COMBINED PRODUCT DISCLOSURE STATEMENT AND POLICY DOCUMENT

TAL Group Plus Life Insurance

Combined Product Disclosure Statement and Policy Document

Issue date 28 June 2024

Insurer & Issuer
TAL Life Limited
ABN 70 050 109 450 AFSL 237848

TAL

Important Information

This section describes the purpose of this document, the Combined Product Disclosure Statement and Policy Document (PDS), and how it should be used. A paper copy of the PDS is available on request without charge.

This PDS, together with the Schedule, form the terms and conditions of the Policy. They set out the terms and conditions relating to the cover available for death only or death and Total and Permanent Disablement as well as Interim Accident Cover and Terminal Illness.

This PDS and the Schedule also explain who can be covered, when cover is provided automatically, when an Eligible Person must apply for cover, when an Eligible Person is entitled to apply to the Insurer for cover to continue under an individual insurance policy issued by the Insurer and when an Eligible Person is no longer covered under this Policy.

Terms and headings used in this PDS

There are a number of terms in this PDS and the application form which have a particular meaning. Where a defined term is used in this PDS or an application form, the first letter of each word is capitalised. For example:

- 'Insured Person' refers to an Eligible Person who has cover under the Policy and in relation to whom you have paid, or have agreed to pay, a premium;
- 'Insurer' refers to TAL Life Limited (ABN 70 050 109 450, AFSL 237848);
- 'Policy Owner' refers to the entity that legally owns the Policy

'The only exceptions are 'we', 'us' and 'our', which refer to the Insurer, and 'you' and 'your', which refer to the reader of this PDS.

Headings have been included to assist understanding, but they do not alter how clauses are to be interpreted (unless stated otherwise or the context indicates the contrary). Where the context provides for it, words indicating the singular can be taken to mean the plural and vice versa.

About this PDS

This PDS provides important information about TAL Group Plus – Life Insurance.

It is recommended that this PDS is read fully before making any decision to purchase or continue to hold TAL Group Plus - Life Insurance.

Any information contained in this PDS is of a general nature only. It does not take into account individual financial situations, needs or objectives.

If you need help in deciding whether to hold this product or any financial products in general, we recommend that you speak to a licensed financial adviser.

If you do not have a financial adviser, please contact us and we can put you in touch with someone who can help.

The information within this PDS is current as at the date of issue.

From time to time the information in this PDS which is not materially adverse may be updated by publishing a note of the change on the Insurer's website www.tal.com.au. Free paper copies of the updated information are available by calling 1800 130 869. If the change is materially adverse, the Insurer will issue a supplementary or replacement PDS.

The Insurer reserves the right to change matters which do not form part of the PDS. This includes administrative matters.

Issuer and Insurer

TAL Group Plus - Life Insurance is issued by:
TAL Life Limited ABN 70 050 109 450
AFSL 237848

Need help?

If you have any questions, you can contact the Insurer on:
T: 1800 130 869
E: corporateadmin@tal.com.au
W: www.tal.com.au.
P: GPO Box 5380 Sydney NSW 2001

The Policy Owner

The Policy is owned by the Policy Owner.

Although cover is provided to Insured Persons, they do not actually own the Policy. If a claim needs to be made by or in respect of an Insured Person, the Policy Owner must first be contacted. The Policy Owner then claims on the Policy. If the claim is accepted by the Insurer, it is paid to the Policy Owner and the Policy Owner then pays any benefits to the Insured Person or their dependents or legal personal representative.

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About TAL

As a leading Australian life insurer, TAL has been protecting people, not things, for over 150 years. Together with our partners, we protect more than 5 million customers and their families, so they have the freedom to keep living the life they planned, no matter what happens.

At TAL, paying claims is the most important thing we do. We're there for customers when they need us most, and we strive to deliver a leading insurance experience and the best possible outcomes. That's why, in financial year 2023, TAL paid $4.2 billion in claims to 50,128 customers and their families, providing support when they needed it most.^

Life Insurance Code of Practice

We have adopted the Life Insurance Code of Practice (the Code) which sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest. It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers as well as how insurers will assess your claim if your policy has a medical definition which specifies an obsolete method of diagnosis or treatment that is no longer used in mainstream medical practice in Australia.

The Code covers many aspects of a customer's relationship with their insurer, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support.

More information can be found on our website, at tal.com.au/code-of-practice.

^ Based on customer covers in force across Group, Retail and Direct and there may be duplicate lives insured. Claims statistics based on total claims paid under TAL Life Limited and TAL Life Insurance Services Limited insurance products (including funeral insurance) between 1 April 2023 and 31 March 2024.

TAL Group Plus – Life Insurance

What is TAL Group Plus – Life Insurance?

TAL Group Plus – Life Insurance is a group insurance product that offers life (including Terminal Illness) and Total and Permanent Disablement cover to corporations and Incorporated Associations seeking to insure a minimum of 5 lives.

Employees, Contractors, Members and, where selected in the Schedule, Spouses, may also be eligible to apply for cover under the terms of the Policy held by the Policy Owner.

To understand who this product has been designed for, the different types of cover, and if the cover is likely to be consistent with your needs, objectives and financial situation, you can review the Target Market Determination (TMD) which can be found at: **tal.com.au** or speak with your financial adviser.

What types of cover are available?

The easy reference table below provides a quick summary of the Benefits and features of cover that are available for selection. Please read the relevant section of this PDS for full details.

BENEFITS & FEATURES	BRIEF DESCRIPTION	SECTION
Death Benefit	A lump sum Benefit is paid to the Policy Owner if an Insured Person dies.	**8.1**
Terminal Illness Benefit	A lump sum Benefit is paid to the Policy Owner if the Insured Person suffers a Terminal Illness.	**8.2**
Total and Permanent Disablement (TPD) Benefit	A lump sum Benefit is paid to the Policy Owner if the Insured Person becomes Totally and Permanently Disabled.	**8.3**
Interim Accident Cover	Provides cover for an Accident during the underwriting process.	**7**
Automatic Cover	Cover is provided to Eligible Persons without underwriting.	**4**
AAL uplifts	An Insured Person may automatically receive an increase in the AAL where there is an increase in the AAL under the Policy. If available under the Schedule, the increase applies to Insured Persons with cover prior to the increase, including those who have been previously declined an increase in cover above the AAL or had any increase in cover above the AAL subject to loadings or exclusions.	**4.4**
Underwritten Cover	An amount and type of cover where an Eligible Person is required to provide Evidence of Insurability.	**6**
Underwriting loadings	Premium loadings are waived for Underwritten Cover, reducing costs and simplifying administration. Application loadings will continue to be recorded and may apply for other purposes, such as Continuation Options.	**6.4**
Cover during Employer Approved Leave	Up to 24 months continuous cover whilst on Employer Approved Leave.	**9**
Overseas cover	Cover is provided 24 hours a day, all year round, with no restrictions on location or time spent temporarily overseas, subject to meeting certain conditions.	**10**
Contractors	Cover is available for eligible Contractors with a written contract for services with an Employer for a minimum of 15 hours per week for a continuous 6-month period.	**3.1**
Extended cover	Up to 60 days additional cover after the Insured Person ceases to be an Employee, Contractor, Spouse or Member.	**12**
Continuation Option	If available under the Schedule, an Insured Person may apply for death only or death and TPD cover under an individual policy with the Insurer without providing health evidence when their cover ends under the Policy. The Continuation Option is not available for Spouse cover option.	**13**
Premium frequency	Monthly, quarterly, half-yearly or annually. For premium frequencies other than annually, a 3% loading applies.	**17**

Cover limits and Benefit Design options

The below table sets out the different cover limits and Benefit Design options that apply to TAL Group Plus Group Life Insurance unless otherwise stated in the Schedule:

FEATURE	LIMITS AND AVAILABLE OPTIONS
Eligible Age Range	16- 65 or 70
Maximum Cover Limit	Death: $3 million Terminal Illness: $3 million TPD: $3 million
Benefit Ceasing Age	Death: 65 or 70 Terminal Illness: 65 or 70 TPD: 65 or 70
Minimum number of lives	5
Cover available	• Death only (including Terminal Illness) • Death (including Terminal Illness) and Total and Permanent Disablement
Benefit Designs available for Sum Insured	• Fixed amount of cover • Formula based amount of cover • Unitised scale of cover
Total and Permanent Disablement (TPD) definition options	Total and Permanent Disablement definitions available for the Policy Owner to choose from which, when selected, will be on the Schedule: • Similar Occupation; • Usual (Own) Occupation; • Specific Medical Conditions; and • Everyday Work Activities and Psychiatric Impairment.
Terminal Illness Certification Period options	• Not more than 12 months • Not more than 24 months
Spouse cover option	There is the option to provide cover for a Spouse.

1

Before a TAL Group Plus – Life Insurance Policy starts

1.1 Who can apply for group insurance?

The invitation to purchase a TAL Group Plus – Life Insurance Policy is only made to Australian-registered corporations and Incorporated Associations receiving this PDS in Australia.

Under these circumstances, the applicant will be the Policy Owner and a Policy will be issued to the Policy Owner.

1.2 Information required for a quotation

For the Insurer to provide group insurance, a quotation must first be provided. So that we can provide a quotation, we will need the following information on the group of persons to be insured. This information includes:

- age;
- gender;
- occupation;
- location (including if temporarily outside Australia);
- salary;
- hours worked per week (Full time Basis or part time);
- employment type (permanent or contractor)
- unique identifier (for example payroll number, Member number);
- claims history (if insured previously);
- the selected Benefit Design.

We may require further information to enable us to assess the risk more accurately and provide the most reasonable and sustainable price for your insurance.

Once we inform you of the information we require, a quotation will be issued to you.

It is important that the information you provide is accurate.

The Insurer reserves the right to alter or withdraw the quotation, should the information be found to be inaccurate or incomplete.

Please also refer to section 18.3 which has information about your duty to take reasonable care not to make a misrepresentation.

1.3 Accepting the insurance quotation

To apply for group insurance, you must complete the prescribed application form (and provide any other information required by the Insurer) and submit it, together with the premium requested by the Insurer, on or before the requested date for commencement of the Policy.

Please make sure the completed application form is consistent with the quotation provided by the Insurer. The commencement of the Policy is subject to the Insurer accepting the application and receipt of the required premium.

1.4 Other important information about insurance risks

You should be aware that certain limitations and exclusions will apply under the Policy. This means that in some cases, the Insurer will not pay a claim or will pay a claim only in limited circumstances; cover may be reduced; or cover will cease. Full details of these limitations and exclusions can be found in section 14 of this PDS.

There are important risks which should be considered when deciding to purchase this product, including:

a. selected Benefits may not provide adequate financial protection for the Insured Persons covered under the Policy;

b. claims will not be paid if the criteria to make a claim are not met or an exclusion applies (see section 14);

c. cover may be altered by an exclusion or limitation (described in section 14) or change in terms at a specified date;

d. Benefits may be reduced, declined or withheld under circumstances described in section 19;

e. claims may not be paid, the Insurer may cancel and/or avoid the Policy, the terms may be changed or an insured Benefit may be reduced where there is a failure to comply with the duty to take reasonable care not to make a misrepresentation (see section 21.3) or in accordance with our legal rights under the *Insurance Contracts Act 1984* (Cth);

f. that the insurance cover under the Policy may be cancelled if the Policy Owner has failed to pay premium by the due date (see section 18)

g. that the Insurer is not bound to accept your application;

h. that the cost of the Policy can increase from year to year due to a range of factors (see section 20);

i. any Special Conditions agreed between the Policy Owner and the Insurer will be stated in the Schedule when it is issued; and

j. the Insurer's offer of Underwritten Cover to an Eligible Person may be subject to exclusions, restrictions or additional conditions that we may reasonably consider to be appropriate and application loadings will continue to be recorded (although not charged).

