.

If your policy has superannuation ownership and we need to refund any contributions made to the policy, any refund is subject to preservation requirements. We'll ask you for details of a complying superannuation fund we can pay the refund to.

Implications for your tax return

Some premiums are tax deductible and some benefits are assessable

Please discuss the tax implications of your insurance with your tax adviser, as they will take your individual circumstances into account. We can only provide general information to be used as a guide, based on current taxation laws, their continuation and their interpretation.

This information is based on individual policy owners. Different tax implications may arise depending on policy ownership. The taxation of superannuation is complex and will depend on your age, the type of contribution and the status of the beneficiary.

Zurich Active Cover

In most cases, you can't claim a tax deduction for the premiums you pay for your policy, where it is held outside of superannuation. One exception to this is if you take out a Zurich Active Cover policy as key person insurance in a business. In this case, part or all of the premiums may be tax deductible, however, there may be other tax implications, such as fringe benefits tax. We recommend you consult your tax adviser on this issue.

If a tax deduction isn't claimable for the premiums, the benefit paid is normally not assessable for taxation purposes. If a tax deduction is claimable, the benefit paid may be assessable for tax purposes.

This tax outcome assumes either:
- death benefits are either received by the original beneficial owner or by an owner who acquired the policy for no consideration
- other benefit payments are received by the life insured or a relative of the life insured including a *partner*, brother, sister, but not for example, a cousin.

If your situation varies from either of these assumptions, there may be different taxation results.

Zurich Income Safeguard

The premiums you pay for replacement of income cover can generally be claimed as a tax deduction by both employees and self-employed people.

Any total disability benefits, partial disability benefits and super contributions option benefits you receive from your policy will generally be assessable as income and must be included in your tax return.

This tax outcome assumes benefits are either received by the:
- original beneficial owner or by an owner who acquired the policy for no consideration
- life insured.

If your situation varies from either of these assumptions, there may be different taxation results.

We'll tell you the amount of premium you've paid for your policy during each financial year and the portion paid for replacement of income benefits.

If you've insured your monthly superannuation contributions using the super contributions option, then these benefits will be applied directly to your fund as superannuation contributions. This benefit counts as part of your income for tax purposes and we don't deduct or withhold tax from it. If you're self-employed you may be entitled to a deduction on some or all superannuation contributions made on your behalf.

Zurich Child Cover

You can't claim a tax deduction for the premiums you pay for this policy. As a tax deduction isn't claimable for the premiums, the benefit paid is normally not assessable for taxation purposes. However, any carer benefits you receive from your policy must be included in your tax return and will be taxed at your marginal income tax rate.

Policies held by superannuation trustees are deductible to the fund rather than individuals

Zurich Active Cover and Zurich Income Safeguard may be set up with external superannuation ownership. Zurich Active Cover will be subject to superannuation optimiser. Premiums paid by a superannuation fund for benefits that align with a condition of release are generally tax deductible to the fund.

For self-managed superannuation funds, please consult your tax adviser on the taxation implications of contributions made by your members to your fund and payments of insurance proceeds from your fund to members. For members of an external superannuation platform provider, please consult the taxation section of the PDS prepared by your platform provider.

Making changes to your policy

You can make changes once your policy is in place

In most cases we need a written request to make a change to your policy. Depending on the change you want to make, we may ask for further information or require a specific application form. If we agree, we'll confirm any changes in writing. A financial adviser can't change or waive any policy conditions.

Your cover is flexible

These policies are very flexible and are designed to provide long-term protection which will change in line with your needs.

How to increase your cover

You can increase cover over time, to reflect your changing insurance needs, for example, you can:

- accept yearly indexation increases
- make use of the future insurability feature by increasing cover when certain specified events occur
- apply for an increase in cover, subject to health, financial, and occupational assessment
- make other changes to your policy, for example, adding extra-cost optional benefits or for income protection cover, changing parameters like the waiting period and benefit period.

Applications for new options and other changes that increase your cover are subject to health, financial, and occupational assessment. This includes increases in cover, apart from increases that are allowed for in policy features, for example, inflation protection.

How to reduce the cost of your cover

You can also reduce your cover to help manage the cost of your insurance over time. This could be a helpful change to consider if you have variable age-stepped premiums, which generally increase each year as you get older.

Here are some ways you can reduce the cost of your insurance. You can:

- reduce your premium by reducing your cover
- make other changes to your policy, for example, removing extra-cost optional benefits or for income protection cover, changing parameters like the waiting period and benefit period.

You can also reject automatic indexation increases at any policy anniversary to maintain the same level of cover.

Please contact us if you would like to discuss any of these options. Our contact details are on the inside back cover of this document.

Converting cover out of super

If the policy owner is the trustee of an *eligible superannuation fund*, the life insured can apply to convert cover to a non-superannuation policy owned by themselves. The life insured can convert the cover any time while they're a member of the fund or within 30 days of leaving the fund.

Tell us if you move overseas

Since your policy might no longer operate as you expect or be suitable to your changed circumstances, we ask that you let us know if you, a life insured or a policy beneficiary start residing overseas. Additionally, we recommend that you first take professional advice on any legal and taxation implications if you, the life insured or a policy beneficiary consider residing overseas in the future. Unfortunately, we are not able to provide that advice, and Zurich cannot accept responsibility for any adverse legal or taxation outcomes on your policy from a person taking up residence overseas.

You may be able to reinstate your cover

If your cover is cancelled, you can reinstate cover in the first 30 days. We'll reinstate cover immediately on your request, provided all outstanding premium is paid.

If the policy is reinstated in this period, we won't pay benefits for any condition which occurs while the policy is cancelled. We also won't pay benefits if the life insured is aware of symptoms or a diagnosis relating to the condition while the policy is cancelled.

After 30 days, you can only apply to reinstate cover if your policy was cancelled due to non-payment of premium.

You'll need to complete a reinstatement application so that we can assess your health, financial situation, lifestyle, and pastimes. You have 12 months to apply for reinstatement using this shorter application process. The 12 months starts on the due date of the first unpaid premium. We don't guarantee reinstatement will be available. We may decline to reinstate or impose conditions on any cover offered.

If we accept your reinstatement application, cover will start again from the date of acceptance, which we'll confirm in writing. Before this time, there is no cover. Benefits aren't payable for any condition which occurs or is apparent while a policy is cancelled.

Reinstatement doesn't mean continuous cover. Some benefits explained in this document are affected by a reinstatement in cover such as exclusion periods which re-start. Please review the section of this document which explains the cover you've selected for further information.

If you're struggling, you can suspend cover and premiums for a period of time

The policies explained in this document include the cover suspension feature unless the policy is funded by a platform account.

Cover suspension feature

The cover suspension feature allows you to put your cover on hold for a chosen period, during which time there is no cover, and you can't make a claim for an event that occurs. The benefit of this feature is that you can stop your premium payments for a period of time to reduce financial pressure and cover will resume without a re-apply process. When the cover suspension ends the policy begins again. Depending on the cover you have, there may be exclusion periods which re-start and affect your ability to make a claim. Make sure you review the details of your cover before you suspend your cover so that you understand how the suspension will affect you.

We'll suspend your cover if you ask us to, on any policy which has been continuously in-force for at least 12 months. Cover suspension can be activated for one to 12 months, starting from the next premium due date. We can't backdate the start of a cover suspension, so you must pay any outstanding premiums before cover can be suspended. When you put cover suspension in place, we won't refund any premiums already paid. If you have paid premiums in advance, cover suspension will begin on the date you have paid premiums up to.

When you request cover suspension, we'll confirm the details in writing. Our confirmation will outline the cover suspension start and end dates as well as the next premium due date.

From the cover suspension start date until the cover suspension end date (the cover suspension period):
- the policy isn't in-force for any life insured
- no premiums are required for that period
- inflation protection increases will continue to be offered if a policy anniversary passes.

Events that are normally covered under the policy aren't covered at any time if, before the end of the cover suspension period, either the:
- event occurs
- life insured is aware of symptoms or a diagnosis of the event.

You can still make a claim for an insured event which occurred before the cover suspension start date if the conditions for a benefit were met when cover suspension started. For example, if you suspend Active Cover after the life insured has a *percutaneous coronary angioplasty* which meets our definition, then you can lodge a claim for that event.

If the life insured is aware of a health concern before cover suspension, taking cover suspension will prevent you from making a claim for that condition. Using the same example, if the life insured has chest pains before you suspend Active Cover, and they need an angioplasty during or after cover suspension, this event won't be covered. The reason it's not covered is that the life insured was aware of a potential health problem that was not yet claimable before the cover suspension started.

The policy will be back in-force again automatically on the cover suspension end date if the premium is paid by the next premium due date. If you don't pay the premium by the next premium due date, we may cancel the policy. You can find information about cancellation of the policy due to non-payment in the 'Unpaid premiums will cause cover to be cancelled' section on page 69.

You can extend the cover suspension or you can end it early

In both cases, you need to tell us that you want to make a change at least 14 days before the cover suspension is due to end. This allows time for us to process your change and send you revised documents.

Any change is only effective when we confirm it in writing.

If the cover suspension period is reduced, an extra exclusion applies:
- the policy doesn't cover any event that would normally be covered under the policy which occurs or is apparent in the first 90 days after the revised cover suspension end date. 'Apparent' means the life insured is aware of symptoms or a diagnosis relating to the condition.

Using cover suspension affects the cover provided by your policy

The cover suspension feature affects the cover provided by your policy after the cover goes back into force.

After the cover suspension end date the policy:
- must be continuously in-force for another 12 months before you can suspend cover again
- is effectively reinstated, which means some benefits aren't payable for set periods after the cover suspension end date. Exclusions that apply for a period of time after a reinstatement, apply for the same period of time after the cover suspension end date.

You can only suspend cover once in any 12-month period and for a maximum of 12 months over the life of the policy.

Interim cover

We provide interim cover while we assess your application

We provide up to 90 days of interim cover against *accidental death* and *accidental injury*, depending on the covers applied for. Interim cover starts when an application is submitted, provided it includes valid payment details.

Interim cover ensures that you have some basic cover in place once you're taking active steps to get comprehensive cover. Interim cover doesn't apply if you already have insurance in place with us or another insurer and you've told us that you're replacing the existing insurance.

Interim cover generally ends when we finish our assessment, which is when we issue a policy, or we decline the application. Interim cover is temporary and has its own policy conditions which are set out below.

Interim cover isn't comprehensive insurance cover

Interim cover doesn't necessarily provide the same coverage as the policy or policies being applied for. Benefit caps apply, regardless of how much cover you apply for. The terms of interim cover are set out in this section. These terms can't be varied or extended by us or your financial adviser. All words appearing in italics are defined terms with special meanings which are explained in the 'Definitions' section, starting on page 84.

Interim cover is for people who are applying for new cover

Interim cover is available to you if you're applying for insurance cover which isn't intended to replace cover you already have with us or another insurer.

If you're applying to increase insurance with us (including where you're applying to replace existing cover at the same time), then interim cover applies only to the amount of the increase, up to the relevant limits set out in this interim cover.

Interim cover doesn't apply to all applicants

You're not eligible for interim cover if any of the following applies:

- you have current insurance with us or another insurer which provides the same or similar cover and which you've told us will be replaced by the cover being applied for
- you have a current application or interim cover with us or another insurer for insurance of a similar type which provides the same or similar cover
- you had interim cover or other *Zurich life insurance policies* in the previous 24 months of a similar type that ended (except where you're increasing cover on an existing policy)
- you previously applied for insurance of a similar type with us or another insurer and the application was declined, deferred, or postponed.

When we say other insurance cover which is the same or similar, we mean insurance which is an individual policy as well as insurance which is part of a package, for example, a mortgage protection policy which contains different insurance covers bundled together.

You're not eligible for interim cover if the insurance you've applied for wouldn't be accepted, based on our normal assessment criteria.

When interim cover starts

Interim cover starts on the interim cover effective date, which is the date that you complete our electronic Zurich Active application for the policy or policies you're applying for and you arrange future premium payments. To arrange premium payments, you can:

- complete a payment authority with valid payment details
- complete a rollover authority with valid payment details
- set up a platform account.

If you select our tele-interview option to complete some of the application, interim cover will still start on the date that you complete our electronic application. We won't delay the start of the interim cover until your tele-interview occurs, even though your application will be incomplete.

If you select our online questionnaire option to complete some of the application, interim cover starts once you've completed the online questionnaire and the electronic application has been submitted to us.

When interim cover ends

Interim cover ends when your application is withdrawn, which is when one of the following happens:

- the date when you or your financial adviser withdraws your application by contacting us
- 90 days after the effective date
- when we decline your application in writing
- when insurance cover starts under another contract of insurance, including interim cover, which covers the life insured and is intended to replace this interim cover
- 21 days after we tell you or your financial adviser that the insurance cover applied for would be subject to non-standard terms, such as a premium loading or an exclusion and you haven't agreed to the change.

Exclusions apply to interim cover

Interim cover doesn't apply if:
- we would have declined your application, based on our normal heath, financial, and occupational assessment criteria
- you apply for more cover than we would accept, based on our normal heath, financial, and occupational assessment criteria. If this happens, we won't provide interim cover for the excess amount
- the event leading to the claim occurs while the life insured is outside Australia.

We won't pay a benefit where the event leading to the claim is caused directly or indirectly by:
- suicide or attempted suicide
- intentional self-inflicted *injury* or act
- *illicit drug use*
- engaging in any criminal activities
- engaging in any pursuit or occupation which would cause us to reject the application for insurance or apply special conditions to acceptance of the application for insurance
- an act of war, whether declared or not. War doesn't include acts of terrorism
- military service, other than death while on war service.

Your duty to take reasonable care not to make a misrepresentation also applies to interim cover

When you apply for Zurich Active policies, you'll declare that you've read and understood your duty to take reasonable care not to make a misrepresentation.

This duty also applies to interim cover. We may void your interim cover if you misrepresent anything on your application form. Please read about your duty to take reasonable care not to make a misrepresentation in the 'Applying for cover' section, starting on page 59.

Contact us if you want to check on your interim cover

Contact us if you want to confirm the currency of your interim cover if you or your financial adviser don't have the details. Our contact details are on the inside back cover of this document.

Your interim cover depends on what you've applied for

We'll provide you with interim cover from the interim cover effective date until the interim cover end date, provided you meet the interim cover eligibility criteria. Interim cover is subject to the specific terms set out in this section.

Interim cover is:
- limited to the type or types of insurance you applied for in the application
- subject to these terms, conditions, and exclusions
- subject to the other relevant terms, conditions, and exclusions of the policy conditions for the insurance you've applied for, except where the policy conditions provide greater cover than this interim cover.

If you've submitted more than one application to us, the maximums set out below apply across all applications being assessed.

Active Cover

If you've applied for Active Cover, we'll pay a benefit if the life insured suffers any of the following events as the result of an *accident* during the period of this interim cover:
- a category A or B health event
- death
- *terminal illness*.

The benefit will be paid if the *accident* occurs during the period of interim cover and the health event, death or *terminal illness* occurs within three months of the *accident*. Only one benefit will be payable during interim cover, being the one which pays the highest benefit.

