MLC Insurance and MLC Insurance (Super)

Your guide to what is included in the Insurance PDS and Super PDS for MLC Insurance and MLC Insurance (Super).

1. MLC Insurance and MLC Insurance (Super) Product Disclosure Statement

Insurance PDS, which contains all the information about the insurance features, terms and conditions.

2. Smart Future Trust – Retail Insurance in Super: for MLC Insurance (Super) Product Disclosure Statement

Super PDS, which applies if you want to have insurance as part of your super arrangements.

3. Meet Vivo

Your holistic health, wellness and recovery program.

Note:

- If you are applying for insurance outside of super, please read the **Insurance PDS**.
- If you are applying for insurance through the Smart Future Trust, please read the **Insurance PDS** and the **Super PDS**.

Important information

The **Insurance PDS** is issued by MLC Limited, the Insurer.

The **Super PDS** is issued by Equity Trustees Superannuation Limited in its capacity as Trustee for the Smart Future Trust.

ACG111-0625
CGP-3269 OCM0349

MLC Insurance
MLC Insurance (Super)

PRODUCT DISCLOSURE STATEMENT

PREPARATION DATE
1 July 2025

INSURER
MLC Limited
ABN 90 000 000 402
AFSL 230694

MLC Life Insurance is becoming Acenda

MLC Limited is now using a new brand: Acenda.

Moving on from the MLC Life Insurance brand and adopting the Acenda name marks a significant milestone in our journey as a thriving Australian-operated insurer, showcasing a refreshed identity. As part of the Nippon Life Group, one of the world's leading and largest insurers, we continue our commitment to putting customers like you at the heart of everything we do.

What does this mean for you?

In the short term, we'll continue using our product names "MLC Insurance", "MLC Insurance (Super)" and "MLC Insurance (Wrap or SMSF)".

As we transition, you may see a mix of references to our new Acenda brand and the former MLC Life Insurance brand and logos, in communications, documents, forms and website content. We thank you for your patience.

Also, MLC Limited, your insurer and the registered company name behind the new Acenda and former MLC Life Insurance brands, will have a name change in the second half of 2025. The company ABN and AFSL will be the same. We'll communicate further with you about this change.

The change to our new brand and to our company name will not impact your cover. For more information about our branding and company name change, go to **acenda.com.au/acenda**

Acenda

Your guide to using this PDS

Important information

Acenda issues and is responsible for this Product Disclosure Statement (PDS) and the insurance described in it.

The information in this PDS may change over time. We will inform you of changes that are materially adverse to you.

We will publish all other changes on **acenda.com.au** which you should check from time to time.

The information in this PDS does not take into account your objectives, financial situation or needs. Please consider how appropriate this information is, based on your personal circumstances.

We recommend you speak with your financial adviser before making any decisions about your insurance.

If you take out insurance described in this PDS, the full legal terms and conditions are in the insurance Policy Documents that we will issue to you or your Trustee. You can also call the number in the **For more information** box to get a free copy of these insurance policies.

Acenda uses the MLC brand under licence from the Insignia Financial Group. Acenda is part of the Nippon Life Insurance Group and is not a part of the Insignia Financial Group.

Acenda is not a registered tax agent. If you wish to rely on the general tax information contained in this PDS to determine your personal tax obligations, we recommend you seek professional advice from a registered tax agent.

If you are taking out insurance through your super fund, your Trustee will provide you with information about your membership in the fund.

MLC Insurance and MLC Insurance (Super) is offered only in Australia. Acenda receives insurance premiums and pays claims from its Statutory Fund No. 1.

The insurances described in this PDS are non-participating and don't entitle the policy owner to participate in the distribution of any surplus of the statutory fund.

This insurance is designed purely for protection and isn't a savings plan. It will never have a surrender or cash value.

In this PDS we use medical terminology to define when certain benefits are payable. Your doctor can help you to understand this medical terminology.

Our sustainability commitment

We believe that operating sustainably will bring opportunities for us to enhance the lives of our customers, people, partners, and community.

Embedding sustainable practices across Acenda goes to the core of our 'Promise for Life' and delivering on our ambition 'to be Australia's leading, most trusted life insurer'.

We believe our commitment to operating sustainably will ensure we are not only meeting global standards on critical issues like climate change but also supporting a higher and more sustainable quality of life for our community.

For more information please visit **acenda.com.au/sustainability**

For more information

You can call us on **13 65 25** for free copies of updates, PDSs or other product documents. For hearing impaired customers, please call **1300 555 727**.
For customers requiring interpreting or translation services, please call **131 450**.

Your guide to using this PDS

In this PDS you'll find the following terms:

For insurance outside super – MLC Insurance		
Acenda/we/us/ our	refers to	MLC Limited, the insurer.
you/your	assumes that	you are both the policy owner and the life insured.
outside super	refers to	insurance which is not governed by super law and not held by a super Trustee.
For insurance inside super – MLC Insurance (Super) and MLC Insurance (Wrap or SMSF)		
Acenda/we/us/ our	refers to	MLC Limited, the insurer.
Trustee	refers to	Equity Trustees Superannuation Limited for insurance through your super in the Smart Future Trust, or The trustee of your super fund if the insurance is purchased through your eligible super wrap account, or The trustee of your complying super fund (for example an SMSF trustee). *Note: for insurance in super the Trustee is the policy owner.*
the Fund (MLC Insurance (Super) only)	refers to	the Smart Future Trust.
your fund	refers to	any complying super fund.
inside super	refers to	insurance held within the super environment and which is subject to super laws. This may include insurances which are held by SMSF trustees.
you/your/ member	refers to	**For MLC Insurance (Super)** – a member of the Fund and the life insured. **For MLC Insurance (Wrap or SMSF)** – a member of the relevant super fund and the life insured.
Eligible super wrap account	refers to	A super investment account from which MLC Insurance premiums can be deducted. The list of eligible super wrap accounts which can fund an insurance premium is available at **acenda.com.au/using-your-insurance/how-to-pay-your-insurance-premiums** These super investment accounts are held externally and are not issued by Acenda.

Making a claim

If you or your beneficiaries need to make a claim, please call us on **1300 125 246** between **8.30am** and **6pm** (AEST/AEDT), Monday to Friday, to find out what you or they need to do, and to get the relevant forms.

For hearing impaired customers, please call **1300 555 727**.

For customers requiring interpreting or translation services please call **131 450**.

Your guide to using this PDS

In this PDS you'll find the following information about your insurance. You should read it all carefully.

1. How insurance works with Acenda

What insurance is, how it works and the types of insurance available.

2. Key information about your insurance

The benefits, features and options available with your insurance. Plus the decisions you need to make when setting it up.

3. Your insurance journey

Understand your insurance journey and the important information you need to know at each step.

4. Summary of the terms and conditions

What you're insured for, when you'll be able to make a claim, how long you'll be paid benefits, and when you can exercise certain features and options.

You'll also find information about:

- What you are not insured for (known as general exclusions) on pages 69 – 70, and page 87; and
- When your insurance will end (known as general termination events) on pages 71 – 72 and page 88.

Your guide to using this PDS

5. Key medical and disability definitions

How we define specific medical conditions and disabilities for your insurance.

In this PDS, you'll know if a medical condition or type of disability has a specific definition because it will start with a capital letter (eg Heart Attack)

6. Special definitions

In this PDS, some words and expressions have specific meanings. You'll know if a word or expression has a special meaning because it will start with a capital letter (eg Totally and Permanently Disabled). The table below explains where you can find the meanings of these words and expressions.

What your insurance includes

In this PDS you'll find the following information about your insurance:

Benefit(s)	Are what we pay when a claimable event occurs. The benefit paid may be the full sum insured, a proportion of the sum insured, or another amount. Benefits can be either a one-off payment (lump sum), or a monthly payment for a period of time, or until you're no longer disabled. There may be more than one benefit available under your insurance, to cover different needs.
Setting(s)	Are a required selection for TPD, Income Protection and Business Expenses (that you select when you apply) which determine when benefits will be paid. Details on these settings can be found under the relevant insurance.
Feature(s)	Are built into your insurance. Some features will automatically apply to you, while others are available to be "turned on" according to the terms and conditions for that feature.
Option(s)	Are available for you to select when you take out your insurance. There are two types of options: • Options that expand your insurance, and increase your premiums, or • Options that limit when you can claim, and reduce your premiums.

1

How insurance works with Acenda

Insurance snapshot

Know your insurance

It's important to understand what's included in your insurance and what's not. This PDS is here to help you understand your insurance.

1. Insurance provides protection

Insurance helps protect against the potentially devastating financial consequences of serious life events like death, disability or a critical illness – at a time when you, your family or your business needs support the most.

Claimable events

Death

Disability

Critical illness

2. Insurance is a contract

Your insurance company agrees to insure you for certain claimable events. In return you agree to pay a premium. Your Policy Document sets out the terms and conditions of your insurance, while the schedule sets out details of what you're insured for (including the sum insured, specific settings and options selected, special terms that you have etc).

Who can own your insurance?

- You or someone else
- A business
- A super Trustee

3. You provide information

Before insurance is issued, you must provide information about your health and individual circumstances. This determines if you can be insured, or if special terms need to apply.

When answering the questions we ask, you have a duty to take reasonable care not to make a misrepresentation. This means you must take reasonable care to answer our questions accurately, to the best of your knowledge.

If you don't comply with your duty, you or your beneficiaries may not be paid a benefit when you need it most.

All the information you need about your duty to take reasonable care not to make a misrepresentation is on pages 114 - 115.

4. You pay a premium

Your premium is the amount you pay for your insurance.

Generally your premiums will be higher when you're:

- insured for higher amounts (sum insured) or for multiple types of insurance, or
- more likely to make a claim (risk of claim).

Premiums are recalculated each year. For more information about premiums see pages 41 – 45.

Some factors that impact your premium amount

Age

Smoking status

Gender

Occupation

Health and medical history

Lifestyle and leisure activities

5. You're insured

Your insurance continues until you cancel it, you don't pay your premiums, it expires or a nominated event occurs that ends it.

For information about when your insurance ends, see the general termination events sections of this PDS on pages 71 – 72 and page 88.

Some insurance terms may change at certain dates – eg at the Review Date after the life insured turns 65, the terms you can claim under for TPD and Income Protection insurance change. The changes are described in the relevant terms and conditions which start from page 54.

Worldwide insurance

Acenda insurance travels with you, which means you're insured 24 hours a day, anywhere in the world.

6. You (or your beneficiaries) make a claim

You or your beneficiaries can make a claim if a claimable event occurs while you're insured.

Some insurances have:

- Exclusions (events or conditions you're not insured for), or
- Exclusion Periods (defined periods of time after a policy starts, or when cover is increased or reinstated and claims for certain events aren't payable), or
- Waiting Periods (defined periods of time after a claimable event during which the claim is not yet payable).

6. You (or your beneficiaries) make a claim *(continued)*

All insurances have specific definitions that must be satisfied before a benefit will be payable.

Some insurances also require a medical condition or disability to reach a specific level of severity. For example:

- For Critical Illness insurance, you must be diagnosed with a non-surgical Critical Condition or have a surgical procedure in respect of a surgical Critical Condition. A Critical Condition is one of a number of specific medical conditions each with a special definition (such as Heart Attack). Many Critical Condition definitions involve specific levels of severity that must be reached; or
- For Income Protection insurance, you must be Totally Disabled or Partially Disabled as defined by us. The definition can vary after two years on claim, depending on the Income Protection type and options you choose. The definition could require a greater level of disability severity at this time, or use a broader assessment to consider any reasonably suited occupation.

For more information about what you can and can't claim for, see the Summary of the terms and conditions section of this PDS on pages 54 – 88.

7. Paying benefits

If your claim is approved the benefit is paid. The insurance terms and conditions describe if the benefit paid is:

- the sum insured for that particular insurance, or
- a proportion of the sum insured, or
- another specified amount.

Our offer

Our offer at a glance

Acenda products

- **MLC Insurance -** available outside super.
- **MLC Insurance (Super) -** available inside super through the Smart Future Trust.
- **MLC Insurance (Wrap or SMSF) -** available inside super for eligible super wrap accounts and self-managed super funds.

You can quickly see when an insurance type is available inside or outside super (or both) using the symbols below.

INSIDE SUPER — Inside Super

OUTSIDE SUPER — Outside Super

INSIDE OUTSIDE SUPER — Inside/Outside Super

Types of insurance available

Insurance we offer	Summary	Find out more
Life Cover INSIDE OUTSIDE SUPER	To provide a lump sum payment if you die or are diagnosed with a Terminal Illness.	Page 18
Total and Permanent Disability (TPD) INSIDE OUTSIDE SUPER	To provide a lump sum payment if you suffer Total and Permanent Disability and can't work again.	Pages 20 - 21
Critical Illness OUTSIDE SUPER	To provide a lump sum payment if you're diagnosed with a non-surgical Critical Condition or have a surgical procedure for a surgical Critical Condition (also known as trauma insurance). Types available: • **Critical Illness Standard** (our standard level of insurance) • **Critical Illness Plus** (our highest level of insurance)	Pages 22 - 26
Child Critical Illness OUTSIDE SUPER	To provide a lump sum payment if your child dies, is diagnosed with a specific non-surgical Critical Condition or undergoes a surgical procedure for a surgical Critical Condition.	Pages 28 - 29
Occupationally Acquired HIV, Hepatitis B or C Infection OUTSIDE SUPER	To provide a lump sum payment for medical professionals who are accidentally infected with HIV, Hepatitis B or Hepatitis C at work.	Page 30
Income Protection INSIDE OUTSIDE SUPER	To replace part of your income if you can't work due to sickness or injury. Types available: • ***Income Assure*** (our standard level of insurance) • ***Income Assure+*** (our highest level of insurance)	Pages 32 - 33
Business Expenses OUTSIDE SUPER	To insure certain business expenses if you can't work due to sickness or injury. Types available: • **Business Expenses** (our standard level of insurance) • **Business Expenses Platinum Option** (our highest level of insurance)	Page 34

Insurance in super at Acenda

In this PDS insurance **inside super** refers to all types of insurance that can be held in super, regardless of who the Trustee is.

You can choose to hold insurance and pay premiums through super.

Acenda issues the policy to the Trustee, who owns it on your behalf. You are both the life insured and a member of your fund.

Importantly, for benefits to be paid to you or your beneficiaries, for your insurance in super you will need to meet both:

- the insurance terms and conditions, and
- a condition of release set by super law.

More information about the conditions of release is on page 50.

Holding your policy in a super fund

Acenda has an arrangement with Equity Trustees Superannuation Limited ABN 50 055 641 757 AFSL 229757, who is the Trustee of the Smart Future Trust (the Fund) ABN 68 964 712 340 to make MLC Insurance (Super) available to you through the Fund.

For details about:

Equity Trustees Superannuation Limited and Smart Future Trust	Please refer to the PDS titled: Smart Future Trust – Retail Insurance in Super: for MLC Insurance (Super) Product Disclosure Statement
Eligible super wrap accounts	Please refer to the PDS for the eligible super wrap account you hold or are taking out.
your own SMSF	Please refer to your fund trust deed.

When considering holding your insurance in super you should consider:

- the type of cover you want
- how you want to pay for your insurance, and
- whether the benefits are paid through a Trustee or directly to you or your beneficiaries.

You should get specific guidance from your financial adviser when making this important decision.

Review Dates

Policies are reviewed by us each year on the Review Date. Generally, policies will continue in force from the Review Date until they expire or a termination event occurs.

In some cases, from the Review Date:

- Your policy terms and conditions may change. This may happen, for example, if:
  - we have updated our Critical Illness Standard insurance offering since the last Review Date, or
  - you turned age 65 since the last Review Date; or
- Your premium may change. For example, this happens because you have had a birthday, if Inflation Proofing applies to your policy, or if our premium rates have changed since the last Review Date.

Structuring your insurance

For some insurance, you can choose what will happen to the sum insured on your other insurances after we pay a claim.

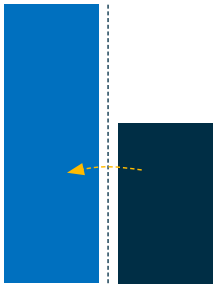
Stand-alone

For stand-alone insurance, a claim on one insurance doesn't impact the sum insured for the other insurance. Premiums are higher than for Extension / Connection insurance.

Extension

Extensions are on one policy.

Connection



Connections are across two policies.

A claim on one insurance reduces the sum insured of the other insurance. Premiums are lower than for stand-alone insurance.

You choose the claim structure when you first take out your insurance so please talk to your financial adviser about what would suit you best.

For the claim structures available on each insurance, see Key information about your insurance on pages 18 - 34.

What you need to know about the risks

There is a risk that the insurance you choose won't meet your needs.

Your financial adviser can assess your circumstances and help you choose the types of insurance and sums insured that best suit your needs.

It's important to consider your future needs now as you may not qualify for some insurances if your health or circumstances change.

If you're replacing part or all of any insurance you hold, you should compare the differences between the existing and replacement policies. Please also consider exclusion periods which may apply from the start of the replacement insurance. Benefits may be limited or not paid if you suffer a claimable event in an exclusion period.

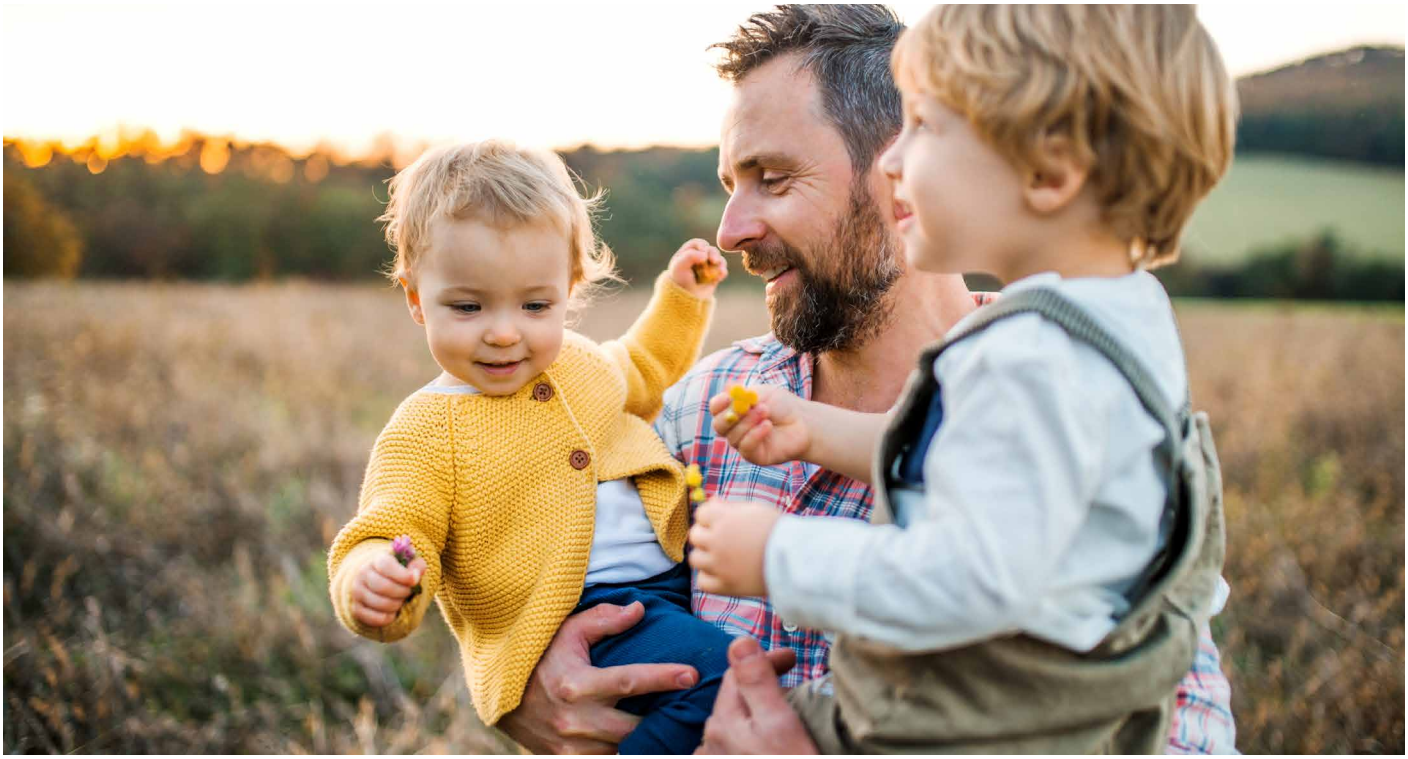
Need help?

Please speak with your financial adviser or call us on **13 65 25**.

For hearing impaired customers, please call **1300 555 727**.

For customers requiring interpreting or translation services, please call **131 450**.

Insurance in action
Case study 1



Jack decides what insurance is right for him

Jack is fast approaching his 40th birthday. He decided it's time to get insurance to protect his wife and two kids in the event he dies or can't work anymore.

Talking with his financial adviser, Jack decides he needs the following from Acenda:

LC **Life Cover**	$750,000 (inside his super)	INSIDE SUPER
TPD **Total and Permanent Disability (TPD)**	$500,000 (inside his super)	INSIDE SUPER
CI **Critical Illness**	$500,000 (outside his super) *(For extra protection, Jack chose Acenda's Critical Illness Plus.)*	OUTSIDE SUPER

Ways Jack reduces his premiums

- **He chooses to pay some of his insurance premiums through his super**, which will help him save money by taking advantage of available tax concessions. This is because he isn't paying all of his premiums from his after-tax income or savings.
- **He adds TPD as an Extension to Life Cover**. Linking these two policies means that if Jack claims on TPD, his Life Cover reduces by the same amount. He can buy back his full Life Cover 12 months after a TPD benefit is paid. Jack has kept his Critical Illness cover as stand alone so it won't be affected by any TPD claim.

Jack makes a claim

When Jack turns 45 years old he's diagnosed with Parkinson's Disease. His Acenda insurance policy is still in place as he has continued to pay his premiums. He meets the necessary medical definition of Parkinson's Disease and he claims on his Critical Illness insurance.

Acenda pays Jack:

- **A $500,000 lump sum from his Stand-alone Critical Illness insurance**

After several months, Jack's Parkinson's Disease has progressed to such an extent, that he can no longer work and he meets the applicable definition of Totally and Permanently Disabled.

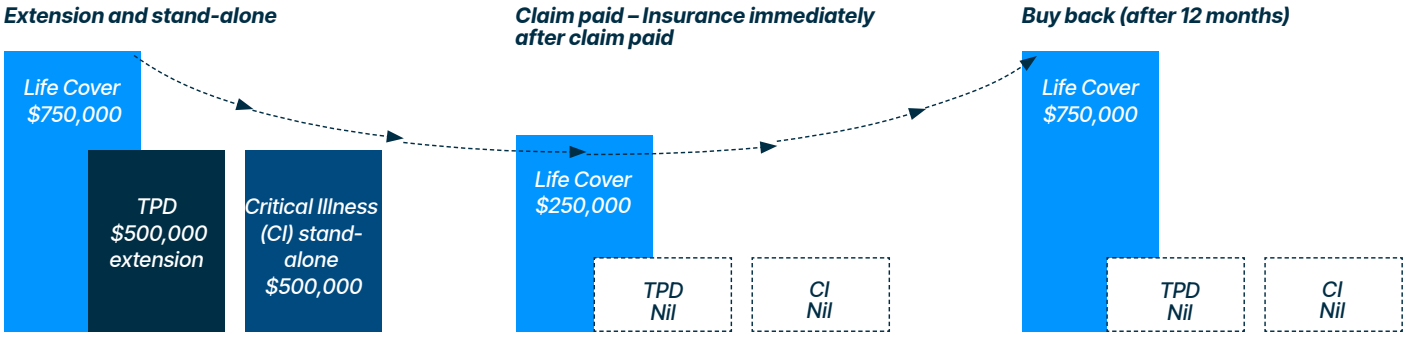
Acenda pays Jack:

- **$500,000 lump sum from his Extension TPD.** Since his TPD is an extension of his Life Cover, Jack's claim reduces his Life Cover by the same amount. It is now reduced from $750,000 to $250,000.

After 12 months Jack can buy back his full Life Cover so he is again insured for $750,000.

What happened to Jack's insurance when he claimed?

Jack's policy structure



Jack takes TPD as an Extension to Life Cover, and Critical Illness as stand-alone.

When a benefit is paid for both TPD and Critical Illness, his Life Cover is reduced by the TPD Extension, but not by the Critical Illness as it is stand-alone.

After 12 months Jack can buy back his full Life Cover so he is again insured for $750,000.

The above is an example for illustrative purposes only and the outcome for you will depend on your circumstances and the terms of your policy.

Insurance in action
Case study 2

Anika makes an *Income Assure* with Severe Disability claim

Anika worked as a paralegal in a large law firm. Her Acenda insurance policy is still in place as she has continued to pay her premiums since taking out her policy at the age of 29.

At the age of 33, she suffers a major stroke.

Anika had some sick leave available from her employer. When structuring her insurance with her financial adviser they agreed that because of this sick leave, a 90-day Waiting Period was the right option for her.

Anika's disabilities from her stroke stop her from performing her occupation as a paralegal and after her 90-day Waiting Period, she starts to receive a benefit of $6,000 per month (representing a proportion of her usual income).

Under Anika's *Income Assure* insurance, after two years of receiving benefits, she must be Severely Disabled in order to continue receiving benefits.

Unfortunately, Anika's condition has not improved and after two years she does meet the definition of Severely Disabled.

Being Severely Disabled and unable to work as a paralegal or in any other occupation she's qualified for, Anika continues to receive monthly benefits, and will likely continue to qualify for benefits until she reaches age 65, when her *Income Assure* insurance expires.

The above is an example for illustrative purposes only and the outcome for you will depend on your circumstances and the terms of your policy.

Insurance in action
Case study 3

Richard makes an *Income Assure+* claim

Richard is a hospital nurse with Acenda Income Protection insurance. On a surfing trip, he suffers a shoulder injury that requires reconstructive surgery with lingering complications.

As his ward nursing role requires him to move patients, the surgery stopped Richard from performing his own occupation.

Acenda pays him an Income Protection benefit of $4,000 per month after his waiting period.

As time goes by, Richard still can't go back to nursing on the ward due to ongoing shoulder complications that meant that he would never regain full use of his shoulder/arm. However, leading up to the one year mark, Richard, his employer and Acenda work together to identify other opportunities that Richard can perform within his restrictions. Richard returns to some part-time modified duties, and with ongoing rehabilitation his condition slowly improves, resulting in Richard increasing his hours gradually.

While working part-time, Richard is paid Partial Disability benefits (being a proportion of his $4,000 monthly benefit that takes into account the income he is now earning).

After 24 months on claim, Richard has now returned to pre-disability hours in his modified occupation, resulting in his earning reaching more than 80% of his pre-disability income. Acenda ceases the claim.

The above is an example for illustrative purposes only and the outcome for you will depend on your circumstances and the terms of your policy.

2

Key information about your insurance

Life Cover insurance

A lump sum is payable if you die or you're diagnosed with a Terminal Illness

Application age (next birthday)

outside super: 11 - 70
inside super: 16 - 70

For Terminal Illness Support insurance option: 19 - 60

For Business Safeguard Option: 19 - 60

Expiry age (insurance expires on the Review Date after reaching the age noted below)

Outside super: 100

Inside super: 74 (at which time a conversion option is available to continue as a non-super policy. This expires on the Review Date after age 100). You'll find more information on pages 46 - 47.

For Terminal Illness Support insurance: 65

For Business Safeguard Option: 65. You'll find more information on pages 57 - 58.

Minimum sum insured

$25,000

Maximum sum insured

No general maximum, but special terms may apply for benefits greater than $15 million.

For Terminal Illness Support insurance option: Lesser of $250,000 and 50% of Life Cover insurance

For Business Safeguard Option: $15 million

Claim structures available

✔ Stand-alone
✘ Extension/Connection

You'll find more information on page 54.

Life Cover insurance pays a benefit if you die or are diagnosed with a Terminal Illness (as defined on page 113) while you are insured.

Life Cover insurance - benefits, features and options

Details are available at the page number listed.

Benefit(s)	Feature(s)	Option(s)
Life Cover Benefit INSIDE OUTSIDE SUPER Page 65	**Increases without further medical evidence** INSIDE OUTSIDE SUPER Pages 64 - 65	**Terminal Illness Support insurance** INSIDE OUTSIDE SUPER Page 67
Terminal Illness Benefit INSIDE OUTSIDE SUPER Page 67	**Economiser** INSIDE OUTSIDE SUPER Pages 63 - 64	**Business Safeguard Option** INSIDE OUTSIDE SUPER Pages 57 - 58
Specific Accidental Injury Benefit INSIDE OUTSIDE SUPER Pages 56 - 57	**Inflation Proofing** INSIDE OUTSIDE SUPER Page 44	**Premium Waiver insurance** INSIDE OUTSIDE SUPER Pages 66 - 67, and 70
Advance Death Benefit OUTSIDE SUPER Page 57		
Financial Planning Benefit OUTSIDE SUPER Page 64		

Please refer to pages 54 – 70 for the terms, conditions and exclusions that apply to Life Cover insurance.

Total and Permanent Disability (TPD) insurance

A lump sum is payable if you become Totally and Permanently Disabled

Application age (next birthday)

Stand-alone and Extension to Life Cover: 16 - 60

Extension to Critical Illness : 19 - 60

Expiry age (insurance expires on the Review Date after reaching the age noted below)

Outside super

Stand-alone and Extension to Life Cover: 100

Extension to Critical Illness: 65

Inside super

Extension to Life Cover: 74 (at which time a conversion option is available to continue as a non-super policy, which expires on the Review Date after age 100).

Extension to Critical Illness: 65

You'll find more information on page 54.

Minimum sum insured

$25,000

Maximum sum insured

Stand-alone and Extension to Life Cover: $5 million for certain professional occupations (such as surgeons, accountants and solicitors).

$3 million for other occupations. You'll find more information on page 67.

Extension to Critical Illness: $2 million

Claim structures available

✔ Stand-alone *(outside super only)*

✔ Extension/Connection

You'll find more information on page 54.

TPD insurance pays you a benefit if you become Totally and Permanently Disabled while insured. You must meet the complete definition of TPD that applies to you for a benefit to be payable.

TPD insurance settings you choose

Below we have provided an overview of the difference between the TPD definitions you can choose when applying for insurance. You'll need to meet the complete TPD definition that applies to you for a benefit to be payable. The full list of definitions, and information about which definition applies, is available at the page numbers listed below.

Definition setting	Overview
Own Occupation OUTSIDE SUPER Page 101 and page 112	When assessing your claim, we'll assess your likely ability to work again in your own occupation, even if you may be able to work in another occupation.
Any Occupation INSIDE OUTSIDE SUPER Pages 100 - 101 and page 109	We'll assess your likely ability to work again in not only your occupation, but also any occupation that you're reasonably suited to by your education, training or experience.

However, if you're performing full-time domestic duties or child rearing at the time you apply for insurance, and for the 12 months prior to disability and at the time disability begins, we'll instead assess your likely ability to perform Normal Physical Domestic Duties.

You can also package Any and Own Occupation insurance for cost efficiencies.

TPD Optimiser INSIDE OUTSIDE SUPER Pages 67 - 68	This efficiently packages your insurance inside super (under an Any Occupation definition) with a policy outside super (with an Own Occupation definition).

A more restrictive TPD definition applies from the Review Date after you turn 65

From the Review Date after you turn 65, the definition used to assess your claim will change to Loss of Independence.

Loss of Independence INSIDE OUTSIDE SUPER Pages 102 - 103	After age 65, your eligibility to be paid a benefit will be assessed on non-work based criteria.

TPD insurance inside or outside super:

If you choose to have your insurance inside super there are extra conditions that apply (refer to Permanent Incapacity on page 112).

TPD insurance - benefits, features and options

Details are available at the page number listed.

Benefit(s)	Feature(s)	Option(s)
Total and Permanent Disability Benefit (INSIDE OUTSIDE SUPER) Pages 100 - 103	**Increases without further medical evidence** (INSIDE OUTSIDE SUPER) Pages 64 - 65	**Double TPD (Life Cover Buy Back with Premium Waiver)** (INSIDE OUTSIDE SUPER) Page 63
Partial Payment Benefit (OUTSIDE SUPER) Page 66	**12-month Life Cover Buy Back** (INSIDE OUTSIDE SUPER) Pages 55 - 56	**14-day Life Cover Buy Back Option** (INSIDE OUTSIDE SUPER) Page 56
Death Benefit (TPD stand-alone only) (OUTSIDE SUPER) Page 62	**Economiser** (INSIDE OUTSIDE SUPER) Pages 63 - 64	**Business Safeguard Option** (INSIDE OUTSIDE SUPER) Pages 57 - 58
Financial Planning Benefit (OUTSIDE SUPER) Page 64	**Inflation Proofing** (INSIDE OUTSIDE SUPER) Page 44	**Premium Waiver insurance** (INSIDE OUTSIDE SUPER) Pages 66 - 67, and 70

Please refer to pages 54 - 70 for the terms, conditions and exclusions that apply to TPD insurance.

Critical Illness insurance

A lump sum is payable if you have a condition which meets one of our Critical Condition definitions

Application age (next birthday)

19 - 60

Expiry age (insurance expires on the Review Date after reaching the age noted below)

75

Minimum sum insured

$25,000

Maximum sum insured

$2,000,000

Claim structures available

✔ Stand-alone
✔ Extension/Connection

You'll find more information on page 54.

Critical Illness insurance pays you a benefit if you are diagnosed with a specified non-surgical medical condition or undergo a surgical procedure for a specified surgical medical condition. The specified medical conditions are referred to in this PDS as Critical Conditions. We define all Critical Conditions in a particular way and our Critical Condition definition must also be fully met while you are insured before a benefit is payable.

Note: You are taken to have a surgical Critical Condition on the date the surgery happens, provided that the surgical procedure meets the Critical Condition definition. The surgery must occur while you are insured.

You are taken to have a non-surgical Critical Condition on the date a Doctor first provides a diagnosis of the condition as meeting the Critical Condition definition. The diagnosis must occur while you are insured.

Types of Critical Illness insurance

CI **Critical Illness Standard**

Critical Illness Standard provides our standard level of insurance, which insures fewer Critical Conditions. It cannot be taken out as stand-alone insurance.

While we may make improvements to the Critical Condition definitions in your favour, we may also change the types of Critical Conditions covered or Critical Condition definitions as advances are made in treatment and diagnostic techniques, to ensure they:

- remain appropriate with regard to medical terminology and classification;
- take into account effective cures, vaccines and modern diagnostic procedures;
- include some diseases considered appropriate in the future; and
- exclude some diseases which are found to have become minor in the future.

We will let you know if we make a change. Changes will apply to all policy owners. You won't be singled out for a change.

For more information see page 60.

CI+ **Critical Illness Plus**

Critical Illness Plus provides our highest level of insurance with the most Critical Conditions insured.

Your Critical Condition definitions will only change where we improve them in your favour.

For more information see page 60.

Important information about Critical Illness insurance

In the case of stand-alone insurance, you'll receive your full Critical Illness insurance benefit if you survive for 14 days after being diagnosed with a non-surgical Critical Condition or you undergo a surgical procedure for a specified surgical medical condition.

Please refer to pages 90 - 98 for the definitions of Critical Conditions.

Critical Illness insurance - benefits, features and options

Details are available at the page number listed.

Available on both Critical Illness Plus and Critical Illness Standard

Available on Critical Illness Plus only

Benefit(s)		Feature(s)		Option(s)	
Critical Illness Benefit Pages 90 - 98		**Increases without further medical evidence** Pages 64 - 65		**Extra benefits option – partial Benefits** Page 26	
Death Benefit (Stand-alone only) Pages 61 - 62	OUTSIDE SUPER	**Economiser** Pages 63 - 64	OUTSIDE SUPER	**Double Critical Illness (Life Cover Buy Back with Premium Waiver)** (Extension / Connection only) Pages 62 - 63	
Child Support Benefit Pages 59 - 60		**Inflation Proofing** Page 44		**12-month Life Cover Buy Back** (Extension / Connection only) Page 55	OUTSIDE SUPER
Financial Planning Benefit Page 64				**Critical Illness Buy Back** Pages 60 - 61	
				Business Safeguard Option Pages 57 - 58	
				Premium Waiver insurance Pages 66 - 67, and 70	

Critical Illness insurance

Requirements for a Benefit to be paid

Insurance for some Critical Conditions has an initial Exclusion Period.

