ANZ SMART CHOICE SUPER FOR EMPLOYERS AND THEIR EMPLOYEES
TAL LIFE LIMITED
PFD FOOD SERVICES P/L 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
TAL Life Limited	ABN 70 050 109 450 AFSL 237848	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
PFD Food Services Pty Ltd	ABN 29 006 972 381	Employer
PFD Food Services P/L Superannuation Plan		Employer Plan

CONTENTS

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 TAL Life 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.

Important information about your insurance contract:

This document does not contain full details of the contract between OnePath Custodians Pty Ltd and its Insurer and only offers a general guide to the insurance offered by OnePath Custodians Pty Ltd. The insurance is provided under a contract between the Trustee and TAL Life Limited (**TAL**). If there is any conflict between this document and the insurance contract with TAL, 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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Sydney NSW 2001

Phone: 13 12 87 weekdays between 8.30am and 6.30 pm (AEST/AEDT)
Email: smartchoice@insigniafinancial.com.au
Website: www.anz.com.au/smartchoicesuper

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.

To view, manage and consolidate your super, simply log on to **www.anz.com.au/smartchoiceaccess** or the ANZ App*, or call 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 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.**

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;
- 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. Default Cover is called 'Automatic Acceptance Cover' in the insurance policy (Policy).

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?'.

WHAT IS VOLUNTARY COVER?

This is usually a fixed amount of Death or Death and TPD and/or Income Protection cover provided subject to underwriting by the Insurer. 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.

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 Cover only or TPD Cover only, 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.

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 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.

COVER ACCEPTANCE

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

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 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 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. If you withdraw your super balance when your life expectancy is 24 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.

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

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

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.

Payment of a TPD Benefit will also reduce the Sum Insured of your Death Cover. If your Sum Insured for TPD Cover and Death Cover are the same amount, your Death Cover will cease.

The Sum Insured for your TPD Cover cannot exceed the Sum Insured for your Death Cover.

INCOME PROTECTION (IP) BENEFIT

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 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. 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.

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;
- 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 provided upon joining ANZ Smart Choice Super or Insurance Activation Letter (as applicable), 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.

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.

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

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 date you meet any of the criteria specified in the 'When does cover cease?' section of the Appendix of this Guide.

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.

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.

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/smartchoicesuper** 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 you apply for any insurance cover, you should take reasonable care not to make any misrepresentations. Failure to do so may significantly impact your ability to claim on any cover granted. For example, the Insurer may be able to cancel the cover and treat it as if it never existed, or vary the amount of the cover, premium payable, expiry date, or other terms of the cover. A misrepresentation can be a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth. If you apply for insurance cover, you have a duty to tell the Insurer about anything that they may ask, which may affect its decision to insure you and on what terms.

Full details about your duty to take reasonable care not to make misrepresentation are set out in the paperwork that is provided as part of the application process.

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 make a misrepresentation in breach of your duty to take reasonable care not to make a misrepresentation, the Insurer may avoid the contract within 3 years of entering into it. If you make a fraudulent misrepresentation, 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 PFD Food Services P/L 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**
Membership category descriptions	**Death and TPD – is available to the following membership categories:** **Category 1:** An Employee who is nominated as an executive employee. **Category 2:** An Employee who is nominated as a white collar permanent employee. Where white collar means clerical, administration and managerial occupations involving office and travel duties, no manual work, and includes occupations with tertiary qualifications that involve very light physical work. **Category 3:** An Employee who is nominated as a non white collar permanent employee. **Category 4:** An Employee who is nominated as a casual employee. **Income Protection – is available to the following membership categories:** **Category 1:** An Employee who is nominated as an executive employee. **Category 2:** Employees of the Employer that are nominated as: • existing members of the Plan with grandfathered cover prior to the Takeover Date; and • other Employees who are not in Category 1, whose cover is subject to application and underwriting.
What is the Maximum Benefit Level?	• For Death cover (including Terminal Illness) – Unlimited. • For TPD cover – $3,000,000. For Income Protection, the amount calculated by the Insurer which is the lesser of: • 75% of your Salary; • the amount of cover the Insurer has agreed to provide in respect of the Insured Person; and • $30,000 per month.
Benefit expiry age	**Death cover:** 70 years old **TPD cover:** 65 years old **Income Protection cover:** 65 years old
Entry age	**Minimum entry age:** 16 next birthday **Maximum entry age:** 65 next birthday
When does cover commence?	**For Default Cover:** the date a member becomes an Eligible Person and meets the eligibility conditions for Default cover. **For Voluntary Cover:** the date the Insurer advises the Eligible Person they have been Underwritten and accepted for Insurance Cover. **For Takeover Cover:** the takeover date if the Insurer has agreed to provide cover under Takeover Terms. **For Transferred Cover:** Transferred Cover will commence from the date the Insurer advises in writing of their acceptance and the conditions of their acceptance.

Default Cover (Benefit Design)

What Default cover is available?

Death (including Terminal Illness) & TPD cover (subject to eligibility):

Categories 1, 2 and 3

Death cover: 12.50% x Salary x Years of Future Service to age 70. Years of Future Service is calculated as the complete years and days to age 70.

Total and Permanent Disablement cover: 12.50% x Salary x Years of Future Service to age 65. Years of Future Service is calculated as the complete years and days to age 65.

Salary means base pre-tax salary derived from their occupation with the Employer.

Salary is determined immediately prior to the Date of Disablement.

Income Protection cover

Category 1: 75% of Monthly Income subject to:

- a 90 day Waiting Period; and
- a 2 year Benefit Period.

Casuals

Category 4

Sum insured by age:

Age Next Birthday (Age NB)*	Death cover (Insured Amount)	TPD cover (Insured Amount)
16–20	$140,000	$140,000
21–25	$150,000	$150,000
26–30	$165,000	$165,000
31–35	$225,000	$225,000
36–40	$245,000	$245,000
41–45	$235,000	$235,000
46–50	$195,000	$195,000
51–55	$150,000	$150,000
56–60	$100,000	$100,000
61–65	$70,000	$70,000
66–70**	$65,000	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 NB at that time.

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

Eligibility for Default Cover

To be eligible for Default Cover the following conditions must be satisfied:

- An Eligible Person must:
  - join the PFD Food Services P/L Superannuation Plan within 180 days of commencement of employment with the Employer;
  - either:
    - be aged 25 or older and have had their account balance reach $6,000 at least once since 1 April 2020; or
    - have made an Election;
- not already have been provided with an automatic insurance cover under this Policy, regardless of whether it is still in force, or has been cancelled or changed;
- employer contribution has been received by the fund on behalf of the person within 180 days prior or 180 days after commencement of cover;
- the Insurance Cover is calculated according to the Insurance Formula;
- the Eligible Person is in a Membership Category for which an AAL applies as provided in the policy schedule;
- at least 75% of Eligible Persons must be Insured Persons;
- the fund is the 'default fund' for superannuation contributions as per the *Superannuation Guarantee (Administration) Act 1992 (Cth)* of the Employer.