The amount we'll pay for any life will be the lower of:
- the initial amount of cover you're applying for
- $1 million for death or *terminal illness*
- $500,000 for a category A health event
- $325,000 for a category B health event
- the initial amount of cover the life insured would have been accepted for under our normal heath, financial, and occupational assessment criteria.

Income protection cover

If you've applied for Zurich Income Safeguard, we'll pay a total disability benefit if, solely as a result of an *accidental injury* during the period of this interim cover the life insured:
- totally stops work
- is unable to earn *monthly income* for a period of at least the chosen waiting period
- is following the advice and recommended treatment of a *medical practitioner*.

We'll pay the benefit if the life insured sustains an *accidental injury*, which occurs after this interim cover starts.

The amount we'll pay you each month, provided the life insured continues to meet the above criteria, will be the lower of:
- $5,000
- the insured monthly benefit you're applying for
- the amount of cover the life insured would have been accepted for under our normal heath, financial, and occupational assessment criteria.

The maximum period we'll pay a benefit for is 12 months.

Child cover

If you've applied for Zurich Child Cover, we'll pay a benefit if an insured child dies as the result of an *accident* or suffers one of the child trauma conditions listed below as the result of an *accident*, where the *accident* occurs during the period of interim cover and death or the condition occurs within 90 days of the *accident*.

Child trauma conditions covered for interim cover are:
- *loss of use of hands, feet or sight*
- *loss of speech*
- *major head trauma (with permanent neurological deficit)*
- *paraplegia*
- *quadriplegia*
- *severe burns (of specified extent)*.

The amount we'll pay for any insured child will be the lower of:
- $200,000
- the amount of cover you're applying for.

You need to provide evidence if you make a claim under interim cover

If you need to claim under your interim cover, you must provide us with sufficient proof that the relevant event occurred between the interim cover effective date and the interim cover end date, including proof that you completed our application.

If your claim is successful, you must pay us the premium for this cover, which is what we would have charged you for the policy you applied for, to cover the period up until the date that we admit your claim.

Making a claim

Here's how to make a claim

We understand that when you need to claim it can be a very difficult and emotional time. We aim to 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.

It's easy to lodge a claim with us. The first step is to complete our claim form, which must be signed and returned to us. You may be able to use our tele-lodgement service, depending on the type of claim you're making.

We'll let you know if this service is available to you.

You can access a claim form on our website or you can contact us if you'd prefer to have a claim form sent to you.

Please note any transfer of ownership is not available during a claim, or if you are aware of an event that could become a claim.

You'll need to gather supporting documents

You're responsible for providing all standard supporting documents for your claim. In some cases, you may need to pay for those documents. For example, where a medical report is required. Most of the medical and financial information you need to prove your claim will be information that you already have.

The documents you submit should be legible, unaltered and include proof to support your claim. If we can't use the information you provide for any reason, we'll let you know why that is and will discuss with you what alternative documents can be provided. Any missing documents may delay the claim process.

In some cases, we use a third party to collect the information we need from you and your treating doctor. We'll let you know how this will work if it applies to your claim.

Before we can pay a claim, we must have evidence to fully support that the relevant policy terms and conditions have been met. If you withhold information that we reasonably require to make this assessment, it will delay your claim and could result in a declined claim.

You may need to prove the information provided at application

In assessing the claim we'll rely on any information that you or the life insured told us as part of the application.

If we didn't verify information when you applied for cover, we reserve the right to verify it when you make a claim.

You must provide us with information, and authorities to obtain information, that we reasonably require to assess your claim. This includes information and authorities we need to:

- verify the information provided in your application
- investigate any non-disclosure or misrepresentation made by you. This may give us a right to avoid or vary your policy, or to refuse to pay a claim.

Here's our standard list of claim requirements

We require the following information to assess your claim:

- proof of a claimable event or condition and when it occurred
- supporting evidence from an appropriate specialist *medical practitioner*
- proof of the life insured's age
- proof of incurred costs where the benefit payment is based on reimbursement.

We may also ask for proof of entitlement to receive payment and a signed discharge from the person entitled to receive payment.

In addition to the standard requirements, we need information specific to the type of claim you're making

The information we need may vary according to the type of claim you're making. Our typical requirements are set out below. We may request information or documents that are not listed below but which are reasonably required to assess your claim.

Documents for health events, occupational impairment, extended care, severity booster and child cover claims

Claims must be supported by:

- confirmatory investigations including, but not limited to, clinical, radiological, histological and laboratory evidence
- if a health events claim is a result of a surgical procedure, evidence that the procedure was medically necessary
- for *occupational impairment* and extended care claims, evidence that provides details of the life insured's occupational and employment arrangements, including duties, responsibilities, hours and place of work as well as occupational history.

Illnesses and injuries must be diagnosed and certified by a *medical practitioner* considered to be an appropriate specialist physician.

'Appropriate' will differ from claim to claim as it depends on the medical condition, standard medical practice, and the specialist physician's qualifications in the relevant area of medicine.

We may reasonably require verification of the diagnosis and certification by an appropriate second specialist physician and we'll pay for the cost of that physician and any reasonable travel costs.

Medicine is constantly evolving. Where the diagnostic techniques used in our health events or trauma condition definitions are impractical to apply or have been superseded due to medical improvements, we'll consider other appropriate and medically recognised tests.

Documents for death and funeral claims

Claims for death benefits and funeral expenses can be lodged by the person who is eligible to receive the death benefit or by the life insured's legal personal representative. The claim must include the funeral invoice and either a copy of the death certificate or cause of death certificate.

Documents for income protection claims

We need the following for income protection claims:

- evidence of absence from work, for example, medical certification, reports and copies of leave records from the life insured's employer, if appropriate
- evidence that provides details of the life insured's occupational and employment arrangements, including duties, responsibilities, hours and place of work
- financial evidence including evidence of other insurance cover on the life insured
- evidence of *pre-claim earnings*, *monthly earnings*, *ongoing income*, and evidence of any payments received while on claim
- evidence of confirmatory investigations which support the claimable condition, for example, clinical, radiological, histological and laboratory evidence. This could include copies of medical records or reports from treating doctors or from independent specialists, if we request them
- copies of personal and business tax returns, assessment notices and other financial evidence to prove the life insured's income, if we request it.

When we need to calculate the amount of the benefit payable, the life insured must allow us to examine their business and personal financial circumstances.

Late income protection claims

Please alert us to any *sickness* or *injury* which may become a claim as soon as you can. The best way to provide prompt notification of a claim in writing is to complete our claim form. We need medical, financial, and occupational evidence dated when the *sickness* or *injury* starts to establish and assess your claim. If you don't tell us about the life insured's *sickness* or *injury* when it happens and the delay affects our ability to confirm the claim event and relevant dates, it may affect your claim.

Return to wellness obligations

If you have an income protection claim with us, we'll provide rehabilitation support which can help the life insured with recovery and with retraining, if required. Rehabilitation can be used to get the life insured back to their same occupation or help them to return to work in a new occupation. It can also be used to improve health and wellbeing.

If the life insured's capacity is restricted, and they're not fully recovered, but may be able to return to some work, we'll reach out and ask them to participate in a rehabilitation or retraining program. Any program we ask the life insured to attend is aimed at working collaboratively with the life insured towards their goals as they recover. We'll reimburse the cost of rehabilitation or retraining that we ask the life insured to do.

Questions you might have about making a claim

Is a medical examination required?

You may be asked to undergo independent medical examinations we reasonably require to assess the claim taking into account evidence already provided. This is at our expense. We'll also cover reasonable travel costs.

Are income protection claims ever paid in advance?

Sometimes. If medical evidence supports the life insured's inability to work for a set period, most often for *injury* claims, we may advance the payment of monthly benefits. Each claim is different, and we can't always make advance payments for income protection claims. Eligibility depends on the life insured's occupation and the relevant injury.

For example, if the life insured is a plumber and they break a leg, we know how long recovery is likely to take and may pay the full claim up-front.

Can I use financial year paperwork?

Yes. We understand that it is often easier to provide financial information based on a financial year. Where we ask for the life insured's average *monthly income* in the 12 months immediately before a point in time, we can be flexible. We'll accept information for the financial year rather than strictly the 12 months before, if you have evidence which is aligned to financial year.

Can my claim be paid in a foreign currency?

No. We pay all claims in Australian dollars.

We pay benefits to the policy owner, unless beneficiaries have been nominated

Payment of benefits under policies held by superannuation trustees

If a benefit is payable under a Zurich Active policy held in superannuation, we'll pay it to the trustee. The trustee will release the benefit from the superannuation fund to the member, subject to the governing rules of the superannuation fund and superannuation law. The trustee may need to conduct further assessment to satisfy themselves that all rules and laws have been met. Members can generally make death benefit nominations with the trustee. The PDS issued by the trustee of the fund will provide more information. For certain *eligible superannuation funds*, we may pay income protection benefits directly to the member on behalf of the trustee.

Payment of the death benefit under Zurich Active Cover

If a valid beneficiary nomination applies when the life insured dies, we'll pay the death benefit to the chosen recipients in the proportions specified. If the nomination is subject to external dispute resolution processes, we'll pay benefits as directed by a court or by the relevant dispute resolution authority.

If there is no valid beneficiary nomination when the life insured dies, we'll pay any death benefit to the:

- policy owner if the policy owner wasn't also the life insured
- policy owner's estate, or as otherwise permitted, if the policy owner was also the life insured.

Payment of all other benefits

We'll pay all benefits under this policy to the policy owner unless otherwise specified in these policy conditions.

Don't forget that tax is payable on income protection benefits

Any total disability benefits, partial disability benefits and super contributions option benefits you receive from your policy will generally be assessable as income and must be included in your tax return. You can find more information in the 'Implications for your tax return' section on page 70.

Examples of what we pay

Here are some examples of what we would pay out under each policy.

Protection for loved ones on your death or terminal illness

David has a **Zurich Active Cover** policy with $1 million death cover.

David took additional death cover to make sure that his wife and young children would be taken care of if something unexpected happened to him.

Two years after taking out his policy, David has a tragic cancer diagnosis, and his treating doctors confirm he won't survive another 24 months.

As death cover includes a terminal illness benefit, we'll pay the $1 million to David now so that he can take an active role in planning his family's financial future.

Funding for time off or the cost of treatment

Anil has a **Zurich Active Cover** policy with an initial amount of cover of $500,000.

Anil took Active Cover because as a self-employed contractor, he wanted to fund time off work if he had a severe health event. He also wanted a financial buffer against out-of-pocket expenses and treatments that a severe illness could bring.

Three years after taking out his policy, Anil is diagnosed with a heart condition, and has a cardiac defibrillator inserted.

As Anil's procedure is a defined health event under his policy (Heart and artery table, category E: *permanent cardiac defibrillator insertion*), we'll pay the category E benefit of $25,000 (5%). Anil's cover is reduced to reflect the claim. His maximum amount payable for any future claim is then $475,000.

Two years later, Anil has an unrelated cancer claim. As Anil's condition is a defined health event under his policy (Cancer table, category D: *cancer*), we'll pay the category D benefit of $100,000 (20%).

With treatment there's a good chance that Anil will recover from his condition. He still has maximum amount payable of $375,000 in place which will be useful if his condition worsens and he needs to make another cancer-related claim. If that doesn't happen, he could claim for one or more unrelated future health events. Or we could pay the benefit for terminal illness or death.

Funding for time off or the cost of treatment

Sarah has a **Zurich Active Cover** policy with an initial amount of cover of $600,000.

Like Anil, Sarah took Active Cover because she wanted to cover against unexpected health concerns.

Four years after taking out her policy, Sarah is diagnosed with *gastrointestinal disease*. Sarah experiences some very severe symptoms and has two stints in hospital.

As Sarah's condition is a defined health event under her policy (Digestive system table, category B: *gastrointestinal disease*, evidenced by...), we'll pay the category B benefit of $390,000 (65%). Sarah's cover is reduced to reflect the claim. Her maximum amount payable for any future claim is then $210,000.

Two years later, Sarah's condition deteriorates, and she meets a more severe category A definition of the same condition. We'll pay the difference between the benefit categories for the two events, which is the maximum benefit amount of $210,000 (100%-65%).

Sarah's claim will reduce the cover to nil, making it less than the protected amount of $150,000 (25% of the initial amount of cover). Although Sarah is now seriously ill, she's not yet 65, so the claim protector will kick in 14 days after her claim. Even though she's been paid $600,000 under the policy, she has a new maximum amount payable of $150,000 in place. That cover can be claimed for an unrelated future health event.

Replacing lost income if you'll never work again

Ling has a **Zurich Active Cover** policy with an initial amount of cover of $800,000.

Ling took Active Cover as her plan B in case she ever had to stop work due to poor health. She knew that short or long term illness could have a severe financial impact.

Eight years after taking out her policy, Ling is involved in a major car accident and is lucky to survive. She suffers extensive permanent physical injuries While she can live a comfortable life with support from her family, she'll never be able to work as a pharmacist ever again.

Ling's condition doesn't meet any of the standard health event definitions, so the safety-net kicks in. We can assess her *occupational impairment*, as her treating doctors confirm she'll never work again. We'll pay the safety-net category A: *occupational impairment* benefit of $800,000. The benefit will help fund Ling's gap in expected earnings and will contribute to out-of-pocket expenses she'll face in adapting her world to work best for her.

Ling's claim will reduce the cover to nil, making it less than the protected amount of $200,000 (25% of the initial amount of cover). As she's not yet 65, the claim protector will kick in 14 days after her claim. Ling's policy will continue to provide her with up to $200,000 of cover for future health events.

Reducing financial stress while you focus on recovery

Joe has a **Zurich Income Safeguard** policy with an insured monthly benefit of $7,500, which will pay benefits up to age 65.

Joe took income protection cover because he was worried about the financial well-being of his young family if *sickness* or *injury* stopped him from working. He knew his job in real estate would stop paying him an income as soon as his sick leave ran out and that his savings wouldn't stretch very far after that.

Two years after taking out his policy, Joe suffers a double fracture of his tibia and fibula in a football tackle. He has a few days in hospital and following surgery is off work for almost eight weeks. Even though his recovery is going to plan, his leg must be elevated and he can't put any weight on it.

Joe selected a 30-day waiting period on his policy, so we'll pay him a monthly benefit of $7,500 if he is totally disabled and his earnings support this monthly benefit amount at the time of the claim. We'll make the first payment 15 days after the waiting period ends, provided we have all the evidence we need and have completed our assessment.

When Joe returns to work, he won't be up to full-time work immediately. If he makes a gradual return to work, we'll pay him a partial disability benefit while he's working at reduced capacity. This will top-up the income he'll earn from his employer. It'll also support his mental recovery as he can get involved in his work and connect with colleagues again.

Giving you space to focus on your child's health

Paul and Aurora have a **Zurich Child Cover** policy with $100,000 cover for their young daughter Lola.

Three years after taking the policy, Lola has a leukaemia diagnosis, which needs ongoing treatment for around six months.

