ANZ SMART CHOICE SUPER FOR EMPLOYERS AND THEIR EMPLOYEES
ZURICH AUSTRALIA LIMITED
FORTESCUE METALS GROUP LTD SUPERANNUATION PLAN

INSURANCE GUIDE | 1 DECEMBER 2024
DEATH AND TOTAL PERMANENT DISABLEMENT COVER
INCOME PROTECTION COVER

ANZ SMART CHOICE SUPER

ENTITY DETAILS IN THIS INSURANCE GUIDE

Name of legal entity	Registered numbers	Abbreviated terms used throughout this Insurance Guide
Retirement Portfolio Service	ABN 61 808 189 263 RSE R1000986	Fund
OnePath Custodians Pty Limited	ABN 12 008 508 496 AFSL 238346 RSE L0000673	OnePath Custodians, OPC, Trustee, us, we, our
Zurich Australia Limited	ABN 92 000 010 195 AFSL 232510	Insurer
Australia and New Zealand Banking Group Limited	ABN 11 005 357 522 AFSL 234527	ANZ
Oasis Asset Management Limited	ABN 68 090 906 371 AFSL 553529	Oasis Asset Management, Administrator
Fortescue Metals Group Ltd	ABN 57 002 954 872	Employer
Fortescue Metals Group Ltd Superannuation Plan		Employer Plan

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IMPORTANT INFORMATION

This Insurance Guide must be read together with the ANZ Smart Choice Super for employers and their employees Product Disclosure Statement (ANZ Smart Choice Super PDS) dated 1 December 2024.

ANZ Smart Choice Super for employers and their employees (**ANZ Smart Choice Super**) is part of the Fund. When an employer joins ANZ Smart Choice Super, their nominated employees become members of the Fund. OnePath Custodians is the Trustee of the Fund and is the issuer of this Guide.

This Guide is issued for the information of new members joining the Employer Plan on or after the issue date of this Guide. Other members should refer to the insurance guide that they received on joining the Employer Plan because the information in this Guide might not be accurate for them.

OPC is a member of the Insignia Financial group of companies, comprising Insignia Financial Ltd (ABN 49 100 103 722) and its related bodies corporate (Insignia Financial Group). The ANZ brand is a trademark of ANZ and is used by OPC under licence from ANZ.

The information in this Guide is of a general nature and has been prepared without taking into account your objectives, financial situation or needs. You should obtain financial advice tailored to your personal circumstances. Before acting on the information or advice, you should consider whether it is appropriate for you, having regard to your objectives, financial situation and needs. You should obtain a copy of the ANZ Smart Choice Super PDS before making any decision about whether to acquire, or to continue to hold, the superannuation product. You can obtain a copy of the PDS by contacting Customer Services on 13 12 87.

The Fund is governed by a trust deed (**Trust Deed**). Together with superannuation law, the Trust Deed sets out the rules and procedures under which the Fund operates and the Trustee's duties and obligations. If there is any inconsistency between the Trust Deed and the PDS or this Guide, the terms of the Trust Deed prevail. A copy of the Trust Deed is available from us at no extra charge.

In the case of this Guide, cover is provided by Zurich Australia Limited (**the Insurer**) under group policies issued to the Trustee. In respect of such policies, the Trustee reserves the right to change insurer, or vary the Benefits or Insurance fee rates from time to time. A separate policy for Death and Total and Permanent Disablement (**TPD**) and Income Protection arrangements applies and each will be referenced as '**Policy**' throughout this Guide.

The insurance is provided under a contract between the Trustee and Zurich Australia Limited (**ZAL**). If there is any conflict between this document and the insurance contract with ZAL, the insurance contract will prevail.

Where the Insurer imposes loadings or exclusions as a result of the member's health, pastimes or other individual circumstances, the Insurer will write to the Trustee and provide specific details relating to the member's cover. The member will receive notification where this occurs.

The Trustee is responsible for the contents of this Guide.

The ANZ Smart Choice Super PDS comprises the following documents:

- ANZ Smart Choice Super for employers and their employees Product Disclosure Statement dated 1 December 2024;
- ANZ Smart Choice Super for employers and their employees Additional Information Guide (AIG);
- ANZ Smart Choice Super for employers and their employees Fees Guide;
- ANZ Smart Choice Super Buy-Sell Spread Guide; and
- This Guide.

The information in this document forms part of the ANZ Smart Choice Super PDS dated 1 December 2024.

The purpose of this Guide is to give you more information and/or specific terms and conditions referred to in the PDS. You should consider all that information before making a decision about ANZ Smart Choice Super.

If you invest in ANZ Smart Choice Super, you can access a copy of the PDS, the AIG and any matter that is applied, adopted or incorporated in the PDS from our website at www.anz.com.au/smartchoicesuper > Downloads – important documents.

To the extent that you are provided with cover as set out in this Guide, these terms and conditions will prevail over those set out in the ANZ Smart Choice Super for employers and their employees Insurance Guide dated 1 December 2024. This Guide, the link to which was included in your Welcome Pack or Insurance Activation Letter (as applicable), contains all the information about the insurance applicable to your Employer Plan.

You may also request a copy of all information (including this Guide) at no extra charge by contacting Customer Services on 13 12 87. A Target Market Determination for the product is available at www.anz.com.au/support/rates-fees-terms/target-market-determinations/

Trustee contact details

OnePath Custodians Pty Limited
ABN 12 008 508 496 AFSL 238346 RSE L0000673

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INSURANCE IN ANZ SMART CHOICE SUPER

This Guide has been prepared to provide general information about the insurance your **Employer** has arranged with the **Trustee** on behalf of its employees who are members of your **Employer Plan**. It explains the terms and conditions of the insurance policy (**Policy**) the Trustee has entered into with the Insurer for those members of your Employer Plan who are insured.

This Guide summarises the insurance arrangements for your Employer Plan and is specific to this Employer Plan. If you are not part of this Employer Plan then please contact Customer Services to obtain the relevant and appropriate insurance guide for your arrangement.

Each Policy, Policy Schedule and endorsements to the Policy form the complete terms and conditions between the Insurer and the Trustee. This Guide sets out the main terms of the Policy covering your Employer Plan within ANZ Smart Choice Super. This Guide is not a legally binding contract of insurance with the Insurer.

Insurance cover is subject to eligibility, acceptance and other terms and conditions of the Policy. In the event of any inconsistency between the terms and conditions of the Policy and this Guide, the Policy terms and conditions will prevail. The Trustee may change the Insurer and/or terms (including Insurance fee rates) of the insurance cover at any time with appropriate notice.

Details of the type of insurance cover and the value of cover in place for you will be shown on your Welcome Pack or Insurance Activation Letter (as applicable) and subsequent Annual Statements each year.

You can also view the sum insured, type of insurance and your insurance fees online. Simply register for ANZ Smart Choice Super online access at www.anz.com.au/smartchoiceaccess or the ANZ App* by calling Customer Services on 13 12 87.

Any material alteration to the terms and conditions outlined in this Guide will be advised in writing.

* Not available on ANZ Plus App.

When reading this Guide, some expressions (shown capitalised, and bold when first used) have a special meaning. The meaning is either explained in context, or in the Appendix or Definitions sections in this Guide.

WHAT TYPE AND AMOUNT OF COVER IS AVAILABLE?

Your Employer can select:

- **Death only Cover,**
- **Death and Total and Permanent Disablement (TPD) Cover,** and/or
- **Income Protection (IP) Cover** (if applicable),

for your Employer Plan.

Your Employer may also choose an amount of **Default Cover** to apply to your Employer Plan.

The type of cover, and the amount of Default Cover, your Employer has selected for your Employer Plan is set out in the Appendix.

The particular benefits arranged for you will be specified in the Welcome Pack sent to you or Insurance Activation Letter (as applicable). Benefits described in this Guide that are not listed in your Welcome Pack may not be available to you.

You may also be eligible to apply for additional cover or cover that differs from the Default Cover applicable to your Employer Plan. This is **Voluntary Cover**.

Please refer to the 'What is Default Cover?' and 'What is Voluntary Cover?' sections of this Guide for further details.

Generally, if you are a member who is eligible for insurance, you will be covered 24 hours a day, 365 days a year, worldwide. The Appendix will specify whether there are any restrictions on cover while you are overseas.

WHEN ARE YOU ELIGIBLE FOR COVER?

To be eligible for the insurance cover established for your Employer Plan, you will generally be required to meet pre-determined eligibility criteria. These criteria, which are set out in the Policy, may include the following items:

- your age;
- occupation;
- employment status;
- residency status; and/or
- hours of work.

The Trustee and the Insurer will assess eligibility to the extent possible based on the details provided by your Employer. To avoid being charged insurance fees for cover you are ineligible for, please ensure that you notify us if you are aware of any reason why you may not be eligible or contact us if you would like to discuss whether you are eligible for Default cover.

If the Trustee and/or the Insurer are told or otherwise become aware that they have accepted insurance fees for cover for which the member is ineligible, the relevant insurance fees will be refunded and no insurance cover will apply for any period during which the member was ineligible. You can elect to cancel, opt-out of or reduce your Default cover at any time by contacting Customer Services on 13 12 87.

For the specific eligibility criteria that applies to your Employer Plan, refer to the Appendix.

WHAT IS DEFAULT COVER?

Your Employer may have chosen Default Cover for your Employer Plan.

Default Cover is cover that is provided to eligible members, without the member needing to provide any evidence of health.

At the time your account is created, your Employer is required to give us the details necessary to:

- determine your eligibility for insurance cover;
- calculate the sum insured that you are entitled to; and
- determine the insurance fee rates and any loadings that are applicable to you.

If your Employer does not provide this information, or until this information is provided, we cannot establish insurance cover in your ANZ Smart Choice Super account. If the information is not provided to us within 180 days of you commencing employment with your Employer, you may no longer be eligible for Default cover. In this instance, you may need to apply to the Insurer for cover, and it will be at the discretion of the Insurer as to whether this cover is provided to you and the terms applicable to that cover.

To ensure your details have been set up correctly by your Employer, check the details found in your Welcome Pack or Insurance Activation Letter (as applicable), including gender, occupational category (if applicable), date of birth, types of insurance and sum insured. If you believe that any of this information is incorrect, you must advise both us and your Employer immediately.

You can also view the sum insured, type of insurance and your insurance fees online. Simply register for ANZ Smart Choice Super online access at www.anz.com.au/smartchoiceaccess or the ANZ App* by calling Customer Services on 13 12 87.

If you are eligible, the level of Default Cover you receive will be determined by the **Benefit Design** for your Employer Plan and specifically the membership category applicable to you. This Plan's Benefit Design is set out in the Appendix. To find out the membership category applicable to you, call Customer Services on 13 12 87. If you believe that you are in an incorrect membership category, please contact both us and your Employer immediately as your eligibility for a future benefit or claim may be affected if you are not in the appropriate membership category.

Default Cover will be provided up to a maximum amount, called the **Automatic Acceptance Limit (AAL)**. The Insurer may have the right to vary or remove the AAL. Refer to the Appendix for further details about the AAL.

Depending on the Benefit Design for your Employer Plan, your **Sum Insured** may also increase or decrease. Any increase in the Sum Insured will be limited to that allowed under the AAL.

Note: If the Benefit Design uses your **Salary** to calculate a benefit, your Employer must notify us of all salary changes as they occur. If we are not notified of a change in salary, and no additional **Insurance fee** has been paid, in the event of a claim the Insurer may pay a lower benefit based on the salary previously advised, or the salary at the last review date.

If you are not eligible to obtain Default Cover, or you have Default Cover, but want a greater amount of cover (including an amount above the AAL), you must apply to the Insurer by submitting an application for Voluntary Cover. For further information see 'What is Voluntary Cover?'.

* Not available on ANZ Plus App.

WHAT IS VOLUNTARY COVER?

Depending on the Benefit Design your Employer has chosen, if you are not eligible for Default Cover, you may be able to apply for:

- Death only Cover;
- Death and TPD Cover; and/or
- IP Cover (if applicable).

The Appendix sets out the types of cover you can apply for and any eligibility criteria you must meet to be able to apply for cover. You cannot apply for TPD Cover without Death Cover.

You can also apply to increase your existing Sum Insured, up to the **Maximum Benefit Level**. The Appendix sets out the Maximum Benefit Level that applies to your Employer Plan. A different Maximum Benefit Level may apply to the different types of cover available.

You can apply to increase the Sum Insured of your Death only cover or TPD Cover, or the Sum Insured for both your Death and TPD Cover. However, you cannot apply to increase the Sum Insured of your TPD Cover above that of your Death Cover.

All applications for Voluntary Cover will be subject to the Insurer's acceptance, following the provision of medical evidence as required by the Insurer. The Insurer reserves the right to offer modified acceptance terms or decline applications for Voluntary Cover for any reason. If the Insurer accepts the Voluntary Cover, they may provide written acceptance to a **Forward Underwriting Limit**. If this is available for your Employer Plan, further details will be provided in the Appendix.

To apply for Voluntary Cover, please contact Customer Services on 13 12 87. You may be contacted by us for additional evidence or further information.

While your application is being considered by the Insurer, you may be eligible for **Interim Accident Cover** (if applicable). Refer to the Appendix for more information.

WHEN DOES COVER COMMENCE?

The commencement date of your cover depends on whether it is Default Cover or Voluntary Cover.

DEFAULT COVER

The commencement date of Default Cover is determined by the terms and conditions applicable to your Employer Plan. In some cases this will also be determined by the category established for you by your Employer. Refer to the Appendix for more information.

VOLUNTARY COVER

Cover commences on the date the Insurer approves your application provided there are sufficient funds in your account to pay for the Insurance fees. We will send a letter to you confirming your cover and the date that your cover commenced.

REDUCING, OPTING-OUT OF OR CANCELLING YOUR COVER

You can reduce the amount of your cover, opt-out of or cancel your cover, at any time by contacting Customer Services on 13 12 87. You cannot reduce your Death **Sum Insured** to an amount below your TPD Sum Insured.

If you reduce, opt-out of or cancel your cover (including Default Cover), your cover may not be increased or reinstated if you wish to do so at a later time. You must apply for any increase in cover.

If you cancel your cover within the first 30 days of its commencement, in some circumstances, some or all of the premiums in respect of any cancelled cover may be refunded to your superannuation account. For more information, call Customer Services.

COVER ACCEPTANCE

Where the Insurer approves your cover or any change in cover on altered terms, your acceptance of these will be required.

14-DAY COOLING-OFF PERIOD

If you feel that the cover does not meet your needs you can request for it to be cancelled, provided you have not made a claim. Your premium will be refunded in full to your superannuation account. You must make this request within 14 days of the cover being issued. Where cover has been duly cancelled under this clause, the Insured Cover will be considered not to have started and no benefits will be payable. The cooling-off period also applies to automatic increases. Should your Sum Insured for your Default cover increase, you can request to cancel the increased portion of the Sum Insured within 14 days from the date we notify you of the increase.

