COMMINSURE PROTECTION

SUPPLEMENTARY COMBINED PRODUCT DISCLOSURE STATEMENT AND POLICY

Issue date: 23 August 2020

This Supplementary Product Disclosure Statement (SPDS) is dated 23 August 2020 and supplements the CommInsure Protection Combined Product Disclosure Statement (PDS) and Policy (issued 23 September 2018). This SPDS outlines changes to the product and should be read together with the PDS. Except where otherwise indicated, terms defined in the PDS have the same meaning in this SPDS.

The following changes are made to the PDS:

1. Inside cover

Remove all the words on the inside cover and replace with the following:

Product Disclosure Statement

This Product Disclosure Statement (PDS) is issued by the insurer, The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035 (referred to as 'CMLA', 'we', 'us' and 'our').

This PDS describes our financial products:

- Total Care Plan
- Income Care
- Income Care Plus
- Income Care Platinum.

The PDS helps you understand the various products which make up CommInsure Protection. It provides information about:

- The purpose of CommInsure Protection products
- The key features and benefits available, and
- The costs, risks and other important aspects of CommInsure Protection.

CMLA has entered into a Joint Cooperation Agreement with AIA Australia Limited (AIA) and Commonwealth Bank of Australia (CBA) for the joint operation of the CMLA and AIA businesses. AIA is part of the AIA Group, the largest publicly listed life insurance group in the Asia Pacific region with a presence in 18 markets. Whilst CBA will remain the ultimate shareholder of CMLA, under the terms of the Joint Cooperation Agreement AIA will have an appropriate level of direct management and oversight of the CMLA business. CMLA is a wholly owned but non-guaranteed subsidiary of Commonwealth Bank of Australia ABN 48 123 123 124 (CBA). Apart from CMLA neither CBA nor its subsidiaries are responsible for any of the statements in this PDS. 'CommInsure' is used under licence by CMLA.

If you need to contact CMLA phone **13 1056** between 8 am and 6 pm (AEST/ADST), Monday to Friday. The principal office of CMLA is:

Level 12, 345 George Street
Sydney 2000

The information in this PDS is general information only and doesn't take into account your individual objectives, financial situation or needs. You should assess whether the products are appropriate for you and talk to a financial adviser before making a decision.

The products described in this PDS are only available to persons in Australia. Applications from outside Australia will not be accepted. All references to monetary amounts in this document are references to Australian dollars.

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Changes in the law may result in changes to the information in this PDS. The examples and illustrations provided in this PDS are only intended to demonstrate how certain benefits are calculated. All benefits are determined in accordance with the relevant policy conditions.

After reading this PDS, you can apply for the products by following the steps outlined in 'How to apply'. Please note that before each applicant enters into or becomes insured under a contract of life insurance with CommInsure, they have a duty of disclosure as described in this PDS.

2. Page 5

The second paragraph under the heading 'Our Commitment' is replaced with the following:

For more information on the Code visit: **commbank.com.au/codeofpractice**

3. Page 6

a. Insert immediately under the heading 'Getting started' the following:

CommInsure Protection

Total Care Plan Super

From 1 April 2020 Total Care Plan Super is closed to new customers. As a result the references in this PDS to Total Care Plan Super are removed.

Self-Managed Super Fund (SMSF) Plan

From 1 April 2020 SMSF Plan is closed to new customers. As a result the references in this PDS to SMSF Plan are removed.

Flexi-linking, split TPD and split IP

References to: *flexi-linked life insured, flexi-linked policy, flexi-linked rider cover, flexi-linked TPD Cover, flexi-linked Trauma Cover, flexi-linking, primary Life Care, primary policy, split TPD, split TPD Cover, split TPD policy, split TPD super policy, split IP, split IP policy, split IP ordinary* in the policy are removed.

Product eligibility: Total Care Plan, Income Care, Income Care Plus and Income Care Platinum

From 1 April 2020 to be eligible to apply for Total Care Plan, Income Care, Income Care Plus and Income Care Platinum financial products you must have either:

- a Continuation option which entitles you to apply for these products, or
- an Option to convert benefit which allows you to convert your cover or
- an entitlement to apply for a replacement CMLA policy.

The terms of the Continuation option and/or Option to convert are set out in your existing CMLA policy. It describes the requirements you must meet to be eligible for a Total Care Plan, Income Care, Income Care Plus or Income Care Platinum product. These products are not otherwise available to new customers.

Agreed value and guaranteed agreed value income protection

CommInsure Protection provides income protection through its life insurance products. Effective from 1 April 2020, the only income protection policy types available for existing customers are as follows:

Outside super (Income Care, Income Care Plus and Income Care Platinum)

- Indemnity
- Extended indemnity

Agreed value and guaranteed agreed value policies are not available through CommInsure Protection from 1 April 2020.

As a result, the references to those policies contained in the PDS are removed.

b. The paragraph under the heading 'Need some help?' is replaced with the following:

Your financial adviser will be able to help you choose the most appropriate insurance for you.

4. Page 27

The section headed 'Cooling-off period.' is replaced with the following:

Cooling-off period

You have a 30 day cooling-off period during which you can cancel your policy. The cooling-off period starts when you receive your policy schedule. If you do cancel, we'll refund any money you've paid less any taxes or government charges we decide to deduct.

If you wish to cancel, we ask that you put your request in writing and send it to us with your policy schedule.

5. Page 58

The third paragraph under 'What exclusions apply' is replaced with the following:

Also we won't pay a *Trauma Cover benefit* for *occupationally acquired hepatitis B or C* if:

- before the *accident* occurred, a cure has been found for hepatitis B and/or hepatitis C or
- the *life insured* has elected not to take available mandatory medical treatment which, if taken, would have prevented the infection with hepatitis B and/or hepatitis C.

6. Page 101

The first two paragraphs under the heading 'Stepped or Level premium' are replaced with the following:

For each type of cover you take out, you can choose whether you want the premium for that cover calculated using our stepped or level premium rates. This applies to *Life Care, Accidental Death Cover, TPD Cover, Trauma Cover*, income protection and Business Overheads Cover.

The choice you make for Life Care also applies to Plan Protection, Guaranteed Insurability (business or personal events) and Business Safe Cover, if any. For Business Safe Cover with Trauma and TPD Cover alone, the choice you make for Trauma applies.

Your choice of stepped or level premiums is shown on the policy schedule. Once you make a choice, you can't change it.

In the table under the heading 'Stepped or Level premium' the level section is replaced with the following:

Up to the *policy anniversary date* before the *life insured* turns 65, your premium doesn't go up as the *life insured* gets older. This is because we set the premium at the *life insured's* age next birthday on the date cover starts. If, however, we consider the policy you're applying for is a replacement of a policy you already hold with us, the premium is set at the *life insured's* age next birthday on the date cover started under the policy being replaced.

When we'll calculate premium using your current age

If you've chosen a level premium and:

- your cover increases (other than as a result of indexation)
- you add another benefit or option to the policy or
- you make any other change to the policy that increases the premium

we calculate the premium for the change in cover using the *life insured's* age next birthday on the date we agreed to the change.

If, however, your cover increases as a result of indexation, we won't use the *life insured's* age next birthday on the date of the increase to calculate the premium for the increased cover. Instead, we'll use their age next birthday on the date the cover first started, usually resulting in a cheaper premium for the increased cover.

Premium increases

A level premium doesn't mean your premium won't ever increase. Like a Stepped premium, your premium will increase if, for example, your cover increases or we increase our premium rates for all our policy owners, which is something we can do at any time but we'll tell you before it happens.

When level premiums end

From the *policy anniversary date* before the *life insured* turns 65, level premiums end and your premium will go up every year as the *life insured* gets older, as with a stepped premium.

7. Page 103

The section 'Policy fee waiver' is replaced with the following:

Policy fee waiver

If we issue two or more policies under the same application, we'll only charge a policy fee on one of them as determined by us.

If the policy on which we are charging the policy fee ends, we'll start charging the policy fee on one of the other in force policies we choose. We'll do this from the next *policy anniversary date* under that policy.

8. Page 108

Under the heading 'Upgrade provision' after the 2nd paragraph add the following:

In addition to the above upgrades, if AIA improves benefits in its product Priority Protection as per the "Policy upgrades" section of its PDS then CMLA will consider those improvements and where applicable will pass the improvements on to you. Benefit improvements will only be passed on if those changes result in no increase in premium rates. These benefit improvements will not apply to the assessment of any claims which relate to health conditions that you already had when the AIA improved benefit was applied by us to your policy. The benefits will be applied to your policy at the same date they apply to policies issued under AIA Priority Protection.

9. Page 115

The section under the heading 'How to make a complaint' is deleted and replaced with the following:

How to make a complaint

Most enquiries can be resolved quickly by simply talking with us. You can call us on **13 1056** between 8 am and 6 pm (AEST/ADST), Monday to Friday, so we can help.

If your enquiry is not resolved to your satisfaction, you may lodge a complaint in writing. Please send your written complaint to:

Customer Relations
PO Box 234
PARRAMATTA NSW 2124

Or via email to:
CMLAcustomerrelations@cba.com.au

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Please mark your letter 'Notice of Complaint'

When you make a complaint we will:

- acknowledge your complaint
- give you a reference number and contact details so that you can follow up if you want to
- make sure we understand the issues and investigate the cause of your concern
- do everything we can to fix the problem
- respond to you as quickly as possible
- keep you informed of our progress if the matter can't be resolved quickly
- keep a record of your complaint
- provide a final response within 45 days.

If we are unable to provide a final response to your complaint within the relevant period, we will:

- inform you of the reasons for the delay
- advise you of your right to complain to the Australian Financial Complaints Authority (AFCA), and
- provide you with AFCA's contact details.

External dispute resolution – Australian Financial Complaints Authority (AFCA)

If you're not satisfied with the handling of your complaint or the decision made, you may refer your complaint to the Australian Financial Complaints Authority (AFCA). AFCA offers a free independent dispute resolution service for consumer and small business complaints.

You can contact AFCA on **1800 931 678** between 9 am and 5 pm (AEST/ADST), Monday to Friday from anywhere in Australia, online at **www.afca.org.au** or by writing to:

Australian Financial Complaints Authority Limited
GPO Box 3
Melbourne VIC 3001

10. Pages 116-117

The section under the heading 'Privacy of personal information.' is deleted and replaced with the following:

CMLA's Privacy Policy.

In this section, 'we', 'our' and 'us' means The Colonial Mutual Life Assurance Society Limited (CMLA).

CMLA has entered into a Joint Cooperation Agreement with AIA Australia Limited (AIA) and Commonwealth Bank of Australia (CBA) for the joint operation of the CMLA and AIA businesses. As part of operationalising the Joint Cooperation Agreement, CMLA has adopted the AIA Australia Group Privacy Policy. This section summarises key information about how we, and the AIA Australia Group, handle personal information. More information can be found in the full version of the AIA Australia Group Privacy Policy which can be found at **aia.com.au/privacy**. The AIA Australia Group comprises CMLA, CMLA Services Pty Ltd ABN 88 622 557 251, Jacques Martin Pty Ltd ABN 55 006 100 830 and Jacques Martin Administration and Consulting Pty Ltd ABN 24 006 787 748 AFSL 235037 as well as AIA, AIA Financial Services Limited ABN 68 008 540 252 AFSL 231109 and their related bodies corporate.

Collection information

The information we collect about you as a customer includes information such as your identity and contact details, other personal details such as gender, marital status and financial information. CMLA will not be able to administer this product for you without this information.

How we collect it

We collect this information directly from you and from others such as service providers, agents, advisers, brokers, employers or family members. Where you provide CMLA with information about someone else, you must have their consent to provide their information to us as described in the AIA Australia Group Privacy Policy.

The law may require us to identify our customers. We do this by collecting and verifying information about you and persons who act on your behalf. The collection and verification of information helps to protect against identity theft, money-laundering and other illegal activities. We may disclose your personal information in carrying out verification e.g. we may refer to public records to verify information and documentation or we may verify with an employer that the information that you have given is accurate.

What we collect

Depending on whether you are an individual or organisation, the information we may collect may vary.

We also collect medical and lifestyle information. Where we need to obtain lifestyle and medical information from health professionals or other parties, we will ask for your consent, except where otherwise permitted by law.

If you're commonly known by two or more different names, you must give us full details of your other name or names. Also, during your relationship with us we may also seek and collect further information about you and about your dealings with us.

Accuracy

It's important you provide us with accurate and complete information. If you don't, you may be in breach of the law and we may not be able to provide you with products and services that best suit your needs.

CBA Group Companies

CBA has agreed to distribute our and AIA Australia Group products and services. For some AIA Australia Group members, CBA provides services that support our products and services or those of other AIA Australia Group members. Accordingly the AIA Australia Group will disclose personal information to CBA to help it distribute products or to enable it to provide services to AIA Australia Group members. For AIA Australia Group members who rely on CBA to provide services, some personal information (but not sensitive information) may be visible on CBA systems. For more information on how information relating to CBA Group Companies is managed please refer to our full privacy policy at **aia.com.au/privacy**.

We may also share information for identity verification and foreign tax compliance reporting in respect of which we and the CBA have agreed to act on each other's behalf. This allows us to both use the same customer information for these purposes without needing to each ask for the information separately. The information shared may include, for example, names, contact details, date of birth, product details and identity numbers such as foreign tax identification or driver's licence numbers.

How do we use your personal information?

We collect, use and exchange your customer information so that we can:

- establish and verify your identity and assess applications for products and services
- price and design our products and services
- administer our products and services
- manage our relationship with you
- manage our risks and help identify and investigate illegal activity, such as fraud
- contact you, for example if we need to tell you something important
- conduct and improve our businesses and improve the customer experience
- comply with our legal obligations and assist government and law enforcement agencies or regulators
- identify and tell you about other products or services that we think may be of interest to you
- to manage and administer our and our Affiliates' and partners' business activities, products and services, including the AIA Vitality program.

We may also collect, use and exchange your information in other ways permitted by law.

Electronic communication

If you've given us your electronic contact details, we may use these details to provide information to you electronically, for example, sending reminders via SMS or email. You may receive information on AIA Australia Group products and services electronically.

Direct marketing

If you don't want to receive direct marketing from us or want to update your direct marketing preferences, you can tell us by calling **13 1056** Monday to Friday 8.00am - 6.00pm (AEST/ADST).

Gathering and combining data to get insights

Improvements in technology enable organisations, like us, to collect and use information to get a more integrated view of customers and provide better products and services.

The AIA Australia Group may combine customer information it has with information available from a wide variety of external sources (for example census or Australian Bureau of Statistics data). We are able to analyse the data in order to gain useful insights which can be used as mentioned above.

In addition, AIA Australia Group members may provide data insights or related reports to others, for example to help them understand their customers better. These are based on aggregated information and do not contain any information that identifies you.

Protecting your information

We comply with the Australian Privacy Principles as incorporated into the Privacy Act 1988 (Cth). The Privacy Act protects your sensitive information, such as health information that's collected on insurance applications.

Who do we exchange your information with?

We may exchange your personal information with members of the AIA Australia Group, so that the AIA Australia Group may adopt an integrated approach to its customers. AIA Australia Group members may use this customer information in the same way we use your information (see 'How do we use your personal information?').

We may exchange your information with third parties where this is permitted by law or for any of the purposes we use your information.

Third parties include:

- your employer or former employers
- brokers, agents and advisers and persons acting on your behalf, for example guardians and persons holding power of attorney
- medical practitioners (to verify or clarify, if necessary, any health information you may provide)
- reinsurers and auditors
- claims-related providers such as assessors and investigators (so that any claim you make can be assessed and managed), insurance reference agencies (where we're considering whether to accept a proposal of insurance from you and, if so, on what terms)
- organisations to whom we may outsource certain functions, for example, direct marketing, statement production and information technology support
- government and law enforcement agencies or regulators
- entities established to help identify illegal activities and prevent fraud
- the life insured, policy owner or beneficiaries of an insurance policy
- private health insurers (including MO Health Pty Ltd) and their contractors and agents.

In all circumstances where our contractors, agents and outsourced service providers become aware of customer information, confidentiality arrangements apply. Customer information may only be used by our agents, contractors and outsourced service providers for our purposes.

We may be required to disclose customer information by law, e.g. under Court Orders or Statutory Notices pursuant to taxation or social security laws or under laws relating to sanctions, anti-money laundering or counter terrorism financing.

Sending information overseas

From time to time we may send your information overseas, including to other AIA Group members and to service providers or other third parties who operate or hold data outside Australia. Where we do this, we make sure that appropriate data handling and security arrangements are in place. Please note that Australian law may not apply to some of these entities.

Information may also be sent overseas to complete certain transactions (such as the assessment of your insurance application or management of your claim), or where this is required by law and regulation of Australia or another country. Other overseas parties can include reinsurers, medical or rehabilitation practitioners.

For more information about which countries we may send your information to, see the AIA Australia Group Privacy Policy available at **aia.com.au/privacy.**

Viewing your personal information

You can (subject to permitted exceptions) request access to your personal information by contacting:

Email:	**CMLAcustomerrelations@cba.com.au**
Phone:	**13 1056** between 8.00 am - 6.00 pm (AEST/ADST), Monday to Friday
Write to:	Customer Relations, PO Box 234, PARRAMATTA NSW 2124

We may charge you for providing access. For more information about our privacy and information handling practices, please refer to the AIA Australia Group Privacy Policy, which is available through **aia.com.au/privacy.**

Making a privacy complaint

We accept that sometimes we can get things wrong. If you have a concern about your privacy you have a right to make a complaint and we'll do everything we can to put matters right. For further information on how to make a complaint and how we deal with your complaint please refer to the AIA Australia Group's Privacy Policy, which is available at **aia.com.au/privacy** or phone **13 1056**.

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11. Medical definition changes

Medical definitions

advanced diabetes mellitus

Replace the meaning of the definition on page 148 with:

Severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a *relevant medical specialist* 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 despite treatment;
- diabetic gangrene resulting in the need for surgical amputation and Loss of Digit*
- severe diabetic nephropathy causing chronic irreversible renal impairment as measured by a corrected creatinine clearance less than 28ml/min (CKD stage 4, International Chronic Kidney Disease classification);
- Neuropathy including:
  - irreversible autonomic neuropathy resulting in postural hypotension, and/or motility problems in the gut with intractable diarrhoea or
  - Polyneuropathy leading to significant mobility problems due to sensory and/or motor deficits.

*'Loss of Digit' means the surgical removal of a finger or toe from the hand or foot at the proximal interphalangeal joint.

bacterial meningitis

Replace the meaning of the definition on page 148 with:

The diagnosis of bacterial meningitis resulting in a permanent neurological deficit causing permanent and significant functional impairment as certified by the *relevant medical specialist*.

benign brain tumour

All references to '*benign brain tumour*' including the definition on page 148 (but excluding, for the avoidance of doubt, references to *'benign brain tumour of limited extent'*) are deleted and replaced with '*benign brain tumour* or *tumour of the spinal cord*, and the definition of '*benign brain tumour or tumour of the spinal cord*' is as follows:

The diagnosis of:

- a non-malignant tumour arising in the brain or spinal cord or
- an acoustic neuroma or
- a meningioma

which results in neurological deficit.

The condition must require:

- chemotherapy or
- radiotherapy or
- cranial or spinal surgery

for its treatment or removal within 12 months.

The diagnosis must be confirmed by a *relevant medical specialist*. The presence of the condition must be confirmed by imaging studies such as CT scan or MRI.

The definition excludes diagnosis of cysts, granulomas, cerebral abscesses, malformations in or of the arteries or veins of the brain, haematomas, and tumours in the pituitary gland.

cancer

Replace the meaning of the definition on page 149 with:

Cancer is the presence of one or more malignant tumours diagnosed by a *relevant medical specialist* and includes each of the following conditions:

1. Lymphoma (including Hodgkin's and non-Hodgkin's disease)
2. Leukaemia other than Chronic Lymphocytic Leukaemia equivalent to Rai Stage 0
3. Multiple myeloma
4. Malignant bone marrow disorders
5. Carcinoma in situ of the breast which has resulted in:
    i. the removal of the entire breast, or
    ii. breast conserving surgery and radiotherapy, or
    iii. breast conserving surgery and chemotherapy (chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells)
6. Carcinoma in situ of the testis
7. Sarcoma
8. Prostatic cancers that are classified as:
    i. T1bN0M0 or greater, or
    ii. T1aN0M0 with a Gleason Score of 6 or more.

This definition of 'cancer' excludes each of the following conditions:

1. All tumours which are histologically described as benign, pre-malignant, borderline malignant, low malignant potential, all grades of dysplasia, all grades of squamous intraepithelial lesions (HSIL and LSIL), and all grades of intra-epithelial neoplasia.
2. Non melanoma skin cancers including:
    i. intraepidermal carcinomas
    ii. basal cell carcinomas, and
    iii. squamous cell carcinomas of skin

    which have not spread to another organ.
3. Melanomas which are classified as less than stage T1bN0M0.
4. Monoclonal gammopathy of unknown significance (MGUS).
5. A prostatic cancer that is not included in the definition of 'cancer' under the list of inclusions above.
6. Chronic Lymphocytic Leukaemia equivalent to Rai Stage 0.
7. A tumour which meets both of the following:
    i. it is described histologically as premalignant or carcinoma in situ; and
    ii. it is not included in the definition of 'cancer' under the list of inclusions above.
8. A cancer which meets both of the following:
    i. it is classified as less than T1N0M0 as defined by the American Joint Committee for Cancer (AJCC); and
    ii. it is not included in the definition of 'cancer' under the list of inclusions above.

chronic lung disease

Replace the meaning of the definition on page 149 with:

End stage respiratory failure requiring permanent, long term oxygen therapy as certified by the *relevant medical specialist*.

coronary artery bypass surgery

Replace the meaning of the definition on page 149 with:

Coronary artery bypass surgery that has occurred to treat coronary artery disease but excluding angioplasty and intra-arterial procedures.

coronary artery angioplasty

All references to '*coronary artery angioplasty*' including the definition on page 149 (but excluding, for the avoidance of doubt, references to *'coronary artery angioplasty - triple vessel'*) are deleted and replaced with '*coronary artery angioplasty – single or double vessel*', and the definition of '*coronary artery angioplasty – single or double vessel*' is as follows:

The person undergoes coronary artery angioplasty to one or two different coronary arteries but only if, in the opinion of a *relevant medical specialist*, the procedure was necessary to treat coronary artery disease.

The *relevant medical specialist's* opinion must be supported by angiographic evidence.

critical care

All references to '*critical care*' including the definition on page 150 are deleted and replaced with *'intensive care (prolonged)'*, and the definition of *'intensive care (prolonged)'* is as follows:

A *sickness* or *injury* that has resulted in the person requiring continuous mechanical ventilation by means of tracheal intubation for seven consecutive days (24 hours per day) in an intensive care unit of an acute care hospital.

Sickness or *injury* as a result of self-inflicted means is excluded.

diplegia

Replace the meaning of the definition on page 150 with:

The total and permanent loss of use of both arms or both legs, resulting from *sickness* or *injury* of the brain or spinal cord.

heart attack

Replace the meaning of the definition on page 151 with:

The death of part of the heart muscle (myocardial infarction) as a result of inadequate blood supply to the relevant area.

The diagnosis of myocardial infarction must be confirmed by a *relevant medical specialist* and evidenced by:

a. a typical rise and/or fall of cardiac biomarkers with at least one biomarker result above the upper limit of the reference range, and

b. at least one of the following:

- signs and symptoms of ischaemia consistent with a myocardial infarction;
- confirmatory new, or presumed new, electrocardiogram (ECG) changes consistent with myocardial infarction;
- imaging evidence confirming the new loss of viable myocardium or new regional wall motion abnormality.

If the above evidence is inconclusive or superseded by technological advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose the occurrence of a myocardial infarction of at least the degree of severity set out above.

Other acute coronary syndromes where death of the heart muscle has not occurred, myocarditis, pericarditis and any cardiomyopathy such as but not limited to takotsubo cardiomyopathy are excluded.

hemiplegia

Replace the meaning of the definition on page 151 with:

The total and permanent loss of use of one arm and one leg on the same side of the body, resulting from *sickness* or *injury* of the brain or spinal cord.

loss of hearing

All references to '*loss of hearing*' including the definition on page 151 (but excluding, for the avoidance of doubt, references to *'partial loss of hearing'*) are deleted and replaced with '*loss of hearing in both ears'*, and the definition of '*loss of hearing in both ears*' is as follows:

The permanent and irreversible loss of hearing in both ears as a result of *sickness* or *injury*, to the extent that the person has an average hearing threshold of 91dB or greater as measured at 500, 1000, 1500, 2000 and 3000 Hz even with amplification. The loss must be certified by a *relevant medical specialist*.

The definition isn't met if the person's level of hearing is lower than the above threshold with the assistance of any type of hearing device, other than a cochlear implant.

loss of use of limbs or sight

Replace the meaning of the definition on page 151 with:

The person has suffered, as a result of *sickness* or *injury* and as certified by a *relevant medical specialist*, any of the following:

- the total and permanent loss of use of both hands
- the total and permanent loss of use of both feet
- the total and permanent loss of use of one hand and one foot
- the total and permanent loss of use of one hand and blindness in one eye
- the total and permanent loss of use of one foot and blindness in one eye; or
- blindness in both eyes.

Blindness means the permanent loss of sight to the extent that:

- visual acuity is 6/60 or less or
- the visual field is reduced to 20 degrees or less of arc

whether aided or unaided.

loss of use of one limb

Replace the meaning of the definition on page 151 with:

The person has suffered, as a result of *sickness* or *injury*, the total and permanent loss of use of one hand or one foot.

major head trauma

All references to '*major head trauma*' including the definition on page 151 are deleted and replaced with '*major head trauma with permanent neurological deficit*', and the definition of '*major head trauma with permanent neurological deficit*' is as follows:

Injury to the head resulting in permanent neurological deficit causing either:

- the permanent and irreversible inability to perform without the assistance of another person any one of the *activities of daily living*, or
- permanent cognitive impairment, where the person has a Mini-Mental State Examination score of 24 or less

as certified by a *relevant medical specialist.*

meningococcal disease

Replace the meaning of the definition on page 152 with:

The diagnosis of meningococcal septicaemia resulting in a permanent neurological deficit causing permanent and significant functional impairment as certified by the *relevant medical specialist*.

multiple sclerosis of limited extent

Replace the meaning of the definition on page 152 with:

The diagnosis of multiple sclerosis as certified by a *relevant medical specialist* and evidenced by magnetic resonance imaging or other investigations acceptable to us and has not resulted in persisting neurological abnormalities.

multiple sclerosis with impairment

Replace the meaning of the definition on page 152 with:

The diagnosis of multiple sclerosis as certified by a *relevant medical specialist* and evidenced by magnetic resonance imaging or other investigations acceptable to us and has resulted in persisting neurological abnormalities.

occupationally acquired hepatitis B or C

Replace the meaning of the definition on page 153 with:

Occupationally acquired hepatitis B or hepatitis C where:

- the virus was acquired by the person as a result of an *accident* occurring while they were engaging in their occupation as a medical professional and
- there is proof of sero-conversion from:

  a) Hepatitis B surface antigen negative to hepatitis B surface antigen positive; or

  b) Hepatitis C antibody negative to hepatitis C antibody positive

which is demonstrated by testing within six months after the *accident*.

Hepatitis B or hepatitis C acquired in any other manner is excluded.

Any *accident* that gives rise to a claim must be treated in accordance with the relevant infection control guidelines for the relevant practice body or state health service including, at a minimum, baseline screening with regular screening at six weeks, twelve weeks and six months post event. This screening requires a supporting negative hepatitis B or hepatitis C test performed on material taken after the date of the *accident*. Blood product and all other blood samples used need to be made available to us for independent testing.

Also, we won't pay a *Trauma Cover* benefit for occupationally acquired hepatitis B or C if:

- before the *accident* occurred, a cure has been found for hepatitis B and/or hepatitis C or
- the *life insured* has elected not to take available mandatory medical treatment which, if taken, would have prevented the infection with hepatitis B and/or hepatitis C.

paraplegia

Replace the meaning of the definition on page 153 with:

The total and permanent loss of use of both legs, resulting from *sickness* or *injury* of the brain or spinal cord.

Parkinson's disease

Delete all references to '*Parkinson's disease*', including the definition on page 153 (but excluding, for the avoidance of doubt, references to '*Parkinson's disease with impairment*').

partial loss of hearing

All references to '*partial loss of hearing*' including the definition on page 153 are deleted and replaced with '*loss of hearing in one ear*', and the definition of '*loss of hearing in one ear*' is as follows:

The permanent and irreversible loss of hearing in one ear as a result of *sickness* or *injury*, to the extent that the person has an average hearing threshold of 91dB or greater as measured at 500, 1000, 1500, 2000 and 3000 Hz even with amplification. The loss must be certified by a *relevant medical specialist*.

The definition isn't met if the person's level of hearing is lower than the above threshold with the assistance of any type of hearing device, other than a cochlear implant.

quadriplegia

Replace the meaning of the definition on page 154 with:

The total and permanent loss of use of both arms and both legs, resulting from *sickness* or *injury* of the brain or spinal cord.

severe rheumatoid arthritis

Replace the meaning of the definition on page 154 with:

The diagnosis of severe rheumatoid arthritis by a *relevant medical specialist*.

The diagnosis must be supported by, and evidence, all of the following criteria:

- the person has undergone and is non-responsive to all reasonable conventional therapy*, and
- the person has failed treatment with one biological disease-modifying anti rheumatic drugs (bDMARD),

as recommended by a *relevant medical specialist*.

Degenerative osteoarthritis and all other arthritides are excluded.

*Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for Rheumatoid Arthritis.

stroke

Replace the meaning of the definition on page 155 with:

An infarct or haemorrhage involving the brain or spinal cord, producing neurological symptoms. There must be evidence consistent with stroke on CT, MRI or other appropriate imaging scan.

The following are excluded:

- migraines
- transient ischemic attacks
- brain injury resulting from trauma
- vascular disease affecting the eye, optic nerve or vestibular function.

surgery of the aorta

Replace the meaning of the definition on page 155 with:

Surgery that has occurred to correct a narrowing, dissection, aneurysm or traumatic injury of the thoracic or abdominal aorta but not its branches.

tetraplegia

Delete all references to '*tetraplegia*', including the definition on page 155.

This Supplementary Combined Product Disclosure Statement (SPDS) and Policy is issued by the insurer, The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035. 'CommInsure' is used under licence by the Colonial Mutual Life Assurance Society Limited (CMLA).

COMMINSURE PROTECTION.

Combined Product Disclosure Statement (PDS) and Policy.

Issue date: 23 September 2018

CommInsure

Product Disclosure Statement

This Product Disclosure Statement (PDS) is issued by the insurer, The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035 (referred to as 'CMLA', 'we', 'us' and 'our') and Colonial First State Investments Limited ABN 98 002 348 352 AFSL 232468, the trustee of the Colonial First State FirstChoice Superannuation Trust ABN 26 458 298 557 (the 'Trust', 'FirstChoice Trust'), (referred to as 'the trustee', or 'the trustee of the FirstChoice Trust').

This PDS describes two separate financial products:

- life insurance products (issued by the insurer, CMLA)
- a superannuation product (issued by the trustee of the FirstChoice Trust, Colonial First State Investments Limited).

CMLA and the trustee of the FirstChoice Trust take full responsibility for the whole of the PDS. A description of the cover available under each of these products is contained in this PDS.

This PDS helps you understand the various products which make up CommInsure Protection. It provides important information about:

- the purpose of the CommInsure Protection products
- the key features and benefits available, and
- the costs, risks and other important aspects of CommInsure Protection.

CMLA and the trustee of the FirstChoice Trust are wholly owned but non-guaranteed subsidiaries of Commonwealth Bank of Australia ABN 48 123 123 124 (CBA). Apart from CMLA and the trustee of the FirstChoice Trust, neither CBA nor its subsidiaries are responsible for any of the statements in this PDS. CBA and its subsidiaries (Commonwealth Bank Group) don't guarantee the CommInsure Protection products. Contributions to the Trust aren't deposits or other liabilities of CBA and its subsidiaries.

If you need to contact CMLA or the trustee of the FirstChoice Trust, phone **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday.

The principal offices of administration of CMLA and the trustee are:

CMLA
Level 22, 1 Market Street
Sydney NSW 2000

Trustee
Level 1, 11 Harbour Street
Sydney NSW 2000

CMLA is responsible for the administration of Total Care Plan Super on behalf of the trustee of the FirstChoice Trust and provides insurance benefits to the FirstChoice Trust. CommInsure is a registered business name of CMLA.

The information in this PDS is general information only and doesn't take into account your individual objectives, financial situation or needs. You should assess whether the product is appropriate for you and talk to a financial adviser before making a decision.

The products described in this PDS are available only to persons in Australia.

Applications from outside Australia won't be accepted. All references to monetary amounts in this document are references to Australian dollars.

Changes in the law may result in changes to the information in this PDS. The examples and illustrations provided in this PDS are only intended to demonstrate how certain benefits are calculated. All benefits are determined in accordance with the relevant policy conditions and, for Total Care Plan Super, the FirstChoice Trust Deed.

After reading this PDS, you can apply for the products described in the PDS by following the steps outlined in 'How to apply' on page 25. Please note that before each applicant enters into or becomes insured under a contract of life insurance with CommInsure, they have a 'Duty of Disclosure' as described on page 27.

Contents.

Overview.

Quick guide to key information

Why CommInsure?

CommInsure is one of the largest insurance providers in Australia with over 3.8 million customers. With roots dating back over 140 years, we have a history of financial strength, security and reliability.

Claims

In 2017, CommInsure paid more than $1 billion in claims. That's over $20 million in claims paid on average each week.

We paid these claims under our Retail, Direct and Group insurance policies.

Life Insurance Code of Practice

The Life Insurance Code of Practice (the Code) is the life insurance industry's commitment to customer service standards.

The Code has been voluntarily developed by the life insurance industry through the Financial Services Council to protect life insurance customers by:

1. Promoting higher standards of service
2. Providing benchmarks of consistency within the industry
3. Establishing a framework for professional behaviour and responsibilities.

The Code sets the standards life insurers are expected to meet when providing services to their customers. One such standard is the requirement for life insurers to be open, fair and honest. The Code also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers.

The Code covers many aspects of a customer's relationship with their insurer, including:

- communication standards
- product design and disclosure requirements
- sales practices and advertising
- buying, altering or policy cancellation practices
- claims practices
- providing assistance to those experiencing financial hardship or have additional needs
- complaint and dispute resolution.

Our commitment

CommInsure is proud to be a signatory to the Code and is committed to doing the right thing for its customers. The Code is monitored by an independent committee, to ensure effective compliance by life insurers. Insurers can be sanctioned if they do not correct breaches of the Code.

For more information on the Code visit **www.commbank.com.au/personal/insurance/life-insurance/life-insurance-code-of-practice.html**

Getting started.

How to use this document

This is a combined PDS and Policy document. The entire document is a PDS but only certain parts of it contain the policy terms. The policy terms, which are our contract with you if a policy is issued, are in parts A, B, C and the Definitions section of this document.

This document has eight parts:

- **Overview** gives an overview of the types of insurance we offer and also explains how to choose cover combinations. Refer page 4.
- **Part A** explains how our life, total and permanent disability (TPD) and trauma cover works. It also sets out the policy terms for these types of cover. Refer page 28.
- **Part B** explains how our income protection works, including our Business Overheads Cover. It also sets out the policy terms for this cover. Refer page 68.
- **Part C** tells you about the policy terms common to all our insurance products. Refer page 100.
- **Part D** tells you about other things you need to know, such as taxation and privacy. Refer page 110.
- **Part E** provides additional information on Total Care Plan Super. Refer page 118.
- **Part F** explains important considerations in taking your insurance inside super. Refer page 126.
- **Definitions** sets out our meanings of certain words and expressions used in this combined PDS and Policy document. Refer page 130.

Follow the colours

We've colour coded the different types of insurance described in this document to help you find what's relevant to you.

If you already know what type of insurance you need, and you want to get straight into the details, the colour code will help you find the information you're looking for.

For a colour code key please see the opposite page.

Need some help?

Your financial adviser will be able to help you choose the most appropriate insurance for you. If you don't have a financial adviser, simply call **1800 241 996** between 8.30 am to 6 pm (Sydney time), Monday to Friday or visit **www.commbank.com.au** to arrange for a financial adviser to contact you.

Risks.

There are a number of risks you should be aware of, including:

- the insurance cover you select may not provide the appropriate cover for all your needs.
- if you don't pay your premiums on time, we can cancel the policy and decline any claim for an event which arises after the cancellation.
- we may vary or may not pay a benefit if you have not complied with your duty of disclosure.
- if a Confirmation of Alternative Policy Terms is required from you and we don't receive it in time, your policy automatically ends and you won't be covered for future events.
- income protection benefits won't be paid inside super if you are not gainfully employed when the disability occurs.
- if you have Total and Permanent Disability (TPD) Cover, from the policy anniversary date before your 65th birthday you are only covered for loss of independent existence (as defined on page 151) and no other condition.
- if you have Trauma Cover, from the policy anniversary date before your 70th birthday you are only covered for loss of independent existence (as defined on page 151) and no other condition.
- the Involuntary Unemployment Cover benefit for CBA Group loans included in our income protection may not be as comprehensive as other unemployment cover available in the market. If this cover applies to you, you'll only be eligible for a benefit if your unemployment is involuntary and continues for more than 60 consecutive days. Other limitations and exclusions apply (please refer to page 80).

Our insurance summary.

Put simply, we offer two main types of insurance:

- **Life insurance** which can cover you for death, terminal illness, total and permanent disability (TPD) and trauma (critical illness).
- **Income protection** which can cover you for loss of income or your business's fixed operating expenses in the event of disability.

The insurance offered in this PDS doesn't have a surrender or cash-in value payable at any point.

Protecting your life

Life Care – leave something behind

Life Care pays a lump sum if you die or are terminally ill and likely to die within 24 months. On death, we provide an advance payment in some circumstances to help cover funeral expenses.

You can also take out Accidental Death Cover, which pays a lump sum if you die due to an accident.

If you have children you can take out Child Cover. Child Cover pays a lump sum if your child dies or meets the definition of a specified child trauma condition (see page 65 for child trauma conditions).

If you're involved in a business, you can use Life Care to insure the key people and your investment in the business. You can also protect your business loan.

Life Care	
Entry age (next birthday)	
Stepped premium (see page 14)	16 to 71*
Level premium (see page 14)	18 to 55*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Cover expiry date Expires on the policy anniversary date before you turn	
Total Care Plan	99
Total Care Plan Super	80
SMSF Plan	99
Amount of cover	
Minimum	No minimum
Maximum	No maximum*

*A maximum of $2 million applies if you're performing domestic duties when you apply for cover.

Life Care	
Included benefits and features	
Life Care benefit	Page 33
Terminal Illness benefit	Page 33
Advance Payment benefit	Page 33
Severe Hardship Booster benefit	Page 34
Life Care Buy Back benefit	Page 34
Life Care Financial Planning benefit	Page 34
Accommodation benefit	Page 35
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Guaranteed Insurability (business events)	Page 40
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Child Cover	Page 64

Accidental Death Cover	
Entry age (next birthday)	
Stepped premium (see page 14)	16 to 71*
Level premium (see page 14)	18 to 55*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Cover expiry date Expires on the policy anniversary date before you turn	
Total Care Plan	99
Total Care Plan Super	80
SMSF Plan	99
Amount of cover In super, Accidental Death Cover must be taken with Life Care and it can't exceed the amount of Life Care. Indexation may cause cover to exceed the maximum.	
Minimum	$10,000
Maximum	$1 million

Child Cover

Entry age (next birthday)	3 to 17*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Cover expiry date Expires on the policy anniversary date before the child turns	18

Amount of cover Must be the same amount of cover for each child. Indexation may cause cover to exceed the maximum.	
Minimum	$10,000
Maximum	$250,000

Total and Permanent Disability (TPD) Cover – because sickness and accidents happen

TPD Cover pays a lump sum if you're totally and permanently disabled. There are different definitions of total and permanent disability that can apply, for example, if you're totally and permanently unable to engage in either your own or any occupation or you suffer loss of use of limbs or sight or loss of independent existence.

For the full definitions of TPD please refer to the definitions starting on page 134.

TPD Cover

Entry age (next birthday)	
Stepped premium (see page 14)	16 to 61*
Level premium (see page 14)	18 to 55*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Cover expiry date Expires on the policy anniversary date before you turn	
Total Care Plan	99
Total Care Plan Super	75
SMSF Plan	99

Amount of cover If TPD Cover is a rider to Life Care it can't exceed the amount of Life Care. Indexation may result in cover exceeding the maximum.	
Minimum	No minimum
Maximum	$5 million*

*A maximum of $2 million applies if you're performing domestic duties when you apply for cover.

TPD Cover

Available definitions

- Own occupation
- Any occupation
- Domestic duties

To be eligible for 'any' or 'own' occupation, you must be working outside the home for at least 20 hours per week. If you don't meet this requirement, you may be eligible for domestic duties TPD.

Included benefits and features

Available options

Trauma Cover – health is everything

Trauma Cover pays a lump sum if you meet the definition of any one of our trauma conditions such as cancer, heart attack or stroke. Each trauma condition is medically defined in this PDS and we'll only pay a benefit for a condition if you meet its precise meaning.

If you have children you can take out Child Cover. Child Cover pays a lump sum if your child dies or meets a specified child trauma condition (see page 65 for child trauma conditions).

Trauma Cover and Child Cover are not available inside super.

For the full range of trauma conditions covered and their specific meanings please refer to the 'Medical definitions' starting on page 148.

Trauma Cover

Entry age (next birthday)	
Stepped premium (see page 14)	16 to 66*
Level premium (see page 14)	18 to 55*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Trauma Cover

Cover expiry date	
Expires on the policy anniversary date before you turn	80
Amount of cover	
If Trauma Cover is a rider to Life Care, it can't exceed the amount of Life Care. Indexation may result in cover exceeding the maximum.	
Minimum	$10,000
Maximum	$2 million*

*A maximum of $1,250,000 applies if you're performing domestic duties when you apply for cover.

Included benefits and features

Available options

Protecting your income

Income protection – works when you're unable to

At its most basic, income protection pays up to 75% of your income when you're unable to perform all or part of your occupation due to sickness or injury. It can also pay up to 100% of your super contributions to your nominated fund.

It also offers a host of features to help cover other costs that might come up in this situation.

If you don't qualify for full income protection because of your health, you may instead be eligible for our Essential Cover which is income protection for accidents only (not sickness). It's also generally a cheaper income protection option.
Refer to page 81.

Income protection

Entry age (next birthday)	
Stepped premium (see page 14)	
for expiry at policy anniversary date before age 60	18 to 55*
for expiry at policy anniversary date before age 65	18 to 61*
for expiry at policy anniversary date before age 70	18 to 64*
Level premium (see page 14)	18 to 55*
Aviation occupation group	20 to 55*
Specialist risk occupation groups	18 to 50*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Cover expiry date

Policy anniversary date before you turn 60, 65 or 70 depending on the age you choose

Monthly cover (based on occupational group)

Maximum cover includes any cover for super contributions. Indexation may cause cover to exceed these maximums. For more information on IP with a benefit period to age 70 please see page 23.

Occupation group	Minimum	Maximum
Occupations other than those in the groups below	$1,500	$30,000*
Specialist risk – medium		$10,000
Specialist risk – high		$7,000
Heavy risk		$7,000

***Notes**:

- A higher maximum may sometimes apply.
- Some mining occupations have a maximum of $10,000.

For more information, please speak to your adviser.

Income protection

Work eligibility

You must be working full time or permanent part time for at least 20 hours per week.

Income Care Plus and Income Care Platinum aren't available for occupations we classify as heavy risk or specialist risk – high.

Benefit period to age policy anniversary date before you turn 70 isn't available for occupations we classify as light manual, manual, heavy risk, aviation, specialist risk – medium and specialist risk – high.

Cover type

Inside super (aligned to superannuation law)

- Indemnity
- Agreed value

Outside super

- Indemnity
- Extended indemnity
- Agreed value
- Guaranteed agreed value

Waiting periods available

A choice of:

- 14 days
- 1 month
- 2 months
- 3 months
- 6 months
- 1 year
- 2 years

Benefit periods available

Occupations other than those set out below

- 2 years
- 5 years
- to the policy anniversary date before you turn 60, 65 or 70

Aviation occupation group

- 2 years
- 5 years
- to the policy anniversary date before you turn 60

Heavy risk or Specialist risk occupation groups

- 2 years
- 5 years

Light manual and Manual occupation groups

- 2 years
- 5 years
- to the policy anniversary date before you turn 60 or 65

Income protection

Income Care – included benefits and features

Income Care Plus – included benefits and features

All benefits in Income Care and:

Income Care Platinum – included benefits and features

All benefits in Income Care Plus but with:

Income protection

Income Care Super and SMSF Plan – included benefits and features

***Note:** The Income Care Super death benefit and the Continuation option aren't available within the SMSF Plan.

Available options

***Note:** The Permanent Disablement Cover option and the Super Continuance option aren't available in Income Care Super or the SMSF Plan.

Business Overheads Cover – keeps your business up when you're down

If you run your own business, taking time off because you're sick or injured can be disastrous.

Business Overheads Cover keeps things ticking over by helping to pay your business' regular fixed operating expenses while you're unable to work.

Business Overheads Cover can pay up to 100% of your fixed operating expenses.

Business Overheads Cover

Entry age (next birthday)	
Stepped premium (see page 14)	18 to 61*
Level premium (see page 14)	18 to 55*

*The maximum entry age won't apply if:

- we consider the new policy you're applying for a replacement of a policy you already hold with us

and

- the new policy is to be issued on the same life and there is no increase in our risk under the policy.

Cover expiry date Expires on the policy anniversary date before you turn	60 or 65
Monthly cover	
Minimum	$1,500
Maximum	$40,000

Policy types

Business Overheads Cover (not available in super)

Work eligibility

You must:

- be a self-employed business owner
- not be working from home and
- be responsible for the payment of eligible business expenses.

Business Overheads Cover isn't available for occupations we classify as heavy risk or specialist risk.

Waiting periods available

A choice of:

- 14 days
- 1 month
- 2 months
- 3 months
- 6 months

Benefit period

Not applicable

Maximum payable

Up to twelve times the monthly benefit

Included benefits and features

Choosing the insurance that's right for you.

When deciding which insurance is right for you, ask yourself these questions:

1. What type(s) of insurance do I need right now?
2. Should I hold insurance inside or outside of the superannuation environment?
3. Does a stepped or level premium suit me?
4. Would I like optional extras?
5. Have my circumstances and needs changed since I took out my current insurance?

1. What type(s) of insurance do I need right now?

Your financial adviser can help you decide which types of insurance you need, taking into account your individual objectives and financial situation.

Consider the following with your adviser:

If you're...	Then...
Single	safeguard your ability to earn an income if you're injured or sick
Double income, no kids	don't risk your current lifestyle if injury or sickness strikes
Family	with children depending on you for everything, protecting them and your partner against the financial impact of your death, sickness or injury becomes a priority
Retired	protect your nest egg, take care of yourself financially and leave something behind if you die
Running your own business	help make sure you can meet every day operating expenses as well as insuring your key staff

2. Should I hold insurance inside or outside of the superannuation environment?

You have the option to buy insurance inside or outside of super.

If you buy insurance outside of super, the policy is held by you in your name. If, on the other hand, you buy insurance inside super, the policy is held by a trustee of a super fund and you are a member of the fund and a life insured under the policy. Insurance inside super is governed by super law and the rules of the super fund.

The following table helps explain the different structures.

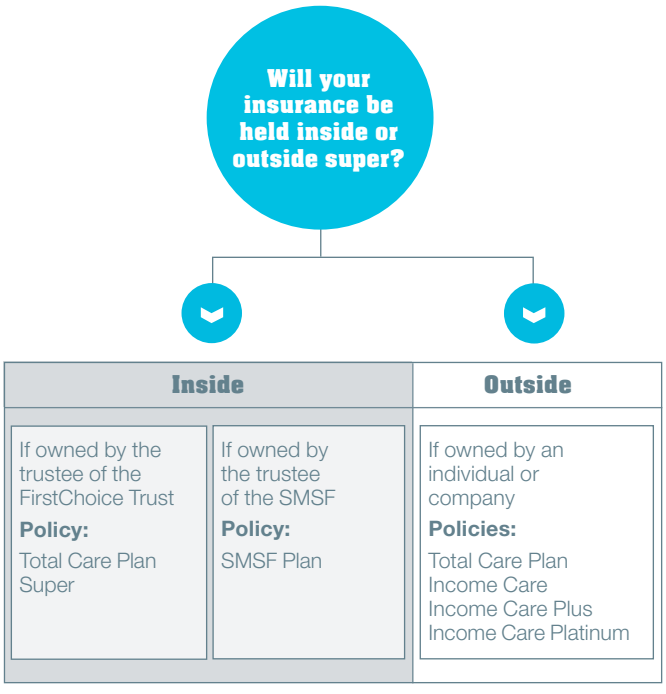
What 'policy' applies?	Who is the policy owner?	Who is the life insured?
Outside super		
Total Care Plan Income Care Income Care Plus Income Care Platinum	An individual or company that is not a super fund trustee	An individual, whether the policy owner or another person
Inside super		
SMSF Plan	The trustee of a self-managed super fund (SMSF)	A member of the SMSF
Total Care Plan Super	Colonial First State Investments Limited, the trustee of the FirstChoice Trust	A member of the FirstChoice Trust

If you want to buy insurance inside super, you have two options:

a) You can become a member of the Total Care Plan Super division of the FirstChoice Trust and the trustee of the FirstChoice Trust will hold the Total Care Plan Super insurance policy on your behalf. Your membership of the Total Care Plan Super division of the FirstChoice Trust provides insurance cover only and has no savings component.

b) Have your SMSF purchase our SMSF Plan. The trustee of your SMSF buys the insurance policy from CommInsure and holds the policy on your behalf. The payment of premiums for the SMSF Plan must be sourced from super and it's the SMSF trustee's responsibility to ensure this happens.

The diagram below explains the insurance outcomes you can access inside and outside super.



Differences in the cover available inside super

Due to super law, we can't offer Trauma Cover, Child Cover, Business Overheads Cover and some of the features of our other cover types inside super. We explain the differences in more detail in Part F starting on page 126.

Why hold insurance inside super?

The main benefit is that you can pay your premiums using pre-tax income paid as a contribution to the super fund or with rollover money from another super fund – this can help improve cash flow. If you are taking out the SMSF Plan, premiums must be paid by the SMSF out of the fund's super monies.

Your financial adviser can help you decide whether to take all or part of your cover inside super. In the meantime, we've put all the information about this in the one place, so before making a decision please read Part F on page 126.

Total Care Plan Super rollover rebate

If you have insurance under Total Care Plan Super and you pay your premium using the super payment method, you may qualify for the rollover rebate of 15% (see page 119 for further details).

3. Does a stepped or level premium suit me?

You can choose between paying stepped or level premium:

Premium options
Stepped
Your premium generally goes up every year as you're getting older.
Level
Your premium doesn't go up because you're getting older. **When level premium ends** Even if you choose a level premium, a stepped premium will automatically apply from the policy anniversary date before you turn 65. **Premiums can still increase** Even if a level premium applies, the amount of premium you pay can still increase. This can happen for a number of reasons. For example: ◆ if automatic indexation applies to increase your cover or you choose to increase your cover, you'll pay more premium because you have more cover. ◆ if we increase our premium rates for all our policy owners.

Premium rate increases

We can at any time change our stepped or level premium rates for all our policy owners. If we increase premium rates, we'll tell you before it happens.

