INSURANCE

GROUP SALARY CONTINUANCE 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 Life's Group Salary Continuance (GSC) Insurance.

The information in this PDS and Policy will help you to decide whether this product is suitable to 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 GSC 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 GSC Insurance?

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

The invitation to purchase a Group Salary Continuance 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 GSC 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 GSC 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 9 (Dictionary) for the documents that make up your **policy**.
'PDS and Policy'	This document which comprises the Group Salary Continuance 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 9 of this PDS and Policy. Other words and expressions with special meanings will be defined in the **policy schedule** which will be issued to you if you purchase this product.

Terms that are defined in the **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 GSC Insurance. Please refer to the definition of **policy** in the Dictionary in Part 2: Policy Terms – Section 9 of this PDS and Policy for the documents that make up your **policy**.

Privacy

When you apply for GSC 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 8.

Setting up your policy

Step 1 – Obtaining a quotation

To establish a **policy** you need to first obtain a quotation for GSC Insurance.

In requesting a quotation, you will need to decide what level of monthly benefit **insured members** ought to be provided with, how soon the **policy** should start, the **waiting period** that is to apply, the **benefit period**, and what optional benefits should apply. 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** (the **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 GSC 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 GSC Insurance?

At a glance

GSC 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 GSC Insurance provides a monthly benefit of up to 75% of salary for an **insured member** who is unable to work due to illness or injury. The flexible nature of OnePath Life's GSC Insurance allows you to tailor insurance cover for the 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
Total Disability Benefit	If an **insured member** is unable to work due to illness or injury, we will pay you the monthly benefit while the **insured member** remains **disabled** for a period which will not exceed the **benefit period**. If an **insured member** is eligible for a Total Disability Benefit, the maximum monthly benefit you can receive in respect of an **insured member** is generally 75% of the **insured member's** monthly **salary**.	✓	18
Partial Disability Benefit	If an **insured member** has reduced working capacity after a period of **total disability**, we will pay you a portion of the monthly benefit for a period which will not exceed the **benefit period**.	✓	18
Death Benefit	If an **insured member** dies while a **disability** benefit is being paid, we will pay you an amount up to three times the monthly benefit.	✓	19
Specific Injury Benefit	If an **insured member** suffers a specific injury within 180 days of the event which caused it, we will pay you the monthly benefit regardless of whether the **insured member** is **totally disabled**. Benefits commence immediately upon the **insured member** being diagnosed with the specific injury and continue for the nominated payment period.	✗	19
Recurring Disablement	If the **insured member** suffers a relapse of the injury or illness that caused the **insured member** to obtain a **disability** benefit within six months of their claim ending, no further **waiting period** will apply and **disability** benefits will continue up to the end of the **benefit period**.	✓	20
Early Notification Incentive Benefit	If we are notified of a claim within 30 days of the event which causes the claim, we will pay you an amount equal to 25% of the first month's **disability** benefit.	✓	19
Emergency Domestic Travel Benefit	If an **insured member** requires **emergency transportation** within Australia to a hospital while in receipt of a Total Disability Benefit, we will reimburse the expenses incurred for **emergency transportation** of the **insured member** up to $1,000.	✗	20
Transfer terms	We may agree to take over the level of insurance benefits provided by your previous insurer and provide equivalent benefits on certain terms.	✓	13
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).	✓	15
Cover during paid and unpaid leave	We provide cover for a maximum period of two years if the **insured member** is on paid or unpaid leave.	✓	15
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.	✓	15
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
Continuation Option	If an **insured member's** cover ends because they cease to satisfy the **eligibility criteria**, they may be able to apply to us for an individual policy providing disability benefits without medical **underwriting**.	✓	16
Interim Accident Cover	While we consider a person's application to become an **insured member**, we will provide cover for **disability** that occurs as a result of an **accident** for up to 90 days.	✓	15

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Return to work assistance	We may pay some or all of the expenses incurred by an **insured member** participating in a return to work program, if we believe that such a program may help the insured member return to work. Please refer to page 10 for more information about the rehabilitation service we offer.	✓	20
Workplace modification assistance	We may pay some or all of the expenses required to modify an **insured member's** place of employment if we believe such modification is necessary to enable the **insured member** to return to work.	✓	20
Premium waiver	You do not have to pay premiums in respect of **insured members** who are **on claim**.	✓	28
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 Life Insurance simultaneously with GSC Insurance.	✓	28
Guaranteed continuing cover	The **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.	✓	11

Optional features

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

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Superannuation Contribution Benefit	You may choose to insure an additional amount of your **insured members'** salaries in the form of a Superannuation Contribution Benefit.	✓	21
Enhanced Bereavement Benefit	If an **insured member** dies or is diagnosed with a **terminal illness** while covered, we will pay you three times the **insured member's** monthly benefit as a lump sum up to a maximum of $60,000 in aggregate.	✓	24
Alternative Benefit Expiry Age Benefit	Age-based terms of 'to age 67' or 'to age 70' are available subject to certain conditions.	✓	24
Escalation Benefit	You can elect for an **insured member's** monthly benefit to increase each year when a claim is being paid by the lesser of the annual **CPI** increase and the **escalation factor**.	✓	21
Nurse Care Benefit	If an **insured member** is **totally disabled**, confined to bed and receiving full-time nursing care during the **waiting period**, we will pay 1/30 of the monthly benefit for up to a maximum of 30 days or until the end of the **waiting period**, whichever occurs first.	✗	21
Recovery Assistance Benefit	If the **insured member** is receiving a Total Disability Benefit, and becomes **totally and permanently disabled** within 12 months of the **date of disability**, we will pay you an additional lump sum amount as indicated in the table below:	✗	21
Early Cash Benefit	If an **insured member** suffers an early cash condition (of which there are eight), we will pay the **insured member's** monthly benefit for a maximum of six months. Not available if the Trauma Recovery Benefit is selected.	✗	22

Age next birthday as at the date you ceased work	Amount of the Recovery Assistance Benefit
Up to age 56	$50,000
57	$45,000
58	$40,000
59	$35,000
60	$30,000
61	$25,000
62	$20,000
63	$15,000
64	$10,000
65	$5,000

Benefit/Feature	Benefit description	Available in superannuation?	Refer to page
Trauma Recovery Benefit	If an **insured member** suffers any of the 42 trauma recovery events (as defined in Section 9 of Part 2: Policy Terms – Dictionary), we will pay you the **insured member's** monthly benefit for a maximum of six months. This benefit is payable during the **waiting period**. Not available if the Early Cash Benefit is selected.	✗	22
Immediate Family Member Benefit	If, while in receipt of the Total Disability Benefit, the **insured member** has been confined to bed and he or she requires care from an **immediate family member**, we may pay you an additional amount of up to $3,000 per month, for a maximum period of three months.	✗	23
Relocation Benefit	We will reimburse the cost of a single standard economy airfare up to three times the **insured member's** monthly benefit if the **insured member** returns to Australia while **totally** or **partially disabled**.	✗	23
Enhanced Recovery Assistance Benefit	If the **insured member** is **totally and permanently disabled** at the end of the 5 years, 7 years or 10 years (as applicable) **benefit period** we will pay you an additional lump sum equal to one times the **salary** of the **insured member** subject to a maximum of $100,000.	✗	24
Tailored Package	We can create a tailored package of benefits to best suit your needs. Speak to one of our dedicated Group Risk Development Managers to learn about the options we offer.	✓	N/A

Availability of cover

The table below sets out the limits and options available under OnePath Life's GSC Insurance. The **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 (excluding stamp duty)	$15,000	
Maximum monthly benefit level	$30,000	
Maximum benefit expiry age	70 years	
Maximum salary replacement percentage	75% of the **salary** of the **insured member**	
Maximum Super Contribution Benefit	12% of the **salary** of the **insured member**	
Waiting periods options	30, 60, 90, 180 and 365 days	
Benefit period options	Fixed term periods:	Age-based terms:
	1 year	to age 60
	2 years	to age 65
	5 years	to age 67
	7 years	to age 70
	10 years	
Premium payment frequency	Annually, half yearly, quarterly or monthly	

Please refer to the 'Benefits' section on page 18 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 any benefit for a **disability** 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 of Part 2: Policy Terms, we will not pay any benefit for a **disability** 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 advisor)
- 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
- the 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

GSC Insurance to be held in superannuation

OnePath Life's GSC 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

OnePath rehabilitation

OnePath provides a range of rehabilitation support services that are tailored to suit the claimant's individual return-to-work goals.

OnePath Rehabilitation takes a holistic and collaborative approach to support your employees with their recovery and work goals. Our multi-disciplinary team have extensive experience in occupational rehabilitation, managing psychological and physical conditions across diverse industries including construction, education, finance, defence, and corporate organisations.

Our Rehabilitation Team has qualifications in rehabilitation counselling, pain management and health and exercise physiology.

The services below may be offered to those claimants suitable to undergo our rehabilitation program:

Initial needs assessment

This assessment helps us to identify and access the right type of rehabilitation services for the claimant through exploration of medical and vocational factors.

Gradually build up the claimant's work capacity and endurance

We work with the claimant and his or her employer (if applicable) to develop a Return to Work Plan. This may involve reduced hours and duties which are gradually increased as the claimant's condition improves. Workstation modifications and aids may also make returning to work easier.

