Mortgage Protector. Policy terms and conditions.

Your cover in detail.

1. The contract.

This Policy is the contract between **you** and **us**. The Policy consists of:

- The application form and all declarations **you** have provided
- These Policy terms and conditions
- The cover wordings for each cover **you** have selected shown on the **policy schedule**
- The **policy schedule**

This Policy terms and conditions details the terms and conditions applying to the covers included in this Policy and should be read together with the **policy schedule** and cover wordings.

The **policy schedule** includes:

- Who owns this Policy (**you**)
- Who's insured (**insured person**)
- The cover(s) for each **insured person**
- The cover(s) and options **you** have selected
- The amount of cover (**sum insured/monthly benefit**)
- Any special terms and conditions
- Other details of **your** Policy

Each cover has built-in benefits and can have additional options **you** may have selected to include in a cover. If **you** have selected an additional option for an **insured person's** cover, the **policy schedule** will show which additional options apply.

Any special terms and conditions that apply to an **insured person's** cover will be included on the **policy schedule**. The special terms and conditions in the **policy schedule** are in addition to the standard terms and conditions and override anything else in this Policy that is inconsistent with them.

You may request a replacement copy of any of these documents from **us**.

2. Free look period.

If **you** aren't satisfied with this Policy **you** may cancel it by writing to **us** within 14 days of receiving the Welcome pack, provided no claim is made. **You** will receive a full refund of any premium **you** have paid.

If **you** add a cover or option to this Policy or increase a **sum insured/monthly benefit** after its **start date** and are not satisfied with the change(s), **you** can reverse the change(s) within 14 days of receiving notification from **us** confirming the change(s) have been made. **We** will refund the additional premium relating to those change(s) provided no claim has been made.

3. Definitions.

The words shown in **bold** in this Policy have the meanings described in section 11 Definitions and the General definitions section of each cover shown on the **policy schedule**.

4. Premiums.

You must pay the premiums when due.

4.1 Premium payments.

a. **We** will calculate the initial premium for each cover that applies to **your** Policy. **Your** total initial premium payable is calculated from the **insured person's** personal details such as age, gender, smoking status and current state of health.

b. It also includes administration and insurance costs including any premium loading that may apply, any benefits or options **you** have selected, any discount that may apply, fees and relevant taxes.

c. **We** may also charge **you** a policy fee. The policy fee is shown on the **policy schedule**.

d. Unless **we** have agreed in advance that **you** can pay the premium in instalments, **you** must pay the premium at the **start date** of each cover and then on each **policy anniversary**.

e. If the premium is payable by instalments, **we** will deduct any instalments overdue from any benefit payments.

f. **We** allow 35 days of grace after payment of a premium falls due.

g. If **we** don't receive the total premium due within the days of grace, **we** will cancel this Policy. **We** will send written notice of this cancellation to **you** at **your** last known address in **our** records. **Our** cancellation is effective regardless of whether **you** receive it.

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h. **We** may reinstate this Policy within one year after the date of the overdue payment if **you** request it and may alter its terms based on **our** underwriting assessment and premium rates at the time.

5. Change to premium and the policy fee.

5.1 Change to premium.

We can change the premiums for each cover at a **policy anniversary**. There can be a variety of reasons for **us** doing this. For example, **we** can do this because:

- of the age of the **insured person**,
- the law changes affecting the terms and conditions of this Policy or the premium rates,
- **we** increase the **sum insured/monthly benefit** as a result of the CPI option unless it is declined by **you**, and/or
- **our** claims experience or costs are different from expected.

5.2 Policy fee.

We may change the policy fee for all policies from time to time at a **policy anniversary**. If this happens, **we** will give **you** at least 30 days' notice before **we** change the policy fee.

5.3 Premium rate commitment.

We won't change our premium rates for an existing cover for an individual **insured person** because of a change in **their** health or personal circumstances. New premium rates can apply because of a change in **their** health or personal circumstances to a cover added after the **start date** or a cover is reinstated.

5.4 Where you increase the sum insured/monthly benefit.

If **you** choose to increase an **insured person's sum insured/monthly benefit** by exercising a cover's Special events option or **you** apply for an increase in the **sum insured** or **monthly benefit** for an **insured person**, **we** will increase the premiums. **We** will advise **you** of the increased premium amount before **we** apply the increase.

5.6 Premium freeze.

You can apply to **us** in writing to freeze **your** premiums so that they don't increase each year. If **we** freeze **your** premiums, the **sum insured/monthly benefit** will decrease for each cover every **policy anniversary** from the date the premium is frozen. The decrease will be calculated by **us** using the age of each **insured person** at the **policy anniversary**.

Conditions.

a. The Policy must have been in place for at least 12 consecutive months.

b. Each **insured person**, other than an insured **child**, must be over age 30 when this premium freeze is applied.

c. **Our** minimum premium requirements will apply to the premium.

d. The CPI option on the covers with the premium freeze will end while **we** are applying this premium freeze.

e. Premium freeze is not available if this Policy or a cover is suspended.

6. Cover renewability pledge.

The cover will automatically renew at each **policy anniversary** until that cover ends for any reason, provided **you** pay the premium due.

7. CPI option.

The **policy schedule** will show if the CPI option applies and which **insured person's** cover it applies to.

We will automatically increase an **insured person's sum insured/monthly benefit** on each **policy anniversary**, unless **you** advise **us** otherwise, by the greater of:

- 2%, or
- an amount **we** determine each year based on the **consumer price index**.

We will send **you** a renewal letter before each **policy anniversary** advising **you** of the new **sum insured/monthly benefit** and the new premium. **You** must advise **us** before each **policy anniversary** if **you** don't require that increase. If **you** decline an increase it won't affect future CPI option increases. Any increases **you** decline are not carried forward to future **policy anniversaries**.

We will adjust the premium to reflect the increased **sum insured/monthly benefit**, including any additional premium loading(s) for medical, occupation or pastime reasons that apply to the cover the CPI option is being applied to.

You do not need to provide any additional health, occupation or pastimes information for an **insured person** for a CPI option increase.

8. Claim conditions applying to all covers.

8.1 Complying with policy.

Before **we** meet any claim under this Policy, **you** and all **insured persons** must:

- comply with this Policy, and
- pay all premiums due, and
- always give true, accurate and complete information to **us**.

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8.2 Proof of claim.

Your claims will be assessed and managed by **us**.

You must provide **us** proof an insured event has occurred and the date of birth for the **insured person** who has suffered the insured event, before **we** pay any claim.

Please refer to each cover section in this Policy for more information about the claim requirements.

8.3 Fraud.

If **you** or any **insured person** is dishonest or fraudulent in any way in relation to a claim under a cover, **we** may:

- decline the claim in part or in full, and/or
- cancel the cover or this Policy from the date **we** determine the fraud has occurred.

If **we** cancel the cover or this Policy due to fraud, **we** may retain all premiums paid for the period before the fraud occurred.

8.4 Requests for information to support a claim.

You and the **insured person** must provide all the information **we** reasonably request. If not, **we** may not pay a claim or stop paying a claim until the information is provided.

8.5 Payment of benefits.

We make payments in New Zealand currency and will pay **you** (or **your** legal representative named in a document such as **your** probated will, letters of administration or enduring power of attorney).

If **we** pay you more than **you** are entitled to under any cover, **you** will be required to repay **us**. If **you** owe **us** money for any reason, **we** may take it into account when calculating **your** benefit payments.

9. Transfer of policy ownership, transfer of payment rights, nominated beneficiary.

9.1 Transfer of policy ownership.

You can change one or all of the **policy owners** by completing a Transfer of policy ownership form. When **you** do this the previous **policy owner/s** give/s up all rights to the Policy and the new owner/s assume/s all contractual rights and obligations under the Policy.

9.2 Transfer of payment rights.

You can transfer **your** rights to receive a benefit under a cover shown on the **policy schedule** by completing a Transfer of payments rights form. The transferees **you** name in the form is/are the person/s **you** have instructed **us** to pay based on the latest Transfer of payments rights form received by **us**. All **policy owners** must sign the Transfer of payment rights form.

The latest Transfer of payment rights form **we** have on **our** file will replace any previous Transfer of payment rights forms. When **you** transfer payment rights **you** are still a **policy owner** and the insurance contract continues between **you** and **us**.

9.3 Nominated beneficiary.

If **your** Policy includes Life cover, **you** can nominate a beneficiary for **us** to pay a Life cover claim to by completing a Nominated beneficiary form.

The latest Nominated beneficiary form **we** have on **our** file will replace any previous Nominated beneficiary forms. When **you** nominate a beneficiary, **you** are still a **policy owner** and the insurance contract continues between **you** and **us**.

9.4 Effective date and obtaining forms.

The transfer of policy ownership, transfer of payment rights and nominated beneficiary become effective from the later of the date **you** nominate in the form, or the date **we** register the transfer. **We** must receive the form before the date of an event resulting in a claim.

You can obtain the Transfer of policy ownership, Transfer of payment rights and Nominated beneficiary forms by contacting **us**.

10. Other terms.

10.1 Cancellation.

a. **You** may cancel this Policy, or one or more covers, at any time by giving written notice to **us**.

   We will cancel this Policy or the cover/s from the later of the date:

   - **we** receive **your** request to cancel this Policy, or
   - **you** advise **us** to cancel this Policy.

