INSURANCE

GROUP LIFE INSURANCE

Product Disclosure Statement
and Policy Terms

1 June 2019

OnePath

ABOUT ONEPATH

OnePath is a leading provider of insurance, superannuation and investment solutions, with a heritage of more than 140 years in helping Australians to grow and protect their wealth.

OnePath life insurance solutions are provided by OnePath Life Limited, a part of the Zurich Insurance Group.

Employing more than 50,000 people worldwide, the Zurich Insurance Group operates in over 210 markets as an insurance specialist and is committed to placing customer needs at the heart of their business. The ultimate holding company of the group, Zurich Insurance Group Ltd, is listed on the SIX Swiss Exchange.

OnePath Life offers a comprehensive range of award-winning insurance covers to help customers achieve their financial goals.

Contents

ABOUT THIS PDS AND POLICY

This Product Disclosure Statement and Policy Terms (PDS and Policy) sets out the benefits, features, options and risks of OnePath's Group Life Insurance. This PDS and Policy explains how to apply for this product and the choices you need to make.

The information in this PDS and Policy will help you to decide whether this product is suitable for you, as well as assist you in comparing products available from other life insurers that you may be considering.

This PDS and Policy contains the full terms and conditions of OnePath's Group Life Insurance. The amount of any benefits payable, how benefits are payable and whether or not optional benefits are included, are determined on a plan-by-plan basis and set out in the **quotation summary**, which will be generated for you if you request a quotation.

The information in this PDS and Policy, including taxation information, is based on the continuance of present laws and our interpretation of those laws.

Who issues Group Life Insurance?

OnePath Life Limited (OnePath Life) ABN 33 009 657 176, AFSL 238341 is the issuer of this product – known as Group Life Insurance.

OnePath Life is a company within the Zurich Insurance Group.

The invitation to purchase a Group Life Insurance product is only made to persons receiving this PDS and Policy in Australia. It is not made, directly or indirectly, to persons in any other country.

Changes to information in this PDS and Policy

The information in this PDS and Policy is up-to-date at the time it was written – see the date at the front of the document.

The information in this PDS and Policy may change over time. You can get updated information at onepath.com.au/insurance/performance/product-updates or ask us for a free paper copy by calling 1800 648 921. If the change is materially adverse, we will issue a supplementary or replacement PDS and Policy.

We also reserve the right to change matters which do not form part of the PDS and Policy. This includes administrative matters.

This PDS and Policy is not personal advice

The information in this PDS and Policy is general information only and does not take into account your personal circumstances, financial situation or needs. You should consider whether the information is appropriate for you, considering your objectives, financial situation and needs.

How to read this PDS and Policy

The following sections in this PDS and Policy explain the terms and conditions, how you can apply for and when to claim benefits for Group Life Insurance. You should read this PDS and Policy carefully and keep it in a safe place.

Part 1:	General Information
Part 2:	Policy Terms

Throughout this PDS and Policy, the following words will have the meanings set out in the table below:

References to	To be read as
'we', 'our', 'us', 'OnePath Life'	OnePath Life Limited (OnePath Life) ABN 33 009 657 176, AFSL 238341, whose **principal office** is at 347 Kent Street, Sydney NSW 2000, and includes any properly appointed delegates.
'you', 'your'	The applicant(s) for Group Life Insurance or the owner of the **policy**, and includes the **policy owner's** properly appointed delegates.
'your policy', 'a policy', 'the policy'	The documents issued by us to you. Please refer to the definition of **policy** in Part 2: Policy Terms – Section 8 (Dictionary) for the documents that make up your **policy**.
'PDS and Policy'	This document, which comprises the Group Life Insurance Product Disclosure Statement and Policy Terms.

Some expressions and words throughout this PDS and Policy, and the **proposal form**, have a special meaning. These words and expressions are shown in **bold** type and are defined in the Dictionary in Part 2: Policy Terms – Section 8 of this PDS and Policy. Other words and expressions with special meanings will be defined in your **policy schedule**, which will be issued to you if you purchase this product. Terms that are defined in your **policy schedule** prevail over any inconsistent term in the Dictionary, unless we agree otherwise.

Headings appear in this PDS and Policy for ease of reference, and are not relevant to the interpretation of the PDS and Policy.

Any words indicating the singular can also mean the plural and vice versa. Any words expressed in the masculine apply equally in the feminine and vice versa.

If special terms or conditions apply to the benefits provided to **insured members** generally, they are shown in your **policy schedule**. An **insured member** may also be accepted for cover on special conditions. If this happens, we will notify you in writing.

Documents that make up your policy

This PDS and Policy describes Group Life Insurance. Please refer to the definition of **policy** in the Dictionary in Part 2: Policy Terms – Section 8 of this PDS and Policy for the documents that make up your policy.

Privacy

When you apply for Group Life Insurance, we collect your personal information (including health and other sensitive information) in order to process your application and, if your application is approved, to manage and administer your insurance cover. To read more about how we collect, use and disclose your personal information, refer to the Privacy section on page 7.

Setting up your policy

Step 1 – Obtaining a quotation

To establish a **policy** you need to first obtain a quotation for Group Life Insurance. If you wish to request a quotation, please contact one of our Group Risk Development Managers or email us at group.quotes@onepath.com.au

If you (or an intermediary acting on your behalf) have already provided us with information about your prospective plan, a **quotation summary** may be attached to this PDS and Policy. A **quotation summary** is guaranteed for 90 days unless we agree to change this period.

It is important that you read and understand the information provided in this PDS and Policy before applying.

Step 2 – Accepting a quotation

Should you choose to accept our offer, you must notify us in writing before the end of the **quotation guarantee period**. You can do this by completing the form supplied to you with the **quotation summary** and returning the completed documentation to the below contact details, along with the premium due.

In order for us to establish your **policy**, the following information is required from you:

- a completed **proposal form** signed by you
- an **at work certificate** signed by you (or if you are a trustee of a superannuation fund, signed by each **participating employer** under your superannuation fund) in respect of each person to be covered
- a final list of persons to be covered under your **policy** and the **member information** which includes details of all proposed **insured members** who have been seconded overseas by their employer to work. To assist you in providing the **member information**, we may give you a specific form or agree with you a basis to provide the **member information** electronically
- 'transfer terms' information, if relevant (refer to Part 2: Policy Terms – clause 2.4 for information on transfer terms), and
- the first annual premium or deposit premium we advise you is payable.

The documentation and premium is to be provided to:

Group Risk Insurance Administration
OnePath Life Limited
GPO Box 4129
Sydney NSW 2001

Email group.risk@onepath.com.au

Step 3 – Issuing your policy

This PDS and Policy does not constitute a legally binding contract of insurance with OnePath Life. A contract is formed when:

- we accept your **proposal form**
- we issue an 'On-risk' letter in accordance with the requirements imposed by the *Corporations Act 2001* (Cth), and
- you have paid the premium.

Once all our requirements are met we shall issue you with a **policy schedule** (your **policy schedule** confirms your cover and contains important details of your insurance).

More information

If you want to know more about obtaining a quotation for Group Life Insurance our dedicated Group Risk Development Managers can assist. You can also:

- contact Group Risk Insurance Administration on 1800 648 921
- visit the OnePath website at onepath.com.au

PART 1: GENERAL INFORMATION

What is Group Life Insurance?

At a glance

Group Life Insurance can be a great way to add value to employees' remuneration packages or offer competitive insurance through a superannuation fund. Cover is provided through a group **policy**, which means one contract – owned by an employer or superannuation fund trustee – providing cover for a group of employees or members of a complying superannuation fund.

OnePath Life's Group Life Insurance provides a lump sum benefit in the event of an **insured member's** death, **terminal illness** or **total and permanent disablement** (**TPD**). The flexible nature of OnePath Life's Group Life Insurance allows you to tailor insurance cover for your group by choosing the most appropriate benefit design.

The built-in benefits, features and options are summarised in the table below. Please read Part 2: Policy Terms for full details of when we pay under any benefit, feature or option.

Built-in benefits and features summary

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Death Cover	If an **insured member** dies, we will pay you a lump sum benefit.	✓	19
Terminal Illness Cover	If an **insured member** is diagnosed with an illness which is likely to lead to their death within 12 months, we will pay you a lump sum benefit.	✓	19
TPD Cover	If the **insured member** becomes **TPD** and meets the conditions of the applicable **TPD** definition, we will pay you a lump sum benefit.	✓	19
Transfer terms	We may agree to take over the cover provided by your previous insurer and provide equivalent benefits on certain terms.	✓	12
Worldwide cover	Cover is provided worldwide, although some restrictions apply if the **insured member** is not an **Australian resident** and is working overseas (see below).	✓	16
Cover during paid and unpaid leave	We provide cover for a maximum period of up to 24 months if the **insured member** is on paid or unpaid leave.	✓	16
Cover while working outside Australia	We automatically cover **Australian residents** working overseas for their **participating employer** for any length of time. **Insured members** who are not **Australian residents** are covered for up to three years while working overseas.	✓	16
Extended Cover	We will provide cover for up to a maximum of 60 days if an **insured member** ceases to satisfy the **eligibility criteria**.	✓	16
Death Cover Continuation Option	If an **insured member's** Death Cover ends because they are no longer **gainfully working**, they may be able to apply to us for an individual **policy** providing Death Cover without medical **underwriting**.	✓	17
Interim Accident Cover	While we consider a person's application to become an **insured member**, we will provide cover for death and **TPD** that occurs as a result of an **accident** for up to 90 days. Interim Accident Cover does not apply to applications for Life Events Cover or **transferred cover**.	✓	15
Discounts	A discount will apply if the premium is paid annually in advance and within 30 days of the due date or if you purchase OnePath Life's Group Salary Continuance Insurance simultaneously with Group Life Insurance.	✓	23
Guaranteed continuing cover	Your **policy** will continue each year upon payment of the premium, regardless of changes to the number of **insured members** or changes to their health or circumstances.	✓	10

Optional features

Generally, the following optional features are available at an extra cost.

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Life Events Cover	If selected, the **insured member** may apply to increase their **insured benefit** without having to supply medical evidence once in any 12 month period (subject to a maximum of three events) when a **specific life event** occurs.	✓	13
TPD Cover Continuation option	If an **insured member's TPD** Cover ends because they are no longer **gainfully working**, they may apply to us for an individual **policy** providing **TPD** Cover without medical **underwriting**.	✓	17
Non-standard TPD definitions	An '**own occupation**' **TPD** definition is available.	✗	30
Non-standard TPD definitions	A '**normal domestic duties**' TPD definition is available.	✓	31
Non-standard Terminal Illness definition	A **terminal illness** definition based on a **certification period** of 24 months (instead of 12 months) is available.	✓	29

Availability of cover

The table below sets out the limits and options available under OnePath Life's Group Life Insurance. Your **policy schedule** will confirm the actual limits and options that apply to your plan.

Minimum benefit entry age	15 years
Maximum benefit entry age	64 years for 'to age 65' and 'to age 67' cover 69 years for 'to age 70' cover
Minimum number of persons to commence a policy	20
Minimum annual premium (including stamp duty)	$15,000
Maximum benefit level	Death Cover – unlimited **TPD** Cover – $5 million
Maximum Terminal Illness Benefit	$1 million
Maximum benefit expiry age	70 years
Duration of cover	Age-based terms: to age 65, to age 67 and to age 70
Premium payment frequency	Annually, half yearly, quarterly or monthly

Please refer to the 'Benefits' section on page 19 of Part 2: Policy Terms – for further details on the benefits provided.