Career Counselling

If the claimant can't return to the same role, we undertake a vocational assessment of their education, employment history and transferrable skills to identify suitable alternative employment or retraining options.

Helping the claimant prepare for job seeking

We help the claimant build the confidence to be job-ready by assisting them with resume preparation, sourcing job leads and developing the skills for successful interviews.

Helping with work-readiness

If the claimant is not quite ready to return to work, he or she may benefit from assistance with developing a daily structure, incorporating exercise, goal setting, and re-engagement in the community, as a stepping stone to returning to work.

Business coaching

If the claimant is pursuing self-employment, he or she can talk to us about whether business coaching may be viable.

How we can help you

If you'd like more information, please feel free to contact the Rehabilitation Team directly at claims.rehabilitation@onepath.com.au

Making a claim

For information about making a claim, refer to Section 7 of Part 2: Policy Terms.

If you want to know more about making a claim for a GSC 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 1–9 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 the cover ends.

The standard benefits provided for **insured members** are described in Section 3. Optional benefits may apply to some or all **insured members**, as set out in Section 4.

There are some circumstances in which we will not pay all, or part of, the benefit amount and these are detailed in Section 5.

The payment of benefits is subject to you and the **insured member** satisfying our claim procedures as set out in Section 7.

1.2 Duration of the policy

The **policy** commences on the **policy start date** and remains in force, as long as you pay the premium in accordance with Section 6 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 clause 8.6.

1.3 Notices

Notices to, or by, us under the **policy** must be in writing and can be delivered by post or email. We will send notifications to you at the postal 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 9 – Dictionary.

1.4 Guaranteed continuing cover

Your **policy** will be renewed each year if you continue to pay the premium and satisfy the other terms of the **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 2.11 and 2.12)
- is working in an occupation that we do not class as an **excluded occupation**
- is employed and working at least 15 hours per week as a **permanent employee** (including any **contractor**) 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 and Section 4 (where applicable), 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 terms** 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 2.6.

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** (unless we agree otherwise in writing)
- 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 the **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 any insurance benefit from any source for an illness or injury 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 terms** unless:
  - the **eligible person** was previously accepted for cover under **automatic acceptance terms** and the cover provided at that time ceased under the **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 you or 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 the **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 monthly benefit.

An application is required for cover in excess of the **AAL** as set out in clause 2.6.

Where we accept an application for cover or additional cover under clause 2.6, 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 the **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 this **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.

Transfer terms will only apply to those persons who were insured under 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 **maximum monthly benefit level**.

We will provide cover from the **transfer date** for **eligible persons** who are **at work** on the last **normal business day** immediately before the **transfer date**.

2.4.1 Not at work for reasons other than illness or injury

For any transferring member insured under the previous policy who is **not at work** on the last **normal business day** immediately before the **transfer date** for reasons other than illness or injury, we will provide the same amount of Total Disability, Partial Disability and Specific Injury Cover (if applicable) issued under the previous **policy** 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 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 **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 last performed when they were **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** provided the **eligible person** is not entitled to a benefit under the former 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 automatic acceptance level. 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 the **policy**.

2.5 Automatic increases in the monthly benefit

2.5.1 Where the insured member is automatically accepted

Provided the **insured member** is in **active employment**, the **insured member's** monthly 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 if the increase in the monthly benefit is up to 25% of the **insured member's** monthly benefit (as determined immediately before the increase) and provided the increased monthly benefit is not more than the **AAL**.

Where you on behalf of an **insured member** or the **insured member** seeks to have his or her monthly 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** monthly benefit will be restricted to the stated limits and we will require the **insured member** to be **underwritten** for that part of the monthly benefit that is in excess of either of those limits.

In all other circumstances, an application is required as explained in clause 2.6.

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 monthly benefit level** (as outlined in the **quotation summary** or **policy schedule**).

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

2.6 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 the **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**.

An application can only be made for cover up to the **maximum monthly 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 2.7.

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.

2.7 Interim Accident Cover

Interim Accident Cover is provided for all, or that part, of the cover for which an application under clause 2.6 is required.

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 2.14
- the date the application is cancelled or withdrawn.

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

The Interim Accident Cover Benefit is the lesser of:

- the monthly benefit amount applied for in the application for cover
- the **maximum monthly benefit level**.

Interim Accident Cover provides a Total Disability Benefit or Partial Disability Benefit only. It does not cover the **insured member** or **eligible person** for a Specific Injury Benefit or any other built-in benefits, built-in features or any optional benefits.

2.8 Maximum monthly benefit level

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

2.9 Member categories

The eligibility rules may refer to different categories of **insured members**. In that case, an **eligible person** is covered for the monthly benefit with the **waiting period** and **benefit period** applicable to the category in which he or she is accepted as an **insured member**. The **maximum monthly benefit level**, the **AAL** and any optional benefits (as set out in Section 4) may also vary between categories of **insured members**.

2.10 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 2.11 and 2.12 below.

2.11 Cover during paid and unpaid leave

An **insured member** is covered under the **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.

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.

2.12 Cover while working outside Australia

An **insured member** who is an **Australian resident** and working overseas for you or a **participating employer** will be covered under the **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 the **policy** for up to three years while working overseas for you or 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 non-**Australian resident**) is travelling overseas during periods of paid or unpaid leave, cover continues in accordance with clause 2.11.

2.13 Extended Cover

Subject to the terms of the **policy**, we will provide cover under the **policy** 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 the **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 2.15
  - the date the **insured member** commences employment with a new employer or commences working as a **contractor**.

2.14 When cover ends for insured members

2.14.1 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 the **insured member** permanently retires from employment
- in relation to an **insured member** who ceases to meet the **eligibility criteria**, the date Extended Cover ends as set out in clause 2.13
- the date the **insured member** is on leave for longer than we have agreed to provide cover for under clause 2.11
- the date the **insured member** is employed overseas for a period longer than we have agreed to provide cover for under clause 2.12
- the date your **policy** ends or is terminated, except to the extent discussed in clause 2.14.2.

2.14.2 If your policy terminates

If your **policy** terminates and **takeover terms** apply, our ongoing liability to pay a GSC 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).

2.15 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 the **policy** is held outside of superannuation, or
- with a **participating employer** where the **policy** is held inside superannuation,

the person has the option to apply for a Continuation Option.

The **insured member** may apply for an individual policy with us on his or her life with a benefit period, waiting period and monthly benefit which are no more favourable than those which applied for that **insured member** under the **policy**. The monthly benefit under the individual policy will be for a maximum of 75% of the person's new salary from his or her gainful occupation, unless the **insured benefit** under the **policy** is based on a percentage less than 75%, in which case the maximum shall be that percentage. The monthly benefit is based on the average monthly earnings for the 12 months immediately prior to the claim, or the nominated insured amount, whichever is the lesser.

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 the **policy** is held outside of superannuation) or with a **participating employer** (if the **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
- not be eligible to receive **disability** benefits under your **policy** or any other policy issued by an insurer, and
- apply for an **indemnity contract** only.

If you or another person or entity is receiving or is eligible to receive a benefit payment in respect of the **insured member** under the **policy**, then we will not issue a Continuation Option in respect of that **insured member**.

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.

2.15.1 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 the **policy** will apply under the individual policy.

The individual policy issued will be OnePath Life's OneCare policy. Cover will be on an indemnity basis 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.

3. BENEFITS

3.1 The benefits we pay

In this section we describe the benefits for which **insured members** are covered.

The benefit paid under the **policy** is a monthly benefit. If a payment is for part of a month, then it will be calculated on the basis of 1/30 of the monthly benefit amount for each day the benefit is payable.

To be eligible for benefits under the **policy**, an **insured member** must, as at the **date of disability**, have been **gainfully working** for an average of at least 15 hours per week as a **permanent employee** (including an eligible **contractor**) over six months or more immediately prior to the **date of disability**.

An **insured member** who is **gainfully working** for at least 15 hours per week as a **permanent employee** (including an eligible **contractor**) and has worked for less than six months immediately prior to the **date of disability**, will also be eligible for benefits, but only if the **insured member** has been working an average of 15 hours per week since he or she became covered.

Any change in employment status during periods of leave, in accordance with clause 2.11, will not affect any entitlements to cover.

3.2 Waiting period

We will pay a **disability** benefit only after the end of the **waiting period**. The **waiting period** commences on the **date of disablement**.

During the **waiting period**, the **insured member** may return to work once to perform the normal duties and hours of their occupation, for up to five consecutive days, without having to recommence the **waiting period**. If this happens, we will add the number of days of work to the **waiting period**. If the **insured member** returns to work, performing the normal duties of their occupation during the **waiting period**, on more than one occasion, the **waiting period** starts again.

A separate **waiting period** applies for each separate illness or injury of the **insured member** which causes **disability** for which the **insured member** can claim under the **policy** unless the **insured member** is claiming under the provisions of Recurring Disablement (see clause 3.9).

