COMBINED PRODUCT DISCLOSURE STATEMENT AND POLICY DOCUMENT

TAL Group Plus Salary Continuance 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 Temporary Disability, Interim Accident Cover and Ancillary Benefits.

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 – Salary Continuance Insurance.

It is recommended that this PDS is read fully before making any decision to purchase or continue to hold TAL Group Plus – Salary Continuance 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 – Salary Continuance Insurance
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 – Salary Continuance Insurance

What is TAL Group Plus – Salary Continuance Insurance?

TAL Group Plus – Salary Continuance Insurance is a group insurance product that offers salary continuance insurance cover to corporations and Incorporated Associations seeking to insure a minimum of five 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 and the optional Ancillary Benefits. Please read the relevant section of this PDS for full details.

BENEFITS & FEATURES	BRIEF DESCRIPTION	SECTION
Temporary Disability Benefit (Total Disability and Partial Disability)	A monthly Benefit will be paid if an Insured Person suffers Temporary Disability. Not payable while a Specific Injury Benefit is payable.	**8**
Temporary Disability Benefit and Pre-disability Earnings indexation	The Temporary Disability Benefit payable and Pre-disability Earnings will increase each claim anniversary by the lower of the annual change in the Indexation Factor and 5%, where the Benefit Period is greater than 2 years.	**10.4**
Payment on death whilst on claim	A lump sum of 3 times the Temporary Disability Benefit will be paid if an Insured Person dies whilst on claim.	**9.2**
Recurring Disability	A Waiting Period will not apply to a subsequent Temporary Disability claim if it relates to the same or related Illness or Injury from which an Insured Person has received a Temporary Disability Benefit payment in the last 6 months.	**10.3**
Approved Rehabilitation Expense	We may pay some or all of the costs involved with a rehabilitation or return to work program for an Insured Person in receipt of a Temporary Disability Benefit.	**9.1**
Cover during Employer Approved Leave	Up to 24 months continuous cover whilst on Employer Approved Leave.	**12**
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.	**13**
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**
Interim Accident Cover	Provides cover for an Accident during the underwriting process.	**7**
Automatic Cover	Cover provided to Eligible Persons without underwriting.	**4**
AAL uplifts	Insured Persons 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**
Extended cover	Up to 60 days additional cover after the Insured Person ceases to be an Employee, Contractor, Spouse or Member.	**15**
Premium frequency	Monthly, quarterly, half-yearly or annually. For premium frequencies other than annually, a 3% loading applies.	**20.1**

OPTIONAL ANCILLARY BENEFITS AVAILABLE		
Trauma Benefit	A lump sum Benefit may be paid during or after the Waiting Period if an Insured Person suffers one of the listed Trauma conditions.	**11.1**
Specific Injury Benefit	A monthly Benefit (for up to the Maximum Benefit Payment Period) may be paid after Temporary Disability Benefits cease if an Insured Person suffers one of the listed Specific Injuries.	**11.2**
Nursing Care Benefit	A Benefit may be paid during the Waiting Period for each day an Insured Person is confined to bed and under the care of a registered nurse. Not payable if an Accommodation Benefit or Family Care Benefit is being paid.	**11.3**
Family Care Benefit	A Benefit may be paid after the Waiting Period where an Insured Person is Totally Disabled, is totally dependent on an Immediate Family Member and the Immediate Family Member suffers a loss of income due to having to care for the Insured Person. Not payable if a Nursing Care Benefit is being paid.	**11.4**
Accommodation Benefit	A Benefit may be paid during or after the Waiting Period to cover accommodation costs of an Immediate Family Member who has chosen to stay near the Insured Person while the Insured Person is confined to bed and has been relocated more than 100 kilometres from home. Not payable if a Nursing Care Benefit is being paid.	**11.5**
Continuation Option	If available under the Schedule, an Insured Person may apply for salary continuance 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 the Spouse cover option.	**16**

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 – Salary Continuance Insurance unless otherwise stated in the Schedule:

FEATURE	LIMITS AND AVAILABLE OPTIONS
Eligible Age Range	16 – 65 or 70
Maximum Cover Limit	$30,000 per month
Benefit Ceasing Age	65 or 70
Minimum number of lives	5
Waiting Period options	• 30 days; • 60 days; • 90 days; and • 180 days.
Benefit Period options	• 2 years; • 5 years; • 10 years • To Age 60; or • To Age 65.
Insured Percentage options	• 50% • 60% • 75%; • 75% for the first 2 years on claim, reducing to 50% thereafter; • 87% (including 12% Superannuation Contribution benefit); or • 87% (including 12% Superannuation Contribution benefit) for the first 2 years on claim, reducing to 62% thereafter.
Total Disability definition options	There are three Total Disability definitions available for the Policy Owner to choose from which, when selected, will be on the Schedule: • All Material and Substantial Duties; • One Material and Substantial Duty; and • All Material and Substantial Duties for the first 2 years on claim, Any Occupation thereafter.
Spouse cover option	There is the option to provide cover for a Spouse.

1

Before a TAL Group Plus – Salary Continuance Insurance Policy starts

1.1 Who can apply for group insurance?

The invitation to purchase a TAL Group Plus - Salary Continuance 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 to provide a quotation

For the Insurer to provide a corporation or Incorporated Association with group insurance, a quotation must first be provided to you. So that we can give you a quotation, you will need to provide us with information on the group of persons to be insured. This information includes:

- **a.** age;
- **b.** gender;
- **c.** occupation;
- **d.** location (including if temporarily outside Australia);
- **e.** salary;
- **f.** hours worked per week (Full-time or part time);
- **g.** employment type (permanent or contractor)
- **h.** unique identifier (for example payroll number, Member number);
- **i.** claims history (if insured previously);
- **j.** the selected Benefit Design.

We may require further information to enable us to assess the risk more accurately and provide you with 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.

You should also refer to section 21.3 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.

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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 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 Temporary Disability and any applicable Ancillary Benefits as stated in the Schedule.

Payment of Temporary Disability Benefits and some Ancillary Benefits are subject to a Waiting Period. The Waiting Period is selected by the Policy Owner and is stated on the Schedule. No Temporary Disability Benefit is payable until the Waiting Period has been completed. Some Ancillary Benefits are payable either during or after the Waiting Period. For more information, refer to sections 8 and 10.1.

2.5 Changes to the Policy

Once the Schedule is issued by the Insurer, any subsequent changes or variations to the terms and conditions of 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 20.4 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 21.3;

b. pay premiums in accordance with the Policy as outlined in section 20;

c. ensure only persons who meet the Eligibility Criteria for cover conditions 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 who meet the Eligibility Conditions (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. supply the Insurer with all information it reasonably requests each Review Date and prior to termination of the Policy;

i. execute and return the Schedule and any endorsements requested to be signed by the Insurer within 30 days of receipt; and

j. 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 the 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 person who is a Member or a Spouse will cease to be an Eligible Person if they cease to be Gainfully Employed on a permanent basis by an Australian-registered corporation. A Spouse will also 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 types, the amounts will be added together for the purposes of determining the Benefit amount for the Insured Person.

3.3 Benefit Design

The Policy Owner selects the Benefit Design (refer to page 7 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 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 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 you and us and the Sum Insured to which the AAL applies is calculated in accordance with a Benefit Design accepted by us.

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 due to a change in eligibility such as hours of work (e.g. was part time, now Full-time), 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 Automatic Acceptance Limit (AAL) and conditions for Automatic Cover (see section 4) 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 AAL 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 that the Insurer believes is necessary for assessing the risk of the Eligible Person.

The circumstances 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 increased 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 Total Disability 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 application), 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.** $15,000 per month 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 for an Eligible Person ends 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 an Eligible Person is paid under Interim Accident Cover, we will pay the amount of Interim Accident Cover as outlined in section 7.2 provided until the earliest of:

- **a.** the first day, in our reasonable opinion, the Eligible Person is no longer Totally Disabled;
- **b.** the date the Eligible Person attains the Benefit Ceasing Age;
- **c.** the date of the Eligible Person's death; and
- **d.** the end of the applicable Benefit Period.