Making a choice

Whether you choose a stepped or level premium depends on a range of factors including your age, your budget, the type of cover you choose and how long you expect to have the policy.

While a level premium may cost more than a stepped premium when your policy begins, it offers more certainty and may be cheaper over the long-term – making it easier to plan your budget and stay protected.

Your financial adviser can help you weigh up your options and show you how a stepped or level premium can impact your personal financial situation. Your choice also affects your eligibility for insurance – see 'Our insurance summary' starting on page 8 for more information.

For more information about stepped and level premiums read page 101.

4. Would I like optional extras?

You can add a wide range of optional benefits to your CommInsure Protection insurance. These options usually cost more but some don't. You can find the optional benefits listed in the cover summary tables in Part A and Part B. For example, Plan Protection option is listed on page 37. Your financial adviser can help you understand which options suit your needs.

5. Have my circumstances and needs changed since I took out my current insurance?

When life changes, so can your insurance needs. A significant life event like changing jobs, starting a business, getting married, having a child, buying property or retiring is usually a good time to review your insurance needs. This may result in a change in the amount or type of protection that best supports you. To review your insurance needs, please speak to your financial adviser.

If you change your occupation, stop smoking, improve your health or otherwise reduce our risk of covering you, you can ask us to consider reducing your premium or removing any special condition or exclusion we applied to your cover. If you do this, you may need to provide us with up to date health and other evidence to allow us to assess the change in risk. The duty of disclosure will also apply.

How our insurance works.

Before choosing your insurance it's important to understand the cover combinations that are available to you.

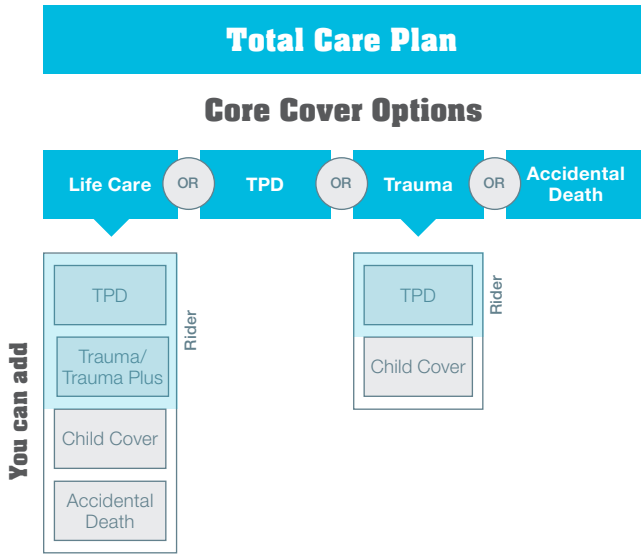
To help you get the right combination of benefits, options and features, we've grouped our various types of insurance into six separate and distinct policies which each have their own policy terms. If you take out two or more policies we'll provide you with a policy schedule for each policy.

The diagrams below describe the combinations of cover available under our policies.

Your financial adviser can help

Your adviser can help you work out how best to structure your cover and the number of policies you need to protect your financial wellbeing.

Total Care Plan



Total Care Plan is our policy that provides Life Care, TPD and Trauma Cover, as well as optional Child Cover and Accidental Death Cover.

You can take one or more of Life Care, TPD and Trauma Cover all under the umbrella of one Total Care Plan policy or you can take two or more of them on a stand-alone basis under separate Total Care Plan policies.

If you take out two or more policies, we'll provide you with a policy schedule for each. Each of these policies have their own separate policy terms.

Example

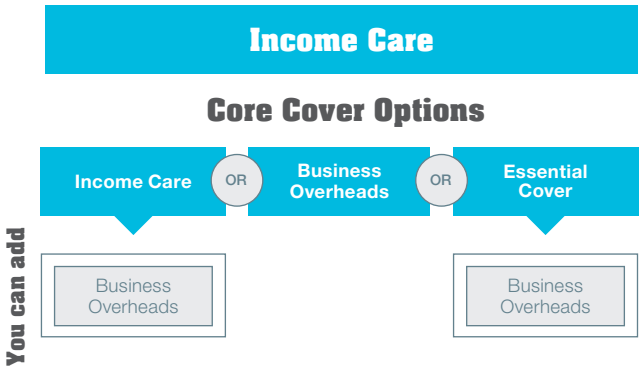
If you want both Life Care and TPD Cover each on a stand-alone basis, we'll issue you with two Total Care Plan policies – one for the Life Care and the other for the TPD Cover.

> **Note**: we charge separate premiums, policy fees and frequency charges for each policy.

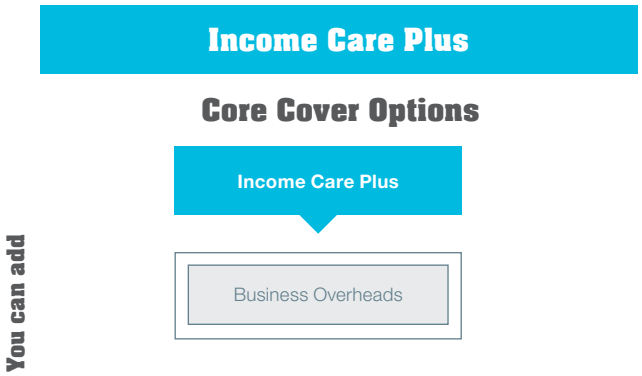
If, on the other hand, you want Life Care and TPD Cover together we'll issue you with one Total Care Plan policy.

> **Note**: if you add TPD or Trauma Cover as a rider to Life Care under the one Total Care Plan policy, the amount of TPD and/or Trauma Cover can't be greater than your amount of Life Care. If we pay a TPD or Trauma Cover claim, Life Care is reduced by the amount paid. See 'Setting up your policy' on page 17 for an explanation of how rider cover works.

Income Care, Income Care Plus and Income Care Platinum



Income Care is our basic income protection policy. It offers a range of income protection benefits including Business Overheads Cover and Essential Cover.



Our Income Care Plus policy provides all the features of Income Care (except for Essential Cover), plus a wide range of extra benefits.

Our Income Care Platinum policy provides all the features of Income Care Plus (except for Essential Cover) as well as a three-tier definition of Total Disability and a more flexible waiting period. Income Care Platinum also includes a more rigorous method of determining a partial disability benefit which allows us to take into account not only the income you are actually earning but also the income you're capable of earning.

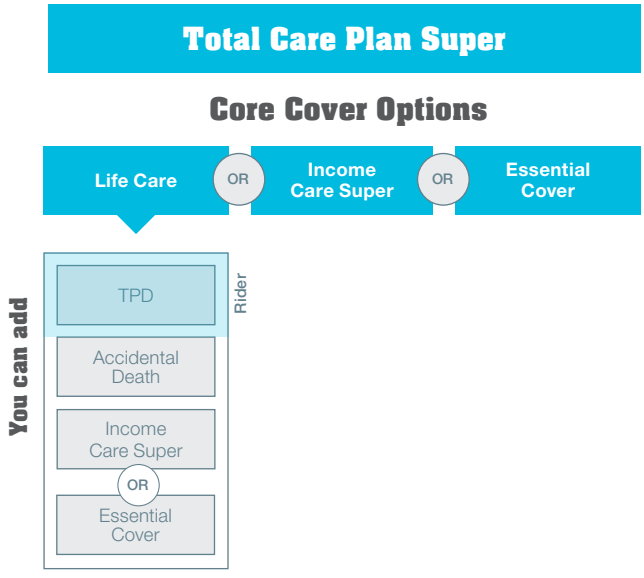
You can take Business Overheads Cover by itself but, if you choose it with Income Care, Income Care Plus or Income Care Platinum you receive a 10% discount on the Business Overheads Cover premiums.

Income Care, Income Care Plus, Income Care Platinum and Business Overheads Cover provide cover outside of super.

You can take Essential Cover under an Income Care policy or inside super under Total Care Plan Super or the SMSF Plan. Essential Cover is an option if your health prevents you from qualifying for our comprehensive income protection.

If you would like income protection inside super, Total Care Plan Super or the SMSF Plan may be for you.

Total Care Plan Super

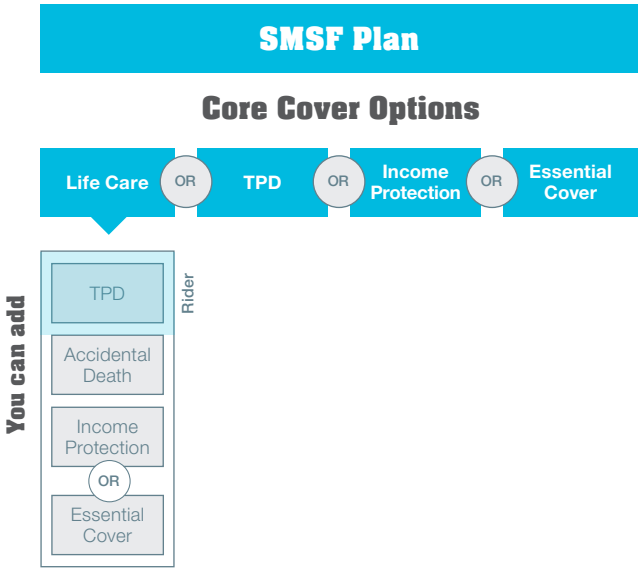


Total Care Plan Super is the policy, owned by the trustee of the FirstChoice Trust, that provides Life Care, TPD Cover, Accidental Death Cover and Income Care Super.

Due to super law, Total Care Plan Super doesn't include Trauma Cover, Child Cover, Business Overheads Cover and some of the features of our other cover types available outside super.

You can add income protection to Total Care Plan Super in combination with Life Care or without Life Care.

The SMSF Plan



The SMSF Plan provides insurance cover to an SMSF with the SMSF trustee(s) as the policy owner. As the policy provides insurance inside the super environment, like Total Care Plan Super, the core benefits under the SMSF Plan are limited to Life Care, TPD Cover, Accidental Death Cover and income protection. The SMSF Plan also offers TPD Cover on a stand-alone basis (if you are considering stand-alone TPD Cover, you need to ensure the cover satisfies the sole purpose test under super legislation).

Setting up your policy.

Ways to structure your cover and the impact on the benefits you can claim

We offer different ways to structure your insurance cover and explain these below. It is important you understand the options available to you because how you structure your cover will impact the policy benefits you can claim.

Policy structure	What is this?	What does this mean for my cover?	Example
Stand-alone	Cover that isn't linked to other cover.	A benefit paid under your stand-alone cover doesn't affect or reduce any other cover you have with us. Equally, your stand-alone cover isn't affected or reduced by a benefit paid under the other cover. With stand-alone cover, you're buying just one type of cover without paying more to cover other risks you're not concerned about or have covered elsewhere.	Minico has $1 million of stand-alone Life Care and $500,000 of stand-alone Trauma cover. We pay Minico a $500,000 Trauma benefit and her Life Care remains at $1 million.
Rider cover	Cover that is linked to other cover under the same policy.	A benefit paid under rider cover reduces the other cover the rider cover is linked to. For instance, you can link TPD Cover to your Life Care. The TPD Cover is the rider cover and, when a benefit is paid under it, the Life Care is reduced by the amount paid. Provides different types of cover at a cheaper premium than what you'd pay if the cover was held across two policies on a stand-alone basis.	John has $1 million of Life Care with a TPD Cover rider of $600,000. He receives a TPD benefit of $600,000 which reduces his Life Care to $400,000.
Flexi-linking	Links cover inside super to different cover outside super across two separate policies.	When a benefit is paid under the policy outside super, the cover under the policy inside super reduces by the amount paid. Provides cover both inside and outside super at a cheaper premium than what you'd pay if the cover was held across two policies on a stand-alone basis.	Supriya has $1 million of Life Care under Total Care Plan Super and $400,000 of Trauma Cover under Total Care Plan. As Supriya has flexi-linked the two policies, payment of her $400,000 trauma claim under Total Care Plan reduces her Life Care under Total Care Plan Super to $600,000.
Split TPD	Instead of having all your TPD Cover under one policy, split TPD splits your cover across two separate policies, one issued inside super to the super fund and the other outside super to you or another person.	Split TPD provides the extra protection of the 'own occupation' TPD Cover that is only available outside super, while still allowing you to use your super to pay for some of your TPD Cover. The policy a TPD benefit is paid under depends on whether the definition of 'any occupation' or 'own occupation' TPD is met. If a TPD benefit is paid in full under one of the policies, no TPD benefit will be payable under the other. Provides TPD cover both inside and outside super for no more than the cost of having only 'own occupation' TPD Cover outside super.	Refer to the split TPD example on page 19.
Split Income Protection (IP)	Instead of having all your IP cover under one policy, split IP splits your cover across two separate policies, one issued inside super to the super fund and the other outside super to you.	Split IP provides the extra protection of benefits only available outside super, while still allowing you to use your super to pay for some of your IP cover. With a split IP arrangement the total benefits paid under both policies will be the same as the total benefits that would have been paid under the policy outside super had it been taken out alone. Provides IP cover both inside and outside super at the same cost as just having the same cover outside super.	Refer to split IP the example on page 21.

For more information about how your cover works when flexi-linking, split TPD or split IP applies, see pages 18, 19 and 21 under the sections 'Do you want flexi-linking to apply?', 'Do you want split TPD?' and 'Will a split IP arrangement apply?' Please also refer to the policy terms in parts A, B, C and the Definitions. It's important that you read this information and consult your financial adviser to work out which, if any, of these structures suit your needs.

Setting up your Life Care, TPD or Trauma Cover

If you choose a Life Care, TPD or Trauma policy, you need to set up a few important things at the start, including:

- who will own the policy?
- who do you want the policy to cover?
- will the policy be held inside or outside super?
- do you want a flexi-linking arrangement to apply?
- for TPD, which TPD definition do you want?
- do you want split TPD?
- the amount of Life Care, TPD or Trauma Cover you need
- do you want to add any options?
- do you want to pay a stepped or level premium?

When we issue the policy, these details are shown on your policy schedule.

Who will own the policy?

Generally, the only person who can make changes or be paid a benefit under the policy is the policy owner.

The table below helps you understand who is the policy owner for each policy type.

Who can be the policy owner	Who can contact us
Total Care Plan	
The person covered under the policy, another person, a company. There can be more than one policy owner, in which case the policy is held jointly. This means that, on a policy owner's death, their interest in the policy passes automatically to the surviving policy owner(s) and not to the deceased's estate.	The policy owner
Total Care Plan Super	
The trustee of the FirstChoice Trust	The member covered under the policy
SMSF Plan	
The trustee(s) of the SMSF	The policy owner

Generally, we pay benefits to the person who owned the policy when the insured event occurred.

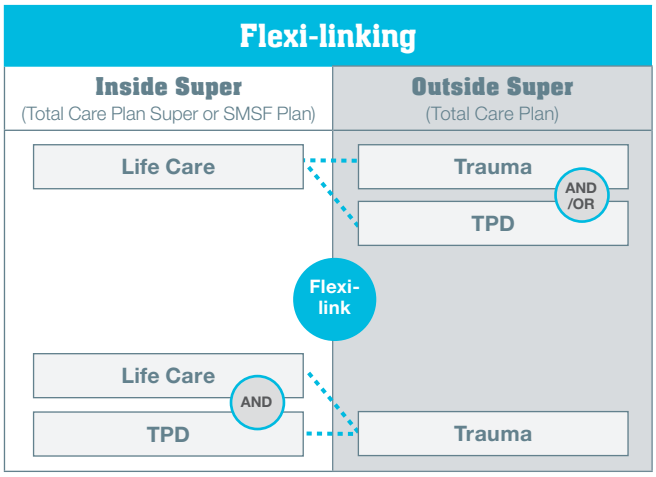
Who do you want the policy to cover?

Up to two adults can be covered under one policy. You may also be able to cover your children on the same policy using the Child Cover option.

Will the policy be held inside or outside super?

The right strategy will depend on your individual circumstances. Speak to your financial adviser to determine what's best for you.

Do you want a flexi-linking arrangement to apply?



Flexi-linking lets you link Life Care under:

- Total Care Plan Super or
- SMSF Plan

to TPD and/or Trauma Cover under a Total Care Plan policy held by you outside of super. We call the TPD and/or Trauma Cover the 'flexi-linked rider cover'.

For more information about how your cover works when flexi-linking applies, see the policy terms in parts A, B, C and the Definitions.

Example

You may want to have your Life Care inside super and your TPD Cover outside super. Although in this case there will be two policies (one for Life Care held within super by the trustee and one for the TPD Cover in your or another person's name), flexi-linking lets you link the TPD Cover to Life Care, allowing you to take advantage of some of the benefits you can normally only enjoy if you have all your cover held under the one policy.

Which TPD definition do you want?

There are three definitions of TPD available under Total and Permanent Disability Cover. They are 'any occupation', 'own occupation' or 'domestic duties'.

If you are working 20 hours or more a week outside the home, we offer you the choice of an 'any occupation' or 'own occupation' TPD definition. Of these TPD definitions, the 'own occupation' definition is generally the easiest to satisfy if you claim but the 'any occupation' definition costs less.

If you don't qualify for 'own' or 'any' occupation TPD, you may be eligible for 'domestic duties' TPD.

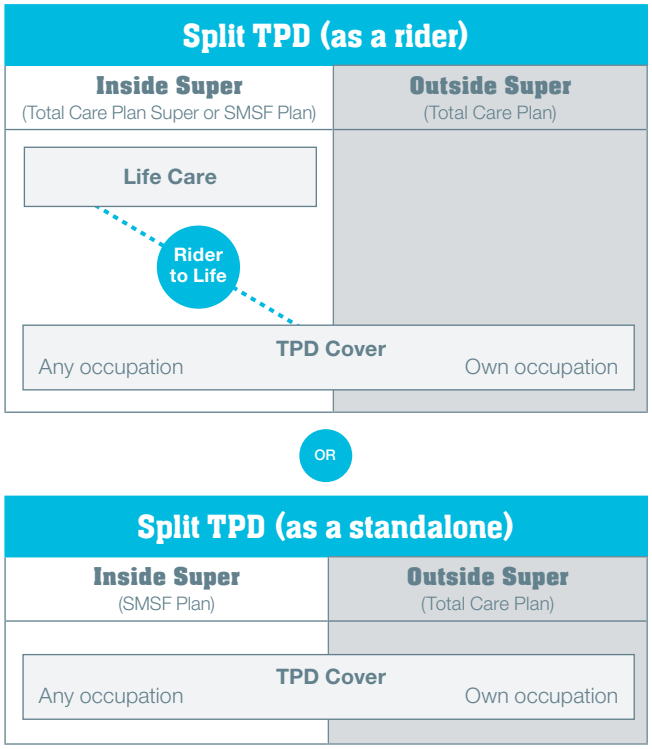
Your financial adviser can help you work out which TPD definition you're eligible for and which is right for you.

For more information about the different TPD definitions, please refer to the definition of total and permanent disablement starting on page 134.

Do you want split TPD?

Split TPD – two policies, one easy package

The diagrams below show how split TPD works and how TPD cover can apply across a super policy and a non-super policy.



Note: split TPD can't apply to 'domestic duties' TPD.

While certain TPD definitions, such as the 'own occupation' definition are not available under Total Care Plan Super or the SMSF Plan, our split TPD arrangement allows you to link these definitions to the TPD 'any occupation' definition available inside super. Split TPD is structured so that you enjoy the benefits of having TPD Cover both inside and outside super for no more than the cost of having 'own occupation' cover outside super.

Although there is separate TPD Cover under two different policies, the linking of the cover across the two policies means we only ever pay a full TPD benefit under one of the policies and never both. The policy we pay a TPD benefit on depends on whether you're assessed as TPD under the policy inside super or the policy outside super. For example, if you're assessed as 'own occupation', but not 'any occupation' TPD, we will pay the TPD benefit outside super. If, on the other hand, you're assessed as 'any occupation' TPD (which by definition means you're also 'own occupation' TPD) the benefit we pay will be inside super.

> **Note:** We always assess a TPD claim under the TPD definitions inside super first. If one of these definitions is met, the benefit must be paid from inside super and will be subject to super taxation rules. You should seek taxation advice from your tax adviser as to the appropriate tax treatment of TPD benefits.

Example

Olivia wants to enjoy the benefits of having TPD Cover inside super but also wants the extra protection offered by having 'own occupation' TPD Cover, which is available only outside super.

Split TPD allows Olivia to achieve this, as two policies are issued – one within super held by the trustee for $200,000 of 'any occupation' TPD Cover and one outside super held by Olivia for the same amount of 'own occupation' TPD Cover.

If Olivia makes a TPD claim, we first assess her claim under the 'any occupation' TPD definition. If Olivia satisfies this definition and we accept the claim, the $200,000 TPD benefit is paid under the policy inside super to the super fund trustee (who will then deal with that payment under the rules of the super fund and subject to super and tax laws). If this happens, the $200,000 of 'own occupation' TPD Cover under the policy owned by Olivia outside super ends and no benefit is ever payable for that cover.

If, however, Olivia does not satisfy the 'any occupation' TPD definition, we then assess her claim under the 'own occupation' TPD definition. If Olivia satisfies the 'own occupation' definition and we accept the claim, the $200,000 TPD benefit is paid directly to Olivia under the policy in her name outside super. If this happens, the $200,000 of 'any occupation' TPD Cover under the policy within super ends and no benefit is ever payable for that cover.

If Olivia does not satisfy the 'own occupation' TPD definition, no benefit is payable under either policy and the TPD Cover under each policy continues as if Olivia had not made a claim. If Olivia makes another TPD claim in the future, the steps above are repeated in assessing Olivia's claim.

If, in this example, Life Care applied under the policy within super, a payment of the TPD benefit under either policy reduces the amount of the Life Care (and any other cover linked to the Life Care) by the amount paid.

TPD inside super

The TPD Cover under a Total Care Plan Super policy must always be a rider to Life Care under that policy.

The TPD Cover under an SMSF Plan can be held as a:

- rider to Life Care under the same SMSF Plan, or
- stand-alone benefit.

If the TPD Cover is a rider to Life Care under a split TPD arrangement, any payment of a TPD benefit reduces the amount of Life Care under the super policy, even if the TPD benefit is paid under the non-super policy.

Important: If split TPD Cover is held under an SMSF Plan, premiums for the cover outside super (under the Total Care Plan policy) must not be paid from SMSF monies. Please consult your financial adviser if you require advice in relation to the payment of premiums for split TPD.

For more information about how your cover works when split TPD applies, see the policy terms in parts A, B, C and the Definitions.

The amount of Life Care, TPD or Trauma Cover you need

The amount of cover you need depends on your individual circumstances. Some things you may want to consider are your mortgage repayments, credit card debt, childcare or education for your children and how much income your family will need to live comfortably. Generally, the higher the amount of cover, the higher the premiums will be. Your adviser can help you determine the amount of cover that suits your circumstances.

Do you want to add any options?

There are a number of options available to help you and your adviser customise your cover. Please refer to 'Our insurance summary', which starts on page 8, for a list of the options available on your cover.

Do you want to pay a stepped or level premium?

Please refer to 'Does a stepped or level premium suit me?' on page 14.

Setting up your income protection policy

If you choose any of our income protection products or Business Overheads Cover, you need to set up a few things at the start. These include:

- who will own the policy and who will it cover?
- will the policy be held inside or outside super?
- will a split IP arrangement apply?
- monthly benefit
- waiting period
- cover expiry date
- benefit period
- policy type
- do you want to add any options?
- do you want to pay a stepped or level premium?
- occupation group.

We print all of these details on your policy schedule we send you.

Who will own the Policy and who will it cover?

Generally, the only person who can make changes or be paid a benefit under the policy is the policy owner. The policy owner is the only person we'll deal with in relation to the policy.

The person who is covered under an income protection policy is usually also the owner of the policy.

We do, however, allow the policy owner to be a company, trust or SMSF. For a company or trust, the person who is to be covered under the policy must have a controlling interest in the company or trust that is satisfactory to us. For an SMSF, the person who is to be covered under the policy must be a member of the fund.

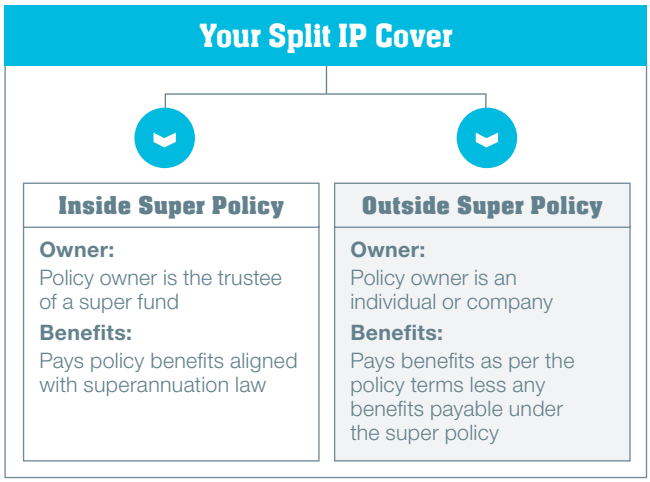
For income protection under Total Care Plan Super, the policy owner is the trustee of the FirstChoice Trust. You become a member of the FirstChoice Trust and the life insured under the policy.

Will the policy be held inside or outside super?

The right strategy will depend on your individual circumstances. Speak to your financial adviser to determine what's best for you.

Will a split IP arrangement apply?

Split IP is IP cover that is split over two policies:



How split income protection (split IP) works

As the benefits on offer inside super are restricted by super law, certain income protection benefits aren't available under Total Care Plan Super or the SMSF Plan or are not as generous as those under Income Care, Income Care Plus or Income Care Platinum.

Our split IP arrangement allows you to structure your income protection so you enjoy the benefits of having cover both inside and outside super. Under split IP you can access benefits not available inside super, while still paying part of your premiums from super.

Under a split IP arrangement we issue two policies. A policy inside super, owned by a super trustee, and a policy outside super, owned by an individual or company.

Although the income protection is split across two policies, the total benefits we'll pay under the cover will be the same as, but no greater than, what we would pay under the policy outside super had split IP not applied.

At time of claim, benefits are first assessed under the policy inside super.

We only then assess benefits under the policy outside super if:

- you don't qualify for a payment inside super or these benefits aren't available inside super due to super law restrictions or
- the benefits are more generous in amount if paid outside super, in which case we first pay the benefit inside super and then pay the difference outside super.

For example, if a total disability benefit isn't payable under the policy inside super because you were unemployed when you became totally disabled, we'll pay the benefit under the policy outside super, as long as the conditions of that policy are fully met. If, on the other hand, you were gainfully employed when you became totally disabled, we'll pay the benefit under the policy inside super and a total disability benefit won't be payable under the policy outside super. Or, if a larger total disability benefit is payable under the policy outside super, we'll pay the difference outside super.

> **Note:** Under split IP, we always assess a claim under the policy inside super first. If the claim is payable under the policy inside super, the benefit must be paid from inside super and will be subject to super taxation rules. You should seek taxation advice from your tax adviser as to the appropriate tax treatment of income protection benefits.

If the policy outside super ends for any reason (e.g. the policy is cancelled by you or cancelled by us for non-payment of premium), the policy inside super continues to provide income protection (as a 'non-split' Income Care Super or SMSF Plan policy only) until it ends. If, on the other hand, the income protection inside super ends for any reason, the cover outside super also ends.

Example

Frank wants to enjoy the benefits of having income protection inside super but also wants the extra protection offered by having outside super.

Split IP offers Frank the best of both worlds. Two policies are issued – an SMSF Plan in Frank's self-managed super fund trustee's name for 'Agreed Value' cover of $5,000 per month and an Income Care policy in Frank's name for the same amount of cover but on a 'Guaranteed Agreed Value' basis.

If Frank's income remains the same

If a claim is made for the total disability benefit, we first assess the claim under the SMSF Plan. If we accept the claim, the total disability benefit (say, $5,000, in this example) is paid under the SMSF Plan to the trustee of Frank's SMSF (who will then deal with that payment under the rules of the super fund and subject to super and tax laws). As the same amount of total disability benefit would've been payable under the Income Care policy, that benefit is not payable under the Income Care policy.

If Frank's income has reduced

If, however, Frank's monthly income had decreased to $4,000 a month between taking out the income protection and making the claim, we would not be able to pay $5,000 a month under the SMSF Plan because, under super law, insurance inside super cannot pay more than Frank's pre-disability income (in this example, $4,000 a month). So, in this case, we would pay Frank's SMSF a total disability benefit of $4,000 a month under the SMSF Plan (i.e. Frank's pre-disability income of $4,000) and pay Frank a separate total disability benefit of $1,000 a month under the Income Care policy (representing the difference between the 'Guaranteed Agreed Value' benefit under the Income Care policy (i.e. $5,000) and the 'Agreed Value' benefit payable under the SMSF Plan (i.e. $4,000).

When we waive premiums

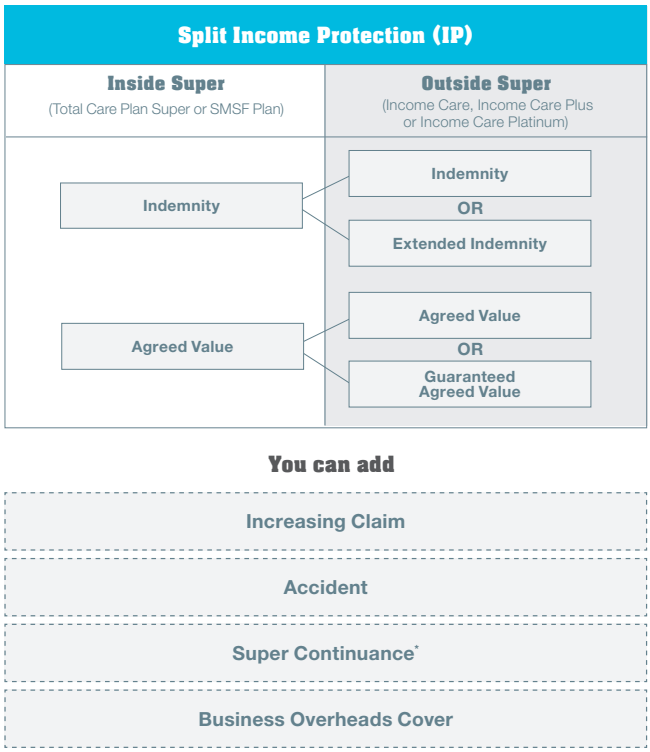
While we're paying the total disability benefits for Frank, we waive premiums for the income protection under both the SMSF Plan and the Income Care policy.

Split IP – Two policies, one easy package

When you use split IP, both policies must have the same policy structure. For example, they will have the same monthly benefit, waiting period, benefit period, cover expiry date and policy anniversary date.

With split IP, the policy inside super will be either a Total Care Plan Super (Income Care Super) policy or an SMSF Plan policy. The policy outside super will be an Income Care, Income Care Plus or Income Care Platinum policy. If you require Essential Cover only, then the policy inside super and the policy outside super will be Essential Cover.

The diagram below shows what policy combinations can be selected for a split IP arrangement:



* Available on the split IP ordinary policy only

If the policy outside super is agreed value or guaranteed agreed value, the policy inside super must be agreed value. If the policy outside super is indemnity or extended indemnity, the policy inside super must be indemnity.

> **Note:** If split IP is held under a SMSF Plan, premiums for the cover outside super (under the Income Care, Income Care Plus or Income Care Platinum policy) must not be paid from SMSF monies. Please consult your financial adviser if you require advice in relation to the payment of premiums for split IP.

For more information about how your cover works when split IP applies, see the policy terms in parts A, B, C and the Definitions.

Occupation group

The type of work you do affects how much your premium is for your income protection. It also affects which types of cover and options are available to you, as well as the monthly benefit, benefit period, waiting period, maximum age and other factors.

Your financial adviser can help you work out how your occupation affects your eligibility for cover.

When you apply you need to tell us your occupation and we will then work out which occupation group best describes what you do and print this on your policy schedule.

The occupation groups are:

Occupation groups	
S	Super professional
K	Medical
J	Legal
P	Professional
G	Managerial
C	Clerical
L	Light manual
M	Manual
H	Heavy risk
A	Aviation
X	Specialist risk – medium
Y	Specialist risk – high

Monthly benefit

This is the monthly amount you want to be covered for. This can be up to 75% of your insurable monthly income.

For Business Overheads Cover you can cover up to 100% of your business' regular fixed operating expenses.

Waiting period

This is the length of time you have to wait before you become eligible to receive a benefit. For more information about how the waiting period works refer to page 75.

You can choose:

Waiting period	Income Protection	Business Overheads Cover
14 days	✔*	✔
1 month	✔	✔
2 months	✔	✔
3 months	✔	✔
6 months	✔	✔
1 year	✔	
2 years	✔	

* The 14 day waiting period isn't available if you work in aviation, a heavy risk or specialist risk occupation group.

The shorter the waiting period, the more your cover costs. Following the waiting period, benefits are paid monthly in arrears.

Cover expiry date

This is how long your cover will last. You can choose a cover expiry date on the policy anniversary date before your:

- 60th birthday
- 65th birthday
- 70th birthday.

Benefit period

This is the longest period over which we keep paying benefits for a claim. You can choose:

- two years
- five years
- to the cover expiry date which applies i.e. the policy anniversary date before your 60th, 65th or 70th birthday.

Benefit periods of two years and five years are not available if you want your cover to expire on the policy anniversary date before your 70th birthday. A benefit period to the policy anniversary date before your 70th birthday isn't available under Essential Cover.

Also, if you work in certain occupations you can only choose certain benefit periods. These are:

- aviation – two years, five years or to the policy anniversary date before you turn 60
- heavy risk or specialist risk – two or five years
- light manual or manual – all benefit periods except to the policy anniversary date before your 70th birthday.

If you are 60 or older, you can only apply for a benefit period to policy anniversary date before your 70th birthday if:

- your occupation is classified as S, K, J, P, G or C and
- you hold income protection with CommInsure or another insurer.

Also, your monthly benefits are capped at $30,000.

For Business Overheads Cover you don't need to choose a benefit period – we'll pay up to twelve times the monthly benefit.

Policy type

The policy type determines how we work out the monthly benefit. You can choose:

- indemnity
- extended indemnity (not available for cover inside super)
- agreed value
- guaranteed agreed value (not available for cover inside super).

You don't need to choose a policy type for Business Overheads Cover. Refer to page 98 for how we work out the Business Overheads Cover benefit.

For Essential Cover you can only choose an 'indemnity' policy type.

Indemnity policy

If you choose an indemnity policy, we base your Total or Partial Disability benefit on the monthly benefit which is the lesser of:

- the amount of your cover (including any indexation increases)
- 75% of your average monthly income in the 12 months before the claim.

Extended indemnity policy

If you choose an extended indemnity policy, we base your Total or Partial Disability benefit on the monthly benefit which is the lesser of:

- the amount of your cover (including any indexation increases)
- 75% of your highest average monthly income in any consecutive 12 month period in the 36 months before the claim.

Agreed value policy

If you choose an agreed value policy, we base your Total or Partial Disability benefit on the monthly benefit you have been insured for (including any indexation increases). This is regardless of any reduction in your income. If, however, the cover is inside super, the Total or Partial Disability Benefit we pay (excluding indexation increases under the Increasing Claim Option) won't ever exceed 100% of your average monthly income in the 12 months before the claim. At claim time we will require you to satisfy us that your income in the 12 month period before you applied for cover justified the amount of cover that we provided you. If you can't do this the monthly benefit (on which we base your Total or Partial Disability Benefit) will be the lesser of the amount of your cover (including any indexation increases) or 75% of your pre-disability income.

Guaranteed agreed value policy

If you provide us with the required evidence of your income or if you're an eligible medical graduate*, you can apply for a guaranteed agreed value policy. With this type of policy we pay the monthly benefit chosen and don't ask you to justify that amount when you claim.

> **Note:** if you're an eligible medical graduate* you don't need to provide us with evidence of your income when you apply for a monthly benefit of no more than $6,250. Benefit levels will be based on your current income. To check if you're eligible for this type of cover please ask your financial adviser.
>
> * Eligible medical graduates are registered, full time degree qualified medical practitioners (with unrestricted registration), dentists and dental surgeons who graduated within the last three years.

Do you want to add any options?

There are a number of options available to help you and your adviser customise your cover. See 'Our insurance summary', which starts on page 8, for a list of the options.

Do you want to pay a stepped or level premium?

See 'Does a stepped or level premium suit me?' on page 14.

What exclusions apply?

To understand the exclusions that apply to your policy you need to:

1. Review the 'special provisions' section of your policy schedule. If any conditions are excluded when we assess your application (e.g. you may have an exclusion for back related conditions), the policy schedule will note that your 'policy is issued subject to Special Provisions, terms or conditions'. You will also have a provisional offer or a Confirmation of Alternative Policy Terms letter from us that details any exclusions.
2. Refer to the exclusions that apply to your cover as follows:

Which exclusions	Page
◆ Life Care exclusions	32
◆ TPD Cover exclusions	46
◆ Trauma Cover exclusions	54
◆ Income protection exclusions	74
◆ Business Overheads exclusions	97

How to apply.

To apply for insurance, please make an appointment with your financial adviser. They can help you by working out things like:

- whether you can apply for insurance (which depends on a few things including your age, work status, pastimes, health and financial circumstances)
- the type of insurance and the amount of cover that suits your needs
- an upfront estimate of the premium you're likely to pay
- any additional requirements we might have (e.g. requests for medical information).

If you don't have a financial adviser, simply call **1800 241 996** between 8:30 am to 6 pm (Sydney time), Monday to Friday or visit **commbank.com.au** to arrange for a financial adviser to contact you.

Replacing an existing policy – There are important considerations you need to be aware of, and discuss with your adviser, when you're applying to replace an existing policy. Please ensure you read and fully understand 'Cancellation of an existing policy' on page 109.

Step 1 – Complete the application form

Your financial adviser will help you to complete the application form, which they may send to us electronically.

As you complete the form it's important you tell us everything that's relevant to your application. For more information about what you need to tell us, please refer to 'Your duty of disclosure' in this PDS.

This gives us a better overall picture of your situation and means that we can assess your application faster. If you only give brief answers it will take us longer to process the application.

Step 2 – We assess your application

When we receive your application, we go through a process called underwriting. Our underwriters consider all relevant factors before we decide whether to accept your application, including the type of cover you want, your income, health, occupation, pastimes, etc.

When we assess your application, we may exclude certain medical conditions or dangerous pastimes from cover, and/or apply an extra charge depending on the risk assessed in your application. If we do, we'll send a provisional offer for you to consider.

Step 3 – We send you a policy schedule

If we accept your application we'll send you a policy schedule for each policy you applied for (noting that you may have applied for more than one policy).

The policy schedule lists all the details of your policy, including things like:

- the name of the policy you have (e.g. Total Care Plan)
- name of the policy owner
- the people whose lives are insured under the policy
- the types of cover we've agreed to and the amount of each type of cover
- when the cover starts
- the premium amount, type and the date the first payment is due
- for income protection, the waiting period and benefit period that applies
- any options you've selected
- whether flexi-linking, split TPD or split IP applies
- whether special conditions apply (please also refer to the provisional offer, if applicable).

Once you receive your policy schedule, it's important to go to the relevant 'Benefits' summary shown at the beginning of Part A or B (i.e. on pages 31 and 71) as this will show which features apply to your policy, based on what's listed in your policy schedule.

All the features in the 'Benefits' summary apply if your policy schedule shows you have the relevant type of cover. For example, if your policy schedule shows you have Trauma Cover, the following features and policy terms listed on page 53 apply:

- Trauma Cover benefit
- Severe Hardship Booster benefit
- Trauma Reinstatement benefit
- Trauma Cover Financial Planning benefit
- Accommodation benefit
- Loyalty Bonus benefit.

If an option isn't listed on your policy schedule, it doesn't apply to your policy.

Once you've worked out which features and options apply, you should read the detailed terms and conditions in Part A or B, as applicable. Part A or B together with Part C and the relevant definitions is your policy document and must be read together with your policy schedule.

You should keep your policy schedule(s), this document and any Provisional Offer together in a safe place. If you need to make a claim you'll need to refer to these documents.

Important: Electronic applications

If you applied for your policy electronically through your financial adviser via our online application process and alternative policy terms applied before the application was made, you'll need to provide us with a Confirmation of Alternative Policy Terms.

Please make sure you provide us with the Confirmation within 28 days of your policy commencing. If you don't, your policy will end. Your adviser can help you with this.

Also, if we accept your application online, your application documents, including the personal statement, will be made available to you. Please check that all information provided to us during the application process is accurate. If you don't believe it is, please contact us as soon as possible on **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday or by sending an email to **LNBReturnedCorro@cba.com.au**.

Interim Accident Cover while you wait

While we're considering your application for cover, or for an increase in cover, we'll insure you against accidents, free of charge, for up to 90 days. Please see the relevant Interim Accident Cover Certificate at the back of this document for details.

Interim accident cover begins when we receive your fully completed application with valid payment details.

When your insurance starts

Your insurance starts from the date we've accepted your application. This date appears on the policy schedule we send you. Your duty of disclosure continues up to that date.

Guaranteed renewable

Your policy is guaranteed renewable.

This means that once the policy is issued we won't, because of the number of claims you make or changes in your health, occupation or pastimes:

- cancel your policy
- increase your premium rates, or
- place any further restrictions on your cover.

Your duty of disclosure.

Before a person enters into a life insurance contract (i.e. the applicant) in respect of their life or the life of another person (i.e. the life to be insured), they have a duty to tell the insurer anything that they know, or could reasonably be expected to know, that may affect the insurer's decision to provide the insurance and on what terms.

The person entering into the contract has this duty of disclosure until the insurance is provided.

The person who has entered into the contract has the same duty before they extend, vary or reinstate the contract.

The person entering into the contract does not need to tell the insurer anything that:

- reduces the risk of the insurance; or
- is common knowledge; or
- the insurer knows or should know as an insurer; or
- the insurer waives the duty to tell the insurer about.

If the insurance is for the life of another person and that person does not tell the insurer something that they know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to comply with their duty of disclosure.

If the person entering into the contract or the life to be insured does not tell the insurer something

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If the insurer does, it may apply the following rights separately to each type of cover.

If the person entering into the contract or the life to be insured does not tell the insurer anything they are required to, and the insurer would not have provided the insurance if they had been told, the insurer may avoid the contract within three years of entering into it.

If the insurer chooses not to avoid the contract, it may, at any time, reduce the amount of insurance provided. This would be calculated using a formula that takes into account the premium that would have been payable if the person entering the contract had told the insurer everything they should have. However, if the contract provides cover on death, the insurer may only exercise this right within three years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount of insurance provided, it may, at any time, vary the contract in a way that places the insurer in the same position it would have been in if the person entering the contract had told the insurer everything they should have. However, this right does not apply if the contract provides cover on death only.

If the failure to comply with the duty of disclosure is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

Cooling-off period.

You have a 28 day cooling-off period during which you can cancel your policy. The cooling-off period starts when you receive your policy schedule. If you do cancel, we'll refund any money you've paid less any taxes or government charges (and, for Total Care Plan Super, subject to superannuation laws).

If you wish to cancel, we ask that you put your request in writing and send it to us with this document and your policy schedule.

Part A.
Protecting your life.

This part contains

What the words mean

Some of the words we use are defined terms that have a particular meaning. These words are italicised and are explained in the definitions section that starts on page 130.

We strongly recommend that you refer to the definitions as you read the policy terms, so you understand what we mean by terms such as *total and permanent disablement, terminally ill* and so on.

What we mean by 'you'

One word that gets used a lot in the policy terms is 'you'. 'You' means the person or persons who apply for the policy and become the policy owner(s) when we issue the policy. The policy owner may also be the person whose life is insured under the policy, i.e. the *life insured*, but this won't always be the case.

If the policy is a *super policy*, the trustee of the super fund is always the policy owner and the fund member is always the *life insured*. So, for Total Care Plan Super, 'you' means the trustee of the FirstChoice Trust and for the SMSF Plan, 'you' means the trustee of the SMSF. The person who is the policy owner is shown in the policy schedule.

Flexi-linking

If this policy is a *primary policy* under *flexi-linking* and it refers to a term, expression or feature under the *flexi-linked policy*, then that term, expression or feature has the meaning it has under the *flexi-linked policy*.

If, on the other hand, this policy is a *flexi-linked policy* under *flexi-linking* and it refers to a term, expression or feature under the *primary policy*, then that term, expression or feature has the meaning it has under the *primary policy*.

Split TPD

If this policy is a *split TPD policy* and it refers to a term, expression or feature under the other *split TPD policy*, then that term, expression or feature has the meaning it has under the other policy.


Leave something behind
with Life Care.

Life Care

Life Care pays a lump sum if you die or are diagnosed with a terminal illness and are likely to die from the illness within 24 months.

Sometimes we also provide an advance payment on death to help cover funeral expenses.

You can also take out Accidental Death Cover, which pays a lump sum if you die due to an accident.

If you have children you can insure them with Child Cover. Child Cover pays a lump sum if your child dies or meets the definition of a specified child trauma condition.

If you're involved in a business, you can use Life Care to insure the key people and your investment in the business. You can also protect your business loan.

Summary

In this section we set out the built in benefits, features and optional extras which apply if you have Life Care.

Included benefits

Benefit	A brief explanation...	Outside super	Inside super		For full details see page...
		Total Care Plan	Total Care Plan Super	SMSF Plan	
Life Care benefit	A lump sum on death	✔	✔	✔	33
Terminal Illness benefit	A lump sum if you are terminally ill and likely to die from the illness within 24 months	✔	✔	✔	33
Advance Payment benefit	An advance of up to $30,000 to help with the cost of funeral expenses	✔	–	–	33
Severe Hardship Booster benefit	Doubles the lump sum if you die, or are likely to die within 24 months, from meningococcal disease, legionnaires' disease or motor neurone disease	✔	✔	✔	34
Life Care Buy Back benefit	Automatically reinstates Life Care if we pay a TPD or Trauma claim	✔	✔	✔	34
Life Care Financial Planning benefit	Up to $5,000 to help cover the costs of financial advice	✔	–	–	34
Accommodation benefit	Helps cover the accommodation costs of an immediate family member who needs to stay nearby if you are terminally ill and confined to bed a long way from home	✔	–	–	35
Loyalty Bonus benefit	Once cover is held for five years, automatically increases payment of the Life Care or Terminal Illness benefit by 5%	✔	✔	✔	35

Included features

Feature	A brief explanation...	Outside super	Inside super		For full details see page...
		Total Care Plan	Total Care Plan Super	SMSF Plan	
Automatic indexation	Automatically increases Life Care each year to help keep pace with inflation	✔	✔	✔	35
Continuation option	Lets you continue Life Care outside super without having to provide further health evidence	–	✔	–	36
Nominating beneficiaries	Allows you to nominate who will receive benefits on your death	✔	✔*	^	36

* Refer to page 121 for information about nominating beneficiaries in Total Care Plan Super.
^ Beneficiary nominations are not accepted by CommInsure. Please refer to the trustee of your SMSF.

Optional extras (at an additional cost)

The optional extras only apply to your policy if they appear in your policy schedule.

Option	A brief explanation...	Outside super	Inside super		For full details see page...
		Total Care Plan	Total Care Plan Super	SMSF Plan	
Accidental Death Cover	A lump sum if you die due to an accident	✔	✔ Life Care is a pre-requisite	✔ Life Care is a pre-requisite	37
Plan Protection	You don't pay premiums while you are totally and temporarily disabled	✔	✔	✔	37
Guaranteed Insurability (personal events)	Lets you increase cover without providing more health information if you experience certain personal events	✔	–	✔	39
Guaranteed Insurability (business events)	Lets you increase cover without providing more health information if certain business events occur	✔	–	–	40
Business Safe Cover	When assessing your application we'll allow for future increases in cover. So, if certain business events occur, you can increase your cover without having to provide more health information	✔	–	–	40
Child Cover	A lump sum if your child dies or meets the definition of a specified trauma	✔	–	–	64

Exclusions

Type of exclusion	What benefit does the exclusion apply to?	For full details see page...
◆ Suicide	◆ Life Care Benefit ◆ Advance Payment Benefit ◆ Accidental Death Cover option ◆ Child Cover option	33, 37 and 66
◆ Malicious act ◆ Attempted suicide ◆ Self-inflicted injury ◆ Qualifying period	◆ Child Cover option	66
◆ Attempted suicide ◆ Self-inflicted injury or infection ◆ Drugs ◆ Alcohol ◆ Criminal activity ◆ War	◆ Accidental Death Cover option	37

Life Care benefit

A lump sum on death.

When we pay it

We pay the *Life Care benefit* if the *life insured* dies while *Life Care* applies to them.

What exclusions apply

We won't pay this benefit if the *life insured* commits suicide within one year from:

- the *date insured from*
- the date *Life Care* came into force
- the date on which the policy was last reinstated, or
- the date of an increase to your cover (the exclusion will then apply only to the amount of the increase).

If replacing other life cover

In this situation, we only apply the *Life Care* suicide exclusion if the suicide occurs during the period that is one year minus the expired period of the suicide exclusion which applied under the life cover replaced.

If the suicide exclusion period which applied to the life cover replaced is at least one year and has expired, then the *Life Care* suicide exclusion doesn't apply except to the extent it applies to a reinstatement of, or increase in, cover.

If the *Life Care* is higher than the life cover it replaced, the *Life Care* suicide exclusion applies in its entirety to the amount of the excess.

If the life cover replaced didn't have a suicide exclusion, the *Life Care* suicide exclusion applies in its entirety.

What we pay

We pay the *Life Care benefit*.

When it ends

Life Care ends on the earliest of the following:

- when the *life insured* dies
- the *cover expiry date* for *Life Care*
- we pay the Terminal Illness benefit
- when this policy ends.

Terminal Illness benefit

A lump sum if you are terminally ill and likely to die from the illness within 24 months.

What we pay

If the *life insured* becomes *terminally ill* while *Life Care* applies we pay the *Life Care benefit* in advance of the *life insured's* death.

Effect of the payment

If we pay a Terminal Illness benefit, all cover for the *life insured* under the policy ends.

Advance Payment benefit

An advance of up to $30,000 to help with the cost of funeral expenses. This benefit isn't available inside super.

When we pay it

We pay this benefit when we receive the *life insured's* full death certificate.

What exclusions apply

We won't pay this benefit if the *life insured* commits suicide within one year from:

- the *date insured from*
- the date *Life Care* came into force
- the date on which the policy was last reinstated, or
- the date of an increase to your cover (the exclusion will then apply only to the amount of the increase).

What we pay

We pay an advance of the *Life Care benefit* of up to $30,000 for each *life insured* (excluding the Life Care Loyalty Bonus benefit and the Life Care Severe Hardship Booster benefit).

If the *Life Care benefit* for a *life insured* is less than $30,000, we'll advance the full amount of the benefit but that means there will be nothing further to pay.

Who we pay

This benefit is only available to a policy owner or *nominated beneficiary* who survives at the time of the claim and who would be entitled to all or part of any *Life Care benefit* that may become payable under this policy.

We pay this benefit to claimants in the proportion to which they would be entitled to any *Life Care benefit*.

Example

Amanda is the life insured under her Total Care Plan policy. Life Care of $20,000 applies under the policy.

Amanda nominated, as beneficiaries under the policy, her two daughters, Chloe and Jessica, to each receive 50% of the Life Care benefit.

Unfortunately, Amanda passes away and a Life Care benefit becomes payable. After Chloe and Jessica submit their mum's full death certificate to CommInsure, each receive a $10,000 Advance Payment benefit to help finance their mum's funeral arrangements.

As the entire Life Care benefit of $20,000 is paid in advance by CommInsure, no further benefits are payable to Chloe and Jessica.