3.3 Total Disability Benefit

We will pay you the monthly benefit during the **benefit period** when an **insured member** is **totally disabled** for longer than the **waiting period**. To be eligible for the Total Disability Benefit, the **insured member** must have been:

- **totally disabled** for at least seven days out of the first 12 consecutive days of the **waiting period**
- continuously **disabled** for the balance of the **waiting period**, and
- at the expiry of the **waiting period, totally disabled**.

The Total Disability Benefit starts to accrue from the day after the end of the **waiting period**.

The monthly benefit is payable, in respect of an **insured member**, monthly in arrears and stops at the earlier of:

- the end of the **benefit period**
- the date the **insured member** attains the **benefit expiry age**
- the death of the **insured member**
- the date the **insured member** is no longer **totally disabled**
- for an **insured member** on a **visa**, the date the **insured member's** employment contract and/or **visa** expires or is otherwise terminated, or the date the **insured member** permanently departs Australia
- the date the **insured member** has been receiving benefits for longer than six consecutive months while residing outside Australia, in accordance with clause 5.5.

3.4 Partial Disability Benefit

We will pay you a proportion of the monthly benefit during the **benefit period** when an **insured member** is **partially disabled** at the expiry of the **waiting period**. To be eligible for the Partial Disability Benefit, the **insured member** must have been:

- **totally disabled** for at least seven days out of the first 12 consecutive days of the **waiting period**
- **disabled** for the balance of the **waiting period**, and
- continuously **disabled** since the end of the **waiting period**.

The proportion of the monthly benefit will be calculated as follows:

$$\frac{(A - B)}{A} \times C$$

where:

A is the total monthly value of the **insured member's salary**

B is the monthly income the **insured member** receives, or is capable of earning, for the month in which they are **partially disabled**. If the **insured member** is not working to their assessed capacity then 'B' will be the amount they could expect to earn if they were. When we assess capacity, consideration will be given to medical evidence, and other factors related to the **insured member's** condition. 'B' must be less than the amount of 'A'. If 'B' is negative in a month, we will treat 'B' as zero.

C is the monthly benefit.

The Partial Disability Benefit begins to accrue if the **insured member** is **partially disabled** and the **waiting period** has ended.

The Partial Disability Benefit is payable monthly in arrears and stops being paid at the earlier of:

- the end of the **benefit period**
- the date the **insured member** attains the **benefit expiry age**
- the death of the **insured member**
- the date the **insured member** is no longer **partially disabled**
- the date the **insured member** receives, or becomes capable of earning, a monthly income equal to or greater than his or her **salary**

- for an **insured member** on a **visa**, the date the **insured member's** employment contract and/or **visa** expires or is otherwise terminated, or the date the **insured member** permanently departs Australia
- the date the **insured member** has been receiving benefits for longer than six consecutive months while residing outside Australia, in accordance with clause 5.5.

3.5 Death Benefit

If an **insured member** dies while eligible for a **disability** benefit, we will pay you an amount equal to three times the **insured member's disability** benefit amount paid in the month immediately preceding his or her death.

If the **insured member** is eligible for a **disability** benefit but dies before benefit payments commence, we will pay the Death Benefit provided that the **insured member** notifies us of their intention to claim a **disability** benefit prior to their death.

The Death Benefit is not payable during the **waiting period**.

3.6 Specific Injury Benefit

This benefit is not available if you are the trustee of a complying superannuation fund.

If an **insured member** suffers a specific injury as set out in the table 'Specific injuries covered under the policy' within 180 days of the event that caused it, we will pay you the monthly benefit for the nominated payment period, but not beyond the date the **insured member** attains the **benefit expiry age**.

Only one Specific Injury Benefit is ever payable in respect of an **insured member**. If an **insured member** is suffering from more than one specific injury at the same time, we will pay you the monthly benefit only in respect of the specific injury which has the longest nominated payment period. We will pay this benefit whether or not the **insured member** is **disabled**. This benefit is payable during the **waiting period**. The Specific Injury Benefit is paid instead of, not in addition to, a Total or Partial Disability Benefit.

If the **insured member** dies during the nominated payment period, we will pay you a lump sum equal to the greater of:

- the total remaining monthly benefits payable under this clause
- the Death Benefit as set out in clause 3.5.

Specific injuries covered under the policy

Specific injury	Nominated payment period
Paralysis*	60 months†
Loss of both feet or both hands‡	24 months
Loss of any combination of two of: • a hand • a foot • sight in one eye‡	24 months
Loss of one leg or one arm‡	12 months
Loss of one foot or one hand or sight in one eye‡	12 months
Loss of thumb and index finger of the same hand‡	6 months
Fractures§ of the:	
• thigh or pelvis	3 months
• leg (between and not including the knee and foot), or knee cap	2 months
• upper arm including the elbow and shoulder bone	2 months
• skull (except bones of the nose or face)	2 months
• lower arm (including wrist but excluding the elbow, hand and fingers)	1.5 months
• jaw or collarbone	1.5 months

* Paralysis means the total and permanent loss of function of two or more limbs.

† If you have selected a two year **benefit period**, this payment period is reduced to 24 months.

‡ Loss means either the:
- total and permanent loss of the use and control of the hand from the wrist, or the foot from the ankle joint
- complete severance of the thumb and index finger from the first phalangeal joint
- irrecoverable total loss of an eye or the sight in an eye.

§ Fracture means any fracture that requires a pin, traction, a plaster cast or other immobilising structure.

The diagnosis of the specific injury must be made by a **specialist medical practitioner** and confirmed by our medical adviser.

If the **insured member** is **disabled** at the end of the nominated payment period during which a Specific Injury Benefit was paid and the **benefit period** has not ended, we will waive the **waiting period** for the **disability** benefit in respect of the **insured member**.

If the Escalation Benefit applies to the **policy**, the Specific Injury Benefit will also be subject to the terms of clause 4.3.

3.7 Early Notification Incentive Benefit

Where we accept a claim for a Total Disability Benefit or Partial Disability Benefit in respect of an **insured member**, we will pay you the Early Notification Incentive Benefit once during a claim period if the **insured member**, no later than 30 days after the occurrence of the event giving rise to a claim:

- notifies us of their intention to make a claim to receive benefits under the **policy**, and
- provides to us the information required by us to establish the occurrence of the event giving rise to the claim.

The Early Notification Incentive Benefit that we will pay you is 25% of the **disability** benefit payable for the first month (or if this

is for less than one month, a pro-rata amount for each day the **insured member** is **disabled**).

The Early Notification Incentive Benefit does not apply to the Specific Injury Benefit or to any other optional benefits.

This benefit is paid in addition to any other non-optional benefit that becomes payable (with the exception of the Specific Injury Benefit) and only becomes payable at the expiration of the **waiting period**.

3.8 Return to work assistance

If we are of the opinion that participation in rehabilitation or a return to work program may help an **insured member** return to work, we may pay some or all of the program expenses approved by us directly to the appropriate service provider. Any payments will be made at our discretion.

For information about OnePath Rehabilitation refer to Part 1: General Information on page 10.

3.9 Recurring disablement

If an **insured member** was previously **on claim** ('Original Claim') and ceased to be entitled to benefits under the **policy** because he or she was no longer **disabled**, and another claim is made in respect of the same or related illness or injury ('Recurrent Claim') which was the cause of the Original Claim, we will treat the Recurrent Claim as a continuation of the Original Claim and the **waiting period** is waived subject to all of the following conditions:

- the **insured member** becomes **disabled** as a result of the same or related illness or injury which was the cause of the Original Claim ('Recurrence') within six months of the Original Claim ending, and
- subject to clause 2.4.5, the **policy** and the **insured member's** cover is still in force.

This means that the Recurrent Claim is part of the same **benefit period** as the Original Claim. We will only pay **disability** benefits for the remaining **benefit period**, which has been reduced by the Original Claim.

We will consider an **insured member** to be suffering from a separate injury or illness and a new **waiting period** and **benefit period** will apply if the recurrence occurs after the expiration of six months since the **insured member** was entitled to be paid a **disability** benefit in respect of the Original Claim.

3.10 Workplace modification assistance

If the **insured member** is receiving Total Disability Benefits or Partial Disability Benefits and we agree that his or her place of employment requires modification in order for him or her to return to work, we may pay all or some of the modification expenses to a service provider. The maximum payment is three times the **insured member's** monthly benefit, and any payments will be made at our discretion.

A payment under this clause may only be made once in respect of each **insured member**.

3.11 Emergency Domestic Travel Benefit

This benefit is not available if you are the trustee of a complying superannuation fund.

If the **insured member** is in receipt of a Total Disability Benefit and requires **emergency transportation** within Australia to a hospital for treatment of the medical condition for which they are receiving a Total Disability Benefit, we will reimburse the expenses incurred for **emergency transportation** of the **insured member**.

The amount we will reimburse is the lesser of:

- the expenses actually incurred for the **emergency transportation**
- the **insured member's** monthly benefit
- $1,000.

The Emergency Domestic Travel Benefit will be reduced by the amount of any payments made by, or recoverable from, another source in respect of the same **emergency transportation** expense. The **insured member** is obliged to inform us if he or she has the right to apply for, or has received, a similar benefit from any other source. Where the **insured member** refuses to provide such information, we may refuse to pay the benefit.

