St.George Protection Plans Supplementary Product Disclosure Statement and Policy Addendum (SPDS Issue number 2)

This SPDS is dated 22 August 2011 and supplements the information contained in the St.George Protection Plans Product Disclosure Statement and Policy Document (**PDS**) which has an effective date of 15 November 2010 and the St.George Protection Plans Supplementary Product Disclosure Statement and Policy Addendum (**SPDS**) which has an effective date of 21 February 2011.

This SPDS Issue number 2 is issued by Westpac Life Insurance Services Limited ABN 31 003 149 157 *(WLIS)*, Australian Financial Services Licence (**AFSL**) Number 233728, for all products, except for Term Life as Superannuation. For Term Life as Superannuation, the issuer of the SPDS is Westpac Securities Administration Limited ABN 77 000 049 472 *(WSAL)*, AFSL Number 233731, RSE Licence Number L0001083. WLIS and WSAL each take full responsibility for the whole of this SPDS Issue number 2. The PDS provides details of your 'cooling off' rights (page 57) and our complaints handling procedures (page 60).

You should read the PDS, SPDS and this SPDS Issue number 2 before making a decision in relation to St.George Protection Plans.

If you take out cover under St.George Protection Plans, your insurance contract will consist of the PDS, SPDS, this SPDS Issue number 2 and your *policy schedule* or *membership certificate*.

This SPDS Issue number 2 has been issued in relation to the following changes:

PDS Chapter 2 – Summary of key features, page 8, all text in the section titled **Premium Holiday** is deleted and replaced with:

Premium Holiday

To save you the hassle of having to cancel your Policy and then having to re-apply when your circumstances change, after you have held your Policy for at least 6 months, we will allow you to suspend your Policy once in any 12 month period for a maximum of 12 months in total over the duration of the Policy if you provide us with evidence to our satisfaction, that during the relevant period you are experiencing financial hardship due to:

- being unemployed;
- being on sabbatical, maternity, paternity or long term leave from work; or
- your household income for the last three months reducing by 30% or more (as compared to the household income over the preceding three month period).

During this period you will not have to pay premiums. However, you will not be eligible to claim for any *sickness, injury*, death or any other event that happens in the period that the premiums are not being paid.

This benefit only applies if you are also an Insured Person. Where there is more than one Policy Owner, all Policy Owners must provide us with their agreement to exercise the Premium Holiday.

Acceptance of your application for a Premium Holiday will mean that your entire Policy will be suspended. This includes any Flexible Linking Plus or Income Linking Plus benefits.

A *sickness* or *injury* is taken to have happened when:

- a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the *sickness* or *injury*; or
- the Insured Person first had any symptom of the *sickness* or *injury* for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor*.

PDS Chapter 2 – Life, Living and TPD benefit specifics, page 21, all text in **6.3 Exclusions** under the heading **Funeral Advancement Benefit** is deleted and replaced with:

We will not pay a Funeral Advancement Benefit if the Insured Person commits suicide (whether sane or insane) within 13 months of the later of:

- the *commencement date*; and
- the date the Policy was last reinstated.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all of the following apply:

- the level of cover provided by us under this Policy is the same amount, or less than, the existing cover being replaced;
- we were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy;
- the other policy and equivalent benefit amount was continuously in force for at least 13 months immediately prior to the issue of this Policy;
- the other policy was cancelled immediately after the issue of this Policy; and
- no claim is pending or payable under the other policy.

PDS Chapter 2 – Life, Living and TPD benefit specifics, page 23, the following text in **9.3 TPD Continuation Benefit** under the heading **TPD Benefit**:

(c) What we will pay

If the Insured Person:

- suffers a *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months; and

- the *sickness* or *injury* is likely to prevent the Insured Person from ever again being able to work in *any occupation* for which they are reasonably qualified because of education, training or experience, and which would pay remuneration at a rate greater than 25% of their *earnings* in the last 12 months of work.

the amount we will pay is the TPD Benefit shown in the *policy schedule* for the Insured Person as at the *date of disablement*.

is deleted and replaced with:

(c) What we will pay

If the Insured Person suffers a *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months; and:

- the *sickness* or *injury* is likely to prevent the Insured Person from ever being able to work in any occupation for which they are reasonably qualified because of education, training or experience; or
- if the Insured Person is able to work in an occupation for which they are reasonably qualified because of education, training or experience but the total remuneration for this occupation is less than 25% of the Insured Person's *earnings* in their last 12 months of work,

then the amount we will pay is the TPD Benefit shown in the *policy schedule* for the Insured Person as at the *date of disablement*.

PDS Chapter 3 – Income Products, Summary of key features, page 35, all text in the section titled **Premium Holiday** is deleted and replaced with:

Premium Holiday

To save you the hassle of having to cancel your Policy and then having to re-apply when your circumstances change, after you have held your Policy for at least 6 months, we will allow you to suspend your Policy once in any 12 month period for a maximum of 12 months in total over the duration of the policy if you provide us with evidence, to our satisfaction, that during the relevant period you are experiencing financial hardship due to:

- being unemployed;
- being on sabbatical, maternity, paternity or long term leave from work; or
- your household income for the last three months reducing by 30% or more (as compared to the household income over the preceding three month period).

During this period you will not have to pay premiums. However, you will not be eligible to claim for any *sickness*, *injury*, death or any other event that happens in the period that the premiums are not being paid.

This benefit only applies if you are also an Insured Person. Where there is more than one Policy Owner, all Policy Owners must provide us with their agreement to exercise the Premium Holiday.

Acceptance of your application for a Premium Holiday will mean that your entire Policy will be suspended. This includes any Flexible Linking Plus or Income Linking Plus benefits.

A *sickness* or *injury* is taken to have happened when:

- a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the *sickness* or *injury*; or
- the Insured Person first had any *symptom* of the *sickness* or *injury* for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor*.

PDS Chapter 4 – Interim Accident and Sickness Cover, page 50, the entire chapter following the heading is deleted and replaced with:

Rest easy. From the moment we receive your completed application form and personal statement you are covered by Interim Accident and Sickness Cover, and you don't even need to pay any extra premium for this cover.

Some of the words in italics within this chapter have specific meanings for this chapter only. Please refer to section 4 for the definitions.

1. Commencement of Interim Accident and Sickness Cover

Interim Accident and Sickness Cover commences when a fully completed application form and personal statement, which has been declared true and correct in respect of each Insured Person, has been received by us.

Alternatively, you can apply for Interim Accident and Sickness Cover prior to completing your application for St.George Protection Plans. This provides you with cover while you are completing your application. To apply for this, you must complete the Interim Accident and Sickness Cover Certificate (signed by you and your adviser) and send it to us. In this case, Interim Accident and Sickness Cover commences on the date we receive your completed Interim Accident and Sickness Cover Certificate. In the event that you make a claim under the Interim Accident and Sickness Cover Certificate, we will require a copy of the signed and dated Statement of Advice (SOA), in which your financial adviser has recommended St.George Protection Plans, to be submitted to us. For your Interim Accident and Sickness Cover to continue, you must ensure that you have completed your application form and personal statement for St.George Protection Plans and that it is received by us within 10 days of the date we receive your Interim Accident and Sickness Cover Certificate.

2. Period of Interim Accident and Sickness Cover

Interim Accident and Sickness Cover will end on the earliest of the following:

- 10 days from the date we received the Interim Accident and Sickness Cover Certificate if we have not received a completed application for St.George Protection Plans;
- 90 days from the date Interim Accident and Sickness Cover commences;
- in respect of each Interim Benefit for each Insured Person, the date we accept the insurance application for that benefit under St.George Protection Plans or you obtain alternative insurance;
- in respect of each Interim Benefit for each Insured Person, the date you withdraw your insurance application for that benefit under St.George Protection Plans; and
- the date we advise you that Interim Accident and Sickness Cover has ceased.

3. Interim Benefits

Interim Death Benefit – The lesser of $1,000,000 or the amount of the Death Benefit applied for in respect of the Insured Person if completed application and personal statement has been submitted to us or the Death Benefit amount recommended in the SOA if completed Interim Accident and Sickness Certificate is submitted, is payable should the Insured Person die as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force.

Interim TPD Benefit – The lesser of $1,000,000, the TPD Benefit applied for in respect of the Insured Person if completed application and personal statement has been submitted to us or the TPD Benefit amount recommended in the SOA if completed Interim Accident and Sickness Certificate is submitted, is payable should the Insured Person become *totally & permanently disabled* as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force. The *total & permanent disability* definition that applies is either *own occupation TPD, any occupation TPD, home duties TPD*, or *general cover TPD* as nominated by you in your application form.

Interim Living Benefit – The lesser of $1,000,000, the Living Benefit applied for in respect of the Insured Person if completed application and personal statement has been submitted to us or the Living Benefit amount recommended in the SOA if completed Interim Accident and Sickness Certificate is submitted, is payable should the Insured Person suffer a specified medical event as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force and the Insured Person subsequently survives for 14 days. The specified medical events relevant to the Interim Living Benefit are defined in the Medical Glossary.

Interim Income Protection Benefit – The lesser of $5,000 per month, the *insured monthly disability benefit* or *insured monthly business overheads benefit* applied for under Income Protection, Income Protection Plus or Business Overheads if completed application and personal statement has been submitted to us or recommended in the SOA if completed Interim Accident and Sickness Certificate is submitted, is payable should the Insured Person become *totally disabled* as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force. The benefit accrues from the end of the *waiting period* applied for under the relevant Policy and ceases to accrue at the earliest of either the date the Insured Person ceases to be *totally disabled* or 6 months from the end of the *waiting period*.

4. Definitions

For the purposes of Interim Accident and Sickness Cover:

- Sickness means a sickness or *disease* which first becomes apparent after the earliest of the following:
  - the application form and personal statement was declared true and correct; or
  - we have received your completed Interim Accident and Sickness Cover Certificate.
- Pre-existing conditions means any *injury, sickness, illness* or *symptom* that:
  (a) you or the Insured Person were aware of, or a reasonable person should have been aware of;
  (b) the Insured Person should have sought advice or treatment (conventional or alternative) from a *doctor* for (in circumstances where a reasonable person would have sought advice or treatment); or
  (c) the Insured Person had a medical consultation for or was prescribed medication or therapy for.

5. Exclusions

A benefit will not be paid if the death, *total & permanent disability*, medical event, *accident*, *injury*, *sickness* or event giving rise to the claim is caused directly or indirectly by:

- an intentional, self-inflicted act or attempted suicide (whether sane or insane);
- an *accident* or *sickness* while the Insured Person is under the influence of alcohol or non-prescription drugs or drugs taken in excess of prescribed amounts;
- any act of war (whether declared or not) except where the Insured Person dies on war service;
- the Insured Person engaging in any sport, pastime or occupation that we would normally cover with a loading, exclusion, decline or deferral; or
- a *pre-existing condition* that existed prior to, or at the time of, application or the date we received your completed Interim Accident and Sickness Cover Certificate.

We will not pay a claim made under an Interim Accident and Sickness Cover Certificate if we are not in receipt of an SOA containing the St.George Protection Plans recommendation made by the financial adviser for the proposed life to be insured.

A benefit will not be paid if the Insured Person's occupation is one that we would not normally cover. In addition, we will take into account how the Insured Person would have been assessed in terms of definitions and benefit amounts under our underwriting rules.

6. Claims

To the extent that they are relevant, the conditions in the St.George Protection Plans Policy or Policies for which you have applied, that relate to the payment of a claim, apply to this cover.

Only one Interim Accident and Sickness Benefit for an Insured Person will be paid in respect of any one *accident* or *sickness*. The cost of obtaining medical evidence that is required for the payment of an Interim Accident and Sickness Benefit claim is to be borne by you. The costs of further medical evidence may be borne by us, however this will be at our discretion.

If you are eligible to make a claim under this cover, it will not prevent your application for a St.George Protection Plans Policy continuing to be assessed. However, we will take into account the change in health of the Insured Person when assessing your application and we may decline your application or apply special loadings, conditions and exclusions.

PDS Chapter 8 – Definitions, page 77, the definition of **regular care of a doctor** is deleted and replaced with:

Regular care of a doctor means the Insured Person:

- has sought advice, care, and treatment from a *doctor* in relation to the *sickness* or *injury* that you are claiming for and is continuing to do so at such times as is reasonable in the circumstances; and
- is following the advice, care and treatment of the *doctor*.

PDS Chapter 8 – Definitions, page 78, the following text in the definition of **total disability** and **totally disabled**:

The above definition applies to occupation categories (as shown in the *policy schedule*) AA, A, P, S, BB during the life of a claim, and, only applies to occupation categories B, C or E for the first 2 years of a claim, after which, the Insured Person will need to demonstrate that they are, because of *sickness* or *injury*:

- unable to perform any occupation for which they are reasonably suited by education, training or experience;
- not working; and
- under the *regular care of a doctor*.

is deleted and replaced with:

The above definition applies to occupation categories (as shown in the *policy schedule*) AA, A, P, S, BB, B or C during the life of a claim and only applies to occupation category E for the first 2 years of a claim, after which, the Insured Person will need to demonstrate that they are, because of *sickness* or *injury*:

- unable to perform any occupation for which they are reasonably suited by education, training or experience;
- not working; and
- under the *regular care of a doctor*.

PDS Chapter 8 – Definitions, page 78, the first paragraph of the definition of **Total & permanent disability** and **totally & permanently disabled** is deleted and replaced with:

(a) for any occupation TPD

- *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months;
- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* is likely to prevent the Insured Person from ever again being able to work in any occupation for which they are reasonably qualified because of education, training or experience; or
- if the Insured Person is able to work in an occupation for which they are reasonably qualified because of education, training or experience but the total remuneration for this occupation is less than 25% of the Insured Person's *earnings* in their last 12 months of work.

The Insured Person will also be considered to be *totally and permanently disabled* if the Insured Person meets the *general cover TPD* definition of *total and permanent disability*.

General cover TPD will apply if the Insured Person had permanently retired prior to the event causing disability.

PDS Chapter 8 – Definitions, page 79, at the end of the definition of **waiting period** add the following:

If you have an Income Protection Plus Policy and a Business Overheads Policy, the Income Protection Plus *waiting period* definition will apply to each Policy.

St. George Protection Plans Supplementary Product Disclosure Statement and Policy Addendum (SPDS)

This SPDS is dated 21 February 2011 and supplements the information contained in St. George Protection Plans Product Disclosure Statement and Policy Document **(PDS)** which has an effective date of 15 November 2010. This SPDS is issued by Westpac Life Insurance Services Limited ABN 31 003 149 157 **(the Insurer)**, Australian Financial Services Licence **(AFSL)** Number 233728, for all products, except for Term Life as Superannuation, for which the issuer of the SPDS is Westpac Securities Administration Limited ABN 77 000 049 472, AFSL Number 233731, RSE Licence Number L0001083 **(the Trustee)**. The Insurer and Trustee take full responsibility for the whole of this PDS.

You should read both the PDS and SPDS before making a decision in relation to St. George Protection Plans.

If you take out cover under St. George Protection Plans, your insurance contract will consist of the PDS, the SPDS and your *policy schedule or membership certificate.*

This SPDS has been issued in relation to the following changes:

PDS Chapter 2 – Life. Living. TPD, page 7, add to the 'What can I add – Living Benefit' in the Term Life and Term Life as Superannuation table and to the "What's included" in the Standalone Living Insurance table the following text:

Child Support Benefit

PDS Chapter 2 – Life. Living. TPD, page 9, add to the 'Features included with a Living Benefit' table the following text:

Child Support Benefit: pays you $10,000 if a *dependant child* dies or suffers a *children's medical event.*

PDS Chapter 2 – Life. Living. TPD, page 12, add to the Living Benefit Plus list of specified medical events under the "Other events" heading the following text:

Severe Osteoporosis

PDS Chapter 2 – Life. Living. TPD, page 13, add to the Living Benefit Plus list of specified medical events in the Advancement Benefit table the
following text:

Carcinoma in situ of the perineum, penis or testicle

Systemic lupus erythematosus (SLE) with lupus nephritis

PDS Chapter 2 – Life. Living. TPD, page 13, before the heading 'Optional Benefits' add the following text:

Child Support Benefit: pays you $10,000 if a *dependant child* dies or suffers a *children's medical event.*

PDS Chapter 2 – Life. Living. TPD, page 25, add to the Living Benefit Plus list of specified medical events under the 'Other events' heading the following text:

Severe Osteoporosis

PDS Chapter 2 – Life. Living. TPD, page 26, add to the Living Benefit Plus list of specified medical events under the 'Advancement Benefit Conditions' heading the following text:

Carcinoma in situ of the perineum, penis or testicle*

Systemic lupus erythematosus (SLE) with lupus nephritis

PDS Chapter 2 – Life. Living. TPD, page 26, add to the Advancement Benefit Table in 15.2(b) the following text:

Carcinoma in situ of the perineum, penis or testicle	20% of the Living Benefit up to a maximum $100,000.
Systemic lupus erythematosus (SLE) with lupus nephritis	20% of the Living Benefit up to a maximum $100,000.

And in section 15.2 (b) after 'We will only pay once under each of these groups of events', add the following text:

Carcinoma in situ of the perineum, penis or testicle

Systemic lupus erythematosus (SLE) with lupus nephritis

PDS Chapter 2 – Life. Living. TPD, page 30, after the 'When does the Policy end?' section, add the following text:

27. Child Support Benefit

27.1 The Child Support Benefit is included on all Standalone Living Insurance Policies, and Term Life Policies with a Living Benefit.

27.2 The Child Support Benefit in respect of each *dependant child* will commence on the later of the following:

- The *review date* following the *dependant child's* 2nd birthday; and
- The *risk commencement date* of the Living Benefit to which the Child Support Benefit is attached.

27.3 We will pay a Child Support Benefit if:

- a *dependant child* dies, or suffers a *children's medical event;* and
- a *doctor* approved by us provides the medical evidence to support the claim.

27.4 We will pay a benefit of $10,000 when we are satisfied that the *dependant child* has satisfied the full definition of the relevant *children's medical event.* The *children's medical events* covered are:

Aplastic anaemia	Loss of limbs
Benign brain tumour	Loss of speech
Blindness	Major head trauma
Brain damage	Major organ transplant
Cancer	Meningitis
Cardiomyopathy	Meningococcal septicaemia
Kidney failure	Paralysis
Encephalitis	Stroke
Loss of hearing	*Terminal illness*

The definitions of the above medical events can be found in the Medical Glossary in chapter 7.

27.5 Exclusions

The Child Support Benefit will not be paid:

- If the *children's medical event* giving rise to the claim is caused directly or indirectly by an intentional self-inflicted injury or attempted suicide (whether sane or insane);
- If the *children's medical event* giving rise to the claim is directly or indirectly caused by a *congenital condition*;
- if the *children's medical event* giving rise to the claim occurs within 3 months of the *commencement date* or last reinstatement of the Living Benefit.

27.6 We have placed the following conditions on the Child Support Benefit:

- The sum insured on the Insured Person's Living Benefit must be greater than or equal to $100,000.
- Upon payment of the Child Support Benefit the cover for that *dependant child* will cease and no further benefit will be payable under the Child Support Benefit in respect of that *dependant child*.

27.7 The Child Support Benefit will end on the earliest of the:

- date the Child Support Benefit is paid in respect of that *dependant child;*
- *review date* on or following the *dependant child's* 16th birthday; and
- *date the Living Benefit for the Insured Person ends for any reason.*

PDS Chapter 7 – Medical Glossary, page 70, the definition of **Cancer (malignant tumours)** is deleted and replace with:

Cancer (malignant tumours)

A malignant tumour pathologically confirmed and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue. Also included are Hodgkin's disease, lymphoma, colorectal cancer (from Dukes stage A) and leukaemia. The following are specifically excluded:

(a) all skin cancers except metastatic squamous cells carcinomas or melanomas of 1.5 millimetres or more in thickness, Clark

Level 3 or more depth of invasion, or with evidence of ulceration;

(b) all tumours which are histologically described as microcarcinoma, pre-malignant or showing the malignant changes of 'carcinoma in situ', including cervical dysplasia rated as CIN 1, 2 or 3 ('carcinoma in situ' of the breast is covered if it results directly in the removal of the entire breast. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment);

(c) chronic lymphocytic leukaemia (less than RAI stage 1); and

(d) prostatic tumours which are histologically described as TNM classification T1 (including T1a, T1b and T1c) or are of another equivalent or lesser classification (prostate cancer is covered if it results directly in total prostatectomy. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment).

PDS Chapter 7 – Medical Glossary, page 70, add the following medical definition:

Carcinoma in situ of the perineum, penis or testicle

The Insured Person is confirmed by biopsy to have localised pre-invasive or low level cancer in one or more of the following sites: perineum, penis or testicle. The pre-invasive or low level cancer must have a TNM classification of Tis.

PDS Chapter 7 – Medical Glossary, page 71, the definition of **Major organ transplant** is deleted and replaced with:

Major organ transplant

The medically necessary

(a) human to human transplant from a donor to the Insured Person (or Insured Child or *dependant child* if applicable); or

(b) placement of the Insured Person (or Insured Child or *dependant child*) on a waiting list, to undergo organ transplant from a human donor,

for one or more of the following: a heart, lung, kidney, liver, pancreas or bone marrow.

A waiting list means the Insured Person (or Insured Child or *dependant child*) has been placed on an official Australian acute care hospital waiting list, approved by us.

PDS Chapter 7 – Medical Glossary, page 73, the definition of **Prostate Cancer – major treatment** is deleted and replaced with:

Prostate cancer – major treatment

Prostate cancer means a tumour which is located within the prostate gland.

Low level prostatic cancers which are histologically described as TNM Classification T1a or T1b or lesser classification and appropriate and necessary major treatment has not been performed specifically to arrest the spread of malignancy are specifically excluded.

Major treatment includes the removal of the entire prostate, radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment.

PDS Chapter 7 – Medical Glossary, page 73, add the following medical definition:

Severe Osteoporosis

Prior to the age of 50, the Insured Person is unequivocally diagnosed with osteoporosis and suffers at least two separate vertebral body fractures or a fracture of the neck of femur due to osteoporosis.

PDS Chapter 7 – Medical Glossary, page 73, add the following medical definition:

Systemic lupus erythematosus (SLE) with lupus nephritis

The unequivocal diagnosis of SLE according to the latest 'American College of Rheumatology revised criteria for the classification of SLE'.

In addition to the diagnosis of SLE, with lupus nephritis must be confirmed by renal changes as measured by a renal biopsy that is grade three or more of the World Health Organisation classification of lupus nephritis and be associated with persisting proteinuria (more than 2+).

PDS Chapter 8 – Definitions, page 75, the definition of **Accident** is deleted and replaced with:

Accident means death, *total and permanent disability, sickness,* or *injury* as a result of a single event that results in a bodily injury sustained as a result of an external traumatic occurrence that is unexpected. This does not include an event that results from *sickness* or *disease*.

PDS Chapter 8 – Definitions, page 75, the definition of **Children's medical event** is deleted and replaced with:

Children's medical event means any of the conditions, injuries or surgeries covered under the Children's Benefit or Child Support Benefit. A *children's medical event* does not include any condition, injury or surgery which is a pre-existing condition that existed prior to, or at the time of application.

Pre-existing condition is taken to mean any injury, sickness, illness or symptom that:

- you, the Insured Person, the *dependant child* or the Insured Child were aware of, or a reasonable person should have been aware of;
- you, the Insured Person, the *dependant child* or the Insured Child should have sought advice or treatment (conventional or alternative) from a medical practitioner or other health professional for (in circumstances where a reasonable person would have sought advice or treatment); or
- you, the Insured Person, the *dependant child* or the Insured Person had a medical consultation for or were prescribed medication or therapy for.

PDS Chapter 8 – Definitions, page 75, add the following definition:

Dependant child means a natural child, or a child under the *legal guardianship* of the Insured Person.

PDS Chapter 8 – Definitions, page 76, the definition of **Injury** is deleted and replaced with:

Injury means a bodily injury which is sustained by the Insured Person after the later of:

- the *commencement date;*
- for an increase in the sum insured of any benefit, the date we increase the benefit (other than a *CPI* or Loyalty Benefit increase); and
- the date this Policy was last reinstated, but before this Policy ends.

Injury also means a bodily injury which you and the Insured Person fully disclosed to us and we agreed to cover.

PDS Chapter 8 – Definitions, page 79, the definition of **Waiting Period** is deleted and replaced with:

Waiting period means the minimum period of time which must elapse before any Income Protection, Income Protection Plus, or Business Overheads benefit entitlement may accrue. Your waiting period is shown in the *policy schedule.*

For Income Protection Plus occupation categories AA, A, P and S, the Insured Person must be either *totally disabled* or partially *disabled* throughout the waiting period in order to keep it running. Except as otherwise stated, if the Insured Person ceases to be *totally disabled* or *partially disabled* at any time, the waiting period stops running. The waiting period will not start to run again unless the Insured Person again becomes *totally disabled* or *partially disabled,* and then it will do so from the beginning. If the Insured Person returns to work (other than in a partial capacity) for 5 consecutive days or less during the waiting period (10 consecutive days or less if the waiting period is 90 days or more), the waiting period does not stop running. Instead those days will be added to the waiting period.

For Income Protection Plus occupation categories BB, B, C and E, and for all occupation categories in Income Protection and Business Overheads:

- Total Disability Benefit: the Insured Person must be *totally disabled* throughout the waiting period in order to keep it running. If they cease to be *totally disabled* at any time, the waiting period stops running. Except as otherwise stated, the waiting period will not start to run again unless the Insured Person again becomes *totally disabled,* and then it will do so from the beginning. If the Insured Person returns to work for 5 consecutive days or less during the waiting period (10 consecutive days or less if the waiting period is 90 days or more), the waiting period does not stop running. Instead those days (excluding if the Insured Person returns to work for up to 10 hours per week) will be added to (and count towards) the waiting period.
- Partial Disability Benefit: the Insured Person must be *totally disabled* for at least 14 of the first 19 days of the waiting period and *totally disabled* or *partially disabled* for the balance of the waiting period. If the Insured Person returns to work other than in a partial capacity for 5 consecutive days or less during the waiting period (10 consecutive days or less if the waiting period is 90 days or more), the waiting period does not stop running. Instead those days (excluding if the Insured Person returns to work for up to 10 hours per week) will be added to (and count towards) the waiting period.

Effective: 15 November 2010

St.George Protection Plans

Product Disclosure Statement and Policy Document (PDS)

st.george

Welcome to St.George Protection Plans

Life can be hard and, when it is, we make bouncing back that little bit easier.

Life is good. Until something bad happens. That's why St.George looks after its customers with a complete range of insurance solutions that will cover you whether you're single, just married, starting a family, retired – in fact, all the protection you need for all the stages in your life.

Life can be expensive, but protecting it with St.George isn't.

Fortunately, you don't have to pay through the nose for comprehensive cover. All our policies are easily affordable and offer excellent value. Please read this Product Disclosure Statement and Policy Document (PDS) carefully so you know just exactly what you're covered for – and what you're not. Remember, this is an important insurance document, so keep it somewhere safe in case you ever need to claim.

Who's who

In this PDS:

- 'we', 'us', and 'our' means the *Insurer*
- the 'Insured Person' means the life to be insured
- the 'Insured Child' means the child to be insured for the Children's Benefit
- 'you' and 'your' means the Policy Owner for all policies except Term Life as Superannuation where it means the Insured Person

The jargon

As you read on, you'll notice that some words are in italics. We need you to know that in this PDS these words have a particular meaning which can be found in chapter 8.

As you would expect in an insurance document, you'll also find quite a few medical terms. These are explained in chapter 7.

To apply for cover or find out more:

Ask your financial planner.

Call us on 1300 366 416, Monday to Friday 8.00am – 6.30pm (Sydney time), for enquiries.

Mail your completed application to GPO Box 4582, Sydney, NSW, 2001

Visit stgeorge.com.au to find out more.

Who's responsible for St.George Protection Plans

The *Insurer* is Westpac Life Insurance Services Limited ABN 31 003 149 157, Australian Financial Services Licence (AFSL) Number 233728.

The issuer for all products, except for Term Life as Superannuation, is the *Insurer.* For Term Life as Superannuation, the issuer is Westpac Securities Administration Limited ABN 77 000 049 472, AFSL Number 233731, RSE Licence Number L0001083 (WSAL).

The *trustee* of Term Life as Superannuation is WSAL which is part of the Superannuation Division of Westpac MasterTrust ABN 81 236 903 448, SFN 281412, SPIN WFS0112AU, RSE Licence Number R1003970 (the *fund*).

The *Insurer* and the *trustee* take full responsibility for the whole of this PDS. The *Insurer* and the *trustee* are wholly owned subsidiaries of Westpac Banking Corporation ABN 33 007 457 141 (the Bank). St.George Protection Plans are not a deposit or other liability of the Bank. Neither the Bank nor any member of the *Westpac Group* (other than the *Insurer* and the *trustee*) guarantees the benefits payable in relation to St.George Protection Plans.

1. Are you protecting your most valuable asset?

1

Car, home and contents insurance protect the things that matter to you. Term Life, Total and Permanent Disablement (TPD), Living (Trauma) and Income Protection Insurance protect the people that matter to you, helping your family avoid financial difficulty in the event of illness, injury or death.

Most people probably don't think twice about having their car and home insured. Yet when it comes to their health and income, they may not have these adequately covered.

What are the chances?

A car being stolen (and not recovered?)	Having to claim on a home and or contents policy?	Becoming disabled for more than 3 months before the age of 65 and having no income?	Suffering from cancer before the age of 65?
Chances of this occurring: 1 in 800[1]	Chances of this occurring: 1 in 13[2]	Chances of this occurring: 1 in 3[3]	Chances of this occurring: 1 in 3[4] Males 1 in 4[4] Females
Annual cost of cover: Comprehensive insurance for a 2007 Toyota Camry Altise (market value): $1,406[5]	Annual cost of cover: Quality Care cover for Home Buildings $250,000 and Contents $50,000: $780[6]	Annual cost of cover: Income Protection Plus cover for a 35 year old male earning $50,000: $490[7]	Annual cost of cover: $250,000 Living Benefit for a 35 year old male: $601[8]

Life insurance can help

Life insurance provides a safety net to safeguard you and protect yourself and your loved ones, should something unforeseen happen.

Life insurance can provide you with the peace of mind that if something were to happen, you can still afford the life you had planned for.

A life insurance payment can be used to:

- clear debts
- pay for funeral expenses
- invest to generate replacement income
- cover child care costs for dependants
- pay medical expenses
- pay for medical rehabilitation
- pay for home modifications
- make any necessary lifestyle changes.

1. Statistics from the National Motor Vehicle Theft Reduction Council – 12 months to March 2010.
2. Insurance Statistics Australia June 2010.
3. Calculations based on data of individual disability income insurance sold by Australian life offices, Institute of Actuaries of Australia 2002. Report of the Disability Committee. IA Aust: Sydney.
4. Cancer Institute NSW 'The Cancer in NSW Incident and Mortality Report' 2007.
5. Premium amount shown is based on Westpac Car Insurance quote for a 35-year-old male on maximum 60% no claim discount with non-financed car (2007 Toyota Camry Altise ACV40R FI Sedan 5 Sp Auto, 4 cylinder, 2362cc) which is garaged in postcode 2095 (Manly, NSW). $500 excess. Premium current as at August 2010.
6. St.George General Insurance Home and Contents insurance quote based on cover for a 35 year old male with previous insurance and full no claim discount, who owns and occupies a single story brick-veneer home in Manly, NSW with deadlocks on all external doors, key window locks on all accessible windows, no alarm. $500 excess. Premium current as at August 2010.
7. Cost based on annual premium after tax deduction (marginal rate of 31.5% including Medicare levy) for an agreed value St.George Protection Plans (Income Protection Plus) Policy, stepped premiums for a managerial occupation, 35 year old male, non-smoker, with a monthly benefit of $3,120 (75% of income), waiting period of 30 days and benefit period to age 65. NSW stamp duty included. Premiums current as at November 2010.
8. St.George Protection Plans Standalone Living Insurance with Living Plus Option, stepped premiums, non smoker, 35 year old male. NSW stamp duty included. Premium current as at November 2010.