A default fund as referred to above, is a fund that an Employer remits superannuation contributions in respect of an employee to, if the employee does not elect to choose a superannuation fund for his or her contributions to be paid into.

Eligibility for Default Cover *(continued)*	Where the above conditions are met, Default cover for an Eligible Person will commence from: • the Policy Commencement Date where the Eligible Person was entitled to be covered for Automatic Acceptance Insurance Cover at that date; or • the earliest of the date: – the Eligible Person was age 25 or older and had an account balance that reached $6,000 at least once since 1 April 2020; or – the Policy Owner received an Election from the Eligible Person. Note there are circumstances where the Default Cover you obtain through automatic acceptance will be subject to Limited Cover conditions. Refer to the 'What is Limited Cover?' and 'When will Limited Cover Conditions apply?' sections of the Appendix on when Limited Cover conditions would apply. For members under 25 years old or with an account balance less than $6,000, cover starts: • when you provide an opt-in election, if we receive it within 180 days of you joining your Employer (or under a PMIF exception). You will receive **Limited Cover** until you are **At Work** for 30 consecutive days after which full cover will commence; or • the day PMIF thresholds† or an exception is met (no opt-in election is required). In this case you will receive **Limited Cover for 24 months, ceasing when you are At Work for 30 consecutive days after the end of the 24 month period.** † When you turn 25 and your account balance is $6,000 or more.
Automatic Acceptance Limit	**Death and TPD cover:** $1,250,000 **Income Protection Cover:** $10,000 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 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 special terms, conditions, restrictions, exclusions or premium loading 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. The underwriting/decision notes will be retained on the member record.
When can the Automatic Acceptance Limit be changed?	The Automatic Acceptance Limit will apply for the duration of the premium rate guarantee period. However, if there has been a change in the eligibility criteria, benefit structure or a change of 25% or more in the number or occupational profile of Insured Persons under the Policy or a particular membership category, the Insurer reserves the right to increase or decrease the amount of the Automatic Acceptance Limit by giving the Trustee written notice. Any Insurance Cover already provided will not be reduced or adversely affected by any change in the Automatic Acceptance Limit.
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 to accept an application subject to any special terms, conditions, restrictions, exclusions, limitations or premium loadings then the Eligible Person or Insured person will be required to confirm they accept the Insurer's offer within 28 days of the date the Insurer notifies the Trustee. Where the Insurer is notified within 28 days that the Eligible Person or Insured Person has accepted the offer, the variation to Insured cover will commence from the date the Insurer received the member's acceptance. Where the Insurer is not notified within 28 days that the Eligible Person or Insured Person has accepted the Insurer's offer, the offer will lapse and the variation to Insured Cover will be deemed to have not commenced. Any subsequent request received after the 28 day period has expired will be subject to underwriting.

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 the Underwriting section of this Appendix, Voluntary Cover will commence from the date advised in writing.
Is Interim Cover available for Death and TPD Cover applications?	Yes. **When Interim Cover begins** If underwriting applies, Interim Cover comes into force in respect of an Eligible Person or Insured Person from the date the Insurer receives a completed personal statement. **Benefit for Interim Cover** If an Eligible Person or an Insured Person with Interim 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 $1,000,000 less any amount of insurance cover already provided under the Policy to the Eligible 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, and cover for that benefit would have been available to them as an Insured Person under the Policy. A Benefit under Interim Cover is not payable: • for a claim arising directly or indirectly from an injury which occurred at any time prior to the date the Insurer receives a completed personal statement; or • where the Death, Terminal Illness or TPD of the Eligible Person is caused directly or indirectly by suicide or self-inflicted act or injury. The Insurer may take into account any information they receive in the course of the claim under Interim 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 Cover available?	**When will Interim Cover end?** Unless otherwise agreed by the Insurer, Interim Cover that begins as set out in this section will end on the earlier of: • 90 days after the Insurer receives a completed personal statement; • the date the Insurer provides notice of the underwriting decision; • the date an application is withdrawn or cancelled or the Insurer is advised that the application is not being proceeded with; • the date the Insured Person ceases to be an Eligible Person; • the date the Insured Person reaches the Benefit Expiry Age; • the date a benefit under Interim Cover becomes payable for the Insured Person; • the date the Insured Person dies or becomes Totally and Permanently Disabled; • the date a Terminal Illness Benefit becomes payable for the Insured Person; and • the Policy Termination Date.

Is Interim Cover available for Income Protection Cover applications?	Yes. **When interim cover begins** If underwriting applies, Interim Cover comes into force in respect of an Eligible Person or Insured Person from the date the Insurer receives a completed personal statement. **Benefit for Interim Cover** If an Eligible Person or an Insured Person with Interim Cover suffers Total or Partial Disability as a result of an illness or injury, the Insurer will pay the lesser of the amount being applied for or $15,000 per month less any amount of insurance cover already provided under the Policy to the Eligible Person. Interim Cover starts in respect of an Eligible Person on the date Insurer receives a completed Personal Statement. A Benefit under Interim Cover is not payable: • for a claim arising directly or indirectly from an illness or injury which occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the Eligible Person or would have become apparent to a reasonable person in the position of the Eligible Person, at any time prior to the date the Insurer receive a completed personal statement; or • for a claim in respect of the Eligible Person which is caused directly or indirectly by suicide or self-inflicted illness or injury. The Insurer may take into account any information they receive in the course of the claim under Interim 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 Cover the Insurer is not liable to pay any other benefits under the Policy. The maximum Benefit Period for a claim under Interim Cover is 2 years. **When will Interim Cover end?** Unless otherwise agreed by the Insurer, Interim Cover that begins as set out in this section will end on the earlier of: • 90 days after the Insurer receives a completed personal statement; • the date the Insurer provides notice of the underwriting decision; • the date an application is withdrawn or cancelled or the Insurer is advised that the application is not being proceeded with; • the date the Insured Person ceases to be an Eligible Person; • the date the Insured Person reaches the Benefit Expiry Age; • the date a benefit under Interim Cover becomes payable for the Insured Person; • the date the Insured Person dies or becomes Totally and Permanently Disabled; • the date a Terminal Illness Benefit becomes payable for the Insured Person; and • the Policy Termination Date.