Insurance risks

You should be aware of the following insurance risks:

- if the premium is not received by us within 30 days of the due date, we may cancel or terminate your **policy** after we give you 30 days written notice and we may charge interest on any amount due. We may not accept an **insured member's** claim that arises after the premium due date
- the maximum amount of the insurance cover you select for your plan may not be sufficient to provide adequate insurance cover for an **insured member** in the event of their illness or injury
- we are not bound to accept your **proposal form**
- if you or an **insured member** do not comply with the Duty of Disclosure (see below) or makes a relevant misrepresentation, we may avoid the contract, or avoid cover in respect of an individual **insured member**
- if an **insured member** is insured for **new events cover**, we will not pay a benefit for death, **terminal illness** or **TPD** (as applicable) caused wholly or partly, directly or indirectly, by a **pre-existing condition**
- if an **insured member** is insured for **limited cover** pursuant to clause 2.4.2.2, we will not pay a benefit for death, **terminal illness** or **TPD** (as applicable) caused by an illness or injury which directly or indirectly caused the transferring member to be **not at work** on the last **normal business day** immediately before the **transfer date**.

Duty of disclosure

Your duty of disclosure

Before you enter into a life insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell us anything that:

- reduces the risk we insure you for, or
- is common knowledge, or
- we know or should know as an insurer, or
- we waive your duty to tell us about.

If an **eligible person** or **insured member** does not tell us everything he or she should have, this may be treated as a failure by you to tell us something that you must tell us.

If you do not tell us something

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

If you do not tell us anything you are required to, and we would not have insured you or entered into the same contract with you if you had told us, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the contract provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the contract or reduce the amount you have been insured for, we may, at any time, vary the contract in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the contract provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

Privacy

In this section 'we', 'us' and 'our' refers to OnePath Life Limited. 'You' and 'your' refers to policy owners and life insureds. Any reference to your personal information includes any health or other sensitive information we may hold about you.

We collect your personal information from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information. Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from onepath.com.au/insurance/privacy-policy

We may disclose your personal information to certain third parties as outlined below. Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information include:

- an organisation that assists us to detect and protect against consumer fraud
- organisations performing administration and/or compliance functions in relation to the products and services we provide
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers)
- our solicitors or legal representatives

- organisations maintaining our information technology systems
- organisations providing mailing and printing services
- persons who act on your behalf (such as your agent or financial adviser)
- the policy owner (or parties acting on behalf of the policy owner)
- regulatory bodies, government agencies, law enforcement bodies and courts
- our related companies (members of Zurich Insurance Group Ltd group), including for carrying out any group business functions
- organisations, including those in an alliance with us or our related companies, to distribute, manage and administer our products and services, carry our business functions, enhance customer service and undertake analytics activities.

We will also disclose your personal information in circumstances where we are required by law to do so.

Examples of such laws are:

- the *Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- there are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

We may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at onepath.com.au/insurance/privacy-policy

Privacy consent

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions, please notify us in writing.

If you give us personal information about someone else, you must show them a copy of this document or our Privacy Policy available at onepath.com.au/insurance/privacy-policy so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

Privacy Policy

Our Privacy Policy contains information about:

- when we may collect information from a third party
- how you may access and seek correction of the personal information we hold about you and
- how you can raise concerns that we have breached the Privacy Act or an applicable code and how we will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing	GPO Box 75 Sydney NSW 2001
Email	insuranceprivacy@onepath.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 13 36 67.

More information can be found in our Privacy Policy at onepath.com.au/insurance/privacy-policy

Overseas recipients

We may disclose your personal information to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in OnePath Life's Privacy Policy at onepath.com.au/insurance/privacy-policy

Choice of fund legislation

If you are not a trustee of a complying superannuation fund and you have taken out your **policy** in order to meet the minimum death insurance requirements under the **choice of fund legislation**, the **choice of fund legislation** stipulates that employers are unable to receive any potential benefit from such insurance if it is to meet that requirement. As such, you must pass on any benefits from the **policy** to the **insured member's** estate or beneficiary(ies). If you do not pass on these benefits, you may be in breach of your Superannuation Guarantee obligations and a Superannuation Guarantee shortfall may arise.

Group Life Insurance to be held in superannuation

OnePath Life's Group Life Insurance can be owned through superannuation. It is important to note however that superannuation law limits the circumstances when superannuation funds can pay benefits.

This may mean that if the **policy** is to be owned by a superannuation fund trustee, any **insured benefit** that we pay to the superannuation fund trustee can only be released by the superannuation fund trustee if it can be paid under superannuation law. If you are a superannuation fund trustee and wish to hold the **policy** for superannuation fund members, we recommend that you seek independent expert advice as to whether **insured benefits** under the **policy** will be able to be paid from the fund.

Enquiries and Complaints

We value your feedback regarding our performance and we're committed to resolving any concerns you may have.

Our customer service team is your first point of contact for any enquiries, raising concerns or providing feedback. Our contact details are below. We will do our best to resolve your concerns genuinely, promptly, fairly and consistently, and keep you informed of the progress.

If you are not satisfied with the response to your complaint or feedback, your concerns will be escalated to our Complaints Resolution Centre.

Phone	1800 648 921
Email	insurancefeedback@onepath.com.au
In writing	OnePath Life Limited GPO Box 4129 Sydney NSW 2000

Further Help – the Australian Financial Complaints Authority (AFCA)

If your concerns have not been resolved to your satisfaction, you can lodge a complaint with AFCA, which provides fair and independent financial services complaint resolution that is free to consumers.

Website	afca.org.au
Email	info@afca.org.au
Phone	1800 931 678 (free call)
In writing	Australian Financial Complaints Authority GPO Box 3 Melbourne VIC 3001

Time limits may apply to complain to AFCA and so you should act promptly or otherwise consult the AFCA website to find out if or when the time limit relevant to your circumstances expires.

Underwriting requirements

Our standard **underwriting** requirements are outlined in our 'Underwriting Guide', which can be downloaded from onepath.com.au or obtained by calling Group Risk Insurance Administration on 1800 648 921.

In some circumstances, we will require information from the **insured member** in addition to the Group Risk Personal Statement. Where this is the case, we shall request this information from the **insured member**. We may also request additional medical, personal, or financial information on a case-by-case basis.

A copy of the standard Group Risk Personal Statement can be found at onepath.com.au/insurance-forms-and-brochures Once completed, it should be submitted to:

Group Risk Insurance Administration
OnePath Life
GPO Box 4129
Sydney NSW 2001

Email group.risk@onepath.com.au

Making a claim

For information about making a claim, refer to Section 6 of Part 2: Policy Terms.

If you want to know more about making a claim for a Group Life Insurance benefit:

- contact Group Risk Insurance Claims on 1800 648 921
- visit the OnePath website at onepath.com.au/insurances/group-insurance/our-services-and-support

PART 2:

1. POLICY TERMS

1.1 Overview

The information in Sections 1–8 of this Part 2: Policy Terms sets out the terms and conditions upon which we agree to insure your **insured members**, the benefit(s) we may pay in the event of a claim, and the rights and obligations which you and we must observe.

These terms and conditions include details of persons who are eligible to be covered as **insured members**, how this happens, and when cover ends.

The standard benefits provided for **insured members** are described in Section 3 and are subject to an overriding limit of the **maximum benefit level** in respect of each **insured member**.

There are some circumstances in which we will not pay all, or part of the benefit amount and these are detailed in Section 4.

The payment of benefits is subject to you and the **insured member** satisfying our claim procedures as set out in Section 6.

1.2 Duration of your policy

The **policy** commences on the **policy start date** and remains in force, as long as you pay the premium in accordance with Section 5 and observe the terms of the **policy**, until the earlier of the:

- **policy** expiry date, shown in the **policy schedule**
- date the **policy** is terminated under Section 7.6.

1.3 Notices

Notices to, or by, us under your **policy** must be in writing and can be delivered by post or email. We will send notifications to you at the postal address or email address you last advised us.

Notifications to us should be sent by post to our **principal office** in Sydney or by email to group.risk@onepath.com.au

A reference to 'the **policy**' or 'your **policy**' in these Policy Terms has the same meaning as the term **policy** in Section 8 – Dictionary.

1.4 Guaranteed continuing cover

The **policy** will be renewed each year if you continue to pay the premium and satisfy the other terms of your **policy**, regardless of changes in the health or circumstances of your **insured members**.

1.5 Varying the policy

You may apply to us in writing to change the terms of your **policy**, and any such variation is only effective if confirmed by us in writing.

Any insurance already in place will be unaffected by such an application up until the effective date of the variation. If you apply to make such a change, and we approve your application, we will provide confirmation by issuing a new **policy schedule**. We will also issue a new **policy schedule** at the expiry of the **premium rate guarantee period**.

2. ELIGIBILITY AND PERIOD OF COVER

2.1 Who can become an insured member?

Only an **eligible person** can become an **insured member** under the **policy**.

An **eligible person** is a person who:

- satisfies the eligibility rules in the **policy schedule**
- is an **Australian resident** or holder of a **visa**
- resides in Australia (unless the person is overseas as set out in clauses 2.12 and 2.13)
- is working in an occupation that we do not class as an **excluded occupation**, and
- is aged at least the **minimum benefit entry age** and not more than the **maximum benefit entry age** on the day he or she is first eligible for cover, or if an application for cover is required, on the date that the **eligible person** applies for cover.

An **eligible person** accepted as an **insured member** under clause 2.2 is covered for the benefits described in Section 3, provided they continue to meet the **eligibility criteria** outlined in the **policy schedule** and the terms of the **policy**.

2.2 Becoming an insured member

An **eligible person** can become an **insured member** in one of the following ways:

- by automatic acceptance as set out in clause 2.3
- by operation of our transfer terms as set out in clause 2.4
- by applying to us online or in writing as set out in clause 2.7.

Cover is subject to you providing to us both the premium for the cover and all **member information** in respect of the **eligible person**, by the following times:

- where automatic acceptance applies, within 30 days after the **policy start date** or **review date** following the day the person first satisfies the **eligibility criteria**
- where transfer terms apply, within 90 days after the **policy start date**
- where an application for cover is required, within 30 days after the date the **eligible person** was first eligible to apply to become an **insured member**, or
- as otherwise agreed in writing by us.

To assist you in providing **member information**, we may give you a specific form, or allow you to provide the information electronically. **Member information** must be provided in respect of all **eligible persons**.

2.3 Automatic acceptance

2.3.1 Automatic acceptance level

When you establish your plan, we may agree to provide an **automatic acceptance level** (**AAL**). An **AAL** is the maximum amount of cover available without **eligible persons** needing to give us any evidence of good health. The amount of any **AAL** we agree to provide depends on a number of factors and will only be provided where all of the following conditions are met:

- there are at least 20 **insured members** at the **policy start date** and at least 20 **insured members** at each annual **review date**
- you provide an **at work certificate** where one is required (if you are a trustee of a superannuation fund, you must provide an **at work certificate** for each **participating employer** under your superannuation fund)
- we are your sole insurer for this type of insurance, and
- at least 75% of all **eligible persons** (or as otherwise agreed to by us in writing) shall become **insured members** at the **policy start date**.