Accordingly, it is important that this PDS is read together with the relevant quotation received prior to making an application for cover.

2

Policy information

2.1 The Policy Owner

All Benefits payable under the Policy are paid to the Policy Owner, unless otherwise instructed in writing by the Policy Owner.

2.2 The Policy

The Policy is a legal contract of life insurance between the Insurer and the Policy Owner.

The documents issued by the Insurer that make up the Policy are:

a. this PDS as at the Start Date; and

b. the Schedule.

Neither the PDS (on its own without a Schedule) nor the insurance quotation constitute a legally binding contract of insurance. A contract of insurance is only formed, and cover is only provided from the Start Date once all the following events have occurred:

a. the Insurer has accepted the completed application and issued the Schedule;

b. the Insurer has issued an on risk letter, advising the Start Date and confirming issue of the Policy; and

c. the Policy Owner has paid the Insurer the requested premium or deposit premium.

The Schedule must be signed and returned to the Insurer as evidence of the Policy Owner's acceptance of the Insurer's offer of insurance.

2.3 Cooling off period

The Policy Owner may cancel the Policy within 14 days of the earlier of:

a. the date the Policy Owner receives the Insurer's on risk letter and the Schedule confirming issue of the Policy; and

b. the end of the fifth day after the Start Date.

The Policy Owner may cancel the Policy during the cooling off period by giving the Insurer notice in writing. If the Policy Owner does this before the expiry of the cooling off period and provided there have not been any claims for Benefits under the Policy, the Insurer will terminate the Policy and refund any premiums paid (less any Government Charges the Insurer is unable to recover).

2.4 Benefits

Subject to the Maximum Cover Limits, the Benefits provided for Insured Persons under the Policy are for death, as well as Total and Permanent Disablement (if applicable), as stated in the Schedule. The Policy also provides Terminal Illness as a built-in Benefit of death cover.

Before a Total and Permanent Disablement Benefit can be paid under the Part A or Part B definitions of Total and Permanent Disablement, the Insured Person must have been continuously unable to return to Gainful Employment from the Date of Claim for a period of at least three consecutive months. Under the Part D definition of Total and Permanent Disablement, the Insured Person must have been unable to perform at least two of the Everyday Work Activities without assistance and despite the use of appropriate aids for at least 12 consecutive months before a Benefit can be paid. This 12 consecutive month period does not apply to an Illness or Injury that is a Specified Medical Condition or where the Illness is a mental disorder.

2.5 Changes to the Policy

Once the Schedule is issued by the Insurer, any subsequent changes or variations to the Policy must be agreed by the Insurer and Policy Owner. However, if there is a change to a law or the way a law is interpreted, including a change to an industry code of practice applicable to the Insurer, the Insurer may also vary the terms and conditions of the Policy. The Insurer may do this where the change means it becomes impossible or impractical for the Insurer to meet its obligations under the Policy or the terms of the Policy would become inconsistent with the law. Refer to section 17.4 for when the Insurer may change Premium Rates.

Any changes will be issued by the Insurer in the form of an endorsement or a revised Schedule.

This section does not restrict the Insurer's ability to change the Policy conditions as permitted under the *Insurance Contracts Act 1984* (Cth) if the Policy Owner or an Insured Person does not take reasonable care not to make a misrepresentation or makes a misstatement of age.

2.6 Policy Owner acknowledgements

In applying for the Policy, the Policy Owner acknowledges:

a. the Insurer has relied on information provided by the Policy Owner or their appointed representative;

b. they have the authority to enter into the Policy; and

c. their appointed representative (if applicable) is their agent in entering into the Policy.

2.7 Policy assignments

The Policy can be assigned in accordance with the *Life Insurance Act 1995* (Cth) with the Insurer's prior written consent. If the Insurer allows the assignment, the assignee will be recorded as the new Policy Owner with all the rights, powers, duties, obligations and privileges of the original Policy Owner.

2.8 Policy Owner obligations

Under the terms and conditions of the Policy, the Policy Owner agrees to:

a. comply with the duty to take reasonable care not to make a misrepresentation set out in section 18.3;

b. pay premiums in accordance with the Policy as outlined in section 17;

c. ensure only persons who are Eligible Persons are advised of the cover and are advised when their cover ends under the Policy;

d. provide the Insurer written details of all Eligible Persons (if details of particular people are not provided, they will not be eligible for insurance cover under Automatic Acceptance) on or before the next Review Date;

e. provide the Insurer in writing details of each person who no longer meets the Eligibility Conditions on or before the next Review Date;

f. notify the Insurer in writing of a change in any Eligible Person's employment status which results in a change from their current Category on or before the next Review Date;

g. provide the Insurer in writing any request to provide insurance cover for the Employees or Contractors (and their Spouse, where the Spouse cover option is selected in the Schedule) of any new Employer acquired by the Policy Owner;

h. execute and return the Schedules and any endorsements, if requested to be signed by the Insurer, within 30 days of receipt; and

i. provide the Insurer with all other information and notices it requires under the Policy.

3

Who can have insurance cover under the Policy?

3.1 Eligibility for cover

A person can only become covered under this Policy if they are an Eligible Person. An Eligible Person is someone who:

- **a.** is an Employee, Contractor, Member or Spouse;
- **b.** is an Australian Resident;
- **c.** is within the Eligible Age Range; and
- **d.** satisfies any further Eligibility Criteria and any other requirements agreed to between the Policy Owner and the Insurer from time to time.

A Spouse will cease to be an Eligible Person if they are no longer a spouse or de facto spouse of an Employee, Contractor or Member or that Employee, Contractor or Member ceases to be an Insured Person.

3.2 Becoming an Insured Person

An Eligible Person can become an Insured Person in one of the following ways:

- **a.** they are an Eligible Person as stated in section 3.1 above and receive Automatic Cover (refer to section 4 for more information); or
- **b.** they are an Eligible Person and receive cover under Takeover Terms (refer to section 5.2 for further information); or
- **c.** they are an Eligible Person who has applied for Underwritten Cover (refer to section 6) and the Insurer has agreed to cover them.

An Insured Person may have all or a combination of Automatic Cover, cover under Takeover Terms and Underwritten Cover. In the circumstance where an Insured Person has a combination of cover types, the amounts will be added together for the purposes of determining the Benefit amount for the Insured Person.

An Insured Person must be covered for death cover and cannot hold:

- **a.** Total and Permanent Disablement cover only; or
- **b.** Total and Permanent Disablement cover for an amount which exceeds their death cover.

3.3 Benefit Design

The Policy Owner selects the Benefit Design (refer to page 11 for options) for each of the Categories of people to be covered and the Insurer agrees to this when the Policy is issued. The agreed chosen Benefit Design is detailed on the Schedule.

3.4 Categories

An Insured Person is provided cover according to the Benefit Design of the Category that they meet the Eligibility Criteria for, from the date they meet the Eligibility Criteria. The Benefit Design, Category and Eligibility Criteria are all chosen by the Policy Owner and are agreed to by the Insurer. The Benefit Design, Eligibility Criteria, Automatic Acceptance Limit, Forward Underwriting Limit, Maximum Cover Limit and whether cover is available under the Policy as Automatic Cover, under Takeover Terms or as Underwritten Cover can differ between Categories.

Where the Policy Owner notifies the Insurer a particular Eligible Person meets the relevant Eligibility Criteria for a Category, they will become an Insured Person in that Category from the date they meet the Eligibility Criteria. Eligibility Criteria may include (but is not limited to) employment status (e.g. full-time, part-time or casual), length of service with the Employer or length of membership of the Incorporated Association, location of work of the Employee, Contractor, Member or Spouse, type of cover (e.g. Automatic Cover, Takeover Terms cover or Underwritten Cover) or a combination of factors.

An Insured Person may also hold cover under two Categories in some circumstances. For instance, they receive Automatic Cover in Category 1 and apply for Underwritten Cover which is in Category 2.

4

Automatic Cover

4.1 Automatic Acceptance Limit (AAL)

The Insurer may agree to provide Automatic Cover for a Category up to an agreed amount, referred to as the Automatic Acceptance Limit (AAL). An AAL is the maximum amount of cover Eligible Persons in that Category can receive without providing the Insurer any Evidence of Insurability. The amount of any AAL the Insurer agrees to provide depends on several factors including:

- **a.** Benefit Design selected by the Policy Owner;
- **b.** Categories chosen by the Policy Owner;
- **c.** number of insured lives under the Policy;
- **d.** levels of cover; and
- **e.** occupation of the Eligible Persons.

An AAL is only provided where there are clearly defined, objective and non-discretionary eligibility conditions agreed between the Policy Owner and the Insurer and the Sum Insured to which the AAL applies is calculated in accordance with a Benefit Design accepted by the Insurer.

4.2 When an Eligible Person can receive Automatic Cover

Where the AAL is greater than zero for a Category, an Eligible Person in that Category will automatically receive Automatic Cover under the Policy from the later of:

- **a.** the Policy Start Date; and
- **b.** the date they become an Eligible Person.

If an Eligible Person was not At Work on the date Automatic Cover commences, their Automatic Cover will be subject to Limited Cover (refer to section 14).

The amount of Automatic Cover that commences for an Eligible Person will be the lesser of:

- **a.** the Sum Insured calculated using the relevant Benefit Design; and
- **b.** the Automatic Acceptance Limit applicable for the relevant Benefit Design, as per the Eligible Person's Category, as set out in the Schedule.

4.3 Automatic increases in cover under the Benefit Design

Where provided under the Schedule, an Insured Person's Sum Insured may automatically increase in accordance with the Benefit Design applicable to them. The amount of the automatic increase will be restricted to the higher of:

- **a.** the Automatic Acceptance Limit (AAL); and
- **b.** any Forward Underwriting Limit (FUL) applicable to the Insured Person.

Where an increase in cover is restricted, any additional cover above the AAL or FUL (as applicable) for the Insured Person must be underwritten.

Changes to the Sum Insured apply from the date of change but are processed at the next Review Date unless we reasonably agree otherwise in writing. Premiums for the increase in cover commence from the date of change.

Refer to section 14 for circumstances where Limited Cover conditions will apply to automatic increases.

4.4 When can the AAL be changed?

Any AAL will apply for the duration of the Rate Guarantee Period. However, if there has been a change in the Eligibility Criteria, Benefit Design or a change of 25% or more in the number or occupational profile of Insured Persons under the Policy or a particular Category, we reserve the right to increase or decrease the amount of the AAL, by giving the Policy Owner 30 days written notice.

4.5 How do changes in AAL affect existing cover?

Where there has been an **increase** in the AAL, the AAL applicable for all existing Insured Persons may be automatically increased to the new level subject to the following conditions:

- **a.** if an Insured Person's Automatic Cover increases as a result of the increase in the AAL, any existing exclusions or loadings will only apply to any cover above the new AAL; and
- **b.** any specific exclusions or loadings which apply to the Underwritten Cover will continue to apply.