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).
Is a 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 equal to the amount of Death Cover, subject to: a. the date of diagnosis of the Terminal Illness is on or after the date their cover commenced under the Policy. No Terminal Illness Benefit will be considered where the date of diagnosis is prior to this date. b. 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 reserves 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. If a Terminal Illness Benefit is paid, all cover under the Policy will cease from that date. 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. If the Policy has terminated, a member will no longer be eligible for a Terminal Illness Benefit from that date unless the date of diagnosis of Terminal Illness was prior to the date the Policy terminated.
TPD Cover	
TPD Benefit	A TPD Benefit will be paid while your cover is in place and current if you become Totally and Permanently Disabled according to TPD Definition 1 (Standard) or TPD Definition 2 (Alternate) subject to the terms of the Policy.
What is the definition of TPD?	Total and Permanent Disablement means in respect of an Insured Member who is: a. gainfully employed as a Permanent Employee or Contractor working 15 or more hours each week for continuous 6 months prior to the Date of Disablement is determined under either Part 1 or, Part 2; or b. gainfully employed as a Casual Employee or Contractor who is not working 15 or more hours each week within the 6 months prior to the Date of Disablement is determined under Part 2. Part 1 (Standard) An Insured Person to whom the TPD (Standard) applies as stated in the Policy Schedule or Employer Plan Schedule, employed in a Permanent Employee capacity, or as a Contractor at the Date of Disablement, and has since been unable to work solely because of illness or injury for a continuous period of at least 6 months, and is in the Insurer's opinion unlikely ever to be able to work in any occupation for which they are reasonably suited by training, education or experience; or otherwise satisfies the definition below of TPD (Alternate). Part 2 (Alternate) A. The Insured Person has been prevented from being able to perform at least two of the Everyday Work Activities without assistance from another adult person, despite the use of appropriate aids, for at least 12 consecutive months and in the Insurer's opinion the Insured Person is unlikely to ever again be able to perform at least two of the Everyday Work Activities without assistance from another adult person, despite the use of appropriate aids. Where Everyday Work Activities means the following activities: a) Mobility – the Insured Person can do the following: • walk without assistance more than 200m on a level surface without stopping; and • bend, kneel or squat to pick something up from the floor from a standing position and straighten up again;

What is the definition of TPD? *(continued)*	b) Communicating – the Insured Person can do the following: • speak in their first language so that they are understood in a quiet room; • understand a simple message in their first language, and relay that message to another person; and • hear, which means the Insured Person has not suffered the irrecoverable profound loss of all hearing in both ears, resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500 hertz, 1000 hertz and 3000 hertz, both natural and assisted, as certified by an appropriate Specialist Medical Practitioner approved by the Insurer; c) Vision – The ability to see which means the Insured Person has not suffered the total and irrecoverable loss of sight (whether aided or unaided) of both eyes as a result of Illness or Injury to the extent that: • visual acuity in both eyes, on a Snellen Scale after correction by suitable lens is less than 6/60; or the visual field is reduced to 20 degrees or less of arc; d) Lifting – The Insured Person can lift a 5 kg weight with either or both hands from a bench/table height, carry it over a 5-metre distance and place it back down at a bench/table height; and e) Manual dexterity – The Insured Person can use their hands or fingers to manipulate small objects with precision (such as picking up a coin or fastening shoelaces or buttons, using cutlery, or using a pen or keyboard to write a short note). or B. An Insured Person has suffered the total and permanent loss of the use of: a) both feet, both hands or sight in both eyes; or b) any combination of two of, a hand, a foot, or sight in an eye. Where "loss of the use of" means: i) the loss of the use of the whole hand or the whole foot, from the wrist or ankle joint; or ii) sight to the extent that visual acuity in the eye, on a Snellen Scale after the correction by a suitable lens, is less than 6/60. or C. The Insurer has determined, directly or indirectly as a result of illness or injury a total and permanent deterioration or loss of mental capacity has required the Insured Person to be under continuous care and supervision by another adult for at least 6 consecutive months and, at the end of that 6 month period, the Insurer considers that they are likely to require permanent ongoing continuous care and supervision by another adult person.
What does Date of Disablement mean?	The date which a Medical Practitioner certifies in writing as the date that the Insured Person ceased work as a result of an illness or injury which is the principal cause of the TPD for which a claim is made, and the Insurer is satisfied, on medical or other evidence, that this is the date that the Insured Person ceased work as a result of an illness or injury which is the principal cause of the TPD for which that claim is made.
Income Protection Cover	
Total Disability Benefit	Where the Insured Person suffers Total Disability, the Insurer will pay a Total Disability Benefit monthly in arrears where the Insured Person has been Totally Disabled for at least 7 out of 12 consecutive days during the Waiting Period and he or she is either: • Totally Disabled immediately after the end of the Waiting Period; or • After receiving a Partial Disability Benefit, Totally Disabled immediately after ceasing to be Partially Disabled as a result of the same or a related cause. The Total Disability Benefit is payable for so long as the Insured Person remains Totally Disabled. The maximum period in respect of which a Total Disability Benefit is payable for the same or related illness or injury is the Benefit Period. The amount of the Total Disability Benefit is 75% of your Salary divided by 12. Where a Total Disability Benefit is payable for a part of a month, We will pay 1/30th of the benefit for each day a Total Disability Benefit is payable.

What is the definition of Total Disability?	Means because of an Injury or Illness the Insured Person: a) has been Totally Disabled for 7 out of 12 consecutive days within the Waiting Period; b) is unable to perform at least one Important Income Producing Duty of his or her regular Occupation; c) is not currently working in any occupation, whether paid or unpaid; and d) is regularly attending and under the ongoing and appropriate care of a Medical Practitioner, including compliance with regular advice and treatment given by that Medical Practitioner.
What is the Definition of Partial Disability?	Means an Insured Person who has been Totally Disabled for 7 out of 12 consecutive days within the Waiting Period and who, after the end of the Waiting Period is no longer Totally Disabled and is: • regularly attending and under the ongoing and appropriate care of a Medical Practitioner, including compliance with regular advice and treatment given by that Medical Practitioner; • earning less than the monthly Salary they were earning immediately prior to the start of the Waiting Period, as a result of illness or injury, or is not otherwise earning an income working; and • as a result of illness or injury cannot undertake their normal hours of work or is unable to perform one or more of the important income producing duties of their Occupation.
Partial Disability Benefit	A Partial Disability Benefit compensates the Insured Person for the reduction in income the Insured Person suffers as a result of illness or injury. If the Insured Person has been Totally Disabled for at least 7 out of 12 consecutive days during the Waiting Period, the Insurer will pay a Partial Disability Benefit monthly in arrears if either: • the person is Partially Disabled immediately after the end of the Waiting Period; or • the person, after receiving a Total Disability Benefit, is Partially Disabled immediately after ceasing to be Totally Disabled as a result of the same or a related cause. The Partial Disability Benefit is payable for so long as the Insured Person remains Partially Disabled. The maximum period in respect of which a Partial Disability Benefit is payable for the same or related illness or injury is the Benefit Period. Where a Partial Disability Benefit is payable for a part of a month, the Insurer will pay 1/30th of the benefit for each day a Partial Disability Benefit is payable. 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** = The Insured Person's annual Salary at the Date of Disablement / 12. **B** = The monthly amount earned by the Insured Person excluding annual leave, long service leave, termination payments and paid parental leave. **C** = The Total Disability Benefit.
When benefit payment ends	Total or Partial Disability Benefit payments will end on the earliest of the following: • the date the Insured Person is no longer Totally Disabled and/or Partially Disabled; • the end of the Benefit Period for which a Total Disability Benefit and/or Partial Disability Benefit has been payable for the same or related illness or injury; • the date the Insured Person dies; • the date the Insured Person reaches the Benefit Expiry Age; • in the case of an Insured Person who is residing or travelling outside Australia, the date 6 months after the end of Waiting Period where a Total Disability Benefit or Partial Disability Benefit has been paid or payable for those 6 months, unless they can provide supporting medical evidence to the Insurer's satisfaction of continued Total Disability and/or Partial Disability from a Medical Practitioner; • the date the Insured Person refuses to undertake reasonable treatment or rehabilitation which could, in the Insurer's opinion, be expected to assist his or her ability to return to his or her occupation on any basis (only applies to Total Disability Benefit); • the date the Insured Person, in the Insurer's opinion, fails to take all reasonable steps to return to his or her occupation if he or she has the capacity to do so (only applies to Total Disability Benefit).
Death whilst on claim	If an Insured Person dies while the Insurer is paying a monthly benefit for that Insured Person, an additional lump sum equal to 3 times the Total Disability Benefit that was last paid or payable for a full month.
Benefit Period	2 years
Waiting Period	90 days

