ANZ SMART CHOICE SUPER FOR EMPLOYERS AND THEIR EMPLOYEES

HANNOVER LIFE RE OF AUSTRALASIA LTD
NTT AUSTRALIA SUPERANNUATION PLAN

INSURANCE GUIDE | ISSUED 1 DECEMBER 2020
DEATH AND TOTAL AND PERMANENT DISABLEMENT COVER

ANZ

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
Hannover Life Re of Australasia Ltd	ABN 37 062 395 484	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	Oasis Asset Management, Administrator
NTT Australia Pty Ltd	ABN 65 003 371 239	NTT, Employer
NTT Australia Superannuation Plan		Employer Plan

CONTENTS

Important information 3
Insurance in ANZ Smart Choice Super 4
What type and amount of cover is available? 4
When are you eligible for cover? 4
What is Default Cover? 4
What is Voluntary Cover? 5
When does cover commence? 5
What are the Benefits? 6
When we won't pay Benefits 6
Who is a Benefit paid to? 6
What are the costs of insurance? 7
When does your cover cease? 7
Cover ceases after inactivity 8
What happens when you leave your Employer? 8
Additional features 8
How to make a claim 8
Duty of Disclosure 9
Insurance risks 9
Appendix 10
Definitions 22
Insurance Fee Schedule 28

IMPORTANT INFORMATION

This version of this Insurance Guide (this 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 2020.

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.

The issuer is a company within the IOOF Group of companies, comprising IOOF Holdings Limited ABN 49 100 103 722 (IOOF) and its related bodies corporate. The ANZ brand is a trademark of ANZ and is used by OPC under licence from ANZ. Neither the issuer, ANZ nor any of their related or associated companies guarantee the repayment of capital, the performance or any rate of return of, the investment options chosen in the Fund. Investments made into the investment options are subject to investment risks and other risks. This could involve delays in the repayment of principal and loss of income or principal invested.

The factual information and advice provided 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 1800 836 545.

The Fund is governed by a trust deed (**Trust Deed**). Together with superannuation law, the Fund's 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 free of charge.

If an employer has selected insurance cover as part of ANZ Smart Choice Super, the insurance cover is provided by OnePath Life or another insurer approved by the Trustee.

In the case of this Guide, cover is provided by Hannover Life Re of Australasia Ltd (**the Insurer**) under a group policy issued to the Trustee. In respect of such a policy, the Trustee reserves the right to change insurer, or vary the benefits or rates of Insurance fees (premium) from time to time.

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 Hannover Life Re of Australasia Ltd (HLRA). If there is any conflict between this document and the insurance contract with HLRA, 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 2020;
- ANZ Smart Choice Super for employers and their employees and ANZ Smart Choice Super for QBE Management Services Pty Ltd and their employees Additional Information Guide (AIG) dated 1 December 2020;
- ANZ Smart Choice Super for employers and their employees Fees Guide dated 1 December 2020;
- ANZ Smart Choice Super Buy-Sell Spread Guide dated 1 December 2020;
- ANZ Smart Choice Super for employers and their employees – Hannover Life Re of Australasia Ltd – **NTT Australia Superannuation Plan** – Insurance Guide dated 1 December 2020.

The information in this document forms part of the ANZ Smart Choice Super for employers and their employees PDS dated 1 December 2020.

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 anz.com/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 Guide dated 30 November 2020. This Guide, the link to which was included in your Welcome Letter, contains all the information about the insurance applicable to your Employer Plan.

You may also request a copy of all information (including this Guide) free of charge by contacting Customer Services.

Trustee contact details

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

347 Kent Street
Sydney NSW 2000

GPO Box 5107
Sydney NSW 2001

Phone 1800 836 545
Email corporatesuper@anz.com
Website anz.com/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. Income Protection (IP) cover is not offered by your Employer Plan.

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 Letter and subsequent Annual Statements each year. If you have not received a Welcome Letter, please contact Customer Services on 1800 836 545.

To view, manage and consolidate your super, simply register for ANZ Internet Banking or the ANZ App, by calling Customer Services on 1800 836 545 or visiting an ANZ branch.

If you are an existing ANZ Internet Banking customer, call Customer Services to link your accounts.

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

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 to this Guide.

WHAT TYPE AND AMOUNT OF COVER IS AVAILABLE?

Your Employer can select:

- **Death only Cover**, and/or
- **Death and Total and Permanent Disablement (TPD) 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 Letter sent to you. Benefits described in this Guide that are not listed in your Welcome Letter 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, 7 days a week. The Appendix will specify whether there are any restrictions on cover while you are **Overseas**.

WHEN ARE YOU ELIGIBLE FOR COVER?

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

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

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

If the Trustee and/or the Insurer are told or otherwise become aware that they have accepted insurance fees for cover for which the member is ineligible, the relevant insurance fees will be refunded and no insurance cover will apply for any period during which the member was ineligible. You can elect to cancel or reduce your Default cover at any time by contacting Customer Services on 1800 836 545.

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 referred to as Agreed Cover in the Policy.

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

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

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

If your Employer does not provide this information, or until this information is provided, we cannot establish insurance cover in your ANZ Smart Choice Super account. If the information is not provided to us within 180 days of you

commencing employment with your Employer, you may no longer be eligible for Default Cover. In this instance, you may need to apply to the Insurer for cover, and it will be at the discretion of the Insurer as to whether this cover is provided to you and the terms applicable to that cover.

To ensure your details have been set up correctly by your Employer, check the details found in your Welcome Letter, 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 via ANZ Internet Banking. Alternatively you can call Customer Services on 1800 836 545 for assistance with your account or to register for ANZ Internet Banking.

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 1800 836 545. 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 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?' below.

WHAT IS VOLUNTARY COVER?

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

- Death only Cover; and/or
- Death and TPD 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. If the Insurer accepts the Voluntary Cover, they may provide written acceptance to a **Forward Underwriting Limit**. If this is available for your Employer Plan, further details will be provided in the Appendix.

To apply for Voluntary Cover, please contact Customer Services on 1800 836 545. You may be contacted by us for additional evidence or further information.

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

WHEN DOES COVER COMMENCE?

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

DEFAULT COVER

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

VOLUNTARY COVER

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

REDUCING OR CANCELLING YOUR COVER

You can reduce the amount of your cover, or cancel your cover, at any time by contacting Customer Services on 1800 836 545. You cannot reduce your Death **Sum Insured** to an amount below your TPD Sum Insured.

If you reduce 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, some or all of the premiums in respect of any cancelled cover may be refunded to your superannuation account in some circumstances. For more information, call Customer Services.

COVER ACCEPTANCE

Where the Insurer approves your cover or any change in cover on altered terms, your acceptance of these will be required within 28 days from the date Insurer notifies their decision.

14-DAY COOLING-OFF PERIOD

If you feel that this cover does not meet your needs you can request for it to be cancelled, provided you have not made a claim. Your premium will be refunded in full to your superannuation account. You must make this request within 14 days of the cover being issued.

Where cover has been duly cancelled under this clause, the Insured Cover will be considered not to have started and no benefits will be payable.

The cooling-off period also applies to automatic increases. Should your Sum Insured for your Default cover increase, you can request to cancel the increased portion of the Sum Insured within 14 days from the date we notify you of the increase. If you exercise this option then your cover will be limited to the amount of cover you had prior to the automatic increase.

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

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

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

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

Please note that an exception may apply if:

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

WHAT ARE THE BENEFITS?

Subject to the terms and conditions of The Policy, the Insurer could pay the Insured Cover for an Insured Person in the event of their:

a. Death, or

b. Terminal Illness, or

c. Total and Permanent Disablement.

DEATH BENEFIT

A Death Benefit will be paid if you die while your cover is in place and current. See 'When Does Your Cover Cease?' on page 7 for more information.

TERMINAL ILLNESS BENEFIT

A Terminal Illness Benefit will be paid if you become **Terminally Ill** while your Death cover is in place and current (refer to page 26 for the definition of Terminal Illness).

The Terminal Illness Benefit is the lesser of your Death cover sum insured and $3 million. If the insured Death Benefit is greater than $3 million, the balance is paid on your death, provided it occurs while your cover is still in place and current.

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.

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 TPD Benefit will be paid.