This means that you won't be insured for Critical Conditions that first appear, first happen or are first diagnosed in that Exclusion Period.

If your insurance is replacing similar insurance, we will calculate the Exclusion Period from the start date of the replaced similar insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the Exclusion Period this way on the amount of insurance you replaced.

An appropriate Specialist and our medical adviser must both agree that our definition for the Critical Condition you are claiming for has been fully met. This may require your condition to have reached a specified level of severity. In the case of a surgical condition, confirmation that the surgery has been performed will be required.

The following table sets out the Critical Conditions insured by Critical Illness Standard and Plus, and any Exclusion Periods that apply. The definitions of the Critical Conditions can be found in the Key medical and disability definitions section on pages 90 - 98.

Critical Conditions	Critical Illness Standard	Critical Illness Plus	Exclusion Period
Aorta Repair – excluding less invasive surgeries		Y	3 months
Aplastic Anaemia – of specified severity		Y	N
Bacterial Meningitis – of specified severity		Y	N
Benign Brain Tumour – of specified severity		Y	N
Blindness – of specified severity		Y	N
Cancer – excluding specified early stage cancers	Y	Y	Standard: 6 months Plus: 3 months
Cardiomyopathy – of specified severity		Y	N
Chronic Kidney Failure – requiring permanent dialysis or transplantation		Y	N
Chronic Liver Failure – of specified severity		Y	N
Chronic Lung Failure – of specified severity		Y	N
Coma – with specified criteria		Y	N
Coronary Artery Angioplasty*		Y	3 months
Coronary Artery Angioplasty - Three or More Different Coronary Arteries.		Y	3 months
Coronary Artery Bypass Surgery – excluding less invasive procedures	Y	Y	3 months
Deafness – permanent		Y	N
Dementia or Alzheimer's Disease – permanent and of specified severity		Y	N
Encephalitis – of specified severity		Y	N
Heart Attack – with evidence of heart muscle damage	Y	Y	3 months
Heart Valve Surgery – of specified severity		Y	3 months
HIV Contracted Through Medical Procedures		Y	N
HIV Contracted Through Your Work		Y	N
Intensive Care – requiring continuous mechanical ventilation for 7 days		Y	N
Loss of Independence – of specified severity	Y	Y	N
Loss of Speech – total and permanent		Y	N
Major Brain Injury – of specified severity		Y	N
Major Burns – of specified severity		Y	N

Critical Conditions	Critical Illness Standard	Critical Illness Plus	Exclusion Period
Major Organ or Bone Marrow Transplant		Y	N
Meningococcal Septicaemia – of specified severity		Y	N
Motor Neurone Disease – unequivocal diagnosis		Y	N
Multiple Sclerosis – of specified severity		Y	N
Muscular Dystrophy – unequivocal diagnosis		Y	N
Open Heart Surgery		Y	N
Out of Hospital Cardiac Arrest		Y	N
Paralysis – permanent and of specified severity		Y	N
Parkinson's Disease – of specified severity		Y	N
Parkinson-Plus Syndrome – unequivocal diagnosis		Y	N
Pneumonectomy – complete removal of entire lung		Y	N
Primary Pulmonary Hypertension – of specified severity		Y	N
Severe Diabetes – of specified severity		Y	N
Severe Osteoporosis – before age 50 and of specified severity		Y	N
Severe Rheumatoid Arthritis – of specified severity		Y	N
Stroke – in the brain and of specified severity	Y	Y	3 months

* Coronary Artery Angioplasty – This benefit will only apply if your Critical Illness benefit is $100,000 or more. The benefit payable for Coronary Artery Angioplasty is 10% of your Critical Illness benefit up to $20,000 per event. For more information on this condition, please see Critical Illness definitions on pages 90 - 98.

Critical Illness insurance

Extra benefits option – partial benefits

This option is available with Critical Illness Plus insurance. You'll be paid a partial (20%) benefit for the additional Critical Conditions insured, subject to the maximum partial benefit payable listed in the table on this page.

This benefit is only payable if it's at least $10,000.

Your Critical Illness insurance will be reduced by the amount of any partial benefit payment made for these additional Critical Conditions.

You can only claim once for each Critical Condition.

The specific definitions of these Critical Conditions, including the level of severity required for benefits to be payable, are described on pages 90 - 98.

Additional critical conditions	Exclusion Period	Maximum partial benefit
Adult Onset Insulin Dependent Diabetes Mellitus	N	$200,000
Deafness in One Ear – permanent	N	
Early Stage Benign Brain Tumour – of specified type	N	
Loss, or Loss of Use, of One Foot or One Hand – total and irrecoverable	N	
Loss of Sight in One Eye – of specified severity	N	
Advanced Endometriosis – of specified severity	N	$100,000
Carcinoma In Situ of the Breast – of specified severity	3 months	
Early Stage Chronic Lymphocytic Leukaemia – of specified severity	3 months	
Early Stage Prostate Cancer – of specified severity	3 months	
Facial Reconstructive Surgery and Skin Grafting – of specified severity	N	
Serious Accidental Injury – requiring 30 consecutive days of acute care hospital confinement.	N	
Congenital Abnormalities of a Child – of specified severity	12 months	$50,000
Inability of a Child to Gain Independence – of specified severity	12 months	
Intensive Care – requiring continuous mechanical ventilation of 5 days	N	
Carcinoma In Situ of the Female Reproductive Organs – of specified severity	3 months	$20,000
Early Stage Melanoma – of specified severity	3 months	
Guillain-Barre Syndrome – of specified severity	N	
Orchidectomy (as Required to Diagnose Carcinoma In Situ Of the Testicle) – with specific requirements	3 months	
Specified Complications of Pregnancy	12 months	

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6

Child Critical Illness insurance

A lump sum is payable if your child has a condition which meets one of our Critical Condition definitions

Application age (next birthday)

3 - 18 (age of your child)

Expiry age (insurance expires on the Review Date after reaching the age noted below)

21 (age of your child)

Minimum sum insured

$10,000

Maximum sum insured

$200,000

You can insure a maximum of 5 children.

Claim structures available

✔ Stand-alone

✘ Extension/Connection

You'll find more information on page 54.

You can only apply for Child Critical Illness insurance if the child's parent or guardian holds one of the following:

- Life Cover insurance;
- Total and Permanent Disability insurance;
- Critical Illness insurance;
- Income Protection insurance; or
- Business Expenses insurance.

Child Critical Illness insurance pays you a benefit if your Child is diagnosed with a specified non-surgical medical condition or undergoes a surgical procedure for a specified surgical medical condition. Such specified medical conditions are referred to in this PDS as Critical Conditions. We define all Critical Conditions in a particular way and our Critical Condition definition must also be fully met while you are insured before a benefit is payable.

Note: Your Child is taken to have a surgical Child Critical Condition on the date the surgery happens, provided that the surgical procedure meets the Child Critical Condition definition. The surgery must occur while you are insured.

Your Child is taken to have a non-surgical Child Critical Condition on the date a Doctor first provides a diagnosis of the condition as meeting the Child Critical Condition definition. The diagnosis must occur while your Child is insured.

Child Critical Illness insurance – benefits, features and options

Details are available at the page number listed.

Benefit(s)	Feature(s)	Option(s)
Child Critical Illness Benefit OUTSIDE SUPER Page 60	**Conversion to an adult policy** OUTSIDE SUPER Page 60	**Premium Waiver insurance** OUTSIDE SUPER Pages 66 - 67, and 70
Financial Planning Benefit OUTSIDE SUPER Page 64		

Important information about Child Critical Illness insurance

Where you make a Critical Illness claim for cancer, a heart attack or a stroke, we will assess your claim against the most favourable to you of:

- the applicable Critical Condition definition in our PDS/Policy Document linked to the full benefit amount; and
- if different, the corresponding medical definition in the Life Insurance Code of Practice (The Code) that is current at the time the claimable event occurs.

Please refer to page 29 for the terms, conditions and exclusions that apply to Child Critical Illness insurance and pages 90 - 98 for the definitions of the Critical Conditions.

Requirements for Benefits to be paid

Insurance for some Critical Conditions starts after an initial Exclusion Period. This means that you won't be insured for Critical Conditions that first appear, first happen or are first diagnosed in the Exclusion Period.

If your insurance is replacing similar insurance, we will calculate the Exclusion Period from the start date of the replaced similar insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the Exclusion Period this way on the amount of insurance you replaced.

An appropriate Specialist and our medical adviser must both agree that the definition for the Critical Condition you are claiming for has been fully met. This may require your child's condition to have reached a specified level of severity. In the case of a surgical condition, confirmation that the surgery has been performed will be required.

The following table sets out the Critical Conditions insured by Child Critical Illness insurance, and any Exclusion Periods that apply.

Child Critical Condition	Exclusion Period
Aplastic Anaemia – of specified severity	N
Bacterial Meningitis – of specified severity	N
Benign Brain Tumour – of specified severity	N
Blindness – of specified severity	N
Cancer – excluding specified early stage cancers	3 months
Cardiomyopathy – of specified severity	N
Chronic Kidney Failure – requiring permanent dialysis or transplantation	N
Chronic Liver Failure– of specified severity	N
Coma – with specified criteria	N
Deafness – permanent	N
Encephalitis– of specified severity	N
Heart Attack – with evidence of heart muscle damage	3 months
Heart Valve Surgery – of specified severity	3 months
HIV Contracted Through Medical Procedures	N
Intensive Care – requiring continuous mechanical ventilation for 7 days	N
Loss of Speech – total and permanent	N
Major Brain Injury – of specified severity	N
Major Burns – of specified severity	N
Major Organ or Bone Marrow Transplant	N
Meningococcal Septicaemia – of specified severity	N
Open Heart Surgery	N
Out of Hospital Cardiac Arrest	N
Paralysis – permanent and of specified severity	N
Pneumonectomy – complete removal of entire lung	N
Primary Pulmonary Hypertension – of specified severity	N
Stroke – in the brain and of specified severity	3 months

Occupationally Acquired HIV, Hepatitis B or C Infection insurance

A lump sum is payable for a medical professional accidentally infected with Human Immunodeficiency Virus (HIV), Hepatitis B or Hepatitis C at work

Application age (next birthday)

19 - 60

This insurance is only available for certain medical occupations such as doctors, surgeons, dentists, nurses and ambulance officers.

Your adviser can help you work out if your occupation is eligible.

Expiry age (insurance expires on the Review Date after reaching the age noted below)

70

Minimum sum insured

$25,000

Maximum sum insured

$1,000,000

Claim structures available

✔ Stand-alone

✘ Extension/Connection

You'll find more information on page 54.

This insurance pays a benefit if, while insured, you become infected with HIV, Hepatitis B or Hepatitis C as a result of an accidental incident while at work and performing the normal duties of your occupation.

Occupationally Acquired HIV, Hepatitis B or C Infection insurance - benefits, features and options

Details are available at the page number listed.

Benefit(s)	Feature(s)	Option(s)
Occupationally Acquired HIV, Hepatitis B or C Infection insurance Benefit OUTSIDE SUPER Pages 65 - 66		**Premium Waiver insurance** OUTSIDE SUPER Pages 66 - 67, and 70
Financial Planning Benefit OUTSIDE SUPER Page 64		

Please refer to pages 65 - 66 for the terms, conditions and exclusions that apply to Occupationally Acquired HIV, Hepatitis B or Hepatitis C Infection insurance.

Income Protection insurance

A monthly benefit is payable if you can't work due to sickness or injury

Application age (next birthday)

19 - 60

Expiry age (insurance expires on the Review Date after reaching the age noted below)

Outside super

Income Assure	70
Income Assure+	70

Special terms apply to insurance after age 65. See pages 78 - 79 and page 88 for details.

Inside super: 65. Insurance can continue to age 70 subject to special conditions. See pages 78 - 79 and page 88.

Minimum sum insured

A monthly benefit of $1,500

Maximum sum insured

A monthly benefit of $30,000

You'll find more information on page 73.

Claim structures available

✔ Stand-alone

✘ Extension/Connection

You'll find more information on page 54.

Income Protection insurance pays a monthly benefit if you are Totally Disabled or Partially Disabled for the longer than the Waiting Period while insured.

Types of Income Protection insurance

Income Assure provides our standard level of insurance. For more information see pages 105 - 106.

Note: for people in certain hazardous occupations:

- *Income Assure* is the only type of insurance available; and
- the choice of Waiting Period and benefit period will be restricted (as described in Income Protection settings below).

Income Assure+ provides our highest level of insurance.

For more information see pages 104 - 105.

Income Protection settings

1. Choice of Waiting Period

Income Assure	*Income Assure+*
14 days	
30 days#	
90 days#	
1 year	
2 years	

There is a Waiting Period before your benefit is paid.

A shorter Waiting Period means your benefit will be paid sooner.

Your premiums will generally be higher for shorter Waiting Periods.

You'll find more information on page 113.

2. Choice of benefit period

Income Assure	*Income Assure+*
2 years#	
5 years#	
Up to age 65	
	Up to age 70

Your benefit period is the maximum period you'll receive your monthly benefit for.

A longer benefit period means your benefit can be paid for a longer time period.

Your premiums will generally be higher for longer benefit periods.

for people in certain hazardous occupations:

- The Waiting Periods available are 30 days and 90 days only, and
- The benefit periods available are 2 years and 5 years only.

Please refer to pages 73 - 88 for the terms, conditions and exclusions that apply to Income Protection insurance, and pages 104 - 106 for the definitions of Total Disability and Partial Disability.

Income Protection insurance — Benefits, Features and Options

Details are available at the page number listed.

- Available on all types of income protection
- Available for *Income Assure* only
- Available for *Income Assure*+ only

Benefit(s)	Feature(s)	Option(s)
Total Disability Benefit Pages 104 - 105 — INSIDE OUTSIDE SUPER	**Premium Waiver** Page 83 — INSIDE OUTSIDE SUPER	**Available on all types of income protection**
Partial Disability Benefit Pages 104 - 106 — INSIDE OUTSIDE SUPER	**Return to work during the Waiting Period** Page 76 — INSIDE OUTSIDE SUPER	**Super Guarantee Benefit** Page 75 — INSIDE OUTSIDE SUPER
Rehabilitation Expenses Page 83 — OUTSIDE SUPER	**Waiting Period Conversion** Page 86 — INSIDE OUTSIDE SUPER	**Indexed Claim Benefit** Page 79 — INSIDE OUTSIDE SUPER
Death Benefit Page 78 — INSIDE OUTSIDE SUPER	**Recurring Disability** Page 83 — INSIDE OUTSIDE SUPER	**Available for *Income Assure*+ only**
Cover for Elective Surgery Page 78 — INSIDE OUTSIDE SUPER	**Increases without further medical evidence** Page 79 — INSIDE OUTSIDE SUPER	**Booster Option** Page 78 — INSIDE OUTSIDE SUPER
	Extended Cover to age 70 Pages 78 - 79 — INSIDE OUTSIDE SUPER	**Short Waiting Period for Accidental Injury and Critical Illness** Page 84 — INSIDE OUTSIDE SUPER
	Inflation Proofing Page 44 — INSIDE OUTSIDE SUPER	**Available for *Income Assure* only**
		Severe Disability Terms Removal Option Page 83 — INSIDE OUTSIDE SUPER
		Short Waiting Period for Accidental Injury Page 84 — INSIDE OUTSIDE SUPER

Business Expenses insurance

A monthly benefit is payable for business expenses if you can't work due to sickness or injury

Application age (next birthday)

19 - 60

Expiry age (insurance expires on the Review Date after reaching the age noted below)

65

Minimum sum insured

A monthly benefit of $1,500

Maximum sum insured

A monthly benefit of $60,000

Claim structures available

✔ Stand-alone

✘ Extension/Connection

You'll find more information on page 54.

Business Expenses insurance will reimburse you for Covered Expenses of your Business if you are Totally Disabled for longer than the Waiting Period while insured.

Types of Business Expenses insurance

BE **Business Expenses** provides our standard level of insurance.

BEP **Business Expenses Platinum Option** provides increased insurance with an extended definition of Totally Disabled and the option to receive a benefit if you become Partially Disabled.

You'll find more information on page 106.

Business Expenses setting you choose

Choice of Waiting Period

You can choose a Waiting Period of 14 or 30 days.

Business Expenses insurance - benefits, features and options

Details are available at the page number listed.

▮ Available on Business Expenses Platinum only

Benefit(s)	Feature(s)	Option(s)
Total Disability Benefit - Business Expenses OUTSIDE SUPER Page 106	**Premium Waiver** OUTSIDE SUPER Page 83	▮ **Partial Disability Benefit** OUTSIDE SUPER Page 106
Death Benefit OUTSIDE SUPER Page 78	**Recurring Disability** OUTSIDE SUPER Page 83	
	Return to work during the Waiting Period OUTSIDE SUPER Page 76	
	Inflation Proofing OUTSIDE SUPER Page 44	

Please refer to pages 73 - 88 for the terms, conditions and exclusions that apply to Business Expenses Insurance, and page 106 for the definitions of Total Disability and Partial Disability.

3

Your insurance journey

Your insurance journey

In this section you'll find:

- Specific information you need to know about each stage of your insurance journey.

Here's a summary of what's in this section:

1. Choosing and buying your insurance *Pages 37 - 38*

Acenda offers a range of insurance to meet your needs. You choose the type of insurance you need and the amount you are insured for.

Your financial adviser can help you choose the insurance that's right for you. They'll provide you with a quote for the cost of the insurance and a copy of this PDS for you to read. They can help you complete the application.

What we cover in this section that you need to know:

- How to apply
- Nominating beneficiaries
- Payments to financial advisers and third parties

2. Assessment and underwriting *Page 39*

We assess your individual circumstances to determine if we can provide insurance, and if we need to apply special terms to your insurance.

We get in touch with you if we have any questions about your application.

What we cover in this section that you need to know:

- How your application is assessed
- Temporary insurance you have while we assess your application (Interim Accident Insurance)

3. Your insurance policy *Page 40*

When we accept your application we issue your policy. You will receive:

- an insurance Policy Document, which sets out the terms and conditions of your insurance, and
- a Policy Schedule which sets out details of what you're insured for (including the sum insured, specific settings and options selected, special terms that you have, etc.).

4. Your premiums *Pages 41 - 45*

Your premium is the amount you pay for your insurance. We recalculate your premiums each year and we send you a new Policy Schedule with details of your insurance for the year ahead, including your premium amount.

What we cover in this section that you need to know:

- Premiums and how they're calculated
- How do your premiums change each year
- Additional information: features, charges and terms

5. Updating your insurance *Pages 46 - 47*

We review your insurance and may update it in certain circumstances from time to time as described in this section. You should also review your insurance with your financial adviser and make changes in line with your needs.

What we cover in this section that you need to know:

- Guarantee of upgrade
- Changing your insurance
- Removing your insurance
- Insurance in super - continuing your policy past age 65
- Continuity of your insurance
- Transferring your insurance between non-super and super
- Converting MLC Insurance (Super) policies
- Replacing your existing insurance
- Cancelling your insurance

6. Making a claim *Page 49*

You or your beneficiaries can make a claim if a claimable event occurs while you're insured.

If you or your beneficiaries need to make a claim, please call us on **1300 125 246** as soon as possible. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**. We'll send out the necessary paperwork.

7. Paying benefits *Page 50*

If your claim is approved the benefit is paid. The insurance terms and conditions describe when the benefit paid will be:

- The sum insured for that insurance, or
- A proportion of the sum insured, or
- Another specified amount.

What we cover in this section that you need to know:

- Benefits for all your insurance
- Benefits for insurance in super and the conditions of release

In addition, this section has information about the following that you also need to know:

- taxation and insurance,
- the Life Insurance Code of Practice, and
- resolving complaints.

1. Choosing and buying your insurance

Below is some important information about how to apply, how you can choose who receives death benefits, and what payments we make to your financial adviser and other third parties.

How to apply

To apply for insurance, please complete an insurance application. This can be done online or in another way approved by Acenda. Your financial adviser can help you with your application. For MLC Insurance (Super) and insurance purchased through your eligible super wrap account, your application is made to the Trustee, who applies to us for insurance on your behalf.

For insurance held by an SMSF Trustee, the Trustee must complete the application as the policy owner.

You'll need the assistance of a financial adviser to apply for your insurance. They can help you with each step of the application process, including preparing a quote, completing and submitting the application, and following up any additional requirements we may have.

Nominating a beneficiary for insurance outside super

Who receives your death benefit?

In your application, you can nominate up to six beneficiaries to receive your death benefit along with the portion you'd like each to receive.

If any of your beneficiaries die before you, their portion of the death benefit will be paid to their estate.

If you don't nominate a beneficiary, your death benefit will be paid to the policy owner or your estate, unless we're legally required to pay the benefit to someone else.

If the policy owner changes (eg if you move your insurance from non-super to super insurance) your nomination is automatically cancelled.

What happens if there's more than one policy owner?

If there are multiple policy owners, they own it jointly. If one policy owner dies, the policy will be owned by the remaining policy owner, or jointly owned by all the remaining policy owners.

If all policy owners have died, we'll pay any benefits to the estate of the policy owner who died last, unless we're legally required to pay someone else.

Please speak with your financial adviser for more information.

Nominating beneficiaries

It's important to keep your beneficiary nomination up to date with changes in your personal circumstances.

You can cancel or change your nomination at any time by completing and returning the Beneficiary Nomination Form available at **acenda.com.au** or call **13 65 25** to request the form. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**.

You should speak with your financial adviser, estate planner or legal representative to decide which type of nomination will best suit your circumstances and how the tax rules apply to your beneficiaries.

Nominating a beneficiary for insurance inside super

Your death benefit is paid to the Trustee who then pays it according to super law.

Your beneficiary nominations need to be lodged with the Trustee.

Please refer to your Trustee for beneficiary nomination options that may be available to you.

Details are available on your super provider's website, PDS or trust deed.

Payments to financial advisers

We have an agreement with your financial adviser to pay commission which is based on the premium paid.

This commission is included in the premium and isn't an additional cost to you. If you don't have a financial adviser, your premium won't be less.

The actual remuneration your financial adviser receives, including any commission, will depend on your financial arrangement with them, and will be disclosed to you by them as required by law.

1. Choosing and buying your insurance

Third party payments

Acenda may also pay third parties for the distribution, promotion or marketing of Acenda's insurance products.

These third parties may include licensees (with whom your financial adviser is a representative).

Any such payment made by Acenda to a third party is not an additional cost to you.

If applicable, any additional payments will be disclosed to you in the relevant Financial Services Guide which the third party must provide to you.

Trustee fees (insurance inside super only)

Acenda may pay Equity Trustees Superannuation Limited for their role and the management of super interests associated with insurance through the Fund.

These payments are not an additional cost to you and may vary from time to time. They are fixed by agreement between Acenda and Equity Trustees Superannuation Limited, for the costs Equity Trustees Superannuation Limited may incur in managing insurance through the Fund, not by the number of insured members or the value of premiums paid. This may be paid by us out of the premiums we receive.

Fees relating to eligible super wrap account insurance policies

Acenda may pay the trustee of your eligible super wrap account a fee for trustee and administrative services in providing MLC Insurance to members of the eligible super wrap platform product.

These payments are not an additional cost to you and may vary from time to time.

2. Assessment and underwriting

Below is some important information about how we assess your application, and temporary insurance that we offer while we are assessing your application.

How is your application assessed?

We assess your application, taking into account your occupation, lifestyle, leisure activities and medical history, to decide whether (and on what terms and conditions) insurance can be offered to you.

In some cases you may not be eligible for the insurance you ask for, or we might offer you insurance at a higher premium, or with an exclusion (eg if you take part in a hazardous sport or have an existing health problem). We may also offer other alternative terms.

Depending on the insurance you apply for, we may need additional financial and medical information. We may ask you to undergo a medical examination or test.

We pay for any medical information asked for during the application process (including reasonable travel costs and out of pocket costs agreed to in advance and the production of any report), unless we tell you otherwise.

We may also write to your Doctor seeking additional information (authorised by you).

If you are not the policy owner, we will not share your personal information with the policy owner without your consent, except to the extent necessary to deal with an application, policy or claim. If we share your personal information this will be in line with privacy and confidentiality requirements.

We'll update your adviser with the progress of your application. If your application isn't accepted, we'll let you know at the earliest possible time.

Interim Accident insurance

While we assess your application, you'll have temporary insurance for each type of insurance you apply for, which will insure you for accidental events during this period. This insurance is called **Interim Accident Insurance.**

For all the important information about this insurance, including when it starts, what it does and does not insure, and when it will end, please see the Interim Accident Insurance Certificate on pages 119 - 120.

3. Your insurance policy

Some important information about when your insurance starts, and what happens if you change your mind before your insurance starts.

When your insurance starts

All the terms and conditions of your insurance are effective from the start date shown in your current Policy Schedule.

What if you change your mind within the cooling off period?

If you request to cancel your insurance within the cooling off period, we'll refund premiums that you've paid.

The cooling off period is 30 days from the day on which your first Policy Schedule was issued.

For insurance inside super, any refund will be paid to the Trustee.

However, if you make an alteration or claim on your insurance during these 30 days, this will confirm your acceptance of your insurance and we won't refund any premiums paid.

4. Your premiums

Some important information about premiums and other charges.

Premiums and how they're calculated

Your premium is the amount of money we charge for the insurance we provide and is calculated by applying your **individual insurance choices** and **personal circumstances** to our standard premium rates.

Your individual insurance choices and personal circumstances

Your adviser in discussions with you, will customise your insurance to suit your individual needs.

Individual insurance choices that impact your premium, which may among other things, include:

- **the type of insurance(s) selected –** the cost of each type of insurance depends on the benefits and features it provides. Higher premiums generally apply for insurances with a broader range of benefits and features, compared to insurance with a more limited range of benefits and features.
- **the benefit amount –** generally, the higher the benefit amount you select for each insurance, the higher the premium.
- **the structure of your insurance(s) –** you can link your TPD or Critical Illness insurance to each other, and to Life Cover insurance. You'll pay less for insurances that are linked because a claim payment from one of these insurances will reduce the benefit amount of other linked insurances.
- **the Options at extra cost selected –** some types of insurance have options available at an extra cost. If you choose any of these options in your insurance, the premium will be higher.
- **whether a discount applies –** if the cover or combination of cover meets certain eligibility criteria, a discount may apply. These discounts are not guaranteed, may be varied or removed, and may not apply over the life of your policy.
- **the frequency of premium payments –** the amount payable each year is higher the more frequently you choose to pay. Monthly is the most expensive, followed by half-yearly. Yearly payments are the least expensive.
- **Inflation Proofing -** if Inflation Proofing applies to your insurance, we will increase the sum insured amount at each Review Date. The premium will generally increase to reflect the change. For more information, see Inflation Proofing on page 44.
- **commission –** your premium includes a commission component. For more information, see Payments to financial advisers on page 37.
- **for Income Protection and Business Expenses, the waiting period selected –** generally, the shorter the waiting period you select, the higher the premium.
- **for Income Protection, the benefit period selected –** the longer the benefit period you select, the higher the premium.

Personal circumstances that impact your premium, which may among other things, include:

- **age –** generally, the older you are, the higher the premium.
- **gender –** life and health outcomes vary by gender, including differences in life expectancy and the rate and duration of injuries or illnesses. As a result, premium rates for each insurance will differ by gender.
- **occupation –** we classify occupations into occupation categories based on the risk an occupation has of experiencing injury or illness. Generally, the higher the risk, the higher the premium.
- **smoking status –** premium rates for smokers are higher than they are for non-smokers.
- **health and family history –** risk factors affecting your health and/or your family history may impact your premiums. This is assessed during the underwriting process.
- **sports and recreational pursuits –** participation in certain sporting activities or recreational pursuits may carry greater risk. This may in turn, impact your premium.
- **state of residence –** your premiums include government charges, and each state and territory government may charge stamp duty on different types of insurances depending on your residence.

Policy fees

Acenda reserves the right to charge you a policy fee, or to change the policy fee if there is one. We'll give you one month's written notice if we do.

If a policy fee applies to your insurance, it will appear in your Policy Schedule.

4. Your premiums

How to get a quote

Your financial adviser will provide you with an indicative quote for your premium based on the types and amounts of insurance you apply for.

This quote will not take into account all of your personal circumstances.

Your actual premium may be different from the quote for reasons including if:

- you make a change to the insurances applied for,
- we assess your application, and are only able to provide insurance if you agree to a higher premium (a Loading) and/or alternate terms. We may decide this is required due to medical or lifestyle reasons or other personal circumstances.

Please speak with your financial adviser.

If you don't have one, please call us on **13 65 25** and we can put you in touch with one. For hearing impaired customers, please call **1300 555 727**.

For customers requiring interpreting or translation services, please call **131 450**.

Where to find your premiums

Your premium will be stated in your Policy Schedule.

We will issue your first Policy Schedule when your insurance commences, and an updated Policy Schedule each year before your Review Date, confirming your premiums and insurance cover from that date.

Paying your first premium

If you pay your first premium before the policy is issued, the payment will be held in a trust account until your application has been accepted or declined.

We keep any interest earned on this money.

If your application is declined, we refund any premium you may have paid to you or, if required by super law, to your super account.

Payment methods

Several payment methods are available, and all premiums are paid in advance.

Your annualised premium will generally be higher if you choose to pay more frequently. Monthly is the most expensive, followed by half-yearly. Yearly payments are the least expensive (see table below).

We can change the frequency loading percentages at any time and will notify you of any material changes. Any changes will apply at your next Review Date.

MLC Insurance (Super) doesn't accept contributions from:

- directed termination payments
- small business sale proceeds
- personal injury payments, or
- transfers from overseas funds.

Frequency of payments	Payment Methods						Frequency Loadings
	Direct Debit	Credit Card	Cheque	BPay	Eligible super wrap account*	Rollover from external super account	
Monthly	Y	Y			Y		7%
Half-Yearly	Y	Y	Y	Y	Y		4%
Yearly	Y	Y	Y	Y	Y	Y	Nil

***acenda.com.au/using-your-insurance/how-to-pay-your-insurance-premiums**
for a list of eligible accounts and which type of premiums can be deducted from that account.

Minimum premiums

The minimum premium for both your initial insurance and for subsequent changes, excluding policy fees is:

Frequency of premium payments	**Minimum premium** (for new applications)	**Minimum premium** (for increases to existing insurance)	**Minimum premium** (for TPD and Critical Illness as connected benefit only)
Monthly	$20	$10	$10
Half-Yearly	$130	$65	$65
Yearly	$250	$125	$125

How do your premiums change each year

We recalculate the premiums for your policy each year at your Review Date. We will also recalculate the premiums for your policy when there is a change to your policy.

If we make changes to your premium, including making changes to our premium rates, the change will only apply to you once a year, effective from your next Review Date. We'll give you at least one month's written notice before premiums change.

If you make changes to your policy, we'll recalculate your premium based on the rates applicable at the time the change is approved by us.

Your premiums will vary depending on several factors including:

- **your age –** for more information, see Your premium structure on page 44.
- **your eligibility for discounts –** we may from time to time offer discounts that may reduce your premiums. These discounts are not guaranteed, may be varied or removed, and may not apply over the life of your policy.
- **the length of time since you applied for cover –** when you first apply for insurance, we undertake a detailed assessment of your personal circumstances. As we know more about your situation at that time, we are able to offer insurance to you at reduced standard premium rates. As the time passes, your premiums will gradually increase to our standard premium rates.

Your premiums will also change if, for example:

- your benefit amount changes, for example because of Inflation Proofing increases,
- your cover changes, for example because there is an automatic change to the terms of your cover when you reach a particular age as set out in your policy.
- there are changes to stamp duty or other government charges,
- there are changes to policy fees (if applicable),
- we make changes to our standard premium rates, or the discounts we offer. For more information, see Changes to premium rates on pages 43 - 44.

Premium rates

We calculate your premiums by reference to our set of standard premium rates, which are available on request. When setting our standard premium rates, we consider a broad range of factors, including the risks associated with each insurance option, and different personal circumstances. Some of these factors are listed in Premiums and how they're calculated on page 41.

Changes to premium rates

When we issue your Policy, we provide you with a Policy Schedule that sets out the premium for your first period of cover. The premium you pay is determined by a set of standard premium rates. The standard premium rates are not guaranteed to stay the same. Your premium can change for a number of reasons, including due to a change in the standard premium rates we use.

We set our standard premium rates to cover expected future claims costs for the group of customers we insure, meet our other costs of doing business and to include a reasonable margin for providing the insurance cover to you.

We regularly review our standard premium rates to ensure they remain appropriate, and if we increase these then your premium will also increase.

When we review our standard premium rates, we will look at factors including the following:

- For expected future claims costs, factors can include recent claims experience, or industry trends which show a likely increase in the future cost of claims;
- For other costs of doing business, factors can include changes to tax, government or other mandatory charges, the cost of reinsurance, the costs to meet compliance and regulatory requirements, distribution costs, and changes to business operating expenses;
- For reasonable margins in providing the insurance cover, factors can include changes to the economic environment such as interest rates, inflation rates and market returns, or the achievement of a fair shareholder target return for the commercial risks taken in providing the insurance.

If we make changes to our standard premium rates, we will always act reasonably and with utmost good faith, and any changes will be applied consistently for policies of the same kind. This means your policy will not be singled out for a change in premium rates.

4. Your premiums

If your premium increases, you have a number of options to manage the cost of your cover, such as reducing your cover or changing the options on your cover. Please speak to us or your financial adviser for assistance.

Your insurance can be customised

Your insurance can be customised to suit your individual needs.

Life changes over time, and we encourage you to regularly review your insurance cover to ensure it continues to meet your needs.

Your adviser can help you review and adjust your insurance cover.

Additional information: features, charges and terms

Your premium structure

Your policy has a variable age-stepped premium structure. This means when we calculate your premiums each year, we do so based on your age and the premium rate that applies at your Review Date. Your premium will usually increase each year as you get older.

Your premiums may also change due to other factors. For more information see How do your premiums change each year on page 43.

Inflation Proofing

If Inflation Proofing applies to your insurance, then each year, on your Review Date, we'll automatically increase your sum insured to take inflation into account.

Your sum insured will increase in line with the Consumer Price Index (CPI) as follows:

- for Life Cover, TPD and Critical Illness the increase to the sum insured at any one Review Date will be the greater of the increase in CPI or 5%.
- for Income Protection the increase to the sum insured at any one Review Date will be the lesser of the increase in CPI or 3%.
- for Business Expenses, the increase to the sum insured at any one Review Date will be the increase in CPI (provided you are not being paid a benefit under the policy).

Your premium will increase to reflect the higher sum insured. We'll let you know about the increase one month before your Review Date.

If you don't want the CPI increase (in part or in full) for a particular year, please contact us within two months after your Review Date.

Inflation Proofing isn't available for Terminal Illness Support, Child Critical Illness, or Occupationally Acquired HIV, Hepatitis B or C Infection insurance.

Premiums inside super – super contributions

When your insurance is held inside super, the premiums you pay directly are considered to be super contributions. These premiums will be for the cost of the insurance. Your insurance won't accept investment contributions.

While you can contribute as much as you like into super, you'll pay additional tax if your contributions exceed certain limits.

These limits may change from time to time.

Your contributions to pay for insurance premiums need to be added to any contributions you and your employer make for contribution cap limit purposes.

There may be other tax implications where premiums are paid from a personal account. To find out more, including the current limits and who can contribute, go to **apra.gov.au** or **ato.gov.au**. You can also speak with your financial adviser.

If you choose to pay your premiums by rollover to the Fund we can only accept the rollover of taxed superannuation monies.