Recurrent Disability	If an Insured Person has a recurrence of a Total Disability or Partial Disability as a result of the same or related injury or illness previously claimed then the Insurer will consider the recurring disability to be a continuation of the previous claim, and the Insured Person will not need to satisfy the Waiting Period again, subject to all of the following conditions: • the recurrence of the Total Disability or Partial Disability occurs within 6 months of the date they were last entitled to receive a Total Disability or Partial Disability Benefit; • the cause of the recurring disability is the same or related to the reasons for the previous claim; and • their Insurance Cover has not ceased. The successive periods of Total Disability and/or Partial Disability will be regarded as continuous for the purpose of determining the remaining portion of the Benefit Period. Where the recurrence of the Total Disability and/or Partial Disability as a result of the same or related injury or illness previously claimed occurs more than 6 months after the date the Insured Person was last entitled to receive the benefit: • the Insured Person will need to satisfy the Waiting Period again; • the Insurer will consider the recurring disability to be a continuation of the previous claim; and • the successive periods of Total Disability and/or Partial Disability will be regarded as continuous for the purpose of determining the remaining portion of the Benefit Period.
Concurrent injuries and/or illnesses	If an Insured Person has more than one illness or injury causing their Total Disability or Partial Disability, even if they are related, only one Total Disability Benefit or Partial Disability Benefit will be payable during any overlapping periods of Total Disability and/or Partial Disability.
Rehabilitation	The Insurer may agree to pay some or all of the costs involved with a rehabilitation or return to work program, approved in writing by the Insurer, for an Insured Person who has been unable to work because of an illness or injury. Any such payments will be made directly by the Insurer to the provider of any associated services or equipment and is in addition to the benefits the Insurer pay to replace the Insured Person's income. There may be circumstances where the Insured Person participates in an approved rehabilitation program which includes a return to work during the Waiting Period. If the Insured Person is unsuccessful in returning to work to their pre-disability duties as part of an approved rehabilitation program, the Waiting Period will still be deemed to commence as at the first date the Insured Person became Totally Disabled and will not recommence if the return to work is greater than 5 days. Any days of work as part of an approved rehabilitation program will not be added to the Waiting Period.
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. The Total Disability Benefit and Partial Disability Benefit will be reduced by any income or amounts paid or payable in respect of the relevant month to the Insured Person, including settlement or commutation amounts, in respect of any of the following: 1) workers compensation or similar legislation or common law; 2) motor accident compensation or similar legislation or common law; 3) statutory or other government payments, but not including CentreLink or its successors; 4) sick leave; 5) income replacement benefits from another insurance policy or a superannuation fund; 6) payment by the Employer excluding annual leave, long service leave, termination payments and paid parental leave. **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. The Total Disability Benefit and/or Partial Disability Benefit will only be reduced in respect of any lump sum payment if any portion of such a payment relates to loss of income. Any lump sums, including commutation amounts, will be divided into 1/60th for the purpose of calculating a reduction in the any benefit. This reduction will then apply on each and every monthly Total Disability Benefit and/or Partial Disability Benefit over the 60 month period or the Benefit Period, whichever is the shorter.
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 or Partial Disability. However, premiums are payable to the Insurer whilst an Insured Person is in receipt of a benefit from another insurer.

When the Insurer won't pay	
Benefit Exclusions	Benefits will not be payable in respect of any Voluntary Cover or Life Events Cover for Death, Terminal Illness or TPD if the Death, Terminal Illness or TPD is caused directly or indirectly by a self-inflicted act or injury of the Insured Person within 13 months of the following: 1) the date of acceptance of the Voluntary Cover or Life Events Cover; 2) the date the Voluntary Cover or Life Events Cover was reinstated, in respect of the reinstated amount; or 3) the date the Voluntary Cover or Life Events Cover increased, in respect of the increased amount. If the Voluntary Cover or Life Events Cover has expired and has subsequently been reinstated, the 13 month period will recommence from the date of reinstatement. For Income Protection: Benefits are not payable if the Insured Person's disablement was caused wholly or partially, directly or indirectly by any of the following: 1) war; 2) an intentional, self-inflicted act; or 3) uncomplicated pregnancy, childbirth or miscarriage unless disability continues for longer than 3 months after the pregnancy ends, in which case the disability will be considered to have commenced at the date the pregnancy ends.
Misstatement of Age	If the age of an Insured Person has been understated, the Benefit in respect of that person will be recalculated and reduced based on the amount of premium already paid and the amount of Insurance Cover that premium would have purchased if the Insurance Cover had been calculated using the correct age. If the age of the Insured Person has been overstated, the Benefit will not change and the Insurer will return any excess premium paid. If the date of birth of the Insured Person has been incorrectly provided and the expiry date of the Insurance Cover would have been different had the correct date of birth been provided, then the Insurer may vary the Insurance Cover by changing its expiry date to the date that would have been the expiry date if the Insurance Cover had been based on the correct date of birth.
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 on pages 29 to 32.
When does cover cease?	
When does cover cease?	Insurance Cover under the Policy will cease for an Insured Person immediately on the earliest of: • the date they reach the Benefit Expiry Age; • subject to the terms set out in the 'Extension of Cover' section of this Appendix, when they cease to be employed by their Employer; • the date they ceased to be a Contractor with a written contract of services to the Employer for a minimum of 15 hours each week for a continuous 6 month period; • the date any Extension of Cover ceases; • the date of their death; • the date they do not meet the conditions for continuation of Insurance Cover during unpaid leave; • the date they no longer meet the conditions for continuation of Insurance Cover while overseas; • the date before they commence active service in the armed forces of any country, not including normal activities as a reservist with the Australian Defence Force, but including operational deployment on active service with the Australian Defence Force; • the date an individual life insurance policy is issued to them by the Insurer under a Continuation Option; • in respect of any Interim Cover provided, the date any Interim Cover ceases for them; • the date they change to a new Membership Category which offers a lower level of Insurance Cover than their previous Membership Category, for the amount in excess of their new Insurance Cover; • the date the Insurer is advised that the Insured Person no longer wishes to be an Insured Person under the Policy; • the date the Insurer is advised that the Insured Person wishes to have their Insurance Cover reduced, in respect of the amount reduced;