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

DEATH AND TPD COVER ARE LINKED

If you are paid a TPD Benefit, this reduces your Death cover by the amount of the Benefit paid. For example, if you have equal amounts of Death cover and TPD cover, payment of the TPD Benefit will mean that you have no further Death cover. However, if the amount of your Death cover is greater than TPD cover, payment of the TPD Benefit will reduce your Death cover by the amount of the TPD Benefit paid.

TPD TAPERING MAY APPLY TO YOUR TPD COVER

TPD tapering is the gradual reduction of the amount of TPD cover to zero. Cover is tapered according to your Age Next Birthday on 1 July each year. If TPD tapering applies to you, more information on this can be found in the Appendix.

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.

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

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 via ANZ Internet Banking or by calling Customer Services. Upon meeting a condition of release, you will receive the Benefit amount, adjusted positively or negatively, for investment earnings.

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.

Under superannuation law, 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 and gender;
- your salary;
- any relevant rating factors applicable to your Employer Plan; and/or
- your health and pastimes.

PAYMENT OF INSURANCE FEES

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

If you have insufficient funds in your account to cover the Insurance fee, you will be advised in writing. You will be given 30 days 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.

Exceptions apply for insurance only members, such that the deduction of Insurance fees will await the Employer's additional contributions and the Employer may not withdraw their consent to incur fees in respect of such arrangements, except with our approval.

Aside from the arrangements for insurance only members, your Employer's arrangement with us to incur the cost of any fees is voluntary and consent for such arrangement may be withdrawn at any time. If this is the case, you will receive 30 days prior notification. We will let you know of the options available to you.

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 Letter provided upon joining ANZ Smart Choice Super, and then for each subsequent year in the Annual Statement issued as at 30 June.

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

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

TAXES AND EXPENSES

Insurance fees are inclusive of any applicable:

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

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

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

WHEN DOES YOUR COVER CEASE?

Your cover will end on the earliest of:

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

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

COVER CEASES AFTER INACTIVITY

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

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

WHAT HAPPENS WHEN YOU LEAVE YOUR EMPLOYER?

On termination of employment with your Employer, your superannuation account in ANZ Smart Choice Super will continue. However, your insurance cover under your Employer Plan will cease from the date you leave the service of your Employer and Insurance fees will no longer be deducted.

You have the following options as outlined below, for insurance cover:

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.
2. You may be able to apply for Choose Your Own cover with OnePath Life within ANZ Smart Choice Super. The terms of cover (including the eligibility conditions and rates that apply) provided by OnePath Life are set out 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 anz.com/smartchoicesuper > Downloads – important documents, or by calling Customer Services.
3. 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.

For full terms and conditions about OneCare Super, refer to the OneCare Super PDS which is available at onepath.com.au/superandinvestments-forms-and-brochures, from your financial planner 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. OnePath Life Limited is the insurer for OneCare Super.

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 decision about whether to acquire OneCare Super.

ADDITIONAL FEATURES

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

HOW TO MAKE A CLAIM

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

For more information about making a claim:

- contact Customer Services on 1800 836 545
- email Customer Services at corporatesuper@anz.com
- visit the ANZ website at anz.com/superclaims

The Insurer requires you, your Employer or us to notify them in writing of any claim as soon as possible.

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 via ANZ Internet Banking or by calling Customer Services. Upon meeting a condition of release, you will receive the benefit amount, adjusted positively or negatively, for investment earnings.

DUTY OF DISCLOSURE

The Trustee, who enters into a life insurance contract in respect of your life, has a duty, before entering into the contract, to tell the Insurer anything that it knows, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms.

The Trustee has this duty until the Insurer agrees to provide the insurance.

The Trustee has the same duty before it extends, varies or reinstates the contract.

The Trustee does not need to tell the Insurer anything that:

- reduces the risk the Insurer insures you for; or
- is of common knowledge; or
- the Insurer knows or should know as an insurer; or
- the Insurer waives your duty to tell the Insurer about.

YOU MUST DISCLOSE RELEVANT INFORMATION

You must tell the Insurer anything you know, or could reasonably be expected to know, that may affect the Insurer's decision to provide the insurance and on what terms. If you do not do so, this may be treated as a failure by the Trustee to tell the Insurer something that the Trustee must tell the Insurer.

You should be aware that failure to disclose information may result in the Insurer avoiding the cover at the time of claim.

If you provide relevant information to the Trustee rather than the Insurer, The Trustee will provide the information you give the Trustee to the Insurer. The Trustee will do this so that you comply with your obligation to provide relevant information to the Insurer.

IF THE TRUSTEE DOES NOT TELL THE INSURER SOMETHING

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

If the Trustee does not tell the Insurer anything the Trustee is required to, and the Insurer would not have provided the insurance or entered into the same contract with the Trustee if the Trustee had told the Insurer, the Insurer may avoid the contract within three years of entering into it.

If the Insurer chooses not to avoid the contract, the Insurer may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if the Trustee had told the Insurer everything it should have. However, if the contract provides cover on death, the Insurer may only exercise this right within three years of entering into the contract.

If the Insurer chooses not to avoid the contract or reduce the amount of insurance provided, the Insurer may, at any time vary the contract in a way that places the Insurer in the same position it would have been in if the Trustee had told the Insurer everything it should have. However this right does. However this right does not apply if the contract provides cover on death.

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

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;
- your insurance cover will not continue when you leave your Employer;
- if you are transferred to another super fund, an Eligible Rollover Fund (**ERF**) or the Australian Taxation Office (**ATO**) as lost or unclaimed monies, your cover will cease (see the AIG for more details);
- the amount or type of insurance cover selected by your Employer may not be sufficient to provide adequate insurance cover in the event of **Injury** or **Illness**;
- your Insurance fee or benefit may be adjusted if your age is mis-stated;
- if your benefit is calculated using your salary while you are in the Employer Plan, we are reliant upon your Employer's notification of any salary changes. Where we are not notified of a change in salary and no additional Insurance fee is paid, in the event of a claim, the Insurer may pay a lower benefit based on the salary that was previously advised or salary at the last review date;
- if you or your Employer do not disclose to the Insurer every matter that they know or could reasonably be expected to know, that would be relevant to the Insurer's decision whether to accept the risk of the insurance and if so, on what terms, the Insurer may avoid the contract within three years of entering into it. If you or your Employer's non-disclosure is fraudulent, the Insurer may avoid the contract at any time. Refer to 'the 'Duty of Disclosure' section within this Guide for more details;
- 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;
- you may not be paid a benefit because an exclusion or restriction applies, based on your personal circumstances;
- insurance fees may increase over time; and
- 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 Insurance Guide dated 1 December 2020 for the NTT Australia Superannuation Plan.

Types of cover available	**Death cover** (including Terminal Illness); or **Death cover** (including Terminal Illness) **and Total and Permanent Disablement (TPD) cover**. **Income Protection Cover is not available through the Employer Plan**.
Category descriptions	**Death and TPD – Category descriptions** **Category 1 and 2 –** New members can opt in to Category 1 or 2 by lodging an Option form that is completed to the Insurer's satisfaction and signed by the member within 30 days of joining the Fund. Any change of Membership Category is subject to the Insurer's written confirmation. You can obtain an Option form by contacting Customer Services on 1800 836 545. **Category 3 –** All Staff (all eligible new members are set up in Category 3).
What is Maximum Insurable Age?	Maximum Insurable Age is the maximum age for which a person can hold Insured Cover, as follows: • Death and Terminal Illness cover: 70th birthday. • Total and Permanent Disablement cover: 70th birthday.
What is the Minimum and Maximum Entry Age?	Minimum entry age is 15 years. Maximum entry age is 64 years.
What is the Maximum Benefit Level?	Unless otherwise agreed by the Insurer, the total amount of Agreed Benefit per Insured Person under all policies with the Insurer and the market is: • for TPD Cover, limited to $3,000,000 per Insured Person; • for Terminal Illness, limited to $3,000,000 per Insured Person; and • for Death Cover, unlimited. The Maximum Benefit is the total of Default Cover and Voluntary Cover.
Default Cover (Benefit Design)	
What Default Cover is available?	**Benefit Design (Agreed Benefit)** Default Cover is referred to as Agreed Cover in the Policy. Agreed Cover is compulsory for all Eligible Persons and commences under Automatic Acceptance from the date they commence employment. The amount of Agreed Cover payable on Death, Terminal Illness or Total and Permanent Disablement for an Insured Person is determined in accordance with the following formula: **Category 1** – Scale Cover **Category 2** – 2 x Salary **Category 3** – 4 x Salary The amount of your Agreed Cover is calculated: • at 1 July each year • when your Employer advises a new Salary for you (where the amount of your Default Cover is based on a formula including your Salary); and • when the level, Insurance fee or formula of your Default Cover is changed. The amount of your Default Cover and Benefit Formula for your Membership Category will be included in your Welcome Letter.

