NEOS PROTECTION

Product Disclosure Statement
1 October 2021

NEOS
LIFE REINVENTED

PROTECTING WHAT'S IMPORTANT TO YOU WITH NEOS

Making sure that you're covered with the right kind of life insurance is an invaluable gift that you can provide to both yourself, and your loved ones. Having the right life insurance gives you the confidence to plan and achieve your life goals, while knowing that should the worst happen, you and your loved ones are protected.

NEOS Protection is a life insurance product designed for that very purpose – to help you protect what's important to you. It includes five types of cover – Life Cover, Total and Permanent Disability (TPD) Cover, Critical Illness Cover, Child Cover and Income Support Cover – allowing you to tailor your insurance to the needs of you and your family.

NEOS Protection is issued and insured by NobleOak Life Limited ABN 85 087 648 708 AFSL 247 302 (NobleOak).

NobleOak is an Australian Prudential Regulation Authority (APRA) regulated life insurer, who has been protecting Australians with award winning cover since 1877. NobleOak is responsible for meeting the terms and conditions of your cover, including the payment of benefits.

This document explains NEOS Protection

How many cover types you have, the options that apply, and whether you purchase NEOS Protection inside superannuation – including within a self-managed superannuation fund (SMSF) – or outside of super (ordinary), is a decision for you to make, with the support of your financial adviser.

This Product Disclosure Statement (PDS) explains what you need to know about the benefits, features, options, risks and costs of NEOS Protection, to help you make these decisions, with the support of your financial adviser. The information and any advice given in this PDS, is general in nature and doesn't take into account your individual objectives, financial situation and needs. You should therefore consider the appropriateness of this information to your situation before acting on it.

The information in this PDS is current as at the date of issue. However, from time to time we may change or update information that is not materially adverse. We'll provide a notice of any such changes at www.neoslife.com.au. If you'd like a free printed copy of the updated information, please email us at customerservice@neoslife.com.au

What is the role of NEOS Life?

NEOS Life (NEOS), a registered business name of Australian Life Development Pty. Ltd. ABN 96 617 129 914 AFSL 502759, is a business focused solely on distributing and administering quality life insurance products to Australians.

Once issued, your NEOS Protection plan is administrated in Australia, by NEOS on behalf of NobleOak.

The NEOS Benefit Fund

NEOS Protection is governed by the rules of NobleOak's NEOS Benefit Fund (Benefit Fund). These rules are approved by NobleOak's Board and APRA. You may request to view the Benefit Fund rules at any time.

When your plan is approved, you'll automatically become a member of the Benefit Fund. We'll also send you a welcome pack with a plan schedule which sets out your cover, your premium and any special terms which apply.

The Life Insurance Code of Practice

As a member of the Financial Services Council of Australia (the FSC), we're bound by the Life Insurance Code of Practice (the Code) which came into effect on 1 July 2017. The Code outlines the standards that we're committed to in providing life insurance services to you. The Code can be found at www.fsc.org.au.

Understanding what we mean

While our aim is to always provide straightforward explanations, some words we use have specific meanings. These words appear throughout the PDS in *italics* and are explained in the Definitions section or, if they're regularly used terms, they're explained below. To help with your understanding of NEOS Protection, we've also capitalised the plan benefits and features, so you can easily identify them.

Terms regularly referred to in this PDS:

Insured person means the person whose life is insured under your plan. The insured person is shown on your plan schedule.

Plan owner means the person or legal entity who owns the plan. The plan owner is shown on your plan schedule.

Plan means the package of one or more cover types provided to you.

You or **your** means the insured person or plan owner as the context requires.

Us, we, our or the **insurer** means NobleOak.

SIS means the *Superannuation Industry (Supervision) Act 1993* or the *Superannuation Industry (Supervision) Regulations 1994* (as applicable). We have reproduced certain definitions from the SIS regulations in the Definitions section. These definitions are valid as of the date of this PDS.

Trustee means a trustee of a superannuation fund, including a SMSF.

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ABOUT NEOS PROTECTION

NEOS Protection allows you to select a combination of cover types and ownership structures to meet your needs as determined by you, with the support of your financial adviser. The flexible nature of these products allows you to tailor multiple covers under the one plan, or link your cover under separate plans (including plans held within and outside of superannuation). The primary benefits provided under these cover types are summarised in this table.

Type of cover	What you're covered for
Life Cover	Life Cover provides a lump sum payment if you die or are diagnosed with a *terminal illness*.
TPD Cover	TPD Cover provides a lump sum payment if you suffer *total and permanent disability* in accordance with the TPD definition provided under your plan.
Critical Illness Cover	Critical Illness Cover provides a lump sum payment if you suffer a specified Critical Illness Event that you're covered for.
Child Cover	Child Cover provides a lump sum payment if the insured child suffers a specified Child Critical Illness Event that they're covered for. It also provides a lump sum payment should the insured child die or be diagnosed with a *terminal illness*.
Income Support Cover	Income Support Cover provides a *monthly benefit* that helps to replace your income if you're unable to work due to *illness* or *injury* and are *disabled*, for longer than the specified *waiting period*.

NEOS Protection is subject to product design and distribution obligations. You can find information about the target market for NEOS Protection in the relevant Target Market Determinations (TMDs) available at www.neoslife.com.au/TMD.

All NEOS Protection plans also include the valuable features listed below.

Worldwide cover

You're fully covered, 24 hours a day, anywhere in the world.

Guaranteed renewable

We guarantee to renew your plan each year until your plan expires, provided you pay your premiums when due. This means we can't cancel your cover, place further restrictions on it or increase your individual premium (before applicable discounts) because of changes to your health, occupation or pastimes.

Guaranteed upgrade of benefits

Any future improvements to the benefits provided under a NEOS Protection cover type will be made available to you, provided they don't result in an increase in your premium and don't disadvantage you in any way.

Any improvements will apply to future claims. They won't apply to current claims, or to claims resulting from an *illness*, *injury* or *disability*, which occurred before these improvements came into effect.

SETTING UP YOUR PLAN

Who can own your plan?

Your plan can be owned by a superannuation fund or outside of super, by you or a legal entity. Your financial adviser can help you decide which ownership option is best for you.

If your plan is owned by a superannuation fund, we generally refer to it is a 'held inside or through super' or, 'superannuation business'.

The ownership options, and the cover types available under each option, are explained further in the table below.

Plan held outside of superannuation	Cover types available
The plan owner can be: • the insured person • the insured person's partner or another individual; or • a company, trust, or other legal entity, excluding the trustee of a superannuation fund. Your plan can have more than one plan owner. In this instance, the owners are known as 'joint tenants.'	• Life Cover • TPD Cover • Critical Illness Cover • Child Cover • Income Support Cover

Plan held inside of superannuation	Cover types available
The plan owner can be: • the trustee of a superannuation master trust of which you're a member; or • the trustee of your SMSF.	• Life Cover • TPD Cover • Income Support Cover

Your choice of inside or outside super will affect your options

You have the choice of having cover inside or outside of super. However, that choice will influence:

1. how you pay your premiums
2. the tax treatment of your premiums and benefits; and
3. the features, benefits and options available under each cover type.

Your financial adviser can help you choose the structure that best suits your needs.

We use the following symbols throughout this PDS to indicate when a benefit/option/definition is available inside superannuation and outside superannuation.

SUPER — Indicates that the benefit/option/definition is available on plans purchased inside a superannuation fund.

NON SUPER — Indicates that the benefit/option/definition is available on plans purchased outside superannuation.

We pay the benefits to the plan owner

Unless we state otherwise, we pay the benefits available under each cover type to the plan owner or nominated beneficiary, where applicable.

If cover is held inside super, we'll pay the benefit under that cover type to the trustee of your super fund. Whether the trustee can release the benefit to you will depend on the super fund's trust deed and superannuation law.

It's important that you ask your trustee or financial adviser for information on whether, and when, any benefit can be released to you.

We pay all benefits and amounts payable under your plan in Australian currency in Australia.

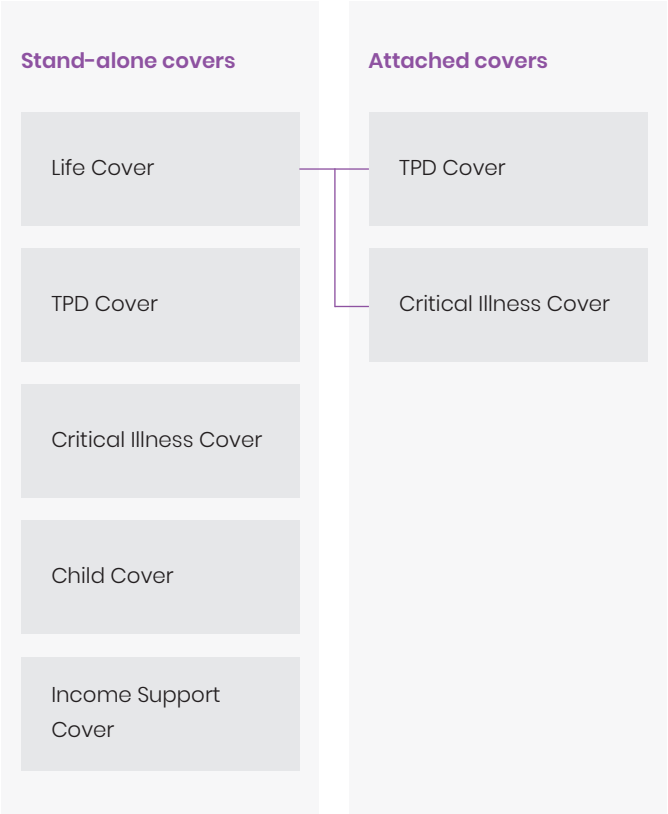
Structuring your cover

You have a number of options available when it comes to structuring your cover. You can hold all your cover types under one plan and your cover may be stand-alone or attached. You can also link cover held under separate plans via linking or splitting.

Your plan schedule will indicate when your cover is stand-alone, attached, linked or split.

Structuring cover outside of superannuation

The following diagram illustrates how you can structure your NEOS Protection cover types outside of superannuation.



Stand-alone cover

Stand-alone cover operates independently of any other cover type you may have. This means that when a benefit is paid for a stand-alone cover type, it won't reduce the *sum insured* for any other cover type you hold.

Attached cover

Attached cover interacts with the other cover types it's attached to. This means that when a benefit is paid for an attached cover type, the *sum insured* of the cover types it's attached to will be reduced by the benefit amount paid. This also means that the premiums payable on the attached cover types will be reduced accordingly.

The premium you pay for attached cover is generally lower than what you'll pay for the same cover types held as stand-alone cover.

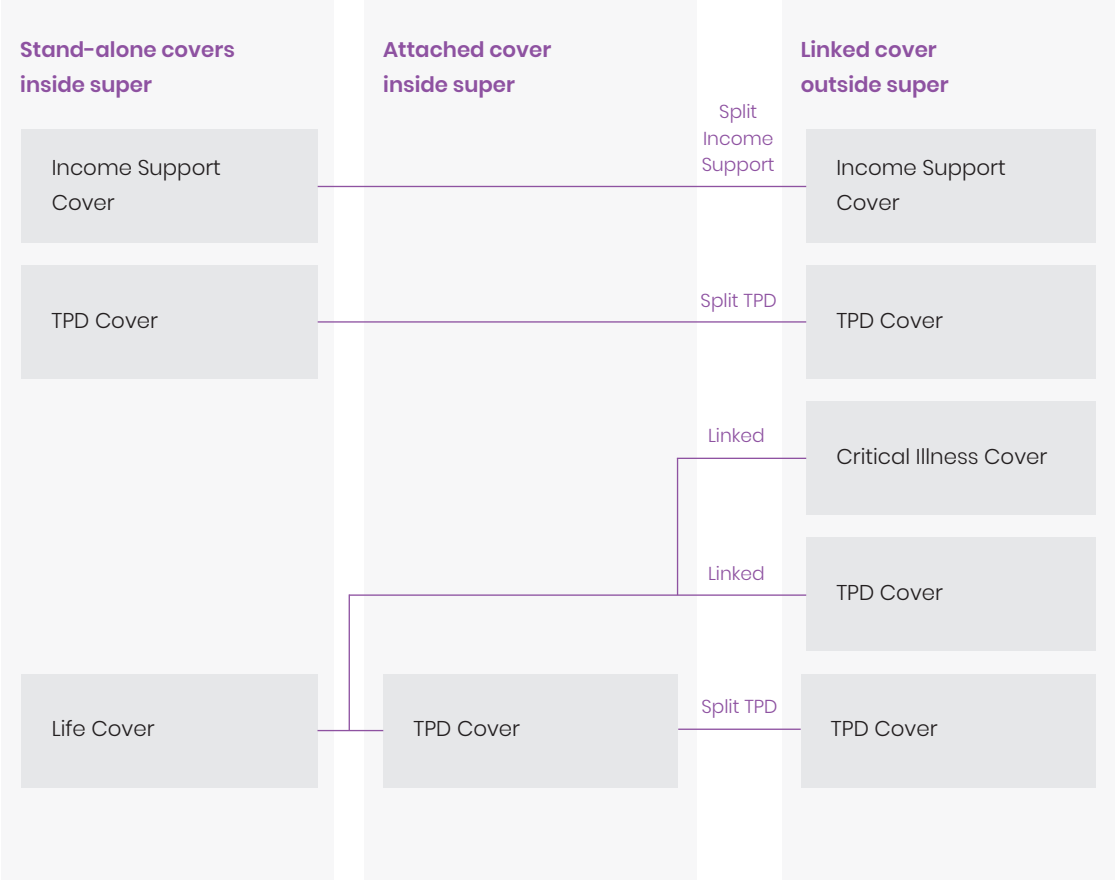
Structuring cover inside of superannuation

The following diagram illustrates how you can structure your NEOS Protection cover types inside of superannuation. As with cover types held outside of super, you can choose whether to have stand-alone or attached cover types. In addition, you may also choose to have linked or split benefits. Linking benefits means that you can access the benefits available under cover types held outside of super, while also holding cover inside super.

An important note

If you structure your NEOS Protection plan inside superannuation:

- you'll need to be a member of the fund
- the trustee of the fund owns the plan on your behalf
- premiums and benefit payments are made through the fund and are subject to restrictions under the governing rules of the fund and in accordance with superannuation law; and
- some benefits and features of the cover type will not apply.



Stand-alone cover

Stand-alone cover operates independently of any other cover type you may have. This means that when a benefit is paid for a stand-alone cover type, it won't reduce the *sum insured* for any other cover type you hold.

Attached cover

Attached cover interacts with the other cover types it's attached to. This means that when a benefit is paid for an attached cover type, the *sum insured* of the cover types it's attached to will be reduced by the benefit amount paid. This also means that the premiums payable on the attached cover types will be reduced accordingly.

The premium you pay for attached cover is generally lower than what you'll pay for the same types of cover held as stand-alone cover.

Linked cover

Linking is a way of bundling your cover by allowing you to have different plan owners for each cover type.

Linking is available between a NEOS Protection plan held outside of superannuation, and a NEOS Protection plan held inside of superannuation.

For example, you may want to have your Critical Illness Cover attached to your Life Cover, but want your Life Cover to be owned by the trustee of your SMSF, and the Critical Illness Cover to be owned by you, outside of superannuation – linking enables you to do this.

As with attached cover, when a benefit is paid, the *sum insured* of all cover types to which it's linked will be reduced by the amount of the benefit that has been paid. This also means that the premiums payable on the linked cover types will be reduced accordingly.

Split cover

Split cover is a way of splitting an individual cover across two separate plans; one held inside of superannuation and the other held outside of superannuation.

Benefits (or the portion of a benefit) which are consistent with the superannuation conditions of release will be held under the plan with ownership inside superannuation. The remaining benefits (or the remaining portion of a benefit) will be held under the plan outside superannuation.

The maximum benefit payable under both plans will never exceed the amount that would have been payable under a single plan held outside of superannuation.

Spilt TPD Cover

Split TPD Cover allows you to purchase TPD Cover with an *own occupation* definition of *total and permanent disability*, with the portion of the TPD Cover which is consistent with a superannuation condition of release held under a plan inside superannuation, and the remainder of the TPD Cover held under a plan outside superannuation.

Any claim you make will firstly be assessed with reference to the terms and conditions of the plan held inside superannuation; and the amount payable will be paid to the trustee of the superannuation fund on your behalf. Any benefits not payable under the superannuation plan, may be paid under the non-superannuation plan, subject to you meeting the applicable terms and conditions.

Split Income Support Cover

Split Income Support Cover allows you to purchase your Income Support Standard Cover with the portion of the Income Support Cover which is consistent with a superannuation condition of release held under a plan inside of superannuation, and the remainder of the Income Support Cover held under a plan outside superannuation. The overall level of cover held will be equivalent to that provided by Income Support Standard Cover, except for the maximum indexation rates that may apply under the Indexation Benefit and Increasing Claims Option.

Any claim you make will firstly be assessed with reference to the terms and conditions of the plan held inside of superannuation; and the amount payable will be paid to the trustee of the superannuation fund on your behalf. Any benefits not payable under the superannuation plan may be paid under the non-superannuation plan, subject to you meeting the applicable terms and conditions.

Applying for cover

Before applying for NEOS Protection, you'll need to speak with your financial adviser. They can help you determine the type of cover and the benefit amount that will best suit your needs.

Once confirmed, your financial adviser can assist you in completing your application.

Eligibility

Unless otherwise agreed to by us in writing, to apply for NEOS Protection you must be:

- *an Australian Resident* or Australian company/trustee; and
- aged 18 or over, or acting as an officer or trustee on behalf of a company or superannuation fund.

You must have also received this PDS in Australia.

Additional eligibility criteria may apply to the insured person for different cover types. You should refer to the eligibility criteria in the Cover Overview section for each cover for more information.

Your duty to take reasonable care

When applying for insurance, you are agreeing that you will take reasonable care not to make a misrepresentation to us before we issue your contract of insurance. A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This obligation applies when you make new applications for insurance, when extending or amending existing insurance and when reinstating insurance, up until your application, amendment or reinstatement is accepted by us and the cover is issued.

If someone assists you to make this application, you are responsible for the information they give to us.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

If you do not meet your duty to take reasonable care

If you do not take reasonable care not to make a misrepresentation, this can have serious impacts on your insurance. Your plan and/or cover could be cancelled and/or avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Guidance for answering our questions

When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure about the meaning of any question, please ask us before you respond.
- Answer every question that we ask you.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it, or check with us.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

If something changes before your cover starts, and the change means you would have answered one of our questions differently, then you should let us know about the change as soon as you can.

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, we may exercise our rights to put us in the position we would have been if that obligation had been met.

Failure to take reasonable care may result in the following:

- we may avoid your cover within three years of entering into it
- we may reduce your cover in accordance with a formula that takes into account the premium that would have been payable, if your duty had been met, or the misrepresentation hadn't been made. Any reduction in respect of the death of an insured person can only occur within three years of the cover commencement date
- we may vary your cover (except for Life Cover) in such a way as to place us in the position we would have been if your duty had been met
- if the misrepresentation is fraudulent, we may refuse to pay your claim at any time and we may treat your cover as having never existed; and/or
- in exercising the above rights, we may apply these rights separately to each type of cover.

Whether we can exercise any of these rights depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation, depending on all the relevant circumstances
- whether the misrepresentation was fraudulent
- what we would have done if the duty had been met; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these rights, we will explain our reasons, how you can respond or provide further information, and also what you can do if you disagree.

When cover starts

Your plan starts when your application has been assessed and approved by us, and we have received the first premium. Until then, we may ask for more information to fully assess your application.

As soon as your cover is approved, a welcome letter will be sent to you via email, along with a plan schedule outlining the full details of your cover, including your plan's commencement date.

If your plan is held inside super, you must also be a member of the fund before your cover can start.

You can change your mind

If for any reason you feel that your plan doesn't meet your needs, you can cancel it by notifying us, within 30 days of the earlier of:

- the date you receive your plan schedule; or
- five business days after your plan commencement date.

This is known as the cooling-off period. Provided you have not made a claim, if you cancel your plan during this period, your plan will be cancelled from the commencement date and we'll refund any premiums you've paid.

If you've applied for cover inside superannuation, your refund may be required to be preserved within superannuation.

LIFE COVER

Cover overview

SUPER NON SUPER

Life Cover provides a lump sum payment in the event of your death or *terminal illness*. This payment is based on the amount of cover you've chosen; also known as your *sum insured*. Life Cover is available both inside and outside superannuation.

Minimum entry age
- 18

Maximum entry age
- 75 for stepped premiums
- 60 for level premiums

Benefit expiry age
- Plan anniversary after you turn 99

Minimum sum insured that can be applied for
- $50,000

Maximum sum insured that can be applied for
- $5,000,000 (at cover commencement)
- $5,000,000 (in total over the life of your plan)

Premium types
- Stepped premium
- Level premium to age 65 (reverts to stepped at the plan anniversary after you turn 65)
- Level premium to age 70 (reverts to stepped at the plan anniversary after you turn 70)

Exclusions

See page 15

Included benefits

The following benefits are included in Life Cover. Some benefits are not available inside superannuation as shown below.