Effect of the payment

If we pay this benefit, we reduce the *Life Care benefit* by the amount paid. Paying this benefit isn't an admission of our liability to pay the *Life Care benefit* and is made without prejudice to our right to deny liability for that benefit.

Severe Hardship Booster benefit

Doubles the lump sum if you die, or are likely to die within 24 months, from meningococcal disease, legionnaires' disease or motor neurone disease.

What we pay

This benefit increases the *Life Care* or Terminal Illness benefit we pay by the lesser of:

- 100% of the *Life Care* or Terminal Illness benefit, and
- $250,000.

However, this doesn't include any increase under the Life Care Loyalty Bonus benefit.

When we pay it

We pay this benefit if the *life insured* dies or becomes *terminally ill* due to *meningococcal disease*, legionnaires' disease or *motor neurone disease* and, as a result, we pay a *Life Care* or Terminal Illness benefit.

We only ever pay this benefit for either death or *terminal illness*, but not both.

Life Care Buy Back benefit

Automatically reinstates Life Care if we pay a TPD or Trauma claim.

Effect of the benefit

If we make one of the payments referred to below then, on the last day of the *buy back period*, your *Life Care*, including any *primary Life Care*, is reinstated to the amount it was before the payment reduced your *Life Care*.

The payments we refer to are as follows:

- we pay a *Trauma Cover* or *TPD Cover benefit* and your *Life Care* is reduced by the amount we paid
- if this policy is a *primary policy*, a claim is paid under *flexi-linked rider cover* and your *primary Life Care* is reduced by the amount we paid under the *flexi-linked rider cover*
- if this policy is a *split TPD super policy*, your *Life Care* for the *split TPD life insured* is reduced by a *split TPD Cover benefit* we pay under the Total Care Plan policy.

If *primary Life Care* is reinstated and *flexi-linking* still applies, the *primary Life Care* remains *primary Life Care* on reinstatement.

Premiums during the Life Care buy back period

If you have cover during the *buy back period*, you must continue to pay premiums, policy fees and frequency charges.

Indexation during the Life Care buy back period

Automatic indexation applies during the *buy back period.* This is based on the amount of *Life Care* in force on the *policy anniversary date* which falls during the *buy back period.* No other increases to *Life Care* can be made during the *buy back period.*

Claims during the Life Care buy back period

If we accept another claim during the *buy back period*, the original *buy back period* no longer applies and a new *buy back period* starts for the later claim.

The amount remaining to be reinstated increases by the amount of the later claim.

When it doesn't apply

This benefit doesn't apply if:

- the *Life Care benefit* is reduced because a *TPD Cover benefit* has been paid for *partial and permanent disability* under this policy or a *flexi-linked policy* or
- the *Life Care benefit* is reduced under a *split TPD super policy* because a *split TPD Cover benefit* has been paid for *partial and permanent disability* under the Total Care Plan policy or
- the policy, under which the *Life Care* applied, ends for any reason before the *Life Care* is due to be reinstated.

Life Care Financial Planning benefit

Up to $5,000 to help cover the costs of financial advice.

Who we pay

We pay this benefit to the policy owner who receives the *Life Care benefit*. If there is more than one policy owner, we pay the benefit to all policy owners jointly, even if only one policy owner claims it.

If, however, the recipients of the *Life Care benefit* are nominated beneficiaries, we pay this benefit to them and not the policy owner(s). In this situation, we only pay the benefit to the nominated beneficiary who makes the claim for it.

We won't pay this benefit to a policy owner's or nominated beneficiary's estate.

When we pay it

We pay this benefit if:

- we pay a *Life Care benefit* for a *life insured* and
- within 12 months after we pay the *Life Care benefit*, a recipient of the *Life Care benefit* obtains financial planning advice from an accredited financial adviser.

For us to pay this benefit, the person claiming it must provide proof of the cost of the financial planning advice for which reimbursement is sought.

What we pay

We pay the cost of the approved financial planning advice but we won't pay more than $5,000 in total for all claims for the benefit.

If the *Life Care benefit* is paid to more than one nominated beneficiary, each beneficiary can claim this benefit but they can only receive up to their share of the $5,000 maximum. Each beneficiary shares in the $5,000 maximum in the same proportion they shared the *Life Care benefit*.

Example

Rakesh is the life insured under his Total Care Plan policy, which includes Life Care of $500,000.

Rakesh nominated, as beneficiaries under the policy, his two children, Ravi and Aditi, to each receive 50% of the Life Care benefit.

Sadly, several years after taking out the policy, Rakesh passes away and Ravi and Aditi each receive a $250,000 Life Care benefit. After receiving her benefit, Aditi obtains financial advice from an accredited financial planner to help her decide how to invest the $250,000. The advice costs $3,000.

Aditi pays the cost and seeks reimbursement from CommInsure of the $3,000 by submitting to CommInsure the financial planner's invoice as proof of the cost of the advice.

Aditi is paid a $2,500 Financial Planning benefit (i.e. her 50% share of the $5,000 maximum benefit).

Three months later Ravi obtains financial advice for himself from an accredited financial planner. The advice costs $3,000 and Ravi seeks reimbursement from CommInsure. Ravi is paid a $2,500 Financial Planning benefit (i.e. his share of the $5,000 maximum benefit).

Accommodation benefit

Helps cover the accommodation costs of an immediate family member who needs to stay nearby if you are terminally ill and confined to bed a long way from home.

When we pay it

We pay this benefit if:

- a Terminal Illness benefit has been paid or is payable, and
- on medical advice from a *medical practitioner* the *life insured* must stay more than 100 kilometres from their home or travel to a place more than 100 kilometres from their home, and
- the *life insured* is confined to bed due to the condition for which the Terminal Illness benefit has been paid or is payable, and
- an *immediate family member* is accommodated near the *life insured* (other than in their home) or has to stay away from their home.

What we pay

We pay up to $350 a day to help cover the costs of accommodating the *immediate family member*.

We pay this benefit for up to 30 days in each 12 month period commencing on:

- the date we first paid the benefit, and
- each anniversary of that date.

When it ends

The benefit ends when *Life Care* ends.

Loyalty Bonus benefit

Once cover is held for five years, automatically increases payment of the Life Care or Terminal Illness benefit by 5%.

When we pay it

If the *life insured* dies or becomes *terminally ill* after the fifth anniversary of the *date insured from* and we pay a *Life Care* or Terminal Illness benefit, we increase the benefit by 5%.

This increase doesn't apply to any Life Care Severe Hardship Booster benefit.

If the policy is reinstated or replaced

If this policy is reinstated or replaced by another policy (and we agree it's a replacement policy), we treat the reinstated or replacement policy (or this policy, if it's the replacement policy) as a continuation of the original policy to work out whether the fifth anniversary has occurred.

When working out if and when the fifth anniversary has occurred, we include the period the policy wasn't in force and also the period that the previous policy was in force.

We do this on the basis that the *Life Care* and Life Care Loyalty Bonus benefit only restart from the date of reinstatement or replacement.

We won't pay a benefit for any condition that first occurred, or the circumstances leading to which first became apparent, while the policy was not in force.

Automatic indexation

Automatically increases Life Care each year to help it keep pace with inflation.

On each *policy anniversary date* we'll increase any *Life Care, Child Cover* and *Accidental Death Cover*.

The rate of increase is the greater of:

- 3%
- any percentage increase in the Australian Consumer Price Index (CPI) (all groups – eight capital cities combined).

To work out the change in the CPI, we'll compare the index figure published three months before your *policy anniversary date* with the index figure published in the corresponding period one year earlier. If the CPI isn't published, then we'll use another appropriate index.

Effect on your premium

When we increase the cover through indexation, we'll also increase the premium. The premium increase is based on:

- the increased cover
- the *life insured's* age next birthday (unless a Level premium applies and the *policy anniversary date* before the *life insured's* 65th birthday has not occurred)
- our then current premium rates for this class of policy, and
- any special additional premium we've previously told you applies.

Any exclusion, additional premium or other special condition we've previously told you about will also apply to the increased cover.

When indexation doesn't apply

Automatic indexation won't apply while we're waiving premiums under the Plan Protection option.

If you don't want indexation

You can choose not to accept this increase by telling us within one month of the *policy anniversary date*. You can phone or write to us.

Continuation option – converting a Total Care Plan Super policy

Lets you continue Life Care outside super without having to provide further health evidence.

Example

Alain set up a Total Care Plan Super policy nine years ago with Life Care. As Alain has now reached age 65 and is no longer working due to poor health, super legislation prevents him from making the contributions needed to maintain his Life Care within super.

Using this Continuation option, Alain continues the Life Care under a new Total Care Plan policy without needing to provide any updated health evidence. By doing this, Alain remains protected with Life Care.

You can, without providing evidence of the *life insured's* health, convert *Life Care* under a Total Care Plan Super policy to death cover we have available under another policy at the date of conversion, as long as:

- the *life insured* is 74 years old or less
- the death cover under the new policy doesn't exceed the *Life Care benefit* which we would have paid under the Total Care Plan Super policy if the *life insured* had died on the date the continuation option is exercised.

After converting the *Life Care*, the Total Care Plan Super policy ceases.

For other conditions that apply please refer to 'General conditions for Continuation options' on page 108.

Nominating beneficiaries under Total Care Plan

Allows you to nominate who will receive benefits on your death.

Under Total Care Plan, you can nominate up to five beneficiaries under section 48A of the Insurance Contracts Act 1984.

If you make a nomination and the *life insured* dies, your *nominated beneficiaries* will receive all or part of the:

- *Life Care benefit*
- Life Care Advance Payment benefit
- Life Care Financial Planning benefit (but only on payment of the *Life Care benefit*)
- Life Care Loyalty Bonus benefit
- Life Care Severe Hardship Booster benefit
- *Accidental Death Cover* (if any).

The following rules apply to a nomination:

- a *nominated beneficiary* can be a natural person, corporation or trust
- a *nominated beneficiary* will receive the designated portion of any money payable under the relevant benefit
- if a *nominated beneficiary* dies before a claim is made under this policy and no change in nomination has been made, then any money payable will be paid to their legal personal representative
- conditional nominations can't be made
- if policy ownership is assigned to another person or entity, then any previous nomination is automatically revoked
- a *nominated beneficiary* has no rights under the policy, other than to receive the relevant benefit proceeds after we have admitted a claim
- you can change a *nominated beneficiary* or revoke a previous nomination at any time before a claim event.

Notes:

- For information about the special rules which apply to nominating beneficiaries under Total Care Plan Super, please refer to page 121.
- Nominations cannot be made under the SMSF Plan.

Accidental Death Cover option

A lump sum if you die due to an accident.

Note: If taking this option under a *super policy*, this cover must be taken with *Life Care* and must not be greater than the amount of *Life Care*.

When we pay it

We pay an *Accidental Death Cover benefit* if the *life insured* dies:

- as a result of an *accident*, and
- within 90 days of the *accident*, and
- before the end of this cover.

We pay this benefit in addition to any *Life Care benefit*.

What we pay

We pay the *Accidental Death Cover benefit*.

Automatic indexation applies to this cover. Please refer to page 35.

What exclusions apply

We won't pay this benefit if death is caused directly or indirectly by:

- suicide or any attempt at suicide
- self-inflicted injury or infection
- the taking of drugs other than prescribed by a *medical practitioner*
- the taking of alcohol
- participation in criminal activity or
- an act of war (whether declared or not).

When this cover ends

Accidental Death Cover ends on the earliest of:

- when the *life insured* dies
- the *cover expiry date* for *Accidental Death Cover*
- when this policy ends
- if *Life Care* applies under this policy, when that cover ends.

Plan Protection option

You don't pay premiums while you are totally and temporarily disabled.

Notes:

- This option is only available if *Life Care* applies to the *life insured* or if the *life insured* is a *split TPD life insured* under a Total Care Plan policy and *Life Care* applies to them under the *split TPD super policy*.
- This option isn't available to occupations we classify as heavy risk, manual or aviation.

When we waive premiums

Under this option, if the *life insured* is *totally and temporarily disabled* for more than three months we'll waive the Life Care and any TPD, Trauma Cover or Child Cover premiums for the policy that fall due after the first three months of *total and temporary disability*. If the *life insured* is a *split TPD life insured* under a Total Care Plan policy, we'll only waive the premiums for the *split TPD Cover* under that policy.

If you have income protection under the same policy we continue to charge premiums for that cover (unless an income protection waiver applies to the cover, see page 89).

This waiver only applies while the *life insured* is *totally and temporarily disabled* after the three month qualifying period and up to the earlier of:

- when the *Life Care* ends under this policy or the *split TPD super policy*, as applicable
- the *policy anniversary date* before the *life insured* turns 65.

While we're waiving premiums:

- the *automatic indexation* described on page 35 doesn't apply and begins again on the *policy anniversary date* immediately after the waiver of premiums ends
- you can't increase your cover under the Guaranteed Insurability option (personal events), Guaranteed Insurability option (business events) or the Business Safe Cover option.

When we won't waive premiums

We won't waive premiums if the *life insured* is *totally and temporarily disabled*, directly or indirectly, by:

- any intentional self-inflicted injury or any attempt at suicide or
- an act of war (whether declared or not).

Guaranteed Insurability option (personal events)

Lets you increase cover without providing more health information if you experience certain personal events.

Effect of the Guaranteed Insurability option

You can increase any *Life Care* and any *Trauma Cover* without further evidence of health after certain personal events occur to the *life insured*.

When you can increase your cover using this option

You can increase your cover once every 12 months before the *policy anniversary date* after the *life insured's* 55th birthday.

How much can I increase my cover by using this option?

Personal event	Cover can be increased by up to the lesser of...
The *life insured*: ◆ marries or reaches the second anniversary of a *de facto relationship* ◆ adopts or becomes a natural parent of a child ◆ has a *spouse* die ◆ has a child start secondary school or ◆ gets divorced.	◆ 25% of the existing cover ◆ $200,000 per event.
The *life insured* mortgages a home or increases a home mortgage.	◆ 50% of the existing *Life Care* ◆ 25% of the existing *Trauma Cover* ◆ the amount of the new mortgage ◆ in the case of an increase to an existing mortgage, the amount of the increase ◆ $200,000.
The *life insured's change in employment* which, within 30 days of the change, results in an increase in annual income of more than $10,000.	◆ 25% of the existing cover ◆ ten times the amount by which annual income has increased as a result of the *change in employment* ◆ $200,000.

Note: If you have both *Life Care* and *Trauma Cover:*

- you must increase your *Life Care* in the same proportion as you increase your *Trauma Cover*, and
- the *Trauma Cover* can never end up being more than the *Life Care*
- if this policy is a *flexi-linked policy* and this option applies to the *flexi-linked life insured*, *flexi-linked Trauma Cover* can't be increased for the *flexi-linked life insured* unless the *primary Life Care* is increased in the same proportion. The *flexi-linked Trauma Cover* can never end up being more than the *primary Life Care*.

Eligibility

- This option isn't available for a policy with Guaranteed Insurability option (business events) or Business Safe Cover option.
- This option isn't available with *split TPD*.
- If this policy is a *flexi-linked policy* under which *flexi-linked Trauma Cover* applies, this option can't apply to the *flexi-linked life insured* under this policy unless it applies to the *life insured* under the *primary policy*.
- This option isn't available if an increase or reinstatement of cover under your policy has been declined.

Requirements

To use this option you must give us written notice within 30 days before or after the personal event or the next *policy anniversary date*. If we ask for it, you must give us proof, satisfactory to us, that the personal event has occurred and the date it occurred.

The increase in cover takes effect from the date we notify you in writing, which will be within 30 days of the date our requirements are met.

Premiums

If you use this option we recalculate the premium to take into account the increase in cover, using the current premium rates and considering the *life insured's* age when the increase occurs. We do this recalculation whether or not a Level premium has been chosen. For more information about how we calculate premiums if you have a Level premium please refer to 'Level premium' on page 101.

We stop charging a premium for this option from the *policy anniversary date* after the *life insured's* 55th birthday.

Restrictions

Marrying a de facto partner

If you use this option for the *life insured's* second anniversary of a *de facto relationship*, you can't use it again if the *life insured* marries the person with whom they had the *de facto relationship*.

Life Care

Life Care can't be increased under this option if a medical loading of more than 50% applies. Medical loadings are specified in your Policy Schedule (refer to the Provisional Offer we provided).

Trauma Cover

Trauma Cover can't be increased under this option if:

- the cover exceeds $2 million or the increase would cause the cover to exceed $2 million
- the cover was issued with special conditions or exclusions or the premium payable for the cover has a premium loading (for special conditions or exclusions, please refer to your policy schedule)
- *Life Care* doesn't apply to the *life insured*, unless this policy is a *flexi-linked policy* and the *Trauma Cover* is *flexi-linked Trauma Cover*
- a death, trauma or disablement benefit has been paid, or is payable, by us for the *life insured* under this or any other policy
- circumstances exist which, if the subject of a claim under this or any other policy, would result in us paying a death, trauma or disablement benefit for the *life insured*.

The sum of all increases to the *Trauma Cover* under this option must not exceed the amount of the *Trauma Cover* in place when it first started.

Same terms will apply

All existing exclusions and special conditions apply to cover increased under this option.

Plan Protection option

You can't use this option if we're waiving premiums under the Plan Protection option. If this policy is a *primary policy* or a *flexi-linked policy* under which *flexi-linked Trauma Cover* applies, you can't exercise this option for the *flexi-linked life insured* while we're waiving premiums for the *life insured* under the Plan Protection option under either this or the other policy.

Change of policy owner

If the original policy owner is no longer the beneficial owner of this policy, this option can only be used if we agree or if the policy owner or beneficial owner is:

- the *life insured*
- the *spouse* of the *life insured*, or
- a trustee who either agrees to the *life insured* using the option or holds the policy for the benefit of, or to be held in trust for, the *life insured* and/or the *life insured's spouse*, children and/or dependants.

  Note: Nominating a beneficiary isn't a change in beneficial ownership.

Flexi-linking

If this policy is a *primary policy* or *flexi-linked policy* under which this option applies to the *flexi-linked life insured*, the option ceases to apply under this policy if, under the other policy, the option ceases to apply to the *flexi-linked life insured*.

Guaranteed Insurability option (business events) and Business Safe Cover option

Guaranteed Insurability option (business events) – Lets you increase cover without providing more health information if certain business events occur.

Business Safe Cover option – When assessing your application, we'll allow for future increases in cover. So, if certain business events occur you can increase your cover without providing more health information.

The business events to which these options can apply are as follows:

- business growth
- key person
- financial interest
- business loan.

The business event indicated on the application for the policy is the only business event for which the relevant option can be used.

Eligibility

The options can be taken for a *life insured* up to age 59 if a Stepped premium is chosen or 54 if a Level premium is chosen.

The options can't be taken together. Neither of them can be taken if the Guaranteed Insurability option (personal events) or *split TPD* or *flexi-linking* is chosen.

When you can increase your cover using these options
Guaranteed Insurability option (business events)
You can increase your *Life Care, TPD Cover* or *Trauma Cover* once every 12 months before the *policy anniversary date* after the *life insured's* 49th birthday (*Trauma Cover*) or 65th birthday (*Life Care* and *TPD Cover*).
Business Safe Cover option
You can increase your *Life Care*, *TPD Cover* or *Trauma Cover* once every 12 months before the *policy anniversary date* after the *life insured's* 60th birthday (*Trauma and TPD Cover*) or 70th birthday (*Life Care*).

The business events are explained below:

What does the business event involve?	When can the cover be increased for the business event?
Business growth	
A business exists in which the policy owner and the *life insured* are involved.	The value of the business grows.
Key person	
In our opinion, the *life insured* is crucial to the operation of the business in which the policy owner is involved.	The value of the *life insured* to the business grows.
Financial interest	
The *life insured* has a financial interest in a business in which the policy owner also has a financial interest. The *life insured* must hold their financial interest in the business as a partner, shareholder or unit-holder and the interest must be the subject of a buy/sell share purchase or business succession agreement.	The value of the *life insured's* financial interest in the business grows.
Business loan	
There is a business loan under which both the policy owner and the *life insured* are borrowers.	The amount of the business loan increases.

Valuing the increase

If an increase in cover is applied for business growth, key person or financial interest, a qualified accountant or valuer we have approved must calculate the revised valuation of the business, the value of the *life insured* to the business or the *life insured's* financial interest in the business, as applicable.

For a business loan, you must provide us with loan documentation, acceptable to us, evidencing the increase in the business loan.

In all cases, we must agree to the financial basis for the revised cover, but we won't withhold our agreement unreasonably.

Premiums

If one of these options are used, we recalculate the premium to take into account the increase in cover. We do this whether or not a Level premium applies and according to the current premium rates based on the *life insured's* age when the cover increases.

We stop charging premium for an option when it can no longer be used.

Restrictions to both

The following restrictions and requirements apply to both the Guaranteed Insurability option (business events) and the Business Safe Cover option.

Exclusions and special conditions

All existing exclusions and special conditions apply to cover increased under one of these options.

Previous increases or reinstatements

An option isn't available if an increase or reinstatement of cover has been declined.

Life Care

Life Care can't be increased if a medical loading of more than 50% applies.

Maintaining proportion

If more than one of *Life Care, Trauma Cover* and *TPD Cover* apply, all the cover must be increased in the same proportion.

Life Care is the maximum

TPD Cover and *Trauma Cover* can never exceed *Life Care* as a result of an increase in cover under one of these options.

TPD and Trauma Cover

Neither *TPD* nor *Trauma cover* can be increased if the cover was issued with special conditions or exclusions or the premium payable for the cover has a premium loading.

Plan Protection option

Neither of the options can be used while we're waiving premiums under the Plan Protection option.

Change of policy owner

If the original policy owner is no longer the beneficial owner of this policy, the option can only be used if we agree or if the policy owner or beneficial owner is:

- the *life insured*
- the *spouse* of the *life insured*, or
- a trustee who either agrees to the *life insured* using the option or holds the policy for the benefit of, or to be held in trust for, the *life insured* and/or the *life insured's spouse*, children and/or dependants.

  Note: Nominating a beneficiary isn't a change in beneficial ownership.

Three year limit

The business event that triggers the increase in cover must have occurred no more than three years before the date the increase is applied for.

Within 30 days of valuation

The increase in cover must be applied for within 30 days of the date the qualified accountant or valuer issues a written revaluation of:

- for business growth, the value of the business
- for key person, the value to the business of the *life insured*
- for financial interest, the value of the *life insured's* financial interest in the business.

Or, for business loan, the application must be made within 30 days of the increase in the business loan.

Information to be provided

We must be given all the financial information we request about:

- for business growth, the valuation of the business
- for key person, the value of the *life insured* to the business
- for financial interest, the value of the *life insured's* financial interest in the business
- for business loan, the increase in the business loan.

The increase in cover takes effect from the date we notify you in writing, which will be no later than 30 days from the date we agree to the financial basis for the revised cover.

> **Note:** If *flexi-linking* applies to this policy, neither Guaranteed Insurability (business events) nor Business Safe Cover option can apply to the *flexi-linked life insured*. Also, if this policy is a *split TPD policy*, neither of these options can apply to the *split TPD Cover*.

Restrictions on the Guaranteed Insurability option (business events)

The following restrictions and requirements apply to the Guaranteed Insurability option (business events).

Life Care

This option can only be used to increase *TPD Cover* or *Trauma Cover* if *Life Care* also applies to the *life insured*.

Maximum cover

$10 million is the maximum amount of *Life Care* which can apply for a *life insured* before we require medical evidence for an increase.

For *TPD* and *Trauma*, there is no limit on increases as long as you don't exceed the maximum cover set out on page 9.

The sum of all increases to the *Trauma Cover* under this option must not exceed the amount of the *Trauma Cover* when it first started.

Timing

This option can't be used on or after the *policy anniversary date* after the *life insured's* 65th birthday.

Trauma Cover can't be increased under this option on or after the *policy anniversary date* before the *life insured's* 50th birthday.

Conditions and loadings

This option can't be used to increase *TPD Cover* or *Trauma Cover* issued with special conditions, premium loadings or exclusions.

Maximum increases

For each of the three types of cover, the maximum increase in cover is the lesser of 25% of the existing cover and the amount set out in the following table:

Business event	Maximum increase
Business growth	the actual increase in the value of the business
Key person	the actual increase in the value of the *life insured* to the business
Financial interest	the actual increase in the value of the *life insured's* financial interest in the business
Business loan	the actual increase in the amount of the business loan

> **Note**: There is a $2 million per annum limit on increases under *Life Care*.

Restrictions on the Business Safe Cover option

The following restrictions and requirements apply to the Business Safe Cover option.

Maximum increases

For each of the three types of cover, the maximum increase in cover is:

Business event	Maximum increase
Business growth	the actual increase in the value of the business
Key person	the actual increase in the value of the *life insured* to the business
Financial interest	the actual increase in the value of the *life insured's* financial interest in the business
Business loan	the actual increase in the amount of the business loan

Percentage cap

A percentage cap on an increase in cover applies if, when the existing cover first started, the amount of the cover was less than:

- for business growth, the total value of the business ('total value')
- for key person, the total value of the *life insured* to the business ('total value')
- for financial interest, the total value of the *life insured's* financial interest in the business ('total value')
- for business loan, the amount of the loan.

If the cap applies, the new amount of cover after the increase can't be more than the original amount of cover when measured as a percentage of the total value or amount of the loan as at the relevant time the respective amounts of cover were put in place.

TPD and Trauma Cover

If only *Trauma Cover* and *TPD Cover* apply, the *TPD Cover* can never exceed the *Trauma Cover*.

When the Business Safe Cover option ends

The Business Safe Cover option ends for a *life insured* on the earliest of the following:

- when the *Life Care, Trauma Cover* or the *TPD Cover* for the *life insured* can no longer be increased under this option
- when we've paid a benefit, or a benefit is payable, for the *life insured* under this policy
- when circumstances exist which, if the subject of a claim, would result in us paying a benefit for the *life insured* under this policy
- on the date the option is cancelled
- for increases in *Trauma Cover* or *TPD Cover*, on the *policy anniversary date* before the *life insured's* 60th birthday
- for increases in *Life Care*, on the *policy anniversary date* before the *life insured's* 70th birthday.

Maximum insurance cover

The maximum cover which can apply for a *life insured* before we require medical evidence for an increase under this option is the lesser of:

For *Life Care*	For *Trauma Cover*	For *TPD Cover*
◆ $10 million ◆ three times the *Life Care* that applied when the cover first started (plus any indexation increases applied)	◆ $2 million ◆ three times the *Trauma Cover* that applied when the cover first started (plus any indexation increases applied) ◆ the amount of any *Life Care*	◆ $5 million ◆ three times the *TPD Cover* that applied when the cover first started (plus any indexation increases applied) ◆ the amount of any *Life Care* ◆ if *Life Care* doesn't apply, the amount of any *Trauma Cover*

For each of the three types of insurance:

- for business growth, the value of the business
- for key person, the value of the *life insured* to the business
- for financial interest, the value of the *life insured's* financial interest in the business
- for business loan, the amount of the business loan.

Because sickness and accidents happen.

TPD Cover

TPD Cover pays a lump sum if you are totally and permanently disabled.

TPD Cover pays a lump sum if you're totally and permanently disabled. There are different definitions of total and permanent disability that can apply, for example, if you're unable to engage in either your own or any occupation or you suffer loss of use of limbs or sight or loss of independent existence.

For the TPD definitions please refer to the definitions starting on page 132.

There are some important features of TPD Cover you should be aware of. For example, from the policy anniversary date before you turn 65:

- TPD only covers loss of independent existence. Please refer to the definition of loss of independent existence on page 151
- TPD Cover under a split TPD policy outside super ends (see page 19 for an explanation of split TPD).

Please make sure you read all the TPD Cover terms and conditions which start on page 47.

Summary

In this section we set out the built in benefits, features and optional extras which apply if you have *TPD Cover*.

Included benefits

Benefit	A brief explanation...	Outside super	Inside super		For full details see page...
		Total Care Plan	Total Care Plan Super	SMSF Plan	
TPD Cover benefit	A lump sum if you're totally and permanently disabled	✔	✔	✔	47
Partial and Permanent Disability	A part payment of the TPD Cover benefit if you're partially and permanently disabled	✔	–	–	47
Death benefit	Under a stand-alone TPD policy, we pay a $10,000 lump sum if you die	✔	–	✔	48
Severe Hardship Booster benefit	Doubles the TPD lump sum if you suffer a specified disability due to an accident	✔	✔	✔	48
TPD Cover Financial Planning benefit	Up to $5,000 to help cover the costs of financial advice	✔	–	–	49
Loyalty Bonus benefit	Once cover is held for five years, automatically increases payment of the TPD Cover benefit by 5%	✔	✔	✔	49
Accommodation benefit	Helps cover the accommodation costs of an immediate family member who needs to stay nearby if, because of your total and permanent disability, you are confined to bed a long way from home	✔	–	–	49

Included features

Feature	A brief explanation...	Outside super	Inside super		For full details see page...
		Total Care Plan	Total Care Plan Super	SMSF Plan	
Automatic indexation	Automatically increases the TPD Cover each year to help keep pace with inflation	✔	✔	✔	50
Continuation option	Lets you continue TPD Cover outside super without providing further health evidence	–	✔	–	50
Option to convert	If you have a stand-alone TPD policy, Life Care can be obtained under another policy without providing health evidence	✔	–	✔	51

Optional extras (at an additional cost)

The optional extras only apply to your policy if they appear in your policy schedule.

Option	A brief explanation...	Outside super	Inside super		For full details see page...
		Total Care Plan	Total Care Plan Super	SMSF Plan	
Plan Protection	You don't pay TPD premiums while you are totally and temporarily disabled	✔	✔	✔	51
Guaranteed Insurability (business events)	Lets you increase TPD Cover without providing health information, if certain business events occur	✔	–	–	51
Business Safe Cover	On assessing your application we'll allow for three times the chosen amount of TPD Cover so, when specific business events occur, you can increase the cover without providing more health information	✔	–	–	51

Exclusions

Type of exclusion	What benefit does the exclusion apply to?	For full details see page...
◆ Suicide attempt ◆ Self-inflicted injury ◆ Survival period ◆ Misconduct	◆ TPD Cover benefit	47

Split TPD

Our *split TPD* arrangement allows you to link *TPD Cover* which is not available inside super (e.g. *own occupation TPD Cover*) with *TPD Cover* which is available inside super (e.g. any occupation *TPD Cover*). Refer to 'Do you want split TPD?' on page 19 for more information.

TPD Cover benefit

A lump sum if you're totally and permanently disabled.

When we pay it

We pay you the *TPD Cover benefit* if the *life insured* becomes *totally and permanently disabled* while *TPD Cover* applies to them.

It is important you understand that if *TPD Cover* still applies on the *policy anniversary date* before the *life insured's* 65th birthday, then from that date we'll only pay a *TPD Cover benefit* if the *life insured* suffers from *loss of independent existence*. For a *super policy*, the *life insured* must also meet the additional requirements that apply under the relevant TPD definition relating to *loss of independent existence.*

Partial and Permanent Disability

A part payment of the TPD Cover benefit if you're partially and permanently disabled.

Notes:

- When we refer in this PDS to the *TPD Cover benefit* or the payment of the benefit, we're also referring to the part payment of the *TPD Cover benefit* for *partial and permanent disability*, unless this PDS states otherwise.
- We won't pay a benefit for *partial and permanent disability* under a *super policy*.

What we pay

If the *life insured* becomes *partially and permanently disabled* while *TPD Cover* applies to them, we pay you a *TPD Cover benefit* but only in an amount equal to the lesser of:

- $500,000 and
- 25% of the *TPD Cover*.

The *TPD Cover* is then reduced by the amount paid. If the *TPD Cover* reduces to less than $10,000 the cover ends.

A payment for *partial and permanent disability* also reduces:

- any *Life Care* or *Trauma Cover* which applies under this policy
- the *Life Care* which applies under a *primary policy* and
- the *TPD Cover* which applies under a *split TPD super policy*

in the same way that cover would have been reduced had the *TPD Cover benefit* been paid for *total and permanent disablement*. However, that cover only reduces by the amount paid for *partial and permanent disability*.

We only pay one benefit

If the *life insured* is *partially and permanently disabled* and you can claim both this benefit and a Partial Trauma Cover benefit (see page 55) for the same condition, we pay the higher of the two benefits, not both.

When the benefit ends

We won't pay for *partial and permanent disability* occurring on or after the *policy anniversary date* before the *life insured's* 65th birthday.

What exclusions apply

Self-inflicted injury, suicide attempt

We won't pay a *TPD Cover benefit* for any condition which arises, directly or indirectly, from an intentional self-inflicted injury or attempt at suicide.

Misconduct

We won't pay a *TPD Cover benefit* for any condition arising solely from a permanent or temporary banning, deregistration or disqualification of the *life insured* which prevents them from pursuing, practising or engaging in their occupation or profession.

Survival period

We won't pay a *TPD Cover benefit* if all of the following applies:

- *Life Care* doesn't apply to the *life insured* under this policy
- the *life insured* is neither a *flexi-linked life insured* nor a *split TPD life insured* to whom *Life Care* applies under the *split super policy*
- the *life insured* suffers a *day one condition*
- the definition of *total and permanent disablement* for which the claim is made, includes a requirement that, as a result of the *day one condition*, the *life insured* be absent from active employment or unable to perform *domestic duties*
- the *life insured* dies from any cause within eight days of first being diagnosed with the *day one condition*.

When TPD Cover ends

TPD Cover ends on the first of:

- we pay the *TPD Cover benefit* other than for *partial and permanent disability*
- we pay any *Life Care benefit*, including the Terminal Illness benefit
- the *TPD Cover* reduces to less than $10,000
- if the *TPD Cover* is *flexi-linked TPD Cover*, when the *primary Life Care* ends for any reason
- if the *TPD Cover* is *split TPD Cover* under a Total Care Plan policy, when any *Life Care* for the *split TPD life insured* under the *split TPD super policy* ends for any reason
- if the *TPD Cover* is *split TPD Cover* under a Total Care Plan policy, the *policy anniversary date* before the *life insured's* 65th birthday
- if the *TPD Cover* is *split TPD Cover* under a Total Care Plan policy, when the *TPD Cover* for the *split TPD life insured* under the *split TPD super policy* ends for any reason
- the *cover expiry date* for *TPD Cover*

- when this policy ends
- if the *TPD Cover* is *split TPD Cover*, when we pay a *TPD Cover benefit* for the *split TPD life insured* under the other *split TPD policy* other than for *partial and permanent disability*.

Loss of independent existence

If *TPD Cover* still applies on the *policy anniversary date* before the *life insured's* 65th birthday, then from that date we'll only pay a *TPD Cover benefit* if the *life insured* suffers from *loss of independent existence*. For a *super policy*, the *life insured* must also meet the additional requirements that apply under the relevant TPD definition relating to *loss of independent existence*.

If flexi-linking or split TPD apply to a policy

If this policy is a *flexi-linked policy*, the amount of any *flexi-linked TPD Cover* for a *flexi-linked life insured* reduces from time to time so it's no greater than the amount of *primary Life Care* applying for the *life insured* under the *primary policy*. If, as a result of this reduction, the *flexi-linked TPD Cover* would be less than $10,000 the cover ends.

If *split TPD Cover* applies to a *life insured* under this policy, the amount of that cover reduces from time to time so it's no greater than the amount of the *split TPD Cover* applying to the *split TPD life insured* under the other *split TPD policy*. If, as a result of this reduction, the *TPD Cover* would be less than $10,000 the cover ends.

If *split TPD Cover* applies to a *life insured* under a policy, it can't increase unless the *split TPD Cover* applying under the other *split TPD policy* is increased to the same amount.

Effect on other benefits

If:

- we pay a *TPD Cover benefit* or
- this policy is a *split TPD super policy* and we pay a *split TPD Cover benefit* under the Total Care Plan policy,

we reduce:

- any *Life Care* by the amount we pay and the Life Care Buy Back benefit may apply (see 'Life Care Buy Back benefit' on page 34)
- any *Trauma Cover* by the amount we pay; if this reduces your *Trauma Cover* to less than $10,000, the *Trauma Cover* ends.

Death benefit

Under a stand-alone TPD policy, we pay a $10,000 lump sum if you die.

When it applies

The Death benefit applies when *TPD Cover* applies to the *life insured* but not *Life Care* or *Trauma Cover*.

However, the benefit doesn't apply for:

- a *flexi-linked life insured* or
- a *split TPD life insured* to whom *Life Care* applies under the *super policy*.

When we pay it

We pay the Death benefit if the *life insured* dies and we don't pay a *TPD Cover benefit* for the *life insured*.

What we pay

We pay a Death benefit of $10,000.

Severe Hardship Booster benefit

Doubles the TPD lump sum if you suffer a specified disability due to an accident.

When we pay it

We pay this benefit if we pay you a *TPD Cover benefit* because, amongst other things, the *life insured* suffered as a direct result of an *injury*:

- the total and permanent loss of use of two limbs; or
- blindness in both eyes; or
- the total and permanent loss of the use of one limb and blindness in one eye;

where

- 'limb' means the whole hand below the wrist or whole foot below the ankle.
- 'blindness' means the permanent loss of sight to the extent that:
  - visual acuity is 6/60 or less or
  - the visual field is reduced to 20 degrees or less of arc

whether aided or unaided and all as certified by a *relevant medical specialist*.

What we pay

We increase the *TPD Cover benefit* by the lesser of:

- 100%
- $250,000
- if *Life Care* applies to the *life insured* under this policy, the difference between that cover and your *TPD Cover* when the *life insured* was first found to have the disability
- if *Trauma Cover* applies to the *life insured* under this policy but not *Life Care*, the difference between that cover and your *TPD Cover* when the *life insured* was first found to have the disability
- if the *TPD Cover* under this policy is *flexi-linked TPD Cover*, the difference between that cover and the *primary Life Care* under the *primary policy* when the *flexi-linked life insured* was first found to have the disability
- if the *TPD Cover* is *split TPD Cover* under a Total Care Plan policy, the difference between that cover and any *Life Care* applying to the *split TPD life insured* under the *super policy* when the *life insured* was first found to have the disability.

This increase doesn't apply to any TPD Cover Loyalty Bonus benefit.

Effect on other benefits

We reduce any *Life Care* and *Trauma Cover* you have (including any loyalty bonus or booster benefits that apply) by the amount of the TPD Cover Severe Hardship Booster benefit payable under this policy or, if the *life insured* is a *flexi-linked life insured* or *split TPD life insured*, under the other policy to which *flexi-linking* or *split TPD* applies.

TPD Cover Financial Planning benefit

Up to $5,000 to help cover the costs of financial advice.

Who we pay

We pay this benefit to the policy owner who receives the *TPD Cover benefit*. If there is more than one policy owner, we pay the benefit to all policy owners jointly, even if only one policy owner claims it.

When we pay it

We pay this benefit if:

- we pay a *TPD Cover benefit* other than for *partial and permanent disability* and
- within 12 months after we pay the *TPD Cover benefit*, a recipient of the benefit obtains financial planning advice from an accredited financial adviser.

To receive this benefit, the person claiming it must provide proof of the cost of the financial planning advice for which they're seeking reimbursement.

What we pay

We pay the cost of the approved financial planning advice but we won't pay more than $5,000 in total for all claims for the benefit.

Example

Bradley and his wife Sally together own a Total Care Plan policy. TPD Cover of $100,000 applies on Bradley's life.

Unfortunately, several years after taking out the policy, Bradley suffers an injury at work and becomes totally and permanently disabled. After Bradley and Sally receive the $100,000 TPD Cover benefit, Sally obtains financial advice from an accredited financial planner to explore the available investment options. The advice costs $3,000.

Sally pays the cost and seeks reimbursement of the $3,000 from CommInsure by submitting to CommInsure the financial planner's invoice as proof of the cost of the advice.

The policy owners, Bradley and Sally, are together paid a $3,000 Financial Planning benefit as reimbursement of the cost of the financial planning advice.

Loyalty Bonus benefit

Once cover is held for five years, automatically increases payment of the TPD Cover benefit by 5%.

When we pay it

If, after the fifth anniversary of the *date insured from*, the *life insured* becomes *totally and permanently disabled* or *partially and permanently disabled* and we pay the *TPD Cover benefit*, we increase the benefit by 5%. The 5% increase doesn't apply to any TPD Cover Severe Hardship Booster benefit.

If the policy is reinstated or replaced

If this policy is reinstated or replaced by another policy (and we agree it's a replacement policy), we treat the reinstated or replacement policy (or this policy, if it's the replacement policy) as a continuation of the original policy to work out whether the fifth anniversary has occurred.

When working out if and when the fifth anniversary has occurred, we include the period the policy was not in force and also the period that the previous policy was in force.

We do this on the basis that the *TPD Cover* and TPD Cover Loyalty Bonus benefit only restart from the date of reinstatement or replacement.

We won't pay a benefit for anything that happened or first became apparent while the policy was not in force.

Effect on other benefits

We reduce any *Life Care* and *Trauma Cover* you have (including any loyalty bonus or booster benefits that apply) by the amount of the TPD Cover Loyalty Bonus benefit payable under this policy or, if the *life insured* is a *flexi-linked life insured* or *split TPD life insured*, under the other policy to which *flexi-linking* or *split TPD* applies.

Accommodation benefit

Helps cover the accommodation costs of an immediate family member who needs to stay nearby if, because of total and permanent disability, you are confined to bed a long way from home.

When we pay it

We'll pay this benefit if:

- a *TPD Cover benefit* has been paid or is payable, and
- on medical advice from a *medical practitioner* the *life insured* must stay more than 100 kilometres from their home or travel to a place more than 100 kilometres from their home, and
- the *life insured* is confined to bed due to the condition for which the *TPD Cover benefit* has been paid or is payable, and
- an *immediate family member* is accommodated near the *life insured* (other than in their home) or has to stay away from their home.

What we pay

We pay up to $350 a day to help cover the costs of accommodating the *immediate family member*.

We pay this benefit for up to 30 days in each 12 month period commencing on:

- the date we first paid the benefit and
- each anniversary of that date.

When it ends

The benefit ends when the *TPD Cover* ends.

Automatic indexation

Automatically increases TPD Cover each year to help keep pace with inflation.

On each *policy anniversary date* we'll increase any *TPD Cover*.

The rate of increase is the greater of:

- 3%
- any percentage increase in the Australian Consumer Price Index (CPI) (all groups – eight capital cities combined).

To work out the change in the CPI we'll compare the index figure published three months before your *policy anniversary date* with the index figure published in the corresponding period one year earlier. If the CPI isn't published, then we'll use another appropriate index.

Effect on your premium

When we increase the cover through indexation, we'll also increase the premium. The premium increase is based on:

- the increased cover
- the *life insured's* age next birthday (unless a Level premium applies and the *policy anniversary date* before the *life insured's* 65th birthday has not occurred)
- our then current premium rates for this class of policy, and
- any special additional premium we've previously told you applies.

Any exclusion, additional premium or other special condition we've previously told you about will also apply to the increased cover.

When indexation doesn't apply

Automatic indexation won't apply while we're waiving premiums under the Plan Protection option.

If the *TPD Cover* is *flexi-linked TPD Cover* and *automatic indexation* doesn't apply to the *primary Life Care* under the *primary policy*, *automatic indexation* doesn't apply to the *flexi-linked TPD Cover*. *Automatic indexation* increases in *flexi-linked TPD Cover* only apply to the extent they don't result in the cover exceeding the *primary Life Care* applying to the *life insured* under the *primary policy.*

If the *TPD Cover* is *split TPD Cover* and *automatic indexation* doesn't apply to the *split TPD Cover* under the other *split TPD policy*, *automatic indexation* doesn't apply to the *split TPD Cover* under this policy. *Automatic indexation* increases in *split TPD Cover* under a Total Care Plan policy only apply to the extent they don't result in the cover exceeding any *Life Care* applying to the *split TPD life insured* under the *split TPD super policy.*

If you don't want indexation

You can choose not to accept this increase by telling us within one month of the *policy anniversary date*. You can phone or write to us.

Continuation option – converting TPD Cover held on a Total Care Plan Super policy

Lets you continue TPD Cover outside super without providing further health evidence.

Example

When Alain was 45 he set up a Total Care Plan Super policy which included TPD Cover.

Alain pays premiums from his super using the FirstChoice Super payment method.

He reviews his insurance every year with his financial adviser. When he reached 55 his adviser recommended that he convert his TPD Cover to a policy outside super to help ensure there would be sufficient superannuation savings for Alain's retirement.

Using the Continuation option, Alain continues the TPD Cover under a new Total Care Plan policy without needing to provide any updated health evidence. By doing this, Alain remains protected with TPD Cover.

This option only applies if you also convert *Life Care* under this policy.

You can convert any *TPD Cover* under a Total Care Plan Super policy to any other total and permanent disablement or similar insurance we have available under another policy at the date of conversion. You can do this without providing evidence of the *life insured's* health, but subject to current occupation and income details (satisfactory to us), and as long as:

- the *life insured* is 60 years old or less
- the total and permanent disablement or similar cover under the new policy doesn't exceed the *TPD Cover benefit* which we would have paid under the Total Care Plan Super policy if the *life insured* became *totally and permanently disabled* on the date the right is exercised.

If you convert *split TPD Cover*, the *split TPD Cover* under the Total Care Plan policy ends.

For other conditions that apply please refer to 'General conditions for Continuation options' on page 108.

Option to convert

If you have a stand-alone TPD policy, Life Care can be obtained under another policy without providing health evidence.

When you can use this option

You can take out *Life Care* under a new individual policy without providing further medical evidence if we pay a *TPD Cover benefit* which ends your *TPD Cover* under the same policy and at that time you have neither *Life Care* nor *Trauma Cover* for the *life insured*.

What you must do

To receive *Life Care* under a new individual policy in this situation you must do certain things. If you don't do these things as required, you can't take out the *Life Care*.

Written notice

You must give us written notice within 30 days after the first anniversary of the payment of the *TPD Cover benefit* (but not before that first anniversary).

Premiums

You must:

- pay the first premium under the new individual policy within the relevant 30-day period
- ensure there are no premiums overdue under this policy when the *TPD Cover* ends.

Requirements

For the new individual policy, you or, where applicable, the *life insured* must meet our minimum policy issue and underwriting requirements.

How we issue the policy

We'll issue the *Life Care* policy to you:

- under a new individual policy on the *life insured's* life which provides *Life Care* in an amount equal to the *TPD Cover* which applied to the *life insured* under this policy on the day before it ended
- from the date you validly exercise the option and no earlier
- on the terms and at the premium rates current for the individual policy when it's issued
- without the benefit of any of the optional features which can be selected under the individual policy, unless we agree otherwise
- with the same premium loadings, exclusions and special conditions that applied to the *life insured* under this policy.

Notes:

- This option only applies if you have *TPD Cover* but don't have *Life Care* or *Trauma Cover* under this policy.
- This option doesn't apply for a *flexi-linked life insured* or for a *split TPD life insured* to whom *Life Care* applies under the *split TPD super policy*.

Plan Protection option

You don't pay TPD premiums while you are totally and temporarily disabled.

To see how Plan Protection Option applies to this cover, please refer to page 37.

Guaranteed Insurability option (business events) and Business Safe Cover option

See 'Guaranteed Insurability option (business events) and Business Safe Cover option' on page 40.

Note: The Guaranteed Insurability option (business events) is only available if *Life Care* applies to the *life insured*.


Because health
is everything.

Trauma Cover

Trauma Cover is designed to help you if a specified trauma condition causes a significant setback to your health.

Most adults rely on the continued growth and success of their career or business to achieve their long term financial goals. If you don't make a full recovery after a set-back in your health or significant financial expenses result, reaching those goals could be at risk.

Trauma Cover pays a lump sum for specified trauma conditions such as cancer, heart attack and stroke. These conditions are medically defined in this PDS and we only pay a benefit for them if you meet the precise meaning of the condition.

To illustrate this using some key trauma conditions:

- for cancer, we only cover certain types of cancer and, for some types, we only cover them if they're sufficiently serious. For example, if you're diagnosed with a non-melanoma skin cancer that hasn't spread to another part of the body, you won't be paid a benefit.
- for heart attack, we only cover heart attacks that are severe and meet the criteria outlined in our definition. For example, if you suffer a heart attack but the cardiac biomarkers are not within the required range you won't be paid a benefit.

If you have children you can insure them with Child Cover. Child Cover pays a lump sum if your child dies or meets the definition of a specified child trauma condition.

Summary

In this section we set out the built in benefits, features and optional extras that apply if you have *Trauma Cover*.

Trauma Cover and *Child Cover* aren't available under a policy inside super.

There are some important features of Trauma Cover you should be aware of. For example, from the policy anniversary date before you turn 70, you're only covered for loss of independent existence. Please refer to the definition of loss of independent existence on page 151. Please make sure you read all the Trauma Cover terms and conditions which start on page 55.

Included benefits

Benefit	A brief explanation...	For full details see page...
Trauma Cover benefit	A full or partial benefit if a specified trauma condition occurs	58
Loyalty Bonus benefit	Once cover is held for five years, automatically increases a payment of the Trauma Cover benefit by 5%	59
Severe Hardship Booster benefit	Doubles the lump sum we pay if certain serious trauma conditions occur	60
Trauma Reinstatement benefit	Automatically reinstates Trauma Cover if we pay a Trauma Cover claim	60
Trauma Cover Financial Planning benefit	Up to $5,000 to help cover the costs of financial advice	62
Accommodation benefit	Helps cover the accommodation costs of an immediate family member who needs to stay nearby if due to a trauma you are confined to bed a long way from home	63

Included features

Feature	A brief explanation...	For full details see page...
Automatic indexation	Automatically increases Trauma Cover each year to help keep pace with inflation	63

Optional extras at an additional cost

The optional extras only apply to your policy if they appear in your policy schedule.

Option	A brief explanation...	For full details see page...
Trauma Plus Cover	A partial benefit for extra trauma conditions	58
Trauma Reinstatement Booster	An enhanced Trauma Reinstatement benefit that allows you to claim for extra Trauma Cover conditions under the reinstated cover	60
Plan Protection	You don't pay trauma premiums while you are totally and temporarily disabled	64
Guaranteed Insurability (personal events)	Lets you increase Trauma Cover without providing more health information if you experience certain personal events	64
Guaranteed Insurability (business events)	Lets you increase Trauma Cover without providing more health information if certain business events occur	64
Business Safe Cover	When we assess your application we'll allow for three times the chosen amount of cover so that, when specific business events occur, you can increase Trauma Cover without providing more health information	64
Child Cover	A lump sum if your child dies or meets the definition of a specified trauma condition	64

Exclusions

Type of exclusion	What benefit does the exclusion apply to?	For full details see page...
◆ Suicide ◆ Malicious act	◆ Child Cover option	66
◆ Suicide attempt ◆ Self-inflicted injury ◆ Qualifying period	◆ Trauma Cover benefit (including Trauma Plus Cover option) ◆ Child Cover option	58 66
◆ Survival period	◆ Trauma Cover benefit (including Trauma Plus Cover option)	58
◆ Pre-existing condition ◆ Previous Trauma conditions	◆ Trauma Reinstatement benefit ◆ Trauma Reinstatement Booster option	60

Trauma Cover condition exclusions

Exclusions which apply to Trauma Cover conditions:

Trauma Cover condition	For full details see page...
Critical care	150
Occupationally acquired hepatitis B or C	153
Occupationally acquired HIV	153
Serious injury	154

Trauma Cover

What it covers

We pay a benefit in full or part for the medical conditions and procedures listed in the tables starting below. These conditions and procedures have specific meanings which are set out in full in the 'Medical definitions' on page 148.