St.George Protection Plans can help cover you.

1

St.George provides a comprehensive range of insurance solutions that offer protection no matter what stage of life you are in:

What is it?	What does it cover?	When might it be needed?
Term Life	Pays a benefit in the event of death or on diagnosis of a *terminal illness.*	Term Life insurance can help cover your family for expenses, such as rent or mortgage payments. This type of cover is beneficial for anyone who wants to ensure that their family can still have the lifestyle planned for them – education, travel and quality of living – for many years to come. It helps to secure your family's future if you're no longer around. Taking this cover within superannuation may provide tax benefits to you.
Living Insurance	Pays a benefit if the Insured Person suffers from one of a range of specific medical events such as cancer, a heart condition or loss of a limb. We also offer a Living Plus Option which provides more comprehensive cover. This type of insurance is sometimes referred to as trauma insurance.	The additional funds which Living Insurance provides can alleviate the financial strain of major hospital expenses and may also allow you to obtain additional or superior medical treatment. Living Insurance can provide financial support when you need it most, taking away a major cause of stress by allowing you and your loved ones to worry about what's important – recovery – not paying the medical bills.
Total and Permanent Disablement (TPD)	Pays a benefit if the Insured Person is unlikely to work again, perform household duties again, or suffer a loss of ability due to a permanent disability.	Provides the money you need to meet the costs of rehabilitation, as well as the financial support to make the necessary lifestyle adjustments. You will have money which can be used to cover expenses such as rent or mortgage payments.
Needlestick Benefit	Pays a lump sum benefit if the Insured Person contracts HIV or Hepatitis B or C whilst performing the duties of their occupation as a medical professional. This Policy is available when you hold another St.George Protection Plans Policy.	The money provided by this benefit can provide financial support when you need it most by providing the Insured Person the necessary funds to concentrate on the important things, and not worry about paying the bills.
Children's Benefit	Pays a lump sum benefit if the Insured Child suffers from one of a range of specific conditions. This Policy is available when you hold another St.George Protection Plans Policy.	The money that the Children's Benefit provides can help to relieve the stresses if your children become ill. This could help you take time off work to care for them, or help with expensive medical treatments.
Income Protection	Replaces up to 80% of the Insured Person's monthly income if they're unable to work at their full capacity due to *sickness* or *injury.*	This is often used to pay rent or mortgage payments, living and medical expenses. It may be necessary for anyone needing to replace the Insured Person's income if they are unable to work at their full capacity.
Income Protection Plus	Offers additional benefits to those provided by Income Protection.	The money received can be used to pay rent or mortgage payments, so you don't have to draw down on assets or take on more debt.
Business Overheads	Provides a monthly benefit if the Insured Person is unable to work at their full capacity in their business due to *sickness* or *injury.*	This benefit can allow the business to continue by funding allowable business expenses such as electricity, gas, telephone, rent, property rates and taxes.

The information in this PDS does not take into account your financial situation, objectives or needs. Before acting on any information in this PDS, you should consider whether it is appropriate to your financial situation, objectives or needs.

Structuring your St.George Protection Plans

You have the ability to fully tailor the Policy to your individual needs. This includes deciding who is best to own the Policy and a choice of a number of premium options.

Ownership options

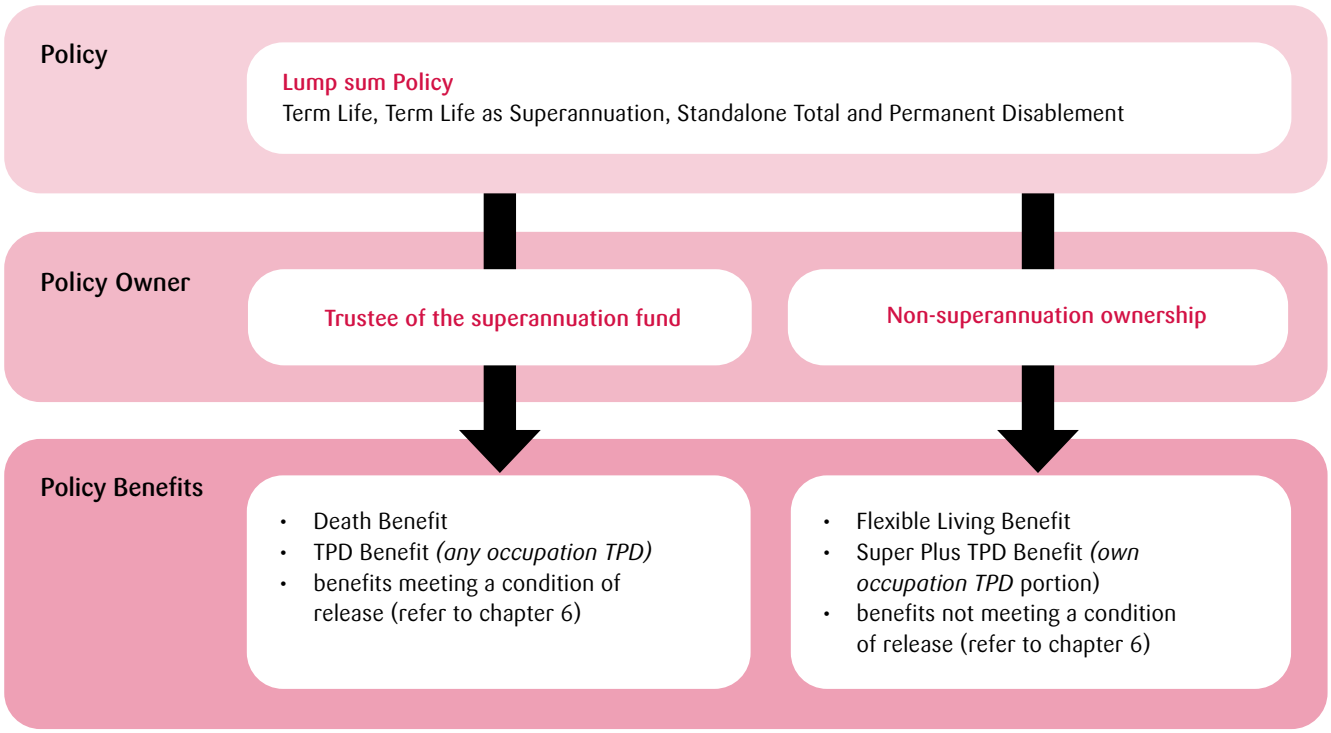
St.George Protection Plans can be structured in many ways to meet your needs. You can choose from different ownership structures, being:

- non-superannuation ownership (i.e. an individual, company or trust);
- a self-managed superannuation fund *(SMSF)*; or
- St.George Protection Plans Superannuation (for Term Life as Superannuation).

You can also choose to have a combination of these structures with the Flexible Linking Plus and Income Linking Plus options described below. This will allow you to maximise the benefits which can be held within superannuation while also providing affordability of cover.

Flexible Linking Plus

Flexible Linking Plus provides you with the flexibility to structure your insurance inside and outside superannuation, giving you greater choice and affordability.



Flexible Living Benefit

When you purchase a Term Life as Superannuation Policy or a Term Life Policy, Flexible Linking Plus allows you to attach a Living Benefit, which may not usually be available through your superannuation fund, to your Policy. The added benefit will be held outside of your superannuation fund.

If you are paid a Flexible Living Benefit, it will be paid directly to you. However, for cover owned by the trustee of your superannuation fund, the benefit will be paid to the trustee. The trustee must abide by the conditions of release in order to release a benefit to you. For further information, please refer to chapter 6.

The Flexible Living Benefit works in the same way as a non-superannuation Living Benefit with regards to how it is priced and how it functions. Because of this, the Flexible Living Benefit is priced lower than the equivalent benefit in a Standalone Living Insurance Policy.

In the event of a claim under a Flexible Living Benefit the sum insured of all other benefits on the Policy will be reduced by the amount paid.

Super Plus TPD Benefit

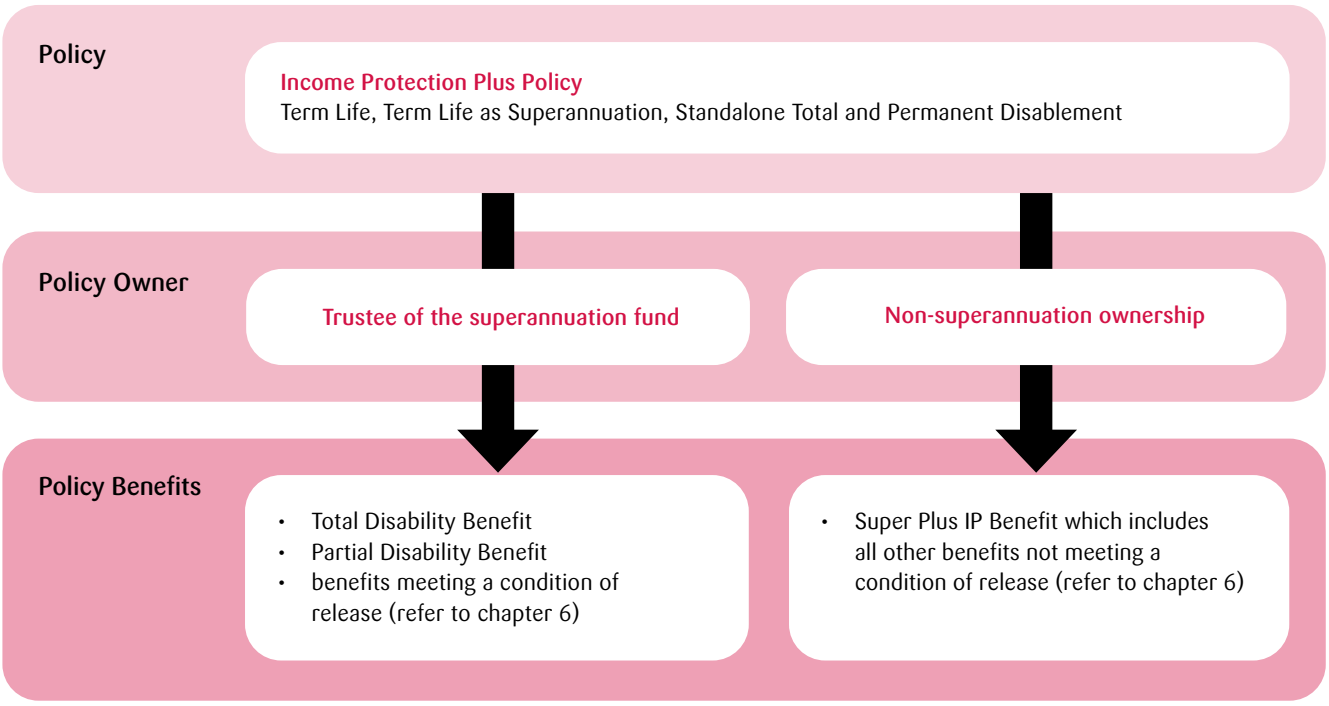
When you purchase a Term Life as Superannuation Policy, a Term Life Policy, or a Standalone Total and Permanent Disablement Policy, Flexible Linking Plus allows you to attach an *own occupation TPD* Benefit, which may not usually be available through your superannuation fund, to your Policy. The added benefit will be held outside of your superannuation fund.

If you are paid a Super Plus TPD Benefit, it will be paid directly to you. However, for cover owned by the trustee of your superannuation fund the benefit will be paid to the trustee. The trustee must abide by the conditions of release in order to release a benefit to you. For further information, please refer to chapter 6.

In the event of a claim under a Super Plus TPD Benefit the sum insured of all other benefits under the Policy will be reduced by the amount paid.

Income Linking Plus

Income Linking Plus allows you to take our most comprehensive income Policy – Income Protection Plus – and have the core benefits of Income Protection paid for through your superannuation fund, and the ancillary benefits (or the 'Plus' benefits) paid for outside of superannuation. This allows you the flexibility to structure your insurance without having to compromise on benefits.



Super Plus IP Benefit

When you purchase an Income Protection Plus Policy, Income Linking Plus allows you to attach the additional benefits which may not usually be available through your superannuation fund, to your Policy. The added benefits will be owned by you and not by the trustee of your superannuation fund.

If you are paid a Super Plus IP Benefit it will be paid directly to you. However, for cover owned by the trustee of your superannuation fund the benefit will be paid to the trustee of the fund. The trustee must abide by the conditions of release in order to release a benefit to you. For further information, please refer to chapter 6.

Premium options

There are a number of different ways to structure your premiums, depending on your needs. You are able to choose "stepped" premiums, which means that your premium will increase each year as the Insured Person gets older. You can also choose "level" premiums, which means that your premium will stay the same for a specified period of time.

That specified period of time can either be

- to age 55 for the "Level 55" premium option (not available in some circumstances on Income products); or
- to age 65 for the "Level 65" premium option.

When the specified period of time has elapsed, the premiums will revert to a stepped structure.

Your premium will increase if your sum insured increases, with *CPI* increases, and when we increase the policy fee.

Your Policy from start to finish.

Simple steps to becoming insured

Applying for insurance may appear complicated and overwhelming but when you break it down into a few simple steps, getting insurance can be straightforward and easy to achieve.

Just follow these steps to apply for cover and to maintain your insurance.

1. Applying for a Policy

Determine the type and amount of cover required.
Your financial planner will help you determine the best insurance for you, assist you with the application, and provide you with a quote for cover.

Read this PDS.
Make sure you understand your insurance cover by reading this PDS. It will form part of your contract with us.

Complete and lodge the application form.
We ask questions about the Insured Person's health, habits and occupation to enable us to determine your premium and cover. It is important that you tell us everything that we should know to assess your application fairly. This is called your Duty of Disclosure – for more information see page 57.

2. Assessing your application

Assessment and underwriting.
We review the information you have provided. If we need additional information we will notify you or your financial planner directly.

Your free immediate Interim Accident and Sickness cover begins!
We provide you with 90 days of free immediate Interim Accident and Sickness Cover while we are considering your application.
For more information see chapter 4.

Confirming your cover.
In most cases we will offer the cover as requested. Occasionally we may only be able to offer cover with special conditions. When this happens we will inform you and request your agreement to proceed.

3. Commencing and maintaining your Policy

Your Policy starts.
Your cover starts when we send you a *policy schedule* or *membership certificate.*

If you change your mind you can cancel your Policy and receive a refund of your premium within the cooling off period. See page 57 for more information.

You start receiving great benefits straight away.

- Guaranteed renewability of your cover.
- Guaranteed upgrades applied automatically at no extra cost.
- Loyalty benefits if you hold a Policy for three or more years.
- Premium Holiday allows you to suspend your Policy for up to 12 months.
- *CPI* increases – to ensure your cover keeps pace with inflation, and
- World wide cover – 24 hours a day, full cover at any time, anywhere in the world.

While you hold a policy.
Each year on your *review date* we will review your premium. For Policies with a stepped premium option, we will apply any age-based and *CPI* increases. For Policies with a level premium option, we will normally only apply increases associated with the *CPI*.

4. If you need to make a claim

Making a claim.
Contact us as soon as you become aware that you need to make a claim. The sooner you contact us, the sooner we can help you – which is why you have insurance in the first place. For more information about making a claim, see chapter 5.

2. Life. Living. TPD.

2

Summary of key features.

Term Life and Term Life as Superannuation — TL TLS

Entry ages: 15-69 (Stepped premium), 15-59 (Level 65 premium), 15-49 (Level 55 premium). Expiry age: 99^

What's Included?

- Death Benefit
- Terminal Illness Benefit
- Future Insurability Benefit (Personal and Business Events)
- Financial Planning Benefit*
- Funeral Advancement Benefit*
- Counselling Benefit*
- Loyalty Benefit

What can I add?

TPD Benefit
Entry ages: 15-59
- TPD Continuation Benefit

TPD options:
- Waiver of Life Premium Benefit*
- TPD Buy Back Benefit
- Double TPD Benefit

Living Benefit*
Entry ages: 15-59
Expiry age: 65^
- Advancement Benefit
- Living Buy Back Benefit

Living options:
- Living Plus Option
- Living Reinstatement
- Double Living Benefit

Flexible Linking Plus
Entry ages: 15-59
Expiry age: 65^
- Flexible Living Benefit
- Super Plus TPD Benefit

More options:
- TPD Buy Back Benefit
- Double TPD Benefit
- Living Plus Option
- Living Reinstatement
- Double Living Benefit

Other Options:
- Business Cover Benefit
- Multi-Link Benefit
- Needlestick Benefit
- Children's Benefit

Standalone Living Insurance — LI

Entry ages: 15-59 (Stepped and Level 65 premium), 15-49 (Level 55 premium). Expiry age: 65^

What's Included?

- Living Benefit
- Advancement Benefit
- Living Insurance Death Benefit
- Financial Planning Benefit
- Counselling Benefit
- Loyalty Benefit

What can I add?

- Living Plus Option
- Living Reinstatement

Other Options:
- Needlestick Benefit
- Children's Benefit

Standalone Total and Permanent Disablement — TPD

Entry ages: 15-59 (Stepped and Level 65 premium), 15-49 (Level 55 premium). Expiry age: 99^

What's Included?

- TPD Benefit
- TPD Continuation Benefit
- TPD Death Benefit
- Financial Planning Benefit
- Counselling Benefit
- Loyalty Benefit

What can I add?

Flexible Linking Plus
Entry ages: 15-59
Expiry age: 65^
- Super Plus TPD Benefit

Other Options:
- Needlestick Benefit
- Children's Benefit

Needlestick Benefit — NB

Entry ages: 15-59. Expiry age: 65^

What's Included?

A benefit providing cover for:
- Occupationally acquired HIV and
- Occupationally acquired hepatitis B & C

Children's Benefit — CB

Entry ages: 2-14. Expiry age: 16^

What's Included?

- Death Benefit
- Children's medical events
- Loyalty Benefit

*These benefits are not available in Term Life as Superannuation. ^On the *review date* on or following the Insured Person's birthday

Who is insured and who owns the Policy?

A Policy can be owned by the Insured Person or another person or entity (e.g. spouse, company or the trustee of a superannuation fund). The Policy Owner is responsible for paying premiums that are due under the Policy.

We allow up to five Policy Owners on a Policy, and each Policy Owner will own the Policy jointly. When a Policy Owner dies, ownership of the Policy automatically goes to the surviving Policy Owners. If all Policy Owners have died, the owner of the Policy will become the estate of the last surviving Policy Owner.

For Policies in Term Life as Superannuation, the Policy is owned by the *trustee*. For more information, please refer to section 9 of chapter 6 on page 62.

Who receives the benefits of the Policy?

The Policy Owner will receive any benefits that become payable on a Policy. If you have a valid *beneficiary* nomination on your Policy, then any Death Benefit, Funeral Advancement Benefit, Financial Planning Benefit or Counselling Benefit will be paid to the *beneficiary*. For more information about *beneficiaries,* see page 54.

Features of your Policy

CPI increases

To ensure the value of your benefits keep up with the cost of living, we will automatically increase the amount of your benefits each year on your *review date* in line with increases in the *CPI.* Benefits under Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone Total and Permanent Disablement and the Children's Benefit are subject to a minimum *CPI* increase of 3% a year.

You may decline a *CPI* increase each year by advising us in writing within 30 days of the *review date.* You may also request in writing that *CPI* increases never apply again. If you have requested that *CPI* never apply again and you wish to restart *CPI* increases, we may ask you for information on the Insured Person's health, occupation or pastimes. We will advise you in writing if and when we will restart *CPI* increases.

Guaranteed renewable

All St.George Protection Plans are guaranteed to continue for the term specified, which means that provided your premiums are paid when due we cannot cancel your insurance even if there is a change in an Insured Person's health, occupation or pastimes.

Guaranteed upgrades

To save you from having to ensure that your Policy is still as good in the future as when you first took it out, we automatically upgrade your Policy should better features and benefits, that don't result in an increase in premium, become available down the track. We will always give you the best definition available under St.George Protection Plans from the time you took out the Policy, to the date of *sickness* or *injury.*

Loyalty Benefit

To reward your loyalty, after you have held your Policy for 3 years from the later of the *commencement date* and 19 October 2009, we will add an extra 5% of any Death Benefit, TPD Benefit, Living Benefit or Children's Benefit payable without further charge.

Multi-Policy discount

If the Insured Person is covered by more than one Policy (Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone Total and Permanent Disablement, Income Protection, Income Protection Plus or Business Overheads) in St.George Protection Plans, you will also receive a multiple policy discount of 5% on the Insured Person's premiums (excluding policy fee and stamp duty).

Premium Holiday

To save you the hassle of having to cancel your Policy and then having to re-apply when your circumstances change, after you have held your Policy for at least 6 months we will allow you to suspend your Policy for a maximum of 12 months in total. During this period you will not have to pay premiums. However, you will not be eligible to claim for any *sickness, injury,* or any other event that happens in the period that the premiums were not being paid. You may only exercise this option once in any 12 month period, and you must show evidence of financial hardship acceptable to us.

A *sickness* or *injury* is taken to have happened when:

- a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the *sickness* or *injury;* or
- the Insured Person first had any *symptom* of the *sickness* or *injury* for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor.*

Worldwide cover – 24 hours a day

We will provide you with full cover at any time, anywhere in the world.

What is excluded under my Policy?

Certain limitations and exclusions apply to life insurance policies. For more information read the information about your benefits starting on page 17.

If an Insured Person suffers a *sickness* or *injury* or undergoes surgery that would make you eligible to claim for more than one benefit under a Policy, we will only pay one benefit for that *sickness, injury* or surgery.

When do my benefits and my Policy end?

Your benefits continue to remain in force until the earliest of the expiry age, the date we pay the benefit, you cancel your benefit, and the date your Policy ends. For more information see section 25 on page 30.

Your Policy will continue until the earliest of the last Insured Person reaching their expiry age, we pay out the benefits for the Insured Person, you cancel your Policy, or you fail to pay the premiums for your Policy. Your Policy may also end if you fail to disclose information to us, or misrepresent information at application. For more information see section 26 on page 30.

Term Life and Term Life as Superannuation.

Term Life and Term Life as Superannuation Policies pay a benefit if the Insured Person dies or suffers from a *terminal illness.*

You apply for the amount of Death Benefit you wish to insure a person for. For an additional cost, optional benefits such as a TPD Benefit and a Living Benefit can be added to your Policy. The amount you apply to insure for under each of these benefits can be different to, but no more than, the Death Benefit amount.

Term Life and Term Life as Superannuation ends on the *review date* on or following the Insured Person's 99th birthday. This page contains a summary of the key features and benefits available, however it is important that you read and understand all the information about your benefits, starting on page 17.

Included benefits

- **Death Benefit:** pays a benefit in the event of the Insured Person's death.
- **Terminal Illness Benefit:** pays a benefit, equal to the amount of the Death Benefit at that time if the Insured Person suffers a *terminal illness.*
- **Future Insurability Benefit:** allows you to increase the Death Benefit, TPD Benefit, and Living Benefit on the occurrence of one of the specified events without further medical underwriting.
- **Financial Planning Benefit*:** reimburses you up to $5,000 for the preparation of a financial plan following the payment of a Death Benefit, Terminal Illness Benefit, TPD Benefit or Living Benefit. This amount will be paid in addition to any other benefits, and is paid once per Insured Person.
- **Funeral Advancement Benefit*:** advances 10% of the Death Benefit up to a maximum of $25,000 for the immediate costs of the Insured Person's funeral. This benefit is paid once per Insured Person.
- **Counselling Benefit*:** reimburses you up to $5,000 for a maximum of 10 counselling sessions following the payment of a Death Benefit, Terminal Illness Benefit, TPD Benefit or Living Benefit. This amount will be paid in addition to any other benefits, and is paid once per Insured Person.

Optional benefits

- **Business Cover Benefit:** this benefit is available for Policies taken out for business purposes, and allows you to increase your cover to match the growth of your business without the need for additional medical underwriting.
- **TPD Benefit:** pays you a benefit in the event that the Insured Person becomes *totally and permanently disabled.* You can choose from four different types of *total and permanent disability* definition depending on the level of protection required and the circumstances of the Insured Person. We call these *own occupation TPD, any occupation TPD, home duties TPD,* and *general cover TPD* definitions. Under Flexible Linking Plus the Super Plus TPD Benefit allows you to maximise the benefits paid through your superannuation fund. This means the *own occupation TPD* portion of the premium is paid through a non-superannuation account, and the *any occupation TPD* portion of the premium is paid through your superannuation fund.

Features included with a TPD Benefit

- **TPD Partial Benefit*:** pays you a partial benefit if the Insured Person is *partially and permanently disabled.*
- **TPD Continuation Benefit:** allows you to continue your TPD Benefit on an *any occupation TPD* definition after the Insured Person's 65th birthday subject to entry requirements and work arrangements.

Options available with a TPD Benefit

- **Waiver of Life Premium Benefit*:** waives all premiums payable on the Policy if the Insured Person is *totally and temporarily disabled* (not available in Flexible Linking Plus).
- **TPD Buy Back Benefit:** allows you to reinstate the Death Benefit immediately after the Insured Person becomes *totally and permanently disabled* (provided they survive for 14 days), by the amount of the TPD Benefit that was paid.
- **Double TPD Benefit:** allows you to reinstate the Death Benefit immediately after the Insured Person becomes *totally and permanently disabled* (provided they survive for 14 days), by the amount of the TPD Benefit that was paid. In addition, premiums payable on the reinstated Death Benefit will be waived for the life of the Policy.

- **Living Benefit*:** pays you a benefit if the Insured Person suffers a specified medical event such as cancer, stroke or heart attack as described on page 12. The Flexible Living Benefit allows you to maximise the benefits paid through your superannuation fund. This means the Living Benefit portion of the premium is paid through a non-superannuation account, and the remaining portion of your Policy premium is paid through your superannuation fund.

Features included with a Living Benefit

- **Advancement Benefit:** pays you a partial benefit for specified medical events noted in the Advancement Benefit table on page 13.
- **Living Buy Back Benefit:** allows you to reinstate the Death Benefit 12 months after the Insured Person suffers a specified medical event (as described on page 12, excluding Advancement Benefit conditions) by the amount of the Living Benefit that was paid.

*These benefits are not available in Term Life as Superannuation unless a Flexible Linking Plus structure has been selected.

Options available with a Living Benefit

- **Living Plus Option:** pays you a benefit if the Insured Person suffers one of the specified additional medical events not already covered in the Living Benefit.
- **Double Living Benefit:** allows you to reinstate the Death Benefit immediately after the Insured Person suffers a specified medical event (as described on page 12, excluding Advancement Benefit conditions), provided they survive for 14 days, by the amount of the Living Benefit that was paid. In addition, premiums payable on the reinstated Death Benefit will be waived for the life of the Policy.
- **Living Reinstatement:** allows you to reinstate the Living Benefit 12 months after the Insured Person suffers a specified medical event (as described on page 12, excluding Advancement Benefit conditions) by the amount of the Living Benefit that was paid.

Policy features

- *CPI* increases
- Guaranteed renewable
- Guaranteed upgrades
- Loyalty Benefit
- Multi-Policy discount
- Premium Holiday
- Worldwide cover

What if I am no longer eligible to contribute to Super?

If you still need your insurance after you are no longer eligible to contribute to superannuation, or no longer eligible to have contributions made on your behalf, you can apply to transfer your insurance under Term Life as Superannuation to a Term Life Policy without further evidence of health on the same insurance conditions.

What should I do now?

Make sure you read and understand all the specifics about the benefits you are applying for. These start on page 17.

A snapshot of Term Life in action*

Geoffrey was a small business owner. 12 years ago he took out a Term Life Policy for $1,000,000, nominating his wife, Vesna, as sole *beneficiary*. Geoffrey's cover was automatically indexed to the *CPI* so that the sum insured kept pace with inflation.

Unfortunately Geoffrey died after becoming ill with melanoma. Vesna lodged a claim on the Term Life Policy and a payment of $1,163,775 was made (given that the rest of the Policy terms and conditions were satisfied). The automatic *CPI* increase to Geoffrey's sum insured saw his cover increase by $163,775 over the term of his Policy.

As Geoffrey had nominated his wife as his sole *beneficiary,* the claim was able to be paid in a timely fashion, protecting Vesna from financial stress during a time of great grief.

Some other examples of Term Life cover claims paid:

Cause	Skull fractures	Cardio/respiratory failure	Industrial accident
Occupation	Tree Surgeon	Accountant	Chemist
Age at claim	34	65	40
Years in force	4 years	8 years 6 months	13 years
Amount paid	$365,115	$852,061	$374,178

(Source: Claims data from the *Insurer*)

* For illustrative purposes only. The above is a case study loosely based on real life examples (names and some details have been altered) and demonstrates how St.George Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

Standalone Living Insurance.

Standalone Living Insurance pays a benefit if the Insured Person suffers a specified medical event, such as cancer, stroke or heart attack.

You apply for the amount of Living Benefit you wish to insure a person for. For an additional cost a Living Reinstatement can be added to your Policy. Standalone Living Insurance ends on the *review date* on or following the Insured Person's 65th birthday. This page contains a summary of the key features and benefits available, however it is important that you read and understand all the information about your benefits, starting on page 17.

Included benefits

2

- **Living Benefit:** pays you a benefit if the Insured Person suffers a specified medical event such as cancer, stroke or heart attack and subsequently lives for 14 days.

  The following specified medical events are covered:

Specified medical event	Living Benefit	Living Benefit Plus
Cancer		
Cancer (malignant tumours)	✓	✓
Prostate cancer – major treatment	✗	✓
Heart disorders		
Angioplasty – triple vessel	✓	✓
Aortic surgery	✗	✓
Cardiomyopathy	✗	✓
Coronary artery bypass surgery	✓	✓
Heart attack	✓	✓
Heart valve surgery	✓	✓
Open heart surgery	✓	✓
Out of hospital cardiac arrest	✓	✓
Pulmonary hypertension	✗	✓
Nervous system disorders		
Alzheimer's disease and other dementias	✗	✓
Motor neurone disease	✗	✓
Multiple sclerosis	✗	✓
Muscular dystrophy	✗	✓
Parkinson's disease	✗	✓
Accident		
Coma	✓	✓
Major head trauma	✓	✓
Paralysis	✗	✓
Severe burns	✓	✓

Specified medical event	Living Benefit	Living Benefit Plus
Body organ disorders		
Blindness	✗	✓
Chronic liver disease	✗	✓
Chronic lung disease	✗	✓
Kidney failure	✓	✓
Major organ transplant	✓	✓
Blood disorders		
Aplastic anaemia	✓	✓
Medically acquired HIV	✗	✓
Occupationally acquired HIV	✗	✓
Other events		
Advanced diabetes	✗	✓
Benign brain tumour	✓	✓
Encephalitis	✗	✓
Intensive care	✗	✓
Loss of hearing	✗	✓
Loss of independent existence	✗	✓
Loss of limbs	✗	✓
Loss of speech	✗	✓
Meningitis	✗	✓
Meningococcal septicaemia	✗	✓
Pneumonectomy	✗	✓
Severe rheumatoid arthritis	✗	✓
Stroke	✓	✓

It is important to note that the Insured Person must meet the full definition of the specified medical event in order to qualify for a benefit. These definitions are given in chapter 7.