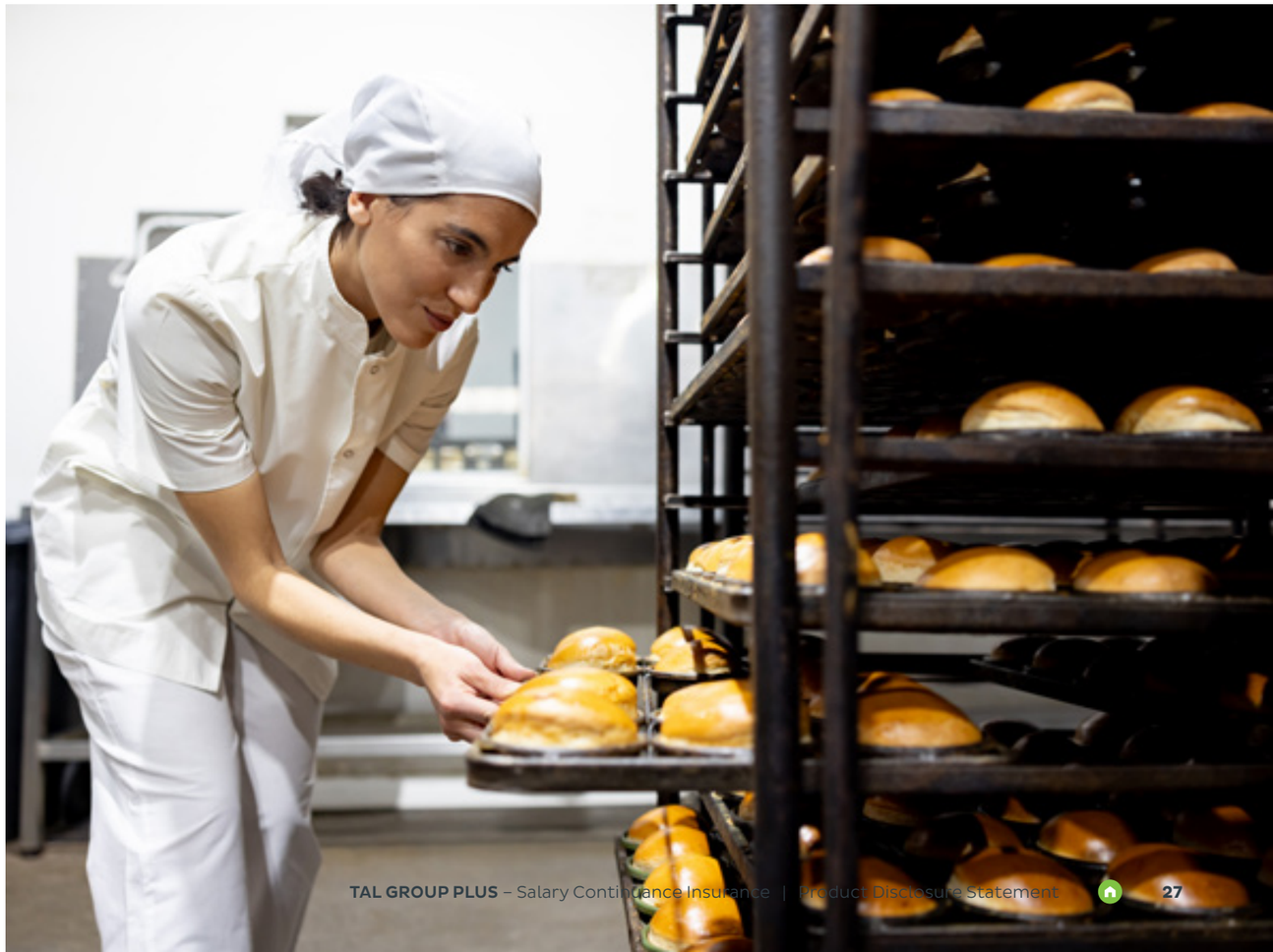
A Benefit payable under the Policy with respect to Interim Accident Cover will be reduced in accordance with section 8.2.

Ancillary Benefits as outlined in section 11 do not apply and are not payable under the Policy with respect to Interim Accident Cover.

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 21.3); or
- **c.** where the Total Disability of the Eligible Person is caused directly or indirectly by attempted suicide or self-inflicted act.



8

Temporary Disability Benefit

8.1 Benefits payable

If an Insured Person suffers Temporary Disability while cover is in force under the Policy, we will pay the Temporary Disability Benefit that applies to that Insured Person, subject to the terms of the Policy. All Benefits are paid to the Policy Owner unless instructed otherwise in writing by the Policy Owner.

An Insured Person's entitlement to a Temporary Disability Benefit starts from the end of the Waiting Period.

The Temporary Disability Benefit is payable until the earliest of:

- **a.** the first day on which the Insured Person is not Temporarily Disabled;
- **b.** the end of the Benefit Period;
- **c.** the date the Insured Person dies;
- **d.** the date the Insured Person attains the Benefit Ceasing Age;
- **e.** in the case of an Insured Person who is residing or traveling outside Australia, 6 months after the end of the Waiting Period unless they can provide supporting medical evidence to our satisfaction of continued Temporary Disability from a Medical Practitioner who has or has had the responsibility for the treatment of the Insured Person's condition;
- **f.** the date the Insured Person refuses to undertake reasonable treatment or rehabilitation as recommended by an appropriate Medical Practitioner which could, in our opinion, be expected to assist their ability to return to Gainful Employment on any basis; and
- **g.** the date the Insured Person, in our opinion, fails to take reasonable steps to return to their Usual Occupation if they have the capacity to do so.

The amount of the Temporary Disability Benefit is calculated using the following formula:

$$\frac{\text{Pre-disability Earnings} - \text{Return to Employment Earnings}}{\text{Pre-disability Earnings}} \times \text{Monthly Benefit}$$

If the Insured Percentage contains a Superannuation Contribution benefit, then this amount of the Temporary Disability Benefit will be paid to the Insured Person's nominated superannuation account.

8.2 Amount of the Temporary Disability Benefit

The Temporary Disability Benefit will be reduced to the extent that the amount in paragraph (a) below exceeds the amount in paragraph (b) or (c) below:

- **a.** the sum of the following:
  - i. the Temporary Disability Benefit amount payable for the month; and
  - ii. Other Payments that apply for the month in which the Benefit is payable; and
  - iii. Return to Employment Earnings; and
- **b.** the Insured Percentage of the Insured Person's monthly Pre-disability Earnings if Totally Disabled; or
- **c.** 100% of the Insured Person's monthly Pre-disability Earnings if Partially Disabled.

A Temporary Disability Benefit is not payable with respect to a month for which the Insured Person is treated, under section 11.2 as being paid a Specific Injury Benefit.

The maximum period we will pay a Temporary Disability Benefit for the same or related Illness or Injury with respect to an Insured Person during the lifetime of the Policy is the Benefit Period.

9

Additional benefits

9.1 Approved Rehabilitation Expense

An Insured Person who is in receipt of, or may be entitled to, a Temporary Disability Benefit may apply to the Insurer for payment of an Approved Rehabilitation Expense.

The Insurer will pay the Approved Rehabilitation Expense for the Insured Person if the expenses are for an Approved Rehabilitation Program and the expenses:

- **a.** are approved by the Insurer prior to payment; and
- **b.** will be incurred by the Insured Person to directly assist the Insured Person to return to any Gainful Employment or to increase the number of hours the Insured Person can work.

The cost of an Approved Rehabilitation Expense will be paid by the Insurer directly to the provider of the Approved Rehabilitation Program. We recommend the Insured Person contact us in advance to understand what we will pay.

9.2 Payment on death

If an Insured Person dies while receiving a Temporary Disability Benefit, Trauma Benefit or Interim Accident Cover benefit, we will pay the Policy Owner (or to another person whom you instruct) an additional sum equal to 3 times the Temporary Disability Benefit which was last paid or payable for a full month.