Age Based cover

Death and TPD Age Based cover:

Category 1 – amount of cover (per unit of cover)

Age Next Birthday	Death	TPD	Age Next Birthday	Death	TPD
16	109,000	109,000	44	37,000	37,000
17	109,000	109,000	45	33,000	33,000
18	109,000	109,000	46	30,000	30,000
19	109,000	109,000	47	26,000	26,000
20	109,000	109,000	48	23,000	23,000
21	109,000	109,000	49	19,000	19,000
22	109,000	109,000	50	16,000	16,000
23	109,000	109,000	51	14,000	14,000
24	109,000	109,000	52	13,000	13,000
25	109,000	109,000	53	11,000	11,000
26	109,000	109,000	54	9,000	9,000
27	109,000	109,000	55	8,000	8,000
28	109,000	109,000	56	7,000	7,000
29	109,000	109,000	57	6,000	6,000
30	109,000	109,000	58	6,000	6,000
31	109,000	109,000	59	5,000	5,000
32	109,000	109,000	60	4,000	4,000
33	109,000	109,000	61	4,000	4,000
34	109,000	109,000	62	4,000	4,000
35	93,000	93,000	63	3,000	3,000
36	86,000	86,000	64	3,000	3,000
37	81,000	81,000	65	3,000	3,000
38	73,000	73,000	66	1,500	1,500
39	67,000	67,000	67	1,500	1,500
40	60,000	60,000	68	1,500	1,500
41	54,000	54,000	69	1,500	1,500
42	48,000	48,000	70	1,500	1,500
43	42,000	42,000			

Eligibility for Default Cover

To be eligible for Default Cover, you must be an **Eligible Person** who is a **Permanent** employee of the Employer or a **Contractor**.

Eligible Person means a person:

- who is an **Australian Resident**; and
- who is not employed in an **Excluded Occupation** or who does not perform any duties of an **Excluded Occupation**; and
- who has an account balance of $6,000 or over^; and
- who is at least 15 years old^; and
- who meets the **Maximum Entry Age**; or
- that the Insurer expressly agrees in writing is an Eligible Person.

For members under 25 years old or with an account balance less than $6,000, Default Cover starts:

- when you provide an opt-in election, if we receive it within 120 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;
- a new application is required if the opt-in is received after 120 days; or
- the day PMIF thresholds† or an exception is met (no opt-in election is required). In this case you will receive **Limited Cover** until you are **At Work** for 30 consecutive days after which full cover will commence.

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

† When you turn 25 and your account balance is $6,000 or more.

Automatic Acceptance	An Eligible Person will be accepted for Default Cover up to the Automatic Acceptance Limit without the need for underwriting provided: a. they are not older than the Maximum Entry Age, and b. they are aged 25 years or over and have an account balance of at least $6,000, unless PMIF exception applies, and c. within 120 days of becoming first eligible, the Fund receives: • a Superannuation Guarantee (SG) contribution that is on-time, and • Minimum Member Details or a satisfactorily completed Member Application Form, and d. they have not received, or are eligible to receive, a terminal illness benefit or total and permanent disability benefit payment from any superannuation fund or insurance policy. Where (a), (b), (c) and (d) have been met, Default Cover by way of Automatic Acceptance commences from: (i) The first date the Eligible Person's account balance is equal to or greater than $6,000 and they are at least 25 years of age, or (ii) The date the opt-in election is provided and it was received within 120 days of you becoming an Eligible Person or it was received within 90 days of the date the Trustee sent the Welcome Letter, or (iii) The first day of the period to which the Superannuation Guarantee (SG) contribution relates, where a PMIF exception applies, and provided the your account is not inactive. If the Insured Person is not At Work on the date Default Cover commences, the Default Cover will be a New Events Cover until the Insured Person has been in At Work for 30 consecutive days. Unless Default Cover has commenced as described above, all cover will be subject to Underwriting.
Automatic Acceptance Limit	Default Death and TPD Cover Cover can only come into effect by Automatic Acceptance for an amount up to the Automatic Acceptance Limit of $1.5 million that applies to the Eligible Person. The Insurer reserves the right to alter the Automatic Acceptance Limit if there is a change to any of the requirements listed in Automatic Acceptance or a 30% change in the number of Insured Persons. Voluntary Cover Nil. All cover will commence from the date the Insurer advises in writing.
Automatic uplift of Automatic Acceptance Limit	If the Insurer increases the Automatic Acceptance Limit then it will apply to all existing Insured Persons where an Automatic Acceptance Limit currently applies even if they have previously been declined, excluded or loaded for cover above the previous Automatic Acceptance Limit. Any exclusions, premium loading, limitations, special terms, conditions or restrictions will continue to apply above the new Automatic Acceptance Limit.
Underwriting	Underwriting occurs where an application for cover which is not available under Automatic Acceptance is subject to assessment by the Insurer. The Insurer may, after considering all information they have requested and received in relation to the Eligible Person, in relation to cover to which Automatic Acceptance does not apply, 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 on whatever terms, or subject to whatever restrictions or with whatever premium loadings the Insurer may consider appropriate, or c. refuse to provide cover for the Eligible Person under the application absolutely. Other than cover that commences through Automatic Acceptance, cover only comes into force in respect of an Eligible Person when the Insurer notifies the Trustee that they accept them for the cover.

Non-standard terms	If the Insurer offers Insured Cover that is subject to an exclusion, premium loading, limitation, special term, condition or restriction, the Eligible Person or Insured Person will be required to confirm they accept the Insurer's offer within 28 days of the date we notify the Trustee of our decision. From the date of the offer, the Insurer will provide Accident Cover (refer to 'Is Accident Cover Available for Death and TPD Cover applications?' on the next page for details). Where the Insurer is notified within 28 days that the Eligible Person or Insured Person has accepted our offer, the variation to Insured Cover will commence from the date the Insurer received their acceptance. Any exclusion, premium loading, limitation, special term, condition or restriction that came into effect will apply above the Automatic Acceptance Limit. Where the Insurer is not notified within 28 days that the Eligible Person or Insured Person has accepted our offer, the Insurer's 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.
Taking over existing cover	The Insurer will commence cover in accordance with the Takeover Terms in the Appendix. The Insurer will not consider a claim where the person is entitled to apply, or has been paid, a benefit under the previous policy. If any individual exclusions, premium loading, limitations, special terms, conditions or restrictions were imposed on the Insured Person's cover under the previous policy, they will also apply to their Insured Cover under the Policy.
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 may have granted to an Insured Person, and b. their 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 New Events cover will apply to the increase until the date the Insured Person is At Work for a 30 consecutive day period. The Insurer reserves the right to request the Trustee to provide certification.
Voluntary Cover	
What types and amounts of Voluntary Cover can members apply for?	All Eligible Persons who are a Permanent Employee or a Contractor. All Voluntary Cover is subject to Underwriting and will commence on the date the Insurer advises in writing. **Amount of Voluntary Cover** There is no limit on the amount of Voluntary Death cover you can apply for. However, there is a maximum of $3 million for Terminal Illness cover and $3 million for TPD cover.