As *cancer (excluding early stage cancers)* is a defined trauma event under the policy, we'll pay the benefit of $100,000. Even if Paul and Aurora have health insurance, and the out-of-pocket medical expenses aren't unaffordable, the insurance benefit gives them options. For example, Aurora can now afford to take a break between consulting assignments to be with Lola. The insurance gives the family breathing space so they can focus the energy they want to on their daughter during a difficult time.

General policy conditions

These conditions apply to the policies explained in this document

These general policy conditions apply to all of the following policies:

- Zurich Active Cover
- Zurich Income Safeguard
- Zurich Child Cover.

These general policy conditions apply in addition to the policy specific policy conditions set out in the previous sections of this document.

What we mean by policy documents

Your policy is made up of the policy conditions in this PDS and the latest policy schedule. The policy schedule will be sent to you when the policy is issued. We'll issue an updated policy schedule after a change.

The policy schedule shows details of the policy including:

- the policy type
- the policy start date
- ownership details
- the life insured
- the amount of cover
- any optional benefits chosen
- any policy conditions specific to your policy
- the benefit end date or dates.

The policy start date shown on the policy schedule and the anniversary of that date is used throughout this document as a reference point in time. For example, benefits generally end on the policy anniversary when the life insured is a certain age.

Please check these policy conditions and the policy schedule carefully to ensure that the policy provides the correct cover and has been established in line with your application.

Benefits which aren't available to new customers

You may be able to apply to vary an existing policy with a benefit or option which was explained in your original PDS, but isn't explained in this document, because it's no longer available. If we accept your application, the policy conditions for the benefit or option are set out in the original PDS.

We'll let you know if insured conditions become redundant

If any of our insured conditions become redundant, for example, if a cure is found for an illness covered under your policy, we'll let you know what that means for your policy.

This policy doesn't have a cash value

This policy only provides the insurance benefits explained in this document. It doesn't have a cash value. We'll put premiums paid for this policy in our No. 2 Statutory Fund and pay claims under this policy from that fund.

The contract is between us and the owner of the policy. If the policy is held in superannuation, this will be the trustee of the fund.

We'll communicate with you as the policy owner

All communications, including instructions, requests, and notifications must be made between the policy owner and us except where we've agreed a different approach. For example, we'll issue communications to the life insured in the case of life insurance policies issued to an *eligible superannuation fund*.

If you choose to receive communications by post, any notice we send will be effective on the earlier of when it arrives, and when it should have been delivered, based on standard postal delivery times.

Zurich's legal obligations and your privacy

Compliance with laws

Your policy conditions do not operate to the extent they would require you or Zurich to do something that risks breaking a law relevant. This applies despite anything to the contrary written in the policy conditions, which are deemed to be varied or nullified to the extent needed to remove the risk of illegality.

In limited cases, current Australian and overseas laws regulating us and other companies in the worldwide Zurich insurance group can restrict us from accepting premium payments, making claim payments or reimbursements, or conducting other financial transactions on life insurance policies we issue.

We might also need to suspend or cancel cover when that is the only action that can be taken to comply – in those cases, if the law allows, we would give you prior notice so that you can explain the matters of concern before we act. New or changed Australian or overseas laws may equally affect such policies.

Australian and overseas trade and economic sanctions laws and regulations are one example of laws that might affect a policy we issue. We will not provide any cover, service or benefit for any person that we reasonably consider to be sanctioned by those laws and will cancel your policy if we reasonably consider that you, a life insured or a policy beneficiary are either a sanctioned person or conducting an activity sanctioned by these laws. We would in those cases then allow you 14 days to show that the person is not a sanctioned person and have cover restored.

Some countries' laws continue applying to their residents, nationals or citizens after they stop living there. Overseas laws can also apply to residents, nationals or citizens of other countries (such as Australia) while they are in that country or if they have another type of connection specified in that country's law. Those overseas laws can apply to the owner, life insured, beneficiary or premium payer of a policy to restrict (or even prevent) us from receiving premiums or doing other activities required to service a policy. In other cases, those laws may impose extra requirements or even prevent us from providing cover at all.

Privacy

We're bound by the Privacy Act 1988 (Cth). Before providing us with any personal or sensitive information, read this outline to understand what we'll do with your information. If you're not the only person providing information, then the other people providing information need to know this too.

We collect and use personal information to manage your insurance

We collect, use, process, and store personal information and, in some cases, sensitive information about you for several purposes. Purposes include complying with our legal obligations, assessing your application for insurance, managing the insurance, improving customer service or products, managing claims and dealing with potential misrepresentation. If you don't agree to provide us with the information, we may not be able to process your application, manage your cover or assess your claims. Other than from you, we may also collect information from government offices and third parties to assess an application or a claim.

By providing us or your financial adviser with your information, you consent to our use of this information which includes us sharing your information with other parties where relevant for the purposes. Other parties can include the policy owner, your financial adviser and their licensee, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our banking gateway providers and credit card transaction processors, and our business partners. We may also use or disclose your information as authorised or required by law within Australia or overseas.

These are the relevant Australian laws that may apply:

- Australian Securities and Investment Commissions Act 2001
- Corporations Act 2001
- Insurance Contracts Act 1984
- Life Insurance Act 1995
- Superannuation Industry (Supervision) Act 1993
- Anti-Money Laundering and Counter-Terrorism Financing Act 2006
- Anti-Money Laundering and Counter-Terrorism Financing Rules Instrument 2007 (No. 1)
- Income Tax Assessment Act 1936
- Income Tax Assessment Act 1997
- Taxation Administration Act 1953
- Superannuation Guarantee (Administration) Act 1992
- Small Superannuation Accounts Act 1995
- Superannuation (Unclaimed Money and Lost Members) Act 1999
- Superannuation Resolution of Complaints) Act 1993
- Superannuation (Government Co-contribution for Low Income Earners) Act 2003
- Family Law Act 1975 (Part VIIIB).

We must also comply with updates to these laws and any associated regulations. In addition to these, other acts may require or authorise us to collect your personal information.

We may use personal information (but not sensitive information) collected about you to tell you about other products and services we offer. If you don't want your personal information to be used in this way, please contact us.

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 in which recipients of your information are likely to be located
- details of how you can access or correct the information we hold about you
- information about how to make a complaint.

For further information about Zurich's Privacy Policy please click the privacy link on our homepage zurich.com.au, contact us by phone on 132 687 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'll:

- keep your data safe
- never sell personal data
- not share personal data without being transparent about it
- put data to work so we can better protect you.

Definitions

These definitions are used throughout this document

In addition to these definitions:
- specific definitions for Zurich Income Safeguard start on page 40
- definitions for Zurich Child Cover start on page 94.

accident/accidental means a fortuitous and unforeseen event, resulting in an injury. The event is not an accident or accidental if it is caused by the life insured's intentional self-inflicted act or if the life insured's intentional self-inflicted act contributes to the injury.

accidental death means death caused by an accident. The accident must be a violent, external, and visible event and death must occur within three calendar months of the accident.

accidental HIV infection means *accidental* infection with Human Immunodeficiency Virus (HIV) due to:

- transfusion of blood or blood products
- organ transplantation
- *accidental* incident at work in the life insured's normal occupation
- the life insured suffering physical or sexual assault – a criminal case must be opened in addition to the life insured starting antiviral therapy.

Transfusions and organ transplants are only covered if they are performed by a registered health professional in Australia.

Any accident which may become a claim must be supported by a negative HIV antibody test taken after the accident. The infection must be evidenced by sero-conversion of the HIV infection within six months of the accident.

We'll need detailed pathology results to confirm the infection, including the results of any follow up tests completed to confirm a weak positive result.

accidental injury means bodily injury caused by an accident. The accident must be a violent, external, and visible event and must occur while the policy is in-force.

activities of daily living (ADLs) are the six categories of ADLs. Each category is made up of a list of specific tasks. If the life insured can't perform the stated number of specific tasks within a category, the whole category is scored as an inability to perform that ADL category.

The ability to perform the tasks of each ADL category must be assessed by a medical specialist appropriate to the medical condition causing the impairment, using our Activities of Daily Living score sheet.

The scoring method works like this:

Degree of impairment	Score
A life insured who is independent in performing a task is regarded as able to do that task. The use of assistive devices, aids or special equipment to independently perform a task, other than wheelchairs and walking frames, is also regarded as able to do that task. Examples of assistive devices, aids and special equipment are raised toilet seats, shower or bath seats, benches and rails, glasses and hearing aids.	'can', 'normal' or 'good'
A life insured who is completely dependent on another adult person(s) to perform a task is regarded as unable to do that task.	'cannot' or 'poor' Poor means a rating of poor or below average as measured and evaluated by the relevant and appropriate test or tests.

When a life insured is being measured on their ability to perform any ADL category tasks:
- scoring must record all impairment
- assistive devices must be used, where they are available.

Supporting objective medical evidence must be provided for each task of an ADL category scored and must include confirmatory investigations including, but not limited to, specialist reports, clinical, radiological, histological and laboratory evidence.

The ADL categories, specific tasks and scoring are detailed in the table below.

ADL categories

ADL category 1: Self-care

Specific tasks:
- bathing
- grooming
- dressing
- eating and feeding
- bowel and bladder function
- mobility

Score required in order to be considered unable to perform this ADL category:
- 'cannot' in at least one specific task.

ADL category 2: Communication

Specific tasks:
- speaking
- reading
- writing
- keyboard use

Score required in order to be considered unable to perform this ADL category:
- 'cannot' in at least one specific task.

ADL category 3: Physical activity

Specific tasks:

Intrinsic
- standing
- sitting
- reclining
- walking
- stooping
- squatting
- kneeling
- reaching
- bending
- twisting

Functional
- carrying
- lifting
- pushing
- pulling
- climbing
- exercising

Score required in order to be considered unable to perform this ADL category:
- 'cannot' in at least three specific tasks.

ADL category 4: Sensory function

Specific tasks:
- hearing
- seeing
- tactile sensation
- tasting
- smelling

Score required in order to be considered unable to perform this ADL category:
- 'cannot' in at least one specific task.

ADL category 5: Hand functions

Specific tasks:
- grasping
- holding
- pinching
- percussive movements
- sensory discrimination

Score required in order to be considered unable to perform this ADL category:
- 'cannot' in at least one specific task.

ADL category 6: Advanced functions

Specific tasks:
- travel (riding, driving)
- sexual function
- social interaction (one on one)
- understand concepts
- memory
- problem solving
- stress adaptation
- sleep pattern
- recreational/social activities (social interaction in a group setting)

Score required in order to be considered unable to perform this ADL category:
- 'cannot' or 'poor' in at least four specific tasks.

acute renal failure means acute reversible failure of the function of both kidneys requiring admission to an *intensive care unit (ICU)* or renal dialysis unit for one of the following:
- temporary haemodialysis
- haemofiltration treatment.

advanced AIDS means HIV infection with a persistent CD4 cell count of less than 200/ul despite appropriate continuous antiretroviral therapy. The life insured must be diagnosed with an associated AIDS-defining illness with AIDS resulting in at least one of the following:
- kaposi's sarcoma or lymphoma
- pneumocystis carinii infection, cryptoccal infection or any other opportunistic infection of the lungs or nervous system
- tuberculosis or other mycobacterium infection at any site
- progressive multifocal leukoencephalopathy
- HIV encephalopathy
- HIV wasting syndrome characterised by more than 10% weight loss, chronic intractable diarrhoea and chronic candidiasis of the respiratory tract or gastrointestinal tract.

any occupation means any occupation, business, or employment the life insured is suited for by education, training, or experience. Earnings from this occupation, business or employment should be more than 25% of the life insured's earnings from their most recent 12 months of work for remuneration or reward.

aortic surgery means surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta performed by thoracoscopic or laparoscopic minimally invasive 'keyhole' techniques.

Aortic surgery doesn't include percutaneous angioplasty or any other intravascular techniques.

aplastic anaemia (requiring treatment) means severe *permanent* and irrecoverable bone marrow failure that meets all of the following:
- is characterised by an almost complete absence of haematopoietic stem cells, resulting in low levels of red and white blood cells and platelets
- requires treatment with one or more of the following:
  - immunosuppressive agents
  - bone marrow transplantation
  - bone marrow stimulating agents
  - peripheral blood stem cell transplant

bacterial meningitis means all potential manifestations of bacterial meningitis causing *permanent* and irreversible inability to perform two out of six *activities of daily living*.

benign central nervous system tumour means a non-malignant tumour of the central nervous system, including:
- tumours of the brain and spinal cord
- meningiomas
- cranial nerve tumours
- pituitary tumours treated by non-transphenoidal techniques.

The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI or other equivalent diagnostic investigation.

bone marrow or stem cell transplant means the life insured is the recipient of a bone marrow or stem cell transplant.

cancer means the presence of a malignant tumour. The tumour must be both:
- characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue
- positively diagnosed with histological confirmation.

Cancer doesn't include any of the following:
- tumours described as early-stage cancer, carcinoma in situ, premalignant, borderline malignant, non-invasive, or of low malignant potential
- hyperkeratoses, basal cell carcinomas, and squamous cell or intra-epidermal carcinomas of skin unless there has been a spread to other organs
- pTa bladder tumours
- stage 0 bowel cancer
- melanomas which are classified as melanoma in situ or stage T1aN0M0.
- all pituitary neuroendocrine tumours unless one of the following applies:
  - there is evidence of metastatic spread;
  - the life insured undergoes surgical removal by open craniotomy
- all cancers of the thyroid unless one of the following applies:
  - having progressed to at least TNM classification T2N0M0
  - where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.

carcinoma in situ means a focal autonomous new growth of carcinomatous cells which has not yet resulted in the invasion of normal tissues.

'Invasion' means one or both of the following:
- an infiltration of normal tissue beyond the basement membrane
- an active destruction of normal tissue beyond the basement membrane.

The tumour must be classified as Tis according to the TNM staging method or FIGO Stage 0. FIGO means the staging method of The Federation Internationale de Gynecologie et d'Obstetrique.

Carcinoma in situ of the fallopian tube is limited to the tubal mucosa.

Carcinoma in situ of the vulva also requires high grade dysplasia of the cervix at CIN-3 or above, confirmed histologically by biopsy.

Carcinoma in situ doesn't include any of the following:
- hyperkeratoses, basal cell carcinomas, and squamous cell or intra-epidermal carcinomas of skin unless there has been a spread to other organs
- pTa bladder tumours
- stage 0 bowel cancer.

cardiomyopathy means disease of the heart muscle causing it to enlarge and become weaker.

chronic lung disease (end stage) means end stage lung disease, including chronic obstructive pulmonary disease and interstitial lung disease. The condition must require long term continuous oxygen therapy prescribed by a specialist physician and meet one of the following measures:
- persistent FEV1 less than 30% predicted
- DLCO less than 40% predicted.

chronic renal failure means chronic irreversible failure of the function of both kidneys requiring *permanent* and ongoing haemodialysis or peritoneal dialysis.