The payment on death while on claim will not be payable if the date of death is within 3 months of a Trauma Benefit being payable to the Insured Person.

10

Additional benefit considerations

10.1 Waiting Period

The Waiting Period will commence on the Date of Claim and the Insured Person must be Totally Disabled for at least the first 14 consecutive days of the Waiting Period and then continue to be Temporarily Disabled for the remainder of the Waiting Period for a Temporary Disability Benefit to be payable.

If an Insured Person returns to work, or in our opinion is capable of performing at least one of their Material and Substantial Duties to some extent after the first 14 consecutive days of Total Disability they will only be considered against the Partial Disability definition for a Benefit from the end of the Waiting Period.

If, during the Waiting Period, an Insured Person does not meet the definition of Temporarily Disabled for:

a. up to five consecutive days, then the Waiting Period will continue, and the Waiting Period will be extended by the total number of days the Insured Person did not meet the definition of Temporary Disability; or

b. more than five consecutive days, then a new Waiting Period will commence from when the Insured Person is next Totally Disabled.

We are not liable to pay a Temporary Disability Benefit or Family Care Benefit under the Policy until the completion of the Waiting Period with no Temporary Disability Benefit or Family Care Benefit amount accruing for the Waiting Period.

10.2 Benefit Period

The Benefit Period includes any period in which an applicable Benefit is or was payable but is calculated to be zero.

For the avoidance of doubt, we are not liable to pay a Benefit for the same or related Illness or Injury once the Benefit Period applicable to the Benefit has expired.

The Benefit Period in respect to Contractors will be limited to the outstanding term of their contract, up to a maximum of 2 years.

10.3 Recurrent Disability

A subsequent period of Temporary Disability for an Insured Person will be deemed to be a continuation of an earlier period of Temporary Disability if cover continues to be in force under the Policy in respect of the Insured Person and the Insured Person's Temporary Disability is caused, directly or indirectly, by the same or related Illness or Injury.

Where a period of Temporary Disability is deemed to be a continuation of an earlier period of Temporary Disability for which a Temporary Disability Benefit was last paid to the Insured Person:

a. if this occurs within six months of the date the Insured Person's last entitlement to a Temporary Disability Benefit under the Policy ceased (that is the date the Insured Person was no longer Temporarily Disabled), we will:

i. treat the subsequent period of Temporary Disability as a continuation of the previous claim; and

ii. waive the Waiting Period for the subsequent period of Temporary Disability; or

b. if this occurs greater than six months after the date the Insured Person's last entitlement to a Temporary Disability Benefit under the Policy ceased (that is the date the Insured Person was no longer Temporarily Disabled), a new Waiting Period will be required to be served and the Benefit Period will be the agreed Benefit Period, less the period for which a claim has already been paid for the same or related Illness or Injury.

10.4 Temporary Disability Benefit and Pre-disability Earnings indexation

We will increase the Temporary Disability Benefit and the Insured Person's Pre-disability Earnings at each 12-month anniversary of when the Temporary Disability Benefit first became payable on the current claim. Indexation is only available for Benefit Periods of greater than two years.

The amount of the increase is the lesser of:

a. the annual change in the Indexation Factor; and

b. five percent.

10.5 Payment of Benefits

If the Insured Person suffers Temporary Disability because of a separate and distinct Illness or Injury during the same claim period, we will only pay one Temporary Disability Benefit at a time for an Insured Person under the Policy.

The maximum amount payable by us for an Insured Person will not exceed the Maximum Cover Limit outlined in the Schedule.

Any Benefit payable under this Policy will be paid monthly in arrears, unless otherwise specified.

Unless provided otherwise in this Policy, if a Benefit is payable for a period of less than one month, the amount payable shall be calculated as 1/365th of the annual Benefit for every day that it is payable.

11

Ancillary Benefits

Whether any or all of the following Ancillary Benefits are provided will be stated in the Schedule.

The following Ancillary Benefits are available:

- Trauma Benefit;
- Specific Injury Benefit;
- Nursing Care Benefit;
- Family Care Benefit; and
- Accommodation Benefit.

11.1 Trauma Benefit

If applicable in the Schedule, an Insured Person can claim a Trauma Benefit at any time, including during the Waiting Period, where they are first diagnosed as having suffered a trauma condition, listed in the table in section 11.1.3 provided the following conditions are met:

a. the trauma condition must have first occurred on or after the date they became an Insured Person for a Trauma Benefit under the Policy;

b. the trauma condition must be diagnosed by a Medical Practitioner and supported by appropriate clinical, histological and laboratory evidence; and

c. any specific treatment forming part of the definition of the trauma condition specified in Section 23 must have been undertaken.

11.1.1 When the Trauma benefit is payable

A Trauma Benefit will be paid once only with respect to an Insured Person during the lifetime of the policy and will be paid as a lump sum. If the Insured Person suffers more than one listed Trauma condition at the same time, the Insured Person will only be entitled to be paid for the Trauma condition which provides the greatest Benefit amount.

A Trauma Benefit is paid in addition to other Benefits payable.

11.1.2 Amount of the benefit

The Trauma Benefit is 3 times the Monthly Benefit amount.

11.1.3 Trauma conditions

HEART CONDITIONS	NEUROLOGICAL CONDITIONS	PERMANENT CONDITIONS	ORGAN DISORDERS
• Angioplasty • Aortic Surgery • Cardiomyopathy (of specified severity) • Coronary Artery Bypass Surgery • Heart Attack • Idiopathic Pulmonary Arterial Hypertension (of specified severity) • Triple Vessel Angioplasty	• Coma (of specified severity) • Dementia including Alzheimer's Disease (permanent) • Encephalitis and Meningitis (resulting in permanent neurological deficit) • Major Head Trauma (with permanent neurological deficit) • Meningococcal Disease (resulting in significant permanent impairment) • Motor Neurone Disease • Multiple Sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities) • Muscular Dystrophy • Paralysis (permanent) • Parkinson's Disease (permanent) • Stroke (resulting in neurological deficit)	• Loss of sight in at least one eye (permanent) • Deafness (permanent) • Loss of Independent Existence (permanent) • Loss of at least one Limb (permanent) • Loss of Speech (permanent)	• Chronic Kidney Failure (requiring permanent dialysis) • Chronic Liver Failure (resulting in permanent symptoms) • Chronic Lung Failure (requiring permanent oxygen therapy) • Major Organ Transplant • Pneumonectomy

BLOOD DISORDERS	CANCERS	OTHER EVENTS
• Aplastic Anaemia (requiring treatment) • Medically Acquired HIV (contracted from a medical procedure or operation) • Occupationally Acquired HIV • Occupationally Acquired Hepatitis B or C	• Benign Brain Tumour (resulting in irreversible neurological deficit) • Cancer (excluding early-stage cancers)	• Severe Burns (of specified severity) • Severe Diabetes Mellitus

11.2 Specific Injury Benefit

If applicable in the Schedule, and subject to 11.2.1 below, an Insured Person can claim a Specific Injury Benefit where they suffer one of the Specific Injuries listed. We will pay at any time, including during the Waiting Period, a Specific Injury Benefit whether or not the Insured Person is working.

11.2.1 When the Specific Injury Benefit is payable

Entitlement to a Specific Injury Benefit starts to accrue from the later of the date the Specific Injury is suffered and the date any Temporary Disability Benefit already being paid ceases to be payable and is paid monthly in arrears until the end of the earliest to occur of:

- **a.** the number of months in the applicable Maximum Benefit Payment Period listed in the table below for the relevant Specific Injury;
- **b.** the number of complete months until the Insured Person reaches the Benefit Ceasing Age; and
- **c.** the end of the Benefit Period.

If more than one Specific Injury is suffered by an Insured Person during a particular Maximum Benefit Payment Period referred to in the table, only the Specific Injury that provides the greatest Benefit amount will be paid.

The amount of the Specific Injury Benefit is the Monthly Benefit amount.

In a month in respect of which the Specific Injury Benefit is treated as being payable it is paid instead of any Temporary Disability Benefit the Insured Person claims.