Is Accident Cover (Interim Accident Cover) available for Death and TPD cover applications?	Yes. **When Does Accident Cover begin?** When the Insurer receives an application for cover for an Eligible Person or an application for an increase in the amount of the Agreed Benefit for an Insured Person, cover known as Accident Cover begins for that person. This does not apply to any increase provided under Life Events Cover. **Benefit for Accident Cover** If an Eligible Person or Insured Person with interim Accident Cover dies as a result of an Injury, or suffers Total and Permanent Disablement as a result of an Injury, the Insurer will pay the lesser of the amount being applied for or $1,500,000 as if they were an Insured Person. Interim Accident Cover will be payable for: a. Death, if the application to the Insurer requested Insured Cover for Death and it is available to them under the Policy, and b. Total and Permanent Disablement, if the application to the Insurer requested Insured Cover for Total and Permanent Disablement and it is available to them under the Policy. **When will interim Accident Cover not be payable?** Interim Accident Cover will not be payable where: a. the Death of the Insured Person is directly or indirectly the result of suicide or attempted suicide, or b. the Total and Permanent Disablement of an Insured Person is directly or indirectly the result of an intentional self-inflicted injury or attempted suicide. The Insurer may take into account any information the Insurer receives in the course of the claim under interim Accident Cover in exercising the Insurer's discretion whether the Insurer accepts, refuses or offers special terms, conditions, restrictions, exclusions or premium loading for any Insured Cover under Underwriting. **When does interim Accident Cover end?** Unless the Insurer has made an offer of Insured Cover that is subject to Non-standard terms, interim Accident Cover for an Eligible Person or an Insured Person ceases on the earliest of: a. when the Insurer notifies the Trustee of their decision under Underwriting, or b. when the application is withdrawn, or cancelled, or the Insurer is advised it is not being proceeded with, or c. at midnight on the 90th day after it commenced, or d. when any event happens which caused the Insured Cover for an Insured Person to cease, or e. the cessation of the Policy. Where the Insurer has made an offer of Insured Cover that is subject to Non-standard terms, interim Accident Cover for an Eligible Person or an Insured Person ceases on the earliest of: a. when the Insurer is notified that the Eligible Person or Insured Person accepts the Insurer's offer, or b. when the Insurer is notified that the Eligible Person or Insured Person has rejected the Insurer's offer, or c. at midnight on the 28th day after the Insurer notifies the Trustee of the Insurer's decision under Underwriting, or d. when any event happens which caused the Insured Cover for an Insured Person to cease, or e. the cessation of the Policy.

Death Cover	
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, provided that: a. the Date of Certification of the Terminal Illness is on or after the date their Insured Cover commenced under the Policy. No Terminal Illness benefit will be considered where the Date of Certification is prior to this date, and b. a Terminal Illness benefit for an Insured Person will be the lesser of their Insured Cover or $3,000,000. Provided they remain an Insured Person, and we continue to receive Premium for their Insured Cover, we will pay the residual Insured Cover for Death calculated as at the Insured Person's date of Death, less any Insured Cover for Terminal Illness that has already been paid, and c. the Insured Person must supply supporting medical evidence from two (2) Doctors at their own expense. At least one (1) 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 the Insurer's choosing and reserve the right to ask for any additional information that the Insurer feel is appropriate. If the Insurer asks for additional information the Insurer will incur the cost of obtaining the additional information, and d. if The Policy has terminated, the Insured Person, will only be eligible for a Terminal Illness benefit where: i. the Date of Certification is prior to the date that the Policy terminated, and ii. the Insured Person is not eligible for a terminal illness, total and permanent disablement or death claim under a new replacement policy. From the date a Terminal Illness claim has been lodged an Insured Person will no longer be eligible for Total and Permanent Disablement, any increase in Insured Cover or any reinstatement of Insured Cover. If a claim for Terminal Illness is admitted, all Insured Cover will cease from that date subject to (b) above. Any residual Insured Cover for Death will be payable on the Death of the Insured Person. Where a Terminal Illness benefit is paid it will be considered as an advance payment of the Insured Cover for Death.
TPD Cover	
Under what conditions will I be paid a TPD Benefit?	If on the Date of Disablement an Insured Person: a. is a Permanent Employee or Contractor, and b. has worked for an average of at least 15 hours per week during the 6 months prior to the Date of Disablement, the Insurer will pay the Insured Cover for Total and Permanent Disablement if the Insured Person satisfies either Part 1, 2, 3, 4 or 5 of the TPD Definitions. If an Insured Person does not satisfy (a) and (b) above on the Date of Disablement the Insurer will only pay the Total and Permanent Disablement benefit if the Insured Person satisfies either Part 3, 4 or 5 of the TPD Definitions. If an Insured Person is suffering from one or more of the Immediate Assessment Conditions and all claim requirements have been received by the Insurer, the 3-month waiting period that applies to Part 1, 4 and 5 will be waived and assessment of a claim commences immediately. In order to satisfy Part 3, 4 or 5, the Insured Person must be disabled to such an extent as a result of that Injury or Illness that in the Insurer's opinion they are unlikely ever at any time in the future to engage in any Gainful Employment for which they are reasonably suited by education, training or experience. TPD Definitions and Date of Disablement definition are set out in the 'Definitions' section of this Guide on pages 27 and 23 respectively.

Does TPD Tapering apply?	Yes, TPD tapering applies. TPD tapering means your TPD cover will reduce (taper) by 10% when you reach Age Next Birthday 62, and continue tapering as per the table below until you reach Age Next Birthday 71 when your TPD cover amount will reduce to $0. Your Age Next Birthday will be assessed on the 1st of July each year (i.e. not on your actual birthday). Your cover will therefore start tapering from the 1st of July that you reach Age Next Birthday 62 and every 1 July thereafter, unless you change your cover amount during the year upon which your Age Next Birthday will be reassessed at the effective date of the change (and then at each 1 July thereafter). For **Category 1**, TPD tapering applies, and the insured amount of TPD cover is as shown in the Age Based cover section on page 11. For **Category 2, Category 3** and Voluntary Cover TPD tapering applies in accordance with the table below. The following table sets out the insured amount of TPD Cover applicable from age 60.

Age next birthday on 1 July	TPD Tapering Factor (as a % of the corresponding insured cover for death)
61	100%
62	90%
63	80%
64	70%
65	60%
66	50%
67	40%
68	30%
69	20%
70	10%
71	Nil cover

When the Insurer won't pay

Exclusions

No benefits are payable where a claim arises directly or indirectly as a result of:

a. War or act of war, or

b. The Insured Person having been in a country listed on the Department of Foreign Affairs and Trade website (www.dfat.gov.au) as subject to a 'do not travel' warning at the time they entered the country, or

c. Any additional exclusion that came into effect through Underwriting or Taking over existing cover.

Where an Eligible Person or an Insured Person is underwritten, the Insurer will advise their terms of acceptance as outlined under the 'Underwriting' section of this Appendix.

Additional exclusions applying to Voluntary Cover

In addition to a. b. and c. above, Voluntary Cover will also not be payable where a claim is directly or indirectly the result of:

d. Suicide, attempted suicide or intentional self-inflicted harm, within 13 months from the date the Voluntary Cover was accepted if the claim is for Death, or

e. Intentional self-inflicted harm or attempted suicide, if the claim is for Total and Permanent Disablement.

Insurance fees

Insurance fee payable (premium)

means the money paid to the Insurer or owed to the Insurer for the insurance they provide under the Policy. The Insurance fee is payable monthly in advance.

See the Insurance Fee Schedule on page 28.