Plan ownership	Benefit	Page
SUPER NON SUPER	Death Benefit	14
SUPER NON SUPER	Terminal Illness Benefit	14
SUPER NON SUPER	Indexation Benefit	30
SUPER NON SUPER	Suspending Cover Benefit	31
SUPER NON SUPER	Future Increase Benefit	31
SUPER NON SUPER	Waiver of Premium While Involuntarily Unemployed Benefit	34
NON SUPER	Funeral Advancement Benefit	14
NON SUPER	Accommodation Benefit	30
NON SUPER	Financial Advice Benefit	34
NON SUPER	Grief Support Benefit	35
NON SUPER	Child's Critical Illness Benefit	35

Optional benefit available at an extra cost

The following benefit is available at an extra cost. Your plan schedule will show which options you've purchased.

Plan ownership	Benefit	Page
SUPER NON SUPER	Disability Premium Waiver Option	37

Included benefits

Death Benefit

SUPER NON SUPER

If you die while your Life Cover is in place, we'll pay the Life Cover *sum insured*.

Terminal Illness Benefit

SUPER NON SUPER

If you're diagnosed with a *terminal illness* while your Life Cover is in place, we'll pay the Life Cover *sum insured*.

Funeral Advancement Benefit

NON SUPER

To aid with the immediate costs of death, this benefit provides an advancement of a portion of your Life Cover *sum insured*. Upon our receipt of a certified copy of the insured person's death certificate, or other satisfactory evidence that the insured person has died, we'll advance the lesser of $25,000 and your Life Cover *sum insured* unless we (acting reasonably) consider there is reasonable doubt as to whether the death benefit will be payable.

Your Life Cover *sum insured* will then be reduced by the amount paid under this benefit.

It's important to note that payment of this benefit is not an admission of our liability to pay a Life Cover claim.

Other included benefits

The additional benefits included in Life Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 30 of this PDS.

Optional benefits

Optional benefits available under Life Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 36 of this PDS.

Adjustments

Your Life Cover *sum insured* will be reduced by any amount paid:

- under this cover for *terminal illness*
- under this cover for the Funeral Advancement Benefit
- for TPD Cover, when your TPD cover is attached or linked to your Life Cover; and
- for Critical Illness Cover, when your Critical Illness Cover is attached or linked to your Life Cover.

Exclusions

We'll not pay any benefit under Life Cover if the event giving rise to the claim is caused or contributed to by:

- anything that is specifically excluded on your plan schedule; or
- suicide, attempted suicide or any intentional self-inflicted act by you, within 13 months of:
  - your cover commencement date
  - an increase in your *sum insured* (this only applies in respect of the increased amount with the exception of any increase in cover as a result of the Indexation Benefit); or
  - the date on which your cover was last reinstated.

However, if your Life Cover is replacing existing life cover provided by us, or another insurer, the 13-month exclusion for suicide or any intentional, self-inflicted act, will not apply if:

- the life cover being replaced has been in place for at least 13 months
- your Life Cover *sum insured* is equal to or less than, the *sum insured* of your existing life cover (if the *sum insured* is higher, then the exclusion will apply to the difference between your new Life Cover *sum insured* and your existing life cover *sum insured*)
- your existing life cover is cancelled within seven days of Life Cover's commencement date. We'll not pay in the event of suicide or any intentional, self-inflicted act until your existing life cover has been cancelled
- all similar exclusions under your existing life cover have expired
- the life cover being replaced has comparable benefits; and
- no claim is paid, payable, lodged or pending under your existing life cover.

When Life Cover ends

Life Cover will end on the earlier of:

- the date we receive your request to cancel your cover
- your death
- your full *sum insured* for Life Cover is paid or reduced to nil
- the date we cancel your plan because premiums were not paid when due
- the date we avoid your cover (treat it as if it never existed) in accordance with our rights in relation to your duty to take reasonable care
- 30 days after you stop being a member of the superannuation fund (if your cover has been purchased inside superannuation); and
- the plan anniversary immediately after you turn 99.

TOTAL AND PERMANENT DISABILITY (TPD) COVER

Cover overview

SUPER NON SUPER

TPD Cover provides a lump sum payment if you suffer *total and permanent disability* as a result of *illness* or *injury*. This payment is based on the amount of cover you've chosen; also known as your *sum insured*.

TPD Cover is available both inside and outside superannuation. The definition of *total and permanent disability* that you can choose is restricted inside superannuation.

Minimum entry age
- 18

Maximum entry age
- 60

Benefit expiry age
- Plan anniversary after you turn 99
- Plan anniversary after you turn 80, when structured inside superannuation

Minimum sum insured that can be applied for
- $50,000

Maximum sum insured that can be applied for
- $3,000,000

Premium types
- Stepped premium
- Level premium to age 65 (reverts to stepped at the plan anniversary after you turn 65)
- Level premium to age 70 (reverts to stepped at the plan anniversary after you turn 70)

TPD definitions available
- Super
- Any occupation
- *Own occupation*

Product structure combinations
- Stand-alone TPD Cover
- TPD Cover attached to Life Cover (your TPD Cover *sum insured* must not exceed your Life Cover *sum insured*)
- TPD Cover linked to Life Cover (your TPD Cover *sum insured* must not exceed your Life Cover *sum insured*)
- Split TPD Cover

Exclusions
- See page 19

Included benefits

The following benefits are included in TPD Cover. Some benefits are not available inside superannuation as shown in the table below.

Plan ownership	Benefit	Page
SUPER NON SUPER	Total and Permanent Disability Benefit	18
SUPER NON SUPER	Death Benefit (for stand-alone TPD Cover)	18
SUPER NON SUPER	Indexation Benefit	30
SUPER NON SUPER	Future Increase Benefit	31
SUPER NON SUPER	Suspending Cover Benefit	31
SUPER NON SUPER	Waiver of Premium While Involuntarily Unemployed Benefit	34
NON SUPER	Specific Loss Benefit	18
NON SUPER	Accommodation Benefit	30
NON SUPER	Financial Advice Benefit	34
NON SUPER	Grief Support Benefit	35
NON SUPER	Child's Critical Illness Benefit	35

Optional benefits available at an extra cost

The following benefits are available at an extra cost. Your plan schedule will show which options you've purchased.

Plan ownership	Benefit	Page
SUPER NON SUPER	Disability Premium Waiver Option	37
SUPER NON SUPER	Life Cover Buy Back Option+	36
SUPER NON SUPER	Accelerated Life Cover Buy Back Option+	36

+Only available when TPD Cover is attached or linked to Life Cover.

TPD definitions

We offer the following *total and permanent disability* (TPD) definitions:

Plan ownership	Benefit	Page
NON SUPER	*Own occupation* TPD	**70**
NON SUPER	Any occupation TPD	**69**
SUPER	Super TPD	**70**

Your financial adviser can let you know which definition is available to you, depending on your occupation.

The definition that applies to your cover will be shown on your plan schedule.

However, following the plan anniversary after you turn 70, the definition of *total and permanent disability* will change. After age 70, *total and permanent disability* will mean you suffer, as defined in the 'Critical illness definitions' section on page 72 of this PDS:

- *loss of independent existence (permanent and irreversible)*
- *loss of use of limbs (total and irrecoverable);* or
- *blindness (total and irrecoverable).*

If TPD Cover is held inside superannuation, in addition to the above, you must also satisfy the definition of *permanent incapacity*.

Split TPD Cover

Split TPD cover allows you to purchase TPD Cover with an *own occupation* definition of TPD across two separate plans; one inside superannuation and the other outside superannuation.

Benefits (or the portion of a benefit) which are consistent with the superannuation conditions of release will be held under the plan issued to the trustee of a superannuation fund. The remaining benefits (or the remaining portion of a benefit) will be held under a plan issued to you outside superannuation.

Any claim you make will firstly be assessed with reference to the terms and conditions of the plan held inside superannuation; and the amount payable will be paid to the trustee of the superannuation fund on your behalf. Any benefits not payable under the superannuation plan may be paid under the non-superannuation plan, subject to you meeting the applicable terms and conditions.

Important things to note

- The premium payable for the plan outside superannuation will be reduced by the premium charged for the superannuation plan. This means that the overall premium you pay will be the same as if you'd purchased a single TPD Cover plan with an *own occupation* definition outside superannuation.
- The TPD Cover *sum insured* for each plan – both the super and non-super plan – must always be the same. This means your TPD Cover *sum insured* under each plan may only be increased or reduced together. This includes any increase via the Indexation Benefit.
- Once the full TPD Cover *sum insured* is paid under one plan, all TPD Cover will cease under both plans.
- In the event that your TPD Cover held inside superannuation is cancelled, your TPD Cover held outside superannuation will also be cancelled. However, in the event that your TPD Cover held outside super is cancelled, the TPD Cover held inside super can still exist.
- Your plan schedule will indicate when splitting applies.

Included benefits

Total and Permanent Disability Benefit

SUPER NON SUPER

If you suffer *total and permanent disability* while this cover is in place, and you meet the conditions of the TPD definition which applies (as stated on your plan schedule), we'll pay your TPD Cover *sum insured*.

Specific Loss Benefit

NON SUPER

If you suffer:

- *loss of use of a single limb (total and irrecoverable);* or
- *loss of sight in one eye (total and irrecoverable),*

as defined in the 'Critical illness definitions' section on page 72 of this PDS, we'll pay 25% of your TPD Cover *sum insured*, up to a maximum of $500,000.

Once paid, we'll reduce your TPD Cover *sum insured*, and the *sum insured* for any attached or linked Life Cover or Critical Illness Cover, by the amount paid under this benefit.

Death Benefit

SUPER NON SUPER

This benefit only applies if you have stand-alone TPD Cover, as stated on your plan schedule.

If you die, and a Total and Permanent Disability Benefit has not been paid or is not payable, we'll pay a benefit of $10,000.

Other included benefits

The additional benefits included in TPD Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 30 of this PDS.

Optional benefits

Optional benefits available under TPD Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 36 of this PDS

Adjustments

Your TPD Cover *sum insured* will be reduced by any amount paid:

- under this cover for a Specific Loss Benefit
- for *terminal illness*, when your TPD Cover is attached or linked to your Life Cover; and
- for Critical Illness Cover, when your Critical Illness Cover is attached or linked to your Life Cover, and your TPD Cover is also attached or linked to your Life Cover.

Following the plan anniversary after you turn 70, the definition of *total and permanent disability* will change. After age 70, *total and permanent disability* will mean you suffer, as defined in the 'Critical illness definitions' section on page 72 of this PDS:

- *loss of independent existence (permanent and irreversible)*
- *loss of use of limbs (total and irrecoverable);* or
- *blindness (total and irrecoverable).*

If TPD Cover is held inside superannuation, in addition to the above, you must also satisfy the definition of *permanent incapacity*.

The maximum TPD Cover available from the plan anniversary after you turn age 70 is $3,000,000 across all plans issued by us. If you're covered for more than $3,000,000 at this age, we'll reduce your aggregate *sum insured*, and we'll reduce your premium accordingly.

Exclusions

We'll not pay any benefit under TPD Cover if the event giving rise to the claim is caused or contributed to by:

- anything that is specifically excluded on your plan schedule; or
- attempted suicide, or any intentional self-inflicted act by you.

When TPD Cover ends

Your TPD Cover will end on the earlier of:

- the date we receive your request to cancel your cover
- your death
- your full TPD Cover *sum insured* is paid or reduced to nil
- the date we cancel your plan because premiums were not paid when due
- the date we avoid your cover (treat it as if it never existed) in accordance with our rights in relation to your duty to take reasonable care
- 30 days after you stop being a member of the superannuation fund (if your cover has been purchased inside superannuation); and
- the plan anniversary immediately after
  - you turn 99, if your cover is outside superannuation
  - you turn 80, if your cover is inside superannuation (in which case, you can apply to continue cover outside superannuation).

CRITICAL ILLNESS COVER

Cover overview

NON SUPER

Critical Illness Cover provides a lump sum payment if you're diagnosed with one of the specified Critical Illness Events included under this cover, and you survive for at least 14 days from the date of diagnosis.

Some Critical Illness Events are also subject to a qualifying period, as explained on page 22.

Critical Illness Cover is not available inside superannuation.

Choice of cover
- Critical Illness Standard
- Critical Illness Plus

Your plan schedule will show which cover you've purchased.

Minimum entry age
- 18

Maximum entry age
- 60

Benefit expiry age
- Plan anniversary after you turn 80
- From the plan anniversary immediately after you turn 70, cover is only provided for *loss of independent existence (permanent and irreversible)*

Minimum sum insured that can be applied for
- $25,000

Maximum sum insured that can be applied for
- $1,000,000 (at cover commencement)
- $2,000,000 (in total over the life of your plan)

Premium types
- Stepped premium
- Level premium to age 65 (reverts to stepped at the plan anniversary after you turn 65)
- Level premium to age 70 (reverts to stepped at the plan anniversary after you turn 70)

Product structure combinations
- Stand-alone Critical Illness Cover
- Critical Illness Cover attached to Life Cover (your Critical Illness Cover *sum insured* must not exceed your Life Cover *sum insured*)
- Critical Illness Cover linked to Life Cover (your Critical Illness Cover *sum insured* must not exceed your Life Cover *sum insured*)

Exclusions
- See page 25

Included benefits

The following benefits are included in Critical Illness Cover.

Benefit	Page	Standard	Plus
Critical Illness Benefit	21	✓	✓
Paralysis Support Benefit	23	✓	✓
Critical Illness Cover Reinstatement Benefit	23	✓	✓
Indexation Benefit	30	✓	✓
Accommodation Benefit	30	✓	✓
Future Increase Benefit	31	✓	✓
Suspending Cover Benefit	31	✓	✓
Waiver of Premium While Involuntarily Unemployed Benefit	34	✓	✓
Financial Advice Benefit	34	✓	✓
Grief Support Benefit	35	✓	✓
Child's Critical Illness Benefit	35	✓	✓
Partial Critical Illness Benefit	22	✘	✓

Optional benefits available at an extra cost

The following benefits are available at an extra cost. Your plan schedule will show which options you've purchased.

Benefit	Page
Life Cover Buy Back Option+	36
Accelerated Life Cover Buy Back Option+	36
Disability Premium Waiver Option	37

+Only available when Critical Illness Cover is attached or linked to Life Cover.

Included benefits

Critical Illness Benefit

We'll pay your Critical Illness Cover *sum insured* if you suffer one of the Critical Illness Events listed in the table below. You must meet our definition of the event, as detailed in the 'Critical illness definitions' section on page 72 of this PDS, and survive for at least 14 days.

If you suffer more than one Critical Illness Event, your *sum insured* is only payable for the first occurring Critical Illness Event, unless the first event to occur is *coronary artery angioplasty*. If *coronary artery angioplasty* occurs, the benefit paid will be 25% of your *sum insured* up to a maximum of $50,000 (unless a benefit is payable for *triple vessel angioplasty* in which case, we'll pay your Critical Illness Cover *sum insured*). Your remaining *sum insured* will be the basis used to determine the benefit payment if you suffer another Critical Illness Event.

More than one payment can be made for *coronary artery angioplasty*.

Critical Illness Events

Each of these events has a specific meaning. Please refer to the 'Critical illness definitions' section from page 72 of this PDS for more information.

Heart conditions

- *Aortic surgery (thoracic and abdominal aorta excluding its branches)*
- *Cardiomyopathy (permanent and irreversible)*
- *Coronary artery angioplasty^*
- *Heart attack (with evidence of heart muscle damage)^*
- *Heart valve surgery^*
- *Coronary artery bypass surgery^*
- *Open heart surgery^*
- *Out of hospital cardiac arrest (excluding medical procedures)^*
- *Pulmonary arterial hypertension (idiopathic and familial)*
- *Triple vessel angioplasty^*

Nervous system conditions

- *Coma (of specified severity and duration)*
- *Dementia including Alzheimer's disease (permanent and irreversible with severe cognitive impairment)*
- *Encephalitis and meningitis (resulting in significant permanent neurological impairment)*
- *Major head trauma (with significant permanent neurological impairment)*
- *Meningococcal disease (resulting in significant permanent impairment)*
- *Multiple sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities)*
- *Muscular dystrophy*
- *Paralysis (total and permanent)*
- *Parkinson's disease (permanent)*
- *Progressive and debilitating motor neurone disease*
- *Stroke (resulting in neurological deficit)^*

Body organ conditions

- *Benign brain tumour (resulting in irreversible neurological deficit)*
- *Cancer (excluding early stage cancers)^*
- *Chronic kidney failure (requiring transplantation or dialysis)*
- *Chronic liver failure (resulting in permanent symptoms)*
- *Chronic lung failure (requiring long-term oxygen therapy)*
- *Major organ transplant (of specified organs from a human donor, or placement on a waiting list)*
- *Pneumonectomy (total)*
- *Severe burns (covering at least 20% of the body's surface area)*
- *Severe rheumatoid arthritis (with significant impairment)*

Blood conditions		
• *Aplastic anaemia (requiring specified treatment)* • *Medically-acquired HIV (contracted from a medical procedure or operation)*	• *Occupationally-acquired HIV* • *Occupationally-acquired hepatitis B or C*	• *Severe diabetes*
Other conditions		
• *Prolonged intensive care* • *Blindness (total and irrecoverable)* • *Loss of hearing (total and irrecoverable)*	• *Loss of independent existence (permanent and irreversible)* • *Loss of use of limbs (total and irrecoverable)*	• *Loss of speech (total and irrecoverable)*

^ These conditions are subject to a 90-day qualifying period as explained below.

90-day qualifying period

Unless we've agreed to waive the 90-day qualifying period because you're replacing existing critical illness cover with our Critical Illness Cover, no benefit will be paid for any of the Critical Illness Events marked with a ^ in the previous table, if the event first occurred, was diagnosed, or symptoms leading to the event occurred, were diagnosed or first became apparent, within 90 days immediately following:

- the Critical Illness Cover commencement date
- an increase in your Critical Illness Cover *sum insured* (this only applies in relation to the increased amount with the exception of any increase in cover as a result of the Indexation Benefit); and
- the date your cover was last reinstated.

When we've agreed to replace existing critical illness cover that was issued by us or another insurer, the 90-day qualifying period will not apply if:

- your existing critical illness cover has been in force for at least 90 days, and all existing qualifying periods on your cover have expired
- the replacement Critical Illness Cover is for the same, or lower, *sum insured* than your existing critical illness cover. If your *sum insured* is higher, then the 90-day qualifying period will apply to the difference between your new Critical Illness Cover *sum insured* and your existing critical illness cover *sum insured*
- your existing critical illness cover provided similar cover for the same Critical Illness Events, including events that are subject to a 90-day qualifying period, included under this cover
- the existing critical illness cover is cancelled within seven days of the issue of your replacement Critical Illness Cover; and
- no claim is payable, or pending, under your existing critical illness cover.

Partial Critical Illness Benefit

This benefit is only available if you've purchased Critical Illness Plus, as shown on your plan schedule.

We'll pay a partial benefit, as indicated in the table below, if you suffer a Partial Critical Illness Event and you survive for at least 14 days from the date of diagnosis.

Any partial benefit paid will reduce your Critical Illness Cover *sum insured*, and the *sum insured* for any attached or linked Life Cover or TPD Cover. When a partial benefit reduces your remaining Critical Illness Cover *sum insured* to below $10,000, we'll pay the entire *sum insured* to you. As a result, your Critical Illness Cover will cease (subject to the Critical Illness Cover Reinstatement Benefit).

You can only claim for each type of partial Critical Illness Event once, except for *carcinoma in situ* where you may make a subsequent claim for a carcinoma that is situated on a uniquely different site of your body to your previous claim.

Partial Critical Illness Event	Maximum benefit
• *Loss of hearing in one ear (permanent)* • *Loss of sight in one eye (total and irrecoverable)* • *Loss of use of a single limb (total and irrecoverable)*	10% of your *sum insured* to a maximum of $100,000
• *Carcinoma in situ*^+ • *Diagnosed benign brain tumour*^ • *Early stage chronic lymphocytic leukaemia*^ • *Early stage melanoma (excluding melanoma in situ)*^ • *Early stage prostate cancer*^	25% of your *sum insured* to a maximum of $100,000
• *Adult onset insulin dependent diabetes mellitus diagnosed after age 30*^ • *Severe ulcerative colitis (requiring permanent immunosuppressive medication)* • *Severe Crohn's disease (requiring permanent immunosuppressive medication)*	20% of your *sum insured* to a maximum of $100,000

^These conditions are subject to a 90-day qualifying period as explained in the above section.