Where the AAL is **decreased**, any existing Insured Persons up to the date of change of the AAL will continue to be subject to the previous AAL. The new decreased AAL will apply to all new Insured Persons (who have never received cover under the Policy) from the date of change of the AAL.

Any cover already provided to an Insured Person will not be reduced or adversely affected by any change in the AAL.

5

Transfer of Cover

5.1 Transfer of cover between Categories

An Insured Person may transfer between Categories as a result of a change in their hours of work (e.g. was part time, now working on a Full-time Basis), location, employment type (e.g., was a Contractor and now an Employee) and the Policy Owner notifies the Insurer by the Review Date of the change. The Insured Person is then transferred to the new Category.

An Insured Person who transfers to a different Category will be provided with cover in their new Category on and from the date of transfer and their cover held under their previous Category on the day before the transfer date, ceases on the day before the date of transfer.

The Insured Person will be provided with cover based on the Benefit Design that applies to their new Category.

Refer to section 14 for details on when Limited Cover conditions apply to new Automatic Cover on transfer between Categories.

5.2 Group takeover terms

In some cases, the Insurer may take over a group insurance policy from another insurer. For this to happen, the proposed cover under the Policy must be comparable to the existing cover under the Previous Policy.

Under Takeover Terms the levels of cover under the Previous Policy may be continued without requiring Evidence of Insurability for groups of Eligible Persons with existing cover under a Previous Policy immediately prior to the Start Date. The Insurer will also determine its liability for claims in accordance with the Takeover Terms. Application of Takeover Terms, and any Special Conditions the Insurer negotiates with the Policy Owner, will be detailed on the Schedule.

The following conditions apply to application of any Takeover Terms:

a. the cover under the Previous Policy must be current and in force immediately before the Start Date of transfer to the Insurer under the Policy;

b. the Policy wholly replaces the Previous Policy cover;

c. the Takeover Terms are limited to the type and amount of cover provided under the Previous Policy subject to the Maximum Cover Limit;

d. the Policy Owner provides the Insurer with all the information the Insurer needs about the operation and terms of the Previous Policy in writing including, but not limited to, names, type and amount of insurance cover and any individual underwriting acceptance terms provided by the previous insurer no later than 90 days after the Start Date, unless the Insurer agrees otherwise;

e. the Policy Owner provides the Insurer with the names of Eligible Persons who are not At Work due to an Illness or Injury on the last working day immediately prior to the Start Date, unless the Insurer agrees otherwise;

f. the terms and conditions of the Policy including the AAL and conditions for Automatic Cover (see Section 4.1) will apply;

g. where the automatic acceptance limit applicable to the Previous Policy is the same as the AAL applicable to the Policy, any specific exclusions and loadings applied to cover provided by the previous insurer will continue to apply under the Policy; and

h. where the automatic acceptance limit applicable to the Previous Policy is lower than the AAL applicable to the Policy, the automatic acceptance limit applicable for all persons insured under the Previous Policy may be automatically increased to the new AAL and any specific exclusions and loadings which applied to cover provided by the previous insurer will only apply to cover above the AAL applicable to the Policy.

The Insurer will not charge any additional premiums for loadings that applied to cover under the Previous Policy. Any applicable loadings will continue to be recorded and additional premiums may be charged for these loadings for other purposes such as for a Continuation Option.

6

Underwriting

6.1 What is underwriting?

Underwriting is the process by which the Insurer assesses a person's insurability for cover under the Policy by requesting Evidence of Insurability. The Insurer will only ask for personal and sensitive information which the Insurer believes is necessary for assessing the risk of the Eligible Person.

The circumstances where an Eligible Person or Insured Person may obtain Underwritten Cover include:

- **a.** an Insured Person is seeking cover above the AAL ;
- **b.** an Insured Person is seeking to remove a Limited Cover condition;
- **c.** an Eligible Person wishes to apply for Voluntary Cover; or
- **d.** the Eligible Person wishes to have their cover reinstated after cessation and the Insurer requires them to be underwritten.

Where underwriting is required, the Insurer requires the Eligible Person to provide Evidence of Insurability.

With respect to an application for Underwritten Cover, we may at our sole discretion:

- **a.** accept the application which may be subject to any exclusions, loadings, restrictions or additional conditions that we may reasonably consider to be appropriate; or
- **b.** decline the application.

6.2 Commencement of Underwritten Cover

Underwritten Cover commences on the date set out in our written acceptance and premiums for the applicable cover commence to be paid from that date. Premium Rates are detailed on the Schedule.

When, as a result of our underwriting decision, any exclusions, loadings, restrictions or additional conditions apply, they will only apply to the amount of Underwritten Cover.

Changes to the Sum Insured apply from the date of change but are processed at the next Review Date unless we reasonably agree otherwise in writing.

6.3 Amount of cover

The total amount of cover (including Automatic Cover and Underwritten Cover) an Eligible Person will be insured for will be the amount of cover stated in our written acceptance of cover and will not exceed the Maximum Cover Limit.

6.4 Premiums payable for Underwritten Cover

Premiums for Underwritten Cover will be payable by the Policy Owner from the date the cover commences.

Any additional premiums in respect of an Insured Person's loadings advised for Underwritten Cover will not be charged. However, any application loadings will continue to be recorded and may be charged for other purposes including but not limited to Continuation Options.

7

Interim Accident Cover

7.1 What is Interim Accident Cover?

If an Eligible Person applies for Underwritten Cover, the Insurer will provide Interim Accident Cover.

Interim Accident Cover means the Insurer will provide an Eligible Person with the cover applied for in their application form for up to 90 days while the Insurer is considering the Eligible Person's application for Underwritten Cover, subject to the relevant terms and conditions of the Policy.

Interim Accident Cover is only payable for claims arising directly from an Accident which first occurs during the period of Interim Accident Cover.

Interim Accident Cover is only available for death and Total and Permanent Disablement and is subject to the Insurer's underwriting guidelines. This means the Insurer may be unable to verify the amount of Interim Accident Cover (if any) until it completes the assessment of the Eligible Person's application for Underwritten Cover. Any conditions or restrictions that would have applied to Underwritten Cover based on the Insurer's underwriting guidelines will also apply to any Interim Accident Cover claim the Eligible Person makes.

If an Eligible Person suffers an Accident before the Insurer accepts their application for Underwritten Cover (but after the Insurer receives the fully completed Personal Statement), that Accident will be taken into account in the Insurer's assessment of the Eligible Person's application for Underwritten Cover once a decision on the Eligible Person's Interim Accident Cover claim is finalised.

7.2 Interim Accident Cover limits

The amount of Interim Accident Cover the Insurer provides will be for the type of Underwritten Cover applied for and be the lesser of:

a. the amount of Underwritten Cover applied for; and

b. $2,000,000, less any Sum Insured under existing cover of the same type for the Eligible Person under the Policy.

7.3 When Interim Accident Cover starts

Interim Accident Cover will commence from the date the Insurer receives the Eligible Person's fully completed Personal Statement.

7.4 When Interim Accident Cover ceases

Interim Accident Cover ceases in respect of an Eligible Person on the earliest of:

a. the Insurer's receipt of the Policy Owner's or the Eligible Person's request to withdraw their application for Underwritten Cover;

b. the Insurer's advice to you of their decision to accept or decline the application for Underwritten Cover;

c. 90 days after Interim Accident Cover commences;

d. the date the person ceases to be an Eligible Person;

e. the date the Eligible Person reaches the Benefit Ceasing Age;

f. the date a Benefit under Interim Accident Cover becomes payable for the Eligible Person;

g. the date the Eligible Person dies;

h. the date a Continuation Option is granted; and

i. the Policy termination date.

7.5 Payment of Interim Accident Cover

If we accept an Eligible Person's claim under Interim Accident Cover, we will pay the amount of Interim Accident Cover as outlined in section 7.2.

7.6 When an Interim Accident Cover Benefit is not payable

A Benefit under Interim Accident Cover is not payable:

a. for a claim arising directly or indirectly from an Accident which occurred at any time prior to the date the Insurer receives a completed Personal Statement;

b. where the Eligible Person has not complied with their duty to take reasonable care not to make a misrepresentation (refer to section 18.3); or

c. where the death or Total and Permanent Disablement of the Eligible Person is caused directly or indirectly by suicide or self-inflicted act.

8

Benefits

8.1 Payment of a death Benefit

If an Insured Person with death cover in force dies, the Insurer will pay the Policy Owner the Insured Person's Sum Insured for the death Benefit calculated as at the Date of Claim, subject to the terms of the Policy.

When we become liable to pay a Benefit for death, all cover under the Policy shall cease at the Date of Claim.

8.2 Payment of a Terminal Illness Benefit

If an Insured Person with death cover in force becomes Terminally Ill, we will pay the Policy Owner, subject to the terms of the Policy, the lesser of:

a. the Insured Person's Sum Insured for a death Benefit calculated as at the Date of Claim; and

b. the Maximum Cover Limit for Terminal Illness.

When we become liable to pay a Benefit for Terminal Illness the Insured Person's death cover and, if applicable, any Total and Permanent Disablement cover shall cease at the Date of Claim.

8.3 Payment of a TPD Benefit

If an Insured Person with Total and Permanent Disablement cover in force suffers an Illness or Injury that leads to Total and Permanent Disablement, we will pay the Policy Owner the Insured Person's Sum Insured for a Total and Permanent Disablement Benefit calculated as at the Date of Claim, subject to the terms of the Policy.

When we become liable to pay a Benefit for Total and Permanent Disablement, the Insured Person's Total and Permanent Disablement cover and death cover shall cease at the Date of Claim.

Where the Benefit Design in respect of an Insured Person for all or part of their cover is such that the Sum Insured does not reduce with age, tapering will apply to the Insured Person's Total and Permanent Disablement cover. If tapering applies, the Total and Permanent Disablement Benefit will gradually reduce:

i. for TPD ceasing at age 65 - by 20% per annum, as per Table 1, from the Insured Person's 61st birthday, to zero by the Benefit Ceasing Age; or

ii. for TPD ceasing at age 70 – by 10% per annum as per Table 2, from the Insured Person's 61st birthday, to zero by the Benefit Ceasing Age.

TABLE 1

AGE	PERCENTAGE REDUCTION OF TPD COVER	EXAMPLE: $500,000 SUM INSURED
Up to 60	Nil	$500,000
61	20%	$400,000
62	40%	$300,000
63	60%	$200,000
64	80%	$100,000
65	100%	Nil

TABLE 2

AGE	PERCENTAGE REDUCTION OF TPD COVER	EXAMPLE: $500,000 SUM INSURED
Up to 60	Nil	$500,000
61	10%	$450,000
62	20%	$400,000
63	30%	$350,000
64	40%	$300,000
65	50%	$250,000
66	60%	$200,000
67	70%	$150,000
68	80%	$100,000
69	90%	$50,000
70	100%	Nil

How tapering applies to your individual circumstances will depend on the Benefit Design selected by the Policy Owner and your Sum Insured.

9

Employer Approved Leave

9.1 Cover whilst on Employer Approved Leave

An Insured Person's cover continues without change while on Employer Approved Leave for up to 24 months, subject to the continued payment of premiums.

An Insured Person's cover may continue for a period exceeding 24 months, subject to:

a. an application for the extended cover period being made to, and accepted by, us prior to expiry of the 24 months from the commencement of Employer Approved Leave; and

b. the continued payment of premiums for the Insured Person.