   We will refund to **you** any unexpired portion of the premium paid for the cover/s cancelled.

b. **We** may cancel this Policy if **you** or any **insured person** materially breach it.

10.2 GST.

All amounts of money referred to in this Policy include Goods and Services Tax (GST) where applicable.

10.3 Headings.

Headings in this Policy are for reference only. They do not form part of this Policy and are not to be used in interpreting it.

10.4 Law.

The law of New Zealand applies to this Policy and the New Zealand Courts have exclusive jurisdiction.

We may change this Policy to accommodate any changes in tax or other legislation that affect it. **We** will notify **you** if **we** make changes under this section.

10.5 Separate insurance.

Each **insured person** under this Policy is insured separately as though each is issued with a separate policy wording.

A material breach of this Policy by one of **them** won't affect the cover of other **insured person(s)** if **they** played no part in the material breach.

10.6 Avoidance of this policy.

If **we** can demonstrate that **you** or an **insured person** misrepresented a material fact within section 6 of the Insurance Law Reform Act 1977 or failed to disclose a material fact in any application or other document on the faith of which **we** issued, reinstated or renewed this Policy, **we** will void this Policy and may retain all premiums paid.

10.7 Misstatement of age.

If the age of an **insured person** is greater than **you** advised **us** in the application form and as set out on the **policy schedule**, **we** will recalculate the **sum insured/monthly benefit** that would have been payable had the age been correctly stated. Any claim payment will be based on the recalculated amount. The amount **we** pay **you** will be lower than the amount shown on the **policy schedule**.

If **their** age is less than **you** have advised **us**, **we** will refund **you** the overpaid premiums for **them**, less any outstanding premiums.

10.8 Smoker/non-smoker premiums.

If **we** have:

- issued a cover using non-smoker premiums, **we** based that on the **insured person's** statement that **they** had not smoked any form of tobacco, used nicotine replacement (including e-cigarettes) or any other substance in the twelve months before the cover **start date**, or
- changed the premiums from smoker premiums to non-smoker premiums **we** based the change on the **insured person's** statement that **they** had not smoked any form of tobacco, used nicotine replacement (including e-cigarettes) or any other substance in the twelve months before the date this change was made, and

either of these statements is found to be untrue, then **we** will reduce the **sum insured/monthly benefit** to what would have been purchased by the premiums paid. This will mean the amount paid at the time of a claim will be lower than the amount shown on the **policy schedule**.

10.9 Policy wording upgrades.

We upgrade cover wordings from time to time for new policies. If the wording applied for new Mortgage Protector policies at the time of **your** claim is more favourable for **you** than **your** original policy wording, then the benefit of the new wording will apply to **your** claim. If the upgrade requires an increase in premiums, this will be applied to **your instalment premium** when it is next reviewed.

The more favourable cover wording will only apply if at the effective date of the new wording you were not suffering from a **pre-existing condition**.

10.10 What to expect at each policy anniversary.

Before each **policy anniversary we** will send **you** a renewal letter setting out the renewal details including the **sum insured/monthly benefit** for each cover and the premium payable. **You** must pay the premiums when due to ensure **your** cover remains in place.

10.11 Making changes to this policy.

You can request changes to **your** Policy in writing. In some situations, **we** can take **your** instructions to change this Policy over the phone. **Our** customer calls are recorded. Any changes that materially alter this Policy will require the authorisation from all **policy owners**. **We** will let **you** know before **we** make the changes what **we** require from **you**.

10.12 Worldwide cover.

This Policy provides cover 24 hours a day worldwide.

10.13 Statutory Fund.

Your Policy is referable to the Fidelity Life Statutory Fund Number 1.

10.14 If you have a concern about your Policy.

If **you** have a concern about **your** Policy, **we** would like to know so **we** can do **our** best to resolve the matter. The matter will be initially handled through **our** internal complaints procedure.

You can contact **us** with **your** concern by:

i Email: customerservice@fidelitylife.co.nz

ii Phone: 0800 88 22 88

iii Mail:
Complaints Officer
Fidelity Life Assurance Company
PO Box 37-275
Parnell
Auckland 1151
New Zealand

We will attend to the matter and take the appropriate steps to try to resolve **your** concern. If the matter cannot be resolved through **our** complaints procedure, **we** will provide **you** a letter of deadlock which **you** can refer to the Insurance and Financial Services Ombudsman (IFSO) who may be able to help **you**.

We are a member of this independent dispute resolution scheme that is approved by the Ministry of Consumer Affairs:
Insurance & Financial Services Ombudsman (IFSO)
PO Box 10-845
Wellington 6143
Phone: (04) 499 7612 or 0800 888 202

More information about **our** complaints procedure can be found on **our** website:
www.fidelitylife.co.nz

11. Definitions.

The definitions set out below apply to all derivatives of the words defined.

Activities of daily living.

a. Bathing or showering - the ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash satisfactorily by other means.

b. Dressing and undressing - the ability to put on, take off, secure and unfasten all necessary garments and as appropriate any braces, artificial limbs or other surgical appliances.

c. Eating and drinking – the ability to feed oneself once food and drink have been prepared.

d. Using a toilet – the ability to use the toilet with or without aids or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.

e. Moving from place to place by walking, wheelchair or with the assistance of a walking aid including mechanical or motorised devices.

The **insured person** will be considered to be able to perform the activity if it can be performed by using equipment or adaptive devices.

Child.

A biological or legally adopted child of an **insured person** (**parent**), or a child for whom the **insured person** has been appointed a guardian by the New Zealand Family Court, or a child who's permanently living with an **insured person** who's financially dependent on that **insured person**.

Financially dependent means the **insured person** is fully responsible for all that child's daily living expenses**.**

Consumer Price Index (CPI).

The Consumer Price Index (all groups) announced by Statistics New Zealand for the 12-month period ending 30 September each year. **We** will determine the rate to apply after this date based on the CPI and apply it on the **policy anniversary** on or immediately after 1 January the following year.

End date.

The end date of this Policy or a cover shown on the **policy schedule**.

Instalment premium.

The amount shown as the instalment premium on the **policy schedule** or the most recent renewal letter. If the instalment premium is payable other than monthly then, for the purposes of the Waiver of premium cover, the instalment premium will be recalculated as though it was payable monthly on the first day of each month.

Insured person.

The person named on the **policy schedule** as the insured person.

Medically necessary.

Health care services that a **medical practitioner** or **specialist medical practitioner**, exercising prudent clinical judgement, would provide to an **insured person** for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury,
- not primarily for the convenience of **them**,
- the most appropriate level or type of service or supply that can be safely provided to **them**, and
- Being provided in the context of the condition covered and not because of treatment for another condition not covered or excluded under the cover.

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Medical practitioner.

A legally qualified and registered medical practitioner who isn't a spouse, relative or business associate of **you** or an **insured person**.

Monthly benefit.

The amount shown for the **insured person** as the regular monthly benefit or monthly benefit on the **policy schedule**.

Parent.

An **insured person** who has a **child** insured under this Policy.

Policy anniversary.

Each anniversary of the **start date** of this Policy.

Policy owner/policy owners.

The person(s) named on the **policy schedule** who has the rights and obligations under this Policy and who has the contract with **us**.

Policy schedule.

The most recent policy schedule issued for this Policy. A new **policy schedule** replaces any previous **policy schedule** from the date shown on the new policy **schedule**.

Pre-existing condition.

A pre-existing condition is any sickness or condition:

- which existed, or
- where its direct cause existed, or
- which the **insured person** had knowledge, signs or symptoms of, whether or not medical treatment was sought, or
- where any test or investigation showed its likely presence,

on or before the **start date** or the effective date of any Policy wording upgrades.

Relative.

A relative means one of the following:

- Spouse or de facto partner
- Parent or in-law
- Sibling
- Child
- Grandparent
- Grandchild

Salary.

Salary means the annual remuneration received by the **insured person** from **their** employment. This does not include other sources of income such as commission, bonuses, overtime or fringe benefits.

Specialist medical practitioner.

A **medical practitioner** who is a Member or Fellow of an appropriately recognised Specialist College and who has Medical Council of New Zealand or Australian vocational registration in the speciality that directly relates to the medical condition experienced by the **insured person**.

Start date.

The date shown on the **policy schedule** when this Policy starts or the date any cover that is subsequently added starts

Sum insured.

The amount of **cover** shown on the latest **policy schedule** or the most recent renewal letter for that cover.

They/their/them.

The **insured person**

You/your.

The **policy owner/policy owners.**

We/our/us.

Fidelity Life Assurance Company Limited.

Mortgage Protector.
Life cover.

Your cover in detail.

1. Introduction.

This Life cover provides **you** with a lump sum payment if an **insured person** dies or is diagnosed with a **terminal illness**.

The **policy schedule** will show which **insured person** this Life cover applies to and any Additional options that may apply.

2. Built-in benefits.

2.1 Death benefit.

We will pay **you** the **sum insured** if an **insured person** dies. Any Trauma cover – accelerated, Trauma multi cover – accelerated, or Total and permanent disability cover – accelerated paid will reduce the Life cover **sum insured**.

2.2 Bereavement benefit.

If an **insured person** dies, **you** may apply for an immediate advance payment of $15,000. If **their** Life cover **sum insured** is less than $15,000, **we** will pay the Life cover **sum insured**.