- **Advancement Benefit:** pays you a partial benefit for specified medical events noted in the Advancement Benefit table below.

  The following specified medical events are covered:

Specified medical event	Living Benefit	Living Benefit Plus
Alzheimer's disease and other dementias – advancement	✗	✓
Angioplasty - single or double vessel	✓	✓ (multi-payment)
Blindness - advancement	✗	✓
Carcinoma in situ of female organs	✓	✓
Diabetes complication	✗	✓
Early stage melanoma	✓	✓
Loss of single limb	✗	✓
Multiple sclerosis – advancement	✗	✓
Parkinson's disease – advancement	✗	✓
Prostate cancer (stages T1a, T1b and T1c)	✓	✓

- **Living Insurance Death Benefit:** pays you $10,000 if the Insured Person suffers one of the specified medical events, but does not live 14 days.
- **Financial Planning Benefit:** reimburses you up to $5,000 for the preparation of a financial plan following the payment of a Living Benefit. This benefit will be paid in addition to any other benefits and is paid once per Insured Person.
- **Counselling Benefit:** reimburses you up to $5,000 for a maximum of 10 counselling sessions following the payment of a Living Benefit. This amount will be paid in addition to any other benefits, and is paid once per Insured Person.

Optional benefits

- **Living Plus Option:** pays you a benefit if the Insured Person suffers one of the specified additional medical events not already covered in the Living Benefit.
- **Living Reinstatement:** allows you to reinstate the Living Benefit 12 months after the Insured Person suffers a specified medical event by the amount of the Living Benefit that was paid.

Policy features

- *CPI* increases
- Guaranteed renewable
- Guaranteed upgrades
- Loyalty Benefit
- Multi-Policy discount
- Premium Holiday
- Worldwide cover

What should I do now?

Make sure you read and understand all the specifics about the benefits you are applying for. These start on page 17.

A snapshot of a Living Benefit in action*

Nadia, a self-employed married mother of two children, decided to protect her family's financial position by taking out a Living Benefit.

Nadia structured her Policy in the following way:

- a Term Life Policy with:
  - a Death Benefit;
  - a TPD Benefit *(any occupation TPD);* and
- a Flexible Linking Plus Policy with a Living Benefit.

A couple of years later, Nadia was diagnosed with a rare form of cancer. She lodged a claim against the Living Benefit. The medical reports confirmed Nadia's medical condition, and as she satisfied all of the Policy terms and conditions, she was paid in excess of $300,000.

Nadia's decision to cover herself against specific medical conditions gave her crucial financial flexibility at a time of great stress. She used the proceeds of her claim to meet the high costs of the latest cancer treatments. Her insurance payment allowed her the option to sell her business and spend more time with her family. She is now working part time and her doctor believes she is in a good position to make a full recovery.

Some other examples of Living Benefit claims paid:

Cause	Breast cancer	Coronary artery surgery	Stomach cancer
Occupation	Computer consultant	Storeperson	Shop assistant
Age at claim	39	45	34
Years in force	7 years	10 years	4 years
Benefit	$294,830	$248,704	$172,369

(Source: Claims data from the *Insurer*)

* For illustrative purposes only. The above is a case study loosely based on real life examples (names and some details have been altered) and demonstrates how St.George Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

Standalone Total and Permanent Disablement.

Standalone Total and Permanent Disablement pays a benefit if the Insured Person becomes *totally and permanently disabled.* It may assist the Insured Person with medical and rehabilitation costs and provide them and their family with financial security.

You apply for the amount of TPD Benefit you wish to insure a person for. Standalone Total and Permanent Disablement ends on the *review date* on or following the Insured Person's 99th birthday. This page contains a summary of the key features and benefits available, however it is important that you read and understand all the information about your benefits, starting on page 17.

Included benefits

- **TPD Benefit:** pays you a benefit in the event that the Insured Person becomes *totally and permanently disabled.*

  You can choose from four different types of *total and permanent disability* definition depending on the level of protection required and the circumstances of the Insured Person. We call these *own occupation TPD, any occupation TPD, home duties TPD,* and *general cover TPD* definitions.

If you choose:	This means:
Any occupation TPD	The Insured Person is unable to ever perform any occupation for which they are reasonably suited by education, training or experience.
Own occupation TPD	The Insured Person is unable to ever again work in the occupation that they were last engaged in immediately prior to claim.
Home duties TPD	The Insured Person is unable to ever again carry out *normal household duties.*
General cover TPD	The Insured Person suffers a loss of independent existence, or total and permanent loss of use of two *limbs*, loss of use of a *limb* and sight in one eye, or sight in both eyes.

  It is important to note that the Insured Person must meet the full definition of *total and permanent disability* in order to qualify for a benefit.

- **TPD Partial Benefit:** pays you a partial benefit if the Insured Person is *partially and permanently disabled.*
- **TPD Continuation Benefit:** allows you to continue your TPD Benefit on an *any occupation TPD* definition after the Insured Person's 65th birthday subject to entry requirements and work arrangements.
- **TPD Death Benefit:** pays you $10,000 if the Insured Person dies and the TPD Benefit has not been paid.
- **Financial Planning Benefit:** reimburses you up to $5,000 for the preparation of a financial plan following the payment of a TPD Benefit. This benefit will be paid in addition to any other benefits and is paid once per Insured Person.
- **Counselling Benefit:** reimburses you up to $5,000 for a maximum of 10 counselling sessions following the payment of a TPD Benefit. This amount will be paid in addition to any other benefits, and is paid once per Insured Person.

Optional benefits

- **Super Plus TPD Benefit:** allows you to maximise the benefits paid through your superannuation fund. This means the *own occupation TPD* portion of the premium is paid through a non-superannuation account, and the *any occupation TPD* portion of the benefit premium is paid through your superannuation fund.

Policy features

- *CPI* increases
- Guaranteed renewable
- Guaranteed upgrades
- Loyalty Benefit
- Multi-Policy discount
- Premium Holiday
- Worldwide cover

What should I do now?

Make sure you read and understand all the specifics about the benefits you are applying for. These start on page 17.

A snapshot of Standalone Total and Permanent Disablement in action*

While out celebrating a case win with his legal team, Doug started to feel dizzy and was having trouble speaking. He put it down to having a few beers on an empty stomach, but caught a cab home early. His symptoms got worse before he collapsed. Pat, Doug's wife, called an ambulance which took him to hospital where he was found to have suffered a stroke.

His stroke affected the left side of his brain which caused problems on the right side of his body and communication. He had trouble speaking, understanding, reading and writing, which meant he was no longer able to practice as a barrister.

His TPD Benefits allowed Doug to access the best possible medical treatment and later, rehabilitation services. Pat was able to stop work to become Doug's primary carer.

Part of the lump sum TPD Benefit was used to pay off the remaining mortgage on their city house, and the balance was invested to generate returns to replace the income Doug had hoped to earn before they retired. The protection offered by their insurance allowed them to keep their country cottage dream alive.

Some other examples of TPD Benefit claims paid:

Cause	Huntington's Disease	Brain Haemorrhage	Multiple Sclerosis
Occupation	Accountant	Cabinet Maker	Team Leader
Age at claim	53	48	41
Years in force	17 years	11 years	15 years 5 months
Benefit	$320,508	$146,039	$112,644

(Source: Claims data from the *Insurer*)

* For illustrative purposes only. The above is a case study loosely based on real life examples (names and some details have been altered) and demonstrates how St.George Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

Life, Living and TPD benefit specifics.

Please take the time to read the details about the benefits your Policy provides. This section will provide you with all of the details of your Policy and is an important part of this PDS.

The coloured icons used throughout will assist you in determining which benefits are applicable. To understand the icon that corresponds to your Policy, please refer to page 7.

Please speak to your financial planner or contact us if you would like any of the details explained to you.

1. Death Benefit

TL TLS

1.1 The Death Benefit will be paid to you, or the *beneficiary* if one has been nominated, if the Insured Person dies while your Policy is in force.

1.2 We will pay the amount of the Death Benefit for the Insured Person as shown in the most recent *policy schedule* or *membership certificate.*

1.3 Exclusions

We will not pay a Death Benefit if the Insured Person commits suicide (whether sane or insane) within 13 months of the later of:

- the *commencement date;*
- for an increase in the Death Benefit for the Insured Person, the date we increase the Death Benefit (other than *CPI* or Loyalty Benefit increases); and
- the date the Policy was last reinstated.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all the following apply:

- the level of cover being issued by us is the same amount, or less than, the existing cover being replaced;
- we were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy;
- the other policy was continuously in force for at least 13 months immediately prior to the issue of this Policy;
- the other policy was cancelled immediately after the issue of this Policy; and
- no claim is pending or payable under the other policy.

2. Terminal Illness Benefit

TL TLS

2.1 The Terminal Illness Benefit will be paid to you if the Insured Person suffers a *terminal illness* while your Policy is in force.

2.2 We will pay the amount of the Death Benefit for the Insured Person at that time and the Policy will end.

3. Future Insurability Benefit

TL TLS

3.1 The Future Insurability Benefit enables you to increase the Death Benefit, TPD Benefit and Living Benefit for an Insured Person without providing further health evidence when a specified Personal or Business Event occurs.

3.2 You must apply for the increase in writing within 30 days of a Personal Event (excluding the periodic increase event), or within 30 days of the *review date* immediately following a Business Event and the periodic increase event.

If you wish to increase your benefits, contact us and we will forward you the relevant forms to complete and advise you of the evidence we require. The evidence must be satisfactory to us, and demonstrate that the Personal Event or Business Event has occurred.

The increased cover does not apply until we have confirmed it in writing, and your premium will increase to reflect the increase in cover. The minimum increase per Personal Event or Business Event is $25,000.

3.3 You can apply to increase the Death Benefit, TPD Benefit and Living Benefit for the following events:

Personal Events		Maximum Increase per Special Event
Marriage	The Insured Person marries (which is recognised by an Australian Court).	The lesser of: • $250,000; and • 25% of the original Death Benefit, TPD Benefit, or Living Benefit.
A de facto *spouse*	The first anniversary of the Insured Person living with another person as de facto *spouse* on a continuous and bona fide domestic basis.	
Birth or adoption	The Insured Person or their *spouse* gives birth to or adopts a child.	
Periodic increase	The Policy Owner has not exercised the Future Insurability Benefit for any reason, and has not had an increase in the Insured Person's sum insured (excluding *CPI* increases and Loyalty Benefit increases) for a period of 3 consecutive years.	
Mortgage	The Insured Person takes out a *mortgage*, or increases the original amount borrowed under an existing *mortgage,* to buy or improve their home.	The lesser of: • $250,000; • 50% of the original Death Benefit, TPD Benefit, or Living Benefit; and • the amount of the new *mortgage* or increase in the original amount borrowed under an existing *mortgage,* as applicable.
Salary increase	The Insured Person's annual salary package increases by at least $10,000 a year. The salary package does not include irregular payments such as bonuses or commissions that may not continue to be made in future.	The lesser of: • $250,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit; and • five times the annual amount of salary package increase.

An increase under the Future Insurability Benefit for a Personal Event will not occur if it would result in the total of all increases in Death Benefits, TPD Benefits, or Living Benefits for an Insured Person (under all Policies with us) without health evidence (other than *CPI* and Loyalty Benefit increases) exceeding the lesser of $1 million and the original Death Benefit, TPD Benefit or Living Benefit for the Insured Person.

Business Events		Maximum Increase per Special Event
Value of the key person in your business increases	The Insured Person is a key person in their business and their value to the business increases. The Insured Person's value to the business is their remuneration package, excluding discretionary benefits, plus their share of net profits of the business distributed in the 12 months immediately before the event occurs.	The lesser of: • $500,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit; • an increase which is proportionate to the increase in the Insured Person's value to the business; and • five times the average annual increase in the gross remuneration package of the Insured Person over the 3 years immediately before the event.
The net value of the Insured Person's financial interest in the business increases	The Insured Person is a partner, shareholder, unit holder or similar principal in a business. The insurance was purchased in accordance with a written share purchase or business succession agreement and the net value of the Insured Person's financial interest in the business increases. The net value of their financial interest in the business is their share of the value of the business, after deducting liabilities of the business, as determined by a valuation method that is acceptable to us.	The lesser of: • $500,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit; • an increase which is proportionate to the increase in the net value of the Insured Person's financial interest in the business; and • the average annual increase in the net value of the Insured Person's financial interest in the business over the 3 years immediately before the event.

Business Events		Maximum Increase per Special Event
The value of the Insured Person's loan increases	The Insured Person is the borrower for a business loan that the Death Benefit is designed to cover, and the value of the loan increases.	The lesser of: • $500,000; • 25% of the original Death Benefit, TPD Benefit, or Living Benefit; and • an increase which is proportionate to the increase in the value of the Insured Person's loan.
Periodic increase	The Policy Owner has not exercised the Future Insurability Benefit for any reason, and has not had an increase in the Insured Person's sum insured (excluding CPI increases and Loyalty Benefit increases) for a period of 3 consecutive years.	The lesser of: • $250,000; and • 25% of the original Death Benefit, TPD Benefit, or Living Benefit.

An increase under the Future Insurability Benefit for a Business Event will not occur if it would result in the total of all increases in Death Benefits, TPD Benefits or Living Benefits for an Insured Person (under all Policies with us) without health evidence (other than CPI and Loyalty Benefit increases) exceeding the lesser of $2 million and the original Death Benefit, TPD Benefit or Living Benefit for the Insured Person.

The Death Benefit must be increased by the same amount, or more than any increase in the TPD Benefit or Living Benefit.

3.4 You cannot apply for a Future Insurability Benefit increase for an Insured Person:

- after the *review date* on, or following the Insured Person's 65th birthday;
- if you have had an increase under this benefit in the last 12 months;
- if you have the Business Cover Benefit on your Policy for the Insured Person;
- if a person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any Policy issued by us;
- where a loading has been applied to the Death Benefit, TPD Benefit, or Living Benefit. However if the loading only applies to the TPD Benefit or Living Benefit, increases are permitted on the benefits without a loading; or
- for salary increases, if the Insured Person is self-employed, a controlling director of the employer or a holding company of the employer, or is able to (directly or indirectly) make or control a decision on the amount of the Insured Person's salary package.

Except for the birth or adoption event, for 6 months immediately after the *commencement date* of an increase under the Future Insurability Benefit, the increased amount:

- will only be payable in the event of an *accident* (or death, *total and permanent disability, sickness* or *injury* as a result of an *accident*); and
- will not be payable for a *terminal illness* which arises during this period.

Any exclusions that apply to the Death Benefit, TPD Benefit and Living Benefit will also apply to any increase in the Death Benefit, TPD Benefit and Living Benefit.

4. Business Cover Benefit

TL OPTIONAL TLS OPTIONAL

4.1 The Business Cover Benefit enables you to increase the Death Benefit, TPD Benefit and Living Benefit for an Insured Person without providing further health evidence when a specified event occurs.

4.2 You must apply for the increase in writing within 30 days of the *review date* immediately following the specified event.

If you wish to increase your benefits, contact us or your financial planner and we will forward you the relevant forms to complete and advise you of the evidence we require. The evidence must be satisfactory to us, and demonstrate that the Business Cover Event has occurred.

A Business Cover Event is only applicable if the purpose of cover at the time of application is directly related to the Business Cover Event.

The increased cover does not apply until we have confirmed it in writing, and your premium will increase to reflect the increase in cover. The minimum increase per Business Cover Event is $25,000.

4.3 You can apply to increase the Death Benefit, TPD Benefit and Living Benefit up to the following maximums:

Maximums	Death Benefit	TPD Benefit	Living Benefit
Maximum increase per event	The lesser of: • $2,000,000; and • 50% of the original Death Benefit.	The lesser of: • $2,000,000; and • 50% of the original TPD Benefit.	The lesser of: • $2,000,000; and • 50% of the original Living Benefit.
Maximum total benefit after Business Cover increases	The lesser of: • $10,000,000; and • 3 times the original Death Benefit.	The lesser of: • $3,000,000; and • 3 times the original TPD Benefit.	The lesser of: • $2,000,000; and • 3 times the original Living Benefit.

4.4 You can apply to increase for the following events:

Business Cover Events		Maximum Increase per Special Event
Value of the key person in your business increases	The Insured Person is a key person in their business and their value to the business increases. The Insured Person's value to the business is their remuneration package, excluding discretionary benefits, plus their share of net profits of the business distributed in the 12 months immediately before the event occurs.	The lesser of: • the Death, TPD and Living Benefit limits in section 4.3; • an increase which is proportionate to the increase in the Insured Person's value to the business; and • five times the average annual increase in the gross remuneration package of the Insured Person over the 3 years immediately before the event.
The net value of the Insured Person's financial interest in the business increases	The Insured Person is a partner, shareholder, unit holder or similar principal in a business. The insurance was purchased in accordance with a written share purchase or business succession agreement and the net value of the Insured Person's financial interest in the business increases. The net value of their financial interest in the business is their share of the value of the business, after deducting liabilities of the business, as determined by a valuation method that is acceptable to us.	The lesser of: • the Death, TPD and Living Benefit limits in section 4.3; • an increase which is proportionate to the increase in the net value of the Insured Person's financial interest in the business; and • the average annual increase in the net value of the Insured Person's financial interest in the business over the 3 years immediately before the event.
The value of the Insured Person's loan increases	The Insured Person is the borrower for a business loan that the Death Benefit is designed to cover, and the value of the loan increases.	The lesser of: • the Death, TPD and Living Benefit limits in section 4.3; and • an increase which is proportionate to the increase in the value of the Insured Person's loan.

An increase under the Business Cover Benefit will not occur if it would result in the total of all increases in Death Benefits, TPD Benefits or Living Benefits for an Insured Person (under all Policies with us) without health evidence (other than *CPI* and Loyalty Benefit increases) exceeding the overall maximums outlined in section 4.3 in relation to the Insured Person for the Death, TPD and Living Benefits under any Policy issued by us.

The Death Benefit must be increased by the same amount, or more than any increase in the TPD Benefit or Living Benefit sum insured.

4.5 You cannot apply for a Business Cover Benefit increase for an Insured Person:

- after the *review date* on or following the Insured Person's 65th birthday;
- if you have had an increase under this benefit in the last 12 months;
- if a person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any Policy issued by us;
- where a loading has been applied to the Death Benefit, TPD Benefit, or Living Benefit.
  However if the loading only applied to the TPD Benefit or Living Benefit, increases are permitted on the benefits without a loading; or
- for salary increases, if the Insured Person is self-employed, a controlling director of the employer or a holding company of the employer, or is able to (directly or indirectly) make or control a decision on the amount of the Insured Person's salary package.

For 6 months immediately after the *commencement date* of an increase under the Business Cover Benefit, the increased amount:

- will only be payable in the event of an *accident* (or death, *total and permanent disability*, *sickness* or *injury* as a result of an *accident*); and
- will not be payable for a *terminal illness* which arises during this period.

Any exclusions that apply to the Death Benefit, TPD Benefit and Living Benefit will also apply to any increase in the Death Benefit, TPD Benefit and Living Benefit.

If the Business Cover Benefit has been selected for an Insured Person, the Future Insurability Benefit is not available for that Insured Person.

5. Financial Planning Benefit

TL TLS* LI TPD

*TLS (with Flexible Linking Plus)

5.1 If we pay a Death Benefit, Terminal Illness Benefit, or the entire sum insured of the TPD Benefit or Living Benefit, we will pay the recipient of the benefit paid the Financial Planning Benefit. Under the Financial Planning Benefit, we will reimburse the recipient of the benefit for the cost of obtaining financial advice.

5.2 We will pay the cost of obtaining financial advice, up to a maximum of $5,000.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the benefit so the total amount payable does not exceed $5,000.

The Financial Planning Benefit will only be paid once per Insured Person across all policies issued by us in respect of that Insured Person.

5.3 The following conditions must be met for the Financial Planning Benefit to be paid:

- the financial plan must be provided by an approved, accredited financial adviser;
- we will only reimburse amounts relating to the preparation and presentation of the plan and not amounts relating to the implementation of the plan, or commission paid to a financial adviser;
- the Financial Planning Benefit must be claimed within 12 months of receiving the benefit; and
- the recipient must be able to provide a copy of the invoice showing a breakdown of the services provided, and/or a receipt showing the amount paid.

6. Funeral Advancement Benefit

TL TLS*

*TLS (with Flexible Linking Plus)

6.1 We will pay funeral expenses, and other immediate costs upon the Insured Person's death. This benefit is only payable once for each Insured Person across all Policies issued by us.

The payment of this benefit does not mean that any other benefit under the Policy will be admitted.

We will require a copy of the death certificate and invoice(s) showing the funeral and other related expenses paid (by whom and the amount paid) which are acceptable to us.

6.2 We will pay 10% of the Death Benefit, up to a maximum of $25,000.

The Death Benefit will be reduced by the amount paid under the Funeral Advancement Benefit.

6.3 Exclusions

We will not pay a Funeral Advancement Benefit if the Insured Person commits suicide (whether sane or insane) within 13 months of the later of:

- the *commencement date;* and
- the date the Policy was last reinstated.

7. Counselling Benefit

TL TLS* LI TPD

*TLS (with Flexible Linking Plus)

7.1 If we pay a Death Benefit, Terminal Illness Benefit, or the entire amount of the TPD Benefit or Living Benefit, we will also pay the recipient of the benefit a Counselling Benefit. Under the Counselling Benefit, we will reimburse the cost of up to 10 counselling sessions for you, the Insured Person or an *immediate family member.*

7.2 We will reimburse the cost of the counselling sessions, up to a maximum of $5,000.

If there is more than one recipient of the benefit, each recipient will be entitled to receive an equal share of the benefit, so the total amount payable does not exceed $5,000.

The Counselling Benefit will only be paid once per Insured Person across all policies issued by us in respect of that Insured Person.

7.3 The following conditions must be met for the Counselling Benefit to be paid:

- the counselling session must be provided by an accredited counsellor approved by us;
- we will only reimburse amounts incurred by the recipient;
- the Counselling Benefit must be claimed within 12 months of receiving the benefit; and
- the recipient must be able to provide a copy of the invoice showing a breakdown of the services provided and the amount paid, and/or a receipt showing the amount paid.

8. Multi-link Benefit

TL OPTIONAL

8.1 The Multi-link Benefit is available when applying for business loan protection for two or more Insured Persons.

If you choose the Multi-link Benefit, then in the event we make a payment under a Death Benefit, TPD Benefit, Living Benefit or Terminal Illness Benefit, including an Interim Benefit, for an Insured Person, we will reduce the amount of every other benefit for all Insured Person(s) under the Policy (this includes benefits in Flexible Linking Plus, which are linked to a Term Life Policy). Each Insured Person's benefits will be reduced by the amount paid. If that amount exceeds an existing benefit for an Insured Person, then that benefit will be reduced to zero and will end.

If you choose the Multi-link Benefit, the TPD Buy Back Benefit, Living Buy Back Benefit, Double TPD Benefit, Double Living Benefit and Living Reinstatement Benefit are not available to you.

8.2 If you choose the Multi-link Benefit and the Policy ends because a benefit has been paid, you can apply to continue the insurance for the Insured Persons for whom the benefit was not paid. You must apply in writing within 30 days of the Policy ending.

You can apply to continue the insurance cover (up to a maximum of the amount that applied immediately before the Policy ended) provided that, at the time of application, the Insured Person is no older than age 69 (for the Death Benefit) and age 59 (for TPD Benefit and Living Benefits). No medical evidence is required however we will need financial information satisfactory to us before we will accept your application to continue the insurance cover. Any loadings, exclusions or special conditions will continue to apply.

9. TPD Benefit

TL OPTIONAL TLS OPTIONAL TPD

9.1 When we will pay

(a) Full benefit

We will pay a benefit if the Insured Person becomes *totally and permanently disabled.*

There are four definitions of *total and permanent disability:*

- *own occupation TPD;*
- *any occupation TPD;*
- *home duties TPD;* and
- *general cover TPD.*

The definition of *total and permanent disability* which applies to the Insured Person will be shown on the *policy schedule* or *membership certificate.*

If your TPD Benefit is made up of more than one definition of *total and permanent disability,* each definition will be considered as a separate benefit for the purposes of calculating the premium amount.

(b) TPD Partial Benefit

For Term Life and Standalone Total and Permanent Disablement Policies, a TPD Partial Benefit is payable if the Insured Person has suffered a *partial and permanent disability.*

The TPD Partial Benefit is not available in Term Life as Superannuation.

9.2 What we will pay

(a) Full benefit

For *total and permanent disability,* the amount we will pay is the TPD Benefit shown in the *policy schedule* or *membership certificate* for the Insured Person as at the *date of disablement.*

If you do not qualify for the TPD Continuation Benefit (as per section 9.3) at any *review date* on or following the Insured Person's 65th birthday, the definition of *total and permanent disability* changes to *general cover TPD.* The maximum benefit at this time is $1 million (plus the Loyalty Benefit) which can be increased by the *CPI* after this time.

(b) TPD Partial Benefit

For *partial and permanent disability,* we will pay the TPD Partial Benefit which is equal to 25% of the TPD Benefit (including the Loyalty Benefit) for the Insured Person at that time, up to a maximum of $500,000.

9.3 TPD Continuation Benefit

We may allow you to continue a TPD Benefit under an *any occupation TPD* definition after age 65, up until the *review date* on or following the Insured Person's 70th birthday, if the Insured Person is still working on a full-time basis, and their occupation class is A as shown in the *policy schedule* or *membership certificate.*

At the *review date* on or following the Insured Person's 65th birthday, the offer to continue the benefit will be issued.

(a) This option will only apply if:

- we have made the offer of continuation to you;
- the Insured Person can provide a declaration within 30 days of each *review date* that they:
  - are actively working on a full time basis;
  - are not planning to cease work in the next 12 months; and
  - have not made a claim, or are not eligible to make a claim for any benefit under any insurance cover issued by us;

- we have accepted your application for this benefit for an Insured Person; and
- you continue to pay premiums for this Policy.

(b) Limits on your cover

At the *review date* on or following the Insured Person's 65th birthday, the amount that can be insured is the lesser of:

- five times the Insured Person's annual income; and
- $1 million.

However, if at the *review date* on or following the Insured Person's 65th birthday their annual income results in a reduced sum insured which will be less than $1 million, the difference up to $1 million can be held under a general cover TPD definition.

Example
Immediately prior to the *review date* following Max's 65th birthday, he had a $2 million TPD Benefit. As Max continued to work full time, earning $110,000 per year, he was entitled to continue his TPD Benefit with:

- $550,000 benefit amount under an *any occupation TPD* definition; and
- $450,000 benefit amount under a *general cover TPD* definition.

(c) What we will pay

If the Insured Person:

- suffers a *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months; and
- the *sickness* or *injury* is likely to prevent the Insured Person from ever again being able to work in any occupation for which they are reasonably qualified because of education, training or experience, and which would pay remuneration at a rate greater than 25% of their *earnings* in the last 12 months of work, the amount we will pay is the TPD Benefit shown in the *policy schedule* for the Insured Person as at the *date of disablement*.

If you do not qualify for TPD Continuation Benefit at any *review date* on or following the Insured Person's 65th birthday, the definition of *total and permanent disability* reverts solely to *general cover TPD.* The maximum benefit at this time is $1 million (plus the Loyalty Benefit) which can be increased by the *CPI* after this time.

9.4 What happens after we pay

After we pay a TPD Benefit, we will reduce the amount of every other benefit for the Insured Person under the Policy (for example a Death Benefit on a Term Life Policy) by the amount paid. If we pay the entire sum insured of the TPD Benefit, the TPD Benefit for the Insured Person ends. If we pay a TPD Partial Benefit, we will also reduce the TPD Benefit for the Insured Person by the amount we paid.

9.5 Exclusions

We will not pay a TPD Benefit if the *sickness* or *injury* giving rise to the claim was caused by an intentional self-inflicted injury or attempted suicide (whether sane or insane).

10. Super Plus TPD Benefit

TL* TLS* TPD*

*TLS, TL & TPD (with Flexible Linking Plus)

The Super Plus TPD Benefit allows a TPD Benefit to be owned by two different Policy Owners. For example, the *any occupation TPD* Benefit can be owned by the trustee of your superannuation fund and the premium payable for this benefit can be paid through your superannuation fund. The *own occupation TPD* portion of the benefit can be owned, and paid for, outside your superannuation fund.

10.1 The following conditions apply to the Super Plus TPD Benefit:

- There will only be one TPD Benefit payment under the Super Plus TPD option. Therefore, if the Insured Person meets the definition of *any occupation TPD* and the benefit is paid, the *own occupation TPD* Benefit ends, and vice versa.
- If the Insured Person meets the definition of both *any occupation TPD* and *own occupation TPD*, the benefit will be paid to the owner of the *any occupation TPD* Benefit.
- All other conditions applying to the payment of TPD Benefits (as per section 9) apply to the Super Plus TPD Benefit.

10.2 Variation of benefits

- If the Insured Person receives a TPD Partial Benefit, the sum insured on both the *own occupation TPD* and *any occupation TPD* portion of the benefit will be reduced by the amount paid.
- For the purposes of Term Life and Term Life as Superannuation, the Super Plus TPD Benefit will be considered as part of the Policy for variation of benefits. Therefore, a payment of the Living Benefit under the Policy (including Flexible Living Benefits) will result in a reduction of the Super Plus TPD Benefit. A payment of the Super Plus TPD Benefit will result in a reduction of the Death Benefit and Living Benefit.

11. Waiver of Life Premium Benefit

TL OPTIONAL

11.1 We will waive payment of the entire premium payable under the Term Life Policy:

- if the Insured Person has been *totally and temporarily disabled* for a continuous period of 6 months; and
- for as long as the Insured Person is *totally and temporarily disabled.*

The premiums paid by you for the 6 months or more that the Insured Person was *totally and temporarily disabled* will be reimbursed.

11.2 If the Insured Person's *total and temporary disablement* recurs from the same or related cause within 6 months of you recommencing payment of the premium under the Policy, payment of the premium will be waived again without the Insured Person having to be *totally and temporarily disabled* for an additional continuous period of 6 months.

If there is more than 6 months between two periods of *total and temporary disablement,* payment of the premium under the Policy will not be waived again until the Insured Person has been *totally and temporarily disabled* for an additional continuous period of 6 months.

11.3 The following conditions apply to the Waiver of Life Premium Benefit:

- you are not entitled to apply for increases to the benefits payable in respect of any Insured Person on the Policy if the premium is being waived, except for increases in the Death Benefit under the Future Insurability Benefit (excluding the periodic increase event);
- the benefits under your Policy will continue to be increased with the *CPI* if we are still offering you *CPI* increases;
- this option is only available while you have a TPD Benefit;
- this option is not available to Insured Persons with *general cover TPD;*
- this option is not available if the Super Plus TPD Benefit is selected; and
- this benefit ends on the *review date* on or following the Insured Person's 65th birthday.

11.4 Exclusions

This option will not apply if the *total and temporary disability* giving rise to the claim was caused by an intentional self-inflicted injury or attempted suicide (whether sane or insane).

12. TPD Buy Back Benefit

TL OPTIONAL TLS OPTIONAL

12.1 Immediately after the later of the:

- Insured Person becoming *totally and permanently disabled;* and
- date we receive claim forms for the *total and permanent disability*;

will reinstate the Death Benefit for that Insured Person by 100% of the TPD Benefit we have paid, provided the Insured Person survives for 14 days. This will occur without you having to provide further evidence of health, occupation or pastimes.