2.3.2 When an eligible person is covered under automatic acceptance

An **eligible person** may be automatically accepted up to the **AAL** for the applicable type of cover under your **policy**, without needing to give us evidence of good health, provided all of the following conditions are met:

- the **AAL** shown in the **policy schedule** is for an amount other than 'nil'
- the eligibility rules are clearly defined and do not allow an individual to determine if he or she will become a member of the plan on a discretionary basis, i.e. as a result of the person's individual choice
- the **eligible person** is **at work** with you or a **participating employer** on:
  - the **policy start date** (or, if not a **normal business day**, the last **normal business day** before the **policy start date**), or
  - the day he or she first satisfies the **eligibility criteria** as confirmed by an **at work certificate** in the case of an **eligible person** meeting the **eligibility criteria** on a date after the **policy start date**
- the **eligible person** satisfies any other terms that we may apply
- the **eligible person** must not be entitled to payment of an insurance benefit for **total and permanent disablement, terminal illness** or be in a **waiting period** for such a benefit
- the **eligible person** must not have previously been accepted for cover under your plan by automatic acceptance (collectively referred to as our **automatic acceptance terms**)

unless:

- the **eligible person** was previously accepted for cover under **automatic acceptance terms** and the cover provided at that time ceased under your **policy** solely because he or she ceased employment with a **participating employer**, and
- the **eligible person** has recommenced employment with the **participating employer**,

in which case the requirement to give us evidence of good health will not apply to the **eligible person** upon recommencing employment with a **participating employer**.

2.3.3 Automatic acceptance and eligible persons not at work

An **eligible person** who is **not at work** as a result of an illness or injury on the **policy start date** or on the day the **eligibility criteria** was first met by the **eligible person** (as the context requires), shall become an **insured member** for **new events cover** only.

When the **insured member** returns to the pre-disability duties (working the same hours and in the same capacity without limitation) he or she performed when he or she was last **at work**, the **insured member's new events cover** will cease and will be replaced with **standard cover** from the date the **insured member** is **at work** after their cover commenced under your **policy**.

2.3.4 Commencement of cover

Cover for an **insured member** accepted under automatic acceptance will commence on the later of the **policy start date** and the date the **eligible person** first meets the **eligibility criteria**.

Upon commencement of cover, the **insured member** is covered for the lesser of:

- the **AAL**
- the **insured benefit**.

An application is required for cover in excess of the **AAL** as set out in section 2.7.

Where we accept an application for cover or additional cover under clause 2.7, cover will commence on the date we accept the application in writing subject to the terms of that acceptance (if any) which we will specify in the **decision note**.

2.3.5 Variation in the AAL and automatic acceptance terms

Any variation to the **automatic acceptance terms** will be outlined in your **policy schedule**.

If the number of **insured members** covered under the **policy** falls below 75% (or as otherwise agreed to by us in writing) of persons eligible for cover based on the **eligibility criteria**, we may remove the **AAL** after consultation with you. Where this occurs, the cover we provide for existing **insured members** as at the date the **AAL** is removed will not be impacted.

When an **AAL** increases, the higher **AAL** may apply to all existing **insured members** irrespective of whether they have been declined cover above the previous lower **AAL** or excluded or loaded for cover above the previous lower **AAL**. Where a loading, limitation or exclusion previously applied above an **AAL** that was lower than the **AAL** we have agreed to increase, the loading, limitation or exclusion will only apply above the new higher **AAL**. We will advise you in writing if we agree to do this and the date from which the change becomes effective.

2.4 Transfer terms

Transfer terms will apply if, before the **policy** starts:

- we are satisfied with the underwriting standards of the previous insurer, and
- we have notified you in writing of our agreement to offer transfer terms and the terms on which we will offer transfer terms.

Transfer terms will only apply to those persons who were insured members of your previous plan at the **transfer date**.

Where we agree to offer transfer terms and you comply with all our requirements, all transferring members will be covered for an **insured benefit** on **underwriting** terms no less favourable than those provided by the previous insurer. This means that we will apply the same **underwriting** terms or rules, if any, that applied in respect of an individual **insured member** under the previous **policy**, including **forward underwriting limits**, premium loadings, restrictions, exclusions and any limitations.

In addition to any specific terms we specify in writing, transfer terms are subject to all of the following conditions:

- the following information is provided to us no later than 90 days after the **transfer date**, unless we agree otherwise in writing:
  - all information we need about the operation and terms of the previous policy in writing including, but not limited to, individual names, level and type of insured benefits and the applicable underwriting acceptance terms, and
  - an **at work certificate** from you certifying the names of all transferring members who were **not at work** due to an illness or injury on the **transfer date**.
- premiums are paid for all transferring members to whom we agree to provide cover under these transfer terms
- cover is provided in accordance with our **quotation summary** including, but not limited to, our respective **maximum benefit levels** for death and **TPD**.

2.4.1 Transfer terms for Death Cover

We will provide Death Cover for all transferring members insured under the previous **policy** who are **eligible persons** on and from the **transfer date**.

2.4.2 Transfer terms for TPD Cover

We will provide **TPD** Cover from the **transfer date** for all transferring members insured under the previous **policy** who are **eligible persons**, and who were **at work** on the last **normal business day** immediately before the **transfer date**.

2.4.2.1 Not at work for reasons other than illness or injury

For any transferring member insured under the previous **policy** who was **not at work** on the last **normal business day** immediately before the **transfer date** for reasons other than

illness or injury, we will take over the same sum insured in respect of the **TPD** Cover provided by the previous insurer provided that:

- on the day before the first day of the relevant absence, the transferring member was **at work**, and
- during the period where the transferring member was absent from work prior to the **transfer date**, he or she was not absent due to an illness or injury.

2.4.2.2 Not at work due to illness or injury

Transferring members insured under the previous policy who were **not at work** on the last **normal business day** immediately before the **transfer date** due to illness or injury will be provided with:

- Death Cover, and
- **TPD** Cover that is **limited cover**,

from the **transfer date**.

When the transferring member returns to the pre-disability duties (working the same hours and in the same capacity without limitation) they performed when they were last **at work**, the **limited cover** will cease and the **insured member** will be covered on the same basis as an **insured member** who was **at work** on the last **normal business day** immediately before the **transfer date**.

Transferring members insured under the previous policy who were **not at work** on the last **normal business day** immediately before the **transfer date** due to illness or injury will not be provided with **limited cover** from the **transfer date** if:

- they had received a lump sum benefit for total and permanent disablement from the previous insurer, or
- they are otherwise entitled to a benefit under the previous insurer's policy.

2.4.3 Special cases

We may negotiate with you special transfer terms in respect of transferring members. These special terms will only apply where we have notified you in writing that such terms are offered.

2.4.4 Transfer terms and AALs

When a plan is transferred to us and we apply a higher **AAL**, the higher **AAL** may apply to all transferred **insured members** including those who were declined cover above the previous insurer's **AAL**, or who had loadings or exclusions applied to their cover above the previous insurer's **AAL**. We will advise you in writing if we agree to do this.

Any loading or exclusions that previously applied will only apply above the new higher **AAL**.

2.4.5. Financial Services Council Guidance Note 11 – Group Insurance Takeover Terms

We will comply with the **FSC Guidance Note** to the extent of any inconsistency with your **policy**.

2.5 Automatic increases in the insured benefit

2.5.1 Where the insured member is automatically accepted

Provided the **insured member** is in **active employment**, the **insured member's insured benefit** may increase automatically on either:

- the **review date**
- another date during a 12 month period which is specified in the **policy schedule**.

The **insured member** will not need to apply to us in writing (as set out in clause 2.7) if the increase in the **insured benefit** is up to 25% of the **insured member's insured benefit** (as determined immediately before the increase) and provided the increased **insured benefit** is not more than the **AAL**.

Where you on behalf of an **insured member** or an **insured member** seeks to have his or her **insured benefit** increase by more than 25%, (for example, the **insured member's salary** has increased by more than 25%) we may agree to waive the requirement that an **insured member** apply to us in writing.

However, unless we agree to waive this requirement in writing, the increase in the **insured member's insured benefit** will be restricted to the stated limits and we will require the **insured member** to be **underwritten** for that part of the **insured benefit** that is in excess of either of those limits.

In all other circumstances, an application is required as explained in clause 2.7.

2.5.2 Other instances

If an **insured member** has been forward **underwritten** to a **forward underwriting limit**, we may agree to accept increases in the **insured member's insured benefit** up to the **forward underwriting limit**, without requiring the **insured member** to provide further medical evidence, so long as the increase is a result of the application of the formula by which **insured benefits** are calculated.

We will only agree to a **forward underwriting limit** in respect of an **insured member** when:

- we have **underwritten** and approved the **insured member's** application for cover or increased cover, and
- we have notified you in writing of the **forward underwriting limit**, which may be up to a **maximum benefit level** (as outlined in the **quotation summary** or **policy schedule**).

We may impose lower **forward underwriting limits** at our discretion.

2.6 Life Events Cover

2.6.1 Conditions for Life Events Cover

If Life Events Cover applies it will be shown in the **policy schedule**.

Provided a **specific life event** occurs after the commencement of an **insured member's** cover under the **policy**, the **insured member** may apply to us to increase his or her **insured benefit**

without supplying medical evidence subject to all of the following conditions:

- at the time of applying for the increase in cover the **insured member** has not made nor is entitled to make a claim in relation to the **policy** or any life insurance **policy** whether it is issued by us or any other insurer
- the **insured member** has not applied for an increase in cover under this option in the previous 12 month period
- if we accept an application under Life Events Cover for an **insured member**, the increase in cover will be on the same terms and conditions as the acceptance terms that currently apply to the **insured member's** cover under the **policy** and shall include any loadings or exclusions applicable to the cover for the **insured member**
- your **policy** is still in force and cover for the **insured member** has not ceased
- the application to increase under this section must be made within 90 days of the occurrence of the **specific life event**
- the acceptance date will be the date the application is accepted by us.

If the conditions set out in clause 2.6 are satisfied and we accept an **insured member's** application for Life Events Cover:

- we will issue a **decision note** to you in respect of the **insured member**, and
- Life Events Cover will commence on the date we accept the **insured member's** application.

The amount of increase in the **insured benefit** available to an **insured member** on the happening of a **specific life event** is one unit of cover if cover is **unit based cover**, or 25% of the **insured member's** cover (as at the date the **insured member** applies for additional cover under this option) if the **insured member's** cover is **fixed dollar cover** or **formula based cover**. However, the increase cannot exceed $250,000 or cause the **insured member's insured benefit** to exceed the **maximum benefit level**.

The proof we require for an **insured member's insured benefit** to be increased upon the occurrence of a **specific life event** is set out in the table on this page.

2.6.2 Limitations applicable to Life Events Cover

Life Events Cover is only available to an **insured member** aged less than 55 years of age at the date of the **specific life event**.

In the event that the **specific life event** is marriage, we will increase the **insured benefit** under the Life Events Cover Option in respect of an **insured member's** marriage only once during the period the **insured member** is covered by the **policy**.

A maximum of one increase in the **insured member's insured benefit** in any 12 month period applies together with a maximum of three increases in the **insured member's** Death only or Death and **TPD** Cover under the **policy** while they remain an **insured member** under the **policy**.