The life insured must be under the continuous care of a renal physician.

colectomy means total or subtotal colectomy resulting in formation of a *permanent* ileostomy or ileorectal anastomosis.

colostomy or ileostomy means the creation of a *permanent* irreversible opening, linking the colon or ileum to the external surface of the body.

coma means a state of unconsciousness with no reaction to external stimuli or internal function. The coma must have a documented Glasgow Coma Scale of eight or less and must continue for a continuous period of at least 72 hours.

Coma doesn't include coma resulting from drug or alcohol intake.

consumer price index means the 'Weighted Average of Eight Capital Cities Index' as published by the Australian Bureau of Statistics. If that index is no longer published or is significantly changed, a comparable replacement index will be applied.

corneal transplant means the life insured is the recipient of a cornea.

coronary artery bypass graft means the undergoing of coronary artery bypass grafting for the treatment of coronary artery disease.

Coronary artery bypass graft doesn't include any of the following:
- angioplasty
- intra-arterial procedures
- other non-surgical techniques.

crohn's disease means diagnosis of Crohn's disease that meets both of the following criteria:
- has failed to be controlled by standard therapy including cortisone treatment
- requires *permanent* immunosuppressive medication.

diabetes (type 1) diagnosed after age 30 means the diagnosis of autoimmune mediated insulin dependent diabetes mellitus (IDDM) after the age of 30. Diagnosis must be made by a consultant endocrinologist.

diabetes with severe life impact means severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist. The condition must be evidenced by at least two of the following:
- severe diabetic retinopathy resulting in visual acuity even when aided of 6/36 or worse in both eyes
- severe diabetic neuropathy causing motor and/or autonomic impairment and resulting in *permanent* and irreversible inability to perform two out of six *activities of daily living*
- diabetic peripheral vascular disease resulting in amputation
- severe diabetic nephropathy causing chronic irreversible renal impairment measured by a corrected creatinine clearance less than 30ml/min.

diagnosis of bilateral hemianopia means unequivocal diagnosis of complete and *permanent* bilateral hemianopia as diagnosed by an appropriate medical specialist.

diagnosis of cavernous sinus thrombosis means unequivocal diagnosis of cavernous sinus thrombosis by a medical specialist via an MRI scan.

diagnosis of motor neurone disease means unequivocal diagnosis of motor neurone disease.

diagnosis of multiple sclerosis means unequivocal diagnosis of multiple sclerosis. The condition must be evidenced by appropriate neuro-imaging and spinal fluid abnormalities.

If spinal fluid abnormalities are not present or the test was not completed, we'll consider other medical evidence that supports the diagnosis.

diagnosis of muscular dystrophy means unequivocal diagnosis of muscular dystrophy, which causes progressive and selective degeneration and weakness of voluntary muscles. The diagnosis must be confirmed by a consultant neurologist or other appropriate specialist physician on the basis of confirmatory neurological investigation. Diagnosis without the presence of signs and symptoms is excluded.

diagnosis of myasthenia gravis means unequivocal diagnosis of myasthenia gravis.

diagnosis of parkinson's disease means unequivocal diagnosis of Parkinson's disease.

Diagnosis of Parkinson's disease doesn't include Parkinson's disease resulting from medication or drugs.

diagnosis of parkinson-plus syndrome (specified) means the unequivocal diagnosis by a consultant neurologist of one of the following Parkinson-Plus syndromes:
- multisystem atrophy
- progressive supranuclear palsy.

All other types of parkinsonism, including secondary parkinsonism due to medication, are excluded.

domestic duties means the following tasks, whether or not the life insured performed these tasks prior to the *sickness* or *injury*:
- 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 for the family
- laundry: washing, drying, and ironing the family's clothes or linens to basic standards
- shopping: purchasing and unpacking everyday household provisions for the family.

early stage chronic lymphocytic leukaemia means chronic lymphocytic leukaemia diagnosed as Rai stage 0, which is defined to be in the blood and bone marrow only.

eligible superannuation fund means a superannuation fund which offers members access to Zurich Active insurance.

encephalitis means an inflammatory disease of the brain resulting in neurological deficit. The condition must result in *permanent* and irreversible inability to perform two out of six *activities of daily living*.

endovascular heart valve repair or replacement means heart valve repair or replacement via percutaneous intravascular techniques not involving open thoracotomy.

endovascular iliac or femoral artery aneurysm repair means iliac or femoral artery aneurysm repair or replacement via percutaneous techniques.

endovascular or open carotid artery stenosis repair means a percutaneous or open carotid artery stenosis repair.

endovascular repair of an aortic aneurysm means abdominal or thoracic aneurysm repair or replacement via percutaneous techniques.

endovascular repair to correct structural lesions of the heart means repair to correct structural lesions of the heart via percutaneous techniques.

end stage liver disease means end stage liver failure defined by irreversible loss of biosynthetic function of the liver accompanied by a persistent coagulopathy and *permanent* jaundice.

End stage liver disease must be evidenced by at least one of the following:
- diuretic resistant refractory ascites
- recurrent portal hypertensive bleeding
- recurrent portal systemic encephalopathy
- recurrent spontaneous bacterial peritonitis
- listing for liver transplantation.

gastrointestinal disease means disease of the gastrointestinal system which is evidenced by both of the following:
- organic pathology obtained by biopsy
- a history of continuous symptoms for at least 12 months.

heart attack means the death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. The diagnosis must be supported by a diagnostic change of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following:
- acute cardiac signs and symptoms consistent with myocardial infarction
- acute ECG changes indicative of acute ischaemia (new ST-T changes, new T wave changes or new left bundle branch block (LBBB))
- new pathological Q waves
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, not undertaken or the tests are superseded due to technical advances, we'll consider other appropriate and medically recognised tests that unequivocally diagnose acute symptomatic myocardial infarction of the same degree of severity, or greater, as outlined above.

The following are not covered under this definition:
- other acute coronary syndromes including but not limited to angina pectoris, where there is no biochemical evidence of myocardial injury
- myocardial infarctions arising from elective percutaneous coronary interventions or coronary artery bypass grafting
- elevations of troponins in the absence of an ischaemic cause (for example but not limited to, myocarditis, apical ballooning (Takotsubo cardiomyopathy), cardiac contusion, pulmonary embolism or drug toxicity)
- myocardial infarction not associated with an acute episode of cardiac symptoms and/or signs, acute ECG changes or changes in cardiac biomarkers.

heart or heart and lung transplant means the life insured is the recipient of a heart or heart and lung transplant.

heart valve replacement or repair means thoracotomy to replace or repair cardiac valves due to heart valve defects or abnormalities.

Heart valve replacement or repair doesn't include any of the following:
- angioplasty
- intra-arterial procedures
- other non-surgical techniques.

illicit drug use means:
- the use of an illegal drug, which is a drug that is prohibited from manufacture, sale or possession in Australia such as cannabis, cocaine, heroin and amphetamine-type stimulants. Illicit drug use includes circumstances where no legal penalty can result from use of an illicit drug such as in jurisdictions where its use is not, or is no longer, criminalised
- the use, other than as prescribed by a *medical practitioner*, of a pharmaceutical, which is a drug that is available from a pharmacy, over the counter or by prescription. For example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids
- the use, other than as prescribed by a *medical practitioner*, of any psychoactive substances which are legal or illegal. For example, kava, synthetic cannabis and other synthetic drugs, or inhalants such as petrol, paint or glue.

injury means bodily injury caused by an accident. The accident must occur while the policy is in-force.

inner ear or middle ear surgery means surgery to the cochlear or middle ear bones.

intensive care unit (ICU) means an Intensive Care Unit accredited by the Australian Council on Healthcare Standards (ACHS).

invasive cancer (of stage 3 or 4) (for Zurich Income Safeguard) means the life insured is confirmed by histological evidence to have cancerous tumours which meet either of the following criteria:
- stage 3 or 4 according to the TNM classification confirmed by imaging
- totally incurable where all treatment regimens and modalities have failed.

The diagnosis must be confirmed by a *medical practitioner* who is an appropriate specialist.

leukaemia, lymphoma, and blood related cancers (of stage 3 or 4) (for Zurich Income Safeguard) means the life insured is confirmed by diagnostic testing (including histological testing when appropriate) to have any of the following disorders:
- the diagnosis of aplastic anaemia
- the diagnosis of multiple myeloma
- the diagnosis of leukaemia, except chronic lymphocytic leukaemia
- Hodgkin's or non-Hodgkin's lymphoma stage 3 or 4.

The diagnosis must be confirmed by a *medical practitioner* who is an appropriate specialist.

liver transplant means the life insured is the recipient of a liver.

lung or heart and lung transplant means the life insured is the recipient of a lung or heart and lung transplant.

medical practitioner means one of the following:
- a medical practitioner legally registered to practise in Australia
- a medical practitioner legally registered to practise in another country who has equivalent qualification.

Medical practitioner generally includes the life insured's general practitioner and any treating specialists involved in diagnosis and management of their condition. For mental health claims, it can include a treating psychiatrist.

Where we need an opinion from a specific medical specialist appropriate to the medical condition, we'll specify.

Medical practitioner doesn't include:
- the policy owner, their relative, business partner or employee
- the life insured, their relative, business partner or employee
- other para-medical professionals including (but not limited to) psychologists, chiropractors, physiotherapists, or naturopaths.

new mental health condition means a mental or behavioural condition, which can include cognitive impairment, classified in one of the following:
- the Diagnostic and Statistical Manual of Mental Disorders (DSM), including any replacement or successor to DSM
- any other clinically recognised diagnostic manual.

The condition must meet both of the following criteria:
- first diagnosed after the policy start date while the policy was in-force
- resulted in ongoing treatment for at least two years.

occupational impairment means the definition of occupational impairment shown on your policy schedule. If the occupational impairment definition shown on your policy schedule is 'not applicable', then occupational impairment is not covered.

Only occupational impairment due to *sickness* or *injury* is covered. The insured event must occur before the policy anniversary when the life insured is 65.

To qualify for a benefit under the own occupation definition, solely due to *sickness* or *injury*, the life insured meets the criteria set out in (a) or (b) below:

(a) all of the following:
- hasn't been working in their *own occupation* for a continuous period of at least three months
- is following the advice of a *medical practitioner* and has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*
- is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again despite having undergone or continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*.

(b) both of the following:
- has suffered permanent and irreversible *whole person impairment* of at least 25%
- is so incapacitated that they're unlikely to be able to work in their *own occupation* ever again.

To qualify for a benefit under the any occupation definition, solely due to *sickness* or *injury*, the life insured meets the criteria set out in (a) or (b) below:

(a) all of the following:
- hasn't been working for a continuous period of at least three months
- is following the advice of a *medical practitioner* and has undergone or is continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*
- is so incapacitated and that they're unlikely to be able to work in *any occupation* ever again despite having undergone or continuing to undergo all reasonable and appropriate treatment including rehabilitation for that *sickness* or *injury*.

(b) both of the following:
- has suffered permanent and irreversible *whole person impairment* of at least 25%
- is so incapacitated that they're unlikely to be able to work in *any occupation* ever again.

We'll assess the life insured's capacity for future work under the own and any occupation definitions using a combination of the following:
- medical opinion provided by a specialist in the life insured's condition
- employability assessments prepared by allied health providers
- labour market information
- any other available evidence of the life insured's condition, including evidence provided by the life insured and anyone acting for the life insured.

To qualify for a benefit under the *domestic duties* occupation definition, solely due to *sickness* or *injury*, the life insured meets the criteria set out in (a) or (b) below:

(a) all of the following:
- has been unable to perform all of the *domestic duties* without an adult person assisting for a continuous period of at least three months
- has been unable to leave their home without an adult person assisting for a continuous period of at least three months
- has been following the advice of a *medical practitioner* and engaging in appropriate treatment for the *sickness* or *injury* in the three-month period
- is so incapacitated that they require ongoing medical care
- is so incapacitated that they're unlikely to be able to perform all of the *domestic duties* without an adult person assisting, ever again.

(b) both of the following:
- has suffered permanent and irreversible *whole person impairment* of at least 25%
- is so incapacitated that they're unlikely to be able to work in *any occupation* ever again.

We'll assess the life insured's capacity for *domestic duties* using a combination of the following:
- medical opinion provided by a specialist in the life insured's condition
- any other available evidence of the life insured's condition, including evidence provided by the life insured and anyone acting for the life insured.

In all cases, a claim for *whole person impairment* is only payable if life insured survives at least 14 days after they meet the definition. The definition isn't met if the life insured is declared brain dead in the 14 days.

open aortic graft surgery – abdominal or thoracic means open surgery with aortic grafting to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta.

Open aortic graft surgery – abdominal or thoracic doesn't include any of the following:
- angioplasty
- intra-arterial procedures including endovascular aortic repair
- other non-surgical techniques.

open iliac or femoral artery aneurysm grafting means open surgery to graft the iliac or femoral artery vessels for the treatment of an aneurysm.

Open iliac or femoral artery aneurysm grafting doesn't include any of the following:
- angioplasty
- intra-arterial procedures
- other non-surgical techniques.

out of hospital cardiac arrest means cardiac arrest (cessation of cardiac function resulting in loss of consciousness, loss of respiratory effort and loss of signs of circulation) that isn't associated with any medical procedure, occurs out of hospital or any other medical facility, and is documented by an electrocardiogram (ECG) showing asystole or ventricular fibrillation.

If an ECG isn't available, we'll consider other medical evidence that confirms an out of hospital cardiac arrest has occurred.

Examples of suitable evidence include but aren't limited to:
- ambulance and hospital medical reports confirming cardiac arrest
- documentation of the administration of Cardiopulmonary Resuscitation (CPR) by an attending ambulance officer or hospital clinical staff
- Automated External Defibrillator (AED) data.

Cardiac arrest related to alcohol, drug or medication abuse is excluded.

own occupation means the life insured's occupation, business, or employment at the start of the *sickness* or *injury* causing *total and permanent disablement*, unless the life insured has been working in a new occupation for less than six months.

If the life insured isn't working in their occupation, business or employment for remuneration or reward, then own occupation is the occupation, business, or employment the life insured most recently worked in for remuneration or reward.

The definition changes if the life insured changes occupation and has been working in their new occupation for less than six months at the start of the *sickness* or *injury* causing *total and permanent disablement*. In this case, own occupation is the last occupation, business, or employment the life insured worked in for a continuous period of at least six months.

pancreas transplant means the life insured is the recipient of a pancreas.

paraplegia means total, *permanent* and irreversible loss of the use of two limbs due to *sickness* or *injury*. A limb is defined as the shoulder down to the hand or the hip down to the foot.

partner means a person the life insured is legally married to or is in a partnership with. Partnership means a prescribed relationship which is registered under State or Territory law for the purposes of the *Acts Interpretation Act 1901*.

percutaneous coronary angioplasty means any of the following procedures, undertaken to correct a narrowing or blockage:
- percutaneous balloon dilatation
- atherectomy
- stent placement.

The procedure must be considered appropriate and necessary based on the *medical practitioner's* interpretation of angiographic evidence.

permanent means all of the following:
- irreversible
- present for a minimum of six months
- expected to show no improvement or reversibility, while on optimal therapy, if appropriate.