+If you're diagnosed with *carcinoma in situ* of the cervix uteri classified as Cervical Intraepithelial Neoplasia grade 3 (CIN-3), we'll pay a portion of the Partial Critical Illness Benefit to you. This amount will be the lesser of 10% of your *sum insured* and $100,000. If you're subsequently diagnosed with a grading higher than CIN-3, we'll pay the Partial Critical Illness Benefit, less any portion already paid, subject to the maximum for *carcinoma in situ* as outlined in the above table.

Paralysis Support Benefit

If you suffer *paralysis (total and permanent)*, your Critical Illness Cover payment will be two times your *sum insured*, to a maximum of $2,000,000. If your *sum insured* is greater than $2,000,000, then your *sum insured* will be paid.

Critical Illness Cover Reinstatement Benefit

You can reinstate your Critical Illness Cover *sum insured* after we pay you a Critical Illness Benefit, or Partial Critical Illness Benefit, without the need to provide medical, pastimes or occupational evidence to us.

If you've claimed for one of the following Critical Illness Events:
- *dementia including Alzheimer's disease (permanent and irreversible with severe cognitive impairment)*
- *blindness (total and irrecoverable)*
- *loss of hearing (total and irrecoverable)*
- *loss of use of limbs (total and irrecoverable)*
- *multiple sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities); or*
- *Parkinson's disease (permanent),*

you can apply to reinstate your cover within 30 days of the later of:
- six months after the date we receive your valid Critical Illness Cover claim form; and
- six months after the date you satisfied the relevant Critical Illness Event definition.

If you've claimed for a Critical Illness Event not listed in the previous paragraph, you can apply to reinstate your cover within 30 days of the later of:
- 12 months after the date we receive your valid Critical Illness Cover claim form; and
- 12 months after the date you satisfied the relevant Critical Illness definition.

If your premium type is stepped, your premium for the reinstated Critical Illness Cover will be based on your age at the time of the reinstatement.

If your premium type is level, your premium for the reinstated Critical Illness Cover will be based on your age at your cover start date.

Any premium loadings, exclusions, limitations or varied terms that applied to your original Critical Illness Cover, as well as the Indexation Benefit, will also apply to your reinstated Critical Illness Cover.

Important things to note

This benefit is not available if:

- the Critical Illness Cover Reinstatement Benefit has already been exercised in aggregate for the full original Critical Illness Cover *sum insured*
- you're older than 70
- you have been paid a benefit for *loss of independent existence (permanent and irreversible)*
- you have been paid, or a claim is being assessed for, or you are eligible to claim for, a Total and Permanent Disability Benefit under TPD Cover; or
- you have been paid, or a claim is being assessed for, or you are eligible to claim for, a benefit for *terminal illness* under Life Cover.

Exclusions on reinstated Critical Illness Cover

We'll not pay a claim under reinstated Critical Illness Cover for:

- the same Critical Illness Event for which we paid a claim under your original Critical Illness Cover
- a condition which is related to a condition for which a claim has been previously paid under your original Critical Illness Cover (or treatment of that condition)
- a condition which first occurred, was diagnosed, or symptoms leading to the event occurred, were diagnosed or first became apparent, before the reinstatement date of your Critical Illness Cover
- *stroke (resulting in neurological deficit), heart attack (with evidence of heart muscle damage), out of hospital cardiac arrest (excluding medical procedures), coronary artery bypass surgery, coronary artery angioplasty, triple vessel angioplasty, heart valve surgery, aortic surgery (thoracic and abdominal aorta excluding its branches), cardiomyopathy (permanent and irreversible), open heart surgery, pulmonary arterial hypertension (idiopathic and familial)* or *chronic kidney failure (requiring transplantation or dialysis)*, if a Critical Illness Benefit has been paid for any of these Critical Illness Events under your original Critical Illness Cover
- *Paralysis (total and permanent)* or *blindness (total and irrecoverable)*, if the cause of the condition was the result of a *stroke (resulting in neurological deficit)* and a Critical Illness Benefit has been paid for *heart attack (with evidence of heart muscle damage), out of hospital cardiac arrest (excluding medical procedures), coronary artery bypass surgery, coronary artery angioplasty, triple vessel angioplasty, heart valve surgery, aortic surgery (thoracic and abdominal aorta excluding its branches), cardiomyopathy (permanent and irreversible), open heart surgery* or *pulmonary arterial hypertension (idiopathic and familial)*, under your original Critical Illness Cover
- *Cancer (excluding early stage cancers), benign brain tumour (resulting in irreversible neurological deficit), carcinoma in situ, early stage melanoma (excluding melanoma in situ), early stage prostate cancer* or *early stage chronic lymphocytic leukaemia*, if a Critical Illness Benefit or Partial Critical Illness Benefit has been paid for any of these conditions under your original Critical Illness Cover; or
- *Heart attack (with evidence of heart muscle damage)* or *stroke (resulting in neurological deficit)* if a Critical Illness Benefit has been paid for *dementia including Alzheimer's disease (permanent and irreversible with severe cognitive impairment)* under your original Critical Illness Cover.

The Future Increase Benefit is not available for the reinstated Critical Illness Cover.

Other included benefits

The additional benefits included in Critical Illness Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 30 of this PDS.

Optional benefits

Optional benefits available under Critical Illness Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 36 of this PDS.

Adjustments

Your Critical Illness Cover *sum insured* will be reduced by any amount paid:

- under your cover for *coronary artery angioplasty* or any Partial Critical Illness Benefit
- for *terminal illness*, when your Critical Illness Cover is attached or linked to your Life Cover; and
- for TPD Cover, when both your TPD Cover and Critical Illness Cover is attached or linked to your Life Cover.

On the plan anniversary immediately after you turn 70, we'll only pay your Critical Illness Cover *sum insured* if you suffer *loss of independent existence (permanent and irreversible)*.

The maximum Critical Illness Cover available at age 70 is $2,000,000 across all plans issued by us. If you're covered for more than $2,000,000 at this age, we'll reduce your aggregate *sums insured*. The Indexation Benefit will continue to be available if your *sum insured* is reduced to $2,000,000.

Exclusions

We'll not pay any benefit under Critical Illness Cover:

- if the event giving rise to the claim is caused or contributed to by:
  - anything that is specifically excluded on your plan schedule; or
  - any intentional, self-inflicted injury or attempted suicide.
- if you don't survive for at least 14 days following the Critical Illness Event
- for any *illness* or *injury* that occurred before the Critical Illness Cover commencement date of which you were aware or someone in your position could have been expected to be aware. This doesn't include an *illness* or *injury* you disclosed to us and we accepted; and
- for Critical Illness Events subject to the 90-day qualifying period – unless we've waived the qualifying period (as explained on page 22) – if the event first occurred, was diagnosed, or symptoms leading to the event occurred, were diagnosed or first became apparent, within the 90-days immediately following:
  - the date we received your fully completed application for Critical Illness Cover
  - an increase in your Critical Illness Cover *sum insured* (but only in respect of the increased amount with the exception of any increase in cover as a result of the Indexation Benefit); and
  - the date your cover is last reinstated.

When your Critical Illness Cover has been reinstated through the Critical Illness Reinstatement Benefit, we'll not pay a claim for certain Critical Illness Events as explained on page 24.

We'll not pay any benefit under your Critical Illness Cover following the plan anniversary immediately after you turn 70 for any Critical Illness Event except for *loss of independent existence (permanent and irreversible)*.

When Critical Illness Cover ends

Critical Illness Cover will end on the earlier of:

- the date we receive your request to cancel your cover
- your death
- your full Critical Illness Cover *sum insured* is paid or reduced to nil
- the date we cancel your plan because premiums weren't paid when due
- the date we avoid your cover (treat it as if it never existed) in accordance with our rights in relation to your duty to take reasonable care; and
- the plan anniversary immediately after you turn 80.

CHILD COVER

Cover overview

NON SUPER

Child Cover provides a lump sum payment if the insured child dies, becomes *terminally ill* or is diagnosed with one of the specified Child Critical Illness Events included under this cover.

Child Cover is not available inside superannuation.

Minimum entry age
- Two

Maximum entry age
- 17

Benefit expiry age
- Plan anniversary after the insured child turns 19

Minimum sum insured that can be applied for
- $10,000

Maximum sum insured that can be applied for
- $200,000

Premium types
- Stepped premium (currently, the same premium rate applies across all ages)

Product structure combinations
- Child Cover can only be applied for in conjunction with Life, TPD or Critical Illness Cover, for an adult. If the adult cover is declined, cancelled (for reasons other than a claim) or lapses, we'll also decline, cancel or lapse your Child Cover.

Exclusions
- See page 29

Included benefits

The following benefits are included in Child Cover.

Included benefits

Death Benefit

We'll pay the Child Cover *sum insured* if the insured child dies while this cover is in place.

Terminal Illness Benefit

We'll pay the Child Cover *sum insured* if the insured child becomes *terminally ill* while this cover is in place.

Critical Illness Benefit

We'll pay the Child Cover *sum insured* if the insured child is diagnosed with, or suffers, one of the Child Critical Illness Events listed in the following table.

Child Critical Illness Events

Heart conditions	
• *Cardiomyopathy (permanent and irreversible)*	• *Heart attack (with evidence of heart muscle damage)^*
Nervous system conditions	
• *Coma (of specified severity and duration)* • *Encephalitis and meningitis (resulting in significant permanent neurological impairment)* • *Major head trauma (with significant permanent neurological impairment)*	• *Meningococcal disease (resulting in significant permanent impairment)* • *Paralysis (total and permanent)* • *Stroke (resulting in neurological deficit)^* • *Subacute sclerosing panencephalitis*
Body organ conditions	
• *Benign brain tumour (resulting in irreversible neurological deficit)* • *Cancer (in children, excluding early stage cancers)^* • *Chronic kidney failure (requiring transplantation or dialysis)*	• *Major organ transplant (of specified organs from a human donor, or placement on a waiting list)* • *Severe burns (covering at least 20% of the body's surface area)*
Blood conditions	
• *Aplastic anaemia (requiring specified treatment)*	• *Medically-acquired HIV (contracted from a medical procedure or operation)*
Other conditions	
• *Blindness (total and irrecoverable)* • *Loss of hearing (total and irrecoverable)* • *Loss of use of limbs (total and irrecoverable)*	• *Loss of speech (total and irrecoverable)* • *Prolonged intensive care* • *Loss of independent existence (permanent and irreversible)*

^ These conditions are subject to a 90-day qualifying period as explained on the following page.

90-day qualifying period

Unless we've agreed to waive the 90-day qualifying period because you're replacing existing child cover with our Child Cover, no benefit will be paid for any of the critical illnesses marked with a ^ in the previous table, if the event first occurred, was diagnosed, or symptoms leading to the event occurred, were diagnosed or first became apparent, within 90 days immediately following:

- the date we received your fully completed application for Child Cover
- an increase in your Child Cover *sum insured* (but only in respect of the increased amount with the exception of any increase in cover as a result of the Indexation Benefit); and
- the date your Child Cover was last reinstated.

When we've agreed to replace your existing child cover, issued by us or another insurer, the 90-day qualifying period will not apply if:

- your existing child cover has been in force for at least 90-days, and all existing qualifying periods on that child cover have expired
- your replacement Child Cover is for the same, or lower, *sum insured* than the existing child cover. If your *sum insured* is higher, then the 90-day qualifying will apply to the difference between your new Child Cover *sum insured* and your existing child cover *sum insured*
- your existing child cover provided similar cover for the same Child Critical Illness Events, including events that are subject to a 90-day qualifying period, included under this cover
- your existing child cover is cancelled within seven days of the issue of your replacement Child Cover; and
- no claim is payable, or pending, under your existing child cover.

Funeral Advancement Benefit

To aid with the immediate costs of death, this benefit provides an advancement of a portion of your Child Cover *sum insured*. Upon our receipt of a certified copy of the insured child's death certificate, or other satisfactory evidence that the insured child has died, we'll advance the lesser of $25,000 and your Child Cover *sum insured* unless we (acting reasonably) consider there is reasonable doubt as to whether the death benefit will be payable.

Your Child Cover *sum insured* will then be reduced by the amount paid under this benefit.

It's important to note that payment of this benefit is not an admission of our liability to pay the Child Cover claim.

Grief Support Benefit

If we pay the full Child Cover *sum insured*, we'll reimburse the cost of grief counselling sessions for you, or an *immediate family member* of the insured child, with an accredited counsellor.

The maximum total amount we'll reimburse under this benefit for each insured child is $1,000.

The Grief Support Benefit must be exercised within 12 months of payment of the full Child Cover *sum insured*.

Continuation of Cover Benefit

If you die or your plan ends for any reason, the child's other parent or guardian may continue Child Cover by moving Child Cover under their NEOS Protection plan.

This can be done at any time up to 60 days after the underlying plan terminates, without the need to provide medical evidence to us.

Conversion of Child Cover Benefit

When the insured child approaches the expiry age for Child Cover, they have the option of converting their existing cover to Life Cover. They may also choose to attach or link Critical Illness Cover, without having to reapply or supply medical evidence to us.

To be eligible for this option, the insured child must exercise it:
- before their Child Cover expires or is cancelled; and
- when they're 18 or 19 years old.

The *sum insured* on their new cover can be up to the same *sum insured* that applied under their Child Cover at the time it expired.

Their new premium will be based on their age and the current premium rates at the time the new cover is issued.

Any exclusions which applied to their Child Cover will also be applied to their new cover.

Other included benefits

The following additional benefits included in Child Cover are described in the section, 'Benefits common to Life Cover, TPD Cover and Critical Illness Cover' from page 30 of this PDS. When reading this section, substitute references to 'you' and 'your' with 'insured child'.
- Indexation Benefit
- Accommodation Benefit
- Suspending Cover Benefit.

Exclusions

We'll not pay any benefit under Child Cover:
- if the event giving rise to the claim is caused or contributed to by an intentional, self-inflicted act, or attempted suicide, within the first 13 months of:
  - the cover start date
  - an increase in the *sum insured* (but only in respect of the increased amount with the exception of any increase in cover as a result of the Indexation Benefit); or
  - the date on which cover was last reinstated
- if the event giving rise to the claim is caused or contributed to by a *congenital condition*
- for any *illness* or *injury* that occurred before Child Cover commencement date
- for any illegal act inflicted on the insured child by you or the child's guardian; and
- for Child Critical Illness Events subject to the 90-day qualifying period (as explained on page 28), if the event first occurred, was diagnosed, or symptoms leading to the event occurred, were diagnosed or first became apparent, within the first 90 days immediately following:
  - the date we received your fully completed application for Child's Cover
  - an increase in your Child's Cover *sum insured* (but only in respect of the increased amount with the exception of any increase in cover as a result of the Indexation Benefit); and
  - the date your Child's Cover was last reinstated.

When Child Cover ends

Child Cover will end on the earlier of:
- the date we receive your request to cancel Child Cover
- your death
- your plan is cancelled as a result of your Life Cover, TPD Cover, or Critical Illness Cover being cancelled or expiring
- the full Child Cover *sum insured* is paid or reduced to nil
- the date we cancel Child Cover because premiums weren't paid when due
- the date we avoid Child Cover (treat it as if it never existed) in accordance with our rights in relation to your duty to take reasonable care; and
- the plan anniversary immediately after the insured child turns 19.

BENEFITS COMMON TO LIFE COVER, TPD COVER AND CRITICAL ILLNESS COVER

Included benefits

The following additional benefits apply to Life Cover, TPD Cover and Critical Illness Cover. Some benefits are not available if cover is held inside superannuation.

Indexation Benefit

SUPER NON SUPER

On each anniversary of your plan, we'll automatically increase your *sum insured* by the higher of:

- 5%; or
- the percentage increase in the *Consumer Price Index (CPI)*.

Your premium will also be increased to reflect the increase in your *sum insured*.

If you don't want the Indexation Benefit to apply, you'll need to let us know within 30 days after the relevant plan anniversary. If you decline an increase, you'll not be excluded from being offered increases in future years.

You can request to remove the Indexation Benefit permanently from your cover at any time, however should you wish to have the Indexation Benefit restarted, we may require further information from you before agreeing to restart it.

The Indexation Benefit will not apply:

- while premiums are being waived under the following options:
  -Disability Premium Waiver Option; or
  -Accelerated Life Cover Buy Back Option;
- while the Suspending Cover Benefit is being exercised; and
- when your combined total *sums insured* for Life Cover, TPD Cover and Critical Illness Cover across all plans issued by us exceed $20,000,000.

Accommodation Benefit

NON SUPER

If we pay:

- your full Life Cover *sum insured* for *terminal illness* and based on the advice of a *medical practitioner*, you're *confined to bed* as a result of the *terminal illness*
- your full TPD Cover *sum insured* and based on the advice of a *medical practitioner*, you're *confined to bed* as a result of the *total and permanent disability* for which we've paid the benefit; or
- your full Critical Illness Cover *sum insured* and based on the advice of a *medical practitioner*, you're *confined to bed* as a result of the Critical Illness Event for which we've paid the benefit

AND

- an *immediate family member* is required to travel more than 100 kilometres from their place of residence to be with you; or
- you're more than 100 kilometres from your place of residence and require an *immediate family member* to be with you,

we'll reimburse up to $250 per day for your *immediate family member's* accommodation costs, for each day you remain *confined to bed*, for a maximum period of 30 days. The Accommodation Benefit will cease to apply if you die.

This benefit must be claimed within 90 days of the Terminal Illness Benefit, Total and Permanent Disability Benefit or Critical Illness Benefit being paid.

A copy of the invoice or accommodation receipt must be provided to us upon request.
This benefit is payable only once for any 12-month period.

Suspending Cover Benefit

SUPER NON SUPER

If you've held your cover for a continuous period of at least 12 months, you can suspend your cover due to hardship for a period of time. During this period, you'll not need to pay premiums, however you'll also be unable to make a claim in respect of any event, *illness* or *injury* that occurs during the suspension period.

To exercise this benefit:

- you must notify us at least 30 days before the premium due date (monthly or annually) from which you wish to suspend your cover
- you must specify the length of the suspension period required (three, six, nine or 12 months)
- acknowledge that premiums and cover will be suspended; and
- provide us with satisfactory evidence of hardship.

At the end of your suspension period, we'll continue your cover and your premium payments will resume, unless you let us know otherwise. If the resumed premiums cannot be collected, then your cover will be cancelled.

You may cancel your suspension of cover early. If you do, we'll resume your premium payments from when your cover resumes.

Your cover may be suspended under this benefit for a maximum of 12 months over the life of your cover.

Future Increase Benefit

SUPER NON SUPER

The Future Increase Benefit allows you to increase your Life Cover, TPD Cover and/or Critical Illness Cover *sum insured* after certain, specified events, without having to supply further medical or other underwriting evidence to us.

The events, and the maximum increase amounts applicable to each event, are shown in the table on the following page.

You may apply for an increase for only one personal, professional, business or plan event per cover type, in any 12-month period.

For all increases applied for under the Future Increase Benefit, the maximum amount you can increase your *sum insured* is the lesser of:

- your *sum insured* at your cover commencement date; and
- $2,000,000,

subject to your total cover not exceeding:

- $5,000,000 for Life Cover
- $3,000,000 for TPD Cover; and
- $2,000,000 for Critical Illness Cover.

The minimum increase amount is $10,000.

If TPD Cover and/or Critical Illness Cover are attached or linked to Life Cover, your Life Cover *sum insured* must always be greater than, or equal to, the higher of your TPD Cover and Critical Illness Cover *sum insured*.

Personal events	Maximum sum insured increase
• You marry, register a de facto relationship or enter into a de facto relationship which is recognised by law • You divorce, legally separate, register a separation from a marriage or registered de facto relationship, or cancel a de facto relationship which is recognised by law • The death of your spouse, registered de facto partner or partner under a de facto relationship which is recognised by law • Your child is born, or you legally adopt a child • Your child starts school • You increase your mortgage for your primary place of residence • You're granted a housing loan by a financial institution to buy your primary residence • You complete your first undergraduate degree at a recognised Australian university; or • You become a carer for the first time.	Lesser of: • 25% of your relevant *sum insured* at the cover commencement date • the amount of the housing loan or increase to the mortgage; and • $200,000.

Professional events	Maximum sum insured increase
• You receive a salary increase of 15% or more • You qualify as a Fellow of your profession • You become a partner of your organisation; or • You commence a private practice.	Lesser of: • 25% of your *sum insured* at the cover commencement date • 10 times your salary package increase; and • $200,000.

Business events	Maximum sum insured increase
• If the original purpose of your cover was to support a business purpose such as a buy/sell arrangement, a share purchase agreement or a business succession agreement, and the value of that business increases (using the same methodology as was used to determine your original cover).	Lesser of: • 25% of your *sum insured* at the cover commencement date • the amount of the increase in the value of the financial interest in the business; and • $200,000.
• If you're responsible for a business loan and there is an increase in the loan liability.	Lesser of: • 25% of your *sum insured* at the cover commencement date • the amount of the increase in the value of the business loan; and • $200,000.
• If you're a *key person* in a business and your value to the business increases.	Lesser of: • 25% of your relevant *sum insured* at the cover commencement date • five times the average of the last three annual increases in your gross remuneration package; and • $200,000.