This benefit is only payable once in respect of each claim of **total disability** made by an **insured member**, is payable in addition to any other benefit that becomes payable but is not payable during the **waiting period**.

4. OPTIONAL BENEFITS

4.1 When optional benefits will apply

Cover for an optional benefit only applies in respect of an **insured member**, or a category of **insured members**, if you have elected that it is to apply to your **policy** and paid the premium for that optional benefit.

All optional benefits (if any) and any non-standard terms that apply to your **policy** are outlined in your **policy schedule**.

4.2 Superannuation Contribution Benefit

If the Super Contribution Benefit (SCB) applies, when a Total Disability Benefit or Partial Disability Benefit is payable in respect of an **insured member**, the **insured member** will also be provided with a benefit calculated as set out below.

The SCB:

- is calculated based on 1/12 of the SCB percentage factor (set out in your **policy schedule**) of the **insured member's salary**
- is paid to you in addition to the monthly benefit, and
- combined with the monthly benefit, is subject to the **maximum monthly benefit level, AAL** and any **forward underwriting limit** that applies to the **insured member**.

The SCB will be reduced proportionally where the **insured member** is entitled to a Partial Disability Benefit.

The terms that apply to the payment of **disability** benefits in the **policy** also apply to the payment of the SCB.

No SCB is payable during the **waiting period**. We will pay the SCB directly to a superannuation provider nominated by you or the **insured member** for the **insured member's** benefit. Or we will pay it to you subject to proof we may request that the amount is subsequently forwarded to a superannuation provider for the **insured member's** benefit.

This benefit will only be paid in circumstances permitted by the relevant laws relating to superannuation contributions and taxation. The superannuation provider must be either a complying superannuation fund or retirement savings account as defined in the relevant superannuation and taxation laws.

4.3 Escalation Benefit

If the Escalation Benefit applies, 12 months after an **insured member** has been continuously **on claim** for a **disability** benefit (including Specific Injury Benefits), the monthly benefit and any Super Contribution Benefit will be increased by the lesser of the annual **CPI** increase and the **escalation factor**.

The adjusted benefit will be similarly increased upon the expiry of each 12 month period for which an **insured member** is continuously **on claim** for a **disability** benefit (including Specific Injury Benefit).

The Escalation Benefit will be applied to increase the monthly benefit even if it causes the monthly benefit to exceed the **maximum monthly benefit level**, **AAL** or any **forward underwriting level** that applies to the **insured member**.

When the **insured member** ceases to be **on claim**, the monthly benefit reverts to the amount which applied prior to benefit escalation under this clause.

4.4 Nurse Care Benefit

This benefit is not available if you are the trustee of a complying superannuation fund.

If the Nurse Care Benefit applies in respect of an **insured member**, an amount equal to 1/30 of the monthly benefit is payable to you for each day, after the first three consecutive days, an **insured member** is:

- **totally disabled** during the **waiting period**
- confined to bed or hospitalised for more than three consecutive days on the advice of the **insured member's medical practitioner**, and
- in receipt of full-time nursing care which is certified by the **insured member's medical practitioner** as necessary for the treatment of the **insured member's disability**, provided the nursing care is performed by a registered and qualified nurse who does not normally reside in the same household and who is not a relative of the **insured member**.

The Nurse Care Benefit is payable for a maximum of 30 days, or until the expiry of the **waiting period**, whichever occurs first.

4.5 Recovery Assistance Benefit

This benefit is not available if you are the trustee of a complying superannuation fund.

If the Recovery Assistance Benefit applies in respect of an **insured member** we will pay you the Recovery Assistance Benefit set out in the table 'Recovery Assistance Benefit Periods under the policy' if:

- the **insured member** is receiving a Total Disability Benefit, and
- the **insured member** becomes **totally and permanently disabled** within 12 months of the **date of disability** for **total disability**.

Recovery Assistance Benefit Periods under the policy

Age next birthday when ceased work	Amount of Recovery Assistance Benefit
Up to age 56	$50,000
57	$45,000
58	$40,000
59	$35,000
60	$30,000
61	$25,000
62	$20,000
63	$15,000
64	$10,000
65	$5,000
66 and older	$0

The Recovery Assistance Benefit is payable in addition to any other benefits which may be payable under the **policy**. Only one Recovery Assistance Benefit is ever payable in respect of an **insured member**.

4.6 Early Cash Benefit

This benefit is not available if you:

- are the trustee of a complying superannuation fund, or
- select the Trauma Recovery Benefit.

The Early Cash Benefit will be payable monthly in advance from the date the **insured member** suffers an early cash condition if an early cash condition happens to the **insured member** while the **policy** in respect of that **insured member** is in force. The duration of the period for which we pay an Early Cash Benefit is determined by the payment period that is applicable to the **waiting period** that applies to your plan, as set out below:

Waiting period	Payment period
30 days	6 months
60 days	4 months
90 days	3 months

Only one Early Cash Benefit is ever payable in respect of an **insured member**. If an **insured member** is suffering from more than one early cash condition at the same time we will only pay for one early cash condition.

We will not pay you any other benefit under the **policy** while we are paying you the Early Cash Benefit.

The following early cash conditions are included under the Early Cash Benefit and are defined in Part 2: Policy Terms – Section 9:

- **burns (severe)**
- **cancer (excluding less advanced cases)**
- **chronic kidney failure (end stage)**
- **coronary artery bypass surgery**
- **heart attack (diagnosed)**
- **heart valve surgery**
- **organ transplant (major)**
- **stroke (diagnosed)**.

If the **insured member** is **disabled** after the Early Cash Benefit period ends due to an early cash condition for which we have paid this benefit, we will pay a Total Disability Benefit or Partial Disability Benefit (as applicable) from when the Early Cash Benefit period ends. There is no **waiting period** for **disability** benefits in this circumstance.

4.7 Trauma Recovery Benefit

This benefit is not available if you:

- are the trustee of a complying superannuation fund, or
- select the Early Cash Benefit.

We will pay you the monthly benefit if a trauma recovery event happens to the **insured member** while the **policy** in respect of that **insured member** is in force.

This benefit is payable whether or not the **insured member** is **disabled**. This benefit is payable during the **waiting period**.

The **insured member's** monthly benefit will be paid in advance each month until the earlier of:

- the end of the payment period of six months for that trauma recovery event
- when the **insured member's** cover ceases under the **policy** pursuant to clause 2.14
- the date of the **insured member's** death.

If the **insured member** suffers either another trauma recovery event or a specific injury (see clause 3.6) while we are paying a Trauma Recovery Benefit, we will pay one benefit only. The benefit we will pay is that which provides for the longest payment period. The Trauma Recovery Benefit is payable only once in respect of any **insured member**.

If the **insured member** is **disabled** at the end of the payment period of six months due to the trauma recovery event for which we have paid this benefit, we will pay a Total or Partial Disability Benefit (as applicable) from the later of the:

- end of the payment period for the trauma recovery event
- end of the **waiting period**.

If the **benefit period** is two years, five years, seven years or 10 years, the maximum period for which we will pay Total Disability Benefits and/or 'Partial Disability Benefits' is reduced by the number of months for which we have already paid the Trauma Recovery Benefit.

The following trauma recovery events are included under the Trauma Recovery Benefit and are defined in Section 9:

Trauma recovery events
alzheimer's disease (diagnosed)†
angioplasty – triple vessel*
aortic surgery*
aplastic anaemia (requiring treatment)

Trauma recovery events
benign brain tumour (permanent impairment or requiring surgical intervention)†
blindness (permanent in both eyes)
burns (severe)
cancer (excluding less advanced cases)*†
cardiomyopathy (permanent and irreversible)
chronic kidney failure (end stage)
chronic liver disease (end stage)
chronic lung disease (end stage)†
cognitive loss (permanent)
coma (of specified severity)
coronary artery bypass surgery*†
deafness (permanent in both ears)
dementia (diagnosed)†
diabetes (severe)*†
encephalitis (permanent and irreversible)
head trauma (permanent and irreversible)†
heart attack (diagnosed)*†
heart valve surgery*
HIV (medically acquired)
HIV (occupationally acquired)
intensive care (prolonged)
loss of independent existence (permanent)
loss of speech (permanent)
loss or paralysis of limb (permanent)
meningitis and/or meningococcal disease (permanent and irreversible)
motor neurone disease (diagnosed)†
multiple sclerosis (diagnosed)†
muscular dystrophy (diagnosed)†
open heart surgery*
organ transplant (major)
osteoporosis (before age 50)*†
parkinson's disease (diagnosed)†
pneumonectomy†
primary pulmonary hypertension (idiopathic pulmonary arterial hypertension with permanent impairment)
rheumatoid arthritis (severe)*†
stroke (diagnosed)*†
systemic sclerosis (permanent and irreversible)*
terminal illness†

* There is no Trauma Recovery Benefit payable if this trauma recovery event first occurs or is first diagnosed, or the symptoms leading to the trauma recovery event occurring or being diagnosed first become **reasonably apparent**, during the first 90 days that cover under the **policy** commences in respect of the **insured member**.

† This trauma recovery event must be diagnosed and certified by a **specialist medical practitioner** approved by us.

4.8 Immediate Family Member Benefit

This benefit is not available if you are the trustee of a complying superannuation fund.