12.2 The following conditions apply to the TPD Buy Back Benefit, and the Death Benefit that has been reinstated:

- you cannot reinstate more than the TPD Benefit we have paid;
- you can increase the reinstated Death Benefit with the *CPI,* provided we are still offering you *CPI* increases;
- the same underwriting assessment and exclusions that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit;
- the Death Benefit will be automatically reinstated once the Insured Person is eligible. You must decline the reinstatement in writing within 30 days of the reinstatement if you do not wish to have the Death Benefit reinstated;
- this benefit is not available to an Insured Person with a *general cover TPD* Benefit;
- this benefit is not available after it has been exercised;
- if the Double TPD Benefit applies, the TPD Buy Back Benefit is not available; and
- this benefit ends on the *review date* on or following the Insured Person's 65th birthday.

13. Double TPD Benefit

TL OPTIONAL TLS OPTIONAL

13.1 Immediately after the later of the:

- Insured Person becoming *totally and permanently disabled;* and
- date we receive claim forms for the *total and permanent disability;*

we will resinstate the Death Benefit for that Insured Person by 100% of the TPD Benefit we have paid, provided the Insured Person survives for 14 days. In addition, any premium payable on the reinstated Death Benefit will be waived for the life of the Policy. This will occur without you having to provide further evidence of health, occupation or pastimes.

13.2 The following conditions apply to the Double TPD Benefit, and the Death Benefit that has been reinstated:

- you cannot reinstate more than the TPD Benefit we have paid;
- you cannot exercise this benefit if a claim for a Terminal Illness Benefit or Living Benefit (or similar benefit) has been paid, or is in progress for the Insured Person;
- the Future Insurability Benefit, Business Cover Benefit and *CPI* increases do not apply to the reinstated Death Benefit;
- the same underwriting assessment and exclusions that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit;
- if this benefit is not selected at the time of the original application, you will be subject to further underwriting assessment;
- the Death Benefit will be automatically reinstated once the Insured Person is eligible. You must decline the reinstatement in writing within 30 days of the reinstatement if you do not wish to have the Death Benefit reinstated;
- this benefit is not available to an Insured Person with a *general cover TPD* Benefit;
- this benefit is not available if the Multi-link Benefit is selected;
- this benefit is not available after it has been exercised;
- if the Double TPD Benefit applies, the TPD Buy Back Benefit is not available; and
- this benefit ends on the *review date* on or following the Insured Person's 65th birthday.

14. TPD Death Benefit

TPD

14.1 We will pay a TPD Death Benefit of $10,000 if the Insured Person dies and the TPD Benefit (including the TPD Partial Benefit) has not been paid.

14.2 A TPD Death Benefit will not be paid if the Insured Person commits suicide (whether sane or insane) within 13 months of the later of the:

- *commencement date* of this Policy; and
- date this Policy was last reinstated.

This exclusion does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all the following apply:

- the level of cover being issued by us is the same amount, or less than, the existing cover being replaced;
- we were specifically told about the intended replacement of the other policy and we agreed to issue this Policy on the basis that it replaced the other policy;
- the other policy was continuously in force for at least 13 months immediately prior to the issue of this Policy;
- the other policy was cancelled immediately after the issue of this Policy; and
- no claim is pending or payable under the other policy.

15. Living Benefit

TL OPTIONAL LI

15.1 We will pay a Living Benefit (Full or Advancement) if:

- an Insured Person suffers a specified medical event (e.g. a specified *sickness, injury,* or surgery); and
- a *doctor* approved by us provides the medical evidence to support the claim.

We will only pay a benefit when we are satisfied that the Insured Person has satisfied the full definition of the relevant medical event. The medical conditions, *injuries* and surgery covered are:

Specified medical event	Living Benefit	Living Benefit Plus
Cancer		
Cancer (malignant tumours)*	✓	✓
Prostate cancer – major treatment*	✗	✓
Heart disorders		
Angioplasty – triple vessel*	✓	✓
Aortic surgery	✗	✓
Cardiomyopathy	✗	✓
Coronary artery bypass surgery*	✓	✓
Heart attack*	✓	✓
Heart valve surgery	✓	✓
Open heart surgery*	✓	✓
Out of hospital cardiac arrest	✓	✓
Pulmonary hypertension	✗	✓
Nervous system disorders		
Alzheimer's disease and other dementias	✗	✓
Motor neurone disease	✗	✓
Multiple sclerosis	✗	✓
Muscular dystrophy	✗	✓
Parkinson's disease	✗	✓
Accident		
Coma	✓	✓
Major head trauma	✓	✓
Paralysis	✗	✓
Severe burns	✓	✓
Body organ disorders		
Blindness	✗	✓
Chronic liver disease	✗	✓
Chronic lung disease	✗	✓
Kidney failure	✓	✓
Major organ transplant	✓	✓
Blood disorders		
Aplastic anaemia	✓	✓
Medically acquired HIV	✗	✓
Occupationally acquired HIV	✗	✓
Other events		
Advanced diabetes	✗	✓
Benign brain tumour	✓	✓
Encephalitis	✗	✓
Intensive care	✗	✓
Loss of hearing	✗	✓
Loss of independent existence	✗	✓
Loss of limbs	✗	✓
Loss of speech	✗	✓
Meningitis	✗	✓
Meningococcal septicaemia	✗	✓
Pneumonectomy	✗	✓
Severe rheumatoid arthritis	✗	✓
Stroke*	✓	✓

Specified medical event	Living Benefit	Living Benefit Plus
Advancement Benefit Conditions		
Alzheimer's disease and other dementias – advancement	✗	✓
Angioplasty - single or double vessel*	✓	✓ (multi-payment)
Blindness - advancement	✗	✓
Carcinoma in situ of female organs*	✓	✓
Diabetes complication	✗	✓
Early stage melanoma*	✓	✓
Loss of single limb	✗	✓
Multiple sclerosis – advancement	✗	✓
Parkinson's disease – advancement	✗	✓
Prostate cancer (stages T1a, T1b and T1c)*	✓	✓

Definitions of each event are given in the Medical Glossary.

* For these specified medical events, the benefit for the Insured Person is only payable if the *sickness, injury* or surgery occurs at least 3 months after the *commencement date* or the last reinstatement of the Policy. This includes any treatment or surgery that occurs over 3 months after cover for the Insured Person begins, however the treatment or surgery is solely attributable to one of the conditions listed above, and that condition occurred within the first 3 months of the *commencement date,* or last reinstatement of the Policy.

If any of the above conditions occur within 3 months of any increase to the benefit for the Insured Person (excluding *CPI* and Loyalty Benefit increases), the increase will not be payable. The benefit payable will be the amount that would have applied if no increase had occurred.

This 3 month exclusion period does not apply to the Policy if it replaces another similar policy issued by another insurer, or another policy issued by us, and all the following apply:

- the level of cover being issued by us is the same amount or less than the existing cover being replaced;
- we were specifically told about the intended replacement of the other policy and we agreed to issue this policy on the basis that it replaced the other policy;
- the other policy was continuously in force for at least 3 months immediately prior to the issue of this Policy;
- the other policy was cancelled immediately after the issue of this Policy; and
- no claim is pending or payable under the other policy.

15.2 What we will pay

(a) Full Benefit payment

You are entitled to claim for the entire amount of your Living Benefit if you meet the definition of the specified medical event as defined in the Medical Glossary, except for the Advancement Benefit conditions.

The amount we will pay is the Living Benefit shown in the policy schedule for that Insured Person.

(b) Advancement Benefit payment

We will pay an Advancement Benefit for the specified medical events listed in the following table:

Condition	What we will pay
Angioplasty – single or double vessel	20% of the Living Benefit up to a maximum of $40,000.
Carcinoma in situ of female organs	25% of the Living Benefit up to a maximum of $100,000.
Prostate cancer (stages T1a, T1b and T1c)	
Early stage melanoma	
Alzheimer's disease and other dementias – advancement	25% of the Living Benefit up to a maximum of $50,000.
Multiple sclerosis – advancement	
Parkinson's disease – advancement	
Loss of single limb	25% of the Living Benefit up to a maximum of $100,000.
Blindness – advancement	
Diabetes complication	40% of the Living Benefit up to a maximum of $200,000.

Please note that the amounts of $200,000, $100,000, $50,000 and $40,000 are not increased with the *CPI.* The minimum benefit payable under the Advancement Benefit is $10,000.

We will only pay once under each of these groups of events:

- Angioplasty – single or double vessel.
- Carcinoma in situ of female organs or Prostate cancer (stages T1a, T1b and T1c).
- Early stage melanoma.
- Alzheimer's disease and other dementias – advancement, multiple sclerosis – advancement, Parkinson's disease – advancement.
- Diabetes complication.

If you have selected the Living Plus Option for the Insured Person and it appears on the *policy schedule* under that Insured Person, an Advancement Benefit for angioplasty – single or double vessel, will be paid for:

- the first angioplasty - single or double vessel; and
- each subsequent angioplasty – single or double vessel procedure which occurs at least 6 months after the previous angioplasty – single or double vessel procedure.

15.3 What happens after we pay

After we pay a Living Benefit we will reduce every other benefit for the Insured Person under this Policy (for example a Death Benefit on a Term Life Policy) by the amount we paid. If we pay the full Living Benefit, the Living Benefit in respect of that Insured Person ends. If the Living Benefit was paid as an Advancement Benefit, we will also reduce the Living Benefit for the Insured Person by the amount we paid.

15.4 Exclusions

We will not pay you a benefit if the *sickness, injury* or surgery giving rise to the claim is caused directly or indirectly by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

16. Flexible Living Benefit

TL* TLS*

*TLS & TL (with Flexible Linking Plus)

The Flexible Living Benefit allows a Term Life or Term Life as Superannuation Policy with a Living Benefit to be owned by two different Policy Owners. For example, the Living Benefit premium of the Policy can be paid for, and owned outside your superannuation fund, and the remaining benefits of the Policy can be paid through and owned by the trustee of your superannuation fund.

For the purposes of Term Life and Term Life as Superannuation, the Flexible Living Benefit will be considered as part of the Policy for variation of benefits. Therefore, a payment of the TPD Benefit under the Policy (including Super Plus TPD Benefits) will result in a reduction of the Flexible Living Benefit and Death Benefit. A payment of the Flexible Living Benefit will result in a reduction of the Death Benefit and TPD Benefit.

All other conditions pertaining to the payment of Living Benefits (as per section 15) apply to the Flexible Living Benefit.

17. Living Buy Back Benefit

TL* TLS*

*TL (with a Living Benefit) & TLS (with Flexible Linking Plus)

17.1 Twelve months after the later of the:

- Insured Person suffering a specified medical event (except for Advancement Benefit conditions); and
- date we receive claim forms in relation to the specified medical event;

you are automatically entitled to reinstate the Death Benefit for the Insured Person by 100% of the Living Benefit we have paid. You can do this without having to provide further evidence of health, occupation or pastimes.

If the Living Benefit reduces the Death Benefit to zero, and this Policy is no longer available when this benefit is exercised, we will issue an individual Policy available at the time which we believe provides the same or similar benefits.

17.2 The following conditions are placed on the Living Buy Back Benefit, and the Death Benefit that has been reinstated:

- you cannot buy back more than the Living Benefit we have paid;
- you can increase the reinstated Death Benefit with the *CPI*, provided we are still offering you *CPI* increases;
- the same underwriting assessment and exclusion clauses that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit;
- you must request the Living Buy Back Benefit in writing within 30 days from the first anniversary of the medical event. The offer lapses and will not be re-offered if we do not receive a written request within 30 days from the first anniversary of the medical event;
- this benefit is not available after it has been exercised;
- if the Double Living Benefit applies, the Living Buy Back Benefit is not available; and
- the Insured Person must be alive at the time of the Living Buy Back Benefit application.

18. Double Living Benefit

TL OPTIONAL TLS* OPTIONAL

*TLS (with Flexible Linking Plus)

18.1 Immediately after the later of the:

- Insured Person suffering a specified medical event (except for Advancement Benefit conditions); and
- date we receive claim forms in relation to the specified medical event;

we will reinstate the Death Benefit for that Insured Person by 100% of the Living Benefit we have paid, provided the Insured Person survives for 14 days. In addition, any premium payable on the reinstated Death Benefit will be waived for the life of the Policy. This will occur without you having to provide further evidence of health, occupation or pastimes.

18.2 The following conditions apply to the Double Living Benefit, and the Death Benefit that has been reinstated:

- you cannot reinstate more than the Living Benefit we have paid;
- you cannot exercise this benefit if a claim for a Terminal Illness Benefit or TPD Benefit (or similar benefit) has been paid, or is in progress for the Insured Person;
- the Future Insurability Benefit, Business Cover Benefit and *CPI* increases do not apply to the reinstated Death Benefit sum insured;
- the same underwriting assessment and exclusions that we originally applied to the Insured Person's Death Benefit will apply to the reinstated Death Benefit;
- if this benefit is not selected at the time of the original application, you will be subject to further underwriting assessment;
- the Death Benefit sum insured will be automatically reinstated once the Insured Person is eligible. You must decline the reinstatement in writing within 30 days of the reinstatement if you do not wish to have the Death Benefit reinstated;
- this option is not available if the Multi-Link Benefit is selected;
- this benefit is not available after it has been exercised;
- if the Double Living Benefit applies, the Living Buy Back Benefit is not available; and
- this benefit ends on the *review date* on or following the Insured Person's 65th birthday.

19. Living Reinstatement Benefit

TL OPTIONAL | TLS* OPTIONAL | LI OPTIONAL

* TLS (optional with Flexible Linking Plus)

19.1 Twelve months after the later of the:

- Insured Person suffering a specified medical event (except for an Advancement Benefit); and
- date we receive claim forms in relation to the specified medical event;

you have the option to reinstate the Living Benefit, and for Term Life and Term Life as Superannuation reinstate the Death Benefit, for the Insured Person by 100% of the Living Benefit we have paid without having to provide further evidence of health, occupation or pastimes.

The Policy terms and conditions may no longer be available when this benefit is exercised. If so, we will issue a new Policy available at the time which we believe provides similar benefits.

19.2 The Policy Owner can exercise the option provided that:

- the reinstatement request is received in writing within 30 days from the first anniversary date of the specified medical event. If your request for reinstatement is not received in this period the offer of reinstatement lapses and will not be re-offered;
- the Living Benefit payment was made before the *review date* on or following the Insured Person's 65th birthday; and
- a TPD Benefit (including TPD Partial Benefit and Super Plus TPD Benefit) has not been paid after the Living Benefit was paid under the Policy.

This option is not available for Policies with a Multi-Link Benefit. This option is not available after you have exercised it once.

19.3 The reinstated Living Benefit and Death Benefit will be on the terms and conditions of the original Living Benefit and Death Benefit with the exception of the following:

- a further reinstatement option will not be available;
- *CPI* increases will not be available; and
- Future Insurability Benefit and Business Cover Benefit increases will not be available.

Any exclusions or special conditions applicable under your Policy will be maintained under the reinstated Living Benefit.

19.4 We will pay a restricted amount of 10% of the Living Benefit, up to a maximum $50,000 for a claim under the reinstated cover if the specified medical event claimed:

- is the same as the original medical event;
- has occurred as a direct or indirect result of the original specified medical event;
- is a heart related condition and the original specified medical event was also a heart related condition;
- is a lung related condition and the original specified medical event was a lung related condition;
- is a stroke and the original specified medical event was a heart related condition;
- is a loss of independent existence; or
- was a cancer related condition and the original specified medical event was also a cancer related condition.

The Insured Person must satisfy the definition of the specified medical event again in order to claim on the reinstated cover. We will not pay a claim under the reinstated cover if the specified medical event occurred or was diagnosed, or the circumstances or *symptoms* leading to diagnosis were apparent before the Living Benefit was reinstated. The reinstated Living Benefit will be reduced by any amount payable under section 19.4.

We will not pay a claim under the reinstated cover for an Advancement Benefit which is related to the original medical event. Otherwise we will pay the reinstated Living Benefit as per section 15.2.

20. Living Insurance Death Benefit

LI

20.1 We will pay a Living Insurance Death Benefit of $10,000 if the Insured Person:

- suffers one of the specified medical events before the Policy ends; and
- subsequently dies within 14 days.

20.2 A Living Insurance Death Benefit will not be paid if the specified medical event giving rise to the claim was caused directly or indirectly by an intentional self-inflicted *injury* or attempted suicide (whether sane or insane).

21. Needlestick Benefit

NB

21.1 The Needlestick Benefit is an optional Policy available at an additional cost and is available with another St.George Protection Plans Policy. If you have cover within your superannuation fund, you will need to choose Flexible Linking Plus or Income Linking Plus to apply. This will allow you to select a different Policy Owner for this benefit.

The Needlestick Benefit is only available where the Insured Person is a medical professional and the option is available to them.

You can apply for a maximum of $500,000 of cover.

We will pay the amount of the Needlestick Benefit for the Insured Person as shown in the *policy schedule*.

21.2 We will pay the Needlestick Benefit sum insured if the Insured Person is diagnosed with:

- occupationally acquired HIV; or
- occupationally acquired hepatitis B & C,

as defined in the Medical Glossary in chapter 7.

21.3 The following conditions apply to the Needlestick Benefit:

- The Needlestick Benefit will only be paid if the Insured Person is infected whilst working in their *usual occupation* as a medical professional.
- *CPI,* Future Insurability Benefit, Business Cover Benefit and Loyalty Benefit increases do not apply to this option.
- If the Insured Person is eligible to claim on both the Needlestick Benefit and a Living Benefit for the same *sickness* or *injury,* then a maximum of $2 million (plus *CPI* increases) will be paid in total.

21.4 Exclusions

No payment will be made where the:

- infection is intentionally self inflicted;
- Insured Person is not working as a medical professional at the time of infection; or
- Insured Person had become positive to the Hepatitis B surface antigen within six months from the *commencement date* of the benefit or within six months of the reinstatement of the benefit.

21.5 The Needlestick Benefit will end on the earliest of the:

- date the Needlestick Benefit is paid;
- *review date* on or following the Insured Person's 65th birthday;
- date the Policy to which the Needlestick Benefit is linked ends for any reason; and
- date we receive your written request to cancel the Policy.

22. Children's Benefit

CB

22.1 The Children's Benefit is an optional Policy available at an additional cost and is available with another St.George Protection Plans Policy. If you have cover within your superannuation fund, you will need to choose Flexible Linking Plus or Income Linking Plus to apply. This will allow you to select a different Policy owner for this benefit.

You can apply to insure any child aged between 2 and 14 inclusive, up to a maximum of $200,000 of cover.

22.2 We will pay a Children's Benefit if:

- an Insured Child dies, or suffers a *children's medical event;* and
- a *doctor* approved by us provides the medical evidence to support the claim.

22.3 We will pay a benefit when we are satisfied that the Insured Child has satisfied the full definition of the relevant *children's medical event.* The events covered are:

Aplastic anaemia
Benign brain tumour
Blindness
Brain damage
Cancer
Cardiomyopathy
Kidney failure
Encephalitis
Loss of hearing
Loss of limbs
Loss of speech
Major head trauma
Major organ transplant
Meningitis
Meningococcal septicaemia
Paralysis
Stroke
Terminal illness

The definitions of the above medical events can be found in the Medical Glossary in chapter 7.

We will pay the amount of the Children's Benefit for the Insured Child as shown in the *policy schedule.*

22.4 Exclusions

The Children's Benefit will not be paid:

- if the *children's medical event* giving rise to the claim is caused directly or indirectly by an intentional self-inflicted injury or attempted suicide (whether sane or insane);
- if the *children's medical event* giving rise to the claim is directly or indirectly caused by a *congenital condition;* or
- for cancer and stroke, if the *children's medical event* giving rise to the claim occurs within 3 months of the *commencement date* or last reinstatement of the benefit.

22.5 We have placed the following conditions on the Children's Benefit.

- The sum insured on your other St.George Protection Plans Policy must be greater than:
  - $50,000 for Term Life, Term Life as Superannuation, Standalone Living Insurance and Standalone Total and Permanent Disablement Policies; or
  - $1,000 per month for Income Protection, Income Protection Plus and Business Overheads.
- At the *review date* on or following the Insured Child's 16th birthday, the Insured Child has the option of applying for cover over their own life. The maximum benefit that is able to be applied for is $200,000. Benefits over this amount will be subject to medical and financial underwriting.
- You must be the natural parent or *legal guardian* of the Insured Child.

- We will only pay this benefit once for each Insured Child, and a child may only be named under one Policy.

22.6 The Children's Benefit will end on the earliest of the:

- date the Children's Benefit is paid;
- *review date* on or following the Insured Child's 16th birthday;
- date the Policy to which the Children's Benefit is linked ends for any reason; and
- date we receive your written request to cancel the Policy.

23. Loyalty Benefit

TL TLS LI TPD CB

23.1 The Loyalty Benefit will be added to all benefits listed on the *policy schedule* where the Policy has been in force for three years from the later of the *commencement date* and 19 October 2009.

23.2 The amount of the Loyalty Benefit will be 5% of any Death Benefit, TPD Benefit, Living Benefit or Children's Benefit.

23.3 The Loyalty Benefit will be taken into account when calculating a TPD Partial Benefit, Advancement Benefit, and any other benefit which is paid as a proportion of the total benefit.

You are not entitled to reinstate the amount of any Loyalty Benefit for the purposes of Living Buy Back Benefit, TPD Buy Back Benefit, Double Living Benefit, Double TPD Benefit and Living Reinstatement Benefit.

The terms and conditions that apply to the payment of the Loyalty Benefit will be the same as those applying to the Death Benefit, TPD Benefit, Living Benefit or Children's Benefit (as applicable).

24. Exclusions

TL TLS LI TPD

In addition to any other exclusions to the benefits described previously, we will not pay any benefit if the claim was caused directly or indirectly by an event or condition covered by any exclusion in your *policy schedule* or *membership certificate*.

25. When does my benefit end?

TL TLS LI TPD

Your benefit under a Policy for an Insured Person continues until the earliest of:

- the date the Insured Person dies;
- the date we pay the entire benefit for the Insured Person;
- the *review date* on or following the Insured Person reaches the expiry age of the benefit;
- for Term Life and Term Life as Superannuation, the benefit amount for the Insured Person is reduced to zero because we have paid a TPD Benefit, Super Plus TPD Benefit, Living Benefit, Flexible Living Benefit or Terminal Illness Benefit;
- you write and ask us to cancel the benefit for the Insured Person; and
- the date your Policy ends.

26. When does the Policy end?

TL TLS LI TPD

Your Policy will continue until the earliest of the:

- date the last Insured Person dies;
- date all benefits for the last Insured Person end;
- date we cancel your Policy because you have not paid your premiums or any other amounts which relate to your Policy;
- date we cancel or avoid your Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you or an Insured Person prior to our acceptance of risk, or during the making of a claim;
- date we receive your written request to cancel your Policy; and
- date you are no longer eligible to make contributions to superannuation, or have contributions made to superannuation on your behalf (for Term Life as Superannuation).

3. Income products.

3

Income products are designed to replace a portion of the income lost when the Insured Person is unable to work at their full capacity due to sickness or injury by providing monthly payments.

Income products are designed to help you avoid the financial stress of drawing down on your assets or taking on more debt if something unexpected were to happen. These payments may be treated almost as if they were your regular pay cheque and used to pay your rent or mortgage payments, day-to-day living expenses and medical expenses.

Which Policy? Simple income cover, more comprehensive income cover, or insurance to cover *allowable business expenses?*	Income Protection	Income Protection Plus	Business Overheads
Agreed value or *indemnity?* What is my benefit based on?	*Agreed value or indemnity*	*Agreed value or indemnity*	*Indemnity*
Waiting period? How long can you last without an income? When do your benefits under an employer superannuation policy expire?	14, 30, 90, 180, 360, 720 days	14, 30, 90, 180, 360, 720 days	14 or 30 days
Benefit period? How long do you need to be paid for? Some occupation classes may be restricted.	2 or 5 years, to age 55 or to age 65	2 or 5 years, to age 55 or to age 65	1 year
Premium options Structure your premium in any one of three ways to maximise the value of your Policy.	Stepped Level 55 (only available on benefit period to age 55) Level 65	Stepped Level 55 (only available on benefit period to age 55) Level 65	Stepped Level 65
Optional benefits	Superannuation Contribution Option Needlestick Benefit Children's Benefit	Accident Benefit Superannuation Contribution Option Super Plus IP Benefit Needlestick Benefit Children's Benefit	Needlestick Benefit Children's Benefit

Summary of key features.

Income Protection — IP

Entry ages: 17-59 (Stepped and Level 65 premium), 17-49 (Level 55 premium, and *benefit period* to age 55). Expiry age: 65^		
What's Included?	• Total Disability Benefit • Partial Disability Benefit • Elective Surgery Benefit • Rehabilitation Expense Benefit • Rehabilitation Program Benefit • Recurrent Disability Benefit • Loyalty Benefit	
What can I add?	• Superannuation Contribution Option	**Other Options:** • Needlestick Benefit • Children's Benefit
What if I work past age 65?	Occupation classes AA, A, P and S may qualify to continue some benefits while they are still working. Expiry age for IP Continuation Option: 75^	

Income Protection Plus — IPP

Entry ages: 17-59 (Stepped and Level 65 premium), 17-49 (Level 55 premium and *benefit period* to age 55). Expiry age: 65^			
What's Included?	• Total Disability Benefit • Partial Disability Benefit • Elective Surgery Benefit • Rehabilitation Expense Benefit • Rehabilitation Program Benefit • Recurrent Disability Benefit • Change of Waiting Period Benefit • Counselling Benefit • Nursing Care Benefit • Specified Injury Benefit • Crisis Benefit	• Death Benefit • Transport within Australia Benefit • Transport from Overseas Benefit • Accommodation Benefit • Family Care Benefit • Home Care Benefit • Respite Care Benefit • Future Insurability Benefit • Waiver of IP Premium Benefit • Loyalty Benefit	
What can I add?	• Accident Benefit • Superannuation Contribution Option	**Income Linking Plus** • Super Plus IP Benefit	**Other Options:** • Needlestick Benefit • Children's Benefit
What if I work past age 65?	Occupation classes AA, A, P and S may qualify to continue some benefits while they are still working. Expiry age for IP Continuation Option: 75^		

Business Overheads — BOH

Entry ages: 17-59. Expiry age: 65^	
What's Included?	• Total Disability Benefit • Partial Disability Benefit • Elective Surgery Benefit • Recurrent Disability Benefit • Death Benefit
Other Options	• Needlestick Benefit • Children's Benefit

^ On the *review date* on or following the Insured Person's birthday.

Who is insured and who owns the Policy?

You generally apply for an Income Policy to protect your own income, in which case you are the Insured Person as well as the Policy Owner. In some limited circumstances, the Insured Person can be different to the Policy Owner. Speak to your financial planner for more information on these circumstances.

Who receives the benefits of the Policy?

As Policy Owner, you pay premiums that are due under the Policy and will receive any benefits that become payable. If you die, any benefit payable on death will be paid to your estate.

Features of your Policy

CPI increases

To ensure the value of your benefits keep up with the cost of living, we will automatically increase the amount of your benefits each year on your *review date* in line with increases in the *CPI*. You may decline this increase by advising us in writing within 30 days of the *review date.* You may also request in writing that indexation increases never apply again. If you have requested that *CPI* never apply again and you wish to restart *CPI* increases, we may ask you for information on the Insured Person's health, occupation or pastimes. We will advise you in writing if we will restart *CPI* increases.

Increasing claims benefit

If you are receiving benefits, the monthly benefit will be increased on each *review date* by the *CPI.*

Premiums waived while we pay you

You do not have to pay premiums, including policy fee and stamp duty, for the period during which you are receiving a Total Disability Benefit or Partial Disability Benefit.

Guaranteed renewable

All St.George Protection Plans are guaranteed to continue for the term specified, which means that provided your premiums are paid when due we cannot cancel your insurance even if there is a change in an Insured Person's health, occupation or pastimes.

Guaranteed upgrades

To save you from having to ensure that your Policy is still as good in the future as when you first took it out, we automatically upgrade your Policy should better features and benefits, that don't result in an increase in premium, become available down the track. We will always give you the best definition available under St.George Protection Plans from the time you took out the Policy, to the date of *sickness* or *injury.*

Loyalty Benefit

To reward your loyalty, after you have held your Policy for 3 years from the later of the *commencement date* and 19 October 2009, we will add a Death Benefit of $50,000 to your Policy without further charge.

Multi-Policy discount

If the Insured Person is covered by more than one Policy (Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone Total and Permanent Disablement, Income Protection, Income Protection Plus or Business Overheads) in St.George Protection Plans, you will also receive a multiple policy discount of 5% on the Insured Person's premiums (excluding policy fee and stamp duty).

Premium Holiday

To save you the hassle of having to cancel your Policy and then having to re-apply when your circumstances change, after you have held your Policy for at least 6 months, we will allow you to suspend your Policy for a maximum of 12 months in total. During this period you will not have to pay premiums. However, you will not be eligible to claim for any *sickness, injury,* or any other event that happens in the period that the premiums were not being paid. You may only exercise this option once in any 12 month period, and you must show evidence of financial hardship acceptable to us.

A *sickness* or *injury* is taken to have happened when:

- a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the *sickness* or *injury;* or
- the Insured Person first had any *symptom* of the *sickness or injury* for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor.*

Worldwide cover – 24 hours a day

We will provide you with full cover at any time, anywhere in the world.

When does the Policy end?

Your Policy will continue until the earliest of the Insured Person reaching their expiry age, we pay out the benefits for the Insured Person, you cancel your Policy, or you fail to pay the premiums for your Policy. Your Policy will also end if you fail to disclose information to us, or misrepresent information at application. For more information see section 29 on page 49.

Income Protection and Income Protection Plus.

Income Protection provides a regular monthly income if the Insured Person becomes disabled because of *sickness* or *injury,* while Income Protection Plus provides more comprehensive cover by including a number of additional benefits.

You apply for the monthly benefit amount you wish to cover the Insured Person for. You can insure 75% of the Insured Person's regular *monthly earnings,* or up to 80% if the Superannuation Contribution Option is selected.

This page contains a summary of the key features and benefits available, however it is important that you read and understand all the information about your benefits, starting on page 39.

Benefits available for Income Protection and Income Protection Plus

- **Total Disability Benefit:** pays a monthly benefit if the Insured Person is *totally disabled* after the *waiting period* because of *sickness* or *injury*. The Insured Person is only required to meet one of three definitions of *total disability* at the time of claim, based on either duties, time or *earnings.*
- **Partial Disability Benefit:** pays a monthly benefit if because of a *sickness* or *injury,* the Insured Person is on reduced duties and earning less than before they became disabled. If the Insured Person's occupation class is AA, A, P or S, and they hold an Income Protection Plus Policy, there is no requirement for them to be *totally disabled* to receive this benefit.
- **Elective Surgery Benefit:** pays a monthly benefit if the Insured Person is *totally disabled* or *partially disabled* because of a transplant (where they are the donor) or cosmetic surgery.
- **Rehabilitation Expense Benefit:** pays a benefit to help meet approved rehabilitation costs incurred while the Insured Person is *totally disabled.*
- **Rehabilitation Program Benefit:** provides the Insured Person with the opportunity to participate in a rehabilitation program selected by us.
- **Recurrent Disability Benefit:** allows the *waiting period* to be waived if the Insured Person becomes disabled within a certain period of time due to the same *sickness* or *injury.*
- **IP Continuation Option:** allows occupation classes AA, A, P and S to continue cover each year after the age of 65 if the Insured Person continues to work on a full time basis.