During the first six consecutive months from the date an increase to an **insured benefit** commences under this clause, the increased amount is only payable if the **insured member's** death or **total and permanent disablement** is caused by an **accident**. Following the expiry of the six consecutive month period, the **insured member's** Life Events Cover will no longer be limited to **accidents** only.

Life Events Cover is not available if we have declined the **insured member's** application for additional cover under clause 2.7.

Specific life event (occurring after the commencement of the insured member's cover)	Evidence to be provided by the insured member
The **insured member's** marriage (or upon the subsistence of an **interdependent relationship** for two years or more).	A completed application form and: • for marriage – a copy of the **insured member's** marriage certificate in respect of a marriage recognised under the *Marriage Act 1961* (Cth) • for an **interdependent relationship** – a copy of evidence that establishes the subsistence of that relationship for at least two years.
A dependent child of the **insured member** starts secondary school.	A completed application form and a copy of a letter of admission from the secondary school the dependent child will be attending.
The **insured member** or their spouse gives birth to or adopts a child.	A completed application form and a copy of the birth certificate or the adoption documentation.
The **insured member** takes out or increases a mortgage on their principal place of residence with an accredited mortgage provider* (excludes redraw and refinancing).	A completed application form and written confirmation from the **insured member's** accredited mortgage provider(s) of: • the amount and effective date of the mortgage, where the **insured member** takes out a new mortgage • the amount of the mortgage immediately preceding the increase, the effective date of the increase and the current level of the increased mortgage, where the **insured member** increases their mortgage, whether with an existing or different mortgage provider.

* Accredited mortgage provider means an authorised deposit-taking institution (as defined in the *Banking Act 1959*) or other reputable financial services business, program or trustee which provides mortgage loans as part of its ordinary business activities and is accredited with the Mortgage Industry Association of Australia.

2.7 Applications for cover

An application in writing is required for all or part of the cover for an **eligible person** or an **insured member** in each of the following circumstances:

- if **automatic acceptance terms** do not apply or an **eligible person** was not automatically accepted
- an **eligible person** requires cover in excess of the **AAL**
- if transfer terms do not apply
- in respect of an increase in the **insured benefit**, if an increase is not automatically provided pursuant to clause 2.5
- if an **insured member's** cover stops under your **policy** for any reason, except where the **insured member** recommences employment with their **participating employer** as described in clause 2.3.2
- they require cover that is not **new events cover**.

If cover for an **insured member** is determined by reference to a formula whereby a decrease in an **insured member's superannuation account balance**, due to **portability legislation**, would result in an increase in the cover provided under the **policy**, an application for cover will be required for the amount of **superannuation account balance** that was transferred from the superannuation fund, if the **insured member's insured benefit** (prior to the transfer being effective) is to be maintained.

An application can only be made for cover up to the **maximum benefit level**.

When considering an application, we may request medical and other information from the **eligible person** or **insured member**. We can accept or decline an application for any reason, or accept an application subject to the application of exclusions, a premium loading or any other special conditions which we consider appropriate.

Until we accept or reject the application, Interim Accident Cover will apply as set out in clause 2.8.

If we accept an application, we will issue a **decision note**.

Where we issue a **decision note** in respect of an **insured member**, the terms outlined in the **decision note** prevail over any inconsistent terms in the **policy** (including the **policy schedule**).

Premiums will be charged from the effective date of any cover we approve.

2.8 Interim Accident Cover

Interim Accident Cover is provided for all, or that part, of the cover for which an application under clause 2.7 is required. Interim Accident Cover does not apply to applications for Life Events Cover or **transferred cover**.

Interim Accident Cover starts from the date an application for cover is received by us.

Interim Accident Cover will end upon the earlier of:

- the date we notify you or the **insured member** in writing that we accept or reject the application for cover or increase in the **insured benefit**
- 90 days after the date Interim Accident Cover starts
- cover otherwise ceasing in accordance with clause 2.15
- the date the application is cancelled or withdrawn.

In the event that an **insured member** or **eligible person** dies or suffers **total and permanent disablement** as the result of an **accident** during the period in which Interim Accident Cover applies, we will pay you the Interim Accident Cover Benefit.

The Interim Accident Cover Benefit is the lesser of:

- the benefit amount applied for in the application for cover
- the difference between the level of increased cover applied for and the current level of cover
- the **maximum benefit level**.

2.9 Maximum benefit level

The **insured member's insured benefit** cannot exceed the **maximum benefit level**.

2.10 Member categories

The eligibility rules in your **policy schedule** may refer to different categories of **insured members**. In that case, an **insured member** is covered for the **insured benefits** applicable to the category in which he or she is accepted as an **insured member**. Any optional benefits may also vary between categories of **insured members**.

2.11 Worldwide cover

We will provide worldwide, 24 hour cover for an **insured member** regardless of whether they are away on business or holiday, subject to clauses 2.12 and 2.13 below.

2.12 Cover during paid and unpaid leave

An **insured member** is covered under this **policy** for a period of up to 24 months while on paid or unpaid leave (including **parental leave**), subject to all of the following conditions being met:

- the premium in respect of the **insured member** must continue to be paid during the period of leave
- the **insured member's** employer must approve the period of leave, prior to the **insured member** commencing leave
- the identity of **insured members** on unpaid or paid leave and the number of **insured members** on such leave must be provided to us when requested and at least annually with the **member information**
- the **insured member's** employer must hold appropriate leave records in respect of that **insured member** that includes:
  - the date the paid or unpaid leave is to commence
  - the date the **insured member** is expected to return to work.

These records must be provided to us upon request.

Prior notification to us of the unpaid or paid leave is not required.

If cover for an **insured member** on paid or unpaid leave is required beyond 24 months, an application in writing to extend cover beyond 24 months is required prior to the expiration of the 24 months. We may accept or decline that application at our sole discretion.

2.13 Cover while working outside Australia

An **insured member** who is an **Australian resident** and working overseas for a **participating employer** will be covered under your **policy** while he or she is working overseas. Prior notification to us of the **insured member's** travel is not required.

If the **insured member** is not an **Australian resident** and holds a **visa**, he or she will be covered under your **policy** for up to three years while working overseas for a **participating employer**. If cover is required beyond three years, an application in writing is required prior to the expiration of the three years. We may accept or decline that application at our sole discretion.

Cover is subject to the following conditions:

- the premium in respect of the **insured member** must continue to be paid during the period the **insured member** is working overseas
- we reserve the right to impose conditions on the cover, and review cover, at the end of the **premium rate guarantee period**, or if there is no **premium rate guarantee period**, at the **review date**. If we impose such terms we will do so in writing, and
- any details regarding the location of **insured members** residing overseas must be provided to us upon request and at least annually with the **member information** at the **review date**.

You must retain records of the following:

- the duration of time the **insured members** are working overseas
- the number of **insured members** working overseas
- the location of **insured members**.

To avoid doubt, if the **insured member** (including a person that is not an **Australian resident**) is travelling overseas during periods of paid or unpaid leave, cover continues in accordance with clause 2.12.

2.14 Extended Cover

Subject to the terms of this **policy**, we will provide Death Cover and **TPD** Cover (if applicable) to an **insured member** for a maximum of 60 days after the date they cease to meet the **eligibility criteria** subject to the following conditions:

- as at the date the **insured member** ceased to meet the **eligibility criteria**, the **insured member** had not received, nor was entitled to receive, a benefit under this **policy**, nor was the **insured member** in a **waiting period** for such a benefit, and
- the Extended Cover will cease on the earlier of:
  - the date the **insured member** reaches the **benefit expiry age**
  - 60 days after the date the **insured member** ceases to meet the **eligibility criteria**
  - the date cover for the **insured member** commences under a retail policy of insurance issued by us under clause 2.16
  - the date the **insured member** commences employment with a new employer or commences working as a **contractor**.

2.15 When cover ends for insured members

2.15.1 Events of termination

An **insured member's** cover will end on the earlier of:

- the date we receive written notification from the **insured member** to cancel the cover
- the date the **insured member** who is not an **Australian resident** is not eligible to work in Australia (whether that is because they no longer hold a **visa** or for any other reason)
- the date the **insured member** reaches the **benefit expiry age**
- the date we cancel and/or avoid your **policy**, or cover in respect of an **insured member**, in accordance with our legal rights
- the date we cancel and/or avoid your **policy**, or cover in respect of an **insured member**, because you have not paid the premium when due
- the date the **insured member** commences **active service** with the armed forces of any country (except where the **insured member** is a member of the Australian Defence Force Reserves, in which case, cover for all benefits will cease only when the Reservist becomes the subject of a call-out order under the *Defence Act 1903* (Cth).
- the date the **insured member** dies
- the date a **TPD** claim is accepted by us and a **TPD** benefit is paid under your **policy** in respect of the **insured member**
- the date a **terminal illness** claim is accepted by us and a **terminal illness benefit** which is equal to the amount of the **death benefit** is paid under your **policy** in respect of that **insured member**
- the date the **insured member** permanently retires from employment (**TPD** Cover only, Death Cover may continue)
- in relation to an **insured member** who ceases to meet the **eligibility criteria**, the date Extended Cover ends as set out in clause 2.14
- when the **insured member** is on leave for longer than we have agreed to provide cover for under clause 2.12

- when the **insured member** is employed overseas for longer than we have agreed to provide cover for under clause 2.13
- the date your **policy** ends or is terminated, except to the extent discussed in clause 2.15.2.

2.15.2 If the Policy terminates

If your **policy** terminates and **takeover terms** apply, our ongoing liability to pay a **terminal illness benefit** or **TPD benefit** to a person who was an **insured member** on the date of termination will be determined in accordance with the **FSC Guidance Note** (see clause 2.4.5).

2.16 Continuation Option

2.16.1 Death Cover Continuation Option

If an **insured member's** cover ends because he or she no longer satisfies the **eligibility criteria** due to the cessation of employment:

- with you or an associated employer specified in your **policy schedule**, if your **policy** is held outside of superannuation, or
- with a **participating employer** where your **policy** is held inside superannuation,

the person has the option to apply for an individual policy with us on his or her life for Death Cover equal to, or less than, the **death benefit** provided by your **policy**.

We will not require the person to provide medical evidence, however, our assessment of their application for an individual policy will take into account other factors such as:

- overseas travel/residence
- existing insurance
- occupation/duties
- income and working hours
- pastimes/pursuits
- smoker status.

To exercise the Continuation Option the person must:

- be 60 years of age or less
- apply in writing by completing an application for the individual policy within 90 days of the date he or she ceases to be an **eligible person** as a result of ceasing employment with you (if your **policy** is held outside of superannuation) or with a **participating employer** (if your **policy** is held inside of superannuation)
- be:
  - an **Australian resident** or holder of a **visa** we consider acceptable, and
  - not residing outside Australia (unless we agree otherwise)
- provide any information we consider relevant that does not relate to medical information
- acknowledge that any restrictions, limitations or loadings that apply to the **insured member's** cover under your **policy** will apply to the new individual policy, and
- not be eligible to receive, or have received, death, **terminal illness** or **TPD benefits** under your **policy** or any other policy issued by an insurer.