By paying your premium with taxed superannuation monies you will only be required to rollover 85% of the total premium, and this will be reflected in your quote and on your Policy Schedule.

The trustee of the Fund can claim a 15% tax rebate of the contribution tax already paid and they have chosen to pass this benefit to you. This amount funds the remaining premium for your insurance.

This rebate is not guaranteed, and if it changes in future, we'll give you one month's notice.

What happens if your premium isn't paid?

If you haven't paid your premiums in full by the date they're due you'll receive a reminder letter.

If you don't pay your outstanding premiums in full by the due date in the letter:

- we'll cancel your policy and your insurance will end, and
- any benefits payable up to the due date will be reduced by the amount of any outstanding premiums owing to us.

You can apply to reinstate your policy within six months of your insurance being cancelled due to non-payment of premiums. However:

- you will need to pay all outstanding premiums; and
- you will need to respond to health or lifestyle questions. The reinstatement of your insurance may be declined dependent on your responses.

There is a short window after cancellation where the insurance can be reinstated without the need to answer these questions. You should contact us soon after your insurance is cancelled if you want it reinstated.

Refunding your premium when you cancel your insurance

If you cancel your insurance and:

- if you pay your premium monthly, your insurance will end on the next date we would have debited your premium if your insurance had not been cancelled, or
- if you pay your premium half-yearly or yearly, your insurance will end when we receive your request to cancel your insurance. Any premium paid by you for a period after that date will be refunded to you or, if required by the super law, to your super account.

Family law charges

The Family Law Act helps super, life insurance and other investments to be divided between parties should there be a marriage or de facto breakdown.

We may be obliged to provide information to other parties and manage your policy in line with court orders. We reserve the right to charge the policy owner a fee if we have to comply with a Family Law injunction or order which alters your rights, liabilities or property interests and to recover any legal costs incurred by us in responding to matters arising from an order or injunction.

Government charges

We reserve the right to charge you an amount for any duty, tax, excise, impost, charge or deduction applied by the federal or state or territory governments as may apply to your policy and such amount will be calculated by reference to the relevant rate that applies at the time your annual premium is calculated.

There is currently no Goods and Services Tax (GST) charged on your premium.

5. Updating your insurance

Below is important information about how we might update your insurance over time, how you can update your insurance to suit your changing needs, and information you need to know about transferring and replacing your insurance.

Guarantee of upgrade

Whenever we improve the terms of a type of insurance you've chosen, and those improvements don't increase your premiums, we'll upgrade the terms of your policy.

Each new improvement only applies from its effective date (eg the date when the new definition or feature starts). This means the improvement only applies to claims, health conditions and events which start or take place after the effective date.

The improvements won't apply to past or existing claims, or claims resulting from health conditions or events which started or took place before the effective date.

Acenda will inform you of the effective date of any improvements to your policy. Should a situation arise where you are disadvantaged by the application of a policy term that has been changed under the Guarantee of upgrade since your policy started, then we will instead apply the prior version of that term whatever is most advantageous to you.

Changing your insurance

At any time, you can make a request to change your insurance, including a change to the sum insured or to add or remove a type of insurance or option. Each change may be subject to underwriting approval and/or assessment against policy terms, so we'll let you know when we accept or decline your request. Your premium may also change as a result of the requested alteration. Your financial adviser can provide the relevant forms and help you decide whether to alter the insurance.

Continuity of your insurance

As long as your premiums are paid, your insurance will continue each year (even if your health worsens), until **your insurance** expires, or a termination event occurs that ends your insurance).

For Critical Illness Standard insurance, after the first three years in force, Critical Illness Standard insurance will continue each year. However it will be on our current terms and conditions which may be updated at each Review Date.

Transferring your insurance between non-super and super policies

You can transfer your insurance between MLC Insurance and MLC Insurance (Super) as long as the insurance is still in place.

Transferring insurance involves replacing it with insurance on another policy. For example, Life Cover insurance outside super can be replaced with Life Cover insurance inside super.

Certain restrictions apply to transfers involving insurance inside super policies and your financial adviser can help you with this.

We reserve the right to refuse a transfer application if you have made a claim or are entitled to make a claim. If we do refuse your transfer application for any reason, your existing insurance will continue unless you choose to cancel or your insurance ends. More information on transferring your MLC Insurance (Super) policy to insurance outside super can be found in Converting MLC Insurance (Super) policies on this page.

Converting MLC Insurance (Super) policies

What is conversion?

This means your insurance inside super ends and a new policy will be issued outside super.

When does conversion happen?

You can convert your MLC Insurance (Super) policy to a non-super policy at any time before the Review Date after you turn 74 (ie the date your MLC Insurance (Super) ends).

How does the conversion work?

On conversion, we'll cancel the MLC Insurance (Super) policy held by the Trustee for you and issue you with a non-super policy with similar types of insurances and sums insured.

The policy terms and conditions will be determined at the date of conversion.

In determining eligibility for insurance, the new policy will be taken to have started on the later of:

- the date similar insurance began under the super insurance policy, or
- the date the super insurance policy was last reinstated.

The sum insured under the new policy won't be more than it was under the old policy at the date of conversion.

Premiums under the new policy will be calculated in line with Acenda's base premium rates at the time of conversion. This will take into account the type of insurance, the sum insured, your age and your acceptance of the terms of the policy.

Any beneficiary nomination made for one life insurance product doesn't apply to the new product when a conversion applies.

You'll need to make a new beneficiary nomination for the non-super policy by completing the Beneficiary Nomination Form available on **acenda.com.au** or call us on **13 65 25** to request the form. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**.

Replacing your existing insurance

If you're replacing your insurance, you should compare your existing and replacement policies. This way you can make sure your replacement insurance is suitable for you.

Please also consider exclusion periods which may apply in your replacement insurance. This is the period of time from the start of your insurance where if you suffer an injury or illness or die during this period, only a limited benefit or no benefit will be payable.

If the insurance you're replacing is issued by Acenda, then you agree that we will cancel that insurance once your new MLC Insurance and/or MLC Insurance (Super) policy starts.

If the insurance you're replacing is with another provider, then once your MLC Insurance and/or MLC Insurance (Super) policy starts, it will be your responsibility to cancel the replaced insurance. If you don't, any amount payable under your replacement insurance will be reduced by any similar amount that you, your estate or nominated beneficiary would be entitled to receive under the insurance that was to be replaced.

Before you take steps to cancel and replace an existing life insurance policy, you should talk to your financial adviser or contact us on **13 65 25**. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**.

A new policy may require you to re-serve Waiting Periods, additional health exclusions may apply, and the new policy may not provide you with the same insurance.

Importantly, do not cancel your existing policy before your replacement insurance is in place.

Waiting Periods do not have to restart

If your insurance is replacing similar insurance, we will calculate the Exclusion Period (including in relation to suicide exclusions) from the start date of the replaced similar insurance if you held that similar insurance or replacement insurance continuously since that date.

Cancelling your insurance

You can cancel your insurance at any time. If you want to cancel your insurance, please call us on **13 65 25**. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**.

For information about the risks and consequences of cancelling your insurance, please speak with your financial adviser or go to **acenda.com.au/cancelyourinsurance**

6. Making a claim

If you need to make a claim, please call us on 1300 125 246 between 8.30am and 6pm (AEST/AEDT), Monday to Friday, to find out what you need to do and to get the relevant forms. For hearing impaired customers, please call 1300 555 727. For customers requiring interpreting or translation services, please call 131 450.

How to claim

When you need to make a claim, please let us know as soon as practicable, preferably within 30 days of the event entitling you to make the claim, so we can start working on it.

You or your representative can contact us and we'll tell you what you need to do and send you the necessary forms.

Different types of insurance may have special claim requirements and we may ask for further proof or information to help in assessing your claim.

We may ask you to provide us with:

- Proof of identity;
- A completed claim form;
- Treating doctor's reports;
- Medical, employment or financial information reasonably required by us to assess the claim; and
- Medical and general authorities to allow us to obtain information from third parties such as your doctors or employer.

Depending on the type of claim, we may also ask you to participate in:

- A medical examination conducted by a doctor appointed by us; and
- An examination, assessment or interview conducted by other professionals we appoint (including functional, employability or vocational assessments, psychological assessments, factual interviews or financial audits).

Any proof or information you are asked to provide is at your cost. However, if we need an examination, assessment or interview by a person we appoint, we'll pay for it.

The information you provide, and we obtain, will be used to assess the claim and verify the information you provided prior to policy commencement.

Delays in notifying us, returning completed forms, attending examinations and interviews or providing the information we require may make it difficult for us to assess your claim and this could also impact your Benefit.

If we don't accept your claim, we'll let you know our reasons.

Claim requirements for Income Protection

If you are Disabled, you should tell us as soon as reasonably practicable after the beginning of the Disability, preferably within 30 days of the Disability beginning.

You can lodge your claim by telephone or we can send you a claim form to complete.

We may ask you to provide us with:

- A report from your treating doctor and other medical information;
- Financial information which may include income information and details of other payments you are entitled to receive.

We request that you return the completed claim form, report from your treating Doctor, financial information and any other information we request as soon as reasonably practicable, preferably within 90 days of the Disability beginning.

We will not refuse to assess a claim but delays in providing information may impact our ability to assess your claim and may impact payment of the benefit.

During any period that you are claiming a benefit, we may require ongoing proof that you remain entitled to a benefit, including further medical, employment and financial information.

Claim requirements for Life Cover

For a claim under Life Cover we may ask for the death certificate, Coroner's report and a copy of the will and probate or grant of letters of administration.

Claim requirements for HIV Contracted Through Medical Procedures and HIV Contracted Through the Life Insured's Work

Please notify us as soon as you can after contracting HIV.

7. Paying benefits

Benefit payments for all insurance

What benefits are paid?

The benefit we pay will be:

- the sum insured, or
- a proportion of the sum insured, or
- another specified amount,

as determined by the terms and conditions of your insurance.

In the case of Income Protection and Business Expenses insurance we'll review your benefit amount regularly in line with the terms and conditions of your insurance.

The terms and conditions of the insurance must be met for benefits to be payable.

Who do we pay?

The benefits will be paid to:

- you, or
- the policy owner if they are someone else (including the Trustee for insurance in super), or
- each nominated beneficiary (according to their share of the benefit), or
- your personal legal representative (Your estate) if there is no Nominated Beneficiary.

Benefits inside super – and the conditions of release

For insurance inside super, the Trustee receives any benefits payable under the policy if you make a claim.

For insurance in super, we will not pay a benefit unless the trustee is able to immediately release that benefit pursuant to a condition of release. This does not apply if your insurance commenced before 1 July 2014.

Your Trustee will release those benefits to you if permitted under super law, which sets out certain conditions of release that you have to meet.

If you don't meet a condition of release for any reason, the Trustee can't release the benefit to you.

If this happens the Trustee will hold the benefit in the Fund as a preserved benefit, until you satisfy a condition of release.

Since 30 June 2014, the Trustee has been required to ensure that insurance available through its fund is consistent with the conditions of release.

Conditions of release

The table below describes which insurance benefits inside super are consistent with the conditions of release.

Type of insurance	Related condition of release
Life Cover	**Death**
Specific Accidental Injury Benefit and TPD	**Permanent Incapacity** – this means the Trustee must be reasonably satisfied that your ill health (whether physical or mental) makes it unlikely that you will engage in Gainful Employment for which you are reasonably qualified by your education, training and experience.
Income Protection	**Temporary Incapacity** – in relation to where you've ceased to be gainfully employed (including where you have ceased temporarily to receive any gain or reward under a continuing arrangement for you to be gainfully employed), this means ill health (whether physical or mental) that caused you to cease to be gainfully employed but does not constitute permanent incapacity. The Trustee may not be able to pass benefits to you, or may reduce benefits if you receive any income provided or arranged by an employer, partnership or business, including fully paid leave such as sick leave, or if Government regulations otherwise limit the benefit that can be paid. A benefit can't be paid for longer than the period of the SIS definition of Temporary Incapacity.
Terminal Illness	**Terminal Medical Conditions** – a terminal medical condition exists in relation to you at a particular time if the following circumstances exist: • two Doctors (at least one of them a Specialist in the area of the related sickness or injury) have certified, jointly or separately, that you are suffering from an illness, or have incurred an injury, that is likely to result in death within a period (the certification period) that ends not more than 24 months after the date of certification, and • for each of the certificates, the certification period has not ended.

The applicable insurance definition must be met for an insurance benefit to be payable and, in addition, the conditions of release described above must also be met.

Taxation, the Life Insurance Code of Practice and resolving complaints

Taxation

This section gives a brief summary of the way insurance is treated for tax purposes as at the preparation date of this PDS.

This isn't a comprehensive and complete guide, it is general information only.

Acenda is not a registered tax (financial) adviser or a registered tax agent.

If you intend to rely on any advice to satisfy liabilities, obligations or claim entitlements that arise, or could arise under taxation law, you should seek advice from a registered tax agent or registered tax (financial) adviser.

For more information, go to **treasury.gov.au**

Tax laws change. To keep up to date, please visit **ato.gov.au**

Tax treatment of insurance outside super

The table below provides a general guide on the potential tax treatments of your insurance:

	Personal	Business
Life Cover insurance	• Premium is not tax deductible. • Benefit is tax-free.	• Premium is likely to be tax deductible when you insure a key person to protect against a revenue loss. • Benefit is likely to be included in the business' assessable income.
Total and Permanent Disability, Terminal Illness Support, Critical Illness, Child Critical Illness and Occupationally Acquired HIV, Hepatitis B or C Infection insurances	• Premium is not tax deductible. • Benefit is tax-free when you insure yourself, your spouse or a qualifying relative. • If you insure anyone else, a taxable capital gain may arise when the benefit is paid to you.	• Premium is likely to be tax deductible when you insure a key person to protect against a revenue loss. • Benefit is likely to be included in the business' assessable income. • In other circumstances the premium may not be tax deductible and a benefit may give rise to a capital gain when paid.
Financial Planning Benefit	• Benefits are generally tax-free. However, seek tax advice specific to your circumstances.	• Seek tax advice specific to your circumstances.
Income Protection, Business Expenses insurances	• If you are self-employed or an employee, the part of the benefit that replaces income is likely to be assessable as income and that part of the premium that relates to the benefit that replaces income is likely to be tax deductible. • Where the life insured dies while receiving Income Protection benefits, the lump sum benefit paid is not likely to be assessable as income.	
Premium Waiver insurance, Policy Fee	• Where there is more than one insurance on your policy, the premium for Premium Waiver and the policy fees for each insurance may be deductible, partly deductible or non-deductible depending on the tax treatment of each type of insurance.	

Taxation, the Life Insurance Code of Practice and resolving complaints

Tax treatment of insurance inside super

Any contributions used to fund your premiums will be reported to the Australian Taxation Office (ATO) for the purpose of calculating super contribution limits.

Where required by law, the Trustee will deduct any tax, duty or government fees and forward the money to the relevant authority.

The government may change how super is taxed. To find out more, please visit **ato.gov.au**

For more detailed information about taxation inside super, please refer to your Trustee.

You must provide your Tax File Number (TFN)

Acenda and the Trustee need your TFN to complete your application for MLC Insurance (Super).

You should also be aware:

- Acenda and the Trustee are authorised to collect your TFN under the Superannuation Industry (Supervision) Act 1993,
- it isn't an offence to decline to notify Acenda and the Trustee of your TFN,
- without your TFN, Acenda and the Trustee may have difficulty (now or in the future) tracing your benefits in order to undertake any account consolidation or payment,
- Acenda and the Trustee are allowed to use your TFN only for lawful purposes (which may change in the future as a result of legislative changes), including if paying out monies, and if identifying and amalgamating super benefits, and
- your TFN will be disclosed to the ATO and will also be passed to other super providers if your benefits are transferred, unless you inform Acenda and the Trustee in writing not to pass on your TFN.

The Life Insurance Code of Practice

Acenda has adopted the Life Insurance Code of Practice which sets industry standards for customer service and Acenda commits to these service standards.

To find out more about the Code of Practice you can visit our website at **acenda.com.au/code-of-practice**

Resolving complaints

If you have a complaint about our organisation, related to our products, services, staff or the handling of a complaint, we'd like an opportunity to put it right.

Please call us on **13 65 25** (Toll free **1800 062 061**) or for international calls **+61 2 9121 6500** (charges apply) between 8.30am and 6pm (AEST/AEDT), Monday to Friday to discuss your concerns. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**.

If we are unable to resolve your issues to your satisfaction, we will put you in contact with our Internal Complaints Resolution Team. For more information, please visit **acenda.com.au/support/customer**

If you're not satisfied with the resolution provided by our Internal Complaints Resolution Team, or we haven't responded to you in 45 calendar days for super or traditional trustee service complaints, and 30 calendar days for other products and services, you can lodge a complaint with the Australian Financial Complaints Authority (AFCA).

AFCA is an independent body that provides a complaint resolution service free of charge to customers. You can contact AFCA at any time, in writing, by email or by phone. AFCA's contact details are below:
Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

Phone: **1800 931 678**
Email: **info@afca.org.au**
Web: **afca.org.au**

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Summary of the terms and conditions

Summary of the terms and conditions for lump sum insurances

In this section you'll find a summary of:

1. **General terms about how you can structure your lump sum insurance**
2. **Terms for specific lump sum insurance, benefits, features and options**
3. **General exclusions applying to lump sum insurance, and**
4. **General termination events applying to lump sum insurance.**

The full terms and conditions that apply to your insurance are in your Policy Document, which we'll send to you when we accept your application.

1. General terms

Structuring your insurance (stand-alone policies, Extensions, Connections and Double Benefits)

You can structure your insurance to be:

- stand-alone insurance, or
- an 'Extension' to your Life Cover and Critical Illness insurance on either:
  - the same policy, or
  - a separate policy as a connected benefit (a 'Connection').

Your financial adviser can help you work out which structure is most appropriate for you.

What is stand-alone insurance?

This is insurance that can be purchased on its own and is independent of all other insurances you purchase. If a claim is paid on one of your stand-alone insurances, your other lump sum insurance with us won't be reduced.

The insurances you can purchase as stand-alone are listed below.

Outside and inside super:

- Life Cover, and
- Income Protection.

Outside super only:

- Total and Permanent Disability (TPD),
- Critical Illness,
- Occupationally Acquired HIV, Hepatitis B and C Infection, and
- Business Expenses.

What is Extension insurance?

Extension insurance allows one insurance type to be attached to another insurance type.

You'll pay less for this structure than stand-alone insurance because a claim payment will reduce the insurance to which it's attached.

The insurances you can purchase as Extensions are:

- Total and Permanent Disability insurance (TPD), and
- Critical Illness insurance.

You can also attach TPD as an Extension to your Critical Illness Extension insurance. If your Critical Illness insurance ends, you may be able to continue your TPD insurance as either an Extension to Life Cover or as stand-alone insurance. Your premiums will change accordingly.

The combined amount of any insurances you choose as Extensions can't exceed the insurance benefit to which they're attached.

You can also choose to have your Extension insurances on a separate policy with a different policy owner. This would allow you to connect insurance held inside and outside super to maximise the cost- effectiveness of your insurance. This is known as a Connection or a 'connected benefit'.

Your financial adviser can help you work out which structure is most appropriate for you.

What are Double Benefits?

Usually, when you are paid a TPD or Critical Illness benefit, your Life Cover sum insured will be reduced by the benefit amount paid. A Double Benefit is an Extension insurance that restores your Life Cover sum insured if you survive 14 days after a TPD or Critical Illness benefit is paid.

A Double Benefit also includes a premium waiver for the restored Life Cover premiums until age 65.

The insurances you can purchase as a Double Benefit are:

- TPD (Extension to Life Cover),
- TPD (Extension to Critical illness), and
- Critical Illness Plus insurance (Extension to Life Cover).

You can also choose to connect your Double Benefit insurance, both inside and outside super, on different policies and with different policy owners.

Your financial adviser can help you work out which structure is most appropriate for you.

2. Summary of terms for:

- Life Cover insurance
- TPD insurance
- Critical Illness insurance
- Child Critical Illness insurance
- Occupationally Acquired HIV, Hepatitis B or C Infection insurance.

In this section, terms and conditions are summarised in alphabetical order so it is easier to follow and find what you're looking for. The full terms and conditions that apply to your insurance are in the Policy Document, which we'll send to you when we accept your application.

12-month Life Cover Buy Back Option (Available with Critical Illness Extension insurance only)

What is the benefit?

When you have Life Cover with a Critical Illness Extension and you receive a benefit under the Extension, your Life Cover insurance decreases by the amount of the Critical Illness Benefit you received.

The 12-month Life Cover Buy Back Option allows you to restore your Life Cover insurance (Restored Life Cover) by the same amount as the Critical Illness Benefit paid, without you having to provide additional evidence of health, occupation or pursuits.

What is the cost of restoring cover?

Your premium for the Restored Life Cover will be based on our premium rates at the time the Life Cover is restored, taking into account the benefit amount, your age, the premium and acceptance terms of the Life Cover (including all loadings, exclusions and special terms).

When is cover restored?

You can include this option when you first take out insurance. If you then receive a Critical Illness Benefit which reduces your Life Cover, you can apply to restore your Life Cover to the amount you had before your claim.

You can do this from the later of:

- 12 months after we receive your claim form (the date the form is received by our claims department), and
- 12 months after you first meet the full Critical Illness definition (the date your condition is confirmed in writing and received by our claims department).

You have up to 30 days after the later of the above dates to ask for your Life Cover to be restored.

What are the conditions (including exclusions)?

- The Specific Accidental Injury Benefit under the Restored Life Cover will not be paid for any loss arising from or contributed to by sickness or injury for which a benefit has been paid under the original Critical Illness insurance.
- If a Terminal Illness Support Benefit or Financial Planning Benefit has previously been paid it will not be available under the Restored Life Cover.
- The policy owner and life insured will remain unchanged under the Restored Life Cover.
- You cannot exercise this 12-month Life Cover Buy Back Option if a benefit for terminal illness has been paid previously.
- You must ask us to restore your Life Cover before the Review Date after you turn 75.

Please refer to Life Cover - When won't a benefit be paid? on page 69 for additional exclusions.

12-month Life Cover Buy Back (available with TPD Extension insurance only)

What is the benefit?

When you have Life Cover with a TPD Extension and you receive a benefit under the Extension, your Life Cover insurance decreases by the amount of the TPD Benefit you received.

This included feature allows you to restore your Life Cover insurance (Restored Life Cover) by the same amount as the TPD Benefit paid, without you having to provide additional evidence of health, occupation or pursuits.

What is the cost of restoring cover?

Your premium for the Restored Life Cover will be based on our premium rates at the time the Life Cover is restored, taking into account the benefit amount, your age, the premium and acceptance terms of the Life Cover (including all loadings, exclusions and special terms).

Summary of the terms and conditions for lump sum insurances

When is cover restored?

Your Life Cover can be restored 12 months after the date the full TPD Benefit is paid. You have up to 30 days after this date to apply to have your Life Cover restored.

What are the conditions (including exclusions)?

- The Specific Accidental Injury Benefit under the Restored Life Cover will not be paid for any loss arising from or contributed to by sickness or injury for which a benefit has been paid under the original Total and Permanent Disability insurance.
- If a Terminal Illness Support Benefit or Financial Planning Benefit has previously been paid it will not be available under the Restored Life Cover.
- The policy owner and life insured will remain unchanged under the Restored Life Cover.
- You cannot exercise this 12-month Life Cover Buy Back if a benefit for terminal illness has been paid previously.
- This included feature is not available if you have exercised the 14-day Life Cover Buy Back Option.
- You must ask us to restore your Life Cover before the Review Date after you turn:
  - 75 for Total and Permanent Disability (Extension to Life Cover), or
  - 65 for Total and Permanent Disability (Extension to Critical Illness).

Please refer to Life Cover - When won't a benefit be paid? on page 69 for additional exclusions.

14-day Life Cover Buy Back Option (available with TPD Extension insurance only)

What is the benefit?

When you have Life Cover with a TPD Extension and you receive a benefit under the Extension, your Life Cover insurance decreases by the amount of the TPD Benefit you received.

This option, however, will automatically restore your Life Cover insurance (Restored Life Cover) by the same amount as the TPD Benefit paid, without you having to provide additional evidence of health, occupation or pursuits.

What is the cost of restoring cover?

Your premium for the Restored Life Cover will be based on our premium rates at the time the Life Cover is restored, taking into account the benefit amount, your age, the premium and acceptance terms of the Life Cover (including all loadings, exclusions and special terms).

When is cover restored?

Your Life Cover is automatically restored if you live for 14 days after we've paid your full TPD Benefit.

What are the conditions (including exclusions)?

- The Restored Life Cover will be payable in the event of your death, Terminal Illness and Specific Accidental Injury.
- If a Terminal Illness Support Benefit or Financial Planning Benefit has previously been paid it will not be available under the Restored Life Cover.
- The policy owner and life insured will remain unchanged under the Restored Life Cover.
- For your Life Cover to be restored, your TPD claim must be paid before the Review Date after you turn:
  - 75 for Total and Permanent Disability (Extension to Life Cover), or
  - 65 for Total and Permanent Disability (Extension to Critical Illness).

Specific Accidental Injury Benefit (feature of Life Cover insurance)

If, due to an Accident, you lose:

- the use of both hands or both feet, or
- the sight in both eyes, or
- the use of one hand and one foot, or
- the use of one hand or one foot and the sight in one eye,

you'll receive 100% of your Life Cover insurance Benefit, up to $2 million.

Or if, due to an Accident, you lose:

- the use of one hand or one foot, or
- the sight in one eye,

you'll only receive 25% of your Life Cover Benefit, up to $500,000.

For insurance inside super that commenced after 30 June 2014, you must also be Permanently Incapacitated as defined on page 112, as a result of the Accident as defined on page 109, to be eligible for a Specific Accidental Injury Benefit.

Conditions that apply to the Specific Accidental Injury Benefit

- Any loss must be total and permanent, be as a direct result of the Accident and occur within six months of the Accident.
- The maximum amount stated is the most you'll be paid, no matter how many MLC Insurance policies (inside or outside super) you hold that cover a Specific Accidental Injury Benefit.
- If you hold more than one Acenda policy that covers a Specific Accidental Injury Benefit and the total of all those Acenda policies is greater than the maximum amount, each policy will proportionally contribute to the maximum amount.
- If you also hold stand-alone Total and Permanent Disability insurance or stand-alone Critical Illness insurance with us, the maximum benefit payable under this Specific Accidental Injury Benefit will be reduced by the total of any benefit paid under those insurances for an event that is also covered under the Specific Accidental Injury Benefit.

When won't a benefit be paid?

If you've already lost the use of one hand, foot or sight in one eye before your insurance started, or was last reinstated, and you subsequently suffer one or more of the Specific Accidental Injury Benefit events (see the previous page) we will only pay 25% of the Life Cover Benefit up to $500,000.

We will not pay the Specific Accidental Injury Benefit where the loss or loss of use, as the case may be, arises from or is contributed to by a self-inflicted injury.

How does a claim affect your insurance?

Your Life Cover insurance will be reduced by the amount of your Specific Accidental Injury Benefit paid. If you also have Terminal Illness Support insurance, this insurance will also be reduced to the lesser of:

- $250,000, and
- 50% of the reduced Life Cover insurance.

We'll reduce the premiums payable in line with the reduced insurance for both your Life Cover and Terminal Illness Support insurance.

If you receive the Specific Accidental Injury Benefit, and you have any of the following insurances:

- TPD insurance held as an Extension to Life Cover insurance,
- TPD insurance held as an Extension to Critical Illness insurance, or
- Critical Illness insurance held as an Extension to Life Cover insurance,

we will reduce your TPD and Critical Illness insurance benefits by the amount of the Specific Accidental Injury Benefit paid.

We'll reduce the premiums payable in line with the reduced insurance for your Life Cover and Critical Illness insurance.

Advance Death Benefit (feature of Life Cover insurance)

If your Life Cover insurance is $20,000 or more and you die, we'll pay an initial once-off Advance Death Benefit payment of $20,000. This will be paid to the remaining policy owner(s) or to your nominated beneficiaries, in the same proportions as requested for paying your Death Benefit.

We'll need a certified copy of your death certificates, or an extract of death registration or other reasonable evidence of death, along with a written request before we pay this advance.

If the Advance Death Benefit is paid, the final Life Cover benefit amount paid to the remaining policy owner(s) and/or beneficiaries will be reduced by $20,000.

Payment of the Advance Death Benefit is not an admission of liability by us to pay the Life Cover insurance Benefit, and may be recovered by us if the Life Cover insurance claim isn't accepted.

Business Safeguard Option (available with Life Cover, TPD and Critical Illness insurances)

If the insurance is used for one of the following nominated business purposes:

- an ownership (buy/sell) agreement where your share of the business is purchased by any remaining partners when certain events occur (for example your death, total and permanent disability or critical illness),
- asset protection (loan guarantee) insurance where you are personally responsible for a business loan (eg you enter a personal guarantee), or
- Revenue Protection (Key Person) insurance (outside super only), you can apply to increase your Life Cover, TPD and Critical Illness insurances, without further medical evidence, when a business event happens. A business event is when the value of your financial interest in the business, loan guarantee, or the value of the key person to your business increases.

Summary of the terms and conditions for lump sum insurances

You must apply for the increase within 30 days of the first Review Date following the relevant business event. Your premiums will rise in line with the increased insurance.

You must provide reasonable proof of the business event. Proof required may include, but is not limited to, company minutes, ownership (buy sell) agreements, audited company accounts and tax returns, or such other documents or evidence as we may require.

You can apply for this option between ages next birthday 19 to 60.

You can apply to increase your insurance under this option until the Review Date after you turn 65.

Maximum benefit increase

You can apply to increase your Life Cover, TPD and/or Critical Illness benefit under this option, up to a maximum amount of the lesser of the increase in the value of your financial interest in the business, loan guarantee, or the value of the key person to your business and:

- For Life Cover:
  - three times your original insurance amount, or
  - $15 million, and
- For TPD:
  - three times your original insurance amount, or
  - $5 million for professional occupations such as accountants, solicitors and surgeons, or
  - $3 million for other occupations, and
- For Critical Illness:
  - three times your original insurance amount, or
  - $2 million.

These limits include the total of all relevant benefits from all life insurance companies covering you.

Conditions that apply to the Business Safeguard Option

- Any insurance increase must be approved by us.
- TPD and/or Critical Illness insurance, as an Extension to Life Cover insurance (see page 54), is only available where you've selected it with your Life Cover insurance.
- TPD and/or Critical Illness insurance as an Extension to your Life Cover insurance or as a connected benefit can't be more than your Life Cover insurance.
- TPD insurance as an Extension to your Critical Illness insurance can't be more than your Critical Illness insurance.
- The total increase to your Life Cover, TPD and/or Critical Illness insurances for all policies from all sources under the Business Safeguard Option can't exceed the value (as applicable) of:
  - your financial interest in the business,
  - the loan guarantee, or
  - the key person to the business (outside super only).
- If your original Life Cover, TPD or Critical Illness insurances were less than 100% of the applicable value at the time, you can subsequently only increase the insurance to the equivalent percentage of value when you apply for an increase.
- During the first six months, after an increase for a loan guarantee, the increase amount protects you only for death, TPD and/or Critical Illness caused by an Accident.
- If the Business Safeguard Option isn't exercised within any three consecutive Review Dates (policy years), no further application for increases can be made unless you can provide reasonable proof that you were not eligible to apply for an increase under this option because the value of your financial interest in the business, loan guarantee, or the value of the key person to your business had not increased during that time.
- You can't apply to increase your insurance (as applicable) under this Option when a claim is made or is entitled to be made.

When won't a benefit be paid?

We will not pay the Life Cover Benefit if you die by suicide within 13 months of the date the insurance started or was last reinstated. If your insurance is replacing similar insurance, we will calculate the 13-month period from the start date of the replaced insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the 13-month period this way on the amount of the insurance you replaced.

We will not pay the Total and Permanent Disability Benefit or a Critical Illness Benefit for any disability, condition or loss suffered by you arising from or contributed to by:

- intentional self-inflicted injury or attempted suicide, or
- sickness or injury that first appeared, happened or was diagnosed before your Total and Permanent Disability insurance or Critical Illness insurances started or was last reinstated (unless disclosed to, and accepted by, us as a part of the application or reinstatement process).

Child Support Benefit (feature of Critical Illness Plus insurance)

If a Child dies, or the first time a Child is taken to have a Child Support Benefit Condition is

- while this insurance is in force, and
- after the Child's second birthday,

you'll receive the Child Support Benefit.

The first time a Child is taken to have a surgical Child Support Benefit Condition is on the date the surgery happens, provided that the surgical procedure meets the Child Support Benefit Condition definition. The surgery must occur while you are insured.

The first time a Child is taken to have a non-surgical Child Support Benefit Condition is on the date a Doctor first provides a diagnosis of the condition as meeting the Child Support Benefit Condition definition. The diagnosis must occur while you are insured.

What we will pay

The Child Support Benefit payable for each Child is $10,000. Payment of this Benefit will not reduce the Critical Illness Plus insurance benefit to which it is connected.

What conditions are covered?

The Child Support Benefit Conditions covered are:

- Aplastic Anaemia – of specified severity
- Bacterial Meningitis – of specified severity
- Benign Brain Tumour – of specified severity
- Blindness – of specified severity
- Cancer – excluding specified early stage cancers
- Cardiomyopathy – of specified severity
- Chronic Kidney Failure – requiring permanent dialysis or transplantation
- Chronic Liver Failure – of specified severity
- Coma – with specified criteria
- Deafness – permanent
- Encephalitis – of specified severity
- Heart Attack – with evidence of heart muscle damage
- Heart Valve Surgery*– of specified severity
- HIV Contracted Through Medical Procedures
- Intensive Care – requiring continuous mechanical ventilation for 7 days
- Loss of Speech – total and permanent
- Major Brain Injury – of specified severity
- Major Burns – of specified severity
- Major Organ or Bone Marrow Transplant*
- Meningococcal Septicaemia – of specified severity
- Open Heart Surgery*
- Out of Hospital Cardiac Arrest
- Paralysis
- Pneumonectomy* – complete removal of entire lung
- Primary Pulmonary Hypertension – of specified severity
- Stroke – in the brain and of specified severity
- Type 1 Diabetes

(* These are surgical conditions)

The definitions for these Child Support Benefit Conditions can be found in the Critical Illness definitions on pages 90 - 98.

The first time your Child has a Child Support Benefit Condition is:

- for surgical conditions, when the underlying condition requiring the surgical intervention first appears, happens or is diagnosed as meeting its definition, and
- for all other conditions, when the condition first appears, happens or is diagnosed as meeting its definition.

Conditions that apply to the Child Support Benefit

The Child Support Benefit:

- will only be payable if the Critical Illness insurance benefit is $100,000 or more, and
- is payable once only for any one Child.

When won't a benefit be paid?

We will not pay a benefit for any Child Support Benefit Condition arising from or contributed to by:

- the Child's intentional self-inflicted injury or attempted suicide,
- sickness or injury that first appeared, happened or was diagnosed before or within three months of when this insurance started or was last reinstated,
- sickness or injury that first appeared, happened or was diagnosed before the Child's second birthday,
- congenital abnormalities that first appeared for the life insured, the life insured's Spouse or any of their children, before this Critical Illness Plus insurance started or was last reinstated,

Summary of the terms and conditions for lump sum insurances

- congenital abnormalities that first appeared before the Child's second birthday, or
- an injury maliciously inflicted on the Child for the purpose of gain from this insurance.

Changes to Critical Illness insurance conditions and definitions

Critical Illness Plus & Critical Illness Standard

As advances are made in treatment and diagnostic techniques, we may improve the types of, and definitions used in, Critical Illness Plus and Critical Illness Standard insurance for both new and existing policies to make sure they remain appropriate, take into account effective cures, vaccines and modern diagnostic procedures, and include and exclude diseases where appropriate. Please see the Guarantee of Upgrade section which explains how we will implement these and other improvements to the terms of your insurance.