If you exercise this option then your cover will be limited to the amount of cover you had prior to the automatic increase.

COVER FOR LOW-BALANCE ACCOUNTS AND FOR MEMBERS UNDER THE AGE OF 25 YEARS

Under the Putting Members' Interests First (PMIF) legislation, unless covered by an exception, default insurance cover cannot be automatically provided to:

- members under 25 years old; or
- members who have a superannuation balance of less than $6,000 (regardless of their age).

You may still opt-in to add insurance cover to your super account or to retain your existing insurance coverage. You will receive notification explaining the changes and how you can retain your insurance cover.

Please note that an exception may apply if:

- you are an emergency services worker, or work in a 'dangerous occupation' (subject to the Trustee making an exclusion election); or
- your Employer fully meets the cost of your insurance cover.

WHAT ARE THE BENEFITS?

Death Benefit and Terminal Illness Benefit

Subject to any restrictions that apply to your cover, your lump sum **Death Benefit** will be paid if you die while your Death Cover is in place and current.

The amount of your Death Benefit will be your Sum Insured for Death Cover on the date of death plus your superannuation account balance.

You can claim a lump sum Terminal Illness Benefit (if available) if you become **Terminally Ill** while your Death Cover is in place and current. Refer to the 'Type of cover available' section of the Appendix to confirm whether a Terminal Illness Benefit is available with the Employer Plan.

Note: If you have insurance within your super, it is important to understand the terms and conditions as you may not be able to claim a Terminal illness benefit until your life expectancy is limited to 12 months or less. If you withdraw your super balance when your life expectancy is greater than 12 months, you may wish to consider maintaining some money in your super account to keep the account open and to ensure a sufficient balance to pay any insurance fees. Withdrawing your full balance could result in the loss of valuable insurance cover.

Total and Permanent Disablement (TPD) Benefit

You can claim a lump sum TPD Benefit if you become Totally and Permanently Disabled while your TPD Cover is in place and current. The Appendix sets out the definition of **Total and Permanent Disablement** applicable to your Employer Plan and in some cases to your particular category.

You must meet the Insurer's claim requirements and satisfy the Insurer on medical and other evidence that you meet the definition of Total and Permanent Disablement before the insured benefit will be paid.

Other restrictions may also apply to your Employer Plan. Refer to the Appendix for more information.

Amount of Death Benefit and TPD Benefit

The Sum Insured for each type of cover you have cannot exceed the Maximum Benefit Level for that type of cover, as set out in the Appendix.

Generally, payment of a Terminal Illness Benefit will reduce the Sum Insured of your Death Cover. If your **Sum Insured** for Terminal Illness Cover and Death Cover are the same amount, your Death Cover will cease. Refer to the Appendix for more information.

TPD tapering may apply to your TPD Cover. TPD tapering is the gradual reduction of the amount of TPD cover to zero, generally in the final five years before reaching age 65 or the benefit expiry age. If TPD tapering applies to you, more information on this can be found in the Appendix.

Income Protection (IP) Benefit (if applicable)

IP Cover is designed to provide you with a monthly amount while you are Totally Disabled or Partially Disabled, to assist you to meet your day-to-day living expenses during your recovery period, giving you time to focus on your health and recovery.

You can claim the monthly Total Disability Benefit if you are Totally Disabled for longer than the **Waiting Period**, while your IP Cover is in place and current.

You can claim the monthly Partial Disability Benefit if you become Partially Disabled while your IP Cover is in place and current. If your Employer has selected IP Cover for your Employer Plan, the Appendix sets out the definition of Total Disability and/or Partial Disability that applies to your Employer Plan.

You must meet the Insurer's claim requirements and satisfy the Insurer on medical and other evidence that you meet the definition of Total Disability or Partial Disability before the insured benefit is paid. The Insurer may also have ongoing claim requirements.

If your Employer has selected IP Cover to apply to your Employer Plan, the Appendix will set out:

- how the monthly amount of your Total Disability Benefit and Partial Disability Benefit will be calculated;

- the period of time during which the Insurer will pay a Total Disability Benefit or Partial Disability Benefit. This is known as the Benefit Payment Period;
- the **Waiting Period** – the monthly benefit starts to accrue from the day after the end of the Waiting Period; and
- any other terms that apply.

WHEN WE WON'T PAY BENEFITS

The Insurer won't pay benefits in certain circumstances. These circumstances are set out in the Appendix.

It is important that you be aware of when a benefit will not be paid.

WHO IS A BENEFIT PAID TO?

As the insurance Policy is issued to the Trustee and cover is offered to you under the Policy as a member of ANZ Smart Choice Super, the Insurer will pay any Benefits to the Trustee. Once we receive the proceeds from the Insurer these will be held in the superannuation environment, in the ANZ Smart Choice Cash investment option. If you would like to switch this amount to another investment option you can do so online. Simply register for ANZ Smart Choice Super online access at www.anz.com.au/smartchoiceaccess or the ANZ App* by calling Customer Services on 13 12 87. Upon meeting a condition of release, you will receive the benefit amount in accordance with the Fund's Trust Deed, adjusted positively or negatively, for investment earnings. We do not guarantee the payment of an insured benefit or the performance of the Insurer.

Any claims made on the Policy must be made through the Trustee as the Policy owner. Before the Trustee can pay any insurance Benefit to you or your beneficiary(ies), the claim must be accepted by the Insurer and approved by the Trustee.

The Trustee may only release a Benefit (including any Terminal Illness, TPD or Income Protection Benefit paid to the Trustee by the Insurer) where you have met a 'condition of release' under superannuation law. If the Trustee cannot release your Benefit, any proceeds will be credited to your super account and paid when you meet a condition of release.

The Trustee will pay any Death Benefit (comprising your account balance and any sum insured amounts for cover in place and current) at the claim date, to the beneficiary(ies) you have nominated in your non-lapsing nomination, unless there is no nomination or your nomination is defective or has been cancelled. See 'Nominating a Beneficiary' in the AIG for information about nominating beneficiaries and non-lapsing nominations and how the Trustee determines a claim if there is no nomination on your account.

If the Insurer rejects, reduces or defers a claim, the Trustee may reduce the Benefit payable to take into account the Insurer's refusal, reduction or deferral. However, after the Trustee has reviewed all relevant medical reports and documents that the Insurer relied upon to make its decision, if the Trustee is of the view that the claim has a reasonable prospect of success, the Trustee will do everything that is reasonable to pursue the matter on your behalf.

* Not available on ANZ Plus App.

WHAT ARE THE COSTS OF INSURANCE?

INSURANCE FEES

The Insurance fees applicable to your Employer Plan are set out in the Appendix. The Insurance fee that applies to you may depend on a variety of factors, including but not limited to:

- the type and level of cover;
- your age and gender;
- your salary;
- any relevant rating factors applicable to your Employer Plan; and/or
- your health and pastimes.

PAYMENT OF INSURANCE FEES

Insurance fees are calculated daily and deducted monthly in advance from your account balance.

If you do not have sufficient funds in your account to cover the Insurance fee, you will be advised in writing. You will be given prior notice to contribute the required funds to your account before your cover may be cancelled.

Your Employer may agree to pay your Insurance fees on your behalf, by way of an Employer additional contribution to reimburse for the Insurance fees deducted from your account. Your Employer may also cancel such an arrangement at any time. Under these conditions, including if you leave your Employer, you may be liable to pay the Insurance fee, including any unpaid fees owing. If your Employer agrees to pay Insurance fees for your Default Cover, and you wish to cancel or opt out of such cover, you should co-ordinate this with your Employer.

For IP Cover, should you wish to change your waiting period or benefit period to a basis other than that provided as the plan's default benefit design, your Employer will no longer meet the cost of cover on your behalf. From then, the Insurance fees for Voluntary cover will apply.

If your Employer terminates its Employer Plan in ANZ Smart Choice Super, your insurance cover – any default and voluntary amounts, will cease and your account will no longer be linked to your Employer. This is to avoid you having duplicate default cover established and incurring multiple Insurance fees. You will receive notification prior to this occurring.

The actual Insurance fee payable for your cover will be advised in the Welcome Pack or Insurance Activation Letter (as applicable) provided upon joining ANZ Smart Choice Super, and then for each subsequent year in the Annual Statement issued as at 30 June.

If your Employer pays your Insurance fees, and you wish to cancel your insurance, you will need to make this request through your Employer.

Further details on your Insurance fees are detailed in the Appendix.

INSURANCE FEE WAIVER

In some cases the Insurer will waive the payment of Insurance fees for IP Cover (where applicable) for you which fall due while you are receiving a benefit.

If this applies to your Employer Plan, further information will be provided in the Appendix, under 'Waiver of premium (Insurance fees)'.

TAXES AND EXPENSES

Insurance fees are inclusive of any applicable:

- administration fees the Insurer charges;
- Federal, State or Territory taxes, or other government charges; and
- expenses incurred in administering any function required by a Federal, State or Territory Government under any legislation in relation to the Policy.

Any applicable stamp duty and other taxes are included in the Insurance fees.

Benefit payments under Income Protection cover are generally considered to be income replacement, and are treated as assessable income. Therefore, the applicable Pay As You Go (PAYG) tax will be deducted before any payment is made to you.

The Insurer may vary or otherwise adjust any amounts (including but not limited to Insurance fees, charges and benefits), under the insurance policies in the manner and to the extent the Insurer determines to be appropriate to take account of the tax.

WHEN DOES YOUR COVER CEASE?

Your cover will end on the earliest of:

- the date you meet any of the criteria specified in 'When does cover cease' in the Appendix; or
- the date the Policy ends for any of the reasons outlined in the Policy; or
- the date you die.

It is very important that you be aware of the dates your cover will end, as depending on the event, you may not receive prior notification of your cover ceasing from either the Trustee or the Insurer.

COVER CEASES AFTER INACTIVITY

Death, TPD and Income Protection cover (if applicable) will cease if we have not received a contribution or rollover into your account for a period of 16 consecutive months and you have not notified us in writing that you want the cover to continue, unless an employer-sponsor contribution or Australian Defence Forces exception applies.

We will write to you during this period of inactivity about your options to keep your cover. You will also be able to request in writing that the Trustee reinstates your cover, within 60 days of the insurance cover ceasing. Your insurance cover will be reinstated with any pre-existing condition exclusions, loadings or restrictions backdated to cessation, and any insurance fees since it ceased will be collected.

CONTINUATION OF COVER

If your Employer notifies us that you have left employment with them, your account will no longer be linked to your Employer's Plan and your Default and Voluntary cover will be converted to a fixed amount of Choose Your Own cover within ANZ Smart Choice Super. The cover will be provided by Zurich Australia Limited, the insurer for Choose Your Own cover within ANZ Smart Choice Super under a separate policy. The cover amount will be equal to the amount of cover held on the date that you have left employment with your Employer.

Where your cover is converted to a fixed amount of Choose Your Own cover, your Insurance fees will be based on the rates for Choose Your Own cover (rather than the Employer Plan's tailored arrangement) and will be effective from the date we process your conversion to Choose Your Own cover or an earlier date. The Choose Your Own terms and conditions will be applicable from the date you left employment with your Employer.

For more information on Choose Your Own cover, please refer to the Standard Employer Plans Insurance Guide which can be found at www.anz.com.au/smartchoicesuper > Downloads – important documents or by calling Customer Services.

WHAT HAPPENS IF THE EMPLOYER TERMINATES THE EMPLOYER PLAN?

At a future date, the Employer Plan in ANZ Smart Choice Super may be terminated. This may occur for various reasons including, but not limited to, a decision by the Employer to establish a new or replacement default superannuation plan, or the cessation of the Employer's business.

Once the Trustee receives an official written request from your Employer to terminate the Employer Plan in ANZ Smart Choice Super, you will receive a letter from the Trustee advising you of this and the implications for your insurance cover. If your insurance cover will cease or change, we will provide you with notification.

WHAT IS THE EFFECT OF CONVERSION TO CHOOSE YOUR OWN COVER?

The rates applicable to Choose Your Own cover are generally higher than rates that apply to tailored employer plans. This means the cost of your cover will generally increase in the event that your Employer notifies us that you have left employment with them.

The rates applicable to Choose Your Own cover are based on your age, gender, type of cover, your occupational category and amount of cover. Any special acceptance terms which apply to your cover including conditions, restrictions, exclusions, limitations and loadings will continue to apply to your converted Choose Your Own cover.

In the event that cover is not available as Choose Your Own cover due to your age, cover will cease on the date you left employment.

You can apply to change your occupational category which will impact on the cost of your cover. Where your occupational category is known this will be retained even after you are no longer linked to your Employer. If your occupational category is not known and you or your Employer do not tell us otherwise, your insurance fee will be calculated in line with premiums for the 'Light Blue collar' occupational category.

This will determine the loadings that are applied to your Insurance fees. You can contact us at any time to advise us of the occupational category that is applicable to you.

Any change to your Insurance fee loadings will be applied from the next business day after the Acceptance Date.

Choose Your Own rates are included in the ANZ Smart Choice Super for employers and their employees Insurance Guide for Standard Employer Plans, which you can find on our website at www.anz.com.au/smartchoicesuper > Downloads – important documents or by calling Customer Services.

You may also have the following options to obtain personal insurance cover as outlined below:

1. You may be able to take up personal insurance cover with the Employer Plan's Insurer through a Continuation Option. You may need to do so within a prescribed time frame from the cessation of your employment, generally this is within 60 days of leaving the service of your Employer. Refer to the Appendix for further information in relation to the Continuation Option. If you elect to exercise a Continuation Option then Choose Your Own cover within ANZ Smart Choice Super is not available.
2. You may apply for insurance cover through OneCare Super. OneCare Super is issued by the Trustee as the Trustee of the Fund and offers Life and/or TPD cover, Income Secure cover and Extra Care cover. Premiums are payable for cover provided through OneCare Super. You can apply for this cover by following the instructions in the OneCare Super PDS. If you elect to apply for insurance cover through OneCare Super at the time of leaving your employer then Choose Your Own cover within ANZ Smart Choice Super is not available.

For full terms and conditions about OneCare Super, refer to the OneCare Super PDS which is available at www.onepathsuperinvest.com.au from your financial adviser or by contacting Customer Services. You should consider the OneCare Super PDS in deciding whether to acquire, or continue to hold, OneCare Super. Underwriting criteria applies. Zurich Australia Limited is the insurer for OneCare Super. Target Market Determinations for OneCare Super can be obtained from www.onepath.com.au/content/dam/onepath/documents/tmd/onecare-super-tmd.pdf.

The information in respect of OneCare Super has been prepared without taking into account your personal objectives, financial situation or needs and you should consider its appropriateness with regard to these factors before acting on it. You should obtain the OneCare Super PDS and consider it before making any decisions about whether to acquire OneCare Super.