Optional benefit available for Income Protection and Income Protection Plus

- **Superannuation Contribution Option:** allows you to cover up to 80% of the Insured Person's *monthly earnings* if they are making superannuation contributions.

Benefits available for Income Protection Plus

- **Change of Waiting Period Benefit:** allows you to reduce the *waiting period* without further health evidence if the Insured Person changes jobs.
- **Counselling Benefit:** reimburses you up to $5,000 for a maximum of 10 counselling sessions following the payment of a Total Disability Benefit. This amount will be paid in addition to any other benefits, and is paid once per Insured Person.
- **Nursing Care Benefit:** pays a benefit if the Insured Person is *confined to bed* for more than 3 consecutive days during the *waiting period.*
- **Specified Injury Benefit:** pays a monthly benefit for the *payment period* if the Insured Person suffers a specified injury, whether or not they are able to return to work.
- **Crisis Benefit:** pays a monthly benefit for 6 months if the Insured Person suffers a specified crisis event, whether or not they are able to return to work.
- **Death Benefit:** pays a benefit if the Insured Person dies while they are entitled to monthly benefit payments.
- **Transport within Australia Benefit:** pays a benefit to enable the Insured Person to be transported within Australia if they become *totally disabled* and are *confined to bed.*
- **Transport from Overseas Benefit:** pays a benefit to enable the Insured Person to return to Australia if they become *totally disabled* whilst overseas.
- **Accommodation Benefit:** pays a benefit to assist in the accommodation costs of a family member who has to travel from their usual place of residence to be with the Insured Person.
- **Family Care Benefit:** pays a monthly benefit to help cover the lost income of a family member if they have to stop work to look after the Insured Person.
- **Home Care Benefit:** pays a monthly benefit to help cover the cost of a professional home carer if required.
- **Respite Care Benefit:** pays for the Insured Person to be placed into a respite care facility if they are *totally disabled* and unable to perform any two activities of daily living.
- **Future Insurability Benefit:** allows the Insured Person to increase their *insured monthly disability benefit* every 3 years without medical evidence.
- **Waiver of IP Premium:** if you are paid a Total Disability Benefit, premium amounts payable during the *waiting period* will be refunded to you.

Optional benefits available with Income Protection Plus

- **Accident Benefit:** pays a benefit if the Insured Person is *totally disabled* for more than 3 consecutive days during the *waiting period* due to an *injury.*
- **Super Plus IP Benefit:** allows you to maximise the benefits paid through your superannuation fund. This means the premiums relating to benefits that meet a condition of release will be paid through your superannuation fund and the premiums relating to all other benefits in Income Protection Plus will be paid outside your superannuation fund.

Policy features

- *CPI* increases
- Increasing claims
- Premiums waived while we pay you
- Guaranteed renewable
- Guaranteed upgrades
- Loyalty Benefit
- Multi-Policy discount
- Premium Holiday
- Worldwide cover

Are there limitations on my benefits?

Your Income Protection and Income Protection Plus benefits may be reduced if you receive income or benefits from other sources.

However for Policies with an occupation class of AA, P or S, these amounts can only be reduced if you didn't tell us about them at the time you applied for this insurance. For more information about limitations, refer to page 48.

What should I do now?

Make sure you read and understand all the specifics about the benefits you are applying for. These start on page 39.

A snapshot of Income Protection in action*

Harry is a 35 year old married man with two young children. He works as a project manager in the building industry. Over five years ago, Harry and his family returned home from an overseas posting in the middle of Australia's property boom, and like many Australians, took out a large mortgage to buy the family home.

Late last year Harry was diagnosed with a blood vessel malformation that put pressure on the lower spinal nerves and reduced his mobility. Harry required surgery and physiotherapy as well as a long period off work to rehabilitate.

Thankfully Harry had taken out an Income Protection Plus Policy 3 years ago. He claimed against the Policy, satisfied all of the policy terms and conditions, and as a result received a monthly benefit payment of $6,619 following the end of the *waiting period.* Nursing Care Benefits were also paid for the period of his hospitalisation. Harry and his family could then meet the mortgage costs and other expenses during his time off work.

Some other examples of Income Protection claims paid:

Cause	Breast cancer	Coronary artery surgery	Stomach cancer
Occupation	Plumber	Lecturer	Quantity Surveyor
Age at claim	48	52	60
Years in force	8 years	3 years	1 year
Benefit	$5,451 per month	$3,319 per month	$2,295 per month

(Source: Claims data from the *Insurer*)

* For illustrative purposes only. The above is a case study loosely based on real life examples (names and some details have been altered) and demonstrates how St.George Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

Business Overheads.

Business Overheads pays a monthly benefit for the day to day costs of running a business for up to 12 months if the Insured Person is disabled because of *sickness* or *injury* and is unable to work at their full capacity in their business. It could mean the difference between the business surviving or collapsing.

This page contains a summary of the key features and benefits available, however it is important that you read and understand all the information about your benefits, starting on page 39.

Benefits available

- **Total Disability Benefit:** pays a monthly benefit if the Insured Person is *totally disabled* after the *waiting period* because of *sickness* or *injury.* The Insured Person is only required to meet one of three definitions of *total disability* at the time of claim, based on either duties, time or *earnings.*
- **Partial Disability Benefit:** pays a monthly benefit if because of a *sickness* or *injury,* the Insured Person is on reduced duties and earning less than before they became disabled.
- **Elective Surgery Benefit:** pays a monthly benefit if the Insured Person is *totally disabled* or *partially disabled* because of a transplant (where they are the donor) or cosmetic surgery.
- **Recurrent Disability Benefit:** allows the *waiting period* to be waived if the Insured Person becomes disabled within a certain period of time due to the same *sickness* or *injury.*
- **Death Benefit:** pays a benefit if the Insured Person dies while they are entitled to monthly benefit payments.

3

Policy features

- *CPI* increases
- Increasing claims
- Premiums waived while we pay you
- Guaranteed renewable
- Guaranteed upgrades
- Loyalty Benefit
- Multi-Policy discount
- Premium Holiday
- Worldwide cover

Are there limitations on my benefits?

Your Business Overheads benefits may be reduced if you receive income or benefits from other sources. For more information about limitations, refer to page 49.

A snapshot of Business Overheads in action*

David runs a successful business as an architect. Unfortunately, last year David had a serious car accident and he broke his right collar bone and arm, rendering him unable to work. His duties within the business were the hands on production of drawings and documents for construction plans, physical site inspections and driving to councils, sites and clients. David's business has a high turnover of revenue, and his outgoings are also high.

Following David's injury, the income his business received reduced dramatically and his company started running at a loss. Fortunately his business was able to survive, due in main part because of David and his team's dedication, and because David was able to claim on his Business Overheads Policy. David's claim was accepted, allowing him to source and pay for a locum architect to keep things running whilst he recovered. His clients continued to be serviced through his company, maintaining his professional status. Thanks to his Business Overheads Policy, David recovered and his business survived, without having to obtain additional finance or put his company in jeopardy.

* For illustrative purposes only. The above is a case study loosely based on real life examples (names and some details have been altered) and demonstrates how St.George Protection Plans may be able to aid you in times of need. Your financial planner will be able to assist you in determining the appropriate cover for you.

Income products benefit specifics.

Please take the time to read the details about the benefits your Policy provides. This section will provide you with all of the details of your Policy and is an important part of this PDS.

The coloured icons used throughout will assist you in determining which benefits are applicable. To understand the icon that corresponds to your Policy, please refer to page 34.

Please speak to your financial planner or contact us if you would like any of the details explained to you.

1. Total Disability Benefit

IP IPP BOH

1.1 If the Insured Person is *totally disabled,* we will pay you a monthly benefit after the end of your *waiting period.* The benefit will be payable monthly in arrears and you will continue to receive a monthly benefit payment until the earliest of the following events:

- the Insured Person is no longer *totally disabled;*
- the end of your *benefit period;* and
- when your Policy ends.

1.2 What we will pay

(a) Income Protection and Income Protection Plus

The benefit you receive will depend on whether you have chosen an *agreed value* or *indemnity* Policy.

The amount of this benefit is reduced by any limitations on benefits (see section 26).

What we will pay when the Insured Person is *totally disabled:*

Agreed value

The monthly Total Disability Benefit is the *insured monthly disability benefit.*

Indemnity

The monthly Total Disability Benefit is the lesser of:

- the *insured monthly disability benefit;* and
- 75%* of the *pre-disability monthly earnings.*

If the *insured monthly disability benefit* with us at the time of application is greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $480,000, the monthly Total Disability Benefit is the lesser of:

- the *insured monthly disability benefit;* and
- a percentage of the *pre-disability monthly earnings,* where the percentage is;
  - 75%* of the first $320,000 of annualised *pre-disability monthly earnings;*
  - 50% of the next $240,000 of annualised *pre-disability monthly earnings;*
  - 20% of the remainder of annualised *pre-disability monthly earnings.*

For *agreed value* Policies, if you overstated the *monthly earnings* of the Insured Person at application (or at the time when you applied for any increase), your *insured monthly disability benefit* will be 75%* of the highest average monthly income for any 12 consecutive months between 2 years before the *commencement date* and the date the Insured Person became *totally disabled.*

* For the purposes of the Superannuation Contribution Option we will use:

Agreed value

The greater of the *income ratio* and 75%.

Indemnity

The greater of the *income ratio* and 75%.

If the *insured monthly disability benefit* with us at the time of application is greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $450,000, we will use the lesser of:

- the *income ratio;* and
- a percentage of the *pre-disability monthly earnings,* where the percentage is;
  - 80% of the first $320,000 of annualised *pre-disability monthly earnings;*
  - 55% of the next $190,000 of annualised *pre-disability monthly earnings;*
  - 20% of the remainder of annualised *pre-disability monthly earnings.*

If the Insured Person is unemployed for reasons other than *total disability* or they take leave without pay, parental or sabbatical leave for 12 months or more immediately before suffering *total disability,* they will only be considered *totally disabled* if, solely because of *sickness* or *injury* they are:

- unable to perform any occupation for which they are reasonably suited by education, training or experience;
- not working; and
- under the *regular care of a doctor.*

If the Insured Person becomes unemployed or they take leave without pay, parental or sabbatical leave, cover under the Policy will continue, provided you pay premiums and any other amounts due. Unemployment does not include permanent retirement from the workforce.

(b) Business Overheads

The amount of this benefit is the lesser of the *insured monthly business overheads benefit,* and the *allowable business expenses* actually incurred in the month the Insured Person is suffering *total disability.*

The amount of this benefit is reduced by any limitations on benefits (see section 27).

1.3 If the Insured Person is a medical professional who performs invasive surgical procedures as the main and important part of their *usual occupation,* we will regard the Insured Person as being *totally disabled* due to *sickness* if:

- they are diagnosed with Human Immunodeficiency Virus or Hepatitis B or C; and
- as a consequence of the diagnosis, they are restricted as a regulatory requirement from performing their *usual occupation.*

1.4 The benefit accrues from the first day of *total disability* after the *waiting period* and is payable monthly in arrears.

If the Insured Person is *totally disabled* for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month. They will still need to meet the *waiting period.*

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *total disability;*
- for Income Protection and Income Protection Plus, the time when the aggregate of the period for which a Total Disability Benefit was payable to you and any period for which a Partial Disability Benefit was payable to you is equal to the *benefit period;*
- for Business Overheads, we have paid 12 times the Total Disability Benefit; and
- your Policy ends.

For Business Overheads, if at the end of the *benefit period* the Insured Person remains *totally disabled* and the total amount paid is less than 12 times the *insured monthly business overheads benefit,* payments will continue until the earliest of the:

- payment of 12 times the monthly *insured monthly business overheads* benefit;
- expiry of a further 12 months;
- cessation of the *total disability;* and
- date the Policy ends.

2. Partial Disability Benefit

IP IPP BOH

2.1 We will pay you a monthly Partial Disability Benefit if the Insured Person is *partially disabled* after the end of the *waiting period.*

2.2 What we will pay

(a) Income Protection and Income Protection Plus

We will pay you a monthly Partial Disability Benefit, calculated as follows:

$$\text{The monthly Total Disability Benefit} \times \frac{\textit{(Pre-disability monthly earnings - Post-disability monthly earnings)}}{\textit{Pre-disability monthly earnings}}$$

The amount of this benefit is reduced by any limitations on benefits (see section 26).

(b) Business Overheads

The amount of this benefit is the lesser of the *insured monthly business overheads benefit,* and the *allowable business expenses* actually incurred in the month the Insured Person is suffering *partial disability.*

The amount earned by the Insured Person from personal exertion will be determined by us on the basis of the contribution of the Insured Person to the *business income* of the business.

The amount of this benefit is reduced by any limitation on benefits (see section 27).

2.3 If the Insured Person is a medical professional who performs invasive surgical procedures as the main and important part of their *usual occupation,* we will regard the Insured Person as being *partially disabled* due to *sickness* if:

- they are diagnosed with Human Immunodeficiency Virus or Hepatitis B or C; and
- as a consequence of the diagnosis, they are restricted as a regulatory requirement from performing their *usual occupation.*

2.4 The benefit accrues from the first day of *partial disability* after the *waiting period* and is payable monthly in arrears.

If the Insured Person is *partially disabled* in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month. They will still need to meet the *waiting period.*

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *partial disability;*
- the time when the aggregate of the period for which a Partial Disability Benefit was payable to you and any period for which a Total Disability Benefit was payable to you is equal to the *benefit period;* and
- your Policy ends.

3. Elective Surgery Benefit

IP IPP BOH

3.1 We will regard the Insured Person as being *totally disabled* or *partially disabled,* as applicable, due to *sickness* if:

- the Insured Person undergoes surgery by a *doctor* while covered under your Policy to:
  - transplant part of their body to another person; or
  - improve their appearance or to prevent their disfigurement; and
- as a consequence of the surgery, the Insured Person would be *totally disabled* or *partially disabled.*

3.2 The *waiting period* will commence from the day on which the Insured Person undergoes surgery.

The benefit will be payable monthly in arrears and you will continue to receive monthly payments until the earliest of the following events:

- the Insured Person is well enough to return to work and earn their regular income;
- the end of the *benefit period;* and
- your Policy ends.

3.3 This benefit will not apply to surgery that takes place within 6 months after the later of:

- the *commencement date;*
- the date we increase the *insured monthly disability benefit* or *insured monthly business overheads benefit* (other than a *CPI* increase); and
- the date this Policy was last reinstated.

4. Rehabilitation Expense Benefit

IP IPP

4.1 We will pay you a Rehabilitation Expense Benefit, in addition to any other benefit under this Policy, if:

- the Insured Person has suffered *total disability* for a continuous period at least as long as the *waiting period;* and
- you or the Insured Person incur the cost of rehabilitation equipment or other capital expenses during the course of rehabilitation or engaging (or attempting to engage) in an occupation, which the Insured Person's *doctor* has certified as being necessary.

The costs must be approved by us before they are incurred.

Examples of eligible expenses include the cost of a wheelchair, artificial limbs, re-education expenses and home or workplace modifications.

4.2 We will reimburse the actual rehabilitation expenses incurred by you or the Insured Person up to a maximum amount, determined in accordance with your type of cover as set out below:

- for Income Protection, up to a maximum of 6 times the monthly Total Disability Benefit; or
- for Income Protection Plus, up to a maximum of 12 times the monthly Total Disability Benefit.

4.3 We will not pay you this benefit for expenses that are reimbursable from any other source.

5. Rehabilitation Program Benefit

IP IPP

5.1 We will pay you a Rehabilitation Program Benefit, in addition to any other benefit under this Policy, if:

- the Insured Person has suffered a *total disability* for a continuous period at least as long as the *waiting period;* and
- you or the Insured Person incur the cost of a rehabilitation program during the course of rehabilitation or engaging (or attempting to engage) in an occupation, which the Insured Person's *doctor* has certified as being necessary.

The costs must be approved by us before they are incurred.

5.2 We will reimburse the actual rehabilitation program costs incurred by you or the Insured Person up to a maximum amount, determined in accordance with your type of cover as set out below:

- for Income Protection, up to a maximum of 6 times the monthly Total Disability Benefit; or
- for Income Protection Plus, up to a maximum of 12 times the monthly Total Disability Benefit.

5.3 The Insured Person must take part in the rehabilitation program to rehabilitate themselves because of the *total disability* you are claiming and not for any other reason. We will not pay you this benefit for expenses that are reimbursable from any other source.

6. Recurrent Disability Benefit

IP IPP BOH

If the Insured Person suffers from the same or related *sickness* or *injury* that has previously resulted in a successful claim, we may not require you to meet the *waiting period* again.

6.1 *Benefit periods* of 1, 2 and 5 years

For *benefit periods* of 2 and 5 years (or 1 year for Business Overheads), a new *waiting period* will not apply if, within 6 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers *total disability* or *partial disability* from the same or a related *sickness* or *injury.* The successive periods during which benefits were payable are added together to determine when the *benefit period* has expired.

For *benefit periods* of 1, 2 and 5 years, a new *waiting period* and a new *benefit period* will apply if:

- at least 6 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers *total disability* or *partial disability* from the same or a related *sickness* or *injury;* and
- either:
  - the *benefit period* for the previous period of *total disability* or *partial disability* had not ended; or
  - the Insured Person had returned to and performed the full duties of their *usual occupation* for their usual *monthly earnings* for at least 6 consecutive months after a Total Disability Benefit or a Partial Disability Benefit ceased to be payable.

Otherwise, no benefit is payable.

6.2 *Benefit periods* to age 55 or to age 65

For a *benefit periods* to age 55 or to age 65, the *waiting period* will not apply if, within 12 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers *total disability* or *partial disability* from the same or a related *sickness* or *injury.*

For *benefit periods* to age 55 or to age 65, a new *waiting period* will apply if at least 12 months after a Total Disability Benefit or a Partial Disability Benefit ceases to be payable, the Insured Person suffers *total disability* or *partial disability* from the same or a related *sickness* or *injury.*

7. Change of Waiting Period Benefit

IPP

7.1 You can shorten the *waiting period* for the Insured Person if the Insured Person changes their employment status. You can do this without having to provide any evidence of the Insured Person's health.

As shown in the table below, a *waiting period* in the first column can be reduced to the corresponding reduced *waiting period* in the second column.

Existing *waiting period*	Reduced to a *waiting period* of
720 days	90 days, 180 days or 360 days
360 days	90 days or 180 days
180 days	90 days
90 days	30 days

Your premium will increase to reflect the shorter *waiting period.*

We consider that an Insured Person has changed their employment status if:

- they cease working for one employer and commence working for another unrelated employer; or
- they cease being employed and commence being self-employed.

7.2 You can only shorten the *waiting period* without having to provide evidence of the Insured Person's health if:

- the Insured Person is not *totally disabled* or *partially disabled* at the time (either during the *waiting period* or while a benefit is payable), and is not eligible to claim;
- the Insured Person was accepted for cover under this Policy without any loadings;
- the Insured Person provides us with written proof that the change of employment status has occurred;
- you request the change in writing within 30 days of the Insured Person joining the new employer;
- the Insured Person is not eligible, and will not become eligible, for income protection cover with the new employer through an insurance Policy, superannuation or pension plan, and has no other income protection in force; and
- where a 720 day *waiting period* applies, you provide us with proof that the Insured Person was covered by an employer related income protection policy with a *benefit period* of 1 year or more while employed by the previous employer.

8. Counselling Benefit

IPP

8.1 If we pay a Total Disability Benefit, we will pay you the Counselling Benefit. The Counselling Benefit provides the cost of up to 10 counselling sessions for you, the Insured Person or an *immediate family member.*

8.2 We will reimburse the cost of the counselling sessions, up to a maximum of $5,000.

The Counselling Benefit will only be paid once per Insured Person across all policies issued by us in respect of that Insured Person.

8.3 The following conditions must be met for the Counselling Benefit to be paid:

- the counselling session must be provided by an accredited counsellor approved by us;
- we will only reimburse amounts incurred by you;
- the Counselling Benefit must be claimed within 12 months of receiving the benefit; and
- you must be able to provide a copy of the invoice showing a breakdown of the services provided and the amount paid, and/or a receipt showing the amount paid.

9. Nursing Care Benefit

IPP

9.1 If the Insured Person is *confined to bed* for more than 3 consecutive days during the *waiting period,* we will pay you a Nursing Care Benefit equal to 1/30th of the monthly Total Disability Benefit for each consecutive day of confinement.

9.2 We will stop paying the Nursing Care Benefit on the earliest of the following events:

- when the Insured Person is no longer *confined to bed;*
- at the end of the *waiting period;*
- after 90 days; and
- when your Policy ends.

9.3 If confinement to bed recurs

If, following a period when the Insured Person was *confined to bed,* and within 6 months (for *benefit periods* of 2 and 5 years), or within 12 months (for *benefit periods* to age 55 and to age 65), the Insured Person again becomes *confined to bed* from the same or a related *sickness* or *injury,* the Nursing Care Benefit becomes immediately payable. The successive periods of being *confined to bed* are added together to determine the duration of any Nursing Care Benefit that we will pay you.

10. Specified Injury Benefit

IPP

10.1 If the Insured Person suffers any of the specified injuries while covered under this Policy, we will pay you a benefit equal to the monthly Total Disability Benefit for the *payment period* from the date the specified injury occurred, even if the Insured Person is able to return to work during that period.

If the Insured Person suffers more than one specified injury at the same time, we will pay you a benefit for the injury with the longer *payment period.*

10.2 We stop paying you a benefit on the earliest of the following events:

- we have paid you a Specified Injury Benefit for the *payment period;*
- your *benefit period ends;* and
- your Policy ends.

10.3 If, at the end of the *payment period,* the Insured Person is suffering *total disability* or *partial disability* as a result of the specified injury, you will be entitled to receive a Total Disability Benefit or Partial Disability Benefit (if eligible) if the *payment period* is equal to or longer than the *waiting period.*

Otherwise, the *waiting period* will be reduced by the *payment period* and will start from the first day the Insured Person is *totally disabled* after the end of the *payment period.* You will be eligible to receive a Total Disability Benefit or Partial Disability Benefit (as appropriate) after the balance of the *waiting period* has expired.

The period of payment of the Specified Injury Benefit is included in determining whether the *benefit period* has expired.

10.4 Specified Injuries

The following are covered:

For these injuries	*Payment period* (months)
Total and permanent loss of use of:	
Both feet or both hands or sight of both eyes	24
Any combination of a hand, a foot, sight in one eye	24
One leg above the knee joint or one arm above the elbow	18
One hand or foot or sight in one eye	12
Thumb and index finger of same hand	6
***Fracture* of:**	
Spine resulting in paraplegia or quadriplegia	60
A thigh	3
The pelvis	3
The skull (except bones of face or nose)	2
An upper arm	2
A shoulder bone	2
The jaw	2
A leg (excluding ankle)	2
A kneecap	2
An ankle*	2
A wrist*	1
A forearm (above wrist)	1
A collarbone	1

* *Fracture* must require a pin, traction, a plaster cast or other immobilising structure for these injuries.

10.5 We will not pay a Specified Injury Benefit if your *waiting period* is 360 days or 720 days.

11. Crisis Benefit

IPP

11.1 If the Insured Person suffers for the first time any of the crisis events while covered under this Policy, we will pay you a benefit equal to the monthly Total Disability Benefit for 6 months from the date the crisis event occurred, even if the Insured Person is able to work during that period.

11.2 We will stop paying you a benefit on the earliest of the following events:

- we have paid you a Crisis Benefit for 6 months; and
- your Policy ends.

If, at the end of the 6 month period, the Insured Person is suffering *total disability* or *partial disability* as a result of the crisis event you will be eligible to receive a Total Disability Benefit or Partial Disability Benefit (as appropriate).

The period of payment of the Crisis Benefit is included in determining whether the *benefit period* has expired.

11.3 We will not pay a Crisis Benefit if the condition first becomes apparent, or the surgery first occurs, within 90 days after the later of the:

- *commencement date;*
- date we increase the *insured monthly disability benefit* (other than a *CPI* increase) but only in respect of the increase; and
- the date this Policy was last reinstated.

We also will not pay a Crisis Benefit if your *waiting period* is 360 days or 720 days.

11.4 Crisis events

Crisis means the Insured Person has suffered one of the following crisis events for the first time (i.e. suffering any of the following conditions or undergoing any of the surgeries below), and a *doctor* approved by us provides the medical evidence to support the claim:

- Advanced diabetes
- Alzheimer's disease and other dementias
- Angioplasty – triple vessel
- Aortic surgery
- Aplastic anaemia
- Benign brain tumour
- Blindness
- Cancer (malignant tumour)
- Cardiomyopathy
- Chronic liver disease
- Chronic lung disease
- Coma
- Coronary artery bypass surgery
- Encephalitis
- Heart attack
- Heart valve surgery
- Intensive care
- Kidney failure
- Loss of hearing
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major head trauma
- Major organ transplant
- Medically acquired HIV
- Meningitis
- Meningococcal septicaemia
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Occupationally acquired HIV
- Open heart surgery
- Out of hospital cardiac arrest
- Paralysis
- Parkinson's disease
- Pneumonectomy
- Pulmonary hypertension
- Severe burns
- Severe rheumatoid arthritis
- Stroke

A full definition of each condition is given in the Medical Glossary in chapter 7. You must satisfy the full definition of the appropriate condition before we will pay this benefit.

12. Death Benefit

IPP BOH

If the Insured Person dies while we are paying you a Total Disability Benefit, Partial Disability Benefit, Crisis Benefit, Specified Injury Benefit or Nursing Care Benefit, a benefit equal to 6 times your monthly Total Disability Benefit will be paid to you.

If you are both the Insured Person and the Policy Owner, we will pay the Death Benefit to your estate.

13. Transport within Australia

IPP

13.1 We will pay you a Transport within Australia Benefit, in addition to any other benefits under this Policy, if the Insured Person:

- becomes *totally disabled* in Australia; and
- is *confined to bed* more than 100 kilometres from their usual place of residence or it is considered medically necessary for the Insured Person to travel to a place more than 100 kilometres from their usual place of residence for reasons directly associated with the *sickness* or *injury* causing *total disability*.

13.2 We will pay a benefit equal to the lesser of:

- reimbursement of the actual, reasonable costs incurred; and
- 2 times the monthly Total Disability Benefit.

13.3 We will not pay you this benefit for expenses that are reimbursable from any other source.

We will pay this benefit once for any particular *sickness* or *injury*.

14. Transport from Overseas Benefit

IPP

14.1 We will pay you a Transport from Overseas Benefit, in addition to any other benefits under this Policy, if the Insured Person:

- becomes *totally disabled* while out of Australia;
- is *totally disabled* for more than 30 days; and
- chooses to return to Australia while *totally disabled*.

14.2 We will pay a benefit equal to the lesser of:

- reimbursement of the actual costs incurred;
- a single standard economy airfare to Australia by the most direct and available route; and
- 3 times the monthly Total Disability Benefit.

14.3 We will not pay you this benefit for expenses that are reimbursable from any other source.

We will pay this benefit once for any particular *sickness* or *injury*.

15. Accommodation Benefit

IPP

15.1 We will pay you an Accommodation Benefit if:

- the Nursing Care Benefit is also payable;
- the Insured Person is *confined to bed* more than 100 kilometres away from their usual residence; and
- an *immediate family member* has to stay away from their usual residence to be with the Insured Person.

15.2 We will pay a benefit equal to reimbursement of accommodation costs incurred in order for the *immediate family member* to be with the Insured Person of up to $200 per day, for a maximum of 30 days in any 12 month period.

15.3 We will not pay you this benefit for expenses that are reimbursable from any other source.

16. Family Care Benefit

IPP

16.1 We will pay you a monthly Family Care Benefit if:

- a Total Disability Benefit is payable in respect of the Insured Person;
- as a result of the *sickness* or *injury,* the Insured Person is totally dependent on an *immediate family member;* and
- as a result, the *immediate family member* has had to cease *gainful employment*.

16.2 We will pay a monthly benefit which is the lesser of:

- the monthly Total Disability Benefit; and
- $2,000.

If the benefit is payable during a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

16.3 The benefit accrues from the first day of *total disability* after the *waiting period* and is payable monthly in arrears.

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *total disability;*
- we have paid you a Family Care Benefit for 6 months;
- your Policy ends;
- the Insured Person ceases to be totally dependent on the *immediate family member;* and
- the *immediate family member* recommences *gainful employment*.

17. Home Care Benefit

IPP

17.1 We will pay you a monthly Home Care Benefit if:

- a Total Disability Benefit is payable in respect of the Insured Person;
- as a result of the *total disability,* the Insured Person is *confined to bed* at home; and
- in the opinion of a *doctor,* the Insured Person is totally dependent upon the care of a paid professional home carer.

17.2 We will pay you a monthly benefit which is the lesser of:

- the monthly Total Disability Benefit; and
- $4,500.

If the benefit is payable in a month for less than the complete month, the amount of the benefit will be reduced on a pro-rata basis based on a 30 day month.

17.3 We will not pay you the Home Care Benefit if the paid professional home carer is you, an *immediate family member,* or business partner of you or the Insured Person.

17.4 The benefit accrues from the first day of *total disability* after the *waiting period* and is payable monthly in arrears.

The benefit will continue to accrue until the earliest of:

- the end of the Insured Person's *total disability;*
- we have paid you a Home Care Benefit for 6 months;
- your Policy ends; and
- the Insured Person ceases to be totally dependent upon the care of a paid professional home carer.

18. Respite Care Benefit

IPP

18.1 We will pay you a Respite Care Benefit if:

- the Insured Person has been paid a Total Disability Benefit for a continuous period of at least 24 months;
- the Insured Person is living in their own home and requiring an *immediate family member* as a full time carer; and
- the Insured Person has a permanent and irreversible inability to perform without assistance any two of the activities of daily living (as defined in the Medical Glossary in chapter 7).

18.2 We will pay the cost of respite care for a maximum of 2 weeks each year of claim after the first 24 months, if the respite care is provided outside the home in a registered respite care facility. The costs must be approved by us before the expenditure occurs.

The lump sum benefit is equal to reimbursement of the actual costs incurred, up to the lesser of

- 2 times the monthly Total Disability Benefit; and
- $5000 per year.

The benefit will not become payable for expenses that are reimbursable from any other source.

19. Future Insurability Benefit

IPP

19.1 You can apply to increase the *insured monthly disability benefit* in writing within 30 days of every third *review date.*

You can request that an increase in the *insured monthly disability benefit* be brought forward up to 4 times during the term of the Policy provided that there is only one increase in any 12 month period.

19.2 The *insured monthly disability benefit* may be increased up to 20% each time it is increased under this benefit.

Your premium will increase to reflect the increase in cover. The increased cover does not apply until we have confirmed it in writing.

The maximum number of increases to the *insured monthly disability benefit* allowed during the term of the Policy is calculated as follows:

$$\text{Maximum number of increases} = \frac{(55 - A)}{3}$$

where A = the age of the Insured Person at the *commencement date.*

19.3 You cannot apply for a Future Insurability Benefit increase for an Insured Person under this insurance cover:

- after the *review date* on or immediately following the Insured Person's 55th birthday;
- if you have had an increase under this benefit in the previous 12 months;
- if any person has made, or is eligible to make, a claim in relation to the Insured Person for any benefit under any insurance cover issued by us;
- if we accepted the Insured Person with a loading;
- if you have exceeded the maximum number of increases permitted for this benefit;
- if after the increase, the *insured monthly disability benefit* would be more than:
  - 75% of the Insured Person's *pre-disability monthly earnings;*
  - the proportion of the Insured Person's *pre-disability monthly earnings* as shown by the *income ratio* if the Superannuation Contribution Option has been selected; or
  - the maximum proportion of the Insured Person's *pre-disability monthly earnings* that is available at new business; or
- if after the increase, the total amount of the *insured monthly disability benefit* would be more than the maximum benefit limits available under Income Protection Plus.