Child Critical Illness insurance

This insurance pays you a lump sum if your Child dies, or the first time your Child is diagnosed with a non-surgical Child Critical Condition or undergoes a surgical procedure for a surgical Child Critical Condition while cover is in force.

Child Critical Illness insurance - Conversion to an adult policy

The Child may elect to convert this insurance to an equivalent adult Life Cover insurance and Critical Illness insurance (Extension to Life Cover) for the same insurance amount.

The Child won't need to provide medical evidence if they apply any time after the Review Date following their 18th birthday and before the Review Date preceding their 21st birthday.

The policy issued will be on the then current policy terms and premiums will be calculated at the then current rates.

Critical Illness insurance

If you are diagnosed by a Doctor with a non-surgical Critical Condition or if you have a surgical procedure for a surgical Critical Condition while the insurance is in force, we will pay you the Critical Illness Benefit (or a proportion of the Benefit if indicated below).

The Critical Conditions covered under this insurance have specifically defined meanings.

You are taken to have a surgical Critical Condition on the date the surgery happens, provided that the surgical procedure meets the Critical Condition definition. The surgery must occur while you are insured.

You are taken to have a non-surgical Critical Condition on the date a Doctor first provides a diagnosis of the condition as meeting the Critical Condition definition. The diagnosis must occur while you are insured.

How payment of other benefits will reduce the Critical Illness benefit

If we pay:

- a Specific Accidental Injury benefit under a policy that is an Extension or Connection to this insurance, or
- a TPD benefit under a policy that is an Extension or Connection to this insurance,

we will reduce your Critical Illness benefit by the benefit paid.

We will reduce future Critical Illness premiums in line with the reduced benefit.

Critical Illness Buy Back Option (available with Critical Illness Plus insurance)

What is the benefit?

This option allows you to restore your Critical Illness insurance (Restored Critical Illness insurance) by the same amount as the Critical Illness Benefit paid, without you having to provide additional evidence of health, occupation or pursuits.

What is the cost of restoring cover?

Your premium for the Restored Critical Illness insurance will be based on our premium rates at the time it is restored, taking into account the benefit amount, your age, the premium and acceptance terms of the Critical Illness insurance (including all loadings, exclusions and special terms).

When is cover restored?

Your cover can be restored 12 months after the date the Critical Illness Benefit (including a benefit for an Extra Benefits Option – Partial Benefits condition) is paid.

You can apply to have your Critical Illness insurance restored up to 30 days after this date.

What are the conditions (including exclusions)?

- If you have Critical Illness as an Extension or a connected benefit to your Life Cover insurance (see page 54) and:
  - you have the option to Buy Back your Life Cover insurance after a claim, you must Buy Back the Life Cover Benefit at the same time you Buy Back your Critical Illness insurance, or
  - you do not have the option to Buy Back your Life Cover insurance after a claim, your Restored Critical Illness insurance will be issued as a stand-alone Critical Illness insurance policy.
- What happens after a full Critical Illness Benefit has been paid?
  - Where a Critical Illness Benefit has been paid, excluding a benefit paid due to an Extra Benefit Option – Partial Benefits condition, the Restored Critical Illness insurance will not provide cover and therefore a claim will not be payable for a Critical Condition:
    - for which a benefit, including a partial benefit, has been paid (excluding Coronary Artery Angioplasty), or
    - which is related to, arises from or is contributed to by (directly or indirectly, or wholly or partly) any Critical Condition (or Extra Benefits Option - Partial Benefits condition) for which a benefit, including a partial benefit, has been paid, except in the circumstances described below in respect of an Extra Benefits Option – Partial Benefits condition claim, or a Cancer or Heart Attack claim.
- What happens after an Extra Benefits Option – Partial Benefit has been paid?
  - Where a benefit has been paid for an Extra Benefits Option – Partial Benefits condition, the Restored Critical Illness insurance will not provide cover and therefore a claim will not be payable for:
    - any Extra Benefits Option – Partial Benefits condition for which a benefit has been paid, or
    - any Extra Benefits Option – Partial Benefits condition which is related to, arises from or is contributed to by (directly or indirectly, or wholly or partly) any Extra Benefits Option – Partial Benefits condition for which a benefit has been paid.
- What happens after a full benefit for Cancer or Heart Attack is first paid?
  - Where a benefit has been paid for Cancer or Heart Attack, we will pay a benefit for a second Cancer or Heart Attack that occurs after the Critical Illness insurance has been restored.
  - In this case we will pay 10% of the Restored Critical Illness sum insured up to a maximum of $50,000. The benefit is not payable if it is less than $10,000.
  - The second Cancer or Heart Attack must be related to, arise from or be contributed to by (directly or indirectly, or wholly or partly) the cause of the original Cancer or Heart Attack.
- What happens after a second benefit has been paid for Cancer or Heart Attack on the Restored Critical Illness insurance?
  - The sum insured under the Restored Critical Illness insurance will reduce by the amount paid for the second Cancer or Heart Attack.
  - Critical Illness Buy Back will not be available for the amount paid in respect of the second Cancer or Heart Attack.
  - The sum insured under any subsequent exercise of the Critical Illness Buy Back Option following any other Critical Illness claim will exclude the amount paid for the second Cancer or Heart Attack.
- Increases without further medical evidence and the Financial Planning Benefit (unless the Financial Planning Benefit has not previously been paid) are not available for the Restored Critical Illness insurance.
- The policy owner and life insured will remain unchanged under the Restored Critical Illness insurance.
- You must ask us to restore your Critical Illness insurance before the Review Date after you turn 75.

Death Benefit (feature of Critical Illness Plus insurance)

If the Critical Illness stand-alone benefit isn't payable because you die within 14 days of being diagnosed with or undergoing a surgical procedure for a Critical Condition, we'll pay a lump sum benefit of $5,000.

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This benefit is in addition to any other amount payable under the policy.

We will not pay this benefit if you die by suicide within 13 months after Critical Illness insurance started, or was last reinstated.

If your insurance is replacing similar insurance, we will calculate the 13-month period from the start date of the replaced insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the 13-month period this way on the amount of the insurance you replaced.

Death Benefit (feature of TPD insurance)

If the TPD stand-alone benefit isn't payable because you die within 14 days of becoming TPD, we'll pay a lump sum death benefit of $5,000.

This benefit is in addition to any other amount payable under the policy.

We will not pay this benefit if you die by suicide within 13 months after TPD insurance started, or was last reinstated.

If your insurance is replacing similar insurance, we will calculate the 13-month period from the start date of the replaced insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the 13-month period this way on the amount of the insurance you replaced.

Double Critical Illness Plus insurance – Life Cover Buy Back Option

What is the benefit?

This option will automatically restore your Life Cover insurance (Restored Life Cover) by the same amount as the Critical Illness Benefit paid, without you having to provide additional evidence of health, occupation or pursuits.

What is the cost of restoring cover?

There is no cost in respect to the premium for the Restored Life Cover until the Review Date after you turn 65.

The acceptance terms of the Life Cover (including all loadings, exclusions and special terms) will continue to apply to the Restored Life Cover.

After the Review Date following your 65th birthday, your premium for the Restored Life Cover will be based on our premium rates at the time the Life Cover is restored, taking into account the benefit amount, your age, the premium and acceptance terms of the Life Cover.

When is cover restored?

If you receive your Critical Illness Benefit before the Review Date following your 65th birthday, and you live for a further 14 days, your Life Cover will be automatically restored.

If we receive your claim form after the Review Date following your 65th birthday, you can ask for your Life Cover to be restored 12 months from the later of:

- the date we receive your claim form, and
- the date you first meet the full Critical Illness Benefit definition

You have up to 30 days after the later of the above dates to ask for your Life Cover to be restored.

What are the conditions (including exclusions)?

- The Specific Accidental Injury Benefit under the Restored Life Cover will not be paid for any loss arising from or contributed to by sickness or injury for which a benefit has been paid under the original Double Critical Illness Plus insurance.
- If a Terminal Illness Support Benefit or Financial Planning Benefit has previously been paid it will not be available under the Restored Life Cover.
- The policy owner and life insured will remain unchanged under the Restored Life Cover.

For your Life Cover to be restored, your Critical Illness claim must be paid before the Review Date after you turn 75.

Additional conditions that apply after the Review Date following your 65th birthday

You cannot exercise this Life Cover Buy Back if a benefit for terminal illness which covers you has been paid previously.

How the payment of other benefits will reduce your Critical Illness benefit

If we pay:

- a Specific Accidental Injury benefit under a policy that is an Extension or Connection to this insurance, or
- a TPD benefit under a policy that is an Extension or Connection to this insurance,

we will reduce your Critical Illness benefit by the benefit paid.

We will reduce future Critical Illness premiums in line with the reduced benefit.

Double Total and Permanent Disability insurance – Life Cover Buy Back Option

What is the benefit?

This option will automatically restore your Life Cover insurance (Restored Life Cover) by the same amount as the TPD benefit paid, without you having to provide additional evidence of health, occupation or pursuits.

What is the cost of restoring cover?

There is no cost in respect to the premium for the Restored Life Cover until the Review Date after you turn 65. The acceptance terms of the Life Cover (including all loadings, exclusions and special terms) will continue to apply to the Restored Life Cover.

After the Review Date following your 65th birthday, your premium for the Restored Life Cover will be based on our premium rates at the time the Life Cover is restored, taking into account the benefit amount, your age, the premium and acceptance terms of the Life Cover.

When is cover restored?

If you receive your full TPD benefit before the Review Date following your 65th birthday, and you live for a further 14 days, your Life Cover will be automatically restored. If you receive your full TPD benefit after the Review Date following your 65th birthday, and you live for a further 12 months, you can ask us to restore your Life Cover benefit.

You can ask us to restore your Life Cover benefit up to 30 days after this date.

What are the conditions (including exclusions)?

- The Specific Accidental Injury Benefit under the Restored Life Cover will not be paid for any loss arising from or contributed to by sickness or injury for which a benefit has been paid under the original Double Total and Permanent Disability insurance.
- If a Terminal Illness Support Benefit or Financial Planning Benefit has previously been paid it will not be available under the Restored Life Cover.
- The policy owner and life insured will remain unchanged under the Restored Life Cover.
- For your Life Cover to be restored, your TPD claim must be paid before the Review Date after you turn:
  - 75 for Total and Permanent Disability insurance (Extension to Life Cover), or
  - 65 for Total and Permanent Disability insurance (Extension to Critical Illness).

Additional conditions that apply after the Review Date following your 65th birthday

You cannot exercise this Life Cover Buy Back if a benefit for terminal illness has been paid previously.

How payment of other benefits will reduce the TPD benefit

If we pay:

- a Critical Illness benefit, or
- a Specific Accidental Injury Benefit

under a benefit that this insurance is an Extension or Connection to, we will reduce your TPD benefit by the benefit paid. We will reduce future premiums in line with the reduced benefit.

Economiser (feature of Life Cover, TPD and Critical Illness insurances)

You can choose to freeze your Life Cover, TPD and Critical Illness insurance premiums (excluding the policy fee) by making a written request. It will take effect from the Review Date following your written request.

As a result:

- your premium will remain the same in the future, and
- your insurance amount will reduce at each Review Date, to an amount that can be purchased by the frozen premium.

Conditions for Economiser

- The Economiser is only available where your premium structure is a variable age-stepped premium (see page 44).
- The Economiser can only be exercised after the life insured's 30th birthday.
- Once the Economiser is exercised, Inflation Proofing, Increases without further Medical Evidence and the Business Safeguard Option will no longer apply.
- The Economiser must be exercised at the same time for all insurances on the policy, and for any insurance that the insurance benefit is connected to as an Extension.
- The premium freeze will take effect from the Review Date after the Economiser is exercised.
- The policy fee may change on each Review Date as described on page 41.
- The premium rate may change in the future as described on page 43.

Summary of the terms and conditions for lump sum insurances

- Any change to the insurance benefit (including increases, decreases and policy loading reviews) will reset the frozen premium at an amount applicable for the new insurance benefit as at the date of the change.
- Once Economiser is in place it can only be cancelled with our approval and cannot be cancelled while the premium is being waived.
- You must advise us in writing to take up Economiser.
- If the insurance benefit reduces to $10,000 or less, the premium freeze ends, and we will recalculate the premium for the insurance so that the insurance benefit does not fall below this minimum level.

Financial Planning Benefit (feature of Life Cover, Terminal Illness Support, TPD, Critical Illness, Child Critical Illness and Occupationally Acquired HIV, Hepatitis B or C Infection insurances)

We'll reimburse you part of the costs charged by a qualified financial adviser for a financial plan if we pay a lump sum benefit of $100,000 or more. The maximum amount of this benefit is $5,000. If there's more than one beneficiary of the insurance benefit, we'll divide the Financial Planning Benefit equally between those who each receive an insurance benefit of at least $100,000.

The reimbursement:

- must be claimed within 12 months of the date on which we pay the lump sum benefit, and
- will apply only once for all Acenda policies covering you.

Increases without further Medical Evidence (feature of Life Cover, TPD and Critical Illness Plus insurances)

Until the Review Date after you turn 55, you can apply to increase your Life Cover, TPD and Critical Illness insurances without further medical evidence if a specified personal or business event happens (see pages 64 - 65).

The increase must be applied for:

- between the day the relevant personal event happens and 30 days after the first Review Date following the event, or
- within 30 days of the first Review Date following the relevant business event.

You will need to provide financial evidence satisfactory to us that supports the increase requested, proof of the personal or business event and request the increase in writing.

Unless we otherwise agree, you can only apply for the increase as a result of a personal or a business event if:

- you were accepted for this insurance without any additional loadings due to your health,
- this insurance is not the result of applying the Life Cover Buy Back Option under TPD insurance or Critical Illness insurance,
- this insurance is not the result of applying the Critical Illness Buy Back Option under Critical Illness insurance, and
- you have not made, or are not entitled to make, a claim under this insurance.

Your premiums will rise in line with the increased insurance.

Personal event

You can apply to increase your Life Cover, TPD and Critical Illness insurances by up to 25% of your original insurance amount, subject to a maximum increase of $200,000, following any of these events:

- you or your Spouse adopt or give birth to a child,
- you get married or divorced,
- you complete an undergraduate degree at a Government-recognised university, or
- you receive an increase in your Earnings of at least 10% in the previous 12 months, or you have a Child who starts secondary school.

You can also apply to increase your Life Cover, TPD and Critical Illness insurances if you take out, or increase, a Mortgage to purchase or improve your home. In this case, the maximum increase we'll allow is the lesser of:

- 50% of your original insurance amount,
- the value of your new Mortgage,
- the value of the latest increase to your existing Mortgage, and
- $200,000.

Business event

You can apply to increase your Life Cover, TPD and Critical Illness insurances if the insurance is issued for one of the following purposes:

- a written ownership (buy/sell), share purchase or business continuation agreement under which you are a partner, shareholder or unit holder in the business,

- asset protection (loan guarantee) insurance, or
- Revenue Protection (Key Person) insurance if you're considered as such in the business (outside super only).

The increase will be in proportion to the increase in value of your financial interest in the business or of the key person to your business (as agreed with us) since the last Review Date.

The maximum increase we'll allow is the least of:

- 25% of your original insurance amount, and
- for a written ownership (buy/sell), share purchase or business continuation agreement under which you are a partner, shareholder or unit holder in the business, the increase, averaged over the preceding three years, in the net value of your financial interest in the business, and
- for asset protection (loan guarantee) insurance, the increase in that part of the business loan you are responsible for, which is averaged over the preceding three years, and
- for Revenue Protection (Key Person) insurance, five times the increase in your value to the business, averaged over the preceding three years, and
- $200,000.

What conditions apply to increases without further medical evidence?

Number and frequency of increases

Until the Review Date after you turn 55, you can apply for increases as many times as the listed events occur while you have the policy. However, you may only apply for one increase during any 12 month period.

Limitations

The maximum amount you can increase your insurance by is the lesser of your original insurance amount of each insurance (Life Cover, TPD or Critical Illness) or $2 million.

If you have more than one insurance policy with us, the maximum amount applies to the combination of all our insurance policies protecting you.

Each policy with the feature of Increases without further Medical Evidence will proportionally contribute to any increase.

The maximum cumulative amount of all increases for Life Cover, TPD and Critical Illness insurances (as applicable) for all policies protecting you is the least of:

- the total of your Life Cover or TPD or Critical Illness insurances (as applicable), and
- $2 million.

If you have TPD and/or Critical Illness insurance as part of your Life Cover, or as a connected benefit (see page 54), our maximum benefit limits for them still apply, and they can't collectively exceed your Life Cover insurance.

During the first six months after certain increases, the increased amounts cover you only for the following specified events caused by an Accident:

Life Cover: for marriage, divorce or Mortgage, the increase covers only death.

Critical Illness: for marriage, divorce or Mortgage, the increase covers only death and critical conditions.

TPD: whatever the reason for the increase, the increase covers only TPD. However, the increased insurance doesn't cover you for any TPD claim caused by sickness or injury that first happened within six months before the increase date.

Your premiums will rise in line with the increase in benefits.

Life Cover insurance

If you die while Life Cover insurance is in force, we will pay the Life Cover Benefit. It is paid to:

- each Nominated Beneficiary (according to their share of the benefit), or
- your personal legal representative (your estate) if there is no Nominated Beneficiary, or
- the policy owner if they are someone else.

Occupationally Acquired HIV, Hepatitis B or Hepatitis C Infection insurance

If while Occupationally Acquired HIV, Hepatitis B or Hepatitis C Infection insurance is in force, you:

- become infected with:
  - Human Immunodeficiency Virus (HIV),
  - Hepatitis B, or
  - Hepatitis C,

and

- the infection is a result of an accidental incident while:
  - at work, and
  - performing the normal duties of your occupation

we will pay the Occupationally Acquired HIV, Hepatitis B or C Infection Benefit.

Summary of the terms and conditions for lump sum insurances

You (or someone representing you) must tell us that:

- you may become infected within 14 days of the accidental incident, and
- you have become infected within 14 days of the diagnosis of infection.

We will send a claim form and/or instructions to you for the submission to us of proof of your entitlement to a benefit.

Documented proof must be provided by you to us that:

- the accidental incident did happen at work and involved a definite source of infection. The proof must include copies of the incident report, the name of the witnesses to the incident and confirmation of the source of infection, and
- the HIV, Hepatitis B or Hepatitis C is a new infection and that seroconversion from the relevant negative antibodies or antigens to positive antibodies or antigens has taken place within six months of the incident.

The proof will be based upon blood or body fluid samples tested by Australian Government-approved pathology laboratories. We must be allowed to independently retest the samples and take further samples for testing. If we do require retesting or further samples, we will pay for it.

Partial Payment Benefit (feature of TPD insurance)

If you suffer the total and irrecoverable loss of:

- the sight in one eye, or
- one foot, or
- one hand,

you'll receive the Partial Payment Benefit.

What we will pay

The Partial Payment Benefit payable will be the lesser of:

- 25% of the Total and Permanent Disability Benefit, and
- $500,000.

This benefit is not payable if it is less than $10,000.

Conditions that apply to the Partial Payment Benefit

The Partial Payment Benefit:

- will only be payable once, and
- will reduce the TPD Benefit by the amount paid.

Definitions for the Partial Payment Benefit

- Loss, or Loss of Use, of one foot or one hand - The total and irrecoverable :
  - loss, or
  - loss of use

  of one foot or one hand.
- Loss of sight in one eye - The permanent loss of sight in one eye, whether aided or unaided, due to sickness or injury to the extent that visual acuity is 6/60 or less.

Premium Waiver – When will we waive your premium?

You can apply for Premium Waiver insurance with Life Cover, TPD, Critical Illness, Child Critical Illness and Occupationally Acquired HIV, Hepatitis B or Hepatitis C Infection insurance.

Please note, Income Protection has its own Premium Waiver feature.

We'll waive your premiums for the insurances listed above if you're:

- suffering TPD under the 'Any Occupation' definition for at least 3 continuous months. Premiums will be waived for the period of disability up to age 65, or
- retrenched. If you're retrenched we'll waive your premiums for 12 months, as long as you've had this insurance and been with the same employer, on a full-time basis, for at least a year. We'll waive your premiums due to retrenchment only once in any five- year period. We will also waive any Income Protection insurance premiums on your policy, or
- suffering total disability. If you remain totally disabled for more than three months, premiums will be waived after these three months while you are totally disabled, up to age 65. If you purchase Premium Waiver insurance on a policy where Income Protection insurance also applies, we'll waive the premiums for your other insurances on the policy.

For Premium Waiver:

- 'Retrenched' means when your employer terminates your full-time employment because your position is no longer needed.

- 'Total disability' and 'totally disabled' means that solely due to Sickness or Injury, you are:
  - unable to perform at least one of the important duties of your occupation which is necessary to producing your Earnings, and
  - not working for Earnings, payment or profit, and
  - being regularly treated or monitored (as appropriate to your condition) by an appropriately qualified Doctor.

Terminal Illness Benefit

If you are diagnosed as having a Terminal Illness while this Life Cover insurance is in force, we will pay the Terminal Illness Benefit.

You do not have to return to Acenda the Terminal Illness Benefit paid if you survive the 24 month period.

For insurance outside super, Terminal Illness means an illness that, even with appropriate medical treatment, in the opinion of the treating Specialist, and where required, a further medical opinion from a Specialist approved by us, is likely to lead to death within a period that ends no more than 24 months from the date we are notified in writing by the approved Specialist.

For insurance inside super, Terminal Illness means an illness that, even with appropriate medical treatment, in the opinion of two Doctors, one of whom is a Specialist approved by us, is likely to lead to death within a period that ends no more than 24 months from the date the Doctors certify the condition ('the Certification Period'). Please notify us in writing of the Terminal Illness within the Certification Period.

Terminal Illness Support insurance

If, while Terminal Illness Support insurance is in force, you are:

- certified as having a Terminal Illness, and
- survive for 30 days after the date the Doctors certify the Terminal Illness,

we will pay the Terminal Illness Support Benefit.

You do not have to return to Acenda the Terminal Illness Support Benefit paid if you survive the 24 month period.

For insurance outside super, Terminal Illness means an Illness that, even with appropriate medical treatment, in the opinion of the treating Specialist, and where required, a further medical opinion from a Specialist approved by us, is likely to lead to death within a period that ends no more than 24 months from the date we are notified in writing by the approved Specialist.

For insurance inside super, Terminal Illness means an illness that, even with appropriate medical treatment, in the opinion of two Doctors, one of whom is a Specialist approved by us, is likely to lead to death within a period that ends no more than 24 months from the date the Doctors certify the condition ('the Certification Period'). Please notify us in writing of the Terminal Illness within the Certification Period.

TPD insurance – How much can you apply for?

You can apply for between $25,000 and:

- $5 million for certain professional occupations such as surgeons, accountants and solicitors, or
- $3 million for other occupations.

Once you reach the Review Date following your 65th birthday:

- the definition of TPD changes to a Loss of Independence definition, and
- if your benefit is over $3 million at that date, your maximum benefits will be reduced to $3 million.

Your financial adviser can help you work out which occupation group applies to you.

TPD Optimiser

You can apply for your TPD insurance using both Any and Own Occupation definitions.

However, if you select the TPD Optimiser option then the Any Occupation part of your TPD insurance is held inside super. The Own Occupation part of your TPD insurance is held outside super.

How does it work?

The total cost for your TPD Optimiser insurance is equivalent to Own Occupation TPD insurance.

The premiums will be split and consist of:

- the Any Occupation part, which will be paid through your insurance inside super,
- the Own Occupation part, which will be paid through your insurance outside super.

Summary of the terms and conditions for lump sum insurances

What happens if you claim?

First, we'll assess whether you meet the 'Any Occupation' TPD definition. If you do, then your TPD benefit will be paid under the policy inside super and your TPD insurance outside super will end.

If you don't meet the Any Occupation definition but do meet the Own Occupation definition, your benefit will be paid under your policy outside super, and your TPD insurance inside super will end.

You can only receive a TPD Optimiser benefit under one of the benefit definitions.

A benefit paid on your TPD Optimiser insurance will end that insurance on both policies and reduce the Life Cover and/or Critical Illness insurance it's attached to, as described on page 54.

What are the conditions for TPD Optimiser?

- TPD Optimiser must have the same benefit amount and the same options (except for the definition of TPD) across both policies.
- All alterations, additions, reductions and cancellations of the TPD insurance must be applied equally to both policies.
- Your TPD insurance held outside super will end on the Review Date after you turn 65. Your TPD insurance inside super will continue using the Loss of Independence definition (see pages 102 - 103). The conditions for continuing to pay premiums through super are on pages 46 - 47.

3. General exclusions that apply to:

- Life Cover insurance
- TPD insurance
- Critical Illness insurance
- Child Critical Illness insurance
- Occupationally Acquired HIV, Hepatitis B, or C Infection insurance
- Premium Waiver insurance

The general exclusions below apply to each insurance as described.

Certain benefits, features, options and definitions may have additional specific exclusions. These can be found in this PDS in the summary of the terms and conditions for the relevant benefit, feature or option, or in the relevant definition.

Life Cover – When won't a benefit be paid?

We won't pay a benefit for death or terminal illness arising from or contributed to by suicide or attempted suicide within 13 months after this insurance*:

- started,
- was last reinstated, or
- was increased (for the increase in the Life Cover insurance benefit).

Terminal Illness Support insurance – When won't a benefit be paid?

We won't pay a benefit for terminal illness arising from or contributed to by an intentional self-inflicted injury or attempted suicide within 13 months after this insurance*:

- started,
- was last reinstated, or
- was increased (for the increase in the insurance benefit).

TPD – When won't a benefit be paid?

You won't receive a benefit for any disability, condition or loss arising from or contributed to by:

- intentional self-inflicted injury or attempted suicide, or
- sickness or injury that first appeared, happened or was diagnosed before your insurance started, or was last reinstated (unless disclosed to, and accepted by us as part of the application or reinstatement process).

For stand-alone TPD insurance, you won't receive the death benefit of $5,000 if you die by suicide within 13 months after this insurance started or was last reinstated*.

Critical Illness – When won't a benefit be paid?

We won't pay a benefit or partial benefit for any critical condition arising from or contributed to by:

- intentional self-inflicted injury or attempted suicide, or
- sickness or injury that first appeared, happened or was diagnosed before your insurance started, or was last reinstated (unless disclosed to and accepted by us as part of the application or reinstatement process).

For stand-alone Critical Illness insurance, you won't receive the death benefit of $5,000 if you die by suicide within 13 months after this insurance started, or was last reinstated*.

Child Critical Illness – When won't a benefit be paid?

You won't receive a benefit for a condition arising from or contributed to by:

- the Child's intentional self-inflicted injury or suicide;
- sickness or injury that first appeared, happened or was diagnosed before the insurance started or was last reinstated (unless disclosed to and accepted by us as part of the application or reinstatement process), or
- an injury maliciously inflicted on the Child for the purpose of gain from this insurance.

Occupationally Acquired HIV, Hepatitis B or C Infection – When won't a benefit be paid?

For Hepatitis B

You won't receive a benefit for any infection starting within six months after this insurance started or was last reinstated.

* If your insurance is replacing similar insurance, we will calculate the 13-month period from the start date of the replaced insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the 13-month period this way on the amount of the insurance you replaced.

Summary of the terms and conditions for lump sum insurances

If your insurance is replacing similar insurance, we will calculate the 6-month period from the start date of the replaced insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the 6-month period this way on the amount of the insurance you replaced.

For HIV, Hepatitis B or C

We won't pay a benefit for any claim arising from or contributed to by:

- intentional self-inflicted infection,
- sickness, injury or infection that first appeared, happened or was diagnosed before this insurance started or was last reinstated (unless disclosed to, and accepted by, us as a part of the application or reinstatement process),
- diagnosis of infection first made after you die,
- infection after the appropriate Government body has recommended a preventative vaccine for use in your occupation, but only if you haven't taken this vaccine, or
- infection after the appropriate Government body has approved a treatment which makes infection inactive and non-infectious, but only if you don't undertake the treatment.

Premium Waiver – When won't we waive your premium?

Due to disability or retrenchment arising from or contributed to by:

- intentional self-inflicted injury or attempted suicide,
- normal and uncomplicated pregnancy or childbirth,
- sickness or injury that first appeared, happened or was diagnosed before your insurance started, or was last reinstated (unless disclosed to, and accepted by us, as part of the application or reinstatement process), or
- war or warlike operations.

Due to retrenchment if you're:

- self-employed,
- an independent contractor,
- employed by a member of your Family, a family company or family trust,
- a partner in a partnership,
- retrenched more than once from the same employment, or
- retrenched more than once in any five year period.

For any insurance increase you obtain in the 12 months before retrenchment, we'll only waive the premium which applied before the increase.

This insurance doesn't apply to any extra premium payable for insurance you add after you're retrenched or disabled, except where premiums are increased under Inflation Proofing (see page 44). We'll only waive the premium that applied before the addition.

4. General termination events - when the following insurances end:

- Life Cover insurance
- TPD insurance
- Critical Illness insurance
- Child Critical Illness insurance
- Occupationally Acquired HIV, Hepatitis B, or C Infection insurance
- Premium Waiver insurance

The general termination events below apply to each insurance as described.
Certain benefits, features, options may have additional criteria for when they'll end. These can be found in this PDS in the summary of the terms and conditions for the relevant benefit, feature or option.

Life Cover – When will your insurance end?

Your Life Cover and Terminal Illness Support insurance will end when:

- you cancel your insurance,
- we pay an amount equal to your full Life Cover or Terminal Illness Support insurance benefit (as applicable),
- your Life Cover is reduced to nil for any reason, for example if you receive a benefit for any Extension insurances linked to your Life Cover (see page 54),
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made, or
- you die.

For insurance inside super your insurance will also end if it's replaced by a non-super policy as detailed on pages 46 - 47.

TPD – When will your insurance end?

Your TPD insurance will end when:

- you cancel your insurance,
- you receive an amount equal to your full TPD insurance benefit,
- this insurance is reduced to nil by payments of Extension insurance benefits (see page 54),
- the Life Cover and/or Critical Illness insurance ends, to which this TPD insurance is an Extension,
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made, or
- you die.

For insurance inside super your insurance will also end if it's replaced by a non-super policy as detailed on pages 46 - 47.

Critical Illness – When will your insurance end?

Your Critical Illness insurance will end when:

- you cancel your insurance,
- you receive an amount equal to your full Critical Illness insurance benefit,
- this insurance is reduced to nil by Extension insurance benefit payments (see page 54),
- the Life Cover insurance ends, to which this Critical Illness insurance is an Extension,
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made, or
- you die.

Summary of the terms and conditions for lump sum insurances

Child Critical Illness – When will your insurance end?

Your Child Critical Illness insurance will end for a Child when:

- you cancel this insurance,
- you receive your full Child Critical Illness insurance benefit for that Child,
- the conversion to an adult policy is exercised,
- the insurance for the last adult Life Insured under the policy ends,
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made, or
- the Child dies.

Occupationally Acquired Hepatitis B or C Infection – When will your insurance end?

Your Occupationally Acquired HIV, Hepatitis B or C Infection insurance will end when:

- you cancel your insurance,
- you receive your full Occupationally Acquired HIV, Hepatitis B or C Infection insurance benefit,
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made, or
- you die.

Premium Waiver – When will your insurance end?

Your Premium Waiver insurance will end when:

- you cancel your insurance,
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premium isn't paid (except while you're claiming under this insurance),
- a fraudulent claim is made, or
- you die.

Summary of the terms and conditions for Income Protection and Business Expenses

In this section you'll find a summary of:

1. **General terms applying to both Income Protection and Business Expenses insurance,**
2. **Terms for Income Protection and Business Expenses insurance, benefits, features and options,**
3. **General exclusions, and**
4. **General termination events.**

The full terms and conditions that apply to your insurance are in the Policy Document, which we'll send to you when we accept your application.

1. General terms

Indemnity cover

Income Protection insurance is indemnity cover. This means that the benefit payable will be based on your income in the months prior to your disablement. This may mean that your actual monthly benefit amount is lower than the maximum Monthly Benefit you applied for and which is stated in your current Policy Schedule.

How much insurance can you apply for?

You can apply for a Monthly Benefit of up to $30,000, depending on your income. This includes the Super Guarantee Benefit (page 75) and the Booster Option, (page 78). This maximum includes all Income Protection insurances you hold with Acenda and other insurers.

Calculating your monthly benefit

Your monthly benefit amount will depend on whether you are entitled to a benefit for Total Disability or Partial Disability, please see pages 104 - 106.

If you are entitled to a Total Disability benefit, your monthly benefit amount will be the lesser of:

- the Monthly Benefit (and Booster Option amount for the first 6 months, if selected) you have applied and been accepted for; and
- your Income Replacement Ratio Amount.

Income Replacement Ratio Amount means the amount calculated by:

- multiplying the relevant part of your Earnings Before Disability per annum with the percentage specified in the table below; and
- dividing that amount by 12.

Your Earnings Before Disability (per annum)	Percentage	Booster Option (if applicable)
First $240,000	70%	20% (for 6 months only)
From $240,001 to $480,000	50%	20% (for 6 months only)
From $480,001 (subject to the maximum Income Protection benefit of $30,000) *	20%	20% (for 6 months only)

* This maximum applies to the combination of all your income protection insurance policies from all sources.

If you are entitled to a Partial Disability benefit, you will receive a proportion of the monthly benefit calculated to reflect the difference between your Earnings Before Disability and Earnings or Potential Earnings After Disability. See pages 104 - 106 for further information on Partial Disability Benefits.

If you are entitled to a Super Guarantee Benefit (see Super Guarantee Benefit Option on page 75) and the combination of the Super Guarantee Benefit with the monthly benefit for either the Total Disability or Partial Disability would result in a combined payment in excess of $30,000, the Super Guarantee Benefit amount will be reduced so that the combined payment does not exceed $30,000.

Additional terms relating to Partial Disability benefits

If you are entitled to a Partial Disability benefit, your monthly benefit will stop when your Earnings or Potential Earnings After Disability reaches 80% of your Earnings Before Disability (or 90% of your Earnings Before Disability in the first six months of a claim if the Booster Option is selected).

After receiving 12 consecutive Partial Disability monthly benefits, we may conduct a financial reconciliation for the purpose of determining any overpayment or underpayment.

Summary of the terms and conditions for Income Protection and Business Expenses

Where we identify an underpayment, we will pay you the amount of the underpayment. Where we identify an overpayment due to variations or deficiencies in the financial information provided by you, we may recover the amount of the overpayment by offsetting the overpayment against any amounts that may subsequently become due in respect of the Life Insured under the policy.

When carrying out a financial reconciliation, we will use your average monthly earnings post disability using information published in your end of year financial statements and/or tax returns.

In the instance that your Earnings After Disability reaches 80% of your Earnings Before Disability, we may finalise the claim.

If you're receiving Total Disability benefits, you won't be eligible for Partial Disability benefits.

Benefit Adjustments

We will reduce the Total Disability Benefit or Partial Disability Benefit (Disability Benefit) payable to you if you receive, or are entitled to receive, any payments (whether lump sum, periodic or otherwise) from the sources listed below.

Payments and entitlements from other sources that will reduce your Benefit

Your Disability Benefit will be reduced if you receive any of the following:

- any sick leave payments paid to you for the same period that Disability Benefits are payable,
- any annual leave payments paid to you during the period Disability Benefits are payable.

Your Disability Benefit will also be reduced if you receive, or are entitled to receive, any of the following:

- any amounts payable under workers' compensation or motor accident compensation legislation relating to loss of income or earning capacity due to disability,
- any amounts payable through the Department of Veterans' Affairs relating to loss of income or earning capacity due to disability,
- any benefits payable under any other income protection or similar insurance policy relating to loss of income or earning capacity due to disability, except benefits payable under an insurance policy that was disclosed to us when you applied for or increased this insurance,
- any benefits payable under any mortgage, loan or credit insurance policy due to disability,
- any payments or entitlement to receive a payment for past or future economic loss in respect of an injury, illness or disability that arise under statute or common law (whether or not statute modifies those benefits), and
- any other payments relating to loss of income or loss of earning capacity due to disability.