If the **policy** terminates or is transferred to another insurer, a Continuation Option will not be available to any **insured member** under the **policy**. Where the **policy** is issued to a complying superannuation fund, this includes the circumstance where the **policy** is terminated and replaced as a result of a successor fund transfer. To avoid doubt, if the **insured member's** application for a Continuation Option is accepted by us, the **insured member** will not be covered under the **policy** between the date the **insured member's** cover ends under the **policy** and the date cover commences under the individual policy.

2.16.2 TPD Cover Continuation Option

If a **TPD** Cover Continuation Option applies, it is shown in your **policy schedule**. It is not a standard feature of the **policy**.

Where it applies, if an **insured member's** cover ends because he or she no longer satisfies the **eligibility criteria** due to the cessation of employment:

- with you or an associated employer specified in your **policy schedule**, if your **policy** is held outside of superannuation, or
- with a **participating employer** where your **policy** is held inside superannuation,

the **insured member** has the option to apply for an individual policy with us on his or her life for **TPD** Cover equal to, or less than, the **TPD benefit** provided by your **policy**.

To exercise the **TPD** Cover Continuation Option, the **insured member** must satisfy the conditions that apply to a Death Cover Continuation Option as set out under clause 2.16.1 and must exercise a Death Cover Continuation Option at the same time. In addition, the **insured member** must be engaged in an occupation which is not an excluded occupation under the individual policy and working the minimum hours required under the individual policy.

2.16.3 Conditions for the individual policy

If the person's application is accepted by us, cover under the individual policy commences in accordance with the terms of that policy. The premium rate under the individual policy will be based on the rates applicable at the time the person's application is accepted by us and may be more than under your **policy**, and any restrictions, limitations and premium loadings that applied under your **policy** will apply under the individual policy.

The individual policy issued will be OnePath Life's OneCare policy with no options added. If the OneCare policy is no longer available, the new policy issued will be the individual policy available at that time that we deem provides the same or similar benefits.

2.17 Applications for transferred cover

An **insured member** can apply for additional cover if on the date we accept their application, he or she:

- has death only cover or death and **total and permanent disablement** cover under a **previous life policy** with another insurer through a superannuation fund ('**previous cover**') and wishes to transfer that **previous cover** into the **policy** ('**transferred cover**')
- has not made, or is not entitled to make, a claim and is not eligible to be paid a benefit in relation to the **previous cover**
- does not have his or her **previous cover** provided through a self-managed superannuation fund or a non-superannuation policy.

The following terms and conditions apply to applications for **transferred cover**:

- the **insured member** must satisfactorily complete the application form we provide, which will contain questions regarding the **insured member's** health that he or she will need to answer to our satisfaction
- we will determine the application only upon receipt of all evidence we reasonably require to assess the application and verify the **previous cover**, its validity and currency
- if we accept the application, we will issue a **decision note** to you in respect of the **insured member** and **transferred cover** will be provided in accordance with all of the following:
  - **transferred cover** commences on the date we accept the application
  - **transferred cover** is provided conditionally upon cancellation of the **previous cover**. If the **previous cover** is not validly cancelled upon our acceptance of the application for **transferred cover**, then in the event we accept a claim for death, **terminal illness** or **total and permanent disablement** in respect of the **insured member**, we will reduce any benefit payable under the **policy** by the amount equal to the amount of **previous cover** that should have been cancelled
  - if, as at the date we accept the application, the **insured member's existing cover** is subject to **special acceptance terms**, those terms:
    (i) will not apply to the **transferred cover** unless we advise you in writing, and
    (ii) will continue to apply to the insured amount of **existing cover**.
  - if the **insured member's previous cover** is subject to a special condition, premium loading or an exclusion ('**previous cover terms**'), we may accept the application subject to **special acceptance terms** or decline the application at our discretion. If we accept the application subject to **special acceptance terms**, those **special acceptance terms** will not apply to the **insured member's existing cover**
  - the terms and conditions of the **policy** apply to the **transferred cover**
  - the **transferred cover** will be in addition to the **existing cover**
  - the amount of **transferred cover** does not count towards any **automatic acceptance level** that may apply in respect of the **insured member**
  - the type and amount of **transferred cover** we accept is such that provides the **insured member** with at least as much and as close as possible to the amount of the **previous cover** except that:
    (i) the amount will be rounded up to the next multiple of $1,000 if it is not already a multiple of $1,000
    (ii) the **transferred cover** cannot exceed $1 million even if the **previous cover** was a higher amount
    (iii) the total combined amount of **transferred cover** and **existing cover** cannot exceed the **maximum benefit level**.

3. BENEFITS

3.1 Death Benefit

If an **insured member** with Death Cover dies, we will pay you the **death benefit** in respect of that **insured member** provided his or her Death Cover has not ended as at the **incurred date**.

The **death benefit** becomes payable on the **incurred date**.

3.2 Terminal Illness Benefit

If an **insured member** with Death Cover suffers **terminal illness**, we will pay you a **terminal illness benefit** in respect of that **insured member** provided his or her Death Cover has not ended as at the **incurred date**.

The **terminal illness benefit** becomes payable on the **incurred date**.

Where the **terminal illness benefit** is less than the **death benefit**, the **death benefit** otherwise payable in respect of the **insured member** will be reduced by the amount of the **terminal illness benefit** paid.

You can choose either of the following **terminal illness** definitions to apply to your plan:

- **Terminal illness** – Standard Definition based on a 12 month **certification period**, or
- **Terminal illness** – Non-standard Definition based on a 24 month **certification period**.

Where a non-standard **terminal illness** definition applies to your plan, it will be shown in your **policy schedule**.

3.3 TPD Benefit

If an **insured member** with **TPD** cover becomes **totally and permanently disabled**, we will pay you a **TPD benefit** in respect of that **insured member** provided his or her **TPD** cover has not ended as at the **event date**.

3.3.1 Tapering of TPD benefits

Where the **TPD benefit** does not reduce gradually to be nil by the **benefit expiry age**, unless we otherwise agree in writing, an **insured member's TPD benefit** will automatically decrease by:

- 10% per annum from the **insured member's** 61st birthday, if the **benefit expiry age** is 70
- 20% per annum from the **insured member's** 63rd birthday, if the **benefit expiry age** is 67, or
- 20% per annum from the **insured member's** 61st birthday, if the **benefit expiry age** is 65.

Where the **benefit expiry age** is an age other than age 65, age 67 or age 70, the amount by which the **insured benefit** reduces will be contained in your **policy schedule**.

Example: Where **benefit expiry age** is 70

TPD sum insured	Age	Tapered TPD benefit	Reduction factor
$500,000	Up to 60	$500,000	0%
	61	$450,000	10%
	62	$400,000	20%
	63	$350,000	30%
	64	$300,000	40%
	65	$250,000	50%
	66	$200,000	60%
	67	$150,000	70%
	68	$100,000	80%
	69	$50,000	90%
	70	$0	100%

Example: Where **benefit expiry age** is 67

TPD sum insured	Age	Tapered TPD benefit	Reduction factor
$500,000	Up to 62	$500,000	0%
	63	$400,000	20%
	64	$300,000	40%
	65	$200,000	60%
	66	$100,000	80%
	67	$0	100%

3.3.2 TPD benefits for insured members aged 67 and over

An **insured member** aged 67 years or over as at the **event date** is ineligible for Part 1 and Part 6 of the **TPD** definition.

3.4 Standard and non-standard TPD definitions

You can choose one of the following **TPD** definition options for your plan.

- Standard **TPD** Definition Option 1
- Standard **TPD** Definition Option 2
- Non-standard **TPD** Definition Option 1
- Non-standard **TPD** Definition Option 2

The **TPD definition** that applies to your plan will be shown in your **policy schedule**.

The parts of the **TPD** definition applicable under each option are set out in the following table:

	Standard TPD Definition Option 1	Standard TPD Definition Option 2	Non-Standard TPD Definition Option 1	Non-Standard TPD Definition Option 2
Part 1a – Any Occupation	✓	✓	✗	✓
Part 1b – Own Occupation	✗	✗	✓	✗
Part 2 – Permanent Impairment	✓	✗	✓	✓
Part 3 – Specific Loss	✓	✗	✓	✓
Part 4 – Activities of Daily Work	✓	✓	✓	✓
Part 5 – Cognitive Loss	✓	✗	✓	✓
Part 6 – Normal Domestic Duties	✗	✗	✗	✓

The **TPD** definition including all Parts 1–6 are set out in Section 8 of this PDS and Policy.

4. BENEFIT LIMITATIONS

4.1 Exclusions

We will not pay a benefit under the **policy** if the event giving rise to the claim is caused directly or indirectly, wholly or partially:

- by **war**, or an act of **war**, occurring in Australia or New Zealand
- by an **insured member** engaging in **war service**.

In effecting your **policy**, you acknowledge that this exclusion means that a benefit may not be paid under the **policy** in respect of an **insured member** who dies in **war service**.

In addition, we will not pay any benefits under your **policy** for anything we have specifically excluded as shown in your **policy schedule**.

4.2 Pre-existing conditions

If an **insured member** is insured for **new events cover** pursuant to clause 2.3.3, we will not pay a benefit for death, **terminal illness** or **TPD** (as applicable) caused wholly or partly, directly or indirectly, by a **pre-existing condition**.

If the **insured member** is insured for **limited cover** pursuant to clause 2.4.2.2, we will not pay a benefit for death, **terminal illness** or **TPD** (as applicable) caused by an illness or injury which directly or indirectly caused the transferring member to be **not at work** on the last **normal business day** immediately before the **transfer date**.

4.3 When the insured benefit payable is reduced

The **insured member's insured benefit** may be reduced in the following situations:

- if, during the period of Extended Cover (see clause 2.14) an **insured member** becomes covered under a policy from another insurer providing similar benefits (the Subsequent Policy), we may reduce or refuse to pay any **insured benefit** which may become payable under your **policy**, by the amount of any similar benefit paid, or payable, in respect of him or her under the Subsequent Policy, if the death, **terminal illness** or **total and permanent disability** arose or occurred during the period of Extended Cover
- if an **insured member's** sum insured is determined by a benefit formula that comprises a **superannuation account balance** component and the **insured member** transfers all or part of his or her superannuation benefit to another fund under **portability legislation**, the **insured member's insured benefit** will be reduced by the amount of the **superannuation account balance** that was transferred to the superannuation fund
- if we issue a **policy** to you, or a cover under the **policy**, on the condition that it replaces insurance issued by another insurer and the insurance being replaced is not cancelled, the amount of any benefits paid under the **policy** will be reduced by any benefits paid or payable under the insurance that was replaced.

4.4 Repayment of benefits

Any **insured benefit** paid by us must be repaid by you to the extent that the **insured benefit**, or part of the **insured benefit**, was not payable under the terms of your **policy**.

4.5 Life Events Cover limitation

If the **insured member's insured benefit** has increased due to a **specific life event**, for the first six months following the increase, we will only pay the increased portion of the **insured benefit** if the **insured member's** death or **total and permanent disablement** results from an **accident**.

4.6 Breach of law

You agree that we may delay, block or refuse to process any transaction without incurring any liability if we suspect that either:

a. the transaction may breach any laws or regulations in Australia or any other country;

b. the transaction involves any person (natural, corporate or governmental) that is itself sanctioned or is connected, directly or indirectly, to any person that is sanctioned under economic and trade sanctions imposed by the United States, the European Union or any country,

c. the transaction may directly or indirectly involve the proceeds of, or be applied for the purposes of, conduct which is unlawful in Australia or any other country.