If, while an **insured member** is covered under the **policy:**

- a **medical practitioner** certifies that the **insured member** is confined to bed due to illness or injury and they require care
- the **insured member** is in receipt of Total Disability Benefits, and
- as a direct result of the **insured member's** illness or injury, an **immediate family member** ceases to earn any income solely because the **insured member** needs the **immediate family member** to care for them,

we will pay you up to an additional 50% of the monthly benefit of which the **insured member** is receiving, subject to a maximum payment of $3,000 per month, for a maximum of three months.

Payment of the Immediate Family Member Benefit will be made in arrears, is payable in addition to any other benefits that become payable but is not payable during the **waiting period**.

The **immediate family member** must:

- not have been employed by the **insured member** or be an employee of an entity under the control of the **insured member** or of which the **insured member** is a principal or director, and
- provide the proof that we reasonably require to confirm that the **immediate family member** ceased to earn any income solely to provide the **insured member** with care.

The proof that we may require may take the form of pay slips, employment records or financial records from the **immediate family member**. We may refuse to make any payments where proof to our satisfaction is not provided.

4.9 Relocation Benefit

This benefit is not available if you are the trustee of a complying superannuation fund.

We will pay the Relocation Benefit once while an **insured member** is **on claim** if the **insured member**:

- becomes **totally disabled** while outside of Australia
- remains **totally disabled** for at least 30 days, and
- returns to Australia while **totally** or **partially disabled**.

The amount we will reimburse is the lesser of:

- the cost of a single standard economy airfare for a scheduled commercial flight by the most direct route to the airport in Australia nearest to where the **insured member** resides, which is reasonable in the circumstances
- expenses actually incurred by the **insured member** in changing previously made air travel arrangements
- three times the **insured member's** monthly benefit.

This benefit is only payable once in respect of each claim for **total disability**.

Payment of the benefit is payable in addition to any other benefit that becomes payable and is payable during the **waiting period**.

This benefit is conditional upon proof from you that:

- there is no more than 15% of **insured members** working overseas at any one time, and
- at the last **review date**, with the provision of **member information**, we have been advised of the number of **insured members** working overseas and the countries that such **insured members** reside in.

We may refuse to make any payments under this clause where proof to our satisfaction is not provided.

4.10 Enhanced Bereavement Benefit

If the **insured member** dies or is diagnosed with a **terminal illness** while covered under the **policy**, we will pay three times the monthly benefit as a lump sum, subject to a maximum of $60,000 in aggregate.

Only one payment can be made under this clause. If we pay the Enhanced Bereavement Benefit for **terminal illness**, we will not pay it upon the death of the **insured member**.

We pay this benefit in addition to any other benefits payable while the **insured member** is **on claim** under the **policy**. The Enhanced Bereavement Benefit is payable in addition to the Death Benefit (See clause 3.5).

4.11 Alternative Benefit Expiry Age Benefit

If the **benefit expiry age** requested by you and accepted by us is an age other than age 65 ('Alternative Benefit Expiry Age'), as shown in your **policy schedule**, an **insured member** may have cover under the **policy** up to the Alternative Benefit Expiry Age subject to the following conditions:

- a specific category may have cover up to the Alternative Benefit Expiry Age so long as the number of **insured members** in that category is no less than 20 (unless we agree otherwise), and
- an **eligible person** who joins the plan at age 65 or older and is aged less than the Alternative Benefit Expiry Age, must apply to us in writing and we must accept that **eligible person's** application if the **eligible person** is to have the **benefit period** extend beyond age 65 or be covered to the Alternative Benefit Expiry Age.

4.12 Enhanced Recovery Assistance Benefit

This benefit is not available if you:

- are the trustee of a complying superannuation fund, or
- select the Recovery Assistance Benefit.

This benefit is only available for the following **benefit periods:**

- 5 years
- 7 years
- 10 years

If the Enhanced Recovery Assistance Benefit applies in respect of an **insured member**, we will pay you one times the **insured member's salary** subject to a maximum of $100,000 if:

- the **insured member** has been **on claim** (including Recurrent Claims) and received a Total Disability Benefit or Partial Disability Benefit for the entire **benefit period**
- we are satisfied that, while **on claim**, the **insured member** has applied their best endeavours to participate in any return to work program recommended by us or their **medical practitioner**, and
- at the end of the **benefit period**, the **insured member** is **totally and permanently disabled**.

The Enhanced Recovery Assistance Benefit is payable in addition to any other benefits which may be payable under the **policy**. Only one Enhanced Recovery Assistance Benefit is ever payable in respect of an **insured member**.

5. BENEFIT LIMITATIONS

5.1 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**
- by an **insured member's** intentional self-inflicted act
- by pregnancy, unless the **insured member** is **disabled** for more than three months after the end of the pregnancy, in which case the **waiting period** is deemed to start on the later of the date **total disability** begins and the end of the pregnancy.

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

We may reduce or refuse to pay any benefits:

- while the **insured member** is imprisoned or on remand in a correctional or rehabilitation facility
- if you or the **insured member** do not comply with our claim requirements, and
- where we have not received notice at the time an **insured member's disability** starts, to the extent our assessment or management of the **insured member's** claim is prejudiced.

We cannot reimburse any expenses which:

- we are not permitted by law to reimburse, or
- are regulated by the *National Health Act 1953* (Cth) or the *Private Health Insurance Act 2007* (Cth).

5.2 Pre-existing conditions

If an **insured member** is insured for **new events cover** pursuant to clause 2.3.3, we will not pay any benefit for a **disability** 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, we will not pay any benefit for a **disability** 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**.

5.3 Reduction of the monthly benefit

5.3.1 Other payments

The Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Early Cash Benefit and Trauma Recovery Benefit will be reduced by **other payments**.

With respect to **other payments** payable as a lump sum, with all or a part of that lump sum paid in compensation for loss of earnings that cannot be allocated to specific months, we will convert that part of the compensation for loss of earnings to income on the basis of 1% of the loss of earnings component for each month that we pay the monthly benefit, for a maximum of eight years. The balance of the lump sum, if any, will not be offset.

5.3.2 Claims incurred on or after age 65

If the **insured member's disability** commences when the **insured member** is age 65 or older and the **benefit expiry age** applicable to the **insured member** is greater than 65 years, the **maximum monthly benefit level** applicable to the **insured member** is reduced to the Maximum Monthly Benefit Payable that corresponds to the **insured member's** age when **disability** commenced as set out in the table below, or the **maximum replacement ratio**, whichever is the lesser:

Age at commencement of disability	Maximum monthly benefit payable
65	$10,000
66	$8,000
67	$6,000
68	$4,000
69	$2,000

5.4 Repayment of benefits

Any benefit paid by us must be repaid either:

- to the extent we were entitled to reduce the benefit paid, but did not do so for any reason
- to the extent that the benefit was paid in respect of an **insured member**, where all or part of the benefit was not payable under the terms of the **policy**.

5.5 Overseas travel

If an **insured member** travels or resides overseas for a period in excess of six consecutive months while **on claim**, payment of any benefits by us will cease.

If the **insured member** returns to permanently reside in Australia and provides us with satisfactory evidence of their continuous **disablement**, we may at our discretion, recommence benefits payments. If we recommence benefit payments, we will not make any payment in respect of a period where the **insured member** was not entitled to benefits in accordance with this clause.

5.6 Multiple disabilities

We pay one monthly benefit at a time, even if the **insured member** suffers more than one illness or injury. This applies to the Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Trauma Recovery Benefit and Early Cash Benefit.

If we pay the monthly benefit to the end of the **benefit period**, we will not pay any further benefit in respect of any injury or illness suffered by an **insured member** after the end of the **benefit period**, where the **insured member** has remained in your employment and has been continuously **disabled** since the end of the **benefit period** as a result of the initial injury or illness for which he or she was **on claim**.

5.7 Other limitations

Your **policy schedule** may contain certain exclusions or limitations. We will not pay any benefits under the **policy** for anything we have specifically excluded as shown in your **policy schedule** or **decision note** issued in respect of an **insured member**.

5.8 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.

6. COSTS

6.1 Premium rates

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

6.2 Payment of premiums

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

6.3 Minimum annual premium

Your annual premium will be at least the minimum annual premium (exclusive of stamp duty) shown in your **policy schedule**.

If the premium we calculate is less than the minimum annual premium, you must pay the minimum annual premium, plus stamp duty. If you do not pay the minimum annual premium, we may cancel or terminate the **policy** by giving you at least 30 days written notice in accordance with clause 8.6.

We may vary the minimum annual premium in accordance with clause 6.7.

6.4 Calculating the premium

We calculate the premium which will apply to the **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 to 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 2.14.

We will calculate the premium having regard to the number of **insured members** covered under the **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 the **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
- gender 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 6.11 for further information
- the claims history of your plan, and
- applicable commission levels agreed between you and an intermediary.

6.5 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, the **policy** may not commence or we may cancel your **policy** 30 days after we give you notice of cancellation in writing.

6.6 Guarantee of premium rates

Subject to clause 6.7, premium rates will be guaranteed from the **policy start date** to the end of the **premium rate guarantee period**.

6.7 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 8.1 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.