Any exclusions which apply to the Insured Person's Income Protection Plus Policy will also apply to an increase in the *insured monthly disability benefit.*

20. Waiver of IP Premium

IPP

If the Insured Person receives a Total Disability Benefit, the premiums paid on the Policy during the *waiting period* will be reimbursed to you.

You must recommence payment of premiums at the earliest of:

- the date the Insured Person stops being *totally disabled;*
- the end of the *benefit period;* and
- the *review date* on or following the Insured Person's 65th birthday.

This benefit is not available if the *waiting period* is 180, 360 or 720 days.

21. Accident Benefit

IPP OPTIONAL

21.1 This benefit is available at an additional cost. This option can be added after the Policy commences and you may be subject to further underwriting assessment at that time. This benefit will only apply if it appears on the *policy schedule* for the Insured Person, and is only available with a 14 or 30 day *waiting period.*

21.2 We will pay you an Accident Benefit if, as a result of an *injury,* the Insured Person is *totally disabled* for more than 3 consecutive days during the *waiting period.*

This benefit will be paid for the shorter of the *waiting period* and the period of *total disability.*

21.3 We will pay an amount that is 1/30th of the Insured Person's monthly Total Disability Benefit for each day that the Insured Person is *totally disabled* during the *waiting period.*

21.4 We will not pay this benefit if the Insured Person is eligible for the Specified Injury Benefit, Crisis Benefit or Nursing Care Benefit under this Policy.

21.5 The benefit accrues from the date the Insured Person first seeks medical advice for the *injury* and has been certified as being *totally disabled.* The benefit is payable monthly in arrears. The benefit will continue to accrue until the earliest of the following events:

- the end of the *waiting period;*
- the end of the Insured Person's *total disability;* and
- your Policy ends.

22. Superannuation Contribution Option

IP OPTIONAL IPP OPTIONAL

22.1 This option allows you to have a monthly insured amount that is higher than is usually available under Income Protection or Income Protection Plus so that in the event of *total disability,* you can continue to make the same level of contribution into superannuation. You will be paid the Total Disability Benefit, of which the relevant amount can be paid into a nominated superannuation fund.

Generally the *insured monthly disability benefit* can be up to 75% of the Insured Person's *monthly earnings,* however with this option you can insure up to 80% of the Insured Person's *monthly earnings.*

The *insured monthly disability benefit* as a percentage of *monthly earnings* is calculated at the time of application and is referred to as the *income ratio.* The *income ratio* will be shown on your *policy schedule.*

22.2 The Superannuation Contribution Option is subject to the following conditions:

- the Total Disability Benefit, inclusive of any superannuation contribution amount, is payable to you; and
- by applying for this option, you agree to pay the superannuation contribution amount into your superannuation fund.

Example

An Insured Person who has annual income of $100,000, and makes superannuation contributions of 9% (superannuation guarantee amount) equating to $9,000. Their total annual *earnings* are therefore $109,000. The *insured monthly disability benefit* can be calculated as follows:

	Annual *earnings* calculation	Additional Superannuation amount	Maximum *insured monthly disability benefit*
Without Superannuation Contribution Option	75% x 109,000	0	
	= 81,750/12	0	
	= $6,812.50		**= $6,820**
Without Superannuation Contribution Option	75% x 109,000	25% x 9,000	
	= 81,750/12	= 2,250/12	
	= $6,812.50	**= $187.50**	**= $7,000**
		Income ratio	= 7,000 x 12/109,000
			= 77.06%

23. Super Plus IP Benefit

IPP*

*IPP (with Income Linking Plus)

The Super Plus IP Benefit allows an Income Protection Plus Policy to be owned by two different Policy Owners. For example, the Total Disability Benefit and Partial Disability Benefit features of the Policy can be paid for through your superannuation fund, and the remaining benefits of the Policy can be paid for and owned outside of your superannuation fund.

Therefore, if the Insured Person becomes *totally disabled* or *partially disabled,* they are able to receive benefits through their superannuation fund, otherwise the benefits will be paid to you.

All other terms and conditions pertaining to the payment of Income Protection Plus Benefits apply to the Super Plus IP Benefit.

24. IP Continuation Option

IP IPP

We may allow you to hold an Income Protection or Income Protection Plus Policy after age 65, up until the *review date* on or following the Insured Person's 75th birthday, if the Insured Person is still working on a full-time basis, and their occupation class is AA, A, P or S as shown in the *policy schedule.*

At the *review date* on or following the Insured Person's 65th birthday, the offer to continue the Policy will be issued.

24.1 This option will only apply if:

- we have made the offer of continuation to you;
- the Insured Person provides a declaration within 30 days of each *review date* that they:
  - are actively working on a full time basis;
  - are not planning to cease work in the next 12 months; and
  - have not made a claim, are not eligible to make a claim, or are not on claim for any benefit under any insurance cover issued by us;
- we have accepted your application for this benefit for the Insured Person; and
- you continue to pay premiums for this Policy.

24.2 From the *review date* on or following the Insured Person's 65th birthday, the Policy will only pay benefits relating to;

- Total Disability Benefit; and
- Specified Injury Benefit.

In addition, if we pay you a benefit under the IP Continuation Option, we will waive premiums for the period during which you are receiving the benefit.

24.3 The following conditions apply to cover provided under the IP Continuation Option:

- The *waiting period* for the IP Continuation Option is restricted to 90 days, the *benefit period* is 2 years, and the maximum *insured monthly disability benefit* is $20,000;
- The contract will be issued on an *indemnity* basis, and *pre-disability monthly earnings* will be taken as the Insured Person's *monthly earnings* in the 12 month period immediately preceding the commencement of *total disability;*
- The Insured Person will be required to sign a declaration within 30 days of every *review date* on or following the Insured Person's 65th birthday, and must make their declaration every year;
- The *benefit period* may extend beyond the *review date* (other than the review date following the Insured Person's 75th birthday) if the Insured Person is on claim, however the Policy will end following the completion of the *benefit period;* and
- The IP Continuation Option is not guaranteed to be offered, re-offered, and may be withdrawn by us at any time.

25. Loyalty Benefit

IP IPP BOH

25.1 The Loyalty Benefit will be added to all benefits listed on the *policy schedule* where the Policy has been in force for three years from the later of the *commencement date* and 19 October 2009.

25.2 We will pay an extra $50,000 should the Insured Person die while the Policy is in force.

25.3 The Loyalty Benefit is paid once per Insured Person across any Income Protection, Income Protection Plus or Business Overheads Policy.

26. Income Protection and Income Protection Plus Limitations

IP IPP

26.1 For all benefits under Income Protection and Income Protection Plus:

- no benefit will be payable for a particular *sickness* or *injury* after the *benefit period* has expired;
- all benefits cease to be payable when the Policy ends; and
- if *total disability* or *partial disability* is caused by more than one *sickness* or *injury,* we will only pay benefits in respect of one *sickness* or *injury* at any one time.

We will not pay the following benefits at the same time:

- Total Disability and Specified Injury;
- Partial Disability and Specified Injury;
- Total Disability and Crisis;
- Partial Disability and Crisis;
- Nursing Care and Crisis;
- Nursing Care and Specified Injury;
- Specified Injury and Crisis;
- Family Care and Home Care;
- Accident Benefit and Specified Injury;
- Accident Benefit and Crisis; or
- Accident Benefit and Nursing Care.

If you are entitled to claim for both the Crisis Benefit and the Specified Injury Benefit as a result of the same event, we will only pay you for one of the benefits, being the benefit with the longest payment period.

26.2 Total Disability Benefit and Partial Disability Benefit Offsets

The amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the sources referred to below. These offsets are applied differently depending on the occupational category you are in. This will be shown on your *policy schedule.*

(a) For *agreed value* policies:

- occupational categories AA, A, P and S (for Income Protection and Income Protection Plus) the amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by regular payments from an existing superannuation fund or another existing insurance policy, made in respect of *sickness* or *injury,* but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum).
- occupational categories BB, B and C (for Income Protection and Income Protection Plus) the amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the following sources:
  - workers or motor accident compensation or under common law relating to *sickness* or *injury;* or
  - regular payments from an existing superannuation fund or another existing insurance policy, made in respect of *sickness* or *injury,* but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum).

(b) For *indemnity* policies:

- occupational categories AA, P and S (for Income Protection or Income Protection Plus) the amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by regular payments from an existing superannuation fund or another existing insurance policy, made in respect of *sickness* or *injury,* but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum).
- occupational category A (for Income Protection and Income Protection Plus) the amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the following sources:
  - workers or motor accident compensation or under common law relating to *sickness* or *injury;* or
  - regular payments from an existing superannuation fund or another existing insurance policy, made in respect of *sickness* or *injury,* but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum).
- occupational category BB, B, C and E the amount of the monthly Total Disability Benefit or Partial Disability Benefit may be reduced or recovered from you if any amounts are paid by the following sources:
  - workers or motor accident compensation or under common law relating to *sickness* or *injury;* or
  - regular payments from an existing superannuation fund or another existing insurance policy, made in respect of *sickness* or *injury,* but only if that policy was not disclosed to us before we issued this Policy or agreed to any increase in cover under this Policy (including regular payments which are converted to a lump sum); or
  - the Insured Person's employer, partnership or business.

The reduction in benefit will be such that the reduced benefit that we pay, when combined with the income from other sources (and the reduced *monthly earnings* for *partial disability)*, does not exceed

- 75%* of *pre-disability monthly earnings;* or
- 100% for *partial disability.*

If the Insured Person receives any amount as outlined in this section, that includes an amount for loss of income resulting from their *sickness* or *injury* for any period we have paid, or will pay, the Insured Person must, on demand by us, repay either the benefits we have paid them or the amount they have been awarded for loss of income, whichever is lower. We can also choose to reduce any amounts we pay in the future to cover such overpayments.

* If the *insured monthly disability benefit* with us at the time of application was greater than $30,000, and the annualised *pre-disability monthly earnings* are greater than $480,000, the amount should not exceed a percentage of the *pre-disability monthly earnings,* where the percentage is;

- 75% of the first $320,000 of annualised *pre-disability monthly earnings;*
- 50% of the next $240,000 of annualised *pre-disability monthly earnings;*
- 20% of the remainder of annualised *pre-disability monthly earnings.*

For the purposes of the Superannuation Contribution Option, we will use the greater of the *income ratio* and 75%.

26.3 What we do not offset

The above sources do not include:

- payments made as compensation for pain and suffering or the loss of use of part of the body;
- Total and Permanent Disablement, Living/Trauma or Terminal Illness payments;
- payments made in respect of the *sickness* or *injury* from business expense insurance policies; or
- an entitlement to paid sick leave.

26.4 Lump sums and non-monthly payments

Any of the amounts referred to in this section which are paid as a lump sum will be converted to an equivalent monthly amount by dividing the lump sum by 60. Any regular amounts that are paid other than monthly will be converted to equivalent monthly amounts.

27. Business Overheads Limitations

BOH

27.1 General

- No benefit will be payable for a particular *sickness* or *injury* after the benefit period has expired.
- All benefits cease to be payable when the Policy ends.
- If *total disability* or *partial disability* is caused by more than one *sickness* or *injury,* we will only pay benefits in respect of one *sickness* or *injury* at any one time.

27.2 Total Disability Benefit and Partial Disability Benefit Offsets

The amount of the Total Disability Benefit or Partial Disability Benefit will be reduced by:

- any amounts paid or payable to you or the Insured Person under other business expenses insurance policies; and
- any income before expenses and tax earned by you or the Insured Person due to personal exertion at the Insured Person's business that is in excess of any salary and salary related costs of replacing the Insured Person.

28. Exclusions

IP IPP BOH

We will not pay you a benefit:

- if the *sickness* or *injury* giving rise to the claim is caused by:
  - an act of war (whether declared or not). This exclusion does not apply to the Death Benefit where the Insured Person dies on war service;
  - intentional self-inflicted *injury* (whether sane or insane);
  - attempted suicide (whether sane or insane);
  - normal and uncomplicated pregnancy and childbirth; or
- for any other specific exclusions which we have included in the *policy schedule.*

29. When does the Policy end?

IP IPP BOH

Your Policy continues until the earliest of:

- we cancel your Policy because you have not paid your premiums or any other amounts which relate to this Policy;
- the Insured Person dies;
- the Insured Person retires or ceases *gainful employment* (unless they intend to return to *gainful employment*) for any reason other than due to *total disability* or *partial disability;*
- we receive your written notice to end this Policy;
- we cancel or avoid the Policy as a result of an innocent or fraudulent non-disclosure and/or misrepresentation made by you prior to our acceptance of risk or during making the claim;
- for Income Protection and Income Protection Plus occupation categories AA, A, P and S (as shown in the *policy schedule*) the earliest of the following events:
  - for a *benefit period* to age 55, the *review date* on or following the Insured Person's 55th birthday;
  - the *review date* that the Insured Person fails to meet the conditions of the annual declaration; or
  - the *review date* on or following the Insured Person's 75th birthday; and
- for Income Protection and Income Protection Plus occupation categories BB, B, C and E (as shown in the *policy schedule*) and Business Overheads:
  - for a *benefit period* to age 55, the *review date* on or following the Insured Person's 55th birthday; or
  - the *review date* on or following the Insured Person's 65th birthday.

No benefits will be payable once a Policy has ended.

4. Interim Accident and Sickness Cover.

4

Rest easy. From the moment we receive your application form and personal statement you are covered by Interim Accident and Sickness Cover, and you don't even need to pay any extra premium for this cover.

Some of the italic words in this chapter have specific meanings for this chapter only. Please refer to section 4 for the definitions.

1. Commencement of cover

Cover commences when a fully completed application form and personal statement, which has been declared true and correct in respect of each Insured Person, has been received by us.

2. Period of cover

Cover will end on the earliest of the following:

- 90 days from the date this cover commences;
- in respect of each Interim Benefit for each Insured Person, the date we accept or decline the insurance application for that benefit under the St.George Protection Plans;
- in respect of each Interim Benefit for each Insured Person, the date you withdraw your insurance application for that benefit under the St.George Protection Plans; and
- the date we advise you that Interim Accident and Sickness Cover has ceased.

3. Interim Benefits

- **Interim Death Benefit** – The lesser of $1,000,000 and the amount of Death Benefit applied for in respect of the Insured Person, is payable should the Insured Person die as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force.
- **Interim TPD Benefit** – The lesser of $1,000,000 and the TPD Benefit applied for in respect of the Insured Person, is payable should the Insured Person become *totally and permanently disabled* as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force. The *total and permanent disability* definition that applies is either *own occupation TPD, any occupation TPD, home duties TPD,* or *general cover TPD* as nominated by you in your application form.
- **Interim Living Benefit** – The lesser of $1,000,000 and the Living Benefit applied for in respect of the Insured Person, is payable should the Insured Person suffer a specified medical event as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force and the Insured Person subsequently survives for 14 days. The specified medical events relevant to the Interim Living Benefit are as defined in the Medical Glossary.
- **Interim Income Protection Benefit** – The lesser of $5,000 per month and the *insured monthly disability benefit* or *insured monthly business overheads benefit* applied for under Income Protection, Income Protection Plus or Business Overheads is payable should the Insured Person become *totally disabled* as a result of an *accident* or *sickness* whilst the Interim Accident and Sickness Cover is in force. The benefit accrues from the end of the *waiting period* applied for under the relevant Policy and ceases to accrue at the earliest of either the date the Insured Person ceases to be *totally disabled* or 6 months from the end of the *waiting period.*

4. Definitions

For the purposes of Interim Accident and Sickness Cover:

- **Sickness** means a *sickness* or *disease* which first becomes apparent after the application form and the personal statement was declared true and correct.
- **Pre-existing conditions** means any *injury, sickness, illness* or *symptom* that:
  (a) you or the Insured Person were aware of, or a reasonable person should have been aware of;
  (b) the Insured Person should have sought advice or treatment (conventional or alternative) from a *doctor* for (in circumstances where a reasonable person would have sought advice or treatment); or
  (c) the Insured Person had a medical consultation for or was prescribed medication or therapy for.

5. Exclusions

A benefit will not be paid if the death, *total and permanent disability,* medical event, *accident, injury, sickness* or event giving rise to the claim is caused directly or indirectly by:

- an intentional self-inflicted act or attempted suicide (whether sane or insane);
- an *accident* or *sickness* while the Insured Person is under the influence of alcohol or non-prescription drugs or drugs taken in excess of prescribed amounts;
- any act of war (whether declared or not) except where the Insured Person dies on war service;
- the Insured Person engaging in any sport, pastime or occupation that we would normally cover with a loading, exclusion, decline or deferral; or
- a *pre-existing condition* that existed prior to, or at the time of application.

A benefit will not be paid if the Insured Person's occupation is one that we would not normally cover. In addition, we will take into account how the Insured Person would have been assessed in terms of definitions and benefit amounts under our underwriting rules.

6. Claims

To the extent that they are relevant, the conditions in the St.George Protection Plans Policy or Policies for which you have applied that relate to the payment of a claim apply to this cover.

Only one Interim Benefit for an Insured Person will be paid in respect of any one *accident* or *sickness.* The cost of obtaining medical evidence that is required for the payment of an Interim Benefit claim is to be borne by you. The costs of further medical evidence may be borne by us, however this will be at our discretion.

If you are eligible to make a claim under this cover, it will not prevent your application for a St.George Protection Plans Policy continuing to be assessed. However we will take into account the change in health of the Insured Person when assessing your application and we may decline your application or apply special loadings, conditions and exclusions.

5. Making a claim.

5

Who to contact

If you wish to make a claim, please contact our Customer Relations Consultants on:

1300 366 416

8.00 am to 6.30 pm (Sydney time)

Monday to Friday.

Our consultants will arrange for you to receive any information or forms you need.

How and when to make a claim

If you are making a claim under Term Life, Term Life as Superannuation, Standalone Living Insurance, Standalone Total and Permanent Disablement, Flexible Linking Plus, Needlestick Benefit or Children's Benefit, you need to tell us within 6 months of the *sickness, injury,* surgery or death occurring.

If you are making a claim under Income Protection, Income Protection Plus, Income Linking Plus or Business Overheads, you need to write or call and tell us within 30 days of your disability. We ask that you return all claim forms within 60 days of receiving them. If you notify us of your *sickness* or *injury* more than 90 days after it occurs, and if we accept your claim, your payments may start from the later of the date on which we receive your notification and the end of your *waiting period.*

Evidence required

Before we will pay a benefit, you must provide satisfactory evidence and the authorities we require for us to obtain further information. This will include medical evidence from a *doctor* acceptable to us. We may also require proof of the Insured Person's age, and if appropriate, proof of the Insured Person's *earnings* or business expenses. You must provide this evidence at your own expense. Please note that we rely on the information that you provide during a claim. If either you or any Insured Person acts fraudulently, we may cancel the Policy or any of its benefits and not pay any benefits.

We may from time to time require you to provide reports or certificates from the *doctor* providing treatment to the Insured Person about the continuing *sickness* or *injury* of the Insured Person (if claims are based on overseas reports or certificates, they must be translated into English by a certified translator). You must do so at your own expense.

We may also require the Insured Person to undergo medical examinations or tests by a *doctor* whom we choose. The Insured Person must allow themselves to be examined at any reasonable time we request. We will pay the reasonable costs of such examinations or tests.

Proof of age

We can ask for proof of the Insured Person's age. You, or the Insured Person, must give us that information. If, when you applied for insurance, the Insured Person's age was lower than we were told it was, we will refund you any premium you have paid above what you should have paid, plus interest. If the Insured Person's age was higher than we were told it was, we will reduce your benefit to what it would have been if the premium you paid us was based on their true age.

Proof of earnings

For Income Protection, Income Protection Plus and Income Linking Plus, we may require you to provide proof of *pre-disability monthly earnings* and from time to time to provide proof of *post-disability monthly earnings* in a period for which you are claiming a benefit. The proof required may include income tax returns, accountant's statements or other proof which is acceptable to us.

For Business Overheads, we may require you to provide proof of *allowable business expenses* for any period for which you are claiming a benefit. We may also require you to provide proof of the normal basis of accounting for such expenses. The proof required may include bills, invoices or other proof which is acceptable to us.

Uses of personal information

We may request certain information from the Insured Person during the assessment of a claim. If this information is not provided, we may not be able to accept or continue the claim.

In addition, if you make a claim under the Policy, you agree that we will collect further personal information about the Insured Person. This includes health information which, for the purposes of assessing the claim, may be necessary to disclose to third parties, such as medical practitioners. You and the Insured Person must agree that the necessary collections and disclosures of personal information will be a condition of making a claim.

What happens after you make your claim?

For Term Life, Term Life as Superannuation, Standalone Total and Permanent Disablement, Standalone Living Insurance, Flexible Linking Plus, Needlestick Benefit and Children's Benefit, after you make a claim we will assess it having regard to the information provided or obtained. We must act reasonably in doing this.

In assessing a claim for a TPD Benefit, we will assume that the Insured Person has taken such measures as may have been reasonable to avert or minimise the *sickness, injury* or *disease* giving rise to the claim.

Payment of claims

For Income Protection, Income Protection Plus, Income Linking Plus or Business Overheads, we will start payment of any benefit (including any amounts that have accrued), after we have accepted liability to pay the claim. We will pay benefits to you monthly in arrears. All payments are made in Australian currency. Should we accept liability to pay a claim, this is not a representation by us that we will continue to accept liability for so long as the Insured Person is not working or working in a reduced capacity. We may cease payment of the benefit at any time where we are of the opinion that the Insured Person is not *totally disabled* or *partially disabled* as required by this Policy. This right exists irrespective of whether the condition of the Insured Person has changed.

For the Waiver of Life Premium Benefit, we will start waiving premiums after we have accepted liability under the benefit. Should we accept liability under the Waiver of Life Premium Benefit, and therefore agree to waive premiums, this is not a representation by us that we will continue to agree to waive premiums for so long as the Insured Person is *totally and temporarily disabled.* We may request that you recommence payment of premiums at any time where we are of the opinion that the Insured Person is not *totally and temporarily disabled* as required by this Policy.

Nominating a beneficiary

You are able to nominate up to five *beneficiaries* to receive a Death Benefit subject to the following rules:

- a nominated *beneficiary* can be a natural person, corporation or trust;
- if a nominated *beneficiary* dies or the corporation or trust ceases to exist before a claim is made under the Policy and no change in nomination has been made, then any money otherwise payable to that *beneficiary* will be paid to you or your estate;
- if ownership of the Policy is assigned or transferred to another person or entity, then any previous nomination becomes invalid; and
- you can change your nomination at any time before the Death Benefit becomes payable by sending us written notice of the change.

If there is no nomination of *beneficiaries* and the Insured Person dies, the Death Benefit is paid equally between the surviving Policy Owners. If there are no surviving Policy Owners, and the Policy has not ended, the benefit will be paid to the estate of the last surviving Policy Owner.

Term Life as Superannuation

There are specific rules about people that can be nominated as *beneficiaries* within a Term Life as Superannuation Policy. For more information on these rules, see chapter 6, section 9.

6. Other important information.

6

1. Your duty of disclosure

Under the Insurance Contracts Act 1984, you and the Insured Person have a duty (before you enter into a contract of life insurance with an insurer) to complete the application form and personal statement honestly and to disclose to us everything you or the Insured Person knows, or could reasonably be expected to know, that is relevant to our decision to issue you with an insurance policy, and if so, on what terms. You do not need to disclose anything that would reduce our risk, that is of common knowledge, that we know or ought to know in the ordinary course of business, or that we tell you that you do not need to disclose. You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of life insurance.

Please consider your responses and the Insured Person's responses to our questions very carefully. Your duty of disclosure extends beyond the time of your completion of the application up until we accept the application and issue a Policy. If the health, occupation or pastimes of the Insured Person have changed between the time you and that Insured Person filled in any of the forms that we require, and the time we issue your *policy schedule* or *membership certificate* to you, you must tell us. This Policy is based on the fact that you and each Insured Person filled in the application form, the personal statement and any other form or information we requested, completely and accurately, and read and understood the material on these forms. This will help us determine whether to provide the insurance, how much to charge for it, and whether any special conditions apply.

As a result of not complying with your duty of disclosure we may not pay a claim, pay only part of a claim or cancel your insurance.

If you fail to comply with your duty of disclosure, and the *Insurer* would not have insured you on any terms if the failure had not occurred, we may invalidate your Policy within three years of the *commencement date.* If your nondisclosure or misrepresentation is fraudulent we may invalidate your Policy at any time. We also have the option to reduce your benefit amount within three years of the *commencement date* if we have not avoided the contract in the circumstances above.

For Term Life as Superannuation

If you are applying for Term Life as Superannuation, the insurance policy is issued by the *Insurer* to the *trustee* of the *fund* for your benefit. In these circumstances, the *trustee* has a duty of disclosure (as explained above) to the *Insurer.* To enable the *trustee* to comply with its duty of disclosure, you must disclose to the *trustee* and the *Insurer* every matter that you know, or could reasonably be expected to know, is relevant to the *Insurer's* decision whether to accept the risk of the insurance and, if so, on what terms. The consequences of non-disclosure are the same as described above.

2. Cooling off period

When you receive your insurance documents, please read these carefully.

If you are not completely satisfied you may cancel your insurance. You have until the earlier of:

- 28 days from the *commencement date;* and
- 23 days after you receive your insurance documents.

If you would like to cancel your insurance within this cooling off period, please contact us.

When we receive your advice to cancel, we will cancel the insurance from the *commencement date* and refund any payments you have made (less any tax that may apply to your premium). You cannot exercise the right of cooling off if you have already made a claim under the Policy.

Term Life as Superannuation

In addition to the information above, for Term Life as Superannuation if your payment includes amounts which superannuation laws do not permit you to take as cash, you will need to transfer these amounts to another superannuation or rollover fund. You must advise us, within one month, of the name and details of the superannuation or rollover fund that you want your monies to be transferred to. If we do not receive these details within one month after you tell us you want to cancel your insurance you will lose your right to cancel the insurance during the cooling off period.

3. Premiums and charges

For each product that you have, the premium and any other charges are the cost of your insurance cover. We calculate your premium when your insurance begins and at each *review date*. We will notify you of your premium in writing before each *review date.* We also calculate your premium if you request any changes to your insurance (eg. an increase in a benefit).

The premium depends on a variety of factors, including the premium option chosen, the type of insurance you have, any optional benefits, the amount of insurance you have for each benefit, the age, gender, smoking status, health, occupation and pursuits of each Insured Person, the frequency at which you choose to pay your premium and any loading specified in your *policy schedule* or *membership certificate.*

Calculating your premium

To calculate your premium, we add together the premium for each benefit for each Insured Person in a Policy and then add the policy fee. For each Policy, the minimum premium is $14 if paying monthly, $42 if paying quarterly, $84 if paying half-yearly, or $150 if paying annually, for each Insured Person plus the policy fee and stamp duty.

You can pay premiums monthly, quarterly, half-yearly or annually. Where premiums are not paid annually, your premium will be loaded by 9%.

If you add an Insured Person to your Policy or increase an existing benefit for an Insured Person between *review dates* and you are paying annually, half-yearly or quarterly, the additional premium that you have to pay for that Insured Person will be the additional premium, multiplied by the number of months from the date this benefit or increase started to the next payment date, divided by the number of months in the payment period.

For example, you add an Insured Person to your Policy three months before the next review rate. The additional annual premium is $400. The additional premium you have to pay following that change is:

$$\frac{400 \times 3}{12} = \$100.00$$

If you add an Insured Person to your Policy or increase an existing benefit for an Insured Person between *review dates* and you are paying monthly, your monthly premiums will increase from the next monthly premium that is payable after the benefit or increase started.

Paying your premium

You can choose the payment method that suits you. You can pay monthly, quarterly, half-yearly or yearly in advance by MasterCard, Visa, automatic debit from your bank account, or by any other method that we may make available. If you choose to pay by automatic debit from your bank account, then please take note of the conditions set out in the Direct Debit Request Service Agreement in section 5. If you are paying yearly in advance, you may also pay by cheque.

Changing your premium

Premiums and discount factors are not guaranteed. However, they can normally only be changed after we have given 3 months written notice to all Policy Owners who have this version of the Policy. In the event of war or invasion involving Australia, we may give immediate notice of premium change.

We will write and tell you if your premiums, or any other amounts, are overdue. We will give you the time specified in the notice to pay this amount. If we don't receive your payment within that time, we will cancel your Policy.

What if you don't pay?

We may let you reinstate the Policy within a certain time if you pay all outstanding amounts. We may also ask for more information about any Insured Person's health, occupation or pastimes before we do so. If an Insured Person's health, occupation or pastimes have changed, we may vary your benefits, charge additional premiums or not let you reinstate the Policy.

Policy fee

Each premium payment includes a policy fee. At 1 October 2010 this fee is $79.60 per year, $43.37 per half-year, $21.68 per quarter, or $7.23 if you pay your premium monthly. The policy fee increases each year according to the *CPI,* and is updated on 1 October.

Periodic payments

We will recover other charges that we incur for periodic payments that you make. The maximum charge is currently 10 cents per payment and this may change without notice.

Stamp duty

For Term Life, Term Life as Superannuation, and Children's Benefit any stamp duty is currently included in the premium.

For Standalone Living Insurance, Flexible Linking Plus, Standalone Total and Permanent Disablement, Needlestick Benefit, Income Protection, Income Protection Plus, Income Linking Plus and Business Overheads, stamp duty, licence fees or similar charges payable in respect of your Policy must be paid in addition to your premium. The rate of stamp duty varies for each state of Australia and can be changed without notice. We will recalculate the amount of stamp duty payable whenever your premium is recalculated. It will also vary if the basis of calculating or charging stamp duty on the Policy is altered.

Financial Planner Remuneration

We may pay commission, administration fees and other benefits to financial planners. We pay these amounts out of the premium we receive from you, **they are not an additional charge to you.**

If you and your financial planner agree on an Advice Service Fee arrangement, we will debit the agreed fee from the account you choose. The amount of this fee is to be negotiated between you and your financial planner – we will pass on the entire amount of this fee to your financial planner.

If you have nominated an initial fee, this will be debited from your chosen account in its entirety when your first Policy goes in force. If you have nominated an ongoing fee, this will be debited at the frequency you choose. The fee will be disclosed to you each year.

Your financial planner will provide details of the benefits he or she will receive if we issue you with insurance in the Financial Services Guide and Statement of Advice that they will give to you.

4. Other bits and pieces

Communication

We will send notices to the last address that you gave us. We say that you receive a notice on the date that you would have received it in the ordinary course of the mail. If you move, you need to tell us of your new address.

Changing your Policy

If you add an Insured Person to your Policy, remove an Insured Person from your Policy, or change any of the insurance under this Policy, we will send you written notice of the change.

We will show the date that any change starts. Any notice we send you forms part of the *policy schedule* or *membership certificate.*

Changes to this PDS

The information in this PDS may change from time to time. When such change is materially adverse, we will issue a supplementary or replacement PDS. Any other changes to the information in this PDS will be available to you at any time on our website. You can ask for a paper copy of such information free of charge by contacting us.

Governing Law

This Policy is governed by the laws of New South Wales.

Currency

All dollar amounts are referred to in Australian currency. All claims will be paid in Australian dollars.

No financial advice

The information in this PDS does not take account of your financial situation, objectives or needs. Before acting on any information in this PDS, you should consider whether it is appropriate to your financial situation, objectives or needs.