The Life cover **sum insured** will reduce by the amount of Bereavement benefit **we** pay.

2.3 Terminal illness benefit.

If an **insured person** is diagnosed with a **terminal illness**, **you** may apply for an advance payment of the Life cover **sum insured**.

The Life cover and any accelerated covers linked to the Life cover will end when this Terminal illness benefit is paid.

2.4 Terminal illness partial benefit.

You may apply for an early payment of the terminal illness benefit for the lesser of:

- 30% of the **sum insured**, or
- $250,000,

if the **insured person** is unequivocally diagnosed by an appropriate **specialist medical practitioner** with one of the following conditions:

- Motor neurone disease
- Stage 3 or 4 exocrine pancreatic cancer
- Stage 4 non-small cell lung cancer
- Stage 4 distal oesophageal cancer
- Stage 4 liver cancer
- Stage 4 stomach cancer
- Class 4 congestive heart failure which is unresponsive to treatment

As the Terminal illness partial payment is an early payment of the Terminal illness benefit, payment of this benefit will result in a reduction of the Life cover **sum insured** and the **sum insured** on any Trauma cover – accelerated, Trauma multi cover – accelerated, or Total and permanent disability cover – accelerated.

2.5 Child's funeral benefit.

The Child's funeral benefit will be payable if:

- **we** receive written notification of a **child** aged between two and 20 (inclusive) has died, and
- the death doesn't directly result from a **known congenital condition**, or any **child pre-existing condition**, and
- the death hasn't occurred within three months of the **start date** or reinstatement of their **parent's** Life cover.

The maximum **we** will pay **you** per **child** is as follows:

- $3,500 if the **child** is aged between 10 and 20 (inclusive) at the date of death, and
- $2,000 less any other amounts payable in respect of the death of that **child** under the terms of the Life Insurance Act 1908 if the child is under the age of 10.

A maximum of one Child's funeral benefit will be paid irrespective of the number of covers the **parent(s)** has with **us** with Child's funeral benefit. The Child's funeral benefit isn't deducted from the **parent's** Life cover **sum insured**.

This Child's funeral benefit ends for a **child** on the earliest of the date:

a. The **child's parents** no longer have any cover with **us** that provides this Child's funeral benefit, or

b. Of that **child's** 21st birthday.

2.6 Financial planning benefit.

When **we** pay a lump sum benefit of at least $100,000 to a beneficiary under the Policy, **we** will reimburse **you**, up to a maximum of $2,500 towards the cost of a fully documented financial plan prepared by a financial advice provider providing a financial planning service for the beneficiary.

Where there is more than one beneficiary the Financial planning benefit will be divided equally between those beneficiaries who each receive a benefit of at least $100,000.

The reimbursement must be claimed within six months of receiving the lump sum benefit and will be payable only once in respect of all policies covering the same **insured person**.

We will require evidence to show that the financial plan has been provided, the qualifications of the financial adviser and the costs charged by the financial advice provider.

2.7 Special events.

You can increase an **insured person's sum insured** once in any 12-month period before **their** 55th birthday without providing additional health information if one of the circumstances shown below occurs.

a. **You** can increase **their sum insured** by up to the lesser of $250,000 or 25% of **their sum insured** at the **start date** of the cover if any of the following events apply to **them**:

- marriage, civil union, divorce or being subject to a separation agreement or order, or
- birth or adoption of a **child**, or
- dependent **child** starting secondary school, or
- reaching ages 25, 30, 35, 40 or 45, or
- death of a spouse, defacto partner, **child** or civil union partner, or
- **they** permanently stop work to provide full time physical care for the first time for a dependant **relative**, who didn't require full time physical care before the **start date**.

b. If **they** take out or increase a mortgage on **their** own home, **you** can increase **their sum insured** by up to the lesser of:

- 50% of the **sum insured** at the **start date**, or
- the increase in the value of the existing mortgage or the amount of a new mortgage, or
- $250,000.

c. If **they** have a **salary** increase of at least $10,000 or a **salary** increase of at least 10% of **their salary**, **you** can increase **their sum insured** by up the lesser of:

- 25% of the **sum insured** at the **start date**, or
- five times the increase in **their salary**, or
- $250,000.

Conditions.

a. **You** must exercise a Special events increase in writing with supporting evidence within the later of either:

- six months following the event, or
- 30 days of the following **policy anniversary**.

b. An increase under Special events isn't available if:

- The **sum insured** at the **start date** includes a premium loading greater than 100%.
- The cover resulted from **you** exercising a Buy back option.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.

c. Any special terms and loadings that applied to the **sum insured** at the **start date** will also apply to the increase on that cover.

d. **Your** premiums will increase in line with the increased **sum insured**. **We** will calculate **your** premium for the increase using the **insured person's** age at the date **you** exercise a Special events increase. The increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional premium.

e. The maximum increase for an **insured person** for all events is the lesser of:

- $1,000,000, or
- the **sum insured** at the **start date**.

2.8 Premium holiday option.

You can apply to **us** in writing once to ask **us** to suspend this Life cover and the premiums for up to 12 consecutive months. The Premium holiday option is only available for the following reasons: redundancy, bankruptcy, tertiary studies or overseas travel.

You must advise **us** how long **you** want the cover and the premiums suspended. In applying for the Premium holiday option **you** acknowledge that reinstating this Life cover within the 12-month period is **your** sole responsibility. **You** can exercise this Premium holiday option during the days of grace by writing to **us** advising the reason why premium payments have stopped.

Conditions.

a. **We** will acknowledge the request, suspend this cover confirming that the Premium holiday option has been activated if a valid reason is given. **We** may require evidence of the reason for the suspension.

b. The maximum **sum insured** under this Premium holiday option is $500,000.

c. **You** can reinstate this Life cover without providing the **insured person's** health information.

d. From the date **you** reinstate this Life cover, premiums are payable on the same terms that applied before the premium holiday. **We** will base the premium on the **insured person's** current age and the premium rates that apply at that time.

2.9 Conversion option.

You can convert this Life cover **sum insured** for an **insured person** to another policy which includes Life cover on the terms applying at the time provided that:

a. this Life cover is in force in its original form, and

b. all premiums have been paid, and

c. the maximum cover without medical evidence is the Life cover **sum insured** shown in the **policy schedule**.

Any special terms and conditions which apply to an **insured person's** Life cover will also apply to the converted cover.

3. Additional options.

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

How **we** apply the CPI option is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** under the Life cover will be applied on the **policy anniversary** before **their** 65th birthday.

4. Claims.

4.1 Notice.

You must notify **us** in writing immediately or as soon as practically possible after **you** become aware of any claim or potential claim under this Life cover.

We will advise **you** of the requirements **we** need to assess **your** claim.

4.2 Obligations.

You must:

- Complete **our** claim form (if required) in full and send it to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of the **insured person's** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of the **insured person's** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require.

For Terminal illness benefit and Terminal illness partial benefit claims the **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the diagnosis, prognosis and supporting medical evidence of the **terminal illness** or condition.
- Undergo one or more medical examinations if **we** reasonably request **them** at **our** expense. This may include blood tests and medical testing.

You must pay any expenses incurred in proving **your** claim.

5. Exclusions.

We will cancel the cover, or the increased portion of cover, and retain any premiums paid if an **insured person**, whether sane or insane, dies by **their** own hand within 13 months of:

- the **start date** or the date of reinstatement, or
- the date of any increases in the **sum insured**, excluding increases due to the CPI option.

This exclusion won't apply if the **insured person** had similar life cover with another insurance company and this cover replaced that cover up to the **sum insured** under the replaced cover provided:

- the previous cover had been in force for at least 13 months before the **start date**, and
- **you** provide **us** proof of the existence and cancellation of that previous policy at the time of claim.

6. When this cover ends.

This Life cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Life cover, or

b. this Policy ends for any reason, or

c. **we** pay a claim for **their terminal illness**, or

d. **we** pay **you** the Trauma cover – accelerated, Trauma multi cover – accelerated, or Total and permanent disability cover – accelerated if any of these are included on the **policy schedule** and there is no remaining Life cover, or

e. **they** die.

7. General definitions.

The definitions shown below apply to all derivatives of the words defined.

Child pre-existing condition.

Any illness, sickness, disease, injury or medical condition existing that:

- the **parent** or **child** was aware of, or
- the **child** had signs or symptoms of, or
- the **child** had investigations or sought medical advice for, or
- a reasonable person or **parent** in the circumstances would seek diagnosis, care or treatment for,

on or before the date the Child's funeral benefit starts for a **child**.

Known congenital condition.

A health anomaly, medical condition or defect which is present at birth which is known by the **parent** or **child** at the date the Child's funeral benefit starts for a **child**.

Terminal illness.

An illness where, after considering the current or future treatment the **insured person** would be reasonably expected to receive, **they** are likely to die within 12 months. The **specialist medical practitioner** treating **their** condition must certify the diagnosis and prognosis of the **terminal illness**. Another **specialist medical practitioner** nominated by **us** must confirm the diagnosis and prognosis.

Mortgage Protector. Survivor's income cover.

Your cover in detail.

1. Introduction

This Survivor's income cover provides **you** with monthly payments for the **term you** have selected if the **insured person** dies or is diagnosed with a **terminal illness**.