In respect of any claim arising for an Insured Person during a period of unpaid Employer Approved Leave, the Salary used to calculate any cover based on the Benefit Design will be that which applied to that Insured Person on their last working day prior to the commencement of their unpaid Employer Approved Leave.

Subject to the conditions above, where the Insured Person does not return to work by the end of the 24 month period, or the end of any extended period beyond the 24 month period agreed in writing by the Insurer, all cover will cease at the end of the relevant period (see Section 14).

10

Overseas cover

10.1 Overseas cover

In addition to section 9, cover shall continue anywhere in the world, 24 hours per day, seven days per week regardless of the Insured Person's location.

An Insured Person's cover continues without change while temporarily employed overseas, subject to:

- the Insured Person continuing to meet the Eligibility Criteria; and
- the continued payment of premiums on behalf of the Insured Person.

10.2 Underwriting overseas

The Insurer does not require an Eligible Person overseas to return to Australia to apply for Underwritten Cover.

10.3 Assessment of a claim overseas

In addition to the claim requirements set out in section 16, where a claim for a Terminal Illness Benefit or TPD Benefit arises for an Insured Person and they are overseas during the assessment of the claim, the Insurer will require them to provide supporting medical evidence to the Insurer's satisfaction to enable assessment of their eligibility for payment.

The Insurer may require the Insured Person to return to Australia for claims assessment. Any costs incurred in returning to Australia for this purpose will not be paid by the Insurer.

The Insurer may, at its discretion, reimburse part or all of the costs relating to tests or medical information, in respect of a claim by the Insured Person.

11

Exclusions, restrictions and limitations

11.1 Exclusions on cover

We will not make a payment under the Policy if the payment would cause us to infringe any Health Insurance Legislation.

Benefits will not be payable in respect of any Underwritten Cover for death, Terminal Illness or Total and Permanent Disablement, if the death, Terminal Illness or Total and Permanent Disablement is caused directly or indirectly by a self-inflicted act or Injury of the Insured Person within 13 months of the following:

a. the date of acceptance of the Underwritten Cover;

b. the date the Underwritten Cover was reinstated, in respect of the reinstated amount; or

c. the date the Underwritten Cover increased, in respect of the increased amount.

11.2 Exclusions on Automatic Cover

If an Eligible Person is eligible for, has received, or is claiming a total and permanent disablement or terminal illness type benefit from any life insurance policy prior to the commencement of their Automatic Cover under the Policy, then the Insured Person is not eligible for Automatic Cover.

11.3 Limited Cover on Automatic Cover

Where an Insured Person receives Automatic Cover and they are not At Work on the date their Automatic Cover commences, their cover will be Limited Cover until they are At Work for 30 consecutive days, at which time Limited Cover will cease.

11.4 Limited Cover applying to new Automatic Cover on transfer between Categories

If an Insured Person receives new Automatic Cover following their transfer to a different Category under the Policy and:

a. the Insured Person is At Work on the date their new Automatic Cover commences, the Insured Person's new Automatic Cover will not be subject to Limited Cover; or

b. the Insured Person is not At Work on the date their new Automatic Cover commences, the amount by which their new Automatic Cover exceeds their previous Automatic Cover (if any) will be Limited Cover until the date they are At Work for 30 consecutive days, at which time Limited Cover will cease.

11.5 Limited Cover applying to automatic increases in the Sum Insured for an Insured Person

Where an Insured Person's Sum Insured increases automatically in accordance with the Benefit Design applicable to them, if Limited Cover already applies to their Automatic Cover, this will also apply to the increase in cover and continue to apply as per the application of the existing Limited Cover terms.

11.6 Failure to notify Salary at the Review Date

If:

a. the amount of cover provided to an Insured Person under the relevant Benefit Design is based on their Salary; and

b. the Policy Owner fails to provide us with updated Salary information at the Review Date (including confirmation that the Insured Person's Salary has not changed),

any Benefit payable by us, at time of claim, will be the lesser of the Sum Insured calculated:

a. by us at the last Review Date; and

b. based on the Salary of the Insured Person at the Date of Claim.

If Salary is not provided within 90 days after the Review Date, we may consider that Salary information has not been provided for that renewal.

11.7 Notified Salary at last Review Date and a subsequent Salary increase

If:

a. the amount of cover provided to an Insured Person under the relevant Benefit Design is based on their Salary;

b. the Policy Owner has provided us with updated Salary information at the most recent Review Date; and

c. the Insured Person's Salary has increased from the Salary notified by the Policy Owner at the most recent Review Date,

we will increase the applicable Sum Insured for the Insured Person to reflect their increase in Salary at the Date of Claim, subject to the Benefit Design, section 11.4 and any additional premium required being paid effective from the date of the increase in the Sum Insured resulting from the Salary increase.

11.8 Misstatement of age

If the age of an Insured Person has been understated, the Sum Insured in respect of that person will be recalculated and reduced based on the amount of premium already paid and the amount of cover that premium would have purchased if the cover had been calculated using the correct age.

If the age of the Insured Person has been overstated, the Sum Insured will not change, and the Insurer will return any excess premium paid.

If the date of birth of the Insured Person has been incorrectly provided and the cover cessation date in section 14 would have been different had the correct date of birth been provided, then the Insurer may instead vary the cover by changing the cessation date to the date that would have been the cessation date if the cover had been based on the correct date of birth.

11.9 Maximum Cover Limits

The maximum amount of cover an Insured Person can hold under the Policy and the maximum amount we will pay to the Policy Owner in respect of an Insured Person will not exceed the Maximum Cover Limit as detailed on the Schedule.

11.10 Non-compliance with duty to take reasonable care not to make a misrepresentation

We may be legally entitled to avoid the cover, vary the amount of the cover or vary the terms of the cover, if the Policy Owner or an Insured Person has not complied with the duty to take reasonable care not to make a misrepresentation as stated in Section 18.3.

11.11 Unpaid premiums

Where the Date of Claim occurs for an Insured Person during a period where premiums owing for that period remain outstanding, any Benefit payments will not be made until such time as any premiums owing have been received.

11.12 Overpayment of benefits

We may require repayment of a Benefit if we did not reduce a Benefit payment when we would have been entitled to do so, or if we paid a Benefit which we were not obliged to pay under the terms and conditions of the Policy. We may elect to reduce future Benefit payments in lieu of such a repayment.

12

Extended Cover

12.1 What is Extended Cover?

Extended Cover is cover which continues to be provided, without charge, for up to 60 days after the Insured Person ceases to meet the requirements to be an Employee, Contractor, Member or Spouse.

12.2 When Extended Cover ceases

Extended Cover for an Insured Person starts on the date they cease to be an Eligible Person and ceases on the earliest of:

- **a.** 60 days after the Insured Person ceases to meet the requirements to be an Employee, Contactor, Member or Spouse;
- **b.** the date the Insured Person's application for a Continuation Option is accepted or declined by us under section 13;
- **c.** the date the Insured Person obtains insurance under another policy for the same or similar benefits to those provided under the Policy; and
- **d.** the date cover ceases under section 14 (other than on ceasing to meet the requirements to be an Employee, Contractor, Member or Spouse).

13

Continuation Option

13.1 What is a Continuation Option?

If the Policy Owner has selected this feature, it will be detailed on the Schedule.

Where an Insured Person is no longer an Eligible Person under the Policy because they have ceased to be an Employee or Contractor of the Employer or have ceased to be a Member for reasons other than for retirement, Illness or Injury, they may apply for a Continuation Option. A Continuation Option allows the person to continue their cover under an individual insurance policy issued by the Insurer, without the need to provide evidence of health.

13.2 Conditions for a Continuation Option

All of the following conditions need to be satisfied for an Insured Person to apply for a Continuation Option:

a. they are not an Insured Person who is a Spouse;

b. the Insured Person is under age 60 (under age 55 for some occupations);

c. the Insured Person is resident in Australia;

d. no Benefits have been paid or are payable to the Insured Person under the Policy, or any other life insurance policy, workers compensation scheme (if the claim is for more than 7 days), other statutory scheme or from Centrelink;

e. the Insured Person has not ceased employment due to Illness or Injury;

f. the Insured Person has not ceased employment due to retirement or joining the armed forces;

g. the Insured Person will be working the required minimum hours per week under the individual policy;

h. the Insured Person will commence employment in an occupation considered by us to be an insurable risk under the individual insurance policy;

i. we receive the Insured Person's application, completed to our satisfaction, together with the relevant premium, within 60 days of the Insured Person ceasing to be an Employee or a Contractor of the Employer or a Member;

j. the application for the Continuation Option must include, but is not limited to:

i. occupational information including salary;

ii. information regarding pastimes, residency, travel, smoking status and any other insurance cover; and

iii. acceptance by the Insurer.

The individual insurance policy issued will be one the Insurer considers contains the same or closest available benefits, to the cover provided on the date the person ceased to be an Employee or a Contractor of the Employer or Member.

The premium for the individual insurance policy issued will be based on the Insurer's standard individual age-based rates and will be subject to any specific exclusions and loadings applying to the Insured Person's cover at the date they ceased to be an Employee or a Contractor of the Employer or a Member.

Where a Continuation Option is granted while the Insured Person is applying for Underwritten Cover, their application and any Interim Accident Cover they were entitled to under the Policy will be cancelled.

If cover for Total and Permanent Disablement (TPD) is requested in the individual policy, the Insurer only offers the choice of the Any Occupation and Activities of Daily Living TPD definitions.

14 When cover ceases

14.1 Cessation of Cover

All cover will cease for an Insured Person immediately on the earliest of:

- **a.** the date the Policy terminates;
- **b.** the date they reach the Benefit Ceasing Age;
- **c.** subject to Extended Cover, the date they cease to meet the requirements to be an Employee, Contractor, Member or Spouse;
- **d.** subject to Extended Cover, the date cover for an Employee, Contractor or Member ends if the Insured Person is a Spouse;
- **e.** the date Extended Cover ceases;
- **f.** the date we pay a Terminal Illness Benefit for the Insured Person;
- **g.** the date we pay a Total and Permanent Disablement Benefit for the Insured Person;
- **h.** the date we pay a death Benefit for the Insured Person;
- **i.** the date we receive a notification from the Policy Owner to cancel cover for an Insured Person;
- **j.** the date the Insured Person no longer meets the Eligibility Criteria;
- **k.** the date immediately before the Insured Person commences active service in the armed forces of any country, not including normal activities as a reservist with the Australian Defence Force, but including operational deployment on active service with the Australian Defence Force;
- **l.** the date an individual life insurance policy is issued to the Insured Person by us under a Continuation Option; and
- **m.** the date the Insured Person has exceed 24 months, or the otherwise agreed period, of Employer Approved Leave.

15 When the Policy ends

15.1 Duration of the Policy

The Policy is effective from the Start Date and remains in effect until the earliest of:

- **a.** the Policy Owner terminating the Policy by providing the Insurer with written notice prior to the Policy termination date;
- **b.** the Insurer terminating the Policy, after having provided the Policy Owner at least 30 days' written notice of its intention to do so, due to the Policy Owner's failure to pay the required premiums and premiums remaining unpaid (see section 17);
- **c.** payment of the last Benefit of the last Insured Person;
- **d.** cover ends for all Insured Persons.