How we adjust your Benefit when the payment or entitlement is a lump sum

If any of the above amounts are payable as a lump sum (including by way of settlement or commutation), we will treat the lump sum as though it was paid or payable in equal monthly instalments for 8 years for the purpose of calculating the amount of the reduction to the Disability Benefit.

How your Benefit will be reduced

The reduction in the Disability Benefit will only be made to the extent required to ensure that the Disability Benefit, when added together with any payments from another source, does not reach:

- 70% of your Earnings Before Disability (or 90% in the first six months of a claim if the Booster option is selected) for Total Disability; or
- 80% of your Earnings Before Disability for Partial Disability (or 90% in the first six months of a claim if the Booster option is selected).

If your entitlement to a payment from another source is in dispute

If your entitlement to payments from another source is in dispute, we will pay your Disability Benefit which would otherwise be payable on a conditional basis until the dispute is resolved. If you are subsequently entitled to the other payments:

- you will repay to us the part of any Disability Benefit which would not have been paid if it were not for the conditional payment (excluding Super Guarantee Benefits); or
- we may at any time recover this amount by offsetting it against any amounts that may subsequently become due.

We may offset overpayments

Where we identify any overpayments, we will offset these amounts against any future payments under the policy.

When we will not reduce your Benefit

The Disability Benefit will not be reduced by:

- social security payments,
- any TPD benefit,
- compensation paid for pain or suffering, or
- super payments.

Super Guarantee Benefit Option

When we will pay

If you select this Option, while a Total Disability Benefit or a Partial Disability Benefit is payable and you are eligible to have contributions to super made on your behalf, we will pay a Super Guarantee Benefit into your nominated super fund.

The Super Guarantee Benefit is payable in addition to the monthly benefit for either Total Disability or Partial Disability (however, the combined Disability Benefit and Super Guarantee Benefit cannot exceed $30,000).

The Super Guarantee Benefit will end when the Total Disability Benefit or Partial Disability Benefit is no longer payable.

What we will pay

The amount of the Super Guarantee Benefit is the lesser of:

- the Super Guarantee Benefit amount shown in your Policy Schedule; and
- the average amount of the super guarantee payments made to your fund over the 12 months prior to Disability (or, one of the other periods in the following table, if applicable).

If one of the following applies to you, the period of time over which your super guarantee payments will be averaged in order to work out the amount of the Super Guarantee Benefit will be the period shown:

If:	Period that applies:
There was more than a 10% decrease in the super guarantee payments that were made in the 12 months prior to Disability compared with the 12 month period before that	The 24 months prior to Disability
In the 12 months prior to Disability, you worked more than 3 consecutive months but less than the full 12 months	The months you actually worked in the 12 months prior to Disability
You have been on unpaid employer approved maternity leave, paternity leave, sabbatical or study leave that commenced at any time in the 12 months immediately prior to Disability	The 12 months prior to starting leave

We will reduce the Super Guarantee Benefit payable to you by the amount of any super payments (excluding voluntary super contributions) made to your fund for the same period that Disability Benefits are payable.

Conditions that apply to the Super Guarantee Benefit Option

The Super Guarantee Benefit cannot be paid to you directly and will be paid as a concessional contribution in your name to your nominated super fund. The super fund must be a complying super fund or retirement savings account and contributions must be permitted by super and tax legislation.

If you need to make a claim on your insurance, you will need to provide details of your super fund or retirement savings account for the benefit to be paid.

Your Super Guarantee Benefit will not be included as income for the purposes of determining your Total Disability Benefit or Partial Disability Benefit.

You cannot convert the Super Guarantee Benefit to any other type of benefit.

The Super Guarantee Benefit cannot be cancelled or removed while you are receiving benefits under the policy.

Claim requirements

If you are Disabled, you should tell us as soon as reasonably practicable after the beginning of the Disability, preferably within 30 days of the Disability beginning.

You can lodge your claim by telephone or we can send you a claim form to complete.

We may ask you to provide us with:

- A report from your treating doctor and other medical information;
- Financial information which may include income information and details of other payments you are entitled to receive.

Summary of the terms and conditions for Income Protection and Business Expenses

We request that you return the completed claim form, report from your treating Doctor, financial information and any other information we request as soon as reasonably practicable, preferably within 90 days of the Disability beginning.

During any period that you are claiming a benefit, we may require ongoing proof that you remain entitled to a benefit, including further medical, employment and financial information.

If requested by us, you must fully participate in any:

- medical examinations conducted by an appropriately qualified doctor appointed by us, and
- examination, interview or assessment by other appropriate professionals appointed by us, including functional, employability or vocational assessments, psychological assessments, factual interviews or financial audits.

If we require any of these examinations, interviews or assessments, we will pay for it.

When do benefits end?

We'll continue to pay benefits until the earliest of:

- you stop being Totally or Partially Disabled,
- you reach your maximum benefit period,
- you unreasonably refuse to undergo or comply with recommended medical treatment or rehabilitation to reduce your disability,
- you have been outside of Australia for three continuous months unless we are satisfied, based on medical evidence, that solely due to Sickness or Injury you are unable to return to Australia (unless we agree otherwise), or
- your Income Protection insurance ends.

Regular medical treatment

Income Protection benefits will only be paid while you are regularly attending a Doctor for your Sickness or Injury and following that Doctor's advice and recommendations for treatment and rehabilitation.

This may include taking prescribed medication or complying with the recommended treatment regime or rehabilitation plan.

Return to work during the Waiting Period

Income Assure+

You can return to work during the Waiting Period.

When your Waiting Period is 14, 30 or 90 days, and you remain at least Partially Disabled, your Waiting Period will not restart if you return to work during the Waiting Period.

If your Waiting Period is more than 90 days, and you return to work at full capacity, the Waiting Period will be extended by the number of days you work. If you return to work for more than 10 consecutive days, your Waiting Period will restart.

Income Assure and Business Expenses (including Platinum Option)

You can return to work during the Waiting Period. The days you work don't have to be consecutive, but the Waiting Period will be extended by the number of days you work.

When your Waiting Period is 14 days or 30 days, and you return to work for more than five consecutive days, your Waiting Period will restart.

If your Waiting Period is more than 30 days, and you return to work for more than 10 consecutive days, your Waiting Period will restart.

For Business Expenses insurance with the Platinum Option, return to work means that you've returned to work at full capacity.

What happens if you are unemployed?

Income Assure and *Income Assure+*

If the policy is owned by a super trustee

No Disability Benefit is payable under this Policy if you become Disabled while you are unemployed and your Disability did not cause you to cease to be Gainfully Employed. At no additional cost, however, and while your *Income Assure* or *Income Assure+* insurance is in force, we provide a separate cover that may enable Disability Benefits to be paid if you become Disabled while unemployed. This cover is provided to you separately as a 'Certificate of Insurance for Disability While Unemployed' (Certificate) and is not owned by the trustee of a super fund.

Benefits may be payable under this Certificate if no Disability Benefit is payable under your *Income Assure* or *Income Assure+* insurance solely because you were unemployed when you became Disabled.

All options, settings, exclusions and any special terms, that apply to your *Income Assure* or *Income Assure+* insurance when you become Disabled apply to your cover under this Certificate.

The Certificate is issued on the basis that you comply with the duty to take reasonable care not to make a misrepresentation when you apply for *Income Assure* or *Income Assure+* insurance. For information about this duty and consequences of failing to comply, see pages 114 - 115.

For more information and full terms that apply, please refer to the Certificate of Insurance for Disability While Unemployed, Preparation Date 16 November 2024, available at **acenda.com.au/pds** or call us on **13 65 25** for a copy.

If the Policy is not owned by a super trustee

You may be eligible for benefits if you become Disabled while you are unemployed, however benefits may be reduced if your Earnings Before Disability have decreased due to your unemployment. If you are unemployed for 12 months or more immediately prior to Disability, you will not be eligible for benefits because Earnings Before Disability is reduced to nil.

You should review your insurance as your circumstances change and speak with your financial adviser to help decide if your insurance remains appropriate for your needs.

What is sabbatical leave?

This means leave taken for study or travel as a normal part of your occupation.

Business Expenses

How does Business Expenses work?

If you're self-employed, or operate a small business, you'll be reimbursed for certain business expenses incurred while you're Totally Disabled, up to your monthly benefit amount for up to 12 months.

If there's more than one person who owns and operates the business, you'll receive your share of the covered business expenses proportionate to the share of the business that you own and operate.

If you're paid less than the full benefit over a year, we'll extend the benefit period while you continue to be disabled for the lesser of another 12 months or until you've been reimbursed an amount equal to the full 12 months' benefit.

If you change businesses, the policy is portable. You have the flexibility to apply this insurance to your new business.

This insurance isn't available if you work in a special risk occupation.

What is a Covered Expense under Business Expenses?

The Covered Expenses are the reasonable and regular normal operating expenses of the business you own and manage, including:

- rent or mortgage payments,
- property levies, rates and taxes,
- equipment or vehicle lease costs,
- electricity, heating and water costs,
- cleaning and laundry costs,
- depreciation on office equipment and premises that the business owns,
- salaries of employees not generating business income,
- costs of accounting services,
- fees for memberships of professional associations,
- business insurance premiums, and
- net cost of a locum.

Covered Expenses do not include:

- any expense that wasn't normally paid before the Disability,
- repayment of the principal of a loan or mortgage that started less than one year before the Disability,
- the cost of equipment or merchandise for the Business, and
- payments or other benefits of any kind to you.

You'll receive a proportion of your Monthly Benefit (1/30th each day) if you're disabled for part of a month.

Expenses which are paid for, or relate to a period of two or more months, will be allocated proportionally for the purpose of calculating the Monthly Benefit.

Summary of the terms and conditions for Income Protection and Business Expenses

2. Summary of terms for:

- Income Protection insurance
- Business Expenses insurance

The full terms and conditions that apply to your insurance are in your Policy Document, which we'll send to you when we accept your application.

Refer to pages 32 - 33 to view the different options available for *Income Assure* and *Income Assure+*

Age 70 benefit period (available with *Income Assure+* insurance only)

If your benefit period is to age 70, your *Income Assure+* insurance will only cover Total Disability and Partial Disability from the Review Date following your 65th birthday. All other benefits and options will cease on the Review Date following your 65th birthday.

Booster Option (available with *Income Assure+* insurance only)

If you select the Booster Option and you are Totally Disabled or Partially Disabled we will pay the Booster Benefit as described below, for up to 6 months.

Calculating your Booster Benefit

If you have the Booster Option:

- the Booster Option amount you have applied and been accepted for will be added to your Monthly Benefit, and
- 20% will be added to the percentage used to calculate your Income Replacement Ratio amount.

You can only select the Booster Option on one *Income Assure+* insurance covering you.

Death Benefit (feature of *Income Assure* and *Income Assure+* insurances)

Your estate will receive six months' benefit as a lump sum if you die while your policy is in force. The maximum benefit is $60,000.

The Death Benefit is payable in addition to any other Benefits that have been paid or are payable. However, if we have paid monthly benefits after you have died, we will deduct these from the Death Benefit.

We will not pay this Death Benefit if the Life Insured dies by suicide within 13 months after this *Income Assure/Income Assure+* insurance started, or was last reinstated.

If your insurance is replacing similar insurance, we will calculate the 13-month period from the start date of the replaced insurance if you held that similar insurance or replacement insurance continuously since that date. We will only calculate the 13-month period this way on the amount of the insurance you replaced.

Death Benefit (feature of Business Expenses insurance)

This insurance pays three months' benefit as a lump sum if you die while the policy is in force.

The maximum benefit is $30,000.

However, if we have paid monthly benefits after you have died, we will deduct these from the Death Benefit.

Cover for Elective Surgery *Income Assure* and *Income Assure+*

You may be eligible for a monthly benefit if you're unable to work because you have undergone:

- elective surgery performed on the advice of an appropriately qualified Doctor,
- an operation to improve your appearance as a result of a sickness or injury, or
- surgery to donate a body organ or bone marrow to another person.

The surgery must take place more than six months after your insurance started, was last reinstated or increased. If you undergo elective or cosmetic surgery within six months of an increase to your Monthly Benefit, we'll only pay the Monthly Benefit that applied before the increase.

In all cases the surgery must be performed by an appropriately qualified Doctor.

Extended Cover to age 70 (feature of *Income Assure* and *Income Assure+* insurances)

If your benefit period is 2 years, 5 years or to age 65, your Income Protection insurance will be automatically extended beyond the Review Date following your 65th birthday if, at that time:

- you are working in Gainful Employment on a full-time basis, and

- you have not ever received, are not receiving, and are not entitled to receive, a Disability Benefit.

If the above requirements are met, your *Income Assure* or *Income Assure+* insurance will be extended until the earlier of:

- you turning 70,
- the date you retire or stop full-time work for six months, or
- the insurance otherwise ends as described in *Income Assure* and *Income Assure+* – When will your insurance end? (see page 88).

The following conditions will apply to Extended Cover from the Review Date following your 65th birthday:

- you will only be covered for Total Disability. All other benefits and options will cease,
- for claims made in relation to any Sickness or Injury or related Sicknesses or Injuries, we will pay a maximum of 12 monthly benefits only, and
- the Waiting Period will be the greater of that shown in your current Policy Schedule and 30 days.

These conditions will not apply to:

- any claim for a Disability where the Waiting Period started before the Review Date following your 65th birthday, or
- any Recurrent Disability claim which is being treated as a continuation of a previous Disability claim (see page 83).

Increases Without Further Medical Evidence (feature of *Income Assure* and *Income Assure+* insurances)

You can request an increase in your *Income Assure* and *Income Assure+* Monthly Benefit of up to 20%, without needing to provide further medical evidence. This is subject to the maximum insurable amount calculated based on the table on page 73 when any of the following events happen:

- you or your Spouse adopt or give birth to a child,
- you get married or divorced,
- you complete an undergraduate degree at a Government-recognised university,
- you receive an increase in your Earnings of at least 10% in the previous 12 months,
- you have a Child who starts secondary school, or
- if you take out, or increase, a Mortgage to purchase or improve your home.

You will need to provide financial evidence satisfactory to us to support the increase requested, proof of the event and request the increase in writing.

Conditions

The application for an increase in the Monthly Benefit must be made between the date the relevant event happens and 30 days after the first Review Date following the event.

Under this feature you can only apply for one increase during any 3 year period. However, you can bring forward an application for increase, so that you can apply for an additional increase during a 3 year period, subject to the following conditions:

- you can only bring forward an application for increase 4 times,
- if you bring forward an application for increase, the Review Date will then commence from the date of the increase for the purposes of Personal Event increases, and
- you cannot bring forward an application for increase if you're on claim under the policy including during the Waiting Period.

Your Monthly Benefit cannot be increased if:

- you are over age 55,
- you are being paid a benefit or are eligible to make a claim for a benefit,
- a medical loading or exclusion applies to your insurance, or the total Income Protection Insurances you hold is $30,000.

For the first 12 months after your monthly benefit is increased without further medical evidence, the increased Monthly Benefit is only payable for Total Disability or Partial Disability caused by an Accident.

Indexed Claim Benefit

To make sure benefits keep pace with inflation, your Monthly Benefit and Earnings Before Disability will be increased annually, up to but not exceeding the Maximum Income Protection Benefit, after your monthly benefit has been paid continuously for a full year. The increase will be equal to the most recent annual CPI rate available at the date we calculate the increase.

Summary of the terms and conditions for Income Protection and Business Expenses

Partial Disability Benefit (feature of *Income Assure+* insurance)

When we will pay

If you are Disabled for longer than the Waiting Period while this insurance is in force and the Total Disability Benefit is not payable, we will pay you the Partial Disability Benefit. For insurance inside super, you must also have satisfied the SIS definition of Temporary Incapacity before any benefits are payable.

The Partial Disability Benefit starts to accrue the day after the Waiting Period ends. The first payment will be due one month later. We will keep paying the Partial Disability Benefit each month while you are Disabled, for up to the benefit period shown in your Policy Schedule. For details see When do benefits end on page 76.

If your Waiting Period is 14, 30 or 90 days and you remain at least Partially Disabled, the Waiting Period will not restart if you return to work during the Waiting Period.

If your Waiting Period is greater than 90 days and you can return to work at full capacity during the Waiting Period:

- your Waiting Period will be extended by the number of days you are at work at full capacity; and
- if you return to work at full capacity for more than 10 consecutive work days, then the Waiting Period will restart.

Partial Disability Benefits that start within 12 months before:

- the Termination Date for all benefit periods, or
- the Review Date following your 65th birthday if your benefit period is 2 years, 5 years or to age 65,

will be payable while you continue to be Partially Disabled for a maximum of 12 months.

If your Waiting Period for a claim first starts while your insurance is in force but it is longer than the period of time remaining before the Policy is due to terminate, then provided also:

- you are Disabled for the entire Waiting Period, and
- at the end of the Waiting Period you are Partially Disabled, Partial Disability Benefits will be payable at the end of the Waiting Period while you continue to be Partially Disabled for a maximum of 12 months.

What we will pay

We will pay you a proportion of the Monthly Benefit, calculated to reflect the difference between your Earnings Before Disability and your Earnings or Potential Earnings After Disability.

We will pay you the lesser of:

a. $$\frac{\text{(Earnings Before Disability - Earnings or Potential Earnings After Disability)}}{\text{Earnings Before Disability}} \times \text{Monthly Benefit (and Booster Option amount for the first 6 months, if selected)}$$

b. $$\frac{\text{(Earnings Before Disability - Earnings or Potential Earnings After Disability)}}{\text{Earnings Before Disability}} \times \text{the Income Replacement Ratio Amount}$$

subject to any adjustments as detailed in Benefit Adjustments (see pages 74 - 75).

Your monthly benefit will stop when your Earnings or Potential Earnings After Disability reaches 80% of your Earnings Before Disability (or 90% in the first six months of a claim if the Booster Option is selected).

After receiving 12 consecutive Partial Disability Benefits, we may conduct a financial reconciliation for the purpose of determining any overpayment or underpayment.

Where we identify an underpayment, we will pay you the amount of the underpayment. Where we identify an overpayment due to variations or deficiencies in the financial information provided by you, we may recover the amount of the overpayment by offsetting the overpayment against any amounts that may subsequently become due in respect of the Life Insured under the policy.

When carrying out a financial reconciliation, We will calculate your average monthly Earnings while Disabled using information published in your end of year financial statements and/or tax returns.

In the instance that your Earnings while Disabled equal or exceed your Earnings Before Disability, we may finalise the claim due to financial loss not occurring.

Partial Disability Benefit (feature of *Income Assure* insurance)

When we will pay

We will pay you the Partial Disability Benefit:

- if you are Partially Disabled while this insurance is in force,
- if you were Totally Disabled for at least 14 days immediately before being Partially Disabled (except where Partial Disability is due to one of the conditions specified in No preceding Total Disability required for certain specified conditions (see this page and the next page), and
- if the Waiting Period is longer than 14 days, you were either Partially or Totally Disabled for the remainder of the Waiting Period.

For insurance inside super, you must also have satisfied the SIS definition of Temporary Incapacity before any benefits are payable.

The Partial Disability Benefit starts to accrue the day after the Waiting Period ends. The first payment will be due one month later. We will keep paying the Partial Disability Benefit each month while you are Partially Disabled, for up to the benefit period shown in your Policy Schedule. For details see When do benefits end (page 76).

If your Waiting Period is 14 days or 30 days and you return to work during the Waiting Period:

- your Waiting Period will be extended by the number of days you are at work in your full capacity, and
- if you return to work in your full capacity for more than 5 consecutive work days, then your Waiting Period will restart.

If your Waiting Period is greater than 30 days and you return to work during the Waiting Period:

- your Waiting Period will be extended by the number of days you are at work in your full capacity, and
- if you return to work in your full capacity for more than 10 consecutive work days, then your Waiting Period will restart.

Partial Disability Benefits that start within 12 months before either the Termination Date or the Review Date following your 65th birthday will be payable while you continue to be Partially Disabled for a maximum of 12 months.

If your Waiting Period for a claim first starts while this insurance is in force but it is longer than the period of time remaining before the Policy is due to terminate, then, provided also:

- you are Disabled for the entire Waiting Period, and
- at the end of the Waiting Period you are Disabled,

Partial Disability Benefits will be payable at the end of the Waiting Period while you continue to be Partially Disabled for a maximum of 12 months.

No preceding Total Disability required for certain specified conditions

Where Partial Disability is due to one of the conditions below, a preceding period of Total Disability is not required to be eligible for a Partial Disability Benefit. For insurance inside super, you must also have satisfied the SIS definition of Temporary Incapacity before any benefits are payable.

- **Motor Neurone Disease** - unequivocal diagnosis. The progressive weakening and wasting of the muscles of the body.

  The unequivocal diagnosis of motor neurone disease must be certain and supported by neurological investigations.
- **Multiple Sclerosis** - of specified severity. The progressive destruction of the insulating layer of myelin in the brain and / or spinal cord. The unequivocal diagnosis of Multiple Sclerosis must be by a consultant neurologist.

  There must be more than one episode of defined neurological deficit with persistent abnormalities.

  Neurological investigations such as lumbar puncture, MRI (Magnetic Response Imaging), evidence of lesions in the central nervous systems and evoked visual responses are required to confirm diagnosis.
- **Muscular Dystrophy** - unequivocal diagnosis. The unequivocal diagnosis of muscular dystrophy by a medical practitioner who is a consultant neurologist on the basis of confirmatory neurological investigations.

Summary of the terms and conditions for Income Protection and Business Expenses

- **Parkinson's Disease** - of specified severity. The unequivocal diagnosis of degenerative idiopathic Parkinson's disease, as characterised by the clinical manifestation of one or more of:
  - rigidity
  - tremor
  - akinesia from degeneration of the nigrostriatal system.

  All other types of parkinsonism (including but not limited to parkinsonism secondary to medication, vascular disease, drugs, metabolic conditions and infections) are excluded. The condition must be diagnosed by a Specialist and confirmed by our medical adviser.
- **Parkinson-Plus Syndrome** - unequivocal diagnosis. The unequivocal diagnosis by a Neurologist of one of the following Parkinson-Plus (atypical parkinsonian) Syndromes:
  - Multiple Systems Atrophy (MSA)
  - Progressive Supranuclear Palsy (PSP)
  - Corticobasal Degeneration/ Syndrome (CBD)
  - Dementia with Lewy bodies (DLB)

  The conditions stated above must be irreversible.

  All other types of Parkinsonism (including but not limited to parkinsonism secondary to medication, vascular disease, drugs, metabolic conditions and infections) are excluded. The condition must be diagnosed by a Specialist and confirmed by our medical adviser.

What we will pay

We will pay you a proportion of the Monthly Benefit, calculated to reflect the difference between your Earnings Before Disability and your Earnings or Potential Earnings After Disability.

The amount we will pay you will be the lesser of:

a. $$\frac{\text{(Earnings Before Disability - Earnings or Potential Earnings After Disability)}}{\text{Earnings Before Disability}} \times \text{Monthly Benefit}$$

b. $$\frac{\text{(Earnings Before Disability - Earnings or Potential Earnings After Disability)}}{\text{Earnings Before Disability}} \times \text{the Income Replacement Ratio Amount}$$

subject to any adjustments as shown in Benefit Adjustments (see pages 74 - 75).

Your monthly benefit will cease when your Earnings or Potential Earnings After Disability reaches 80% of your Earnings Before Disability.

After receiving 12 consecutive Partial Disability Benefits, we may conduct a financial reconciliation for the purpose of determining any overpayment or underpayment.

Where we identify an underpayment, we will pay you the amount of the underpayment. Where we identify an overpayment due to variations or deficiencies in the financial information provided by you, we may recover the amount of the overpayment by offsetting the overpayment against any amounts that may subsequently become due in respect of the Life Insured under the policy.

When carrying out a financial reconciliation, we will calculate your average monthly Earnings from when you become Disabled using information published in your end of year financial statements and tax returns.

In the instance that your Earnings from when you become Disabled equal or exceed Earnings Before Disability, we may finalise the claim due to financial loss not occurring.

Premium Waiver (feature of *Income Assure* and *Income Assure+* insurance)

Your Income Protection premiums will be waived while you're receiving benefits.

Any premiums paid while you're Disabled and receiving benefits, including during the Waiting Period, will be refunded.

Premiums for other types of insurances will still be due.

Premium Waiver (feature of Business Expenses insurance)

Your Business Expenses insurance premiums, including premiums paid during the Waiting Period, will be refunded to you while you're disabled and you're receiving benefits.

Premiums for other types of insurances will still be due.

Recurring Disability (feature of *Income Assure* and *Income Assure+* insurances)

If you suffer a Recurrent Disability we will treat it as a continuation of the previous Disability (for the purposes of the Waiting Period and determining the benefit period) if:

- the Recurrent Disability occurs within 6 months of the previous Disability stopping, and
- either:
  - your benefit period is to age 70, or
  - the Recurrent Disability starts before the Review Date following your 65th birthday, or
  - the Recurrent Disability starts after the Review Date following your 65th birthday but the monthly benefits for the previous Disability had started less than 12 months before that Review Date.

If the Recurrent Disability is a continuation of the previous Disability, then:

- no Waiting Period will apply to the Recurrent Disability claim if the Waiting Period had been satisfied under the previous Disability claim, and
- the benefit period for both the previous Disability and the Recurrent Disability combined will not exceed the benefit period shown in your current Policy Schedule.

However, where your previous Disability started less than 12 months before:

- the Termination Date, or
- the Review Date following your 65th birthday (where your benefit period is 2 years, 5 years or to age 65),

monthly benefits will be payable for the Recurrent Disability while you continue to be Disabled for a maximum of 12 months only, despite any other provision.

Recurring Disability (feature of Business Expenses insurance)

If your disability recurs after you returned to work, while this insurance is in force, and within six months of your return to full-time work, we'll consider it a continuation of your previous disability.

If this is the case, you can continue your claim as soon as the disability recurs, with no new Waiting Period.

The cause of the disability must be the same as, or related to, the previous disability for which you have received a benefit.

If the disability recurs after six months, we'll treat it as a new claim.

Rehabilitation Expenses (outside super only - feature of *Income Assure* and *Income Assure+* insurances)

If you are Disabled, we will pay a third party provider for the provision of occupational rehabilitation services, such as the cost of a rehabilitation and/or retraining course or special equipment which will directly assist you to return to work. The rehabilitation service must be approved by us in advance of the provision of the service.

This amount could be up to 12 times your monthly benefit and is paid in addition to your Total or Partial Disability benefits and any other benefits.

Severe Disability Terms Removal Option (Available with *Income Assure* insurance only)

If you have selected this Option, after two years on claim the definitions of Total Disability and Partial Disability will not require you to be Severely Disabled.

Summary of the terms and conditions for Income Protection and Business Expenses

Short Waiting Period for Accidental Injury and Critical Illness Option (feature of *Income Assure+* insurance only, only where 14 or 30 day Waiting Periods apply)

If you have selected this Option you will be eligible to receive Benefits during the Waiting Period if you are Totally Disabled for at least three consecutive days as a result of:

- an Accident and the Total Disability occurred within 30 days of the date of the Accident; or
- a Critical Condition (or symptoms of a later diagnosed Critical Condition)

Benefit

We will pay 1/30th of the Monthly Benefit amount for each day you are Totally Disabled during the Waiting Period.

This benefit will accrue from the first day that you are Totally Disabled and will continue until the earlier of:

- the end of the Waiting Period, or
- until you are no longer Totally Disabled.

This benefit will be paid in arrears.

Critical Illness Conditions

The Critical Conditions covered have specifically defined meanings. We do not consider that you have a Critical Condition if you do not meet the definition for that Critical Condition.

The Critical Conditions are:

- Cancer - excluding specified early stage cancers,
- Coma - with specified criteria,
- Heart Attack - with evidence of heart muscle damage,
- Major Burns - of specified severity, and
- Stroke - in the brain and of specified severity.

There is no cover for a Critical Condition until you are first diagnosed as fully meeting our definition of the Critical Condition. The definitions for these Critical Illness Conditions can be found on pages 90 - 98.

Exclusion Periods

- The Short Waiting Period will not apply for a Critical Condition if the Critical Condition is one of the following Critical Conditions and symptoms of the Critical Condition first appeared or happened, or the Critical Condition was diagnosed during the first 3 months after this *Income Assure+* insurance started or was last reinstated:
  - Heart Attack - with evidence of heart muscle damage
  - Stroke - in the brain and of specified severity
  - Cancer - excluding specified early stage cancers; or

If there is a reappearance, recurrence, or subsequent diagnosis of a Critical Condition, following a first appearance, happening or diagnosis of that condition within the exclusion period shown above, the Waiting Period will only be shortened if it can be proven that the reappearance, recurrence or subsequent diagnosis is independent of, and not related to, the earlier appearance, happening or diagnosis.

If this *Income Assure+* insurance is a replacement of similar insurance, the exclusion periods set out above will be waived to the extent that the waiting period would have been shortened under the replaced insurance had it continued in force.

Condition must meet the definition

The specified Critical Condition must meet all the terms of its definition. It must be diagnosed by a Specialist and confirmed by our medical adviser.

Short Waiting Period for Accidental Injury Option (feature of *Income Assure* only, only where 14 or 30 day Waiting Periods apply)

This Option allows you to receive benefits sooner by paying you a benefit during the Waiting Period if your Total Disability:

- is caused by an Accident, and
- it begins within 30 days of the Accident.

To be eligible for this benefit you must be Totally Disabled as a result of an Accident for a period of at least three consecutive days from the day you first seek medical advice for your injury.

We will pay 1/30th of the Monthly Benefit for each day you are Totally Disabled during the Waiting Period.

This benefit will accrue from the first day that you are Totally Disabled and will continue until the earlier of:

- the end of the Waiting Period, or
- until you are no longer Totally Disabled.

This benefit will be paid in arrears.

Total Disability Benefit (feature of *Income Assure+* insurance only)

When we will pay

If you are Disabled for longer than the Waiting Period while this insurance is in force, and at the end of the Waiting Period you are Totally Disabled, then we will pay you the Total Disability Benefit. You must be Disabled for the entire Waiting Period. The Total Disability Benefit starts to accrue the day after the Waiting Period ends.

For insurance inside super, you must also have satisfied the SIS definition of Temporary Incapacity before any benefits are payable.

The first payment will be due one month later. We will keep paying the Total Disability Benefit each month while you are Totally Disabled, for up to the benefit period shown in your current Policy Schedule.

For details see When do benefits end (see page 76).

If your Waiting Period is 14, 30 or 90 days and you remain at least Partially Disabled, the Waiting Period will not restart if you return to work during the Waiting Period.

If your Waiting Period is longer than 90 days and you return to work in your full capacity during the Waiting Period:

- the Waiting Period will be extended by the number of days you are at work in your full capacity; and
- if you return to work in your full capacity for more than 10 consecutive work days, then your Waiting Period will restart.

Total Disability Benefits that start within 12 months before:

- the Termination Date for all benefit periods; or
- the Review Date following your 65th birthday if your benefit period is 2 years, 5 years or to age 65,

will be payable while you continue to be Totally Disabled for a maximum of 12 months.

If the Waiting Period for a claim first starts while this insurance is in force but it is longer than the period of time remaining before the Policy is due to terminate, then, provided also:

- you are Disabled for the entire Waiting Period, and
- at the end of the Waiting Period you are Totally Disabled,

Total Disability Benefits will be payable at the end of the Waiting Period while you continue to be Totally Disabled for a maximum of 12 months.

Benefits are not concurrently payable for both Total and Partial Disability for the same period of disability.

What we will pay

The amount we will pay you will be the lesser of:

a. the Monthly Benefit (and Booster Option amount for the first 6 months, if selected), and

b. the Income Replacement Ratio Amount

subject to any adjustments shown in Benefit Adjustments (see pages 74 - 75).

Total Disability Benefit (feature of *Income Assure* insurance only)

When we will pay

If you are Totally Disabled for longer than the Waiting Period while this insurance is in force, we will pay you the Total Disability Benefit. You must be Totally Disabled for the entire Waiting Period. The Total Disability Benefit starts to accrue the day after the Waiting Period ends.

For insurance inside super, you must also have satisfied the SIS definition of Temporary Incapacity before any benefits are payable.

The first payment will be due one month later. We will keep paying the Total Disability Benefit each month while you are Totally Disabled, for up to the benefit period shown in your current Policy Schedule.

For details see When do benefits end (see page 76).

If your Waiting Period is 14 days or 30 days and you return to work during the Waiting Period:

- your Waiting Period will be extended by the number of days you are at work, and
- if you return to work for more than 5 consecutive work days, then your Waiting Period will restart.

If your Waiting Period is longer than 30 days and you returns to work during the Waiting Period:

- the Waiting Period will be extended by the number of days you at work, and
- if you return to work for more than 10 consecutive work days, then the Waiting Period will restart.

Summary of the terms and conditions for Income Protection and Business Expenses

Total Disability Benefits that start within 12 months before either the Termination Date or the Review Date following your 65th birthday will be payable while you continue to be Totally Disabled, for a maximum of 12 months.

If the Waiting Period for a claim first starts while this insurance is in force but it is longer than the period of time remaining before the Policy is due to terminate, then, provided also:

- you are Disabled for the entire Waiting Period, and
- at the end of the Waiting Period you are Totally Disabled,

Total Disability Benefits will be payable at the end of the Waiting Period while you continue to be Totally Disabled for a maximum of 12 months.

Benefits are not concurrently payable for both Total and Partial Disability for the same period of disability.

What we will pay

We will pay you the lesser of:

a. the Monthly Benefit, and

b. the Income Replacement Ratio Amount,

subject to any adjustments shown in Benefit Adjustments (see pages 74 - 75)

Waiting Period Conversion (feature of *Income Assure* and *Income Assure+* insurances)

You can apply to change the Waiting Period of your insurance from 24 months to 90 days without further medical evidence if you have left your employer and your cover under an eligible Group Salary Continuance scheme or other similar arrangement (Salary Continuance Arrangement) ends and the conditions outlined below are met.

All aspects of your history, except your medical history, will be assessed to determine whether we can offer to convert the Waiting Period and, if so, the conditions which may apply.

We may decline your application to convert the Waiting Period on the basis of this evidence or other information, when considered in light of our standard underwriting guidelines applicable at the time of your application.

Alternatively, we may accept the conversion subject to a change to the occupation category that applies or a change to the monthly benefit.

Conditions that apply to the Waiting Period Conversion

The Waiting Period Conversion can only be exercised by you if:

- when the insurance started the Waiting Period was 24 months,
- when the insurance started you were insured under a Salary Continuance Arrangement which had a 24 month benefit period,
- you have left your employer and your cover under the Salary Continuance Arrangement has ended,
- you don't exercise a continuation option under the Salary Continuance Arrangement,
- you are Gainfully Employed and your Earnings are greater than or equal to your average Earnings in the continuous 12 month period before cover under the Salary Continuance Arrangement ended,
- you have not ceased Gainful Employment due to sickness or injury,
- you have not made, and are not eligible to a make, a claim under:
  - the Salary Continuance Arrangement,
  - any other policy providing disability income insurance with any life insurer, or
  - any TPD benefit with any life insurer,
- it is exercised within 60 days of the cover under the Salary Continuance Arrangement ending,
- the insurance is not part of a transfer from another Acenda product and has not been issued as part of a continuation option, unless it has been fully underwritten,
- you provide evidence satisfactory to us to support the request to convert the Waiting Period,
- it is exercised before the Review Date following your 55th birthday.

A Salary Continuance Arrangement includes a Group Salary Continuance scheme, or similar arrangement provided by an employer that was issued by a life company registered in Australia.

3. General exclusions that apply for:

- Income Protection
- Business Expenses

The general exclusions below apply to each insurance as described.

Certain benefits, features, options and definitions may have additional specific exclusions. These can be found in this PDS in the summary of the terms and conditions for the relevant benefit, feature or option, or in the relevant definition.

Income Protection - When won't a benefit be paid?