The **policy schedule** will show which **insured person** this Survivor's income cover applies to and any Additional options that may apply.

2. Built-in benefits

2.1 Death Benefit.

We will pay **you** the **monthly benefit** for the **term** if the **insured person** dies. Any Survivor's income – trauma cover – accelerated, or Survivor's income – total and permanent disability cover – accelerated paid will reduce the Survivor's income **monthly benefit**.

We will pay **you** the **monthly benefit** in arrears. The **monthly benefit** payments for an **insured person** will stop at the end of the **term**.

2.2 Terminal illness benefit.

If the **insured person** is diagnosed with a **terminal illness**, **you** may apply for an advance payment of the death benefit.

We will pay **you** the **monthly benefit** in arrears. The **monthly benefit** payments for an **insured person** will stop at the end of the **term**.

2.3 Special events.

You can increase an **insured person's monthly benefit** once in any 12-month period before **their** 55th birthday without proving additional health information if one of the circumstances shown below occurs.

a. **You** can increase their **monthly benefit** by up to the lesser of $1,000 or 10% of **their monthly benefit** at the **start date** of the cover if any of the following events apply to **them**:

- marriage, civil union, divorce or being subject to a separation agreement or order, or
- birth or adoption of a **child**, or
- dependent **child** starting secondary school, or
- reaching ages 25, 30, 35, 40 or 45, or
- death of a spouse, defacto partner, **child** or civil union partner, or
- **they** permanently stop work to provide full time physical care for the first time for a dependant **relative** who didn't require full time physical care before the **start date.**

b. If **they** take out or increase a mortgage on **their** own home, **you** can increase **their monthly benefit** by up to the lesser of:

- 10% of the **monthly benefit** at the **start date**, or
- the increase in the value of the existing mortgage or the amount of a new mortgage, divided by 12 and divided by the **term**, or
- $1,000.

c. If **they** have a **salary** increase of at least $10,000 or a **salary** increase of at least 10% of **their salary**, **you** can increase **their monthly benefit** by up to 10%.

Conditions.

a. **You** must exercise a Special events increase in writing with supporting evidence within the later of either:

- six months following the event, or
- 30 days of the following **policy anniversary**.

b. An increase under Special events isn't available if:

- The **monthly benefit** at the **start date** includes a premium loading greater than 100%.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.

c. Any special terms and loadings that applied to the **monthly benefit** at the **start date** will also apply to the increase on that cover.

d. The maximum increase for an **insured person** for all events is the lesser of:

- $3,000, or
- the **monthly benefit** at the **start date.**

e. **Your** premiums will increase in line with the increased **monthly benefit**. **We** will calculate the premium for the increase using the **insured person's** age at the date **you** exercise the Special events increase. The increased **monthly benefit** applies from the date **we** confirm the new **monthly benefit** to **you**, subject to payment of the additional premium.

2.4 Premium holiday option.

You can apply to **us** in writing once to ask **us** to suspend this Survivor's income cover and the premiums for an **insured person** for up to 12 consecutive months. The Premium holiday option is only available for the following reasons: redundancy, bankruptcy, tertiary studies or overseas travel.

You must advise **us** how long **you** want the cover and the premiums suspended. In applying for the Premium holiday option **you** acknowledge that reinstating this Survivor's income cover within the 12-month period is **your** sole responsibility. **You** can exercise this Premium holiday option during the days of grace by writing to **us** advising the reason why premium payments have stopped.

Conditions.

a. **We** will acknowledge the request, suspend this cover confirming that the Premium holiday option has been activated if a valid reason is given. **We** may require evidence of the reason for the suspension.

b. The maximum **monthly benefit** under this premium holiday option is $1,500.

c. **You** can reinstate this Survivor's income cover without providing the **insured person's** health information.

d. From the date **you** reinstate this Survivor's income cover, premiums are payable on the same terms that applied before the premium holiday. **We** will base the premium on the **insured person's** then current age and the premium rates that apply at that time.

3. Additional options

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

How **we** apply the CPI option is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** will be applied on the **policy anniversary** before **their** 65th birthday.

If **we** are paying **you** a **monthly benefit** under this cover or any Survivor's income – trauma cover – accelerated, or Survivor's income – total and permanent disability cover – accelerated, **your** claim payments won't be increased by CPI unless the Claims escalation option is included in this cover.

3.2 Claims escalation option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to and the claims escalation rate which applies to **their** cover.

Once **we** have paid **you** the **monthly benefit** for more than three months, **we** will increase the **monthly benefit** on each quarter of the date payment started. The amount of the increase will be the quarterly equivalent of the annual claims escalation rate shown in the **policy schedule**.

4. Claims.

4.1 Notice.

You or the **insured person** must notify **us** in writing immediately or as soon as practically possible if **you** or **they** become aware of any claim or potential claim under this Survivor's income cover.

We will advise **you** of the requirements **we** need to assess **your** claim.

4.2 Obligations.

You must:

- Complete **our** claim form in full and send it to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of the **insured person's** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of the **insured person's** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require.

For **terminal illness** the **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the diagnosis, prognosis and supporting medical evidence of the **terminal illness.**
- Undergo one or more medical examinations if **we** reasonably request **them** at **our** expense. This may include blood tests and medical testing.

You must pay any expenses incurred in proving **your** claim.

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5. Exclusion.

We will cancel the cover, or the increased portion of cover, and retain any premiums paid if an **insured person**, whether sane or insane, dies by **their** own hand within 13 months of:

- the **start date** or the date of reinstatement, or
- the date of any increases in the **monthly benefit**, excluding increases due to the CPI option.

This exclusion won't apply if the **insured person** had similar life cover with another insurance company and this cover replaced that cover up to the **monthly benefit** under the replaced cover provided:

- the previous cover had been in force for at least 13 months before the **start date**, and
- **you** provide **us** proof of the existence and cancellation of that previous policy at the time of claim.

6. When this cover ends.

This Survivor's income cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Survivor's income cover, or

b. when **we** have paid the full **monthly benefit** for the full **term**, or

c. this Policy ends for any reason, or

d. **they** die.

7. Nominated Beneficiary or Transfer of Payment Rights.

You can nominate a beneficiary/ies (section 9.3 of the Policy terms and conditions) or a transferee/s (section 9.2 of the Policy terms and conditions) before the death of the **insured person**. The **nominated beneficiary/ies** or transferee/s cannot be changed or revoked once **we** start paying a benefit.

If **you** are the only **policy owner** and also the **insured person** and there is no **nominated beneficiary/ies** or transferee/s, **we** will not pay the **monthly benefit** if **you** die**. We** will instead calculate a lump sum based on the **present-day value** of the **monthly benefit** payments for the **term**. That lump sum will be paid to **your** estate or personal representative.

If while **we** are paying the **monthly benefit** to a person, that person dies, the **monthly benefit** payment to that person will end. **We** will instead calculate a lump sum payment based on the **present-day value** of the **monthly benefit** payments for the balance of the **term**. The lump sum will be paid to that person's estate or legal representative.

8. General definitions.

The definitions shown below apply to all derivatives of the words defined.

Present-day value

The current value of the sum of the **monthly benefit** payments remaining during the **term** when each payment is discounted by a rate that is a function of the annual interest rate as reasonably determined by **us**. Because the buying power of a dollar decreases over time the amount of the **present-day value** will always be less than the sum of the remaining **monthly benefit** payments.

Term

The maximum period shown on the **policy schedule** for an **insured person** that **we** pay **you** the **monthly benefit**.

Terminal illness

An illness where, after considering the current or future treatment the **insured person** would be reasonably expected to receive, **they** are likely to die within 12 months. The **specialist medical practitioner** treating **their** condition must certify the diagnosis and prognosis of the **terminal illness**. Another **specialist medical practitioner** nominated by **us** must confirm the diagnosis and prognosis.

Mortgage Protector. Trauma cover.

Your cover in detail.

1. Introduction.

This Trauma cover provides **you** with a lump sum payment if an **insured person** suffers from a **trauma condition**.

The **policy schedule** will show which **insured person** this Trauma cover applies to and any Additional options that may apply.

2. Built-in benefits.

2.1 Trauma conditions.

Trauma condition means any one of the conditions listed in the below sections and meeting the respective definition in section 8.