ADDITIONAL FEATURES

If your Employer has selected additional features for your Employer Plan, these will be detailed in an 'Additional features' section of the Appendix. You should be aware that in order to access some of these features, a time period within which to apply may be applicable.

HOW TO MAKE A CLAIM

In the event of a claim, the process has been made as easy as possible.

For more information about making a claim:

- contact Customer Services on 13 12 87
- email Customer Services at smartchoice@insigniafinancial.com.au
- visit the ANZ website at www.anz.com.au/superclaims

The Insurer requires you, your Employer or us to notify them in writing of any claim within the time limit specified in the Policy. Please refer to the Appendix for further details.

If the Insurer does not receive notice in writing within the required time, the Insurer may reduce or refuse to pay the benefit to the extent its assessment of the claim is prejudiced.

The Insurer will generally send us or your Employer claim forms as soon as reasonably possible after receiving notice of a claim. The sending of claim forms does not constitute an admission of liability in respect of any claim lodged.

Claim forms must be completed as soon as it is reasonably practicable for you to do so.

The Insurer generally asks for medical information and evidence to enable the claim to be assessed. If a claim is lodged, you may be required to be interviewed and attend medical and vocational assessments and rehabilitation and the Insurer may obtain information by surveillance. You, your Employer and we are also required to provide the Insurer with all information required in order to determine your eligibility for benefits. If you are residing or travelling overseas, in the event of a claim the Insurer may require you to return to Australia for medical treatment and assessment. The Insurer will not pay any costs relating to your return to Australia.

Once we receive the proceeds from the Insurer these will be held in the superannuation environment, in the ANZ Smart Choice Cash investment option. If you would like to switch this amount to another investment option you can do so online. Simply register for ANZ Smart Choice Super online access at www.anz.com.au/smartchoiceaccess or by calling Customer Services. Upon meeting a condition of release, you will receive the benefit amount in accordance with the Fund's Trust Deed, adjusted positively or negatively, for investment earnings.

DUTY TO TAKE REASONABLE CARE

THE DUTY TO TAKE REASONABLE CARE

When applying for insurance, you have a legal duty to take reasonable care not to make a misrepresentation to the Insurer.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

IF YOU DO NOT MEET YOUR DUTY

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where the Insurer later investigates whether the information given to them was true. For example, they may do this when a claim is made.

ABOUT THIS APPLICATION

When you apply for life insurance, the Insurer conducts a process called underwriting. It's how they decide whether they can provide cover, and if so, on what terms and at what cost.

The Insurer will ask questions they need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to the Insurer in response to their questions is vital to their decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, the Trustee may pass on to the Insurer personal information you provide to the Trustee.

You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the Trustee.

GUIDANCE FOR ANSWERING THE INSURER'S QUESTIONS

You are responsible for the information provided to the Insurer. When answering their questions, you should:

- Think carefully about each question before answering. If you are unsure of the meaning of any question, please ask the Insurer before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume the Insurer will ask others such as your doctor.
- Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections).

CHANGES BEFORE YOUR COVER STARTS

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts.

Before your cover starts, the Insurer may ask about any changes that mean you would now answer their questions differently, as any changes might require further assessment or investigation.

NOTIFYING THE INSURER

If, after your cover starts, you think you may not have met your duty, please tell the Insurer immediately and they will let you know whether it has any impact on your cover.

TELEPHONE CONTACT

After you submit your application, the Insurer may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into also applies during any phone contact with the Insurer.

IF YOU NEED HELP

It's important that you understand this information and the questions the Insurer asks. Ask the Insurer for help if you have difficulty answering their questions or understanding the application process.

If you're having difficulty due to a disability, understanding English or for any other reason, help is available and can be provided if required. You can have a support person you trust with you.

WHAT CAN THE INSURER DO IF THE DUTY IS NOT MET?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to the Insurer. These are set out in the *Insurance Contracts Act 1984 (Cth)*. They are intended to put the Insurer in the position they would have been in if the duty had been met.

For example, the Insurer may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including all of the following:

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific the Insurer's questions were and how clear the information they provided on the duty was
- what the Insurer would have done if the duty had been met – for example, whether they would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before the Insurer exercises any of these remedies, they will explain their reasons, how to respond and provide further information, and what you can do if you disagree.

INSURANCE RISKS

As your Employer has included insurance as part of its superannuation arrangements, under ANZ Smart Choice Super, there are a number of insurance risks you should be aware of:

- if the Insurance fees are not paid to the Insurer within the time limits under the Policy, the Insurer may cancel or terminate the insurance cover by written notice to the Trustee without notice to you;
- if you are transferred to another super fund, or the Australian Taxation Office (ATO) as lost or unclaimed monies, your cover will cease (see the AIG for more details);
- the amount or type of insurance cover selected by your Employer may not be sufficient to provide adequate insurance cover in the event of **Injury** or **Illness**;
- your Insurance fee or benefit may be adjusted if your age is mis-stated;
- if your benefit is calculated using your salary while you are in the Employer Plan, we are reliant upon your Employer's notification of any salary changes. Where we are not notified of a change in salary and no additional Insurance fee is paid, in the event of a claim, the Insurer may pay a lower benefit based on the salary that was previously advised or salary at the last review date;
- if you or your Employer do not disclose to the Insurer every matter that they know or could reasonably be expected to know, that would be relevant to the Insurer's decision whether to accept the risk of the insurance and if so, on what terms, the Insurer may avoid the contract within three years of entering into it. If you or your Employer's non-disclosure is fraudulent, the Insurer may avoid the contract at any time. Refer to the '**Duty to Take Reasonable Care**' section within this Guide for more details;
- you may not be paid a benefit because an exclusion or restriction applies, based on your personal circumstances;
- if you have been paid a TPD benefit and have residual Death cover remaining you may wish to consider maintaining some money in your super account to keep the account active and to ensure there is sufficient balance to pay any insurance fees;
- insurance fees may increase over time;
- the Trustee relies on information provided by your Employer about you at the time that you are admitted into ANZ Smart Choice Super, including the appropriate category of membership, as well as changes in your information over the course of your membership, for example changes in salary. Some of the information your Employer provides may determine your benefits according to your eligibility. Where any information is found to be inaccurate, the Trustee will not be responsible for the inaccuracy or any reliance on it. Inaccurate information may result in eligibility being denied or benefits being declined.

You should check your insurance cover with your Employer to ensure your insurance accurately reflects your current employment details.

APPENDIX

This Appendix forms part of the Guide dated 1 December 2024 for the Fortescue Metals Group Ltd Superannuation Plan.

Type of cover available	**Death cover** (including Terminal Illness) **Death cover** (including Terminal Illness) and **Total and Permanent Disablement (TPD) cover** **Income Protection cover.**
Category descriptions	**Death and TPD – is available to the following membership categories:** **Category P1:** An employee who works in the Perth CBD and has a 'white collar' occupational category. **Category N1:** An employee who is in a non-Perth based role. **Category C1:** A Casual employee who has a 'white collar' occupational category and who works in Perth or Port Hedland (no Mine Site Work). **Category C2:** A Casual employee who is not eligible for Category C1 (Non-Perth and Mine Site Work). **Income Protection – is available to the following membership categories:** **Category P1:** All employees who are in Perth based roles working at least 15 hours per week. **Category N1:** All employees who are in Non-Perth based roles working at least 15 hours per week.
What is the Maximum Benefit Level?	The total amount of Insured Cover held by the Insurer and all cover held under other policies with any other insurer is: • For Death cover – Unlimited • For Terminal Illness – $3,000,000 • For TPD cover – $5,000,000 For Income Protection: • $30,000 per month where the Insured Person is less than 65 years of age. • $10,000 per month where the Insured Person is 65 years of age or older. If the Insured Person is in receipt of an Income Protection monthly benefit on their 65th birthday, the maximum monthly benefit after the Insured Person's 65th birthday will be limited to $10,000 per month. The maximum monthly benefit includes any amount insured under any other policies with the Insurer or any other insurer.
Default Cover (Benefit Design)	
What Default cover is available?	**Death (including Terminal Illness) & TPD cover (subject to eligibility):** **Categories P1 & N1:** 15% × Salary × Years of Total Service from commencement of service to age 70. 'Years of Total Service from commencement of service to age 70' means the period in complete years from the date joined Employer to age 70. **Income Protection cover** **Categories P1 & N1:** 75% of the insured person's pre-disability base Salary Monthly Income subject to: • a 90 day Waiting Period; and • a 2 year Benefit Period. If in receipt of a Monthly Benefit it will not cease on payment of a total and permanent disablement or terminal illness benefit. If immediately prior to the date of Disability, an Insured Person was no longer a Permanent Employee working for their Employer for at least 15 hours per week, the Monthly Income will be averaged over the 12 months immediately prior to the date of Disability. In the case of Death (including Terminal Illness), TPD cover, and Income Protection cover above: • Salary means base pre-tax salary derived from their occupation with the Employer, plus allowances. Unless otherwise agreed, 'Salary' does not include director's fees, overtime payments, commissions, bonuses, mandated Superannuation contributions, investment income, income received from deferred compensation plans, disability income policies, retirement plans or any income derived from non-vocational activities. • Salary is determined immediately prior to the Date of Disablement or date of Disability (as applicable).

Casuals

Categories C1 and C2:

Sum insured by age:

Age next birthday*	Death cover (Insured Amount) ($)	TPD cover (Insured Amount) ($)
16–20	80,000	180,000
21–25	100,000	200,000
26–30	120,000	220,000
31–35	200,000	250,000
36–45	300,000	300,000
46–50	195,000	195,000
51–55	150,000	150,000
56	100,000	100,000
57	100,000	90,000
58	100,000	80,000
59	100,000	70,000
60	80,000	60,000
61	60,000	50,000
62	40,000	40,000
63	40,000	30,000
64–65	40,000	20,000
66–70**	35,000	NIL

* Your level of cover is determined:
(a) as at the cover commencement date; and
(b) on 1 July each year, based on your age next birthday at that time.

**Between Age NB 66 and 70, Death cover only is provided. There is no TPD cover.

Eligibility for default cover

Subject to the terms below, cover is compulsory for all **Eligible Persons** on commencement of employment.

Cover can only be obtained for an Eligible Person.

Eligible Person means a person:

- who is an **Australian Resident**; and
- is aged between the **Minimum Entry Age^** and **Maximum Entry Age;** and
- meets the insured cover requirements; and
- who is employed by the employer; or
- that the Insurer expressly agrees in writing is an Eligible Person.

^ You must provide an opt-in election if you are under 25 or with an account balance less than $6,000, unless you are covered by a PMIF exception.

Automatic Acceptance & Commencement of Cover	An Eligible Person who has commenced a First Member Account will be accepted for Agreed Cover up to the Automatic Acceptance Limit without the need for underwriting provided: (a) They are not older than the Maximum Entry Age; and (b) They are aged 25 years or over and have an account balance within the Fund of at least $6,000, unless they are a PMIF Exception Member; and (c) Within 180 days of becoming First Eligible, the Fund receives: • A Superannuation Guarantee (SG) contribution that is On-time, and • Minimum Member Details or a satisfactorily completed Member Application Form; and (d) They have not received, or are eligible to receive, a terminal illness benefit or total and permanent disability benefit payment from any superannuation fund or insurance policy. Where (a), (b), (c) and (d) have been met, Agreed Cover by way of Automatic Acceptance commences from: (i) The first date the Eligible Person's account balance in the Fund is equal to or greater than $6,000 and they are at least 25 years of age; or (ii) The date the Trustee receives a PMIF Opt-in Election Form provided it was received within 120 days of becoming First Eligible or it was received within 90 days of the date the Fund sent the Welcome Pack; or (iii) The first day of the period to which the Superannuation Guarantee (SG) contribution relates, where they are a PMIF Exception Member, and provided the Eligible Person's account is not Inactive. If they were not At Work on the date Agreed Cover commences, the Agreed Cover will be Limited Cover until the Insured Person has been in Active Employment for 30 consecutive days. Unless Agreed Cover has commenced as described above, or under another clause of the policy, all cover will be subject to underwriting. Additionally Agreed Cover can only commence by Automatic Acceptance for an amount up to the Automatic Acceptance Limit. Voluntary Cover will not commence under Automatic Acceptance. The Insurer reserves the right to alter the Automatic Acceptance Limit if: (a) There is greater than a 30% change in the number of Insured Persons since the date the Insurer last reviewed the premium rates; or (b) Less than 75% of Eligible Persons are covered under the policy; or (c) The Insurer is not the sole insurer for Insured Persons of the Plan; or (d) The policy is no longer the default insurance arrangement for the Employer under superannuation legislation.
Automatic Acceptance Limit	**Death and TPD cover:** $1,600,000 **Income Protection Cover:** $25,000 per month
Underwriting	Where Automatic Acceptance does not apply to an Eligible Person, the Insurer may, after considering all information they have requested and received in relation to the Eligible Person, in their absolute underwriting discretion, either: (a) accept the Eligible Person for such cover under the Policy; or (b) offer to accept the Eligible Person for such cover under the Policy subject to whatever exclusions, premium loadings, limitations, special terms, conditions, restrictions or Forward Underwriting Limit as the Insurer considers appropriate; or (c) refuse to provide such cover for the Eligible Person under the Policy absolutely. Other than cover that commences through Automatic Acceptance, cover only comes into force in respect of an Eligible Person on the date the Insurer notifies the Trustee that they accept them for the cover. In addition if a member who does not join when first eligible will be required to be underwritten to receive Agreed Cover on the plan's benefit design (rather than a fixed sum insured). For Group Life, the Trustee may increase the amount of Agreed Cover for an Insured Person in certain scenarios, for more information refer to 'Automatic increases to agreed cover' in the Appendix of this Guide.