You won't receive a benefit for any disability, condition or loss arising from, or contributed to, by:

- intentional self-inflicted injury or attempted suicide,
- normal and uncomplicated pregnancy or childbirth,
- sickness or injury that first appeared, happened or was diagnosed before your insurance started, or was last reinstated (unless disclosed to and accepted by us as part of the application or reinstatement process), or
- war or warlike operations (but this doesn't apply to any benefit payable on your death).

Criminal Act and incarceration exclusion

Benefits will not be payable where the claim arises directly or indirectly from committing, or attempting to commit, a Criminal Act for which you:

- have a conviction recorded, and
- are serving, or have served, a term of imprisonment as a result of a conviction.

If you have been charged with a Criminal Act which may incur a term of imprisonment, we may delay making a decision on whether to accept or decline the claim, or cease paying benefits, until the conclusion of criminal proceedings, including sentencing, and we have sufficient information to determine if this exclusion clause applies.

Criminal Act means any summary or indictable offence within the meaning of relevant State or Commonwealth legislation or an offence with a similar meaning under foreign law.

In addition, no benefits are payable while a Life Insured is incarcerated.

Business Expenses - When won't a benefit be paid?

We won't reimburse you for expenses incurred for any disability, condition or loss arising from or contributed to by:

- intentional self-inflicted injury or attempted suicide,
- normal and uncomplicated pregnancy or childbirth,
- sickness or injury that first appeared, happened or was diagnosed before your insurance started, or was last reinstated (unless disclosed to and accepted by us as part of the application or reinstatement process), or
- war or warlike operations (this exclusion doesn't apply to any benefit payable on your death).

We won't reimburse you for expenses such as:

- expenses you could claim from elsewhere,
- payment or other benefits of any kind to you,
- any expense not normally paid before the disability,
- repayment of the principal of a loan or mortgage that started less than a year before the disability, or
- the cost of equipment or merchandise for your business.

Summary of the terms and conditions for Income Protection and Business Expenses

4. General termination events when the following insurances end:

- Income Protection
- Business Expenses

The general termination events below apply to each insurance as described.
Certain benefits, features, options may have additional criteria for when they'll end. These can be found in this PDS in the terms and conditions for the relevant benefit, feature or option.

Income Assure and *Income Assure+* - When will your insurance end?

Your *Income Assure* and *Income Assure+* insurance will end when:

- you cancel your insurance,
- you retire or stop doing paid work and don't intend to do paid work anymore for reasons other than disability,
- the Termination Date for this insurance is reached, as shown on your current Policy Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made,
- you die,
- you have a two year, five year or to age 65 benefit period and you are entitled to receive a benefit at the Review Date following your 65th birthday, or
- after the Review Date following your 65th birthday you haven't done full-time paid work for six months, except when this is a direct result of Total Disability.

Business Expense - When will your insurance end?

Your Business Expenses insurance will end when:

- you cancel your insurance,
- you retire or stop work and don't intend to work anymore, for reasons other than disability,
- you haven't done paid work for 12 months except when this is a direct result of Disability, or if we agreed in writing that this insurance will continue for longer,
- the Termination Date for this insurance is reached, as shown on your Schedule,
- we cancel your insurance because your premiums aren't paid,
- a fraudulent claim is made, or
- you die.

5

Key medical and disability definitions

1. Critical Condition definitions for Critical Illness, Child Critical Illness and Income Protection insurances

Note: The Life Insurance Code of Practice may define minimum standard definitions that apply for certain medical conditions under Critical Illness insurance where we issued your Life Insurance Policy on or after 1 July 2017, and may change from time to time.

Where you make a critical illness claim for cancer, a heart attack or a stroke, we will assess your claim against the most favourable of:

- the applicable definition in our PDS/Policy Document linked to the full benefit amount, and
- if different, the corresponding medical definition in the Life Insurance Code of Practice that is current at the time the claimable event occurs.

Adult Onset Insulin Dependent Diabetes Mellitus (partial benefit)

The diagnosis after age 30 of Type 1 (autoimmune) diabetes, confirmed by development of diabetes associated islet autoantibodies and requiring insulin to manage the condition.

Advanced Endometriosis – of specified severity (partial benefit)

The presence of endometrial tissue (normal lining of the uterus) outside the uterus, usually in the pelvic cavity.

Advanced endometriosis is a partial or complete obliteration of the cul-de-sac (Pouch of Douglas) by endometriotic adhesions, and/or the presence of endometriomas (cysts containing endometriotic material), and/or the presence of deep endometrial deposits involving the pelvic side wall, cul-de-sac and broad ligaments, or involving the wall of the bladder, ureter and bowel for which surgical treatment is required.

Aorta Repair – excluding less invasive surgeries

The correction of narrowing, dissection or aneurysm of the aorta through the chest or abdominal wall, excluding angioplasty, intra-arterial procedures or other nonsurgical procedures.

Aplastic Anaemia – of specified severity

Means bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring as a minimum one of the following treatments:

- marrow stimulating agents
- bone marrow transplantation
- blood product transfusions
- immunosuppressive agents.

Bacterial Meningitis – of specified severity

Severe inflammation of the membrane that surrounds the brain and spinal cord which results in a permanent impairment of at least 25% of Whole Person Function. Bacterial meningitis as a result of HIV infection is excluded.

Benign Brain Tumour – of specified severity

The presence of a non-cancerous tumour of the brain or spinal cord which is histologically confirmed and results in:

- at least 25% permanent impairment of the Whole Person Function, or
- the undergoing of neurosurgical intervention for its removal.

The following are excluded:

- intracranial cysts, granulomas and haematomas
- intracranial malformation in or of the arteries and veins, and
- tumours of the pituitary gland.

Blindness – of specified severity

The permanent loss of all sight in both eyes, whether aided or unaided, due to sickness or injury to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 20 degrees or less of arc.

Carcinoma In Situ of the Breast – of specified severity (partial benefit)

The presence of histologically proven localised pre-invasive cancer in the breast, where cancer cells do not penetrate the basement membrane nor invade the surrounding tissues or stroma.

This includes, but is not limited to, pre-invasive cancer of the milk ducts or lobules.

Carcinoma In Situ - Female Reproductive Organs – of specified severity (partial benefit)

The presence of histologically proven carcinoma in situ of:

- corpus uteri
- fallopian tube
- ovary
- perineum (excluding skin equivalent cancers)
- vagina (excluding skin equivalent cancers)
- vulva (excluding skin equivalent cancers)
- cervix.

Carcinoma in situ means a focal autonomous new growth of carcinomatous cells which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The carcinoma in situ must be classified as Tis according to the TNM staging method or FIGO Stage 0.

Cancer – excluding specified early-stage cancers.

Means any malignant tumour diagnosed with histological confirmation and characterised by:

- the uncontrolled growth of malignant cells,
- invasion and destruction of normal tissue, and
- the ability to spread (metastasise) to other parts of the body.

The term malignant tumour includes leukaemia and lymphoma.

The following are excluded:

- All tumours which are histologically classified as any of the following:
  - pre-malignant,
  - non-invasive,
  - carcinoma in situ, unless stated otherwise,
  - high-grade dysplasia, including cervical dysplasia CIN1, CIN2, and CIN3, or
  - borderline or low malignant potential.
- Chronic lymphocytic leukaemia in its early stages (less than RAI stage 1).
- Prostate cancer which is histologically described as TNM classification T1(a) or (b) or another equivalent or lesser classification with a Gleason score of 5 or less unless:
  - the person insured is required to undertake major interventionist therapy including radiotherapy, brachytherapy, chemotherapy, biological response modifiers or any other major treatment, or
  - the tumour is completely untreatable.
- Carcinoma In Situ of the Breast, except where it leads to the removal of the breast by a mastectomy or removal of the carcinoma in situ by breast conserving surgery (lumpectomy, complete local excision, wide local excision, partial mastectomy), together with radiotherapy or chemotherapy. The procedure must be performed as a direct result of the carcinoma in situ and specifically to arrest the spread of malignancy, and be considered the necessary and appropriate treatment.
- Skin cancer other than melanoma that:
  - shows signs of ulceration as determined by histological examination, or
  - is greater than 1.0 mm depth of invasion (Breslow), or
  - is at least Clark Level 3 of invasion.
- Basal cell carcinoma of the skin.
- Squamous cell skin carcinoma unless it has spread to other organs.
- All non-melanoma skin cancers unless having spread to the bone, lymph node or an other distant organ.
- Pituitary adenoma/pituitary neuroendocrine tumour (PitNET).

Cardiomyopathy – of specified severity

The inability of the heart muscle to function properly resulting in permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Chronic Kidney Failure – requiring permanent dialysis or transplantation

The final stage of kidney disease that requires permanent dialysis or a transplant.

Chronic Liver Failure – of specified severity

The final stage of liver disease with at least two of the following conditions:

- permanent jaundice,
- ascites (abnormal retention of fluids within the abdominal cavity)
- deteriorating liver function tests, and
- encephalopathy (related brain disease).

1. Critical Condition definitions for Critical Illness, Child Critical Illness and Income Protection insurances

Chronic Lung Failure– of specified severity

The final stage of lung disease, needing permanent oxygen therapy with a consistent pulmonary function test result of:

- FEV1 less than 40% predicted; or
- a DLCO less than 40% predicted.

Coma – with specified criteria

A total loss of consciousness and responsiveness in which the life insured is incapable of sensing or responding to external stimuli that results in a documented Glasgow Coma Scale of 6 or less for at least 72 hours.

Congenital Abnormalities of a child – of specified severity (partial benefit)

If the life insured or life insured's Spouse gives birth to a child that survives for at least 28 days and is diagnosed with one of the following:

- Down's syndrome – a specific genetic abnormality caused by an extra chromosome 21 that causes mental retardation and physical abnormalities.
- Spina bifida – defective closure of the spinal column due to neural tube deficit with a meningomyelocele or meningocele and resulting in neurological deficit.
- Tetralogy of Fallot – an anatomical abnormality with severe or total right ventricular outflow tract obstruction and a ventricular septal defect allowing right ventricular deoxygenated blood to bypass the pulmonary artery and enter the aorta directly. The diagnosis must be supported by an echocardiogram, and invasive surgery must be performed to correct the condition.
- Transposition of great vessels – a congenital heart defect where the aorta arises from the right ventricle and the pulmonary artery from the left ventricle. The diagnosis must be supported by an echocardiogram, and invasive surgery must be performed to correct the condition.
- Congenital blindness – complete absence of the sense of sight from birth.
- Congenital deafness – complete absence of the sense of hearing from birth.

Congenital abnormalities that first appeared in a child, before this Extra Benefits Option started or was last reinstated, are excluded for any existing or future children.

Benefits are not payable if payment has been made under Inability of a Child to gain independence.

Coronary Artery Angioplasty

An operation to correct narrowing or obstruction of one or more coronary arteries. Intra-arterial investigation procedures are excluded.

This critical condition applies only for policies where the Critical Illness benefit is $100,000 or more.

The benefit payable for this critical condition is 10% of the life insured's Critical Illness benefit up to a maximum of $20,000 per event.

After this benefit is paid, this insurance will continue, with the benefit reduced by the amount paid. Critical Illness premiums will be reduced in line with the reduced benefit.

A benefit will be paid for subsequent angioplasty procedures provided that they are necessary.

Coronary Artery Angioplasty - Three or More Different Coronary Arteries

The actual undergoing of an operation to correct narrowing or obstruction of three or more different coronary arteries when considered the necessary and appropriate treatment.

This procedure can be completed in one procedure or via multiple procedures within a two month period.

The benefit payable is 100% of the life insured's Critical Illness benefit.

Coronary Artery Bypass Surgery – excluding less invasive procedures

The surgical grafting of a bypass to a coronary artery to overcome narrowing or obstruction, excluding coronary artery angioplasty, intra-arterial procedures or other non-surgical procedures.

Deafness – permanent

Irreversible loss of hearing in both ears, after which the better ear:

- has an auditory threshold of greater than 90 decibels from the frequencies of 500 hertz to 3,000 hertz, even with amplification, and
- is diagnosed and certified by an appropriate specialist Doctor, using standardised equipment.

Deafness in One Ear – permanent (partial benefit)

The irreversible and irreparable loss of hearing in one ear, where the ear has an auditory threshold of greater than 90 decibels from the frequencies of 500 hertz to 3,000 hertz, even with amplification.

Dementia or Alzheimer's Disease – permanent and of specified severity

The unequivocal diagnosis of Dementia or Alzheimer's disease, by a Doctor, causing permanent failure of brain function.

A deterioration in the life insured's Mini Mental State Examination score to 24 or less is required. Alternatively, we will consider other neuropsychometric tests acceptable to us that conclusively diagnose the condition to at least the same level of stated severity.

Early Stage Benign Brain Tumour – of specified type (partial benefit)

The presence of a non-cancerous tumour of the brain or spinal cord, giving rise to symptoms of increased intracranial pressure such as papilledema, mental symptoms, seizures, or sensory/motor skills impairment. The diagnosis must be confirmed by a consultant neurologist and the presence of the condition must be confirmed by imaging studies such as CT scan or MRI.

The following are excluded:

- intracranial cysts, granulomas and haematomas
- intracranial malformation in or of the arteries and veins, and
- tumours of the pituitary gland.

Early Stage Chronic Lymphocytic Leukaemia (CLL) – of specified severity (partial benefit)

The presence of chronic lymphocytic leukaemia diagnosed as less than RAI stage 1 (characterised by lymphocytosis and enlarged lymph nodes).

Early Stage Melanoma – of specified severity (partial benefit)

The presence of one or more malignant melanomas. The melanoma must be less than or equal to 1.0mm depth of invasion or Clark Level 3. The diagnosis must be by biopsy. The malignancy must be characterised by the uncontrollable growth and spread of malignant cells.

Early Stage Prostate Cancer – of specified severity (partial benefit)

The presence of prostate cancer histologically described as:

- TNM classification T1 (a) or (b) (or another equivalent classification), or
- a Gleason score of five or less.

Encephalitis – of specified severity

Severe inflammation of brain substance which results in the life insured suffering either:

- permanent loss of at least 25% of Whole Person Function, or
- permanent
  - loss of the ability to perform one or more Activities of Daily Living (ADL) without physical help from someone else, or
  - severe cognitive impairment (with a score of 15 or less out of 30 in a Mini Mental State Examination) which leads to the need for continuous supervision to protect the life insured or other people. A Mini Mental State Examination tests various functions including arithmetic ability, memory and physical orientation to assess cognitive ability.

The permanent loss or impairment described above must have existed continuously for at least six months.

Encephalitis as a result of HIV infection is excluded.

Facial Reconstructive Surgery and Skin Grafting – of specified severity (partial benefit)

The undergoing of skin grafting and plastic or reconstructive surgery above the neck which is deemed medically necessary for the treatment of facial disfigurement as a direct result of an Accident requiring inpatient hospital treatment of the life insured. The Accident must occur while the insurance is in force.

Guillain-Barre Syndrome – of specified severity (partial benefit)

The unequivocal diagnosis by a Neurologist of Guillain-Barre Syndrome, requiring 6 consecutive weeks or more of inpatient hospitalisation and rehabilitation.

Heart Attack – with evidence of heart muscle damage

Heart Attack (Myocardial Infarction) means the death of part of the heart muscle because of inadequate blood supply, confirmed by a Cardiologist and evidenced by:

- typical rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference range together with any one of the following:
  - typical acute cardiac symptoms and signs consistent with heart attack, or

1. Critical Condition definitions for Critical Illness, Child Critical Illness and Income Protection insurances

- new serial ECG changes showing the development of any one of the following:
  - ST-T changes
  - left bundle branch block (LBBB), or
  - pathological Q waves, or
- imaging evidence of new and irreversible:
  - loss of viable myocardium, or
  - regional wall motion abnormality, or
- left ventricular ejection fraction less than 50%, at least three months after the event.

Elevated biomarkers and signs and symptoms that arise from causes other than heart attack, are excluded, including those as a result of elective percutaneous procedures and other acute coronary syndromes.

If the above tests are inconclusive or superseded by technological advances, we'll consider other appropriate and medically recognised tests.

Heart Valve Surgery – of specified severity

The surgical repair or replacement of a defective heart valve or valves, as a consequence of heart valve defects or abnormalities that cannot be corrected by non-surgical techniques.

HIV Contracted Through Medical Procedures

Accidental infection with Human Immunodeficiency Virus (HIV) as a direct result of one of the following medical procedures:

- blood transfusion, or transfusion with blood products
- organ transplant to the life insured
- assisted reproductive techniques, or
- any other procedure or operation performed by a medical practitioner or dentist.

The procedure must have occurred in Australia and have been performed by a recognised and registered medical practitioner or dentist.

Any event that might lead to a claim must be reported to us within 14 days. The claim must be supported by a negative HIV antibody test on a blood sample taken immediately after the event.

We must have access to the blood sample tested and must be able to take further samples if we think this is needed.

Seroconversion must occur within six months of the event.

A benefit will not be paid if any of the following are true:

- the HIV infection has any other cause, including sexual activity or recreational intravenous drug use, or
- the Australian Government has approved a treatment which makes HIV inactive and non-infectious.

HIV Contracted Through Your Work

Infection with Human Immunodeficiency Virus (HIV) as a result of an injury while the life insured is working at their normal occupation.

You (or someone representing you) must tell us that the life insured:

- may have become infected within 14 days of the accidental incident, and
- has become infected within 14 days of the diagnosis of infection.

Documented proof must be provided by you to us that:

- The accidental incident happened at work and involved a definite source of infection. The proof must include copies of the incident report, the name of the witnesses to the incident and confirmation of the source of infection.
- The HIV is a new infection and that seroconversion from the relevant negative antibodies or antigens to positive antibodies or antigens has taken place within six months of the incident.

A benefit will not be paid if any of the following are true:

- the HIV infection has any other cause, including sexual activity or recreational intravenous drug use,
- before the injury the Australian Government has recommended an HIV vaccine for use in the life insured's occupation, but the life insured has not taken this vaccine, or
- the Australian Government has approved a treatment which makes HIV inactive and non-infectious.

Infections that occur or continue despite you having taken the preventative vaccine or the approved treatment will be covered.

Inability of a Child to Gain Independence – of specified severity (partial benefit)

The life insured's Child, as a result of sickness or injury, will be permanently unable to perform any two or more of the following groups of activities of daily living without physical help from someone else:

- bathing or showering
- dressing

- moving from place to place, in and out of bed and in and out of a chair
- eating and drinking
- using the toilet.

The life insured's Child also suffers an inability to gain independence which results in permanent loss of at least 25% of either the brain's mental function or its physical control function which leads to a need for continuous supervision of the Child to protect them or other people.

A claim can only be made once the initial assessment or diagnosis is reconfirmed after six months. Benefits are not payable:

- if the inability of an existing or future Child to gain independence is caused or contributed to by sickness or injury that first appeared, happened or was diagnosed before this Extra Benefits Option started or was last reinstated, and
- if payment has been made under Congenital Abnormalities of a child.

Injury – means bodily injury

Intensive Care – requiring continuous mechanical ventilation for 5 days (partial benefit)

Mechanical ventilation by means of tracheal intubation for 5 consecutive days (24 hours per day) in an intensive care unit of an acute care hospital.

Intensive Care – requiring continuous mechanical ventilation for 7 days

Mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) in an intensive care unit of an acute care hospital.

Loss of Independence – of specified severity

The life insured suffers a Loss of Independence as a result of sickness or injury if they:

- are permanently unable to perform two or more Activities of Daily Living (ADL) without physical help from someone else, or
- have severe permanent cognitive impairment (with a score of 15 or less out of 30 in a Mini Mental State Examination) which leads to a need for continuous supervision of the life insured to protect them or other people.

A Mini Mental State Examination is a test which samples various functions including arithmetic, memory and orientation to assess cognition.

The Loss of Independence circumstances must have existed continuously for at least six months.

Loss, or Loss of Use, of One Foot or One Hand – total and irrecoverable (partial benefit)

The total and irrecoverable:

- loss, or
- loss of use

of one foot or one hand.

Loss of Sight in One Eye – of specified severity (partial benefit)

The permanent loss of sight in one eye, whether aided or unaided, due to sickness or injury to the extent that visual acuity is 6/60 or less.

Loss of Speech – of total and permanent

Total and permanent loss of ability to speak. A claim can only be made once the initial diagnosis is reconfirmed after three months.

Major Brain Injury – of specified severity

Physical head injury that results in the life insured suffering either:

- a permanent loss of at least 25% of Whole Person Function, or
- permanent:
  - loss of the ability to perform one or more Activities of Daily Living (ADL) without physical help from someone else, or
  - severe cognitive impairment (with a score of 15 or less out of 30 in a Mini Mental State Examination) which leads to a need for continuous supervision to protect the life insured or other people. A Mini Mental State Examination tests various functions including arithmetic ability, memory and physical orientation to assess cognitive ability.

The permanent loss or impairment described above must have existed continuously for at least six months.

Major Burns – of specified severity

Full thickness burns to 20% or more of the body surface, or to 50% of the face or 50% of both hands requiring surgical debridement and/or grafting.

1. Critical Condition definitions for Critical Illness, Child Critical Illness and Income Protection insurances

Major Organ or Bone Marrow Transplant

The transplant, or placement on an Australian waiting list approved by us for:

- transplant of any of the following organs from a human donor to the life insured:
  - kidney
  - liver
  - heart
  - lung
  - pancreas
  - small bowel, or
- bone marrow transplant.

This treatment must be considered medically necessary and the condition affecting the organ or bone marrow deemed untreatable by any other means other than transplant, as confirmed by a Specialist.

Meningococcal Septicaemia – of specified severity

Severe infection in the blood stream that causes blood poisoning which results in a permanent impairment of at least 25% of Whole Person Function.

Motor Neurone Disease – unequivocal diagnosis

The progressive weakening and wasting of the muscles of the body. The unequivocal diagnosis of motor neurone disease must be certain and supported by neurological investigations.

Multiple Sclerosis – of specified severity

The progressive destruction of the insulating layer of myelin in the brain and / or spinal cord. The unequivocal diagnosis of Multiple Sclerosis must be by a consultant neurologist.

There must be more than one episode of defined neurological deficit with persistent abnormalities. Neurological investigation such as lumbar puncture, MRI (Magnetic Response Imaging), evidence of lesions in the central nervous systems and evoked visual responses are required to confirm diagnosis.

Muscular Dystrophy – unequivocal diagnosis

The unequivocal diagnosis of muscular dystrophy by a medical practitioner who is a consultant neurologist on the basis of confirmatory neurological investigations.

Open Heart Surgery

Open heart surgery for the treatment of a cardiac defect, cardiac aneurysm or benign cardiac tumour.

Orchidectomy (as required to diagnose Carcinoma In Situ of the testicle) – with specific requirements (partial benefit)

The removal of one or both testes by radical orchidectomy as required to positively or negatively diagnose Carcinoma in Situ (Tis) of the testicle. The removal must be the appropriate and necessary treatment.

Orchidectomy for any other reason is specifically excluded.

Out Of Hospital Cardiac Arrest

Cardiac arrest which is not associated with any medical procedure and is documented by an electrocardiogram (ECG), occurs out of hospital and is due to cardiac asystole or ventricular fibrillation with or without ventricular tachycardia.

If an ECG is not available, we will reasonably consider other evidence which unequivocally confirms a cardiac arrest has occurred. Such evidence may include Automated External Defibrillator (AED) data, ambulance or hospital medical records, documented administration of cardiopulmonary resuscitation (CPR) by an attending ambulance officer or hospital clinical staff.

Paralysis – permanent and of specified severity

Total and permanent loss of the function of two or more limbs caused by damage to the nervous system.

Parkinson's Disease – of specified severity

The unequivocal diagnosis of degenerative idiopathic Parkinson's disease, as characterised by the clinical manifestations of one or more of:

- rigidity
- tremor
- akinesia from degeneration of the nigrostriatal system.

All other types of parkinsonism (including but not limited to parkinsonism secondary to medication, vascular disease, drugs, metabolic conditions and infections) are excluded.

Parkinson-Plus Syndrome – unequivocal diagnosis

The unequivocal diagnosis by a Neurologist of one of the following Parkinson-Plus (atypical parkinsonian) Syndromes:

- Multiple Systems Atrophy (MSA)
- Progressive Supranuclear Palsy (PSP)

- Corticobasal Degeneration/Syndrome (CBD)
- Dementia with Lewy bodies (DLB)

The conditions stated above must be irreversible.

All other types of parkinsonism (including but not limited to parkinsonism secondary to medication, vascular disease, drugs, metabolic conditions and infections) are excluded.

Pneumonectomy – complete removal of entire lung

The removal of an entire lung when considered the necessary and appropriate treatment.

Primary Pulmonary Hypertension – of specified severity

A condition associated with right ventricular enlargement established by cardiac catheterisation resulting in permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Serious Accidental Injury – requiring 30 consecutive days of acute care hospital confinement. (partial benefit)

The life insured suffers a serious accidental injury resulting in confinement to an acute care hospital for a period of 30 consecutive days (24 hours per day) under the full-time care of a Doctor.

Severe Diabetes – of specified severity

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:

- Severe Diabetic Retinopathy resulting in visual acuity uncorrected and corrected of 6/36 or worse in both eyes
- Severe Diabetic Neuropathy causing motor and/or autonomic impairment
- Diabetic Gangrene leading to surgical intervention
- Severe Diabetic Nephropathy causing chronic irreversible renal impairment (as measured by a corrected creatinine clearance below the laboratory/ies measured normal range).

Severe Osteoporosis – before age 50 and of specified severity

The life insured:

- before the age of 50, suffers at least two vertebral body fractures and/or a fracture of the neck of femur, due to osteoporosis, and
- has bone mineral density reading with a T-score of less than -2.5 (ie 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

Severe Rheumatoid Arthritis – of specified severity

The unequivocal diagnosis of severe rheumatoid arthritis by a Rheumatologist. The diagnosis must be supported by, and evidence, all of the following criteria:

- at least a six-week history of severe rheumatoid arthritis which involves three or more of the following joint areas:
  - proximal interphalangeal joints in the hands
  - metacarpophalangeal joints in the hands
  - metatarsophalangeal joints in the foot
  - wrist, elbow, knee, or ankle
- simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone)
- typical rheumatoid joint deformity, and
- at least two of the following criteria:
  - morning stiffness
  - rheumatoid nodules
  - erosions seen on x-ray imaging
  - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis.

Or, if the above criteria is not met we will also consider under the following definition:

The diagnosis must be supported and evidenced by all of the following criteria:

a. diagnosis of Rheumatoid Arthritis as specified by the American College of Rheumatology and European League Against Rheumatism: 2010 Rheumatoid Arthritis Classification Criteria; and

b. symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or 4 large joints (ankles, knees, hips, elbows, shoulders); and

1. Critical Condition definitions for Critical Illness, Child Critical Illness and Income Protection insurances

c. the Insured person has failed at least 6 months of intensive treatment with two conventional disease modifying antirheumatic drugs (DMARDS). This excludes corticosteroids and non steroidal anti-inflammatories; and

d. the disease must be progressive and non-responsive to all conventional therapy.

Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for Rheumatoid Arthritis.

Degenerative osteoarthritis and all other arthridities are excluded.

Specified Complications of Pregnancy (partial benefit)

The life insured is diagnosed with one of the following:

- Disseminated Intravascular Coagulation (DIC) where there is a pregnancy related cause of the DIC which has resulted in a life threatening haemorrhage from multiple sites.
- Ectopic pregnancy – pregnancy in which implantation of a fertilised ovum occurs outside the uterine cavity. The ectopic pregnancy must be ended by laparotomy or laparoscopic surgery.
- Hydatidiform mole – the development of fluid-filled cysts in the uterus after the degeneration of the chorion during pregnancy which results in death of the embryo.
- Stillbirth – the birth of an infant after at least 20 completed weeks of gestation or of 400 grams or more of birth weight, which shows no signs of life after birth.

Elective termination of pregnancy is specifically excluded.

Stroke – in the brain and of specified severity

An incident in the blood vessels of the brain or bleeding in the brain leading to neurological effects that last for at least 24 hours.

There must be clear evidence on a CT, MRI or similar scan that a stroke has occurred.

Transient ischaemic attacks, symptoms due to migraine, vascular disease of the optic nerve, physical head injury, reversible neurological deficit or any blood vessel incident outside the cranium, except embolism resulting in stroke, are excluded.

Type 1 Diabetes (Child Support Benefit)

Means diabetes mellitus type 1 with an early onset, which requires insulin injections to control the disease.

2. Total and Permanent Disability (TPD) definitions

Note: No Total and Permanent Disability Benefit will be paid unless you satisfy all the terms of the relevant definition.

For a claim to be payable for stand-alone TPD, you must survive for at least:

- 14 days to claim for TPD based on permanent impairment
- 14 days to claim for TPD based on the total and irrecoverable loss of limbs or sight.

TPD Definition	When this TPD definition applies
Any Occupation	Applies: • if you selected Any Occupation cover; and • until the Review Date after your 65th birthday; and • if the Home Duties definition doesn't apply (see next page).
Own Occupation	Applies: • if you selected Own Occupation cover; and • until the Review Date after your 65th birthday; and • if the Home Duties definition doesn't apply (see next page).
Home Duties	Applies if you were performing full-time domestic duties or child rearing: • at the time of application for insurance, and • for the 12 months prior to the disability, and • at the time the disability begins.
Loss of Independence	Applies from the Review Date following your 65th birthday

TPD – Any Occupation Definition

The Life Insured is Totally and Permanently Disabled if they have a disability caused by sickness or injury and they satisfy the criteria in paragraphs (a), (b) or (c):

(a)

- as a result of their disability, they are completely unable to work at any occupation they are reasonably suited to by way of education, training or experience that would result in a rate of Earnings of more than 25% of their rate of Earnings during the continuous 12 month period before they were disabled, and are unlikely ever to be able to do so again; and
- these circumstances have existed continuously for at least 3 months,

or

(b)

- they suffer a permanent impairment of at least 25% of Whole Person Function; and
- as a result of this impairment, they are disabled to such an extent that they are completely unable to work at their usual occupation or any other occupation they are reasonably suited to by way of education, training or experience, and are unlikely ever to be able to do so again,

or

(c)

they have suffered from the total and irrecoverable loss of:

- the use of both hands; or
- the use of both feet; or
- the sight in both eyes; or
- the use of one hand and one foot; or
- the use of one foot and the sight in one eye; or
- the use of one hand and the sight in one eye.

In all cases, where the Policy is owned by the trustee(s) of a super fund and this Total and Permanent Disability insurance first commenced after 30 June 2014, the Life Insured must also be Permanently Incapacitated.

For the purposes of the above definitions, "Earnings" means:

- where the Life Insured is self-employed (ie directly or indirectly owns part of or all of a business or practice), the income of the business or practice generated by the personal efforts of the Life Insured after the deduction of their appropriate share of business or practice expenses in generating that income,
- where the Life Insured is an employee (ie does not directly or indirectly own part of or all of a business or practice), the total remuneration paid by the employer to the Life Insured including salary, commissions, fees, regular bonuses, regular overtime, fringe benefits and regular super contributions paid by the employer on behalf of the Life Insured and
- whether the Life Insured is self-employed or employed, Earnings do not include investment income and are calculated before tax.

TPD – Own Occupation Definition

(This applies until the Review Date after the Life Insured reaches age 65. For Total and Permanent Disability insurance inside super, Own Occupation cover is only available if it was selected and commenced before 1 July 2014).

The Life Insured's own occupation means the occupation in which they were engaged at the time of their application for this insurance unless they have changed their occupation since then.

If the Life Insured has changed their occupation since their application for this insurance, the Life Insured's own occupation means the last occupation in which the Life Insured was engaged for a continuous period of at least six months prior to their date of disability.

The Life Insured is Totally and Permanently Disabled if they have a disability caused by sickness or injury and they satisfy the criteria in paragraphs (a), (b), or (c):

(a)

- as a result of their disability they are completely unable to work at their own occupation and are unlikely ever to be able to do so again; and
- these circumstances have existed continuously for at least 3 months,

or

(b)

- they suffer a permanent impairment of at least 25% of Whole Person Function; and
- as a result of this impairment, they are disabled to such an extent that they are completely unable to work at their own occupation and are unlikely ever to be able to do so again,

or

(c)

they have suffered from the total and irrecoverable loss of:

- the use of both hands; or
- the use of both feet; or
- the sight in both eyes; or
- the use of one hand and one foot; or
- the use of one foot and the sight in one eye; or
- the use of one hand and the sight in one eye.

TPD – Home Duties Definition

(This applies until the Review Date after the Life Insured reaches age 65)

If the Life Insured was performing full-time domestic duties or child rearing:

- at the time of application for insurance, and
- for the 12 months prior to the disability, and
- at the time the disability begins,

the Life Insured is Totally and Permanently Disabled if they have a disability caused by sickness or injury and they satisfy the criteria in paragraphs (a), (b) or (c):

(a)

- as a result of their disability they are completely unable to perform a majority of the Normal Physical Domestic Duties, and are unlikely ever to be able to do so again; and
- these circumstances have existed continuously for at least 3 months,

or

(b)

- they suffer a permanent impairment of at least 25% of Whole Person Function; and
- as a result of this impairment, they are disabled to such an extent that they are completely unable to perform a majority of the Normal Physical Domestic Duties, and are unlikely ever to be able to do so again,

or

(c)

they have suffered from the total and irrecoverable loss of:

2. Total and Permanent Disability (TPD) definitions

- the use of both hands; or
- the use of both feet; or
- the sight in both eyes; or
- the use of one hand and one foot; or
- the use of one foot and the sight in one eye; or
- the use of one hand and the sight in one eye.

In all cases, where the Policy is owned by the trustee(s) of a super fund and this Total and Permanent Disability insurance first commenced after 30 June 2014, the Life Insured must also be Permanently Incapacitated.

If the Life Insured was not performing full-time domestic duties or child rearing:

- at the time of application, and
- for the 12 months prior to the disability, and
- at the time the disability begins,

the Any Occupation Definition will apply.

"Normal Physical Domestic Duties" means the household duties normally performed by a person who remains at home completing full-time unpaid domestic duties. It does not include a person working in a regular occupation including part time and/or paid voluntary work that provides an income.

Normal Physical Domestic Duties specifically include:

- cooking and preparing meals – meaning the ability to prepare meals using kitchen appliances
- cleaning the home – meaning the ability to carry out the basic internal household chores using domestic equipment such as a vacuum and mop
- washing clothes – meaning the ability to do the household's laundry
- shopping for groceries – meaning the ability to purchase general household grocery items (excluding online shopping), and
- safely driving a car – the physical ability to drive a car, and
- caring for Children – meaning the ability to care for and supervise Children (where applicable).

You will be considered to be unable to carry out Normal Physical Domestic Duties if you are unable to perform four or more of these duties.

TPD – Loss of Independence Definition (This applies on and from the Review Date after the Life Insured reaches age 65)

The Life Insured suffers a Loss of Independence if, continuously for at least 3 months, and as a result of sickness or injury, they satisfy the criteria in paragraphs (a), (b) or (c):

(a) they have suffered from the total and irrecoverable loss of:

- the use of both hands; or
- the use of both feet; or
- the sight in both eyes; or
- the use of one hand and one foot; or
- the use of one foot and the sight in one eye; or
- the use of one hand and the sight in one eye.

or

(b) they are due to Sickness or Injury incapacitated to such an extent that for 12 consecutive months, the Life Insured has been unable to perform at least two (2) of the following **activities of daily work** without the help of another person (even if using appropriate aids), and based on medical advice (including advice from the Life Insured's Doctor), is unlikely to be able to do so ever again:

- **Moving** – the ability to:
  - walk more than 200m on a level surface without stopping due to breathlessness, angina or severe pain anywhere in the body; or
  - bend, kneel or squat to pick something up from the floor and straighten up again, and get in and out of a standard sedan car.
- **Communicating** – the ability to:
  - hear and speak with sufficient clarity to be able to hold a conversation in a quiet room in the insured person's first language; or
  - understand a simple message given in the insured person's first language and relay that message to another person.
- **Reading** – the visual acuity to read ordinary newsprint and pass the standard eyesight test for a car license.
- **Lifting** – the ability to lift a 5 kg weight with either or both hands from bench/table height, carry it over a 5m distance and place it back down at bench/table height.
- **Using the hands** – the ability to use the hands or fingers to handle small objects with precision and success (such as picking up a coin,

tie shoelaces, button a shirt, use cutlery or write a short note with a pen or keyboard).

or

(c) they have severe permanent cognitive impairment (with a score of 15 or less out of 30 in a 'Mini Mental State Examination'), which leads to a need for continuous supervision of the Life Insured to protect them or other people. A Mini Mental State Examination is a test which samples various functions including arithmetic, memory and orientation to assess cognition.