2.1.1 The conditions covered for a full benefit payment.

The conditions **we** will pay the **sum insured** for are as follows:

Accidentally acquired HIV

Alzheimer's disease

Angioplasty – triple vessel

Aorta surgery

Aplastic anaemia

Benign brain tumour or benign spinal tumour

Cancer

Carcinoma in situ – major treatment

Cardiomyopathy

Chronic kidney failure (renal failure)

Chronic liver failure

Chronic lung disease

Cognitive impairment

Coma

Coronary artery bypass surgery

Creutzfeldt-Jakob disease (CJD)

Dementia

Encephalitis

Heart attack

Heart valve surgery

Intensive care

Loss of independent existence

Loss of limb and eye

Loss of limbs

Loss of sight in both eyes

Loss of speech

Major head trauma

Major organ transplant

Meningitis and/or meningococcal disease

Motor neurone disease

Multiple sclerosis

Muscular dystrophy

Occupationally acquired HIV

Open heart surgery

Out of hospital cardiac arrest

Paralysis

Parkinson's disease

Peripheral neuropathy

Pneumonectomy

Primary pulmonary hypertension

Severe burns

Severe diabetes

Severe inflammatory bowel disease

Stroke

Systemic sclerosis

Total deafness in both ears

2.1.2 The conditions covered for a partial benefit payment.

The conditions **we** will pay a **partial benefit** for are as follows:

Adult onset type 1 insulin dependent diabetes mellitus

Alzheimer's disease diagnosis

Aneurysm

Angioplasty – two vessels or less

Carcinoma in situ without major treatment

Chronic lymphocytic leukaemia

Colostomy and/or ileostomy

Dementia diagnosis

Early stage prostate cancer

Hydrocephalus

Loss of one limb

Loss of sight in one eye

Major burns

Malignant melanoma diagnosis

Multiple sclerosis diagnosis

Parkinson's disease diagnosis

Severe osteoporosis

Severe rheumatoid arthritis

Systemic lupus erythematosus

Total deafness in one ear

2.2 How much do we pay?

When the **insured person** suffers a **trauma condition** for the first time after the **start date** and after the **stand-down period** (where applicable), **we** will pay **you** either:

- the **sum insured**, or
- the amount specified for a **partial benefit** payment.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), then **we** will reduce the **sum insured** and **our** payment so that when added to any amount paid or payable under the existing policy, the total for **them** doesn't exceed $2,000,000.

The Trauma cover **sum insured** will reduce by the amount of any partial payment of the **sum insured** payable under this cover for an **insured person** except when **we** pay an Inbuilt child's trauma benefit. **We** will adjust the premium accordingly. If **we** pay the full **sum insured**, Trauma cover will end for that **insured person**.

2.2.1 Trauma cover – accelerated.

If the **policy schedule** shows Trauma cover – accelerated applies to an **insured person,** payment of the **sum insured** is an advance payment of the Life cover this Trauma cover – accelerated is attached to. **We** will reduce that Life cover by the amount **we** pay for the **trauma condition** and adjust the premium accordingly.

An **insured person's** Trauma cover – accelerated **sum insured** can't exceed **their** Life cover **sum insured**.

2.2.2 Trauma cover – standalone.

If the **policy schedule** shows Trauma cover – standalone applies to an **insured person, we** will only pay a claim for the Trauma cover – standalone if **they** survive for at least 14 days after the diagnosis of the **trauma condition**.

2.3 Stand-down period.

If a **trauma condition** stated below occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the **insured person**, or would have become apparent to a reasonable person in **their** position, within three months of:

- the **start date** or the date of reinstatement then no benefit will ever be payable for that **trauma condition** under this cover, or
- the date of any increase in the **sum insured** (excluding increases due to the CPI option), then no benefit will ever be payable for that **trauma condition** for that increase in **sum insured**.

The stand down applies to the following conditions:

a. **Cancer condition**, **heart attack**, **out of hospital cardiac arrest** or **stroke**.

b. **Angioplasty – two vessels or less** or a**ngioplasty – triple vessel**, if there was narrowing or blockage of one or more arteries.

c. **Coronary artery bypass surgery** if there existed disease of the arteries.

d. **Aorta surgery** if there was narrowing, dissection or aneurysm of the abdominal or thoracic aorta.

e. **Heart valve surgery** if there was heart valve defects or abnormalities.

The **stand-down period** won't apply if an **insured person** had similar cover with **us** or another insurance company and this cover replaced that cover, up to the **sum insured** under the replaced cover, provided the previous cover had been in force for at least three months.

2.4 Inbuilt child's trauma benefit.

The Inbuilt child's trauma benefit will be payable if:

- a **child** aged between two and 20 (inclusive) suffers a **trauma condition** defined in section 8 (apart from **adult onset type 1 insulin dependent diabetes mellitus)**, and
- the **trauma condition** occurs for the first time after the **start date** and after the **stand-down period** (where applicable), and
- the **child** survives for 14 days after suffering the **trauma condition**.

Where the **trauma condition** directly results from **known congenital conditions** or any **child pre-existing conditions**:

- At the **start date** or reinstatement date, no benefit will ever be payable for that **trauma condition** for that **child**.
- At the **start date** the **parent's sum insured** is increased, no benefit will ever be payable for the Inbuilt child's trauma benefit for the amount that relates to that increase in **sum insured**.

We will pay **you** per **child** the lesser of:

- 20% of the **parent's sum insured** up to $50,000, or
- if the **trauma condition** is a **partial benefit**, 10% of the **parent's sum insured** up to $25,000.

A maximum of one Inbuilt child's trauma benefit will be paid per **child** irrespective of the number of **trauma conditions** that **child** suffers or the number of covers a **parent(s)** has with **us** with the Inbuilt child's trauma benefit or equivalent type child's trauma benefit.

Payment of the Inbuilt child's trauma benefit doesn't reduce the **parent's sum insured**.

The Inbuilt child's trauma benefit ends for a **child** on the earliest of the date:

a. the **child's parent(s)** no longer have any cover with **us** that provides this Inbuilt child's trauma benefit, or

b. of that **child's** 21st birthday, or

c. **we** pay an Inbuilt child's trauma benefit or equivalent type child's trauma benefit claim for that **child**.

2.4.1 Conversion of Inbuilt child's trauma benefit.

A **child** covered under the Inbuilt child's trauma benefit can apply for a policy with **our** Life cover and Trauma cover – accelerated available at that time without having to provide additional health information within the 30 days before and after reaching the **child's** 21st birthday.

The maximum amount of Life cover and Trauma cover – accelerated that can be applied for is 20% of one of the **parent's sum insured** on the day immediately before that **child's** 21st birthday up to $50,000.

We will calculate the premium for the Life cover and Trauma cover – accelerated at age 21 based on the sum insured, gender and smoking status of that **child**.

The Life cover and Trauma cover – accelerated will exclude any claim if the **trauma condition** directly results from any:

- **known congenital conditions**, or
- **child pre-existing conditions**.

The conversion of Inbuilt child's trauma benefit isn't available if the **child** had either had a claim paid or is entitled to make a claim under the Inbuilt child's trauma benefit.

This conversion of Inbuilt child's trauma benefit ends for a **child** on the earliest of:

a. the **child's parent(s)** no longer have any cover with **us** that provides the Inbuilt child's trauma benefit, or

b. 30 days after that **child's** 21st birthday.

2.5 Financial planning benefit.

If **we** pay a lump sum benefit of at least $100,000 to a beneficiary under this Policy, **we** will reimburse, up to a maximum of $2,500, the cost of a fully documented financial plan prepared by a financial advice provider providing a financial planning service for the beneficiary.

Where there's more than one beneficiary, **we** will divide the financial planning benefit equally between those beneficiaries who each receive a benefit of at least $100,000.

The reimbursement must be claimed within six months of receiving the lump sum benefit and will be payable only once in respect of all policies with **us** covering the same **insured person**.

We will require evidence to show that the financial plan has been provided, the qualifications of the financial adviser and the costs charged by the financial advice provider.

2.6 Special events.

You can increase an **insured person's sum insured** once in any 12-month period before **their** 55th birthday without providing additional health information if one of the circumstances shown below occurs.

a. **You** can increase **their sum insured** by up to the lesser of $250,000 or 25% of **their sum insured** at the **start date** of the cover, if any of the following events apply to **them**:

- marriage, civil union, divorce or being subject to a separation agreement or order, or
- birth or adoption of a **child**, or
- dependent **child** starting secondary school, or
- reaching ages 25, 30, 35, 40, or 45, or
- death of a spouse, defacto partner, **child** or civil union partner, or
- **they** permanently stop work to provide full time physical care for the first time for a dependant **relative** who didn't require full time physical care before the **start date**.

b. If **they** take out or increase a mortgage on **their** own home, **you** can increase **their sum insured** by up to the lesser of:

- 50% of the **sum insured** at the **start date**, or
- the increase in the value of the existing mortgage or the amount of a new mortgage, or
- $250,000.

c. If **they** have a **salary** increase of at least $10,000 or a **salary** increase of at least 10% of **their salary**, **you** can increase **their sum insured** by up to the lesser of:

- 25% of the **sum insured** at the **start date**, or
- 5 times the increase in **their salary**, or
- $250,000.

Conditions.

a. **You** must exercise a Special events increase in writing with supporting evidence within the later of either:

- six months following the event, or
- 30 days of the following **policy anniversary**.

b. An increase under Special events isn't available if:

- The **sum insured** at the **start date** includes a premium loading greater than 100%.

- The cover's been issued as a result of a Trauma reinstatement option or any other trauma cover reinstatement.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.

c. Any special terms and loadings that applied to the **sum insured** at the **start date** will also apply to the increase on that cover.

d. **Your** premiums will increase in line with the increased **sum insured**. **We** will calculate the premium for the increase using the **insured person's** age at the date **you** exercise a Special events increase. The increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional premium.

e. The maximum increase for an **insured person** for all events is the lesser of:

- $1,000,000, or
- the **sum insured** at the **start date**.

f. If **they** have Trauma cover – accelerated **their** Trauma cover **sum insured** can't exceed the Life cover **sum insured**.

g. The total cover when added to all other trauma type covers with any insurer after an increase cannot exceed $2,000,000.