The conditions and procedures you are covered for depend on the type of *Trauma Cover* you take out under your policy. You can take out:

- *Trauma Cover*, which covers you for the essential medical conditions and procedures we call the Trauma Cover conditions in this PDS
- Trauma Plus Cover, which covers you for the extra medical conditions and procedures we call the Trauma Plus Cover conditions in this PDS.

The schedule to your policy shows the type of cover you have.

Please note whether you have *Trauma Cover* or Trauma Plus Cover, from the *policy anniversary date* before the *life insured's* 70th birthday you are only covered for *loss of independent existence* and no other medical condition or procedure.

You can only take out Trauma Plus Cover if you first take out *Trauma Cover*.

If you take out Trauma Plus Cover with *Trauma Cover* and a condition or procedure is covered under both, we pay the benefit for the condition or procedure under Trauma Plus Cover and not *Trauma Cover*, as this results in a higher benefit. For instance, if you have Trauma Plus Cover and we pay a claim for *early stage melanoma*, we pay the benefit under Trauma Plus Cover (40%, maximum $200,000) and not under *Trauma Cover* (20%, maximum $100,000).

Trauma Cover conditions

Body system	Condition or procedure	How much we pay*
Cancer and tumours	*benign brain tumour*	100%
	benign brain tumour of limited extent	20%, maximum $100,000
	cancer	100%
	early-stage breast cancer	10%
	early-stage cancer of the vulva or perineum	20%, maximum $100,000
	early-stage prostate cancer	20%, maximum $100,000
	early-stage melanoma	20%, maximum $100,000
Heart and vessels	*cardiac arrest*	100%
	cardiomyopathy	100%
	coronary artery angioplasty	10%, maximum $25,000
	coronary artery angioplasty – triple vessel	100%
	coronary artery bypass surgery	100%
	heart attack	100%
	heart valve surgery	100%
	open heart surgery	100%
	primary pulmonary hypertension	100%
	stroke	100%
	surgery of the aorta	100%

* The percentages are expressed as a percentage of the amount of the *Trauma Cover* applying to the *life insured*. A $10,000 minimum benefit payment applies if the benefit isn't $0 or calculated to be $0.

Trauma Cover conditions (continued)

Body system	Condition or procedure	How much we pay*
Brain and nerves	*bacterial meningitis*	100%
	coma	100%
	dementia and Alzheimer's disease	100%
	diplegia	100%
	encephalitis	100%
	hemiplegia	100%
	major head trauma	100%
	motor neurone disease	100%
	muscular dystrophy	100%
	multiple sclerosis with impairment	100%
	multiple sclerosis of limited extent	25%, maximum $50,000
	paraplegia	100%
	Parkinson's disease with impairment	100%
	quadriplegia	100%
	tetraplegia	100%
Kidneys	*end stage kidney failure*	100%
Digestive system	*end stage liver failure*	100%
Respiratory	*chronic lung disease*	100%
	pneumonectomy	100%
Ear, nose and throat	*loss of hearing*	100%
	loss of speech	100%
Eye	*blindness*	100%
Musculoskeletal	*loss of use of limbs or sight*	100%
	loss of use of one limb	10%
	severe rheumatoid arthritis	100%
Endocrine system	*advanced diabetes mellitus*	100%
Blood	*aplastic anaemia*	100%
	medically acquired HIV	100%
	meningococcal disease	100%
	occupationally acquired hepatitis B or C	100%
	occupationally acquired HIV	100%
Other	*critical care*	10%
	loss of independent existence	100%
	major organ or bone marrow transplant	100%
	serious injury	10%
	severe burns	100%

* The percentages are expressed as a percentage of the amount of the *Trauma Cover* applying to the *life insured*. A $10,000 minimum benefit payment applies if the benefit isn't $0 or calculated to be $0.

Trauma Plus Cover conditions

Body system	Condition or procedure	How much we pay*
Cancer and tumours	*early-stage cancer of the cervix uteri*	20%, maximum $100,000
	early-stage cancer of the vagina	20%, maximum $100,000
	early-stage chronic lymphocytic leukaemia	20%, maximum $100,000
	early-stage cancer of the fallopian tubes	20%, maximum $100,000
	early-stage melanoma	40%, maximum $200,000
	early-stage ovarian cancer	20%, maximum $100,000
	early-stage penile cancer	20%, maximum $100,000
	surgical removal of a hydatidiform mole	20%, maximum $100,000
Brain and nerves	*Parkinson's disease*	20%, maximum $100,000
Ear, nose and throat	*partial loss of hearing*	20%, maximum $100,000
Eye	*partial blindness*	20%, maximum $100,000
Digestive system	*severe Crohn's disease*	20%, maximum $100,000
	severe ulcerative colitis	20%, maximum $100,000
Endocrine system	*diabetes mellitus complications*	40%, maximum $200,000

* The percentages are expressed as a percentage of the amount of the *Trauma Cover* applying to the *life insured*. A $10,000 minimum benefit payment applies if the benefit isn't $0 or calculated to be $0.

As you can see from the tables above, for all the Trauma Plus Cover conditions and for certain Trauma Cover conditions (collectively called the Partial Trauma Cover conditions in this PDS), we only pay a part of the *Trauma Cover benefit* (a Partial Trauma Cover benefit). We may also do this under the Trauma Reinstatement Booster option described on page 60. Payment of a Partial Trauma Cover benefit reduces the amount of your *Trauma Cover* by the amount paid.

Trauma Cover and Trauma Plus Cover

Trauma Cover

A full or partial benefit if a specified trauma condition occurs.

Trauma Plus Cover

A partial benefit for extra trauma conditions.

When we pay it

We pay the *Trauma Cover benefit* (subject to the qualifying period described below) if the *life insured* meets the definition of:

- *loss of independent existence* before the *Trauma Cover* ends or
- one of the other *Trauma Cover* or Trauma Plus Cover conditions before the earlier of:
  - the *policy anniversary date* before the *life insured's* 70th birthday
  - the end of the *Trauma Cover*.

What exclusions apply

We won't pay a *Trauma Cover benefit,* including a Partial Trauma Cover benefit, if:

- the *life insured's* Trauma Cover condition or Trauma Plus Cover condition is caused directly or indirectly by any intentional self-inflicted injury or any attempt at suicide, or
- the *life insured* dies within 14 days after they first met the definition of the Trauma Cover condition or Trauma Plus Cover condition.

A qualifying period also applies, see this page.

We won't pay a *Trauma Cover benefit* for *occupationally acquired HIV* if:

- the infection with HIV is caused directly or indirectly by sexual activity or recreational intravenous drug use or
- before the *accident* occurred, the Australian government recommended an HIV vaccine for use in the occupation of the person, which vaccine the person had not taken or
- before the *accident* occurred, the Australian government approved a treatment which renders the HIV virus inactive and non-infectious to others.

Also, we won't pay a *Trauma Cover benefit* for *occupationally acquired hepatitis B or C* if:

- before the *accident* occurred, a cure has been found for hepatitis B and/or hepatitis C or
- the *life insured* has elected not to take available medical treatment which, if taken, would have prevented the infection with hepatitis B and/or hepatitis C.

When it ends

Trauma Cover ends on the earliest of:

- if the *Trauma Cover* is *flexi-linked Trauma Cover*, when the *primary Life Care* ends for any reason
- the *cover expiry date for Trauma Cover*
- when this policy ends
- the cover reduces to less than $10,000
- the *life insured* dies
- we pay any *Life Care benefit*, including the Terminal Illness benefit.

Trauma Cover also ends if we pay a benefit for a condition or procedure other than a Partial Trauma Cover condition (see pages 55 to 57).

Qualifying period

What conditions does it apply to?

A 90 day qualifying period applies to the following:

- all the Trauma Plus Cover conditions
- *cancer*
- *coronary artery angioplasty*
- *coronary artery angioplasty – triple vessel*
- *coronary artery bypass surgery*
- *early-stage breast cancer*
- *heart attack*
- *stroke.*

When does it apply?

The qualifying period applies if the procedure or the symptoms or diagnosis of the condition occurred, or the circumstances leading to the procedure or the condition became apparent, either before or within the first 90 days from:

- the *date insured from*
- the date of any increase to the *Trauma Cover* other than by *automatic indexation* (in which case the qualifying period applies only to the amount of the increase)
- the date the *Trauma Cover* was first added or reinstated to this policy (except where the *Trauma Cover* was reinstated under the Trauma Reinstatement benefit) or
- in the case of the Trauma Plus Cover conditions, the date we first agreed to provide cover for those conditions.

What happens if it applies?

If the qualifying period applies to the condition or procedure, we won't pay the *Trauma Cover benefit* for that procedure or condition or for any other procedure or condition which is directly or indirectly caused by, or related to, that procedure or condition.

If replacing other trauma cover

If we've agreed to replace existing trauma cover you have which is subject to a qualifying period of at least 90 days, the qualifying period under this policy for the same trauma conditions and procedures is the lesser of:

- 90 days
- any unexpired qualifying period under the trauma cover being replaced (including a qualifying period applied to the cover after it first started, for example, reinstatement or increases).

If the qualifying period under the trauma cover being replaced has expired, we waive the qualifying period under this policy for the same trauma conditions and procedures.

If the *Trauma Cover* under this policy exceeds the trauma cover being replaced, we apply the full 90 day qualifying period to the difference in cover.

If this policy is flexi-linked

If this policy is a *flexi-linked policy*, the amount of any *flexi-linked Trauma Cover* for a *flexi-linked life insured* reduces from time to time so it's no greater than the amount of *primary Life Care* applying for the *life insured* under the *primary policy*. The cover ends if, as a result of this reduction, the *flexi-linked Trauma Cover* would be less than $10,000.

Other insurances

We may reduce the amount of the *Trauma Cover benefit* payable (to nothing if necessary) if a benefit is payable on the *life insured's* life under any other policies of insurance similar to the *Trauma Cover*.

We calculate the reduction on the basis that the amount of the *Trauma Cover benefit* payable, when added to any other benefit payable on the *life insured's* life, doesn't exceed $2 million or a greater amount at our discretion. In calculating the reduction, we won't take into account any cover you told us about before the *Trauma Cover* first started.

If, having made the reduction, the amount of *Trauma Cover benefit* paid is less than the amount for which you've been paying premiums, we'll refund the additional premium you've paid over the previous 12 months. We base this refund on the premium which would have applied to the *Trauma Cover benefit* actually paid out.

Effect on other benefits

We reduce the amount of any *TPD Cover* by the amount of *Trauma Cover benefit* paid. The *TPD Cover* ends if this reduces *TPD Cover* to less than $10,000.

We also reduce the amount of any *Life Care* by the amount of *Trauma Cover benefit* paid.

If you can claim both a Partial Trauma Cover benefit and a *TPD Cover benefit* for *partial and permanent disability* arising from the same condition, we pay the higher of the benefits, not both.

Partial Trauma Cover benefit

When we won't pay more than once

We won't pay a Partial Trauma Cover benefit more than once for:

- any of the Trauma Plus Cover conditions
- *benign brain tumour of limited extent*
- *critical care*
- *early-stage breast cancer*
- *early-stage cancer of the vulva or perineum*
- *early-stage melanoma*
- *early-stage prostate cancer*
- *loss of use of one limb*
- *multiple sclerosis of limited extent*
- *serious injury.*

Reduction of Trauma Cover

If we pay a Partial Trauma Cover benefit, we reduce the *Trauma Cover* by the amount we pay (including any Trauma Cover Loyalty Bonus benefit). The *Trauma Cover* ends if it's reduced to less than $10,000.

Loyalty Bonus benefit

Once cover is held for five years, automatically increases payment of the Trauma Cover benefit by 5%.

When we pay it

If the *life insured* meets the definition of a *Trauma Cover* condition or Trauma Plus Cover condition after the fifth anniversary of the *date insured from* and we pay a *Trauma Cover benefit* (including a Partial Trauma Cover benefit), we increase the benefit by 5%. The 5% increase doesn't apply to any Trauma Cover Severe Hardship Booster benefit (see page 60).

If the policy is reinstated or replaced

If this policy is reinstated or replaced by another policy (and we agree it's a replacement policy), we treat the reinstated or replacement policy (or this policy, if it's the replacement policy) as a continuation of the original policy to work out whether the fifth anniversary has occurred.

When working out if and when the fifth anniversary has occurred, we include the period that the policy was not in force and also the period in which the previous policy was in force.

We do this on the basis that the *Trauma Cover* and the Trauma Cover Loyalty Bonus benefit only restart from the date of reinstatement or replacement.

We won't pay a benefit for anything that happened or first became apparent while the policy was not in force.

Effect on other benefits

We reduce any *Life Care* and *TPD Cover* (including any loyalty bonus or booster benefits that apply) by the amount of the Trauma Cover Loyalty Bonus benefit.

Severe Hardship Booster benefit

Doubles the lump sum we pay for certain serious trauma conditions.

When we pay it

We pay this benefit if we pay a *Trauma Cover benefit* for one of the following:

- *diplegia*
- *hemiplegia*
- *loss of use of limbs or sight*
- *paraplegia*
- *quadriplegia*
- *severe burns*
- *tetraplegia.*

If this happens we increase the *Trauma Cover benefit* by the lesser of:

- 100%
- $250,000
- if *Life Care* applies to the *life insured* under this policy, the difference between that cover and your *Trauma Cover* when the *life insured* first met the definition of the condition
- if *flexi-linked Trauma Cover* applies, the difference between that cover and the *primary Life Care* when the *flexi-linked life insured* first met the definition of the condition.

This increase doesn't apply to any Trauma Cover Loyalty Bonus benefit.

Effect on other benefits

We reduce any *Life Care* and *TPD Cover* (including any loyalty bonus or booster benefits that apply) by the amount of the Trauma Cover Severe Hardship Booster benefit.

Trauma Reinstatement benefit and Trauma Reinstatement Booster option

The Trauma Reinstatement benefit is a built in feature of *Trauma Cover* but you can, at an additional cost, enhance the features of the benefit by taking out the Trauma Reinstatement Booster option.

Trauma Reinstatement benefit

Automatically reinstates Trauma Cover if we pay a Trauma Cover claim.

Trauma Reinstatement Booster option

An enhanced Trauma Reinstatement benefit that allows you to claim for extra Trauma Cover conditions under the reinstated cover.

When it applies

The Trauma Reinstatement benefit and Trauma Reinstatement Booster option only apply if:

- we pay a claim for the *Trauma Cover benefit* which reduces *Trauma Cover* to less than $10,000, and
- the definition of the Trauma Cover condition for which we paid the claim was met prior to the *policy anniversary date* before:
  - the *life insured's* 70th birthday or
  - for the Trauma Reinstatement Booster option, the *life insured's* 65th birthday.

If you took out the Trauma Reinstatement Booster option and it no longer applies, the Trauma Reinstatement benefit may still apply.

If the Trauma Reinstatement benefit or Trauma Reinstatement Booster option apply, the *Trauma Cover* is automatically reinstated to the amount that applied under the policy immediately before the *Trauma Cover* was reduced to less than $10,000.
This happens on the last day of the *buy back period*.

If this policy is a *flexi-linked policy* and the reinstated *Trauma Cover* is *flexi-linked Trauma Cover*, the reinstated cover can't exceed the amount of *primary Life Care* applying to the *flexi-linked life insured* when the reinstatement occurs.

When it doesn't apply

Neither the Trauma Reinstatement benefit nor the Trauma Reinstatement Booster option apply:

- if either have previously applied to the *Trauma Cover*
- if we have paid a *TPD Cover* or Terminal Illness benefit for the *life insured*
- if this policy is a *split TPD policy* and we have paid a *split TPD Cover benefit* for the *life insured* under this policy or the *super policy*

- if we pay a *Trauma Cover benefit* for *loss of independent existence*
- when the Trauma Cover ends or
- when this policy ends.

Reinstatement

If *Trauma Cover* is reinstated:

- any exclusions, medical, occupational or pastime loadings which applied to the original cover also apply to the reinstated cover
- all policy conditions apply to the reinstated cover except for:
  - the Trauma Reinstatement benefit and the Trauma Reinstatement Booster option
  - the Guaranteed Insurability option (both personal events and business events)
  - the Trauma Cover Loyalty Bonus benefit and
  - the Trauma Cover Severe Hardship Booster benefit.

When we pay

If none of the exclusions listed under 'When we won't pay' apply and your claim under the reinstated *Trauma Cover* is payable, we pay the *Trauma Cover benefit* provided for in the tables on pages 55 and 57.

If, however, you have the Trauma Reinstatement Booster option, the amount of the *Trauma Cover benefit* we pay may be limited for certain Trauma Cover conditions, as explained below under 'What happens if you have the Trauma Reinstatement Booster option'.

When we won't pay – exclusions

We won't pay a claim under the reinstated *Trauma Cover* for:

1. any Trauma Cover condition that first occurred or was first diagnosed, or the symptoms of which first became reasonably apparent, before the reinstatement of the *Trauma Cover*
2. the same Trauma Cover condition for which we paid a claim under the original *Trauma Cover*
3. a Trauma Cover condition which, in our opinion (as confirmed by a *relevant medical specialist* we nominate):
   - arises in connection with
   - is a complication of
   - results from or
   - is a treatment for

   a condition for which we paid a claim under the original *Trauma Cover*
4. any condition listed under 'Heart and vessels' in the 'Trauma Cover conditions' table on page 55, if under the original *Trauma Cover* we paid a claim for any one or more of the conditions listed
5. any condition listed under 'Cancer and tumours' in the tables on pages 55 and 57, if under the original *Trauma Cover* we paid a claim for any one or more of the conditions listed
6. *paraplegia, quadriplegia, hemiplegia, diplegia* or *tetraplegia* as a result of a *stroke*, if under the original *Trauma Cover* we paid a claim for any one or more of the conditions listed under 'Heart and vessels ' in the 'Trauma Cover conditions' table on page 55
7. any condition listed under 'Heart and vessels' in the 'Trauma Cover conditions' table on page 55, if under the original *Trauma Cover* we paid a claim for *paraplegia, quadriplegia, hemiplegia, diplegia* or *tetraplegia* as a result of a *stroke.*

What happens if you have the Trauma Reinstatement Booster option

If the Trauma Reinstatement Booster option appears on your policy schedule, we won't apply:

- the 2nd, 3rd or 4th exclusion under 'When we won't pay' if:
  - the claim under the reinstated *Trauma Cover* is for a condition listed under 'Heart and vessels' in the 'Trauma Cover conditions' table on page 55 and
  - we paid a claim under the original *Trauma Cover* for any one or more of the conditions listed under 'Heart and vessels'.
- the 2nd, 3rd or 5th exclusion under 'When we won't pay' if:
  - the claim under the reinstated *Trauma Cover* is for a condition listed under 'Cancer and tumours' in the tables on pages 55 and 57, and
  - we paid a claim under the original *Trauma Cover* for any one or more of the conditions listed under 'Cancer and tumours'.

If:

- we don't apply any one or more of the 2nd, 3rd, 4th and 5th exclusions to your claim under the reinstated *Trauma Cover* because you have the Trauma Reinstatement Booster option and
- the claim is payable because no other exclusion applies under 'When we won't pay' and you otherwise meet the policy conditions,

we limit any benefit payable under the reinstated *Trauma Cover* to that set out in the table on the following page:

If under the original ***Trauma Cover***, a claim was paid for any one or more of the Trauma Cover conditions:	If the Trauma Cover condition for which you claim under the reinstated ***Trauma Cover*** is:	How much we pay*
listed under 'Heart and vessels' in the 'Trauma Cover conditions' table on page 55	a condition listed under 'Heart and vessels' in the 'Trauma Cover conditions' table on page 55	10% of your *Trauma Cover*, maximum $50,000^
listed under 'Cancer and tumours' in the tables on pages 55 and 57	a condition listed under 'Cancer and tumours' in the tables on pages 55 and 57, except for *cancer*	10% of your *Trauma Cover*, maximum $50,000
	a *cancer* which is not a *second primary cancer*	10% of your *Trauma Cover*, maximum $50,000
	a *cancer* which is a *second primary cancer*	the *Trauma Cover benefit* provided for in the tables on pages 55 to 57

* A $10,000 minimum benefit payment applies if the benefit isn't $0 or calculated to be $0.

^ If the claim under the reinstated *Trauma Cover* is for *coronary artery angioplasty*, the maximum benefit we pay is $25,000.

Once we pay a benefit subject to the $25,000 or $50,000 maximum referred to in this table, we won't pay another benefit that is also subject to either of those maximums.

Trauma Cover Financial Planning benefit

Up to $5,000 to help cover the costs of financial advice.

Who we pay

We pay this benefit to the policy owner who receives the *Trauma Cover benefit*. If there is more than one policy owner, we pay the benefit to all policy owners jointly, even if only one policy owner claims it.

When we pay it

We pay this benefit if:

- we pay a *Trauma Cover benefit* (but not a Partial Trauma Cover benefit) and
- within 12 months after we pay the *Trauma Cover benefit*, a recipient of the benefit obtains financial planning advice from an accredited financial adviser.

To receive this benefit, the person claiming it must provide proof of the cost of the financial planning advice for which they're seeking reimbursement.

What we pay

We pay the cost of the approved financial planning advice but won't pay more than $5,000 in total for all claims for the benefit.

Example

Andrew and his wife Racheal together own a Total Care Plan policy. Trauma Cover of $150,000 applies on Andrew's life.

Unfortunately, several years after taking out the policy, Andrew is diagnosed with a benign brain tumour for which Andrew and Racheal receive a $150,000 Trauma Cover benefit from CommInsure. Racheal then arranges financial advice from an accredited financial planner to explore the available investment options. The advice costs $7,000.

Racheal pays the cost and seeks reimbursement of the $7,000 from CommInsure by submitting to CommInsure the financial planner's invoice as proof of the cost of the advice.

As the financial planning advice cost Racheal more than CommInsure's maximum benefit of $5,000, Andrew and Racheal are together paid a $5,000 Financial Planning benefit as part reimbursement of the cost of the financial planning advice.

Accommodation benefit

Helps cover the accommodation costs of an immediate family member who needs to stay nearby if due to a trauma you are confined to bed a long way from home.

When we pay it

We pay this benefit if:

- a *Trauma Cover benefit* has been paid or is payable, and
- on medical advice from a *medical practitioner* the *life insured* must stay more than 100 kilometres from their home or travel to a place more than 100 kilometres from their home, and
- the *life insured* is confined to bed due to the condition for which the *Trauma Cover benefit* has been paid or is payable, and
- an *immediate family member* is accommodated near the *life insured* (other than in their home) or has to stay away from their home.

What we pay

We pay up to $350 a day to help cover the costs of accommodating the *immediate family member*.

We pay this benefit for up to 30 days in each 12 month period commencing on:

- the date we first paid the benefit and
- each anniversary of that date.

When it ends

The benefit ends when the *Trauma Cover* ends.

Automatic indexation

Automatically increases Trauma Cover each year to help keep pace with inflation.

On each *policy anniversary date* we'll increase any *Trauma Cover*.

The rate of increase is the greater of:

- 3%
- any percentage increase in the Australian Consumer Price Index (CPI) (all groups – eight capital cities combined).

To work out the change in the CPI we'll compare the index figure published three months before your *policy anniversary date* with the index figure published in the corresponding period one year earlier. If the CPI isn't published, then we'll use another appropriate index.

Effect on your premium

When we increase the cover through indexation, we'll also increase the premium. The premium increase is based on:

- the increased cover
- the *life insured's* age next birthday (unless a Level premium applies and the *policy anniversary date* before the *life insured's* 65th birthday has not occurred)
- our then current premium rates for this class of policy and
- any special additional premium we've previously told you applies.

Any exclusion, additional premium or other special condition we've previously told you about will also apply to the increased cover.

When indexation doesn't apply

Automatic indexation won't apply while we're waiving premiums under the Plan Protection option.

If the *Trauma Cover* is *flexi-linked Trauma Cover* and *automatic indexation* doesn't apply to the *primary Life Care* under the *primary policy, automatic indexation* doesn't apply to the *flexi-linked Trauma Cover*. *Automatic indexation* increases in *flexi-linked Trauma Cover* only apply to the extent they don't result in the cover exceeding the *primary Life Care* applying to the *life insured* under the *primary policy*.

If you don't want indexation

You can choose not to accept this increase by telling us within one month of the *policy anniversary date*. You can phone or write to us.

Plan Protection option

You don't pay trauma premiums while you are totally and temporarily disabled.

To see how the Plan Protection option applies to this cover, please refer to page 37.

Guaranteed Insurability option (personal events)

Lets you increase Trauma Cover without providing more health information if you experience certain personal events.

See 'Guaranteed Insurability option (personal events)' on page 39.

Note: The Guaranteed Insurability option (personal events) is only available if *Life Care* applies to the *life insured*.

Guaranteed Insurability option (business events) and Business Safe Cover option

See 'Guaranteed Insurability option (business events) and Business Safe Cover option' on page 40.

Note: The Guaranteed Insurability option (business events) is only available if *Life Care* applies to the *life insured*.

Child Cover option

A lump sum if your child dies or meets the definition of a specified trauma.

You can only take out *Child Cover* if you first take out *Life Care* or stand-alone *Trauma Cover*.

When we pay it

We pay you the *Child Cover benefit* if the *insured child* dies or meets the definition of a Child Trauma Cover condition while *Child Cover* applies to them (subject to the qualifying period described on page 66).

The Child Trauma Cover conditions the *insured child* is covered for are shown in the table on the next page. These conditions have specific meanings which are set out in the 'Medical definitions' on page 148.

For certain Child Trauma Cover conditions (collectively called the Partial Child Trauma Cover conditions in this PDS), we only pay a part of the *Child Cover benefit* (a Partial Child Cover benefit) as shown in the following table.

Automatic indexation applies to this cover. Please refer to page 63.

Child Cover conditions

Body system	Condition	How much we pay*
Cancer and tumours	*benign brain tumour*	100%
	cancer	100%
Heart and vessels	*cardiac arrest*	100%
	cardiomyopathy	100%
	coronary artery angioplasty	10%
	coronary artery angioplasty – triple vessel	100%
	coronary artery bypass surgery	100%
	heart attack	100%
	open heart surgery	100%
	surgery of the aorta	100%
Brain and nerves	*bacterial meningitis*	100%
	coma	100%
	diplegia	100%
	encephalitis	100%
	hemiplegia	100%
	major head trauma	100%
	muscular dystrophy	100%
	paraplegia	100%
	quadriplegia	100%
	stroke	100%
	subacute sclerosing panencephalitis	100%
	tetraplegia	100%
Kidneys	*end stage kidney failure*	100%
Digestive system	*end stage liver failure*	100%
Respiratory	*chronic lung disease*	100%
Ear, nose and throat	*loss of hearing*	100%
	loss of speech	100%
Eye	*blindness*	100%
Musculoskeletal	*loss of use of limbs or sight*	100%
	loss of use of one limb	10%
	severe rheumatoid arthritis	100%
Blood	*aplastic anaemia*	100%
	medically acquired HIV	100%
Other	*critical care*	10%
	major organ or bone marrow transplant	100%
	severe burns	100%
	serious injury	10%

* The percentages are expressed as a percentage of the amount of *Child Cover* applying to the *insured child*. A $10,000 minimum benefit payment applies if the benefit isn't $0 or calculated to be $0.

What exclusions apply

We won't pay a *Child Cover benefit*, including a Partial Child Cover benefit, if:

- the Child Trauma Cover condition is caused directly or indirectly by any intentional self-inflicted injury or any attempt at suicide
- the qualifying period applies
- the *insured child's* death or Child Trauma Cover condition is caused by a malicious act of the *insured child's* parent or guardian or by a malicious act of someone who lives with or supervises the *insured child* and who is acting in collusion with the *insured child's* parent or guardian, or
- the *insured child's* death is caused by suicide and the suicide occurs within one year from:
  - the date the *Child Cover* first applied to the *insured child*
  - the date on which the policy was last reinstated or
  - the date of an increase to the *Child Cover* (the exclusion will then apply only to the amount of the increase).

Partial Child Cover benefit

Reduction of Child Cover

If we pay a Partial Child Cover benefit we reduce the *Child Cover* by the amount we pay (including any Child Cover Loyalty Bonus benefit). The *Child Cover* ends if it reduces to less than $10,000.

When it ends

Child Cover ends for an *insured child* on the earliest of:

- the *cover expiry date* for *Child Cover*
- the death of the *insured child*
- the cover reduces to less than $10,000
- when this policy ends
- we pay a benefit for a Child Trauma Cover condition other than a Partial Child Trauma Cover condition.

Restrictions

If we pay the *Child Cover benefit* for death we won't pay it for any of the Child Trauma Cover conditions.

We won't pay the Partial Child Cover benefit more than once for:

- *coronary artery angioplasty*
- *critical care*
- *loss of use of one limb*
- *serious injury.*

Qualifying period

What conditions does it apply to?

A 90 day qualifying period applies to the following Child Trauma Cover conditions:

- *cancer*
- *coronary artery angioplasty*
- *coronary artery angioplasty – triple vessel*
- *coronary artery bypass surgery*
- *heart attack*
- *stroke.*

When does it apply?

The qualifying period applies if the procedure, or the symptoms or diagnosis of the condition occurred, or the circumstances leading to the procedure or the condition became apparent, either before or within the first 90 days from:

- the *date insured from*
- the date of any increase to the *Child Cover* other than by *automatic indexation* (in which case the qualifying period applies only to the amount of the increase)
- the date the *Child Cover* was first added or reinstated to this policy or
- the date the *Child Cover* first applied to the *insured child*.

What happens if it applies?

If the qualifying period applies to the condition or procedure, we won't pay the *Child Cover benefit* for that procedure or condition or for any other procedure or condition which is directly or indirectly caused by, or related to, that procedure or condition.

If replacing other child cover

If we've agreed to replace existing child cover you have which is itself subject to a qualifying period of at least 90 days, the qualifying period under this Child Cover option for the same Child Trauma Cover conditions is the lesser of:

- 90 days
- any unexpired qualifying period under the child cover being replaced (including a qualifying period applied to the cover after it first started, for example, reinstatement or increases).

If the qualifying period under the child cover being replaced has expired, we waive the qualifying period under this Child Cover option for the same conditions and procedures.

If the *Child Cover* under this policy exceeds the child cover being replaced, we apply the full 90 day qualifying period to the difference in cover.

Other insurances

We may reduce the amount of the *Child Cover benefit* payable (to nothing if necessary) if a benefit is payable for the *insured child* under any other policies of insurance similar to the *Child Cover*.

We'll calculate the reduction on the basis that the amount of the *Child Cover benefit* payable, when added to any other benefit payable for the *insured child*, doesn't exceed $250,000 or a greater amount at our discretion. In calculating the reduction, we won't take into account any cover you told us about before the *Child Cover* first started.

If, having made the reduction, the amount of *Child Cover benefit* paid is less than the amount for which you've been paying premiums, we'll refund the additional premium you've paid over the previous 12 months. We'll base this refund on the premium which would have applied to the *Child Cover benefit* actually paid out.

Child Cover Loyalty Bonus benefit

Once cover applies for five years, automatically increases payment of the Child Cover benefit by 5%.

When we pay it

If the *insured child* dies or meets the definition of a Child Trauma Cover condition after the fifth anniversary of the *date insured from* and we pay a *Child Cover benefit* (including a Partial Child Cover benefit) we'll increase the benefit by 5%.

If the policy is reinstated or replaced

If this policy is reinstated or replaced by another policy (and we agree it's a replacement policy), we treat the reinstated or replacement policy (or this policy, if it's the replacement policy) as a continuation of the original policy to work out whether the fifth anniversary has occurred.

When working out if and when the fifth anniversary has occurred, we'll include the period that the policy was not in force and also the period that the previous policy was in force.

We do this on the basis that the *Child Cover* and Child Cover Loyalty Bonus benefit only restart from the date of reinstatement or replacement.

We won't pay a benefit for anything that happened or first became apparent while the policy was not in force.

Please note we treat a policy issued under the Child Continuation option as a replacement policy.

Child Continuation option

Replace Child Cover without providing more health information.

Within 30 days before the *cover expiry date* for *Child Cover*, either:

- the *insured child* can ask us in writing to provide death and trauma cover under a new individual policy on his or her life, or
- you, as the owner of the policy under which the *Child Cover* is issued, can ask us to replace the *Child Cover* with an equivalent amount of *Life Care* and *Trauma Cover* under this policy on the *insured child's* life.

If we receive a request from both the *insured child* and the owner of this policy, only the first request received by us is effective. The second request is invalid. If both requests are received at the same time, the *insured child's* request applies to the exclusion of the other request.

If we receive such a request, we will issue the policy or the replacement cover under this policy, as applicable, without requesting medical evidence if:

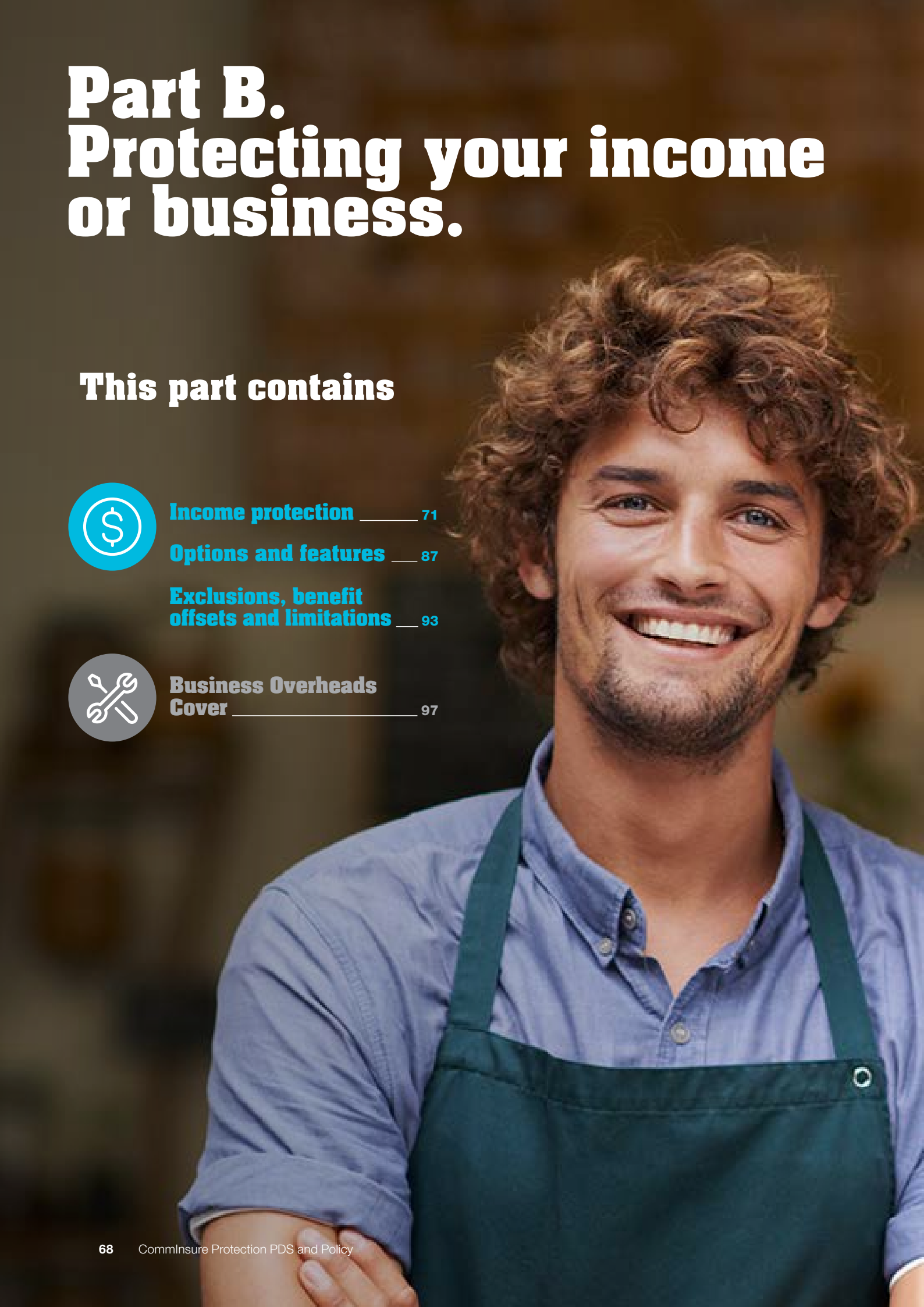
- the cover for the *insured child* under this policy ends on the *cover expiry date* for *Child Cover* and no earlier
- this policy is still in force on the *cover expiry date* for *Child Cover*
- the premium for the *insured's child's* cover under this policy isn't overdue as at the *cover expiry date* for *Child Cover*
- we receive the first premium for the new policy or the replacement cover, as applicable, before the *cover expiry date* for *Child Cover*
- we're not paying or intending to pay a benefit for the *insured child* under this policy and no circumstances exist which, if the subject of a claim under this policy, would result in us paying a benefit for the *insured child*
- our minimum policy issue requirements are met for the new policy
- our underwriting requirements are met.

We issue the new death and trauma cover:

- under this policy as *Life Care* and *Trauma Cover* or
- under a new individual policy owned by the *insured child*
- providing death and trauma cover, as applicable
- in an amount no greater than the amount of *Child Cover* which applied to the *insured child* under this policy on the day before the *cover expiry date* for *Child Cover*
- effective from the day after the *cover expiry date* for *Child Cover*
- on the terms and at the premium rates current for the individual policy or the *Life Care/Trauma Cover* under this policy, as applicable, when it's issued
- without the benefit of any of the optional features which can be selected under the individual policy or this policy, as applicable, (including Trauma Plus Cover) unless we agree otherwise
- with the same premium loadings, exclusions and special conditions that applied to the *Child Cover* for the *insured child* under this policy when the cover ended
- on the condition that there was no misrepresentation, or failure to comply with the duty of disclosure, under the Insurance Contracts Act 1984 (Cth) or any comparable legislation when the *Child Cover* for the *insured child* was applied for.

Part B. Protecting your income or business.

This part contains



What the words mean

Some of the words we use are defined terms that have a particular meaning. These words are italicised and are explained in the definitions section that starts on page 130.

We strongly recommend that you refer to the definitions as you read the policy terms, so you understand what we mean by terms such as *totally disabled, partially disabled* and so on.

What we mean by 'you'

One word that gets used a lot in the policy terms is 'you'. 'You' means the person or persons who apply for the policy and become the policy owner(s) when we issue the policy. The policy owner may also be the person whose life is insured under the policy, i.e. the *life insured*, but this won't always be the case.

If the policy is a *super policy*, the trustee of the super fund is always the policy owner and the fund member is always the *life insured*. So for Total Care Plan Super, 'you' means the trustee of the FirstChoice Trust and, for the SMSF Plan, 'you' means the trustee of the SMSF.

The person who is the policy owner is shown in the policy schedule.

What type of cover do I have?

The income protection you are covered for depends on the type of cover you take out. You can take out:

- **Essential Cover** – covers you for accidents only. You can take this either inside or outside super.
- **Income Care** – covers you outside super for the basic benefits.
- **Income Care Plus** – covers you outside super for the basic benefits plus extras at an additional cost.
- **Income Care Platinum** – covers you outside super for all the Income Care Plus benefits plus, at an additional cost, the three-tier Total Disability definition and a more flexible waiting period.
- **Income Care Super** – covers you inside super under the FirstChoice Trust.
- **Income Protection** – covers you inside super under your SMSF.

The schedule to your policy shows the type of cover you have.

Inside/outside super

As income protection inside and outside super differs, we explain the differences.

Split IP

If this policy is a s*plit IP policy* and it refers to a term, expression or feature under the other *split IP policy*, then that term, expression or feature has the meaning it has under the other policy.

Income protection – works when you're unable to.

Income protection

Put simply, income protection generally pays up to 75% of your income when you're unable to perform all or part of your occupation due to injury or sickness.

It also offers a host of features to help cover other costs that might come up in this situation.

If you don't qualify for full income protection because of your health, you may instead be eligible for our Essential Cover which is income protection for accidents only (not sickness). It's also generally a cheaper income protection option.

Income protection summary

The table below tells you what benefits, features and options apply to your income protection, depending on whether you have taken out Income Care, Income Care Plus, Income Care Platinum, Income Care Super or Income Protection under the SMSF Plan. This table doesn't apply to Business Overheads Cover, which is explained from page 97.

Please make sure you also read 'Exclusions, benefit offsets and limitations' from page 93. This is important information which applies to all types of income protection.

We pay all benefits in Australian dollars directly to you, except for any part of a benefit consisting of the *super continuance monthly benefit*, which we pay on your behalf to your super plan. We pay benefits monthly in arrears (i.e. in the month after the month in which you became entitled to the benefit).

For income protection inside super, all benefits are paid to the trustee of the super fund (either the trustee of the FirstChoice Trust or SMSF).

Benefits

Benefit	A brief explanation...	Outside super			Inside super		For full details see page...
		Income Care	Income Care Plus	Income Care Platinum	Income Care Super	SMSF Plan	
Total Disability benefit	A monthly benefit to help replace lost income if you're unable to work at all due to disability	✔	✔	✔	✔	✔	76
Three-tier Total Disability definition	Pays a Total Disability benefit, not only if you're unable to work at all due to disability, but also if you're working up to 10 hours a week or earning up to 20% of your pre-disability income	–	–	✔	–	–	146
Partial Disability benefit	A partial monthly benefit to help replace lost income if you're disabled but can still work	✔	✔	✔	✔	✔	76
Recurrent Disability benefit	Allows you to continue your original claim without satisfying the waiting period again if your disability reoccurs within 12 months	✔	✔	✔	✔	✔	77
Boosted Total Disability benefit	Boosts the monthly benefit by one third if you are totally disabled by a serious medical condition	✔	✔	✔	✔	✔	77
Medical Professionals benefit	A lump sum benefit if you are a medical professional whose work is affected by an HIV or hepatitis infection	✔	✔	✔	–	–	78

Benefit	A brief explanation...	Outside super			Inside super		For full details see page...
		Income Care	Income Care Plus	Income Care Platinum	Income Care Super	SMSF Plan	
Reward Cover benefit	Up to $100,000 of Accidental Death Cover at no extra cost after you've held your income protection for three years	✔	✔	✔	✔	✔	79
Rehabilitation benefit	A benefit if you are totally or partially disabled and participate in an approved occupational rehabilitation program	✔	✔	✔	–	–	79
Involuntary Unemployment Cover benefit for CBA Group loans	A monthly benefit for up to three months to help cover CBA minimum monthly loan repayments if you've been involuntarily unemployed for more than 60 consecutive days	✔	✔	✔	–	–	80
Income Care Super Death benefit	A $10,000 lump sum if you die while covered under Income Care Super	–	–	–	✔	–	81
Specific Injuries benefit	A monthly benefit, if the injury you suffer was caused by a specified medical event. We pay even if you can return to work	–	✔	✔	–	–	82
Crisis benefit	A lump sum if you are diagnosed with one of 19 specified medical conditions, whether or not you can return to work	–	✔	✔	–	–	83
Accommodation benefit	Helps cover the cost of accommodating an immediate family member nearby if you become totally disabled and need to stay a long way from home to receive treatment	–	✔	✔	–	–	83
Family Support benefit	Subsidises an immediate family member's lost income for up to three months if they have to take time off work to care for you while totally disabled	–	✔	✔	–	–	84
Home Care benefit	Helps cover the cost of a professional housekeeper for up to six months if you are totally disabled and confined to, or near, a bed after the waiting period	–	✔	✔	–	–	84
Rehabilitation Expenses benefit	Helps cover the expenses of participating in an approved occupational rehabilitation program or trying to return to work (e.g. making structural changes to the office) when you are totally disabled	–	✔	✔	–	–	85
Bed Confinement benefit	Helps cover the additional costs incurred if you are totally disabled and confined to bed for at least three days continuously during the waiting period	–	✔	✔	–	–	85
Death benefit	Helps meet expenses by paying a lump sum if you die	–	✔	✔	–	–	85
Transportation benefit	Helps cover the cost of emergency transport to an Australian hospital if required by your total disability	–	✔	✔	–	–	85

Benefit	A brief explanation…	Outside super			Inside super		For full details see page…
		Income Care	Income Care Plus	Income Care Platinum	Income Care Super	SMSF Plan	
Overseas Assist benefit	Helps cover the cost of an economy air fare to return to Australia if you are totally disabled for at least a month while overseas	–	✔	✔	–	–	86
Domestic Help benefit	Helps cover the cost of hiring a housekeeper or child-minder when your spouse can't perform domestic duties due to injury	–	✔	✔	–	–	86

Essential Cover

Cover	A brief explanation…	Outside super			Inside super		For full details see page…
		Income Care	Income Care Plus	Income Care Platinum	Income Care Super	SMSF Plan	
Essential	Income protection for accidents only	✔	–	–	✔	✔	81

Features

Income protection also provides a range of other built in features that make your cover more flexible. For more information refer to page 89 under 'Features'.

Feature	A brief explanation…	Outside super		Inside super		For full details see page…
		Income Care, Income Care Plus	Income Care Platinum	Income Care Super	SMSF Plan	
Waiving premiums while paying benefits	We waive income protection premiums while paying monthly benefits	✔	✔	✔	✔	89
Waiving premiums for personal circumstances	Don't pay income protection premiums for up to six months if you're unemployed, on parental leave or experiencing financial hardship	✔	✔	✔	✔	89
Waiver of waiting period for specific conditions	For claims for certain medical conditions you don't have to meet the waiting period	✔	✔	✔	✔	90
Automatic indexation	Automatically increases cover each year to help keep pace with inflation	✔	✔	✔	✔	90
Guaranteed insurability	Lets you increase your cover in line with income without providing further health evidence	✔	✔	✔	✔	91
Reduced waiting period	Lets you reduce your waiting period without providing further health evidence if your income protection with an employer or super fund ends	✔	✔	✔	✔	91
Extended cover	Extends your income protection by five years	✔	✔	✔	✔	92
Continuation option	Continue Total Care Plan Super income protection outside super without providing further health evidence	–	–	✔	–	92

Options (at an additional cost)

Income protection also provides a range of options that make your cover more flexible. The optional extras only apply to your policy if they appear in your policy schedule.

Option	A brief explanation...	Outside super		Inside super		For full details see page...
		Income Care Income Care Plus	Income Care Platinum	Income Care Super	SMSF Plan	
Permanent Disablement Cover	A lump sum instead of the normal monthly benefits we would pay	✔	✔	–	–	87
Increasing Claim	Increases claim payments to help keep pace with inflation	✔	✔	✔	✔	87
Accident	A benefit if total disability occurs during the waiting period due to an accident	✔	✔	✔	✔	88
Super Continuance	Covers your super contributions	✔	✔	–	–	88

Exclusions

Type of exclusion	What benefit does the exclusion apply to?	For full details see page...
◆ Pre-existing condition ◆ War ◆ Self-inflicted injury or attempted suicide ◆ Misconduct ◆ Elective surgery	◆ All income protection benefits including Essential Cover	81 and 93
◆ Suicide or attempted suicide ◆ Self-inflicted injury or infection ◆ War ◆ Jail	◆ Reward Cover benefit	79
◆ Alcohol ◆ Drugs ◆ Criminal activity	◆ Reward Cover benefit ◆ Essential Cover	79 and 81
◆ Approved HIV or hepatitis infection treatment	◆ Medical Professionals benefit	78
◆ Dental injury ◆ Self-inflicted infection	◆ Essential Cover	81
◆ No CBA Group loan ◆ Non-continuous unemployment ◆ Working overseas ◆ Work ending status ◆ Serious misconduct ◆ Voluntary unemployment ◆ Qualifying period	◆ Involuntary Unemployment Cover benefit for CBA Group loans	80

Waiting period

A *waiting period* applies to all of our income protection products and also to Business Overheads Cover.

This is the period for which the *life insured* must be *totally disabled* or *partially disabled* from the same *sickness* or *injury* to qualify for a Total or Partial Disability benefit or a Business Overheads Cover benefit.

Income Care, Income Care Plus, Income Care Super, SMSF Plan and Business Overheads Cover

The *waiting period* starts on the date the *life insured* first consults a *medical practitioner* about the condition causing the *total disability* or, for Income Care Plus policies where the *life insured's occupation group* is S, K, J or P, *partial disability*.

If, however:

- the *life insured* first ceases work or, in the case of *partial disability*, works in a reduced capacity due to the relevant condition no more than seven days before they first consulted a *medical practitioner* about the condition and
- you provide us with reasonable medical evidence about when the *total* or *partial disability* started we treat the *waiting period* as having started on the date the *life insured* first ceased work or worked in a reduced capacity, as applicable.

The following rules apply to the *waiting period*:

- For all income protection and Business Overheads Cover policies (except Income Care Plus or Business Overheads Cover where the *life insured's occupation group* is S, K, J or P) the *life insured* must be *totally disabled* for at least 14 out of the first 19 consecutive days of the *waiting period* to qualify for a Total Disability benefit, a Partial Disability benefit or a Business Overheads Cover benefit.
- For Income Care Plus and Business Overheads Cover policies where the *life insured's occupation group* is S, K, J or P, the *life insured* must be *partially disabled* or *totally disabled* for at least 14 out of the first 19 consecutive days of the *waiting period* to qualify for a Partial Disability benefit, a Total Disability benefit or a Business Overheads Cover benefit, if applicable.
- After the *waiting period* begins, the *life insured* can return to work at full capacity but if they do so we extend the *waiting period* by the number of days worked. If the *life insured* returns to work at full capacity for more than five consecutive days (where the *waiting period* is one month or less) or for more than 10 consecutive days (where the *waiting period* is more than one month), the *waiting period* starts again.
- If the *sickness* or *injury* from which the *life insured* suffers is directly or indirectly related to pregnancy, childbirth or miscarriage (including post-natal depression), the *waiting period* won't begin any earlier than the last day of a three month period during which the *life insured* has been continuously *totally disabled* or *partially disabled* from the relevant *sickness* or *injury*. If the *life insured* is not so disabled for the three month period, the *waiting period* won't begin and no benefit is payable.

Income Care Platinum

The *waiting period* starts on the date the *life insured* first consults a *medical practitioner* about the condition causing the *total disability* or, where the *life insured's occupation group* is S, K, J or P, *partial disability*.

If, however:

- the *life insured* first ceases work or, in the case of *partial disability*, works in a reduced capacity due to the relevant condition no more than seven days before they first consulted a *medical practitioner* about the condition and
- you provide us with reasonable medical evidence about when the *total* or *partial disability* started we treat the *waiting period* as having started on the date the *life insured* first ceased work or worked in a reduced capacity, as applicable.

The following rules apply to the *waiting period*:

- Where the *life insured's occupation group* is G, C, L, M, A or X, the *life insured* must be *totally disabled* for at least 14 out of the first 19 consecutive days of the *waiting period* to qualify for a Total Disability benefit or a Partial Disability benefit.
- Where the *life insured's occupation group* is S, K, J or P, the *life insured* must be *partially disabled* or *totally disabled* for at least 14 out of the first 19 consecutive days of the *waiting period* to qualify for a Partial Disability benefit or a Total Disability benefit.
- After a *waiting period* of more than three months begins, the *life insured* can return to work at full capacity but if they do so we extend the *waiting period* by the number of days worked. If the *life insured* returns to work at full capacity for more than five consecutive days (where the *waiting period* is one month or less) or for more than 10 consecutive days (where the *waiting period* is more than one month), the *waiting period* starts again.
- After a *waiting period* of three months or less begins, the *waiting period* won't ever be extended and only starts again if in a month you're not at least *partially disabled*.
- If the *sickness* or *injury* from which the *life insured* suffers is directly or indirectly related to pregnancy, childbirth or miscarriage (including post-natal depression), the *waiting period* won't begin any earlier than the last day of a three month period during which the *life insured* has been continuously *totally disabled* or *partially disabled* from the relevant *sickness* or *injury*. If the *life insured* is not so disabled for the three month period, the *waiting period* won't begin and no benefit is payable.