If the Insured Person is Temporarily Disabled at the end of the relevant Maximum Benefit Payment Period in the table, a claim for a Nursing Care Benefit and Temporary Disability Benefit will be determined in accordance with the terms and conditions of this Policy.

The maximum period we will pay a Specific Injury Benefit for the same or related Illness or Injury with respect to an Insured Person during the lifetime of the Policy is the Benefit Period.

The table sets out the Maximum Benefit Payment Period for each Specific Injury. A Specific Injury in in the table has the meaning given to it, if any, in section 23 Medical Definitions.

If an Insured Person dies while we are paying a Specific Injury Benefit for that person under this Policy, we will pay the Policy Owner an additional sum equal to the remaining number of Specific Injury Benefit payments outlined in the table below.

SPECIFIC INJURY	MAXIMUM BENEFIT PAYMENT PERIOD (NUMBER OF MONTHS)
Paralysis (permanent)	60
Loss of Two Limbs, or Loss of Sight in Both Eyes	24
Loss of a Single Limb (permanent) and Loss of Sight in One Eye (permanent)	24
Loss of a Single Limb (permanent), or Loss of Sight in One Eye (permanent)	12
Loss of thumb and index finger on the same hand	6
Fracture of the femur, or fracture of the pelvis	3
Fracture of the humerus, or fracture of the clavicle	2

11.3 Nursing Care Benefit

The Nursing Care Benefit is designed to provide an Insured Person with financial support for any nursing care.

11.3.1 When the Nursing Care Benefit is payable

If applicable in the Schedule, a Nursing Care Benefit will be payable during the Waiting Period for an Insured Person who is Totally Disabled provided a Medical Practitioner certifies all of the following:

- **a.** the Insured Person is under the care of a registered nurse visiting at least once a day;
- **b.** the Insured Person's confinement to bed is for a period of more than 48 continuous hours; and
- **c.** after an initial period of more than 48 hours of confinement to bed, the Insured Person requires bed rest for a substantial part of each subsequent day.

A Nursing Care Benefit is payable once we receive certification by the Medical Practitioner of the above and is payable only once for the same or related Illness or Injury.

If an Accommodation Benefit or Family Care Benefit is being paid with respect to the same or related Illness or Injury, a Nursing Care Benefit will not be payable with respect to the Insured Person.

11.3.2 Amount of the Nursing Care Benefit

The Nursing Care Benefit is 1/30th of the Temporary Disability Benefit for each day the above conditions are met.

11.3.3 When does the Nursing Care Benefit payment end?

The Nursing Care Benefit payment ceases on the earliest of:

- **a.** the date the above conditions are not met;
- **b.** the expiry of the Waiting Period;
- **c.** 90 days of the Nursing Care Benefit being paid;
- **d.** the date the Insured Person dies; and
- **e.** the date the Insured Person reaches the Benefit Ceasing Age.

11.4 Family Care Benefit

A Family Care Benefit is designed to compensate an Immediate Family Member upon whom the Insured Person has become totally dependent for their essential needs due to an Illness or Injury and who has suffered a loss of income due to having to take care of the Insured Person.

11.4.1 When the Family Care Benefit is payable

If applicable in the Schedule, a Family Care Benefit will be payable after the Waiting Period, where:

- **a.** the Insured Person is Totally Disabled;
- **b.** the Insured Person is totally dependent on an Immediate Family Member for their essential needs due to an Illness or Injury;
- **c.** the income of the Insured Person's Immediate Family Member referred to in paragraph b) is reduced as a result of having to take care of the Insured Person; and
- **d.** the Insured Person has provided evidence to our satisfaction which demonstrates the Immediate Family Member's loss of income whilst caring for the Insured Person during their period of Total Disability.

Any such payments will be made to the nominated Immediate Family Member.

The Family Care Benefit is payable once for the same or related Illness or Injury.

If a Nursing Care Benefit is being paid with respect to the same or related Illness or Injury, a Family Care Benefit will not be payable with respect to the Insured Person.

11.4.2 Amount of the Family Care Benefit

The Family Care Benefit is payable for each day the Immediate Family Member has taken care of the Insured Person and is the lesser of:

- **a.** the amount of the reduction in the Immediate Family Member's pre-tax monthly income (averaged over the last 12 months) calculated on a daily basis; and
- **b.** the amount equal to 50% of the Insured Person's Temporary Disability Benefit calculated on a daily basis.

11.4.3 When the Family Care Benefit payment ends

The Family Care Benefit is payable for up to 90 days as long as the above conditions are met.

11.5 Accommodation Benefit

The Accommodation Benefit allows an Immediate Family Member to be accommodated near the Insured Person to take care of them where the Insured Person has been relocated because of their Illness or Injury and is confined to a bed.

11.5.1 When the Accommodation Benefit is payable

If applicable on the Schedule, an Accommodation Benefit is payable at any time, including during the Waiting Period, for an Insured Person where an Immediate Family Member has chosen to stay at a place near the Insured Person provided the Insured Person:

- **a.** is Totally Disabled;
- **b.** is confined to a bed due to an Injury or Illness for a substantial part of each day; and
- **c.** on the advice of the Insured Person's Medical Practitioner, has been relocated from home to a place more than 100 kilometres from the Immediate Family Member whom the Insured Person has nominated as their carer.

Any payment will be made to the Immediate Family Member as long as they can provide evidence to our satisfaction which demonstrates that they incurred the accommodation expense.

The Accommodation Benefit is payable once for the same or related Illness or Injury.

If a Nursing Care Benefit is being paid with respect to the same or related Illness or Injury, an Accommodation Benefit will not be payable with respect to the Insured Person.

11.5.2 Amount of the Accommodation Benefit

The Accommodation Benefit is payable for each night the nominated Immediate Family Member stays at the place near the Insured Person and is the lesser of:

a. the actual accommodation cost per night; and

b. $250 per night's accommodation.

11.5.3 When the Accommodation Benefit payment ends

The Accommodation Benefit is payable once for up to 30 days in any 12-month period.

12 Employer Approved Leave

12.1 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.

Where an Insured Person becomes Temporarily Disabled during a period of unpaid Employer Approved Leave, the Temporary Disability Benefit will start to accrue from the later of:

- **a.** the day after the expiry of the Waiting Period, and
- **b.** the return-to-work date for their 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 Insurance Cover will cease at the end of the relevant period (see Section 17). If the person would like to reinstate their Insurance Cover, they will need to be underwritten.

13 Overseas cover

13.1 Overseas cover

In addition to section 12, 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:

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

13.2 Underwriting overseas

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

13.3 Assessment of a claim overseas

In addition to the claims requirements in section 19, in the case of an Insured Person who is residing or travelling outside Australia, a Temporary Disability Benefit and any applicable Superannuation Contribution benefit will continue for up to six months whilst overseas. After six months the Insured Person will need to provide supporting medical evidence to our satisfaction to continue receiving a Temporary Disability Benefit and any applicable Superannuation Contribution benefit.

The Insurer may require the Insured Person to return to Australia for assessment of their claim. Any costs incurred by the Insured Person 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 incurred overseas by the Insured Person for tests or medical information in respect of a claim by the Insured Person.

14

Exclusions, restrictions and limitations

14.1 Exclusions on cover

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

No Temporary Disability Benefit will be payable if the claim is caused by, or in any way is contributed to by:

a. an intentional self-inflicted injury;

b. normal pregnancy or childbirth unless Temporary Disability continues for longer than 3 months after the pregnancy ends, in which case the Temporary Disability will be considered to have commenced at the date the pregnancy ends;

c. War;

d. service in the armed forces of any national or international organisation (other than non-active service within Australian armed forces reserve units within Australia);

e. any exclusions outlined in the Special Conditions of the relevant Schedule that applies to the Insured Person; or

f. any exclusions or restrictions we may apply to an Insured Person as a condition of acceptance of cover.

14.2 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.

14.3 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.

14.4 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.

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

Where an Insured Person's Sum Insured increases 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.

14.6 Failure to notify Salary at the Review Date

If 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.

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

If:

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

b. 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 any additional premium being paid effective from the date of the increase in the Sum Insured resulting from the Salary increase.