If any of the health events use a different timeframe for the measurement of permanent, it will be stated in the specific health event definition.

permanent cardiac defibrillator insertion means the life insured has a *permanent* cardiac defibrillator inserted.

Permanent cardiac defibrillator insertion doesn't include cardiac pacemaker insertion.

permanent total aphasia means the life insured can't manage day-to-day activities due to an inability to communicate. This must be evidenced by:

- total and irreversible loss of speech
- no intelligible vocalisation.

The loss must be confirmed to be total and irreversible at least three months after speech was first lost.

Permanent total aphasia doesn't include loss of speech due to psychological reasons.

permanent unresponsive state means a condition of profound non-responsiveness in the wakeful state caused by brain damage and characterised by a non-functioning cerebral cortex, the absence of any discernible adaptive response to the external environment and an inability to communicate for a continuous period of at least three months.

pneumonectomy means removal of an entire lung.

portal vein thrombosis means isolated thrombosis of the portal vein.

prostate cancer means localised prostate cancer characterised by focal autonomous new growth of cancer cells.

quadriplegia means total, *permanent* and irreversible loss of the use of all four limbs due to *sickness* or *injury*.

Limb is defined as the shoulder down to the hand or the hip down to the foot.

radical or modified radical mastoidectomy means removal of the mastoid bone and bones of the middle ear due to chronic disease.

renal transplant means the life insured is the recipient of a kidney transplant.

severe burns (for Zurich Income Safeguard) means tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness) burns to at least one of the following:
- 20% or more of the body surface area as measured by The Rule of Nines or the Lund & Browder Body Surface chart
- 50% or more of both hands, requiring surgical debridement and/or grafting
- 50% or more of both feet, requiring surgical debridement and/or grafting
- 50% or more of the face, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

severe congestive cardiac failure means failure of the functioning of the ventricles of the heart with poor cardiac output and congestion of the lungs or systemic veins.

severe crohn's disease means diagnosis of severe or refractory Crohn's disease confirmed by a gastroenterologist, that meets both of the following criteria:
- failed to be controlled by initial therapy (eg. corticosteroids, 5-ASA)
- requires ongoing maintenance therapy (eg. immunosuppressant or biologic agent therapy) treatments.

Maintenance therapy must have been in use for at least 12 months.

severe epilepsy means averaging more than two witnessed grand mal (tonic clonic) epileptic attacks per week over a six month period, despite optimal stabilised therapy. The epilepsy must be managed by a neurologist.

severe loss of binaural hearing means total and irreversible loss of more than 75% of binaural hearing, even with amplification.

Binaural hearing is measured as explained in the American Medical Association publication 'Guide to the Evaluation of Permanent Medical Impairment' (current at the time of testing) or an equivalent guide to impairment.

severe osteoporosis before age 50 means before the age of 50, the life insured meets both of the following:
- suffers at least two vertebral body fractures or a fracture of the neck or the femur, due to osteoporosis
- records a bone mineral density T-score of less than -2.5 (ie. 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

severe peripheral vascular disease means atherosclerosis which results in both of the following
- severe arterial insufficiency in vessels
- ischaemia of the limbs.

severe rheumatoid arthritis (with permanent daily life impact) means unequivocal diagnosis of rheumatoid arthritis confirmed by a rheumatologist or clinical immunologist. The condition must be evidenced by both:
- failure to respond to at least three disease-modifying anti-rheumatic drugs (DMARDs) including one bDMARD, taken consistently for a period of at least nine months. This excludes corticosteroids and non-steroidal anti-inflammatories.
- a permanent and irreversible inability to perform at least one of the *activities of daily living*.

Severe rheumatoid arthritis (with permanent daily life impact) doesn't include degenerative osteoarthritis or any other arthritides.

sickness means sickness or disease including any pre-existing sickness or disease that the life insured told us about in the application that we agreed to cover.

small bowel transplant means the life insured is the recipient of a small bowel.

stroke means a neurological event caused by a cerebrovascular incident and confirmed by an appropriate medical specialist.
Stroke must be evidenced by both of the following:
- the onset of objective neurological signs and clinical symptoms
- neuro-imaging.

If the above tests are inconclusive or our noted diagnostic techniques are impractical to apply or have been superseded, we'll consider other appropriate and medically recognised tests.

Stroke doesn't include transient ischaemic attacks or cerebral symptoms due to migraine.

surgical repair to correct structural lesions of the heart means undergoing thoracotomy to repair a structural lesion of the heart.

Surgical repair to correct structural lesions of the heart doesn't include any of the following:
- angioplasty
- intra-arterial procedures
- other non-surgical techniques.

terminal illness means any condition caused by *sickness* or *injury*, where despite all reasonable medical treatment, the life insured is expected to live for no more than 24 months.

Terminal illness must be confirmed and certified by both of the following:
- a *medical practitioner* who is treating the condition and can provide supporting evidence of the condition, possible medical treatment and prognosis
- if required by us, a specialist *medical practitioner* who is an expert in the condition.

Extra certification is required if the policy is held in superannuation to comply with superannuation law. In this case:
- two certifications are always required
- the period of life expectancy certified by each of the two *medical practitioners*, must not have ended.

total pericardiectomy for constrictive pericarditis means undergoing thoracotomy with a total pericardiectomy for constrictive pericarditis.

transplant waiting list means that on specialist medical advice, the life insured goes onto an official Australian acute care hospital waiting list for organ transplant.

ulcerative colitis (severe) means the diagnosis of severe ulcerative colitis confirmed by a gastroenterologist, that meets both of the following criteria:
- failed to be controlled by initial therapy (eg. corticosteroids, 5-ASA)
- requires ongoing maintenance therapy (eg. immunosuppressant or biologic agent therapy) treatments.

Maintenance therapy must have been in use for at least 12 months.

uncomplicated pregnancy or childbirth means pregnancy, childbirth or termination which doesn't result in any serious medical complication. Included are participation in an IVF or similar program, normal discomforts such as morning sickness, backache, ankle swelling or bladder problems, giving birth, miscarriage, or a termination. Uncomplicated pregnancy also includes conditions which first appear during pregnancy and are recognised as pregnancy-related, temporary conditions. These include carpel tunnel syndrome, varicose veins and high blood pressure.

whole person impairment means whole person impairment based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition. We'll consider other appropriate and medically recognised tests that measure whole person impairment at the same degree of severity or greater

Zurich life insurance policies mean any:
- Zurich Active policy issued on or after 1 October 2016
- Zurich Wealth Protection policy
- other policy originally issued by Zurich Australia Limited (ABN 92 000 010 195) prior to 1 August 2022 acquired following individual underwriting
- other policy issued as a replacement of any of the above, but excluding any group life policy held by a corporate or trustee of a superannuation fund to provide cover for a defined group of people.

These definitions are specific to Child Cover

bacterial meningitis or meningococcal septicaemia (with severe life impact) means all potential manifestations of bacterial meningitis or meningococcal septicaemia resulting in permanent and irreversible neurological deficit confirmed by a specialist physician and one of the following:

- permanent and irreversible inability to perform at least one of the *activities of daily living* without the help of another adult person
- permanent and irreversible *whole person impairment* of at least 25%.

benign tumour in the brain or spinal cord (with neurological deficit) means a non-malignant tumour in the brain or spinal cord which is histologically described and which produces neurological deficit, resulting in one of the following:

- a permanent and irreversible inability to perform at least one of the *activities of daily living*
- the undergoing of surgery to remove the tumour.

The impairment must be certified by an appropriate medical specialist.

The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI or other equivalent diagnostic investigation.

Benign tumour in the brain or spinal cord (with neurological deficit) doesn't include any of the following:

- cysts, granulomas and cerebral abscesses
- malformations in, or of, the arteries or veins of the brain
- tumours in or arising from the pituitary gland (including pituitary neuroendocrine tumours). Tumours in or arising from the pituitary gland are covered only if the life insured undergoes surgical removal by open craniotomy.

cancer (excluding early stage cancers) means the presence of a malignant tumour, including leukaemia, malignant lymphoma and other haemopoietic malignancies.

The tumour must be both:

- confirmed by histological examination, or appropriate pathological testing in the case of non-solid tumours
- characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue.

The severity of the condition will mean either:

- the life insured requires major interventionist therapy including surgery to remove the tumour, radiotherapy, chemotherapy, biological response modifiers or any other major treatment
- the tumour is sufficiently advanced such that major interventionist therapy is no longer recommended.

Cancer (excluding early stage cancers) doesn't include any of the following:

- chronic lymphocytic leukaemia less than Rai stage 1
- all cancers described as carcinoma in situ. Carcinoma in situ of the breast is covered only if it requires one of the following:
  - the removal of the entire breast, including nipple sparing mastectomy
  - breast conserving surgery and radiotherapy
  - breast conserving surgery and chemotherapy. Chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells.

Carcinoma in situ of the breast treated by breast conserving surgery and other forms of adjuvant systemic therapy, including endocrine manipulation therapy, hormonal manipulation therapy or non-endocrine adjuvant therapy, isn't covered.

- all skin cancers unless one of the following applies:
  - they have metastasised to other organs
  - the tumour is a malignant melanoma of stage T1bN0M0 or higher.
- all cancers of the prostate unless one of the following applies:
  - histological classification is a Gleason score of 7 or above
  - the tumour has progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system
  - major interventionist therapy or hormonal therapy has been undertaken specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment. Major interventionist therapy includes a total prostatectomy, chemotherapy, radiotherapy or brachytherapy.
- all cancers of the bladder unless having progressed to at least TNM classification T1N0M0
- all cancers of the thyroid unless one of the following applies:
  - having progressed to at least TNM classification T2N0M0
  - where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
- all pituitary neuroendocrine tumours unless one of the following applies:
  - there is evidence of metastatic spread
  - the life insured undergoes surgical removal by open craniotomy.
- all tumours which are histologically classified as pre-malignant, non-invasive, high-grade dysplasia, borderline or having low malignant potential.

cardiomyopathy (with significant permanent impairment) means impaired ventricular function resulting in significant permanent physical impairment. The degree of impairment must be at least Class 3 of the New York Heart Association classification of cardiac impairment.

chronic kidney failure (end stage) means end stage renal failure presenting as chronic irreversible failure of both kidneys to function. The condition must be evidenced by one of the following:

- permanent regular renal dialysis
- renal transplant.

diplegia means the permanent and total loss of function of both sides of the body resulting from disease, illness or injury of the brain or spinal cord.

encephalitis (with permanent neurological deficit) means an inflammatory disease of the brain caused by viral or bacterial infection, resulting in permanent neurological deficit and one of the following:

- a permanent and irreversible inability to perform at least one of the *activities of daily living* without the help of another adult person
- permanent and irreversible *whole person impairment* of at least 25%.

The impairment must be certified by an appropriate medical specialist.

hemiplegia means the permanent and total loss of function of one side of the body resulting from disease, illness or injury of the brain or spinal cord.

loss of use of a hand or foot or sight in one eye means the total and irreversible loss of use of one of the following:

- an entire hand
- an entire foot
- sight in one eye, to the extent that even when aided, one of the following applies:
  - eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart
  - the degree of vision is less than or equal to 20 degrees of arc.

loss of use of hands, feet or sight means the total and irreversible loss of the use of two or more of:

- an entire hand
- an entire foot
- sight in one eye, to the extent that even when aided, one of the following applies:
  - eyesight is reduced in that eye to 6/60 or worse of central visual acuity on the Snellen test chart
  - the degree of vision is less than or equal to 20 degrees of arc.

loss of hearing means irreversible hearing loss in the better ear. Even with amplification, the average hearing threshold must be 91dB or greater as measured at 500, 1,000 and 1,500 Hz.

loss of sight means permanent and irrecoverable loss of sight, to the extent that one of the following applies:

- even when aided, eyesight is reduced in both eyes to 6/60 or worse of central visual acuity on the Snellen test chart
- 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 *sickness* or *injury*.

Loss of speech must have existed continuously for a period of at least three months and be permanent and irreversible.

Loss of speech doesn't include loss of speech related to any psychological cause.

major head trauma (with permanent neurological deficit) means accidental cerebral injury resulting in permanent neurological deficit and one of the following:

- a permanent and irreversible inability to perform at least one of the *activities of daily living* without the help of another adult person
- permanent and irreversible *whole person impairment* of at least 25%.

The impairment must be certified by a consultant neurologist.

major organ transplant (or waiting list) means one of the following:

- the life insured undergoes an organ transplant
- on specialist medical advice, the life insured goes onto an official Australian acute care hospital waiting list for organ transplant
- the life insured undergoes permanent mechanical replacement of an organ.

Only events relating to the following organs are covered:

- kidney
- heart
- liver
- lung
- pancreas
- small bowel
- bone marrow.

Major organ transplant (or waiting list) doesn't include the transplantation of any other organs, or parts of any organ, or of any other tissue.

paraplegia means the permanent and total loss of use of both legs resulting from disease, illness or injury of the brain or spinal cord.

quadriplegia means the permanent and total loss of use of both arms and both legs resulting from disease, illness or injury of the brain or spinal cord.

severe burns (of specified extent) means tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness) burns to at least one of the following:

- 20% of the body surface area as measured by The Rule of Nines or the Lund & Browder Body Surface chart
- 50% or more of both hands, requiring surgical debridement and/or grafting
- 50% or more of both feet, requiring surgical debridement and/or grafting
- 50% or more of the face, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

stroke (of specified severity) means a cerebrovascular event producing neurological sequela lasting at least 24 hours. The stroke must be evidenced by CT (Computerised Tomography), MRI (Magnetic Resonance Imaging) or similar scan which clearly shows one of the following:

- infarction of brain tissue
- intracranial or subarachnoid haemorrhage.

The following aren't covered:

- cerebral symptoms due to transient ischaemic attacks
- reversible neurological deficit
- migraine
- cerebral injury resulting from trauma or hypoxia
- disturbances of vision or balance due to disease of the eye, optic nerve, or the vestibular apparatus of the ear.

Contact us

Contact us if you need help

We or your adviser can answer questions about any of the policies explained in this document.

We or your adviser can also help you with changes to your policy, to help keep cover in line with your needs. For example, if you want to make use of an option on your policy.

Please contact our Customer Care team or your adviser in the most convenient way for you:

131 551

Monday to Thursday
8.30am – 7.00pm AEST

Friday 8.30am – 5.30pm AEST

Zurich Customer Care
Locked Bag 994
North Sydney NSW 2059

Find out more when it suits you best

We have plenty of information on our website to help you. We also have a self-service portal you can sign-up to.

zurich.com.au

Here are some useful locations on our website:

zurich.com.au/existingcustomers
- previous versions of this PDS
- information about policy upgrades that may affect you
- information about premium rate increases in recent years

zurich.com.au/controlyourcover
- tips on how to manage the cost of your cover over time

zurich.com.au/tmd
- Target Market Determinations (TMDs) for the products in this PDS. TMDs describe who each product may be suitable for, based on likely needs, objectives, and financial situation.

zurich.com.au/myzurich
View or update your details online
Login or register for My Zurich, our 24/7 self-service customer portal, where you can:
- view your policy information
- access policy-related documents
- update your payment or contact details
- decline inflation protection increases
- update beneficiary details.