Plan event	Maximum sum insured increase
• On every third anniversary of the commencement of your cover; provided that your *sum insured* has not been increased under this Future Increases Benefit during the previous three years.	Lesser of: • 25% of the *sum insured* at the cover commencement date; and • $200,000.

To apply for an increase under this benefit, you must provide any evidence we request to demonstrate that the personal, professional, business or plan event has occurred.

Your application also needs to be made:
- within 30 days of the occurrence of the personal, professional, business or plan event; or
- within 30 days of the plan anniversary immediately following the personal, professional, business or plan event.

Your increased *sum insured* will not apply until we've confirmed it in writing to you; which will be no later than 30 days from the date you satisfied our requirements. Your premium will also be increased to reflect the increase in your cover. Your premium for the increased *sum insured* will be based on your age at the time of the increase.

Important things to note

Within the first six months of an increase to a *sum insured*, the increased amount of the *sum insured* will only be payable for death, *total and permanent disability* or a Critical Illness Event (as applicable) which results from an *accident*.

This benefit is not available:
- immediately after you turn 60
- if you've made, or are eligible to make, a claim under any Life Cover, TPD Cover or Critical Illness Cover issued by us; or
- if your cover is issued with a medical loading greater than 100%, as stated on your plan schedule.

Financial Advice Benefit

NON SUPER

If we pay your full Life Cover, TPD Cover or Critical Illness Cover *sum insured*, we'll reimburse the cost of engaging a financial adviser to prepare a financial plan(s) for you and/or any other beneficiaries under your cover. The financial adviser must be operating under an Australian Financial Services Licence.

The total amount payable under this benefit will be the lesser of the actual fee charged by the financial adviser and $3,000.

The financial plan must be provided within 12 months of receiving the full *sum insured* from us and this benefit will only be paid once, regardless of how many cover types you have with us.

A copy of the invoice or receipt showing the amount paid and the services provided must be provided to us upon request.

Waiver of Premium While Involuntarily Unemployed Benefit

SUPER NON SUPER

If you become *involuntarily unemployed* (other than as a direct result of *illness* or *injury*), we'll waive your premium for up to three months over the life of your plan while you're unemployed.

To exercise this waiver, you must notify us within 30 days of the premium due date from which you're applying to have your premiums waived. You'll need to provide us with satisfactory evidence of your *involuntary unemployment*.

If your plan includes Child Cover, we'll also waive any premiums that become payable for the Child Cover.

At the end of your waiver period, your premium payments will resume unless you let us know otherwise. If the resumed premiums cannot be collected, then your cover will be cancelled.

Important things to note

- Your plan must have been in place for at least 12 consecutive months before you can exercise this waiver.
- You must be registered with an Australian government approved employment agency as of the date you notify us that you want to exercise the waiver.
- The waiver is not available if you're self-employed.
- The waiver is only available if you're paying your premiums monthly, and is only available in respect of future premiums (i.e. premiums that have not yet been paid by you).
- We'll waive premiums under this benefit for separate periods of time you're *involuntarily unemployed*, subject to a maximum of three months over the life of your plan.

Grief Support Benefit

NON SUPER

If we pay your Life Cover, Critical Illness Cover, or TPD Cover *sum insured*, we'll reimburse the cost of grief counselling sessions.

The maximum total amount we'll reimburse under the Grief Support Benefit in respect of each insured person is $1,000.

The Grief Support Benefit must be claimed within 12 months of payment of your *sum insured* and the counselling session must be provided by an accredited counsellor.

A copy of the invoice or receipt showing the amount paid and the services provided must be provided to us upon request.

Child's Critical Illness Benefit

NON SUPER

We'll pay a benefit payment of $10,000 when a child who is financially dependent on you:

- dies
- is diagnosed as *terminally ill*; or
- suffers a Child Critical Illness Event listed on page 27 of this PDS.

The Child's Critical Illness Benefit is available when the child is aged between one and 18. However, this benefit will only be paid once for an individual child across all Life, Critical Illness and TPD Covers issued by us, and is only ever payable once under a cover type.

The Child's Critical Illness Benefit is not payable for an *illness* which occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent:

- when the child was aged less than one; or
- before your cover commencement date.

Optional benefits

The below optional benefits are available at an extra cost. If selected, they will be shown on your plan schedule.

Life Cover Buy Back Option

SUPER NON SUPER

This option is only available if you have Critical Illness Cover or TPD Cover, attached or linked to your Life Cover.

This option allows you to reinstate your Life Cover *sum insured* after it has been reduced as a result of a benefit being paid on your attached, or linked, Critical Illness Cover or TPD Cover, without having to provide further evidence of medical, pastimes or occupation to us.

You may apply to reinstate your attached or linked Life Cover *sum insured* within 30 days of the 12-month anniversary of:

- the date we received your fully completed claim form in relation to which the full or partial Critical Illness Cover or TPD Cover *sum insured* is paid; or
- the date you satisfied the:
  - Critical Illness Event definition in respect of the Critical Illness Benefit paid; or
  - the TPD definition in respect of the Total and Permanent Disability Benefit paid.

If your premium type is stepped, the premium for your reinstated Life Cover will be based on your age at the time of the reinstatement.

If your premium type is level, the premium for your reinstated Life Cover will be based on your age at your plan commencement date.

Important things to note

- Any premium loadings, exclusions or varied terms that applied to your original Life Cover, will also apply to the reinstated Life Cover.
- The Indexation Benefit will apply to the reinstated Life Cover.
- The Future Increase Benefit is not available under your reinstated Life Cover.
- This option expires on the plan anniversary immediately after you turn 65.

Accelerated Life Cover Buy Back Option

SUPER NON SUPER

This option is only available if you have Critical Illness Cover or TPD Cover, attached or linked to your Life Cover.

If we pay your full Critical Illness Cover or TPD Cover *sum insured*, the amount of the attached or linked Life Cover *sum insured* that is reduced will be reinstated on the later of:

- 14 days after we receive your Critical Illness Cover or TPD Cover claim form; and
- the date we pay your Critical Illness Cover or TPD Cover claim.

We'll waive future premiums for the portion of your Life Cover *sum insured* that is reinstated under this option, up until the plan anniversary immediately after you turn 65.

This option cannot be exercised if:

- a benefit has been paid for *terminal illness*, we're in the process of assessing a *terminal illness* claim or you're eligible, or imminently likely to be eligible, to make a claim for *terminal illness*
- you don't survive for at least 14 days following the *illness* or *injury* that caused your Critical Illness Event or *total and permanent disability*
- only a partial TPD payment was made under the Specific Loss Benefit (unless multiple payments have been made which total the full TPD Cover *sum insured*); or
- only a partial critical illness payment was made under the Partial Critical Illness Benefit (unless multiple payments have been made which total the full Critical Illness Cover *sum insured*).

Important things to note

- Your reinstated Life Cover *sum insured* cannot be increased under the Indexation Benefit or Future Increase Benefit.
- Any premium loadings, exclusions or varied terms which applied to your original Life Cover will also apply to your reinstated Life Cover.
- This option expires on the plan anniversary immediately after you turn age 65.

Disability Premium Waiver Option

SUPER NON SUPER

We'll waive your premiums for your Life Cover, TPD Cover and/or your Critical Illness Cover if, as a result of *illness* or *injury*, for three consecutive months you're:

- totally unable to work in any occupation for which you're suited by training, education or experience
- not earning an income; and
- following the advice of a *medical practitioner*.

We'll waive your premiums until the earlier of:

- your return to work
- you commence earning an income; or
- the plan anniversary immediately after you turn 65.

If your plan includes Child Cover, we'll also waive any premiums that become payable for the Child Cover while we're waiving your premiums under this option.

Important things to note

- A waiver of your premium under this option will not apply when your *illness* or *injury* is caused by:
  - any intentional, self-inflicted act
  - war or an act of war (whether declared or not); or
  - anything we've specifically excluded, as stated on your plan schedule.
- The Indexation Benefit will not apply to the cover for which your premiums are being waived.
- You cannot increase your cover under the Future Increase Benefit when your premiums are being waived.
- This option expires on the plan anniversary immediately after you turn 65.

INCOME SUPPORT COVER

Cover overview

SUPER NON SUPER

Income Support Cover provides an ongoing *monthly benefit* when you're *disabled* as a result of *illness* or *injury*.

Choice of cover
- Income Support Super
- Income Support Standard

Minimum entry age
- 18

Maximum entry age
- 60

Eligibility requirement

You must be employed and working at least 20 hours per week at the time of application

Expiry ages
- The plan anniversary after you turn 65

Minimum sum insured that can be applied for
- $1,500 per month

Maximum sum insured that can be applied for

The maximum *sum insured* is the lower of $30,000 per month and:
- 70% of your combined *regular income*, monthly *passive income* and monthly *ongoing business income* up to $16,667 per month ($200,000 annually); plus
- 50% between $16,668 and $36,667 per month ($240,000 annually); plus
- 20% between $36,668 and $78,333 per month ($500,000 annually); less
- your monthly *passive income* and monthly *ongoing business income*.

Where your monthly *passive income* is equal to or less than 10% of your *regular income*, this will be deemed as zero for the purpose of determining your maximum *sum insured*.

You may also apply for up to an additional 10% of your *sum insured* as a *superannuation sum insured* under the Superannuation Contribution Option, subject to a maximum of $2,000 per month.

Your *sum insured* and any *superannuation sum insured* will never exceed $30,000 per month under your Income Support Cover.

Premium type
- Stepped
- Level to age 65

Waiting periods
- 4, 8, 13 or 26 weeks

Benefit periods
- Two or five years
- To age 65

Product structure combinations available
- Stand-alone
- Split

Exclusions
- See page 50

Choice of cover

You can choose to structure Income Support Cover either inside or outside of superannuation. Your plan schedule will show which level of cover you've purchased.

Plan ownership	Level of cover	Description
SUPER	Income Support Super	• Protection that you can hold within superannuation as all benefits comply with superannuation legislation.
NON SUPER	Income Support Standard	• Protection that you can hold outside of superannuation. Benefits which are not consistent with the superannuation conditions of release can be paid.

Included benefits

The following benefits are included in Income Support Cover.

Optional benefits available at an extra cost

The following benefits are available at an extra cost. Your plan schedule will show which options you have purchased.

Split Income Support Cover

Split Income Support Cover allows you to purchase your Income Support Standard Cover both inside and outside of superannuation. Under this option, the portion of your Income Support Cover which is consistent with superannuation rules, is held under a plan inside superannuation. The remaining benefits of the Income Support Cover are then held under a plan outside superannuation. The overall level of cover which you'll hold will be equivalent to that provided by Income Support Standard Cover, except for the maximum indexation rates that may apply under the Indexation Benefit and Increasing Claims Option.

When your Income Support Cover is spilt across two plans, any claim you make will first be assessed with reference to the terms and conditions of the plan held inside of superannuation; and the amount payable will be paid to the trustee of the superannuation fund on your behalf. Any benefits not payable under the superannuation plan, may be paid under the non-superannuation plan; subject to you meeting the applicable terms and conditions.

Important things to note

- The premium payable for the plan held outside superannuation will be reduced by the premium charged for the plan held inside superannuation. This means that the overall premium you pay will be the same as if you held stand-alone Income Support Standard Cover.
- Your *sum insured, superannuation sum insured, waiting period, benefit period*, and any loadings or exclusions (if applicable) on each plan, must always be the same.
- Should the plan held within superannuation be cancelled or lapsed, the non-superannuation plan will also be cancelled or lapsed.
- If the non-superannuation plan is cancelled or lapsed, the plan inside superannuation will continue as stand-alone Income Support Super Cover.
- The maximum benefits payable under both plans will never exceed what would be payable under stand-alone Income Support Standard Cover.
- Your plan schedules will indicate when splitting applies.

Benefit calculations

Your *monthly benefit* is the actual amount payable to you each month during a claim. The following section outlines important information about how your Income Support Cover *monthly benefit* is calculated in the event you become *disabled*.

Monthly benefit

If you're *disabled* solely as a result of *illness* or *injury*, we'll pay you a *monthly benefit*. Your maximum potential *monthly benefit* is based on a portion of your *total monthly income*, less *passive income* and *ongoing business income* that you receive while *disabled*, as explained below.

Calculating your monthly benefit

Your *monthly benefit* is the lesser of:

- your *income replacement amount* (as explained below), less *current passive income*, less *current ongoing business income*; and
- the *sum insured* stated on your plan schedule.

Your *monthly benefit* will also be reduced by 75% of any *post-disability income* (if you're *partially disabled*) and *other payments* (as explained on page 50).

Your *income replacement amount* is calculated as:

- 70% of the first $16,667 of your *total monthly income*
- 50% of the next $20,000; and
- 20% of the next $41,666.

Your *total monthly income* is your combined *pre-disability income*, *current passive income* and *current ongoing business income*.

After the first 24 months of your *benefit period*, your *sum insured* and *income replacement amount* will be reduced by a ratio of 6/7 for the purpose of calculating any *monthly benefit* for the remainder of the *benefit period*.

Current passive income

When calculating your *total monthly income* and *monthly benefit*, we'll only consider *current passive income* if this exceeds 10% of your *pre-disability income*.

Where your *current passive income* exceeds 10% of your *pre-disability income*, we'll consider all of your *current passive income*, not just the amount which exceeds 10% of your *pre-disability income*.

Example calculations – receiving a Total Disability Benefit

Example 1

Totally disabled, for the first 24 months of the *benefit period*

A	*Pre-disability income*		$10,000
B	*Current passive income*		$1,200
C	*Current ongoing business income*		$0
D	*Total monthly income*	A + B + C	**$11,200**
E	*Income replacement amount*	D x 70%*	**$7,840**
F	Maximum potential *monthly benefit*	E – B – C	**$6,640**
G	*Sum insured*		$7,000
H	*Monthly benefit*	Lesser of F, G	**$6,640**

*The rate applied will change for any *total monthly income* above $16,667, per the *income replacement amount* formula

Example 2

Totally disabled, after the first 24 months of the *benefit period*

A	*Pre-disability income*		$10,000
B	*Current passive income*		$1,200
C	*Current ongoing business income*		$0
D	*Total monthly income*	A + B + C	**$11,200**
E	*Income replacement amount* (reduced)	D x 70%* x 6/7	**$6,720**
F	Maximum potential *monthly benefit*	E – B – C	**$5,520**
G	*Sum insured*		$7,000
H	*Sum insured* (reduced)	G x 6/7	**$6,000**
I	*Monthly benefit*	Lesser of F, H	**$5,520**

*The rate applied will change for any *total monthly income* above $16,667, per the *income replacement amount* formula

Example calculations – receiving a Partial Disability Benefit

Example 3

Partially disabled with 60% *work capacity*, for the first 24 months of the *benefit period*

A	*Monthly benefit* (if *totally disabled*)*		$6,640
B	*Post-disability income* (60% *work capacity*)		$6,000
C	*Post-disability income* (reduced)	B x 75%	**$4,500**
D	*Monthly benefit*	A – C	**$2,140**

*See Example 1 for calculation of the *monthly benefit* for *total disability* for the first 24 months of the *benefit period*

Example 4

Partially disabled with 60% *work capacity*, after the first 24 months of the *benefit period*

A	*Monthly benefit* (if *totally disabled*)*		$5,520
B	*Post-disability income* (60% *work capacity*)		$6,000
C	*Post-disability income* (reduced)	B x 75%	**$4,500**
D	*Monthly benefit*	A – C	**$1,020**

*See Example 2 for calculation of the *monthly benefit* for *total disability* after the first 24 months of the *benefit period*

Work capacity

Where you have *work capacity*, but are not working or working below your *work capacity* as a result of causes other than *illness* or *injury* and this continues for at least 2 months, then *post-disability income* will be calculated based on what you could reasonably be expected to earn if you were working at your *work capacity*.

Benefit period

This is the maximum amount of time we'll pay you a *monthly benefit* in relation to any one or related *illness* or *injury*.

We offer the following *benefit periods*:
- two or five years; and
- to age 65.

Once a *monthly benefit* has been paid for the entire *benefit period* for any one or related *illness* or *injury*, then no further claim for that same or related *illness* or *injury* will be paid.

If your *benefit period* is five years or less, you can only claim one full *benefit period* for any one or related *illness* or *injury*.

If you make multiple claims for any one or related *illness* or *injury*, any periods of time on claim after the original period on claim, whether they are continuations of your original claim or new claims (as set out under the 'Relapse Benefit' on page 46), will be considered part of the original *benefit period* and, for *benefit periods* of five years or less, be added together to determine when the *benefit period* expires.

Disability requirements

The following section outlines important information about the *disability* requirements you must meet for benefits to accrue.

Waiting period

Your *waiting period* is the minimum period of time you must be *totally disabled* or *partially disabled* as a result of the same or related *illness* or *injury* before you're eligible to claim a *disability* benefit.

The longer the *waiting period* you choose, the lower your premium will be.

We offer *waiting periods* of 4, 8, 13 or 26 weeks.

Your chosen *waiting period* will be shown on your plan schedule.

Waiting period commencement

Your *waiting period* will start on the earlier of:

- when you first consult a *medical practitioner* about the *illness* or *injury* that is causing your *disability*, and you're certified as *totally disabled* or *partially disabled*; or
- when you first stop working due to that *illness* or *injury* (as long as you consult a *medical practitioner* within seven days and provide reasonable medical evidence about when the condition began).

Disability requirements during the waiting period

This varies according to the occupation category shown on your plan schedule.

For occupation categories MED, LAW, WCP, WCA, WCM or LBC, to be eligible for a *monthly benefit* at the end of the *waiting period*, you must have been *totally disabled* or *partially disabled* for the duration of the *waiting period*.

For occupation categories BC, HB or SRA, to be eligible for a *monthly benefit* at the end of the *waiting period* you must have been:

- *totally disabled* for 14 days out of the first 19 consecutive days of the *waiting period*; and
- *totally disabled* or *partially disabled* for the remainder of the *waiting period*.

Working during the waiting period

Any days worked during the *waiting period*, where you worked the daily equivalent of more than 80% of your *regular work hours* or earned the daily equivalent of more than 80% of your *pre-disability income*, will be added to the end of the *waiting period*.

If you worked the daily equivalent of more than 80% of your *regular work hours* or earned the daily equivalent of more than 80% of your *pre-disability income*, for 5 consecutive days during the *waiting period*, the *waiting period* will restart.

Disability definitions

Total disability

Total disability means solely because of *illness* or *injury*, you're:

- unable to perform the *important income producing duties* of *suitable work*
- under the regular care and following the advice of a *medical practitioner* in relation to that *illness* or *injury*; and
- not working (whether paid or unpaid) and you do not have any *work capacity*.

Suitable work

The definition of *suitable work* changes based on how long you have been receiving a *monthly benefit*. Until the first 24 months of the *benefit period* have expired, *suitable work* is based on your ability to work in your *regular occupation*. After the expiry of the first 24 months of your *benefit period*, *suitable work* is based on your ability to work in *any occupation*.

If you have Income Support Super, you must also meet the SIS definition of *temporary incapacity* to be considered *totally disabled*.

SIS definition of *temporary incapacity*

Temporary incapacity, in relation to a member of a superannuation fund who has stopped being *gainfully employed* (including a member who has ceased temporarily to receive any gain or reward under a continuing arrangement for the member to be *gainfully employed*), means ill-health (whether physical or mental) that caused the member to cease to be *gainfully employed* but does not constitute *permanent incapacity*.

Note: If you're unemployed and your plan is held inside superannuation, you'll not be eligible to make an Income Support Cover claim while you're unemployed. If you do become unemployed, please discuss your options with your financial adviser.

Partial disability

Partial disability means solely because of *illness* or *injury*, you're not *totally disabled* and you:

- are working in *suitable work* for less than 80% of your *regular work hours*
- have *work capacity* for less than 80% of your *regular work hours*
- earning *regular income* less than 80% of your *pre-disability income*; and
- are under the regular care and following the advice of *medical practitioner* in relation to that *illness* or *injury*.

Suitable work

The definition of *suitable work* changes based on how long you have been receiving a *monthly benefit*. Until the first 24 months of the *benefit period* have expired, *suitable work* is based on your ability to work in your *regular occupation*. After the expiry of the first 24 months of your *benefit period*, *suitable work* is based on your ability to work in *any occupation*.

Included benefits

Total Disability Benefit

SUPER NON SUPER

If you're *totally disabled*, we'll pay you a *monthly benefit*.

Your benefit will begin to accrue from the first day after the end of your *waiting period*. This will continue, for as long as you're *totally disabled*, until the end of your *benefit period*, the expiry of your cover or your death; whichever comes first.