14.8 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 we 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 17 would have been different had the correct date of birth been provided, then the Insurer may instead vary the cover by changing its cessation date to the date that would have been the cessation date if the cover had been based on the correct date of birth.

14.9 Maximum Cover Limits

We will limit any Temporary Disability Benefit and any applicable Superannuation Contribution benefit payable to an Insured Person with respect to a particular month to the Maximum Cover Limit stated in the Schedule. Similarly, we will limit the amount of the Temporary Disability Benefit used to calculate payment on death whilst on claim or an Ancillary Benefit to the Maximum Cover Limit stated in the Schedule.

14.10 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 has Person has not complied with the duty to take reasonable care not to make a misrepresentation as stated in Section 21.3.

14.11 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 or other payments will not be made until such time as any premiums owing have been received.

14.12 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.

15

Extended Cover

15.1 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.

15.2 When Extended Cover ceases

Extended Cover ceases for an Insured Person on the earliest of:

- **a.** 60 days after the Insured Person ceases to meet the requirements to be an Employee, Contractor, Member or Spouse;
- **b.** the date an application for a Continuation Option is accepted or declined by us (see section 16);
- **c.** the date an Insured Person obtains insurance under another policy for the same or similar benefits as those provided under the Policy; and
- **d.** the date cover ends under section 17 (other than on ceasing to meet the requirements to be an Employee, Contractor, Member or Spouse).

16

Continuation Option

16.1 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.

16.2 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 they ceased to be an Employee or a Contractor of the Employer or a 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.

17 When cover ceases

17.1 Cessation of cover

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

- **a.** the date the Policy terminates;
- **b.** the date they reach Benefit Ceasing Age;
- **c.** subject to Extended Cover, the date they cease to meet the Policy 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 the Insured Person dies;
- **g.** the date we receive a notification from the Policy Owner to cancel cover for an Insured Person;
- **h.** the date the Insured Person no longer meets the Eligibility Criteria;
- **i.** the date 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;
- **j.** the date an individual life insurance policy is issued to the Insured Person by us under a Continuation Option; and
- **k.** the date the Insured Person has exceed 24 months, or the otherwise agreed period, of Employer Approved Leave.

18 When the Policy ends

18.1 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 the premiums remaining unpaid (see Section 20);
- **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.

18.2 No cash value on termination

The Policy has no cash value on termination.

19 Claims

19.1 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, on an ongoing basis if required; 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.

19.2 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 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, 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;

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.

A claim payment will be dependent on the Insured Person being or having been under the care and following or having followed the reasonable advice and treatment plan of a Medical Practitioner and an appropriate Specialist Medical Practitioner (where applicable) which includes:

a. following the treatment advice and actively engaging in the treatment plan developed by a Medical Practitioner and Specialist Medical Practitioner, including health and return to work plan, medication, specialist intervention and therapies; and

b. following and actively participating in an accredited Rehabilitation Service, an Approved Rehabilitation Program or return to work program, where appropriate.

Benefit payments may be withheld if the Insured Person:

a. is not following the advice or treatment plan as prescribed by the Medical Practitioner;

b. is not under the care of an appropriate Specialist Medical Practitioner, where appropriate; or

c. is not meeting their injury management plan obligations, work capacity assessment obligations and return to work obligations.

19.3 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.

19.4 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 to us in writing; and

b. the terms of the Policy.

19.5 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 initial and ongoing assessment of any claim.

19.6 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.

20 Costs

20.1 Premiums

Premiums for salary continuance 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 the Policy Owner's 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 outline the period during which Premium Rates will not change, unless one of the below triggers in section 20.4 occurs.

20.2 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 – Salary Continuance 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, 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 misstatements 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.

20.3 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 20.4. Premiums may be varied at the expiry of the Rate Guarantee Period by providing 30 days' notice.

20.4 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 20.2 for factors the Insurer takes into account in determining any Premium Rate changes.

20.5 Premium waiver while on claim

We will waive any premiums payable in respect of an Insured Person during payment of a Benefit while they are in receipt of a Temporary Disability Benefit.

20.6 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.

21 Additional information

21.1 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.

21.1.1 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.

21.2 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.

21.3 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 under TAL Group Plus – Salary Continuance 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.

21.3.1 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.

21.3.2 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.

21.3.3 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.

21.3.4 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.

21.4 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.

21.5 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.

21.6 Governing law

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

21.7 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.

21.8 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.

21.9 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.

21.10 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.

21.11 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 in relation to the Policy. An input tax credit will not be available to the Policy Owner.

21.12 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.

21.13 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.

22 Definitions

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

TERM	DEFINITION
Accident	means an unforeseen violent, external and visible event.
Accommodation Benefit	means, if applicable in the Schedule, a benefit payable in accordance with section 11.4.
Ancillary Benefit	means, if specified in the Schedule, any one or more of the following: **a.** Specific Injury Benefit **b.** Trauma Benefit **c.** Nursing Care Benefit **d.** Family Care Benefit **e.** Accommodation Benefit
Any Occupation	means an occupation that the Insured Person is reasonably suited for after considering the Insured Person's work experience, training, education and transferable skills regardless of whether the work or employment is available. An occupation that an Insured Person is reasonably suited for includes suitable alternate occupations where up-skilling is required, and the training course/program can be completed within 12 months on a Full-time basis or 24 months on a part-time basis.
Approved Rehabilitation Expense	means an expense that may be paid under section 9 for occupational or vocational rehabilitation services to assess, assist and support an Insured Person who is on a claim, to return (or attempt to return) to their occupational duties, any other occupation or new vocational options. It excludes any program providing hospital treatment or an ancillary health service within the meaning of the Health Insurance Legislation or any other program which might cause the Policy to cease to be exempt from the relevant Health Insurance Legislation.
Approved Rehabilitation Program	means a program, device or course of treatment approved by us and a Medical Practitioner that will assist in the Insured Person's rehabilitation and their return to work, but excluding any program that might contravene or cause the Policy to cease to be exempt from any provision in the Health Insurance Legislation.
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; **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 applicable 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(s)	means an insured benefit payable under the Policy that is: **a.** a Temporary Disability Benefit; and **b.** if applicable, an Ancillary Benefit.
Benefit Ceasing Age	means the day the person 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 apply to the Policy Owner when the Policy is in force.
Benefit Period	means the maximum period for which we will pay a Temporary Disability Benefit and/or a Specific Injury Benefit as specified in the Schedule.

TERM	DEFINITION
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 16.
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 the later of the following: **a.** the date the Insured Person ceases to work due to Illness or Injury; and **b.** the date a Medical Practitioner 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. If (b) is less than seven days after (a) then the Waiting Period will commence on the date determined under (a) otherwise it will be the date determined under (b).
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 applicable Schedule to determine whether an Eligible 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 Eligible Persons.
Employer Approved Leave	means leave (including unpaid leave) that has been granted by **a.** in the case of an Employee or Contractor, the Employer; and **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.
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 15.
Family Care Benefit	means, if applicable in the Schedule, a benefit payable in accordance with section 11.5.
Forward Underwriting Limit (FUL)	means the maximum level to which an Insured Person's cover can be increased in the future by means of their 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	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.
Immediate Family Member	means spouse, partner, de-facto, children, parents and siblings.
Income Support Benefits	means monetary benefits which are paid or entitled to be paid to replace a person's loss of income or income earning capacity as a result of Illness or Injury 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.
Indexation Factor	means the percentage change in the Consumer Price Index (Weighted Average All Capital Cities) as last published by the Australian Bureau of Statistics in respect of the 12-month period finishing on 30 September of each year. This factor will be determined at 30 November each year and applied, where indicated, for the following calendar year. If the Consumer Price Index (Weighted Average All Capital Cities) is not published by 30 November or is no longer produced, then the Indexation Factor will be calculated based upon a retail price index we consider to be a reasonable replacement. If the percentage change in the Consumer Price Index (Weighted Average All Capital Cities), or any substitute for it, is negative, the Indexation Factor will be taken as zero.
Injury	means bodily injury solely resulting from an Accident.
Insured Percentage	means the percentage as outlined in the Schedule.
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 Total Disability 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.