Availability

The offer made in this PDS is available only to persons receiving this PDS in Australia.

Where we put your money

Term Life, Standalone Total and Permanent Disablement, Flexible Linking Plus, Children's Benefit, Needlestick Benefit, and the insurance policy issued by the *Insurer* to the *trustee* under Term Life as Superannuation are included in Westpac Life No. 1 Statutory Fund. All other St.George Protection Plan products in this Policy are included in the Westpac Life No. 4 Statutory Fund. We pay your benefits from these funds. The money in the funds is regulated under the Life Insurance Act 1995.

No cash value

None of the products in St.George Protection Plans allow you to share in any profit or surplus and your Policy does not have a surrender or cash value. If you cancel your insurance at any time except within the cooling off period, you will not be entitled to any payment.

5. Direct Debit Request Service Agreement

This agreement sets out the terms on which you have authorised the *Insurer* (Debit User ID No. 002631) and the *trustee* (Debit User ID No. 002631) under your Direct Debit Request to arrange for amounts that become payable in respect of your St.George Protection Plans Policy, to be made by deduction from your account at your financial institution (nominated account) using the direct debits payments system (also known as the Bulk Electronic Clearing System). The direct debits will be made at the rate and frequency specified in the *policy schedule* or the latest notice that we have provided to you (whichever is later).

- We agree to be bound by this agreement when we receive your Direct Debit Request complete with the particulars we need to draw down an amount under it. Please ensure that you keep a copy of this agreement as it sets out certain rights you have against us and certain obligations you have to us in giving us your Direct Debit Request.
- You will need to:
  - complete a new Direct Debit Request for any other product you purchase from us, or if you move from one of our products to another; and
  - ask us to discontinue any Direct Debit Request that is in force if you cancel a product (debits may continue to be made to your nominated account until you do so).
- Your Direct Debit Request authorises us to arrange for payment to us for the amounts, and at the times, required by the terms of your Policy and your instructions to us in relation to it. It also enables any changes in those amounts, and payment times, to occur automatically - you will not need to complete a new form.
- You can:
  - cancel, vary, defer or suspend the Direct Debit Request; or
  - stop or suspend an individual debit from taking place under it,

  by calling us on 1300 366 416, 8.00 am to 6.30 pm Sydney time, Monday to Friday (in some cases, we will need your written confirmation). You need to allow us 6 working days before the next drawing date to process your request, or the debit may still be made. (You may also be able to stop an individual debit by contacting your own financial institution. You may be liable for financial institution charges if you do this - your financial institution should have information on these).
- If a due date for a debit falls on a weekend or public holiday, the debit will be processed on the next business day. Please check with your financial institution if you are uncertain about when a debit will be processed to your nominated account.
- You must ensure that you have sufficient clear funds available in the nominated account by the due date to permit the payments under the Direct Debit Request. Please check with us if you are uncertain when debits will be processed to your nominated account.
- If a drawing is unsuccessful, we will not draw again until the next scheduled drawing date. If your drawing is to pay for insurance benefits, we will re-draw the missed payment as well as the current payment. Drawings will be suspended after two unsuccessful attempts. Your financial institution may charge you fees and interest for unsuccessful debits.
- Please contact our Customer Relations Centre on 1300 366 416 if you have any questions about your Direct Debit Request, such as concerns about a debit that we make under it. We investigate and deal with in good faith any dispute relating to an alleged incorrect or wrongful debit within 3 business days of receiving such a query, claim or complaint. This may include us and our bank reviewing our respective records. If necessary we will contact your financial institution to review its records. We will advise you as soon as practicable (generally within 5-10 days) depending on the nature and extent of the dispute, and the measures taken to resolve it. You may also dispute any amount we draw under your Direct Debit Request by contacting your financial institution.
- We can vary this Service Agreement at any time after giving you at least 14 days notice of the changes.
- We will keep information about your financial institution account details confidential, except
  - to the extent necessary to resolve any claim you might make relating to a debit which you claim has been made incorrectly (which includes the disclosure of such information to Westpac Banking Corporation ABN 33 007 457 141, the sponsor of our use of the direct debits payment system);
  - if you consent to disclosure of such information; or
  - we are required to disclose such information by law.
- Direct debiting through the direct debit payments system is not available on all accounts provided by financial institutions. Please ensure that your financial institution allows direct debits on your nominated account before completing your Direct Debit Request. Also, before you complete your Direct Debit Request, it is your responsibility to check your nominated account details

against a recent statement from your financial institution to ensure the details on your Direct Debit Request are completed correctly.
- We incur charges in relation to certain periodic payments we receive through the direct debit payments system. If a charge applies in respect of your payments, we will increase the amount deducted from your financial institution account to cover this expense. The maximum charge is currently 10 cents per payment. The amount of the charge, and the types of payments to which it applies may change without notice.

6. Protection of your privacy

Privacy legislation protects your personal information and gives you rights in regard to the way we handle that information. The following privacy information and consents are for you. Additional information and consents for the Insured Person are set out in the personal statement.

By signing the application form, you agree to the following:

The *Insurer,* the *trustee* (for Term Life as Superannuation), any other member of the *Westpac Group,* and third parties such as your financial planner and reinsurers ('the Parties') may exchange with each other any information about you including:

- any information provided by you in your application; and
- any other personal information you provide to any of them or which they otherwise lawfully obtain about you.

If you have identified any person as a *beneficiary,* you agree to ensure that each such person is made aware that:

- you have nominated him/her as a *beneficiary* of the Policy;
- the *Insurer* and the *trustee* hold a record of their personal information for this purpose; and
- he/she may contact the *Westpac Group,* or request access to his/her information, by calling 1300 366 416.

If the *Insurer* or the *trustee* engages anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then you agree the *Insurer,* the *trustee* and the Service Provider may exchange with each other any information referred to above.

The *Insurer,* or the *trustee* might give any information referred to above to entities other than the Parties and the Service Providers where it is required or allowed by law or where you have otherwise consented.

You agree that any information referred to above can be used by the Parties and any Service Provider for assessing the application for this Policy and, if the application is accepted, to issue the Policy, for administration of the Policy, planning, product development and research purposes.

You can access most personal information that members of the *Westpac Group* hold about you (sometimes there will be a reason why that is not possible, in which case you will be told why).

If you fail to provide any information requested in the application form or personal statement, or do not agree to any of the possible exchanges or uses detailed above, the *Insurer* may be unable to accept the application. To find out what sort of personal information members of the Westpac Group have about you, or to make a request for access, please telephone 1300 366 416.

Financial Crimes Monitoring

To meet our regulatory and compliance obligations for Anti-Money Laundering and Counter Terrorism Financing, we will be increasing the levels of control and monitoring we perform. You should be aware that:

- transactions may be delayed, blocked or refused where we have reasonable grounds to believe that they breach Australian law or the law of any other country; and
- we may from time to time require additional information from you to assist us in the above compliance process

Where legally obliged to do so, we may disclose the information gathered to regulatory and/or law enforcement agencies.

You must not initiate, engage in or effect a transaction that may be in breach of Australian law (or the law of any other country).

Marketing Information

Members of the *Westpac Group* would like to be able to contact you, or send you information, regarding other products and services. If you do not wish to receive this information, please:

- call us on 1300 366 416; or
- write to
  St.George Protection Plans
  Customer Relations Consultant
  GPO Box 5455, Sydney,
  NSW 2001.

You do not need to do this if you have already told us you do not wish to receive information of this sort.

7. Complaints

Contact Us

We want you to be totally satisfied with your insurance, now and in the future. If you have any inquiries or complaints about your insurance, please speak to us about it.

Our Customer Relations Centre is just a telephone call away on:

1300 366 416
8.00 am to 6.30 pm (Sydney time)
Monday to Friday

If you wish to make a formal enquiry or complaint, please call our Customer Relations Centre or address it in writing to:

St.George Protection Plans
Customer Relations Consultant
GPO Box 5455
Sydney NSW 2001

When we receive your written enquiry or complaint it will be recorded, investigated and acted upon. We will endeavour to respond to a complaint as soon as possible and within 45 days.

Financial Ombudsman Service

If you have a complaint about your Policy (except Term Life as Superannuation) which is not answered to your satisfaction or within 45 days, you may raise the matter directly with the:

Financial Ombudsman Service
GPO Box 3
Melbourne VIC 8007
Telephone: 1300 780 808
Facsimile: 03 9613 6399
Website: www.fos.org.au
Email: info@fos.org.au

The Service will attempt to settle the matter by conciliation. It also has the power to arrange a formal hearing if the matter cannot be resolved.

Before you ask the Service to help you, please try to resolve the issue with us. There are some circumstances where the Service cannot deal with your complaint. They can advise you of these circumstances.

Superannuation Complaints Tribunal

If you are not satisfied with the outcome of your complaint or the *trustee's* decision in relation to Term Life as Superannuation, you may contact the Superannuation Complaints Tribunal. The Tribunal is an independent body set up by the Federal Government to assist members or *beneficiaries* to resolve certain types of complaints with fund trustees.

The Tribunal may be able to assist you to resolve your complaint, but only if you are not satisfied with the response received from the *trustee's* handling of your complaint. If the Tribunal agrees to consider your complaint, it will attempt to resolve the matter through enquiry and conciliation.

If conciliation fails the Tribunal may make a determination in relation to the dispute.

Your correspondence for the Tribunal should be addressed to:

The Superannuation Complaints Tribunal
Locked Bag 3060
Melbourne
VIC 3001

The Tribunal may also be contacted on 1300 884 114.

8. Understanding Tax

Goods and Services Tax (GST)

Under current legislation, GST is not levied on life insurance premiums (including policy fees). This does not include the Advice Service Fee.

Tax and other charges deducted from benefits

We will deduct from any benefit paid under your Policy, any tax, duties or levies we are required by law to deduct.

We may require you to pay tax and other charges

We may require you to pay any taxes, levies or duties which relate to your Policy. If the level of tax, duties or levies is varied or if additional tax, duties or levies are imposed, we may require you to pay this additional amount.

We may cancel your Policy if you do not pay this amount.

Taxation treatment of your Policy (except Term Life as Superannuation)

The taxation information described in this section is a general statement only, and is based on present tax laws at September 2010 and interpretation of those laws. Your individual situation may differ and you should seek independent professional tax advice.

Product	Premium impact	Benefit impact
• Term Life • Flexible Linking Plus • Standalone Living Insurance • Standalone Total and Permanent Disablement • Needlestick Benefit • Children's Benefit	**For individuals** Premiums are not tax deductible. **For business** The deductibility of premiums will depend on the specific circumstances of each Policy. For example, if you take out Term Life and the objective of the Policy is to cover the loss of business revenue associated with the loss of a key employee, the premiums paid by the business may be an allowable tax deduction. There may be fringe benefits tax implications in respect of premiums, where benefits are to be applied for employees or their dependants. Certain components of the Total and Permanent Disablement insurance premium may not be tax deductible and you should seek specific tax advice.	**For individuals** Generally any benefits will not be treated as assessable income for tax purposes. However, there may be capital gains tax implications in certain circumstances*. We recommend you seek individual tax advice. **For business** The assessability of the benefit will depend on the specific circumstances of the Policy. For example, if you take out Term Life and the objective of the Policy is to cover the loss of business revenue associated with the loss of a key employee, the benefit may be treated as assessable income. There may also be tax implications if a death benefit termination payment is made by the business to dependants or non-dependants of the deceased.
• Income Protection • Income Protection Plus • Income Linking Plus	Premiums paid are generally tax deductible.	Payments you receive are generally assessable for tax purposes.

* Such as when we pay a Death Benefit under a Term Life Policy and the Policy Owner is not the original owner of the Policy, or where we pay a benefit under a Living Insurance or Standalone Total and Permanent Disablement Policy and the Policy Owner is not the Insured Person or a relative (as defined for tax purposes).

9. Understanding Super

Westpac MasterTrust (the *fund*)

The *fund* is a regulated superannuation fund under the Superannuation Industry (Supervision) Act 1993 and is a Registrable Super Entity (RSE) under the Act. The *Insurer* is responsible for day-to-day management including the recording of contributions, administration and payment of benefits on behalf of the *trustee.*

The operation of the *fund* is governed by the Trust Deed. You can request a free copy of the Trust Deed by writing to us or calling 1300 366 416.

The *trustee* is indemnified for liability it incurs in respect of the insurance, unless the liability arises from fraud, a negligent act, default, omission, breach of duty or breach of trust, or such other act or omission specified by superannuation legislation.

Tax File Numbers (TFNs) and contributions

While you are not required by law to supply the *trustee* with your TFN, you will be ineligible to apply for Term Life as Superannuation if you have not provided us with your TFN.

Due to Government legislation, the *trustee* is unable to accept non-concessional contributions (generally after-tax contributions made by you, or on your behalf, other than employer contributions) from you if you have not provided your TFN. The *trustee* has further determined that the *fund* will not accept any contributions made by you or on your behalf unless your TFN has been provided. Please read the Tax File Number Notification in the application form for further details relating to the quoting of your TFN.

Membership of the fund

As a member of the *fund* with insurance, you pay contributions to the *fund* to cover the premiums that are due under the insurance policy.

To be a member of the *fund* with insurance you must be eligible to contribute to superannuation or have contributions made to superannuation on your behalf. Please note that the eligibility criteria to make contributions may change from time to time as required by law.

Eligibility to contribute to superannuation

The rules that apply to superannuation contributions generally depend on your age and/or employment status. The current rules are outlined below.

Age	When contributions can be made
If you're aged under 65 years	You can make contributions to superannuation or have contributions made on your behalf at any time. You don't need to be employed or meet any other eligibility rules.
If you're aged between 65 and 74 years	You can make contributions, or have them made on your behalf (except for *spouse* contributions) if you have been *gainfully employed* for at least 40 hours in a period of not more than 30 consecutive days in the financial year in which you wish to make the contributions or have contributions made on your behalf. You must make a new employment declaration for each financial year. *Spouse* contributions can only be made on your behalf if you meet the work test described above and you are under 70 years of age. Superannuation Guarantee contributions (SG) are only required to be made until age 70.
If you're aged 75 years and over	Only mandated employer contributions (award or certified agreement but not SG) are allowed.

Contributions into Term Life as Superannuation

The following contributions can be accepted:

Contributions made by	Description
Your employer	• Your employer can make mandated or voluntary employer contributions. • You may be able to arrange salary sacrifice contributions with your employer. These are additional employer contributions made from your pre-tax salary.
You	You can make your own personal contributions to superannuation from your after tax income. In some cases you may be able to claim a personal tax deduction for these contributions.
Your *spouse*	Your *spouse* may make contributions to your superannuation, as long as the contribution is paid from an account in the name of the contributing *spouse* or a joint account where the contributing *spouse* is an account holder.

The following contributions cannot be accepted:

Contributions made by	Description
Government	Subject to eligibility criteria, each year the Government can contribute up to $1 for each dollar of personal after tax contributions you make depending on your level of income. Personal contributions made to Term Life as Superannuation may qualify you for Government co-contributions, but the *fund* is unable to accept these co-contributions. You must nominate another superannuation account to accept these contributions.

Contributions caps

The Government has set caps on the amount of contributions which can be made each year on a concessional basis. Additional tax applies to contributions in excess of the relevant cap.

These caps depend on whether the contributions are classified as concessional or non-concessional contributions, or are being made as a result of the sale of a qualifying small business. The caps apply to all contributions you make to any superannuation fund, including the *fund,* as they apply on a per person basis. The table below outlines the types of contributions that may count towards your contributions caps.

Concessional contributions cap	This cap includes the following types of contributions: • Employer contributions (including salary sacrifice) • After tax contributions for which you claim a personal tax deduction • The taxable component of directed termination payments over $1 million contributed under the transitional rules for employment termination payments*	The cap is $25,000 per member for the 2010/11 financial year, and will be indexed to Average Weekly Ordinary Time Earnings (AWOTE), rounded down to the nearest $5,000 in subsequent years. For those aged 50 or over at any time in a transitional financial year, a transitional cap of $50,000 (not indexed) will apply. Transitional financial years are the years between 2008/09 and 2011/12 inclusive. Concessional contributions in excess of the relevant cap will be subject to additional tax (refer to 'Taxation treatment of Term Life as Superannuation' on page 64).
Non-concessional contributions cap	This cap includes the following types of contributions: • After tax contributions for which no tax deduction is claimed (including *spouse* contributions) • Amounts transferred from overseas super funds (excluding the taxable amount of such transfers)* • Amounts in excess of the CGT cap* • Amounts of concessional contributions in excess of the concessional contributions cap	The cap is $150,000 per member for the 2010/11 financial year. This will not be separately indexed, but will remain fixed at six times the concessional contributions cap (currently $25,000). People under age 65 will be able to 'bring forward' future entitlements to two years' worth of non-concessional contributions, allowing up to $450,000 over a three year period to be contributed without an additional tax liability. There is no indexation during the three year period. Non-concessional contributions in excess of the relevant cap will be subject to additional tax (refer to 'Taxation treatment of Term Life as Superannuation' on page 64).
CGT cap	Contributions made from certain amounts arising from the disposal of qualifying small business assets, provided that a tax deduction is not claimed for the contribution*	A lifetime cap of $1.155 million for the 2010/2011 financial year (indexed) is available, provided that this is a personal contribution for which no deduction is claimed.

* These contribution types are not able to be made to Term Life as Superannuation. They are included to show you the main types of contributions that may count towards your contributions caps.

There are no caps on amounts contributed from certain payments for personal injury, provided that no deduction is claimed for the contribution.

In addition to the member caps described above, superannuation funds are generally unable to accept single non-concessional contributions in excess of $450,000 (or $150,000 if you are 65 or over on 1 July of the financial year in which you contribute) from a member in any financial year.

Please note that it is your responsibility to ensure contributions to superannuation are within your concessional and non-concessional contributions caps. The *trustee* is required to reject certain single contributions which are in excess of the non-concessional contributions caps (as outlined above) but cannot monitor your overall position.

Taxation treatment of Term Life as Superannuation

(a) Tax concessions on contributions

Employer contributions

Employers can claim tax deductions on all contributions to superannuation on behalf of their employees, subject to the eligibility rules described in 'Eligibility to contribute to Superannuation' on page 62.

Personal contributions

You may be eligible to claim a full tax deduction on your personal after tax contributions if you are self employed or substantially self employed. There are no limits on the amount you may claim as a deduction (provided you have an assessable income to offset), but additional tax will apply on those contributions made in excess of the concessional contributions cap (refer to 'Contributions caps' on page 63).

To be able to claim the deduction, you will need to provide a valid personal tax deduction notice to the *trustee* by the earlier of:

- the date you lodge your personal tax return in which you claim the deduction for the contributions;
- the end of the financial year following the financial year in which you made the contributions;
- the date the *trustee* ceases to hold the contributions covered in the notice; and
- the date you cease to be a member of the *fund* (generally the date your cover ceases).

Spouse contributions

Your *spouse* may be able to claim a tax offset of up to $540 for contributions they make to your superannuation account. The maximum offset will be available if your income is below $10,800 pa and reduces to nil once your income is $13,800 pa. Government eligibility rules apply. Income is taken to mean assessable income, plus reportable fringe benefits, plus reportable employer superannuation contributions.

(b) Tax payable on contributions

Concessional contributions

The following concessional contributions are subject to taxation at a maximum rate of 15% within Term Life as Superannuation:

- employer contributions; and
- personal after tax contributions for which you claim a personal tax deduction.

Excess concessional contributions

If contributions are made in excess of the relevant concessional contributions cap (refer to 'Contributions caps' on page 63), those contributions are liable for additional tax at a rate of 31.5%. The Australian Taxation Office (ATO) will inform you of this liability and provide you with a Release Authority which will allow you to meet the liability by withdrawing amounts from a superannuation fund. Alternatively, you may pay the tax with your own money. Term Life as Superannuation will not be able to release amounts to pay your tax liability since no account balance is maintained for you.

Non-concessional contributions

No tax is payable on the non-concessional contributions made to the *fund* unless the relevant non-concessional contributions cap (refer to 'Contributions caps' on page 63) is exceeded.

Excess non-concessional contributions

If your contributions are made in excess of the non-concessional contributions cap, those contributions are liable for tax at a rate of 46.5%. The ATO will inform you of this liability and provide you with a Release Authority. You must withdraw the required amount from a superannuation fund to pay the tax, using the Release Authority. Term Life as Superannuation will not be able to release amounts to pay your tax liability since no account balance is maintained for you.

(c) Tax on superannuation lump sums

Taking a cash lump sum benefit

Any tax the *trustee* is required to deduct will depend on your age and the tax components within your benefit, as shown in the table below:

Age	Taxable component	Tax-free component
Under 55	20% + Medicare levy	Tax free
55-59	Up to $160,000*: Nil Above $160,000*: 15% + Medicare levy	Tax free
60 and over	Tax free	Tax free

This amount is the low rate cap for 2010/2011 and will be indexed to AWOTE rounded down to the nearest $5,000 in subsequent years.

If you are under age 60 and the *trustee* does not hold your Tax File Number (TFN), it is required to deduct tax on the taxable component at the highest marginal tax rate plus the Medicare levy.

Taking a cash lump sum as a result of suffering from a terminal medical condition

Members who are suffering from a terminal medical condition will be able to receive a lump sum superannuation benefit that is exempt from tax. For this product, this would result from receiving a Terminal Illness Benefit. Refer to section 11 for a definition of terminal medical condition.

(d) Tax on death benefits

Death benefits paid as a lump sum to your dependants (for tax purposes) are tax-free. A dependant for tax purposes includes your *spouse* or former *spouse,* your children under 18, a person who was wholly or substantially financially dependent on you at the time of your death and a person with whom you were in an *interdependency relationship* at the time of your death.

Death benefits paid as a lump sum to a non-dependant for tax purposes will be taxed in the following manner:

Tax free component	Tax free
Taxable component (taxed element)	Taxed at 15% plus the Medicare levy
Taxable component (untaxed element)	Taxed at 30% plus the Medicare levy

An untaxed element arises where the lump sum death benefit contains an insurance payout, and the benefit is paid to a non-dependant. The amount of the untaxed element is calculated by using a statutory formula.

Death benefits paid as a lump sum to your estate are taxed within the estate depending on whether your *beneficiaries* are your dependants or non-dependants for tax purposes.

Term Life as Superannuation does not pay death benefits as pensions. The tax treatment of death benefits paid as an income stream is different to that outlined above. You should consult your financial planner for advice.

Beneficiary Nomination Guidelines for Term Life as Superannuation

(a) Payment in the event of your death

You can nominate one or more persons to receive the whole or a part of your benefit in the event of your death. If you do so, the nominated person will be paid the relevant share of your benefit on your death if at that time:

- the nominated person is a dependant or your legal personal representative (normally the executor of your will);
- you have not revoked the nomination; and
- your nomination is not invalid for any reason (see below).

For this purpose a dependant includes:

- your *spouse;*
- any of your children (including adopted, step and adult children);
- any person with whom you are in an *interdependency relationship* at your death; and
- any other person who is financially dependent on you at the date of your death.

If you do not make a nomination, or the nomination you make is defective, your benefit will be paid to your legal personal representative or, failing that, to one or more of your dependants as the *trustee* determines. It is a non-binding nomination.

(b) It is important to review your nomination regularly

You should review your nomination regularly to ensure that it continues to reflect your wishes. You can change your nomination at any time by completing the Nomination of Beneficiaries Form, obtainable by telephoning the Customer Relations Centre on 1300 366 416. You can also revoke your nomination at any time without making a new one by writing to us.

Normally, after being notified of your death, the *trustee* will consider whether to approve the last nomination received from you. Once the *trustee* approves it, your nomination becomes valid and binding. But the *trustee* will not approve a nomination if it has reason to believe that the nomination was invalid when you made it, or became invalid afterwards.

(c) Invalid nomination

Your nomination will be invalid when you make it if:

- it is unclear to the *trustee* (e.g. because it is illegible or because the nominated proportions do not total 100%);
- the *trustee* has actual knowledge that, when you made the nomination, you did not understand the consequences of making it; or
- you do not sign or date the form or the signature has not been witnessed properly.

Your nomination may also become invalid after you make it if certain events occur, including marriage, divorce, and commencing or ceasing co-habitation with a person of either sex. At the date of your death, your nomination may have become invalid if a nominated person has either:

- died; or
- is no longer your dependant.

You should contact us to revise your nomination if any of these events occur.

(d) What if I don't make a nomination?

If you do not nominate any *beneficiaries* then your benefit will normally be payable to your estate.

(e) Professional estate and financial planning advice

Ordinarily, a valid nomination will be approved by the *trustee* and so become binding. You should therefore take professional estate and financial planning advice before making one.

Family law – treatment of superannuation on divorce

(a) Family Law Act 1975 ('FLA')

Provisions of the FLA deal with the treatment of superannuation on relationship* or marriage breakdown with a *spouse.* The FLA provides that a member's superannuation benefit may be split with the member's *spouse* or former *spouse* on marriage or relationship breakdown. Alternatively a payment flag may be imposed on your benefit in the *fund.*

* Legislation to expand the FLA to cover relationship breakdown as well as marriage breakdown came into effect on 1 March 2009 (with the possible exception of South Australia and Western Australia).

You only accrue a benefit in the *fund* in the unfortunate event that you have a valid claim under the Term Life as Superannuation Policy. In this event, we will deposit the relevant amount of insurance to your account with the *fund*.

In order for the *trustee* to commence any payment split or impose a payment flag on your account, the *trustee* must have been served with either:

- a superannuation agreement, made between you and your *spouse* or former *spouse,* and in accordance with the requirements of the FLA; or
- an order of the Family Court of Australia, that specifies how your benefit is to be split with your *spouse* or former *spouse* or that a payment flag must be applied to your account.

The FLA also specifies that the *trustee* must be provided with certain evidence of marriage or relationship breakdown if you serve a superannuation agreement on the *trustee.* You and/or your *spouse* or former *spouse* may arrange for the required documents to be served on the *trustee.* Documents can only be served on the *trustee* for the purposes of the FLA at the following address:

Family Law and Superannuation Officer
Legal Department
Westpac Securities Administration Limited
Westpac Place, 275 Kent St
SYDNEY NSW 2000

All documents served on the *trustee* should be either an original or a certified copy.

If the *trustee* is required to effect a payment split on your benefit, the value of your account will reduce by the amount that is paid to, or for the benefit of, your *spouse* or former *spouse.*

(b) Information about your superannuation benefit

Where an eligible person under the FLA wishes to negotiate a superannuation agreement with you (which may be before or during a relationship, or after relationship breakdown) or facilitate the preparation of an order of the Family Court, they may apply to the *trustee* to receive information about your benefit. Where the application is made in accordance with the requirements of the FLA, the *trustee* will be obliged to provide the requested information and will not be permitted to inform you about the application.

(c) Fees and expenses may apply

If your accrued benefit and/or account with the *fund* becomes affected by the FLA and the *trustee* is required to take certain action, you will be notified of any fees that may be charged by the *trustee* for undertaking such action.

(d) Professional advice

The FLA involves many complex requirements in relation to splitting a superannuation benefit. It is recommended that, if you believe your benefit will be affected by the FLA, you should consult your legal adviser, financial planner and/or accountant. Should you have any questions in relation to the above, please do not hesitate to call our Customer Relations Centre on 1300 366 416, 8.00am to 6.30pm (Sydney time), Monday to Friday.

(e) Conditions applying to payment of benefits under superannuation law

Superannuation law restricting payments from superannuation funds applies to all benefits paid under the Policy. This means the *trustee* can only release benefits to you if you meet a condition of release for superannuation law purposes.

Examples of some circumstances (referred to as conditions of release) in which the *trustee* currently may be permitted to release preserved benefits are as follows:

- meeting the financial hardship conditions;
- qualifying on compassionate grounds;
- departing Australia permanently, having been a temporary resident of Australia (on a specified class of visa);
- having reached your preservation age and permanently retired from full or part-time employment;
- having turned 60 and ceased employment with an employer on or after that age
- suffering from a terminal medical condition;
- having turned 65;
- temporary incapacity; or
- becoming *permanently incapacitated.*

Preservation age is between age 55 and 60, depending on your date of birth:

Date of birth	Preservation age
Before 1 July 1960	55
From 1 July 1960 to 30 June 1961	56
From 1 July 1961 to 30 June 1962	57
From 1 July 1962 to 30 June 1963	58
From 1 July 1963 to 30 June 1964	59
On or after 1 July 1964	60

A terminal medical condition exists at a particular time if two medical practitioners certify that you are suffering from an *illness,* or have incurred an *injury,* that is likely to result in death within 12 months from the date of the certification (the certification period). At least one of the medical practitioners must be a specialist in the area of your *illness* or *injury.*

If you do not satisfy a condition of release, the *trustee* must preserve the benefit in the fund until it is allowed to release it.

7. Medical glossary.

7

Activities of daily living

The activities of daily living are:

Bathing	The ability to shower or bathe
Dressing	The ability to put on or take off clothing.
Toileting	The ability to use the toilet, including getting on or off.
Mobility	The ability to get in and out of bed and a chair.
Continence	The ability to control bladder and bowel function.
Feeding	The ability to get food from a plate into the mouth.

Advanced diabetes

Severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist and resulting in at least two of the following criteria:

(a) severe diabetic retinopathy resulting in visual acuity whether aided or unaided of 6/36 or less in both eyes;
(b) severe diabetic neuropathy causing motor and/or autonomic impairment;
(c) diabetic gangrene leading to surgical intervention;
(d) severe diabetic nephropathy causing chronic irreversible renal impairment (as measured by a corrected creatinine clearance below the laboratory's measured normal range); or
(e) persistent sensory neuropathy.

Alzheimer's disease and other dementias

Significant and permanent failure of brain function confirmed by a consultant neurologist. The dementia must also result in either:

(a) an inability to perform at least one of the activities of daily living; or
(b) a need for continual professional supervision as confirmed by the consultant neurologist.

Dementia resulting from alcohol or drug abuse is excluded.

Alzheimer's disease and other dementias – advancement

The Insured Person is diagnosed by a registered medical practitioner specialising in the field relevant to this condition, as suffering from this condition, but the condition has not caused a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment').

Angioplasty – single or double vessel

Undergoing either angioplasty, cardiac keyhole surgery or stent insertion on one or two coronary arteries, as considered necessary by a cardiologist to treat coronary artery disease.

Angiographic evidence is required to confirm the need for this procedure.

Angioplasty – triple vessel

Undergoing for the first time either angioplasty, cardiac keyhole surgery or stent insertion on 3 or more coronary arteries in the same procedure, as considered necessary by a cardiologist to treat coronary artery disease.

Angiographic evidence is required to confirm the need for this procedure.

Aortic surgery

Surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta, but not its branches. This does not include angioplasty, intra-arterial procedures and other non-surgical procedures.

Aplastic anaemia

Permanent bone marrow failure, which results in anaemia, neutropenia and thrombocytopenia requiring treatment, with at least one of the following:

(a) permanent reliance on blood product transfusions;
(b) marrow stimulating agents;
(c) bone marrow transplantation; or
(d) immunosuppressive agents.

Benign brain tumour

Non-cancerous tumour in the brain or spinal cord which produces neurological deficit causing permanent and significant functional impairment, as confirmed by a consultant neurologist and by imaging studies such as a CT or MRI scan or requires radical surgery for its removal.

The following are excluded:

(a) cysts, granulomas and cerebral abscesses;
(b) malformations in, or of, the arteries or veins of the brain;
(c) haematomas;
(d) tumours in the pituitary gland; and
(e) acoustic neuroma and other cranial nerve tumours.