In the event the Insurer terminates the Policy due to the Policy Owner's failure to pay outstanding premiums, the Policy termination date will be the date immediately after the end of the 30 day period referred to in paragraph (b) above.

If a claim is made with a Date of Claim after the premium is due, but before the Policy is terminated, the Insurer will not pay the claim unless the Policy Owner pays the Insurer the overdue premium prior to the date the Insurer cancels the Policy.

Termination of the Policy will not reduce the liability for any premiums due and payable under the Policy up to the date of termination and will not affect the entitlement of an Insured Person to make a claim in respect of an event which occurred before the termination of the Policy.

The Policy Owner is responsible for informing Insured Persons of the termination of the Policy.

15.2 No cash value on termination

The Policy has no cash value on termination.

16 Claims

16.1 Making a claim

The Policy Owner must notify us in writing of an event that is likely to give rise to a claim as soon as reasonably possible.

Upon receipt of a written notification of a claim:

a. we will provide you with claim forms, which must be completed and returned to us with the information and documentation we may reasonably require from time to time to assess the claim; and

b. we may require the Insured Person to provide any additional information that we consider necessary for the assessment of the claim, including their eligibility for cover, on an ongoing basis or otherwise. This includes, but is not limited to, health certificates, Medical Practitioner reports, Employer reports, financial statements, income tax returns and evidence of claim.

16.2 Claim requirements

Upon receipt of the completed claim forms with respect to an Insured Person, we may require the Insured Person to:

a. undergo an examination by a Medical Practitioner of our choice or other relevant professional of our choice;

b. provide further medical evidence from their own Medical Practitioner; or

c. supply written authorities to enable us to access any information reasonably necessary to assess the Insured Person's eligibility for a Benefit. If the Insured Person chooses to withhold consent and does not complete a written authority, the Insurer may be unable to process the claim and the claim may be declined until the Insurer is able to obtain the information and evidence it reasonably requires.

We may require an Insured Person to undertake such assessments (including medical, occupational and vocational) we consider reasonably necessary to determine the Insurer's liability to pay a claim. The Insurer's assessments may also include investigating whether the duty to take reasonable care not to make a misrepresentation was complied with when the Policy was applied for, cover reinstated or changed or when an Insured Person applied for Underwritten Cover.

Payment of a Total and Permanent Disablement Benefit is conditional upon an Insured Person undertaking such rehabilitation, training, retraining, re-skilling or treatment (medical or otherwise) as reasonably required by us, from time to time.

If the Insured Person:

a. fails to attend any pre-arranged medical examination, examination or assessment; or

b. refuses or delays undertaking such required activities and we reasonably form the view that we have been prejudiced by this refusal or delay,

we reserve the right to deny the claim or reduce the Benefit amount we pay (up to its entirety) by an amount that fairly reflects the extent of that prejudice.

We will pay for an Insured Person to undertake rehabilitation, training or re-skilling or treatment (medical or otherwise) if:

a. in our reasonable opinion the Insured Person's potential to return to any Gainful Employment will benefit from the activities; and

b. we have approved the activity and agree to pay the cost of the activity; and

c. the expenses are incurred to directly assist the Insured Person to return to work or to increase the number of hours the Insured Person can work in their Usual Occupation, or where relevant, in other Gainful Employment, or to undertake a vocational retraining program, but excluding any program providing hospital treatment or an ancillary health service within the meaning of the Health Insurance Legislation.

16.3 Cost of claims

We are not responsible for any costs associated with completing and providing the initial claim forms and the information that we may require for commencing assessment of a claim.

We will reimburse the expenses incurred by the Insured Person in obtaining evidence we request that is in addition to initial information required. However, if an Insured Person fails to attend any pre-arranged medical examination or assessment or provides insufficient notice of an inability to attend, they will be liable to pay any fees incurred.

16.4 Payment of claim – General conditions

The Insurer will request evidence from the Policy Owner that the Insured Person meets the Eligibility Criteria for cover under the Policy, any Transfer Terms and increases in the AAL when the claim is lodged.

We will commence the assessment of a claim once we are provided with the claim forms fully completed to our satisfaction and all the evidence we consider necessary for the assessment of the claim.

We will either admit or reject the claim at our sole discretion.

If we admit the claim, we will pay the Benefit that the Insured Person is entitled to under the Policy, which will be calculated by us, provided that:

a. the claim is valid under the law; and

b. where applicable, the Insured Person is in ongoing compliance with medical advice and treatment provided by the treating Medical Practitioner.

Any payment for the claim will be made in accordance with the following:

a. the method of payment the Policy Owner advises us in writing; and

b. the terms of the Policy.

16.5 Claim while an Insured Person is overseas

If an Insured Person makes a claim from outside Australia, we may require the Insured Person to return to Australia at their expense for assessment of any claim.

16.6 Claims after cessation of cover

Cessation of cover shall not prejudice any entitlement to make a claim in relation to an event that happened before an Insured Person's cover ceased.

If the Policy terminates, we will determine our liability for claims made after termination by applying Takeover Terms as the "outgoing insurer", or by such other terms as agreed by the Policy Owner and us. Where we apply Takeover Terms as the "outgoing insurer", if there is any inconsistency between the terms of the Policy and Takeover Terms, the Policy will prevail to the extent of the inconsistency.

In the event there is a dispute between us and any "incoming insurer" as defined in Takeover Terms, we agree to participate in the adjudication process set out in Takeover Terms.

17 Costs

17.1 Premiums

Premiums for death only and death and Total and Permanent Disablement cover are structured on an age rate or unit rate basis. Policies, or Categories with an age rate basis will mean that generally Premium Rates increase as the Insured Person ages. Policies or Categories on a unit rate basis have the same premium per $1,000 Sum Insured for all Insured Persons.

Policies may have different Categories covering different cohorts of Insured Persons within the same Policy. Depending on the Eligibility Criteria of each Category, Insured Persons may move between Categories.

Age-based Premium Rates are calculated based on occupation profile and historical claims experience. Unit-based Premium Rates are calculated based on occupation profile, historical claims experience, gender and age profile of the Insured Persons.

Any Rate Guarantee Period outlined in the Schedule will set the period during which Premium Rates will not change, unless one of the below triggers in section 17.4 occurs.

17.2 Calculation of the premium

The amount of the premium is the total cost of cover for all Insured Persons coved under the Policy. The premium is based on:

a. the Premium Rates;

b. any applicable commission or other remuneration (such as referral fees) we pay to the Policy Owner's financial adviser, broker or other distributor of TAL Group Plus – Life Insurance which are factored into the cost of the Policy (the financial adviser, broker or distributor will provide details of the payments they receive from us and are generally calculated by reference to the premium and subject to commission caps imposed by law);

c. the total amount of the Sum Insured of all Insured Persons covered under the Policy;

d. any government levies, GST, taxes or charges not included in the Premium Rates.

The Premium Rate will depend on the level of risk for the Insurer such as:

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

b. the demographics of the Insured Persons (e.g. age, occupation, and gender distributions); and

c. any applicable claims history.

For Insured Persons with Underwritten Cover, the premium in respect of their cover is based on factors such as (but not limited to):

a. their personal and family medical history;

b. their age;

c. their gender;

d. any required tests (e.g. blood tests, scans etc);

e. their occupation and employment status (for example, Full-time Basis, part-time, role they perform);

f. their past times;

g. the amount of cover requested;

h. any applicable conditions we place on their cover as a result of our decision.

The Insurer can only accept payments from the Policy Owner directly.

The Policy Owner must pay the premiums (including any additional premiums for Insured Persons with Underwritten Cover) to us on or before the Premium Due Date. Premiums are calculated by us annually in advance which is then converted based on the premium payment frequency noted in the Schedule. For premium payment frequencies other than annual, a 3% loading is added to the rates for administration purposes.

Where an Insured Person's Sum Insured under the Policy is varied, the premium payable to us will be adjusted to reflect this change in the Sum Insured effective from the date of variation. Where we have not received the correct amount of premium from the Policy Owner in respect of an Insured Person by the Premium Due Date, including but not limited to, an error or omission (for example a misstatement of the Insured Person's age):

a. we may send a written notice to the Policy Owner for the outstanding premiums;

b. the Policy Owner must pay any outstanding premiums within 30 days from the date of our written notice; and

c. we may terminate the Policy if the outstanding premium is not paid to us within 30 days from the date of our written notice.

The Insurer may offset any premiums due under the Policy but unpaid by the Policy Owner with respect to an Insured Person against any Benefit payable to the Policy Owner for the Insured Person.

Our receipt of any premium after the Premium Due Date (on a regular basis or otherwise) is not to be construed as a waiver of our rights in relation to the overdue premiums under the Policy.

17.3 Guarantee of Premium Rates

Premium Rates will be guaranteed from the Start Date until the end of the Rate Guarantee Period, except in the circumstances set out in clause 17.4. Premiums may be varied at the expiry of the Rate Guarantee Period by providing 30 days' notice.

17.4 Variation of Premium Rates

The Insurer may change the Premium Rates prior to the end of the Rate Guarantee Period by providing 30 days' notice if

a. we agree to the Policy Owner's request for a change in the terms or conditions of the Policy;

b. Australia is involved in War, whether declared or not, or the armed invasion of Australia;

c. there has been a change of 25% or more in the number and/or occupational profile of Insured Persons under the Policy or particular Category since the start of the Rate Guarantee Period;

d. a change to the Premium Rate is required in respect of cover provided for any or all Insured Persons under the Policy due to any change to past, current or future Government Charges relating to the Policy;

e. the number of Insured Persons under the Policy falls below 5;

f. in our reasonable opinion, the information the Policy Owner has provided us for a quotation is not accurate;

g. our pricing assumptions are impacted by the requirements of any:

i. code of practice applicable to us; or

ii. directions issued by a regulatory body with supervisory/licensing authority over us;

h. there is an alert, advisory, notification, declaration, formal announcement, proclamation or other similar publication issued in relation to a pandemic in Australia from:

i. the Australian Government (including a relevant Australian Government department, authority, minister or officer);

ii. the government of a State or Territory of Australia (including a relevant State or Territory government department, authority, minister or officer); or

iii. the WHO,

and there are more than 10,000 reported cases of the illness in Australia.

If no Rate Guarantee Period is specified in the Schedule, the Insurer may change the Premium Rates at any time by providing the Policy Owner with at least 30 days' notice.

See section 17.1 for factors the Insurer takes into account in determining any Premium Rate changes.

17.5 Additional premiums for Underwritten Cover

Insured Persons will need to arrange for the Policy Owner to make additional payments to the Insurer to cover the cost of the additional premium payable for the Insured Person's Underwritten Cover.

The Policy Owner is advised of the additional premium payable for Underwritten Cover once that cover is accepted by the Insurer.

18 Additional information

18.1 Privacy

The way in which we collect, use and disclose your personal and sensitive information (collectively, 'personal information') is explained in our privacy policy. Our Privacy policy is available via **tal.com.au** or free of charge on request. The contact details are provided below.

Our privacy policy contains details about the following:

- the types of personal information that we collect and hold;
- how we collect and hold personal information;
- the purposes for which we collect, hold, use and disclose personal information;
- how our customers may access personal information about them which is held by us and how they can correct that information; and
- how we deal with any complaints that our customers may have regarding privacy issues.