Part months will be paid at the rate of 1/30th of the *monthly benefit* for each day you are *disabled*.

The *monthly benefit* payable to you will be calculated as explained on page 40.

Partial Disability Benefit

SUPER NON SUPER

If you're *partially disabled*, we'll pay you a portion of the *monthly benefit* that would have been payable to you if you were *totally disabled*.

Your benefit will begin to accrue from the first day after the end of your *waiting period*. This will continue, for as long as you're *partially disabled*, until the end of your *benefit period*, the expiry of your cover or your death; whichever comes first.

Part months will be paid at the rate of 1/30th of the *monthly benefit* for each day you are *disabled*.

The *monthly benefit* payable to you will be calculated as explained on page 40.

Waiver of Premium While on Claim Benefit

SUPER NON SUPER

We'll waive your premiums for Income Support Cover while we're paying you a *monthly benefit*.

Any premiums that you paid during your *waiting period* will also be refunded (refunds will be pro-rated if you pay your premiums annually).

Waiver of Premium While Involuntarily Unemployed Benefit

SUPER NON SUPER

If you become *involuntarily unemployed* (other than as a direct result of *illness* or *injury*), we'll waive your premium for up to three months over the life of your plan while you're unemployed.

To be eligible for the waiver, your Income Support Cover must have been in place for at least 12 consecutive months.

In order to apply for the waiver, you must notify us before your premium due date. You'll need to provide us with satisfactory evidence of your *involuntary unemployment*.

At the end of your waiver period, all premium payments will resume, unless you let us know otherwise. If the resumed premiums cannot be collected, your cover will be cancelled.

Important things to note

- You must be registered with an Australian government approved employment agency by the date you notify us that you want to exercise this benefit.
- The waiver is not available if you are self-employed.
- The wavier is only available if you're paying your premiums monthly and is only available in respect of future premiums (i.e. premiums that have not yet been paid by you).
- We'll waive premiums under this benefit for separate periods of *involuntary unemployment*, subject to a maximum of three months over the life of your plan.

Future Increase Benefit

SUPER NON SUPER

If your *regular income* increases, this benefit allows you to increase your *sum insured* and *superannuation sum insured* by up to 15%, without having to provide further medical evidence to us.

You may increase your *sum insured* on each plan anniversary, up until the plan anniversary immediately after you turn 55.

The increase allowed is the lesser of:

- 15% of your *sum insured*; and
- the actual increase in your *regular income*.

You may increase your *superannuation sum insured* in proportion to any increase you have made to your *sum insured* under this benefit.

This increase is in addition to any increase in cover as a result of the Indexation Benefit.

Important things to note

- You must request the increase within 30 days of your plan anniversary date.
- Any increase is subject to you providing financial evidence to support the increase amount and confirmation that you're actively at work at the time of the increase.
- The total of all increases to your *sum insured* and *superannuation sum insured* cannot exceed the original *sum insured* and *superannuation sum* insured at your cover commencement date.
- Maximum *sum insured* limits apply as outlined on page 38.
- The minimum increase is $250 per month.
- This benefit cannot be exercised if:
  - a claim is being paid under your plan, a claim is being assessed or you're eligible to make a claim under your plan or another NEOS Protection plan on your life; or
  - your cover is issued with a medical loading greater than 100%, as stated on your plan schedule.

Suspending Cover Benefit

SUPER NON SUPER

If you've held your cover for a continuous period of at least 12 months, you can suspend your cover due to hardship (and/or unemployment if cover is held in super) for a period of time. During this period, you'll not need to pay premiums, however you'll also be unable to make a claim in respect of any event, *illness* or *injury* that occurs during the suspension period.

To exercise this benefit, you must:

- notify us at least 30 days before the premium due date (monthly or annually) from which you wish to suspend your cover
- specify the length of the suspension period required (three, six, nine or 12 months); and
- provide us with evidence of hardship (or unemployment) that we deem satisfactory (acting reasonably).

At the end of your suspension period, we'll continue your cover and your premium payments will resume, unless you let us know otherwise. If the resumed premiums cannot be collected, then your cover will be cancelled.

Your cover may be suspended under this benefit for a maximum of 12 months over the life of your cover.

Indexation Benefit

SUPER NON SUPER

We'll automatically increase your *sum insured* and *superannuation sum insured* (if applicable), at each plan anniversary.

The rate of increase will be the percentage increase in the *Consumer Price Index (CPI)*.

The increase will be limited to a maximum of 5% when Income Support Cover is held inside superannuation or split across a superannuation plan and a non-superannuation plan.

Your premium will also be increased to reflect the increase in your *sum insured* and *superannuation sum insured*.

Your *sum insured* and *superannuation sum insured* will not be reduced if the percentage change in *CPI* is negative.

If you don't want the Indexation Benefit to apply, you'll need to let us know at least 30 days after the relevant plan anniversary. If you decline an increase, you'll not be excluded from being offered increases in future years.

You can request to remove the Indexation Benefit permanently from your cover at any time, however should you wish to have the Indexation Benefit restarted, we may require further information from you before agreeing to restart it.

The Indexation Benefit will not apply if, at the Plan anniversary date:

- we're paying you a *disability* benefit; or
- your cover is suspended under the Suspending Cover Benefit.

Relapse Benefit

SUPER NON SUPER

Benefit period to age 65

If you return to work on a full-time basis after receiving a Total Disability Benefit or Partial Disability Benefit, and you suffer a relapse of the same or related *illness* or *injury* within 12 months, your w*aiting period* will be waived and your *disability* claim will be treated as a continuation of the original claim.

If the relapse occurs after 12 months, then your *disability* claim will be treated as a new claim and require you to serve the full *waiting period*.

Benefit period two or five years

If you return to work on a full-time basis after receiving a Total Disability Benefit or Partial Disability Benefit, and you suffer a relapse of the same or related *illness* or *injury* within six months, the *waiting period* will be waived, and the *disability* claim will be treated as a continuation of the original claim.

If the relapse occurs after six months, then your *disability* claim will be treated as a new claim and require you to serve the full *waiting period*.

Important things to note

- If you make multiple claims for any one or related *illness* or *injury*, any periods of time on claim after the original period on claim, whether they are continuations of your original claim or new claims, will be considered part of the original *benefit period* and, for *benefit periods* of five years or less, be added together to determine when the *benefit period* expires.
- This means you will only be assessed for *total disability* or *partial disability* under your *regular occupation* and be eligible for the higher *monthly benefit* available during the first 24 months of your *benefit period* for a total cumulative period of 24 months across your original *disability* claim and any continuations and new claims for the same or related *illness* or *injury*.

Death Benefit

SUPER NON SUPER

If you die while this cover is in place, we'll pay a lump sum benefit equal to six times your *sum insured*, subject to a maximum of $50,000 across all income insurance covers held with us.

You don't have to be claiming a *disability* benefit at the time of your death to be eligible for this benefit.

Rehabilitation Benefit

SUPER NON SUPER

If we're paying you a Total Disability Benefit or Partial Disability Benefit, we'll pay the costs of your participation in a rehabilitation program approved by us, and/or for any equipment that we agree are needed for your rehabilitation.

The maximum amount payable under this benefit over the life of your cover is 12 times your *sum insured*. This benefit is payable in addition to any other benefit payable under your cover.

Important things to note

- If we're paying you a Total Disability Benefit or Partial Disability Benefit for cover held under a superannuation plan, we'll only pay for rehabilitation and/or equipment costs where we can pay the provider directly.
- If we're paying you a Total Disability Benefit or Partial Disability Benefit for cover held outside of superannuation, we'll pay any provider directly in the first instance and reimburse you for any approved costs where this is not possible.
- You must notify us before you commence any rehabilitation program or purchase any equipment and we must agree (acting reasonably) that these are for your rehabilitation.
- We'll not reimburse any expense that you're entitled to have reimbursed by another source or for expenses that we are not permitted to pay by law.

Elective Surgery Benefit

SUPER NON SUPER

A *monthly benefit* is payable if your *total disability* or *partial disability* is as a result of:

- elective surgery performed on the advice of a *medical practitioner*
- an operation to improve your appearance which was caused solely as a result of an *illness* or *injury*; or
- surgery to donate a body organ or bone marrow to another recipient.

This surgery must take place at least six months after your cover commencement or reinstatement date.

If you increased your *sum insured* in the 6 months prior to the elective surgery, then your *monthly benefit* will be determined based on the *sum insured* prior to that increase.

Optional benefits

The below optional benefits are available at an extra cost. If selected, they will be shown on your plan schedule.

Increasing Claim Option

SUPER NON SUPER

If we've paid you a Total Disability Benefit or a Partial Disability Benefit for 12 months or more, we'll increase your *pre-disability income, sum insured* and *superannuation sum insured* (if applicable) on the yearly anniversary of when benefits first become payable, for as long as we continue to pay you a benefit.

We'll increase your *pre-disability income, sum insured* and *superannuation sum insured* (if applicable) by the percentage change in the *Consumer Price Index (CPI)*.

Your *pre-disability income, sum insured* and *superannuation sum insured* (if applicable) will not be reduced if the percentage change in *CPI* is negative.

The increase will be limited to a maximum of 5% when a *monthly benefit* is being paid under Income Support Cover held inside superannuation.

When we stop paying the Total Disability Benefit or Partial Disability Benefit to you, any cover you continue to maintain will be based on the *sum insured* and *superannuation sum insured* which applied immediately prior to the end of your *total disability* or *partial disability* claim.

Superannuation Contribution Option

SUPER NON SUPER

This option allows you to insure up to an additional 10% of your *sum insured* as a *superannuation sum insured* to cover *statutory employer superannuation contributions* made to you.

Your *superannuation sum insured* is subject to a maximum of $2,000 per month and your combined *sum insured* and *superannuation sum insured* will never exceed $30,000 per month.

Any time we pay a Total Disability Benefit or Partial Disability Benefit, we'll pay a *monthly superannuation benefit* into a complying superannuation fund on your behalf.

We'll pay your *monthly superannuation benefit* to the superannuation fund from which a rollover of monies or deposit for the purposes of paying premiums originated. Where this is not possible or where a *monthly superannuation benefit* is payable under a non-superannuation plan, we'll pay your *monthly superannuation benefit* to a complying superannuation fund nominated by you.

You must provide us with instructions and any information we request (acting reasonably) to enable us to pay the *monthly superannuation benefit*.

Your *monthly superannuation benefit* is the lesser of:

- your *superannuation sum insured* multiplied by the proportion of your *sum insured* that you received as a *monthly benefit*; and
- $2,000 per month.

After the first 24 months of your *benefit period*, your *monthly superannuation benefit* will reduce due to the reduction in your *monthly benefit*.

Example calculations – receiving a Total Disability Benefit

Example 5

Totally disabled, for the first 24 months of the *benefit period*

A	*Monthly benefit* (if *totally disabled*)*		$6,640
B	*Sum insured*		$7,000
C	*Superannuation sum insured*		$700
D	*Monthly superannuation benefit*	**A** / **B** x **C**	**$664**

*See Example 1 for calculation of the *monthly benefit* for *total disability* for the first 24 months of the *benefit period*

Example 6

Totally disabled, after the first 24 months of the *benefit period*

A	*Monthly benefit* (if *totally disabled*)*		$5,520
B	*Sum insured*		$7,000
C	*Superannuation sum insured*		$700
D	*Monthly superannuation benefit*	**A** / **B** x **C**	**$552**

*See Example 2 for calculation of the *monthly benefit* for *total disability* after the first 24 months of the *benefit period*

Example calculations – receiving a Partial Disability Benefit

Example 7

Partially disabled with 60% *work capacity*, for the first 24 months of the *benefit period*

A	*Monthly benefit* (if *partially disabled*)*		$2,140
B	*Sum insured*		$7,000
C	*Superannuation sum insured*		$700
D	*Monthly superannuation benefit*	**A** / **B** x **C**	**$214**

*See Example 3 for calculation of the *monthly benefit* for *partial disability* for the first 24 months of the *benefit period*

Example 8

Partially disabled with 60% *work capacity*, after the first 24 months of the *benefit period*

A	*Monthly benefit* (if *partially disabled*)*		$1,020
B	*Sum insured*		$7,000
C	*Superannuation sum insured*		$700
D	*Monthly superannuation benefit*	**A** / **B** x **C**	**$102**

*See Example 4 for calculation of the *monthly benefit* for *partial disability* after the first 24 months of the *benefit period*

Adjustments

Your *monthly benefit* may be reduced if you receive *other payments*, which includes:

- any payments you receive or are entitled to receive in respect of your *injury* or *illness* under state, territory or federal legislation, or as damages under common law, for a loss of income, loss of earning capacity, or any other economic loss (including any benefits or payments for work injury damages), including but not limited to worker's compensation and motor accident claims
- any payments you receive or are entitled to receive in respect of your *injury* or *illness* from any other individual or group disability insurance policy, credit or mortgage insurance, or superannuation pension plans not disclosed at the commencement of the cover or when you applied to increase your cover
- any payments you receive or are entitled to receive from your employer, including but not limited to sick leave and similar payments (but excluding any amount treated as *post-disability income*); and
- any social security payments or other government grants you receive or are entitled to receive in respect of your *injury* or *illness*, to the extent permitted by law.

If the *other payment* is a lump sum payment, then for the purpose of the reduction, this will be treated as a series of 60 monthly payments, with each monthly payment equal to 1/60th of the lump sum payment.

Your *monthly benefit* will not be reduced by any benefits paid under NEOS Protection Life Cover, TPD Cover or Critical Illness Cover.

Example calculation – receiving a Total Disability Benefit

Example 9

Totally disabled, for the first 24 months of the *benefit period*

A	*Monthly benefit* (if *totally disabled*)*		$6,640
B	*Other payments*		$2,000
C	*Monthly benefit* (after adjustments)	A – B	**$4,640**

*See Example 1 for calculation of the *monthly benefit* for *total disability* for the first 24 months of the *benefit period*

We pay one benefit at a time

If you're *totally disabled* or *partially disabled* as a result of separate and distinct *illness* or *injuries*, only one *monthly benefit* is payable under your Income Support Cover. However, the *monthly benefit* payable will be the benefit that provides the highest payment to you.

Exclusions

No Income Support Cover benefit will be paid if your *illness* or *injury* giving rise to your claim (or your death in relation to a death benefit payment) is a result of or related to:

- anything that's specifically excluded on your plan schedule
- attempted suicide or an intentional, self-inflicted *injury*
- normal and uncomplicated pregnancy, miscarriage or childbirth. For the purpose of this exclusion, the following are not considered complications of pregnancy, childbirth or miscarriage:
  - multiple pregnancy
  - threatened or actual miscarriage
  - participation in an IVF or similar program; or
  - discomfort commonly associated with pregnancy such as morning sickness, backache, varicose veins, ankle swelling and bladder problems.
- your participation in criminal activity or any periods of incarceration
- a cessation or reduction in your performance of all, or some, of the duties of your *regular occupation* due to permanent or temporary banning, deregistration, suspension, disqualification or restriction of any license, registration or similar requirement of your employment or profession by any governing or industry body applicable to your trade, employment or profession
- war or an act of war (except in relation to a death benefit payment); or
- for any *illness* or *injury* that occurred before the Income Support Cover commencement date of which you were aware or someone in your position could have been expected to be aware (excluding any *illness* or *injury* that was disclosed to and accepted by us).

We'll also not pay for any reimbursement of expenses which are regulated by the National Health Act 1953 (Cth) or the Private Health Insurance Act 2007 (Cth).

If you become *totally disabled* or *partially disabled* while on sabbatical, maternity, paternity or long service leave and you have been on this leave for 12 consecutive months or more, no *monthly benefit* will be payable under Income Support Cover.

When Income Support Cover ends

Income Support Cover will end on the earlier of:

- the date we receive your request to cancel your cover
- your death
- the date we cancel your plan because premiums were not paid when due
- the date we avoid your cover (treat it as if it never existed) in accordance with our rights in relation to your duty to take reasonable care
- your retirement or other intentional permanent cessation of *gainful employment* (for reasons other than *total disability*)
- if this cover has been purchased inside superannuation, 30 days after you cease to be a member of the superannuation fund; and
- the plan anniversary immediately after you turn 65.

PREMIUMS AND OTHER COSTS

How much will it cost?

The cost of your plan depends on a range of factors, including:

- your cover types
- your *sum insured*
- the options you choose (including the *waiting period* and *benefit period* for Income Support Cover)
- your gender
- whether or not you smoke
- your occupation
- your premium frequency
- the length of time you hold your plan
- stamp duty and any other government charges; and
- whether you select stepped or level premiums.

During the assessment of your application, we may apply a premium loading (such as a percentage on top of the standard premium rate) as a result of your state of health, family history or pastimes at that time.

Each year we'll send you an annual anniversary notice outlining your premium payable.

Your premium type

The way we calculate your premium depends on the premium type you select. The premium type applying to each cover type is shown on your plan schedule.

Stepped premiums

With stepped premiums, we re-calculate your premium on each plan anniversary based on your age on that anniversary. Stepped premiums will generally increase each year in line with your increase in age and the increase in your *sum insured* and any *superannuation sum insured* as a result of the Indexation Benefit (if applicable).

Level premiums

With level premiums, we calculate your premium based on an age-based premium rate determined at your cover commencement date. Unless we change premium rates as described below, this rate will apply until the plan anniversary after you turn 65 (if you selected level premiums to age 65), or after you turn 70 (if you selected level premiums to age 70). After this time, stepped premiums will apply, which means your premium will increase each year in line with your age, possibly significantly with the first increase.

If your *sum insured* and/or any *superannuation sum insured* increases, including as a result of the Indexation Benefit, your premium for the increased amount will be based on your age at the date of increase.

Level premium are generally higher than stepped premiums during the initial years of your plan, but are lower in later years.

Can premium rates change?

The premium you pay may increase each year due to regular age increases (if you have stepped premiums as described above), if you increase your *sum insured* and/or *superannuation sum insured* (including through the Indexation Benefit), due to a reduction in the new cover reward discount, and as a result of any increase in tax, duty or charge introduced by government.

However, base stepped and level premium rates are guaranteed not to increase in the first three years following your plan commencement date.

After that, premium rates are not guaranteed, and we may increase or decrease your premium in the future, regardless of which premium type you select. Any change to premium rates will apply to all plans in a defined group. We'll not single out an individual plan.

If we change the premium rates, we'll write to you to let you know at least 30 days before the change takes effect.

Premium discounts

You may be eligible for a premium discount. We have three types of discounts:

- size discount – based on your *sum insured* and *superannuation sum insured* in dollar terms
- multi-benefit discount – if you take out a combination of eligible covers; and
- new cover discounts – temporary discounts for new customers who complete the application process.

The benefit of any discount will be reflected in your plan schedule and anniversary notice. We don't guarantee premium discounts, and we may remove or vary the current discounts under these terms.

Paying your premium

The following premium frequencies and payment methods are available.

Premium frequencies	Payment methods
• Monthly • Yearly	• Credit Card • Direct Debit

If you pay your premium monthly, we'll apply a premium frequency loading to your premium. This loading is a percentage of the annual premium and helps cover the costs of collecting your premium on a more frequent basis.

The frequency loading for paying monthly is 8% at the date this PDS was prepared.

If you stop paying your premiums

To ensure your cover continues, you must pay your premium when it's due. If you don't pay your premium within 30 days of the due date, we'll write to advise that your cover will be cancelled. If we cancel your plan, all cover will cease, and you'll be unable to make a claim for any event which occurs after the date cover stopped.

Plan reinstatement

If your plan is cancelled for non-payment of premiums, you may apply to us within 12 months to have it reinstated.

Reinstatement is subject to our approval process and you may need to provide updated medical evidence or information about your pastimes and occupation to us. As a result of this process, we may apply new exclusions or loadings to your plan/s. Any exclusion or loading previously placed on your plan, and the periods for which they applied, may also be reinstated.

Upon approval, all outstanding premiums will need to be paid. Your cover will commence on the reinstatement date. You will be unable to make a claim for any event which occurs between the date your cover stopped and the reinstatement date.

Government taxes and charges

Your premium may include allowances for current government charges and taxes including stamp duty. Stamp duty is either incorporated into your base premium rate or added as an additional charge. If it's an additional charge, it will be shown on your plan schedule.

We may pass on to you any applicable new, or increased, government taxes or charges. We'll write to you to let you know at least 30 days before the change takes effect.

Taxation information

The information provided in this section relates to cover held outside superannuation. It's general in nature, and based on our interpretation of the tax laws and rulings current at the date this PDS was prepared. Individual circumstances can be quite different, and the law may change, so we recommend that you speak with a taxation professional with respect to your own situation.