Automatic uplift of Automatic Acceptance	If the Insurer increases the Automatic Acceptance Limit then the new higher Automatic Acceptance Limit will apply to all existing Insured Persons for whom the Automatic Acceptance Limit applies and irrespective of whether they have previously been declined, excluded or loaded for cover above the previous lower Automatic Acceptance Limit. Any exclusions, premium loading, limitations, special terms, conditions or restrictions will continue to apply to cover above the new Automatic Acceptance Limit.
Cover subject to special terms	If the Insurer offers special terms, conditions, restrictions, exclusions or premium loading, the Eligible Person or Insured Person will be required to accept these terms and cover will commence from the date that their acceptance is received by the Insurer, provided that this acceptance is within 28 days of the date of the Insurer's offer. From the date of our offer, the Insurer will provide additional interim Accident Cover for the lesser of 28 days or the date that the Eligible Person or Insured Person accepts or refuses this offer. Any exclusions, premium loading, limitations, special terms, conditions or restrictions that came into effect as a result of underwriting, will apply above the Automatic Acceptance Limit.
Voluntary Cover	
What types of Voluntary Cover can members apply for?	• Death only Cover • Death and TPD cover • Income Protection cover Additional voluntary cover will be a fixed sum insured.
When does an increase in Voluntary Cover commence?	Subject to the requirements set out in Underwriting section of this Appendix, Voluntary Cover will commence from the date advised in writing.
Is Interim Accident Cover available for Death and TPD Cover applications?	Yes. **When Interim Accident Cover begins** If underwriting applies, Interim Accident Cover comes into force in respect of an Eligible Person or Insured Person from the date the Insurer receives an application for cover. Interim Accident Cover does not apply to any increase in cover provided under the terms of Life Events Cover as set out in this Appendix. **Benefit for Interim Accident Cover** If an Eligible Person or an Insured Person with Interim Accident Cover dies as a result of an Injury, or suffers Total and Permanent Disablement as a result of an Injury, the Insurer will pay the lesser of the amount being applied for or $1,500,000 as if they were an Insured Person. Interim Accident Cover will be payable for: • death, if the person's application to the Insurer is in respect of death and cover for that benefit would have been available to them as an Insured Person under the Policy; and • Total and Permanent Disablement, if the person's application to the Insurer is in respect of Total and Permanent Disablement cover for that benefit would have been available to them as an Insured Person under the Policy. Interim Accident Cover will not be payable where: • the Death of an Insured Person is directly or indirectly the result of suicide or attempted suicide; or • the Total and Permanent Disablement or an Insured Person is directly or indirectly the result of an intentional self-inflicted injury or attempted suicide; or • the Death or Total and Permanent Disablement of an Insured Person is directly or indirectly the result of an exclusion on their Insured Cover. The Insurer may take into account any information they receive in the course of the claim under Interim Accident Cover in exercising their discretion whether they accept, refuse or offer special terms, conditions, restrictions, exclusions or premium loading for any insured Cover under the terms set out within the 'Underwriting' section of the Appendix.

Is Interim Accident Cover available for Death and TPD Cover applications? *(continued)*	**When will Interim Accident Cover end?** Unless otherwise agreed by the Insurer, Interim Accident Cover that begins as set out in this section will end on the earlier of: • when the Insurer notifies the Trustee of the Insurer's decision under the terms set out within the 'Underwriting' section of the Appendix; or • when the application is withdrawn, or cancelled, or the Insurer is advised that it is not being proceeded with; or • subject to the terms under the 'Cover subject to special terms' section of the Appendix at midnight on the 90th day after it commenced; or • when any event happened under the section 'When does cover cease' section of the Appendix; or • the cessation of the Policy.
Is Interim Accident Cover available for Income Protection Cover applications?	Yes **When Interim Accident cover begins** If underwriting applies, Interim Accident Cover comes into force in respect of an Eligible Person or Insured Person from the date the Insurer receives an application for cover. **Benefit for Interim Accident Cover** If an Eligible Person or an Insured Person with Interim Accident Cover suffers Total Disability as a result of an Injury, the Insurer will pay the lesser of the amount being applied for or $15,000 per month as if they were an Insured Person. The Insurer is not liable to pay a benefit for Partial Disability under Interim Accident Cover. Interim Accident Cover will not be payable where the Total Disability of an Insured Person is directly or indirectly the result of an intentional self-inflicted injury. The Insurer may take into account any information they receive in the course of the claim under Interim Accident Cover in exercising their discretion whether they accept, refuse or offer special terms, conditions, restrictions, exclusions or premium loading for any Insured Cover under the terms set out within the 'Underwriting' section of the Appendix. During the period the insurer pays a benefit in connection with Interim Accident Cover the Insurer is not liable to pay any other benefits under the Policy. The maximum Benefit Period for a claim under Interim Accident Cover is 2 years. **When will Interim Accident Cover end?** Unless otherwise agreed by the Insurer, Interim Accident Cover that begins as set out in this section will end on the earlier of: • when the Insurer notifies the Trustee of the Insurer's decision under the terms set out within the 'Underwriting' section of the Appendix; or • when the application is withdrawn, or cancelled, or the Insurer is advised that it is not being proceeded with; or • subject to the terms under the 'Cover subject to special terms' section of the Appendix at midnight on the 90th day after it commenced; or • when any event happened under the section 'When does cover cease' section of the Appendix; or • the cessation of the Policy.

Death Cover	
Death Cover	If a Member dies, the Insurer will pay to the Trustee the Sum Insured for that Member (subject to the terms of the Policy). The amount the Insurer will pay is the Insured Cover that is in force on the Date of Death if the claim is for death, or the Date of Certification, if the claim is for Terminal Illness.
Is Terminal Illness Benefit provided?	Yes. Where the Insurer is satisfied that an Insured Person has been diagnosed with a Terminal Illness, the Insurer will pay a Terminal Illness Benefit, subject to: (a) The Date of Certification of the Terminal Illness is on or after the date their Insured Cover commenced under the Policy. No Terminal Illness benefit will be considered where the Date of Certification is prior to this date; and (b) A Terminal Illness Benefit will be the lesser of the Insured Person's Cover or $3,000,000. Provided they remain an Insured Person and the Insurer continues to receive premium for their cover, the Insurer will pay the residual Death Benefit balance calculated as at the Insured Person's date of death, less any Terminal Illness Benefit that has already been paid; and (c) The Insured Person must supply, at their own expense, supporting medical evidence from two Doctors, at least one of the Doctors must be a specialist practising in the field to which the Terminal Illness relates. The Insurer will require this information in a form of their choosing and reserve the right to ask for any additional information that they feel is appropriate. Where the Insurer asks for additional information, the Insurer will incur the cost of obtaining this information. (d) If the Policy has terminated, the Insured Person, will only be eligible for a Terminal Illness benefit where: (i) The Date of Certification is prior to the date that the Policy terminated; and (ii) The Insured Person is not eligible for a terminal illness, total and permanent disablement or death claim under a new replacement policy. Where a Terminal Illness Benefit is paid it will be considered as an advance payment of the Insured Person's Death Benefit. If a Terminal Illness Benefit is paid, all cover under the Policy will cease from that date. However, Subject to paragraph (b) above any residual Death Benefit balance will be payable on death of the Insured Person. From the date a Terminal Illness claim has been lodged, a member will no longer be eligible for any TPD Cover, any increase in cover or any reinstatement of cover that would otherwise occur under the provisions of the Policy.
TPD Cover	
TPD Benefit	If a Member suffers from TPD, the Insurer will pay to the Trustee the Sum Insured for that Member (subject to the terms of the Policy). The amount the Insurer will pay is the Insured Cover that is in force on the Date of Disablement.
What is the definition of **TPD**? For members where TPD Cover commenced prior to 1 July 2014.	'TPD' means Total and Permanent Disablement as defined below. The definition(s) applicable to the Policy are set out in this Appendix. The following parts of the TPD definition apply, as set out below: If on the Date of Disablement the Insured Member is Employed for 15 hours per week or more the following definitions apply: Parts (a), (b), (c), (d) & (e) If on the Date of Disablement the Insured Member is Employed for less than 15 hours per week the following definitions apply: Parts (b), (c), (d) & (e). **a. Unlikely to do own occupation or a similar occupation ever again.** An Insured Member having been absent from his or her **Occupation** solely through injury or Illness for a period of six (6) consecutive months and is incapacitated to such an extent that, in the Insurer's opinion, after consideration of medical and other relevant evidence, the Insured Member was, at the end of the period of six (6) consecutive months absence from employment, unlikely to ever engage in or work for reward in his or her own **Occupation** and any similar occupation for which he or she is reasonably suited by education, training or experience; or the Insured Member meets the Specific Loss definition on the next page.

What is the definition of TPD?

For members where TPD Cover commenced prior to 1 July 2014.

(continued)

b. Specific Loss of use of limbs and /or sight.

An Insured Member suffers the permanent loss of use of two (2) limbs or the sight of both eyes; or the permanent loss of use of one (1) limb and the sight of one (1) eye (where limb is defined as whole hand or the whole foot) in circumstances where the loss will never be regained.

c. Unable to look after yourself ever again.

Where the Insured Member is engaged in permanent employment for less than 15 hours per week or has attained the age of 65, or in other circumstances as specified in this Appendix, an Insured Member having been absent from his or her **Occupation** solely through injury or Illness for a period of six (6) consecutive months and is incapacitated to such an extent that, in the Insurer's opinion, after consideration of medical and other relevant evidence, the Insured Member was, at the end of the period of six (6) consecutive months absence from employment, unlikely to ever be able to perform at least two (2) Activities of Daily Living without the physical help of someone else. For the purpose of this definition, Activities of Daily Living means:

a. bathing and/or showering; or

b. dressing; or

c. moving from place to place including in and out of bed and in and out of a chair; or

d. eating or drinking; or

e. using the toilet.

d. Unlikely to do household duties ever again.

Where an Insured Member's **Occupation** is classified as 'Home Duties', an Insured Member having been absent from his or her **Occupation** solely through injury or Illness for a period of six (6) consecutive months and is incapacitated to such an extent that, in the Insurer's opinion, after consideration of medical and other relevant evidence, the Insured Member was, at the end of the period of six (6) consecutive months absence from employment, unlikely to ever again attend to at least two (2) normal physical domestic household duties.

For the purposes of this definition, 'normal physical domestic household duties' means:

- Cleaning the family home; or
- Shopping for food and household items; or
- Meal preparation and laundry services; or
- Leaving the house without the assistance of another person; or
- Looking after dependent child/children under 16 years of age or in full time secondary education, where applicable; or
- Providing full time care for a disabled person(s) who is a member of their immediate family, where applicable.

If the Insured Member is able to perform the normal physical domestic household duties with the assistance of another person or with the use of assistive devices, they are deemed to be able to perform these duties. The Insured Member must be under the regular care and attention and following the advice of a **Doctor** for that injury or Illness. Evidence that the Insured Member carried out the duties on a daily basis prior to their period of disability will be required.

e. Unlikely to do basic activities associated with work ever again.

The Insured Person suffers an Illness or Injury, that in the Insurer's opinion:

i. totally and irreversibly prevents them from performing two of the Activities of Daily Working without assistance from another adult person for at least 3 consecutive months, and

ii. since they became ill or injured, they have been under the regular care and attention of a Doctor for that Illness or Injury, and

iii. in the Insurer's opinion, the Illness or Injury means that they are unlikely to ever again be able to perform at least two of the Activities of Daily Working without assistance from another adult person.

What is the definition of TPD?

For members where TPD Cover commenced on or after 1 July 2014.

Total and Permanent Disablement means in respect of an Insured Member who on the Date of Disablement:

(a) Is a Permanent Employee or Contractor; and

(b) Has worked for an average of at least 15 hours per week during the 6 months prior to the Date of Disablement.

The Insurer will pay the insured cover for Total and Permanent Disablement if the Insured Person satisfies either Part 1, Part 2, Part 3, Part 4 or Part 5 below.

If an Insured Person does not satisfy (a) and (b) above on the Date of Disablement the Insurer will only pay the Total and Permanent Disablement benefit if the Insured Person satisfies either Part 3, Part 4 or Part 5 below.

If an Insured Person is suffering from 1 or more of the Immediate Assessment Conditions and all claim requirements have been received by the Insurer, the 3 month waiting period that applies to Part 1, Part 4 and Part 5 is waived and assessment of a claim commences immediately.

In order to satisfy Part 3, Part 4 or Part 5, the Insured Person must be disabled to such an extent as a result of that Injury or Illness that in the Insurer's opinion they are unlikely ever at any time in the future to engage in any **Gainful Employment** for which they are reasonably suited by education, training or experience.

Part 1 – Unlikely to do a suited occupation ever again.

The **Insured Person** is unable to do any work as a result of Injury or Illness for 3 consecutive months and in the Insurer's opinion at the end of that 3 months they continue to be so disabled as the result of their ill-health (whether physical or mental) that they are unable to resume their previous occupation at any time in the future and will be unlikely ever at any time in the future to engage in **Gainful Employment** for which they are reasonably suited by education, training or experience.

Part 2 – Significant impairment to your whole body function.

The **Insured Person** is engaged in **Gainful Employment** when suffering an Injury or Illness and, as a result of that Injury or Illness, they:

(a) Suffer 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 4th Edition', or the equivalent guide to the evaluation of impairment approved by the Insurer; and

(b) Are disabled to such an extent, as a result of this impairment, that the **Insured Person** is unlikely ever at any time in the future to engage in any occupation, business, profession or employment for which they are reasonably suited by education, training or experience.

Part 3 – Loss of limbs and/or sight.

The **Insured Person** suffers the total, permanent and irrecoverable loss of:

(a) the use of two limbs; or

(b) the sight of both eyes, or

(c) the use of one limb and sight of one eye.

Part 4 – Permanent deterioration or loss of intellectual capacity.

The **Insured Person**, as a result of Illness or Injury, is first diagnosed with Cognitive Loss and is under the continuous care and supervision by another adult for at least 3 consecutive months and, at the end of that 3 month period, they are likely to require permanent ongoing continuous care and supervision by another adult.

Part 5 – Unlikely to do basic activities associated with work ever again.

The **Insured Person** suffers an Illness or Injury, that in the Insurer's opinion:

(a) totally and irreversibly prevents them from performing two of the **Activities of Daily Working** without assistance from another adult person for at least 3 consecutive months; and

(b) since they became ill or injured, they have been under the regular care and attention of a **Doctor** for that Illness or Injury, and

(c) in the Insurer's opinion, the Illness or Injury means that they are unable to ever again be able to perform at least two of the **Activities of Daily Working** without assistance from another adult person.