If you would like a copy or if you have any questions about the way in which we collect, use, secure and disclose your personal information, please contact us using the details below:

TAL
1300 209 088
customerservice@tal.com.au
www.tal.com.au
GPO Box 5380, Sydney NSW 2001

Your personal information will be collected to enable us to provide, or arrange for the provision of, our insurance products and services. We may request further personal information in the future, for example, if you want to make a claim and we need to collect your health or financial information. If you do not supply the required information, we may not be able to provide the requested product or service to you or pay the claim.

In processing and administering your insurance benefits (including at the time of claim) we may disclose your personal information to other parties such as organisations to whom we outsource our mailing and information technology, government regulatory bodies and other related bodies corporate. We may also disclose your personal information (including health information) to other bodies such as reinsurers, your financial adviser, health professionals, investigators, lawyers and external complaints resolution bodies.

In administering your insurance benefits your personal information may be disclosed to service providers in another country. In these circumstances we have robust operational processes to protect the information including due diligence, vendor management and a formal contract requiring adherence with Australian privacy laws. Details about the countries to which we disclose information are available in our privacy policy.

Generally, we do not use or disclose any personal information for a purpose other than providing our products and services, unless:

- you consent to the use or disclosure of your information;
- the use or disclosure is required or authorised under an Australian law or a court/tribunal order;
- the purpose is related to improving our products and services and seeking customer input such as market research; or
- the use or disclosure of the information is reasonably necessary for one or more enforcement related activities conducted by, or on behalf of, an enforcement body e.g. the police.

From time to time we or our related bodies corporate and business partners may wish to contact you (where we have your valid consent) to provide you with information about other products and services in which you may be interested. These consents shall remain in effect in accordance with relevant law or unless and until you notify us that you do not want to receive direct marketing communications from us (or our related companies).

We rely on the accuracy of the information you provide. If you think that we hold information about you that is incorrect, incomplete or out of date, please let us know using the communication methods detailed above.

Under the current privacy law, you are generally entitled to access the personal information we hold about you. To access that information, simply make a request in writing to us. This process enables us to confirm your identity for security reasons and to protect your personal information from being sought by a person other than yourself.

There are some limited exemptions where we would be unable to provide the personal information that we hold about you in response to your request.

If, for any reason, we decline your request to access and/or update your information, we will provide you with details of the reasons and where appropriate, a list of the documents that are not being provided directly to you. In some circumstances it may be appropriate to provide you with access to information that you've requested via an intermediary, such as providing medical information to a treating GP rather than directly to yourself. If this is the case, we will let you know. Please also refer to our privacy policy for further information.

Additional information about privacy rights and how to make a privacy related complaint can be found at the website of the Privacy Commissioner (www.oaic.gov.au) including sensible steps that you can take to protect your information when dealing with organisations and when using modern technology.

18.1.1 Security and storage of personal information

We understand the importance of ensuring that the personal information you entrust to us is safe and secure. We take steps to protect the personal information we hold about you from unauthorised access, unauthorised disclosure, loss, misuse or interference by implementing a range of electronic, physical and technological safeguards.

We have processes in place to identify, manage and remediate privacy and data breaches in accordance with our obligations under the Notifiable Data Breaches scheme.

Please also refer to our privacy policy on our website at www.tal.com.au for further information.

18.2 Complaints

If you wish to make a complaint about our services or your privacy, you may lodge it by addressing it to:

Internal Dispute Resolution (IDR) Team
TAL Life Limited
GPO Box 5380, Sydney NSW 2001

Email: IDRcomplaints@tal.com.au
Phone: 1300 795 877
Website: www.tal.com.au

We will attempt to resolve your complaint within 30 days from the date it is received. If we are unable to resolve your complaint within that period, we will inform you of the reasons for the delay and let you know when we expect to provide a response to your complaint.

Australian Financial Complaints Authority (AFCA)

If your complaint is not resolved to your satisfaction within 30 days from the date you lodged your complaint, then, you can lodge a complaint with AFCA. AFCA provides fair and independent financial services complaint resolution that is free to consumers.

AFCA's contact details are as follows:

Online: www.afca.org.au
Email: info@afca.org.au
Phone: 1800 931 678 (free call within Australia)
In writing: Australian Financial Complaints Authority
GPO Box 3, Melbourne VIC 3001

Time limits may apply to complaints to AFCA. You may wish to consult the AFCA website or contact AFCA directly to find out if there is a time limit on lodging a complaint with AFCA.

18.3 Duty to take reasonable care not to make a misrepresentation

We give notice to the Policy Owner and any Eligible Persons applying for Underwritten Cover of TAL Group Plus – Life Insurance, (referred to in both cases as 'you' or 'your' in this section) of their duty to take reasonable care not to make a misrepresentation.

When applying for life insurance, you have a legal duty under a consumer insurance contract to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

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.

18.3.1 What can happen if the duty is not met?

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

For example, the Insurer may:

a. avoid the cover (treat it as if it never existed);

b. vary the amount of the cover; or

c. vary the terms of the cover.

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

a. whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances;

b. what the Insurer would have done if the duty had been met – for example, whether it would have offered cover, and if so, on what terms;

c. whether the misrepresentation was fraudulent; and

d. in some cases, how long it has been since the cover started.

Before any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

18.3.2 Guidance for answering questions

You are responsible for the information provided to the Insurer. When answering questions, please:

a. think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond;

b. answer every question;

c. answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.

d. review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Please note that there may be circumstances where the Insurer later investigates whether the information given to it was true and complete.

For example, it may do this when a claim is made.

18.3.3 Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances. As any changes might require further assessment or investigation, it could save time if you let the Insurer know about any changes when they happen.

18.3.4 If you need help

It's important that you understand your obligations and the questions that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know 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.

18.4 Notices

A notice sent by email is treated as being given when the email (including any attachment) is sent to the receiving party at the email address last notified by that party, unless the sending party receives a notification of delivery failure or an out-of-office message within 24 hours of the email being sent.

A notice which is posted is treated as being given four days from the date of posting.

Notifications to the Insurer should be sent by post to GPO Box 5380, Sydney NSW 2001 or by email to corporateadmin@tal.com.au.

18.5 Currency

All premium and claim payments made in connection with the Policy must be made in Australian dollars.

All monetary amounts referred to under the Policy are in Australian dollars.

18.6 Governing law

The Policy is subject to the laws applying in New South Wales and the jurisdiction of the courts in New South Wales.

18.7 Guaranteed continuation of cover

Subject to meeting the duty to take reasonable care not to make a misrepresentation and payment of premiums, the Policy will continue at each Review Date so long as premiums are paid and other terms of the Policy are satisfied, regardless of changes to the health of Insured Persons.

18.8 Supply of information and evidence

The Policy Owner must do everything appropriate to enable compliance within a reasonable time with any of our reasonable requests for information and evidence in connection with the Policy (including information relating to eligibility for cover, age, gender and health of Insured Persons).

The Policy Owner must provide us with annual reporting containing details of Eligible Persons under the Policy at the Review Date and changes during the year in a format as agreed between the Policy Owner and us.

18.9 The Insurer may inspect the Policy Owner's records

The Insurer may inspect and take copies of any records the Policy Owner, their agents or representatives have, which the Insurer believes are relevant to the Policy. If the Insurer does this, it will do so during normal working hours and give reasonable notice of the inspection.

The Insurer will continue to reserve this right after termination of the Policy until the later of:

a. 2 years after the Policy termination date; and

b. the settlement of all claims under the Policy.

18.10 Statutory fund and non-participating policy

The Policy is issued from the Insurer's Statutory Fund Number 1.

The Policy will be non-participating. This means that it does not entitle the Policy Owner or the Insured Person to participate in the distribution of any surplus of the statutory fund.

18.11 Goods and Services Tax (GST)

The insurance provided under the Policy is treated as input taxed under the GST law and the premium will not be subject to GST. The premium rates are inclusive of any GST costs incurred by TAL in relation to the Policy. An input tax credit will not be available to the Policy Owner.

18.12 Government taxes and charges

Where we pay the Benefit(s) to the Policy Owner under the Policy, the Policy Owner is responsible for calculating, deducting and remitting any tax payable on Benefit(s).

If the Insurer is required by law to withhold or pay any Government Charges in connection with a Benefit paid to the Policy Owner or Insured Person, which are not included in the Premium Rates, the Insurer will deduct the relevant amount from the Benefit and pay it to the proper authority.

Because of the differing taxation implications it is important the Policy Owner seeks independent professional taxation advice relevant to the Policy Owner's particular circumstances and regarding the taxation implications of paying premiums and receiving and on-paying Benefits under the Policy.

18.13 What happens if we make an error?

We work hard to make sure you receive accurate information and that the Policy and any claim you make will be administered correctly. However, from time to time we do make and identify errors. If this happens, we will try to make things right.

If you think we have made an error, please tell us right away so that we can investigate and take action.

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Definitions

The following definitions apply to TAL Group Plus – Life Insurance and are used throughout this PDS and the application form.

TERM	DEFINITION
Accident	means an unforeseen violent, external and visible event.
At Work	means: **a.** the person is actively performing or capable of actively performing all of the duties and work hours of their Usual Occupation on a Full-time Basis with their employer free from any limitation due to Illness or Injury. A person who is on Employer Approved Leave for reasons other than Illness or Injury, who would otherwise be capable of performing their Usual Occupation on a Full-time Basis, will be considered as having met the requirement of this definition; and **b.** the person is not entitled to, or receiving, Income Support Benefits.
Australian Resident	means: **a.** an Australian citizen; or **b.** a New Zealand citizen living and working in Australia; or **c.** a permanent resident of Australia with an appropriate Visa; or **d.** a person living and working in Australia and holding a Visa that allows them to be Gainfully Employed.
Automatic Acceptance Limit (AAL)	means the maximum level of cover that can be provided as Automatic Cover, as specified in the Schedule.
Automatic Cover	means the cover which we provide without requiring Evidence of Insurability based on the Benefit Design for each Category nominated by the Policy Owner.
Benefit	means an insured benefit payable under the Policy for: **a.** death; **b.** Total and Permanent Disablement; or **c.** Terminal Illness.
Benefit Ceasing Age	means: **a.** death cover: attains age 65 or 70 **b.** Terminal Illness cover: attains age 65 or 70 **c.** TPD: attains age 65 or 70.
Benefit Design	means the type and level of Benefits and applicable options depending on the terms of the Schedule that applies to the Policy Owner when the Policy is in force.
Category / Categories	means the applicable category in which an Eligible Person is accepted as an Insured Person as set out in the Schedule.
Continuation Option	if applicable in the Schedule, means the option under section 13.
Contractor	means a person under a written contract of service with the Employer for a minimum of 15 hours per week for a continuous 6 month period and is, under the contract, having Salary and Superannuation Contributions paid in respect to them.
Date of Claim	means in respect of a claim for a: **a.** death Benefit, the date of death; **b.** Terminal Illness Benefit, the date (if two different dates, the later date) on which two Medical Practitioners (at least one of whom is a Specialist Medical Practitioner) certify that the Insured Person's life expectancy is likely reduced to 12 months or 24 months (see Terminal Illness Certification Period in the Schedule for the applicable period) or less; and **c.** Total and Permanent Disablement Benefit, the later of the following: I. the date the Insured Person ceases to work due to Illness or Injury; and II. the later of the dates a Medical Practitioner: i. first examines the Insured Person in relation to the Illness or Injury for which they are claiming; and ii. has stated, in a written format acceptable to us, as being the date that the Insured Person suffered from the Illness or Injury that is the principal cause of the Insured Person's inability to work.

