ZURICH

Underwriting Guide

Insurance

August 2022

Contents

Zurich's approach to underwriting

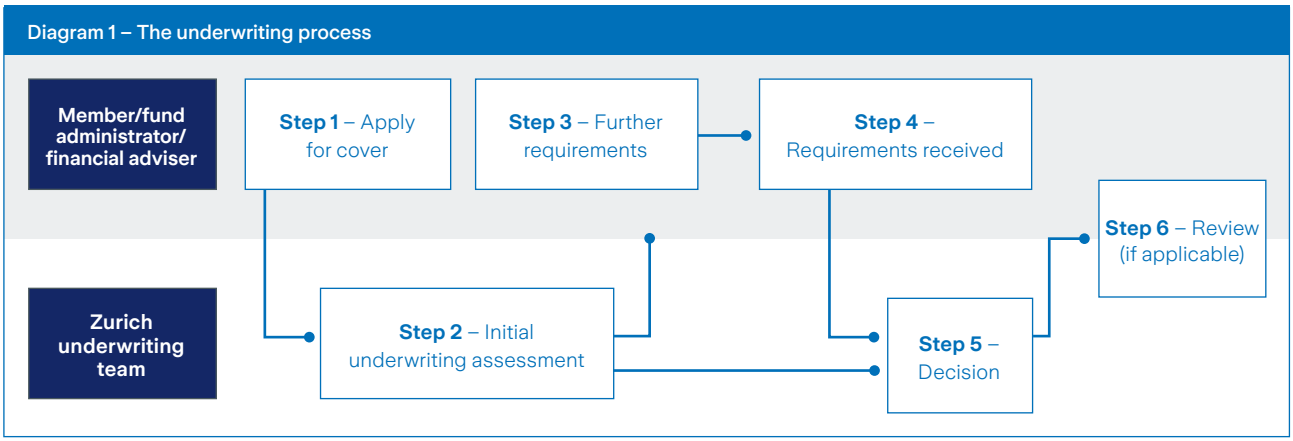
This brochure provides an outline of the underwriting process and services for Zurich's group insurance and master trust products.

At Zurich, we know how important it is to make the underwriting process easy. We aim to provide a positive and consistent outcome in a timely manner. In order to achieve this, members of our underwriting team will take personal responsibility for your member's application and will think outside the square and propose alternate solutions where possible.

The Underwriting Process

Applications that require underwriting will follow the process shown in Diagram 1. Each step in the process is explained in further detail below.

Diagram 1 – The underwriting process



Step 1 – Apply for cover

Members need to apply for cover, or an increase in their cover when:

- automatic acceptance terms do not apply
- they require cover in excess of the Automatic Acceptance Level (AAL)
- they wish to increase their sum insured
- transfer terms do not apply to them (in the case of a new plan starting with Zurich) or their cover exceeds their previous cover transferred
- their cover ceases for any reason and they would like it reinstated.

If a member wishes to apply for additional cover, please arrange for the member to complete either a Fund personal statement or a Zurich Group personal statement and submit it to Zurich (with any required attachments as outlined in the form). You can obtain a copy of the Zurich Group personal statement from our website at zurich.com.au/group-insurance/documents

You play an important role in the underwriting process for plan members. It will be your job to:

- relay all relevant information and requests from us to the member
- follow up all outstanding requests with the member
- forward all relevant information back to us
- assist the member with their enquiries.

Step 2 – Initial underwriting assessment

During the initial assessment of a member's underwriting application, it will be decided to either:

- grant cover to the member
- decline to provide cover (see step 4, on page 4)
- request additional information in order to make a decision.

The information provided within the personal statement will be considered, along with any of the attached information. Factors which will be considered as part of the assessment include the member's:

- personal and family medical history
- pastimes and pursuits
- occupation and duties
- existing cover, and the amount of cover being requested.

Our service commitment to you is to perform the initial assessment of applications within three business days.