Type of cover	Tax treatment of premium	Tax treatment of benefit
Life Cover	Generally not deductible	Generally not assessable as income[+]
Total and Permanent Disability Cover (TPD)	Generally not deductible	Generally not assessable as income[+]
Critical Illness Cover	Generally not deductible	Generally not assessable as income[+]
Child Cover	Generally not deductible	Generally not assessable as income[+]
Income Support Cover	Generally deductible	Generally treated as assessable income

[+]Capital gains tax may apply if the benefit is paid to someone who is not the original owner of the plan, or it's paid to someone who is not a relative of the insured person (as defined for tax purposes).

Income Support Cover

The premium for your Income Support Cover will generally be deductible from your assessable income under Section 8-1 of the *Income Tax Assessment Act 1997* (Cth). Any benefit paid will generally be treated as income and taxed accordingly.

IMPORTANT INFORMATION

What we pay your financial adviser

We may pay your financial adviser a commission. Any amount paid is factored into the cost of your plan.

Your financial adviser will provide you with a Financial Services Guide and where applicable, a Statement of Advice, which will detail the benefits they receive for selling you your plan.

No cash value

The types of cover described in this PDS don't have a surrender value or a cash-in value at any point.

Risks

Before applying for any form of insurance, it's important to understand the potential risks. You should consider the below risks before making your decision to purchase a NEOS Protection plan.

- The cover type, or amount of cover, may not be appropriate for your needs (you should consider the options you select carefully).
- If you become unable to pay your premium in the future, your cover may be cancelled.
- If you don't disclose to us every matter that you think, or could reasonably be expected to know, is relevant to our decision to provide cover to you, we may avoid your cover or reduce the benefit amount payable.
- Should an exclusion apply to your plan, a benefit may not be paid to you.
- Premium rates are not guaranteed, and we may increase or decrease your premium in the future, regardless of which premium type you select.
- If some or all of your cover is held inside superannuation, you may be unable to access the benefit amount if you don't meet a condition of release under superannuation law.

Complaints

If you have a complaint about our service or your privacy, please contact our Dispute Resolution Officer on 1300 090 188 or via email at customerservice@neoslife.com.au.

Your feedback is valued. We'll acknowledge your complaint within 24 hours of receiving it and endeavour to resolve your complaint as soon as possible. If we're unable to resolve your complaint within 30 days from the date your complaint is lodged with us, we'll inform you of the reasons for the delay and ask for an extension. If you're not satisfied with the outcome of any complaint, then you can refer the matter to the Australian Financial Complains Authority (AFCA).

AFCA is an independent body providing financial services complaint resolution free to customers. You can contact AFCA as follows:

Australian Financial Complaints Authority

GPO Box 3,
Melbourne VIC 3001
Phone: 1800 931 678
Email: info@afca.org.au
Website: www.afca.org.au

Your privacy

We recognise the importance of protecting your personal information that is collected and used by us, and we will follow privacy practices and procedures to maintain your privacy and protect your information. At all times we will safeguard your personal information and that of any person insured under your plan, as required by the Privacy Act 1988.

Your consent

By applying for insurance with us, you will be consenting to the collection, use and disclosure of your personal information in the manner set out below. If we are not provided with the required information, we will not be able to provide you with a quote for the insurance, consider your application or provide you with any insurance.

Collection of personal information, including sensitive information

We only collect personal information that is needed to assist us in providing a service to you and your family. When you provide your personal information to us, you are consenting to its use in accordance with this policy. Generally, we keep a record of:

- personal information that identifies you, such as your name, date of birth and address, your financial institution details or credit card details, your vocational and your lifestyle pursuits
- sensitive information about you including, amongst other things, health information for the purposes of assessing applications and claims under life insurance products. We will obtain your consent before we collect sensitive information about you, unless we are otherwise permitted by law to make the collection; and
- information from other service providers we use in the insurance application process and administration of your life insurance cover such as medical practitioners, pathologists, and other service providers we utilise for the purposes of assessing your insurance application and managing any claim.

We will collect personal information, including sensitive information, directly from you, or from your nominated treating doctor or other health provider. If we need to collect personal or sensitive information from third parties (such as the service providers mentioned above), we will ask for your consent to do so.

We don't ordinarily return, respond to, or store unsolicited personal information that we receive.

Use and disclosure of personal information

We will only use or disclose personal information that you provide to us for:

- the purpose of assessing and providing your insurance cover and managing your plan including any claims
- another purpose which has been disclosed to you, with your consent; or
- if we are required or authorised by law to do so.

Following your consent, we may disclose your personal and sensitive information to the appointed service providers where this information will assist with processing your insurance application and any changes you seek to make to it. You can also request that we disclose information to another person on your behalf, including your financial adviser, solicitor, accountant, executor, administrator, trustee, guardian or attorney.

We will take reasonable steps to ensure that these third parties are also bound by the Privacy Act confidentiality and non-disclosure principles, and are prohibited from using your personal information for any other purpose than those described in this privacy policy. However, we will not accept responsibility for the unauthorised use of personal information by third parties.

We may also disclose your personal information to our related companies.

Marketing

We may also use your information to inform you about any other products and services offered or promoted by us. In order to do this, we may disclose your personal information on a confidential basis to such other licensed distributors that we may choose to do this through.

You may call or write to us at any time to let us know that you do not want to receive any further marketing communications from us.

Privacy Policy

Our Privacy Policy contains information about how you may access personal information held by us and how you can seek correction of such information. It also contains information about how you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint.

You may obtain a copy of our Privacy Policy from www.neoslife.com.au

GENERAL PLAN CONDITIONS

Changing the plan owner

You may apply to transfer the ownership of your plan to another person, subject to relevant law, including superannuation law, by requesting and completing a Memorandum of Transfer form (which must be signed by you and the transferee) and sending it to us with your plan schedule.

Notices

You can contact us on 1300 090 188 or via email at customerservice@neoslife.com.au. Any notice you give us under your plan will be effective from the date your call or email is received by a customer service agent. In circumstances where we require you to send us a notice in writing (including via email) we will inform you of this.

Any notice which we give you must be in writing, and will be sent to the last contact address you provided (including email address). The notice will be effective from the date it is posted or emailed to you.

Variations to your plan

Subject to the following and the section, 'Guaranteed upgrade of benefits' on page 6 of this PDS, any variation made to your plan which affects your benefits, must be agreed to by us and you. Any agreement by us will be made to you in writing.

However, there are circumstances when we may unilaterally vary this plan. This can occur:

- as a result of any changes in the law or our regulatory requirements; or
- if the variation is not prejudicial to you.

Any unilateral variation of your plan will apply to all plans in a defined group. You'll be notified in writing at least 30 days before any new condition applies.

Replacement cover

In the instance that your plan, or a cover type issued under your plan, replaces existing cover with us, or cover with another insurer, your cover with us is conditional upon the existing cover being cancelled. If your cover under the existing plan is not cancelled prior to a claim arising under this plan, we'll reduce any amount payable by us by the amount received under the plan that was to be replaced.

CLAIMS

Notifying us of a claim

We're here, along with your financial adviser, to support you through the claims process. If you think you're eligible to make a claim or are unsure and would like some assistance, it's important that you, or your financial adviser, contact us as right away. We'll then explain the claims process and requirements, so we can get your claim underway as soon as possible.

You should notify us of a claim in a timely manner unless it is impractical to do so. If our assessment has been compromised by a delay in you notifying us of your intention to claim, your claim or benefit payment may be delayed, prevented or reduced. If we reduce your claim or benefit payment due to a delay in your claim notification, we will do so by an amount that proportionally represents the extent to which our interests were prejudiced as a result of the delay.

Payment of premiums

An event giving rise to a claim must occur while your cover is in place. Benefit payments will only be made, start to accrue or continue to accrue, when cover is in place.

It's important to continue paying your premiums while your claim is being assessed to ensure your cover is not cancelled.

General claim requirements

To enable us to assess liability for your claim we may need financial, medical, vocational and other relevant information, or an examination or assessment by a person nominated by us. Where we reasonably need information, an examination or assessment, we will confirm the need and purpose of the request with you and will require your cooperation.

To help support your claim we may also need the following (including certified copies where appropriate):

- a completed claim form
- your plan schedule
- proof of the event which resulted in a claim being made
- proof of payment, when a claim for reimbursement is being made
- proof of age (unless previously provided)
- proof of probate and a death certificate for all Death Benefit claims; and
- an interview with our representative.

If we need an examination or assessment, we'll pay for the cost. However, costs which you may incur as a result of completing claim forms or providing financial information to us, is payable by you.

Medical requirements

We must be satisfied of our liability before a benefit can be paid. Depending on the type of claim and your individual circumstances, you may be required to provide or undertake the following:

- an examination by a *medical practitioner* from our panel of providers. This may involve imaging studies and clinical, histological and laboratory evidence
- an examination by an appropriate *specialist medical practitioner* registered in Australia or New Zealand (or other country approved by us), who is not you, the insured person (if different), your partner or spouse, or their partner or spouse; and/or
- proof that a surgical procedure was medically necessary and was the usual treatment for the underlying condition.

For Terminal Illness Benefit claims, two *medical practitioners* must certify the extent and prognosis of the *illness* or *injury*; one being the *medical practitioner* who is a specialist practising in an area related to the *illness* or *injury* and treating the condition and the other being a *medical practitioner* nominated by us. Both *medical practitioners* must confirm your diagnosis and life expectancy.

For Income Support Cover claims, you'll be required to provide an initial medical attendants report or equivalent medical information and ongoing medical certificates and information or evidence which are to be provided at intervals reasonably necessary to enable us to assess the impact of your *illness* or *injury* on your *work capacity*.

For Critical Illness Event, Partial Critical Illness Event or Child Critical Illness Event claims, if the medical diagnostic techniques and/or investigations used in the critical illness definitions have been superseded due to medical advancements, we will consider other appropriate and medically recognised methods or tests ('alternative diagnostic techniques') used to investigate and diagnose the condition to at least the same level of severity.

For us to consider alternative diagnostic techniques, they:

- must, based on medically acceptable standards, be generally recognised in Australia by *medical practitioners* who are specialists practicing in an area related to the relevant *illness* or *injury* as an appropriate investigative or diagnostic technique for that *illness* or *injury*; and
- must not be experimental and must be medically equivalent or superior to the diagnostic technique or investigation referenced in the definitions.

Financial requirements

For Income Support Cover claims, you'll need to provide documents verifying your *regular income*, *passive income* and *ongoing business income* as stated in the application and for periods before and after the event which gave rise to your claim, as often as is reasonably required for us to confirm our liability for your claim.

These documents may include business and personal taxation returns, profit and loss statements, other financial statements and audit documents regarding your business and personal financial circumstances.

For Income Support Cover Super claims, you'll be required to provide proof of income in order to comply with SIS regulations.

Following advice of a Medical Practitioner

Claim payments will be dependent on you following the reasonable advice of a *medical practitioner*. This includes:

- following, and actively participating in, a recommended course of treatment and rehabilitation for any conditions for which the claim is being made
- complying with reasonable requests for occupational therapy, retraining and accepting reasonable job modifications that would allow a return to work; and
- actively participating in recommended return to work trials or job placements.

If you travel or reside outside Australia while receiving benefit payments, payments will only continue if, in travelling or residing outside Australia, you're following the advice of the treating *medical practitioner*. In this instance, you should advise your case manager in advance of your travel start date.

If you're outside of Australia when the event giving rise to your claim occurs, your entitlement to claim may be suspended if we're unable to appraise the medical opinion or data needed to assess your claim. As a result, you may have to return to Australia in a reasonably timely manner for medical assistance before your claim can be assessed.

Your obligation regarding disability duration and severity

In providing you your plan, we've contracted to insure you for the agreed cover set out in your plan schedule. While we've accepted the risks associated with any potential loss, you also have an obligation to mitigate your loss. You must not knowingly contribute to the severity or longevity of your disablement, or your claim may not be accepted.

We may reduce or decline to pay benefits during any period, or periods, of *total disability* or *partial disability* caused by failure to seek and follow medical advice or treatment. We'll waive this requirement if, in the opinion of the *medical practitioner* or *specialist medical practitioner* (where required), continued or future treatment would be of no benefit.

Confirmation of information provided in your application for insurance

In the assessment of your claim, we may confirm the accuracy of information you provided; in your application for insurance, a request to reinstate your insurance, or a request to make any other changes to the insurance, in order to verify your entitlement to the insurance cover, re-instatement of cover, or other change to cover.

We will advise you if this is required and this may include information of a medical, financial, vocational or other relevant nature where reasonable in the circumstances.

We may require written authorities from you, permitting third parties, (e.g., other insurers, doctors, medical practices, hospitals, other health service providers, accountants, former employers, Medicare and other relevant third parties) to provide us with information to confirm your entitlement to the insurance cover, re-instatement of cover, or other change to cover.

Fraudulent claims

If you fraudulently make a claim we may reduce or decline to pay you benefits and we may cancel your plan.

Payment of your claim

If you're legally competent to apply for a claim and your claim is approved, all benefits will be paid to you or your legal personal representative. In the event that you're judged not legally competent, we'll pay the benefits to whomever we're legally permitted to make payments.

You may nominate beneficiaries to receive the claim proceeds if a benefit is payable due to your death. We will pay your death benefit in such proportions as nominated by you. A beneficiary nomination form can be obtained at our website, or by calling us.

If the plan is owned by a trustee of a complying superannuation fund, and your claim is accepted, all benefits will be paid to the trustee.

We'll not be liable to you for any loss you suffer (including consequential loss) caused by the fact that we're required by law to delay, block, freeze or refuse to process a transaction.

If cover is provided under Income Support Cover, and a claim is made for a period of *disability* of less than one month, your benefit will be paid on a pro-rata basis. The payment will be made at a rate of 1/30th of the *monthly benefit* for each day you're *totally disabled* or *partially disabled*.

Misstatement of information

If your age, gender, weight, smoking status or occupation has been incorrectly provided and the premium paid is lower than required, any claim payments that are subsequently made will be reduced. If we would not have provided cover had the correct information been provided, we may make other changes to your plan, including cancelling your cover. Refer to page 11 for more information on your duty to take reasonable care.

If the premium paid is higher than required, any overpaid premiums will be refunded.

If your date of birth has been incorrectly provided and the expiry date of your plan would have been different, then we may vary your plan by changing its expiry date to the date it would have been had you provided the correct date of birth to us.

DIRECT DEBIT SERVICE AGREEMENT

Definitions

Account means the account held at your financial institution from which we're authorised to arrange for your premium to be debited.

Agreement means the direct debit service agreement between you and us.

Banking day means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.

Debit day means the day that your premium payment is due to us.

Debit payment means a particular transaction where a debit is made to your account.

Direct debit request means the direct debit request you've provided to us.

Premium means the premium payable for the cover provided by your NEOS Protection plan at the debit day.

We/us/our means NobleOak (or any subsequent insurer of the insurance product).

You/your means the person who provided the direct debit request to us.

Your financial institution is the financial institution where you hold the account that you have authorised us to debit.

Debiting your account

By providing a direct debit request, you have authorised us to arrange for funds to be debited from your account for the purpose of paying the premium on your NEOS Protection plan. You should refer to the direct debit request and this agreement for the terms of the arrangement between us and you.

We will only arrange for funds to be debited from your account for payment of the premium as authorised in the direct debit request. The amount of the premium may vary from time to time. We will not notify you of this variation unless we're required to do so under the terms and conditions of your NEOS Protection plan.

We will not issue a billing notification prior to debiting your account. If the debit day falls on a day that is not a banking day, we may direct your financial institution to debit your account on the following banking day. If you're unsure about which day your account has or will be debited, you should ask your financial institution.

Changes by us

We may vary any details of this agreement or a direct debit request at any time by giving you at least 14 days written notice.

Changes by you

You may change the arrangements under a direct debit request by contacting us subject to:

- if you wish to stop or defer a debit payment you must notify us at least seven days before the next debit day. This notice should be given to us in the first instance;
- you may also cancel your authority with us to debit your account at any time by giving us at least seven days' notice before the next debit day. This notice should be given to us in the first instance.

You may also cancel a direct debit request by contacting your financial institution.

Your obligations

It's your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the direct debit request.

If there are insufficient clear funds in your account to meet a debit payment:

- you may be charged a fee and/or interest by your financial institution
- you may also incur fees or charges imposed or incurred by us; and
- you must arrange for the debit payment to be made by another method, or arrange for sufficient clear funds to be in your account by an agreed time, so that we can process the debit payment.

You should check your account statement to verify that the amounts debited from your account are correct.

If we're liable to pay goods and services tax ("GST") on a supply made in connection with this agreement, then you agree to pay us on demand an amount equal to the consideration payable for the supply, multiplied by the prevailing GST rate.

Disputes

If you believe that there has been an error in debiting your account, you should notify us as soon as possible so that we can resolve your query.

If we conclude as a result of our investigations that your account has been incorrectly debited, we will respond to your query by arranging for your financial institution to adjust your account (including interest and charges) accordingly. We will also notify you of the amount by which your account has been adjusted.

If we conclude as a result of our investigations that your account has not been incorrectly debited, we will respond to your query by providing you with reasons and any evidence for this finding.

Any queries you may have about an error made in debiting your account should be directed to us in the first instance so that we can attempt to resolve the matter between us and you. If we cannot resolve the matter you can still contact your financial institution, which will obtain details from you of the disputed transaction and may lodge a claim on your behalf.

Accounts

You should check:

- with your financial institution whether direct debiting is available from your account, as direct debiting is not available on all accounts offered by financial institutions
- your account details which you provided to us are correct by checking them against a recent account statement; and
- with your financial institution before completing the direct debit request if you have any queries about how to complete the direct debit request.

Confidentiality

We will keep any information (including your account details) in your direct debit request confidential. We will make reasonable efforts to keep any such information that we have about you secure, and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

We will only disclose information that we have about you:

- to the extent specifically required by the law; or
- for the purposes of this agreement (including disclosing information in connection with any query or claim).

Notices

If you wish to notify us about anything relating to this agreement, our contact details are below.

Where we're providing you with notification in writing, we'll send the notice via email.

Change of life insurer

If we cease to be the insurer of the life insurance cover provided by NEOS Protection as a result of the insurance being transferred to another registered life insurer, then in order for premium payments to continue, the authorities provided to us under your direct debit request will be transferred to the new insurer without the need for your consent.

Providing instructions

Your direct debit request may be provided to us in writing, by calling us or by such other electronic means that we choose to accept from time to time.

Unless we require otherwise, instructions from you in connection with this agreement (including any change to the account to which your direct debit request applies) may be provided to us in writing, by calling us or by e-mail.

Contact us

Phone: 1300 090 188

Email: customerservice@neoslife.com.au

Website: www.neoslife.com.au

Mail: GPO Box 239, Sydney NSW 2001

Hours: Monday to Friday 8:00am – 6:00pm EST

COMPLIMENTARY INTERIM ACCIDENT COVER

Within this section 'you' and 'your' refers to the plan owner or the person to be insured, as the context requires.

Interim Accident Cover is designed to provide you with limited cover while your application is being assessed by us.

Your Interim Accident Cover will start as soon as we receive:
- your fully completed application form
- a completed personal statement; and
- a completed premium deduction authority.

Your Interim Accident Cover will cease on the earliest of:
- 90 days after commencement of the Interim Accident Cover
- the date your plan is issued
- when you withdraw your application, or it's declined or deferred by us; and
- if our request for further information is not answered within 14 days.

If you have an accident that makes you eligible to receive a benefit under Interim Accident Cover, and the cover being applied for is to replace existing cover, we'll reduce the interim benefit by the amount payable under your existing cover.

Life Interim Accident Cover

If you've applied for Life Cover, we'll pay the Life Interim Accident Cover benefit if you die as a direct result of an *injury* (or injuries) caused by an *accident*. To be eligible for this benefit, both the *accident* and your death must have occurred while you were covered by Life Interim Accident Cover, and death must have occurred within 90 days of the *accident*.

Total and Permanent Disability (TPD) Interim Accident Cover

If you've applied for TPD Cover, we'll pay the TPD Interim Accident Cover benefit if, solely because of an *injury* (or injuries) caused by an *accident*, you become *totally* and *permanently disabled*. To be eligible for this benefit, the *accident* must have occurred while you were covered by TPD Interim Accident Cover, and it must have resulted in your *disability* which causes you to become TPD within 90 days of the *accident*.

Your claim will be assessed against the TPD definition applied for in your application, provided we would normally offer that definition based on your circumstances and occupation.