TERM	DEFINITION
DSM	means the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA). If the Diagnostic and Statistical Manual of Mental Disorders is no longer used or published, we will use another manual similar to it for the determination as determined by the Royal Australian and New Zealand College of Psychiatrists.
Eligibility Criteria	means the conditions as set out in the Schedule to determine whether a person is eligible for cover under the Policy.
Eligible Age Range	means aged between 16 and up to age 65 or 70 as stated in the Schedule.
Eligible Person	means a person who satisfies the criteria set out in section 3.1.
Employee	means a person who is Gainfully Employed by the Employer.
Employer	means the entity stated in the Schedule that: **a.** is the Policy Owner or a related body corporate (within the meaning of the *Corporations Act 2001* (Cth) of the Policy Owner; and **b.** employs the Eligible Person under the Policy.
Employer Approved Leave	means leave (including unpaid leave) that has been granted by: **a.** in the case of an Employee or Contractor, the Employer; **b.** in the case of a Spouse or Member, the employer for whom most of their hours of Gainful Employment are undertaken, in accordance with the employer's employment practices, supportable by documentary evidence.
Everyday Work Activities	means the following activities: **a.** Mobility – the Insured Person can do the following: i. walk without assistance more than 200m on a level surface without stopping; and ii. bend, kneel or squat to pick something up from the floor from a standing position and straighten up again; **b.** Communicating – the Insured Person can do the following: i. speak in their first language so that they are understood in a quiet room; and ii. understand a simple message in their first language, and relay that message to another person; **c.** Vision – the Insured Person can, with or without glasses or contact lenses, read ordinary newsprint and pass the standard eyesight test for a standard passenger car licence; **d.** Lifting – the Insured Person can lift a 5 kg weight with either one or both hands from a bench/table height; and **e.** Manual dexterity – the Insured Person can use their hands or fingers to manipulate small objects with precision (such as picking up a coin or fastening shoelaces or buttons, using cutlery, or using a pen or keyboard to write a short note).
Evidence of Insurability	means a Personal Statement and such other medical, financial, employment, occupational and other information we may reasonably require to assess and underwrite cover under the Policy.
Extended Cover	means cover which continues to be provided in accordance with section 12.
Forward Underwriting Limit (FUL)	means the maximum level to which an Insured Person's cover can be increased in the future by means of the Benefit Design, without the requirement to provide further Evidence of Insurability, in circumstances where the Insured Person: **a.** previously provided us with Evidence of Insurability for the purposes of our underwriting assessment; and **b.** the Insured Person continues to meet the Eligibility Criteria on the date of the increase in cover within their Benefit Design.
Full-time Basis	means at least 30 hours per week.
Gainfully Employed / Gainful Employment	means employed for gain or reward, or in the expectation of gain or reward, where gain or reward includes the receipt of remuneration such as salary, wages, bonuses, commissions, fees or gratuities, in return for personal exertion.

TERM	DEFINITION
Government Charges	means: **a.** any charge, duties or taxes (including but not limited to State or Territory stamp duties); or **b.** any other form of financial imposition levied under any law of a State or Territory or under the laws of the Commonwealth of Australia.
Health Insurance Legislation	means the *National Health Act 1953* (Cth), *Health Insurance Act 1973* (Cth), *Private Health Insurance Act 2007* (Cth) or any similar legislation or regulation in connection with health insurance, as amended from time to time.
Illness	means a sickness or disease.
Income Support Benefits	means monetary benefits which are paid or entitled to be paid to replace an Eligible Person's loss of income or income earning capacity as a result of Injury or Illness and includes, but is not limited to, the following categories of benefits: **a.** benefits payable under Commonwealth or State legislation to replace loss of income or income earning capacity due to disability; **b.** benefits payable under an insurance policy to replace loss of income due to disability, whether or not those benefits are payable directly to the person; **c.** benefits payable under a superannuation fund in respect of the person's temporary incapacity.
Incorporated Association	means an association that must operate in accordance with the requirements of the relevant associations incorporation laws of the State or Territory in which it is registered.
Injury	means bodily injury solely resulting from an Accident.
Insured Person	means an Eligible Person who has cover under the Policy and in relation to whom you have paid, or have agreed to pay, a premium.
Insurer	means TAL Life Limited (ABN 70 050 109 450, AFSL 237848).
Interim Accident Cover	means cover provided in the event of death or Total and Permanent Disablement as a result of an Accident that we may provide to an Eligible Person while assessing their application for Underwritten Cover.
Limited Cover	means cover provided under the Policy for the Insured Person is only with respect to claims arising from: **a.** an Illness the symptoms of which first became apparent; or **b.** an Injury which first occurred, on or after the date cover commenced, or the date cover was increased (as applicable). The Illness or Injury referred to in paragraph (a) and (b) respectively cannot be caused by, or in any way contributed to by, any Illness or Injury the Insured Person was aware of, or a reasonable person in the Insured Person's position would have been expected to have been aware of, at any time prior to the commencement of Limited Cover.
Maximum Cover Limit	means the maximum amount of cover an Insured Person can be insured for and is entitled to be paid under the Policy, as specified in the Schedule.
Medical Practitioner	means, unless we agree otherwise, a medical doctor legally qualified and registered with the Australian Health Practitioner Regulation Agency (AHPRA) to practice in the profession of medical practice as defined by AHPRA but shall not include chiropractors, physiotherapists, psychologists or alternative health providers. The Medical Practitioner cannot be: **a.** the Insured Person; **b.** the Insured Person's spouse or partner in a de facto relationship, parent, child, sibling or close family relative; **c.** the Insured Person's business partner, associate, employer or employee; or **d.** a fellow shareholder or unit holder of the Insured Person in a company or trust that is not a publicly listed company or trust.
Member	means a member of an Incorporated Association and who is Gainfully Employed on a permanent basis by an Australian-registered corporation.

TERM	DEFINITION
Personal Statement	means either a fully completed: **a.** paper statement for an application for Underwritten Cover; or **b.** online statement consisting of an application for Underwritten Cover completed on our online underwriting system and the policy declaration outlining the content of the online statement signed by the Eligible Person.
Policy	means the TAL Group Plus - Life Insurance Policy issued by the Insurer to the Policy Owner under the terms and conditions set out in this PDS. It includes the Schedule and any endorsement, document or notice which evidences any alteration or variation of the Policy.
Policy Owner	means the entity that legally owns the Policy as identified in the Schedule.
Premium Due Date	means the date premiums are payable which is 30 days from our written notice to the Policy Owner, unless otherwise agreed.
Premium Rates	means the cost of the cover stated in the Schedule and used to calculate the premiums for cover.
Previous Policy	means the insurance policy in respect of groups of Eligible Persons, which is a life policy as defined under the *Life Insurance Act 1995* (Cth) which: **a.** provided death cover or death and total and permanent disablement cover; **b.** that was in force on the day before cover for the relevant Eligible Person commenced under the Policy; and **c.** that we agree to treat as a Previous Policy for the purposes of the Policy.
Privacy Laws	means the *Privacy Act 1988* (Cth), including the Australian Privacy Principles, and any regulations made under that Act as amended from time to time.
Psychiatric Impairment Rating Scale	means the scale for assessing the Whole Person Impairment of a psychiatric disorder as applied by a Psychiatrist who has undergone appropriate training in this assessment method.
Psychiatrist	means, unless we agree otherwise, a Medical Practitioner who has a fellowship accredited by The Royal Australian and New Zealand College of Psychiatrists (FRANZCP) and is currently registered as a practicing psychiatrist but shall not include psychologists or alternative health providers. The Psychiatrist must not be the Insured Person's business partner, a member of the Insured Person's immediate family or their employer.
Rate Guarantee Period	means the period, if any, set out in the Schedule.
Review Date	means the annual review date of the Policy as set out in the Schedule.
Salary	means the salary as agreed with the Policy Owner and defined in the applicable Schedule.
Schedule	means the document the Insurer sends to the Policy Owner which sets out the terms specific to the Policy Owner's Policy. A new Schedule will be issued at any time there is a change to the Policy, such as a variation in Benefit Design. The Schedule is a legal document and forms part of the insurance contract.
Special Conditions	means any alternative terms and conditions to the Policy as detailed in the Schedule.
Specialist Medical Practitioner	means a Medical Practitioner who: **a.** if the claimed Illness is a mental health condition, is a Psychiatrist who has diagnosed the condition as a mental disorder using criteria outlined in the DSM; or **b.** is a specialist as determined by the relevant medical registration boards and registered with the Australian Health Practitioner Regulation Agency (AHPRA), and is currently practicing in a specialist area related to the Illness or Injury that the claim is for.
Spouse	means a person who is (and so long as they are): **a.** a spouse or de facto spouse of an Employee, Contractor or Member who is an Insured Person; and **b.** Gainfully Employed on a permanent basis by an Australian-registered corporation.
Start Date	means the commencement date of the Policy as set out in the Schedule.

TERM	DEFINITION
Sum Insured	means the amount of cover that is in force under the Policy for an Insured Person which is agreed by us calculated in accordance with the applicable insurance Benefit Design.
Superannuation Contributions	means a compulsory contribution by an employer to a superannuation fund regulated by and complying with the *Superannuation Industry (Supervision) Act 1993* (Cth), on behalf of an Insured Person.
Takeover Terms	means Financial Services Council Guidance Note No. 11 (Group Insurance Takeover Terms) dated 9 May 2013, as may be amended or replaced from time to time.
Terminal Illness / Terminally Ill	means: **a.** two Medical Practitioners have separately certified in writing that an Insured Person suffers from an Illness, or has incurred an Injury, that is likely to result in the death of the Insured Person within a period ('the certification period') that ends not more than 12 months or 24 months (see Terminal Illness Certification Period in the Schedule for the applicable period) after the date of the certification; **b.** at least one of the registered Medical Practitioners is a Specialist Medical Practitioner; **c.** the Illness or Injury and certification referred to in paragraph (a) occurs while the Insured Person continues to have cover under the Policy; **d.** for each of the certificates, the certification period has not ended; and **e.** we are satisfied, on medical or other evidence, that despite reasonable medical treatment, the Illness or Injury will lead to the Insured Person's death within 12 months or 24 months (see Terminal Illness Certification Period in the Schedule for the applicable period) of the date of the certifications.
Total and Permanent Disablement / Totally and Permanently Disabled (TPD)	means, the Insured Person satisfies Part A, Part B, Part C or Part D as applicable in the Schedule whilst they have Total and Permanent Disablement cover in force under the Policy. **PART A – SIMILAR OCCUPATION** Total and Permanent Disablement means in our opinion, an Insured Person with Total and Permanent Disablement cover under the Policy: **1.** is, solely because of Illness or Injury, under the regular care of and following the advice of a Medical Practitioner; **2.** was, immediately prior to the Date of Claim, Gainfully Employed (or on Employer Approved Leave); **3.** is under the Benefit Ceasing Age; and **4.** the Insured Person, solely because of Illness or Injury: **a.** has been continuously unable to return to Gainful Employment from the Date of Claim for a period of at least three consecutive months; and **b.** in our opinion is unlikely to ever again engage in any Gainful Employment for which they are reasonably suited by their education, training or experience, taking account of, at the date we form our opinion: i. any retraining, re-skilling, Gainful Employment or voluntary work that has been undertaken or that could reasonably be expected to be undertaken within a reasonable period by the Insured Person; and ii. any rehabilitation that has been undertaken or could reasonably be expected to be undertaken within a reasonable period by the Insured Person, as determined by us. In forming our opinion, including whether an Insured Person may likely be able to engage in any Gainful Employment for which they are reasonably suited by education, training or experience, we will have regard to all evidence available to us including but not limited to: **1.** medical evidence (including the medical evidence provided by the Insured Person's Medical Practitioners), the advice of a Specialist Medical Practitioner approved by us, the advice of other experts (medical or otherwise) and any other information that we consider to be appropriate and relevant at the date we form our opinion; **2.** whether the Insured Person has exhausted all reasonable and appropriate treatment options by the date we form our opinion; **3.** any retraining, re-skilling, Gainful Employment or voluntary work that has been undertaken by the date we form our opinion, or that could reasonably be expected to be undertaken by the Insured Person within a reasonable period following the date we form our opinion; and **4.** any rehabilitation that has been undertaken by the date we form our opinion or could reasonably be expected to be undertaken by the Insured Person within a reasonable period following the date we form our opinion.