Keep in touch with your financial adviser too

Your financial adviser is your first point of contact for financial advice. We can only provide you with factual information about these policies and how they work.

Zurich Australia Limited
ABN 92 000 010 195, AFSL 232510
Zurich Customer Care: 131 551
Website: zurich.com.au

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ZURICH

Zurich Insurance-only Superannuation Plan

Product Disclosure Statement

Issue Date: 1 October 2024

The issuer

This Product Disclosure Statement (PDS) has been prepared by Brighter Super Trustee (ABN 94 085 088 484 AFSL 230511) ('Trustee') & Zurich Australia Limited (ABN 92 000 010 195 AFSL 232510) ('Zurich').

The Trustee for Brighter Super (ABN 23 053 121 564) ('Fund') is the issuer of this PDS. Brighter Super may refer to the Trustee or the Fund as the context may be. This PDS contains important information for members of the Fund. The different entities of Zurich and Brighter Super are not guaranteed by or responsible for, or liable in respect of, products and services provided by the other. The Zurich Insurance-only Superannuation Plan is a division of Brighter Super ('Zurich Plan').

The Trustee provides members with access to death and disablement cover through superannuation, and accepts contributions and rollovers only for the purposes of paying premiums for that cover. Members do not have an account balance in the Fund if their fund membership is only under the Zurich Insurance-only Superannuation Plan.

The Trustee holds the insurance policy on your behalf as a member of the Zurich Plan.

This PDS refers to the Zurich Wealth Protection and Zurich Active PDSs issued by Zurich Australia Limited with an issue date 1 October 2024, as supplemented or replaced from time to time, for which Zurich is responsible. The Zurich Wealth Protection and Zurich Active PDSs may be obtained from the Trustee or Zurich on request, at no charge or are available from your financial adviser. You should read both PDSs before making a decision. The Trustee is not the issuer of the insurance policies or the Zurich Wealth Protection and Zurich Active PDSs.

About the Fund

Brighter Super has been a complying regulated superannuation fund since 1 July 1995 within the meaning of the Superannuation Industry (Supervision) Act 1993 (Cth) (SIS Act). It is able to accept superannuation guarantee contributions as well as other additional employer contributions and rollovers.

Brighter Super is governed by a Trust Deed which outlines the governing rules of the Fund. A copy of the Trust Deed is available at brightersuper.com.au/about-us/governance. You can obtain a copy of the Trust Deed free of charge by contacting us. Under the terms of the Deed, the Trustee has the power to amend any of the provisions of the Deed if permitted by relevant law.

An annual report about the management and financial condition of the Fund is prepared each year. You can view the annual report online at brightersuper.com.au/about-us/governance/annual-reports. You may also elect to have a hard copy of the annual report sent to you free of charge.

About Zurich Australia Limited

Zurich Australia Limited (ABN 92 000 010 195 AFSL 232510) ('Zurich') provides the insurance cover described in this PDS. Further information about the insurance cover is in the separate PDSs issued by Zurich ('Zurich PDSs').

Applications to the Trustee for membership of the Zurich Plan must be made along with an application for insurance. The application for membership of the Zurich Plan and application for insurance can be submitted electronically by your financial adviser acting on your behalf. You should consider both this PDS issued by the Trustee and the relevant PDS issued by Zurich before completing the application for membership of the Zurich Plan and any application for insurance.

The Trustee has delegated administration of the Zurich Plan to Zurich. With the Trustee's consent, Zurich may engage other service providers to assist with aspects of the Plan's administration.

The information contained in this PDS is general information only. Your objectives, financial situation or needs have not been taken into account. You should consider the appropriateness of the information in this PDS, taking into account your objectives, financial situation and needs, before acting on any information in the PDS. Information about tax provided in this PDS is a guide only and is based on our understanding of the tax laws current at the date of the PDS. These laws can change, so you should speak to your tax adviser regarding the tax consequences of holding insurance cover through superannuation. References to superannuation law in this PDS include the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations as amended from time to time.

All of the information contained in this PDS is current at the time of preparation of this PDS. Information contained in this PDS can change from time to time. If the change is to information that is not materially adverse information, the updated information will be available at zurich.com.au. A paper copy of any updated information will be given, or an electronic copy will be made available, to you on request without charge by contacting Zurich (see the contact details on page 14).

In this PDS:

- 'Fund' refers to Brighter Super
- 'Trustee' refers to Brighter Super Trustee
- 'You', 'Your' refers to the person who will become the life insured
- 'Member' refers to a member of the Zurich Plan

Contents

This PDS dated 1 October 2024 covers the financial product issued by the Trustee and provides a summary of the insurance products issued by Zurich under Zurich Wealth Protection and Zurich Active policies. For the avoidance of doubt, Zurich is not an RSE licensee and legally not able to issue interests in superannuation funds, and the Trustee is not a licensed insurer and legally not able to issue insurance policies. Zurich does not issue, underwrite or guarantee the superannuation interest described in this PDS. The Trustee is not responsible for the operation, nor is the issuer of, the insurance policies and any associated programs or discounts issued or offered by Zurich.

This PDS provides important information that will help you understand the types of insurance benefits available and the tax treatment that may apply, your options for meeting the costs of the insurance, and the potential risks of holding insurance through superannuation.

While the Trustee has determined that insurance cover described in the Zurich PDSs can be held through superannuation, this does not mean that it is suitable for your personal situation, objectives or needs.

Introducing the Zurich Insurance-only Superannuation Plan

The Trustee provides members with access to death and disablement insurance cover within superannuation. Your account does not have an account balance and is not subject to investment returns.

Your insurance policy will commence once you have become a member of the Zurich Plan and Zurich has confirmed acceptance of your insurance application. The Trustee will only accept your application for membership of the Zurich Plan if your application for insurance is accepted by Zurich and you have provided the Trustee with your Tax File Number (TFN)[1].

Other than interim cover that may be provided by Zurich while your insurance application is being assessed, your insurance cover in the Zurich Plan only commences once applicable premiums are paid from contributions and/or rollovers received. Membership of the Zurich Plan is subject to terms and conditions determined by the Trustee from time to time.

The Trustee accepts contributions and rollovers to pay the premiums for insurance policies held through the Zurich Plan, subject to the terms and conditions summarised in this PDS.

The insurance benefits available through the Zurich Plan have been designed for consumers with certain objectives, financial situations and needs. Not all insurance benefits are suitable for all consumers and you need to consider, with the help of any financial adviser advising you, whether they are right for you. Zurich has made a target market determination for each insurance benefit available through the Zurich Plan. The determination sets out key attributes of the insurance, the needs and objectives it is intended to address, eligibility requirements, financial capacity expectations, some key exclusions and how it is to be sold. You can find these documents on the Zurich website at zurich.com.au/tmd.

The insurance benefits available

If your application for cover is accepted, Zurich will issue an insurance policy to the Trustee and you will be the life insured under the policy. You have access to various types of insurance cover from which you may select, provided you meet relevant eligibility criteria and other terms and conditions relating to the acceptance of cover.

The insurance products available through superannuation under this PDS are:

- **Zurich Wealth Protection** which provides the following types of insurance:
  - Life insurance – providing cover for death and terminal illness;
  - Total and Permanent Disablement insurance (TPD) – providing cover for total and permanent disablement or 'permanent incapacity';
  - Income protection insurance – providing cover for 'temporary incapacity' where you are unable to work to earn income due to sickness or injury.
- **Zurich Active** which provides the following types of insurance:
  - Cover for death, terminal illness and a range of specified health events that result in 'permanent incapacity';
  - Income protection insurance – providing cover for 'temporary incapacity' where you are unable to work to earn income due to sickness or injury.

As a member of the Zurich Plan, you may be provided with insurance cover through one insurance product or multiple insurance products. Also, your insurance cover may give rise to multiple superannuation interests ('interests') in the Zurich Plan, in relation to a single insurance product or multiple insurance products.

The terms and conditions of the available insurance cover under this PDS, including limitations and exclusions, are described in the Zurich Wealth Protection PDS and Zurich Active PDS current at the date when cover is applied for. The amount of cover you select and any special conditions Zurich applies to your cover will be set out in a policy schedule. A copy of the policy schedule will be sent to you by Zurich if your application for insurance is accepted.

Holding insurance cover through superannuation

It is important to note that there are differences between holding insurance cover directly from Zurich and holding insurance cover through a superannuation account. These differences include:

- When you have insurance cover through superannuation, the Trustee is the owner of the insurance policy and holds it on your behalf as the life insured. You cannot apply for cover on the life of another person (eg. spouse or child) via superannuation.
- Insurance cover held through superannuation is subject to superannuation law which governs the type of insurance benefits that can be provided via a superannuation fund. These rules do not apply to insurance cover obtained directly by you outside of superannuation. This means that not all types of

[1]You are not required by law to provide us with your TFN, However, if you would like to participate in this product, your Tax File Number is necessary.

insurance cover described in the Zurich Wealth Protection PDS and Zurich Active PDS can be held through a superannuation account. For example, trauma cover is not available through the Zurich Plan.

- Not all the insurance features (including definitions) benefits or options available in respect of insurance cover described in the Zurich Wealth Protection PDS and Zurich Active PDS apply to insurance cover held in the Zurich Plan. For example, TPD cover through superannuation cannot be based on your permanent incapacity to perform your own occupation only.
- To the extent premiums are paid to superannuation as a contribution (ie. not rollovers), the contribution may be deductible against your income if you lodge a valid 'Notice of intent to claim or vary a deduction for personal super contributions' and the Trustee issues an acknowledgement of that notice. The Trustee can generally claim a tax deduction for premiums paid to Zurich in respect of insurance including premiums paid by a partial rollover. For partial rollovers, you are not able to claim the premiums as a deduction against your income. Instead, the tax deduction received by the Trustee on premiums paid by partial rollovers will usually be passed on to you in the form of a reduced premium. Situations where this premium reduction may cease in the future are explained in the section 'Paying premiums by rollover from another superannuation fund' on page 6.
- If you have a complaint relating to insurance cover held in the Zurich Plan, Zurich will assist with the processing of such complaints in line with the Trustee's complaint handling process amended from time to time.

The Zurich Wealth Protection PDS and Zurich Active PDS explain which insurance benefits are not included, or are subject to additional terms, when held through superannuation. Benefits not included through superannuation may be accessed via a second policy owned directly by you through the Zurich Superannuation Optimiser structure – for more details, refer to the relevant Zurich PDS. The Zurich Wealth Protection Financial planning advice reimbursement benefit will not form part of the Zurich Insurance-only Superannuation contract terms. Instead it will be provided under a separate insurance certificate, made by Zurich directly to you.

The terms and conditions applicable to insurance cover differ depending on whether you have insurance cover directly under the Zurich Wealth Protection PDS or Zurich Active PDS or you have insurance cover through the Zurich Plan or the Fund.

For further information about the differences, refer to the Zurich PDSs available from the Trustee or Zurich on request at no charge, or consult your financial adviser.

The suitability of insurance cover available to you via the Fund depends on your individual circumstances. The Trustee and Zurich are unable to provide personal financial advice to you in relation to insurance cover through superannuation.

Before applying for insurance cover under a Zurich Wealth Protection or Zurich Active policy, you should carefully read the relevant Zurich PDS which sets out important information including:

- Eligibility for insurance cover. If you are not eligible for insurance cover you will not be able to become a member of the Fund for this purpose.
- When completing an application for insurance, if you do not comply with your duty to take reasonable care not to make a misrepresentation, 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. The duty to take reasonable care not to make a misrepresentation is explained in the Zurich PDSs.
- Insurance benefits provided including when cover starts and ends, minimum and maximum insured amounts and any applicable payment limits. Interim cover may apply while your application is being processed. Refer to the relevant Zurich PDS for more information. If you have multiple types of cover under related policies, benefit payments under either of the related policies may reduce the benefits under the other policy.
- The cost of cover.
- The terms and conditions of those benefits, including important definitions.
- Exclusions and restrictions on the payment of those benefits.

As with any insurance provided to individuals, Zurich may impose additional conditions, exclusions, restrictions or premium loadings (depending on your personal circumstances) as a condition of the acceptance of cover. If you agree to these additional terms, they will be set out in a policy schedule, a copy of which will be provided to you.

You should also consider whether you need to consult a financial adviser before applying for insurance cover and becoming a member of the Fund. Your financial adviser can provide you with a Statement of Advice and other disclosure documents relevant to your insurance, taking into account your individual situation.

You will only be entitled to a benefit from the Zurich Plan if a benefit is paid by Zurich because an insured event occurs while you are covered under a policy, and you have satisfied a condition of release under superannuation law. See page 9 for more information on conditions of release.

Fees and costs

The cost of insurance

The cost of insurance under a Zurich Wealth Protection or Zurich Active policy is referred to as the premium and is determined by Zurich. Zurich may apply a management fee on Zurich Wealth Protection as part of the premium, depending on the frequency of your premium payments. Premiums can be paid monthly, quarterly, half-yearly or yearly in advance, with the management fee (if applicable) for a year being higher the more frequent your premium payments are.

The actual cost for you will depend on the insurance cover you select and a range of factors as explained in the relevant Zurich PDS. Your financial adviser can provide you with a quotation that will set out the indicative cost of your insurance for the first year of the policy. Zurich may impose additional insurance costs (loadings) depending on your personal circumstances as a condition of the acceptance of cover. You will be advised of any loadings at the time of application. The cost of insurance may be adjusted for any changes to your cover during the year.

Further information about the calculation of insurance premiums, including management fees, if applicable charged by Zurich, can be found in the relevant Zurich PDS.

Other fees and costs

The Trustee pays the premium (including any management fee, if applicable, charged by Zurich and, stamp duty) with amounts you contribute or rollover to the Zurich Plan. Zurich may pay commissions to your financial adviser from the money it receives. Commissions are not paid by the Trustee and are not additional to these premiums. Zurich also pays a Fund Administration Fee to the Trustee to cover the costs associated with administering the product within the Fund. In addition to the Fund Administration Fee paid by Zurich, the Trustee may also charge an additional Fund Insurance Administration Fee to further cover operating costs incurred in providing insurance to members which is recouped from the tax deduction available to the Trustee on insurance premiums. These payments are not an additional cost to you and may vary from time to time.

The Trustee does not charge any additional fees or costs to members associated with their membership of the Zurich Plan. The Trustee may bill you directly for any liability arising under any government charges or imposts relating to your Fund membership or deduct any such liability from an insured benefit that is or becomes payable to you.

Paying for insurance through superannuation

Premiums can be paid either by you or your employer making superannuation contributions to the Zurich Plan or by rolling over benefits from another superannuation fund. Some conditions apply to the types of contributions and rollovers that can be accepted by the Trustee as explained below. Under the administrative arrangements, Zurich will accept contributions and initiate rollovers (where a member consents) to the Fund on behalf of the Trustee and then immediately apply the amounts collected to pay premiums.

Making contributions to superannuation

Contributions can be paid yearly, half-yearly, quarterly or monthly, and must be in Australian dollars.