Total Disability benefit

A monthly benefit to help replace lost income if you're unable to work at all due to disability.

Under our Income Care Platinum three-tier total disability definition, a Total Disability benefit is paid, not only if you're unable to work at all due to disability, but also if you're working up to 10 hours a week or earning up to 20% of your pre-disability income.

What we pay

If the *life insured* is *totally disabled*, we pay the Total Disability benefit.

For a *super policy*, the Total Disability benefit is the *monthly benefit*.

For an *ordinary policy*, the Total Disability benefit is the total of the *monthly benefit* and any *super continuance monthly benefit*.

Split IP

If *split IP* applies, the Total Disability benefit we pay under the *split IP ordinary policy* is reduced by the amount of any Total Disability benefit or Partial Disability benefit payable under the *split IP super policy*. If the benefit is reduced to nil, it is not payable under the *split IP ordinary policy*.

When we start paying

The Total Disability benefit starts to accrue from the first day after the *waiting period* has ended. For the benefit to start to accrue, the *life insured* must be *totally disabled* by the same *sickness* or *injury* beyond the *waiting period*.

We then start paying the benefit monthly in arrears (i.e. in the month after the month in which you became entitled to the benefit).

When we stop paying

We pay the Total Disability benefit until the first of the following occurs:

- the *benefit period* ends
- the *life insured* is no longer *totally disabled*
- the policy ends
- the *cover expiry date* for income protection
- the *life insured* dies
- we pay a *Permanent Disablement benefit* for the *life insured under* the Permanent Disablement Cover option (see page 87)
- the *life insured* unreasonably refuses to undergo medical treatment for their *total disability* as recommended by their *medical practitioner*, including participation in an *approved occupational rehabilitation program*.

Partial Disability benefit

A partial monthly benefit to help replace lost income if you can only work in a reduced capacity due to disability.

What we pay

If the *life insured* is *partially disabled*, we pay the Partial Disability benefit.

We calculate the benefit using this formula:

$$\frac{(A - B)}{A} \times C$$

where:

- A is the *life insured's pre-disability income*
- B is the life *insured's monthly income* for the month for which you're claiming *partial disability*
- C is your *monthly benefit* plus any *super continuance monthly benefit*.

Income Care Platinum – If, for reasons other than *sickness* or *injury*, the *life insured* has not in our opinion been working to their capability for at least two consecutive months, 'B' also includes any *monthly income* the *life insured* could reasonably be expected to earn if they were working to the extent of their capability. In determining this, we will consider all available medical evidence and any other relevant matters.

Example

Natasha earns $4,000 a month before tax and has an Income Care policy with a monthly benefit of $3,000 and no super continuance monthly benefit. When she becomes partially disabled as a result of a car accident, she can only work 20 hours a week and earns $2,500 a month before tax.

We calculate Natasha's Partial Disability benefit like this:

- A is $4,000
- B is $2,500
- C is $3,000.

$$\frac{(\$4{,}000 - \$2{,}500)}{\$4{,}000} \times \$3{,}000$$

As Natasha is still earning $2,500 per month, the formula shows that we need to pay her a Partial Disability benefit of $1,125.

If *split IP* applies, the Partial Disability benefit we pay under a *split IP ordinary policy* is reduced by the amount of any Total Disability benefit or Partial Disability benefit payable under the *split IP super policy*. If the benefit is reduced to nil, it is not payable under the *split IP ordinary policy*.

When we start paying

The Partial Disability benefit starts to accrue from the first day after the *waiting period* has ended. For the benefit to start to accrue, the *life insured* must be *partially disabled* by the same *sickness* or *injury* beyond the *waiting period*.

We then start paying the benefit monthly in arrears (i.e. in the month after the month in which you became entitled to the benefit).

When we stop paying

We pay the Partial Disability benefit until the first of the following occurs:

- the *benefit period* ends
- the *life insured* is no longer *partially disabled*
- the policy ends
- the *cover expiry date* for income protection
- the *life insured dies*
- if the *life insured's occupation group* is A, H, X or Y, the date two years after the date we started paying the Partial Disability benefit
- we pay a *Permanent Disablement benefit* for the *life insured* under the Permanent Disablement Cover option (see page 87)
- the *life insured* unreasonably refuses to undergo medical treatment for their *partial disability* as recommended by their *medical practitioner*, including participation in an *approved occupational rehabilitation program*.

Unemployment and leave without pay

If the *life insured* becomes *unemployed* or goes on leave without pay while we're paying a Partial Disability benefit, the maximum benefit we pay is:

- for a *super policy*, 75% of your *monthly benefit*
- for an *ordinary policy*, 75% of the total of your *monthly benefit* and any *super continuance monthly benefit*.

If, in this situation, *split IP* applies, the maximum amount we pay in total for the Partial Disability benefit under both policies is 75% of the total of the *monthly benefit* and any *super continuance monthly benefit* under the *split IP ordinary policy*.

If income is reduced to less than 20%

For an *ordinary policy* other than an Income Care Platinum policy, we pay a Total Disability benefit, instead of a Partial Disability benefit, for up to six months if:

- the *life insured* has been *totally disabled* for at least the *waiting period* and then returns to work on a partial basis and
- because of the *life insured's partial disability*, their *monthly income* is 20% or less of their *pre-disability income* or they are working for ten hours or less per week.

We'll only continue to pay the Total Disability benefit while we're satisfied the *life insured* remains *partially disabled* in the terms described on page 76.

Becoming totally disabled

If the *life insured* becomes *totally disabled* by the same, or a related, *sickness* or *injury* for which we're paying a Partial Disability benefit, the Partial Disability benefit ends and the Total Disability benefit starts to accrue instead.

Recurrent Disability benefit

Allows you to continue your original claim without satisfying the waiting period again if your disability reoccurs within 12 months.

What it does

If you make separate claims for the same or a related *disability*, in certain circumstances we'll treat the second claim as a continuation of the original claim and waive the *waiting period* on the second claim.

We do this if all of the following applies:

- the *life insured* has returned to work on a full time basis:
  - after receiving a Total Disability benefit, Partial Disability benefit or Specific Injuries benefit or
  - after six months after receiving a Crisis benefit or
  - if the Specific Injuries benefit is paid as a lump sum, after the period over which the benefit would have been paid had it been paid as a *monthly benefit* and not a lump sum
- the *life insured* suffers a recurrence of the same or a related condition, and
- the recurrence results in *disability* within 12 months from the date the *life insured* was last on claim but before the *cover expiry date* for income protection.

The date last on claim

For certain benefits, we consider the date the *life insured* was last on claim to be:

- for the Crisis benefit, the date six months after the benefit was payable
- for a lump sum Specific Injuries benefit, the last day of the period over which we would have paid the benefit if you had taken it as a *monthly benefit*.

Two and five year benefit periods

If your *benefit period* is two or five years, the *disability* must result within six months from the date the *life insured* was last on claim but before the *cover expiry date* for income protection.

Boosted Total Disability benefit

Boosts the monthly benefit by one third if you are totally disabled by a serious medical condition.

When it applies

This benefit applies if we agree to pay a *total disability* claim and we're satisfied the *life insured's total disability* is such that they are in a *serious medical condition*.

What it does

To calculate the Total Disability benefit payable, we use the following formula to work out the *monthly benefit*:

A × (1 + 1/3)

in which A is the amount of the *monthly benefit* determined under the definition on page 140.

> **Note**: This more generous calculation of the *monthly benefit* only applies when we're calculating the Total Disability benefit and not when we're calculating a *Permanent Disablement,* a *super continuance monthly benefit* or any other benefit under this policy.

If *split IP* applies, the Boosted Total Disability benefit we pay under the *split IP ordinary policy* is reduced by the amount of any Total Disability benefit (whether boosted or not) or Partial Disability benefit payable under the *split IP super policy*. If the benefit is reduced to nil, it is not payable under the *split IP ordinary policy*.

Medical Professionals benefit

A lump sum benefit if you are a medical professional whose work is affected by an HIV or hepatitis infection.

When it applies

This benefit applies to you if the policy is an *ordinary policy* and, when your cover starts, the *life insured* is practising in a medical profession.

By 'practising in a medical profession' we mean the *life insured's occupation group* is K or the *life insured* is one of the following:

- dermatologist
- gastroenterologist
- gynaecologist
- haematologist
- nephrologist
- neurologist
- oncologist
- ophthalmologist
- paediatrician
- pathologist (degree qualified)
- radiologist (medical degree qualified) or
- rheumatologist

where the *life insured* is registered to practise their medical profession, with registration regulated by an Act of Parliament of an Australian state or territory.

The cover applies while the *life insured* is practising a medical profession in terms of these requirements and, in practising their medical profession, they have been:

- performing or assisting in *exposure-prone medical procedures* monthly on average or more frequently
- making reasonable efforts to comply with relevant and readily available current state and Commonwealth departmental guidelines dealing with infection of health care workers.

What we pay

We pay the lesser of:

- $100,000, and
- six times the total of your *monthly benefit* and any *super continuance monthly benefit*

but never less than $10,000.

When we pay it

We pay this benefit if:

- the *life insured* contracts a persistent infection of the Human Immunodeficiency Virus (HIV), Hepatitis B or Hepatitis C and
- as a result of the infection, the *life insured* ceases to perform or assist in *exposure-prone medical procedures* in compliance with both their demonstrable professional obligations to the public and the demonstrable policies of the registered authority, board, association or body which authorises or licenses the *life insured* to practice in their medical profession.

We pay this benefit whether or not the *life insured* acquired the infection as a result of practising their medical profession.

We pay this benefit in addition to any other benefit, but only once for each *life insured*.

What exclusions apply

We won't pay this benefit if, before the *life insured* suffers from the relevant infection, the Australian Government or relevant government body has approved a medical treatment which if applied to the *life insured*:

- would be likely to make it improbable that the infection could be transmitted to patients for whom the *life insured* performs or assists in medical procedures and
- would allow the registered authority, board, association or body which authorises or licenses the *life insured* to practise their medical profession, to permit the *life insured* to perform or assist in *exposure-prone medical procedures*.

Reward Cover benefit

Up to $100,000 of Accidental Death Cover at no extra cost after you've held your income protection for three years.

We give you $50,000 Accidental Death Cover on the third anniversary of the date the *life insured* was first covered under this policy.

We then increase the Accidental Death Cover by $10,000 on each anniversary after the third anniversary until the cover reaches $100,000 in total.

Policy anniversary	Amount of Accidental Death Cover
3rd	$50,000
4th	$60,000
5th	$70,000
6th	$80,000
7th	$90,000
8th	$100,000

The Accidental Death Cover starts on the third anniversary and ends on the date the income protection or Business Overheads Cover for the *life insured* ends under this policy.

Note: The Reward Cover benefit does not apply under a *split IP ordinary policy.*

What we pay

We pay the amount of Accidental Death Cover that applies on the date of the *life insured's* death.

We increase the benefit we pay by 100% if, when the *life insured* dies, the *life insured*:

- is also a policy owner under this policy and
- has a Total Care Plan policy with us, either alone or jointly.

When we pay it

We pay this benefit if:

- the *life insured* dies as a result of an *accident* within 90 days of the *accident* occurring and
- the death occurs before your Accidental Death Cover ends.

What exclusions apply

We won't pay this benefit if death is caused directly or indirectly by:

- suicide or any attempt at suicide
- self-inflicted injury or infection
- the taking of alcohol
- the taking of drugs other than as prescribed by a *medical practitioner*
- participating in criminal activity, or
- an act of war (whether declared or not).

We won't pay this benefit if the *life insured* dies while he or she is serving a jail sentence.

If the policy is reinstated or replaced

If this policy is reinstated or we agree to replace it with another policy, we treat the reinstated or replacement policy as a continuation of the original policy on the following basis:

- if you already have Accidental Death Cover, it only restarts from the date of reinstatement or replacement and we won't pay a benefit if, while the policy was not in force, the *life insured* dies or the *accident* resulting in the *life insured's* death occurs
- when working out whether an anniversary has occurred and the amount of your Accidental Death Cover, we include the period the policy wasn't in force and also the period that the previous policy was in force.

Rehabilitation benefit

A benefit if you are totally or partially disabled and participate in an approved occupational rehabilitation program.

You can claim this benefit if the policy is an *ordinary policy* and:

- we pay you a Total Disability benefit or a Partial Disability benefit for a period of *disability* before the *cover expiry date* for income protection and
- during that period, the *life insured* is actively participating and co-operating in an *approved occupational rehabilitation program* which we've approved in advance and agree is designed to assist the *life insured* return to the paid work they were performing in their own occupation before their *disability* (or, where medically necessary, a new occupation).

If *split IP* applies, you can still claim this benefit under the *split IP ordinary policy* even if we're paying all the Total Disability benefits or Partial Disability benefits under the *split IP super policy*.

What we pay

We pay the cost of the *approved occupational rehabilitation program* directly to the accredited occupational rehabilitation provider.

The maximum amount payable for the benefit over the life of the policy is the lesser of:

- 12 times the total of the *monthly benefit* and any *super continuance monthly benefit*
- $30,000.

The benefit is paid in addition to any other benefit under this policy.

When we pay it

The cost of the *approved occupational rehabilitation program* is payable for each month the *life insured* participates in the program but is only paid once the requirements on page 79 are met. Where benefits are payable for part of a month, the benefit is divided by 30 to arrive at a daily benefit.

When it ends

The benefit ends on the first of the following:

- we've paid the maximum amount of the benefit
- when the provider of the *approved occupational rehabilitation program* indicates the rehabilitation goal is unlikely to be achieved in the expected timeframe
- the *benefit period* ends
- the *life insured* is no longer disabled
- this policy ends
- the *cover expiry date* for income protection
- the *life insured* dies
- the *life insured* unreasonably refuses to undergo medical treatment for their *disability* recommended by their *medical practitioner*, including participation in an *approved occupational rehabilitation program*
- we pay a *Permanent Disablement benefit* for the *life insured* under the Permanent Disablement Cover option (see page 87).

Involuntary Unemployment Cover benefit for CBA Group loans

A monthly benefit for up to three months to help cover CBA minimum monthly loan repayments if you've been involuntarily unemployed for more than 60 consecutive days.

When we pay it

We pay an *Involuntary Unemployment benefit* if the policy is an *ordinary policy* and:

- the *life insured* has a loan and
- the *life insured* has been employed for at least 180 consecutive days and
- immediately after that period of *employment*, the *life insured* becomes *unemployed* for more than 60 consecutive days.

What we pay

We pay 1/30th of the *Involuntary Unemployment benefit* for each additional day the *life insured* is *unemployed* after the 60 consecutive days and the *life insured's loan* remains in place.

We pay the benefit monthly in arrears directly into the *loan* account.

Multiple periods of unemployment

Once we've paid an *Involuntary Unemployment benefit* the *life insured* must, after that period of *unemployment*, be *employed* for at least 180 consecutive days to qualify for the benefit again.

If the *life insured* becomes *unemployed* within 90 days of the end of a previous period of *unemployment*, we treat it as one continuous period of *unemployment*. We won't treat more than two separate periods of *unemployment* as one continuous period of *unemployment*.

What exclusions apply

We won't pay the *Involuntary Unemployment benefit*:

- for any period of unemployment for which the *life insured* doesn't have a loan
- for any period when the *life insured* is not continuously *unemployed*
- if the *unemployment* occurs while the *life insured* is working outside Australia or
- if the *life insured* becomes *unemployed*, directly or indirectly, because:
  - a period of casual, seasonal or temporary work ends
  - a *fixed-term contract* or specified period of work ends
  - of deliberate or serious misconduct or
  - the *life insured* resigns, accepts voluntary redundancy, retires early or abandons their *employment*.

If both *totally disabled* and *unemployed*

If the *life insured* is both *totally disabled* and *unemployed* at the same time, we only pay the highest of the Total Disability benefit and the *Involuntary Unemployment benefit*, not both.

If *split IP* applies, we only pay the highest of:

- the *Involuntary Unemployment benefit* and
- the total amount of the Total Disability benefits payable under the *split IP* policies.

If the total amount of the Total Disability benefits is higher, we don't pay the *Involuntary Unemployment benefit.*

More than one loan

If the *life insured* has more than one *loan*, we pay the *Involuntary Unemployment benefit* for each *loan*. However, even if the *life insured* has two or more *loans*, we won't for a month ever pay in total more than the *monthly benefit* shown in your policy schedule, as increased or decreased under this policy.

60 day qualifying period

We won't pay the *Involuntary Unemployment benefit* if the *life insured* becomes *unemployed* or was aware that they were about to become *unemployed*:

- before
- on, or
- within 60 days after

the *date insured from* or the reinstatement of this policy.

Replacing existing unemployment cover

If we've agreed to replace existing unemployment cover you have with us which is itself subject to a similar qualifying period of at least 60 days, the qualifying period under the *Involuntary Unemployment benefit* is the lesser of:

- 60 days
- any unexpired qualifying period under the unemployment cover being replaced (including a qualifying period applied to the cover after it first started, for example, reinstatement or increases).

If the qualifying period under the unemployment cover being replaced has expired, we waive the qualifying period under the *Involuntary Unemployment benefit*, except for reinstatements or increases.

If the unemployment cover under this policy exceeds the unemployment cover being replaced, we apply the full 60 day qualifying period to the difference in cover.

When we stop paying

We pay the *Involuntary Unemployment benefit* until the first of the following occurs:

- when the *life insured* no longer has a loan
- when the *life insured* returns to any gainful occupation
- we have paid the benefit for three months for any one continuous period of *unemployment*
- when the *life insured* ceases to be a permanent Australian resident
- if the *life insured* becomes *unemployed* during the term of a *fixed term contract*, the expiry date of that contract
- when a *Total and Permanent Disablement benefit* (including the *Permanent Disablement benefit* under this policy), *Terminal Illness benefit*, *Trauma benefit* or other similar benefit becomes payable for the *life insured* under this or any other insurance policy
- when the policy ends
- the *cover expiry date* for income protection
- the *life insured* dies.

Income Care Super Death benefit

We pay $10,000 if the *life insured* dies while he or she is covered under Income Care Super (offered under Total Care Plan Super).

If *split IP* applies, we'll pay this benefit even if a death benefit is payable under the *split IP ordinary policy*.

Essential Cover (accidents only)

Income protection for accidents only.

What we pay

We pay the benefits we pay under an income protection policy.

When we pay it

We only pay a benefit if it becomes payable as a result of an *accident*.

What exclusions apply

The following are excluded:

- self-inflicted injury
- a dental injury caused by chewing, biting or malocclusion
- an injury which is caused directly or indirectly by attempt at suicide, self-inflicted infection, participation in criminal activity, an act of war (whether declared or not), the taking of alcohol or the taking of drugs other than prescribed by a *medical practitioner* or
- an injury in connection with a condition which first occurred, or first became apparent, before the cover under this policy or an increase in cover came into effect (for this purpose, a condition includes, but is not limited to, a disease, infection, hernia or cerebral vascular accident).

The policy terms are replaced

Under Essential Cover, this policy will apply as if:

- the definition of '*injury*' set out in the 'Definitions' (see page 131) is replaced with the definition of '*accident*' (see page 131)
- all references to the defined term *sickness* in the policy are deleted
- the words 'because of *sickness* or *injury*' in each of the definitions of '*partial disability/partially disabled*' and '*total disability/totally disabled*' are replaced by the words 'because of an injury that first occurred in the last 60 days'
- all references to the defined terms *cardiomyopathy*, *primary pulmonary hypertension*, *motor neurone disease*, *multiple sclerosis with impairment*, *muscular dystrophy*, *dementia* and *Alzheimer's disease*, *Parkinson's disease with impairment*, *chronic lung disease* and *severe rheumatoid arthritis* in the policy are deleted
- the words 'and the requirement for the injury to have first occurred in the last 60 days' appear immediately after the words '*waiting period*' where they appear:
  - in 'Recurrent Disability benefit' (see page 77) and
  - in 'Recurring disability' (see page 92)
- the words 'as a result of an *injury*' appear immediately after the word 'contracts' where that word appears in 'When we pay it' under the 'Medical Professionals benefit' (see page 78).

If *split IP* applies, Essential Cover must apply under both *split IP policies*.

Note: If you cancel Essential Cover, your income protection policy ends.

Specific Injuries benefit

A monthly benefit if the injury you suffer was caused by a specified medical event. We pay even if you can return to work.

When it applies

This benefit is only available if your *waiting period* is three months or less.

When we pay it

We pay the Specific Injuries benefit if, as a result of an *injury*, the *life insured* suffers one of the following events before the *cover expiry date* for income protection.

Event	We pay for up to...
paraplegia	60 months*
quadriplegia	60 months*

* unless your *benefit period* is two years, in which case the maximum payment period is 24 months.

Loss of sight or limbs

Total and permanent loss of use of ...	We pay for up to...
both hands or both feet or sight in both eyes	24 months
one hand and one foot	24 months
one hand and sight in one eye	24 months
one foot and sight in one eye	24 months
one arm or one leg	18 months
one hand or one foot or sight in one eye	12 months
thumb and index finger from the same hand	6 months

Fractures

Fracture requiring a plaster cast or other immobilising device of the following bones	We pay for up to...
thigh	3 months
pelvis (except coccyx)	3 months
skull (except bones of the face or nose)	2 months
arm, between elbow and shoulder	2 months
shoulder blade	2 months
leg (above the foot)	2 months
kneecap	2 months
elbow	2 months
collarbone	1.5 months
forearm, between wrist and elbow (shaft)	1.5 months

We pay the Specific Injuries benefit monthly in advance from the date the event occurs. There is no *waiting period.* We'll pay the benefit even if the *life insured* is working.

When we stop paying

We stop paying the Specific Injuries benefit when the first of the following occurs:

- the payment period ends
- the policy ends
- the *cover expiry* for income protection
- the *life insured dies*
- we pay a *Permanent Disablement benefit* for the *life insured* under the Permanent Disablement Cover option (see page 87).

What we pay

We pay the *monthly benefit* and any *super continuance monthly benefit*. The part of the benefit which is the *super continuance monthly benefit* is paid to your nominated super plan. Refer to page 88 for more information.

If one *injury* causes more than one of the relevant events, we pay only for the event with the longest payment period.

If the *life insured* is *disabled* at the end of the payment period, then we pay a Total or Partial Disability benefit, subject to the conditions of this policy.

Lump sum option

If we agree to pay a Specific Injuries benefit for an event for which the payment period is 24 months or less, you can choose to receive that benefit as a lump sum instead of as monthly payments.

How we pay the lump sum

We pay a lump sum equal to:

A × B

where:

- A is the number of months in the payment period for the event
- B is the total of the *monthly benefit* and any *super continuance monthly benefit*.

Receiving a lump sum in instalments

If the event's payment period is 18 months, you can choose to receive:

- one third of the lump sum after six months and the remaining two thirds after 18 months or
- two thirds of the lump sum after 12 months and the remaining one third after 18 months.

If the event's payment period is 24 months, you can choose to receive half the lump sum after 12 months and the other half after 24 months.

If you choose to take the lump sum in instalments but the *life insured* dies before we have paid all the instalments, you won't be paid the remaining instalments.

Crisis benefit

A lump sum if you suffer one of 19 specified medical conditions, whether or not you can return to work.

When it applies

This benefit is only available if your *waiting period* is three months or less.

When we pay it

We pay the benefit if the *life insured* meets the definition of one of the following medical conditions before the *cover expiry date* for income protection (even if the *life insured* continues to work):

- *cancer*
- *cardiac arrest*
- *cardiomyopathy*
- *coronary artery bypass surgery*
- *diplegia*
- *end stage kidney failure*
- *heart attack*
- *heart valve surgery*
- *hemiplegia*
- *loss of independent existence*
- *major head trauma*
- *major organ or bone marrow transplant*
- *motor neurone disease*
- *multiple sclerosis with impairment*
- *open heart surgery*
- *primary pulmonary hypertension*
- *severe burns*
- *stroke*
- *surgery of the aorta.*

These conditions are defined in the 'Medical definitions' starting on page 148.

What we pay

We pay a lump sum equal to six times the total of the *monthly benefit* and any *super continuance monthly benefit*. The payment period is six months.

The portion which is the *super continuance monthly benefit* is paid to your nominated super plan. Refer to page 88 for more information. We only pay a benefit once in any consecutive 12-month period. If the *life insured* is *disabled* or *permanently disabled* six months after you were entitled to the Crisis benefit, we pay a Total or Partial Disability benefit or *Permanent Disablement benefit*, subject to the conditions of this policy.

Accommodation benefit

Helps cover the cost of accommodating an immediate family member nearby if you become totally disabled and need to be a long way from home to receive treatment.

When we pay it

We pay this benefit if:

- the *life insured* is *totally disabled* before the *cover expiry date* for income protection and
- on a *medical practitioner's* advice, the *life insured* must stay more than 100 kilometres from their home or the *life insured* travels to a place more than 100 kilometres from their home and
- the *life insured* is confined to bed and
- an *immediate family member* is accommodated near the *life insured* and has to stay away from their home.

What we pay

We pay $350 a day for up to 30 days in each 12 month period commencing on:

- the date we first paid the benefit and
- each anniversary of that date.

Family Support benefit

Subsidises an immediate family member's lost income for up to three months if they have to take time off work to care for you while you are totally disabled.

When we pay it

We pay this benefit if:

- the *life insured* is *totally disabled* after the end of the *waiting period*
- we're paying a Total Disability benefit for the *life insured* under this policy
- due to the *life insured's total disability*, the *life insured* totally depends on an *immediate family member* for their everyday *home care needs* to enable them to live at home and
- the *immediate family member's* monthly income has fallen due to taking care of the *life insured*.

If *split IP* applies, you can still claim this benefit under the *split IP ordinary policy* where we're only paying the Total Disability benefit under the *split IP super policy*.

What we pay

We pay each month in arrears, for up to three months, the lesser of:

- 75% of the total of the *monthly benefit* and any *super continuance monthly benefit*
- the amount by which the *immediate family member's* monthly income has fallen.

To work out by how much an *immediate family member's* monthly income has fallen, we compare the monthly income they are earning while caring for the *life insured* with the average monthly income they were earning for the 12 months before they started caring for the *life insured*.

By 'monthly income', we mean the *immediate family member's* pre-tax monthly income minus any expenses they incurred in earning that income.

The benefit starts to accrue from the first day you qualify for the benefit after the *waiting period* has ended.

When we stop paying

We stop paying the benefit when the first of the following occurs:

- the *life insured* is no longer *totally disabled*
- we've paid the benefit for three months
- the policy ends
- the *cover expiry date* for income protection
- the end of the *benefit period*
- the *life insured dies*
- we pay a *Permanent Disablement benefit* for the *life insured* under the Permanent Disablement Cover option (see page 87).

Home Care benefit

Helps cover the cost of a professional housekeeper for up to six months if you are totally disabled and confined to, or near, a bed after the waiting period.

When we pay it

We pay the benefit if, we're paying a Total Disability benefit for the *life insured's total disability* and because of that disability the *life insured* is:

- confined to, or near a bed, other than in a hospital or similar institution that provides nursing care and
- totally dependent on a paid professional housekeeper (not an *immediate family member*) for their essential everyday *home care needs*.

If *split IP* applies, you can still claim this benefit under the *split IP ordinary policy* where we're only paying the Total Disability benefit under the *split IP super policy*.

What we pay

We pay each month in arrears, for up to six months, the lesser of:

- $150 a day
- the total of the *monthly benefit* and any *super continuance monthly benefit*.

The benefit starts to accrue from the first day you qualify for the benefit after the *waiting period* has ended.

When we stop paying

We stop paying the benefit when the first of the following occurs:

- the *life insured* is no longer *totally disabled*
- we've paid the benefit for six months
- the policy ends
- the cover *expiry date* for income protection
- the end of the *benefit period*
- the *life insured* dies
- we pay a *Permanent Disablement benefit* for the *life insured* under the Permanent Disablement Cover option.

Rehabilitation Expenses benefit

Helps cover the expenses of participating in an approved occupational rehabilitation program or trying to return to work (e.g. making structural changes to the office) when you are totally disabled.

When we pay it

We pay this benefit if we're paying the Total Disability benefit for the *life insured's total disability* and the *life insured* is paying rehabilitation expenses as a direct result of:

- participating in an *approved occupational rehabilitation program* or
- engaging in or trying to engage in an occupation.

If *split IP* applies, you can still claim this benefit under the *split IP ordinary policy* where we're only paying the Total Disability benefit under the *split IP super policy*.

Some examples of rehabilitation expenses covered by this benefit are the cost of travelling to attend an *approved occupational rehabilitation program* or the cost of structural changes to your office.

What we pay

We reimburse, monthly in arrears, the actual expenses the *life insured* paid minus any amounts already reimbursed by others.

We pay up to nine times the total of the *monthly benefit* and any *super continuance monthly benefit*.

The benefit starts to accrue when the expenses are incurred.

What we won't pay

We won't reimburse:

- money spent without our prior approval or
- the cost of the *approved occupational rehabilitation program* itself.

When we stop paying

We stop paying the benefit when the first of the following occurs:

- we've made payments equal to nine times the total of the *monthly benefit* and any *super continuance monthly benefit*
- the *life insured* is no longer *totally disabled*
- the policy ends
- the *cover expiry date* for income protection
- the end of the *benefit period*
- the *life insured* dies
- we pay a *Permanent Disablement benefit* for the *life insured* under the Permanent Disablement Cover option.

Bed Confinement benefit

Helps cover the additional costs incurred if you are totally disabled and confined to bed for at least three days continuously during the waiting period.

When we pay it

We pay this benefit if:

- due to *sickness* or *injury* which confines the *life insured* to bed they can't perform at least one income-producing duty of their occupation and
- the *life insured* is confined to bed continuously for at least three days during the *waiting period* and
- a *medical practitioner* certifies that the *life insured* needs the continuous care of a registered nurse.

What we pay

We pay, monthly in arrears, 1/30th of the total of the *monthly benefit* and any *super continuance monthly benefit* for each day (including the first three days), during the *waiting period*, the *life insured* continues to meet the requirements for this benefit.

We pay this benefit for up to 90 days, but not for a day after the end of the *waiting period*.

Death benefit

Helps meet expenses by paying a lump sum if you die.

If the *life insured* dies before the *cover expiry date* for income protection, we pay a benefit equal to the lesser of:

- four times the total of the *monthly benefit* and any *super continuance monthly benefit*
- $75,000.

We pay this benefit to the surviving policy owner(s) or, if there are none, to your estate.

If *split IP* applies, we'll pay this benefit even if a death benefit is payable under the *split IP super policy*.

Transportation benefit

Helps cover the cost of emergency transport to an Australian hospital if required by your total disability.

When we pay it

We pay this benefit if the *life insured*:

- is *totally disabled* before the *cover expiry date* for income protection and
- has to be transported to a hospital within Australia in an emergency because of the condition which caused their *total disability*.

What we pay

The benefit is $500.

Overseas Assist benefit

Helps cover the cost of an economy air fare to return to Australia if you are totally disabled for at least a month while overseas.

When we pay it

We pay this benefit if, before the *cover expiry date* for income protection, the *life insured* is *totally disabled* for at least a month while they are outside Australia and decide to return to Australia because of continuing *total disability*.

What we pay

We reimburse the cost of the *life insured's* economy airfare to return to Australia by the most direct route, including connecting flights, minus any amounts reimbursed by others.

We'll pay up to three times the total of the *monthly benefit* and any s*uper continuance monthly benefit.*

We only pay the benefit once during the life of a claim, even if the claim relates to different causes of *total disability*.

Domestic Help benefit

Helps cover the cost of hiring a housekeeper or child-minder when your spouse can't perform domestic duties due to injury.

When we pay it

We pay this benefit if:

- the *life insured's spouse* is *accidentally disabled* when they are 45 years or younger and engaged in full time *domestic duties* and
- the *life insured* is paying child-minding or housekeeping expenses because their *spouse* can't perform their normal *domestic duties*.

What we pay

We reimburse, monthly in arrears, the child-minding or housekeeping expenses the *life insured* pays in a month if their *spouse* can't perform their normal *domestic duties* due to their *accidental disability*.

We'll pay up to $750 a month and pay the benefit for a maximum of three months in total for the term of the policy.

The benefit starts to accrue from the first day you qualify for the benefit.

When we stop paying

We stop paying the benefit when the first of the following occurs:

- the *life insured's spouse* is no longer *accidentally disabled*
- we've paid the benefit for three months
- the *life insured's spouse* reaches age 46
- this policy ends
- the *life insured's spouse* dies.

Options and features.

Options

We describe the available options below. To check which options are available for which types of policy please refer to page 74.

Permanent Disablement Cover option – only for cover outside super

A lump sum instead of the normal monthly benefits we would pay.

Choosing this option

If you want this option, you have to select it from the start of the policy. Once selected, you can't cancel it.

This option is only available if your *benefit period* is to the *policy anniversary date* before age 65 or age 70.

What it does

Under this option, you can ask us to pay the *Permanent Disablement benefit* if the *life insured*:

- becomes *permanently disabled* before the *cover expiry date* for income protection.

If you do this, we pay the *Permanent Disablement benefit* instead of any benefits we would have paid under this policy for the *sickness* or *injury* which made the *life insured permanently disabled* or for any other *sickness* or *injury* the *life insured* suffers.

If we pay the *Permanent Disablement benefit*, we no longer have any obligation to pay any benefits for the *life insured*, whether for:

- the *sickness* or *injury* that made the *life insured permanently disabled*
- any other *sickness* or *injury* or
- the *life insured's unemployment* under the Involuntary Unemployment Cover benefit for *CBA Group Loans*.

We still pay the Medical Professionals benefit if the *life insured* becomes *permanently disabled* by an infection for which we pay the benefit (see page 78).

Note: This option isn't available for Business Overheads Cover, a *super policy* or a *split IP policy*.

Increasing Claim option

Increases claim payments to help keep pace with inflation.

The way this option applies differs depending on whether the policy is a *super policy* or not:

Super policy	*Ordinary policy*
What it does	**What it does**
If we have paid a Total or Partial Disability benefit for a *life insured* for more than 12 consecutive months, we increase the *monthly benefit* for the purpose of calculating the claim payments by the lesser of: ◆ the *indexation factor* or ◆ 5% on each anniversary of the date benefits first started to accrue.	If we have paid a Total or Partial Disability benefit for a *life insured* for more than 12 consecutive months, we increase the *monthly benefit* and any *super continuance monthly benefit* for the purpose of calculating the claim payments by the *indexation factor* on each anniversary of the date benefits first started to accrue.

If *split IP* applies, the benefits may have been paid by us under either policy or a combination of both.

If *split IP* applies, this option must apply to both policies. We apply increases under the option before *split IP* has been applied to determine the respective benefits payable under each policy.

To illustrate, after applying *split IP* in the example on page 21, we pay Frank's SMSF a Total Disability benefit of $4,000 a month under the SMSF Plan and pay Frank a separate Total Disability benefit of $1,000 (i.e. $5,000 minus $4,000) a month under the Income Care policy.

If we continue to pay the benefits for 12 consecutive months and the relevant *indexation factor* is 7%, we:

- increase the *monthly benefit* of $4,000 a month under the SMSF Plan by 5% (the maximum indexation increase for a super policy) to $4,200 and
- increase the *monthly benefit* of $5,000 a month under the Income Care policy by 7% to $5,350.

The total amount of Total Disability benefit then paid across both the SMSF Plan and the Income Care Policy is $5,350. $4,200 is paid under the SMSF Plan and $1,150 is paid to Frank under the Income Care policy.

The $1,150 paid to Frank under the Income Care policy is arrived at by reducing the new indexed *monthly benefit* of $5,350 by the $4,200 payable under the SMSF Plan.

This option doesn't apply if we're paying a Total Disability benefit under Extended cover (see page 92).

We won't, under this option, increase the *monthly benefit* and any *super continuance monthly benefit* for a claim if:

- your *benefit* period is to the *policy anniversary date* before age 70 and
- the benefits we pay for the claim first started to accrue after the *policy anniversary date* before the *life insured's* 65th birthday.

We stop charging for this option on the *policy anniversary date* before the *life insured's* 65th birthday.

Accident option

A benefit if total disability occurs during the waiting period due to an accident.

What it does

If the *life insured* is *totally disabled* due to *injury* for three consecutive days during the *waiting period*, the Accident option pays 1/30th of your *monthly benefit* (excluding any *super continuance monthly benefit*) for each day the *life insured* is *totally disabled* during the *waiting period*.

To be paid a benefit under this option you must:

- have a 14 day or one month *waiting period* (including under Extended cover)
- not be entitled to a Crisis benefit, Bed Confinement benefit or Specific Injuries benefit (whether as a *monthly benefit* or a lump sum) for the *life insured*.

If *split IP* applies, this option must apply to both policies. The benefit we pay under a *split IP ordinary policy* is reduced by the amount of the benefit payable under the *split IP super policy*.

How long we pay

We pay this benefit until the end of the *waiting period* or until the *life insured* is no longer *totally disabled*, whichever comes first.

Super Continuance option – only for cover outside super

Covers your super contributions.

What it does

Under the option, we'll cover 100% of certain superannuation contributions made for the *life insured's* benefit. We call this cover the *super continuance monthly benefit*.

What we pay

We pay this benefit as part of the Total, Partial or other relevant disability benefit.

For the benefit, we generally pay the lesser of:

- the amount we agreed to cover you for
- 1/12th of the super contributions made for the *life insured* in the 12 months before their disability.

We calculate the benefit in this way whether you have an indemnity, extended indemnity, agreed value or guaranteed agreed value policy.

For full details of how we calculate the benefit, please refer to the definition of *super continuance monthly benefit* on page 144.

If we pay the *super continuance monthly benefit*, we pay it on your behalf to your nominated super plan instead of directly to you.

The plan you nominate must be:

- a regulated super fund
- a retirement savings account or
- another super plan we approve.

When we won't pay it

We won't pay the *super continuance monthly benefit* if:

- you haven't nominated a super plan which meets the requirements set out above or
- super or taxation laws prevent us from making the payment.

Split IP

We won't, because of *split IP*, reduce the *super continuance monthly benefit* under the *ordinary policy*.

Features

The features described in this section automatically apply under income protection.

Waiving premiums while paying benefits

We waive your income protection premiums while paying monthly benefits.

Which premiums we waive

This waiver applies to premiums for an income protection policy.

Becoming disabled

You don't have to pay income protection premiums which are to be paid on a *premium due date* occurring:

- while we're paying Total or Partial Disability benefits or monthly Specific Injuries benefits, or
- if we paid the Specific Injuries benefit as a lump sum, during the payment period for which we would have paid the benefit had we paid it monthly, or
- during the six month period after we pay the Crisis benefit (each referred to as a 'payment period').

Also, if a *waiting period* of three months or less applies and we agree to pay Total or Partial Disability benefit, we refund any income protection premiums which you paid on a *premium due date* occurring during the *waiting period*.

> **Note:** For information on premium waivers applying to *Life Care* when the *life insured* is *totally and temporarily disabled*, please refer to the Plan Protection option on page 37.

For *split IP policies*, this premium waiver applies to both *split IP policies*, even if benefits are not being paid under one of the policies. For example, if the *life insured* is *unemployed* at the time of disability and, as a result, we are only paying benefits under the *split IP ordinary policy*, the premium waiver also applies under the *split IP super policy*.

When this happens we apply the premium waiver to income protection premiums under a *split IP policy* so that the premiums are:

- waived even if the *premium due date* under the policy occurs during a payment period applying under the other *split IP policy*
- refunded if the *premium due date* under the policy occurs during the *waiting period*, even if the benefits are paid under the other *split IP policy*.

Waiving premiums for personal circumstances

You don't pay income protection premiums for up to six months if you're unemployed, on parental leave or experiencing financial hardship.

Which premiums we waive

This waiver applies to premiums for an income protection policy.

Flexibility to choose when to waive premiums

You can ask us to waive payment of your premiums at different times over the life of your policy as long as:

- you don't ask us more than once in any 12 month period and
- we haven't, over the life of your policy and under this premium waiver, already waived your premiums for six months in total.

Once we have waived your premiums for six months (whether for one or more claims) no more waivers apply under this premium waiver.

When we waive premiums

We'll waive the payment of premiums on your request if all of the following applies:

- your policy has been in force for six continuous months
- while the *life insured* is under 70 they are:
  - *involuntarily unemployed* or
  - on *parental leave* or
  - suffering *financial hardship*.

The waiver for *involuntary unemployment* isn't available for a *life insured* who is *self-employed*.

The premiums we waive are those we decide are for the period the *life insured* is *involuntarily unemployed* or on *parental leave* or suffering *financial hardship*. We decide this based on a pro-rata of the premium paid or payable, depending on your premium payment frequency.

We won't waive premiums for any one event (whether it be *involuntary unemployment* or *parental leave* or *financial hardship*) for more than three months in total.

When will premiums re-start

The payment of premium re-starts when the first of the following occurs:

- we have waived your premiums for three months for one of the relevant events
- we have, under this premium waiver, waived your premiums for six months in total
- the *life insured* is no longer *involuntarily unemployed* or on *parental leave* or suffering *financial hardship*.

Requirements

What you'll need to provide us and when depends on the event for which you're requesting the premium waiver:

What you need to provide…	When you need to provide it…
For *involuntary unemployment*	
Statements from the *life insured's* former employer and, if applicable, the employment agency with which they're registered.	Within 30 days of the date the *life insured* first became *involuntarily unemployed.*
For *parental leave*	
Statements from the *life insured's* employer and, if applicable, *medical practitioner.* If the *life insured* is *self-employed*, you must also provide us with any additional information we require about the *self-employment*.	30 days before the *parental leave* begins.
For *financial hardship*	
If the *financial hardship* is due to the *life insured's spouse's involuntary unemployment:* ◆ Statements from the *life insured's spouse's* former employer and, if applicable, the employment agency with which they're registered.	Within 30 days of the date the *life insured's financial hardship* began.
If the *financial hardship* is due to the death of the *life insured's spouse*: ◆ the death certificate of the *life insured's spouse*.	Within 30 days of the date the *life insured's financial hardship* began.

Waiver of waiting period for specific conditions

For claims for certain medical conditions you don't have to meet the waiting period.

We will waive the *waiting period* for a claim for a Total or Partial Disability benefit (but not a Business Overheads Cover benefit) if the *waiting period* is three months or less and the *sickness* or *injury* which causes the *life insured's disability* is *loss of use of limbs or sight*, *loss of independent existence* or a *serious medical condition*. We will only waive the *waiting period* once under the policy. For the waiver to apply to a claim for a Partial Disability benefit under a *super policy*, the *life insured's disability* must have caused the *life insured* to cease *gainful employment*.

If *split IP* applies and we waive the *waiting period* for a claim under one of the policies then we also waive the *waiting period* under the other policy.

Automatic indexation

Automatically increases cover each year to help keep pace with inflation.

On each *policy anniversary date* we increase the *monthly benefit* and any *super continuance monthly benefit* by the greater of 3% or the *indexation factor*.

However, an increase won't apply if the *policy anniversary date* occurs during the *waiting period* or while you're entitled to benefits.

Your premium will increase to take into account the increase in the *monthly benefit* and any *super continuance monthly benefit*.

You can choose not to accept this increase by telling us in writing within one month of the *policy anniversary date*.

If *split IP* applies and we aren't applying the increase for one of the policies, we won't apply the increase for the other policy. Increases can't apply to one policy without also applying to the other.

Note:

- Despite increases in cover under indexation, any benefit we pay under a *super policy* won't be greater than the *life insured's pre-disability income*.
- If the *benefit period* applying to income protection is to the *policy anniversary date* before age 70, we stop increasing the *monthly benefit* and any *super continuance monthly benefit* on the *policy anniversary date* occurring immediately before the *life insured's* 65th birthday.

Guaranteed insurability

Lets you increase your cover in line with income without providing further health evidence.

What it does

Once in any three year period up to the *life insured's* 55th birthday, you can apply to increase your cover in line with an increase in the *life insured's monthly income* without having to provide any evidence of the state of the *life insured's* health.

We then increase the amount of the *monthly benefit* and any *super continuance monthly benefit* shown in your policy schedule (each as increased by indexation):

- from the next *premium due date*
- in line with the increase in the *life insured's monthly income* and
- by a maximum of 10%.

Split IP

If *split IP* applies and we increase cover under one of the policies, we also apply the increase under the other policy. Increases can't apply to one policy without also applying to the other. The amount of the *monthly benefit* must always be the same under the *split IP* policies.

Requesting the increase

You must apply within 30 days before or after the *policy anniversary date* which occurs immediately after the date on which the *life insured's monthly income* is to be increased. You must provide any financial information we request about the *life insured's monthly income* (including a statement of the *life insured's* income over the previous two years).

When it isn't available

You can't request an increase in cover:

- if the *life insured's occupation* group is X (specialist risk – medium) or Y (specialist risk – high)
- if a medical loading applies to the *life insured*
- on or after the *life insured's* 55th birthday
- if we're already paying or intend to pay any benefit for the *life insured*
- if circumstances exist under which we would pay a benefit if you made a claim for the *life insured* or
- if the original policy owner is no longer the beneficial owner of this policy, unless we agree.

Effect on your premium

We increase your premium to reflect the increased cover, taking into account the *life insured's* age and the current premium rates. If you've chosen a level premium, we'll still take into account the *life insured's* age when the increase occurs.

Reduced waiting period

Lets you apply to reduce your waiting period without providing further health evidence if income protection you had with your employer or superannuation fund ends.

What it does

If:

- a two year *waiting period* applies to the *life insured* under this policy and
- cover ends for the *life insured* under a *group income protection policy*

you can, without providing medical evidence, apply to reduce the *waiting period* to one year, six months or three months.

While we won't require updated medical evidence, our acceptance of your application is subject to your current occupation and income details being satisfactory to us.

When to apply

You must apply to reduce your *waiting period* within 30 days after cover ends for the *life insured* under the *group income protection policy.* If you have met our requirements and we accept your application, we'll then reduce your *waiting period* from the next *premium due date*.

Requirements

For you to reduce the *waiting period*, all of the following requirements must have been met:

- when the *waiting period* under this policy first became two years:
  - the *benefit period* under this policy must have been to the *cover expiry date* (i.e. to the *policy anniversary date* before the *life insured's* 60th, 65th or 70th birthday)
  - the cover for the *life insured* under *the group income protection policy* must have been for a two year benefit period and
  - you must have told us in writing about the cover for the *life insured* under the *group income protection policy*
- when the cover ended for the *life insured* under the *group income protection policy*, the *life insured* must have been covered under this policy and a two year *waiting period* must have applied
- when you applied for this policy, no benefits must have been paid for the *life insured* under the *group income protection policy*
- when you applied to reduce the *waiting period* under this policy:
  - the *group income protection policy** must not have ended and
  - we must not have been paying, or intending to pay, any benefits for the *life insured* under this policy and
  - neither you nor the *life insured* have taken up an option under the *group income protection policy* which provides for the continuation of the *life insured's* cover under another policy issued by the group insurer.

***** Note: This means the entire *group income protection policy* and not just the *life insured's* cover under that policy.

Medical loading restriction

The *waiting period* can't be reduced if a medical loading applies under this policy when the *waiting period* first became two years or when you applied to reduce the *waiting period*.

Extended cover

Extends the term of your income protection by five years.

When it applies

We give you cover for *total disability* from the *cover expiry date* for income protection until the *extended cover expiry date* if you meet all of these conditions:

- the *life insured* must be in *occupation group* C, G, P, J, K or S
- the *cover expiry date* for income protection shown for the *life insured* on your policy schedule must be the *policy anniversary date* before the *life insured's* 65th birthday
- we must not be paying or intending to pay you a benefit for the month before the *cover expiry date* for income protection
- the *life insured* must be covered under this policy on the day before the *cover expiry date* for income protection.

This feature applies under *split IP* but it won't apply to one policy if it can't apply to the other.

Waiting period and benefit period

The *waiting period* for extended cover is the greater of:

- one month
- the *waiting period* in your policy schedule.

The *benefit period* for extended cover is one year, even if the *benefit period* in your policy schedule is greater than one year.

Indemnity policy

During the period of your extended cover you have an *indemnity policy* (even if the *monthly benefit* in your policy schedule shows 'extended indemnity', 'agreed value' or 'guaranteed agreed value').

Benefits we pay

The only benefits we pay under extended cover are the Total Disability benefit and the Reward Cover benefit.

In calculating a Total Disability benefit under extended cover, the *monthly benefit* will be no more than $30,000.

Premiums

A Stepped premium applies for extended cover premiums, even if a Level premium appears in your policy schedule.

End of Total Disability benefit

We only pay a Total Disability benefit under extended cover until the first of:

- the *life insured* is no longer *totally disabled*
- the one year *benefit period* ends
- the *extended cover expiry date*
- this policy ends
- the *life insured* dies.

Recurring disability

If you make separate claims for the same or a related *total disability* under extended cover, in certain circumstances we treat the second claim as a continuation of the original claim and waive the *waiting period* on the second claim.

We do this if all of the following applies:

- the *life insured* has returned to work on a full time basis after receiving a Total Disability benefit under extended cover and
- the *life insured* suffers a recurrence of the same or a related condition and
- the recurrence results in *total disability* within six months from the date the *life insured* was last on claim but before the *extended cover expiry date*.

Continuation option – converting income protection inside Total Care Plan Super

Lets you continue Total Care Plan Super income protection outside super without providing further health evidence.

Example

Sofia set up a Total Care Plan Super policy nine years ago which covered her for income protection. Sofia is paying premiums from her super using the FirstChoice Super payment method.

When reviewing her insurance needs this year with her financial adviser it was recommended to convert her income protection to a policy held outside super so that there would be sufficient superannuation savings for Sofia's retirement.

Using this Continuation option, Sofia continues the income protection under a new Income Care policy without needing to provide any health evidence. By doing this, Sofia remains protected with income protection.

You can convert any income protection under Total Care Plan Super to any other income protection we have available under another policy at the date of conversion. You can do this even if *split IP* applies to the cover under Total Care Plan Super.

You can do this without providing evidence of health, but subject to current occupation and income details (satisfactory to us), as long as:

- the *life insured* is 60 years old or less or, if the *benefit period* is to the *policy anniversary date* before age 70, the *life insured* is 63 years old or less and
- the income protection under the new policy doesn't exceed the benefit which we would've paid under Total Care Plan Super if the *life insured* became disabled on the date the right is exercised.

For other conditions that apply please refer to 'General conditions for Continuation options' on page 108.

Exclusions, benefit offsets and limitations.

The exclusions, benefit offsets and limitations described in this section apply to income protection, including Business Overheads Cover and a *Permanent Disablement benefit*, where applicable.

Exclusions

War

We won't pay a benefit for any condition arising, directly or indirectly, as a result of war or act of war (whether declared or not).

Self-inflicted injury or attempted suicide

We won't pay a benefit for any condition arising, directly or indirectly, as a result of any intentional self-inflicted injury or any attempt at suicide.

Misconduct

We won't pay a benefit for any condition arising solely as a result of a permanent or temporary banning, deregistration or disqualification of the *life insured* which prevents them from pursuing, practising or engaging in their occupation or profession.

Pre-existing conditions

We won't pay any benefit in connection with a *pre-existing condition*, except if:

- you and the *life insured* were unaware of the condition, or the circumstances leading to it, before the cover started or increased and couldn't reasonably be expected to have been aware or
- you disclosed the condition or circumstances to us before the cover started or increased and we haven't excluded cover for the condition or any condition resulting from the circumstances.