Step 3 – Further requirements

In general, we will request further medical information where a member is seeking a Death or Total and Permanent Disablement (TPD) sum insured in excess of $1.5m or a Income Protection sum insured above $10,000 monthly benefit. The specific requirements are outlined in the tables on the next page.

Further requirements and medical tests may also be required as a result of information provided in the personal statement – for example, the member has indicated that they have had health related issues in the past.

We ask that neither you or the member organise any medical tests or reports before we have assessed the initial application (the personal statement). This ensures that only the appropriate tests are performed and unnecessary ones are not undertaken. In addition, Zurich often pays for such medical tests to be performed. If these are arranged without our advice or request, reimbursement of the member's costs may not be possible.

You will be notified of any additional information required via notifications from the RiskWorks Case Management system. RiskWorks provides you full details, online and in real time, of an application's status with underwriting.

How are medical tests arranged

Depending on the arrangements of your plan, the requirements are ordinarily organised by our medical services provider. In this case, the medical services provider will contact the member directly to arrange these. When the results are ready, they will be provided back to Zurich to allow further underwriting assessment to occur.

Automatic medical requirements and Forward Underwriting Limits (FUL)

Group Life

Insured benefit	Automatic requirement	Benefit range	FUL
$0 – $1,500,000	• Personal statement	$0 – $1,300,000 >$1,300,000 – $1,500,000	$1,500,000 $2,000,000 (based on automatic requirements for $1,500,001 – $2,000,000)
$1,500,001 – $2,000,000	• Personal statement • Bloods screen (Fasting MBA20, HIV, Hepatitis B & C serology)	$1,500,001 – $1,800,000 >$1,800,000 – $2,000,000	$2,000,000 $3,000,000*† (based on automatic requirements for $2,000,001 – $3,000,000)
$2,000,001 – $3,000,000	• Personal statement • Bloods screen (Fasting MBA20, HIV, Hepatitis B & C serology) • MediQuick		$3,000,000†
$3,000,001 – $5,000,000	• Personal statement • Bloods screen (Fasting MBA20, HIV, Hepatitis B & C serology) • GP Medical Examination • PMAR by usual doctor		N/A
$5,000,001 +	• Personal statement • Bloods screen (Fasting MBA20, HIV, Hepatitis B & C serology) • PMAR by usual doctor • Specialist Medical Exam • MSU, FBC, Exercise ECG		N/A

* If the applicant does not provide and/or undertake the new set of requirements, they will only be forward underwritten to $2,000,000.

† Subject to the plan's maximum benefit limit not being exceeded.

Group Income Protection

Monthly benefit	Automatic requirement	Benefit range	FUL
$0 – $10,000	• Personal statement	$0 – $8,500 >$8,500 – $10,000	$10,000 $15,000* (based on automatic requirements for $10,001 – $15,000)
$10,001 – $15,000	• Personal statement • PMAR by usual doctor	$10,001 – $14,000 >$14,000 – $15,000	$15,000 $20,000† (based on automatic requirements for $15,001 – $20,000)
$15,001 – $20,000	• Personal statement • Bloods screen (Fasting MBA20, HIV, Hepatitis B & C serology) • PMAR by usual doctor	$15,001 – $19,000	$20,000
$20,001 – $30,000	• Personal statement • Bloods screen (Fasting MBA20, HIV, Hepatitis B & C serology) • PMAR by usual doctor • MediQuick	>$19,000 – $30,000	$30,000*§

* If the applicant does not provide and/or undertake the new set of requirements, they will only be forward underwritten to $10,000 per month.

† If the applicant does not provide and/or undertake the new set of requirements, they will only be forward underwritten to $15,000 per month.

‡ Subject to the plan's maximum not being exceeded.

§ If the applicant does not provide and/or undertake the new set of requirements, they will only be forward underwritten to $20,000 per month.

Step 4 – Receipt of underwriting requirements

When we receive underwriting requirements or additional information relating to a member's application, the case file is updated and provided to the underwriter to continue the assessment. If requirements are not received within 90 days (excluding Personal Medical Attendants Reports – PMARs) the member's application may be closed. We will notify you of this, usually via email. If the only outstanding piece of information is a PMAR, we will keep the application open for longer, and continue to follow up.