Critical Illness Interim Accident Cover

If you've applied for Critical Illness Cover, we'll pay the Critical Illness Interim Accident Cover if, solely because of an *injury* (or injuries) caused by an *accident*, you suffer a covered Critical Illness Event. To be eligible for this benefit, the *accident* must have occurred while you were covered by Critical Illness Interim Accident Cover, the Critical Illness Event must have occurred within 90 days of the *accident* and, you must survive at least 14 days following the Critical Illness Event. The Critical Illness Events covered include:
- *major head trauma (with significant permanent neurological impairment)*
- *paralysis (total and permanent)*
- *blindness (total and irrecoverable)*
- *loss of hearing (total and irrecoverable)*
- *severe burns (covering at least 20% of the body's surface area)*
- *loss of speech (total and irrecoverable); and*
- *loss of use of limbs (total and irrecoverable).*

Income Support Interim Accident Cover

If you've applied for Income Support Cover, we'll pay the Income Support Interim Accident Cover benefit if, solely because of an *injury* (or injuries) caused by an *accident* you become *totally disabled*. To be eligible for this benefit, the *accident* must have occurred while you were covered by Income Support Interim Accident Cover, and *total disability* must have occurred within 90 days of the *accident*.

How much we will pay

For Life Cover, TPD Cover and Critical Illness Cover, the benefit payable is the lesser of:
- the amount applied for
- $1,000,000; and
- the amount that would have been approved under our underwriting and assessment guidelines.

For Income Support Cover, the *monthly benefit* payable is the lesser of:
- the amount applied for
- $5,000 per month; and
- the amount that would have been approved under our underwriting and assessment guidelines.

You'll receive this benefit for each month that you're *totally disabled* after the end of the *waiting period* you applied for, up to a maximum of 12 *monthly benefit* payments.

Exclusions

An Interim Accident Cover benefit will not be paid:

- for any *illness*
- for any *accident* that first occurred prior to your application date
- for any reason that would make you ineligible for that particular cover type
- for suicide, attempted suicide or any intentional, self-inflicted act
- for war or an act of war (whether declared or not); and
- for any other exclusion that we would have applied through our usual underwriting and assessment guidelines.

If a claim is made under Interim Accident Cover, this will be taken into account when assessing your application and we may decline your application on this basis.

COMPLIMENTARY INTERIM ROLLOVER COVER

Within this section 'you' and 'your' refers to the plan owner or the person to be insured, as the context requires.

Interim Rollover Cover is designed to provide you with limited cover while we are waiting for your nominated superannuation fund to transfer premiums to us by rollover.

All claims will be subject to the terms and conditions of the applicable NEOS Protection cover you applied for and will be reduced by any amount paid under Interim Accident Cover.

Interim Rollover Cover applies to:

- Life Cover, TPD Cover and/or Income Support Cover which you have applied for and which is to be paid by rollover of monies from your nominated superannuation fund; and
- Critical Illness Cover which you have applied for when this is linked to Life Cover which is to be paid by rollover of monies from your nominated superannuation fund.

Interim Rollover Cover does not apply where the NEOS Protection cover you applied for is replacing cover on another life insurance policy that is still in force.

Your Interim Rollover Cover will start as soon as we:

- notify you that we intend to provide NEOS Protection cover, including confirmation of the *sum insured* and any optional benefits and exclusions which would apply to your issued plan; and
- have received everything we need to issue the plan for the applicable cover(s), including superannuation fund premium payment details.

For clarity, you are only provided with Interim Rollover Cover on the terms described, for those covers (Life Cover, TPD Cover, Critical Illness Cover and/or Income Support Cover) you have applied for and which we have notified you that we intend to provide.

Your Interim Rollover Cover ceases on the earliest of:

- the date your plan is issued
- when you withdraw your application; and
- 30 days after commencement of the Interim Rollover Cover.

Life Interim Rollover Cover

If you die while covered by Life Interim Rollover Cover, we will pay the NEOS Protection Life Cover benefits which would have been payable to you if your plan had been issued at the time the Interim Rollover Cover commenced, based on the *sum insured*, optional benefits and any exclusions that would apply to your issued cover. We will pay any Life Interim Rollover Cover benefits to your estate.

Total and Permanent Disability (TPD) Interim Rollover Cover

If you suffer *total and permanent disability* while covered by Total and Permanent Disability Interim Rollover Cover, we will pay the NEOS Protection TPD Cover benefits which would have been payable to you if your plan had been issued at the time the Interim Rollover Cover commenced, based on the *sum insured*, optional benefits and any exclusions that would apply to your issued cover. We will pay any TPD Interim Rollover Cover benefits to the person to be insured.

Critical Illness Interim Rollover Cover

If you suffer a Critical Illness Event not marked with a ^ while covered by Critical Illness Interim Rollover Cover, we will pay the NEOS Protection Critical Illness Cover benefits which would have been payable to you if your plan had been issued at the time the Interim Rollover Cover commenced, based on the *sum insured*, optional benefits and any exclusions that would apply to your issued cover. We will pay any Critical Illness Interim Rollover Cover benefits to the person to be insured.

Income Support Interim Rollover Cover

If you suffer *total disability* or *partial disability* while covered by Income Support Interim Rollover Cover we will pay the NEOS Protection Income Support Cover benefits which would have been payable to you if your plan had been issued at the time the Interim Rollover Cover commenced, based on the *sum insured*, optional benefits and any exclusions that would apply to your issued cover. We will pay any Income Support Interim Rollover Cover benefits to the person to be insured. From the plan commencement date, benefits will be paid to the plan owner.

GENERAL DEFINITIONS

Accident
Means a random and unforeseen event that results in loss, damage or harm, independent of all other causes.

Activities of daily living
Means all of the following five activities:

- Dressing – the ability to put on and take off all garments and medically-necessary braces or artificial limbs usually worn, and to fasten and unfasten them, without the standby assistance of another person
- Toileting – the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing without the standby assistance of another person
- Bathing – the ability to wash oneself either in the bath or shower or by sponge bath, without the standby assistance of another person
- Eating – the ability to get nourishment into the body by any means once it has been prepared and made available without the standby assistance of another person; and
- Transferring – the ability to move in and out of a chair or bed without the standby assistance of another person.

Any occupation
Means any occupation for which you are reasonably suited or capable of performing based on education, training or experience, including any education, training or experience which has been acquired through occupational rehabilitation programs, re-skilling, retraining or employment during any period on claim.

Australian resident
Means a person who is an Australian or New Zealand citizen, an Australian permanent resident or holder of a temporary 457 working visa or equivalent (as approved by the Department of Immigration and Citizenship), who is residing in Australia at the time of the application.

Benefit period
Means the maximum period that we'll pay a *monthly benefit* in relation to any one or related *illness* or *injury*.

If your benefit period is five years or less, you can only claim one full benefit period for any one or related *illness* or *injury*.

Blindness (total and irrecoverable)
Means the *loss of sight (permanent)* in both eyes.

Confined to bed
Means you're hospitalised for at least three consecutive days, or a *medical practitioner* has certified that you need to be continuously confined to bed for at least three consecutive days, and the continuous care of a registered nurse is required.

Congenital condition
Means a condition present at birth as a result of either hereditary or environmental influences.

Consumer Price Index (CPI)
Means the consumer price index as defined and published by the Australian Bureau of Statistics (or any body which succeeds it), being a weighted average of the eight Australian capital cities combined, for successive 12-month periods, finishing on 30 September each year and applicable from the next calendar year.

Current ongoing business income
Means the *ongoing business income* earned by you during the month of *disability* for which a *monthly benefit* is being calculated.

Current passive income
Means the average monthly *passive income* earned by you for the consecutive 12-month period immediately preceding the date of your *disability* and as periodically reassessed while on claim.

Where current passive income is equal to or less than 10% of your *pre-disability income*, this will be deemed as zero for the purposes of calculating your *total monthly income* and *monthly benefit*.

Disability/disabled
This refers to *total disability* or *partial disability* as the context implies.

Gainfully employed and gainful employment
Means to be employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment.

Illness
Means an *illness* or disease.

Injury
Means an *injury* to the body caused by an *accident*.

Immediate family member
Means spouse, child, sibling, parent, father in-law or mother in-law, de facto partner, or person in a bona fide domestic living arrangement who is financially interdependent.

Important income producing duties
Means the duties of your occupation which can be considered primarily essential to producing your income and which:
- are normally required for the purposes of your occupation
- do not include exceptional duties which are not normally required to perform your occupation; and
- cannot be reasonably omitted, modified or substituted by you or, where applicable, your employer.

Income replacement amount
Has the meaning described on page 40 of this PDS.

Involuntarily unemployed or involuntary unemployment
Means that you become unemployed due to retrenchment, redundancy or if your employer is in administration or liquidation.

For the avoidance of doubt, involuntarily unemployed excludes retirement, resignation, unsuccessful probation period, unpaid leave, voluntary redundancy, the end of a fixed term contract or dismissal from employment, or early completion of a project.

Key person
Means an employed person who is essential to the economic prosperity of the business in which he or she is employed.

Limb
Means an arm, leg, hand or foot. In respect of this definition, the hand or foot starts from the wrist or ankle joint, respectively.

Loss of sight (permanent)
Means the total and irrecoverable loss of sight (whether aided or unaided) in an eye, as a result of *illness* or *injury* to the extent that visual acuity in the eye, on a Snellen Scale after correction by a suitable lens is less than 6/60, or to the extent that the visual field is reduced to 10 degrees or less of arc.

For clarity:
- Any loss of sight that is reversible through treatment or visual aids, including (but not limited to) cataracts, is excluded as it would not be considered irreversible.
- Visual acuity is reduced to at least 6/60 means that even with the use of visual aids, you need to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.
- Visual field is reduced to at least 10 degrees of arc means that your field of vision is less than 10 degrees in diameter.

Loss of use of limbs (total and irrecoverable)
The total and irrecoverable loss of use of two or more *limbs*.

Loss of use of a single limb (total and irrecoverable)
Means the total and irrecoverable loss of use of one *limb*.

Loss of independent existence (permanent and irreversible)
Means *significant cognitive impairment* or permanent and irreversible inability to perform any two of the *activities of daily living* without the standby assistance of another person.

Monthly benefit
Means the actual amount payable to you each month during a claim. The monthly benefit is payable monthly in arrears.

Monthly superannuation benefit
Means the actual amount payable to your nominated superannuation fund each month during a claim. The monthly superannuation benefit is payable monthly in arrears.

Medical practitioner
Means a medical practitioner who is legally qualified and registered to practice in Australia (or if outside Australia, has the equivalent medical qualifications and is approved by us as having such qualifications) that is not you, the plan owner or an *immediate family member* or business partner of you or the plan owner.

Note: chiropractors, physiotherapists and alternative therapy providers are not regarded as medical practitioners.

Normal domestic duties
Means all of the following activities, unassisted by another person:
- Cleaning the home – the ability to carry out basic internal household chores using various tools such as a mop or vacuum cleaner
- Cooking meals – the ability to prepare meals using basic ingredients and normal kitchen appliances
- Washing laundry – the ability to do laundry by using the washing machine and being able to hang clothes on a washing line or clothes airer
- Shopping for groceries – the ability to physically purchase general household grocery items with either the use of a shopping basket or trolley; and
- Taking care of children (where applicable) – if you normally look after a child or children up to the age of 12 as part of your everyday activities, taking care of dependent children means the ability to care for and supervise the children, including preparation of meals, bathing, dressing and getting the children to and from school by the usual mode of transport.

Normal domestic duties do not include duties performed outside of your home for salary, reward or profit.

Ongoing business income
Means any income, profits or other remuneration that has not been treated as *regular income* and that you continue to receive or are entitled to receive from any current or former business, including any related entities, in which you have had any ownership.

Other payments
Has the meaning described on page 50 of this PDS.

Own occupation
Means the most recent occupation that you were engaged in immediately prior to the date of your *total and permanent disability*.

Partial disability and **partially disabled**
Has the meaning as described on page 42 of this PDS.

Passive income
Means income which you receive that is not income earned from personal exertion, working or from the conduct of a business. Passive income includes income such as interest, dividends, net rental income, ongoing contractual royalties, annuities, or other similar income.

Post-disability income
Means the *regular income* earned by you during the month of *disability* for which a *monthly benefit* is being calculated.

Pre-disability income
Means your average *regular income* for the consecutive 12-month period immediately preceding the date of your *disability*.

If you are self-employed and not earning a readily identifiable monthly salary or wage amount, we may determine your pre-disability income based on your average *regular income* for the latest financial year preceding the date of your *disability*.

If you're not *gainfully employed*, or are on sabbatical, maternity, paternity or long service leave immediately preceding the date of your *disability*, or at any time during the 12-month period above, pre-disability income is based on your average *regular income* earned in the consecutive 12-months prior to when that period of unemployment or leave commenced.

If you're not *gainfully employed*, or have been on sabbatical, maternity, paternity or long service leave for more than 12 months immediately preceding the date of your disability, no *monthly benefit* will be payable.

Where your income is subject to material monthly or seasonal variation, we may choose (acting reasonably) to use a longer assessment period, up to 24 months, to assess your average *regular income*.

Regular income
If you're self-employed or a working director, regular income is your share of the gross monthly income generated by the business, or professional practice, as a result of your personal exertion less your share of the allowable business expenses necessarily incurred in generating that income.

If you're not self-employed or a working director, regular income is your gross monthly income earned from personal exertion by way of total remuneration package including salary, regular overtime, salary sacrifice amounts, bonuses, commissions, share of profits and other fringe benefits. Bonuses, commissions, share of profits and other similar payments will only be included if they are reliably recurrent, in which case they will be spread over the period to which they relate and capped so that they comprise no more than 30% of your regular income.

In each case:
- regular income does not include *passive income, ongoing business income* or any *statutory employer superannuation contributions*
- where your income includes large amounts or amounts that are not reliably recurrent in nature, such as bonuses, redundancy payments, over-time, one-off transaction fees, proceeds from the sale of assets, or income which are large amounts not usual for your work or which are not reasonably considered recurring amounts, these will be excluded from your regular income
- if there is a delay between the time you generate your income and when you receive it, we will deem your income to have been received in the month in which it was generated; and
- your regular income will be limited to what we expect you can earn by working no more than 50 hours per week.

Regular occupation
Means the occupation in which you were working immediately prior to the *illness* or *injury* causing *disability*, unless you:
- were working in that occupation for less than ten hours a week; or
- were unemployed or on sabbatical, long service, maternity or paternity leave for more than 6 months,

in which case regular occupation will be *any occupation*.

If you had been working in more than one occupation that meets the above criteria, your regular occupation will include all of those occupations.

Regular occupation is not restricted to mean your occupation or employment with your employer at the date of your *disability*.

Regular work hours

Means the typical weekly hours you worked, and were paid for, throughout the period in which your *pre-disability income* is determined. Where your claim is being assessed against your ability to perform your *regular occupation*, the maximum work hours we'll consider is 50 paid hours per week. Where your claim is being assessed against your ability to perform *any occupation*, the maximum work hours we'll consider is 40 paid hours per week.

Significant cognitive impairment

Means a total and permanent deterioration, or loss of intellectual capacity, to the extent that you require ongoing continuous care and assistance by another adult to perform any of the *activities of daily living*. Severe cognitive decline must be confirmed by formal neuropsychological testing by a *specialist medical practitioner*.

Specialist medical practitioner

Means a *medical practitioner* who practices in a specialty field and is listed on the Australian Health Practitioner Regulation Agency (AHPRA) Specialist Register who is not you, the plan owner or an *immediate family member* or business partner, employee or employer of you or the plan owner.

Statutory employer superannuation contributions

Means the actual monthly superannuation contributions paid or payable by your employer, including from your business or professional practice if you are self-employed or a working director, as required by law. This does not include voluntary superannuation contributions made by you or your employer above the minimum required by law.

Suitable work

For the first 24 months of your *benefit period*, suitable work means your *regular occupation*. After the expiry of the first 24 months of your *benefit period*, suitable work means *any occupation*.

Sum insured

Means the amount of cover you're insured for, as shown in your plan schedule.

Superannuation sum insured

Means the amount of cover you're insured for under the Superannuation Contribution Option, as shown in your plan schedule.

Terminal illness and terminally ill

Means that:

- a *medical practitioner* who is a specialist practising in an area related to the relevant *illness* or *injury* certifies that you suffer from an *illness*, or have incurred an *injury*, that is likely to result in your death within 24 months of certification; regardless of any reasonable medical treatment that may be undertaken; and
- after consideration of the medical evidence, we (acting reasonably) agree with that prognosis.

When Life Cover is structured inside superannuation, you must also satisfy the SIS definition of *Terminal Medical Condition* (see below under Superannuation Definitions).

We may ask you to provide additional evidence to allow us to verify the prognosis, including by attending an assessment by, or providing information to, additional *medical practitioners* selected by us.

Total and permanent disability and totally and permanently disabled

Any occupation TPD

If the 'any occupation' definition applies to your TPD Cover, then *total and permanent disability* means that as a result of *illness* or *injury*, you:

- have been absent from, and unable to work, for three consecutive months; and
- are disabled at the end of these three consecutive months, in our opinion (acting reasonably) after consideration of medical and any other evidence, to such an extent that you're unlikely to be able to engage in any occupation ever again:
  - for which you're reasonably suited by education, training or experience; and
  - which is likely to generate a *regular income* of at least 25% of your average *regular income* in the 12 months prior to your claim.

OR

- suffer at least 25% permanent whole person impairment as defined in the American Medical Association publication, 'Guides to the Evaluation of Permanent Impairment', 6th Edition, or an equivalent guide to impairment approved by us; and
- are disabled to such an extent that you're unlikely be able to engage in any occupation ever again:
  - for which you're reasonably suited by education, training or experience; and
  - which is likely to generate a *regular income* of at least 25% of your average *regular income* in the 12 months prior to your claim.

OR

- are totally and permanently unable to perform at least two of the five *activities of daily living* without the physical assistance of another person.

OR

- suffer:
  - *blindness (total and irrecoverable)*
  - *loss of use of limbs (total and irrecoverable);* or
  - *loss of sight (permanent)* and *loss of use of a single limb (total and irrecoverable).*

OR

- have been solely performing *normal domestic duties* for more than 12 consecutive months immediately prior to the *illness* or *injury* that gave rise to your claim and:
- you haven't been able to perform the *normal domestic duties* for three consecutive months; and
- in our opinion (acting reasonably) after consideration of medical and any other evidence, you're incapacitated to such an extent that you're unlikely ever to be able to perform all of the *normal domestic duties* again.

Own occupation TPD

If the '*own occupation*' definition applies to your TPD Cover, then *total and permanent disability* means that as a result of *illness* or *injury*, you:

- have been absent from and unable to work in your *own occupation* for three consecutive months; and
- are disabled at the end of these three consecutive months, in our opinion (acting reasonably) after consideration of medical and any other evidence, to such an extent that you're unlikely to be able to engage in your *own occupation* ever again.

OR

- suffer at least 25% permanent whole person impairment as defined in the American Medical Association publication, 'Guides to the Evaluation of Permanent Impairment', 6th Edition, or an equivalent guide to impairment approved by us; and
- are disabled to such an extent that you're unlikely to be able to engage in your *own occupation* ever again.

OR

- are totally and permanently unable to perform at least two of the five *activities of daily living* without the physical assistance of another person.

OR

- suffer:
  - *blindness (total and irrecoverable)*
  - *loss of use of limbs (total and irrecoverable);* or
  - *loss of sight (permanent)* and *loss of use of a single limb (total and irrecoverable).*

OR

- have been solely performing *normal domestic duties* for more than 12 consecutive months immediately prior to the *illness* or *injury* that gave rise to your claim and:
- you haven't been able to perform the *normal domestic duties* for three consecutive months; and
- in our opinion (acting reasonably) after consideration of medical and any other evidence, you're incapacitated to such an extent that you're unlikely to be able to perform all of the *normal domestic duties* again.

Super TPD

If the 'super' definition applies to your TPD Cover, then *total and permanent disability* means that as a result of *illness* or *injury*, you:

- have been absent from, and unable to work, for three consecutive months; and
- are disabled at the end of these three consecutive months, in our opinion (acting reasonably) after consideration of medical and any other evidence, to such an extent that you're unlikely to be able to engage in any occupation ever again for which you're reasonably suited by education, training or experience.

OR

- suffer at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 6th edition, or an equivalent guide to impairment approved by us; and
- are disabled to such an extent that you're unlikely to be able to engage in any occupation ever again for which you're reasonably suited by education, training or experience.

OR

- are totally and permanently unable to perform at least two of the five *activities of daily living* without the physical assistance of another person; and
- are disabled to such an extent that you're unlikely to be able to engage in any occupation ever again for which you're reasonably suited by education, training or experience.

OR

- suffer:
  - *blindness (total and irrecoverable)*
  - *loss of use of limbs (total and irrecoverable)*; or
  - *loss of sight (permanent)* and *loss of use of a single limb (total and irrecoverable)*; and

are disabled to such an extent that you're unlikely to be able to engage in any occupation ever again for which you're reasonably suited by education, training or experience.

OR

- have been solely performing *normal domestic duties* for more than 12 consecutive months immediately prior to the *illness* or *injury* that gave rise to the claim and:
  - you haven't been able to perform the *normal domestic duties* for three consecutive months; and
  - in our opinion (acting reasonably), after consideration of medical and any other evidence, you're incapacitated to such an extent that you:
    - are unlikely to be able to perform all of the *normal domestic duties* again; and
    - are disabled to such an extent that you're unlikely to be able to engage in any occupation ever again for which you're reasonably suited by education, training or experience.