6.8 Misstatement of age

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

6.9 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 GSC 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 GSC Insurance product.

6.9.1 Stamp duty

Stamp duty is payable in addition to the premium rates.

This is a charge levied by each state and territory government (except the ACT) and we pass it on to the appropriate state or territory revenue office. The amount of stamp duty payable varies according to the **insured member's** state or territory of residence and may change from time to time.

An up-to-date listing of the percentage or dollar amount of duty that applies to **insured members'** premiums can be obtained by contacting Group Risk Insurance Administration on 1800 648 921.

6.9.2 Other expenses

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

- any federal, state or territory taxes and charges or any other government charges (the premium rates do not include such taxes, duties and charges, but references in the **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 the **policy**.

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

6.9.3 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.

6.10 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.

6.11 Discounts

6.11.1 Combined plan discount

If you establish a OnePath Life Group Life Insurance policy with the same **policy start date** and annual **review date** as this OnePath Life GSC 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 Life Insurance policy remains the same as the annual **review date** chosen for the GSC **policy**, and both policies remain in force.

6.11.2 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 6.5. All details will be outlined in the **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.

6.12 When we will waive the premium

We will waive the payment of the premium in respect of an **insured member** receiving a Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Recovery Assistance Benefit, Early Cash Benefit (if applicable) or Trauma Recovery Benefit (if applicable).

7. CLAIMS

7.1 Notification of claim

You must advise us in writing of any claim or potential claim as soon as it is reasonably possible for you to do so.

You must make all reasonable efforts to:

- ensure the **insured member** knows he or she must advise you as soon as he or she becomes **disabled**, and
- make enquiries if an **insured member** is on sick leave.

7.2 How to make a claim

We will generally send claim forms to you or the **insured member** 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.

Claim forms must be completed within 30 days of the **insured member** first becoming **disabled** or as soon as it is reasonably possible for the **insured member** to do so.

In the event of the death of an **insured member**, you or a representative acting on behalf of the **insured member's** estate should notify us within 30 days of the death of the **insured member**, or as soon as reasonably possible.

7.3 Payment of a claim

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

- where the **insured member** was accepted (or an increase in benefit was accepted) under automatic acceptance or our transfer terms, that you and the **insured member** met all our requirements
- the **insured member's disability** or other entitlement to claim
- the **insured member's** age
- any income received during the **benefit period**
- the **insured member's salary**, and
- any relevant payments received during the **benefit period**.

You or the **insured member** must establish, and continue to demonstrate, entitlement by:

- providing medical reports from treating **medical practitioners** (at your, or the **insured member's**, expense)
- when reasonably required by us (and at our expense), being examined by a **medical practitioner** we nominate who must confirm the condition
- providing pathology, blood tests, x-ray or other appropriate evidence
- the **insured member** being under the regular care of, and **following the advice of a medical practitioner**, and
- when reasonably required by us (and at our expense) the **insured member** will:
  - undergo an employability assessment
  - be interviewed
  - agree to an audit of his or her financial circumstances, and
  - provide any other relevant information.

If the **insured member** fails to attend any pre-arranged consultation, he or she will be liable to pay any charges incurred by us in arranging the consultation.

7.4 Reimbursement of claim costs

Any costs incurred outside Australia in connection with a claim in respect of an **insured member** who is overseas in accordance with clause 2.10, 2.11 or 2.12 must be paid by you or the **insured member**. We may agree to reimburse these costs at our discretion.

8. GENERAL CONDITIONS

8.1 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 6.3.

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.

8.2 Administration

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

8.3 Profit sharing

Generally we do not offer profit sharing for GSC insurance policies.

Most plans will be non-profit, but in some cases we may offer a self-experience profit-sharing formula.

Where we offer profit sharing, it will be detailed in your **quotation summary**.

8.4 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 the **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.

8.5 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.

If you do not advise us of a change in an **insured member's salary** (or if included, performance-related annual bonuses and commissions) in accordance with this clause, and pay any additional premium if an increase in cover is accepted without application, then we may pay a benefit based on the **insured member's salary** previously advised to us.

8.6 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 6.3 and 6.5 or 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 of receipt from our written notice.

8.7 Governing law

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

8.8 Currency

All payments to, or from, us are to be made in Australian currency.

If the **insured member** is working overseas, the **salary** of the **insured member** must be advised to us in Australian currency and we will take no responsibility for foreign exchange risk.

8.9 Statutory fund

The **policy** is issued from the statutory fund shown in the **policy schedule**, but does not give you any rights of ownership of the assets of that fund. The statutory fund from which the **policy** is issued will depend on whether it is ordinary or superannuation business.

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

8.10 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**.

9. 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 the injury or death of the **insured member**.

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

- one of the contributing causes of injury and death 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
- the **insured member** was injured or died as a result of an activity in respect of which he or she 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, or
- 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 the like). Reserve duty is excluded.

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
- 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 means the terms set out in clause 2.3.

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

Benefit period is the maximum period of time that a benefit will be paid for any one illness or injury while the **insured member** is **totally disabled** or **partially disabled**.

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**.

Contractor means a person is performing all the normal duties of his or her work and is working on a contracted basis for at least 15 hours per week and is under a fixed term contract of no less than one year in duration.

Consumer Price Index/CPI means the Consumer Price Index (all groups: all capital cities) published by the Australian Bureau of Statistics or a replacement index we select.

Date of disability/date of disablement means:

- in relation to **disability**,
  - the first date, after ceasing working in his or her **usual occupation**, the **insured member** attends a medical consultation with a **medical practitioner** and is certified as having no capacity to perform one or more duties of his or her **usual occupation** necessary to produce **salary**.
- in relation to **TPD**, the first day after the expiry of the **TPD waiting period**.

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

Disability/Disabled/Disablement means **total disability** or **partial disability** in relation to an **insured member** (as the context requires).

Eligibility criteria means the rules for eligibility set out in clause 2.1.

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

Emergency transportation means emergency transportation where, in the opinion of a **medical practitioner**, an **insured member** requires immediate treatment in circumstances where there is a serious threat to the **insured member's** life or health. Ambulance transportation is excluded.

Escalation factor is defined in the **policy schedule**.

Event date means (in relation to **TPD**) the first day of the **TPD waiting period** during which the **insured member**, in our opinion, has not worked solely because of injury or illness.

Following the advice of a medical practitioner means the **insured member** is following the regular advice of the treating **medical practitioner** on an ongoing basis including recommended courses of treatment and rehabilitation.

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

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

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.

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.

Immediate family member means a:

- spouse
- son, daughter, father, mother, brother, sister, father-in-law or mother-in-law, or
- person in a bona fide domestic living arrangement and is financially interdependent. You must provide us with satisfactory evidence that there is an established and ongoing interdependency.

Indemnity contract means an individual policy which calculates a claimant's benefit entitlements based on his or her income at the time of claim rather than at the time the claimant's application for cover under that policy was accepted.

Insured benefit means any benefit provided under the **policy** as the context requires including the Total Disability Benefit, the Partial Disability Benefit, the Specific Injury Benefit and any optional 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 the **policy** and is either an employee or **contractor** of an employer or partner in a partnership where the **policy** is employer owned, or a member of a complying superannuation fund where the **policy** is owned by a trustee of a complying superannuation fund.

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 monthly benefit level means the maximum monthly benefit level shown in the **policy schedule**.

Maximum replacement ratio means the maximum percentage of the **insured member's** monthly **salary** we will pay as a monthly benefit, and is the lesser of:

- 75% of the **insured member's** monthly **salary**, or
- the maximum replacement ratio stated 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 speciality, and who is not 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. This includes, but is not limited to, the following:

- name
- date of birth
- sex
- occupation
- state, territory and country of residence
- **salary** (in Australian currency)
- employee/member status (i.e. whether the person is on unpaid or paid leave)
- date the person joined the company
- date the person first satisfied the **eligibility criteria**, and
- if required, an **at work certificate**.

Minimum benefit entry age is 15 years.

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).

Normal business day means any day which is not a weekend or a public holiday, on which businesses normally operate.

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

On claim means the dates for which you are eligible to receive a benefit in respect of the **insured member** under the **policy**.

Other payments means amounts payable (including settlement* or commutation amounts) in respect of the **insured member**:

- by way of a statutory insurance scheme that pays amounts for, or calculated by reference to, loss of income or earning capacity (including amounts for past or future economic loss) as a result of injury or illness. Examples of such schemes include: workers' compensation and compulsory third-party motor vehicle insurance
- in respect of, or calculated by reference to, loss of income or earning capacity (including amounts for past or future economic loss) as a result of injury or illness, whether the amount is payable under legislation or otherwise
- by way of damages under common law, in respect of, or calculated by reference to, loss of income or earning capacity (including amounts for past or future economic loss) as a result of injury or illness
- in respect of, or calculated by reference to, any paid parental leave, where the **insured member** suffers **disability** during a period of parental leave
- for the purpose of income replacement, under any other disability, injury or illness insurance policy.

It does not include amounts for, or calculated by reference to:

- Disability Support Pension payable by Centrelink or its successors
- sick leave
- annual leave
- redundancy payments
- long service leave entitlements
- investment income
- total and permanent disability benefits, trauma benefits or terminal illness benefits.