Continuation option

We also pay in connection with a *pre-existing condition* if the cover for the *life insured* under this policy was issued on the exercise of a continuation option in another policy under which we covered the *life insured*.

On the exercise of the continuation option in the other policy, the *life insured* must have been covered under that policy for:

- the same benefit, and for the same or a greater amount of cover, the *life insured* is covered for under this policy when the claim arises
- the same or a longer benefit payment period the *life insured* is covered for under this policy when the claim arises and
- the condition for which the claim is made under this policy.

Elective surgery

You can only claim for *disability* resulting from voluntary medical treatment if the treatment takes place more than six months after your cover started, increased or was last reinstated.

Voluntary medical treatment includes:

- cosmetic or other elective surgery and
- surgery to transplant body organs to the body of another person.

Benefit offsets and reductions

If you claim a benefit and there is income from other sources, your benefit is offset or reduced as described below.

How we offset the benefit for an ordinary policy

If you or the *life insured* receive one or more *offset payments* in relation to the *life insured* that, in total, exceed 10% of the *life insured's pre-disability income*, we reduce the Total or Partial Disability benefit we pay as follows:

Total Disability benefit offset

We reduce the Total Disability benefit by the *offset payments* to the extent the sum of:

- the Total Disability benefit under this policy and
- the amount of the *offset payments*

exceeds the greater of:

- 75% of the *life insured's pre-disability income*
- the total of the *monthly benefit* and any *super continuance monthly benefit*.

Partial Disability benefit offset

We reduce the Partial Disability benefit by the *offset payments* to the extent the *life insured's pre-disability income* is exceeded by the sum of:

- the Partial Disability benefit under this policy
- the *life insured's monthly income* and
- the amount of the *offset payments*.

How we offset the benefit for a super policy

Step 1 Apply offset payments

If you or the *life insured* receive one or more *offset payments* in relation to the *life insured* that, in total, exceed 10% of the *life insured's pre-disability income*, we reduce the Total or Partial Disability benefit we pay as follows:

Total Disability benefit offset

We reduce the Total Disability benefit by the *offset payments* to the extent the sum of:

- the Total Disability benefit under this policy, and
- the amount of the *offset payments*

exceeds the greater of:

- 75% of the *life insured's pre-disability income*
- the *monthly benefit.*

Partial Disability benefit offset

We reduce the Partial Disability benefit by the *offset payments* to the extent the *life insured's pre-disability income* is exceeded by the sum of:

- the Partial Disability benefit under this policy
- the *life insured's monthly income*, and
- the amount of the *offset payments*.

Step 2 Benefit reduction under superannuation law

Whether or not step 1 applies to you, we also reduce the Total or Partial Disability benefit we would pay to the extent necessary to make sure the total of the amounts set out below is no greater than the *life insured's pre-disability income.*

The amounts referred to are:

- the amount of the Total or Partial Disability benefit* after applying any *offset payments* under step 1, and
- any *employer payments*

for the month for which you're claiming the benefit.

This reduction under step 2 also applies to the Accident option benefit even though step 1 doesn't.

Note: *When calculating this, we won't take into account the amount of the benefit attributable to any increases under the Increasing Claim option.

Refunding your premiums

If we reduce the benefit we pay due to benefit offsets and reductions, we refund a part of the premium you paid us in the last 12 months, in proportion to the reduction of the benefit. The refund is paid to you, as the policy owner.

Split IP

If *split IP* applies, we apply the benefit offsets and reductions under the two policies so that the total amount of benefits we pay under the two policies is no less than what we would have paid under the *split IP ordinary policy* had:

- *split IP* not applied and
- the benefit offsets and reductions applied in full only to the *split IP ordinary policy*.

Also, where *split IP* applies, we do not use these 'offset' provisions to offset payments under the *split IP ordinary policy* by payments under the *split IP super policy* and vice-a-versa. Payments under the *split IP ordinary policy* are reduced by payments under the *split IP super policy,* as specifically provided for in the policy conditions applying to *split IP*.

Limitations

Geographical limits

If the *life insured* travels or resides outside Australia before or during a claim, we won't pay benefits for more than six months in total, unless the *life insured* is unable to return to Australia for medical reasons which are acceptable to us.

Benefits depend on the *life insured* being under the immediate *regular medical care* of a *medical practitioner* when the *life insured* returns to Australia.

Payments won't be backdated for a period the *life insured* isn't in Australia.

If we're paying benefits for a *life insured* and the *life insured* leaves Australia without our prior written consent, we may stop payments after six months in total.

Reference to 'Australia' in the above means within the territorial boundaries of Australia.

Reduction of cover for income protection to age 70

If the *benefit period* applying to income protection is to the *policy anniversary date* before age 70, the *monthly benefit* and any *super continuance monthly benefit* is reduced in amount by 20% on the *policy anniversary date* immediately before the *life insured's* 65th birthday and then by a further 10% on each following *policy anniversary date*.

The reductions apply as per the following table:

Policy anniversary date **before the** ***life insured*** **turns:**	**% of cover applying**
64	100%
65	80%
66	70%
67	60%
68	50%
69	40%

A reduction in cover won't affect benefits we are paying for a claim which already started before the relevant reduction took place.

A reduction in cover won't occur if, on the relevant *policy anniversary date*, we are paying a claim for the *life insured*. Reductions resume on the *policy anniversary date* after we stop paying your claim. In this situation, your cover won't reduce by as much as it would have had we not been paying a claim on the relevant *policy anniversary date*.

Aviator's benefit limit

If the *life insured's occupation group* in your policy schedule is A (Aviation), we'll only ever pay a maximum of $2 million for the *life insured* under this policy.

Income Care Plus/Platinum benefits

If you can claim both the Specific Injuries benefit and the Crisis benefit, we pay the benefit with the longest payment period, but not both.

The payment period for the Crisis benefit is taken to be six months. The payment period for a lump sum Specific Injuries benefit is taken to be the period over which we would have made payments if we'd paid the benefit monthly.

While the Specific Injuries benefit or the Crisis benefit is payable, you aren't entitled to a:

- Total Disability benefit
- Partial Disability benefit
- Involuntary Unemployment Cover benefit for CBA Group loans or
- Bed Confinement benefit.

Also, if *split IP* applies, you aren't entitled to a Total Disability benefit or Partial Disability benefit under a *split IP super policy* while a Specific Injuries benefit or Crisis benefit is payable under the *split IP ordinary policy*.

We won't pay the Home Care benefit while you are receiving the Family Support benefit or the Accommodation benefit.

Benefits end if Life Care ends

If you have income protection and *Life Care* under a Total Care Plan Super policy, any income protection benefits you're receiving end if your *Life Care* ends. If, in this case, the Total Care Plan Super policy is a *split IP super policy*, any income protection benefits we're paying under the *split IP ordinary policy* also end.

Cover expiry date

We won't pay any benefit for any period after the *cover expiry date* for income protection or Business Overheads Cover, as applicable.

Keeps your business up when you're down.

Protecting your Business.

Business Overheads Cover

If you run your own business, taking time off because you're sick or injured can be disastrous.

Business Overheads Cover keeps things ticking over by helping to pay your business's regular fixed operating expenses while you're unable to work.

Business Overheads Cover can pay up to 100% of your fixed operating expenses.

Summary

In this section we summarise the benefits and features of Business Overheads Cover. Business Overheads Cover is not available under a policy inside super.

Included benefits

Benefit	A brief explanation...	For full details see page...
Business Overheads monthly benefit	Pays up to 100% of your business's regular fixed operating expenses – up to $40,000 per month – if you're totally disabled	98
Reward Cover benefit	Provides up to $100,000 of Accidental Death Cover at no extra cost after you've held the policy for three years. If you also have a Total Care Plan policy when you die due to an accident, we'll double the Reward Cover benefit	79

Included features

Feature	A brief explanation...	For full details see page...
Waiving premiums	You don't have to pay any Business Overheads Cover premiums in certain circumstances	99
Automatic indexation	Each year we automatically increase your cover to help keep pace with inflation	99

Exclusions

Type of exclusion	What benefit does the exclusion apply to?	For full details see page...
◆ Pre-existing condition ◆ War ◆ Attempted suicide ◆ Self-inflicted injury ◆ Misconduct ◆ Elective surgery	◆ Business Overheads monthly benefit	93
◆ Suicide or attempted suicide ◆ Self-inflicted injury or infection ◆ Alcohol ◆ Drugs ◆ Criminal activity ◆ Jail	◆ Reward Cover benefit	79

Business Overheads Cover

Please make sure you read the 'Income protection summary' on page 71.

Business expenses we cover

We cover the usual, regular, fixed operating expenses of the *business*, including:

- rent
- principal and interest payments for a business mortgage
- principal and interest repayments for a loan taken for the purposes of the *business*
- property rates and taxes
- electricity, telephone, gas, heating and water costs
- cleaning and laundry
- the remuneration and associated costs of any non-income generating employee
- any remuneration and associated costs of hiring an income generating employee after the *life insured* became *totally disabled* (the employee must be hired to perform the work the *life insured* normally does)
- leasing or hiring costs of equipment or motor vehicles
- insurance premiums
- accountancy and audit fees
- subscriptions to professional associations, including professional membership fees
- security or advertising costs incurred under a contractual arrangement with a third party
- bank fees and charges
- *business* vehicle registration and insurance
- postage, printing and stationery
- cost of repairs and maintenance incurred under a contractual arrangement with a third party
- any expenses we've specifically agreed to in writing.

Business expenses we don't cover

The business expenses we don't cover include (but aren't limited to):

- any amounts paid to the *life insured,* an *immediate family member* or to any joint owner of the *business*
- remuneration and associated costs of any income generating employee unless:
  - **(a)** the costs were the costs of hiring the employee after the *life insured* became *totally disabled* and
  - **(b)** the employee was hired to perform the work the *life insured* normally did
- any payments for goods, stock in trade, plant or equipment
- any allowance for depreciation in real estate or of plant and equipment
- any portion of a business expense which someone else who has an interest in the *business* normally pays
- any payment which we work out on a fair and reasonable basis not to be a usual, regular, fixed operating expense.

When we pay a benefit

We pay a benefit if the *life insured* is still *totally disabled* by the same *sickness* or *injury* after the *waiting period* has ended. We pay this benefit in addition to any other benefit we're liable to pay under this policy.

The benefit starts to accrue from the first day the *life insured* is *totally disabled* after the *waiting period* has ended. We pay it monthly in arrears.

Please refer to our explanation of the '*waiting period*' on page 75.

What benefit we pay

The benefit we'll pay for each month is the lesser of:

- the *Business Overheads monthly benefit*
- the covered business expenses incurred during that month while the *life insured* is *totally disabled* less your or the *life insured's* portion of the income of the *business* derived from trading during the month.

When we work out the benefit we pay for a month, we apply the following rules:

- your or the *life insured's* portion of the income of the business derived from trading during the month will include any income generated by any employee(s) hired after the *life insured* became *totally disabled* to do the work the *life insured* normally did.
- if a covered business expense was paid before the *life insured* was *totally disabled*, but we're satisfied that the business expense relates to a complete month during which the *life insured* was *totally disabled*, then we treat a proportion of that business expense (as we consider appropriate) as if it had been paid during that month.

Reducing the benefit for other business expenses insurance

We reduce the benefit by any amount received for the month from any other insurance policy which reimburses you or the *life insured* for business expenses, unless we've agreed in writing not to do this.

If we do this, we only reduce the benefit to the extent the combined insurance payments would be more than your covered business expenses.

How long we pay it

We stop paying the benefit on the first of the following:

- the *life insured* is no longer *totally disabled*
- we've paid 12 times the *Business Overheads monthly benefit* for any one continuous period of *total disability*
- we've paid 12 times the *Business Overheads monthly benefit* for any one *sickness* or *injury*
- this policy ends
- the *cover expiry date* for Business Overheads Cover
- the *policy anniversary date* before the *life insured's* 65th birthday
- the *life insured's* death.

Change of ownership

You must tell us if the underlying ownership of the *business* changes. Underlying ownership means a beneficial interest in the *business* held directly or through any interposed corporation, partnership or trust. If this changes, we may change the *Business Overheads monthly benefit* in a way that reflects those changes.

Reward Cover benefit

Refer to page 79.

Waiving premiums

You don't have to pay any Business Overheads Cover premiums in certain circumstances.

You don't have to pay Business Overheads Cover premiums while we're paying a *Business Overheads monthly benefit*.

If a *waiting period* of 3 months or less applies and we're paying a *Business Overheads monthly benefit*, we refund any premiums which fell due and were paid during the *waiting period*.

Also, you don't have to pay Business Overheads Cover premiums if premiums are being waived for the same *life insured* under the 'Waiving premiums while a benefit is being paid' or 'Waiving premiums for personal circumstances' feature of income protection offered under this PDS, whether the Business Overheads Cover is standalone or not.

Automatic indexation

On each *policy anniversary date*, we'll increase the *Business Overheads monthly benefit* by the greater of 3% or the *indexation factor*.

An increase won't however apply if the *policy anniversary date* occurs during the *waiting period* or while you're entitled to benefits.

Your premium will increase to take into account the increase in the *Business Overheads monthly benefit*.

You can choose not to accept this increase by telling us in writing within one month of the *policy anniversary date.*

Exclusions

Refer to page 93.

Geographical limits

Refer to page 94.

Cover expiry date

Refer to page 95.

Part C. Other policy conditions.

This part sets out the policy terms for

Paying premiums.

You must pay the premiums on or before the *premium due date*. If we don't receive the entire premium within 30 days of the *premium due date*, we may cancel this policy. We will send you prior notice of the cancellation.

Premium due date

Premiums are payable annually in advance but, depending on your payment method, can be paid in monthly, quarterly or half yearly instalments. Each date on which a premium is due is a *premium due date*.

Stepped or Level premium

You can choose whether you want your premium calculated using our stepped or level premium rates.

The choice you make is shown in the policy schedule. Once you make your choice for your policy, you can't change it and it applies to all lives insured and all types of cover under the policy.

Here's how a stepped and level premium works:

Stepped

Your premium generally goes up every year as the *life insured* gets older.

This is because we calculate the premium using the *life insured's* age next birthday on each *policy anniversary date*.

The premium for an increase in cover is calculated in the same way.

Other premium increases

A stepped premium doesn't just increase with age. It can also increase for other reasons. For example, because your cover increases or we increase our premium rates for all our policy owners, which is something we can do at any time but we'll tell you before it happens.

Level

Up to the *policy anniversary date* before the *life insured* turns 65, your premium doesn't go up as the *life insured* gets older. This is because we set the premium at the *life insured's* age next birthday on the date cover starts.

When we'll calculate premium using your current age

If you've chosen a level premium and:

- your cover increases (other than as a result of indexation)
- you add another benefit or option to the policy or
- you make any other change to the policy that increases the premium

we calculate the premium for the change in cover using the *life insured's* age next birthday on the date we agreed to the change.

If, however, your cover increases as a result of indexation, we won't use the *life insured's* age next birthday on the date of the increase to calculate the premium for the increased cover. Instead, we'll use their age next birthday on the date the cover first started, resulting in a cheaper premium for the increased cover.

Premium increases

A level premium doesn't mean your premium won't ever increase. Like a Stepped premium, your premium will increase if, for example, your cover increases or we increase our premium rates for all our policy owners, which is something we can do at any time but we'll tell you before it happens.

When level premiums end

From the *policy anniversary date* before the *life insured* turns 65, level premiums end and your premium will go up every year as the *life insured* gets older, as with a stepped premium.

How much you pay

The premium you pay for the first 12 months is shown in the policy schedule. This is based on our current premium rates, which we won't change for you in the first year of your policy.

Premium rate increases

We don't guarantee premium rates in later years will be the same as current rates. We, as insurer, can change the rates for all policies in a group whether a stepped or level premium applies, but we won't change the rates for a policy by itself. We will give you at least 30 days' notice before any increase in premium rates.

Factors which affect your premium

There are many factors which affect the calculation of your premium, including:

Factor	How it may affect the calculation of your premium
Age	Generally, the older the *life insured*, the higher the cost of your insurance.
Health	The better the state of the *life insured's* health, the cheaper your insurance.
Gender	Mortality and illness rates differ between men and women, resulting in differing premium rates.
Occupation	Each occupation group has different duties associated with it. The greater the risk associated with the general duties of that occupation group, the greater the cost of insurance for that occupation group.
Smoker status	Smoker premiums are generally higher than non-smoker premiums.
Sporting or recreational activities	Certain sporting or recreational activities carry more risk than others, therefore the riskier the sporting or recreational activities the *life insured* undertakes, the higher the cost of your insurance.
Policy options you select	Generally, the more policy options you select, the higher the cost of your insurance.
Whether you choose a stepped or level premium	Premiums vary depending on whether you choose a stepped or level premium. How your choice affects the premiums you pay is explained above.
Combination of cover	The more cover types you include in your policy, the higher the cost of your cover.
Type and amount of cover	The cost of your insurance depends on the cost of the type of cover you select. Generally, the greater the amount of cover, the more expensive it is.
Stamp duty	Where charged, stamp duty increases your premium as the premium reflects the duty we believe is payable, according to stamp duty laws and practices.
Any loadings or special provisions applied to the policy	Some loadings or special provisions may increase the cost of your insurance premium.

Policy fee

We, as insurer, charge a policy fee to cover some of the administration costs of setting up and maintaining the insurance policy.

The annual policy fee you are charged depends on your premium payment frequency, as shown in the table below:

Premium payment frequency	Annual policy fee
Monthly	$90
Quarterly	$84
Half-yearly	$80
Annually	$75

Minimum premium and policy fee

The minimum amount you must pay in total for premium and policy fee is as follows:

Frequency	Minimum amount	
	Total Care Plan, Total Care Plan Super and SMSF Plan	Income Care, Income Care Plus and Income Care Platinum
Annual	$250	$300
Half-yearly	$130	$160
Quarterly	$70	$85
Monthly	$25	$30

There is no minimum amount for a Total Care Plan policy which is a *flexi-linked policy* or to which *split TPD* applies. Also, there is no minimum amount for the *split IP ordinary policy.*

Premium payment options and frequency charge

You can pay premiums monthly, quarterly, half-yearly or annually. If you decide to pay by direct debit, your financial institution may charge you for setting up and making direct debit payments. Your financial institution can provide more information.

If you choose to pay your premiums more frequently than annually, you will pay a frequency charge.

Here is a summary of the various payment options and the applicable frequency charge.

Method of premium payment	Premium payment frequency			
	Monthly	Quarterly	Half-yearly	Annually
Direct debit	✔	✔	✔	✔
Credit card	✔	✔	✔	✔
Employer contributions paid via super stream	✔	✔	✔	✔
FirstChoice Super payment method. See page 119	✔	✔	✔	✔
External Super payment method. See page 119	–	–	–	✔
Frequency charge	8% of annual premium excluding policy fee		4% of annual premium excluding policy fee	Nil

When premiums are charged?

If your method of premium payment is Direct Debit or Credit Card, premiums are charged to your bank or credit card account on the 1st, 7th, 14th, 21st or 28th day of the month next following the date your application is accepted.

For example, if your application is accepted on 29 June and you're paying by direct debit, your bank account will be debited on 1 July.

Changing the frequency charge and policy fee

We, as insurer, can increase the policy fee and frequency charge at any time but you'll be given at least 30 days' notice before any such increase.

Policy fee waiver

When you apply for your policy, we'll assess whether you qualify for a policy fee waiver.

If you do, the waiver applies as follows:

- If, on accepting your application for the policy, there is cover for the same *life insured* under:
  - a Total Care Plan policy or a Total Care Plan Super/ SMSF Plan policy that is not a *split IP super policy* (the waived policy) and
  - an Income Care, Income Care Plus, Income Care Platinum or Business Overheads Cover policy (the other policy),

we won't charge the policy fee on the waived policy or policies for as long as the other policy remains in force on the same *life insured*.

If, however, the other policy starts after the waived policy or policies, we only stop charging the policy fee from the next *premium due date* under the waived policy or polices.

- A policy fee isn't payable under a *split IP ordinary policy*.
- A policy fee isn't payable under a policy while it's a *flexi-linked policy*.
- A policy fee isn't payable on a Total Care Plan policy to which *split TPD applies*.

Commission

Our current practice is to pay commissions and other benefits to financial advisers. We factor these amounts into the cost of the insurance and aren't additional amounts you have to pay.

No surrender value

Your policy doesn't have a surrender or cash-in value at any point.

What we do with your premiums

The premiums for Total Care Plan, Income Care, Income Care Plus, Income Care Platinum, Business Overheads Cover and SMSF Plan are placed in our No.5 Statutory Fund and benefits are paid from that fund.

Premiums for Total Care Plan Super are placed in our No. 1 Statutory Fund and benefits are paid from that fund.

If we cancel insurance

If we cancel your insurance because you haven't paid the premium, you can apply to have it reinstated within twelve months of the date the unpaid premium became due.

The following conditions apply:

- we must receive, to our satisfaction, evidence of health, occupation, pastimes or other relevant information
- if your cover is reinstated, it only restarts from the reinstatement date
- we may impose conditions for the reinstated cover (including, for a *super policy*, any conditions we consider necessary for the policy to be consistent with super law)
- we won't pay a benefit for anything that happened or first became apparent while the cover was not in force
- if we re-instate the policy, you must pay all unpaid premiums.

Premium quote

A premium quote is available on request from your adviser.

How to make a claim.

You must promptly tell us in writing of any claim or potential claim.

You and the *life insured's* attending *medical practitioner(s)* must complete the claims kit and return it to us.

When we receive it we'll assess your claim and let you know the outcome. We will contact you if we need more information.

What we need from you

We won't pay a claim unless you meet our claims requirements.

Proof of age

We won't pay any benefit until we receive proof of the *life insured's* age which is satisfactory to us.

Financial and other information

We may also ask you to give us, at your expense, other information we consider necessary to assess the claim. This may include an examination of the *life insured's* financial records and tax returns.

If the *life insured* is *self-employed*, a working director or a partner in a partnership, we may also examine the accounting records of the *business* or practice if we consider this necessary.

We may also ask you to keep a record of your daily activities and provide us with this information on a regular basis.

Medical and other examinations

We only pay a benefit if the *life insured* undergoes, at our expense, any medical or other examination we consider necessary. Medical examinations are conducted by a *medical practitioner* of our choice.

If an income protection or Business Overheads Cover claim is on-going, you must at your expense give us regular evidence of the *life insured's* state of health.

We also require the *life insured's* authority to obtain further medical information about them.

In certain circumstances, we may ask a *medical practitioner* of our choice to independently review the available medical evidence to confirm the findings of other *medical practitioners* as to the existence of the relevant medical condition (e.g. *terminal illness*).

Once we make a payment to you or as instructed by you, we have fulfilled our obligation and you are responsible for how the money is disbursed.

Regular reporting

If you're being paid an income protection or Business Overheads Cover claim, we'll ask you to give us regular evidence of the *life insured's* state of health, at your own expense. From time to time we'll also ask you to provide medical reports, proof of earnings and receipts of any business expenses you claim.

Your obligations

Our obligation to pay benefits depends on you meeting your claims and other obligations under the policy.

Flexi-linking, split TPD and split IP.

Flexi-linking

If *flexi-linking* applies to this policy, the following additional terms and conditions apply to it, depending on whether the policy is the *primary policy* or the *flexi-linked policy*. Whether *flexi-linking* applies and whether this policy is the *primary policy* or *flexi-linked policy* is shown on your policy schedule.

If this policy is the *flexi-linked* policy

- The amount of any *flexi-linked Trauma Cover* is reduced by the amount of any *TPD Cover benefit* payable under the *primary policy*.
- The *flexi-linked rider* cover ends if the *primary Life Care* ends for any reason (e.g. payment of a Terminal illness benefit, cancellation due to non-payment of premiums).
- The amount of the *flexi-linked rider* cover automatically reduces so it's never greater than the *primary Life Care*.
- Indexation can't apply unless it also applies under the *primary policy*.
- Indexation ceases to apply if it ceases to apply under the *primary policy*.

If this policy is the primary policy

- The amount of any *TPD Cover* is reduced by the amount of any benefit payable under the *flexi-linked Trauma Cover*.
- The amount of the *primary Life Care*, including any bonus or booster benefits, is reduced by the amount of any benefit, including any bonus or booster benefits, payable under the *flexi-linked Trauma Cover* or *flexi-linked TPD Cover*.
- The Guaranteed Insurability option (personal events) ceases to apply when *flexi-linked Trauma Cover* is reinstated under the Trauma Reinstatement benefit or the Trauma Reinstatement Booster option applying under the *flexi-linked policy*.
- Indexation can't apply unless it also applies under the *flexi-linked policy*.
- Indexation ceases to apply if it ceases to apply under the *flexi-linked policy*.

Split TPD

If *split TPD* Cover applies under this policy, the following additional terms and conditions apply to the policy, depending on whether the policy is the *super policy* or the Total Care Plan policy. Whether *split TPD Cover* applies under this policy and whether this policy is the *super policy* or Total Care Plan policy is shown on your policy schedule.

If *split TPD* hasn't ended earlier, it ends on the *policy anniversary date* before the *split life insured's* 65th birthday.

If this policy is the Total Care Plan policy

- The *TPD Cover benefit* ends and no *TPD Cover benefit* (or other related benefit) is ever payable if *a Life Care, TPD Cover* or Terminal illness benefit becomes payable under the *split TPD super policy*.
- We only ever pay a *TPD Cover benefit* under this policy or the *split TPD super policy* but never both, except where we first pay a *TPD Cover benefit* for *partial and permanent disability* under this policy and then later pay a *TPD Cover benefit* under the *split TPD super policy*.
- The *TPD Cover* ends if the *TPD Cover* under the *split TPD super policy* ends for any reason.
- The *TPD Cover* automatically reduces to the same amount of *TPD Cover* that applies under the *split TPD super policy*.
- Indexation can't apply unless it also applies under the *split TPD super policy*.
- Indexation ceases to apply if it ceases to apply under the *split TPD super policy*.

If this policy is the split TPD super policy

- The *TPD Cover* ends and no *TPD Cover benefit* (or other related benefit) is ever payable, if we pay a *TPD Cover benefit* under the Total Care Plan policy because a *TPD Cover benefit* wasn't payable under this policy. This doesn't apply if the *TPD Cover benefit* we pay is for *partial and permanent disability*.
- We only ever pay a *TPD Cover benefit* under this policy or the Total Care Plan policy but never both, except where we first pay a *TPD Cover benefit* for *partial and permanent disability* under the Total Care Plan policy and then later pay a *TPD Cover benefit* under this policy.
- The *Life Care* and *TPD Cover*, including any bonus or booster benefits, is reduced by the amount of any *TPD Cover benefit* payable under the Total Care Plan policy, including for *partial and permanent disability* or any bonus or booster benefits.
- The *TPD Cover* automatically reduces to the same amount of *TPD Cover* that applies under the Total Care Plan policy.
- The *TPD Cover* can continue even if the *TPD Cover* under the Total Care Plan policy ends.
- Indexation can't apply unless it also applies under the Total Care Plan policy.
- Indexation ceases to apply if it ceases to apply under the Total Care Plan policy.

Split IP

If *split IP* applies, the following additional terms and conditions apply depending on whether the policy is the *split IP super policy* or the *split IP ordinary policy*. Your policy schedule shows whether *split IP* applies and whether the policy is the *split IP super policy* or *split IP ordinary policy*.

If *split IP* hasn't ended earlier, it ends on the *cover expiry date* for income protection.

If this policy is the *split IP ordinary policy*

- We won't pay a benefit under it while the same benefit is payable under the *split IP super policy*, unless:
  - this policy states otherwise or
  - the amount we would pay under this policy is more. If it is, we pay the difference under this policy.
- The cover under it ends if the cover under the *split IP super policy* ends.
- Indexation can't apply unless it also applies under the *split IP super policy*.
- Indexation ceases to apply if it ceases to apply under the *split IP super policy*.

If this policy is the *split IP super policy*

- You aren't entitled to a Total Disability benefit or Partial Disability benefit while a Specific Injuries benefit or Crisis benefit is payable under the *split IP ordinary policy*.
- The cover under it can continue even if the cover under the *split IP ordinary policy* ends.
- Indexation can't apply unless it also applies under the *split IP ordinary policy*.
- Indexation ceases to apply if it ceases to apply under the *split IP ordinary policy.*

General policy conditions.

Legal interpretation

The policy is governed by the laws of New South Wales.

Changes in the law

We can immediately change any of the terms and conditions of the policy, including premiums, if there is a material change to the law and as a result:

- it becomes impossible or impractical to carry out our obligations under the policy
- the basis of taxation on us or the policy is changed
- government levies relating to us or the policy are imposed or changed or
- the provisions of the policy would otherwise become inconsistent with the law.

This doesn't apply to the extent it would prevent the policy from being treated as life insurance business under the Life Insurance Act 1995 (or any legislation that replaces it).

We'll notify you of any variation of the policy we make.

Notices

Unless you and we otherwise agree:

- you must give any notices to us in writing
- any notice which we give to you must also be given in writing and is effective if it's delivered personally or delivered or posted to the address last known to us.

Policy schedule

The policy schedule contains the individual details of your policy and must be read in conjunction with these policy conditions.

Worldwide cover

Once the policy is issued, it provides cover 24 hours a day, wherever the *life insured* is in the world, subject to any specific exclusions.

Upgrade provision

If we introduce future versions of the policy, we'll upgrade all policies in a group to include the improved terms and conditions within a reasonable time frame, but only if no policy in the group is disadvantaged.

Improved terms and conditions don't apply to any medical conditions the *life insured* already had when the improvement took place.

General conditions for Continuation options

The continuation options described on pages 36, 50, 67 and 92 can only be exercised on the following basis:

- during the term of this policy, we have received written notice of your intention to convert and the first premium payable under the new policy
- the date of conversion is the first day after the end of this policy and
- this policy is in force and all premiums are paid to the date of conversion.

New policy issued under Continuation options

The new policy issued under the Continuation options:

- will be issued on the *life insured's* life
- will be owned by the *life insured* or a trustee of a super plan holding the policy for the *life insured's* benefit
- may, in the case of a new Total Care Plan policy, contain benefits similar to the *TPD Cover* and Plan Protection option under this policy on the date it's converted, as long as:
  - the benefit applies under this policy
  - the benefit is generally available on the new policy and
  - when aggregated with all similar benefits under any other policy or policies we've issued on the *life insured's* life, the total amount would not exceed the maximum benefit that we accept.
- will provide cover on and from the date of conversion
- will be issued upon and subject to the same privileges, terms and conditions (including exclusions) as similar policies we issue at the date of conversion
- will require payment of a premium calculated according to our premium rates and policy fees applying for the class of policy at the date of conversion
- may include extra premiums and/or special provisions or conditions we consider correspond to those we've applied under this policy.

Transfer of ownership

You can generally transfer the ownership of a policy by completing a Memorandum of Transfer and having it registered by us. However certain requirements may need to be met if transferring ownership to or from a super fund.

SMSF Plan

If you hold an SMSF Plan, you agree to operate the SMSF at all times in accordance with the trusts of the fund and in a manner which ensures that it complies with the Superannuation Industry (Supervision) Act 1993 (SIS).

You also agree to notify us if at any time the policy ceases to be subject to the trusts of the SMSF, or the SMSF ceases to be administered in accordance with its trusts, or it ceases to comply with SIS. Should any of these events happen we may terminate the SMSF Plan and issue a replacement policy, or make any changes to the terms and conditions of the policy as we consider appropriate.

When cover starts and ends

Cover for a *life insured* under the policy starts from the date we confirm in writing.

Cover for the *life insured* ends on the first of:

- the *cover expiry date* for the cover (or, if applicable, the extended cover expiry date)
- the date the policy ends
- the death of the *life insured*
- the date we cancel the cover:
  - because you request us to cancel your cover (you must do this in writing) or
  - for non-payment of premium or
  - for any other reason.

If the cover is income protection and Business Overheads Cover doesn't apply, the cover also ends if the *life insured* suffers *permanent disablement* and a *Permanent Disablement benefit* is paid.

Refunds

We may refund premiums if we receive a written request from you to cancel cover. This depends on when your premiums are paid up to.

Confirmation of Alternative Policy Terms under electronic applications

This policy terminates at midnight on the date which is 28 days after the *date insured from* ('termination date') if:

- this policy was applied for electronically via our online application process and, before the application was made, alternative policy terms applied to the application as part of the process; and
- we did not receive, on or before the termination date, a Confirmation of the Alternative Policy Terms in the form, and signed by the persons, required by us.

Cancellation of an existing policy

If it was indicated in the application for this policy that this policy is to replace existing cover that insures the *life insured*, the cover under this policy is conditional on that existing cover being cancelled before the occurrence of an insured event under the existing cover.

Until this cancellation occurs, no cover applies under this policy despite any provision in it to the contrary. If cover under this policy exceeds the existing cover to be replaced, cover only applies under this policy to the extent that it exceeds the existing cover.

Part D. Other things you need to know.

This part tells you about other things you need to know, such as taxation, risks and so on

Taxation.

This section provides general information about taxation implications. As individual circumstances can differ, you should discuss any taxation issues with your tax adviser.

Total Care Plan

Generally, premiums for Total Care Plan policies aren't tax deductible but, in most situations, any benefits we pay to the policy owner or their estate aren't subject to personal tax.

In some circumstances it's possible to claim a tax deduction for premiums paid but this may result in benefits being assessable income for tax purposes. This could apply if, for example, an employer or business owns the policy and is paying the premiums.

Income Care, Income Care Plus and Income Care Platinum (including Business Overheads Cover)

You can generally claim the premium for your policy as a tax-deduction against your assessable income. For Income Care, Income Care Plus and Income Care Platinum, this applies whether you're self-employed or employed.

Generally, any Income Care, Income Care Plus or Income Care Platinum benefits (including any super continuance monthly benefit) and Business Overheads Cover benefits are treated as assessable income and taxed accordingly. Special considerations apply to the Permanent Disablement Cover option, Crisis benefit and Super Continuance monthly benefit.

Permanent Disablement Cover option

If you select this option, approximately 10% of your premiums won't be tax-deductible. We'll tell you the exact amount of non-deductible premiums in an annual premium statement.

If you receive a lump sum under the option, it generally won't be treated as assessable income and therefore won't be taxable.

Crisis benefit

If we pay a lump sum Crisis benefit it won't be treated as income and won't be taxable.

Super continuance monthly benefit

The super continuance monthly benefit is paid to your nominated super fund as your personal contribution and should be included in your assessable income and treated by the fund trustee as a non-concessional contribution.

If you satisfy the tests for claiming a tax-deduction for personal super contributions and give the trustee the appropriate notices within the required timeframes, you may claim some or all of the super continuance monthly benefit as a tax-deduction and the super fund trustee will treat the equivalent amount as a taxable contribution.

Total Care Plan Super

Contributions

Contributions can either be pre-tax or after tax.

Pre-tax contributions include those made by your employer or those made personally for which you're eligible to claim a tax deduction. Pre-tax contributions are also known as concessional contributions and are generally taxed at 15% when received by your super fund (although the tax-deduction available to the FirstChoice Trust when used to pay eligible premiums generally offsets this tax liability).

After tax contributions are also known as non-concessional contributions and are those you make personally for which you can't claim a tax deduction, as well as contributions your spouse makes for you. They may instead entitle you to a super co-contribution of up to $500, depending on your total income and your level of after tax contributions.

The Australian Taxation Office (ATO) monitors all super contributions made in relation to members and tests these against the contributions caps described below.

Concessional contributions cap

The concessional contributions cap is $25,000*.

Concessional contributions within the cap are taxed at 15% for most people, although an extra 15% tax applies to part or all of your concessional contributions if you earn more than $250,000* (including these contributions). Excess concessional contributions are effectively taxed at your marginal tax rate, plus an interest charge. You may elect to withdraw up to 85% of the excess from the super fund. Excess concessional contributions will also count towards your non-concessional contributions cap, unless withdrawn.

Non-concessional contributions cap

Also known as after-tax contributions, non-concessional contributions are not taxed when received by your super fund. The non-concessional contributions cap is $100,000*. If you're under 65 any time during a financial year, you can elect to use a 'bring forward rule', which allows you to also bring forward up to the next two years' worth of cap and contribute up to $300,000* any time during a three-year period. However, if your total superannuation balance at 30 June 2017 is equal to or greater than $1.6 million, your non-concessional contributions cap is Nil.* In addition, if your total superannuation balance at that time is close to $1.6 million, the amount you can contribute under the 'bring forward rule' may be reduced.

If you exceed your non-concessional cap, you can elect to withdraw any contributions exceeding your cap, plus 85% of an associated earnings amount. The withdrawn contribution is not taxed, but 100% of the associated earnings amount is taxed at your marginal tax rate, less a 15% tax offset. If you do not withdraw non-concessional contributions that exceed your cap, they will be subject to excess non-concessional contributions tax of 45%* (plus applicable levies and charges).

* From 1 July 2018 income tax year

Super member benefits

Any tax free component is always received tax free.

The taxable component (taxed element) is taxed as follows:

Age	Super lump sum benefits (inclusive of Medicare Levy)	Super Income Streams
Age 60 and above	Not subject to tax	Not subject to tax
Preservation age to 59	First $205,000** (indexed), 0% Balance over $205,000**, 17%	Marginal tax rates (MTR)* less a 15% tax offset
Below preservation age	22%***	MTR* (no tax offset entitlement unless disability super income stream)

* Applicable levies and charges may apply

**Low rate cap (from 1 July 2018 income tax year)

***Where your marginal tax rate is lower than the specified rate it will apply instead.

Death benefits

Depending on the recipient of your death benefits, it may be paid as a lump sum, income stream or a combination of both.

The amount of tax payable on any benefit paid as a lump sum on death depends on who receives the benefit. If the lump sum is paid to a death benefits dependant (under tax law) there is no tax payable.

A person qualifies as a death benefits dependant if they are:

- a spouse, including a person to whom you're married, a person (whether of the same or a different sex) with whom you are living on a genuine domestic basis in a relationship as a couple or a person with whom you are in a relationship registered under state or territory law
- a former spouse
- a child (including an adopted child, step child or ex-nuptial child, a child of your spouse or your child within the meaning of the Family Law Act 1975) under age 18
- a person with whom you have an interdependency relationship, or
- a person financially dependent on you.

A child aged 18 or over isn't generally considered a death benefits dependant, unless they are financially dependent. Therefore, lump sum death benefits paid to children aged 18 or over aren't usually tax free.

The division of final benefits into tax-free and taxable (including taxed and untaxed elements) is determined by formulae in the tax legislation which consider individual factors including period of fund membership and age at death.

Taxation of super death benefits paid to a death benefits dependant

Any tax free component is always received tax free.

The taxable component is taxed as follows:

Age of deceased	Type of Super death benefit	Age of recipient	Taxation treatment
Any age	Lump sum	Any age	Tax free (refer above)
Age 60 and above	Income stream	Any age	Tax free
Under 60	Income stream	Age 60 and above	Tax free
Under 60	Income stream	Under 60	MTR* less 15% tax offset

*Applicable levies and charges may apply.

Please note that:

- The taxable component of super death benefits paid as a lump sum to a non-death benefits dependant is subject to 17% (inclusive of Medicare Levy) on the taxed element and 32% (inclusive of Medicare Levy) on the untaxed element.
- Super death benefits paid to your legal personal representative are treated as if they have been paid to a death benefits dependant to the extent these beneficiaries have or could be expected to benefit from the death benefit, and are treated as if they have been paid to a non-death benefits dependant to the extent that these beneficiaries have or could be expected to benefit from the death benefit. Any tax payable is payable by the legal personal representative but Medicare Levy does not apply.
- If the person receiving the benefit doesn't provide their tax file number before the payment is made, total taxable component will be subject to PAYG withholding tax of 45% or 47% depending on residency for tax purposes, plus any applicable levies and charges.
- Super death benefits paid to the legal personal representative of a deceased estate aren't subject to Pay As You Go (PAYG) withholding tax.

Terminal medical conditions

You will receive a lump sum in the event of a terminal medical condition (i.e. terminal illness).

Lump sum payments made under the super condition of release 'terminal medical condition' are entirely free from income tax.

Total and Permanent Disability (TPD) benefits paid from Total Care Plan Super

You may elect to receive a lump sum or income stream in the event of TPD.

Where a lump sum is paid, you may qualify for an increase in your tax free component as determined by a formula in the tax legislation which considers individual factors including period of fund membership and age at date of disability.

Where a lump sum is paid, any tax free component is always received tax free.

The taxable component (taxed element) is taxed as follows:

Benefit recipient's age	Treatment of taxable component (includes Medicare Levy)
Under preservation age	Taxed at 22%**
Preservation age to 59	First $205,000*; 0%, Remainder, 17%**
Age 60+	Tax-free

*Low rate cap (from 1 July 2018 income tax year)

**Where your marginal tax rate is lower than the specified rate it will apply instead.

Where an income stream is paid, any tax free component is always received tax free.

The taxable component (taxed element) is taxed as follows:

Age	Treatment of taxable component (includes Medicare Levy)
Age 60 and above	Not subject to tax
Below age 60	Marginal tax rates (MTR)* less a 15% tax offset

* Applicable levies and charges may apply.

Generally, split TPD premiums referable to super policies taken out by super fund trustees may be claimable as a tax deduction to the trustees and benefits paid may be subject to super and taxation laws. However, as individual trustee circumstances may differ, we recommend that you seek taxation advice on the appropriate taxation treatment of your split TPD premiums and/or benefits.

Income protection benefits

The tax laws treat income protection benefits similar to salary or wages, so when paying any benefit to you the trustee of the FirstChoice Trust must deduct tax at PAYG withholding rates from each payment. The Superannuation Pension tax offset doesn't apply to income protection benefits.

You will be required to complete a Tax File Number declaration form so the trustee of the FirstChoice Trust knows how much tax to withhold.

Other taxes and levies

From time to time the federal government may impose additional taxes or levies which the trustee of the FirstChoice Trust may need to deduct from any super benefit payment.

SMSF Plan and split TPD/IP

You should discuss with your tax adviser the taxation implications of your SMSF holding the SMSF Plan and taking out split TPD/IP.

Changes and enquiries.

How do you ask us to make changes?

It's really important you tell us if your personal details change, especially your mailing address. If you need to change your personal details please ensure you notify us by contacting us on **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday. If you don't, you risk missing important updates about your application or cover.

You may also want to change your level of insurance protection to reflect changing circumstances. Please speak to your financial adviser or phone one of our Customer Service Consultants.

Enquiries

You must be provided with any information you reasonably require to understand your benefits.

For further information about CommInsure Protection or an explanation of your benefits or if you have any other enquiries please contact one of our Customer Service Consultants on **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday.

Changes to this PDS.

The information in this PDS is up to date as at the issue date stated on the front cover of the PDS but is subject to change from time to time. Where a change of information isn't materially adverse, a new PDS or supplementary PDS may not be issued with the updated information.

Instead, you'll be able to find the updated information on the website **https://commbank.com.au/personal/insurance/brochures-forms** or you can call **13 1056** between 8 am and 8 pm (Sydney time) Monday to Friday. If you request a paper copy of the information, we will send it to you free of charge.

Responsible investment.

CommInsure is a signatory to the United Nations Principles for Responsible Investment and aims to be a responsible investor by considering environmental, social and corporate governance (ESG) factors in the investment decision making process. CommInsure believes that the consideration of ESG factors or risks into investment decisions enhances long-term fund performance. Policyholder premiums are invested by CommInsure to pay out future claims.

How to make a complaint.

Most problems can be resolved quickly and simply by talking with us. You can call one of our Customer Service Consultants on **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday, to get help resolving your problem.

If you wish, you may also lodge your complaint in writing. Please send your written complaint to:

cservice@cba.com.au

or

Complaints Manager
Customer Relations
Commonwealth Bank Group
Reply Paid 41
Sydney NSW 2001

Please mark your letter 'Notice of Complaint'.

When you make a complaint we will:

- acknowledge your complaint and make sure we understand the issues
- investigate the cause of your concern
- do everything we can to fix the problem
- respond to you as quickly as possible
- keep you informed of our progress if the matter can't be resolved quickly
- keep a record of your complaint
- give you our name, a reference number and contact details so that you can follow up if you want to; and
- provide a final response within 90 days for Total Care Plan Super and 45 days for other products.

If we're unable to provide a final response to your complaint within the relevant period, we'll:

- inform you of the reasons for the delay;
- advise of your right to complain to the relevant external dispute body and
- provide you with the contact details for the relevant external complaints body.

If you're not satisfied with our handling of your complaint or our response to your complaint, you may have the right to lodge a complaint with the:

- Superannuation Complaints Tribunal (SCT) for Total Care Plan Super or
- Financial Ombudsman Service Limited (FOS) for Total Care Plan, Income Care, Income Care Plus, Income Care Platinum and the SMSF Plan.

External dispute resolution

Superannuation Complaints Tribunal (SCT)

If you're not satisfied with the FirstChoice Trust's handling of your complaint or decision about Total Care Plan Super, you may have the right to lodge a complaint with the SCT. The SCT is a Commonwealth body that deals with complaints about super.

Before the SCT has jurisdiction to deal with the matter, it must be satisfied that the complaint was referred to an appropriate person under the FirstChoice Trust's internal enquiries and complaints arrangements. The SCT can't deal with your complaint until you have made reasonable efforts to have the complaint resolved by the FirstChoice Trust. If, after you've made a complaint to the FirstChoice Trust, you're not satisfied with the response, or don't receive a response, within 90 days, you can then lodge a complaint with the SCT.

The SCT can't deal with certain matters, for example decisions that relate to the management of the FirstChoice Trust as a whole, such as investment performance, the level of fees and charges or employer decisions. If the SCT accepts the complaint, it will attempt to resolve the matter through conciliation. If a complaint can't be resolved by conciliation and hasn't been withdrawn by the SCT, it proceeds to review.

This means the SCT will consider submissions and make a decision to work out the outcome of the complaint. To contact the SCT, you can telephone **1300 884 114** between 9 am and 5 pm (Sydney time), Monday to Friday from anywhere in Australia. Alternatively, visit their website at **www.sct.gov.au**.

Financial Ombudsman Service Limited (FOS)

If you aren't satisfied with our response to your complaint about one of our products (other than Total Care Plan Super) you may refer your complaint to the FOS.

FOS offers a free, independent dispute resolution service for the Australian banking, insurance and investment industries. FOS will advise you of any complaints it can't consider when you contact it.

To contact FOS, you can:

- telephone **1800 367 287** between 9 am and 5 pm (Sydney time), Monday to Friday
- go online at **www.fos.org.au**
- write to:

  Financial Ombudsman Service Limited
  GPO Box 3
  Melbourne VIC 3001

Australian Financial Complaints Authority

The Australian Government is in the process of replacing FOS and the SCT with a single complaints handling body called the Australian Financial Complaints Authority (AFCA). AFCA is expected to operate from 1 November 2018, at which date life insurance and superannuation customers can take their complaints to AFCA.

Privacy of personal information.

Collection information

The information we collect about you as a customer includes information such as your identity and contact details, other personal details such as gender, marital status and financial information.

How we collect it

We collect this information directly from you and from others such as service providers, agents, advisers, brokers, employers or family members.

The law may require us to identify our customers. We do this by collecting and verifying information about you and persons who act on your behalf. The collection and verification of information helps to protect against identity theft, money-laundering and other illegal activities. We may disclose your personal information in carrying out verification e.g. we may refer to public records to verify information and documentation or we may verify with an employer that the information that you have given is accurate.

What we collect

Depending on whether you are an individual or organisation the information we may collect may vary.

We also collect medical and lifestyle information. Where we need to obtain lifestyle and medical information from health professionals or other parties, we will ask for your consent, except where otherwise permitted by law.

If you're commonly known by two or more different names, you must give us full details of your other name or names. Also, during your relationship with us we may also seek and collect further information about you and about your dealings with us.

Accuracy

It's important you provide us with accurate and complete information. If you don't, you may be in breach of the law and we may not be able to provide you with products and services that best suit your needs.

How do we use your personal information?

We collect, use and exchange your customer information so that we can:

- establish and verify your identity and assess applications for products and services
- price and design our products and services
- administer our products and services
- manage our relationship with you
- manage our risks and help identify and investigate illegal activity, such as fraud
- contact you, for example if we need to tell you something important
- conduct and improve our businesses and improve the customer experience
- comply with our legal obligations and assist government and law enforcement agencies or regulators
- identify and tell you about other products or services that we think may be of interest to you.

We may also collect, use and exchange your information in other ways permitted by law.

Electronic communication

If you've given us your electronic contact details, we may use these details to provide information to you electronically, for example, sending reminders via SMS or email. You may receive information on the Commonwealth Banks group's products and services electronically.

Direct marketing

If you don't want to receive direct marketing from us or want to update your direct marketing preferences, you can tell us by calling **13 1056** Monday to Friday 8 am and 8 pm (Sydney time).

Gathering and combining data to get insights

Improvements in technology enable organisations, like us, to collect and use information to get a more integrated view of customers and provide better products and services.

The Commonwealth Bank group may combine customer information it has with information available from a wide variety of external sources (for example census or Australian Bureau of Statistics data). We are able to analyse the data in order to gain useful insights which can be used as mentioned above.

In addition, Commonwealth Bank group members may provide data insights or related reports to others, for example to help them understand their customers better. These are based on aggregated information and do not contain any information that identifies you.

Protecting your information

We comply with the Australian Privacy Principles as incorporated into the Privacy Act 1988 (Cth). The Privacy Act protects your sensitive information, such as health information that's collected on insurance applications.

Who do we exchange your information with?

We may exchange your personal information with other members of the Commonwealth Bank group, so that the group may adopt an integrated approach to its customers. Group members may use this customer information in the same way we use your information (see 'How do we use your personal information?' on this page).

We may exchange your information with third parties where this is permitted by law or for any of the purposes we use your information.

Third parties include:

- your employer or former employers
- brokers, agents and advisers and persons acting on your behalf, for example guardians and persons holding power of attorney
- medical practitioners (to verify or clarify, if necessary, any health information you may provide)
- reinsurers and auditors
- claims-related providers such as assessors and investigators (so that any claim you make can be assessed and managed), insurance reference agencies (where we're considering whether to accept a proposal of insurance from you and, if so, on what terms)
- organisations to whom we may outsource certain functions, for example, direct marketing, statement production and information technology support
- government and law enforcement agencies or regulators
- entities established to help identify illegal activities and prevent fraud.

In all circumstances where our contractors, agents and outsourced service providers become aware of customer information, confidentiality arrangements apply. Customer information may only be used by our agents, contractors and outsourced service providers for our purposes.

We may be required to disclose customer information by law, e.g. under Court Orders or Statutory Notices pursuant to taxation or social security laws or under laws relating to sanctions, anti-money laundering or counter terrorism financing.

Sending information overseas

From time to time we may send your information overseas, including to overseas Commonwealth Bank group members and to service providers or other third parties who operate or hold data outside Australia. Where we do this, we make sure that appropriate data handling and security arrangements are in place. Please note that Australian law may not apply to some of these entities.

Information may also be sent overseas to complete certain transactions (such as the assessment of your insurance application or management of your claim), or where this is required by law and regulation of Australia or another country. Other overseas parties can include reinsurers, medical or rehabilitation practitioners.

For more information about which countries we may send your information to, see the Commonwealth Bank group privacy policy available at **commbank.com.au**.