When does cover cease? (continued)	• the policy termination date; • the date the relevant Employer Plan terminates; • the date they no longer meet the Eligibility Criteria; • 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; • 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; • the day your PMIF exception is no longer applicable. Additionally, for Death only cover and Death and TPD Cover following applies: • the date a Terminal Illness Benefit becomes payable; • the date a TPD Benefit becomes payable.
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; 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; c. when the Trustee notifies the Insurer that it wishes to terminate the Policy; 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; e. when legal proceedings are commenced for the winding up of the Trustee; f. the day your PMIF exception is no longer applicable.
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.
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 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; b. they reach the Benefit Expiry Age; c. the date they obtain insurance for the same or similar benefits; d. the date an application for a Continuation Option is accepted or declined by the Insurer.
Is Continuation Option available?	Yes, for members that leave their Employer and choose not to receive Choose Your Own cover within ANZ Smart Choice Super. Not available if you cease to be a member of the Fund.

What are the conditions of the Continuation Option?	All of the following conditions need to be satisfied before an Insured Person can apply for a Continuation Option: 1. they are under age 60; 2. no benefits have been paid or are payable to them under the Policy, or any other benefits have or are being paid under any other life insurance policy; 3. they had not ceased employment due to illness or injury; 4. they must be commencing employment in an Occupation considered by the Insurer to be an insurable risk under the individual insurance policy; 5. the Insurer receives an application, completed to their satisfaction, for a Continuation Option, together with the relevant premium, within 60 days of cessation of the employment with the Employer; 6. the individual insurance policy issued will be one the Insurer consider contains the same or similar benefits, to the Insurance Cover provided on the date they ceased to be an Employee of the Employer; 7. the premium for the individual insurance policy issued will be based on the Insurer's standard individual age based rates, and will be subject to any specific exclusions and loadings applying to their Insurance Cover at the date they ceased to be an Employee of the Employer; 8. the application for the Continuation Option must include, but is not limited to: i) occupational information including Salary; and ii) information regarding pastimes, residency, travel and smoking status; and 9. acceptance by the Insurer of any application. Where a Continuation Option is granted while the Insured Person is applying for Underwritten Cover, their application and any Interim Cover they were entitled to will be cancelled. If an Insured Person elects to exercise a Continuation Option then Choose Your Own cover within ANZ Smart Choice Super is not available.
General	
Increases to Default Cover	The Trustee may increase the amount of Default Cover for an Insured Person by recording that it has commenced for the increased amount if: a. The amount of the Default 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 Default Cover is consistent with the formula used for Default Cover; and c. The Insured Person was At Work when their Default 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. 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 **(Not applicable to Income Protection Cover)**	An Insured Person may apply for Life Events Cover which will enable them to increase their Insurance Cover. Life Events Cover is available to an Insured Person in any of the following circumstances: a) the birth of the Insured Person's child/children; b) the adoption of a child/children by the Insured Person; c) the marriage of the Insured Person; or d) effecting a mortgage on the purchase or construction of the Insured Person's primary place of residence (either alone or jointly with another person); e) a dependent child of the Insured Person starts secondary school. The Insured Person can only increase their cover once in any 12 month period, and increase their cover only once for each Nominated Event. Insured Person can increase their cover provided: • the Insured Person is less than 60 years of age at the date the Insurer receives a completed application for Life Events Cover; • the Insured Person has not previously had an application for Insurance Cover declined; • the Life Events Cover application being accepted by the Insurer in writing; • the payment of the applicable additional premiums; • during the first 6 months after the Insurer has accepted the application, Limited Cover only will apply to the Life Events Cover provided as a result of the application; • an application for Life Events Cover can only be made by an Insured Person once in any 12 month period; • the Insured Person is already covered for the Benefits for which the Life Events Cover relates; and • the Insurer receives a Life Events Cover application completed by the Insured Person to the Insurer's satisfaction together with satisfactory / certified evidence of the occurrence of the relevant event, within 90 days of the relevant circumstance and prior to their Death, Terminal Illness or Date of Disablement. The following conditions apply to the amount of Life Events Cover that is available: • the minimum amount of Life Events Cover which can be applied for is $25,000; and • the maximum amount of Life Events Cover which can be applied for by an Insured Person is the lesser of 25% of their Insurance Cover and $200,000 provided this does not cause the total of any existing Insurance Cover and any Life Events Cover applied for to exceed the Maximum Benefit Limit. The Insurer will not pay the increased cover if Death, Terminal Illness or TPD is caused directly or indirectly by a self-inflicted act or injury of the Insured Person that occurred within the first 13 months from the date the Insurer agrees to any increase in cover. Cover will commence on the date that the Insurer notifies the Trustee in writing that the Insurer has agreed to accept cover.
What is Limited Cover and when will Limited Cover Conditions apply?	Limited Cover means Insurance Cover is only payable for claims arising directly from an illness or injury which first occurs or is diagnosed or the signs or symptoms first become apparent, after the date the Insurance Cover commenced, was reinstated or increased under the Policy. Benefits arising directly or indirectly by a self-inflicted act are not payable under Limited Cover. If an Insured Person that is provided with Default Cover is eligible for, has received, or is claiming a total and permanent disablement or terminal illness type benefit from any superannuation fund or life insurance policy prior to the commencement of the Default Cover then Limited Cover will apply indefinitely. Otherwise, if Default cover commences: • within 180 days of the date you commenced employment with the Employer, then your cover will be Limited Cover until the date you are At Work for 30 consecutive days, at which time Limited Cover will cease; or • after 180 days of the date you commenced employment with the Employer, your cover will be Limited Cover for a 24-month period, after which you must be At Work for 30 consecutive days in order for Limited Cover to cease.