When can the Insurer vary the terms of the policy (including the premium rate)?	During the **Guarantee Period**, the Insurer may not vary any of the terms and conditions of the of the Policy, including the Premium Rate in the Insurance Fee Schedule on page 28, unless: a. the number of Insured Persons within a category varies by more than 30%, or b. the number of Insured Persons within a category who are working Overseas for their Employer is greater than 10%, or c. the formula used to calculate the Agreed Cover for any category of membership alters, or d. Insured Cover was granted, or persons admitted to the Plan, on terms contrary to those agreed between the Trustee and the Insurer, or e. the conditions under which persons are eligible for Insured Cover alter, or f. in the Insurer's opinion any changes in occupations, countries in which Insured Persons are located, or other circumstances, leads to a material change in the risk, or g. there is a change in any government legislation, charge, licence fee, tax or other impost that is directly attributable to the Policy, or h. there is a change in any external brokerage or administration fee attributable to the Policy, or i. the Trustee invites (by tender or otherwise) another party to propose alternative pricing, terms or conditions for the Insured Cover presently provided under the Policy, or j. If a joint policy discount is included under Premium Rate in the Policy Schedule, and one policy ceases, the Insurer reserves the right to remove the joint policy discount offered and adjust the Premium Rate in the Insurance Fee Schedule on page 28. A variation in the terms and conditions of the Policy will have effect from the date the Insurer nominates to pick up clause 10.6 of the Policy. **The Insurer's right to vary the conditions** At the termination of the Guarantee Period, the Insurer may vary any of the terms and conditions of the Policy, including the rates of premium, subject to giving 3 months notice of the variation to the Trustee. However, no variation in the terms of the Policy may be made which would enable the Insurer to refuse to continue to insure an Insured Person under the Policy while the Policy remains in place and current.
When does cover cease?	
When does an Insured Person's cover cease?	Insured Cover for an Insured Person ceases on the earlier of the date: a. when the Insured Person reaches their Maximum Insurable Age, or b. when the Insured Person ceases to be an Insured Person of the Employer Plan, or c. when the Insured Person ceases to be an Australian Resident, or d. subject to the terms set out in the 'Extension of Cover' section of this Appendix, from the date the Insured Person ceases to be employed by their Employer, or e. when the Insured Person commences active service with the armed forces of any country, other than a member of the Australian Defence Force Reserves whilst performing duties within Australia, or f. on the date the Insured Person is accepted under a Continuation Option policy, or g. subject to the terms set out in 'Terminal Illness' section of this Appendix, on the date the Insurer admits a claim for a benefit for the Insured Person, or h. on the date the Insured Person exercises their right to direct future contributions to another fund and transfers their entire account balance to this fund as a result of choice of fund legislation, or i. when the Insured Person is on Employer approved leave for longer than the period of time that the Insurer has agreed to provide cover for them, or j. when the Insured Person ceases to reside in Australia or fails to meet the Insurer's agreed terms for cover during Employer secondment Overseas, or k. when the Insured Person dies, or l. when the Insured Person permanently retires from the workforce, or m. when the Insured Person is the subject of a fraudulent claim under the Policy, or n. on the date the Trustee gives notice that the Insured Cover will cease for the Insured Person, or o. when all cover for every Insured Person under the Policy ceases, or p. the day your PMIF exception is no longer applicable, or q. Insured Person's account balance reduces to $0, or is insufficient to pay Premium, and the Premium remains unpaid for 2 months. Where the Insured Person had previously paid a Premium, cover will be cancelled 2 months after the date the person first went into arrears. For avoidance of doubt, where the Eligible Person has never paid a Premium, cover will be deemed not to have commenced, or r. unless the Insured Person has a PYS exemption, at the end of the period for which Premiums have already been paid upon the Insured Person's account becoming Inactive.

Reinstatement of Cover	Cover for an Insured Person that has ceased is only reinstated if the Insurer agrees in writing. Reinstated cover is subject to any terms, conditions or restrictions that the Insurer considers appropriate at the time of reinstatement.
Claims after an Insured Person's Insured Cover has ceased	The Insurer will not pay a benefit for Death, where the date of Death is after the date that Insured Cover ceased. The Insurer will not pay a benefit for Total and Permanent Disablement, where the Date of Disablement is after the date that Insured Cover ceased. The Insurer will not pay a benefit for Terminal Illness, where the Date of Certification is after the date that Insured Cover ceased. Where the Insured Person is eligible for a Death, Total and Permanent Disablement or Terminal Illness claim under a new replacement policy, then the Insurer will not pay a benefit for them.
What happens when an employee leaves their Employer?	
Alternate Cover	If an Insured Person ceases to be employed by their Employer that is covered under the Policy, provided that person is not receiving or entitled to receive payment of benefits under the Policy, that person shall be the subject of an Extension of Cover, as outlined below.
Extension of Cover	Where the provisions of 'Alternate Cover' as described above apply, an Insured Person shall be deemed to have Accident Cover in place and current until the earlier of: a. 60 days after the date their cover ceased due to leaving employment with the Employer, or b. the person reaching the Maximum Insurable Age, or c. the person being engaged under a contract of employment other than with the Employer, or d. the person becoming insured under any other arrangement other than the Employer Plan under which the person is eligible to obtain death or total and permanent disablement benefits including a policy obtained through a Continuation Option. If Accident Cover begins under Alternate Cover, the amount of Accident Cover payable will be the lesser of $1,500,000 or the Insured Cover in force at the date it ceased under the Policy.
Is a Continuation Option available?	Yes. If an Insured Person ceases to be employed by their Employer, he or she may affect other cover for Death only and where applicable, total and permanent disablement under a personal life insurance policy with another insurer nominated by the Insurer. The Insured Person may only obtain the other cover if the conditions in 'When can the Continuation Option be applied for?' are met. The other cover is subject to the conditions listed under 'What are the conditions of the Continuation Option?' as well as those that appear in the other insurance policy when it is issued.
When can the Continuation Option be applied for?	The Insured Person to obtain cover under the Continuation Option, provided that: a. they exercise the continuation option within 60 days of ceasing employment, and b. they are less than 60 years of age at the date of ceasing employment, and c. they must not have commenced active service with the armed forces of any country, except as a member of the Australian Defence Force Reserves performing duties within Australia, and d. they are commencing employment as a Permanent Employee or Contractor, working 15 hours or more each week in an occupation that is not deemed to be an uninsurable risk by our nominated insurer, and e. they are commencing employment within 90 days of ceasing employment, and f. they are not ceasing employment due to a redundancy, and g. they have not submitted and must not be entitled to submit a claim under the Policy, and h. the premium for the personal life insurance policy is paid. The premium payable for the personal life insurance policy will be subject to our nominated insurer's premium rates and minimum premium.

What are the conditions of the Continuation Option?	The person's cover under the other policy affected as a result of the above, is subject to: a. the person completing an application to the insurer that the Insurer nominates and providing that insurer with the personal information it requires, and b. the person paying the premium due under the other policy, and c. the amount of cover under the other policy being no more than the lesser of $1,000,000 or the amount insured under this policy at the time of ceasing employment or the amount available with the Insurer's nominated insurer, and d. any conditions, restrictions, exclusions or increase in premium which apply to the person under this Policy applying to the other policy, and e. cover under the other policy only continuing up to the person's Maximum Insurable Age or their 70th birthday, whichever occurs first. Cover under the personal life insurance policy will only continue up to the Cover Ceasing Age or Insurance Person's 65th birthday, whichever occurs first.
Additional features	
Life Events Cover	The Insurer will allow an Insured Person to increase their Agreed Benefit without providing medical evidence if a Nominated Event occurs. The maximum amount of the increase is the lesser of: • 25% of their Agreed Cover, or • $200,000, or • the increase in mortgage (if existing), or the amount of the mortgage (if new). When one Nominated Event occurs, an Insured Person can apply to increase their Agreed Cover without providing medical evidence if: • the Insured Person has cover in place and current on the date that the Nominated Event occurred, and • the Insured Person is less than age 60 on the date the Insured Person applies for the increase in Agreed Cover under these 'Life Events Cover' terms, and • the Insured Person has not been declined, or have any exclusions, premium loading, limitations, special terms, conditions or restrictions applying to their Agreed Cover under the Policy, and • the Insured Person is not applying for, entitled to, or has not been paid a TPD benefit or Terminal Illness benefit from the Employer Plan, any superannuation fund or life insurance policy, and • the Insured Person provides sufficient proof to the Insurer's satisfaction that the Nominated Event occurred, and • the Insured Person has completed and signed an application to request the increase in the Agreed Cover is received by the Insurer within 90 days of the Nominated Event, and • the Insured Person's Insured Cover will not exceed the Maximum Insured Cover shown in this Appendix, and • the Insured Person is At Work on the date of the Nominated Event occurred and At Work on the date the Insurer accepts the application, and • have an account balance of $6,000 or over*. * You must provide an opt-in election if you are under 25 or with an account balance less than $6,000, unless you are covered by a PMIF exception. The Insured Person can only: – increase their cover once for any Nominated Event in any 12 month period; and – increase their cover once for each Nominated Event; and – apply for same type of cover for which they are currently insured. The increase under Life Events Cover does not apply to Voluntary Cover. Cover will commence on the date that the Insurer notifies the Trustee in writing that the Insurer has agreed to accept the increase to Default Cover. New Events cover will apply to the increased portion of Insured Cover for the first 12 months after the Insurer have accepted the application. Insurer will not pay the increased cover if Death as a result of suicide, or Total and Permanent Disablement as a result of self-inflicted Injury, occurred within the first 13 months from the date the Insurer agreed to the increase under this clause.