If a member's application is closed and the outstanding information is subsequently received, the member's application may be re-opened, depending upon how much time has elapsed and whether or not any medical test results and information remains valid (as outlined in the table below). In addition, the member will be required to complete a 'Statement of Continued Good Health' which confirms that the member's health status has not changed since they originally applied.

It may happen that during the assessment a member decides not to proceed with the application. In such cases, we will require a written request to cease assessment from the member.

Time period for which medical tests remain valid

Requirement	Acceptance period from the date Zurich received the personal statement
HIV, MBA and Hepatitis B & C serology tests	6 months
Medical examination	6 months
ECG	12 months
Personal statement	12 months*

* After three months, a Declaration of Health is required.

Step 5 – Decision

Once a decision has been made regarding a member's application, you will be notified (usually via email).

You will receive a decision note, which will outline the terms and conditions under which the member's insurance cover has been granted.

A number of decision types are possible:

Acceptance at standard rates

The member's requested cover has been granted at the standard premium rate. No special loadings or exclusions have been added.

Acceptance with exclusions

Where an individual has an increased risk of making a claim, due to a particular health issue, or as a result of pastimes they participate in, cover may be granted with some exclusions.

For example:

- if a member has had a previous knee injury, they may be excluded from being able to claim a benefit in relation to further complications with their knee
- if a member regularly goes skydiving, they may be excluded from making a claim in the event of death, illness or injury they incur as a result of the skydiving.

If any exclusions have been added to a member's cover, details regarding this will be included in the decision note provided to you. It is important to remember that the policy will still provide cover for events which have not been excluded.

Acceptance with a premium loading

If an exclusion is not appropriate, rather than decline to provide a member with cover, we may add a premium loading. This will mean that additional premiums will be payable for that member, in addition to the standard rates applicable to the other members of the plan. Any premium loading payable will be advised on the decision note provided to you when the member is accepted for cover.

Decision not to offer cover

In extreme cases, we may determine that we cannot provide the requested cover to an individual member.

Where a member has cover under the relevant Automatic Acceptance Level (AAL) for a plan, this cover is maintained. They are just denied the additional cover they have requested.

Due to privacy reasons, we are only able to provide brief information regarding the reasons why cover has been denied on the decision note. If you would like the member to receive further details, please contact us and we will arrange for the member's health information (the results of tests performed) to be sent to the member's treating doctor. The member then makes an appointment to see the doctor, who provides them with the required information regarding their health.

This process is utilised for privacy and sensitivity reasons. For example, the tests performed could have revealed a health condition of which the member may be unaware. It is therefore preferable that the delivery of this information is performed by the member's doctor, who is trained in such matters.

Forward Underwriting Limits

Where a member's sum insured is linked to their salary levels, for example, where the member's salary continuance benefit is 75% of their salary, it is desirable that their cover increases along with any salary increases they receive in the future. This should be the case even where the member's sum insured has exceeded any relevant AAL or where they have been underwritten for additional cover. This is catered for by utilising what is known as a 'Forward Underwriting Limit' (FUL).

Members may be 'forward underwritten' to a level of cover above that initially required. This will allow the member's cover to increase along with future salary increases, up to the FUL granted. For example, where

a member requests a salary continuance sum insured of $11,000 per month, they may be forward underwritten up to the amount of $15,000 monthly benefit.

You and the member will be advised of any applicable FULs when underwritten cover is granted. The general Forward Underwriting Limits applicable to members are outlined in the tables on the previous pages.

Step 6 – Possible review of an underwriting decision

If you believe you can provide further information that may alter our decision to decline cover, or that may alter the addition of a loading or exclusion, please contact us to discuss the member's options.

We note that where a review is requested and further medical tests or examinations are required, these may be at the member's expense.

Explanations of medical terms

The following key terms have been provided to help explain what each requirement involves.