Transferred Cover	An Eligible Person may apply for Transferred Cover equal to the level of cover provided under a Previous Policy without the same level of Evidence of Insurability as the Insurer normally require, provided that the Eligible Person submits a fully completed application for Transferred Cover and the below criteria are satisfied: • Transferred Cover will commence from the date the Insurer advises in writing of their acceptance and the conditions of their acceptance; • Transferred Cover only commences subject to the cancellation of the Member's cover under the Previous Policy (following the Insurer's acceptance of the application to transfer cover). Any Benefit paid under this Policy will be reduced by the amount of any Benefit that is paid or payable under the Previous Policy; • Any Transferred Cover that comes into force is in addition to any existing cover in respect of the Member under the Policy and is provided as Voluntary Cover; • Unless otherwise agreed by the Insurer, Transferred Cover shall be for an amount that: a) is necessary to provide the Member with Insurance Cover as close as possible to the cover the person had under the Previous Policy which is being transferred; b) does not exceed: i For Death and Death and TPD Cover: $1,000,000; ii. For Income Protection: $6,000 per month even if cover was higher under the Previous Policy and will not exceed 75% of Salary with a Benefit Period of 2 years and a 90 day Waiting Period unless agreed by the Insurer in writing; and c) when combined with any existing Insurance Cover held by the Eligible Person, does not exceed a total Insurance Cover amount greater than the Maximum Benefit Limit. Any restrictions, exclusions or special conditions (including premium or occupational loadings) which applied to the Member under the Previous Policy will apply to the Transferred Cover and the Insurer may impose additional conditions, exclusions, restrictions or alternative terms to this cover; and Any Forward Underwriting Limit that applied to the Eligible Person under the Previous Policy will not apply under the Policy. Premiums for Transferred Cover will be payable from the date cover commences and are not refundable if the cover under the Previous Policy is not cancelled.
Takeover cover	The Insurer's practice is to adhere to FSC Group Insurance Takeover Terms under FSC Guidance Note No. 11.
Cover during Employer approved leave	Subject to the terms of the 'When does Cover cease?' section of this Appendix, cover will continue in respect of an Insured Person on: • Employer approved paid leave provided premiums continue to be paid and compliance with other conditions of the Policy. • Employer approved unpaid leave provided: a. they continue to be employed by their Employer and the Insurer receives premiums in respect of them; and b. the period of leave is no longer than 2 years. Cover may continue after 2 years on such terms as the Insurer may permit. Additionally for Income Protection Cover, where an Insured Person suffers Total or Partial Disability during Employer approved unpaid leave, their Monthly Benefit accrues from the later of: i) the day 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 any Insurance Cover, the salary which applied to the Insured Person on their last working day immediately prior to the commencement date of their leave period will apply. 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. If an Insured Person goes on a period of unpaid leave and premiums are not paid in respect of all or part of that period, then Insurance Cover will cease on the day prior to the commencement of the period of unpaid leave. If that person returns to work with their Employer on the agreed return to work date after a period of unpaid leave during which the relevant premiums had not been paid, then cover will be reinstated subject to the following conditions: • Limited Cover will apply to Insurance Cover up to the AAL from the date of return to work until they have been At Work for 60 consecutive days, after which time Full Cover will apply; and • Underwriting is required for any Insurance Cover above the AAL.

Overseas Cover	Subject to the terms of section 'When does Cover cease' section of this Appendix, Insured Cover will continue for an Insured Person 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 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. Where the Trustee, Employer or associated Employer starts to pay the premium in respect of an Insured Person after a period during which the relevant premiums had not been paid (and hence Insurance Cover did not continue), then Insurance Cover may be reinstated subject to both of the following conditions: • Limited Cover will apply to Insurance Cover up to the AAL from the date the premium is paid until they have been At Work for 60 consecutive days, after which time Full Cover will apply; and • Underwriting is required for any Insurance Cover above the AAL.
Assessment of Claim Overseas	In the case of an Insured Person who is residing or travelling outside Australia, a Total Disability Benefit and/or Partial Disability Benefit will continue for up to six months whilst overseas subject to the Insured Person satisfying claims requirements to the Insurer's satisfaction . After six months the Insured Person will need to provide supporting medical evidence to Insurer's satisfaction to continue receiving a Total Disability Benefit and/or Partial Disability Benefit. Where a claim for a Terminal Illness or TPD Benefit payment arises for an Insured Person and they are overseas during the assessment of the claim, the Insurer will require them to provide supporting medical evidence to the Insurer's satisfaction to enable assessment of their eligibility for payment. 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. **Income Protection** In the case of an Insured Person who is residing or travelling outside Australia a Total Disability Benefit and/or Partial Disability Benefit will continue for up to six months whilst overseas subject to the Insured Person satisfying claims requirements to the Insurer's satisfaction . After six months the Insured Person will need to provide supporting medical evidence to Insurer's satisfaction to continue receiving a Total Disability Benefit and/or Partial Disability Benefit. **TPD and Terminal Illness** Where a claim for a Terminal Illness or TPD Benefit payment arises for an Insured Person and they are overseas during the assessment of the claim, the Insurer will require them to provide supporting medical evidence to the Insurer's satisfaction to enable assessment of their eligibility for payment.
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.

DEFINITIONS

Age Criteria	means the minimum and maximum entry ages stated in the Policy Schedule.
Annual Review	means the date stated in the Policy Schedule.
At Work	means i) where the Eligible Person is: a) a Permanent Employee or a Casual Employee who is working at the relevant time and not on leave - he or she is actively performing all the normal duties of their Occupation with the Employer without restriction or limitation due to illness or injury; or b) a Permanent Employee or a Casual Employee who is not working at the relevant time or is on leave approved by the Employer - he or she is, in the Insurer's opinion, capable of performing all the normal duties of their Occupation with their Employer without restriction or limitation due to illness or injury; and ii) not receiving or not entitled to receive income support benefits from any source including workers compensation benefits, statutory transport accident benefits or disability income benefits. An Eligible Person who does not meet these requirements will be described as not At Work.
Australian Resident	means a person who permanently resides in Australia or resides in Australia on a temporary working visa as agreed by the Insurer.
Automatic Acceptance Limit (AAL)	means the maximum amount of Insurance Cover based on the Insurance Formula, provided without Underwriting. The AAL will be stated in the Appendix.
Benefit	means the Death and/or TPD Insurance Cover as stated in the Policy Schedule. Terminal Illness and Interim Cover are Benefits provided under the terms and conditions of the Policy but will not be stated in the Policy Schedule or Employer Plan Schedule.
Benefit Expiry Age	means the maximum age to which a Benefit will be provided as set out in the Policy Schedule or Employer Plan Schedule.
Casual Employee	means an Eligible Person who is Gainfully Employed by the Employer on a casual basis.
Contractor	means an Eligible Person under a written contract of service with the Employer for a minimum of 15 hours each week for a continuous 6 month period and is, under the contract, having Salary and Superannuation Guarantee Contributions paid in respect of them.
Date Of Disablement	means the date which a Medical Practitioner certifies in writing as the date that the Insured Person ceased work as a result of an illness or injury which is the principal cause of the TPD for which a claim is made, and the Insurer is satisfied, on medical or other evidence, that this is the date that the Insured Person ceased work as a result of an illness or injury which is the principal cause of the TPD for which that claim is made.
Eligibility Conditions	mean the conditions stated in the Policy which need to be met in order for Insurance Cover to be provided.
Eligibility Criteria	means the criteria for a Membership Category stated in the Policy Schedule.
Eligible Person	in addition to other Eligibility Conditions, in order to be provided cover, a person must be: • Aged 15 or older and less than age 65; • be a Member of the Fund; and • be employed by the Employer.
Employee	means a person who is Gainfully Employed by the Employer.
Employer	means the entity stated in the Policy Schedule employing Eligible Persons under the Policy.
Employer's Default Superannuation Fund	means the superannuation fund recognised as such for the purposes of the Superannuation Guarantee (Administration) Act 1992 or successor statutes.
Endorsement	means any written amendment to the terms and conditions of the Policy the Insurer agrees with and provides to the Policy Owner.
Election	means a written election as agreed between the Policy Owner and the Insurer, provided to the Policy Owner that is made by an Eligible Person in accordance with the Superannuation Industry (Supervision) Act 1993.