What does Date of Disablement mean? (For Insured Persons whose Insured Cover for Total and Permanent Disablement commenced in the Fund **prior to 1 July 2014**	means the earlier of the date: (a) The 6 consecutive months absence from work that results in Total and Permanent Disablement began under (a) of 'What is the definition of TPD?'; or (b) The Insured Person suffers the permanent Loss Of Use Of two (2) limbs or the sight of both eyes; or the permanent Loss Of Use Of one (1) limb and the sight of one (1) eye (where limb is defined as whole hand or the whole foot) in circumstances where the loss will never be regained; or (c) The 6 consecutive month's inability to perform at least 2 of the Activities of Daily Living that results in Total and Permanent Disablement began; or (d) The 6 consecutive month's inability to perform at least 2 of the normal physical domestic household duties that results in Total and Permanent Disablement began, or (e) The 6 consecutive month's inability to perform at least 2 of the *Activities of Daily Working* that results in *Total and Permanent Disablement* began.
What does Date of Disablement mean? (For Insured Persons whose Insured Cover for Total and Permanent Disablement commenced in the Fund **on or after 1 July 2014**)	means the earlier of the date: (a) The Insured Person is diagnosed with an Immediate Assessment Condition; or (b) The 3 consecutive months absence from work that results in Total and Permanent Disablement began under Part 1 of 'What is the TPD Definition?'. However, if the Insured Person undertakes a formalised graded return to work which fails within 12 months, the Insurer will take the Date of Disablement as being the date on which the person first ceased work; or (c) The permanent impairment under Part 2 of 'What is the TPD Definition' that results in Total and Permanent Disablement began; or (d) The Insured Person suffers the Loss Of Use Of the sight in both eyes, or Loss Of Use Of both limbs, or the Loss Of Use Of both the sight in 1 eye and 1 limb; or (e) The Insured Person suffers the Loss Of Use Of the sight of another eye or the Loss Of Use Of another limb, having already suffered the Loss Of Use Of the sight of an eye or the Loss Of Use Of a limb; or (f) The Cognitive Loss that results in Total and Permanent Disablement was first diagnosed; or (g) The 3 consecutive month's inability to perform at least 2 of the Activities of Daily Working that results in Total and Permanent Disablement began.
Does TPD Tapering apply?	All **Total and Permanent Disablement** cover will automatically reduce from their 65th birthday (age 66 next birthday) as set out below:

Age next birthday calculated at 1 July each year	Proportion of Sum Insured payable of TPD
Up to 65	100%
66	80%
67	60%
68	40%
69	20%
70	10%

Income Protection Cover	
Total Disability Benefit	Where the Insured Person suffers Total Disability, the Insurer will pay a monthly benefit that accrues from the day after the expiry of the Waiting Period. The Insurer will continue to pay a benefit for Total Disability for the period the Insured Person suffers Total Disability during the Benefit Period.
What is the definition of Total Disability?	Means because of an Injury or Illness the Insured Person is: a. Unable to perform at least 1 income producing duty of his or her occupation, and b. Under the regular care and following the advice of a Doctor, and c. Not working in any occupation, whether for reward or not for reward. An income producing duty is a duty of the Insured Person's occupation immediately before they became disabled which generates 20% or more of their Monthly Income.

What is the Definition of Partial Disability?	Means because of an Injury or Illness an Insured Person has suffered Total Disability continuously for a period of at least 7 days out of 12 consecutive days and: (a) Has ceased to suffer Total Disability; and (b) Has resumed partial employment or, in the Insurer's opinion, is deemed capable of returning to partial employment duties; and (c) As a result of the Injury or Illness that caused their Total Disability has received, or could in the Insurer's opinion receive, a Post-Disability Income that is less than their Monthly Income; and (d) Is under the continuous and regular care of a Doctor undergoing the appropriate treatment.
Partial Disability Benefit	If immediately before suffering Partial Disability an Insured Person has suffered Total Disability continuously for a period of at least 7 days out of 12 consecutive days and: (a) Has ceased to suffer Total Disability; and (b) Has resumed partial employment or, in the Insurer's opinion, is deemed capable of returning to partial employment duties; and (c) As a result of the Injury or Illness that caused their Total Disability has received, or would in the Insurer's opinion receive, a Post-Disability Income that is less than their Monthly Income; and (d) Is under the continuous and regular care of a Doctor undergoing the appropriate treatment; the Insurer will pay a Partial Disability benefit during the Benefit Period. No Partial Disability benefit is payable until the expiry of the Waiting Period. The amount the Insurer must pay for Partial Disability is calculated in accordance with the following formula, less any Other Disability Income that accrues to the Insured Person during the month: $\frac{A - B}{A} \times C$ Where: **A** Is the Insured Person's pre disability Monthly Income, **B** Is the Insured Person's actual Monthly Income earned during the month of Partial Disability, **C** Is the monthly benefit which would otherwise be payable if the Insured Person had suffered Total Disability. If an Insured Person suffers Partial Disability and no work is available then, after considering all the medical and other evidence available to the Insurer, then the Insurer will calculate their Post-Disability Income based on the Insurer's assessment of the Insured Persons capacity to earn.
Benefit Indexation	The Insurer will increase the monthly benefit for an Insured Person by the lesser of the annual CPI percentage increase or 5% for every 12 months where they are in receipt of a Total Disability Benefit.
Death whilst on claim	If an Insured member dies while the Insurer is paying a monthly benefit for that Insured Member, an additional lump sum equal to 3 times the monthly benefit that was payable immediately prior to the date of death. The lump sum death benefit is only payable by the Insurer upon receipt of satisfactory evidence.
Benefit Period	2 years The Benefit Period starts the day after the expiry of the Waiting Period. The Benefit Period is the maximum duration that any 1 claim will be paid. However, where the Insurer has continuously paid a benefit for the entire Benefit Period they will pay a benefit for a Disability that is caused by the same or related Injury or Illness, where: (a) The periods of Disability are separated by a period of at least 6 months; and (b) The Insured Person returned to being At Work for their Employer for at least 6 consecutive months undertaking all of the duties and hours of their usual occupation immediately prior to Disability; and (c) Premium has continued to be paid; and (d) The requirements for the Waiting period (as below) have been met for the subsequent Disability. The Insurer is not liable to continue to pay a Monthly Benefit once the Insured Person reaches the Cover Ceasing Age in the Policy Schedule and shown at Cover Ceasing Age.

Waiting Period	90 days The Insurer is not liable to begin to pay any Total Disability or Partial Disability benefit until the expiry of the Waiting Period. The Waiting Period starts on the date an Insured Person who suffers an Injury or an Illness first receives medical advice from a Doctor about their condition and the Doctor certifies that on that day the Insured Person suffers Total Disability. Where an Insured Person suffering Total Disability returns to work during the Waiting Period and this return to work proves unsuccessful due to the Injury or Illness causing Total Disability, then the original Waiting Period will continue if the number of days they return to work for is no more than 10% of the Waiting Period.
Recurrent Disability	Where cover for an Insured Person is in force, a period of Disability will be deemed to be a continuation of an earlier period of Disability, if the Disability is caused by the same medical condition and is separated from the previous period of Disability by a period of less than 6 months active full time work. If a period of Disability is deemed to be a continuation of an earlier period of Disability the Waiting Period does not apply to it and it will be a continuation of the same Benefit Period. If the period of Disability is not deemed to be a continuation of an earlier period of Disability under this clause then a new Waiting Period and Benefit Period will apply. An Insured Person's usual hours of work prior to their Disability will be considered as their full time work.
Reduction of the IP Benefit payable	The monthly benefit for Total Disability or Partial Disability shall be reduced by any Other Disability Income that the Insured Person is entitled to during that month. Unless the Insurer has agreed otherwise, a reduction will only be made where their Monthly Benefit plus any Other Disability Income exceeds 75% of the Members pre-disability Monthly Income or the Maximum Monthly Benefit. If the entitlement of an Insured Person to Other Disability Income is in dispute, the Insurer may at their discretion pay the full amount of the benefit due under the Policy on a conditional basis until the dispute is resolved. If the Insurer chooses to pay, and the Insured Person receives Other Disability Income, the Insurer may offset those payments received from future benefits or recover the amount of benefit the insurer has paid which would have been offset. **Example of a Benefit reduction to your Income Protection Benefit calculation** Jesse is currently not working due to an injury and has an accepted Income Protection claim for which she is in receipt of a Total Disability benefit of $5,000 per month. Jesse's injury was sustained at work so concurrently to her Income Protection claim, she is also in receipt of Workers' Compensation benefit payments for which she receives $3,000 per month. Based on this example, Jesse's Total Disability Benefit will be calculated as follows: $5,000 – $3,000 = $2,000 per month.
Waiver of premium (Insurance fees)	The Insurer will waive the portion of the premium otherwise due to them for an Insured Person when the Insurer is paying them a benefit for Total Disability. However, premiums are payable to the Insurer whilst an Insured Person is in receipt of a benefit from another insurer.
Approved rehabilitation benefit	If an Insured Person suffers Total Disability or Partial Disability and the Insurer agrees that a program is likely to assist in their return to work, they may pay for the cost of Approved Rehabilitation in addition to the benefits otherwise payable for the Insured Person. Any payment of this benefit will be made to the service provider and the expense must be approved by the Insurer in writing before it is incurred. The approval of the Approved Rehabilitation benefit is at the Insurer's absolute discretion.
Workplace modification benefit	If the Insured Person is receiving Total Disability or Partial Disability benefits and the Insurer agrees that modification to their place of employment is necessary in order for them to return to work, the Insurer may pay all or some of the modification expenses. The workplace modification benefit will be paid in addition to any other benefit payable under the Policy. Any payment of this benefit will be made to the service provider and the expense must be approved by the Insurer in writing before it is incurred. The approval of a workplace modification benefit is at the Insurer's absolute discretion.

When the Insurer won't pay	
Benefit Exclusions	Insured Cover will not be payable where a claim is directly or indirectly the result of: (a) War or act of war; or (b) The Insured Person having been in a country listed on the Department of Foreign Affairs and Trade website (www.dfat.gov.au) as subject to a 'do not travel' warning at the time they entered the Country; or (c) Any additional exclusion that came into effect under underwriting or the Insurer taking over existing cover; (d) For Income Protection cover, intentional self-inflicted harm or attempted suicide; or (e) For Income Protection cover, normal and uncomplicated pregnancy or childbirth. Complications of pregnancy, multiple pregnancy, threatened or actual miscarriage, participation in an IVF or similar programme, discomfort (such as morning sickness, backache, varicose veins, ankle swelling, bladder problems) are excluded; or (f) For Income Protection cover, participation in a criminal act. In addition to (a), (b) and (c) above, Voluntary Cover for group life cover will also not be payable where a claim is directly or indirectly the result of suicide, attempted suicide or intentional self-inflicted harm, within 13 months from the date the Voluntary Cover was accepted.
Insurance fees	
Insurance fees (premium) payable	Means the money paid to the Insurer or owed to the Insurer for the insurance they provide under the Policy. See the Insurance Fee Schedule.
When does cover cease?	
When does Cover cease?	Cover for an Insured Person ceases on the earlier of: (a) when they reach the Cover Ceasing Age; or (b) when they cease to be an Insured Person under the Employer Plan; or (c) when they cease to be an Australian Resident; or (d) subject to the terms set out in the 'Extension of Cover' section of this Appendix, when they cease to be employed by their Employer; or (e) when they commence active service with the armed forces of any country, except as a member of the Australian Defence Force Reserves whilst performing duties within Australia; or (f) when they are accepted under a Continuation Option policy; or (g) subject to the terms set out in 'Is a Terminal Illness Benefit provided' section of this Appendix, when the Insurer admits a claim for a benefit for them (Applicable to Death and TPD cover); or (h) when they exercise their right to direct future contributions to another fund and transfer their entire account balance to this fund as a result of choice of fund legislation (except where the person continues to maintain fund insurance premiums and continues to be employed by the Employer); or (i) for Income Protection cover, when they are on Employer approved leave for longer than the period of time that the Insurer has agreed to provide cover for them; or (j) when they cease to reside in Australia or fail to meet the Insurer's agreed terms set out in the 'Employer secondment overseas' section of this Appendix; or (k) when they die; or (l) when they retire permanently from the workforce; or (m) when they are subject to a fraudulent claim under the Policy; or (n) when the Trustee wishes cover to cease for the Insured Person, if it gives us a notice to that effect; or (o) when all cover for every Insured Person under the Policy ceases; or (p) when their account balance reduces to $0, or is insufficient to pay the premium (Insurance fees), and the premium (Insurance fees) remains unpaid for two months. Where the Insured Person had previously paid a premium, cover will be cancelled two months after the date the person first went into arrears. For avoidance of doubt, where the Eligible Person has never paid a premium, cover will be deemed not to have commenced; or (q) if we have not received a contribution or rollover into your account for a period of 16 consecutive months and you have not notified us that you want the cover to continue, unless an employer-sponsor contribution exception applies; or (r) the day your PMIF exception is no longer applicable and you are either under 25 years of age, or have an account balance which has never reached $6,000 since November 2019.

When all cover ceases	All cover under the Policy ceases on the earlier of: (a) when the Trustee has failed to provide the Insurer with the information it is obliged to provide for the Insurer to establish the total amount of premium due to the Insurer for the preceding 12 months within 90 days of an Annual Review Date; or (b) when the Trustee has failed to pay the Insurer a final premium, deposit premium or an Instalment within 30 days of the date it fell due; or (c) when the Trustee notifies the Insurer that it wishes to terminate the Policy; or (d) when the Plan is wound up or is amalgamated with an there fund in circumstances where the Trustee ceases to be the Trustee of the Plan; or (e) when legal proceedings are commenced for the winding up of the Trustee.
Reinstatement of cover	Cover for an Insured Person that has ceased is only reinstated if the Insurer agrees to reinstate the cover in writing. Reinstated cover is subject to any terms, conditions or restrictions the Insurer considers appropriate at the time of the reinstatement. There may be circumstances where reinstatement without underwriting is possible, such as where insurance cover has ceased due to 16 months continuous inactivity or you no longer meet other regulatory requirements or an exception. If this is the case, reinstatement terms may be available and you will be informed of those terms either prior to, or at the time your cover cancels.
What happens when an employee leaves their Employer?	
Choose Your Own Cover	If your Employer notifies us that you have left employment with them, your Default and Voluntary cover will be converted to a fixed amount of Choose Your Own cover within ANZ Smart Choice Super. The cover will be provided by Zurich Australia Limited, the insurer for Choose Your Own cover within ANZ Smart Choice Super. The cover amount will be equal to the amount of cover held on the date that you have left your Employer.
Alternate Cover	If an Insured Person ceases to be employed by their Employer and Choose Your Own cover within ANZ Smart Choice Super does not apply, provided that person is not receiving or entitled to receive payment of benefits under the Policy, that person is entitled to: (a) an extension of Insured cover as outlined below, and (b) exercise a Continuation Option, as outlined below.
Is Extension of Cover available?	Yes, for members that leave their Employer and choose not to receive Choose Your Own cover within ANZ Smart Choice Super.
What are the conditions of the Extension of Cover?	Where the terms outlined in the Alternate Cover section above apply, an Insured Person shall be deemed to have Accident Cover in place and current until the earlier of: (a) 60 days after the date their cover ceased due to leaving employment with the Employer; or (b) they reach the Cover Ceasing Age; or (c) they are engaged under a contract of employment other than with the Employer; or (d) they become insured under any other life or income protection insurance arrangement, including a policy issued as a result of a continuation option. If Accident Cover begins under Alternative Cover, the amount of Accident Cover payable will be: (a) for group life cover, the lesser of $1,500,000 or the cover in force at the date it ceased under the Policy. (b) for income protection cover, the lesser of $15,000 per month or the cover in force at the date it ceased under the Policy. Where this applies, a person is only eligible to receive a Monthly Benefit for a total of 24 months.
Is Continuation Option available?	Yes. The Continuation Option is an option for an Insured Person to apply to continue cover for Death only, and where applicable TPD and Income Protection under a personal life insurance policy issued by another insurer nominated by the Insurer without evidence of health and subject to the conditions of a Continuation Option set out on the next page.