As noted above, the frequency of your contributions will determine the amount of the management fee (if applicable) and premiums charged by Zurich.

The following table summarises what payment methods are available based on the contribution type:

Contribution type	Payment method				
	Direct Debit	BPAY®	Credit Card	Super Stream compliant method*	Rollover
Personal	✓	✓	✓	✓	×
Self-Employed	✓	✓	✓	✓	×
Spouse	✓	✓	✓	✓	×
Employer (Compulsory)	✓	×	✓	✓	×
Employer – Salary Sacrifice	✓	×	✓	✓	×
Employer – Voluntary	✓	×	✓	✓	×
Rollover	×	×	×	×	✓

To pay by credit card or direct debit from an Australian bank account, you must provide a valid authority to enable the contribution to be deducted when due. Any direct debit instruction you provide is subject to the terms of the Direct Debit Request Service Agreement as set out in the application form. Cheques are not accepted.

If you choose to pay the premium yearly or half-yearly, contributions can also be made by BPAY®. If you choose to make contributions by BPAY®, Zurich will provide you with payment instructions each year.

As these accounts do not offer a superannuation savings or investments facility, the Trustee cannot accept contributions in excess of the premiums due. The Trustee is also unable to accept Government contributions into these accounts. If the Trustee is unable to accept or allocate money to your account, the money will be returned without interest. Any interest earned on the unallocated money while in the Fund's bank account will be allocated to the Fund's General Reserve.

® Registered to BPAY Pty Ltd ABN 69 079 137 518. Only available if premiums are paid yearly or half-yearly.

* SuperStream is the prescribed mechanism for employers to make super contributions on behalf of their employees by submitting data and payments electronically in a consistent and simplified manner prescribed by the Australian Taxation Office (ATO) as part of their regular payroll cycle.

Eligibility to contribute to superannuation

To make contributions to the Fund, certain conditions must be met under superannuation law, depending on your age and who is making the contribution. Generally, you are eligible to contribute to superannuation (or have voluntary employer contributions made on your behalf) on or before the 28th day after the end of the month in which you turn 75, and subject to contribution caps.

From 1 July 2022, there have been changes to the eligibility age in respect of the work test for personal superannuation contributions.

Please visit **www.ato.gov.au** for more information in relation to work test changes. .

If you are not eligible to contribute to superannuation, you may wish to contribute via rollover from another complying superannuation fund, in which case your membership of the Fund can continue. If you are over the age of 75 and do not inform the trustee whether or not you are eligible to contribute to superannuation, the trustee may transfer the ownership of the policy to you so you can apply to convert your cover to a non-superannuation policy.

For information about the documentation needed to convert your cover to a non-superannuation policy, or to discuss changing the payment type to rollover, contact Zurich's Customer Care team on 131 551.

Under superannuation law, we cannot accept personal contributions from you or your spouse, including personal tax-deductible contributions, if we do not hold your Tax File Number (TFN).

To make contributions, certain conditions must be met

as determined by the Trustee as set out in this PDS. This includes the condition that you provide us with your TFN when you apply for membership of the Fund[1].

Where contributions have been paid to Zurich for the purpose of paying insurance premiums during a period when you were over the age of 75, those premiums will not be refunded by Zurich. This is because Zurich provides insurance cover for the period the premiums have paid for. Zurich is not responsible for monitoring eligibility to contribute.

Limits on superannuation contributions made each financial year

Government contribution caps limit the amount of contributions that can be paid into the superannuation system for you each financial year, whether they are made to one or more superannuation funds. It is your responsibility to ensure you do not exceed these caps. Taxation penalties may apply where these caps are exceeded, usually levied on you directly. For information about the contribution caps, refer to ato.gov.au.

Tax on contributions

Generally the Trustee is required to pay tax of 15% on concessional contributions (employer contributions and, if you are eligible, personal contributions that you advise the Trustee you intend to claim as a tax deduction against your personal income where the Trustee acknowledges your intended claim). Premiums paid are generally tax deductible to the Trustee, so that any tax payable on contributions will be offset by the amount of the tax deduction available. If the amount of tax payable on contributions (including personal contributions for which you intend to claim a tax deduction against your income) cannot be met by the Trustee, the Trustee may not acknowledge your intended claim.

An additional 15% tax liability for certain concessional contributions may apply if your combined income and concessional contributions for Division 293 purposes exceeds $250,000 in the financial year. In this case, the ATO will issue you a Division 293 notice, if you receive a notice from the ATO, you should not elect for amounts to be released from the Zurich Plan, as you do not have an account balance in the Zurich Plan.

If you pay premiums by making non-concessional contributions (for example, where you are not eligible to claim a tax deduction for personal contributions, or your spouse makes non-deductible contributions for you) the Trustee will not pass on to you the benefit of any tax deduction on premiums.

Paying premiums by rollover from another superannuation fund

If your premiums are paid yearly, you may pay by rollover from another superannuation fund. If you choose this option, you must provide a valid authority that instructs the Trustee to request from your nominated fund the amount required. You may do this by providing an Enduring Rollover Authority, which allows the Trustee to request your nominated fund to roll over benefits each year until you revoke the instruction. Your nominated fund may apply limits or other conditions on rollovers, including partial rollovers, such as minimum withdrawals or limiting the number of allowable rollovers in a 12 month period, and may charge fees for processing your request. You should check the terms and conditions with your nominated fund, and ensure there is a sufficient balance in your account to cover the rollover each year.

[1]You are not required by law to provide us with your TFN, However, if you would like to participate in this product, your Tax File Number is necessary.

If you roll over from another complying taxed superannuation fund, the Trustee's current practice for members with cover through a Zurich Wealth Protection or Zurich Active policy is to pass on the benefit of the tax deduction available for premiums, by reducing the rollover amount required by 15%. For example, if the premium due (including management fee and stamp duty) is $1,000 and the value of the tax deduction is $150, the portion of the premium to be paid by the partial rollover is reduced to $850. The result is that the premium you pay is reduced by 15%. You will be notified of the reduced amount required before the partial rollover request is sent to your nominated fund. Notice will be given to you if this practice changes. As the provision of this reduction relies on the Trustee exercising its discretion, the Trustee may reduce or cease applying this reduction at any time in the future where the Trustee considers it appropriate to do so. The Trustee is unable to accept rollovers that have an untaxed element. You should check if your nominated superannuation fund is an untaxed fund before arranging a rollover.

The Trustee is unable to accept rollovers that contain United Kingdom (UK) transfer or New Zealand KiwiSaver transfer amounts for the Zurich Plan. The Trustee is also unable to accept rollovers that are not equal to the specific amount due. Rollovers that cannot be accepted will be returned in full to the transferring superannuation fund. If a rollover is returned, you will be requested to provide alternate instructions so that the premium can be paid.

Non-payment of premium

Contributions or rollovers must be received when the premium is due for payment. Under the administrative arrangement, Zurich will notify you directly of the premium obligations. If contributions or rollovers are not received by Zurich when the premium is due, Zurich may be entitled to cancel the insurance after giving notice to you.

If a payment sufficient to meet the amount due is not made by the date notified, Zurich will then cancel the insurance and you will cease to be a member of the Zurich Plan.

The Trustee is not responsible for ensuring your insurance cover does not lapse due to insufficient or late premium payments. You may have to re-apply for insurance cover if it lapses, and any application may be declined. Insurance cover may cease in other circumstances.

Cooling-off period

Zurich provides a 30 day cooling-off period during which time you can cancel your insurance for any reason (for example, if you decide that it does not meet your needs). If you cancel insurance during the cooling-off period, your membership of the Zurich Plan will also cease. You will be entitled to a refund of the premium (including any management fee if applicable) paid to Zurich. Any amount in the Zurich Plan that is subject to preservation will be repaid by way of transfer to another complying superannuation fund. Please see the 'Refunds' information provided on the following page.

If you wish to use the cooling-off period, you must not have made a claim and must notify Zurich (in writing or by phone and include the details of the superannuation fund you would like your refund transferred to – see Zurich's contact details on page 14) within 30 days of the earlier of:

- the date you receive your copy of the policy schedule from Zurich; or
- the end of the 5th day after the policy was issued, and your membership commenced.

Varying your insurance cover

After you become a member of the Zurich Plan, you can apply to make changes to your insurance (such as vary the type or amount of insurance cover) at any time. For example, you may increase the amount of your death, TPD or income protection cover, subject to Zurich's assessment of your application and approval, and payment of applicable premiums. If you want to increase your cover, you will need to complete the Zurich Insurance Application Form. Other alterations to your cover can be made with a letter or a short application form, depending on the change. For information about the documentation needed to vary your cover, contact Zurich's Customer Care team on 131 551.

Eligibility criteria and minimum and maximum insurance amounts apply. Refer to the relevant Zurich PDS for information. Any changes will be effective only if Zurich accepts your application and will be shown in a revised policy schedule, a copy of which will be provided to you.

Cessation of cover (and membership)

Insurance cover ceases in certain circumstances as described in the applicable Zurich PDS including termination of the applicable insurance policy by you (in writing, by a notice provided to Zurich), on your death or when the benefit expiry date is reached. Your insurance cover in the Zurich Plan may also cease if you have related cover under a non-superannuation Zurich insurance policy.

At any time while you are a member of the Zurich Plan, or within 30 days of leaving the Zurich Plan, you can apply to have cover converted to a non-superannuation policy by contacting Zurich.

For further information about the cessation of cover, refer to the relevant Zurich PDS and your policy schedule. Transferred insurance-only members should refer to the disclosure documents previously provided to them while a member of the Zurich Master Superannuation Fund, or the Macquarie Superannuation Plan, which can be obtained on request by contacting Zurich using the General Enquiries details shown on page 14.

Refunds

Superannuation contributions and rollovers received into the Zurich Plan (which the Zurich Plan cannot accept or retain because it does not offer a superannuation savings or investments facility) are subject to superannuation preservation rules. In cases where a premium is refunded by Zurich to the Trustee (for example, a part refund of yearly premium where cover is cancelled before the next cover anniversary, or a full refund of the initial premium paid where cover is cancelled in the cooling-off period), the refund must be rolled over to another complying superannuation fund unless you satisfy a condition of release.

If you paid your premium via a rollover, your premium is reduced by 15%, therefore reducing the amount required to be rolled over. In the case of a refund, your refund amount is based on the rollover amount received (from your superannuation fund), not the gross premium amount.

The Trustee may also voluntarily transfer amounts to the ATO in certain circumstances where the trustee believes it is in the best interests of that member.

Should an amount be transferred to the ATO:

- the ATO will be able to proactively transfer that amount to a person's active superannuation account; and
- information about ATO-held superannuation will be available to members at ato.gov.au or through a myGov account linked to the ATO.

The Trustee will provide members with prior written notice of transfers to the ATO.

Benefit payments and tax

Death, terminal illness and total and permanent disability benefits can only be paid to eligible members in the form of a lump sum. Income protection benefits are paid to eligible members in the form of a regular income stream.

To claim a benefit, you must satisfy Zurich's claim requirements. For information about this, refer to the relevant Zurich PDS.

Zurich will pay the insurance benefit as soon as the requirements in your policy have been satisfied. Payments will not be made under the policy until the Trustee has determined to whom the benefit must be paid. This might be you, your beneficiary, your legal personal representative or one or more of your dependants. In the case of death benefits, you may nominate your beneficiaries (see page 10).

The Trustee will only pay the amount it is entitled to receive from Zurich less any tax that must be withheld. Any benefits paid are treated as superannuation benefits for tax purposes. Where required, tax payable on a benefit will be withheld before an amount is paid by or on behalf of the Trustee. In some cases where a superannuation benefit is payable, the Trustee may direct Zurich to pay the benefit directly to members.

Conditions of release

There are rules in place to restrict when your super can be accessed. Where the terms and conditions of the Zurich policy are met, Zurich pays the insurance benefit to the Trustee. These benefits will generally be categorised as preserved amounts and can only be accessed on meeting a 'condition of release'.

Generally, the Trustee pays your benefits from the Fund as a lump sum. Conditions of release include:

- reaching your preservation age and you have permanently retired
- ceasing a gainful employment arrangement on or after reaching age 60
- reaching age 65, whether you have retired or not
- reaching your preservation age (payment restricted to a transition to retirement pension)
- permanent or temporary incapacity^
- severe financial hardship ^
- compassionate grounds ^
- terminal medical condition^
- death

^ Under superannuation law there are strict qualifying criteria that must be met in each of these circumstances.

Lump sum benefits

Lump sum benefits will not be paid until the Trustee has determined to whom the benefit will be paid. If a lump sum benefit becomes payable, tax may be deducted before a benefit is paid. Any insurance benefit received by the Trustee from Zurich will not attract investment earnings for the period that it is held in the Zurich Plan, as there is no account balance or investment component for these accounts

The taxation of lump sum death benefits will depend on the relationship between the deceased member and the beneficiary. If the beneficiary is a dependant (as defined under taxation law) of the deceased member the benefit may be paid free of tax. Otherwise, the taxable component of the death benefit will generally be taxed at up to 15% plus the Medicare levy. If the benefit contains an untaxed element then a tax of 30% plus the Medicare levy can apply. Refer to page 10 for information about who qualifies as a 'dependant'. You should note that an adult child (aged 18 or more) is not a dependant for taxation purposes, unless they otherwise are financially dependent on the deceased member or in an interdependency relationship with the deceased as defined in superannuation law.

The taxation of lump sum benefits that qualify as a permanent incapacity benefit will depend on your age and other circumstances. If you are aged 60 or more, the benefit is generally tax free unless it includes an untaxed element. If you are under age 60, any tax-free component can be received free of tax. The balance of the benefit may be taxable, depending on whether you have reached your preservation age and you meet the taxation definition of Disability Superannuation Benefit.

Your preservation age depends on your date of birth as follows:

Before 1/7/1960	age 55
1/7/1960 – 30/6/1961	age 56
1/7/1961 – 30/6/1962	age 57
1/7/1962 – 30/6/1963	age 58
1/7/1963 – 30/6/1964	age 59
From 1/7/1964	age 60

If you are at or above your preservation age but under age 60, the taxable component up to the low rate cap amount ($245,000 for the 2024/2025 financial year, which may be indexed in future years) is received tax free. The taxable component above the low rate cap amount will be taxed at a maximum rate of 15% plus the Medicare levy. If you are under your preservation age, the taxable component of the benefit will be taxed at a maximum of 20% plus the Medicare levy.

In order to meet the taxation definition of Disability Superannuation Benefit, the Trustee will require certificates from two legally qualified medical practitioners confirming that because of the ill health, it is unlikely that you can ever be gainfully employed in a capacity for which you are reasonably qualified because of education, experience or training.

Terminal illness benefits that qualify as the payment of a benefit to a person with a terminal medical condition (requiring the Trustee to be satisfied that you are

suffering a terminal medical condition as defined in superannuation law) are tax free. This tax treatment applies if, in summary, the following circumstances exist:

- two registered medical practitioners have, jointly or separately, certified that the person suffers from an illness, or has incurred an injury, that is likely to result in the death of the person within a 24 month period after the date of the certification (the certification period);
- at least one of the medical practitioners is a specialist practising in an area relating to the illness or injury suffered by the person; and
- for each of the certificates, the certification period has not ended.