* To avoid doubt, settlement amounts include but are not limited to settlements made out of court in respect of legal proceedings or contemplated legal proceedings.

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

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

Partial disability/partially disabled means in our opinion based on medical or other evidence satisfactory to us, solely as a result of illness or injury, the **insured member** is:

- capable of performing their **usual occupation** in a reduced capacity, and only has capacity to earn a monthly income that is less than their monthly **salary**, or
- incapable of performing one or more duties of his or her **usual occupation** necessary to produce **salary**, gainfully working and receiving monthly income that is less than their monthly **salary**, and
- **following the advice of a medical practitioner** in relation to their illness or injury for which they are claiming.

The **insured member** will be considered capable of performing their **usual occupation** in a reduced capacity even if such work is not made available to the **insured member**.

Participating employer means the **policy owner** (if the **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 GSC Insurance?' and 'How to read this PDS and Policy' on page 3 of this PDS and Policy
- the **policy schedule**
- any notices issued or received by us under the **policy**
- the **decision note** (if applicable) and
- any written variation to the **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 start date shown in the **policy schedule**.

Pre-existing condition means an injury which 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**.

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 GSC Insurance product from us.

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

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

Reasonably apparent means a reasonable person in the circumstances could be expected to have been aware of the symptoms.

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

Salary means:

- where the **insured member** is employed, the annual cash salary remuneration which the **insured member** receives from their employer for the **insured member's** personal exertion immediately prior to the **insured member** becoming **disabled**. If salary includes non-cash benefits or fringe benefits provided as a direct substitute for salary or the inclusion of performance-related commission and bonuses, this will be shown in the **policy schedule**, or
- where the **insured member** directly or indirectly owns all or part of the business from which he or she earns his or her usual income, the gross amount earned by the business in the 12 months immediately prior to the **insured member** becoming **disabled**, as a direct result of the **insured member's** personal exertion or activities through his or her **usual occupation** after allowing for the costs and expenses incurred in deriving that income.

To avoid doubt, the requirement that the salary must be received for the **insured member's** personal exertion will not apply if the **insured member** becomes **disabled** during a period of paid or unpaid leave. When this happens, we will calculate the **insured member's** monthly benefit based on the salary applicable to the **insured member** immediately prior to the **insured member** becoming **disabled**, as confirmed by you at the time of claim.

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.

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**.

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 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 under the **policy**.

Total disability/totally disabled means solely as a result of illness or injury, the **insured member** is:

- medically certified as being incapable of performing one or more duties of his or her **usual occupation** necessary to produce **salary**
- not engaged in any occupation, and
- **following the advice of a medical practitioner** in relation to their illness or injury for which they are claiming.

The **insured member** won't be considered unable to perform a duty of their **usual occupation** if he or she refuses to accept:

- any reasonable omission, modification or substitution of that duty, or
- the use of any appropriate assistive aids that would enable the **insured member** to perform that duty.

Totally and permanently disabled/TPD means, in relation to the optional Recovery Assistance Benefit and Enhanced Recovery Assistance Benefit, the **insured member** is **gainfully working** at the time they suffer an illness or injury and in our opinion based on medical or other evidence satisfactory to us, solely because of that injury or illness, the **insured member**:

- has not worked during the entire **TPD waiting period**, and
- as at the **date of disablement** is unlikely ever to work in any **gainful employment** or which he or she is reasonably suited by education, training or experience.

TPD waiting period means a 183 consecutive day period.

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

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.

Usual occupation means the occupation in which the **insured member** is regularly engaged at the time they suffer an injury or illness which leads to their **disability**.

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 is the number of consecutive days for which an **insured member** must be **totally disabled** or **partially disabled**, as the case may be, before the Total or Partial Disability Benefit is payable.

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**.

Early Cash Benefit Conditions and Trauma Recovery Events

Activity/Activities of daily living are:

- 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.

Alzheimer's disease (diagnosed) means the unequivocal diagnosis of Alzheimer's disease, made by a **medical practitioner** who is a consultant neurologist or geriatrician, confirming dementia due to failure of the brain function with cognitive impairment for which no other recognisable cause has been identified.

Angioplasty – triple vessel means the undergoing of angioplasty (with or without insertion of a stent or laser therapy) to three or more coronary arteries during a single surgical procedure, or two procedures no more than two months apart, that is considered necessary on the basis of angiography evidence to correct the narrowing or blockage of three or more coronary arteries.

Aortic surgery means the undergoing of surgery or endovascular repair that is considered necessary to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta.

The insertion and/or removal of intra-arterial balloon pumps into and/or out of the aorta are not covered.

Aplastic anaemia (requiring treatment) means the acquired bone marrow failure that:

- results in anaemia, neutropenia and thrombocytopenia, and
- requires treatment with one or more of the following:
  - marrow stimulating agents
  - bone marrow transplantation
  - peripheral blood stem cell transplantation
  - blood product transfusions
  - immunosuppressive agents.

Benign brain tumour (permanent impairment or requiring surgical intervention) means the diagnosis of a benign (non-malignant) tumour in the brain or an acoustic neuroma which results in the **insured member:**

- suffering at least 25% permanent whole person impairment as defined in the American Medical Association *Guides to the Evaluation of Permanent Impairment,* 5th edition, or an equivalent guide to impairment approved by us, or
- being permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another adult person, or
- undergoing a craniotomy to remove the tumour.

Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.

Blindness (permanent in both eyes) means the permanent loss of sight in both eyes, whether aided or unaided, as a result of illness or injury such that visual acuity is 6/60 or less in both eyes, or such that the visual field is reduced to 20 degrees or less of arc.

Burns (severe) means tissue injury caused by thermal, electrical or chemical agents causing full thickness burns to either:

- 20% or more of the body surface area as measured by the 'Rule of Nines' or the Lund and Browder Body Surface Chart
- 50% or more of both hands, requiring surgical debridement and/or grafting
- 50% or more of both feet, requiring surgical debridement and/or grafting
- 50% or more of the face, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

Cancer (excluding less advanced cases) means the presence of one or more malignant tumours including leukaemia, lymphoma and Hodgkin's disease characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

- Melanomas are covered if they either:
  - have a TNM classification of at least T1b
  - have evidence of ulceration
  - are at least Clark Level 3 depth of invasion
  - are at least 1.0mm Breslow thickness
  - as determined by histological examination.
- Prostatic cancer is covered if it is either:
  - a TNM classification of at least T1c
  - a Gleason score of at least 6
  - required to have 'major interventionist treatment' to arrest the spread of malignancy.

    'Major interventionist treatment' includes removal of the entire prostate, radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment.
- Carcinoma in situ* of the breast is covered if either:
  - treatment requires the removal of the entire breast
  - treatment requires breast conserving surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy).
- Carcinoma in situ* of the testicle is covered if treatment requires the removal of the testicle.

* Carcinoma in situ is covered where the procedures are required to be performed specifically to arrest the spread of malignancy and are considered the appropriate and necessary treatment.

The following cancers are not covered:

- all hyperkeratoses or basal cell carcinomas of the skin
- all other melanomas
- all other prostatic cancers
- all squamous cell carcinomas of the skin unless there has been a spread to other organs
- chronic lymphocytic leukaemia less than Rai Stage 1
- all other tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2, and CIN-3), or which are histologically described as pre malignant, or which are classified as FIGO Stage 0, or which have a TNM classification of Tis. 'FIGO' refers to the staging method of the International Federation of Gynaecology and Obstetrics.

Cardiomyopathy (permanent and irreversible) means impaired ventricular function of variable aetiology resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Chronic kidney failure (end stage) means end stage renal disease which requires permanent dialysis or renal transplantation.

Chronic liver disease (end stage) means end stage liver failure together with permanent jaundice, ascites or encephalopathy.

Chronic lung disease (end stage) means end stage lung disease requiring permanent supplementary oxygen, as confirmed by a specialist **medical practitioner**.

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**.

Coma (of specified severity) means total failure of cerebral function characterised by total unconsciousness and unresponsiveness to all external stimuli, resulting in a documented Glasgow Coma Scale of 6 or less, for a continuous period of at least 72 hours.

Medically induced comas are excluded.

Coronary artery bypass surgery means the undergoing of coronary artery bypass surgery that is considered necessary to treat coronary artery disease causing inadequate myocardial blood supply. Surgery does not include angioplasty, intra-arterial procedures or non-surgical techniques.

Deafness (permanent in both ears) means the total and permanent loss of hearing in both ears to the extent that the loss is greater than 90 decibels across all frequencies. Deafness (permanent in both ears) does not cover the situation where an **insured member** can hear, either partially or fully, with the assistance of an aid (apart from a Cochlear implant).

Dementia (diagnosed) means the unequivocal diagnosis of dementia, made by a **medical practitioner** who is a consultant neurologist or geriatrician, confirming dementia due to failure of the brain function with cognitive impairment for which no other recognisable cause has been identified. A Mini-Mental State Examination score of 24 or less is required.