We may delay or withhold paying a benefit if that payment may breach any law or regulation, including any sanctions regulations.

You must provide all information to us which we reasonably require in order to manage our economic and trade sanctions risk or to comply with any laws or regulations in Australia or any other country. You agree that we may disclose any information concerning you or an **insured member** to any law enforcement, regulatory agency or court where required by any such law or regulation in Australia or elsewhere.

5. COSTS

5.1 Premium rates

The premium rates will be set out in the **quotation summary** and in your **policy schedule**.

5.2 Payment of premiums

Your **policy** does not start until the first premium due has been paid, or we accept a deposit premium.

5.3 Minimum annual premium

The annual premium that must be paid will be at least the minimum annual premium shown in your **policy schedule**.

If the premium we calculate is less than the minimum annual premium, you must pay the minimum annual premium. If you do not pay the minimum annual premium, we may cancel or terminate your **policy** by giving you at least 30 days written notice in accordance with clause 7.6.

5.4 Calculating the premium

We calculate the premium which will apply to your **policy** from the **policy start date** until the first **review date** based on the **member information** we are initially provided. Thereafter, we will calculate the annual premium at each annual **review date** irrespective of the premium payment frequency, based on **member information** you must provide us. If you do not provide us with the **member information** within 30 days of the date we advise you of the information we require, we will estimate and notify you of an interim premium. The premium is payable in respect of an **insured member** from the date the **insured member's** cover commences under the **policy** until the date cover ends under clause 2.15.

We will calculate the premium having regard to the number of **insured members** covered under your **policy** at the annual **review date** and the amount and type of the benefits provided. If this changes in the period until the next **review date**, we will recalculate the premium at that time to reflect this and:

- if you have paid too much, we will apply the overpayment to reduce the next premium due, or
- if you have not paid enough, we will notify you of the additional premium you owe (the adjustment premium).

If your **policy** ends, any overpayment of premium is refunded or any adjustment premium is payable, as the case may be.

We may also apply loadings to individual **insured members** based on our assessment of individual risks. Where we do this, we will notify you.

A range of factors are taken into account when the premium is calculated for your plan. The premium will be affected by significant factors such as the:

- sum insured – the larger the sum insured the larger the premium
- age demographic of **insured members** – the premium generally increases with age
- sex demographic of **insured members**
- occupation of **insured members** – generally, occupations with hazardous duties or higher occupational risk have higher premium rates
- grouping of polices, refer to 'Discounts' in clause 5.11 for further information
- the claims history of your plan, and
- applicable commission levels agreed between you and an intermediary.

5.5 When the premium is due

The first premium is due on, before or within 30 days of the **policy start date** or, if you have paid a deposit premium, on the date specified when we notify you of the balance of the premium payable until the first **review date**. Thereafter, premiums are due within 30 days of the **review date**, or such later date as set out in your **policy schedule**.

Any interim premium or adjustment premium we advise is due on the date specified in the notice advising you of the interim or adjustment premium.

If the premium, interim premium or adjustment premium is not paid by you when due, your **policy** may not commence or we may cancel your **policy** 30 days after we give you notice of cancellation in writing.

5.6 Guarantee of premium rates

Subject to clause 5.7, premium rates will be guaranteed from the **policy start date** to the end of the **premium rate guarantee period**.

5.7 When we can change the premium rates and/or the minimum annual premium

We calculate the premium using the premium rates shown in the **premium rate schedule**. We can change the premium rates or the minimum annual premium either:

- at expiration of the **premium rate guarantee period**
- at any time on or after the **review date** provided a **premium rate guarantee period** is not in force
- at any time in the event of **war** occurring in Australia or New Zealand
- at any time if clause 7.1 applies

- if there is a change in any government charge, licence fee, tax or any other impost that is directly or indirectly attributable to the **policy**.

If we change the premium rates or the minimum annual premium, we will provide you with at least 30 days notice in writing.

5.8 Misstatement of age

If an **insured member's** age is misstated, we will adjust the premium or the **insured benefit** based on the **insured member's** correct age.

5.9 Stamp duty, taxes and expenses

The taxation implications of insurance benefits and premiums under non-superannuation and superannuation policies will differ depending on individual circumstances. You should consider all potential taxation consequences that may apply to the premiums and benefit payments under a Group Life Insurance product.

Your specific circumstances are not taken into account in providing this information. It is important that you seek professional and independent taxation advice specific to your circumstances regarding the taxation implications of purchasing a non-superannuation or superannuation Group Life Insurance product.

5.9.1 Stamp duty

Stamp duty is included in the premium rates.

5.9.2 Other expenses

In addition to the premium, you are required to pay:

- any federal, state or territory taxes and charges (other than stamp duty, which is included in the premium rates). References in your **policy** to payment of the premium include any such additional amounts, and
- any expenses we incur in administering any function required of us by a federal, state or territory government under any legislation in relation to your **policy**.

We reserve the right to recoup these charges through the premium you pay for your **policy**, and increase the premium to cover any increase in these charges.

5.9.3 Goods and Services Tax (GST) implications

The **policy** is input taxed for GST purposes. This means that no GST is payable by us on the premium you pay. There is no GST charged on the premium payable for your cover.

In the event that the **policy** or the premium applicable to one or more specific benefit types is no longer input taxed for GST purposes, we reserve the right to charge GST in addition to the premium which you are required to pay. If this occurs we will notify you in writing.

5.10 Interest

We may charge you interest on any amount due to us which is outstanding for more than 30 days. Interest will be calculated based on the five-year bond yield plus 3% as at the date the premium initially became due, as published in the *Australian Financial Review*. If this rate is no longer published, we will determine a similar replacement rate.

5.11 Discounts

5.11.1 Combined plan discount

If you establish a OnePath Life Group Salary Continuance **policy** with the same **policy start date** and annual **review date** as the OnePath Group Life Insurance policy, we will reduce the annual premium for both policies by 2.5%. This discount will only continue to apply while the annual **review date** of the OnePath Life Group Salary Continuance **policy** remains the same as the annual **review date** chosen for the Group Life policy, and both policies remain in force.

5.11.2 Annual on-time payment discount

A premium discount will apply if the annual premium is paid annually in advance and within 30 days of the due date specified in clause 5.5. All details will be outlined in your **policy schedule**. If the annual premium is not paid within 30 days of the due date, the annual on-time payment discount will not apply.

6. CLAIMS

6.1 Notification of claim

You must advise us in writing of any claim as soon as it is reasonably possible for you to do so. In the case of a claim for a **TPD benefit**, you must advise us of a claim or potential claim on the earlier of:

- within 30 days of the **event date**
- within 30 days after the expiration of the **waiting period** applicable to the **TPD** definition
- as soon as it is reasonably practicable for you to do so.

If we do not receive written notice within the time specified, we may reduce or refuse to pay the **insured benefit** to the extent our assessment of the claim is prejudiced.

You must make all reasonable efforts to ensure that each **insured member** covered for a **TPD benefit** knows that he or she must advise you of circumstances giving rise to a potential claim to enable you to advise us in accordance with the timings given above.

6.2 How to make a claim

We will generally send claim forms to you, the **insured member**, or in the case of a deceased **insured member**, their legal personal representative, within seven days of receiving notice of a claim. Providing claim forms for completion does not constitute an admission of liability in respect of any claim lodged.

We generally ask for medical information and evidence to enable a claim for a **TPD benefit** or **terminal illness benefit** to be assessed.

During the course of a **TPD** claim, the **insured member** may be required to be interviewed, attend vocational assessments and rehabilitation, and provide us with all information required in order to determine their eligibility for benefits.

6.3 Payment of a claim

Payment of a claim is conditional upon you or the **insured member** providing a properly executed claim form and proof, in a form that is subject to our verification, of all the following:

- where the **insured member** was accepted (or an increase in the **insured benefit** payable was accepted) under automatic acceptance or our transfer terms, that you and the **insured member** met all our requirements
- the **insured member's** entitlement to claim the applicable **insured benefit**
- the **insured member's** age.

You or the **insured member** must establish an entitlement to an **insured benefit** by:

- providing an original or certified death certificate (if applicable), a birth certificate (or other proof of birth to our satisfaction) and all other documentation we require
- providing medical reports as we require from any treating **medical practitioners**
- when reasonably required by us (and at our expense), being examined by a **medical practitioner** nominated by us
- undergoing any pathology, blood tests, x-rays or any other medical investigations we reasonably deem necessary
- undergoing an employability assessment
- being interviewed by us
- providing financial documentation (including, without limitation, tax returns, notices of assessment, group certificates and the like), and
- providing all other relevant information we request.

Where an **insured member** dies outside of Australia, we may require proof of the **insured member's** death to take the form of an original death certificate or copy of the death certificate that is certified by the Australian Embassy in the country of the **insured member's** death. If such proof is not produced, we may refuse to pay the **death benefit**.

6.4 Overseas claims assessment

We may require an **insured member** claiming a **terminal illness benefit** or **TPD benefit** while outside of Australia to return to Australia, at the **insured member's** own expense, for claim assessment and where the **insured member** refuses to do so, we may refuse to pay a benefit.

6.5 Reimbursement of claim costs

Any costs incurred outside Australia in connection with a claim in respect of an **insured member** who was overseas must be paid by you or the **insured member**. We may agree to reimburse these costs at our sole discretion.

7. GENERAL CONDITIONS

7.1 Risk profile

If any aspect of the membership profile of **insured members** (including number, sex, age, occupation) changes by more than 25% from that existing at the **policy start date** or the date on which we last reviewed the premium rates, by written notice to you we may:

- stop accepting new **insured members**
- increase the premium rate (including during the **premium rate guarantee period**)
- vary the **automatic acceptance terms**
- vary or remove the **AAL**
- require you to pay the minimum annual premium as outlined in clause 5.3.

If the number of **insured members** covered under the **policy** falls below 75% (or as otherwise agreed to by us in writing) of persons eligible for cover based on the **eligibility criteria**, we may remove the **AAL**, as described in clause 2.3.5.

7.2 Administration

To enable us to properly administer the **policy**, you must notify us of the entry and exit of individual **insured members**.

7.3 Profit sharing

The **policy** may be entitled to participate in profits that are based on self-experience profit sharing. If you are eligible and have elected to participate in self-experience profit sharing, all details will be specified in your **policy schedule**.

7.4 Records

You must maintain records of the **member information** and all relevant information relating to each claim, including the **insured member's** attendance record and duties (claims information). You must also retain records regarding the duration of time **insured members** are working overseas, the number of them and their overseas location. You must give us any **member information** or claims information we request.

You must provide, or procure your agents or administrators to provide, us or our nominated representative, access to inspect, audit and take copies of the **member information**, claims information or other information or records relevant to your **policy**. We will conduct such an audit only during normal office hours and only after we have given you reasonable notice. We will also take all reasonable steps to minimise any inconvenience to you.

7.5 Changes to member and other information

You must notify us of any changes to **member information** or other information relevant to the **policy** which we advise, within 30 days after the **review date**, or as we otherwise agree in writing with you.

7.6 Termination of policy

You can terminate the **policy** at any time by giving us at least 30 days written notice.