What are the conditions of the Continuation Option?	For the Insured Person to obtain cover under the Continuation Option for Death only, Death and TPD or Income Protection: (a) they must exercise the Continuation Option within 60 days of ceasing to be employed by their Employer; and (b) they must be less than 60 years of age at the date of ceasing employment; and (c) they must not have commenced active service with the armed forces of any country, except as a member of the Australian Defence Force Reserves whilst performing duties within Australia; and (d) they must be commencing employment as a Permanent Employee or Contractor, working 15 hours or more each week in an occupation that is not deemed to be an uninsurable risk by the nominated Insurer; and (e) they are commencing alternative employment within 90 days of ceasing employment; and (f) they are not ceasing employment due to a redundancy; and (g) they have not submitted and must not be entitled to submitted claim under the Policy and additionally for income protection cover, must not have previously received any benefits under the Policy or similar payments under any other policy; and (h) the premium for the personal life or income protection insurance policy is paid. The premium payable for the personal life or income protection insurance policy will be subject to the nominated insurer's premium rates and minimum premium. (i) the benefit under the Continuation Option being the lesser of: • for group life cover, the insured cover under the Policy at the time of ceasing employment or $1,000,000 or the amount available with the nominated insurer. • for income protection cover, the insured cover under the Policy at the time of ceasing employment, 75% of income declared to the insurer of the personal life insurance policy, the Maximum Monthly Benefit , or the amount available with the nominated insurer. The personal life insurance policy will be provided on the terms, conditions and rates that are available at the time with the nominated insurer and they must satisfactorily complete the nominated insurer's application form and meet their criteria. Any special terms, conditions, restrictions, exclusions or premium loading applying to the person under the Policy will apply under the personal life insurance policy. In the case of income protection cover, an indemnity style policy will be issued. For group life cover, cover under the personal life insurance policy will only continue up to the Cover Ceasing Age or their 65th birthday, whichever occurs first. For income protection cover, the monthly benefit under the personal income protection insurance policy will be no more than the entitlement under the Policy. The Benefit Period and Waiting Period which last applied to the Insured Person will apply, however where the personal life insurance policy does not offer the same features, the Benefit Period will be rounded down and the Waiting Period will be rounded up. Cover under the personal life insurance policy will only continue up to the Cover Ceasing Age or their 65th birthday, whichever occurs first.
General	
Automatic increases to Agreed Cover (group life cover only)	The Trustee may increase the amount of Agreed Cover for an Insured Person by recording that it has commenced for the increased amount if: a. The amount of the Agreed Cover when increased does not exceed the Automatic Acceptance Limit or any Forward Underwriting Limit that the Insurer has granted to an Insured Person, and b. The Agreed Cover is consistent with the formula used for Agreed Cover, and c. The Insured Person was At Work when their Agreed Cover increased under The Policy. If an Insured Person does not meet this requirement, then Limited Cover will apply to the increase until the date the Insured Person is At Work for a 30 consecutive day period. The Insurer reserves the right to request the Policy Owner to provide certification. If these requirements have not been met, any increase is subject to underwriting.

Life Events Cover (applicable for group life cover only)	An Insured Person can increase their Default Cover Agreed Benefit without providing medical evidence if a Nominated Event occurs. The maximum amount of the increase is the lesser of 25% of their Agreed Benefit, $200,000, the increase in mortgage (if existing) or the amount of the mortgage (if new). The increase due to the Nominated Event does not apply to Voluntary Cover. The Insured Person can only increase their cover once for any Nominated Event in any 12 month period, and increase their cover only once for each Nominated Event. When a Nominated Event occurs, an Insured Person can increase their cover provided: • they are an Insured Person with cover in place and current on the date the Nominated Event occurred; and • they are less than 60 years of age on the date they applied for cover under these 'Life Events Cover' terms; and • they have not been declined for cover, or have any special terms, condition, restriction, exclusion or premium loading applying to their cover, under the Policy; and • they must not be applying for, entitled to, or have been paid a TPD benefit or Terminal Illness Benefit from the Policy, any superannuation fund or life insurance policy; and • they provide the Insurer with sufficient proof to their satisfaction that the Nominated Event occurred; and • the fully completed and signed application to request the increase in cover is received by the Insurer within 90 days of the Nominated Event; and • their Agreed Benefit will not exceed the Maximum Benefit Level shown in this Appendix; and • they are At Work on the date the Nominated Event occurred and At Work on the date the Insurer accepts the application. The increase to Agreed Cover will commence on the date that the Insurer notifies the Trustee in writing. Cover will be Limited Cover for the increased portion of Insured Cover and will apply for the first 12 months after the Insurer has accepted the application. The Insured Person can only increase their Agreed Cover once for any Nominated Event in any 12 month period and can only increase their Agreed Cover once for each Nominated Event. The Insured Person will be eligible to increase their Agreed Cover for the same type of cover for which they are currently insured. The Insurer will not pay the increased Agreed Cover if Death, or Total and Permanent Disablement, was the result of suicide, or a self-inflicted Injury, that occurred within the first 13 months from the date they agree to the increase.
Limited Cover	means the Insurer will only consider a claim arising from an Illness which first Manifests itself or an Injury which occurred on or after the date the cover commenced, most recently commenced or increased (where applicable) under the Policy and was not related to the condition that occurred before the date the cover commenced, most recently commenced or increased (where applicable) under the Policy.

Transfer of cover	An Eligible Person can elect to transfer other existing cover to the Fund if they are insured under: (a) A group life insurance policy; or (b) An individual retail life insurance policy provided they were underwritten and accepted for cover within the previous 5 years. The transfer of other existing cover to the Fund is subject to the Eligible Person meeting the following criteria: (i) The Eligible Person must be aged less than 65; and (ii) The Eligible Person must not be working in an Excluded Occupation; and (iii) The Eligible Person must confirm that their insured benefit in the existing fund or insured policy will cease on cover commencing under the Policy. No claim will be considered under the Policy where they retain any form of their previous cover elsewhere; and (iv) For income protection cover, the Eligible Person must transfer their entire account balance to the Fund; and (v) The Eligible Person must not continue the cover, after acceptance of the transfer under the Policy, under any other insurance arrangement, reinstate cover or effect a continuation option with any fund; and (vi) The Eligible Person must provide a copy of their most recent Benefit Statement or Policy Renewal Statement dated within the previous 12 months as evidence of their current cover and insured benefit previously held. This includes a copy of the advice they received from the insurer or fund advising them of acceptance of their insurance and if the acceptance was on standard terms or subject to additional terms; and (vii) The Eligible Person's existing cover must not be subject to any premium loading, restriction, exclusion or pre-existing condition exclusion or restriction in regard to medical or other conditions; and (viii) The Eligible Person must satisfactorily complete the Fund's Transfer of Cover Application Form, including answering 'no' to the agreed health questions, that is received by the Fund within 31 days of being signed and dated. Where all of the above requirements have been met, cover will commence from the latter of the date the Insurer accepts the Transfer of Cover Application Form and their account balance being sufficient to pay Premium. If their account balance is not sufficient to pay Premium within 31 days of the date the Insurer accepts the Transfer of Cover Application Form then the transfer of cover will not be considered to have started and a new Transfer of Cover Application Form is required to be completed. The amount of cover will be transferred across as Voluntary Cover for the same type of cover. For income protection cover, if this is not available they will receive the next higher Waiting Period and the next lower Benefit Period. The total Insured Cover after transfer must not exceed a Monthly Benefit of $15,000 per month for income protection cover or $1,500,000 for group life cover. When combined with existing Insured Cover in the Fund the total must not exceed the Maximum Monthly Benefit or Maximum Insured Cover (as applicable). Where any of the above requirements have not been met, transfer of cover will not be considered to have started and any Premium paid in relation to this section (Transfer of cover) will be refunded.
Takeover terms	Take over terms apply, in accordance GSC Guidance Note 11.

Cover during Employer approved leave	Subject to the terms of 'When does Cover cease?' section of this Appendix, cover will continue in respect of an Insured Person on Employer approved leave provided they continue to be employed by their Employer and the Insurer receives premium in respect of them. The Insurer requires to be notified prior to the commencement of any period of leave if cover is not to be continued in respect of an Insured Person during such period of leave. When an Insured Person returns to work with their Employer, cover that was terminated by the Insured Person during the period of leave can only be reinstated subject to underwriting. Additionally for income protection cover: • the period of leave is no longer than 2 years, although cover may continue after 2 years on such terms as the Insurer permits. • where an Insured Person suffers Total Disability during Employer approved leave, their Monthly Benefit accrues from the latter of: (i) the days after the expiry of the Waiting Period; and (ii) the return to work date agreed with their Employer. • where an Insured Person's salary is used to calculate their Agreed Benefit or Monthly Income used to calculate their Monthly Benefit, the salary or Monthly Income which applied to the Insured Person on their last working day immediately prior to the commencement date of their leave period will apply. Additionally for group life cover: • the Total & Permanent Disablement definition that would have applied to the Insured Member on the date their Employer approved leave commenced will continue to apply for the first 2 years of their Employer approved leave. However, if an Insured Person continues to be on Employer approved leave for more than 2 years, the Total & Permanent Disablement definition that will apply until the Insured Person has returned to employment and is At Work will be b, c or d, where the member's Total & Permanent Disablement commenced prior to 1 July 2014, or Part 3, Part 4 or Part 5, where the member's Total & Permanent Disablement commenced on or after 1 July 2014. • if an Insured Person's salary is used to calculate their cover, the cover during the period of Employer approved leave will be calculated using the salary of the Insured Person on the last working day immediately prior to the commencement date of their leave period.
Employer secondment Overseas	Subject to the terms of section 'When does Cover cease' section of this Appendix, Insured Cover will continue for an Insured Person seconded to work Overseas for their Employer provided: (a) they continue to be employed by their Employer, or associated employer, and the Insurer continues to receive the premium in respect of them; and (b) the period of Employer secondment Overseas is no longer than 5 years; and (c) in the Insurer's opinion, the residence Overseas continues to be temporary in nature; and (d) the Insured Person is not insured under any other arrangement with their Employer or associated employer; and (e) the details of all Insured Person's working Overseas were provided to the Insurer at the time the Insurer prepared their quotation. The Insurer requires to be notified prior to the commencement of any period of Overseas residence if cover is not to be continued in respect of an Insured Person during such period. When an Insured Person returns to Australia and resumes work with their Employer, cover that was terminated by the Insured Person during the period of Overseas residence can only be reinstated subject to underwriting.
Benefit whilst residing Overseas	Whilst an Insured Person is Overseas, or resides in Australia and subsequently travels Overseas, the Insurer reserves the right to ask the Insured Person to return to Australia at their own expense in the event they lodge a claim for TPD, Terminal Illness or Income Protection. For income protection cover, when an Insured Person is Overseas, or resides in Australia and subsequently travels Overseas and becomes disabled, the Insurer will not be liable to pay benefits for more than a total of 6 months while they remain Overseas. However, if the entitlement to the benefit is continuing, the Insurer must continue to pay the Monthly Benefit again with effect from the date they return to Australia. The Insurer reserves the right to ask the Insured Person to return to Australia at their own expense for the ongoing assessment of a claim.
Leave due to injury or illness	Insured Cover will continue for an Insured Person who is absent from work due to Injury or Illness provided they continue to be employed by their Employer and the Insurer receives Premium for them. If Insured Cover does not continue for an Insured Person during a period of leave then the Insurer must be notified in writing before the period of leave commences and can only be reinstated subject to underwriting.

Claims	
Notice of claim	Initial notice of claim must be given to the Insurer as soon as possible after the incident that has caused the claim. This process ensures the Insurer can efficiently and effectively manage all claims. The Insurer will only consider a claim where the delay in notification does not prejudice their ability to assess the claim.
Proof of claim	The Insurer is not able to complete the assessment of a claim for the Insured Person until they have received the requirements the Insurer reasonably considers necessary to properly assess the claim. Assessment of any claim is conditional on the Insured Person or their representative agreeing to provide any requested information to the Insurer about the claim in the timeframe the Insurer communicates, if required, agreeing to be interviewed by the Insurer or someone the Insurer appoints. The Insured Person must attend any medical examinations or other assessments which the Insurer may require at their discretion. The Insurer will not pay for any costs incurred in obtaining any evidence, including for travel or accommodation, unless the cost was approved by the Insurer prior to it being incurred.
Medical examination and assessments	The Insurer will pay the practitioner's fees if they arrange for the Insured Person to be medically examined or assessed in connection with a claim. If the Insured Person fails to attend the Insurer will not proceed with the assessment of their claim and will suspend further payments until they attend. If the Insurer incurs a non-attendance fee, they may ask for the non-attendance fee to be paid by the Insured Person prior to continuing to assess the claim.
Reviewing claims	The Insurer will not pay any costs or expenses incurred by the Policy Owner or the Insured Person in obtaining evidence to support their request for a review of a claim the Insurer has declined.
Claims after the insured person's insured cover has ceased	For group life cover: The Insurer will not pay a benefit for Death, where the date of death is after the date that Insured Cover ceased. The Insurer will not pay a benefit for Total and Permanent Disablement, where the Date of Disablement is after the date that Insured Cover ceased. The Insurer will not pay a benefit for Terminal Illness, where the Date of Certification is after the date that Insured Cover ceased. Where the Insured Person is eligible for a death, total and permanent disablement or terminal illness claim under a new replacement policy then the Insurer will not pay a benefit for them. For income protection cover: If the Waiting Period for an Insured Person began before cover ceased, the Insurer will be liable to pay a benefit for them as a result of an Injury or Illness under the terms of The Policy until they are At Work. The Insurer will not pay a benefit for a person if the Waiting Period commences after the date the Insured Cover ceased.
Claim payment (for income protection cover)	After the conclusion of the Waiting Period the Insurer will pay all Total Disability and Partial Disability benefits monthly in arrears. Subject to the Waiver of premium section of this Guide, the Insurer will only pay a Monthly Benefit for an Insured Person where Premium has been calculated and paid. If a benefit is payable for less than the whole month, the Insurer will pay 1/30th of the benefit for each day the benefit is payable. If the Insurer is required by law to deduct any amount from a benefit, they may deduct the amount they consider they are obliged to deduct and pay it to the relevant collection authority. The Insurer's liability to pay the relevant benefit under the Policy will be discharged to the extent of the Insurer's payment of the deduction amount. If an Insured Person has more than 1 Injury or Illness causing their Total Disability or Partial Disability, whether they are related or not, only 1 Total Disability benefit or Partial Disability benefit will be payable. The insurer will cease payments for an Insured Person at the earliest of the following events: (a) They no longer meet the definition of Total Disability or Partial Disability; or (b) They die; or (c) The Benefit Period expires; or (d) They attain the Cover Ceasing Age; or (e) They are no longer under the regular care of and following the advice of a Doctor; and (f) They reside Overseas for a period longer than agreed by the Insurer (refer to the Employer secondment overseas section of this Guide); or (g) The Policy Owner or the Insured Person fails to provide the Insurer with any requested information that is required to assess the Insured Person's claim; or (h) A fraudulent claim is made by the Insured Person. The Insurer will pay all benefits to the Trustee. If the Trustee instructs the Insurer in writing to pay anyone other than the Trustee then the payment in accordance with that written instruction is a full discharge of the Insurer's liability for the claim. All benefits will be paid in Australian currency.