TERM	DEFINITION
Continued – Total and Permanent Disablement / Totally and Permanently Disabled (TPD)	**PART B – USUAL (OWN) OCCUPATION** Total and Permanent Disablement means in our opinion, an Insured Person: **1.** is, solely because of Illness or Injury, under the regular care of and following the advice of a Medical Practitioner; **2.** was, immediately prior to the Date of Claim, Gainfully Employed (or on Employer Approved Leave); **3.** is under the Benefit Ceasing Age; and **4.** the Insured Person, solely because of Illness or Injury: **a.** has been continuously unable to return to Gainful Employment from the Date of Claim for a period of at least three consecutive months; and **b.** in our opinion is unlikely to ever again engage in their Usual Occupation, taking account of, at the date we form our opinion: i. any retraining, re-skilling, Gainful Employment or voluntary work that has been undertaken or that could reasonably be expected to be undertaken within a reasonable period by the Insured Person; and ii. any rehabilitation that has been undertaken or could reasonably be expected to be undertaken within a reasonable period by the Insured Person, as determined by us. In forming our opinion, including whether an Insured Person may likely be able to engage their Usual Occupation, we will have regard to all evidence available to us including but not limited to: **1.** medical evidence (including the medical evidence provided by the Insured Person's Medical Practitioners), the advice of a Specialist Medical Practitioner approved by us, the advice of other experts (medical or otherwise) and any other information that we consider to be appropriate and relevant at the date we form our opinion; **2.** whether the Insured Person has exhausted all reasonable and appropriate treatment options by the date we form our opinion; **3.** any retraining, re-skilling, Gainful Employment or voluntary work that has been undertaken by the date we form our opinion, or that could reasonably be expected to be undertaken by the Insured Person within a reasonable period following the date we form our opinion; and **4.** any rehabilitation that has been undertaken by the date we form our opinion or could reasonably be expected to be undertaken by the Insured Person within a reasonable period following the date we form our opinion. **PART C – SPECIFIC MEDICAL CONDITIONS** Total and Permanent Disablement means in our opinion, an Insured Person: **1.** is, solely because of Illness or Injury, under the regular care of and following the advice of a Medical Practitioner; **2.** was, immediately prior to the Date of Claim, Gainfully Employed (or on Employer Approved Leave); **3.** is under the Benefit Ceasing Age; and **4.** the Insured Person, solely because of Illness or Injury: **a.** is unable to return to Gainful Employment due to a Specific Medical Condition; and **b.** in our opinion is unlikely to ever again engage in any Gainful Employment for which they are reasonably suited by their education, training or experience.

TERM	DEFINITION
Continued – Total and Permanent Disablement / Totally and Permanently Disabled (TPD)	**PART D – EVERYDAY WORK ACTIVITIES AND PSYCHIATRIC IMPAIRMENT** Total and Permanent Disablement means in our opinion, an Insured Person: **1.** is, solely because of Illness or Injury, under the regular care of and following the advice of a Medical Practitioner, or for the purposes of 4(b) of this Part D under the regular care and attention of a Psychiatrist; **2.** was, immediately prior to the Date of Claim, Gainfully Employed (or on Employer Approved Leave); **3.** is under the Benefit Ceasing Age; and **4.** the Insured Person, solely because of Illness or Injury, satisfy (a) or (b) below: **a.** due to that Illness or Injury: i. the Insured Person has been prevented from being able to perform at least two of the Everyday Work Activities without assistance from another adult person, despite the use of appropriate aids, for at least 12 consecutive months (this 12 months does not apply where the Insured Person is suffering one or more of the Specified Medical Conditions); and ii. in our opinion the Insured Person is unlikely to ever again be able to perform at least two of the Everyday Work Activities without assistance from another adult person, despite the use of appropriate aids; or **b.** the Illness is a mental disorder that: i. has been diagnosed by a Psychiatrist under the DSM; and ii. the Insured Person's treating Psychiatrist considers the Insured Person has reached Maximum Medical Improvement; and iii. has been assessed by a suitably qualified Psychiatrist, appointed by us, under the Psychiatric Impairment Rating Scale as having an impairment of 19% or above, where Maximum Medical Improvement means that the Insured Person's recovery from the Illness has reached a point where no further recovery or functional improvement is expected even with additional intervention or treatment (medical and non-medical).
Underwritten Cover	means cover or an additional amount of cover in respect of an Eligible Person and that is provided on acceptance by the Insurer of an application, including Evidence of Insurability.
Usual Occupation	means, in the case of an Insured Person who is: **a.** an Employee or Contractor, the role of the Insured Person in their employment with the Employer; and **b.** a Member or Spouse, the role of the Insured Person in their employment with the employer for whom most of their hours of Gainful Employment are undertaken. In the event of a TPD claim, Usual Occupation is determined immediately prior to Date of Claim.
Visa	means a current and valid visa issued in accordance with the *Migration Act 1958* (Cth) or any amending or replacing Act which enables an Eligible Person or Insured Person to be Gainfully Employed in Australia.
Voluntary Cover	means Underwritten Cover that is provided to an Eligible Person who is not already an Insured Person. The amount and type of cover is chosen by the Eligible Person at the time of application, within the Benefit Design.
War	means: **a.** any invasion, act of armed aggression, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, or military or usurped power, nationalisation, by or under the order of any Government, foreign nation or Public authority; **b.** acts of terrorists or other insurgent organisations; and **c.** persons actively taking part in riots, civil commotions or civil unrest.
Whole Person Impairment (or WPI)	means as defined in the American Medical Association publication titled Guides to the Evaluation of Permanent Impairment until an equivalent Australian guide, sanctioned by the Australian Medical Association, has been produced, at which time the calculation in the relevant Australian guide will apply.

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Specific medical conditions

For the purpose of the Policy, the following terms shall have the meanings as set out in the table below.

TERM	DEFINITION
Cardiomyopathy (of specified severity)	means a disease of the heart muscle characterised by structural, functional and/or electrophysiological dysfunction of the heart muscle, resulting in significant permanent and irreversible cardiac impairment to the degree of at least Class III of the New York Heart Association classification of cardiac impairment. The diagnosis, severity of the condition as well as the permanency of cardiac impairment must be confirmed by an appropriate Specialist Medical Practitioner.
Chronic Lung Failure (requiring permanent oxygen therapy)	means end-stage lung disease with a consistent pulmonary function test result of: • A forced expiratory volume in one second (FEV1) less than 40% of predicted; or • A diffusing capacity (DLCO) less than 40% of predicted; and on permanent oxygen therapy.
Dementia including Alzheimer's Disease (permanent)	means the unequivocal diagnosis of dementia by a consultant neurologist or geriatrician. The diagnosis must confirm dementia or Alzheimer's Disease due to permanent failure of brain function with associated cognitive impairment. A Mini-Mental State Examination score of 24 or less out of 30 or evidence from another neuropsychometric test that is acceptable to us is required.
Idiopathic Pulmonary Arterial Hypertension (of specified severity)	means idiopathic pulmonary arterial hypertension confirmed by investigations including cardiac right heart catheterisation, resulting in physical permanent impairment to the degree of at least Class 3 of World Health Organisation (WHO) functional class for pulmonary hypertension. The condition must be diagnosed by an appropriate Specialist Medical Practitioner.
Major Head Trauma (with permanent neurological deficit)	means accidental head injury resulting in neurological deficit causing: i. permanent Whole Person Impairment of at least 25%; or ii. the Insured Person being totally and permanently unable to perform any one of the Activities of Daily Living.
Motor Neurone Disease	means the unequivocal diagnosis of a progressive form of debilitating Motor Neurone Disease. The diagnosis must be confirmed by an appropriate Specialist Medical Practitioner and supported by clinical neurophysiology and other ancillary testing.
Multiple Sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities)	means the unequivocal diagnosis of multiple sclerosis by an appropriate Specialist Medical Practitioner. The condition must have resulted in more than one episode of well-defined neurological deficit with persisting neurological abnormalities. Neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, and evoked auditory responses are required to confirm diagnosis.
Muscular Dystrophy	means the unequivocal diagnosis of muscular dystrophy, confirmed by genetic test results and supportive investigations including electromyography. The diagnosis must be confirmed by an appropriate Specialist Medical Practitioner.
Paralysis (permanent)	means the total and permanent inability to move two or more limbs through Sickness or Injury causing permanent damage to the nervous system. This includes, but is not limited to, quadriplegia, paraplegia, diplegia and hemiplegia.
Parkinson's Disease (permanent)	means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease by an appropriate Specialist Medical Practitioner, and characterised by chronic progressive manifestation of bradykinesia with at least one of the following: • rigidity; or • rest tremor. All other types of Parkinsonism are excluded (e.g. secondary to medication).

The following definitions apply for Specific Medical Conditions definitions:

TERM	DEFINITION
Activities of Daily Living	means: • Bathing – The ability for the Insured Person to wash themselves either in the bath or shower. If the Insured Person performs these tasks by using equipment or adaptive devices, we will consider them able to bathe themselves. • Dressing – The ability for the Insured Person to put on and take off all garments. If the Insured Person is using modified clothing or adaptive devices including but not limited to tape fasteners or zipper pulls to perform this task, we will consider the Insured Person able to dress themselves. • Feeding – The ability for the Insured Person to get food from a plate into the mouth once it has been prepared. If the Insured Person is able to perform this task using assistive devices including but not limited to modified utensils and adaptive dinnerware, we will consider the Insured Person able to feed themselves. • Toileting – The ability for the Insured Person to get on and off the toilet and clean themselves. If the Insured Person can care for a stoma or catheter or uses adaptive devices to perform this task, we will consider them able to toilet themselves. • Mobility – The ability for the Insured Person to move in and out of bed and a chair. If the Insured Person uses motorised equipment and supportive devices including but not limited to bed rails, grab bars, walkers, transfer platforms and canes, we will consider the Insured Person able to mobilise themselves.
Whole Person Impairment	means as defined in the current edition of the American Medical Association publication titled Guide to the Evaluation of Permanent Impairment until an equivalent Australian guide, sanctioned by the Australian Medical Association, has been produced, at which time the definition in the relevant Australian guide will apply.

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