We may only terminate the **policy** in the circumstances explained in clauses 5.3 and 5.5 in accordance with our legal rights.

You must inform the **insured members** of the notice that we serve upon you to terminate as soon as possible and no later than 14 working days from receipt of our written notice.

7.7 Governing law

Your **policy** is governed by the law that applies in the state or territory of Australia in which your **policy** is registered.

7.8 Currency

All payments to, or from, us are to be made in Australian currency. If the **insured member** holds **formula based cover** and is working overseas, the **insured member's** salary must be advised to us in Australian currency and we will take no responsibility for foreign exchange risk.

7.9 Statutory fund

Your **policy** is issued from the statutory fund shown in your **policy schedule**, but does not give you any rights of ownership of the assets of that fund.

Your **policy** does not acquire a cash surrender value.

7.10 Cooling-off period

You may cancel your **policy** within 14 days of the earlier of:

- the date you receive your **policy schedule**
- the date you receive an 'On-risk' letter confirming our acceptance of your application or **proposal form**
- the end of the fifth day after the **policy start date**.

You may cancel your **policy** during the cooling-off period by giving us notice in writing and returning your **policy schedule**. If you do this, we will terminate your **policy** and will refund any money paid (except any amounts of taxation which we are unable to recover). However, you cannot exercise your right to cancel your **policy** or get a refund at any time after an **insured member** has made a claim for benefits under the **policy**.

8. DICTIONARY

Terms described in the **policy schedule** or **decision note** have the meaning shown there, while the following terms in this PDS and Policy have the following meanings:

Accident means an external event which was unexpected and unintended causing death or injury.

The following situations are not accidents, and any claims arising from these situations are excluded:

- one of the contributing causes of death or injury was any of the following conditions:
  - illness
  - disease
  - allergy
  - any gradual onset of a physical or mental infirmity.
- the injury or death, which was unintended and unexpected, was the result of an intentional act or omission, or
- the **insured member** was injured or died as a result of an activity in respect of which they assumed the risk or courted disaster, irrespective of whether he or she intended injury or death.

Active employment means the **insured member** is **gainfully working** and, in our opinion, is:

- actively performing all the duties of his or her occupation, free from any limitation due to illness or injury or on leave taken for reasons unrelated to injury or illness, and
- is capable of actively performing all the duties of his or her occupation free from any limitation due to illness or injury on a **full-time** basis (even if not employed **full-time**).

Active service refers to an **insured member's** occupation as part of a military force (including without limitation the defence force, including the army, the navy, the air force or like). Reserve duty is excluded.

Activity/Activities of daily living means:

- bathing and/or showering
- dressing and undressing
- eating and drinking
- using a toilet to maintain personal hygiene
- getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or with assistance of a walking aid.

Activity/Activities of daily work means:

- **bending** – the ability to bend, kneel or squat to pick something up from the floor and straighten up again.
- **communicating** – the ability to:
  - clearly hear with or without a hearing aid or alternative aid if required
  - comprehend and express oneself by spoken or written language with clarity and
  - interact with others by listening, comprehending and speaking on a day-to-day basis and in a work environment.
- **vision (reading)** – the ability to read, with or without correction with suitable lenses, to the extent that an ophthalmologist can certify that:
  - visual acuity is equal to, or better than, 6/48 in both eyes, or
  - constriction is within or greater than 20 degrees of fixation in the eye with the better vision.
- **walking** – the ability to walk more than 200m on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body.
- **lifting** – the ability to lift, carry or otherwise move objects weighing up to 5kg using one or both hands.
- **manual dexterity** – the ability, with reasonable precision and success, to:
  - use at least one hand, its thumb and fingers, including the ability to pick up and manipulate small objects, and
  - use a keyboard.

At work means the **insured member** is:

- actively performing all the duties of his or her occupation free from any limitation due to illness or injury
- working his or her usual hours free from any limitation due to illness or injury, and
- is not in receipt of and/or entitled to claim income support benefits from any source including workers' compensation benefits, statutory motor accident benefits or disability income benefits (including government income support benefits).

An **insured member** who does not meet these requirements is correspondingly described as **not at work**.

At work certificate means the form in which you certify those **eligible persons** who were **at work** and **not at work** on the requisite date.

Australian resident means an Australian citizen, a New Zealand citizen or a permanent resident within the meaning of the *Migration Act 1958* (Cth).

Automatic acceptance level/AAL means the **automatic acceptance level** shown in the **policy schedule**.

Automatic acceptance terms has the meaning set out in clause 2.3.1.

Benefit expiry age means the age at which cover ceases as set out in the **policy schedule**.

Casual employee means an **eligible person** working on a temporary, as required basis, is paid on an hourly basis for the period worked, does not accrue entitlements for sick leave and annual leave, and who is not otherwise a **permanent employee**.

Certification period has the meaning given in the definition of **terminally ill** and **terminal illness**.

Choice of Fund legislation means *Superannuation Guarantee (Administration) Act 1992, the Superannuation Guarantee (Administration) Regulations 2018, the Superannuation Guarantee Charge Act 1992,* as amended from time to time, or any other present or future law of the Commonwealth of Australia or any state or territory, which we may determine to be relevant law for the purposes of this definition.

Cognitive loss (permanent) means a total and permanent deterioration or loss of intellectual capacity due to the loss of or damage to neurons in the brain (or through acquired brain injuries or progressive neurodegenerative disease) that has required the **insured member** to be under continuous care and supervision by another adult person for at least six consecutive months; that has been clinically observed and evidenced by accepted standardised testing, and that at the end of the six-month period they are likely to require ongoing continuous care and assistance by another adult person to perform any of the **activities of daily living**.

Contractor means a person is performing all the normal duties of his or her work, is working on a contracted basis and is under a fixed term contract of not less than one year in duration.

Date of disablement means:

(a) for Part 1 and Part 6 of the **TPD** definition, the first day after the expiry of the **waiting period**

(b) for all other parts of the **TPD** definition, the first day that all of the elements of the definition are satisfied.

Death benefit is the amount applying to the **insured member** by reference to the **policy schedule** or the **decision note** as at the **insured member's** date of death.

Decision note means the document we issue in respect of an **insured member** when that **insured member's** application for cover, an increase in cover, or variation in cover has been assessed and determined by us, setting out details of the following:

- the type and level of **insured benefits** provided for that **insured member** (if any)
- the date the cover starts or an increase in cover starts, and
- any special conditions applying.

Eligibility criteria means the rules for eligibility set out in clause 2.1 of the **policy** and the **policy schedule**.

Eligible person means a person who meets the **eligibility criteria**.

Event date means:

(a) for Part 1(a) and Part(b) of the **TPD** definition, the first day of the **waiting period** during which the **insured member**, in our opinion, solely because of injury or illness, has not worked

(b) for Part 2 of the **TPD** definition, the date on which the **insured member** suffers a permanent impairment of at least 25% of whole person function as described in the American Medical Association's publication *Guides to the Evaluation of Permanent Impairment,* 5th edition, or an equivalent guide to impairment approved by us, that results in the **insured member's total and permanent disablement**

(c) for Part 3 of the **TPD** definition, the date the **insured member** suffers the loss of the use of two limbs (where 'limb' is defined as the whole hand or the whole foot), the sight in both eyes, or the sight in one eye and the use of one limb

(d) for Part 4 of the **TPD** definition, the first day that the **insured member**, in our opinion, solely because of injury or illness, is totally unable to perform at least three **activities of daily work**

(e) for Part 5 of the **TPD** definition, the date on which the **insured member** suffers a total and permanent deterioration or loss of intellectual capacity that results in the **insured member's total and permanent disablement**

(f) for Part 6 of the **TPD** definition, the first day of the **waiting period** during which the **insured member**, in our opinion, solely because of injury or illness, has been unable to perform **normal domestic duties**, leave their **home** unaided or work in any occupation.

Excluded occupation is an occupation for which cover is not available under the **policy**.

Existing cover means any insured amount of cover that the **insured member** held under your **policy** prior to the date the application for **transferred cover** was accepted by us.

Fixed dollar cover means that the amount of the benefit for Death Cover and/or the amount of the benefit for **TPD** Cover that you, the **insured member**, or the **insured member's** employer (if applicable), has requested and we have agreed to provide that is fixed at a specific amount.

Formula based cover means the amount of the benefit for Death Cover and/or **TPD** Cover which has been determined via the application of a formula for cover chosen by you (if your **policy** is held outside of superannuation) or by the **participating employer** (if the **policy** is held inside of superannuation) and agreed to by us. **Formula based cover** is determined by reference to an **insured member's salary**.

Forward underwriting limit means the amount up to which we will accept future increases in the **insured benefits**, without further application from an **insured member**.

FSC Guidance Note means The Financial Services Council Guidance Note No. 11 Group Insurance Takeover Terms dated 9 May 2013, as amended from time to time.

Full-time means working at least 30 hours per week.

Gainful employment means any occupation or work for reward or financial benefit, or the hope of reward of financial benefit, whether on a permanent or temporary basis, and whether or not of a lesser grade, status or level of remuneration or for lesser hours than the **insured member's** occupation(s) held prior to the **event date**.

Gainfully working means employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment.

Home means the **insured member's** principal place of residence.

Incurred date means, in respect of a claim for the:

(a) **Death benefit**, the date of death of an **insured member**

(b) **Terminal illness benefit**, the date of the latest **written certification** by a **medical practitioner** which we accept as evidence of **terminal illness**, or

(c) **TPD benefit**, the **event date**.

Insured benefit means any benefit provided under your **policy** as the context requires including the **TPD benefit**, the **terminal illness benefit** and/or the **death benefit**, as varied by any **decision note** that we issued in respect of an individual **insured member**.

Insured member refers to a person who is covered by your **policy** and is either an employee or **contractor** of an employer or partner in a partnership where your **policy** is employer owned, or a member of a complying superannuation fund where your **policy** is owned by a trustee of a complying superannuation fund.

Interdependent relationship means a close personal relationship between two people who live together, where one or each of them provides the other with financial support, and one or each of them provides the other with domestic support and care.

Limited cover means cover other than cover for an illness or injury which directly or indirectly caused the transferring member to be **not at work** on the last **normal business day** immediately before the **transfer date**.

Maximum benefit entry age means the maximum benefit entry age as shown in the **policy schedule**.

Maximum benefit level means the **maximum benefit level** as shown in the **policy schedule**.

Medical practitioner means a registered and qualified **medical practitioner** in Australia, or another country as approved by us, who in our opinion, is qualified in an appropriate specialty, and who is not you, the **insured member**, or the **insured member's** spouse, family member, business partner, employee or employer.

Member information means all information in respect of an **eligible person** which we advise you we require which can include, but is not limited to the following:

- name
- date of birth
- sex
- occupation
- state, territory or country of residence including details of persons who have been seconded overseas by their employer for work
- employee/member status (i.e. whether the person is on unpaid or paid leave)
- date the person first satisfied the **eligibility criteria** and, if required, an **at work certificate**
- date the person joined the company
- sum insured (in Australian dollars) and formula for cover.

Minimum benefit entry age means the minimum benefit entry age as shown in the **policy schedule**.

New events cover means the **insured member** will not be covered for any **pre-existing condition**. The **insured member** will only be covered for an illness which became apparent to the **insured member**, or any injury which occurred to the **insured member**, on or after the date that cover commenced, recommenced or increased (as applicable) under the **policy**.