Income benefits

The benefits paid under your income protection insurance (in the form of regular income payments that qualify as temporary incapacity benefits under superannuation law) must be included in your tax return and will be taxed at your marginal income tax rate. This tax treatment applies if, in summary, you ceased to be gainfully employed (including if you have ceased temporarily to receive any gain or reward under a continuing arrangement for you to be gainfully employed) due to ill-health (whether physical or mental) but the ill-health does not constitute permanent incapacity.

Death benefit nominations

This section of this Zurich Plan PDS sets out rules relating to death benefit nominations. You have the option of advising the Trustee how you wish any death benefit to be paid from the Zurich Plan. You may nominate your dependants (as defined in superannuation law) or a legal personal representative to receive a lump sum benefit.

To make a nomination simply complete and return the original or a scanned copy of the Binding Death Benefit Nomination (non-lapsing) form. The form is available on the Zurich website at zurich.com.au or by calling Zurich's Customer Care team on 131 551.

In order to be valid and effective your nomination must meet the following criteria:

- it is made in writing and signed by you in the presence of two witnesses who are over 18 years of age and not named as beneficiaries in your nomination;
- it clearly identifies the proportions in which the death benefit is to be allocated between nominated beneficiaries, if more than one;
- it must not be signed by an attorney or any other agent on your behalf;
- it complies with any other form and content requirements of the Trustee from time to time.

To remain a valid and effective nomination, a nominated beneficiary must still be a dependant at the time of death. If your nomination, or a part of it, is no longer valid and effective at the time of payment, the Trustee cannot pay the death benefit (or that part of it) in accordance with the nomination and will, instead, apply the process set out below.

The nomination will also cease to be valid and effective if you revoke it, it lapses in prescribed circumstances or you make a new valid and effective nomination.

A nomination only applies to the death benefit payable under each particular insurance product you hold, for which a nomination has been made. There can only be one nomination in place for each insurance product at any given time. Therefore if you hold multiple products any subsequent nomination in respect of a product revokes a prior nomination in respect of that product only – which may mean you need to make multiple nominations. You may revoke or change your nomination in respect of a product at any time by completing a new Binding Death Benefit Nomination (non-lapsing) form.

You should periodically review each of your nominations to ensure you still wish for the Trustee to pay the person(s) you have nominated, because it will not automatically become invalid after a fixed period of time. To amend or revoke a nomination, you must complete and return a new Binding Death Benefit Nomination (non-lapsing) form.

Details of any nomination that you have made will be included in your annual statement, however the validity and effectiveness of any nomination is only determined by the Trustee as at the date of death.

Definition of dependant

Under superannuation law, a dependant includes:

- your current spouse (including de facto spouse) of either gender;
- your children of any age (including adopted children, stepchildren and your spouse's children);
- someone who is financially dependent on you; or
- someone with whom you have an 'interdependency relationship'.

Two people have an 'interdependency relationship' if the criteria in superannuation law is satisfied. This includes:

- they have a close personal relationship; and
- they live together; and
- one or each of them provides the other with financial support; and
- one or each of them provides the other with:
  - domestic support and personal care, but not if one of them provides domestic support and personal care to the other under an employment contract or a contract for services or on behalf of another person or organisation such as a government agency, a body corporate or a benevolent or charitable organisation; or

– support or care of a type and quality normally provided in a close personal relationship, rather than by a mere friend or flatmate.

Two people also have an interdependency relationship if they have a close personal relationship but they do not meet the other requirements of interdependency because:

- either or both of them suffer from a disability including a physical, intellectual or psychiatric disability; or
- they are temporarily living apart.

Please note, children aged 18 or more are not considered to be dependants for taxation purposes unless they satisfy the definition of dependant in superannuation law in some other way. Depending on who you nominate there may be different taxation consequences. You should obtain taxation advice about this, having regard to your personal circumstances.

Definition of legal personal representative

Your legal personal representative, for the purpose of any distribution of death benefits, usually means the executor of the will or administrator of the estate of a deceased person.

What if the binding nomination lapses in prescribed circumstances?

In such cases, your nomination will become wholly ineffective. This means an entire nomination will become automatically invalid in the event of marriage, divorce or entering or ending an equivalent de facto relationship.

What if a nominated beneficiary is not your dependant or your legal personal representative?

In such cases, the nomination relating to the portion of the benefit attributable to that nominated benefit will be ineffective.

No nomination

Where there is no binding death benefit nomination or a binding death nomination has been made but it is ineffective in whole or in part, the Trustee must pay the death benefit (or applicable proportion) in accordance with the Trust Deed. This generally means that the benefit will be paid to your legal personal representative (which may include an executor named in your will without a grant of probate where the death benefit is less than the probate limit of $350,000), unless the Trustee:

- has not identified your legal personal representative or a person who has filed an application for grant of probate or letters of administration within six months of the Trustee being notified of your death; or
- is notified, by a person that the Trustee considers reasonably qualified to form the view, that your estate (excluding, for this purpose, the death benefit) is insolvent because the estate's assets (excluding, for this purpose, the death benefit payable from the Fund) will be exhausted in meeting the estate's liabilities.

If either of the above apply, the benefit is instead paid to your spouse or, if none, your children (including an unborn child) in equal shares (where there are more than one). If you have more than one spouse at the date of death, the benefit is paid to them in equal shares. Note that a person is only a 'spouse' or a 'child' if the Trustee is aware of the person's existence and is satisfied of their status as such.

If you have no spouse or children, the benefit is paid to your legal personal representative (even if your estate is insolvent) or, if the benefit is not paid to your legal personal representative, it must be dealt with as unclaimed money under government legislation.

Risks of holding insurance through superannuation

There are risks you should consider before deciding to hold insurance through superannuation, including:

- In addition to the terms and conditions of the applicable insurance policy which govern the grant of insurance cover, and payment of benefits, by Zurich to the Trustee, insurance benefits through superannuation are also subject to superannuation law and the Brighter Super Trust Deed. In relation to the insurance benefits provided by the Trustee, if there is any inconsistency between the applicable insurance policy and the Trust Deed, the Trust Deed prevails.
- If you change your mind about holding insurance (during the cooling-off period – see page 7) you will not usually be able to obtain a refund of premiums in cash (preservation rules mean that the refund will usually have to be paid to another superannuation product).
- A benefit paid from superannuation is a benefit for tax purposes. Depending on your tax circumstances, it may be subject to more tax than would otherwise apply if the benefit was paid from the same insurance held outside of superannuation.
- Limits apply to the amount you can contribute to superannuation each year. Any contributions you make to the Fund in order to pay premiums will reduce the amount you may be able to contribute to other superannuation accounts you hold for retirement savings purposes.
- Where you choose to pay premiums by rollover from another superannuation fund, your retirement savings will be reduced so that you may have less available to you on retirement than otherwise may have been the case.
- Taxation or superannuation law may change in the future, altering the suitability of holding insurance in superannuation.

These are risks of holding insurance through superannuation. For details on the risks applicable to the insurance itself, please refer to and consider the information provided on risks within the relevant Zurich PDS.

Your financial adviser and how to apply

This superannuation product (including the insurance available through this product) is available through financial advisers. Your financial adviser may act as your agent and lodge on your behalf an application for membership of the Zurich Plan. If your application is accepted, Zurich may pay your financial adviser a commission for selling the insurance. You can obtain details from your financial adviser of any commission paid. The commission is paid by Zurich out of insurance premiums it receives from the Fund. Commissions are not paid by the Trustee.

Your financial adviser can assist you to make an application for membership of the Fund, along with an application for insurance. If your financial adviser lodges an online application on your behalf, the financial adviser is required to confirm that they have authorisation to act as your agent. It is your responsibility to ensure that the information provided to Zurich and the Trustee by your financial adviser is accurate and complete. The Trustee and Zurich will rely on the accuracy of the information provided via the online application as if a paper application was signed and submitted by you.

Applications for membership of the Zurich Plan can only be accepted after the insurance application has been accepted by Zurich. In accepting your application, the Trustee and Zurich will rely on declarations and authorisations made by you, either directly or via your agent, relating to the following matters:

- You have appointed your financial adviser to act on your behalf in relation to the application and, if you choose to submit an online application, you have appointed your financial adviser to help you complete and submit the application.
- You have received this PDS and the relevant Zurich PDS for the insurance product(s) you have chosen to apply for.
- You confirm the information supplied in connection with the application, such as information about your health, financial situation, lifestyle and pastimes, is true and correct and no information material to the application has been withheld.
- You authorise the collection of premiums from the account designated in the application, and where you have designated a bank account, you confirm you have received a copy of the Direct Debit Request Service Agreement.
- You have read the Privacy Statement (see page 13) and the Anti-money laundering and counter-terrorism financing requirements (see page 13) contained in this PDS.
- Where you have chosen to have premiums paid by making new contributions to superannuation, you are eligible to do so under superannuation law.

Tax file number collection

Collection, use and disclosure of tax file numbers (TFNs) by superannuation funds is authorised under superannuation law. The Trustee will only use your TFN for purposes authorised by law. The purposes may change in the future as a result of legislative change.

The purposes currently authorised include:

- taxing benefit payments at lower rates than may otherwise apply;
- passing your TFN to the ATO;
- allowing the Trustee to provide your TFN to another superannuation provider if your benefit is transferred to that provider. However, the Trustee will not do so if you advise in writing that you do not want it to be passed on; and
- locating accounts in the Fund or, with your consent, consolidating certain accounts within the superannuation environment.

Declining to quote your TFN is not an offence, however, if you do not provide your TFN:

- the Trustee cannot accept contributions made by you or someone on your behalf (other than your employer);
- certain concessional contributions and other amounts may be subject to an additional no-TFN tax;
- you may pay more tax on your superannuation benefits than you have to; and
- it may be more difficult to find your superannuation benefits if you lose contact with your superannuation fund.

As a consequence, the Trustee has determined that it will not accept your application for membership of the Fund until you provide your TFN.

Trustee Privacy Policy

Brighter Super respects the privacy of your personal information. You can find out how we use and protect your personal details by getting a copy of our Privacy policy at brightersuper.com.au/about-us/governance/reports-and-policies/privacy. A paper copy of our privacy policy can be provided free of charge on request.

The way in which Zurich collects, uses and discloses your personal and sensitive information (personal information) is explained in Zurich's Privacy Policy. Please refer to the Zurich Wealth Protection and Zurich Active PDS for information on how your personal information will be used.

Anti-money laundering and counter-terrorism financing requirements

As a result of anti-money laundering and counter-terrorism financing requirements in Government legislation, you may be required to provide proof of identity prior to being able to access your benefits in cash (called 'customer identification and verification' requirements).

These requirements may also be applied by the Trustee from time to time in relation to the administration of your superannuation benefits as required or considered appropriate under the Government's legislation. You will be notified of any requirements when applicable. If you do not comply with these requirements there may be consequences for you, for example, a delay in the payment of your benefits.

If requested, you agree to provide additional information and assistance and comply with all reasonable requests to facilitate the Trustee's and Zurich's compliance with AML/CTF Laws in Australia or an equivalent law in an overseas jurisdiction and/or its internal policies and procedures.

You undertake that you are not aware and have no reason to suspect that:

- the money used to fund the insurance is derived from or related to money laundering, terrorism financing or similar activities (illegal activities); and
- proceeds of insurance made in connection with this product will fund illegal activities.

In making an application pursuant to this Zurich Plan PDS, you consent to the Trustee disclosing, in connection with AML/CTF Laws and/or its internal policies and procedures, any of your personal information as defined in the Privacy Act 1988 (Cth) we have.

In certain circumstances, we may be obliged to freeze or block a payment receipt or benefit payment where it is used in connection with illegal activities or suspected illegal activities. Freezing or blocking can arise as a result of the monitoring that is required by AML/CTF Laws and/or its internal policies and procedures. If this occurs, we are not liable to you for any consequences or losses whatsoever and you agree to indemnify the Trustee and Zurich if they are found liable to a third party in connection with the freezing or blocking of a payment or benefit payment.

The Trustee and Zurich retains the right not to provide services to any applicant that either Trustee or Zurich decides, in its sole discretion, that it does not wish to supply.

Who to contact

In the first instance, enquiries should be directed to Zurich:

General enquiries

Telephone: 131 551

Email: client.service@zurich.com.au

Post: Zurich Insurance-only Superannuation Plan
C/- Zurich Australia Limited
Locked Bag 994, North Sydney NSW 2059

Claims

Telephone: 131 551

Email: life.claims@zurich.com.au

Post: Zurich Insurance-only Superannuation Plan
C/- Zurich Life Claims
Locked Bag 994, North Sydney NSW 2059

You should be aware that all telephone conversations with you or your financial adviser are recorded.

Privacy Officer

Brighter Super

Telephone: 1800 444 396

Email: info@brightersuper.com.au

What to do if you have a complaint

Superannuation law requires the Trustee to take all reasonable steps to ensure that complaints are properly considered and dealt with within 45 days unless an alternative timeframe applies (for example a complaint about a death benefit distribution must be resolved within 90 days of the end of the 28 day objection period).

If you have a complaint, Zurich's Customer Care team is your first point of contact for raising complaints or providing feedback. You can contact Zurich directly via phone, email or in writing and Zurich will resolve your issue fairly, respectfully and efficiently, and will keep you informed of their progress.

If you're not satisfied with our response to your complaint, your concerns will be escalated to Zurich's Dispute Resolution Team who will work closely with you to find a solution quickly and amicably.

Zurich's contact details can be found in the 'Who to contact' section of this PDS.

You can also contact Brighter Super Trustee, the contact details for the Complaints officer are:

Email: complaints@brightersuper.com.au

Telephone: 1800 444 396

Post: Complaints Officer
Brighter Super
GPO Box 264
Brisbane Qld 4001

You may wish to refer the matter directly to the Australian Financial Complaints Authority (AFCA), which provides an independent dispute resolution service that is free to consumers. However, please note that AFCA will usually refer the complaint back to the Trustee for resolution through the Trustee's complaints handling process.

Contact details for AFCA are as follows:

The Australian Financial Complaints Authority

Online: www.afca.org.au

Email: info@afca.org.au

Telephone: 1800 931 678

Post: Australian Financial Complaints Authority
GPO Box 3, Melbourne VIC 3001

Time limits or other limits may apply to complaints to AFCA and so you should act promptly or otherwise consult the AFCA website to find out if or when a time limit relevant to your circumstances expires, or information about other limits.

Further details about the complaints handling process, are available on request by contacting the Zurich Plan administrator.

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Brighter Super Trustee
ABN 94 085 088 484, AFSL 230511, RSE L0000178
Level 20, 333 Ann Street, Brisbane QLD 4000
GPO Box 265, Brisbane QLD 4001

Zurich Australia Limited
ABN 92 000 010 195, AFSL 232510
Zurich Customer Care: 131 551
Email: client.service@zurich.com.au
Website: zurich.com.au

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