2.7 Conversion option for Trauma cover – standalone.

If a Trauma cover – standalone is shown in the **policy schedule** for an **insured person**, then before **their** 65th birthday **you** may convert that Trauma cover – standalone to a Trauma cover – accelerated for up to the **sum insured** with an equal amount of Life cover, without providing additional health information.

Conditions.

a. The conversion isn't available if:

- The **sum insured** at the **start date** includes a premium loading or an exclusion.
- The cover has been issued as a result of a Trauma reinstatement option or any other trauma cover reinstatement.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.
- The **insured person** has suffered from or is suffering from a **terminal illness** at the **conversion date**.
- The **insured person** is under the age of 16.

b. **We** will calculate the premiums for the Life cover and the converted Trauma cover – accelerated for **them** based on **their** age at the **conversion date**.

c. If **they** die within three months of the **conversion date**, other than by **accident**, the converted Life cover with the Trauma cover – accelerated won't apply. Where this happens, **we** will assess the claim under the Trauma cover – standalone terms and conditions.

2.8 Relocation benefit.

If an **insured person**:

a. has been residing outside New Zealand for more than three consecutive months, and

b. **they** then suffer from a **trauma condition** while residing outside of New Zealand, and

c. **we** have accepted a claim for the **sum insured**,

we will reimburse **you** the lesser of:

- $10,000, or
- the actual cost of a single standard economy airfare from **their** location to New Zealand for **them** and one support person (where **medically necessary**) by the most direct route available plus any additional transport costs to an approved medical facility in New Zealand.

We will pay this Relocation benefit once only for each **insured person** regardless of other covers which may include this Relocation benefit. The Relocation benefit is paid in addition to the **sum insured**. **You** will need to provide **us** with the original invoice and receipt for payment before **we** pay a claim.

This Relocation benefit isn't payable:

- for a **child** under the Inbuilt child's trauma benefit, or
- as a result of any **partial benefit** payment.

3. Additional options.

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

How **we** apply the CPI option is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** will be applied on the earliest of:

- the **policy anniversary** before **their** 65th birthday, or
- the total sum insured for all trauma type cover/s for **them** with **us** and any other insurer, reaches $2,000,000.

3.2 Buy back option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

12 months after payment of the full **sum insured** under the Trauma cover – accelerated **you** may buy back the Life cover without providing additional health information.

The maximum amount of Life cover that **you** can buy back is the Trauma cover – accelerated amount **we** paid. **We** will contact you to let you know that the option is able to be exercised.

If **we** pay the **sum insured** for a **trauma condition** listed below, **you** may buy back the Life cover six months after **we** pay the **sum insured**:

Paralysis, Alzheimer's disease, dementia, loss of limb and eye, loss of limbs, loss of sight in both eyes, multiple sclerosis or Parkinson's disease.

You may exercise this Buy back option once only within 90 days after the end of either the six or 12-month period and before **their** 70th birthday**.**

Once the Life cover has been bought back, the portion of the Life cover which has been bought back can't be bought back again at any time.

We will calculate the premium based on the rates applicable for the **insured person's** age and the Life cover **sum insured** bought back at the time **you** exercise the Buy back option.

Any Life cover bought back under the Buy back option will be subject to the same terms and conditions that applied to the Life cover when issued.

3.3 Trauma reinstatement option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

12 months after payment of the full **sum insured** under Trauma cover, other than for **loss of independent existence** or **total and permanent disability**, **you** may buy back the Trauma cover without providing additional health information.

This option is subject to the following conditions:

a. **You** may exercise this Trauma reinstatement option once only within 90 days after the end of the 12-month period and before **their** 65th birthday.

b. The maximum amount that **you** can repurchase is the lesser of the benefit paid and $2,000,000. If **they** have Trauma cover – accelerated **their** repurchased Trauma cover **sum insured** can't exceed the Life cover **sum insured**.

c. **We** will calculate the premium based on the rates applicable for both the age of the **insured person** and the Trauma cover **sum insured** bought back at the time **you** exercise the trauma reinstatement option.

d. The Trauma cover bought back under the Trauma reinstatement option will be subject to the same terms and conditions that applied to the **sum insured** at the **start date**.

e. If **they** are subsequently diagnosed with a **trauma condition**, **we** will pay the bought back amount only if the **trauma condition** occurred, was diagnosed, or the symptoms leading to a diagnosis became apparent after the Trauma cover **sum insured** was bought back.

f. **We** won't pay the bought back Trauma cover **sum insured** if the **trauma condition** is:

- the same as the original **trauma condition**, or
- directly or indirectly caused by or related to the original **trauma condition**, or symptoms or conditions which caused the original **trauma condition** to occur, or
- a **loss of independent existence**, or
- a **heart condition** and the original **trauma condition** was also a **heart condition**, or
- a **stroke** or **paralysis** (directly or indirectly resulting from a **stroke**) and the original **trauma condition** was a **stroke**.

g. The Trauma reinstatement option isn't available where **we** have paid a claim for any partial benefit.

h. The bought back cover won't include any options or built-in benefits except payment of the **trauma conditions** as defined in section 2.1.

i. If the original **trauma condition** claimed for was for a **cancer condition** or a **heart condition**, a discount will apply to the premium on the bought back cover. **We** will determine the discount that will apply by the original **trauma condition** that was claimed for.

3.4 Total and permanent disability option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

3.4.1 Total and permanent disability before age 65.

Total and permanent disability means that **we** are satisfied that one of the following events occurs before the **insured person's** 65th birthday:

a. **Own occupation.**

If own occupation is shown in the **policy schedule** for an **insured person,** then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months, and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever be able to work in any capacity in **their own occupation**, or

b. **Any occupation.**

If any occupation is shown in the **policy schedule** for an **insured person**, then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever be able to perform **their own occupation** or **any occupation**, or

c. **Home duties.**

If the **insured person** wasn't **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, regardless of whether own occupation or any occupation is shown in the **policy schedule**, **total and permanent disability** shall mean that **they** for an uninterrupted period of at least three months:

- have been under medical supervision with the complete inability to perform all normal **home duties**, and
- have been unable to leave the home without assistance, and
- in **our** reasonable opinion based on medical and other relevant evidence, are unlikely to ever again be able to perform all normal **home duties**.

3.4.2 Total and permanent disability from age 65 to age 70.

If **we** are satisfied that after the **insured person's** 65th birthday **they** were continuing to perform **their** usual occupational duties without limitation or restriction due to sickness or injury for at least 25 hours per week, then **we** will assess any claim for **total and permanent disability** made before **their** 70th birthday under the definition that applied before **their** 65th birthday.

If **they** were performing **their** occupational duties with limitations or restrictions due to sickness or injury, **we** will assess the claim under the definition applying under the section 3.4.4.

3.4.3 Home duties from age 65.

If the **insured person** was not **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, and the event causing the **total and permanent disability** happens after **their** 65th birthday, **we** will assess the claim under the definition applying under the section 3.4.4.

3.4.4 Total and permanent disability from age 70.

Where the event causing the **total and permanent disability** happens after the **insured person's** 70th birthday, or where sections 3.4.2 or 3.4.3 apply, the following definition applies:

Total and permanent disability means that **we** are satisfied that **they** are totally and permanently unable to perform at least two **activities of daily living** as a result of sickness or injury without the assistance of an adult.

3.4.5 Total and permanent disability partial benefit.

We will pay a **partial benefit** if the **insured person** suffers the total and permanent loss of use of one hand, one foot or the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or

- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

3.4.6 How much do we pay?

When the **insured person** suffers a **total and permanent disability**, **we** will pay **you** either:

- the **sum insured**, or
- if the **total and permanent disability** is a **partial benefit,** 25% of the **sum insured** up to $75,000.

Where a **trauma condition** and **total and permanent disability** result from the same sickness or injury, **we** will pay either a claim for a **trauma condition** or a **total and permanent disability** not both.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), then **we** will reduce the **sum insured** and **our** payment so that when added to any amount paid or payable under the existing policy, the total for that **insured person** doesn't exceed $5,000,000.

If the **policy schedule** shows Trauma cover – accelerated applies to an **insured person**, payment of the Total and permanent disability option is an advance payment of the Life cover this Trauma cover – accelerated is attached to. **We** will reduce that Life cover and the Trauma cover – accelerated by the amount **we** pay for the **total and permanent disability** and adjust the premium accordingly.

3.4.7 Total and permanent disability early payment benefit.

If the cause of the **insured person's total and permanent disability** is due to one of the below conditions, **we** will waive the requirement for **them** to be absent from employment or unable to undertake full-time **home duties** for an uninterrupted period of three months. The conditions are:

- Alzheimer's disease
- Cardiomyopathy
- Chronic lung disease
- Severe rheumatoid arthritis
- Dementia
- Major head trauma
- Motor neurone disease
- Systemic sclerosis
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease

4. Claims.

4.1 Notice.

You or the **insured person** must notify **us** in writing immediately or as soon as practically possible if **you** or **they** become aware of any claim or potential claim under this Trauma cover.

We will advise **you** of the requirements **we** need to assess **your** claim.

We won't pay any claim until **we** receive all the requirements **we** need to assess the claim and confirm that **they** meet the definition of a **trauma condition**.

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4.2 Obligations.

You and the **insured person** (if possible) must:

- Complete **our** claim form in full and send it to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of **their** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of **their** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require. This may include financial and occupational evidence.