Cover during Employer approved leave	Subject to the terms of 'When does an Insured Person's Cover cease?' section of this Appendix, cover will continue in respect of an Insured Person on Employer approved leave provided: a. they continue to be employed by their Employer and the Insurer receives Insurance fees 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. When an Insured Person returns to work with their Employer, cover that was terminated by the Insured Person during the period of leave may be reinstated in accordance with the terms set out in 'Reinstatement of Cover' section of this Appendix. The Insurer requires to be notified in writing 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's salary is used to calculate their Agreed Cover, the Agreed Cover during the period of Employer approved leave will be calculated using the salary of the Insured Person on the working day immediately before their leave commenced.
Cover during leave due to injury or illness	Cover will continue in respect of an Insured Person who is absent from work due to Injury or Illness provided they continue to be employed by their Employer and the Insurer receives Insurance fees in respect of them. When an Insured Person returns to work with the Employer, cover that was terminated by the Insured Person during the period of leave may be reinstated in accordance with the terms set out in 'Reinstatement of Cover' of this Appendix. The Insurer requires to be notified in writing 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.
Cover during Employer secondment Overseas	Subject to the terms set out in 'When does an Insured Person's Cover Ceases' cover will continue for the Insured Person seconded to work Overseas for the Employer provided: a. they continue to be employed by their Employer, or an associated employer, and we continue to receive Premium for them, and b. the period of Employer secondment Overseas is no longer than 5 years, and c. in the Insurer's opinion, the residence Overseas is temporary in nature, and d. the Insured Person is not insured under any other arrangement with their Employer or associated employer, and e. the details of all employees seconded Overseas to work were provided to the Insurer at quotation stage and those details are updated at each annual review date or at any time the Insurer requests. The Insurer requires to be notified prior to the commencement of any period of Overseas residence if cover is not to be continued in respect of an Insured Person during such period. When an Insured Person returns to Australia and resumes work with the Employer, cover that was terminated by the Insured Person during the period of Overseas residence may be reinstated in accordance with the terms set out in 'Reinstatement of Cover' in this Appendix.
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 they reasonably consider are 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 and, if required, agreeing to be interviewed by the Insurer or someone they appoint. The Insured Person must attend any medical examinations or other assessments which the Insurer may require at their discretion. The Insurer will not pay for any costs incurred in obtaining any evidence, including for travel or accommodation, unless the cost was approved by the Insurer prior to it being incurred.

Medical examination and assessments	The Insurer may arrange for an Insured Person to be medically examined in connection with a claim. If the Insurer does so: a. the person who examines the Insured Person may be any appropriate registered medical practitioner or other health care practitioner chosen by the Insurer at the discretion of the Insurer, and b. the Insured Person must attend the examination, and c. the Insurer will pay the practitioner's fees. If the Insurer arranges for an Insured Person to be medically examined and they fail to attend the examination: a. the Insurer will not proceed with the assessment of their claim until they attend, and b. the Insurer may suspend further payments of any benefit payable in respect of the member until such time as the member attends, and c. if the Insurer incurs a non-attendance fee the Insurer may ask for the non-attendance fee to be paid by the Insured Person or Trustee prior to continuing to assess the claim.
Reviewing claims	The Insurer will not pay any costs or expenses incurred by the Trustee or the Insured Person in obtaining evidence to support their request for a review of a claim the Insurer has declined.
Payment of Benefits	All Benefits to be paid in respect of an Insured Person shall be paid to the Trustee (or a person nominated by the Trustee) who may hold the monies in trust for the benefit of that Insured Person and when applicable, in accordance with the terms of any trust deed. When the Insurer's claim requirements have been satisfied in respect of an Insured Person the Benefit shall be paid as a lump sum payment. Subject to the terms and conditions in the Policy, where it is determined by the Insurer that an Insured Person is eligible for the payment of a Benefit, the amount payable is the amount of the Insured Person's Insured Cover at their Incident Date. All payments shall be made in Australian dollars.
Making a claim when residing overseas	When an Insured Person is Overseas or resides in Australia and subsequently travels Overseas and becomes disabled or terminally ill, the Insurer reserves the right to ask the Insured Person to return to Australia at their own expense for assessment of their Total and Permanent Disablement or Terminal Illness claim.
General	
Takeover terms	Existing cover held under the Previous Policy on the day prior to the Commencement Date will continue for an Insured Person for the same type of benefit they had under the Previous Policy. For example, if a person only had Death cover under the Previous Policy, the Insurer will only provide Takeover Cover terms on Death cover under this policy, even if they are eligible for other cover types. Any individual conditions, exclusions or restrictions that applied to the transferred cover under the Previous Policy on the day before the Commencement Date will continue to apply until they expire according to their terms. This includes any limited cover and exclusions. Any takeover of cover is limited to the Maximum Benefit Level. The Insurer will provide cover and determine their liability for claims made in respect of the transferred cover by applying FSC Guidance Note 11 as the 'incoming insurer'. If there is any inconsistency between the terms and conditions of this policy and FSC Guidance Note 11, the Policy terms and conditions prevail to the extent of the inconsistency.

DEFINITIONS

Accident Cover	means cover for an unintended and unexpected Injury only.
Activities of Daily Working	means: a. Walking – they cannot walk more than 200 metres on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body, b. Rising/Sitting – they are unable to rise and sit using a raised chair with arms without the help of another person, c. Dexterity – they are unable to write legibly with a pen or pencil or use a keyboard with either hand, d. Communication – they cannot: i. Clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room in their first language, or ii. Understand simple messages in their first language, or iii. Speak with sufficient clarity to be clearly understood in their first language, e. Eyesight - their visual ability is reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.
Agreed Cover	means the amount of benefit that Insurer have agreed to for an Insured Person. Agreed Cover is in the Policy Schedule and in the Appendix under Default Cover.
Annual Review Date	means the effective date at which we review the Insured Cover and Premium each year. The Annual Review Date is in the Policy Schedule.
At Work	means that an Eligible Person or Insured Person: a. is actively performing all of the duties and hours of their usual occupation for their Employer, or b. If on Employer approved leave (except leave caused by Injury or Illness) they would otherwise be able to attend work and perform their normal duties without restriction due to Injury or Illness.
Australian Resident	means an Australian citizen or a person who is the holder of an Australian permanent visa within the meaning of Section 30 of the *Migration Act 1958* or resides in Australia on a Temporary Work (Skilled) visa (class 457). It also includes a New Zealand citizen who is residing and working in Australia.
Automatic Acceptance	means Agreed Cover/ Default Cover commencing under this Plan.
Automatic Acceptance Limit	means the maximum amount for which cover may come into force as a result of Automatic Acceptance that is stated in the Appendix.
Benefit	means the benefit payable to the Trustee under the ANZ Smart Choice Super insurance policy with respect to the insured member's cover.
Cognitive Loss	means a total and permanent deterioration or loss of intellectual capacity.
Contractor	means an Eligible Person or Insured Person who is working on a fixed term contract for a duration of at least 12 months that requires them to perform identifiable duties for a regular number of hours each week.
Cover Ceasing Age	means the maximum age that cover is provided under The Policy. The Cover Ceasing Age is in the Appendix.
Date of Certification	means the latter of the dates 2 Doctors approved by the Insurer have certified (the date of diagnosis), jointly or separately, that the Insured Person suffers a Terminal Illness. At least 1 of the Doctors must be a specialist practising in the field to which the Terminal Illness relates. Each of the certificates must be supported by test results and the certification period must not have ended.
Date of Commencement	means the date the Policy commenced. The Date of Commencement is in the Policy Schedule.