Forward Underwriting Limit	means the maximum level, advised after Underwriting, to which Insurance Cover for an Eligible Person can increase, based on the Insurance Formula, without further Underwriting.
Full Cover	means Insurance Cover for any illness or injury after the person was nominated for Insurance Cover, where the Insurance Cover is not affected by the date the illness became apparent or the injury occurred.
Gainfully Employed	means working for reward in an Occupation (which can include a contract for services) without restriction due to illness and injury.
Insurance Cover	means the Benefits provided under the terms and conditions of the Policy.
Insurance Formula	means the calculation method for Insurance Cover elected by the Employer or Policy Owner and agreed by the Insurer as stated in the Policy Schedule or Employer Plan Schedule.
Insured Person	means any Eligible Person for whom Insurance Cover has been provided by the Insurer.
Limited Cover	means Insurance Cover is only payable for claims arising directly from an illness or injury which first occurs or is diagnosed or the signs or symptoms first become apparent, after the date the Insurance Cover commenced, was reinstated or increased under the Policy. Benefits arising directly or indirectly by a self-inflicted act are not payable under Limited Cover.
Maximum Benefit Limit	means: • an amount as determined by the Insurance Formula as stated in the Policy Schedule or Employer Plan Schedule; and • the maximum Benefit amount the Insurer will pay in respect of an Insured Person as set out in the Appendix.
Medical Practitioner	means, unless the Insurer agrees otherwise: a) a medical practitioner legally qualified and registered to practice in Australia; or b) if the claimed condition is a mental health condition, it is to be diagnosed in accordance with the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the definition of a medical practitioner means a person who is legally qualified and registered as a practising psychiatrist by the relevant medical registration boards and/or the Specialist Recognition Advisory Committee coordinated through the Australian Health Insurance Commission. Chiropractors, physiotherapists, psychologists or alternative health providers are not regarded as Medical Practitioners. The Medical Practitioner cannot be: • the Insured Person; • the Insured Person's spouse/partner in a de facto relationship; • a close family relative of the Insured Person; • business associates or partners of the Insured Person; • fellow security holders in the same company/trust (ignoring publically listed entities); or • an employer or employee of the Insured Person.
Member	means a person admitted by the Trustee as a member of the Fund under the Fund's governing rules.
Membership Category	means the common group set out in the Policy Schedule to which Insured Persons belong because of their Occupation and/or their employment status. Membership categories are described in the Appendix.
Minimum Average Hours	means an Insured Person who is a Contractor and has worked a minimum of 15 hours per week for the 3 months immediately prior to the Date of Disablement. The 3 month period may be adjusted as follows: • where an Insured Person returns from an agreed period of leave, it will include time prior to the commencement of the agreed period of unpaid leave if 3 complete months have not elapsed prior to the Date of Disablement; • where an Insured Person has been working for less than 3 months, the equivalent period will be the time since commencement with the Employer to the Date of Disablement.
Occupation	means the primary duties for which the Eligible Person is paid a Salary.
Permanent Employee	means the Eligible Person is Gainfully Employed by the Employer on a permanent full-time or permanent part-time basis.

Personal Statement	means an application form issued by the Insurer for the purpose of Underwriting an Eligible Person for Insurance Cover.
Policy Commencement Date	means the Policy Commencement Date stated in the Policy Schedule.
Policy Owner	means the Trustee.
Policy Schedule	means the document issued by the Insurer to the Policy Owner, stating specific details relating to the Policy, including any Special Conditions.
Policy Termination Date	means the date the Policy ends on the earlier of when the Insurer receives written notice from the Policy Owner and as set out in the Policy.
Premium Rates	means the cost of the Insurance Cover stated in the Policy Schedule and used to calculate the premiums for Insurance Cover.
Previous Policy:	means the insurance policy in respect of a Member, which is a life policy as defined under the *Life Insurance Act 1995 (Cth)* which: a) provided Death Cover or Death and Total and Permanent Disablement Cover; b) that was in force on the day before the Member's Transferred Cover commenced under the Policy; and that the Insurer agrees to treat as a Previous Policy for the purposes of the Policy.
Professional	means an Insured Person who: • has recognised tertiary qualifications relevant to their Own Occupation; • is a member, or eligible to be a member of a professional or government body where that membership is needed for engaging in their Own Occupation; • has a base Salary of at least $100,000 per annum; and • works in a sedentary capacity, primarily in an office environment.
Related Entity	means a related body corporate of the Employer.
Salary	Total employment cost (base salary) as advised by the Employer.
Special Conditions	means variations and modifications to the Policy or Employer Plan agreed by the Insurer and stated in the Policy Schedule or Employer Plan Schedule.

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 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: $0.46
TPD: $0.29

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

[$300,000 × (0.46 + 0.29)] ÷ $1,000 = $225

INSURANCE FEE TABLE FOR (CATEGORY 1, CATEGORY 2) DEFAULT AND VOLUNTARY DEATH ONLY AND DEATH AND TPD COVER PER $1,000 OF SUM INSURED

Membership Categories 1 and 2				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
16	0.36	0.14	0.04	0.03
17	0.39	0.15	0.04	0.02
18	0.42	0.16	0.05	0.02
19	0.44	0.17	0.05	0.02
20	0.45	0.17	0.05	0.02
21	0.44	0.17	0.05	0.02
22	0.43	0.16	0.05	0.02
23	0.41	0.16	0.05	0.02
24	0.39	0.16	0.05	0.02
25	0.37	0.16	0.04	0.03
26	0.35	0.16	0.04	0.04
27	0.33	0.16	0.05	0.05
28	0.31	0.17	0.06	0.06
29	0.29	0.17	0.07	0.07
30	0.28	0.17	0.09	0.09
31	0.28	0.18	0.10	0.10
32	0.28	0.19	0.12	0.11
33	0.29	0.20	0.14	0.13
34	0.30	0.21	0.16	0.15
35	0.32	0.22	0.19	0.17
36	0.35	0.24	0.21	0.19

Membership Categories 1 and 2				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
37	0.38	0.26	0.24	0.21
38	0.42	0.28	0.26	0.24
39	0.46	0.30	0.29	0.28
40	0.51	0.33	0.32	0.32
41	0.56	0.36	0.36	0.36
42	0.62	0.39	0.39	0.42
43	0.67	0.43	0.44	0.49
44	0.73	0.47	0.48	0.56
45	0.80	0.51	0.53	0.64
46	0.86	0.56	0.59	0.74
47	0.93	0.62	0.66	0.84
48	1.01	0.68	0.74	0.96
49	1.09	0.75	0.84	1.08
50	1.17	0.83	0.94	1.22
51	1.27	0.91	1.07	1.38
52	1.37	1.00	1.22	1.55
53	1.49	1.10	1.39	1.73
54	1.62	1.21	1.59	1.92
55	1.77	1.32	1.82	2.13
56	1.94	1.45	2.09	2.35
57	2.13	1.58	2.40	2.58