PMAR

A PMAR is a 'Personal Medical Attendant's Report'. This is a report that the member's usual treating doctor completes, regarding their medical history. The doctor completes the report based on the information they already have on file about the member. The member will not usually be required to go to the doctor or have any additional medical test or examinations in order for this report to be completed by their doctor.

Blood screen

A 'blood screen' is a group of several blood tests. The following tests are usually included in a blood screen:

- an HIV (Human Immunodeficiency Virus) test, which determines whether an individual is carrying HIV
- an MBA20 (also known as a SMA12), which measures various properties of the blood chemistry of a member including liver and renal function, glucose levels, lipids and electrolytes
- a Hepatitis B and C serology blood test, which determines whether an individual is currently, or has previously, carried the Hepatitis B or C virus.

Medical examination

This is a physical examination performed by a doctor whereby the member completes the section of a Medical Exam Form in regards to their medical history and the doctor completes a section of the Medical Exam Form regarding their relationship with the patient, details of the member's circulatory system (heart function, blood pressure), measurements (height, weight), respiratory system, digestive and lymphatic systems, genito-urinary system, nervous system, musculoskeletal system and skin and an overall summary.

MediQuick

This is a quick medical examination that requires the member to undergo blood pressure and height/weight recording, a urinalysis and answer a few medical related questions. A MediQuick can be performed by a nurse at a member's home or office.

MSU (microscopic urinalysis)

This is a urine test that is the study of the urine under a microscope and can disclose evidence of diseases such as diabetes mellitus, kidney diseases such as glomerulonephritis, and chronic infections of the urinary tract.

Exercise ECG

An Exercise Electrocardiogram (ECG) measures the electrical activity of the heart during exercise. It is usually performed while the patient walks or jogs on a treadmill.

Full Blood Count

This is a blood test that measures the various components of the blood which includes white cells, red cells and platelets.

All underwriting forms and supporting information should be mailed to:
Group Risk Insurance Administration,
Zurich, GPO Box 4129, Sydney NSW 2001

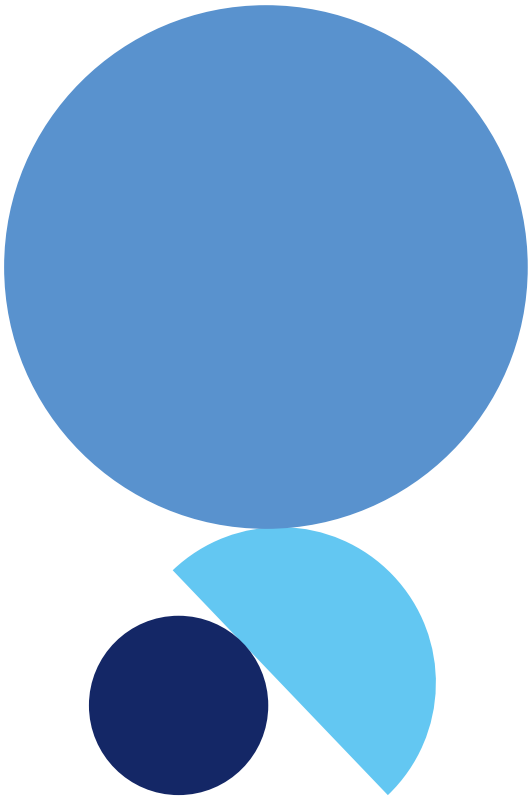
Questions?

If you have any questions, please contact Zurich's underwriting team on either:

1800 199 414, weekdays between 8.30am and 5.00pm (Sydney time)

group.risk.uw@zurich.com.au

References in this flyer to 'you' refer to the fund administrator.



Group Risk Insurance
Phone 1800 199 414
Email group.risk.uw@zurich.com.au

Address
GPO Box 4129
Sydney NSW 2001

Zurich Australia Limited (Zurich)
ABN 92 000 010 195 AFSL 232510

zurich.com.au

RHEN-018627-2022 574579_OPL4254/0822

ZURICH®