DEFINITIONS

Accident Cover	Means cover for an unintended and unexpected Injury only.
Active Employment	Means in the Insurer's opinion a person is capable of performing all of the normal duties of their usual occupation, without restriction by any Injury or Illness, for at least 30 hours per week (whether or not they are actually working those hours).
Activities of Daily Working	Means: (a) Walking – they can walk more than 200 metres on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body. (b) Rising/Sitting – they are able to rise and sit using a raised chair with arms without the help of another person. (c) Dexterity – they are able to write legibly with a pen or pencil or use a keyboard with either hand. (d) Communication – they can: (i) Clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room in their first language, or (ii) Understand simple messages in their first language, or (iii) Speak with sufficient clarity to be clearly understood in their first language. (e) Eyesight – their visual ability is such that they can function independently in a workplace without physical assistance from another person even with or without the use of assistive devices.
Agreed Cover	Means the amount of benefit that the Insurer has agreed to for an insured person.
Annual Review Date	Means the effective date at which the Trustee and the Insurer review the Insured Cover and Premium each year.
Approved Rehabilitation	Means a program, device or course of treatment certified by a Doctor or other health professional to be necessary for the rehabilitation of a person but excluding any program providing hospital treatment or an ancillary health service within the meaning of the *National Health Act 1953* or any other program which might cause the Policy to cease to be exempt from the *National Health Act 1953* or *Health Insurance Act 1973* or any similar legislation in connection with health insurance.
At Work	Means that an Eligible Person or Insured Person: (a) is actively performing all of the duties and hours of their usual occupation for their Employer; or (b) if on Employer approved leave (except leave caused by Injury or Illness) they would otherwise be able to attend work and perform their normal duties without restriction due to Injury or Illness; or (c) is not in receipt of and/or entitled to claim income support benefits from any source including but not limited to workers compensation benefits, statutory transport accident benefits and disability income benefits.
Australian Resident	Means an Australian citizen or a person who is the holder of an Australian permanent visa within the meaning of Section 30 (1) of the *Migration Act 1958* or resides in Australia on a temporary working visa. It also includes a New Zealand citizen who is residing and working in Australia.
Automatic Acceptance	Means Agreed Cover or Insured Cover (as applicable) commencing under the section 'Automatic Acceptance & Commencement of Cover' in the Appendix.
Automatic Acceptance Limit	Means the maximum amount for which cover may come into force as a result of Automatic Acceptance that is stated in the Appendix.
Benefit Period	Has the meaning provided in the Appendix of this Guide.
Casual	Means engaged in employment of a temporary nature where continuity of employment is not guaranteed by the Employer regardless of hours worked or the period of employment.
Choice of Fund	Means the meaning given to it in the Superannuation Guarantee (Administration) Act 1992 and related legislation.
Cognitive Loss	Means a total and permanent deterioration or loss of intellectual capacity.
Contractor	Means a person who is working on a fixed term contract for the Employer with a duration of at least 12 months that requires the person to perform identifiable duties for a regular number of hours each week.

Cover Ceasing Age	Means: • for Death Cover, cover ceases on the Insured Person's 70th birthday; and • for TPD Cover (excluding casuals), cover ceases on the Insured Person's 70th birthday; and • for Casual employees, Default TPD Cover ceases on the Insured Person's 65th birthday and Voluntary TPD Cover ceases on the Insured person's 70th birthday; and • for Income Protection Cover, cover ceases on the Insured Person's 70th birthday.
CPI	Means the Consumer Price Index (all groups and all capital cities) published by the Australian Bureau of Statistics. If no such CPI is published, the CPI will be a figure determined by the Insurer at the Insurer's discretion.
Date of Commencement	Means the Date of Commencement of the Policy.
Date of Certification	Means the latter of the dates 2 Doctors approved by the Insurer have certified (the date of diagnosis), jointly or separately, that the Insured Person suffers a Terminal Illness. At least 1 of the Doctors must be a specialist practising in the field to which the Terminal Illness relates. Each of the certificates must be supported by test results and the certification period must not have ended.
Disability	Means either Total Disability or Partial Disability.
Doctor	Means a registered medical practitioner who is legally qualified and properly registered to practice in Australia or New Zealand and acceptable to the Insurer. That person may not be the Insured Person, or the spouse, family member, business partner, employee or Employer of the Insured Person.
Eligible Contribution	Means contributions that include Superannuation Guarantee, additional Employer contributions, personal contributions (including voluntary contributions and contributions made by a spouse), rollovers directly from another superannuation account held on behalf of the Eligible Person and automatic transfers from other superannuation funds. An amount allocated by the Australian Tax Office, co-contributions and the low income super tax offset are not considered an Eligible Contribution.
Eligible Person	Means a person who satisfies the conditions described in 'Who is eligible for cover' in this Guide.
Employed (for group life cover)	Means (a) Engaged under a contract of employment with an Australian Employer (which includes on secondment or transfer to an international subsidiary or an associated or affiliated company of an Australian employer); or (b) On employer approved leave for less than 2 years with an Australian Employer; or (c) Working for an overseas Employer for at least 15 hours per week.
Employer Contribution	Means the mandatory Superannuation Guarantee contribution amount remitted by their Employer to be credited to the Insured Person's account in respect of a period of employment.
Excluded Occupation	Means, for the purpose of Transfer of Cover only: (a) Aviation worker such as a pilot, air traffic controller or aerial photographer; (b) Emergency services worker such as a fireman, police officer, ambulance officer or paramedic, except as a volunteer; (c) Entertainer working professionally such as an actor, dancer, musician or performer; (d) Forestry worker such as a tree feller or sawmill worker; (e) Horse racing industry worker such as a jockey, trainer or strapper; (f) Offshore worker such as a fisherman, oil rig worker or diver; (g) Seasonal worker; (h) Security worker such as a security guard, doormen, bouncer or crowd controller; (i) Sex worker; (j) Sports person working professionally or semi-professionally; (k) Underground or underwater worker; (l) Working at heights above 10 metres such as a rigger, scaffolder or roof worker.

First Eligible	means a person is first eligible to join the Fund on the later of: (a) The first time they commence employment with a Participating Employer at which time a Fund membership number is first allocated to them; or (b) When their employer becomes a Participating Employer but only where the employer selects the Fund to be the current default superannuation fund for the purpose of Superannuation Guarantee contributions for their employees at which time a Fund membership number is first allocated to them. Should an employee of a Participating Employer first become eligible to receive a Superannuation Guarantee contribution at a date later than (a) or (b), then this date will become the date they were first eligible to join the Fund.
First Member Account	Means the account in the Fund that is allocated to the Eligible Person when they have no other account open in the Fund.
Forward Underwriting Limit	Means any amount of Agreed Cover for an Insured Person that the Insurer has notified the Trustee which they will accept for automatic increases under the section 'Increases to Agreed Cover' without the requirement of further evidence.
Gainful Employment	Means employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment at the time we assess the claim and includes part-time occupations, an occupation which may be perceived by the Eligible Person or Insured Person to be of lower status than their previous occupation or an occupation in which they do not earn as much income as they did in their previous occupation.
Illness	Means a sickness, disease or disorder.
Immediate Assessment Conditions	Means any of the following: (a) **Blindness** – the permanent loss of sight in both eyes, whether aided or unaided, due to Injury or Illness to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 20 degrees or less of arc, as certified by an ophthalmologist. (b) **Cardiomyopathy** – condition of impaired ventricular function of variable aetiology (often not determined) resulting in significant physical impairment, i.e. Class 3 on the New York Heart Association classification of cardiac impairment or a left ventricular ejection fraction of less than 35%. (c) **Chronic Lung Disease** – the permanent end stage respiratory failure with FEV1 test results of consistently less than 1 litre or requiring continuous permanent oxygen therapy or FEV1 of less than 35% of predicted value on two separate occasions 6 months apart and confirmed by a pulmonologist. (d) **Dementia and Alzheimer's Disease** – the clinical diagnosis of dementia (including Alzheimer's disease) as confirmed by a consultant neurologist, psycho-geriatrician, psychiatrist or geriatrician. The diagnosis must confirm permanent irreversible failure of brain function resulting in significant cognitive impairment for which no other recognisable cause has been identified. Where significant cognitive impairment means a deterioration in the person's Mini-Mental State Examination scores to 24 or less and deterioration would continue but for any effective treatment. Dementia related to alcohol or drug abuse are excluded. (e) **Diplegia** – the total loss of function of symmetrical sides of the body due to Injury or Illness, where such loss of function is permanent. (f) **Hemiplegia** – the total loss of function of 1 side of the body due to Injury or Illness, where such loss of function is permanent. (g) **Loss of Hearing** – the complete and irrecoverable loss of hearing, both natural and assisted from both ears of 90dB or more over the frequencies 500Hz, 1000Hz, 2000Hz, and 3000Hz on 2 occasions taken 6 months apart. The loss of hearing must be as a result of Injury or Illness, as certified by an ear, nose and throat specialist. (h) **Loss of Speech** – the total and irrecoverable loss of the ability to produce intelligible speech as a result of permanent damage to the larynx or its nerve supply or the speech centres of the brain. The loss must be certified by an appropriate medical specialist not less than ninety days after the ability to speak was first lost. (i) **Major Head Trauma** – Injury caused by an external force to the head resulting in neurological deficit causing either:

Immediate Assessment Conditions (continued)

(i) A permanent loss of at least 25% whole person function (as defined by the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment latest Edition' or the equivalent guide to the evaluation of impairment approved by the Insurer); or

(ii) The permanent and irreversible inability to perform without the assistance of another person any 2 of the following activities of daily living:

(i) **Dressing** – the ability to put on and take off clothing,

(ii) **Bathing** – the ability to wash or shower without assistance,

(iii) **Toileting** – the ability to use the toilet, including getting on and of,

(iv) **Mobility** – the ability to get in and out of a bed and a chair,

(v) **Continence** – the ability to control bowel and bladder function,

(vi) **Feeding** – the ability to get food from a plate into the mouth, as certified by a consultant neurologist.

(j) **Motor Neurone Disease** – unequivocal diagnosis of motor neurone disease by a consult neurologist and confirmed by neurological investigations.

(k) **Multiple Sclerosis** – the unequivocal diagnosis of multiple sclerosis as confirmed by a consultant neurologist and characterised by demyelination in the brain and/or spinal cord evidenced by Magnetic Resonance Imaging or other investigations acceptable to the Insurer. There must have been more than 1 episode of well-defined neurological deficit affecting different anatomical sites with a permanent loss of at least 25% whole person function as defined by the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment (current edition)' or equivalent guide to impairment approved by the Insurer.

(l) **Muscular Dystrophy** – the unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist with at least 25% Impairment of Whole Person Function that is permanent, as defined in the current American Medical Association impairment approved by the Insurer.

(m) **Paraplegia** – the permanent loss of use of both legs resulting from spinal cord Injury or Illness.

(n) **Parkinson's Disease** – the unequivocal diagnosis of Parkinson's disease by a consultant neurologist with the inability to perform without the assistance of another person any 2 of the following activities of daily living:

(i) **Dressing** – the ability to put on and take off clothing,

(ii) **Bathing** – the ability to wash or shower without assistance,

(iii) **Toileting** – the ability to use the toilet, including getting on and off,

(iv) **Mobility** – the ability to get in and out of a bed and a chair,

(v) **Continence** – the ability to control bowel and bladder function,

(vi) **Feeding** – the ability to get food from a plate into the mouth.

(o) **Primary Pulmonary Hypertension** – primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation resulting in significant permanent physical impairment to the degree of at least Class 3 on the New York Heart Association classification of cardiac impairment, or where there is a pulmonary artery pressure (PAP) of more than 30mmHg.

(p) **Quadriplegia** – the permanent loss of use of both arms and both legs, resulting from spinal cord Injury or Illness.

(q) **Severe Burns** – tissue injury caused by thermal, electrical or chemical agents causing third degree burns to 20 per cent or more of the Body Surface Area as measured by the 'rule of Nines' or the Lund and Browder Body Surface Chart, or to the whole of the face or the whole of both hands requiring surgical debridement and/or grafting.

(r) **Severe Rheumatoid Arthritis** – the unequivocal diagnosis of Severe Rheumatoid Arthritis by a rheumatologist in accordance with the '2010 Rheumatoid Arthritis Classification Criteria' published by the American College of Rheumatology and European League Against Rheumatism, with evidence of persistent joint inflammation and progressive disease. There must be evidence of a poor clinical response to:

(i) At least six (6) months of treatment with oral disease modifying anti-rheumatic drugs (DMARDs); and

(ii) All conventional therapy including biological agents.

Degenerative osteoarthritis and all other arthritis are excluded.

Inactive/ Inactivity	Means the Policy Owner has not received an amount for an Insured Person's account for 16 consecutive months.
Injury	Means bodily injury caused by violent, external and visible means.
Insured Cover	Means the amount of benefit that the Insurer has agreed to for an Insured Person.
Insured Person	Means an Eligible Person for whom cover other than Accident Cover is in place and current.
Limited Cover	Means the Insurer will only consider a claim arising from an Illness which first manifests itself or an Injury which occurred on or after the date the Insured Person's cover commenced, most recently commenced or increased (where applicable) under the Policy and was not related to the condition that occurred before the date their cover commenced, most recently commenced or increased (where applicable) under the Policy.
Loss Of Use Of	Means: (a) The permanent loss of sight, whether aided or unaided due to Injury or Illness to the extent that the visual acuity is 6/60 or less in both eyes, or to the extent that visual field is reduced to 20 degrees or less of arc, as certified by an ophthalmologist; or (b) The loss of the use of a leg from at or above the ankle, or an arm from at or above the wrist, which is permanent.
Manifests	Means that symptoms exist which would cause an ordinary prudent person to seek diagnosis, care or treatment, or that medical advice or treatment has been recommended by or received from a Doctor.
Maximum Entry Age	Means the maximum age of a person to be eligible to apply for cover under the Policy. The Maximum Entry Age for new members is prior to their 67th Birthday.
Maximum Monthly Benefit	Has the meaning provided in the Appendix of this Guide.
Member Application Form	Means the form a person completes to join the Fund.
Minimum Entry Age	Means the minimum age of a person to be eligible to apply for cover under the Policy. The Minimum Entry Age is age 15. You must provide an opt-in election if you are under 25, unless you are covered by a PMIF exception.
Minimum Member Details	Means name, date of birth, address and the date employment commenced.
Monthly Benefit	Means the amount of Insured Cover for an Insured Person.
Monthly Income	Means: (a) where the Insured Person is employed, 1/12th of the annual pre-tax income paid by the Employer to the Insured Person; or (b) where the Insured Person directly or indirectly owns all or part of the business, including all or part ownership through another legal entity, from which they earn their usual income, 1/12th of the gross amount earned by the business in the 12 months immediately before the period of Total Disability, as a direct result of the Insured Person's personal exertion or activities through their usual occupation after allowing for the costs and expenses incurred in deriving that income. Income from the business will not include investment income, profit distributions or similar payments that may continue in the event of Total Disability or Partial Disability.
Nominated Event	Means: (a) Marriage; or (b) Divorce; or (c) The Insured Person or their Partner gives birth or adopts a child; or (d) The Insured Person purchases a home for their permanent residence with a mortgage on that residence of $100,000 or more; or (e) The Insured Person takes out a new business loan, or increases an existing business loan, of more than $100,000.