Where the Policy is owned by the trustee(s) of a super fund and this Total and Permanent Disability insurance first commenced after 30 June 2014, the Life Insured must also be Permanently Incapacitated.

For a claim to be payable under stand-alone TPD you must survive for at least 14 days after the event leading to Total and Permanent Disability.

3. Total Disability and Partial Disability definitions for Income Protection and Business Expenses insurances

Income Assure+

Totally Disabled and Total Disability - means either "Definition A" or "Definition B" below, as applicable.

Definition A applies:

- before the Review Date following the Life Insured's 65th birthday;
- for the Waiting Period and the benefit period if your benefit period is 2 or 5 years; or
- for the Waiting Period and first 24 months of a benefit period if your benefit period is to age 65 or 70.

Definition B applies:

- from the Review Date following the Life Insured's 65th birthday; or
- after the first 24 months of a benefit period if your benefit period is to age 65 or 70.

Definition A

Totally Disabled and Total Disability means, solely due to Sickness or Injury the Life Insured is:

- not capable of performing each and every Material Duty of their occupation; and
- not working in any occupation for Earnings, payment or profit; and
- regularly attending a Doctor for their Sickness or Injury and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury).

Definition B

Totally Disabled and Total Disability means, solely due to Sickness or Injury the Life Insured is:

- not capable of performing each and every Material Duty of any occupation for which they are reasonably suited by way of education, training or experience; and
- not working in any occupation for Earnings, payment or profit; and
- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury).

Partially Disabled and Partial Disability - means either "Definition A" or "Definition B" below as applicable.

Definition A applies:

- before the Review Date following the Life Insured's 65th birthday
- for the Waiting Period and the benefit period if your benefit period is 2 or 5 years; or
- for the Waiting Period and first 24 months of a benefit period if your benefit period is to age 65 or 70.

Definition B applies:

- from the Review Date following the Life Insured's 65th birthday; or
- after the first 24 months of the benefit period if your benefit period is to age 65 or 70.

Definition A

Partially Disabled and Partial Disability means solely due to Sickness or Injury the Life Insured is:

- Either:
  - working in some capacity, and not capable of working at full capacity in their occupation; or
  - not working and capable of working in some capacity, but not full capacity, in their occupation; and
- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury); and

their Earnings or Potential Earnings After Disability is less than 80% of their Earnings Before Disability (or 90% of their Earnings Before Disability in the first six months of a claim if the Booster Option is selected).

If the Life Insured was working more than 40 hours per week prior to Disability, we will assess their full capacity based on 40 hours per week.

Definition B

Partially Disabled and Partial Disability means solely due to Sickness or Injury the Life Insured is:

- Either:
  - working in some capacity, and not capable of working at full capacity in any occupation for which they are reasonably suited by education, training or experience; or
  - not working and capable of working in some capacity, but not full capacity, in any occupation for which they are reasonably suited by way of education, training or experience; and

- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury); and

their Earnings or Potential Earnings After Disability is less than 80% of their Earnings Before Disability (or 90% of their Earnings Before Disability in the first six months of a claim if the Booster Option is selected).

If the Life Insured was working more than 40 hours per week prior to Disability, we will assess their full capacity based on 40 hours per week.

Income Assure

Totally Disabled and Total Disability - means either "Definition A" or "Definition B" below as applicable.

Definition A applies:

- before the Review Date following the Life Insured's 65th birthday; and
- for the Waiting Period and first 24 months of a benefit period.

Definition B applies:

- from the Review Date following the Life Insured's 65th birthday; or
- after the first 24 months of the benefit period.

Definition A

Totally Disabled and Total Disability means solely due to Sickness or Injury the Life Insured is:

- not capable of performing each and every Material Duty of their occupation; and
- not working in any occupation for Earnings, payment or profit; and
- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury).

Definition B

Totally Disabled and Total Disability means solely due to Sickness or Injury the Life Insured is:

- not capable of performing each and every Material Duty of any occupation for which they are reasonably suited by way of education, training or experience; and
- not working in any occupation for Earnings, payment or profit; and
- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury); and
- after 24 months of the benefit period, also Severely Disabled unless the Severe Disability Terms Removal Option applies.

Partially Disabled and Partial Disability - means either "Definition A" or "Definition B" below as applicable.

Definition A applies:

- before the Review Date following the Life Insured's 65th birthday; and
- for the Waiting Period and first 24 months of a benefit period.

Definition B applies:

- from the Review Date following the Life Insured's 65th birthday; or
- after the first 24 months of the benefit period.

Definition A

Partially Disabled and Partial Disability means solely due to Sickness or Injury the Life Insured is:

- Either:
  - working in some capacity, and not capable of working at full capacity in their occupation; or
  - not working and capable of working in some capacity, but not full capacity, in their occupation; and
- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury); and

their Earnings or Potential Earnings After Disability is less than 80% of their Earnings Before Disability.

If the Life Insured was working more than 40 hours per week prior to Disability, we will assess their full capacity based on 40 hours per week.

3. Total Disability and Partial Disability definitions for Income Protection and Business Expenses insurances

Definition B

Partially Disabled and Partial Disability means solely due to Sickness or Injury the Life Insured is:

- Either:
  - working in some capacity, and not capable of working at full capacity in any occupation for which they are reasonably suited by education, training or experience; or
  - not working and capable of working in some capacity, but not full capacity, in any occupation for which they are reasonably suited by way of education, training or experience; and
- regularly attending a Doctor and following that Doctor's advice and recommendations for treatment (relevant to their Sickness or Injury); and
- after 24 months of the benefit period, also Severely Disabled unless the Severe Disability Terms Removal Option applies; and

their Earnings or Potential Earnings After Disability is less than 80% of their Earnings Before Disability.

If the Life Insured was working more than 40 hours per week prior to Disability, we will assess their full capacity based on 40 hours per week.

Severe Disability Terms Removal Option

If You have selected this Option the definitions of Total Disability and Partial Disability will not include a requirement that You also be Severely Disabled, which otherwise applies after the first 24 months of the benefit period.

Business Expenses with Platinum Option

Total Disability and Totally Disabled (Business Expenses insurance with Platinum Option) - Totally Disabled and Total Disability means that solely due to sickness or injury, you're:

- unable to perform at least one of the important duties of your occupation which is necessary to produce your Business Earnings, and not working for Earnings, payment or profit, or
- unable to perform the duties of your occupation necessary to produce your Business Earnings for more than 10 hours per week with the result that your Business Earnings After Disability are reduced to 20% or less than your Business Earnings Before Disability;

and being regularly treated or monitored (as appropriate to your condition) by an appropriately qualified Doctor.

Partial Disability and Partially Disabled (Business Expenses insurance with Platinum Option) - Partially Disabled and Partial Disability means that solely due to sickness or injury, you're:

- unable to fully perform the duties of your occupation, and
- working in a reduced capacity in the business, and
- not Totally Disabled, and
- being regularly treated or monitored (as appropriate to your condition) by an appropriately qualified Doctor.

Business Expenses

Total Disability and Totally Disabled (Business Expense insurance) - Totally Disabled and Total Disability means that solely due to sickness or injury, you're:

- unable to perform at least one of the important duties of your occupation which is necessary to produce your Business Earnings, and
- not working for Earnings, payment or profit, and
- being regularly treated or monitored (as appropriate to your condition) by an appropriately qualified Doctor.

6

Special definitions

Glossary of common terms

Accident Means an event where bodily injury is caused directly and solely by violent, external and visible means, independently of all other causes.

Activities of Daily Living Means:

- bathing or showering
- dressing
- moving from place to place, in and out of bed and in and out of a chair
- eating and drinking, or
- using the toilet.

Any Occupation If you choose this definition, we'll assess your likely ability to ever be able to work again, taking into account not only your occupation, but also any occupation which you're reasonably suited to by way of education, training or experience.

For full details of when a TPD insurance benefit may be payable, please see pages 100 - 103. For insurance inside super there may also be tax and super law implications, depending on your choice of definition. Please see pages 51 - 52.

Business Means the business or practice owned and managed by the Life Insured. If the Life Insured's Business is owned and operated through a company, we will treat Covered Expenses paid by the company as if they were paid by the Life Insured.

Business Earnings (Business Expenses insurance only) For the purposes of Business Expenses insurance, means the gross turnover of the business, less all the expenses, costs and overheads of running it, and before tax. Where more than one person owns and manages the business (directly or through a company) business earnings will mean only those Earnings generated by the life insured in proportion to their share of ownership of the business.

Business Earnings After Disability (Business Expenses insurance only) For the purposes of the Business Expenses Platinum Option, means the share of Business Earnings of the life insured while they are Partially Disabled.

Business Earnings Before Disability (Business Expenses insurance only) For the purposes of the Business Expenses Platinum Option, means your share of Business Earnings in the continuous 12-month period before you became Totally Disabled or Partially Disabled.

(What is a) business expense?
The covered expenses are the reasonable and regular normal operating expenses of the business you own and manage, including:

- rent or mortgage payments
- property levies, rates and taxes
- equipment or vehicle lease costs
- electricity, heating and water costs
- cleaning and laundry costs
- depreciation on office equipment and premises that the business owns
- salaries of employees not generating business income
- costs of accounting services
- fees for memberships of professional associations
- business insurance premiums, and
- net cost of a locum (see page 111).

Child For insurance policy purposes means a person who is:

- age 20 or younger, and
- the natural child, stepchild, adopted child or a child under the legal guardianship of the life insured.

Complying Super Fund Means a regulated super fund that qualifies for concessional tax rates. A Complying Super Fund must meet the requirements that are set out under section 40 of the Superannuation Industry (Supervision) Act 1993.

Connection Means an attached insurance where benefits are modified according to adjustments and benefit payments on another insurance on a different policy.

A Connection is a variation of an Extension, which is an attached insurance as described above on the same policy.

For more information on Extensions and Connections, see page 54.

Consumer Price Index (CPI)
Means the 'Consumer Price Index: All Groups Index Weighted Average for Eight Capital Cities' published by the Australian Bureau of Statistics or, if that isn't available, any reasonable substitute chosen by us.

If the percentage increase in the CPI, or any substitute for it, is negative, we will treat the CPI increase as being nil.

Glossary of common terms

Critical Condition Means one of the specific medical conditions covered under Critical Illness or Child Critical Illness insurance and which has the special definition given in this PDS which must be met before a Critical Illness or Child Critical Illness benefit will be payable.

Covered Expenses means the expenses set out on page 77.

Disabled and Disability (for Income Protection insurance only) Means Totally Disabled or Partially Disabled.

Doctor Means a person who is registered in Australia as a medical practitioner by the Medical Board of Australia, or a medical practitioner with qualifications equivalent to Australian medical practice or registration standards if practicing outside Australia. Medical practitioner does not include:

- you;
- your business partner; or
- your immediate family members.

Where reasonable, we require the Doctor to be a Specialist, particularly if the condition is more commonly diagnosed and treated by a Specialist. Note – a chiropractor, psychologist, physiotherapist and/or allied or alternative health provider is not a medical practitioner unless registered as a medical practitioner by the Medical Board of Australia.

Earnings Means:

- where the life insured is self-employed (ie directly or indirectly owns part of or all of a business or practice), the income of the business or practice generated by the personal efforts of the life insured (after the deduction of their appropriate share of business or practice expenses in generating that income), and voluntary super contributions paid on behalf of the Life Insured (excluding Super Guarantee payments);
- where the life insured is an employee (ie does not directly or indirectly own part of or all of a business or practice), the total remuneration paid by the employer to the life insured including salary, commissions, fees, regular bonuses, regular overtime, fringe benefits and voluntary super contributions paid by the employer on behalf of the life insured, and
- whether the life insured is self-employed or employed, Earnings do not include investment income and any regular super guarantee payment, and are calculated before tax.

Earnings or Potential Earnings After Disability (*Income Assure* and *Income Assure+* insurances only) Means the greater of:

- The Life Insured's Earnings while they are Disabled; and
- Where Partial Disability Definition A applies, the Earnings the Life Insured could reasonably be expected to earn if they were working to their capacity in their own occupation; or
- Where Partial Disability Definition B applies, the Earnings the Life Insured could reasonably be expected to earn if they were working to their capacity in any occupation they are reasonably suited to by education, training or experience.

Earnings Before Disability (*Income Assure* and *Income Assure+* insurances only) Means the greater of (as applicable):

- The Life Insured's average Earnings in the 12 months immediately prior to Disability;
- The Life Insured's average Earnings in the 24 months immediately prior to Disability, if the Life Insured's Earnings while working or on unpaid employer leave in the 12 months immediately prior to Disability have reduced by more than 10% from the previous 12 month period;
- The Life Insured's average Earnings over the months actually worked in the 12 month period immediately prior to Disability, if the Life Insured has worked more than 3 consecutive months immediately prior to Disability but less than 12 months in total in the 12 month period immediately prior to Disability; or
- The Life Insured's average Earnings in the 12 months immediately prior to the date the Life Insured commenced leave, if the Life Insured has been on unpaid employer approved maternity leave, paternity leave, sabbatical or study leave that commenced at any time in the 12 months immediately prior to Disability.

However, if the Life Insured was on unpaid employer leave for the entire 24 months immediately prior to disability or unemployed for the entire 12 months prior to disability, 'Earnings Before Disability' is nil.

Exclusion(s) are specific events you are not covered for.

Standard exclusions apply to everyone who has a certain type of insurance and are described in this PDS.

Specific exclusions are based on your individual circumstances, including hazardous occupations or pastimes and pre-existing medical conditions. Specific exclusions are applied at the time we assess an application for insurance or an alteration for existing insurance. We will tell you before we apply any specific exclusions.

Exclusion Periods Some Critical Conditions are covered only after a period of time known as an 'exclusion period'. This means you aren't covered for Critical Conditions if symptoms of the Critical Condition first appear or happen, or the Critical Condition is first diagnosed, within the exclusion period after your insurance began, was last reinstated or increased.

Extension Means an attached insurance where benefits are modified according to adjustments and benefit payments on another insurance.

An Extension may be on the same or a different policy.

Where an Extension is held on a different policy it is also known as a Connection.

For more information on Extensions and Connections, see page 54.

Family Means Spouse, children, parents, brother(s) or sister(s).

Gainfully Employed or Gainful Employment Means working for Earnings, payment or profit.

Income Replacement Ratio Amount Means the amount described on page 73. Or Means the amount calculated by:

- multiplying the relevant part of your Earnings Before Disability per annum by the percentage specified in the table below; and
- dividing that amount by 12.

Earnings Before Disability (per annum)	% *
First $240,000	70%
From $240,001 to $480,000	50%
From $480,001 (subject to the maximum benefit of $30,000)	20%

*** if you have the Booster Option, 20% will be added to your percentage for up to 6 months.**

Indemnity cover Means a type of Income Protection insurance where the benefit amount payable is based on the income you are earning in the months prior to your disablement (see page 110).

Injury Means a bodily injury but does not include a bodily injury that becomes apparent after cover under your Policy ceases.

(What is a) Key Person? This is an employee or business owner without whose knowledge or expertise the business would suffer material financial loss.

Revenue Protection (Key Person) insurance is used by a business or employer to protect against financial loss that may result from the loss of service of a key person in the event of death, sickness or injury.

(Who is the) life insured? This is the person whose circumstances we assess and accept to be insured and is named in the Schedule. One person can be insured per policy.

Loading(s) are a higher premium that we charge for your insurance based on your individual circumstances, including hazardous occupations or pastimes and pre-existing medical conditions.

Loadings are applied at the time we assess an application for insurance or an alteration for existing insurance. We will tell you before we apply any loadings.

(What is a) locum? A locum is a person engaged to work in your business from an external source as a direct replacement for you.

Net cost of a locum means the cost incurred in engaging a locum less the gross sales, earnings or billings generated by the locum.

Material Duties

Material Duties means those duties of an occupation that:

- are essential to; and
- cannot be reasonably modified in or excluded from,

the normal performance of that occupation in the national economy instead of how it is performed for a particular employer.

Material Duties do not include:

- the commute to and from the Life Insured's place(s) of work; and
- working in excess of 40 hours per week (regardless of the occupation or the life insured's usual practice).

Maximum Income Protection Benefit means the maximum monthly amount of cover we will provide in respect of a life insured which is $30,000 per month.

Where the combination of the Super Guarantee Benefit with the monthly benefit for either the Total Disability or Partial Disability would result in a combined payment in excess of $30,000, the Super Guarantee Benefit amount will be reduced so that the combined payment does not exceed $30,000.

Monthly Benefit means, for Income Protection and Business Expenses insurance, the Monthly Benefit amount shown in your current Schedule.

Mortgage Means a loan secured by a first mortgage over the life insured's home.

Normal Physical Domestic Duties Means the household duties normally performed by a person who remains at home completing full-time unpaid domestic duties. It does not include a

Glossary of common terms

person working in a regular occupation including part time and/or paid voluntary work that provides an income.

Normal Physical Domestic Duties specifically include:

- cooking and preparing meals – meaning the ability to prepare meals using kitchen appliances
- cleaning the home – meaning the ability to carry out the basic internal household chores using domestic equipment such as a vacuum and mop
- washing clothes – meaning the ability to do the household's laundry
- shopping for groceries – meaning the ability to purchase general household grocery items (excluding online shopping), and
- safely driving a car – the physical ability to drive a car, and
- caring for Children – meaning the ability to care for and supervise Children (where applicable).

You will be considered to be unable to carry out Normal Physical Domestic Duties if you are unable to perform four or more of these duties.

Own Occupation (available outside super only) If you choose this definition, we'll assess your likely ability to ever be able to work again, taking into account your own occupation. This means you may be eligible for your TPD insurance benefit if you can't work in your own occupation, even if you may be able to work in another occupation. You'll be charged a higher premium if you choose Own Occupation. Not all occupations are eligible for this definition.

Permanent Incapacity and Permanently Incapacitated Means the life insured's ill-health (whether physical or mental) which makes it unlikely that the life insured will ever engage in Gainful Employment for which the life insured is reasonably qualified by education, training or experience.

(Who is the) policy owner? (MLCI) This is the person or entity that applies, and is accepted as the person who is entitled to receive benefits under the policy. The policy owner is named in the Schedule and is the only person who may extend, vary, cancel or otherwise exercise any rights under the policy.

The policy owner can be an individual or individuals, a company, partnership or the trustee(s) of a family trust.

Ownership must be the same for all insurances under the one policy.

Income Protection insurance must generally be owned by the life insured.

(Who is the) policy owner? (MLCI SMSF) The Trustee of your SMSF takes out insurance on your behalf and becomes the policy owner. For more information go to page 9 and page 50.

(Who is the) policy owner? (MLCIS) When you take out MLC Insurance (Super), you become a member of the Fund. The Trustee of the Fund takes out insurance on your behalf and becomes the policy owner. You can find more detailed information on the Fund on page 9 and page 50.

(Who is the) policy owner? (MLCI Wrap Super) The trustee of your eligible super wrap account will also be the trustee for your MLC Insurance. They become the policy owner. For more information go to page 9 and page 50.

Recurrent Disability means a Disability that occurs while this insurance is in force and was caused by or is related to the Sickness or Injury that caused the previous Disability and for which we have paid a Benefit previously.

Revenue Protection (Key Person) insurance Is insurance to protect a business or employer against financial loss that results from the loss of service of a key person due to their death, sickness or injury.

Review Date Is the date shown on your current Schedule on which the review of your benefits and premiums each year take effect.

(What is) sabbatical leave? This means leave taken for study or travel as a normal part of your occupation.

Schedule Means the schedule issued to you with the policy for MLC Insurance and MLC Insurance (Super) and updated from time to time. An updated schedule will be issued each year or any time there is a change in the benefits or types of insurance provided under the policy.

The updated schedule will replace the previous schedule from the time that it is issued by us.

Severely Disabled and Severe Disability Means the Life Insured:

Either has:

- a psychiatric disorder that has been diagnosed by a psychiatrist as:
  - Schizophrenia spectrum or other psychotic disorders;
  - Bipolar Disorder;
  - Major Depressive disorder with melancholic or psychotic features;
  - Anxiety disorders with severe regular panic attacks and significant avoidant behaviours such as agoraphobia;
  - Trauma and Stressor related disorders – post-traumatic stress disorder (PTSD) and/or severe traumatisation; or
  - another psychiatric disorder as defined in the 'Diagnostic and Statistical Manual of Mental Disorders', fifth edition of similar severity.

or

- a physical Sickness or Injury that has been diagnosed by a Specialist Doctor;

and

- is following the advice and recommendations for treatment by a psychiatrist or Specialist Doctor as applicable for each Sickness or Injury in accordance with the most recent guidelines from either:
  - National Health and Medical Research Council (NHMRC), or
  - the relevant College of Specialists

and

- as assessed by a Specialist Doctor qualified to make such an assessment, has:
  - an impairment rating of at least 20% of Whole Person Function according to the the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' current as at the date of impairment, or
  - a score on the Psychiatric Impairment Rating Scale of 19% or more.

Sickness Means an illness or disease that becomes apparent while this Policy is in force.

SIS definition of Temporary Incapacity means in relation to a member who has ceased to be gainfully employed (including a member who has ceased temporarily to receive any gain or reward under a continuing arrangement for the member to be gainfully employed), means ill-health (whether physical or mental) that caused the member to cease to be gainfully employed but does not constitute permanent incapacity.

Specialist Means a Doctor who is an appropriate specialist in a relevant medical field.

Spouse Means a husband or wife or a partner in an equivalent de facto relationship, including same-sex relationships.

Terminal Illness

For insurance outside super, Terminal Illness means an Illness that, even with appropriate medical treatment, in the opinion of the treating Specialist, and where required, a further medical opinion from a Specialist approved by us, is likely to lead to death within a period that ends no more than 24 months from the date we are notified in writing by the approved Doctor.

For insurance inside super, Terminal Illness means an Illness that, even with appropriate medical treatment, in the opinion of two Doctors, one of whom is a Specialist approved by us, is likely to lead to death within a period that ends no more than 24 months from the date the Doctors certify the condition ('the Certification Period'). We must be notified in writing of the Terminal Illness within the Certification Period.

Termination Date Is the date when your insurance ends. The termination date may vary for different types of insurance.

Waiting Period A Waiting Period means your benefit won't be paid straight after the claimable event happens. Once an event occurs you have to wait a certain period of time before you can make a claim.

Insurance with longer Waiting Periods generally cost less than insurance with shorter Waiting Periods because they only pay benefits for long term events.

Whole Person Function Is defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' current as at the date of impairment, or an equivalent guide to impairment approved by us.

Your duty to take reasonable care not to make a misrepresentation

Your policy or the policy you are applying for is a consumer insurance contract and the duty below applies to you.

About this application and your duty

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

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

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

The duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

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

- think carefully about each question before you answer. If you are unsure about any question, we are here to help and you can contact us,
- answer every question,
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it,
- review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted, and
- you must not assume that we will contact your doctor for any medical information. If you are unsure about whether you should include information or not, please include it.

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts. The duty applies when you answer questions in your application and whenever we obtain more information from you.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you need help understanding the process of buying insurance or answering our questions.

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

What can we do if the duty is not met?

If the person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

For example we may:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

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

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances;
- what we would have done if the duty had been met - for example, whether we would have offered cover, and, if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, including what you can do if you disagree.

Privacy Notification

This privacy notification covers Acenda and the Trustee, who are collectively referred to as 'we, us and our' in this section of the PDS. Acenda uses the MLC brand under licence from the Insignia Financial Group. Acenda is part of the Nippon Life Insurance Group and is not a part of the Insignia Financial Group.

The Trustee is governed by the EQT Holdings Limited (EQT Group) Privacy Statement. Acenda is governed by its own privacy policy. These privacy policies are available as follows:

Acenda

acenda.com.au/privacy-policy or call **13 65 25**. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **131 450**.

Trustee

eqt.com.au/global/privacystatement or call **+61 3 8623 5000**

We encourage you to review the privacy policies of both entities for further information.

We collect and hold a range of personal information about our customers.

This notification tells you how we collect your personal information, what we use it for and who we share it with. By providing your personal information to us, you consent to the collection, use and disclosure of your personal information in accordance with this Privacy Notification.

How we collect your personal information

We'll collect your personal information from you directly in many cases. This may include when you complete a form, call us, or use the websites (which may use cookies) on which we make our products and services available. As insurer, Acenda may collect information directly from you or from the Trustee when you complete an application for insurance, make a claim or request a change to your insurance cover. Sometimes we collect your personal information from third parties and other sources including:

- medical practitioners or medical facilities;
- our representatives and distributors, insurance brokers, other insurers and reinsurers;
- your relatives, representatives and legal advisers;
- your employer;
- related bodies corporate of both the Trustee and Acenda;
- service providers such as information brokers, investigators, lawyers, financial advisers, doctors and other medical and occupational experts;
- credit reporting agencies or information providers;
- social media platforms (eg if you log in for our services using your social media profile);
- devices (including wearable devices) in relation to which you agree to provide personal information to us; and
- external dispute resolution bodies, and public sources, including statutory or government organisations, and public registers.

When the law authorises or requires us to collect information

We may collect information about you because we are required or authorised by law to collect it. There are laws that affect financial institutions, including company and tax law, which require us to collect personal information. For example, we require personal information to verify your identity under Commonwealth Anti-Money Laundering law.

Sensitive information

Sometimes we need to collect and hold sensitive information about you, for example when you are applying for an insurance product. This will generally include information about your health, activities that may impact your health, your health history, fitness and physical activities. We may also give you the ability to provide your voiceprint to identify yourself to our call centres.

"Sensitive information" is information about a person's health (this can include genetic or biometric information), racial or ethnic origin, political opinions, membership of a political association,

religious beliefs or affiliations, philosophical beliefs, membership of a professional or trade association or trade union, sexual preferences or practices, criminal record, health information, genetic or biometric information.

We only collect, hold or use sensitive information with your specific consent or in other limited situations which the law allows. We will not disclose your sensitive information to anyone, other than in these circumstances.

How we use your personal information

We use your personal information to:

- provide you with the products and services you've asked for or under which you may receive cover or benefits;
- consider whether you are eligible for a product or service, including identifying or verifying you or your authority to act on behalf of another person;
- process and underwrite your application (including deciding whether or not to provide cover), determine your eligibility under insurance policies and provide you with products and services;
- administer products and services which includes answering your requests and complaints, managing claims and making payments, varying products and services, conducting market research, and managing our relevant product portfolios;
- develop and improve our products and services;
- assist us in running our business including performing administrative and operational tasks (such as training and managing staff, risk management, planning, research and statistical analysis, and systems development and testing);
- prevent or investigate any fraud or crime, or any suspected fraud or crime;
- tell you about other products or services that may be of interest to you, or running competitions and other promotions (this can be via email, telephone, SMS, iM, mail, or any other electronic means including via social networking forums), unless you tell us not to;
- identify opportunities to improve our service to you and improving our service to you;
- determine whether a beneficiary will be paid a benefit; and
- assist in arrangements with other organisations (such as loyalty program partners) in relation to a product or service we make available to you.

We may also collect, hold, use and disclose your personal information:

- as required by legislation or codes that are binding on us;
- for any purpose for which you have given your consent; and
- to combine the information that we hold about you with information about you collected from or held by external sources to enable the development of consumer insights about you so that we can better serve you. We may also use external parties to undertake the process of creating these insights.

What happens if you don't provide your personal information to us?

If you don't provide your personal information to us, we may not be able to:

- provide you with the product or service you want;
- manage or administer your product or service, for example assess a claim or pay a benefit under a policy or product;
- personalise your experience with us;
- verify your identity or protect against fraud; or
- let you know about other products or services that may better meet your needs.

Disclosing your personal information

We may disclose your personal information to other organisations for any purposes for which we use your information. This includes disclosing your personal information to other third parties including:

- Acenda's parent company, Nippon Life Insurance Company and its related bodies corporate;
- the Trustee's related bodies corporate;
- those involved in providing, managing or administering any aspect of your product or service or any product under which you receive or may receive benefits;
- service providers such as information brokers, investigators, lawyers, financial advisers, doctors and other medical and occupational experts;

Privacy Notification

- authorised representatives of Acenda or other parties who sell our products or services;
- super and managed funds organisations, and their advisers and service providers;
- to entities (and their representatives or service providers) involved in issuing, maintaining and providing administration support relating to your insurance product held within super;
- medical professionals, medical facilities or health authorities who verify any health information you may provide;
- reinsurers, claim assessors and investigators;
- brokers or referrers who refer your application or business to us;
- organisations we sponsor and loyalty program partners, including organisations we have an arrangement with to jointly offer products or have an alliance with to share information for marketing purposes;
- police and other enforcement bodies and government agencies where we are required or authorised by law to help detect and prevent illegal activities;
- other government or regulatory bodies (including the Australian Securities and Investment Commission and the Australian Tax Office) as requested or as required or authorised by law (in some instances these bodies may share it with relevant foreign authorities);
- media or social networking sites that provide us with opportunities to place messages in front of you;
- service providers that maintain, review and develop our business systems, procedures and technology infrastructure, including testing or upgrading our computer systems.
- joint venture partners that conduct business with us;
- organisations that assist with our product planning, analytics, research and development;
- mailing houses and telemarketing agencies and media organisations who assist us to communicate with you;
- other organisations involved in our normal business practices, including our agents and contractors, as well as our accountants, auditors or lawyers and other external advisers; and
- credit reporting bodies or other approved third parties who are authorised to assess the validity of identification information;
- fraud reporting agencies (including organisations that assist with fraud investigations and organisations established to identify, investigate and/ or prevent any fraud, suspected fraud, crime, suspected crime, or misconduct of a serious nature);
- organisations we sponsor and loyalty program partners;
- rating agencies to the extent necessary to allow the rating agency to rate particular investments; and
- where you've given your consent or at your request, including to your representatives, or advisers

Disclosing your personal information outside of Australia

Depending on the product or service we provide to you, we may disclose your personal information to organisations outside Australia, in countries such as France, India, Japan, New Zealand, the Philippines, Singapore, South Korea, Switzerland, UK and USA. It is generally unlikely that the EQT Group will disclose your personal information overseas, however, any overseas disclosure does not affect the commitment to safeguarding your personal information and reasonable steps will be taken to ensure any overseas recipient complies with Australian privacy laws.

We may store your information in the cloud or various other types of remote, networked or electronic storage. As electronic or networked storage can be accessed from various countries via an internet connection, it's not always practical to know in which country your information may be held. If your information is stored in this way, disclosures may occur in countries other than those listed.

Our Privacy Policy

For more information about how we collect and use your personal information, including information about how you can access or correct your information or make a complaint, please refer to our Privacy Policy at **acenda.com.au/privacy-policy**

Interim Accident Certificate

This information is provided by MLC Limited ABN 90 000 000 402 AFSL 230694 (Acenda), the issuer of this Interim Accident Insurance.

We are pleased to provide this Interim Accident Insurance, at no extra cost, while your application for MLC Insurance and/ or MLC Insurance (Super), whether for a new policy or an addition to an existing policy, is being considered. This insurance is provided separately to MLC Insurance (Super) and is not part of the Fund. The Trustee has no liability or obligation to you for this Interim Accident Insurance.

The terms and conditions of this Interim Accident Insurance Certificate are set out below.

When will we pay?

You'll receive the benefits of the Interim Accident Insurance if the life insured dies, is Totally and Permanently Disabled, is diagnosed with a non-surgical critical condition, undergoes a surgical procedure for a surgical critical condition or becomes Totally Disabled, as a result of a bodily injury caused by accidental means, which occurs while the life insured is covered by this insurance.

Life Cover and TPD insurance

If you applied for any of these insurances for a life insured, and that life insured dies within 12 months, or is Totally and Permanently Disabled, as a result of a bodily injury which is caused by accidental means during the term of this insurance, you'll receive the lowest of

- $1,000,000
- the benefit you applied for, or
- the benefit we would allow under our assessment guidelines.

Critical Illness insurance

(Applicable outside super only)

If you applied for Critical Illness insurance for a life insured, and that life insured is diagnosed with one of the following critical conditions, as a result of bodily injury which is caused by accidental means during the term of this insurance:

- coma[1]
- major burns[1]
- major brain injury[1]
- blindness[1]
- paralysis[1], or
- loss of independence.

You'll receive the lowest of:

- $600,000
- the Critical Illness Benefit you applied for on the life insured, or
- the Critical Illness Benefit we would allow for that life insured under our normal assessment guidelines.

The definitions of each critical condition that will apply are the definitions for those conditions set out in the current MLC Insurance Policy Document, and as outlined in the Product Disclosure Statement (PDS). Interim cover will only be provided for those conditions that are covered under the terms of the insurance for which you've applied.

Income Protection insurance

If you've applied for Income Protection insurance for a life insured, and that life insured is Totally Disabled as a result of a bodily injury which is caused by accidental means during the term of this insurance, you'll receive the lowest of:

- $10,000 a month
- the benefit you applied for, or
- the Income Protection benefit we would allow under our assessment guidelines.

You'll receive this benefit each month that the life insured is continuously Totally Disabled after the end of the Waiting Period you applied for, up to a maximum of 12 months. If the life insured is Disabled for part of a month the benefit will be reduced proportionately.

Conditions

Other than as varied by these terms, the following (as set out in this PDS and the Policy Document), shall apply to this Interim Accident Insurance:

- the Any Occupation definition of Totally and Permanently Disabled
- the definition of totally disabled under Income Protection insurance, or
- the standard conditions, Waiting Periods, limitations and exclusions, subject to any options you applied for.

In applying the definitions to your Interim Accident Insurance, in respect of an application for MLC Insurance (Super) or MLC Insurance (Wrap or SMSF), a reference to the Trustee as set out in the Policy Document issued by us for MLC Insurance (Super) should be read as a reference to you.

1 These conditions are not covered if you have applied for Critical Illness Standard.

Interim Accident Certificate

When does Interim Accident Insurance start?

Unless we nominate an earlier date, Interim Accident Insurance starts when we or the Trustee receive an application for MLC Insurance, MLC Insurance (Wrap or SMSF) or MLC Insurance (Super) at any of its offices together with either:

- one full instalment of the premium, or
- a fully completed Direct Debit Request Schedule or Credit Card Deduction Authority or Direct Payment.

If the application is submitted electronically, Interim Accident Insurance will start upon submission.

If your application isn't accepted, any premium received by us will be refunded, less any Government charges or taxes, to you or to the Trustee for MLC Insurance (Super) members.

Your Interim Accident Insurance is void if the premium payment for either MLC Insurance and/or MLC Insurance (Super) is dishonoured.

Your duty to take reasonable care not to make a misrepresentation

Interim Accident Insurance will only be available if you and the life insured nominated in the application for MLC Insurance and/or MLC Insurance (Super) have completed the application accurately and honestly, to the best of your knowledge, complying with your duty to take reasonable care not to make a misrepresentation as set out in your application.

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts. The duty applies when you answer questions in your application and whenever we obtain more information from you.

We pay one benefit

We won't pay more than one benefit under this Interim Accident Insurance for any one Accident to any life insured.

Benefit limits

If you're applying to replace an existing policy, the amount of any benefit will be limited to the amount (if any) by which the sum proposed to be insured under the MLC Insurance and/or MLC Insurance (Super) application exceeds the sum insured under the policy to be replaced.

When won't we pay?

In addition to our standard exclusions (as set out in the current MLC Insurance and/or MLC Insurance (Super) Policy Document and outlined in this PDS), we won't pay under this insurance for death or disability arising from or contributed to by:

- any condition that you or the life insured knew about before applying for MLC Insurance and/or MLC Insurance (Super), or
- the life insured engaging in any occupation, sport or pastime that we wouldn't cover under our assessment guidelines.