When cover is structured through superannuation, you must also satisfy the definition of *permanent incapacity* as defined by the *Superannuation Industry (Supervision) Act (SIS) 1993* or the *Superannuation Industry (Supervision) Regulations 1994* (as applicable).

Total monthly income

Has the meaning described on page 40 of this PDS.

Totally disabled and total disability

Has the meaning described on page 42 of this PDS.

Waiting period

Has the meaning described on page 41 of this PDS.

Work capacity

Means our assessment (acting reasonably) of your capacity to work in *suitable work* expressed in hours per week. In performing this assessment, we'll take into consideration:

- available medical evidence (including the opinion of your medical practitioner) and other relevant evidence related to your medical condition (including information provided by you); and
- the extent to which you can perform the *important income producing duties* of you *regular occupation* or *any occupation*, as applicable, without substantial risk of exacerbating your *illness* or *injury*.

For the purpose of the assessment of work capacity, we will not consider non-medical factors such as the availability of suitable employment.

Superannuation definitions

The following definitions have been reproduced from SIS. You should be aware that if any of these definitions are changed in SIS, the corresponding definition reproduced here will be obsolete and replaced by the amended definition in SIS.

Permanent incapacity

Permanent incapacity in relation to a member of a superannuation fund means ill-health (whether physical or mental), where the trustee is reasonably satisfied that the member is unlikely, because of their ill-health, to engage in *gainful employment* for which the member is reasonably qualified by education, training or experience.

Temporary incapacity

Temporary incapacity in relation to a member of a superannuation fund who has ceased to be *gainfully employed* (including a member who has ceased temporarily to receive any gain or reward under a continuing arrangement for the member to be *gainfully employed*), means ill-health (whether physical or mental) that caused the member to cease to be *gainfully employed* but does not constitute *permanent incapacity*.

Terminal medical condition

Terminal medical condition exists in relation to a member of a superannuation fund at a particular time if the following circumstances exist:

- two registered *medical practitioners* have certified, jointly or separately, that you suffer from an *illness*, or have incurred an *injury*, that is likely to result in your death within a period (the certification period) that ends not more than 24 months after the date of the certification
- at least one of the registered *medical practitioners* is a specialist practicing in an area related to the *illness* or *injury* suffered by you; and
- for each of the certificates, the certification period has not ended.

Critical illness definitions

Adult onset insulin dependent diabetes mellitus diagnosed after age 30

The diagnosis after the age of 30 of Type 1 diabetes mellitus for which insulin is required for survival.

Aortic surgery (thoracic and abdominal aorta excluding its branches)

Surgery to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or traumatic *injury* to the aorta. For the purpose of this definition, aorta means the thoracic and abdominal aorta, but not its branches.

Aplastic anaemia (requiring specified treatment)

Bone marrow failure, which results in anaemia, neutropenia and thrombocytopenia requiring specified treatment, with at least one of the following:

- blood product transfusions
- marrow stimulating agents
- immunosuppressive agents; or
- bone marrow transplantation (including stem cell transplantation).

Benign brain tumour (resulting in irreversible neurological deficit)

A non-cancerous tumour in the brain, resulting in an irreversible neurological deficit which has caused:

- a permanent impairment of at least 25% of the *whole person function*; or
- you to be totally and permanently unable to perform any one of the *activities of daily living* without the standby assistance of another person.

The presence of the underlying tumour must be confirmed by CT scan, MRI or other imaging studies.

Blindness (total and irrecoverable)

The *loss of sight (permanent)* in both eyes.

Cancer (excluding early stage cancers)

The presence of one or more malignant tumours, including lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders that are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue beyond the basement membrane.

The following cancers are excluded:

- Tumours which are histologically described as premalignant or show the malignant changes of *carcinoma in situ* (including cervical dysplasia, HSIL, LSIL, CIN III and lower).
- Carcinoma in situ of the breast, unless a procedure is required for:
  - the removal of the entire breast; or
  - there is breast conserving surgery together with radiotherapy or chemotherapy.

  These procedures must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment.
- Carcinoma in situ of the testicle, unless a procedure is required for the removal of the entire testicle. The procedure must be performed specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment.
- Melanomas, unless:
  - there is evidence of metastases
  - the melanoma is at least Clark level 3
  - the melanoma is showing signs of ulceration; or
  - the melanoma is greater than 1.0mm maximum thickness as determined by examination using the Breslow method.
- All hyperkeratosis, intraepidermal carcinomas, basal cell carcinomas and squamous cell carcinomas of skin, unless it has spread to other organs.
- Chronic lymphocytic leukaemia less than Rai stage 1.
- Prostatic cancers which are TNM Classification T1a, T1b or less, and have a Gleason score of less than 6. Prostatic cancer which is TNM classification T1a, T1b or less, and which has a Gleason score of less than 6, are covered if major interventionist therapy including radiotherapy, chemotherapy, biological response modifiers or any other major treatment has been required to arrest the spread of malignancy.

Cancer (in children, excluding early stage cancers)

The presence of one or more malignant tumours, including lymphoma (including Hodgkin's and non Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders that are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue beyond the basement membrane.

The following cancers are excluded:

- tumours which are histologically described as premalignant or show the malignant changes of carcinoma in situ (including cervical dysplasia, HSIL, LSIL, CIN III and lower);
- Melanomas, unless:
  - there is evidence of metastases
  - the melanoma is at least Clark level 3
  - the melanoma is showing signs of ulceration; or
  - the melanoma is greater than 1.0mm maximum thickness as determined by examination using the Breslow method.
- all hyperkeratosis, intraepidermal carcinomas, basal cell carcinomas and squamous cell carcinomas of skin unless it has spread to other organs; and
- chronic lymphocytic leukaemia less than Rai stage 1.

Carcinoma in situ

A carcinoma in situ is characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method or FIGO Stage 0.

Only carcinoma in situ of the following sites are covered:

- breast
- cervix uteri (excluding Cervical Intraepithelial Neoplasia (CIN) classifications including CIN-1 and CIN-2)
- corpus uteri
- fallopian tube (the tumour must be limited to the tubal mucosa)
- ovary
- penis
- perineum
- prostate
- testicle
- vagina; and
- vulva.

Note: FIGO refers to the staging method of the Fédération Internationale de Gynécologie et d'Obstétrique.

Cardiomyopathy (permanent and irreversible)

A disease of the heart muscle causing the heart muscle to enlarge and become weaker, resulting in significant permanent and irreversible cardiac impairment to the degree of at least Class 3 of the New York Heart Association functional classification system.

Chronic kidney failure (requiring transplantation or dialysis)

End-stage renal failure presenting as chronic irreversible failure of both kidneys to function, resulting in renal transplantation or the permanent requirement for renal dialysis.

The definition will also be met if, despite the need for renal transplantation or permanent requirement for renal dialysis as confirmed by a *specialist medical practitioner*, you choose renal supportive care.

Chronic liver failure (resulting in permanent symptoms)

End stage liver failure resulting in permanent jaundice (yellow discolouration of the skin or eyes), ascites (abnormal build-up of fluid in the abdomen) and/or encephalopathy (a decline in brain function that occurs as a result of severe liver disease).

Chronic lung failure (requiring long-term oxygen therapy)

Any lung condition causing a stable daytime arterial blood pressure of 55mmHg (7.3kPA) or less at rest; or end-stage lung disease requiring long-term oxygen therapy.

Coma (of specified severity and duration)

A state of unconsciousness with no reaction to external stimuli or internal needs, resulting in a documented Glasgow Coma Scale of 8 or less, for a continuous period of at least 72 hours.

Coronary artery angioplasty

The actual undergoing of coronary artery angioplasty to correct a narrowing or blockage of one or more coronary arteries.

Coronary artery bypass surgery

Bypass grafting performed to correct or treat coronary artery disease.

Dementia including Alzheimer's disease (permanent and irreversible with severe cognitive impairment)

The unequivocal diagnosis of dementia by a *specialist medical practitioner*. The diagnosis must confirm dementia or Alzheimer's Disease due to permanent and irreversible failure of brain function with associated severe cognitive impairment.

Severe cognitive impairment means a Mini-Mental State Examination score of 24 or less out of 30, or an equivalent level of deterioration assessed under another clinically-appropriate cognitive assessment instrument.

Diagnosed benign brain tumour

A non-malignant tumour of the central nervous system, including:

- tumours of the brain and spinal cord
- meningiomas
- cranial nerve tumours; and
- pituitary tumours treated surgically by non-transphenoidal techniques.

The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.

Early stage chronic lymphocytic leukaemia

The presence of chronic lymphocytic leukaemia diagnosed as Rai Stage 0, which is defined to be in the blood and bone marrow only.

Early stage melanoma (excluding melanoma in situ)

The presence of one or more malignant melanomas of 1.0mm or less maximum thickness with no evidence of ulceration, as determined by histological examination using the Breslow method. Melanoma in situ is excluded.

Early stage prostate cancer

The presence of a tumour confined within the prostate, which is histologically described as TNM Classification T1a or T1b, or a Gleason Score of less than 6, where major medical interventionalist therapy is not required.

Encephalitis and meningitis (resulting in significant permanent neurological impairment)

The unequivocal diagnosis of encephalitis or meningitis where the condition is characterised by severe inflammation of the brain, or the meninges of the brain, resulting in permanent neurological impairment causing:

- at least a permanent 25% impairment of *whole person function*; or
- you to be totally and permanently unable to perform any one of the *activities of daily living* without the standby assistance of another person.

Heart attack (with evidence of heart muscle damage)

The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following:

- signs and symptoms of ischaemia (inadequate blood supply to the heart muscle) consistent with a heart attack
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB])
- development of pathological Q waves in the ECG; or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, other appropriate and medically recognised tests will be considered.

The following are not covered:

- a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease; and
- other acute coronary syndromes including, but not limited to, angina pectoris.

Heart valve surgery

Surgery to replace or repair a cardiac valve as a consequence of a cardiac valve abnormality or a cardiac aneurysm or other cardiac defects.

Loss of hearing (total and irrecoverable)

The total and irrecoverable loss of hearing, both natural and assisted (except by Cochlear implant), in both ears as a result of *illness* or *injury*.

Loss of hearing in one ear (permanent)

The total and irrecoverable loss of hearing in one ear, both natural and assisted, as a result of *illness* or *injury*.

Loss of independent existence (permanent and irreversible)

Significant cognitive impairment or permanent and irreversible inability to perform any two of the *activities of daily living* without the standby assistance of another person.

Loss of sight in one eye (total and irrecoverable)

The *loss of sight (permanent)* in one eye.

Loss of speech (total and irrecoverable)

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 to the speech centres of the brain, due to *illness* or *injury*.

Loss of use of limbs (total and irrecoverable)
The total and irrecoverable loss of use of two or more *limbs*.

Loss of use of a single limb (total and irrecoverable)
The total and irrecoverable loss of use of one *limb*.

Major head trauma (with significant permanent neurological impairment)
Accidental head *injury* resulting in neurological impairment causing:
- at least a permanent 25% impairment of *whole person function*; or
- you to be totally and permanently unable to perform any one of the *activities of daily living* without the standby assistance of another person.

For the purposes of this definition, the meaning of accidental head injury includes a bump, blow or jolt to the head, or a penetrating head injury.

Major organ transplant (of specified organs from a human donor, or placement on a waiting list)
Either the undergoing of, or upon the advice of a *specialist medical practitioner* the placement on a waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit for the human to human transplant from a donor to you of:
- bone marrow; or
- one of the following organs or a permanent mechanical replacement of one of the following organs:
  - kidney
  - heart
  - lung
  - liver
  - pancreas; or
  - small bowel.

The transplant of all other organs, parts of organs or any other tissue transplant is excluded.

Medically-acquired HIV (contracted from a medical procedure or operation)
Accidental infection, after the commencement of your NEOS Protection plan, with the human immunodeficiency virus (HIV) where the virus was acquired in Australia by you from one of the following medically necessary events conducted by a recognised and registered health professional:
- a blood transfusion
- transfusion with blood products
- organ transplant
- assisted reproductive techniques; or
- a medical procedure or operation performed by a *medical practitioner* or dentist.

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

HIV infection transmitted by any other means including sexual activity or the use of drugs, other than as prescribed by a *medical practitioner*, is excluded.

This Critical Illness Event will not apply, and no payment will be made, when a cure has become available or where you don't take any vaccine available prior to the Critical Illness Event. 'Cure' means an Australian Government-approved treatment, which renders the HIV inactive and non-infectious, or results in there being little or no impact on life expectancy.

'Vaccine' means a preparation approved by the Australian Government and recommended for use by the Government authority to produce immunity to the HIV.

Meningococcal Disease (resulting in significant permanent impairment)
The unequivocal diagnosis of meningococcal septicaemia resulting:
- in at least a permanent 25% impairment of *whole person function*; or
- you being totally and permanently unable to perform any one of the *activities of daily living* without the standby assistance of another person.

Multiple sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities)
A disease characterised by demyelination in the brain and/or spinal cord. Multiple sclerosis must be unequivocally diagnosed. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities.

Neurological investigations such as MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, evoked auditory responses and the presence of oligo-clonal bands within cerebrospinal fluid (CSF) in accordance with the 2017 McDonald Criteria are required to confirm diagnosis.

Muscular dystrophy
The unequivocal diagnosis of muscular dystrophy.

Occupationally-acquired hepatitis B or C

Infection, after the commencement of your NEOS Protection plan, with hepatitis B or C when the infection is acquired as a result of:

- an *accident* arising out of your normal occupation; or
- a malicious act of another person, or persons, arising out of your normal occupation.

Proof of a new hepatitis B or C infection must be registered within six months of the *accident* or malicious act.

Any incident giving rise to a potential claim must:

- be reported to the relevant authority or employer
- be reported to us with evidence substantiating the occurrence and nature of the incident; and
- be supported by a negative hepatitis B or C test taken within seven days of the incident.

We encourage you to report any incident giving rise to a potential claim to us within 30 days.

The infection must manifest itself within six months of the *accident* or malicious act. The infection must not have arisen from a deliberately, self-inflicted or induced cause, or from sexual activity (whether as part of normal occupational duties or otherwise), or from the use of drugs not medically prescribed to you.

This Critical Illness Event will not apply, and no payment will be made, where a cure has become available or where a medical treatment is developed and approved which makes these viruses inactive and non-infectious. 'Cure' means an Australian Government-approved treatment which renders hepatitis B or hepatitis C (as applicable), inactive and non-infectious, or results in there being little or no impact on life expectancy.

Hepatitis B or C infection transmitted by any other means, including sexual activity or recreational intravenous drug use is excluded.

Occupationally-acquired HIV

Infection with the human immunodeficiency virus (HIV) where such infection arose from an *accident* relating to your occupation, subject to the following conditions:

- the *accident* must have occurred after the commencement of your NEOS Protection plan; and
- proof of its occurrence must be registered with us including:
  - tests taken by a *medical practitioner* within seven days of the *accident* which resulted in a sero-negative HIV result; and
  - documents confirming any relevant authority was notified at the time of the *accident*.

We encourage you to report an accident giving rise to a potential claim to us within 30 days.

The infection must manifest itself as a sero-positive HIV test result within six months of the reported occurrence. The infection must not have arisen from a deliberately, self-inflicted or induced cause or from sexual activity (whether as part of normal occupational duties or otherwise), or from the use of drugs not medically prescribed to you.

We reserve the right to obtain independent tests and investigations, including the taking of blood samples.

This Critical Illness Event will not apply, and no payment will be made, where a cure has become available or where you don't take any vaccine available prior to the Critical Illness Event. 'Cure' means an Australian Government-approved treatment which renders the HIV inactive and non-infectious, or results in there being little or no impact on life expectancy.

'Vaccine' means a preparation approved by the Australian Government and recommended for use by the Government authority to produce immunity to the HIV.

Open heart surgery

The undergoing of open chest surgery for the surgical treatment of a cardiac defect, cardiac aneurysm or benign cardiac tumour.

Out of hospital cardiac arrest (excluding medical procedures)

A loss of cardiac output that is not associated with any medical procedure and is due to:

- cardiac asystole; or
- ventricular fibrillation with or without ventricular tachycardia.

The cardiac arrest must occur outside of a hospital and be documented by electrocardiogram.

Paralysis (total and permanent)

The total and permanent loss of function of two or more *limbs* through *illness* or *injury* causing permanent damage to the nervous system. This includes, but is not limited to, quadriplegia, paraplegia, diplegia and hemiplegia.

Parkinson's disease (permanent)

The unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of the following:

- rigidity (extreme stiffness or resistance with passive movement of the major joints whilst in a relaxed position)
- tremor (involuntary trembling of the body or limbs); and
- akinesia (loss or impairment of the power of voluntary movement),

resulting from the degeneration of the nigrostriatal system.

All other types of Parkinsonism are excluded (e.g. secondary to medication).

Pneumonectomy (total)

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

Pulmonary Arterial Hypertension (idiopathic and familial)

The unequivocal diagnosis of pulmonary arterial hypertension which is either:

- idiopathic (from a spontaneous or unknown cause); or
- familial (inherited or genetic)

with right ventricular enlargement (enlarged right side of the heart muscle) established by investigations including cardiac catheterisation.

Progressive and debilitating motor neurone disease

The unequivocal diagnosis of a progressive form of debilitating motor neurone disease.

Prolonged intensive care

An *illness* or *injury* that has resulted in you requiring continuous mechanical ventilation by means of tracheal intubation for ten consecutive days (24 hours per day), in an authorised intensive care unit of an acute care hospital.

No amount will be paid where intensive care is the result of the consumption of alcohol or the use of non-prescribed drugs.

Severe burns (covering at least 20% of the body's surface area)

Tissue *injury* caused by thermal, electrical or chemical agents causing third degree full thickness or deep partial thickness burns, to at least:

- 20% of the body surface area as measured by the Lund and Browder Body Surface Chart
- 50% of both hands, requiring surgical debridement and/or grafting; or
- 50% of the face, requiring surgical debridement and/or grafting.

Severe Crohn's disease (requiring permanent immunosuppressive medication)

The unequivocal diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, which requires permanent immunosuppressive medication.

Severe ulcerative colitis (requiring permanent immunosuppressive medication)

The unequivocal diagnosis of ulcerative colitis that has failed to be controlled by standard therapy including cortisone treatment, which requires permanent immunosuppressive medication.

Severe diabetes

A certified consultant endocrinologist has confirmed that at least two of the following complications have occurred as a direct result of diabetes:

- severe diabetic retinopathy resulting in visual acuity (whether aided or unaided) and corrected of 6/36 or worse in both eyes
- severe diabetic neuropathy causing motor and/or autonomic impairment
- diabetic gangrene leading to surgical intervention; or
- severe diabetic nephropathy causing chronic irreversible renal impairment as measured by a corrected creatinine clearance less than 28ml/min (CKD stage 4, International Chronic Kidney Disease classification).

Severe rheumatoid arthritis (with significant impairment)

Diagnosis of rheumatoid arthritis, confirmed by appropriate radiology and blood tests, that has failed to respond to all treatment regimens including, but not limited to, immunosuppressive and biological agents, causing permanent reduction of at least 25% to *whole person function*;

OR

The unequivocal diagnosis of severe rheumatoid arthritis by a Rheumatologist, supported and evidenced by at least a six-week history of severe rheumatoid arthritis, which involves three or more of the following joint areas:

- proximal interphalangeal joints in the hands
- metacarpophalangeal joints in the hands
- metatarsophalangeal joints in the foot; and
- wrist, elbow, knee, or ankle.

Degenerative osteoarthritis and all other arthritides are excluded.

Stroke (resulting in neurological deficit)

A cerebrovascular event producing neurological deficit. This requires clear evidence on a CT, MRI or similar, appropriate scan or investigation that a stroke has occurred and of infarction of brain tissue, intracranial and/or subarachnoid haemorrhage. Transient ischaemic attacks, non-stroke related reversible neurological deficit, cerebral symptoms due to migraine, cerebral *injury* resulting from critical *illness* or hypoxia and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Subacute sclerosing panencephalitis

The unequivocal diagnosis of this disorder.

Triple Vessel Angioplasty

The actual undergoing for the first time of coronary artery angioplasty to correct a narrowing or blockage of three or more coronary arteries within the same procedure. In the event that not all coronary arteries can be corrected in a single procedure and a second procedure is required, a benefit will be payable provided the second procedure occurs no more than two months after the first.

To find out more about NEOS, please visit our website at: www.neoslife.com.au

For assistance, please contact us on the below details:

Customer service
Phone: 1300 090 188
Email: customerservice@neoslife.com.au

Claims
Phone: 1300 090 188
Email: claims@neoslife.com.au