On-time	Means the Superannuation Guarantee (SG) contribution is paid by the Participating Employer to the Fund by the quarterly payment due date as specified in the *Superannuation Industry (Supervision) Act 1993 (Cth).*
Other Disability Income	Means any income, other than income under the Policy, which a person may derive during a month for which a benefit under the Policy is being assessed, whether that income was actually received or not, and includes: (a) Any other income derived as a result of incapacity under any other insurance policy, and (b) Federal or Territory legislation; and (c) Sick leave entitlements; and (d) Termination payments from the Employer. It does not include: (e) Income earned from investments, (f) Any lump sum total and permanent disablement benefit, lump sum superannuation benefit, lump sum trauma or terminal illness style of benefit, (g) Annual leave or long service leave entitlements; or (h) Centrelink payments. Any Other Disability Income that is in the form of a lump sum, or is commuted for a lump sum, has a monthly equivalent of 1% of the lump sum for each month a disability benefit is paid. If it can be shown that a portion of the lump sum represents compensation for pain and suffering, or the loss of use of a part of the body, the Insurer will not take that portion into account as Other Disability Income. Where a common law, workers compensation or statute payment is received as a lump sum and pain and suffering cannot be isolated from loss of earnings, the Insurer will convert this to income on the basis of 1% of the lump sum for each month a disability benefit is paid.
Overseas	Means anywhere other than the Commonwealth of Australia and its Territories or New Zealand.
Participating Employer	Means an employer who makes or agrees to make Superannuation Guarantee (SG) contribution payments to the Fund on behalf of an employee who is a member of the Fund. For the avoidance of doubt, a Participating Employer includes: (a) An employer who has selected the Fund to be the current default superannuation fund for the purpose of Superannuation Guarantee (SG) contribution payments for their employees; and (b) An employer who has selected a different fund to be their default superannuation fund but directs Superannuation Guarantee (SG) contribution payments for an Eligible Person to the Fund under Choice of Fund legislation. A self-employed person is not a Participating Employer.
Partner	Means a legal spouse or a person living with an Insured Person as their spouse on a bona-fide domestic basis, they may be the same sex as the Insured Person.
Permanent Employee	Means an Eligible Person who is employed on a permanent basis under an ongoing contract that: a. requires an Eligible Person to perform identifiable duties for a regular number of hours each week; and b. provides an Eligible Person to accrue annual leave, sick leave, leave loading and long service leave.
PMIF Election	Means the notification, in the form agreed between the Policy Owner and the Insurer, provided to the Fund by an Eligible Person, of their election to have cover taken out or maintained by the Fund in respect of them despite being aged less than 25 years or their account balance being less than $6,000.
PMIF Exception Member	Means the following Eligible Persons that the Policy Owner is permitted to provide insurance cover in respect of despite their account balance in the Fund having not reached $6,000 or their age is less than 25 years: a) An Eligible Person to whom the contribution exception applies in accordance with section 68AAE of the *Superannuation Industry (Supervision) Act 1993 (Cth);* or b) An Eligible Person to whom the dangerous occupation exception applies in accordance with section *68AAF of the Superannuation Industry (Supervision) Act 1993 (Cth*); or c) An Eligible Person who has made a PMIF Election.
PMIF Opt-in Election Form	Means the form the Eligible Person completes to opt-in for Insured Cover as described under automatic acceptance and commencement of cover.

Post-Disability Income	Means any income that an Insured Person may derive after the commencement of the Waiting Period during a month for which a benefit under the Policy is being assessed. If an Insured Person is suffering Partial Disability but has not received such income, in order to enable the Insurer to calculate the benefit the Insurer will estimate their capacity to earn and substitute an amount for partial earnings.
Premium	Means the money paid to the Insurer or owed to the Insurer for the insurance provided under the Policy.
PYS Election	Means the notification, in the form agreed between the Policy Owner and the Insurer, provided to the Policy Owner by an Insured Person to continue their Insured Cover if their account in the Fund becomes Inactive.
PYS Exempt Member	Means the following persons that the Policy Owner is permitted to provide insurance cover in respect of despite their account in the Fund being Inactive: a) An Eligible Person who has made a PYS Election; or b) An Eligible Person to whom section 68AAA(6) of the *Superannuation Industry (Supervision) Act 1993 (Cth)* applies.
Sum Insured (Agreed Benefit)	**Default Cover:** the amount of insured benefit calculated in accordance with the Benefit Design. **Voluntary Cover:** the amount agreed to by the Insurer. **Sum Insured** is also referred to as the Agreed Benefit in the Appendix.
Superannuation Guarantee (SG)	Means the mandatory Superannuation Guarantee (SG) contribution amount remitted to the Fund by an employer on behalf of an employee that is to be credited to the person's superannuation account in the Fund in respect of a period of employment.
Terminal Illness or Terminally Ill	Means a disease or condition that is highly likely to result in the Insured Person's death within 24 months from the Date of Certification.
Total and Permanent Disablement	Has the meaning given in the Appendix of this Guide.
Voluntary Cover	Means the amount of Voluntary Cover the Insurer has underwritten and accepted for the Insured Person. Voluntary Cover is available as a fixed amount subject to underwriting
Waiting Period	Has the meaning provided in the Appendix of this Guide.
Welcome Pack	Means the letter the Fund sends on first joining the Fund.

INSURANCE FEE SCHEDULE

HOW TO CALCULATE YOUR ANNUAL INSURANCE FEE (PREMIUM)

The premium you pay for Death only or Death and TPD cover is dependent upon your age (as at 1 July, or on the effective date of any change to your level of insurance cover), gender, type of cover, and amount of cover. The following formula shows how to calculate an annual premium using the premium rates based on your age next birthday (ANB) from the table below.

(ANB premium rate × sum insured) ÷ $1,000 = annual premium

The cost of your insurance cover may differ to the premium rates shown in the table below as the rates that will apply to you may be affected by medical or other loadings applied by the Insurer and are indicative only. The premium rates shown are inclusive of any applicable taxes that may be charged.

For example:

John works in a non-Perth location and has $300,000 of Default Death and TPD cover. At 30 June, John is 38 years old. His next Birthday is on 1 May at which time he will be 39.

As John's age next birthday is 39, the applicable Insurance fees for his cover will be:

Death: $0.6293
TPD: $0.8019

As his level of cover is $300,000, the annual Insurance fee that he will pay is:

[$300,000 × (0.6293 + 0.8019)] ÷ $1,000 = $429.36

INSURANCE FEE TABLE FOR (CATEGORY N1, CATEGORY C2) DEFAULT AND VOLUNTARY DEATH ONLY AND DEATH AND TPD COVER PER $1,000 OF SUM INSURED

Age next birthday	Male/Female Death	Male/Female TPD
16	0.6293	0.2944
17	0.6293	0.2944
18	0.6293	0.2944
19	0.6293	0.2944
20	0.6293	0.2944
21	0.6293	0.2944
22	0.5887	0.3350
23	0.5481	0.3350
24	0.5075	0.3350
25	0.4974	0.3756
26	0.4669	0.3756
27	0.4568	0.3756
28	0.4568	0.3756
29	0.4568	0.4263
30	0.4568	0.4263
31	0.4263	0.4669
32	0.4263	0.4669
33	0.4568	0.5075
34	0.4669	0.5481
35	0.4974	0.5583
36	0.5075	0.5989
37	0.5177	0.6395
38	0.5684	0.7207
39	0.6293	0.8019
40	0.6902	0.8831
41	0.7308	1.0150
42	0.7816	1.1673
43	0.8526	1.3703

Age next birthday	Male/Female Death	Male/Female TPD
44	0.9338	1.6037
45	1.0150	1.7966
46	1.1165	2.1112
47	1.2383	2.4360
48	1.3195	2.7913
49	1.4616	3.2379
50	1.5834	3.7251
51	1.7154	4.2123
52	1.8575	4.8517
53	2.0199	5.5318
54	2.2026	6.3235
55	2.3650	7.0238
56	2.5883	7.8561
57	2.8319	8.7798
58	3.0958	9.8557
59	3.4003	11.1346
60	3.7352	12.5048
61	4.0600	13.9563
62	4.4051	15.5397
63	4.7604	17.2043
64	5.1055	19.1125
65	5.5115	21.1932
66	5.9276	23.2943
67	6.4453	25.6491
68	7.0441	28.5012
69	7.6024	31.6477
70	8.2114	35.0886

INSURANCE FEE TABLE FOR (CATEGORY P1, CATEGORY C1) DEFAULT AND VOLUNTARY DEATH ONLY COVER AND DEATH AND TPD COVER PER $1,000 OF SUM INSURED

Age next birthday	Male/Female Death	Male/Female TPD
16	0.4771	0.1523
17	0.4771	0.1523
18	0.4771	0.1523
19	0.4771	0.1523
20	0.4771	0.1523
21	0.4771	0.1523
22	0.4365	0.1624
23	0.4162	0.1624
24	0.3857	0.1624
25	0.3756	0.1929
26	0.3451	0.1929
27	0.3350	0.1929
28	0.3350	0.1929
29	0.3350	0.2030
30	0.3350	0.2030
31	0.3147	0.2335
32	0.3350	0.2436
33	0.3451	0.2538
34	0.3553	0.2842
35	0.3857	0.2842
36	0.3959	0.3147
37	0.4162	0.3350
38	0.4365	0.3756
39	0.4771	0.4263
40	0.5177	0.4669
41	0.5481	0.5481
42	0.6090	0.6293
43	0.6598	0.7207

Age next birthday	Male/Female Death	Male/Female TPD
44	0.7105	0.8526
45	0.7816	0.9338
46	0.8526	1.1165
47	0.9440	1.2688
48	1.0049	1.4718
49	1.1165	1.6951
50	1.2079	1.9590
51	1.3195	2.2026
52	1.4312	2.5375
53	1.5530	2.8928
54	1.6951	3.2988
55	1.8270	3.6743
56	1.9793	4.1006
57	2.1721	4.5777
58	2.3751	5.1359
59	2.6086	5.7652
60	2.8725	6.4656
61	3.1262	7.1862
62	3.3800	7.9881
63	3.6540	8.8610
64	3.9281	9.8455
65	4.2630	10.9113
66	4.5878	11.9872
67	5.0040	13.1950
68	5.4709	14.6668
69	5.9276	16.2806
70	6.4047	18.0569

HOW TO CALCULATE YOUR ANNUAL INSURANCE FEE (PREMIUM)

The Insurance fee (premium) you pay for Income Protection cover is dependent upon your age (as at 1 July, or on the effective date of any change to your level of insurance cover), gender, Monthly Income*, Waiting Period and the Benefit Period.

The following formula shows how to calculate an annual premium using the relevant premium rates from the table below.

Premium rate × (75% × Annual Income) ÷ 100

The cost of your insurance cover may differ to the premium rates shown in the table below as the rates that will apply to you may be affected by medical or other loadings applied by the Insurer and are indicative only. The premium rates shown are inclusive of any applicable taxes that may be charged.

For example:
John works in a non-Perth location and his annual Salary is $100,000. John is 38 years old. His next birthday is on 1 May, at which time he will be 39.

The benefit design for the Employer Plan is a 90 day Waiting Period and a 2 year Benefit Period. As John's age next birthday is 39, the applicable Insurance fee for his cover will be:

ANB premium rate = 0.3902

0.3902 × (75% × $100,000) ÷ 100 = $292.65

The annual Insurance fee that he will pay is: $292.65.

* Refer to definition of 'Monthly Income' in the definitions section for information on what constitutes your Monthly Income.

INSURANCE FEE TABLE FOR (CATEGORY N1) INCOME PROTECTION – 90 DAY WAITING PERIOD/2 YEAR BENEFIT PERIOD PER $100 OF ANNUAL BENEFIT

Age next birthday	Male/Female
16	0.2391
17	0.2391
18	0.2391
19	0.2391
20	0.2391
21	0.2391
22	0.2391
23	0.2391
24	0.2391
25	0.2391
26	0.2391
27	0.2391
28	0.2391
29	0.2391
30	0.2391
31	0.2517
32	0.2517
33	0.2643
34	0.2769
35	0.2895
36	0.3147
37	0.3272
38	0.3650
39	0.3902
40	0.4279
41	0.4657
42	0.5160
43	0.5664

Age next birthday	Male/Female
44	0.6293
45	0.6922
46	0.7803
47	0.8684
48	0.9691
49	1.0824
50	1.2208
51	1.3719
52	1.5355
53	1.7117
54	1.8879
55	2.0893
56	2.3032
57	2.5424
58	2.8067
59	3.1087
60	3.4360
61	3.8136
62	4.2541
63	4.4554
64	4.9589
65	5.5127
66	6.1420
67	6.8342
68	7.6145
69	6.4566
70	2.2781

INSURANCE FEE TABLE FOR (CATEGORY P1) INCOME PROTECTION – 90 DAY WAITING PERIOD/2 YEAR BENEFIT PERIOD PER $100 OF ANNUAL BENEFIT

Age next birthday	Male/Female
16	0.1007
17	0.1007
18	0.1007
19	0.1007
20	0.1007
21	0.1007
22	0.1007
23	0.1007
24	0.1007
25	0.1007
26	0.1007
27	0.1007
28	0.1007
29	0.1007
30	0.1133
31	0.1133
32	0.1133
33	0.1133
34	0.1259
35	0.1384
36	0.1384
37	0.1510
38	0.1636
39	0.1762
40	0.1888
41	0.2140
42	0.2265
43	0.2517

Age next birthday	Male/Female
44	0.2895
45	0.3147
46	0.3524
47	0.3902
48	0.4405
49	0.4909
50	0.5538
51	0.6167
52	0.6922
53	0.7677
54	0.8433
55	0.9314
56	1.0321
57	1.1327
58	1.2460
59	1.3845
60	1.5229
61	1.7117
62	1.9005
63	2.0012
64	2.2026
65	2.4291
66	2.6808
67	2.9577
68	3.2724
69	2.7563
70	0.9691

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