The **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the occurrence of the **trauma condition**.
- Undergo one or more medical examinations if **we** reasonably request **them** at **our** expense. This may include blood tests and medical testing.
- **We** may also request other additional claim proofs necessary to complete **our** assessment of the claim including an independent opinion from an appropriate **medical practitioner** or **specialist medical practitioner** approved by us.

You must pay any expenses incurred in proving **your** claim.

5. Exclusion.

You can't claim under this cover in connection with an intentional self-inflicted act or injury.

6. When this cover ends.

This Trauma cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Trauma cover, or

b. this Policy ends for any reason, or

c. **we** pay the **sum insured** for **them**, or

d. **they** die, or

e. if **they** have Trauma cover – standalone, on **their** 70th birthday.

7. General definitions.

The definitions shown below apply to all derivatives of the words defined. Where applicable, an **insured person** will include a **child**.

Accident.

Bodily injury caused solely and directly by violent, accidental, external or visible means. The injury must be unintended and unexpected.

Any occupation.

An occupation for which the **insured person** is suited to by education, training or experience, which would remunerate at a rate greater than 25% of **their** earnings over the last 12-month period of employment.

Cancer condition.

Cancer, carcinoma in situ – major treatment, carcinoma in situ – without major treatment, chronic lymphocytic leukaemia, malignant melanoma diagnosis and **early stage prostate cancer.**

Child pre-existing condition.

Any illness, sickness, disease, injury or medical condition existing that:

- the **parent** or **child** was aware of, or
- the **child** had signs or symptoms of, or
- the **child** had investigations or sought medical advice for, or
- a reasonable person or **parent** in the circumstances would seek diagnosis, care or treatment for,

on or before the date the Inbuilt child's trauma benefit starts for a **child**.

Conversion date.

The later of the:

- date the conversion of the Trauma cover – standalone to Trauma cover – accelerated becomes effective, or
- actual date **we** receive the first premium for the Life cover and the Trauma cover – accelerated.

The conversion date can't be backdated.

Gainfully employed.

Working in an occupation or job as an employee for reward, salary, commission or any other income. For an **insured person** who is self-employed, working in any business or professional practice which could produce income for that business or professional practice.

Heart condition.

Aorta surgery, angioplasty – triple vessel, angioplasty – two vessels or less, cardiomyopathy, coronary artery bypass surgery, heart attack, heart valve surgery, open heart surgery, out of hospital cardiac arrest or **primary pulmonary hypertension**.

Home duties.

The duties normally associated with a person who is engaged in full time unpaid home duties within the family home, and isn't employed in any occupation or working outside the **insured person's** home for salary, reward or profit and includes:

a. Cleaning the family home, such as using a vacuum cleaner, sweeping with a broom, using a mop and cleaning dishes (automatic or manual).

b. Cooking the family meals, such as preparing fresh and frozen food and using an oven, stove or microwave oven.

c. Doing the family's laundry, such as loading and unloading a washing machine, hanging out clothes or using a dryer, folding clothes and ironing.

d. Shopping, such as attending shops or using the phone or internet to purchase food for the family.

e. Taking care of **their** dependent children (where applicable) such as supervising, lifting, transporting, feeding and bathing.

We won't consider an **insured person** who's actively seeking employment or is performing less than full time unpaid **home duties** to be performing **home duties**.

Known congenital condition.

A health anomaly, medical condition or defect which is:

- present at birth, and
- known by the parent or child at the date the Inbuilt child's trauma benefit starts for a child.

New York Heart Association Classification of Cardiac Impairment.

Class 1 – no limitation of physical activity, no symptoms with ordinary physical activity.

Class 2 – slight limitation of physical activity, symptoms occur with ordinary physical activity.

Class 3 – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity.

Class 4 – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.

Own occupation.

The field of work in which the **insured person** has trained in, specialises in and was engaged immediately before becoming **totally and permanently disabled**.

Partial benefit.

A part payment of the **sum insured**. The definitions and the amount paid for each **trauma condition** partial benefit is detailed in section 8 and if applicable sections 3.4.5 and 3.4.6 for **total and permanent disability**.

Stand-down period.

The period set out in section 2.3 where no benefit will ever be payable under this cover.

Terminal illness.

An illness where, after considering the current or future treatment the **insured person** would be reasonably expected to receive, death is likely to occur within 12 months.

Total and permanent disability.

A sickness or injury resulting in the **insured person** meeting the definition as outlined in section 3.4.

Trauma condition.

A condition as defined in section 8.

Whole person function.

The evaluation of whole person function derived from the most recent edition of the American Medical Association's book Guides to the Evaluation of Permanent Impairment (Guides) as assessed by an appropriately qualified **medical practitioner**.

8. Trauma definitions.

Trauma conditions covered for a full benefit payment.

Accidentally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV) acquired via blood transfusion or accidental means, with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to **us** within thirty days of the incident. The report must be supported by a negative HIV antibody test within seven days of the incident.

Transmission via any form of sexual activity or deliberate injection of a drug not prescribed by a **medical practitioner** is excluded.

Alzheimer's disease.

The confirmed diagnosis by a **specialist medical practitioner** of Alzheimer's disease with the permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Angioplasty – triple vessel.

Undergoing a coronary artery angioplasty to correct narrowing or blockage of three or more coronary arteries within one or more procedures within a two-month period.

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Aorta surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to correct any narrowing, dissection or aneurysm of the abdominal or thoracic aorta by repair or its replacement.

Aplastic Anaemia.

Bone marrow failure that results in anaemia, neutropenia and thrombocytopenia and requires treatment with at least one of the following:

- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplant
- Peripheral blood stem cell transplant
- Blood product transfusions.

Benign brain tumour or benign spinal tumour.

A non-cancerous tumour in the brain or spinal cord that gives rise to characteristic symptoms of intracranial pressure, such as papilloedema, mental symptoms, seizures and sensory impairment and results in:

- permanent neurological damage and functional impairment diagnosed by an appropriate **specialist medical practitioner**, or
- surgical treatment for its removal where this is considered the appropriate and **medically necessary** treatment.

A tumour in the pituitary gland will be covered if it results in:

- permanent neurological damage and functional impairment diagnosed by an appropriate **specialist medical practitioner**, or
- requires a craniotomy to remove it.

Neurological damage and functional impairment include but aren't limited to: memory loss, impaired speech, vision loss and paralysis on one side of the body.

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

Cysts, granulomas, malformations in or of the arteries or veins of the brain and haematomas are excluded.

Cancer.

The confirmed presence of one or more invasive malignant tumours diagnosed by a **specialist medical practitioner** with supporting histological evidence of uncontrolled growth of malignant cells and invasion of normal tissue beyond the basement membrane. The term malignant tumour also includes leukaemia, sarcoma, malignant bone marrow disorders, and malignant lymphomas.

In addition to the above, only cancers meeting the following specified level of advancement for that cancer are covered:

- Hodgkin's and Non-Hodgkins lymphoma (all stages)
- Chronic lymphocytic leukaemia of Rai stage 1 or higher
- Malignant melanomas meeting any of the following criteria:
  - at least Clark level 3 depth of invasion, or
  - 1mm Breslow thickness or greater, or
  - showing evidence of ulceration.
- Prostatic cancers meeting any of the following:
  - at least TNM classification T2, or
  - a Gleason score greater than or equal to 6, or
  - the entire prostate has been removed through a prostatectomy, or
  - **medically necessary** treatment by radiotherapy or chemotherapy has been performed.
- Papillary and follicular carcinoma of thyroid of at least TNM classification T2
- Squamous cell carcinomas of the skin where the carcinomas have spread to other organs, bones or lymph nodes
- Other cancers not listed above of at least TNM classification T1

This definition doesn't include the following:

- Tumours showing the malignant changes of carcinoma-in-situ (including cervical dysplasia CIN1, CIN2 and CIN3).
- Tumours histologically classified as pre-malignant or having low-malignant potential.
- All hyperkeratoses or basal cell carcinomas of the skin.

Carcinoma in situ – major treatment.

The actual undergoing of treatment for pre-invasive carcinoma in situ. The tumour must be positively diagnosed by a **specialist medical practitioner** as Tis according to the TNM classification or FIGO stage 0, with supporting histological evidence and resulting in one of the following being performed:

- **radical surgery**, or
- **medically necessary** treatment by radiotherapy or systemic chemotherapy.

Radical surgery means the actual undergoing of **medically necessary** surgery to remove an entire affected organ or breast. Where surgery involves the colon, radical surgery means partial or full colectomy.

Cardiomyopathy.

Impaired ventricular function of variable aetiology, resulting in physical impairments to the degree of at least class 3 of the **New York Heart Association Classification of Cardiac Impairment**.

Chronic kidney failure (renal failure).

End stage renal failure diagnosed by an appropriate **specialist medical practitioner** and presenting as chronic irreversible failure of both

kidneys to function and resulting in regular renal dialysis being started.

Chronic liver failure.

End stage liver failure diagnosed by an appropriate **specialist medical practitioner** based on any of the following symptoms: permanent jaundice, ascites and encephalopathy.

Chronic lung disease.

End stage lung disease requiring permanent oxygen therapy and with:

- FEV_1 test results of consistently less than one litre, or
- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Cognitive impairment.

Injury or illness of the brain resulting in permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Coma.

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continually with the use of a life support system for at least 72 hours.