Date of Disablement	means the earlier of the date: a. the Insured Person is diagnosed with an Immediate Assessment Condition, or b. the three consecutive months absence from work that results in Total and Permanent Disablement began under Part 1 of the TPD Definitions. However, if the Insured Person undertakes a formalised graded return to work which fails within 12 months, the Insurer will take the Date of Disablement as being the date on which the person first ceased work, or c. the permanent impairment under Part 2 of of the TPD Definitions that results in Total and Permanent Disablement began, or d. the Insured Person suffers the Loss Of Use Of the sight in both eyes, or the Loss Of Use Of both limbs, or the Loss Of Use Of both the sight in 1 eye and 1 limb, or e. the Insured Person suffers the Loss Of Use Of the sight of another eye or the Loss Of Use Of another limb, having already suffered the Loss Of Use Of the sight of an eye or the Loss Of Use Of a limb, or f. the Cognitive Loss that results in Total and Permanent Disablement was first diagnosed, or g. the 3 consecutive month's inability to perform at least two of the Activities of Daily Working that results in Total and Permanent Disablement began.
Doctor	means a registered medical practitioner who is legally qualified and properly registered to practice in Australia or New Zealand or as otherwise agreed by the Insurer. That person may not be the Eligible Person or Insured Member, their business partner, a member of their immediate family or their Employer.
Eligible Person	means a person who: a. is an Australian Resident, and b. is aged between the Minimum Entry Age and the Maximum Entry Age, and c. is not employed in an Excluded Occupation, or who does not perform any duties of an Excluded Occupation, and d. meets the Insured Cover requirements, if any are stated in the Policy Schedule, and e. is employed by the Employer, or f. the Insurer expressly agrees in writing is an Eligible Person.
Employer	means the Employer in the Policy Schedule and any associated entity the Insurer agrees to in writing.
Excluded Occupation	means: a. Aviation worker such as a pilot, air traffic controller or aerial photographer, b. Emergency services worker such as a fireman, police officer, ambulance officer or paramedic, except as a volunteer, c. Entertainer working professionally such as an actor, dancer, musician or performer, d. Forestry worker such as a tree feller or sawmill worker, e. Horse racing industry worker such as a jockey, trainer or strapper, f. Mining worker such as a miner, mineral explorer earth driller or explosives handler, g. Offshore worker such as a fisherman, oil rig worker or diver, h. Seasonal worker, i. Security worker such as a security guard, doormen, bouncer or crowd controller, j. Sex worker, k. Sportsperson working professionally or semi-professionally, l. Underground or underwater worker, m. Working at heights above 10 metres such as a rigger, scaffolder or roof worker.
Forward Underwriting Limit	means any amount of Agreed Cover for an Insured Person that the Insurer have notified the Trustee. Insurer will accept for automatic increases without the requirement of further evidence.
Gainful Employment	means employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment at the time we assess the claim and includes part-time occupations, an occupation which may be perceived by the Eligible Person or Insured Person to be of lower status than their previous occupation or an occupation in which they do not earn as much income as they did in their previous occupation.
Guarantee Period	means the Guarantee Period in the Policy Schedule.
Illness	means a sickness, disease or disorder.

Immediate Assessment Conditions	means any of the following: a. **Blindness** – the permanent loss of sight in both eyes, whether aided or unaided, due to Injury or Illness to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 20 degrees or less of arc, as certified by an ophthalmologist. b. **Cardiomyopathy** – condition of impaired ventricular function of variable aetiology (often not determined) resulting in significant physical impairment, i.e. Class 3 on the New York Heart Association classification of cardiac impairment or a left ventricular ejection fraction of less than 35%. c. **Chronic Lung Disease** – the permanent end stage respiratory failure with FEV1 test results of consistently less than 1 litre or requiring continuous permanent oxygen therapy or FEV1 of less than 35% of predicted value on two separate occasions 6 months apart and confirmed by a pulmonologist. d. **Dementia and Alzheimer's Disease** – the clinical diagnosis of dementia (including Alzheimer's disease) as confirmed by a consultant neurologist, psycho-geriatrician, psychiatrist or geriatrician. The diagnosis must confirm permanent irreversible failure of brain function resulting in significant cognitive impairment for which no other recognisable cause has been identified. Where significant cognitive impairment means a deterioration in the person's Mini-Mental State Examination scores to 24 or less and deterioration would continue but for any effective treatment. Dementia related to alcohol or drug abuse are excluded. e. **Diplegia** – the total loss of function of symmetrical sides of the body due to Injury or Illness, where such loss of function is permanent. f. **Hemiplegia** – the total loss of function of one (1) side of the body due to Injury or Illness, where such loss of function is permanent. g. **Loss of Hearing** – the complete and irrecoverable loss of hearing, both natural and assisted from both ears of 90dB or more over the frequencies 500Hz, 1000Hz, 2000Hz, and 3000Hz on two (2) occasions taken six (6) months apart. The loss of hearing must be as a result of Injury or Illness, as certified by an ear, nose and throat specialist. h. **Loss of Speech** - the total and irrecoverable loss of the ability to produce intelligible speech as a result of permanent damage to the larynx or its nerve supply or the speech centres of the brain. The loss must be certified by an appropriate medical specialist not less than ninety days after the ability to speak was first lost. i. **Major Head Trauma** – Injury caused by an external force to the head resulting in neurological deficit causing either: i. A permanent loss of at least 25% whole person function (as defined by the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment latest Edition' or the equivalent guide to the evaluation of impairment approved by us, or ii. The permanent and irreversible inability to perform without the assistance of another person any 2 of the following activities of daily living: (i) Dressing – the ability to put on and take off clothing, (ii) Bathing – the ability to wash or shower without assistance, (iii) Toileting – the ability to use the toilet, including getting on and off, (iv) Mobility – the ability to get in and out of a bed and a chair, (v) Continence – the ability to control bowel and bladder function, (vi) Feeding – the ability to get food from a plate into the mouth, as certified by a consultant neurologist. j. **Motor Neurone Disease** – unequivocal diagnosis of motor neurone disease by a consult neurologist and confirmed by neurological investigations. k. **Multiple Sclerosis** – the unequivocal diagnosis of multiple sclerosis as confirmed by a consultant neurologist and characterised by demyelination in the brain and/or spinal cord evidenced by Magnetic Resonance Imaging or other investigations acceptable to the Insurer. There must have been more than 1 episode of well-defined neurological deficit affecting different anatomical sites with a permanent loss of at least 25% whole person function as defined by the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment (current edition)' or equivalent guide to impairment approved by the Insurer. l. **Muscular Dystrophy** – the unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist with at least 25% *Impairment of Whole Person Function* that is permanent, as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', or an equivalent guide to impairment approved by the Insurer.

Immediate Assessment Conditions *continued*	m. **Paraplegia** – the permanent loss of use of both legs resulting from spinal cord Injury or Illness. n. **Parkinson's Disease** – the unequivocal diagnosis of Parkinson's disease by a consultant neurologist with the inability to perform without the assistance of another person any 2 of the following activities of daily living: i. Dressing – the ability to put on and take off clothing, ii. Bathing – the ability to wash or shower without assistance iii. Toileting – the ability to use the toilet, including getting on and off, iv. Mobility – the ability to get in and out of a bed and a chair, v. Continence – the ability to control bowel and bladder function, vi. Feeding – the ability to get food from a plate into the mouth, o. **Primary Pulmonary Hypertension** – primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation resulting in significant permanent physical impairment to the degree of at least Class 3 on the New York Heart Association classification of cardiac impairment, or where there is a pulmonary artery pressure (PAP) of more than 30mmHg. p. **Quadriplegia** - the permanent loss of use of both arms and both legs, resulting from spinal cord Injury or Illness. q. **Severe Burns** – tissue injury caused by thermal, electrical or chemical agents causing third degree burns to 20 per cent or more of the Body Surface Area as measured by the 'Rule of Nines' or the Lund and Browder Body Surface Chart, or to the whole of the face or the whole of both hands requiring surgical debridement and/or grafting. r. **Severe Rheumatoid Arthritis** - the unequivocal diagnosis of Severe Rheumatoid Arthritis by a rheumatologist in accordance with the '2010 Rheumatoid Arthritis Classification Criteria' published by the American College of Rheumatology and European League Against Rheumatism, with evidence of persistent joint inflammation and progressive disease. There must be evidence of a poor clinical response to: i. At least six (6) months of treatment with oral disease modifying anti-rheumatic drugs (DMARDs), and ii. All conventional therapy including biological agents. Degenerative osteoarthritis and all other arthritis are excluded.
Injury	means bodily injury caused by violent, external and visible means.
Insured Cover	means the total insurance cover that Insurer agrees to for an Insured Person.
Insured Person/s	means an Eligible Person for whom cover other than Accident Cover is in place and current.
Loss Of Use Of	means: a. the permanent loss of sight, whether aided or unaided due to Injury or Illness to the extent that the visual acuity is 6/60 or less in both eyes, or to the extent that visual field is reduced to 20 degrees or less of arc, as certified by an ophthalmologist, or b. the loss of the use of a leg from at or above the ankle, or an arm from at or above the wrist, which is permanent.
Maximum Entry Age	means the maximum age an Eligible Person can apply for Insured Cover. The Maximum Entry Age is in the Appendix.
Maximum Insurable Age	means the maximum age to which cover will be provided under the policy in respect of an Insured Person. The Maximum Insurable Age is in the Appendix and is referred to as Cover Ceasing Age in the Policy.
Membership Category	means a category of membership within an Employer Plan to which a member of that plan can belong because of their occupation, employment status or seniority.
Minimum Entry Age	means the minimum age an Eligible Person can apply for Insured Cover. The Minimum Entry Age is in the Appendix.
Minimum Member Details	means name, date of birth, address and the date employment commenced.
New Events	means Insured Cover that is provided for an Illness first diagnosed, or an Injury that first occurs, on or after the date Insured Cover commences or recommences for an Insured Person.