Viewing your personal information

You can (subject to permitted exceptions) request access to your personal information by contacting Customer Relations:

Email: CustomerRelations@cba.com.au

Phone: **1800 805 605** between 8.30 am - 6.00 pm (Sydney/Melbourne time) Monday to Friday

Write to: CBA Group Customer Relations
Reply Paid 41
Sydney NSW 2001

We may charge you for providing access. For more information about our privacy and information handling practices, please refer to the Commonwealth Bank group Privacy Policy, which is available through **commbank.com.au** or on request from any Commonwealth Bank branch.

Making a privacy complaint

We accept that sometimes we can get things wrong. If you have a concern about your privacy you have a right to make a complaint and we'll do everything we can to put matters right. For further information on how to make a complaint and how we deal with your complaint please refer to Commonwealth Banks Group's Privacy Policy, which is available at **commbank.com.au** or upon request at any Commonwealth Bank branch.

Part E. More information about Total Care Plan Super.

This part contains information about the superannuation aspects of Total Care Plan Super

Paying your premiums.

When you take cover under Total Care Plan Super, you are making superannuation contributions so the insurance premiums can be paid for you by the trustee of the FirstChoice Trust. To contribute to superannuation, you must be eligible to do so.

Generally, the trustee of the FirstChoice Trust can only accept contributions to the FirstChoice Trust in the following circumstances:

If you are:	The trustee of the FirstChoice Trust can accept:
under 65 years	◆ compulsory employer contributions (i.e. superannuation guarantee, award) and ◆ other employer or personal contributions.
65 to 69 years	◆ compulsory employer contributions (i.e. superannuation guarantee, award) and ◆ other employer or personal contributions if you're gainfully employed for at least 40 hours in a period of not more than 30 consecutive days in the financial year in which the contributions were made.
70 to 74 years (includes up to 28 days after the month in which you turn 75)	◆ compulsory employer contributions (i.e. superannuation guarantee, award) and ◆ other employer contributions or personal contributions you made if you're gainfully employed for at least 40 hours in a period of not more than 30 consecutive days in the financial year in which the contributions were made.
75 years and over	◆ compulsory employer contributions (i.e. superannuation guarantee, award).

Transfers or rollovers

Super payment method

You can pay your premiums by transferring or rolling over money from:

- a superannuation account in the FirstChoice Trust (we call this the FirstChoice Super Payment Method) or
- a selected complying super fund (we call this the External Super Payment Method because the premium is transferred from a fund other than the FirstChoice Trust).

To do this, you'll need to complete a Superannuation Payment Authority (Authority) which allows us to act on your behalf to transfer or rollover money.

When paying by the FirstChoice Super Payment Method, you can pay monthly, quarterly, half-yearly or annually.

When paying by the External Super Payment Method, you can only:

- pay annually
- pay from a super fund we'll accept transfers from and
- for a rollover, rollover from a taxed source.

For more information contact our Customer Service Consultants on **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday.

If you choose the FirstChoice or External Super Payment Method, we're only authorised to request the amount required to pay the annual premium, policy fee and frequency charge. The Authority is a standing order that applies to the first and all subsequent transfers or rollovers until you withdraw it in writing and nominate another method of payment or cancel your cover.

Rollover rebate

If you pay your premium using either the FirstChoice or External Super Payment Method, a rollover rebate of 15% applies to your premium which reduces the amount you need to pay.

The calculation of the rollover rebate is based on 15% of the total amount of the premium, policy fee and frequency charge.

For example, if:

- the total you pay is $1,000 and
- you pay using the FirstChoice Super Payment Method

a $150 rebate is applied (i.e. 15% of $1,000). The rollover rebate is applied, meaning you only need to pay $850.

If this policy ends the Rollover rebate does not have any cash or surrender value.

The rollover rebate is a benefit paid at the discretion of the trustee of the FirstChoice Trust and may be withdrawn or changed in the future.

Total Care Plan Super Rollover Discount

If you take out Total Care Plan Super on stepped premiums and choose to pay using the FirstChoice or External Super Payment Method, a 10% discount will be applied by us to the premiums (but not the policy fees) for any Life Care and TPD Cover. The discount applies for as long as you maintain your Total Care Plan Super cover on this basis.

Refunds

If your cover under Total Care Plan Super ends, any premiums refunded are subject to super law and taxation. After deducting applicable taxes, premium refunds are transferred to a superannuation fund of your choice or, if you don't choose, the SuperTrace Eligible Rollover Fund.

Employer Contributions

Your employer is also able to make contributions to cover your insurance premiums. To comply with super regulations, your employer is obliged to use the electronic Contribution Transaction Request messaging and payment process. As a result, the available payment mechanisms are limited to Direct Credit or BPAY via a specific employer arrangement.

For information on how to establish this arrangement your adviser will be able to guide you or please contact our Customer Service Consultants on **13 1056** between 8 am and 8 pm (Sydney time), Monday to Friday.

Restrictions on access to benefits.

If we pay a claim, we pay the benefit to the trustee of the FirstChoice Trust (who is the policy owner).

Interest accrues on insurance benefits from the date liability is admitted under the policy to the date the trustee of the FirstChoice Trust pays the benefit or transfers it from the FirstChoice Trust. The rate of interest is that provided for under the Insurance Contracts Act.

The benefit remains preserved in the FirstChoice Trust until the trustee of the FirstChoice Trust can pay it under the trust deed and super law. This requires you to meet a condition of release as follows.

Releasing terminal illness benefits – terminal medical condition

The trustee of the FirstChoice Trust can release terminal illness benefits if you have a terminal medical condition.

You have a terminal medical condition if two medical practitioners (either jointly or separately) certify that you're suffering from an illness, or have incurred an injury, that is likely to result in your death within 24 months after the date of certification.

At least one of the medical practitioners must be a specialist practising in an area related to the illness or injury suffered by you. The terminal medical condition certificate is valid for 24 months from the date of certification.

Releasing TPD benefits – permanent incapacity

The trustee of the FirstChoice Trust can release TPD benefits if you're permanently incapacitated.

You're permanently incapacitated if the trustee of the FirstChoice Trust is reasonably satisfied that due to ill-health, whether physical or mental, you're unlikely to engage in gainful employment for which you're reasonably qualified by education, training or experience.

The trustee of the FirstChoice Trust generally requires that the permanent incapacity be certified by at least two legally qualified medical practitioners.

Releasing income protection benefits – temporary incapacity

For the trustee of the FirstChoice Trust to release income protection benefits:

- you must be temporarily incapacitated i.e. you must have ceased to be gainfully employed due to ill health, whether physical or mental (without being permanently incapacitated)
- the benefits must be to continue all or part of the gain or reward you were receiving before you became incapacitated and
- you must remain incapable of engaging in the kind of employment you engaged in immediately before your incapacity.

Transferring restricted benefits

If the trustee of the FirstChoice Trust can't release a benefit you have the option to transfer the benefit to another complying superannuation arrangement of your choice.

If you don't transfer the benefit within 45 days of the trustee of the FirstChoice Trust asking you to do so, the trustee of the FirstChoice Trust will transfer the benefit to SuperTrace Eligible Rollover Fund ABN 73 703 878 235 (SuperTrace). See page 124 for information about SuperTrace.

Other conditions of release

Other conditions of release under super law include reaching age 65 or reaching your preservation age and permanently retiring.

This table shows preservation ages as determined by your date of birth:

Date of birth	Preservation age
Before 1 July 1960	55
1 July 1960 to 30 June 1961	56
1 July 1961 to 30 June 1962	57
1 July 1962 to 30 June 1963	58
1 July 1963 to 30 June 1964	59
1 July 1964 or after	60

Preserved money can be released in other limited circumstances, including:

- you've reached age 60 and an arrangement under which you were gainfully employed has come to an end after reaching that age
- your death
- the trustee of the FirstChoice Trust believes you satisfy the severe financial hardship criteria after meeting a number of regulatory requirements
- the Department of Human Services approves payment on specified compassionate grounds
- other circumstances as approved by the Australian Prudential Regulation Authority (APRA).

You can transfer preserved amounts to another complying superannuation arrangement which will continue to preserve these amounts.

Conditions of release for temporary residents

Preserved benefits can be released in the following circumstances:

- you were a temporary resident who has left Australia, your visa has expired and you're not a New Zealand citizen
- your death
- you've become permanently incapacitated
- you suffer from a terminal medical condition.

Nominating beneficiaries.

What is a non-lapsing death benefit nomination?

A non-lapsing death benefit nomination is a request by you to the trustee of the FirstChoice Trust to pay your death benefit to the person or persons nominated on your non-lapsing death benefit nomination form. The Trustee may consent to your nomination if your nomination satisfies the requirements described in the following paragraphs.

The Trustee is required to follow your nomination if, prior to your death, you complete and it receives your valid non-lapsing death benefit nomination, and the Trustee consents to that nomination.

The nomination remains valid until you revoke or make a new nomination. This can provide you with greater certainty on who will receive your death benefit when you die.

Who can I nominate?

A valid non-lapsing death benefit nomination can only nominate your legal personal representative and/or your dependants.

Your legal personal representative is the person appointed on your death as the executor or administrator of your estate.

Your dependants are:

a) your current spouse
This includes the person at your death to whom you are married or with whom you are in a de facto relationship (whether of the same sex or a different sex) or in a relationship that is registered under a law of a State or Territory.

b) your child
This includes any person who at your death is your natural, step, adopted, ex-nuptial or current spouse's child, including a child who was born through artificial conception procedures or under surrogacy arrangements with your current or then spouse.

c) any person financially dependent on you
This includes any person who at your death is wholly or partially financially dependent on you. Generally, this is the case if the person receives financial assistance or maintenance from you on a regular basis that the person relies on or is dependent on you to maintain their standard of living at the time of your death.

d) any person with whom you have an interdependency relationship
This includes any person where at your death:

- you have a close personal relationship with this person
- you live together with this person
- you or this person provides the other with financial support, and
- you or this person provides the other with domestic support and personal care.

An interdependency relationship is not required to meet the last three conditions, if the reason these requirements cannot be met is because you or the other person are suffering from a disability.

In establishing whether such an interdependency relationship exists, all of the circumstances of the relationship are taken in to account, including (where relevant):

- the duration of the relationship
- whether or not a sexual relationship exists
- the ownership, use and acquisition of property
- the degree of mutual commitment to a shared life
- the care and support of children
- the reputation and public aspects of the relationship (such as whether the relationship is publicly acknowledged)
- the degree of emotional support
- the extent to which the relationship is one of mere convenience, and
- any evidence suggesting that the parties intended the relationship to be permanent.

If you are considering relying on this category of dependency to nominate a person, you should consider talking to your legal adviser and completing a statutory declaration addressing these points as evidence of whether such a relationship exists.

How do I make a valid non-lapsing death benefit nomination?

To make a valid non-lapsing death benefit nomination:

- you must be at least 18 years of age
- you must complete in writing the non-lapsing death benefit nomination form available in the CommInsure Protection Application form or on our website or by calling us
- you must only nominate your legal personal representative and/or a person(s) who is your dependant
- you must provide the full name, date of birth and the relationship which exists between you and each of the nominated beneficiaries
- you must ensure that the proportion payable to each person nominated is stated and you have allocated 100% of your death benefit
- your nomination must not be ambiguous in any other way
- you must sign the non-lapsing death benefit nomination form in the presence of two witnesses who are both at least age 18 and are not nominated by you as a beneficiary on the form.

For your validly completed non-lapsing death benefit nomination to be effective you must send and the Trustee must receive and consent to your validly completed non-lapsing death benefit nomination prior to your death.

You may seek to revoke your nomination or make a new non-lapsing death benefit nomination at any time by completing a new non-lapsing death benefit nomination form in writing, available in the CommInsure Protection Application form or on our website or by calling us.

Is my nomination effective?

It is important to be aware before completing a non-lapsing death benefit nomination that if your non-lapsing death benefit nomination is valid and the Trustee consents to that nomination, the Trustee must follow the nomination and it cannot be overruled by the Trustee.

However, if you nominate a person who is not your legal personal representative or a dependant when you die, then your nomination will not be valid to the extent that it relates to that person despite any consent granted by the Trustee.

If you nominate your legal personal representative, your death benefit will be paid to your estate and distributed in accordance with your Will or the laws of intestacy. This means that the distribution may be challenged if someone disputes your Will or the distribution of your estate.

If you nominate one or more of your dependants, your death benefit will be paid directly to them.

If a person nominated on your non-lapsing death benefit nomination form is no longer a dependant at the date of your death, then the proportion of your death benefit which would have been payable to that person will be paid to your legal personal representative.

Tax may be withheld from your death benefit when paid to your dependants or distributed from your estate. There are differing tax treatments of death benefits depending on how old you are, how old your nominated beneficiaries are and who you nominate and whether it is paid as a pension or lump sum.

How is my death benefit paid?

At the time of your death, the Trustee will contact the people you have nominated in your non-lapsing death benefit nomination to ensure that they are still a dependant or your legal personal representative.

The Trustee is also generally required to establish the identity of this person before paying out your death benefit.

If you have nominated one or more of your dependants, they will be provided the choice of taking their proportion of the death benefit as a lump sum cash payment or a pension. Please note, however, that from 1 July 2007 if you have nominated a child, the death benefit must be paid to them as a lump sum cash payment unless the child:

- is under age 18
- is under age 25 and is financially dependent on you, or
- has a certain type of disability.

If your child's personal circumstances change so that they no longer meet one of these exceptions, the Trustee will pay the remaining account balance to them as a lump sum cash payment. In addition, if your child does receive your death benefit as a pension, they must commute it to a tax-free lump sum by age 25 unless they remain disabled.

Where a death benefit is paid to your legal personal representative, it must be paid as a lump sum.

What if I don't have a valid non-lapsing death benefit nomination?

Your death benefit will be paid to your legal personal representative if:

- at the time of your death, you have not completed or the Trustee has not received and consented to a valid non-lapsing death benefit nomination
- you have revoked your last non-lapsing death benefit nomination and you have not made a new non-lapsing death benefit nomination
- the person or persons you have nominated cannot be identified or are not your dependant or legal personal representative at the time of your death, or
- the Trustee determines that the whole of your non-lapsing death benefit nomination is otherwise invalid.

This is general information only and does not take into account your personal circumstances. Please talk to your financial adviser for more information on non-lapsing death benefit nominations and your personal estate planning needs.

Important information

It is important to review your nomination regularly to ensure it is still appropriate to your personal circumstances and reflects your wishes. If, after making a non-lapsing death benefit nomination, you marry, separate or divorce, enter a de facto relationship (including same-sex), have a child, or if someone you nominate has died, or someone becomes or is no longer financially dependent upon you or in an interdependency relationship with you, then you should review your non-lapsing death benefit nomination or consider making a new nomination.

Information we send you.

After your application for Total Care Plan Super is accepted, you'll be sent a policy schedule setting out the cover which applies to you. You should read this carefully together with the Total Care Plan Super policy terms and conditions in this document.

If there are any changes to your cover that are materially adverse to you, the trustee of the FirstChoice Trust will notify you of the change in writing.

While your cover is in force, you'll be kept regularly informed about your cover.

As at 30 June each year, we'll send you an annual statement which shows details of the insurance cover under the policy and any changes to contributions (premiums) and fees and charges.

An annual report to members will also be made available to you which provides information on the management of the FirstChoice Trust.

Providing your Tax File Number (TFN).

Under the Superannuation Industry (Supervision) Act 1993 (SIS) the FirstChoice Trust is authorised to collect your TFN and to use it for lawful purposes. These purposes may change due to legislative change.

The lawful purposes for which your TFN can be used are as follows:

- the trustee of the FirstChoice Trust can validate your TFN by means of an electronic validation service provided by the ATO for the purpose of ensuring the information we have about you on our record is accurate and up to date
- the ATO can give your TFN to the trustee of the FirstChoice Trust if:
  - you haven't quoted your TFN to the trustee of the FirstChoice Trust but you have provided your TFN to other providers previously or
  - the TFN you provide to the trustee of the FirstChoice Trust doesn't match the records the ATO holds for you. Where this occurs, the trustee of the FirstChoice Trust is required to update the record it holds for you unless you have instructed it not to record your TFN
- your TFN can be communicated to the other fund when you request a rollover, unless you have provided your written instruction to the contrary.

While it's not an offence to withhold your TFN, providing it to the trustee of the FirstChoice Trust has the following advantages:

- tax on contributions won't increase
- other than the tax that ordinarily applies, no additional tax will be deducted when you draw down your super benefits
- it will be easier to trace all your different super accounts so you receive all your super benefits when you retire.

Another advantage is that the FirstChoice Trust can accept all types of contributions that can be made. This is important for Total Care Plan Super for the reasons explained below.

Under super law the trustee of the FirstChoice Trust can't accept member contributions unless it has your TFN. Member contributions include all personal contributions you make and contributions made by any person on your behalf other than your employer. As the trustee can't accept member contributions until it has your TFN, it won't be able to arrange insurance cover for you because it won't have any contributions to pay for the cover.

If employer contributions are to be made for you and the trustee of the FirstChoice Trust doesn't have your TFN, the trustee of the FirstChoice Trust won't be able to arrange insurance cover for you because, after deducting extra tax from the contribution, the contribution won't be enough to pay the premium.

The trustee of the FirstChoice Trust.

The trustee of the FirstChoice Trust is the holder of a Registrable Superannuation Entity (RSE) Licence under the Superannuation Industry (Supervision) Act 1993 (SIS).

As a member of the Commonwealth Bank Group, the trustee of the FirstChoice Trust is covered under the Group's 'Directors and Officers' indemnity and 'Professional' indemnity insurance policies. These policies maintain adequate cover to protect the interests of members.

The trustee of the FirstChoice Trust is responsible for holding the Trust's assets and looking after your rights. The trustee of the FirstChoice Trust must act according to the rules of the Trust as set out in the trust deed, general law and in compliance with SIS.

The rules governing the Trust are in the trust deed, which sets out the rights and obligations of the trustee of the FirstChoice Trust and the members. You can request a copy of the trust deed by contacting a Customer Service Consultant. See Changes and Enquires on page 114 for details.

The trust deed may be changed at any time, but any changes that may adversely affect you can generally only be made if:

- permitted by SIS or
- all affected members agree to the change.

We'll advise you if a change is made to the trust deed that affects you.

Eligible Rollover Fund.

The trustee of the FirstChoice Trust has selected the SuperTrace Eligible Rollover Fund (SuperTrace) as the fund to which the FirstChoice Trust member benefits may be transferred in certain circumstances.

Any member benefits may be transferred if:

- the trustee of the FirstChoice Trust loses contact with you
- where required, you don't elect to transfer your benefits to another superannuation fund.

SuperTrace is part of the Commonwealth Bank Group's range of products and is administered by CMLA. The trustee of SuperTrace is Colonial Mutual Superannuation Pty Ltd ABN 56 006 831 983 AFSL 235025.

If you are transferred to SuperTrace, you cease to be a member of the FirstChoice Trust and become a member of SuperTrace and subject to SuperTrace's governing rules. You may be eligible to use a 'Continuation Option' to continue your insurance cover (see page 36).

Please note that SuperTrace:

- has a different fee structure (see the SuperTrace PDS for more details)
- has a low-risk investment approach, so you will need to consider whether this is appropriate to your circumstances when you transfer to SuperTrace and
- doesn't offer death or disability cover.

Contact details for SuperTrace

If you would like a copy of the SuperTrace PDS please contact a Customer Service Representative at:

SuperTrace
Locked Bag 5429
Parramatta NSW 2124
Phone: **1300 788 750**
Facsimile: 1300 700 353

Alternatively you may view the SuperTrace PDS at:
supertrace.com.au

Family Law.

Family law legislation allows for the division of superannuation of married, de facto and same-sex couples that have divorced or separated. This legislation doesn't extend to terminating de facto or same-sex relationships in Western Australia. The legislation allows the following key family law processes to occur in relation to your super.

Information request

This is a written request for information about your super and is used to work out the value of the superannuation asset. This request may be made by you, your spouse (including a de facto spouse) or a person intending to enter a superannuation agreement with you (such as a pre-nuptial agreement).

The response to an information request will only be issued to the person making the request. If a request is received from your spouse or intending spouse, the legislation states that you must not be informed of the request.

Payment flag

A payment flag may be placed on your superannuation through an agreement by you and your spouse or through a court order. The presence of this flag requires the trustee of the FirstChoice Trust to prevent certain types of withdrawals being made from your superannuation.

Splitting instructions

Splitting instructions specify how your superannuation is to be divided. This may be expressed as a dollar amount or as a percentage. These splitting instructions may be made in the form of a superannuation agreement between you and your spouse or by court order. In both cases, valid instructions are binding on the trustee of the FirstChoice Trust.

The trustee of the FirstChoice Trust can take action to separate your spouse's entitlement from your superannuation entitlement after receiving valid splitting instructions.

The trustee of the FirstChoice Trust will ask your spouse where to send their entitlement. If the spouse doesn't provide instructions within a specified timeframe, their entitlement will be transferred to SuperTrace.

The provisions of the family law legislation allow for the charging of reasonable fees for the administration of family law transactions. We don't currently charge fees but we will notify you if we decide to introduce them in the future.

For full details about the effect of family law on your superannuation, please contact your financial adviser or call **1300 730 324** between 9 am and 5 pm (Sydney time), Monday to Friday.

Anti-Money Laundering and Counter-Terrorism Financing laws.

These laws establish a regulatory regime to combat money laundering and the financing of terrorism. They impose significant obligations on the trustee of the FirstChoice Trust who is required to comply with these laws, including the need to establish your identity (and if relevant, the identity of a beneficiary and other persons associated with your membership).

The trustee of the FirstChoice Trust may from time to time ask for information to help with this process. The trustee of the FirstChoice Trust will notify you if it needs to establish your identity or needs more information.

The trustee of the FirstChoice Trust may be required to report information about you to the relevant authorities and may not be able to tell you when this occurs. The trustee of the FirstChoice Trust may not be able to transact with you or other persons. This may include delaying, blocking, freezing or refusing to process a transaction. This may have an impact on your benefit and could result in a loss of that benefit.

Part F.
Differences in insurance inside and outside super.

The benefits and features of the insurance we offer in the superannuation environment differ in some very important ways from the insurance we offer outside super. Many of these differences exist because superannuation law restricts the benefits and features of the insurance that can be offered inside super. It's important you understand these differences.

There are also some differences across Total Care Plan Super and the SMSF Plan.

Major differences between our insurance inside and outside of super.

Life Care, TPD Cover and Trauma Cover

Two of the major differences between our insurance inside and outside of super are:

- Total Care Plan Super and the SMSF Plan give you the option to include income protection which provides many of the features of our Income Care product – in short, you can have life, TPD and income protection all under the one policy.
- Total Care Plan Super and the SMSF Plan don't include Trauma Cover. If Trauma Cover is important to you, you'll need to consider cover outside of super.

Other differences

The following benefits are only available outside super:

- a more comprehensive definition of TPD which includes the 'own occupation' and other TPD definitions not permitted under super law.
- Advance Payment benefit (see page 33)
- Financial Planning benefit (see page 34)
- Accommodation benefit (see page 35)
- TPD Cover benefits for partial and permanent disability (see page 47).

Also, these optional extras aren't available inside super:

- Child Cover (see page 64)
- Guaranteed Insurability (business events) (see page 40)
- Business Safe Cover (see page 40)
- Guaranteed Insurability (personal events) see page 39. **Note:** this option is available under the SMSF Plan

Income protection

Some of the differences between income protection inside and outside of super are as follows:

Death benefit

Total Care Plan Super includes a $10,000 lump sum death benefit. This isn't included in Income Care, Income Care Plus or Income Care Platinum. Nor is it included in the SMSF Plan.

Business Overheads Cover

Business Overheads Cover isn't available inside super.

Other differences

The following features aren't available inside super:

- Medical Professionals benefit (see page 78)
- Rehabilitation benefit (see page 79)
- Involuntary Unemployment Cover benefit for CBA Group loans (see page 80).

Also, these optional extras aren't available inside super:

- Permanent Disablement Cover option (see page 87)
- Super Continuance option (see page 88).

Income Care Plus and Income Care Platinum

Income Care Plus and Income Care Platinum aren't available inside super.

Summary of Life Care and TPD differences inside and outside of super across the two super policies

Benefit	Outside super		Inside super			
	Total Care Plan		Total Care Plan Super		SMSF Plan	
	Life	TPD	Life	TPD	Life	TPD
Death benefit	✔	✔*	✔	–	✔	✔*
Terminal Illness benefit	✔	–	✔	–	✔	–
TPD benefit	–	✔	–	✔	–	✔
TPD 'own occupation' definition	–	✔	–	–	–	–
Advance Payment benefit	✔	–	–	–	–	–
Severe Hardship Booster benefit	✔	✔	✔	✔	✔	✔
Buy Back (of Life Care after TPD Cover and split TPD Cover claim) benefit	✔	–	✔	–	✔	–
Financial Planning benefit	✔	✔	–	–	–	–
Accommodation benefit	✔	✔	–	–	–	–
Loyalty Bonus benefit	✔	✔	✔	✔	✔	✔

* Stand-alone TPD policies only.

Feature	Outside super		Inside super			
	Total Care Plan		Total Care Plan Super		SMSF Plan	
	Life	TPD	Life	TPD	Life	TPD
Automatic indexation	✔	✔	✔	✔	✔	✔
Interim Accident Cover	✔	✔	✔	✔	✔	✔
Continuation option	–	–	✔	✔	–	–
Option to convert	–	✔*	–	–	–	✔*
Nominating beneficiaries	✔	–	✔	–	–	–
Rollover rebate	–	–	✔	✔	–	–

* Stand-alone TPD policies only.

Option	Outside super		Inside super			
	Total Care Plan		Total Care Plan Super		SMSF Plan	
	Life	TPD	Life	TPD	Life	TPD
Child Cover	✔	–	–	–	–	–
Guaranteed Insurability (personal events)	✔	–	–	–	✔	–
Guaranteed Insurability (business events)	✔	✔	–	–	–	–
Business Safe Cover	✔	✔	–	–	–	–
Accidental Death Cover	✔	–	✔*	–	✔*	–
Plan Protection	✔	–	✔	–	✔	–

* Must be taken in conjunction with and not exceed Life Care.

Summary of income protection differences inside and outside of super

Benefit	Outside super	Inside super	
	Income Care/ Income Care Plus/ Income Care Platinum	Total Care Plan Super	SMSF Plan
Total Disability benefit	✔	✔	✔
Partial Disability benefit	✔	✔	✔
Recurrent Disability benefit	✔	✔	✔
Boosted Total Disability benefit	✔	✔	✔
Death benefit – a payment of up to four times the monthly benefit	Income Care Plus/ Platinum only*	–	–
Death benefit – Inbuilt death benefit ($10,000)^	–	✔	–
Medical Professionals benefit	✔	–	–
Reward Cover benefit	✔	✔	✔
Rehabilitation benefit	✔	–	–
Involuntary Unemployment Cover benefit for CBA Group loans	✔	–	–

^ This Death benefit isn't included in Income Care or the SMSF Plan.
* Not available for Essential Cover.

Option	Outside super	Inside super	
	Income Care/ Income Care Plus/ Income Care Platinum	Income Care Super	SMSF Plan
Permanent Disablement Cover option	✔	–	–
Increasing Claim option	✔	✔	✔
Accident option	✔	✔	✔
Super Continuance option	✔	–	–

Definitions.

This part contains

General definitions.

This term…	Means…
accident	A bodily *injury* occurring while this policy is in force and which is caused solely and directly by violent, accidental, external and visible means, independent of any other cause.
cover expiry date	The date shown as such in the policy schedule for the relevant type of cover. Depending on the cover that applies to you, a cover expiry date is shown in your policy schedule for each of the following types of cover: ◆ Life Care ◆ TPD Cover ◆ Trauma Cover ◆ Child Cover ◆ Accidental Death Cover ◆ Income protection ◆ Business Overheads Cover.
date insured from	The date shown as such in the policy schedule.
day one condition	A condition which is *cardiomyopathy, primary pulmonary hypertension, major head trauma, motor neurone disease, multiple sclerosis with impairment, muscular dystrophy, paraplegia, quadriplegia, hemiplegia, diplegia, tetraplegia, dementia and Alzheimer's disease, Parkinson's disease with impairment, blindness, loss of speech, loss of hearing, chronic lung disease* or *severe rheumatoid arthritis.*
domestic duties	All of the following duties: ◆ cleaning the usual place of dwelling ◆ purchasing household food and items used for cleaning ◆ preparing meals for the household ◆ performing for the household laundry services such as washing or ironing ◆ driving or transporting family to and from school, sport, work or social events (where applicable) ◆ taking care of a child or family member dependents (where applicable).
immediate family member	Includes a *spouse*, parent, parent-in-law, sibling and a child.
injury	An accidental bodily injury occurring while this policy is in force.
life insured	The person shown as such in the policy schedule.
medical authority	The registered authority, board, association or body that has the power to authorise or license a person to practise as a *medical practitioner* in the relevant Australian state or territory.
medical practitioner(s)	A person who meets all of the following: ◆ the person isn't you, the *life insured* or an *immediate family member* or business partner of you or the *life insured* ◆ the person is a legally qualified medical practitioner whose credentials have been formally accepted by the *medical authority* of the Australian state or territory in which they practise ◆ the person is registered by the *medical authority* to carry out the duties of a medical practitioner according to the authority's rules ◆ the person is, if reasonably required by us, a specialist in a relevant field of medicine ◆ the person is not an allied health professional such as a chiropractor, physiotherapist, psychologist or alternative therapy provider.
ordinary policy	A policy which is issued by us pursuant to this PDS and which is not a *super policy*.
policy anniversary date	Each anniversary of the *date insured from*.
premium due date(s)	The *date insured from* and each *policy anniversary date*. If we accept the payment of premiums in monthly, quarterly or half-yearly instalments, each date an instalment is due is a premium due date.
relevant medical specialist(s)	A *medical practitioner* we consider to be a specialist in the relevant field of medicine.
sickness	An illness or disease that becomes apparent while the policy is in force.
spouse	A spouse of a person includes: ◆ another person (whether of the same or a different sex) with whom the person is in a relationship that is registered under a prescribed law of a State or Territory as a prescribed kind of relationship and ◆ another person who, although not legally married to the person, lives with the person on a genuine domestic basis in a relationship as a couple.
super policy	A Total Care Plan Super policy or SMSF Plan policy, as applicable.

Life insurance (lump sum) definitions.

This term…	Means…
Accidental Death Cover/ Accidental Death Cover benefit	Accidental Death Cover is the cover provided under the Accidental Death Cover option. The amount of the cover is that shown in the policy schedule as increased or decreased under the policy. This amount is the Accidental Death Cover benefit we pay.
automatic indexation	The indexation of cover under the policy as explained on page 35.
buy back period	The period starting on the later of: ◆ the date of the Trauma condition or *TPD* that resulted in the reduction of cover, ◆ the date we receive your completed claim form for the Trauma condition or *TPD* that resulted in the reduction of cover and ending on the later of: ◆ the date 12 months after the period started ◆ the date we pay the claim that resulted in the reduction in cover.
change in employment	Includes a change in employment while the *life insured* remains employed by the same employer, but does not include a change in employment while the *life insured* remains *self-employed* or if the change involves a change to *self-employment*. For this purpose, *self-employed* and *self-employment* includes: ◆ employment by the *life insured's* own company ◆ employment by an *immediate family member* of the *life insured* ◆ employment by a company owned by one or more *immediate family members* of the *life insured* ◆ employment by a trust whose beneficiaries are *immediate family members* of the *life insured* ◆ employment by another *life insured* under the policy.
Child Cover/Child Cover benefit	The cover applying to an *insured child* under the Child Cover option. The amount of the cover is that shown in the policy schedule as increased or decreased under the policy. This amount is the Child Cover benefit we pay. For Partial Child Cover conditions we pay a part of the Child Cover benefit (a Partial Child Cover benefit) as explained on page 64.
de facto relationship	The *life insured*, although not legally married to a person, lives with the person on a genuine domestic basis in a relationship as a couple.
flexi-linked life insured	The *life insured* to whom *primary Life Care* applies under the *primary policy* and *flexi-linked rider cover* applies under the *flexi-linked policy*. The *Life Care* for this *life insured* is shown as 'flexi-linked' in the policy schedule. For *flexi-linking* to apply, the *primary Life Care* and *flexi-linked rider cover* must apply to the same *life insured*.
flexi-linked policy	The Total Care Plan policy shown as the 'flexi-linked policy' in the policy schedule. The flexi-linked policy provides the *flexi-linked rider cover.*
flexi-linked rider cover	*Flexi-linked Trauma Cover* or *flexi-linked TPD Cover* or both, as the context requires.
flexi-linked TPD Cover	*TPD Cover* applying to the *flexi-linked life insured* under the *flexi-linked policy*, being cover to which *flexi-linking* applies. Flexi-linked TPD Cover includes a benefit payable for *partial and permanent disability*, the TPD Cover Severe Hardship Booster benefit and the TPD Cover Loyalty Bonus benefit under the *flexi-linked policy*.
flexi-linked Trauma Cover	*Trauma Cover* applying to the *flexi-linked life insured* under the *flexi-linked policy*, being cover to which *flexi-linking* applies. Flexi-linked Trauma Cover includes a Partial Trauma Cover benefit, the Trauma Cover Severe Hardship Booster benefit and the Trauma Cover Loyalty Bonus benefit under the *flexi-linked policy.*
flexi-linking	The arrangement described as such in this PDS where *Life Care* for a *life insured* under a *primary policy* and *Trauma* and/or *TPD Cover* for the same *life insured* under a *flexi-linked policy* are linked.
insured child	The person shown in the policy schedule as the *life insured* with the *Child Cover* option.
Life Care/ Life Care benefit	Life Care is the cover shown as such in the policy schedule as increased or decreased under the policy. This amount is the Life Care benefit we pay. If the Life Care is *primary Life Care*, it's reduced by the amount of any benefit payable under the *flexi-linked rider cover* applying under the *flexi-linked policy.* If this is a *super policy* and *Life Care* applies to a *split TPD life insured*, it's reduced by the amount of any benefit payable for the *split TPD life insured* under the Total Care Plan policy to which the *split TPD* applies.
nominated beneficiary/ies	A natural person, corporation or trust nominated by you to receive any money payable under *Life Care* or *Accidental Death Cover.*

This term…	Means…
own occupation	The *life insured's* full time gainful occupation immediately before *total and permanent disablement* or *total and temporary disability*, as applicable.
partial and permanent disability/partially and permanently disabled	The *life insured* has sustained, as a direct result of *sickness* or *injury*: ◆ *loss of use of one limb* or ◆ *partial blindness*.
primary Life Care	*Life Care*, including the Terminal Illness benefit, applying to the *flexi-linked life insured* under the *primary policy.*
primary policy	The *super policy* shown as the 'primary policy' in the policy schedule. The primary policy provides the *primary Life Care.*
split TPD life insured	The *life insured* to whom *split TPD Cover* applies under a *super policy* and a Total Care Plan policy. The *TPD Cover* for this *life insured* is shown as 'split' in the policy schedule for each policy. For *split TPD* to apply, the *TPD Cover* under the *super policy* and the Total Care Plan policy must apply to the same *life insured*.
split TPD	The arrangement described as such in this PDS where 'any occupation' *TPD Cover* for a *life insured* under a *super policy* is linked to 'own occupation' *TPD Cover* for the same *life insured* under a Total Care Plan policy. The arrangement ends on the *policy anniversary date* before the *split TPD life insured's* 65th birthday.
split TPD Cover/split TPD Cover benefit	The split TPD Cover is the *TPD Cover* to which *split TPD* applies. Split TPD Cover is shown in the policy schedule for each of the *super policy* and Total Care Plan policy. Split TPD Cover includes a benefit payable for *partial and permanent disability*, the TPD Cover Severe Hardship Booster benefit and the TPD Cover Loyalty Bonus benefit under the *split TPD policy*. The split TPD Cover benefit is the benefit we pay for split TPD Cover.
split TPD policy	A *super policy* or Total Care Plan policy under which *split TPD Cover* applies. A split TPD policy shows in its policy schedule the other split TPD policy.
split TPD super policy	A *super policy* to which *split TPD* applies.
terminally ill/ terminal illness	The *life insured* is terminally ill if all of the following apply: ◆ two *medical practitioners* each certify in writing the *life insured* has a *sickness* or *injury* that, despite reasonable medical treatment in the *life insured's* circumstances, is likely to result in their 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 *medical practitioners* is a specialist practising in an area related to the *life insured's sickness* or *injury* ◆ based on such medical or other evidence we reasonably require to be provided, we are satisfied • with the prognosis reached in each of the certifications and • that the prognosis was first made while *Life Care* applied to the *life insured* ◆ for each of the certificates, the certification period has not ended.
totally and temporarily disabled/total and temporary disability	The *life insured* is, as a result of *sickness* or *injury*, disabled in circumstances where the disability: ◆ has, for a period of three consecutive months: • caused the *life insured* to be continually and significantly unable to perform their *own occupation* and • prevented the *life insured* from engaging in any occupation for wage or profit and ◆ has caused the *life insured* to be under the regular care and attendance of, or following treatment prescribed by, a *medical practitioner* throughout the three month period and on an ongoing basis.
TPD Cover/ TPD Cover benefit	TPD Cover is the cover shown as such in the policy schedule as increased or decreased under the policy. The TPD Cover benefit is the amount we pay under TPD Cover and, unless this PDS says otherwise, includes the benefit we pay for *partial and permanent disability*. If the TPD Cover is *flexi-linked TPD Cover*, it can't exceed the amount of *primary Life Care* applying under the *primary policy.* If the TPD Cover under this policy is *split TPD Cover*, it can't exceed the amount of *split TPD Cover* applying under the *super policy* or Total Care Plan policy, as applicable.

This term…	Means…
Total and Permanent Disability/Disablement/ Totally and Permanently Disabled (TPD)	For an *ordinary policy*: **Own Occupation** If the *TPD Cover* appears as 'own occupation' in the policy schedule, TPD means the *life insured*: ◆ has suffered *loss of independent existence* or ◆ has suffered *loss of use of limbs or sight* or ◆ meets all of the following: • they have been absent from their *own occupation* as a result of *sickness* or *injury* for a period of three consecutive months; • at the end of the three months, they continue to be incapacitated to such an extent that they will be unlikely to engage in their *own occupation* ever again; • they are under the regular treatment, and following the advice, of a *medical practitioner* or ◆ meets all of the following: • they have been absent from their *own occupation* as a result of a *day one condition;* • they continue to be incapacitated to such an extent that they will be unlikely to engage in their *own occupation* ever again; • they are under the regular treatment, and following the advice, of a *medical practitioner*. If the *life insured* has been engaged in full time *domestic duties* at the time of their *sickness* or *injury*, the previous two definitions are replaced by the following two TPD definitions: ◆ meets all of the following: • they have been, through *sickness* or *injury*, unable to perform *domestic duties* for a period of three consecutive months; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life or ◆ meets all of the following: • they have, as a result of a *day one condition,* been unable to perform *domestic duties;* • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life. If, at the time of the *life insured's sickness* or *injury,* the *life insured* is permanently retired from the workforce and is not engaged in full time *domestic duties*, the *life insured* is only TPD if they have suffered *loss of independent existence.*

This term…	Means…
Total and Permanent Disability/Disablement/ Totally and Permanently Disabled (TPD)	For an *ordinary policy*: **Any Occupation** If the *TPD Cover* appears as 'any occupation' in the policy schedule, TPD means the *life insured*: ◆ has suffered *loss of independent existence* or ◆ has suffered *loss of use of limbs or sight* or ◆ meets all of the following: • they have been absent from active employment as a result of *sickness* or *injury* for a period of three consecutive months; • throughout the three months, they have as a result of the *sickness* or *injury* been unable to engage in any occupation for which they are reasonably suited by education, training or experience and which would pay remuneration at a rate greater than 25% of their earnings during their last consecutive 12 months of work; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life or ◆ meets all of the following: • they have been absent from active employment as a result of a *day one condition;* • they are as a result of the *day one condition* unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life. If the *life insured* has been engaged in full time *domestic duties* at the time of their *sickness* or *injury*, the previous two definitions are replaced by the following two TPD definitions: ◆ meets all of the following: • they have been, through *sickness* or *injury*, unable to perform *domestic duties* for a period of three consecutive months; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life or ◆ meets all of the following: • they have, as a result of a *day one condition,* been unable to perform *domestic duties;* • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life. If, at the time of the *life insured's sickness* or *injury,* the *life insured* is permanently retired from the workforce and is not engaged in full time *domestic duties*, the *life insured* is only TPD if they have suffered *loss of independent existence.* **Domestic Duties** If the *TPD Cover* appears as 'domestic duties' in the policy schedule, TPD means the *life insured*: ◆ has suffered *loss of independent existence* or ◆ has suffered *loss of use of limbs or sight* or ◆ meets all of the following: • they have been, through *sickness* or *injury*, unable to perform *domestic duties* for a period of three consecutive months; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to perform *domestic duties*; • they are likely to be so disabled for life or ◆ meets all of the following: • they have, as a result of a *day one condition*, been unable to perform *domestic duties;* • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life.

This term…	Means…
Total and Permanent Disability/Disablement/ Totally and Permanently Disabled (TPD)	For a *super policy*: **Any Occupation** TPD means the *life insured*: ◆ meets all of the following: • they have suffered *loss of independent existence;* • they have as a result of the *loss of independent existence* been unable to engage in any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life or ◆ meets all of the following: • they have suffered *loss of use of limbs or sight;* • they have as a result of the *loss of use of limbs or sight* been unable to engage in any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life or ◆ meets all of the following: • they have been absent from active employment as a result of *sickness* or *injury* for a period of three consecutive months; • throughout the three months, they have as a result of the *sickness* or *injury* been unable to engage in any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life or ◆ meets all of the following: • they have been absent from active employment as a result of a *day one condition;* • they are as a result of the *day one condition* unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life. If the *life insured* has been engaged in full time *domestic duties* at the time of their *sickness* or *injury*, the previous two definitions are replaced by the following two TPD definitions: ◆ meets all of the following: • they have been, through *sickness* or *injury*, unable to perform *domestic duties* for a period of three consecutive months; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life or ◆ meets all of the following: • they have, as a result of a *day one condition,* been unable to perform *domestic duties;* • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to engage in (whether or not for reward) any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life. If, at the time of the *life insured's sickness* or *injury,* the *life insured* is permanently retired from the workforce and is not engaged in full time *domestic duties*, the *life insured* is only TPD if they meet all of the following: • they have suffered *loss of independent existence;* • they have as a result of the *loss of independent existence* been unable to engage in any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life.

This term…	Means…
Total and Permanent Disability/Disablement/ Totally and Permanently Disabled (TPD)	For a *super policy*: **Domestic Duties** If the *TPD Cover* appears as 'domestic duties' in the policy schedule, TPD means the *life insured*: ◆ meets all of the following: • they have suffered *loss of independent existence;* • they have as a result of the *loss of independent existence* been unable to engage in any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life or ◆ meets all of the following: • they have suffered *loss of use of limbs or sight;* • they have as a result of the *loss of use of limbs or sight* been unable to engage in any occupation for which they are reasonably suited by education, training or experience; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they are likely to be so disabled for life or ◆ meets all of the following: • they have been, through *sickness* or *injury*, unable to perform *domestic duties* for a period of three consecutive months; • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to perform *domestic duties* and to engage in any occupation for which they are reasonably suited by education, training or experience and • they are likely to be so disabled for life or ◆ meets all of the following: • they have, as a result of a *day one condition*, been unable to perform *domestic duties;* • they are under the regular treatment, and following the advice, of a *medical practitioner;* • they continue to be so incapacitated to the extent that they are unable to perform *domestic duties* and to engage in any occupation for which they are reasonably suited by education, training or experience; • they are likely to be so disabled for life.
Trauma Cover/Trauma Cover benefit	Trauma Cover is the cover shown as such in the policy schedule as increased or decreased under the policy. This amount is the Trauma Cover benefit we pay. For Partial Trauma Cover conditions we pay a part of the Trauma Cover benefit (a Partial Trauma Cover benefit) as explained on page 59. If the Trauma Cover is *flexi-linked Trauma Cover*, it can't exceed the amount of *primary Life Care* applying under the *primary policy.*

Income protection and Business Overheads Cover definitions.

This term…	Means…
accidentally disabled/ accidental disability	Means that, due to *injury*, the *life insured's spouse* can't perform *domestic duties* and is under the regular treatment, and following the advice, of a *medical practitioner*.
agreed value policy	You have this type of policy if the *monthly benefit* shown in the policy schedule appears as 'agreed value'.
annualised monthly benefit	This is the amount calculated as follows: $\frac{12 \times (A \text{ minus } B)}{C}$ where: ◆ A is the total of the amounts shown in the policy schedule as the 'monthly benefit' and the 'super continuance monthly benefit' (each as increased or decreased under the policy). ◆ B is the amount by which the benefit, which would have been payable had you not chosen to receive the *Permanent Disablement benefit*, would have been reduced due to a benefit offset under the policy (see 'Benefit offsets' on page 93). ◆ C is 1, unless the *permanent disablement* for which the *Permanent Disablement benefit* is payable is a *serious medical condition*, in which case C is 0.75.
approved occupational rehabilitation program	A program specifically designed to assist the *life insured* return to the remunerative work they were performing in their own occupation before their *total disability* (or, where medically necessary, a new occupation). It's a formal program devised and managed by an accredited occupational rehabilitation provider and which has been approved by the *life insured's medical practitioner*. It excludes any program providing 'hospital treatment' or 'general treatment' within the meaning of the Private Health Insurance Act 2007 (Cth) or any other program which might cause this policy to cease to be exempt from any legislation in connection with health insurance, including the Private Health Insurance Act 2007 (Cth).
bank	The Commonwealth Bank of Australia or other entity within the Commonwealth Bank Group of companies.
benefit period	The period shown as such in the policy schedule, which is the longest period over which a benefit will be paid for any one continuous period of *disability*. A new period starts from the end of each *waiting period*.
business	The business or professional practice specified in your application for the policy, to which Business Overheads Cover relates.
business expenses	Business expenses which are necessarily and regularly incurred and are reasonably similar in amount and nature to other expenses incurred in the last 12 months. If an expense exceeds another expense incurred in the last 12 months by more than 20%, then it won't be considered reasonably similar in amount to the other expense. If a business expense incurred in a month relates, or is referable, to a period of two or more months, we only treat the proportion of the business expense we consider appropriate as being incurred in that month. If a business expense relates, or is referable, to a 12 month period that expense must be reconciled against the relevant financial returns or statements recording the expense for the 12 month period and, if necessary, an adjustment of benefits we paid will be made between you and us to reflect the business expense actually incurred for a month. If we have overpaid benefits, you must refund to us the overpayment. If we have underpaid benefits, we must pay you the shortfall.
Business Overheads monthly benefit	The benefit shown as such in the policy schedule as increased or decreased under the policy.
continuously unemployed	*Unemployment* which continues without interruption where the *life insured* is registered as *unemployed* with a recognised employment agency and actively seeking *employment*. The *life insured* does not have to be in receipt of unemployment benefits from the Australian Government to be continuously unemployed.
disability/disabled	*Total disability* or *partial disability/totally disabled* or *partially disabled*.
employed/ employment	*Permanently employed/permanent employment* or employed/employment under a *fixed term contract*. This does not include being *self-employed* or in *self-employment*.
employer payments	The monthly value of payments the *life insured* is receiving, or is entitled to receive, from their employer on any account, including sick leave, annual leave or long service leave but excluding *monthly income*.
extended cover expiry date	The *policy anniversary date* before the *life insured's* 70th birthday.
extended indemnity policy	You have this type of policy if the *monthly benefit* shown in the policy schedule appears as 'extended indemnity'.

This term…	Means…
exposure-prone medical procedure(s)	A procedure where there is potential for contact between the skin (usually finger or thumb) of the person practising a medical profession and sharp surgical instruments, needles or tissues (splinters/pieces of bone/tooth) in body cavities or in poorly visualised or confined body sites such as the mouth. A procedure without these characteristics is not an exposure-prone medical procedure because it's unlikely to pose a risk of transmission of blood-borne viruses from the infected person practising a medical profession to their patient.
financial hardship	Financial hardship means: ◆ the *life insured's spouse* is *involuntarily unemployed* or ◆ the *life insured's spouse* dies.
fixed term contract	One or more contracts providing for at least 20 hours per week of continual and regular employment, where such contract(s) is/are: ◆ for salary or wages ◆ for a term no longer than a specified period ◆ with the same employer, being an employer who employs at least five employees and ◆ for a combined period of at least 18 consecutive months.
gainfully employed/gainful employment	Employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment.
group income protection policy	A group income protection policy which is issued by a life insurance company and held by: ◆ a trustee of a superannuation fund of which the *life insured* was a standard employer-sponsored member in terms of the Superannuation Industry (Supervision) Act or ◆ an employer under which the *life insured* and others were insured in their capacity as employees of the employer.
guaranteed agreed value policy	You have this type of policy if the *monthly benefit* shown in the policy schedule appears as 'guaranteed agreed value'.
home care needs	Includes cooking, cleaning, shopping, banking and similar needs. It doesn't include the provision of nursing or similar services.
income producing duty/income producing duties	An income producing duty is a duty of the *life insured's* main *occupation* we consider primarily essential to producing the *life insured's monthly income*. Income producing duties are all the duties of the *life insured's* main *occupation* we consider primarily essential to producing the *life insured's monthly income*.
indemnity policy	You have this type of policy if the *monthly benefit* shown in the policy schedule appears as 'indemnity'.
indexation factor	The most recent annual percentage change in the Consumer Price Index (CPI) (all groups – eight capital cities combined) published by the Australian Bureau of Statistics. If no CPI is published, we use a figure we consider most nearly replaces it. Where the *indexation factor* is applied to the indexation of cover it's the last change that occurred three months before the *policy anniversary date* of the policy.
involuntary unemployment/ involuntarily unemployed	Loss of permanent full-time employment as a result of being terminated or made redundant by an employer for reasons other than disability or misconduct, where such loss of employment is not of a voluntary nature. While the person is *unemployed* they must be actively seeking employment and be either in receipt of unemployment benefits from the Australian Government or, if they are ineligible to receive such benefits, registered as *unemployed* with a recognised employment agency. If the person is ineligible to receive unemployment benefits and they intend to register as *unemployed* with a recognised employment agency, they must do so within 30 days of first becoming *unemployed*. The person isn't involuntarily unemployed if they were *self-employed* immediately before their *unemployment*.
Involuntary unemployment benefit	The lesser of the following amounts: ◆ the amount shown as the *monthly benefit* in the policy schedule, as increased or decreased under the policy ◆ the *minimum monthly repayment*. If there is no *minimum monthly repayment*, the Involuntary Unemployment benefit is nil. If benefits are payable for part of a month, the Involuntary Unemployment benefit is divided by 30 to arrive at a daily benefit.
loan(s)	A home loan, investment home loan, line of credit facility, business loan, personal loan or margin loan which is funded by the *bank*.