TERM	DEFINITION
Material and Substantial Duty	means a Duty of an Insured Person's Usual Occupation which generates their Pre-disability Earnings. **Duty** means the activities or tasks that are normally required for, and form a significant and integral part of, the performance of the Insured Person's Usual Occupation that cannot be omitted or modified. Duties do not include: **a.** activities or tasks which are not necessary to perform the occupation within the trade/profession (for example, duties that are not necessary with another employer or within another business); or **b.** the commute to and from a place of work.
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.
Monthly Benefit	means the lesser of: **a.** the amount calculated by multiplying the applicable Insured Percentage by the Insured Person's Pre-disability Earnings **b.** the amount of cover we have agreed to provide in respect of the Insured Person; and **c.** the Maximum Cover Limit.
Nursing Care Benefit	means, if applicable in the Schedule, a benefit payable in accordance with section 11.3.

TERM	DEFINITION
Other Payment(s)	means, subject to paragraphs (d) and (e) of this definition, any amount paid or payable in connection with, or arising out of, the Illness or Injury causing the Insured Person's Temporary Disability which they may receive or be entitled to receive during a month a benefit is payable including but not limited to: **a.** any amount paid or payable: i. under another income protection insurance policy, salary continuance insurance policy, loan protection insurance policy, or similar policy, in any jurisdiction; ii. under any workers' compensation, motor accident compensation, statutory compensation or similar scheme, however named, in any jurisdiction or other similar state, federal, territory or extraterritorial legislation; iii. under unwritten law or under state, federal, territory or extraterritorial legislation; iv. as employer-funded sick leave, personal leave or any other employer-paid leave in any jurisdiction; **b.** any out of court settlement sum, or any award of money sum by a court, tribunal, arbitrator or government body in any jurisdiction; **c.** whether an amount under paragraph (a) or (b) of this definition is: i. a lump sum, a periodic payment, a combination of a lump sum and a periodic payment, or otherwise; or ii. in the nature of a capital payment or income payment (as those terms are understood having regard to normal accounting standards and practice), has no bearing on whether that amount is an Other Payment or otherwise; **d.** note that an Other Payment does not include: i. an amount paid or payable under this Policy or Return to Employment Earnings; ii. payment from Centrelink, Department of Veterans Affairs, or any equivalent or replacement agencies; iii. a total and permanent disability, terminal illness or critical illness type lump sum benefit; iv. annual leave or long service leave; or v. a pension or annuity paid from a superannuation fund other than a disability pension, whether a lump sum, a periodic payment, a combination of a lump sum and a periodic payment, or otherwise; **e.** in addition to the amounts, benefits and payments excluded under paragraph (d), we will not consider any portion of an amount paid or payable to the Insured Person to be an Other Payment, if the Insured Person establishes to our satisfaction, acting reasonably, that it represents or covers compensation for or payment in respect of: i. pain and suffering; ii. the loss of a part, or the use of a part of the body to the extent that such compensation is not income or capital (as those terms are understood having regard to normal accounting standards and practice); iii. medical expenses; or iv. reasonable legal expenses, and, for clarity, to the extent that the Insured Person cannot establish to our satisfaction, acting reasonably, that any portion of an amount paid or payable to them represents compensation for or payment in respect of those items set out in paragraphs (e)(i) to (e)(iv) above, the entirety of that amount will be deemed to be an Other Payment; and **f.** where an Other Payment is in the form of a lump sum or is commuted to a lump sum, unless You and we agree otherwise, the Monthly Benefit will be reduced by an amount equal to one sixtieth (1/60) of the lump sum over a period of sixty months or the remainder of the Benefit Period, whichever is the less.

TERM	DEFINITION
Partial Disability/ Partially Disabled	means that solely because of Illness or Injury, the Insured Person is: **a.** working (whether or not for remuneration) in a reduced capacity or capable of performing at least one of their Material and Substantial Duties; **b.** following the advice and treatment plan of a Medical Practitioner in relation to the Illness or Injury; **c.** not capable of working more than 80% of the Insured Person's usual average working hours in the 12 months immediately before the start of the Waiting Period. The usual average working hours immediately before the start of the Waiting Period will be limited to 40 hours a week (if the Insured Person was working more than 40 hours a week); and **d.** is unable to perform at least one Material and Substantial Duty necessary to generate income in the Insured Person's Usual Occupation. All work undertaken by the Insured Person must be approved by us and the Insured Person's Medical Practitioner. An Insured Person will be considered to be able to perform a Material and Substantial Duty of their Usual Occupation if they refuse to accept: **a.** any reasonable modification or substitution of that duty; or **b.** the use of any appropriate assistive aids, including those available to them through our Rehabilitation Service, that would enable the Insured Person to perform that duty.
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 Insured Person.
Policy	means the TAL Group Plus – Salary Continuance 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.
Pre-disability Earnings	means the Insured Person's Salary immediately before the start of the Waiting Period. If the Insured Person is on unpaid Employer Approved Leave, Pre-disability Earnings will be calculated based on the period immediately before the Insured Person went on unpaid Employer Approved Leave.
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 salary continuance 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.
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.

TERM	DEFINITION
Rehabilitation Service	means a service to assess, assist and support a claimant to return (or attempt to return) to their occupational duties or to adopt an alternative vocation. Such Rehabilitation Services arranged or nominated by us may include (but will not be limited to): **a.** engagement in a program or service approved and considered by us to be likely to assist in the successful rehabilitation of an Insured Person but excluding any program providing "hospital treatment" or "general treatment" within the meaning of the Health Insurance Legislation or any other program which might cause the policy to cease to be exempt from the relevant Health Insurance Legislation; **b.** modifications to an Insured Person's work environment; **c.** house and car modifications; **d.** work experience programs providing Insured Persons with opportunities to gain work experience that we reasonably consider will assist in obtaining future ongoing employment; or **e.** employment assistance through the provision of employment services to unemployed Insured Persons including counselling, action planning, job-search skills, job-placement services, the provision of labour market information, case management and follow-up; or retraining to assist the Insured Person with obtaining employment skills for their own reasonable re-training and re-skilling.
Review Date	means the annual review date of the Policy as set out in the Schedule.
Return to Employment Earnings	means, in respect of an Insured Person who is Partially Disabled, the income received by the Insured Person during the month they make or which, though not actually received during the month, we reasonably apportion to them for the month, and any income which, in our opinion, they could reasonably be expected to earn while Partially Disabled during that month. Where an Insured Person who is Partially Disabled becomes self-employed, Return to Employment Earnings will be the Insured Person's share of the net profit and/or net loss of the business, whether the income is paid to them or not. Income from the Insured Person's business is calculated after the deduction of expenses necessarily incurred or normally required in producing that income but before the deduction of tax. The potential Return to Employment Earnings will take into consideration the Insured Person's Return to Employment Earnings compared to the number of hours worked, and their capability to work compared to their average weekly working hours in the 12 months immediately before the start of the Waiting Period. The average working hours immediately before the start of the Waiting Period will be limited to the lesser of: **a.** the Insured Person's normal average weekly working hours (excluding overtime); and **b.** 40 hours a week. The potential Return to Employment Earnings will also take into consideration medical advice, which may include the opinion of the Insured Person's Medical Practitioner, the advice of experts in remuneration levels in the occupations that the Insured Person is capable of performing, and other relevant information that we consider to be appropriate.
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 **c.** is currently practicing in a specialist area related to the Illness or Injury that the claim is for.
Specific Injury Benefit	means, if applicable in the Schedule, a benefit payable in accordance with section 11.2.