Nominated Event	means: • marriage, or • divorce, or • the Insured Person or their Partner gives birth or adopts a child, or • the Insured Person purchases a home for their permanent residence with a mortgage on that residence of $100,000 or more, or • the Insured person takes out a new business loan, or increases an existing business loan, of more than $100,000, or • the Insured Person or their Partner's child starts secondary school.
Overseas	means anywhere other than the Commonwealth of Australia and its Territories, or New Zealand.
Partner	means a legal spouse or any person living with an Insured Person as their spouse on a bona-fide domestic basis, they may be the same sex as the Insured Person.
Permanent Employee	means an Eligible Person who is employed on a permanent basis under an ongoing contract that: a. requires the Eligible Person to perform identifiable duties for a regular number of hours each week, and b. allows the Eligible Person to accrue annual leave, sick leave, leave loading (where applicable) and long service leave.
Plan	means the entity identified under Plan in the Policy Schedule.
Policy	means the contract of insurance which began on the Date of Commencement as varied from time to time and which continues until properly terminated under the terms of the policy. The documents that make up the Policy are: a. the document in which the Trustee applied for the Policy, and b. this Guide including the Policy Schedule, and c. all documents which record an authorised variation of the Policy, and d. any statement relevant to the Insured Cover under the Policy completed by or on behalf of any Insured Person, and e. all documents that set out a condition, restriction or increase in Premium that applies to an Insured Person.
Premium	means the money paid to the Insurer, or owed to Insurer, for the insurance they provide under the Policy.
Salary	means base salary, including bonuses, commission and allowances.
Sum Insured (Agreed Benefit)	Default Cover: The amount of insured benefit calculated in accordance with the Benefit Design. Voluntary Cover: The amount agreed to by the Insurer. Sum Insured is also referred to as the Agreed Benefit in the Appendix.
Terminal Illness or Terminally Ill	means a disease or condition that is highly likely to result in the Insured Person's death within 12 months from the Date of Certification.
Total and Permanent Disability (TPD) or Totally and Permanently Disabled	means an Injury or Illness that causes disability to the extent the Insured Person qualifies for benefit under Total and Permanent Disablement.

TPD Definitions	**Part 1 – Unlikely to Return to Work** The Insured Person is unable to do any work as a result of Injury or Illness for three (3) consecutive months and in the Insurer's opinion at the end of that three (3) months they continue to be so disabled as the result of their ill-health (whether physical or mental) that they are unable to resume their previous occupation at any time in the future and will be unlikely ever at any time in the future to engage in Gainful Employment for which they are reasonably suited by education, training or experience. **Part 2 – Permanent Impairment** The Insured Person is engaged in Gainful Employment when suffering an Injury or Illness and, as a result of that Injury or Illness, they: a. suffer a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment 4th Edition', or the equivalent guide to the evaluation of impairment approved by the Insurer, and b. are disabled to such an extent, as a result of this impairment, that the Insured Person is unlikely ever at any time in the future to engage in any occupation, business, profession or employment for which they are reasonably suited by education, training or experience. **Part 3 – Loss of Use of** The Insured Person suffers the total, permanent and irrecoverable Loss Of Use Of: a. 2 limbs, or b. The sight of both eyes, or c. 1 limb and the sight of 1 eye. **Part 4 – Cognitive Loss** The Insured Person, as a result of Injury or Illness, is first diagnosed with Cognitive Loss and is under the continuous care and supervision by another adult for at least three (3) consecutive months and, at the end of that three (3) month period, they are likely to require permanent ongoing continuous care and supervision by another adult. **Part 5 – Activities of Daily Working** The Insured Person suffers an Injury or Illness, that in the Insurer's opinion: a. totally and irreversibly prevents them from performing 2 of the Activities of Daily Working without assistance from another adult for at least 3 consecutive months, and b. since they became ill or injured, they have been under the regular care and attention of a Doctor for that Injury or Illness, and c. they are unable to ever again be able to perform at least two (2) of the Activities of Daily Working without assistance from another adult.
Voluntary Cover	means the amount of Voluntary Cover the Insurer have underwritten and accepted for the Insured Person.

INSURANCE FEE SCHEDULE

CATEGORY 1, 2 & 3: HOW TO CALCULATE YOUR ANNUAL INSURANCE FEE (PREMIUM)

The premium you pay for Death only or Death and TPD cover is dependent on 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 the amount of cover. The following formula shows how to calculate an annual premium using the relevant premium rates from the table below.

Premium rate × sum insured ÷ 1,000
= annual Insurance fee (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 and other fees that may be charged.

For example:

John has $300,000 of Default Death and TPD Cover. At 30 June 2020, John is 38 years old. His next Birthday is on 1 May 2021, at which time he will be 39. As John's Age Next birthday is 39, the applicable premium for his cover will be:

Death: $0.28

TPD: $0.18

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

[$300,000 × (0.28 + 0.18)] ÷ 1,000 = $138

CATEGORY 1, 2 & 3: INSURANCE FEE TABLE FOR DEFAULT DEATH ONLY COVER AND DEATH AND TPD COVER PER $1000 OF SUM INSURED

Age Next Birthday	Male Death only	Female Death only	Male TPD only	Female TPD only
16	0.28	0.09	0.07	0.04
17	0.28	0.09	0.07	0.04
18	0.28	0.09	0.07	0.04
19	0.28	0.09	0.07	0.04
20	0.28	0.09	0.07	0.04
21	0.28	0.09	0.07	0.04
22	0.27	0.08	0.08	0.04
23	0.25	0.08	0.08	0.04
24	0.23	0.08	0.08	0.04
25	0.23	0.07	0.09	0.04
26	0.21	0.07	0.09	0.04
27	0.20	0.07	0.09	0.05
28	0.20	0.07	0.09	0.05
29	0.20	0.07	0.10	0.05
30	0.20	0.08	0.10	0.05
31	0.19	0.08	0.11	0.06
32	0.19	0.08	0.11	0.07
33	0.20	0.09	0.12	0.08
34	0.21	0.10	0.13	0.10
35	0.22	0.11	0.13	0.11
36	0.23	0.12	0.14	0.13
37	0.23	0.13	0.14	0.14
38	0.25	0.14	0.16	0.15
39	0.28	0.17	0.18	0.18
40	0.30	0.18	0.20	0.21
41	0.32	0.20	0.23	0.24
42	0.34	0.22	0.26	0.28
43	0.38	0.23	0.31	0.32

Age Next Birthday	Male Death only	Female Death only	Male TPD only	Female TPD only
44	0.41	0.25	0.36	0.36
45	0.45	0.26	0.41	0.39
46	0.47	0.28	0.50	0.44
47	0.48	0.30	0.61	0.51
48	0.50	0.33	0.71	0.59
49	0.51	0.35	0.86	0.68
50	0.56	0.39	0.98	0.79
51	0.60	0.43	1.11	0.90
52	0.75	0.48	1.16	1.04
53	0.89	0.53	1.25	1.17
54	0.97	0.58	1.43	1.33
55	1.04	0.64	1.59	1.46
56	1.14	0.70	1.78	1.62
57	1.24	0.77	1.99	1.76
58	1.36	0.84	2.25	1.91
59	1.49	0.91	2.54	2.09
60	1.65	0.99	2.87	2.27
61	1.79	1.06	3.21	2.45
62	1.94	1.17	3.58	2.69
63	2.09	1.29	3.97	2.98
64	2.24	1.44	4.40	3.32
65	2.41	1.60	4.88	3.69
66	2.59	1.78	5.37	4.06
67	2.81	2.00	5.91	4.47
68	3.06	2.24	6.57	4.95
69	3.31	2.47	7.29	5.50
70	3.57	2.72	8.09	6.11

Customer Services

1800 836 545 weekdays between 8.30am and 8.00pm (AEST)

corporatesuper@anz.com

anz.com/smartchoicesuper

Australia and New Zealand Banking Group Limited (ANZ) ABN 11 005 357 522. 512003_IA4507/1220

anz.com/smartchoicesuper