Membership Categories 1 and 2				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
58	2.36	1.73	2.76	2.82
59	2.62	1.89	3.16	3.07
60	2.92	2.06	3.63	3.33
61	3.27	2.24	4.16	3.60
62	3.67	2.44	4.75	3.87
63	4.13	2.65	5.43	4.15
64	4.67	2.88	6.19	4.50

Membership Categories 1 and 2				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
65	5.28	3.16	7.05	4.91
66	5.96	3.51	n/a	n/a
67	6.74	3.97	n/a	n/a
68	7.61	4.48	n/a	n/a
69	8.60	5.07	n/a	n/a
70	9.72	5.72	n/a	n/a

INSURANCE FEE TABLE FOR (CATEGORY 3. CATEGORY 4) DEFAULT AND VOLUNTARY DEATH ONLY COVER AND DEATH AND TPD COVER PER $1,000 OF SUM INSURED

Membership Categories 3 and 4				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
16	0.66	0.26	0.08	0.05
17	0.73	0.27	0.08	0.04
18	0.77	0.29	0.09	0.04
19	0.82	0.30	0.10	0.04
20	0.83	0.31	0.10	0.04
21	0.82	0.31	0.10	0.04
22	0.79	0.30	0.09	0.04
23	0.75	0.30	0.09	0.04
24	0.71	0.29	0.08	0.04
25	0.68	0.29	0.08	0.05
26	0.64	0.29	0.08	0.07
27	0.60	0.30	0.09	0.09
28	0.56	0.30	0.11	0.12
29	0.53	0.31	0.13	0.14
30	0.51	0.32	0.16	0.16
31	0.51	0.33	0.19	0.19
32	0.51	0.34	0.23	0.21
33	0.53	0.36	0.26	0.24

Membership Categories 3 and 4				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
34	0.56	0.38	0.30	0.27
35	0.59	0.41	0.34	0.30
36	0.64	0.44	0.39	0.34
37	0.70	0.47	0.44	0.39
38	0.77	0.51	0.49	0.44
39	0.85	0.55	0.54	0.51
40	0.94	0.60	0.60	0.58
41	1.03	0.65	0.66	0.67
42	1.13	0.72	0.72	0.77
43	1.24	0.78	0.80	0.89
44	1.35	0.86	0.89	1.03
45	1.46	0.94	0.98	1.18
46	1.59	1.04	1.09	1.35
47	1.72	1.14	1.22	1.54
48	1.85	1.26	1.36	1.76
49	2.00	1.38	1.54	1.99
50	2.16	1.52	1.74	2.25
51	2.33	1.67	1.97	2.54

Membership Categories 3 and 4				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
52	2.52	1.84	2.24	2.85
53	2.74	2.02	2.56	3.18
54	2.98	2.22	2.93	3.53
55	3.25	2.43	3.36	3.92
56	3.57	2.67	3.85	4.32
57	3.93	2.91	4.42	4.75
58	4.34	3.19	5.07	5.19
59	4.82	3.48	5.82	5.65
60	5.37	3.79	6.68	6.13
61	6.01	4.13	7.65	6.62

Membership Categories 3 and 4				
Age Next Birthday (ANB)	Death		Total and Permanent Disablement	
	Male $	Female $	Male $	Female $
62	6.75	4.49	8.75	7.13
63	7.60	4.87	9.99	7.63
64	8.58	5.30	11.39	8.29
65	9.71	5.82	12.97	9.03
66	10.97	6.46	n/a	n/a
67	12.40	7.30	n/a	n/a
68	14.01	8.25	n/a	n/a
69	15.83	9.32	n/a	n/a
70	17.89	10.53	n/a	n/a

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's annual Salary is $100,000. John is 38 years old. On his next birthday 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 = 0.09

0.09 × (75% × $100,000) ÷ 100 = $67.50

The annual Insurance fee that he will pay is: $67.50.

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

INSURANCE FEE TABLE FOR (CATEGORY 1) INCOME PROTECTION – 90 DAY WAITING PERIOD/2 YEAR BENEFIT PERIOD PER $100 OF ANNUAL BENEFIT

Age Next Birthday	Male	Female
16	0.06	0.11
17	0.06	0.11
18	0.06	0.11
19	0.06	0.11
20	0.06	0.11
21	0.06	0.11
22	0.06	0.11
23	0.06	0.11
24	0.06	0.11
25	0.06	0.11
26	0.06	0.11
27	0.06	0.11

Age Next Birthday	Male	Female
28	0.06	0.12
29	0.06	0.12
30	0.06	0.13
31	0.06	0.13
32	0.06	0.13
33	0.07	0.14
34	0.07	0.15
35	0.07	0.15
36	0.08	0.16
37	0.08	0.17
38	0.09	0.18
39	0.09	0.20

Age Next Birthday	Male	Female
40	0.10	0.22
41	0.11	0.24
42	0.12	0.26
43	0.13	0.28
44	0.15	0.31
45	0.16	0.35
46	0.18	0.38
47	0.20	0.42
48	0.22	0.47
49	0.25	0.52
50	0.28	0.57
51	0.32	0.62
52	0.35	0.68

Age Next Birthday	Male	Female
53	0.40	0.75
54	0.45	0.81
55	0.50	0.88
56	0.56	0.96
57	0.63	1.04
58	0.71	1.12
59	0.79	1.20
60	0.89	1.28
61	0.99	1.37
62	1.10	1.46
63	1.23	1.55
64	1.39	1.67
65	0.68	0.79

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

Age Next Birthday	Male	Female
16	0.12	0.20
17	0.12	0.20
18	0.12	0.20
19	0.12	0.20
20	0.12	0.20
21	0.12	0.20
22	0.12	0.20
23	0.12	0.20
24	0.12	0.20
25	0.12	0.20
26	0.12	0.20
27	0.11	0.21
28	0.11	0.22
29	0.11	0.23
30	0.11	0.24
31	0.12	0.25
32	0.12	0.26
33	0.12	0.26
34	0.13	0.28
35	0.14	0.29
36	0.14	0.30
37	0.15	0.32
38	0.16	0.35
39	0.18	0.38
40	0.19	0.41
41	0.21	0.45
42	0.23	0.49
43	0.25	0.54

Age Next Birthday	Male	Female
44	0.28	0.60
45	0.31	0.66
46	0.34	0.73
47	0.38	0.81
48	0.43	0.89
49	0.48	0.98
50	0.53	1.08
51	0.60	1.19
52	0.67	1.30
53	0.76	1.42
54	0.85	1.55
55	0.95	1.68
56	1.07	1.82
57	1.20	1.97
58	1.34	2.12
59	1.50	2.28
60	1.68	2.44
61	1.88	2.60
62	2.10	2.77
63	2.34	2.94
64	2.64	3.17
65	1.28	1.51

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