TERM	DEFINITION
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 start date of the Policy and is stated in the Schedule.
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 Contribution	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 amended from time to time.
Temporarily Disabled / Temporary Disability	means Total Disability or Partial Disability, as applicable.
Temporary Disability Benefit	means the Benefit described in section 8 payable in respect of either Total Disability or Partial Disability.
Totally Disabled / Total Disability	means, the Insured Person satisfies Part A, Part B or Part C as applicable in the Schedule whilst they have cover in force under the Policy. **PART A – ALL MATERIAL AND SUBSTANTIAL DUTIES OF USUAL OCCUPATION** Totally Disabled means that solely because of Illness or Injury, the Insured Person is: **a.** not working in any capacity (this includes Full-time, part-time and casual), whether or not for remuneration; **b.** following the advice and treatment plan of a Medical Practitioner in relation to the Illness or Injury, and **c.** unable to perform all the Material and Substantial Duties necessary to generate income in the Insured Person's Usual Occupation (if the Insured Person is able to perform any duties necessary to generate income in their Usual Occupation, they are not Totally Disabled). **PART B – ONE MATERIAL AND SUBSTANTIAL DUTY OF USUAL OCCUPATION** Totally Disabled means that solely because of Illness or Injury, the Insured Person is: **a.** not working in any capacity (this includes Full-time, part-time and casual), whether or not for remuneration; **b.** following the advice and treatment plan of a Medical Practitioner in relation to the Illness or Injury, and **c.** unable to perform one of the Material and Substantial Duties necessary to generate income in the Insured Person's Usual Occupation (if the Insured Person is able to perform any duties necessary to generate income in their Usual Occupation, they are not Totally Disabled).

TERM	DEFINITION
Continued – Totally Disabled / Total Disability	**PART C – ALL MATERIAL AND SUBSTANTIAL DUTIES OF USUAL OCCUPATION, ANY OCCUPATION SWITCH** Totally Disabled means that solely because of Illness or Injury, the Insured Person is: **a.** not working in any capacity (this includes Full-time, part-time and casual), whether or not for remuneration; **b.** following the advice and treatment plan of a Medical Practitioner in relation to the Illness or Injury; **c.** unable to perform all the Material and Substantial Duties necessary to generate income in the Insured Person's Usual Occupation (if the Insured Person is able to perform any duties necessary to generate income in their Usual Occupation, they are not Totally Disabled); and **d.** after the expiry of the first 2 years of the Benefit Period, the Insured Person is unable to perform Any Occupation. **APPLICABLE TO ALL TOTAL DISABILITY DEFINITIONS** If the Insured Person had been working in more than one occupation, Usual Occupation will include all of those occupations. An Insured Person will be considered to be able to perform a Material and Substantial Duty of their Usual Occupation or Any Occupation as applicable, if they refuse to accept: **a.** any reasonable modification or substitution of that duty; or **b.** the use of any appropriate assistive aids, including those available to them through our Rehabilitation Service, that would enable the Insured Person to perform that duty.
Trauma Benefit	means, if applicable in the Schedule, a benefit payable in accordance with section 11.1.
Underwritten Cover	means cover or an additional amount of cover in respect of an Insured 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.
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.
Waiting Period	means a continuous period specified in the Schedule.
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.

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Medical definitions

Where improvements are made to the following conditions and related definitions, as documented in sections 11.1 and 11.2 as at the date of this PDS and updated regularly, these improved definitions will be included in your Policy. In the unlikely event you and/or the Insured Person are unexpectedly disadvantaged in any way, the former wording of the definition will apply. If the Insured Person has any existing symptoms before an improved condition definition being included, the Insured Person will be assessed at claim time on the definition that provides the better outcome for the Insured Person.

TERM	DEFINITION
Angioplasty	means the actual undergoing of coronary artery angioplasty, which is an endovascular procedure to correct a narrowing or blockage of one or more coronary arteries. Payment is limited to the amount of Temporary Disability Benefit for one month.
Aortic Surgery	means surgery to repair or correct an aortic aneurysm, aortic dissection, an obstruction of the aorta, a coarctation of the aorta or traumatic injury to the aorta. For the purpose of this definition, aorta means the aortic arch, ascending aorta and descending aorta, but not its branches.
Aplastic Anaemia (requiring treatment)	means unequivocal diagnosis of aplastic anaemia by a Specialist Medical Practitioner resulting in at least two of the following: • anaemia; • neutropenia; or • thrombocytopenia; and Requiring ongoing treatment with at least one of the following: • blood product transfusion; • marrow stimulating agents; • immunosuppressive agents; or • bone marrow transplantation.
Benign Brain Tumour (resulting in irreversible neurological deficit)	means a non-cancerous tumour in the brain, meninges, pituitary gland or spinal cord, resulting in irreversible neurological deficit which has caused: • permanent Whole Person Impairment of at least 25%; or • the Insured Person to be totally and permanently unable to perform any one of the Activities of Daily Living. The presence of the underlying tumour must be confirmed by CT Scan, MRI or other imaging studies. Cysts, granulomas, vascular aneurysms or haematomas are not covered.

TERM	DEFINITION
Cancer (excluding early stage cancers)	means any malignant tumours diagnosed with histological or cytological confirmation and characterised by: • the uncontrolled growth of malignant cells; and • invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders. The following are not covered: • All tumours which are histologically described as any of the following: **a.** pre-malignant; **b.** non-invasive (includes tumours that are classified as Tis, Cis or pTa unless stated otherwise); **c.** low-grade or high-grade dysplasia; or **d.** borderline or low malignant potential. • All carcinoma in situ except the following: **a.** Carcinoma in situ of the breast which requires the removal of the entire breast. **b.** Carcinoma in situ of the breast which requires breast conserving surgery with either radiotherapy or chemotherapy. **c.** Carcinoma in situ of the testicle that requires removal of the entire testicle. • All skin melanomas unless the melanoma: **a.** has evidence of metastasis; **b.** is at least Clark level 3; **c.** is showing signs of ulceration; or **d.** is greater than 1.0mm maximum thickness using the Breslow method. • All non-melanoma skin cancers unless they have spread to the bone, lymph node or other distant organs. • Chronic lymphocytic leukaemia unless it has progressed to Rai stage 1 or more. • All prostatic cancers unless the prostate cancer: **a.** has a Gleason score of 6 or more; or **b.** requires major interventional therapy including radiotherapy, chemotherapy, biological response modifiers or any other major treatment to arrest the spread of malignancy. If a surgical procedure is performed, it must be considered appropriate and necessary to arrest the spread of malignancy.
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 Kidney Failure (requiring permanent dialysis)	means the actual undergoing of permanent dialysis treatment prescribed by a renal physician due to impairment of kidney function to a severity constituting end stage kidney failure.
Chronic Liver Failure (resulting in permanent symptoms)	means end stage decompensated liver failure characterised by the presence of liver cirrhosis and development of complications of cirrhosis, including jaundice, ascites and/or encephalopathy.
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.

TERM	DEFINITION
Coma (of specified severity)	means a state of unconsciousness which requires mechanical ventilation by means of tracheal intubation for a continuous period of at least 72 hours. No amount will be paid where Coma of the Insured Person results from the use of alcohol, recreational or non-prescribed drugs, or any drug taken other than as medically directed.
Coronary Artery Bypass Surgery	means bypass grafting performed to correct or treat coronary artery disease.
Deafness (permanent)	means the irrecoverable profound loss of all hearing below 91 decibels, both natural and assisted, as a result of Illness or Injury.
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.
Encephalitis and Meningitis (resulting in permanent neurological deficit)	means the unequivocal diagnosis of encephalitis or meningitis where the condition is characterised by severe inflammation of the brain or the meninges resulting in permanent neurological deficit causing: • permanent Whole Person Impairment of at least 25%; or • the Insured Person being totally and permanently unable to perform any one of the Activities of Daily Living.
Heart Attack	means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be supported by diagnostic rise and/ or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following: • signs and symptoms of ischaemia consistent with myocardial infarction; • ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]); • development of pathological Q waves in the ECG; or • imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. If the above tests are inconclusive, other appropriate and medically recognised tests will be considered or, if at least three months after the event the Insured Person's left ventricular ejection fraction is less than 50%. The following are not covered: • a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease; • other acute coronary syndromes including but not limited to angina pectoris.
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.
Loss of Independent Existence (permanent)	means significant cognitive impairment, or the total and irrecoverable loss of ability, due to Illness or Injury, to perform at least two of the Activities of Daily Living without the physical assistance of another person.
Loss of Sight in One Eye (permanent)	means the total and irrecoverable loss of sight (whether aided or unaided) in one eye, as a result of Illness or Injury to the extent that visual acuity in the eye, on a Snellen Scale after correction by a suitable lens is less than 6/60, or to the extent that the visual field is reduced to 20 degrees or less of arc.
Loss of Sight in Both Eyes	means the total and irrecoverable loss of sight (whether aided or unaided) in both eyes, as a result of Illness or Injury to the extent that visual acuity in the eyes, on a Snellen Scale after correction by a suitable lens is less than 6/60, or to the extent that the visual field is reduced to 20 degrees or less of arc.
Loss of a Single Limb (permanent)	means the total and irrecoverable loss of use of a limb (an upper or lower extremity), or physical severance of a hand at or above the wrist or of a foot at or above the ankle.