Diabetes (severe) means that a **medical practitioner** who is a specialist physician has confirmed that at least two of the following complications have occurred as a direct result of diabetes:

- nephropathy requiring regular dialysis or a kidney transplant
- proliferative retinopathy
- peripheral vascular disease leading to chronic infection or gangrene, requiring a surgical procedure
- neuropathy including either:
  - irreversible autonomic neuropathy resulting in postural hypotension, and/or motility problems in the gut with intractable diarrhoea
  - polyneuropathy leading to severe mobility problems due to sensory and/or motor deficits.

Encephalitis (permanent and irreversible) means the severe inflammatory disease of the brain resulting in neurological deficit causing either:

- a permanent impairment of at least 25% of whole person function 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, or
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Head trauma (permanent and irreversible) means cerebral injury resulting in permanent neurological deficit, as confirmed by a **medical practitioner** who is a consultant neurologist and/or an occupational physician, causing either:

- a permanent impairment of at least 25% of whole person function 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, or
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Heart attack (diagnosed) means the death of a portion of heart muscle arising from inadequate blood supply to the relevant area. The diagnosis must be supported by the following being present and consistent with acute myocardial infarction (and not due to medical intervention):

- rise and/or fall of cardiac biomarkers (such as Troponins or cardiac enzyme CK-MB), with at least one value above the 99th percentile of the upper reference range of laboratory normal, and
- one of the following:
  - acute new cardiac symptoms and signs consistent with myocardial infarction
  - new ST elevation
  - new T wave changes
  - new Left bundle branch block (LBBB)
  - new pathological Q waves.

If the above test results are inconclusive, not undertaken or the tests are superseded due to technical advances, we will consider other appropriate and medically recognised tests that unequivocally diagnose myocardial infarction of the same degree of severity, or greater, as outlined above.

The following are not covered under this definition:

- other acute coronary syndromes including but not limited to angina pectoris, myocardial infarctions arising from elective percutaneous coronary interventions or coronary bypass grafting that do not satisfy the requirements of the ESC/ACCF/AHA/WHF 3rd Edition of the 'universal definition of myocardial infarction', and
- elevations of troponins in the absence of overt ischaemic disease (for example but not limited to, myocarditis, apical ballooning, cardiac contusion, pulmonary embolism or drug toxicity).

Heart valve surgery means the undergoing of surgery that is considered necessary to correct or replace cardiac valves as a consequence of heart valve defects or abnormalities but does not include angioplasty, intra-arterial procedures or non-surgical techniques.

HIV (medically acquired) means the accidental infection with Human Immunodeficiency Virus (HIV) which we believe, on the balance of probabilities, arose from one of the following medically necessary events which must have occurred to the **insured member** in Australia as a result of a procedure authorised by a recognised health professional:

- a blood transfusion
- transfusion with blood products
- organ transplant to the **insured member**
- assisted reproductive techniques
- a medical procedure or operation performed by a doctor or a dentist.

Notification and proof of the incident will be required via a statement from the appropriate Statutory Health Authority that the infection is medically acquired.

We must have open access to all blood samples and be able to obtain independent testing of such blood samples.

There will be no cover and no benefit payable if a medical 'cure' is found for AIDS or the effects of HIV, or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any Australian Government approved treatment which renders HIV inactive and non-infectious.

HIV infection acquired by any other means, including infection as a result of sexual activity or recreational intravenous drug use, is excluded.

HIV (occupationally acquired) means infection with the Human Immunodeficiency Virus (HIV) where the virus was acquired as a result of an accident occurring while performing the **insured member's** usual occupation and sero-conversion of the HIV infection must occur within six months of the accident.

HIV infection acquired by any other means including sexual activity or recreational intravenous drug use is excluded.

Any accident creating a possible claim must be:

- reported to the relevant authority or employer within seven days of the accident, and
- reported to us with proof of the accident within 30 days of the accident, and
- supported by a negative HIV antibody test taken after the accident.

We must have open access to all blood samples and be able to obtain independent testing of such blood samples.

There will be no cover and no benefit payable if a medical 'cure' is found for AIDS or the effects of HIV, or a medical treatment is developed that prevents AIDS occurring. 'Cure' means any Australian Government approved treatment, which renders HIV inactive and non-infectious.

Hydrocephalus (requiring surgical intervention) means excessive cerebrospinal fluid within the brain resulting from injury, infection or tumour, which causes increased intra-cranial pressure. There must be a requirement of surgical intervention to treat the condition.

Intensive care (prolonged) means the **insured member** is in an authorised intensive care unit of an acute care hospital for at least 10 consecutive days and requires continuous mechanical ventilation by tracheal intubation for five consecutive days (24 hours per day).

Loss of independent existence (permanent) means a condition whereby we have determined the **insured member** is totally and irreversibly unable to perform at least two of the five **activities of daily living** without the assistance of another adult person.

Loss of speech (permanent) means the total and permanent loss of the ability to produce intelligible speech due to permanent damage to the larynx or its nerve supply or a disorder affecting the speech centres of the brain. Loss of speech related to any psychological cause is excluded.

Loss or paralysis of limb (permanent) means the total and permanent loss of use of a whole hand or a whole foot as a result of illness or injury, or the total and permanent loss of the use of one arm or one leg as a result of paralysis.

Meningitis and/or **meningococcal disease (permanent and irreversible)** mean meningitis or meningococcal septicaemia causing either:

- a permanent impairment of at least 25% of whole person function 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
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Motor neurone disease (diagnosed) means the unequivocal diagnosis of a progressive form of debilitating motor neurone disease, as confirmed by a **medical practitioner** who is a consultant neurologist.

Multiple sclerosis (diagnosed) means the unequivocal diagnosis of multiple sclerosis made by a **medical practitioner** who is a consultant neurologist on the basis of confirmatory neurological investigation. There must be more than one episode of confirmed neurological deficit.

Muscular dystrophy (diagnosed) means the unequivocal diagnosis of muscular dystrophy, as confirmed by a **medical practitioner** who is a consultant neurologist on the basis of confirmatory neurological investigation.

Open heart surgery means the undergoing of open heart surgery that is considered necessary to correct a cardiac defect, cardiac aneurysm or cardiac tumour.

Organ transplant (major) means the **insured member:**

- undergoes human-to-human or animal-to-human organ transplant, or
- has been placed on an Australian waiting list approved by us, or
- undergoes permanent mechanical replacement for one or more of the following organs:
  - kidney
  - heart
  - lung
  - liver
  - pancreas
  - small bowel
  - the transplant of bone marrow (excluding autologous).

Stem cell transplant performed to treat auto-immune disease or for cosmetic purposes is excluded from transplant.

This treatment must be considered medically necessary and the condition affecting the organ deemed untreatable by any other means other than organ transplant, as confirmed by a specialist physician.

Osteoporosis (before age 50) means the **insured member** is unequivocally diagnosed with osteoporosis by bone density scanning and suffers at least two vertebral body fractures or a fracture of the neck of femur due to osteoporosis.

The diagnosis of osteoporosis must occur prior to the age of 50.

Parkinson's disease (diagnosed) means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of:

- rigidity
- tremor
- akinesia from degeneration of the nigrostriatal system.

All other types of parkinsonism, including secondary parkinsonism due to medication, are excluded.

Pneumonectomy means the undergoing of surgery to remove an entire lung. This treatment must be deemed the most appropriate treatment and medically necessary.

Primary pulmonary hypertension (Idiopathic pulmonary arterial hypertension with permanent impairment) means primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation and resulting in significant physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Rheumatoid arthritis (severe) means the unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. To fulfil the criteria for severe rheumatoid arthritis there must be all of the following:

- diagnosis of rheumatoid arthritis as specified by the '2010 Rheumatoid Arthritis Classification Criteria'*
- symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or four large joints (ankles, knees, hips, elbows, shoulders)
- have failed at least six months of intensive treatment with two conventional disease-modifying antirheumatic drugs (DMARDs). This excludes corticosteroids and non-steroidal anti-inflammatories
- the disease must be progressive and non-responsive to all conventional therapy^.

* American College of Rheumatology and European League Against Rheumatism.

^ Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for rheumatoid arthritis.

Stroke (diagnosed) means the diagnosis of a stroke that meets all of the following:

- cerebrovascular incident producing neurological deficits lasting more than 24 hours, and
- evidenced by acute onset of new objective neurological signs and symptoms, and
- evidenced by neuro-imaging changes consistent with the signs and symptoms, and
- confirmed by a **medical practitioner** who is a consultant neurologist.

Includes where there is infarction of brain tissue, intracranial or subarachnoid haemorrhage or embolisation from extracranial source.

Transient ischaemic attacks, migraine, vascular disease affecting the eye, optic nerve or vestibular functions, and incidental imaging findings (CT or MRI brain scan without clearly related clinical symptoms (silent stroke)), or as a result of hypoxia and trauma are excluded.

If neuro-imaging is unavailable, then we will consider a claim based on conclusive evidence of unequivocal diagnosis by two specialist consultant neurologists.

Systemic sclerosis (permanent and irreversible) means the unequivocal diagnosis of systemic sclerosis, made by a **medical practitioner** who is a consultant physician, characterised by skin thickening accompanied by various degrees of tissue fibrosis and chronic inflammatory infiltration in visceral organs, causing either:

- a permanent impairment of at least 25% of whole person function 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
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Terminal illness 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 under the **policy**.

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