Blindness

The permanent loss of sight of both eyes, whether aided or unaided, as a result of *sickness, disease* or *injury* such that visual acuity is 6/60 or less in both eyes, or such that the visual field is reduced to 20 degrees or less of arc.

Blindness – advancement

The permanent loss of sight of one eye, whether aided or unaided, as a result of sickness, disease or injury such that visual acuity is 6/60 or less in one eye, or such that the visual field is reduced to 20 degrees or less of arc.

Brain damage

Brain damage, as confirmed by a medical practitioner who is a consultant neurologist, which results in neurological deficit causing at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment').

Cancer (malignant tumours)

A malignant tumour pathologically confirmed and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue. Also included are Hodgkin's disease, lymphoma, colorectal cancer (from Dukes stage A) and leukaemia. The following are specifically excluded:

(a) all skin cancers except metastatic squamous cells carcinomas or melanomas of 1.5 millimetres or more in thickness or Clark Level 3 or more depth of invasion;

(b) all tumours which are histologically described as microcarcinoma, pre-malignant or showing the malignant changes of 'carcinoma in situ', including cervical dysplasia rated as CIN 1, 2 or 3 ('carcinoma in situ' of the breast is covered if it results directly in the removal of the entire breast. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment);

(c) chronic lymphocytic leukaemia (less than RAI stage 1); and

(d) prostatic tumours which are histologically described as TNM classification T1 (including T1a, T1b and T1c) or are of another equivalent or lesser classification (prostate cancer is covered if it results directly in total prostatectomy. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment).

Carcinoma in situ of female organs

Carcinoma in situ means localised cancer characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and /or active destruction of normal tissue beyond the basement membrane.

Carcinoma in situ of the following sites is covered:

(a) Cervix-uteri – the tumour must be classified as TIS according to the TNM staging method or FIGO stage 0. (This excludes Cervical Intraepithelial (CIN) classifications CIN 1 and CIN 2).
(b) Fallopian tube – where the tumour must be limited to the tubal mucosa and classified as TIS according to the TNM staging method or FIGO stage 0.
(c) Vagina – where the tumour must be classified as TIS according to the TNM staging method or FIGO stage 0.
(d) Vulva – where the tumour must be classified as TIS according to the TNM staging method or FIGO stage 0.
(e) Breast – where the tumour must be classified as TIS according to the TNM staging method or FIGO stage 0.

FIGO refers to the staging method of the International Federation of Gynaecology and Obstetrics.

Cardiomyopathy

Impaired ventricular function of variable aetiology resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association (or equivalent) classification of cardiac impairment.

Chronic liver disease

End stage liver failure characterised by:

(a) permanent jaundice; and
(b) ascites or encephalopathy.

Chronic lung disease

End stage respiratory failure requiring permanent oxygen therapy, the diagnosis of which includes an FEV 1 test result of less than 1 litre.

Coma

A state of unconsciousness with no reaction to external stimuli, resulting in a Glasgow Coma Scale of 6 or less persisting continuously and requiring the use of a life support system for a period of at least 3 consecutive days.

Coronary artery bypass surgery

Coronary artery bypass surgery with the use of bypass graft(s) to one or more coronary arteries for treatment of coronary artery disease. The surgery must be the most appropriate treatment for the disease. All non-surgical procedures such as laser, angioplasty or other intra-arterial techniques are excluded.

Diabetes complication

Type 1 insulin dependent diabetes mellitus, as certified by a consultant endocrinologist and resulting in at least two of the following criteria:

(a) urinary protein excretion of more than 300mg per day;
(b) diabetic retinopathy with a minimum severity of at least exudates and/or dot-blot haemorrhages; or
(c) persistent sensory neuropathy.

Early stage melanoma

The presence of one or more malignant melanomas which are less than 1.5mm Breslow thickness and less than Clark level 3 depth of invasion, confirmed histologically by biopsy.

The malignancy must be characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

Encephalitis

Severe inflammatory disease of the brain resulting in neurological deficit that causes either:

(a) at least 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist; or
(b) an inability to perform at least one of the activities of daily living.

Heart attack

The occurrence of an acute myocardial infarction, which means the death of a portion of heart muscle due to inadequate blood supply as evidenced by:

(a) new electrocardiograph changes associated with myocardial infarction; and
(b) the elevation above the laboratory's upper limit of normal of the biochemical markers (such as troponin or cardiac enzymes) indicative of myocardial infarction.

If the above tests are inconclusive or superseded by technological advances, we will consider other appropriate and medically recognised tests in support of a diagnosis as confirmed by a consultant cardiologist.

Lesser acute coronary syndromes including unstable angina and acute coronary insufficiency are excluded as part of this definition.

Heart valve surgery

Any surgery performed to repair or replace a cardiac valve as a consequence of a heart valve defect.

Intensive care

Sickness or *injury* that has for the first time resulted in the Insured Person requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital.

Intensive care as a result of drug or alcohol abuse is excluded.

Kidney failure

End stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which permanent regular renal dialysis is instituted or renal transplantation undergone.

Loss of hearing

Total irreversible and irreparable loss of hearing, both natural and assisted, in both ears as a result of a *disease, sickness* or *injury* as certified by an appropriate medical specialist.

Loss of independent existence

As a result of *sickness* or *injury,* the Insured Person:

(a) has a permanent and irreversible inability to perform, without assistance, any two of the activities of daily living; or
(b) suffers cognitive impairment that requires permanent and constant supervision, which must be established and the diagnosis reaffirmed after a continuous period of at least 6 months of such impairment.

Loss of limbs

The complete and irrecoverable loss of use of both hands or both feet, or one hand and one foot, as a result of *disease, sickness* or *injury.*

Loss of single limb

The complete and irrecoverable loss of use of one hand or one foot as a result of *disease, sickness* or *injury.*

Loss of speech

Complete and irrecoverable loss of speech as a result of *disease, sickness* or *injury* as certified by a consultant neurologist.

Major head trauma

Accidental head *injury* resulting in neurological deficit that:

(a) causes at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as certified by a consultant neurologist; or
(b) results in a permanent and irreversible inability of the Insured Person, to perform, without the physical assistance of an adult, any one of the activities of daily living.

Major organ transplant

The medically necessary:

(a) human to human transplant from a donor to the Insured Person (or Insured Child if applicable); or
(b) placement of the Insured Person (or Insured Child) on a waiting list, to undergo organ transplant from a human donor, for one or more of the following: a heart, lung, kidney, liver, pancreas or bone marrow.

A waiting list means the Insured Person (or Insured Child) has been placed on an official Australian acute care hospital waiting list, approved by us.

Medically acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) that on the balance of probabilities arose from one of the following medical procedures performed in Australia by a registered health professional:

(a) blood or blood product transfusion;
(b) organ transplant to the Insured Person;
(c) assisted reproductive techniques; or
(d) medical/dental procedure or operation.

This benefit will not apply in the event that any cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of infection with the HIV virus or the occurrence of AIDS prior to the making of a claim.

Meningitis

Unequivocal diagnosis of bacterial meningitis by a consultant neurologist resulting in:

(a) at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment'); or
(b) has a permanent and irreversible inability to perform, without assistance, any one of the activities of daily living.

Meningococcal septicaemia

Unequivocal diagnosis of meningococcal septicaemia by a consultant neurologist resulting in:

(a) at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment'); or
(b) has a permanent and irreversible inability to perform, without assistance, any one of the activities of daily living.

Motor neurone disease

The Insured Person is unequivocally diagnosed by a consultant neurologist, as suffering from motor neurone disease.

Multiple sclerosis

The definite diagnosis of multiple sclerosis with persisting neurological abnormalities that cause at least 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist.

Multiple sclerosis – advancement

The Insured Person is diagnosed by a registered medical practitioner specialising in the field relevant to multiple sclerosis, as suffering from multiple sclerosis, but the condition has not caused a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment').

Muscular dystrophy

The Insured Person is unequivocally diagnosed by a consultant neurologist, as suffering from muscular dystrophy, on the basis of confirmed neurological investigations.

Occupationally acquired hepatitis B and C

Occupationally acquired hepatitis B and C where the virus was acquired due to an *accident* occurring while the Insured Person was engaging in their *usual occupation* as a medical professional and proof of seroconversion from:

(a) Hepatitis B surface antigen negative to Hepatitis B surface antigen positive; or
(b) Hepatitis C antibody negative to Hepatitis C antibody positive,

being demonstrated by testing within six months of the *accident*. Hepatitis B or Hepatitis C acquired in any other manner is excluded.

Any *accident* that potentially may give rise to a claim must be treated in accordance with the relevant infection control guidelines for the relevant practice body or state health service, including, at a minimum, baseline screening with regular screening at six weeks, 12 weeks and six months post event. This screening will require a supporting negative Hepatitis B or Hepatitis C test performed on material taken after the *accident* date. Blood product and all other blood samples used will need to be made available for independent testing.

This benefit will not apply in the event that any cure is found for Hepatitis B and/or Hepatitis C, or if the Insured Person had elected not to take a medical treatment that is available which results in the prevention of infection with Hepatitis B and/or Hepatitis C prior to the making of a claim.

Occupationally acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where the virus was acquired due to an *accident* occurring while the Insured Person was engaging in their *usual occupation*. Sero-conversion of the HIV infection must occur within 6 months of the *accident*.

HIV infection acquired by any other means including sexual activity or non-prescribed intravenous drug use is excluded.

Any *accident* giving rise to a potential claim must be reported to us within 7 days of the *accident* and supported by a negative HIV Antibody test taken after the *accident*. We must be given access to test independently all the blood samples used.

This benefit will not apply in the event that any cure is found for AIDS or the effects of the HIV virus, or a medical treatment is developed that results in the prevention of infection with the HIV virus or the occurrence of AIDS prior to the making of a claim.

Open heart surgery

Open chest surgery for the surgical treatment of a cardiac defect, cardiac aneurysm or cardiac tumour.

Out of hospital cardiac arrest

Cardiac arrest occurring out of hospital not associated with any medical procedure and documented by an ECG or ECG rhythm strip showing cardiac asystole or ventricular fibrillation.

Paralysis

The total and permanent loss of use through *sickness* or *injury* of:

(a) both legs (paraplegia);
(b) both arms and legs (quadriplegia);
(c) one side of the body (hemiplegia); or
(d) both sides of the body (diplegia).

Parkinson's disease

The definite diagnosis of Parkinson's disease with persisting neurological abnormalities that causes at least a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guide to the Evaluation of Permanent Impairment'), as confirmed by a consultant neurologist. Parkinson's disease resulting from alcohol or drug abuse is excluded.

Parkinson's disease – advancement

The Insured Person is diagnosed by a registered medical practitioner specialising in the field relevant to Parkinson's disease, as suffering from Parkinson's disease, but the condition has not caused a 25% permanent impairment of whole person function (according to the current edition at the time of claim of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment').

Pneumonectomy

The undergoing of surgery to remove an entire lung. This treatment must be deemed the most appropriate treatment and medically necessary by an appropriate medical specialist and supported by our medical advisers.

Pneumonectomy which is directly caused by smoking tobacco or use of other drugs not prescribed by a doctor is excluded.

Prostate cancer (stages T1a, T1b and T1c)

The tumour is located within the prostate gland and is histologically described as TNM Classification T1a, T1b or T1c.

Prostate cancer – major treatment

Prostate cancer means a tumour which is located within the prostate gland.

Low level prostatic cancers which are histologically described as TNM Classification T1a, T1b or T1c or lesser classification and appropriate and necessary major treatment has not been performed specifically to arrest the spread of malignancy are specifically excluded.

Major treatment includes the removal of the entire prostate, radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment.

Pulmonary hypertension

Primary pulmonary hypertension associated with right ventricular enlargement, established by cardiac catheterisation, resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment as confirmed by a cardiologist.

Severe burns

Tissue *injury* caused by thermal, electrical or chemical agents causing third degree burns to:

(a) at least 20% of the body surface area as measured by the 'rule of 9' or the Lund & Browder Body Surface Chart (or equivalent classification);
(b) both hands, requiring surgical debridement and/or grafting; or
(c) the face, requiring surgical debridement and/or grafting.

Severe rheumatoid arthritis

The diagnosis of severe rheumatoid arthritis by a rheumatologist. The diagnosis must be supported and evidenced by, all of the following criteria:

(a) at least a 6 week history of severe rheumatoid arthritis which involves 3 or more of the following joint areas:
    i. proximal interphalangeal joints in the hands;
    ii. metacarpophalangeal joints in the hands; or
    iii. metatarsophalangeal joints in the foot, or any joint of the wrist, elbow, knee or ankle; and
(b) simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone);
(c) typical rheumatoid joint deformity; and
(d) at least 2 of the following criteria:
    i. morning stiffness;
    ii. rheumatoid nodules;
    iii. erosions seen on x-ray imaging; or
    iv. the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis.

Degenerative osteoarthritis and all other arthridities are excluded.

Stroke

Any cerebrovascular accident (CVA) or incident resulting in neurological deficit. The stroke must:

(a) be confirmed by a consultant neurologist; and
(b) be evidenced by neuro-imaging (eg. CT, MRI or similar scanning technique).

Cerebral events with reversible neurological deficits, migraine, hypoxic events, trauma, and neurovascular disease affecting the eye or vestibular functions are excluded.

8. Definitions.

8

Accident means death, *total and permanent disability, sickness,* or *injury* as a result of a single event that results in a *bodily injury* that is unexpected. This does not include an event that results from *sickness* or *disease.*

Accidental death means death as a result of a single event that results in *bodily injury* that is unexpected. This does not include an event that results from *sickness* or *disease.*

Agreed value means we will not reduce the amount you are paid when the Insured Person is disabled because their *monthly earnings* have reduced since taking out the insurance, provided income details were correctly disclosed at the time of application.

Allowable business expenses means the following items of expenditure if they are incurred in the normal conduct and operation of the *Insured Person's business:*

- Accountants' and auditors' fees
- Advertising
- Business insurance premiums
- Cleaning, electricity, gas, heating, laundry, telephone (including mobile phone) and water
- Leasing costs of equipment and vehicles
- *Mortgage* interest payments
- Property rates and taxes
- Rent
- Salaries of non income producing employees including related costs such as pay roll tax and superannuation
- Subscriptions to professional bodies and publications
- Other fixed expenses normally incurred in the conduct of the *Insured Person's business* and which were identified in the application for this Policy and agreed to by us
- Any net costs associated with employing a locum after the Insured Person became *totally disabled* to perform the work normally performed by them. Net costs is treated as the total expense incurred with hiring the locum less the revenue generated by the locum.

Allowable business expenses will not include:

- The cost of books, equipment, fittings, goods, implements or products used in the *Insured Person's business*
- Depreciation of equipment and vehicles
- The salary and the salary-related costs of the Insured Person
- Repayment of *mortgage* or loan principal
- Salaries and related costs of income producing employees
- Salaries and related costs paid to any of the Insured Person's relatives, unless the relative has been a full-time employee of the *Insured Person's business* for at least 6 months prior to the commencement of *total disability*
- Any share of the expenses of the *Insured Person's business* which is not normally attributable to the Insured Person
- Expenses of a private or domestic nature.

Any occupation TPD means a definition of *total and permanent disability.*

Beneficiary means a person to whom a Death Benefit or share of a Death Benefit, Funeral Advancement Benefit or share of Funeral Advancement Benefit, is paid at your direction.

Benefit period means the maximum period of time measured from the end of the *waiting period* for which a benefit entitlement in respect of any one *sickness* or *injury* may continue to accrue (subject to recurrent disability). Your *benefit period* is shown in your *policy schedule.*

Bodily injury means physical damage to the body sustained as a result of an external traumatic occurrence.

Business income means the gross income of the business before expenses and tax.

Children's medical event means any of the conditions, injuries or surgeries covered under the Children's Benefit. A *children's medical event* does not include any condition, *injury* or surgery which is a pre-existing condition that existed prior to, or at the time of application.

Pre-existing condition is taken to mean any *injury, sickness, illness* or *symptom* that:

- you or the Insured Child were aware of, or a reasonable person should have been aware of;
- you or the Insured Child should have sought advice or treatment (conventional or alternative) from a medical practitioner or other health professional for (in circumstances where a reasonable person would have sought advice or treatment); or
- you or the Insured Person had a medical consultation for or were prescribed medication or therapy for.

Commencement date means the date we accept your application for insurance and issue you with a *policy schedule* or *membership certificate.*

Confined to bed means *totally disabled* and required by a doctor to stay in bed under the full-time care of a registered nurse. The nurse cannot be you or a *spouse,* parent, child, sibling or business partner of you or the Insured Person.

Congenital condition means a condition present at birth as a result of either hereditary or environmental influences.

CPI means the percentage increase in the Consumer Price Index ('weighted average of eight capital cities combined') as published by the Australian Bureau of Statistics or its successor over the 12 month period ending 31 March each year. The *CPI* will apply for the subsequent year commencing 1 October. If the *CPI* is not published, or is considered by us to be inappropriate, the percentage increase shall be calculated by reference to such other index of inflation as, in our opinion, most nearly replaces it. If the *CPI* is negative, we will consider it to be zero.

Date of disablement means 3 months after ceasing work or home duties due to *sickness* or *injury.* Applicable to the TPD Benefit.

Disease means an abnormal condition of an organism that impairs bodily functions, associated with specific *symptoms* and signs. It may be caused by external factors or by internal dysfunctions.

Doctor means a person who:

- is a registered medical practitioner in Australia or New Zealand (or is a medical practitioner of another country with qualifications acceptable to us); and
- is not:
  - you or the Insured Person; or
  - a *spouse*, parent, child, sibling or business partner of you or the Insured Person.

Earnings means the income earned by the Insured Person's own personal exertion before tax, but after deduction of any expenses incurred in earning that income.

Fracture means the disruption in the continuity of the bone, with or without displacement, demonstrated by radiographic or scanning technique.

Fund means Westpac MasterTrust ABN 81 236 903 448, SFN 281412, SPIN WFS0112AU, RSE Licence Number R1003970.

Gainful employment and **gainfully employed** means

- For employees, a person is working for salary, wages, or commission.
- For self-employed, a person is working in a business or professional practice and as a result of their personal exertion is generating an income from the business or professional practice.

General cover TPD means a definition of *total and permanent disability.*

Home duties TPD means a definition of *total and permanent disability.*

Illness means *sickness.*

Immediate family member means a *spouse,* parent, child or sibling.

Important income producing duties means those duties which could reasonably be considered primarily essential to producing the Insured Person's monthly income.

Income ratio means the *insured monthly disability* benefit as a percentage of *monthly earnings.* It is calculated at the time of application.

Indemnity means if the Insured Person's *monthly earnings* have reduced since taking out your insurance we may reduce the amount you are paid when the Insured Person is disabled.

Injury means an accidental *bodily injury* which is sustained by the Insured Person after the later of:

- the *commencement date;*
- for an increase in the sum insured of any benefit, the date we increase the benefit (other than a *CPI* or Loyalty Benefit increase); and
- the date this Policy was last reinstated, but before this Policy ends.

Injury also means an accidental *bodily injury* which you and the Insured Person fully disclosed to us and we agreed to cover.

Insured Child means the child to be insured for the Children's Benefit.

Insured monthly business overheads benefit means the amount we have covered you for as shown in the *policy schedule.*

Insured monthly disability benefit means the amount we have covered you for as shown in the *policy schedule.*

Insured Person means the person whose life is insured, or the life to be insured. The name of each Insured Person is in the *policy schedule* under the heading, Insured Person.

Insured Person's business means the business, profession or occupation of the Insured Person.

Insurer means Westpac Life Insurance Services Limited ABN 31 003 149 157, AFSL 233728.

Interdependency relationship means a close personal relationship between two people who live together, where one or both of them provide for the financial and domestic support and personal care of the other. An *interdependency relationship* may still exist if there is a close personal relationship but the other requirements are not satisfied because of some physical, intellectual or psychiatric disability.

Legal guardian is a person who has been given the legal power to make important decisions on behalf of another person, such as where that person should live, or what care and services that person should have.

Limb means an arm or leg, including the whole hand or the whole foot.

Membership certificate means the document which sets out the details of the insurance we provide you under Term Life as Superannuation.

Monthly earnings means:

- if the Insured Person is not self-employed, the normal monthly value of the remuneration package paid to the Insured Person by their employer, including salary, superannuation contributions, fees, commissions, regular overtime and bonus payments and packaged fringe benefits.
  Remuneration package does not include income which is not derived from the Insured Person's personal exertion or activities, such as interest or dividend payments or
- if the Insured Person is self-employed:
  - the normal monthly income earned by the *Insured Person's business,* practice or partnership due to the Insured Person's personal exertion or activities, less
  - the Insured Person's share of the expenses of the business, practice or partnership that were necessarily incurred in producing the normal monthly income.

Monthly earnings are calculated before deducting income tax.

Mortgage means a loan secured by a first mortgage over the Insured Person's principal place of residence. The mortgage must be with an authorised deposit-taking institution (ADI), or any other mortgage provider that we agree to.

Normal household duties means the duties normally performed by a person who remains at home and is not working in a regular occupation for income, including cleaning the house, washing, shopping for food, cooking meals and caring for minor children. For the avoidance of doubt, an Insured Person will not be considered to be unable to carry out all *normal household duties* if the Insured Person is able to perform any one or more of the listed duties.

Our means the *Insurer.*

Own occupation means the occupation that the Insured Person was last engaged in immediately prior to the event giving rise to a claim.

Own occupation TPD means a definition of *total and permanent disability.*

Partially and permanently disabled means the loss of use of one *limb* or sight in one eye due to *sickness* or *injury.*

Partial disability and **partially disabled** means

(a) for Income Protection and Income Protection Plus
- the Insured Person:
  - is working and is able to perform one or more of the *important income producing duties* of their *usual occupation,* but is unable to perform all of them;
  - is working and is able to perform all of the *important income producing duties* of their *usual occupation,* but in a reduced capacity; or
  - is working in another occupation; and
- the *monthly earnings* of the Insured Person are less than the amount of their *pre-disability monthly earnings;* and
- the Insured Person is under the *regular care of a doctor.*

(b) for Business Overheads
- the Insured Person:
  - is working and is able to perform one or more of the *important income producing duties* of their *usual occupation,* but is unable to perform all of them;
  - is working and is able to perform all of the *important income producing duties* of their *usual occupation,* but in a reduced capacity; or
  - is working in another occupation; and
- the Insured Person is suffering a loss in *business income;* and
- the Insured Person is under the *regular care of a doctor.*

Payment period means the period of time you will be paid after suffering a specified injury under the Specified Injury Benefit.

Permanently incapacitated means ill-health (whether physical or mental), where the trustee is reasonably satisfied that you are unlikely, because of the ill-health, to engage in *gainful employment* for which you are reasonably qualified by education, training or experience.

Policy Owner means the person to whom the benefit is paid. For Term Life as Superannuation the Policy Owner is the *trustee.*

Policy schedule means the document which sets out the details of the insurance we provide you, and forms part of your contract with the *Insurer.*

Post-disability monthly earnings means the Insured Person's *monthly earnings* after becoming *partially disabled.*

Pre-disability monthly earnings means:

For Income Protection and Income Protection Plus:

- if the monthly benefit type shown in the *policy schedule* is *indemnity,* the Insured Person's highest average *monthly earnings* in any consecutive 12 month period in the 36 months immediately preceding the commencement of *total disability,* increased by the *CPI* each *review date* since that date; or
- if the monthly Benefit Type shown in the *policy schedule* is *agreed value,* the Insured Person's highest average *monthly earnings* in any consecutive 12 month period between the 2 years prior to the *commencement date* and when the *waiting period* commences, increased by the *CPI* each *review date* since that date.

For the IP Continuation Option:

- the Insured Person's *monthly earnings* in the 12 month period immediately preceding the commencement of *total disability.*

Regular care of a doctor means the Insured Person:

- has sought advice, care and treatment from a *doctor* in relation to their *sickness* or *injury* and is continuing to do so at such times as is reasonable in the circumstances;
- is following the advice, care and treatment of the *doctor;* and
- is taking all other reasonable measures to avert or minimise any disabling *sickness* or *injury.*

Review date is either the anniversary of the date your insurance cover started, or if you have placed your Policy in a portfolio with a different *review date,* the *review date* of the portfolio.

Sickness means a sickness or *disease* which first becomes apparent after the later of:

- the *commencement date;*
- for an increase in the sum insured for any benefit, the date we increase the benefit (other than a *CPI* or Loyalty Benefit increase); and
- the date this Policy was last reinstated, but before this Policy ends.

Sickness also means a sickness or *disease* which you and the Insured Person fully disclosed to us and we agreed to cover.

A sickness is taken to have first become apparent when:

- a *doctor* first gave the Insured Person advice, care or treatment or recommended that the Insured Person seek advice, care or treatment for the sickness; or
- the Insured Person first had any symptom of the sickness for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *doctor.*

SMSF means a self managed superannuation fund as defined by section 17A of the *Superannuation Industry (Supervision) Act 1993* (Cth). With limited exceptions, self managed superannuation funds have less than five members, all of which are trustees or directors of the trustee company.

Spouse means:

- your husband or wife via marriage; or
- your de facto partner or any other person with whom you are in a relationship (provided that this relationship is registered under a certain state or territory law); or
- another person who, although not legally married to you, lives with you on a genuine domestic basis in a relationship as a couple.

Symptom means a departure from normal function or feeling which is noticed by the Insured Person, indicating the potential presence of *sickness* or abnormality. A symptom is taken to have existed when first noticed by the Insured Person.

Terminal illness means a *sickness* or *injury* which is expected to result in death within 12 months from the notice of claim. This is to be evidenced by a medical report from the treating registered specialist medical practitioner, and in some circumstances, confirmed by a registered medical practitioner of our choice.

Total and temporary disablement or **totally and temporarily disabled** means:

- the Insured Person has suffered a *sickness* or *injury;* and
- the Insured Person is unable to work because of that *sickness* or *injury* in any occupation for which the Insured Person is reasonably suited by education, training or experience. If the Insured Person's TPD Benefit is defined as home duties TPD, the Insured Person is deemed to be unable to work if he or she is prevented from carrying out all normal household duties.

Total disability and **totally disabled** means:

(a) the Insured Person is, because of *sickness* or *injury:*
- unable to perform one or more of the *important income producing duties* of their *usual occupation;*
- not working; and
- under the *regular care of a doctor,* or

(b) the Insured Person is, because of *sickness* or *injury:*
- not working for more than 10 hours per week in their *usual occupation,* and not working in any other occupation;
- unable to perform the *important income producing duties* of their usual occupation for more than 10 hours per week; and
- under the *regular care of a doctor,* or

(c) the Insured Person is continuously *partially disabled* after the end of the *waiting period,* and the *post-disability monthly earnings while partially disabled* are less than or equal to 20% of *pre-disability monthly earnings.*

The above definition applies to occupation categories (as shown in the *policy schedule*) AA, A, P, S or BB during the life of a claim, and, only applies to occupation categories B, C or E for the first 2 years of a claim, after which, the Insured Person will need to demonstrate that they are, because of *sickness* or *injury:*

- unable to perform any occupation for which they are reasonably suited by education, training or experience;
- not working; and
- under the *regular care of a doctor.*

Total and permanent disability and **totally and permanently disabled** means:

(a) for any occupation TPD

- *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months;
- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* is likely to prevent the Insured Person from ever again being able to work in any occupation for which they are reasonably qualified because of education, training or experience, and which would pay remuneration at a rate greater than 25% of their earnings in the last 12 months of work.

The Insured Person will also be considered to be *totally and permanently disabled* if the Insured Person meets the general cover *TPD* definition of *total and permanent disability.*

General cover TPD will apply if the Insured Person had permanently retired prior to the event causing disability.

(b) for own occupation TPD

- *sickness* or *injury* which has prevented the Insured Person from working in their *own occupation* for at least 3 consecutive months;
- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* is likely to prevent the Insured Person from ever again being able to work in their *own occupation.*

The Insured Person will also be considered to be *totally and permanently disabled* if the Insured Person meets the *general cover TPD* definition of *total and permanent disability.*

General cover TPD will apply if the Insured Person had permanently retired prior to the event causing disability.

(c) for home duties TPD

- *sickness* or *injury* which has prevented the Insured Person from carrying out all normal household duties for at least 3 consecutive months;
- the 3 month period has ended before the *review date* on or following the Insured Person's 65th birthday; and
- the *sickness* or *injury* is likely to prevent the Insured Person from ever again being able to carry out all *normal household duties.*

The Insured Person will also be considered to be *totally and permanently disabled* if the Insured Person meets the *general cover TPD* definition of *total and permanent disability.*

(d) for general cover TPD

- the Insured Person has suffered either:
  - a Loss of Independent Existence (as defined in the medical glossary); or
  - total and permanent loss of use of two limbs, use of one limb and sight in one eye or sight in both eyes.

Trustee means Westpac Securities Administration Limited ABN 77 000 049 472, AFSL Number 233731, RSE Licence Number L0001083.

Us means the *Insurer.*

Usual occupation means the occupation in which the Insured Person was last engaged before becoming *totally disabled* or *partially disabled.*

Waiting period means the minimum period of time which must elapse before any disability benefit entitlement may accrue. Your *waiting period* is shown in the *policy schedule.*

- **Total Disability Benefit**
  The Insured Person must be *totally disabled* throughout the *waiting period* in order to keep it running. If they cease to be *totally disabled* at any time, the *waiting period* stops running. The *waiting period* will not start to run again unless the Insured Person again becomes *totally disabled,* and then it will do so from the beginning.

- **Partial Disability Benefit**
  For Income Protection Plus occupation categories AA, A, P and S it is enough
  - that the Insured Person is *totally disabled* for at least 14 of the first 19 days of the *waiting period* and *partially disabled* for the balance of the *waiting period;* or
  - *partially disabled* for the entire *waiting period.*

  For Income Protection Plus occupation categories BB, B and C, and for all occupation categories in Income Protection and Business Overheads, it is enough that from the date of *total disability* the Insured Person is *totally disabled* for at least 14 of the first 19 days of the *waiting period* and *totally* or *partially disabled* for the balance of the waiting period.

- **Returning to work in the *waiting period***
  For the Total Disability Benefit, if the Insured Person returns to work for 5 consecutive days or less during the *waiting period* (10 consecutive days or less if the *waiting period* is 90 days or more), the *waiting period* does not stop running. Instead those days will be added to (and count towards) the *waiting period.*

The table below shows the maximum number of consecutive days you can return to work during the *waiting period.*

Waiting period	Maximum Number of Days
14 or 30 days	5
90, 180, 360, or 720 days	10

For the Partial Disability Benefit if the Insured Person returns to work other than in a partial capacity for 5 consecutive days or less during the *waiting period* (10 consecutive days or less if the *waiting period* is 90 days or more), the *waiting period* does not stop running, instead those days will be added to (and count towards) the *waiting period.* However, if the Insured Person returns to work in other than a partial capacity for more than 5 consecutive days during the *waiting period* (10 consecutive days if the *waiting period* is 90 days or more), the *waiting period* stops running.

We means the *Insurer.*

Westpac Group means Westpac Banking Corporation ABN 33 007 457 141 and its related bodies corporate, which include the *Insurer* and the *trustee.*

You and **your** means the Insured Person for Term Life as Superannuation, and for all other Policies means the Policy Owner.

Notes:

Notes:

To apply for cover or find out more:

Call us on 1300 366 416, Monday to Friday 8.00am – 6.30pm (Sydney time).

Mail us at GPO Box 4582, Sydney, NSW, 2001

Visit stgeorge.com.au to find out more.

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