Furthermore, we won't pay if:

- the cover applied for would have been declined under our assessment guidelines, or
- you lodge a claim for an event or condition that would have been excluded under the underwriting process.

When does Interim Accident Insurance end?

We will cancel your Interim Accident Insurance by notice in writing on the earliest of the following:

- 90 days after the start of this Interim Accident Insurance unless before then we tell you a different date
- the date we issue a Schedule following our acceptance of your application for MLC Insurance and/or MLC Insurance (Super) (or in the case of additional insurance, when we issue a revised Schedule to you)
- when we advise you that your application hasn't been accepted
- when we advise you that your Interim Accident Insurance has ended, or
- when you withdraw your application.

Your application for MLC Insurance and/or MLC Insurance (Super)

If you claim under your Interim Accident Insurance for any life insured, we'll take this into account in considering your application for MLC Insurance and/or MLC Insurance (Super) on the life insured. We may decide not to accept your application on this basis.

We may accept or reject your application. No insurance will take effect (apart from this Interim Accident Insurance) before we accept your application and issue a policy to you (or in the case of additional insurance, when we issue a revised Schedule to you).

No financial adviser or other person is authorised to change these conditions, whether in writing or otherwise. No changes will be binding upon Acenda.

Acenda

Contact us

For more information call anywhere in Australia on **13 65 25**, international callers on **+612 9121 6500** or contact your financial adviser. For hearing impaired customers, please visit **accesshub.gov.au/about-the-nrs** to contact us via your preferred NRS call channel. For customers requiring interpreting or translation services please call **13 14 50**.

Postal address
Acenda
PO Box 23455
Docklands VIC 3008

You can find further details on our website
acenda.com.au

AC5778-0425
CGP-6165

Smart Future Trust – Retail Insurance in Super: For MLC Insurance (Super)

PRODUCT DISCLOSURE STATEMENT

PREPARATION DATE
1 July 2025

ISSUER
Equity Trustees Superannuation Limited
ABN 50 055 641 757
AFSL 229757

In its capacity as Trustee for the Smart Future Trust (the Fund)
ABN 68 964 712 340

INSURER
MLC Limited
ABN 90 000 000 402
AFSL 230694

Important information

This Product Disclosure Statement (PDS or Super PDS) has been prepared on behalf of Equity Trustees Superannuation Limited as Trustee of the Smart Future Trust (the Fund).

References to 'we', 'us' or 'our' are references to the Trustee, unless otherwise stated.

The insurance referred to in this PDS is issued by MLC Limited (trading as Acenda), (Insurer). Acenda uses the MLC brand under licence from the Insignia Financial Group. Acenda is part of the Nippon Life Insurance Group and is not a part of the Insignia Financial Group. The Acenda logo is shown in this PDS with Acenda's consent.

The information in this PDS may change from time to time. Any changes or updates that aren't materially adverse will be available at **acenda.com.au.** You also can obtain a paper copy of these updates at no additional cost by contacting us. An online copy of this PDS is available at **acenda.com.au/pds**

This PDS is a summary of significant information about membership in the Smart Future Trust and the MLC Insurance (Super) insurance cover available through your membership of the Fund. We're the issuer of the super interest in the Fund referred to in this PDS. You should consider all this information before making a decision about the product.

Before you direct us to acquire, or otherwise make a decision about, the insurance offered through this product, please read:

- this PDS issued by Equity Trustees Superannuation Limited (Super PDS);
- the current MLC Insurance and MLC Insurance (Super) PDS issued by the Insurer (Insurance PDS);
- the MLC Insurance (Super) Target Market Determination (TMD).

The full legal terms and conditions for any insurance cover provided to you by the Insurer are contained in the relevant Policy Documents issued by the Insurer, copies of which will be provided to you.

The Insurer does not issue, underwrite or guarantee the super interest(s) described in this PDS.

The information in this PDS is general in nature and doesn't take into account your objectives, financial situation or individual needs. Before acting on any of this information you should consider whether it is appropriate for you. You should consider obtaining financial advice and/or taxation advice before making any decisions based on this information.

This offer is made in Australia in accordance with Australian laws.

In some cases, information in this PDS has been provided to us by the Insurer or third parties. While it is believed the information is accurate and reliable, the accuracy of that information is not guaranteed in any way. Any statements attributable to the Insurer have been shown with the Insurer's consent (which has not expired).

This PDS contains (in summary) general tax information and should not be relied on to determine your personal tax obligations. We recommend you seek professional advice from a registered tax agent.

For more information, please contact us or speak with your financial adviser.

Contents

You may want to have insurance as part of your super arrangements.

This PDS sets out how you can instruct us to take out insurance cover on your behalf through the Fund.

Importantly, there is no investment and no investment earnings in relation to the super interest as described in this PDS. Your interest in the Fund will be membership of the Fund and the insurance cover you instruct us to take out for you.

For a copy of the Insurance PDS that sets out the terms and conditions of the insurance cover provided through MLC Insurance (Super) in the Fund, please go to **acenda.com.au/pds**

The Fund and your Trustee

The Fund is the Smart Future Trust.

It is a resident regulated super fund within the meaning of the *Superannuation Industry (Supervision) Act 1993* and is not subject to a direction under section 63 of that Act.

The Trustee is Equity Trustees Superannuation Limited.

The Trustee is responsible for the operation of the Fund, including management and administration.

The full legal terms which govern your membership of the Fund are contained in the Fund Trust Deed. The full legal terms which govern the MLC Insurance (Super) cover provided to you through the Fund are contained in the applicable Policy Document issued by the Insurer.

How insurance in super works

When you apply for MLC Insurance (Super) you become a member of the Fund, and the insurance cover is purchased through the Fund.

You'll be the person covered by the insurance however the insurance is issued to us, and we'll hold it on your behalf.

The money you pay into the Fund for the insurance will generally be treated as super contributions[1].

We'll then use those contributions to pay insurance premiums. Holding insurance through the Fund will affect what happens when you make a claim, the benefit payments, and the tax treatment and cost of insurance.

Rollovers from another fund are not contributions but can be used to pay insurance premiums.

You should discuss whether this structure is appropriate for you with your financial adviser and registered tax agent.

What documents will be issued to us and to you?

Certain documents are referenced in this PDS. Below is a summary to help you understand what they are, and who issues them:

Document	What is it?	Issued by us as the Trustee	Issued by the Insurer
Super PDS	This PDS, which sets out information you need to know about membership of the Smart Future Trust.	Yes	
Trust Deed	The document which outlines the full legal terms which govern your membership of the Fund.	Yes	
Annual Statement	A document which includes a summary of all transaction details for the financial year.	Yes	
Insurance PDS	The PDS which sets out the information you need to know about the insurance. This PDS has information about insurance held both inside and outside of super.		Yes
Insurance Contract	The insurance which is issued to the Trustee. It comprises the Policy Document and the Policy Schedule.		Yes
Policy Document	The document which outlines the full legal terms of your insurance. A copy will be provided to you.		Yes
Policy Schedule	The document which outlines the types of insurance, the amount of the insurance and premium that applies for that year. A copy will be provided to you.		Yes

We or Acenda may also issue change communications from time to time, if there are any changes made to the insurance benefits or terms that may impact you.

You can request, at no additional cost, a copy of the PDSs, change communications, Policy Document or the Fund Trust Deed referred to in this PDS by contacting us on **13 65 25**. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **13 14 50**.

1 Either as concessional (pre-tax) or non-concessional (after tax) contributions

Insurance you can apply for

The types of insurance available through the Fund may include:

- Death cover
- Total and Permanent Disability (TPD) cover, and
- Income Protection cover.

For more information about the insurances available through the Fund, and the terms and conditions of the insurance, you'll also need to read the Insurance PDS, as well as this Super PDS.

You must be provided with the Insurance PDS before you can apply for insurance through the Fund.

All references in this PDS to 'Insurance PDS' mean the Product Disclosure Statement named MLC Insurance and MLC Insurance (Super), issued by Acenda, the Insurer.

The Insurance PDS contains information about insurance both inside and outside of super, and transactions you can undertake including increasing existing benefits, altering or taking out new benefits or other insurance options. It also contains information about:

- your duty to take reasonable care not to make a misrepresentation. A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth. The duty also applies when extending or making changes to existing insurance, and reinstating insurance.
- maximum insured amounts and applicable payment limits
- terms and conditions including important definitions that must be met before benefits are payable, and
- exclusions and restrictions that may apply.

For TPD and Income Protection cover, the insurance excludes cover for claims caused or contributed to by sickness or injury that first appeared, happened or was diagnosed before this insurance started unless it was disclosed to, and accepted by, the Insurer as a part of the application process.

For the terms and conditions of your existing insurance through the Fund (if any) please refer to your relevant Policy Document. For any matters relating to insurance outside of super contact your adviser or the Insurer directly. You should consider the Insurance PDS issued by Acenda, and the TMD, when deciding whether to acquire, or continue to hold, such insurance cover.

For a copy of the Insurance PDS or TMD or for further information about an insurance product, speak to your adviser. You can also contact us on **13 65 25** or go to **acenda.com.au/pds** to obtain a copy of the Insurance PDS. For hearing impaired customers, please call **1300 555 727**. For customers requiring interpreting or translation services, please call **13 14 50**.

It's important to note that acquiring insurance inside super through the Fund is different to acquiring insurance outside of super. Key differences include:

- the Trustee (not you) is the policyholder for insurance acquired through the Fund;
- superannuation laws apply to insurance held through the Fund (which impact when insurance benefits can be paid and how premiums and benefits are treated for tax purposes);
- complaints relating to insurance through the Fund must be dealt with by the Trustee's complaints handling process.

Your financial adviser can help explain the differences, having regard to your personal circumstances.

How to apply

To apply for insurance through the Fund you will need to complete the insurance application form, answering all the medical and personal history questions.

We will use your completed insurance application form to apply for insurance on your behalf.

The Insurer will then consider your application.

Information about how the Insurer assesses your application, including any special terms the Insurer may apply, is set out in the Insurance PDS.

If you are not an existing member of the Fund when you apply for insurance through the Fund, you will also need to complete an application for Fund membership (using the form accompanying this PDS), acceptance of which is conditional upon the Insurer's acceptance of your insurance application. Your membership of the Fund commences when cover starts.

The insurance

Insurance cover starts when your application is accepted and the Insurance Contract is issued by the Insurer.

The Insurance Contract is made up of the Policy Document and Policy Schedule. You'll receive a copy of the Policy Document. You'll also receive a new Policy Schedule each year, close to the anniversary of the insurance.

We're the owner of the Insurance Contract but you'll be given a copy.

The Policy Schedule will confirm the type of insurance being held in the Fund, the amount of the insurance and also inform you about the premium that applies for that year.

What you need to know about the risks in relation to your insurance through the Fund

There is a risk that the insurance won't meet your needs. Your adviser can assess your circumstances and help you choose a type and amount of insurance to suit your needs.

They can help you consider your future needs now as you may not qualify for some insurances if your circumstances change. If you're replacing your insurance, you should compare the differences between the existing and replacement policies. Please also consider exclusion periods which may apply from the start of the replacement insurance. Benefits may be limited or not paid if you suffer a claimable event in an exclusion period.

This way, you can help ensure the replacement insurance is suitable for you. If you are replacing insurances, do not cancel that insurance before the new insurances are in place (after the insurance is issued).

There are some other risks you need to consider. For example, using super money to pay insurance premiums may reduce your potential retirement savings.

There are conditions and exclusions that apply to insurance cover under the Policy Terms which may affect your entitlement to insured benefits. You may also have an individual exclusion applied at commencement following underwriting, and should this occur it will be displayed in your Policy Schedule.

Also laws governing super (including insurance in super) or the taxation of super may change from time to time and may impact the suitability of you holding insurance in super, or the amount or circumstances of any payment.

Paying for insurance, costs and fees

Insurance costs

The cost of the insurance cover is known as the premium.

Stamp duty and other government charges may also be payable in respect of the insurance.

The Insurer will provide you or your adviser with a quote which sets out the expected cost of the insurance.

There are a number of ways to pay for insurance, including directly (by making contributions into the Fund to cover the cost of the premiums) or by rollover from an external super fund. You cannot pay for insurance through the Fund with contributions from your employer or spouse.

To understand all of the fees and costs that might be payable for the insurance cover (including how these are calculated), please refer to the sections below in this PDS and the Insurance PDS.

Payments into the Fund, excluding rollovers, to cover the cost of insurance premiums are generally considered to be super contributions.

There are caps on the amount you can contribute to super. If you exceed these caps you may pay additional tax.

These contribution caps apply across all contributions you make into super or those made on your behalf, including employer super contributions and other personal contributions you make across all super accounts that you have, even where those accounts are with different super providers.

For more information about taxation implications of insurance arrangements in super refer to the Taxation section in this PDS.

To find out who can contribute, go to **apra.gov.au** or **ato.gov.au**. You can also speak to your financial adviser.

How is the first premium treated?

Any premium paid stays in a trust account while the application for insurance through the Fund is being considered by the Insurer, until the application is accepted or declined (in which case the premium is refunded). Any interest earned on monies in the trust account will be retained by the Fund and paid to the Insurer.

If your application for insurance is not finalised before the end of the income year, we will not record the contribution (in the form of a premium) as being received until the following income year when your application is approved.

Trustee fees

As at the date of preparation of this PDS, we do not charge you a fee for your membership of the Fund for this super interest or for setting up your insurance through the Fund. If this changes, we'll let you know at least three months before introducing the fee.

As the Trustee of the Fund, Equity Trustees Superannuation Limited receives payments from the Insurer in connection with our role and the management of super interests associated with this product. These payments are not an additional cost to you and may vary from time to time. They are by agreement between the Trustee and the Insurer, having regard to the costs we incur in managing this product based on the number of insured members and may be paid by the Insurer out of the premiums they receive.

Family Law Charges

The *Family Law Act* allows super, life insurance and other investments to be divided between parties should there be a marriage or de facto relationship breakdown.

We may be obliged to provide information to other parties and manage the insurance in line with court orders or binding family law agreements. We may charge a fee for any costs we incur. We will let you know the amount of the fee, if applicable.

Claiming on the insurance

We will make a claim on your behalf to the Insurer by submitting your completed claim forms to the Insurer. Please refer to the Insurance PDS for how to make a claim.

You'll need to satisfy the insurance terms for the insurance benefit to be paid.

The insurance terms are described in the Insurance PDS and will also be set out in the Policy Document.

Any insurance benefits paid in respect of insurance held through MLC Insurance (Super) are part of your super and will be paid to us as the Trustee of the Fund.

We'll then release the benefits to you providing you meet a condition of release set by law.

The condition of release that may be relevant for each type of insurance is shown in the table below:

Type of insurance	Related conditions of release
Accidental Death Benefit and Life Cover	Death
Accidental Injury Benefit and TPD	**Permanent Incapacity** – this means the Trustee is satisfied that your ill-health (whether physical or mental) makes it unlikely that you will engage in gainful employment for which you are reasonably qualified by education, training or experience.
Income Protection	**Temporary Incapacity** – this means ill health (whether physical or mental) that caused you to cease to be gainfully employed but does not constitute permanent incapacity. This applies where you've ceased to be gainfully employed (including where you have ceased temporarily to receive any gain or reward under a continuing arrangement for you to be gainfully employed). A benefit can't be paid for longer than the period of Temporary Incapacity.
Terminal Illness	**Terminal Medical Condition** – a terminal medical condition exists in relation to you at a particular time if the following circumstances exist: • two registered medical practitioners have certified, jointly or separately, that you are suffering from an illness, or have incurred an injury, that is likely to result in death within a period (the certification period) that ends not more than 24 months after the date of the certification • at least one of the registered medical practitioners is a specialist practicing in an area related to the illness or injury suffered by the person, and • for each of the certificates, the certification period has not ended.

Irrespective of the conditions of release described above, the applicable insurance definition in the Policy Document must be met for an insurance benefit to be payable.

For new insurance benefits inside super that commenced after 30 June 2014, super trustees are required to provide insurance benefits that are consistent with the conditions of release.

Therefore, all new insurance through the Fund after that date will be consistent with a relevant condition of release.

This means that all valid claims for such insurance benefits will meet the relevant condition of release, and we will be able to release to you the benefit we receive from the Insurer.

Most benefits can be paid to you or your beneficiary following a valid claim. However in rare cases you may not meet a condition of release, and we therefore can't release the benefit to you.

In such a case, the benefit must be held in a super fund as "preserved benefits", until you do meet a condition of release. We'll seek instructions from you about where you would like the benefit to be held. Until your instructions are received and processed, the benefit will not accrue interest.

The law is strict about how and when you can access preserved benefits.

You can generally access preserved benefits when you reach age 65.

Before age 65 you can generally access preserved benefits if you are age 60 and fully retire or if you satisfy another condition of release.

For more information about the conditions of release, go to **apra.gov.au** or **ato.gov.au**

Death Benefits and nominating a Beneficiary

We'll generally pay any insurance death benefit we have received to your eligible beneficiaries (typically your dependants) or your legal personal representative (estate) in accordance with super laws.

Nominating a Beneficiary

You're able to nominate how you prefer your insurance benefits are distributed on your death, as described below.

Beneficiary Nomination Option	What this means
Non-lapsing binding death benefit nomination	You may specify dependants and/or your estate as beneficiaries and nominate the appropriate proportion of the insurance benefits payable to each. If your nomination has been accepted by us and is valid and effective when you die, usually we must pay the insurance benefit to those you nominated in your latest nomination, in the proportions you requested.
Non-binding death benefit nomination	Under this option, you may also specify dependants and/or your estate as beneficiaries and proportions payable to each however we'll determine who receives the insurance benefit, taking into account relevant laws and other factors. Your nomination will guide us as to your wishes, but it will not be binding. We have absolute discretion to determine who will receive the insurance death benefits.

The Beneficiary Nomination Options in the table above don't expire, and therefore you should update your nomination as your circumstances change.

You will need to complete the nomination of beneficiary section of the relevant application form if you wish to make a nomination. For a binding death benefit nomination to be binding on us, the nomination must be valid and effective. A court order may override a binding beneficiary nomination.

If you haven't made an insurance death benefit nomination, we'll have absolute discretion over who receives the benefit in the event of your death (subject to relevant laws).

You can change any insurance death benefit nomination you have made or replace it with a different type of death benefit nomination by completing the **Beneficiary nomination form** available from **acenda.com.au/beneficiaryform**. You can cancel a nomination at any time by writing to us.

Who can you nominate?

When you make a death benefit nomination, under super laws you can only nominate a dependant and/or legal personal representative. A dependant may include:

- your spouse (including a de facto spouse or same-sex partner)
- children (including adopted children, step-children, a child of your spouse or someone who is your child within the meaning of the *Family Law Act 1975)*
- individuals who are financially dependent on you at the time of your death, or
- someone in an 'Interdependency Relationship' (see definition on the next page) with you.

Your legal personal representative is either the executor under your Will or a person(s) granted letters of administration for your estate if you die without having left a valid Will.

If you don't have any such beneficiaries at the time of your death, then we may pay the benefit to another person. When nominating beneficiaries you should take these restrictions into account.

An interdependency relationship exists if two persons (whether or not related by family) have a close personal relationship, live together, one or each of them provides the other with financial support, and one or each of them provides the other with domestic support and personal care.

Two persons will still have an interdependency relationship if they have a close personal relationship but they don't satisfy the other requirements set out above if the reason they don't satisfy the other requirements is that:

- they are temporarily living apart, or
- if either of or both of the two persons suffer from a disability that prevents them from satisfying the other requirements.

It is important that you review your nomination regularly and keep your beneficiary nomination up to date with changes in your personal circumstances.

If you make a non-lapsing binding death benefit nomination your nomination will not automatically become invalid in the event of marriage, divorce or any other life-changing event. In these circumstances, your last valid nomination may no longer reflect your intentions and, unless you update it, we'll still pay the person named in the nomination so long as they are still an eligible beneficiary.

We'll confirm the details of your nomination each year via your annual statement. You can cancel or change your nomination at any time by completing the relevant form available from **acenda.com.au/beneficiaryform** or by calling us on **13 65 25**. For hearing impaired customers, please call **1300 555 727.** For customers requiring interpreting or translation services, please call **13 14 50.**

You should speak to your financial adviser, estate planner or legal representative and registered tax agent to determine which type of nomination will best suit your circumstances and how the complex tax rules about death benefits and beneficiaries may affect you. The definition of 'dependant' for tax purposes is different (eg it does not include an adult child unless they are financially dependent on, or in an interdependency relationship with, you).

Non-lapsing binding death benefit nominations

How do you make a valid non-lapsing binding death benefit nomination?

In order to make a valid non-lapsing binding death benefit nomination, it must:

- be in writing, stating the full name and, unless the nomination is to your legal personal representative, the date of birth of eligible beneficiaries and their relationship to you
- be signed and dated by you in the presence of two adult witnesses who are not nominated beneficiaries
- contain a signed and dated declaration from the witnesses that your beneficiary nomination was made in their presence, and
- for multiple beneficiaries, specify the proportions of the benefit to go to each beneficiary (the total must add up to no more than 100%).

We must confirm our acceptance of your nomination.

Can your non-lapsing binding death benefit nomination become invalid?

Yes. Your non-lapsing binding death benefit nomination can become invalid for a number of reasons, including when a beneficiary is no longer an eligible beneficiary at the time of your death. In these cases we'll have discretion over who receives the benefit amount allocated to that beneficiary.

When insurance in super ends

If premiums are paid and the terms of the insurance are met, it will continue until the expiry date of the insurance is reached, or a termination event happens. See the Insurance PDS for further details.

Cooling off period

If the insurance is cancelled within the applicable cooling off period, the Insurer will refund to us all premiums paid.

We will then refund the amount to you subject to super preservation requirements.

If the monies paid include preserved or restricted non-preserved benefits, you must nominate another complying super fund or rollover vehicle to which these amounts are to be rolled over.

However, if you make an alteration to the insurance or claim on the insurance during the cooling off period, this will confirm acceptance of the insurance and any premiums paid won't be refunded.

For further details about the cooling off period, please see the Insurance PDS.

Note: If the cancelled cover is the only cover held through the Fund, your membership of the Fund for this super interest will also cease.

Cancelling insurance

You can cancel the insurance at any time by request to the Insurer. The Insurer will refund to us premiums paid for any cover relating to the period after the effective date of the cancellation.

We will then refund the amount to you subject to super preservation requirements.

If the monies paid include preserved or restricted non-preserved benefits, you must nominate another complying super fund or rollover vehicle to which these amounts are to be rolled over.

For more information about the risks and consequences of cancelling your insurance, please speak with your financial adviser or go to **acenda.com.au/cancelyourinsurance**

For further details about cancelling the insurance, please see the Insurance PDS.

Converting to insurance outside of super

You can convert the insurance in super to insurance outside of super at any time, as long as the insurance is still in place (while your policy is active and premiums are paid up to date). Contact your financial adviser or the Insurer for further information.

How does conversion work?

On conversion the Insurer will cancel the insurance through super, and issue you a new insurance policy outside super, with similar types of insurance and amounts of insured benefits.

At that point your interest in the insurance product offered through the Fund ends. Any premiums relating to your insurance through super will be refunded in accordance with the usual arrangements applicable to cancelling insurance (see above). Your entitlement to receive any insurance benefits through super also ends and your membership of the Fund will cease (unless you hold another account in the Fund).

> Any beneficiary nomination for the insurance in super will also end when the insurance through super ends.

The amount of insured benefits under the new insurance will not be more than it was under the old insurance at the date of conversion.

Premiums under the new insurance will be calculated in line with the Insurer's premium rates for the cover at the time of conversion.

Any beneficiary nomination made for the insurance in super will not apply to the new insurance outside of super. To make a new beneficiary nomination for your insurance outside of super you will need to complete the Insurer's nomination of beneficiary forms.

See the Insurance PDS for further details.

Taxation

The information in this section is of a general nature and is a summary only of relevant tax laws based on our understanding at the preparation date of this document. Tax laws are subject to change and their impact depends on your personal situation. It should not be relied on solely for making financial decisions. We recommend that you seek professional tax advice regarding your own taxation position.

Tax laws change. To keep up-to-date, please visit **ato.gov.au**

Any contributions used to fund premiums will be reported to the Australian Taxation Office (ATO) for the purpose of calculating your usage of the relevant super contribution cap.

Where required by law, we'll deduct any tax, duty or government fees and forward the money to the relevant authority.

How are super contributions taxed?

Contributions are generally either tax free (non-concessional contributions) or taxed at a concessional rate of 15% (concessional contributions).

Non-concessional contributions include personal (non-deductible) contributions you (or your spouse) make for you. Concessional contributions include, but aren't limited to, contributions from your employer (including salary sacrifice) or, if you're eligible, personal contributions for which you can claim a tax deduction.

An additional 15% tax may also apply on the concessional contributions of high income earners whose adjustable taxable income exceeds $250,000 per annum. This tax will be assessed by the ATO and will be charged to the individual.

Insurance premiums may be tax deductible to the Fund.

Where the premium is deductible to the Fund, we are able to offset any tax payable on contributions by the amount of the deduction. This may reduce the amount of tax you pay from your super account on concessional contributions.

If you choose to fund insurance premiums by rollover from an external super account, we will pass on any tax refund to you by reduction of premium. However, when rolling over, you should consider the impact on the tax and preservation components on each of your super interests.

To find out more about the taxation implications and the preservation components inside super, speak to a financial adviser or registered tax agent.

What are the maximum contribution amounts?

There are limits on how much concessional or non-concessional contributions you can pay (or receive) into your super fund(s) each financial year without having to pay extra tax. These limits are called 'contribution caps'.

Your contributions for the payment of insurance premiums are added to any contributions you or your employer make across all your super accounts for the purpose of applying the concessional and non-concessional contribution caps.

If you exceed these caps you may pay additional tax. These caps may change from time to time.

To find out more about current contribution caps, the taxation implications of exceeding these caps, or any tax law changes, go to **ato.gov.au** and/or speak to a financial adviser or registered tax agent.

Do you intend to claim a tax deduction for contributions used to fund the insurance premium?

Individuals under the age of 67 are generally permitted to claim a tax deduction for personal contributions.

If you are aged 67 to 74 you will need to meet a work test, or work test exemption, in order to be eligible to claim a tax deduction for your personal contributions.

If you intend to claim a tax deduction for any contributions used to fund premiums, you'll need to provide us a **Notice of intent to claim or vary a deduction for personal super contributions** form within the relevant time limits.

To find out more go to **ato.gov.au** and/or speak to your tax agent.

Also, if your application for insurance is not finalised before the end of the income year, we will not record the contribution as being received until the following income year when your application is approved.

This could have implications for the income year in which you are entitled to a tax deduction and can also impact your contribution caps.

What is the work test?

To meet the work test, you must be gainfully employed for at least 40 hours over a 30 consecutive day period during the financial year that you make the contribution(s).

If you have recently retired, are aged 67 to 74 and your Total Super Balance[1] is less than $300,000, the work test exemption may allow you to claim a tax deduction for personal super contributions that you make during the first financial year in which you don't meet the work test.

[1] Total Super Balance: Your Total Super Balance for a financial year is the value, at 30 June of the previous financial year, of all of your accumulation or pre-retirement phase accounts, retirement phase accounts, such as an account based pension, and funds in the process of being transferred from one super account to another (known as 'in-transit rollovers'). You can find out your Total Super Balance by logging in to your **my.gov.au** account.

How are insurance benefits taxed?

The rules relating to the taxation of benefits are complex and you should speak to a financial adviser or obtain professional tax advice from a registered tax agent.

Where required we or our agent will withhold tax from benefit payments and forward the money to the ATO.

Providing your Tax File Number (TFN)

Under the *Superannuation Industry (Supervision) Act 1993*, your super fund is authorised to collect, use and disclose your TFN, which will only be used for lawful purposes.

These purposes may change in the future as a result of legislative change. The trustee of your super fund may disclose your TFN to another super provider, when benefits are being transferred, unless you request the trustee of your super fund in writing that your TFN not be disclosed to any other super provider.

It is not an offence not to quote your TFN. However giving your TFN to your super fund will have the following advantages (which may not otherwise apply):

- your super fund will be able to accept all types of contributions to your account/s
- the tax on contributions to your super account/s will not increase
- other than the tax that may ordinarily apply, no additional tax will be deducted, and
- it will make it much easier to trace different super accounts in your name so that you receive all your super benefits when you retire.

You should provide your tax file number (TFN) to us. If we don't have it, your application for MLC Insurance (Super) and membership of the Fund cannot be accepted.

Also, without a TFN you may be taxed at the highest marginal tax rate for the benefits that are paid to you.

We will verify your TFN with the ATO. For more information visit **ato.gov.au**

Complaints resolution

If you have a complaint about any of the products, or the services you've received, we'd like an opportunity to put it right.

Please call us on **13 65 25** (Toll free **1800 062 061**) or for international calls **+61 2 9121 6500** (charges apply) between 8.30am and 6pm (AEST/AEDT), Monday to Friday, to discuss your concerns.

If we are unable to resolve your issues to your satisfaction, we will put you in contact with our Internal Complaints Resolution Team. For more information, please visit **acenda.com.au/support/customer**

If you're not satisfied with the resolution provided by our Internal Complaints Resolution Team, or we haven't responded to you in 45 calendar days, you can lodge a complaint with the Australian Financial Complaints Authority (AFCA).

AFCA is an independent body that provides a complaint resolution service free of charge to customers. You can contact AFCA at any time, in writing, by email or by phone. AFCA's contact details are:

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

Phone: **1800 931 678** (free call)
Email: **info@afca.org.au**
Website: **afca.org.au**

If you have a complaint about financial advice you receive, you should follow the complaint resolution process explained in the Financial Services Guide provided by your financial adviser.

Other information

Keeping you informed

Each year, you'll be provided with information so you can stay informed about your super interest in the Fund (including your insurance) and any changes that may arise including:

- a statement of the insurance with a summary of all transaction details for the financial year
- information in relation to any material changes, and
- confirmation of non-routine transactions you make on the insurance.

We may provide this information to you by mail, email or by making the information available on **acenda.com.au**

We'll let you know when information about the insurance has been made available online. If you prefer to receive information (including any updates) about your account in the Fund (including any insurance) by mail, please let us know.

Anti-Money Laundering

We're required to comply with our obligations under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006 (AML/ CTF Act) (Cth)* and the Australian Sanctions laws.

We (or the Insurer on our behalf) may need to collect information from you, anyone acting on your behalf or your related parties.

All documents we request need to be dated, and must be an original or certified copy of original document(s) (not a photocopy of a certified copy of original document(s), not faxed or scanned copies) and must be valid at the time you send them to us. Amongst its other AML/CTF obligations, we are required to adhere to AUSTRAC's reporting requirements.

We may decide to delay or refuse any request to process any transaction, including suspending a withdrawal application, freeze accounts or restrict access to funds (where permissible under any applicable legislation), if we're concerned that the request or transaction may breach any obligation we have under the *AML/ CTF Act*, or cause us to commit or participate in an offence, under any law.

To the extent permitted by law, we'll incur no liability to you if we do so.

Privacy information

We and the Insurer collect your personal information from you directly wherever we can, but in some cases we may collect it from third parties such as your adviser. We do this to determine your eligibility and to administer the product.

If personal information is not provided, we or the Insurer may not be able to provide you the product or a service, or administer it appropriately. We may collect information about you because we are required or authorised by law to collect it. There are laws that affect financial institutions, including company and tax law, which require us to collect personal information. For example, we require personal information to verify your identity under the AML/CTF Act.

We may disclose your personal information to other EQT Holdings Limited Group (EQT Group) members and to external parties including the Insurer for purposes that include: insurance management, product development and research. For more information refer to **eqt.com.au/global/privacystatement**
It is generally unlikely that we will disclose your personal information overseas, however, any overseas disclosure does not affect our commitment to safeguarding your personal information and we will take reasonable steps to ensure any overseas recipient complies with Australian privacy laws.

We, other EQT Group members, and the Insurer may use your personal information to contact you about products and for marketing activities. If you do not wish for the Insurer to contact you about products and for marketing activities, you need to contact them directly on **13 65 25** or **privacy@mlcinsurance.com.au**

You can let us know at any time if you no longer wish to receive these direct marketing offers by contacting us.

More information about how we collect, use, share and handle your personal information is in our Privacy Statement (**eqt.com.au/global/privacystatement**), including how to access or correct information we collect about you and how to make a complaint about a privacy issue. Contact us for a paper copy or if you have any questions or comments.

For more information about the collection of your personal information by the Insurer, please refer to the Insurance PDS.

Your notes

Your notes

Your notes

Acenda

Contact us

For more information (including to obtain a copy of this PDS and the Insurance PDS) visit **acenda.com.au** or call us from anywhere in Australia on **13 65 25** or contact your financial adviser. For hearing impaired customers, please visit **accesshub.gov.au/about-the-nrs** to contact us via your preferred NRS call channel. For customers requiring interpreting or translation services, please call **13 14 50**.

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VIVO

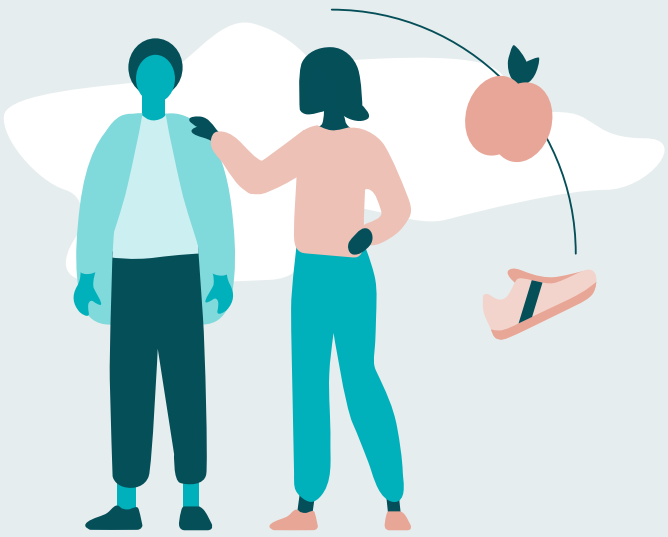
BY MLC LIFE INSURANCE

Meet Vivo

Your holistic health, wellness and recovery program

No matter where you are on life's journey, Vivo offers a range of health and wellness services that provide you and your immediate family* with care and support when you need it.

Offered at no extra cost to those insured by MLC Life Insurance, Vivo helps unlock the value of your insurance today. From prevention to recovery, for both mind and body, see how Vivo can meet your individual needs to help live a healthier life.



Powered by MLC Life Insurance

Services to suit your needs

Whether you're looking to improve your everyday health and wellness, dealing with a medical concern, or requiring recovery support, Vivo connects you with a global network of services and experts that can help.

Vivo Wellness

Get proactive with your wellness to maintain overall health

Speak directly to dieticians and exercise physiologists about your fitness, nutrition, health and wellbeing goals. Benefit from personalised reports, programs and advice tailored to your needs.

Vivo Health

Access a global medical network for tailored advice

Access a network of more than 50,000 leading specialists from Australia and around the world for a medical second opinion quickly. Have the confidence of Australian GPs providing personal, online answers within 24 hours.

Vivo Recovery

Get back on track after illness or injury

Achieve your recovery goals and reconnect with your community, with the support you need to get back to what you love - at work and at home.

Vivo Specialist Care

Receive support for mental health, cancer and pain

Take control of your mental health, cancer care and ongoing pain management with specialist guidance and coaching.

Vivo Virtual Care

Vivo Virtual Care offers quick and convenient access to online services that you and your immediate family can use every day. Completely confidential, these services can be access at any time and as often as you need them.

How to get started

Vivo is your go-to program to access a network of experts providing the care and support you need to achieve your health, wellness and recovery goals. When you're insured by MLC Life Insurance you can:

- Access Vivo at no additional cost
- Explore all Vivo has to offer at **vivowellbeing.com.au** and get started today.