This term…	Means…
minimum monthly repayment(s)	The minimum amount the *life insured* must pay under a *loan* for the month commencing on the first day from which the benefit for the relevant *unemployment* accrues. If the relevant *unemployment* continues beyond that month, the minimum monthly repayment will, for each subsequent month during which the relevant *unemployment* continues, be the minimum amount the *life insured* must pay under their *loan* for that month. When calculating the minimum monthly repayment, we apply the following rules: ◆ the lowest rate of interest payable under the *loan* applies ◆ we disregard any overdue payment or interest on such a payment or any fees, charges, expenses, taxes, duties or other imposts payable under the *loan* as a result of the overdue payment ◆ we won't take into account any more than the amount required to discharge the *life insured's* liability under the *loan* when they first became aware of their impending *unemployment*.
monthly benefit	**For a policy other than a *super policy*** **Guaranteed agreed value** For a *guaranteed agreed value policy*, the monthly benefit is the amount shown as such in the policy schedule as increased or decreased under the policy. **Agreed value, indemnity or extended indemnity** For an *agreed value policy*, *indemnity policy* or *extended indemnity policy*, the monthly benefit is the lesser of the following amounts: ◆ the amount shown as such in the policy schedule as increased or decreased under the policy ◆ 75% of the *life insured's pre-disability income* but, for an *agreed value policy*, this amount only applies if the *life insured's* average *monthly income* in the 12 months before the present level of cover was applied for was insufficient for us to have accepted the *life insured* for that level of cover. **Daily benefit** If benefits are payable for part of a month, the monthly benefit is divided by 30 to arrive at a daily benefit. **For a *super policy*** **Agreed value** For an *agreed value policy* the monthly benefit is the lesser of the following amounts: ◆ the amount shown as such in the policy schedule as increased or decreased under the policy ◆ the *life insured's pre-disability income* ◆ 75% of the *life insured's pre-disability income* but this amount only applies if the *life insured's* average *monthly income* in the 12 months before the present level of cover was applied for was insufficient for us to have accepted the *life insured* for that level of cover. **Indemnity** For an *indemnity policy*, the monthly benefit is the lesser of the following amounts: ◆ the amount shown as such in the policy schedule as increased or decreased under the policy ◆ 75% of the *life insured's pre-disability income.* **Daily benefit** If benefits are payable for part of a month, the monthly benefit is divided by 30 to arrive at a daily benefit.
monthly income	**For a policy other than a *super policy*** **For a *life insured* who is not an employee (e.g. self-employed, a working director or partner in a partnership)** The monthly income generated by the business or practice directly due to the *life insured's* personal exertion or activities, less: ◆ the *life insured*'s monthly share of *business expenses* and ◆ the monthly value of any superannuation contributions covered under the Super Continuance option. **For a *life insured* who is an employee** The total monthly value of remuneration paid for the *life insured* by their employer, where remuneration means: ◆ salary ◆ fees ◆ commission ◆ bonuses (as averaged over the previous three years) ◆ regular overtime and ◆ fringe benefits. Superannuation contributions are excluded from total monthly value of remuneration. If, however, the total superannuation contributions made for the *life insured's* benefit by their employer exceeds 15% of the *life insured's* remuneration in the relevant 12 month period, 1/12th of the excess is included in the total monthly value of remuneration. **For a *super policy*** **For a *life insured* who is not an employee (e.g. self-employed, a working director or partner in a partnership)** The monthly income generated by the business or practice directly due to the *life insured's* personal exertion or activities, less the *life insured's* monthly share of *business expenses*. **For a *life insured* who is an employee** The total monthly value of remuneration paid for the *life insured* by their employer where remuneration means: ◆ salary ◆ fees ◆ commission ◆ bonuses (as averaged over the previous three years) ◆ regular overtime ◆ fringe benefits and ◆ superannuation guarantee contributions the *life insured*'s employer pays for the *life insured*. If *split IP* applies, all superannuation contributions are excluded.

This term…	Means…
occupation	The type of business, service, trade or employment encompassing the duties carried out by the *life insured*. It is not specific to any place of employment, particular employer or position.
occupation group	The group in which the *life insured's* occupation is listed under our standard occupation categories. The *life insured's* occupation group when cover first started for them is shown in the policy schedule.
offset payments	The offset payments are: ◆ payments from a workers' compensation claim, motor accident claim or any claim made under similar state or federal legislation ◆ payments from any other insurance that provides income payments due to *sickness* or *injury* and ◆ if the *life insured's occupation group* is A (Aviation), payments due to a temporary loss of a licence granted under the Civil Aviation Act 1988 or any comparable legislation. However, offset payments do not include the following: ◆ a lump sum or part of a lump sum paid as compensation for pain and suffering or the loss of use of a part of the body ◆ a lump sum total and permanent disablement benefit or ◆ a lump sum trauma benefit paid under an insurance policy (but not a Crisis benefit paid under this policy). **Lump sum offset payments** If a payment is an offset payment and is in the form of, or exchanged for, a lump sum, the lump sum has a monthly equivalent of 1/60th of the lump sum over a period of 60 months.
parental leave	Parental leave means: ◆ the *life insured* is employed by an employer and ◆ they take temporary leave from employment for the care of a new born or new adopted child for a predetermined period and ◆ the leave is approved by the *life insured's* employer as being on 'parental' leave and ◆ the leave is taken by the *life insured* while they are still employed by the employer that approved the leave or ◆ the *life insured* is *self-employed* ◆ they take temporary leave from their *self-employment* for the care of a new born or new adopted child and, had they been employed by an employer, they would have been considered by us to be on parental leave and ◆ they have been *self-employed* for a continuous period of six months before the leave started.
partial disability/ partially disabled	**For a policy other than Income Care Platinum** The *life insured* is not *totally disabled* but, because of *sickness* or *injury*: ◆ they are unable to work in their own occupation at full capacity ◆ they are working in their own occupation in a reduced capacity or working in another occupation ◆ their *monthly income* is less than their *pre-disability income* and ◆ they are under *regular medical care*. If the *life insured* becomes *unemployed* or goes on leave without pay while a Partial Disability benefit is payable, *partial disability/partially disabled* changes to mean that the *life insured* is not *totally disabled* but, because of *sickness* or *injury*: ◆ they are only capable of working in their main *occupation* in a reduced capacity or working in another occupation ◆ their *monthly income* would be less than their *pre-disability income* and ◆ they are under *regular medical care*. **For Income Care Platinum** The *life insured* is not *totally disabled* but, because of *sickness* or *injury*: ◆ they are unable to work in their main *occupation* at full capacity ◆ they are working in their own occupation in a reduced capacity or working in another occupation ◆ their *monthly income* is less than their *pre-disability income* and ◆ they are under *regular medical care*. If the *life insured* becomes *unemployed* or goes on leave without pay while a Partial Disability benefit is payable, *partial disability/partially disabled* changes to mean that the *life insured* is not *totally disabled* but, because of *sickness* or *injury*: ◆ they are only capable of working in their main *occupation* in a reduced capacity or working in another *occupation* ◆ their *monthly income* would be less than their *pre-disability income* and ◆ they are under *regular medical care*.

This term…	Means…
permanent disablement/ permanently disabled	The *life insured* has suffered: ◆ a *work ending condition* or ◆ a *serious medical condition* or ◆ *loss of use of limbs or sight* or ◆ *loss of independent existence*.
permanent disablement benefit	**To age 65** If the *benefit period* applying to the *life insured* is to the *policy anniversary date* before age 65, the Permanent Disablement benefit is the lesser of the following amounts: ◆ $3 million ◆ the amount which is A x the *annualised monthly benefit*, where A is: • 15, if the *life insured's relevant age* is less than 40 years • 13, if the *life insured's relevant age* is 40 years or more but less than 45 years • 11, if the *life insured's relevant age* is 45 years or more but less than 50 years • 9, if the *life insured's relevant age* is 50 years or more but less than 56 years • 65 minus the *life insured's relevant age*, if the *life insured's relevant age* is more than 55 years. If the lesser of the above amounts is a nil or negative amount, the Permanent Disablement benefit is nil. **To age 70** If the *benefit period* applying to the *life insured* is to the *policy anniversary date* before age 70, the Permanent Disablement benefit is the lesser of the following amounts: ◆ $3 million ◆ the amount which is A x the *annualised monthly benefit*, where A is: • 16, if the *life insured's relevant age* is less than 40 years • 14, if the *life insured's relevant age* is 40 years or more but less than 45 years • 12, if the *life insured's relevant age* is 45 years or more but less than 50 years • 11, if the *life insured's relevant age* is 50 years or more but less than 56 years • 9, if the *life insured's relevant age* is 56 years or more but less than 61 years • 70 minus the *life insured's relevant age*, if the *life insured's relevant age* is more than 60 years. If the lesser of the above amounts is a nil or negative amount, the Permanent Disablement benefit is nil.
permanent employment/ permanently employed	At least 20 hours per week of continual, permanent and regular employment for salary or wages, where such employment: ◆ is with an employer who employs at least five employees and ◆ is not temporary, seasonal, casual or under a contract based on a specified period or completion of specified work.

This term...	Means...
pre-disability income	**For a policy other than a *super policy*** **Agreed value or guaranteed agreed value** For an *agreed value policy* or *guaranteed agreed value policy,* the *life insured's* pre-disability income is the *life insured's* highest average *monthly income* in any consecutive 12 month period occurring between the date which is 12 months before the present level of cover was applied for and the date of the *life insured's* most recent period of *disability* (or, if applicable, the date of the *injury* or condition which resulted in the Specific Injuries benefit, Crisis benefit or Death benefit becoming payable). If benefits continue to be paid for more than 12 months, this amount is increased by the *indexation factor* every 12 months on the anniversary of the date benefits started. If there is an indexed increase, the most recent indexed amount will be the minimum pre-disability income for future claims. **Extended Indemnity** For an *extended indemnity policy*, the *life insured's* pre-disability income is the highest average *monthly income* the *life insured* received in any consecutive 12 month period in the 36 months before their most recent period of *disability* (or, if applicable, before the *injury* or condition which resulted in the Specific Injuries benefit, Crisis benefit or Death benefit becoming payable). If benefits continue to be paid for more than 12 consecutive months, this amount is increased by the *indexation factor* every 12 months on the anniversary of the date benefits started. **Indemnity** For an *indemnity policy*, the *life insured's* pre-disability income is the average *monthly income* the *life insured* received during the 12 months before their most recent period of *disability* (or, if applicable, before the *injury* or condition which resulted in the Specific Injuries benefit, Crisis benefit or Death benefit becoming payable). If the *life insured* has been on unpaid employer-approved maternity leave, paternity leave or study leave that commenced at any time in the 12 months before the *life insured's* most recent period of *disability* (or, if applicable, before the *injury* or condition which resulted in the Specific Injuries benefit, Crisis benefit or Death benefit becoming payable), the *life insured's* pre-disability income is the average *monthly income* the *life insured* received during the 12 months before the unpaid leave commenced. If the *life insured* returns to work from leave on a reduced income, we reduce the *life insured's* average *monthly income* by the same proportion by which their income decreased compared to what it was immediately before the *life insured* commenced leave. If benefits continue to be paid for more than 12 months, this amount is increased by the *indexation factor* every 12 months on the anniversary of the date benefits started. **For a *super policy*** The *life insured's* pre-disability income is the average *monthly income* the *life insured* received during the 12 months before their most recent period of *disability*.
pre-existing condition	A pre-existing condition is any condition: ◆ that first occurred or ◆ the circumstances leading to which first became apparent before the cover under this policy started or increased.

This term…	Means…
regular medical care	The person is under the regular treatment, and/or following the advice, of a *medical practitioner* with whom the person has personally consulted, including: ◆ following all reasonable measures as advised by the *medical practitioner* to avert or minimise any *injury* or *sickness* and ◆ undergoing review by the *medical practitioner* on at least a monthly basis, unless the *medical practitioner* reasonably specifies otherwise.
regular occupation	Regular occupation means: ◆ for a *life insured* who was actively working for reward for 20 or more hours per week at any time in the 12 months immediately before the *sickness* or *injury* that causes their *disability* or *permanent disablement*, the occupation in which the *life insured* last performed that work before suffering the *sickness* or *injury* or ◆ for a *life insured* who does not fall within the preceding bullet point, any occupation for which the *life insured* is reasonably suited by education, training or experience. A *life insured* won't be taken to be actively working if they are on *parental* or *long service leave*.
relevant age	The age in years the *life insured* will reach on their next birthday after the date the *Permanent Disablement benefit* first becomes payable for the *life insured.* The date the *Permanent Disablement benefit* first becomes payable can't be a date earlier than the date on which we are satisfied the *life insured* is *permanently disabled* and we have been asked to pay the *Permanent Disablement benefit*.
self-employed/ self-employment	The *life insured*: ◆ is working in a business or an enterprise for at least 20 hours per week ◆ has power or control over the business or enterprise because they own it or are a shareholder in the company that owns it or are a partner in the partnership that owns it and ◆ is working for payment or reward and they aren't an employee.
serious medical condition	The *life insured* is, as a result of a *day one condition*: ◆ under *regular medical care* ◆ neither in active employment nor any type of work (whether or not for reward) and ◆ incapacitated to such an extent that they are completely unable to engage in their *regular occupation* (whether or not for reward) and are unlikely to do so ever again.
split IP	The arrangement described as such in this PDS where income protection for a *life insured* is spread across both a *super policy* and an *ordinary policy* so that any benefits that can be paid inside superannuation are paid under the *super policy* and any benefits that can't are paid under the *ordinary policy.*
split IP policy	A *split IP super policy* or *split IP ordinary policy*. Each split IP policy shows in its policy schedule the other split IP policy to which *split IP* applies.
split IP ordinary policy	An *ordinary policy* to which *split IP* applies, as shown in the policy schedule for the policy.
split IP super policy	A *super policy* to which *split IP* applies, as shown in the policy schedule for the policy.
super continuance monthly benefit	The lesser of the following amounts: ◆ the amount shown as such in the policy schedule as increased or decreased under the policy ◆ 1/12th of the amount of total superannuation contributions made for the *life insured's* benefit by them or their employer in the 12 months immediately before their most recent period of *disability* (or, if applicable, before the *injury* or condition which resulted in the Specific Injuries benefit, Crisis benefit or Death benefit becoming payable). If benefits are payable for part of a month, the *super continuance monthly benefit* is divided by 30 to arrive at a daily benefit.

This term…	Means…
total disability/ totally disabled	**For an Income Care or Income Care Plus policy:** The *life insured* is, because of *sickness* or *injury:* ◆ unable to perform an *income producing duty* and ◆ under *regular medical care* and ◆ not working. **The above definition changes** If: ◆ the *life insured's occupation group* is H, X or Y in the policy schedule and ◆ the *life insured's benefit period* is greater than two years and ◆ the *life insured* has been totally disabled for two years the definition changes to mean that the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working. If: ◆ the *life insured's occupation group* is A in the policy schedule and ◆ the *life insured* is an eligible commercial airline pilot or flight engineer within that *occupation group* and ◆ the *life insured* is aged 55 or more then, for the *life insured*, total disability/totally disabled means the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working. If, for 12 months or more immediately before a claim, the *life insured* has been: ◆ *unemployed* (excluding sabbatical leave) or ◆ on parental or long service leave then, for the *life insured*, total disability/totally disabled means the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working. **Business Overheads Cover** For Business Overheads Cover, total disability/totally disabled means that, because of *sickness* or *injury*, the *life insured* is: ◆ unable to perform at least one *income producing duty* and under *regular medical care* and ◆ not working for more than ten hours per week. If the *life insured* works for more than ten hours per week, whether or not they're working for reward or working in the *business*, we don't consider them to be totally disabled.

This term…	Means…
total disability/ totally disabled	**For Income Care Platinum** The *life insured* is under *regular medical care* for a *sickness* or *injury* and, because of the *sickness* or *injury*, is: ◆ unable to perform an *income producing duty* and ◆ not working Or ◆ unable to generate, in their main *occupation*, *monthly income* greater than 20% of their *pre-disability income* and ◆ not generating *monthly income* greater than 20% of their *pre-disability income* Or ◆ unable to perform their *income producing duties* for more than the required number of hours; and ◆ not working for more than the required number of hours, where the required number of hours is 10 hours per week, except where the *life insured* was on average working 20 hours or less a week in the 12 months before their *sickness* or *injury*, in which case the required number of hours is 5 hours per week. **The above definition changes** If: ◆ the *life insured's occupation group* is X in the policy schedule and ◆ the *life insured's benefit period* is greater than two years and ◆ the *life insured* has been totally disabled for two years the definition changes to mean that the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working. If: ◆ the *life insured's occupation group* is A in the policy schedule and ◆ the *life insured* is an eligible commercial airline pilot or flight engineer within that *occupation group* and ◆ the *life insured* is aged 55 or more then, for the *life insured*, total disability/totally disabled means the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working. If, for 12 months or more immediately before a claim, the *life insured* has been unemployed (excluding sabbatical leave) or on parental or long service leave then, for the *life insured*, total disability/totally disabled means the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working.

This term…	Means…
total disability/ totally disabled	**For a *super policy*:** The *life insured* suffers from *sickness* or *injury* and, because of that *sickness* or *injury,* all of the following apply: ◆ the *life insured* has ceased to be *gainfully employed* ◆ the *life insured* is unable to perform an *income producing duty* ◆ the *life insured* is under *regular medical care* ◆ the *life insured* is not working. **The above definition changes** If: ◆ the *life insured's occupation group* is H, X or Y in the policy schedule and ◆ the *life insured's benefit period* is greater than two years and ◆ the *life insured* has been totally disabled for two years The definition changes to mean that the *life insured* is, because of *sickness* or *injury*: ◆ unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ under *regular medical care* and ◆ not working. If: ◆ the *life insured's occupation group* is A in the policy schedule and ◆ the *life insured* is an eligible commercial airline pilot or flight engineer within that *occupation group* and ◆ the *life insured* is aged 55 or more Then, for the *life insured*, total disability/totally disabled means the *life insured* suffers from *sickness* or *injury* and, because of that *sickness* or *injury,* all of the following apply: ◆ the *life insured* has ceased to be *gainfully employed* ◆ the *life insured* is unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ the *life insured* is under *regular medical care* and ◆ the *life insured* is not working. If, for 12 months or more immediately before a claim, the *life insured* has been on parental or long service leave, then, for the *life insured*, *total disability/totally disabled* means the *life insured* suffers from *sickness* or *injury* and, because of that *sickness* or *injury,* all of the following apply: ◆ the *life insured* has ceased to be *gainfully employed* ◆ the *life insured* is unable to perform any occupation for which they are reasonably suited by education, training or experience and ◆ the *life insured* is under *regular medical care* and ◆ the *life insured* is not working.
unemployed/ unemployment	◆ if *permanently employed*, loss of *employment* as a result of being terminated or made redundant by one's employer, where such loss is not of a voluntary basis ◆ if employed on a *fixed term contract*, loss of *employment* before the expiry date of the contract as a result of being terminated or made redundant by one's employer, where such loss is not of a voluntary nature. In either case, this definition isn't met if the person's loss of *employment* was immediately preceded by a period of *self-employment*.
waiting period	The period shown as such in the policy schedule. How the waiting period works is explained on page 75.
work ending condition	A *life insured* has a work ending condition if all of the following applies: ◆ we have paid benefits under this policy for the *life insured's total disability* or *partial disability* for a period of 36 consecutive months (the '36 month disability period') ◆ during the *36 month disability period*, the *life insured* actively participated in, and co-operated with, any rehabilitation programs or activities we reasonably requested the *life insured* to participate in ◆ immediately after the *36 month disability period*, the *life insured* is, as a result of the *sickness* or *injury* that gave rise to the claim for *total disability* or *partial disability* benefits, neither in active employment nor any type of work (whether or not for reward) and this status continues for a period of 3 consecutive months ◆ during the 3 consecutive months, the *life insured* is under *regular medical care* ◆ immediately after the 3 consecutive months, the *life insured* is, as a result of the *sickness* or *injury* that gave rise to the claim for *total disability* or *partial disability* benefits, incapacitated to such an extent that they are completely unable to engage in their *regular occupation* (whether or not for reward) and are unlikely to do so ever again.

Medical definitions.

This term…	Means…
activity/ies of daily living	Dressing – putting on and taking off clothing. Toileting – using the toilet, including getting on and off. Mobilising – getting in and out of bed and a chair. Maintaining continence – having good control of bowel and bladder function. Feeding – getting food from a plate into the mouth. Bathing – washing or showering.
advanced diabetes mellitus	Advanced diabetes mellitus (either insulin or non-insulin dependent) 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 ◆ Severe Diabetic Nephropathy causing chronic irreversible renal impairment (as measured by a corrected creatinine clearance below the laboratory/ies measured normal range) ◆ Diabetic Gangrene leading to surgical intervention as certified by a *relevant medical specialist*. Other *diabetes mellitus complications* are excluded.
aplastic anaemia	Bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment, with at least one of the following: ◆ blood product transfusions ◆ marrow stimulating agents ◆ immunosuppressive agents or ◆ bone marrow transplantation.
bacterial meningitis	The unequivocal diagnosis of bacterial meningitis resulting in a neurological deficit causing permanent and significant functional impairment.
benign brain tumour	Diagnosis of: ◆ a non-malignant tumour arising in the brain ◆ an acoustic neuroma or ◆ a meningioma giving rise to increased intracranial pressure which results in neurological deficit. The condition must require: ◆ chemotherapy ◆ radiotherapy or ◆ cranial surgery for its treatment or removal within 12 months. The diagnosis must be confirmed by a *relevant medical specialist*. The presence of the condition and intracranial pressure must be confirmed by imaging studies such as CT scan or MRI. The definition excludes diagnosis of cysts, granulomas, cerebral abscesses, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine.
benign brain tumour of limited extent	Diagnosis of: ◆ a non-malignant tumour arising in the brain or ◆ an acoustic neuroma. The diagnosis must be confirmed by a *relevant medical specialist*. The presence of the condition must be confirmed by imaging studies such as CT scan or MRI. The definition excludes diagnosis of cysts, granulomas, cerebral abscesses, malformations in or of the arteries or veins of the brain, haematomas, meningiomas and tumours in the pituitary gland or spine.
blindness	The permanent loss of sight in both eyes due to *sickness* or *injury* to the extent that: ◆ visual acuity is 6/60 or less in both eyes or ◆ the visual field is reduced to 20 degrees or less of arc whether aided or unaided, and all as certified by a *relevant medical specialist*.

This term…	Means…
cancer	Cancer is the presence of one or more malignant tumours that are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. This definition of 'cancer' includes each of the following conditions: 1. Lymphoma (including Hodgkin's and non-Hodgkin's disease) 2. Leukaemia other than Chronic Lymphocytic Leukaemia equivalent to Rai Stage 0 3. Multiple myeloma 4. Malignant bone marrow disorders 5. Carcinoma in situ of the breast which has resulted in: i. the removal of the entire breast, or ii. breast conserving surgery and radiotherapy, or iii. breast conserving surgery and chemotherapy (chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells) 6. Carcinoma in situ of the testis 7. Prostatic cancers that are classified as: i. T1bN0M0 or greater, or ii. T1aN0M0 with a Gleason Score of 6 or more This definition of 'cancer' excludes each of the following conditions: 1. Cervical dysplasia, LSIL, HSIL, CIN1, CIN2, CIN2/3 and CIN3. 2. Non melanoma skin cancers including: i. intraepidermal carcinomas ii. basal cell carcinomas, and iii. squamous cell carcinomas of skin which have not spread to another organ. 3. Melanomas which are classified as less than stage T1bN0M0. 4. A prostatic cancer that is not included in the definition of 'cancer' under the list of inclusions above. 5. Chronic Lymphocytic Leukaemia equivalent to Rai Stage 0. 6. A tumour which meets both of the following: i. it is described histologically as premalignant or carcinoma in situ; and ii. it is not included in the definition of 'cancer' under the list of inclusions above. 7. A cancer which meets both of the following: i. it is classified as less than T1N0M0 as defined by the American Joint Committee for Cancer (AJCC); and ii. it is not included in the definition of 'cancer' under the list of inclusions above.
cardiac arrest	Cardiac arrest which meets all of the following: ◆ it is due to: • cardiac asystole or • ventricular fibrillation with or without ventricular tachycardia ◆ it isn't associated with any medical procedure ◆ its occurrence is confirmed by an electrocardiogram or, if an electrocardiogram is not available, by such alternative medical evidence we consider reasonable in the circumstances (for example, ambulance or hospital medical reports).
cardiomyopathy	The diagnosis of cardiomyopathy by a *relevant medical specialist* resulting in significant physical impairment which is classified as Class 3 or greater under the New York Heart Association classification of cardiac impairment.
chronic lung disease	Permanent end stage respiratory failure with FEV1 test results of less than one litre and requiring continuous permanent oxygen therapy.
coma	A state of unconsciousness resulting in the following for at least 72 continuous hours: ◆ a documented Glasgow Coma Scale score of 6 or less and ◆ the use of a life support system.
coronary artery bypass surgery	The undergoing of bypass surgery to treat coronary artery disease but excluding angioplasty and intra-arterial procedures.
coronary artery angioplasty	The person undergoes coronary artery angioplasty but only if, in the opinion of a *relevant medical specialist*, the procedure was necessary to treat coronary artery disease. The *relevant medical specialist's* opinion must be supported by angiographic evidence.

This term…	Means…
coronary artery angioplasty – triple vessel	The person undergoes coronary artery angioplasty to three or more different coronary arteries, but only if: ◆ performed in the same procedure or in two procedures no more than 60 days apart; and ◆ in the opinion of a *relevant medical specialist*, the procedure(s) was/were necessary to treat coronary artery disease. The *relevant medical specialist's* opinion must be supported by angiographic evidence.
critical care	A *sickness* or *injury* that has resulted in the person requiring continuous mechanical ventilation by means of tracheal intubation for ten consecutive days (24 hours per day) in an intensive care unit of an acute care hospital. *Sickness* or *injury* as a result of self-inflicted means is excluded.
dementia and Alzheimer's disease	Clinical diagnosis of dementia (including Alzheimer's disease) as confirmed by a *relevant medical specialist*. The diagnosis must confirm irreversible failure of brain function resulting in significant cognitive impairment. Significant cognitive impairment means a deterioration in the person's Mini-Mental State Examination score to 24 or less, where the deterioration would continue but for any effective treatments.
diabetes mellitus complications	Diagnosis of Type 1 insulin dependent diabetes mellitus resulting in at least two of the following criteria: ◆ urinary protein excretion of more than 300mg per day ◆ diabetic retinopathy with a minimum severity of at least exudates and/or dot-blot haemorrhages ◆ persistent sensory neuropathy as certified by a *relevant medical specialist*.
diplegia	The total and permanent loss of use of both sides of the body, resulting from *sickness* or *injury*.
early-stage breast cancer	Diagnosis of carcinoma in situ of the breast.
early-stage cancer of the cervix uteri	Means any one of the following: ◆ Cervical intraepithelial neoplasia of the cervix (CIN) of at least CIN2/3. ◆ High grade squamous intraepithelial lesions of the cervix (HSIL) categorised as HSIL, HSIL CIN2/3 or HSIL CIN3. ◆ Carcinoma in situ of the cervix (CIS). All pathology must be confirmed histologically by biopsy. Lesions categorised as LSIL, CIN1, CIN2 or HSIL CIN2 are excluded.
early-stage cancer of the fallopian tubes	Diagnosis of carcinoma in situ (limited to tubal mucosa) of a fallopian tube.
early-stage cancer of the vagina	The diagnosis of a carcinoma in situ (or intraepithelial neoplasia) of the vagina.
early-stage cancer of the vulva or perineum	Carcinoma in situ of the vulva or perineum, as certified by a *relevant medical specialist*.
early-stage chronic lymphocytic leukaemia	The diagnosis of Chronic Lymphocytic Leukaemia (CLL) classified as Rai Stage 0.
early-stage melanoma	The diagnosis of a malignant melanoma on biopsy which is classified as stage T1aN0M0.
early-stage ovarian cancer	Diagnosis of carcinoma in situ of an ovary.
early-stage penile cancer	Diagnosis of carcinoma in situ of the penis.
early-stage prostate cancer	Prostatic cancers that are classified as T1aN0M0 and have a Gleason Score of less than 6.
encephalitis	The diagnosis of encephalitis by a *relevant medical specialist*, where the specialist certifies all of the following: ◆ the person suffers from the severe inflammation of brain substance; ◆ the inflammation results in significant neurological sequelae; ◆ the inflammation causes the person to be: • cognitively impaired with a Mini-Mental State Examination score of 24 or less; or • unable to perform, without the assistance of another person, any one of the *activities of daily living* and the person is likely to be so disabled for life.
end stage kidney failure	End stage kidney failure which: ◆ presents as the chronic and irreversible failure of both kidneys to function; and ◆ results in regular kidney dialysis or a kidney transplantation.
end stage liver failure	End stage liver failure resulting in permanent jaundice, ascites or encephalopathy.

This term…	Means…
heart attack	The death of part of the heart muscle (myocardial infarction) as a result of inadequate blood supply to the relevant area. The diagnosis of myocardial infarction must be confirmed by a *relevant medical specialist* and evidenced by: a. a typical rise and/or fall of cardiac biomarkers with at least one biomarker result above the upper limit of the reference range, and b. at least one of the following: ◆ signs and symptoms of ischaemia consistent with a myocardial infarction; ◆ confirmatory new, or presumed new, electrocardiogram (ECG) changes consistent with myocardial infarction; or ◆ imaging evidence confirming the new loss of viable myocardium or new regional wall motion abnormality. If the above evidence is inconclusive or superseded by technological advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose the occurrence of a myocardial infarction of at least the degree of severity set out above. Other acute coronary syndromes where death of the heart muscle has not occurred are excluded.
heart valve surgery	Surgery to replace or repair a heart valve.
hemiplegia	The total and permanent loss of use of one side of the body, resulting from *sickness* or *injury*.
loss of hearing	Complete and irrecoverable loss of hearing from both ears as a result of *sickness* or *injury*, as certified by a *relevant medical specialist*. This definition isn't met if the person's hearing has been restored through any natural or assisted means, unless the assisted means is a device implanted in the cochlea.
loss of independent existence	A *relevant medical specialist* certifies that, as a result of *sickness* or *injury*: ◆ the person suffers cognitive impairment which requires them to be permanently and constantly supervised for a continuous period of at least six months; or ◆ there is permanent and irreversible inability to perform, without the assistance of another person, any two of the *activities of daily living*. A person won't be considered unable to perform an *activity of daily living* if they can still perform the activity with the assistance of an artificial aid we consider reasonable for the person to use.
loss of speech	The total and irrecoverable loss of the ability to produce intelligible speech as a result of *sickness* or *injury* which causes permanent damage to the larynx or its nerve supply or the speech centres of the brain. The loss must be certified by a *relevant medical specialist*.
loss of use of limbs or sight	The person has suffered, as a result of *sickness* or *injury*: ◆ the total and permanent loss of use of two limbs; or ◆ blindness in both eyes; or ◆ the total and permanent loss of the use of one limb and blindness in one eye; where: ◆ 'limb' means the whole hand below the wrist or whole foot below the ankle ◆ 'blindness' means the permanent loss of sight to the extent that: • visual acuity is 6/60 or less or • the visual field is reduced to 20 degrees or less of arc whether aided or unaided and all as certified by a *relevant medical specialist*.
loss of use of one limb	The person has suffered, as a result of *sickness* or *injury*, the total and permanent loss of use of one 'limb', where limb means the whole hand below the wrist or whole foot below the ankle.
major head trauma	*Injury* to the head resulting in neurological deficit causing either: ◆ the permanent and irreversible inability to perform without the assistance of another person any one of the *activities of daily living*, or ◆ permanent cognitive impairment, where the person has a Mini-Mental State Examination score of 24 or less as certified by a *relevant medical specialist.*

This term…	Means…
major organ or bone marrow transplant	The person undergoes, or has been placed on a waiting list for, an organ transplant from a human donor for one or more of the following organs: ◆ kidney ◆ lung ◆ pancreas ◆ heart ◆ liver ◆ small bowel or ◆ bone marrow. The treatment must be considered medically necessary and the condition affecting the organ deemed untreatable by any means other than organ transplant, as confirmed by a *relevant medical specialist.* A 'waiting list' means the waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit.
medically acquired HIV	Accidental infection of a person with Human Immunodeficiency Virus (HIV) from a medically necessary procedure or operation performed in Australia by a recognised and registered health professional, including but not limited to, a medical/paramedical practitioner and a dentist. A medically necessary procedure or operation includes but is not limited to: ◆ a transfusion with blood or blood products; ◆ an organ transplant to the person; ◆ an assisted reproductive technique; and ◆ a root canal. If we consider it necessary, we must, for independent testing: ◆ be given access to all blood samples taken from the person; and ◆ be permitted to take additional samples. We won't pay a benefit for medically acquired HIV if, before the accidental infection occurred, the Australian government approved a medical treatment which if applied to the person would: ◆ render their HIV inactive and non-infectious to others; or ◆ prevent them from developing Acquired Immunodeficiency Syndrome (AIDS); or ◆ where they have developed AIDS, cure the AIDS.
meningococcal disease	The diagnosis by a *relevant medical specialist* of meningococcal septicaemia or meningitis resulting in: ◆ permanent whole person impairment of at least 25% (as defined in the 6th edition of the American Medical Association's publication 'Guides to the Evaluation of Permanent Impairment'), or ◆ the permanent and irreversible inability to perform without the assistance of another person any one of the *activities of daily living.*
motor neurone disease	The diagnosis of motor neurone disease as certified by a *relevant medical specialist*.
multiple sclerosis with impairment	The diagnosis of multiple sclerosis as certified by a *relevant medical specialist*, where the condition: ◆ is characterised by demyelination in the brain and spinal cord, evidenced by magnetic resonance imaging or other investigations acceptable to us; and ◆ has resulted in more than one episode of well-defined neurological deficit with persisting neurological abnormalities.
multiple sclerosis of limited extent	The diagnosis of multiple sclerosis as certified by a *relevant medical specialist*, where the condition: ◆ is characterised by demyelination in the brain and spinal cord, evidenced by magnetic resonance imaging or other investigations acceptable to us; and ◆ has resulted in more than one episode of well-defined neurological deficit without persisting neurological abnormalities.
muscular dystrophy	The diagnosis of muscular dystrophy as certified by a *relevant medical specialist*.

This term…	Means…
occupationally acquired hepatitis B or C	Occupationally acquired hepatitis B or hepatitis C where: ◆ the virus was acquired by the person as a result of an *accident* occurring while they were engaging in their occupation as a medical professional and ◆ there is proof of sero-conversion from: a) Hepatitis B surface antigen negative to hepatitis B surface antigen positive; or b) Hepatitis C antibody negative to hepatitis C antibody positive, which is demonstrated by testing within six months after the *accident*. Hepatitis B or hepatitis C acquired in any other manner is excluded. Any *accident* that gives rise to a claim must be treated in accordance with the relevant infection control guidelines for the relevant practice body or state health service including, at a minimum, baseline screening with regular screening at six weeks, twelve weeks and six months post event. This screening requires a supporting negative hepatitis B or hepatitis C test performed on material taken after the date of the *accident*. Blood product and all other blood samples used need to be made available to us for independent testing. Also, we won't pay a *Trauma Cover benefit* for occupationally acquired hepatitis B or C if: ◆ before the *accident* occurred, a cure has been found for hepatitis B and/or hepatitis C or ◆ the *life insured* has elected not to take available medical treatment which, if taken, would have prevented the infection with hepatitis B and/or hepatitis C.
occupationally acquired HIV	Accidental infection of a person with Human Immunodeficiency Virus (HIV) where all of the following apply: ◆ the *accident* occurred while the person was covered for this *Trauma Cover* condition and while they were carrying out their normal occupational duties ◆ an HIV antibody test was taken by the person within 7 days after the *accident* ◆ the test produced negative results which were reported to us in writing within 30 days after the *accident* ◆ sero-conversion indicating HIV infection occurred within 6 months after the *accident*. If we consider it necessary, we must, for independent testing: ◆ be given access to all blood samples taken from the person and ◆ be permitted to take additional samples. We won't pay a benefit for occupationally acquired HIV if, before the accidental infection occurred, the Australian government approved a medical treatment which if applied to the person would: ◆ render their HIV inactive and non-infectious to others; or ◆ prevent them from developing Acquired Immunodeficiency Syndrome (AIDS); or ◆ where they have developed AIDS, cure the AIDS. Nor will we pay a benefit if: ◆ the infection with HIV is caused directly or indirectly by sexual activity or recreational intravenous drug use or ◆ before the *accident* occurred, the Australian government recommended an HIV vaccine for use in the occupation of the person and the person failed to take it.
open heart surgery	Open heart surgery for treatment of a cardiac defect, cardiac aneurysm or cardiac tumour.
paraplegia	The total and permanent loss of use of both legs or both arms, resulting from spinal cord *sickness* or *injury*.
Parkinson's disease	The diagnosis of Parkinson's disease certified by a *relevant medical specialist.*
Parkinson's disease with impairment	The diagnosis of Parkinson's disease certified by a *relevant medical specialist,* confirming that the condition has caused significant progressive physical impairment, likely to continue progressing but for any treatment benefit.
partial blindness	The permanent loss of sight in one eye due to *sickness* or *injury* to the extent that: ◆ visual acuity is 6/60 or less in one eye or ◆ the visual field is reduced to 20 degrees or less of arc whether aided or unaided, and all as certified by a *relevant medical specialist*.
partial loss of hearing	Complete and irrecoverable loss of hearing from one ear as a result of *sickness* or *injury*, as certified by a *relevant medical specialist*. This definition isn't met if the person's hearing has been restored through any natural or assisted means, unless the assisted means is a device implanted in the cochlea.
pneumonectomy	The medically necessary and appropriate removal of an entire lung on the recommendation of a *relevant medical specialist*.
primary pulmonary hypertension	Primary pulmonary hypertension established by cardiac catheterisation resulting in significant permanent physical impairment which is classified as Class 3 or greater under the New York Heart Association classification of cardiac impairment.

This term…	Means…
quadriplegia	The total and permanent loss of use of both arms and both legs, resulting from spinal cord *sickness* or *injury*.
second primary cancer	A *cancer,* the cells of which: ◆ are found in a different part of the body and ◆ are unrelated (as determined by biopsy or equivalent medical evidence) to the Trauma Cover condition, listed under 'Cancer and tumours' in the tables on pages 55, 56 and 57, for which we paid the claim under the original *Trauma Cover*.
serious injury	An *injury* resulting in the person being confined to an acute care hospital for a period of 30 consecutive days (24 hours per day) under the full time care of a *medical practitioner*. *Injury* as a result of self-inflicted means is excluded.
severe burns	A severe burn is a full thickness burn to: ◆ 20% or more of the body surface area as measured by the age appropriate use of 'The Rule of Nines' or the Lund and Browder Body Surface Chart; or ◆ both hands, requiring surgical debridement and/or grafting; or ◆ both feet, requiring surgical debridement and/or grafting; or ◆ the face, requiring surgical debridement and/or grafting.
severe Crohn's disease	The confirmed diagnosis of Crohn's disease with ongoing signs and symptoms of inflammatory bowel disease with altered bowel function that: ◆ has failed to be controlled by standard therapy including cortisone treatment, and ◆ requires permanent immunosuppressive medication.
severe rheumatoid arthritis	The person meets one of the following: ◆ Diagnosis of severe rheumatoid arthritis by a *relevant medical specialist* where all of the following applies: • the diagnosis has been confirmed by appropriate radiology and blood tests • the person has undergone all reasonable treatment regimens, including but not limited to immunosuppressive and biological agents, as recommended by the person's medical specialist for the rheumatoid arthritis • despite undergoing all reasonable treatment regimens as recommended by the specialist, the rheumatoid arthritis has caused the person permanent whole person impairment of at least 25% (as defined in the 6th edition of the American Medical Association's publication 'Guides to the Evaluation of Permanent Impairment'). ◆ 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. Degenerative osteoarthritis and all other arthritides are excluded.
severe ulcerative colitis	The confirmed diagnosis of ulcerative colitis with ongoing signs and symptoms of inflammatory bowel disease with altered bowel function that: ◆ has failed to be controlled by standard therapy including cortisone treatment, and ◆ requires permanent immunosuppressive medication.

This term…	Means…
stroke	An infarct or haemorrhage involving the brain or spinal cord, producing neurological symptoms. There must be evidence consistent with stroke on CT, MRI or other appropriate imaging scan. The following are excluded: ◆ migraines ◆ transient ischemic attacks, and ◆ brain injury resulting from: a. trauma, or b. vascular disease affecting the eye, optic nerve or vestibular function.
subacute sclerosing panencephalitis	The unequivocal diagnosis of subacute sclerosing panencephalitis.
surgery of the aorta	Surgery to correct a narrowing, dissection or aneurysm of the thoracic or abdominal aorta but not its branches.
surgical removal of a hydatidiform mole	Surgical removal of a hydatidiform mole.
tetraplegia	The total and permanent loss of use of both arms and both legs, together with loss of head movement, resulting from brain or spinal cord *sickness* or *injury*.

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Interim Accident Cover Certificate

CommInsure Protection

Income Care, Income Care Plus, Income Care Platinum and Business Overheads Cover

The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA)

We provide interim accident cover (cover) while we are considering your application for Income Care, Income Care Plus, Income Care Platinum or Business Overheads Cover or for an increase in cover (application).

Cover is provided on the terms and conditions set out in this Interim Accident Cover Certificate. You do not have to pay an extra premium for this cover. To the extent that they are relevant, the conditions relating to payment of a claim in the policy you applied for (for an application for an increase in cover, the existing policy conditions apply), apply to your cover.

This cover does not apply to you:

- if the cover you are applying for is intended to replace other cover you have with CMLA, or
- if, at the time this certificate is issued, cover of the same type exists in respect of the life to be insured and that cover relates to an application for cover which is the same as, or similar to, the cover the subject of the application to which this cover relates.

1 Commencement of cover

Cover commences on the date CMLA holds your fully completed application and a cheque in payment of the first premium or, if premium payment is not by cheque, an effective direct debit request/credit card authority. Cover is subject to your premium payment being credited to CMLA by the relevant financial institution.

2 Period of cover

Your cover will automatically end on the earliest of the following dates:

- 90 days from the date this cover commences
- the date we accept your application on standard or special terms
- the date we decline your application
- the date your application is withdrawn, and
- the date we advise you that this cover is cancelled.

3 Monthly accident benefit

Income Care/Income Care Plus/Income Care Platinum

If your application is for cover under Income Care, Income Care Plus or Income Care Platinum, we will, on a monthly basis, pay you a monthly accident benefit if the life to be insured suffers total disability as a result of an accident. We will start paying the monthly accident benefit if total disability as a result of the same accident continues after the waiting period selected in your application for the relevant cover (for an application for an increase in cover, the existing waiting period applies), and the benefit will only be paid for the period of total disability or six months, whichever is the lesser. The monthly accident benefit is payable for only one period of total disability and is not payable for any subsequent period. The monthly accident benefit in this case is the lesser of the following amounts:

- $5,000
- the total of the monthly benefit and any super continuance monthly benefit you applied for in your application for the relevant cover in respect of the life to be insured
- the total of the monthly benefit and any super continuance monthly benefit which would normally be offered by us based on underwriting rules.

Business Overheads Cover

If your application is for Business Overheads Cover, we will, on a monthly basis, pay you a monthly accident benefit if the life to be insured suffers total disability as a result of an accident. We will start paying the monthly accident benefit if total disability as a result of the same accident continues after the waiting period selected in your Business Overheads Cover application (for an application for an increase in cover, the existing waiting period applies), and the benefit will only be paid for the period of total disability or six months, whichever is the lesser. The monthly accident benefit is payable for only one period of total disability and is not payable for any subsequent period.

This certificate must be retained by the applicant/life to be insured.

Continued overleaf.

The monthly accident benefit in this case is the lesser of the following amounts:

- $5,000
- the business overheads monthly benefit you applied for in your application for the cover in respect of the life to be insured
- the business overheads monthly benefit which would normally be offered by us based on underwriting rules.

We will pay the monthly accident benefit in the month immediately following the month during which you became entitled to it. Where the benefit is payable for part of a month, the monthly accident benefit is divided by 30 to arrive at a daily benefit.

4 Definitions

For the purposes of this cover:

- 'accident' means bodily injury caused solely and directly by violent, accidental, external and visible means, independent of any other cause and which occurs while this cover applies
- 'life to be insured' means the person named as such in the application
- 'total disability' has, to the extent relevant, the meaning set out in the policy you applied for (for an application for an increase in cover, the existing policy meaning applies), but must be the result of an accident
- 'waiting period' is the waiting period you selected in your application for the relevant policy (for an application for an increase in cover, the existing policy meaning applies) and otherwise has, to the extent relevant, the meaning set out in that policy
- 'you' the person or persons named as the applicant in the application.

5 Exclusions

A monthly accident benefit will not be paid under this cover if the total disability is caused directly or indirectly by:

- suicide or any attempt at suicide
- self-inflicted injury or infection
- the taking of drugs other than prescribed by a medical practitioner
- the taking of alcohol
- an injury the life to be insured suffers while outside of Australia
- a physical condition which you knew about before this cover commenced
- engaging in any pursuit or occupation that we would not normally cover on standard terms
- participation in criminal activity
- an act of war (whether declared or not).

6 Application for insurance

If you are eligible to make a claim under this cover, it may not prevent your application from being accepted. However, we will take into account the change in the health of the life to be insured when assessing your application and we may decline your application or apply special loadings, conditions and exclusions.

005-453 230918 (CI224)

Interim Accident Cover Certificate

CommInsure Protection

Total Care Plan, Total Care Plan Super (including Income Care Super) and SMSF Plan

The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA)

We provide interim accident cover (cover) while we are considering your application for Total Care Plan, Total Care Plan Super or the SMSF Plan or for an increase in cover under one of these policies (application).

The circumstances in which we will pay a benefit under this cover and the amount of the benefit vary according to the benefits you applied for in your application.

Cover is provided on the terms and conditions set out in this Interim Accident Cover Certificate. You do not have to pay an extra premium for this cover. To the extent that they are relevant, the conditions in the policy you applied for relating to payment of a claim apply to your cover (for an application for an increase in cover, the existing policy conditions apply).

This cover does not apply to you if:

- the cover you are applying for is intended to replace other cover you have with CMLA;
- the cover you are applying for is income protection under the SMSF Plan or Total Care Plan Super to which the split IP arrangement described in the CommInsure Protection PDS is to apply; or
- the cover you are applying for is TPD Cover under the SMSF Plan or Total Care Plan Super to which the split TPD Cover arrangement described in the CommInsure Protection PDS is to apply.

Also, the income protection set out in paragraph 4 of this certificate does not apply to you if, at the time this certificate is issued, cover of the same type exists in the respect of the life to be insured and that cover relates to an application for income protection which is the same as, or similar to, income protection under Total Care Plan Super or the SMSF Plan.

A lump sum benefit is payable only once under this cover.

1 Commencement of cover

Cover commences on the date CMLA holds your fully completed application and a cheque in payment of the first premium or, if premium payment is not by cheque, an effective direct debit request/credit card authority or rollover authority. Cover is subject to your premium payment being credited to CMLA by the relevant financial institution or superannuation fund.

2 Period of cover

Your cover will automatically end on the earliest of the following dates:

- 90 days from the date this cover commences
- the date we accept your application on standard or special terms or decline your application
- the date your application is withdrawn, and
- the date we advise you that this cover is cancelled.

3 Lump sum benefits

Life Care

If you applied for Life Care, we will pay a benefit if the life to be insured dies as a result of an accident. Death must occur within 90 days of the accident.

The amount of the benefit is the lesser of:

- $1 million and
- the amount of Life Care you applied for.

Trauma Cover

If you applied for Trauma Cover, we will pay a benefit if the life to be insured survives for 14 days after meeting the definition of one of the following medical conditions as a result of an accident:

- Major Head Trauma
- Tetraplegia
- Paraplegia
- Blindness
- Quadriplegia
- Severe Burns
- Hemiplegia
- Loss of use of Limbs or Sight
- Diplegia.

These medical conditions have the meanings set out in the Total Care Plan policy you applied for (for an application for an increase in cover, the existing policy definitions apply), but the medical condition must be the result of an accident.

The amount of the benefit payable is the lesser of:

- $1 million and
- the amount of Trauma Cover you applied for.

This certificate must be retained by the applicant/life to be insured.

Continued overleaf.

CommInsure

005-453 230918 (CI224)

Total and Permanent Disability (TPD) Cover

If you applied for TPD Cover, we will pay a benefit if the life to be insured is totally and permanently disabled as a result of an accident. The TPD definition that applies is that which would have applied under the policy had we accepted your application, but TPD must be the result of an accident.

The amount of the benefit payable is the lesser of:

- $1 million and
- the amount of TPD Cover you applied for.

Child Cover

If you applied for Child Cover, we will pay a benefit if the child life to be insured dies as a result of an accident or meets the definition of one of the following medical conditions as a result of an accident:

- Major Head Trauma
- Tetraplegia
- Paraplegia
- Blindness
- Quadriplegia
- Severe Burns
- Hemiplegia
- Loss of use of limbs or Sight
- Diplegia.

These medical conditions have the meanings set out in the Total Care Plan policy you applied for (for an application for an increase in cover, the existing policy definitions apply), but the medical condition must be the result of an accident.

In the event the child life to be insured dies, the death must occur within 90 days of the accident for a benefit to be payable under this cover.

If we pay a benefit for death, we will not pay a benefit for any of the medical conditions and if we pay a benefit for one of the medical conditions, we will not pay the benefit for death or any other medical condition.

The amount of the benefit payable is the lesser of:

- $100,000, and
- the amount of the Child Cover you applied for.

4 Income protection

If you applied for new income protection under Total Care Plan Super or the SMSF Plan or for an increase in cover under one of these policies, we will, on a monthly basis, pay you a monthly accident benefit if you, as the life to be insured, suffers total disability as a result of an accident.

We will start paying the monthly accident benefit if total disability as a result of the same accident continues after the waiting period, and the benefit will only be paid for the period of total disability or six months, whichever is the lesser. The monthly accident benefit is payable for only one period of total disability and is not payable for any subsequent period.

The monthly accident benefit in this case is the lesser of the following amounts:

- $5,000
- the total of the monthly benefit you applied for in your application
- the total of the monthly benefit which would normally be offered by us based on underwriting rules
- the average monthly income you received during the 12 months before your total disability.

5 Definitions

For the purposes of this cover:

- 'accident' means bodily injury caused solely and directly by violent, accidental, external and visible means, independent of any other cause and which occurs while this cover applies
- 'child to be insured' means the person named as such in the application
- 'life to be insured' means the person named as such in the application
- 'monthly income' has, to the extent relevant, the meaning set out in the income protection you applied for (for an application for an increase in cover, the existing meaning applies)
- 'total disability' has, to the extent relevant, the meaning set out in the income protection you applied for (for an application for an increase in cover, the existing meaning applies), but must be the result of an accident
- 'waiting period' is the waiting period you selected in your application (for an application for an increase in cover, the existing meaning applies) and otherwise has, to the extent relevant, the meaning set out in the income protection you applied for
- 'you' means the person or persons named as the applicant in the application.

6 Exclusions

A benefit will not be paid if death, a medical condition, total and permanent disablement or total disability is caused directly or indirectly by:

- suicide or any attempt at suicide
- self-inflicted injury or infection
- the taking of drugs other than prescribed by a medical practitioner
- the taking of alcohol
- an injury the life to be insured or child life to be insured suffers while outside Australia
- a physical condition which the policy owner(s) or the life to be insured knew about before this cover commenced
- engaging in any pursuit or occupation that we would not normally cover on standard terms
- participation in criminal activity
- an act of war (whether declared or not).

Nor will we pay a benefit under this cover if the child life to be insured's death or medical condition is caused directly or indirectly by an injury or infection inflicted on a child life to be insured by you or a life to be insured or by the child life to be insured's parent or legal guardian or by any other person who has responsibility for the care of the child life to be insured or who resides with the child life to be insured.

7 Application for insurance

If you are eligible to make a claim under this cover, it will not prevent your application from being accepted. However, we will take into account the change in the health of the life to be insured when assessing your application and we may decline your application or apply special loadings, conditions and exclusions. If you are eligible to make a claim under this cover in respect of a child life to be insured, we will not accept your application for Child Cover.

005-453 230918 (CI224)