TERM	DEFINITION
Loss of Two Limbs	means the total and irrecoverable loss of use of two limbs (an upper or lower extremity), or physical severance of two hands at or above the wrist or two feet at or above the ankle.
Loss of Speech (permanent)	means the total and irrecoverable loss of the ability to produce intelligible speech, as a result of permanent damage to the larynx or its nerve supply or to the speech centres of the brain, due to Illness or Injury.
Major Head Trauma (with permanent neurological deficit)	means accidental head injury resulting in neurological deficit causing: • permanent Whole Person Impairment of at least 25%; or • the Insured Person being totally and permanently unable to perform any one of the Activities of Daily Living.
Major Organ Transplant	means either the undergoing of, or upon the advice of a Specialist Medical Practitioner the placement on a waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit for, the human to human transplant from a donor to the Insured Person of bone marrow or one of the following organs or a permanent mechanical replacement of one of the following organs: • kidney; • heart; • lung; • liver; • pancreas; or • small bowel. The transplant of all other organs, parts of organs or any other tissue transplant is excluded.
Medically-Acquired HIV (contracted from a medical procedure or operation)	means accidental infection, after the inception of the Policy, with the human immunodeficiency virus (HIV) where the virus was acquired in Australia by the Insured Person from one of the following medically necessary events conducted by a recognised and registered health professional: • a blood transfusion; • transfusion with blood products; • organ transplant to the Insured Person; • assisted reproductive techniques; or • a medical procedure or operation performed by a Medical Practitioner or dentist Notification and proof of the incident will be required via a statement from the appropriate Statutory Health Authority that the infection was medically acquired. HIV infection transmitted by any other means including sexual activity or the use of drugs, other than as prescribed by a Medical Practitioner for the Insured Person is excluded. No payment will be made where: • the Insured Person has not followed the advice of a Medical Practitioner; or • a functional cure has become available. A functional cure is where the Insured Person has: • been fully cured from the HIV infection; or • achieved a level of health where the HIV infection does not prevent the Insured Person from working in their Own Occupation. We will make this assessment based on the opinion from the relevant medical specialist and/or relevant governing body of the Insured Person's profession, if applicable.
Meningococcal Disease (resulting in significant permanent impairment)	means the unequivocal diagnosis of meningococcal septicaemia resulting in: • permanent Whole Person Impairment of at least 25%; or • 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.

TERM	DEFINITION
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.
Occupationally Acquired Hepatitis B or C	means infection, after the inception of the Policy, with Hepatitis B or C where the infection is acquired as a result of: • an accident arising out of the Insured Person's normal occupation; or • a malicious act of another person or persons arising out of the Insured Person's normal occupation. Proof of new Hepatitis B or C infection must be registered within six months of the accident or malicious act. Any incident giving rise to a potential claim must be: • reported to the relevant authority or employer within seven days of the incident; • reported to us with proof of the incident within 30 days after the incident; and • supported by a negative Hepatitis B or C test taken within seven days of the incident. The infection must be diagnosed within six months of the accident or malicious act. No payment will be made if: • the Insured Person has not followed the advice of a Medical Practitioner; • the Hepatitis B or C infection resulted from sexual activity or drug use not medically prescribed for the Insured Person; or • the Insured Person achieves a functional cure. A functional cure is where the Insured Person has: • been fully cured from the Hepatitis B or Hepatitis C; or • achieved a level of health where Hepatitis B or Hepatitis C does not prevent the Insured Person from working in their Own Occupation. We will make this assessment based on the opinion from the relevant medical specialist and/or relevant governing body of the Insured Person's profession, if applicable.

TERM	DEFINITION
Occupationally Acquired HIV	infection is acquired as a result of: • an accident arising out of the Insured Person's normal occupation; or • a malicious act of another person or persons arising out of the Insured Person's normal occupation. The infection must be diagnosed with a positive anti-HIV antibody test result within six months of the reported occurrence. Proof of the new HIV infection must be reported and registered within six months of the accident or malicious act. Any incident giving rise to a potential claim must be: • reported to the relevant authority or employer within seven days of the incident; • reported to us with proof of the incident within 30 days after the incident; and • supported by a negative HIV test taken within seven days of the incident. No payment will be made if: • the Insured Person has not followed the advice of a Medical Practitioner; • the HIV infection resulted from sexual activity or drug use not medically prescribed for the Insured Person; or • the Insured Person achieves a functional cure. A functional cure is where the Insured Person has: • been fully cured from the HIV infection; or • achieved a level of health where the HIV infection does not prevent the Insured Person from working in their Own Occupation. We will make this assessment based on the opinion from the relevant medical specialist and/or relevant governing body of the Insured Person's profession, if applicable.
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).
Pneumonectomy	means the undergoing of surgery to remove an entire lung. This treatment must be deemed the most appropriate treatment and medically necessary.
Severe Burns (of specified severity)	means tissue Injury caused by thermal, electrical or chemical agents causing partial or full thickness burns to at least: • 20% of the body surface area as measured by the Lund and Browder Body Surface Chart; • 50% of both hands, requiring surgical debridement and/ or grafting; or • 50% of the face, requiring surgical debridement and/ or grafting. First degree burns, also termed superficial burns, are excluded and will not be considered as part of the required percentage.
Severe Diabetes Mellitus	means that an endocrinologist has confirmed that at least two of the following complications have occurred as a direct result of diabetes: • severe diabetic retinopathy resulting in visual acuity (whether aided or unaided) and corrected of 6/36 or worse in both eyes; • severe diabetic neuropathy causing motor and/or autonomic impairment; • diabetic gangrene leading to surgical intervention; or • severe diabetic nephropathy causing chronic irreversible renal impairment as demonstrated with a glomerular filtration rate of 15 to 30 ml/min (Stage 4 kidney disease).

TERM	DEFINITION
Stroke (resulting in neurological deficit)	means a cerebrovascular event producing a new neurological deficit confirmed through clinical examination. This requires clear evidence on a CT, MRI or similar, appropriate scan or investigation that a stroke has occurred and of infarction of brain tissue, intracerebral and/or subarachnoid haemorrhage. The following are not covered: • transient ischaemic attacks; • non-stroke related reversible neurological deficit; • cerebral injury resulting from trauma; • cerebral injury resulting from hypoxia; • vascular disease affecting the eye or optic nerve; • ischaemic disorders of the vestibular system; • migraine or neurological deficit due to migraine.
Triple Vessel Angioplasty	means the actual undergoing for the first time of coronary artery angioplasty to correct a narrowing and/or blockage in three or more for the following major arteries in a single procedure: • left main coronary artery • left anterior descending coronary artery • left circumflex coronary artery • right coronary artery In the event that not all coronary arteries can be corrected in a single procedure and a second procedure is required, a benefit will be payable provided the second procedure occurs no more than one month after the first.

The following definitions apply for Specific Injury and Trauma 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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TAL Group Plus – Salary Continuance Insurance
Combined Product Disclosure Statement and Policy Document | Issue Date 28 June 2024
TAL Life Limited (ABN 70 050 109 450) (AFSL 237 848)

TALG4608/0624