Normal business day means any day which is not a weekend or a public holiday on which an **insured member's** employer normally operates.

Normal domestic duties mean the tasks performed by an **insured member** whose sole occupation is to maintain their family **home**. These tasks are unassisted:

- cleaning of the **home**
- cooking of meals for their family
- doing their family's laundry
- shopping for their family's food, and
- taking care of dependent children (where applicable).

Normal domestic duties do not include duties performed outside the **insured member's home** for salary, reward or profit.

Not at work means the **insured member** does not satisfy the definition of **at work**.

Own occupation means the **insured member's** occupation immediately prior to the **event date**.

Parental leave includes maternity leave, paternity leave and/or adoption leave.

Part-time means working at least 15 hours per week, but less than 30 hours per week.

Participating employer means the **policy owner** (if your **policy** is held outside of superannuation) or the **participating employer** named in the **policy schedule** (if the **policy** is held inside of superannuation).

Permanent employee means an **eligible person** working on a permanent basis and not as a **casual employee**.

Policy means the documents issued by us to you and includes:

- the terms outlined in Part 2 of this PDS and Policy (as updated or supplemented from time to time)
- the sections titled 'Who issues Group Life Insurance?' and 'How to read this PDS and Policy' on page 1 of this PDS and Policy
- the **policy schedule**
- any notices issued or received by us under your **policy**
- the **decision note** (if applicable), and
- any written variation to your **policy**.

Policy owner means the policy owner shown in the **policy schedule**.

Policy schedule means the document we send you which sets out details of your **policy**, including any special conditions, amendments or endorsements. A new **policy schedule** will be issued at any time there is a change in your **policy** such as a variation of benefits. The new **policy schedule** will apply from the effective date shown on the new **policy schedule**.

Policy start date means the **policy** start date shown in the **policy schedule**.

Portability legislation means the provisions of the *Superannuation Industry (Supervision) Regulations 1994*, as amended from time to time, which regulate the transfer or rollover of superannuation benefits, or any present or future law of the Commonwealth of Australia or any state or territory which we may determine to be relevant law for the purposes of this definition.

Pre-existing condition means an injury that first occurred, or an illness which first became apparent, to the **insured member**, or any directly or indirectly related condition, before the date cover in respect of that **insured member** commenced, recommenced or increased.

Premium rate guarantee period means the **premium rate guarantee period** shown in the **policy schedule**.

Premium rate schedule means the premium rate table shown in the **policy schedule**.

Previous cover means death only cover or death and **total and permanent disablement** cover under a **previous life policy** with another insurer through a superannuation fund.

Previous cover terms means any special condition, premium loading or exclusion that applies to the **insured member's previous cover**.

Previous life policy means a 'life policy' under the *Life Insurance Act 1995* (Cth) that we agree to treat as a previous life policy for the purposes of the **policy**.

Principal office means our office located at 347 Kent Street, Sydney NSW 2000.

Proposal form means the application form we will provide you to complete in order for you to purchase a Group Life Insurance product from us.

Quotation guarantee period means 90 days unless we agree to change this period.

Quotation summary means the Group Life Insurance quotation we issue you. It contains the **premium rate schedule** and the terms on which we will offer cover to your prospective plan.

Review date means an annual date agreed to between you and us as shown in the **policy schedule**.

Special acceptance terms include exclusions, premium loadings and other special conditions we apply to the **insured member's** cover.

Specialist medical practitioner means a **medical practitioner** who is a specialist practising in the relevant medical field of the **insured member's** illness or injury.

Specific life event means:

- the **insured member's** marriage or involvement in a **interdependent relationship** for two or more years
- the date on which a dependent child of the **insured member** starts secondary school
- the date on which the **insured member** or the **insured member's** spouse gives birth to or adopts a child, or
- the date on which the **insured member** takes out or increases a mortgage on their principal place of residence with an accredited mortgage provider (excludes redraw and refinancing).

Standard cover means the **insured member** will be covered on the same basis as an **insured member** who was **at work** on the date his or her cover commenced under the **policy**.

Superannuation account balance means the dollar value of the accumulation fund maintained by you (where we have issued this **policy** to the trustee of a complying superannuation fund) in respect of an **insured member** under your plan.

Takeover terms means the terms that apply to the transfer of cover under the **policy** to another insurer including but not limited to the terms that specify when the new or incoming insurer becomes responsible for claims, the acceptance terms on which the incoming insurer takes over the cover and when cover under the **policy** ceases in respect of transferring members.

Terminal illness/Terminally ill – Standard Definition means an illness or injury where all of the following (a), (b), (c), (d) and (e) are satisfied in respect of an **insured member**:

(a) two **medical practitioners** certify in writing ('**written certification**') that the **insured member** suffers from an illness or has incurred an injury that, despite reasonable medical treatment, is likely to result in the **insured member's** death within 12 months from the date of **written certification** ('**certification period**')

(b) we are satisfied from medical or other evidence that the **insured member** will likely, despite reasonable medical treatment, die from the illness or injury within the **certification period**

(c) at least one of the **medical practitioners** is a **specialist medical practitioner**, and one which may be appointed by us

(d) for each **written certification**, the **certification period** has not ended, and

(e) the **written certification** by both **medical practitioners** must be dated during the period the **insured member** is insured for Death Cover under the **policy**.

Terminal illness/Terminally ill – Non-Standard Definition means an illness or injury where all of the following (a), (b), (c), (d) and (e) are satisfied in respect of an **insured member**:

(a) two **medical practitioners** certify in writing ('**written certification**') that the **insured member** suffers from an illness or has incurred an injury that, despite reasonable medical treatment, is likely to result in the **insured member's** death within 24 months from the date of **written certification** ('**certification period**')

(b) we are satisfied from medical or other evidence that the **insured member** will likely, despite reasonable medical treatment, die from the illness or injury within the **certification period**

(c) at least one of the **medical practitioners** is a **specialist medical practitioner**, and one which may be appointed by us

(d) for each **written certification**, the **certification period** has not ended, and

(e) the **written certification** by both **medical practitioners** must be dated during the period the **insured member** is insured for Death Cover under your **policy**.

Terminal illness benefit means, in respect of an **insured member**, the lesser of:

- the **death benefit** as at the date of the latest **written certification**, and
- $2.5 million.

Total and Permanent Disablement/Totally and Permanently Disabled/TPD means:

Part 1a – Any Occupation

An **insured member** satisfies all of the following (a), (b), (c) and (d):

(a) is aged 66 years or less on the **event date**

(b) is **gainfully working** for an average of at least 15 hours per week as a **permanent employee** (including an eligible **contractor**) on the day immediately prior to the **event date**, and

(c) has either:

(i) worked for at least six consecutive months or more immediately prior to the **event date**, or

(ii) worked for less than six consecutive months immediately prior to the **event date** but has in fact worked for an average of 15 hours or more per week since commencing cover under the **policy**, and

(d) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member**:

(i) has not worked at any time during the **waiting period**, and

(ii) as at the **date of disablement** is unlikely ever to be able to work in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

Part 1b – Own Occupation

An **insured member** satisfies all of the following (a), (b), (c) and (d):

(a) is aged 66 years or less on the **event date**

(b) is **gainfully working** for an average of at least 15 hours per week as a **permanent employee** (including an eligible **contractor**) on the day immediately prior to the **event date**, and

(c) has either:

(i) worked for at least six consecutive months or more immediately prior to the **event date**, or

(ii) worked for less than six consecutive months immediately prior to the **event date** but has in fact worked for an average of 15 hours or more per week since commencing cover under your **policy**, and

(d) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member**:

(i) has not worked at any time during the **waiting period**, and

(ii) as at the **date of disablement** is unlikely ever to be able to work in their **own occupation**.

Part 2 – Permanent Impairment

An **insured member** satisfies all of the following (a), (b) and (c):

(a) is **gainfully working** on the day immediately prior to the **event date**

(b) solely because of injury or illness, he or she suffers at least 25% permanent whole person impairment as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment,* 5th edition, or an equivalent guide to impairment approved by us, and

(c) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member** as at the **date of disablement** is unlikely ever to be able to work in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

Part 3 – Specific Loss

An **insured member** satisfies all of the following (a) and (b)†

(a) solely because of injury or illness, suffers the total and permanent loss of the use of either:

(i) two limbs (where 'limb' is defined as the whole hand or the whole foot), or

(ii) the sight in both eyes, or

(iii) one limb and the sight in one eye,

which is certified by at least two **medical practitioners**, and

(b) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member** as at the **date of disablement** is unlikely ever to be able to work in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

† Part (b) only applies if the **policy owner** is a superannuation fund trustee.

Part 4 – Activities of Daily Work

An **insured member** satisfies all of the following (a) and (b)†

(a) solely because of injury or illness, the **insured member** is totally and irreversibly unable to perform at least three **activities of daily work**, and

(b) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member** as at the **date of disablement** is unlikely ever to be able to work in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

Part 5 – Cognitive Loss

An **insured member** satisfies all of the following (a) and (b)†

(a) solely because of injury or illness, the **insured member** suffers **cognitive loss**, and

(b) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member** as at the **date of disablement** is unlikely ever to be able to work in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

Part 6 – Normal Domestic Duties

An **insured member** satisfies all of the following (a) and (b):

(a) is aged 66 years or less on the **event date**, and

(b) in our opinion based on medical or other evidence satisfactory to us, solely because of injury or illness, the **insured member**:

  (i) has been unable to perform **normal domestic duties**, leave their **home** unaided or work in any occupation during the **waiting period**, and

  (ii) as at the **date of disablement** is unlikely ever to be able to perform **normal domestic duties** or work in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

Total and Permanent Disability Benefit/TPD Benefit means the amount specified in the **policy schedule** in relation to the **insured member** as at the **event date**, as varied by any **decision note** we issue in respect of an individual **insured member** (if any).

Transfer date means the date your **policy** commenced with us.

Transferred cover means cover that the **insured member** wishes to transfer into the **policy** in accordance with clause 2.17.

Unit based cover means cover that is based on a number of units, where one unit represents a set amount at a certain age.

Underwritten/underwriting means the process we undertake to assess an **eligible person's** application for cover including obtaining and considering information concerning their medical, health and employment status and such other information as we, at our discretion, require.

Visa means a current and valid visa permitting residency (excluding a visa allowing permanent residency in Australia) or employment in Australia issued in accordance with the *Migration Act 1958* (Cth) or any amending or replacing *Act* which enables an **eligible person** or **insured member** to work in Australia.

Waiting period means a 183 consecutive day period.

War includes, but is not limited to, declared war and armed aggression by one or more countries resisted by any country, combination of countries or international organisations.

War service includes but is not limited to, participation in an action to defend a country or region from civil disturbance or insurrection, or in an effort to maintain peace in a country or region.

Written certification has the meaning given in the definition of **terminally ill** and **terminal illness**.

† Part (b) only applies if the **policy owner** is a superannuation fund trustee.

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Group Risk Insurance Administration

OnePath Life
Phone 1800 648 921
Email group.risk@onepath.com.au

Address
GPO Box 4129
Sydney NSW 2001

OnePath Life Limited (OnePath Life) ABN 33 009 657 176 AFSL 238341

OnePath

onepath.com.au