The Trauma cover – standalone benefit for **coma** will only be paid where the **insured person** survives for at least a further fourteen days without the use of a life support system.

Coma related to alcohol or drug abuse is excluded.

Coronary artery bypass surgery.

Medically necessary coronary artery bypass graft surgery to correct coronary artery disease that is causing inadequate myocardial blood supply.

Angioplasty, intra-arterial procedures and other non-surgical techniques are excluded.

Creutzfeldt-Jakob disease (CJD).

The unequivocal diagnosis of CJD by a **specialist medical practitioner** with signs and symptoms of cerebellar dysfunction, severe progressive dementia, uncontrolled muscle spasm, tremor and athetosis resulting in the **insured person** requiring permanent and continual supervision for **their** safety.

Dementia.

The confirmed diagnosis by a **specialist medical practitioner** of dementia with the permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)

- Deductive or abstract reasoning

Encephalitis.

Severe inflammation of the brain diagnosed by a **specialist medical practitioner** as resulting in:

- significant and permanent neurological sequelae, or
- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Heart attack.

The death of a portion of heart muscle as a result of inadequate blood supply. The basis of diagnosis must be confirmed by an appropriate **specialist medical practitioner** and evidenced by a typical rise and/or fall of cardiac biomarkers (Troponin I, Troponin T or CK-MB) and must also be supported by one of the following changes consistent with a heart attack:

- new cardiac symptoms and signs, or
- electrocardiogram (ECG) tests showing new significant changes, or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, **we** will consider other appropriate and medically recognised tests provided in support of the diagnosis.

The following are excluded:

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

Heart valve surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to replace or repair a cardiac valve or valves as a consequence of heart valve defects or abnormalities.

Intensive care.

An **accident** or sickness which, at the recommendation of an appropriate **specialist medical practitioner**, has resulted in the **insured person**:

- requiring continuous mechanical ventilation by means of tracheal intubation for at least five consecutive days (24 hours per day), or
- being admitted to the intensive care ward of an appropriately certified hospital for at least five consecutive days (24 hours per day).

Intensive care as a direct or indirect result of drug or alcohol abuse is excluded.

Loss of independent existence.

As a result of disease, sickness or injury, the **insured person** is totally and permanently unable to perform at least two of the **activities of daily living** without the assistance of an adult.

Loss of limb and eye.

The **insured person** suffers the total and permanent loss of the use of:

- one foot or one hand, and
- the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or

- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Loss of limbs.

The **insured person** suffers the total and permanent loss of the use of either both feet, both hands or one foot and one hand.

Loss of sight in both eyes.

The **insured person** suffers the permanent and irreversible loss of sight in both eyes.

The permanent and irreversible loss of sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in both eyes after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Loss of speech.

The total and permanent 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, whether caused by injury, tumour or sickness.

Loss of speech due to psychological reasons is excluded.

Major head trauma.

Permanent neurological deficit caused by an external accidental injury to the head which is confirmed by a **specialist medical practitioner** as resulting in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Major organ transplant.

The actual transplant, or placement on an official waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit, of one or more of the following organs or tissues:

- Kidney
- Heart
- Lung
- Liver (including live donor liver transplants)
- Pancreas
- Small bowel
- Bone marrow
- Blood-forming stem cell transplant.

The transplant must be confirmed by an appropriate **specialist medical practitioner** as being **medically necessary** and treatable only by a transplant. The transplant of all other organs, parts of organs (except for liver transplant) or any other tissue transplant is excluded.

Meningitis and/or meningococcal disease.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of meningitis and/or meningococcal disease including meningococcal septicaemia that results in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

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Motor neurone disease.

The unequivocal diagnosis of motor neurone disease by two appropriate **specialist medical practitioners**.

Multiple sclerosis.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of multiple sclerosis confirming more than one episode of well-defined neurological abnormalities and

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability to perform at least one of the **activities of daily living** without the assistance of an adult, or
- Expanded Disability Status Scale (EDSS) level of 7.5 or higher.

The diagnosis must be based on confirmatory neurological investigations e.g. lumbar puncture, evoked visual responses, evoked auditory responses and NMR (Nuclear Magnetic Resonance) evidence of lesions of the central nervous system.

Muscular dystrophy.

The unequivocal diagnosis of muscular dystrophy by an appropriate **specialist medical practitioner**.

Occupationally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV) acquired via blood transfusion or accidental means during the course of carrying out the **insured person's** normal occupation, with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to **us** within thirty days of the incident. The report must be supported by a negative HIV antibody test within seven days of the incident.

Transmission via any form of sexual activity or deliberate injection of a drug not prescribed by a **medical practitioner** is excluded.

Open heart surgery.

Undergoing open heart surgery to treat a cardiac defect, cardiac aneurysm or benign cardiac tumour.

Repair via catheter surgery, minimally invasive 'keyhole' or similar techniques are excluded.

Out of hospital cardiac arrest.

A sudden unexpected stoppage of effective heart action which:

- isn't associated with any medical procedure, and
- is documented by an electrocardiogram, and
- occurs outside a hospital, and
- is due to either cardiac asystole (complete failure of the heart causing cardiac arrest) or ventricular fibrillation (heart abnormality with ineffective twitching of the heart chambers).

Paralysis.

The total and permanent loss of use of one or more limbs resulting from injury or disease.

Limb means an entire arm or leg and included in this definition is monoplegia, diplegia, hemiplegia, paraplegia, quadriplegia and tetraplegia. The diagnosis must be confirmed by a **specialist medical practitioner**.

Parkinson's disease.

The unequivocal diagnosis of Idiopathic **Parkinson's disease** by a **specialist medical practitioner** resulting in:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Peripheral neuropathy.

Irreversible loss of function of peripheral nerves, diagnosed by a **specialist medical practitioner** and resulting in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Peripheral neuropathy related to alcohol or drug use is excluded.

Pneumonectomy.

The removal of an entire lung. This must be considered the **medically necessary** treatment by an appropriate **specialist medical practitioner**.

Primary pulmonary hypertension.

Irreversible raised pressure in the pulmonary arteries with right ventricular enlargement established by investigations including cardiac catheterisation.

Severe burns.

Tissue injury caused by thermal, electrical or chemical agents that results in third degree burns to at least:

- 20% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or
- 50% of both hands requiring surgical debridement and/or grafting, or
- 25% of the face requiring surgical debridement and/or grafting.

Severe diabetes.

The confirmation by an appropriate **specialist medical practitioner** that the **insured person** has experienced at least two of the following complications as a direct result of diabetes:

- retinopathy that results in corrected visual acuity of 6/36 or worse in both eyes, or
- neuropathy causing:
  - irreversible autonomic neuropathy that results in postural hypotension and/or motility problems in the gut with intractable diarrhoea, or
  - polyneuropathy leading to severe mobility problems due to sensory and/or motor deficits, or
- chronic infection or gangrene that results in amputation of a whole hand or foot, or
- nephropathy causing chronic, irreversible kidney impairment for at least three months where the glomerular filtration rate has reduced to less than 28ml/min (Chronic kidney disease stage 4, International Chronic Kidney Disease classification).

Severe inflammatory bowel disease.

The confirmed diagnosis by an appropriate **specialist medical practitioner** of either:

- Crohn's disease, or
- ulcerative colitis,

that has failed surgical treatment, is resistant to conventional medical intervention, and requires either:

- permanent immunosuppressive therapy, or
- surgical removal of the entire large bowel (colon and rectum).

Stroke.

A cerebrovascular incident including infarction of brain tissue, intracranial or subarachnoid haemorrhage, or embolisation from an intracranial source as evidenced by CT, MRI or similar scan.

Transient ischaemic attacks and cerebral symptoms due to migraine are excluded.

Systemic sclerosis.

The unequivocal diagnosis of systemic sclerosis, as confirmed by an appropriate **specialist medical practitioner**, causing:

- skin thickening accompanied by various degrees of tissue fibrosis, and
- chronic inflammatory infiltration in visceral organs, and
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Total deafness in both ears.

The total and irreversible loss of hearing both natural and assisted, in both ears as a result of sickness or injury as confirmed by a **specialist medical practitioner**.

Trauma conditions covered for a partial benefit.

Adult onset type 1 insulin dependent diabetes mellitus.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is diagnosed by a **specialist medical practitioner** after **their** 30th birthday with Type 1 diabetes mellitus which requires insulin.

Alzheimer's disease diagnosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with Alzheimer's disease by a **specialist medical practitioner**.

Aneurysm.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** has either:

- a cerebral aneurysm of any size that is treated by a **specialist medical practitioner** surgically via clipping or endovascular surgery; or
- an aortic aneurysm that has been definitely identified through MRI or CT scanning and:
  - is larger than 5.5cm in diameter, or
  - is larger than 3.5cm in diameter and growing at a rate faster than 0.5cm in diameter per year, or
  - has ruptured.

Angioplasty – two vessels or less.

We will pay 25% of the **sum insured** up to a maximum of $25,000 each time the **insured person** undergoes a coronary artery angioplasty to correct narrowing or blockage of one or two coronary arteries. If the **sum insured** is less than $10,000 **we** will pay the **sum insured**.

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Carcinoma in situ – without major treatment.

We will pay 10% of the **sum insured** to a maximum of $25,000, the first time the **insured person** is diagnosed by a **specialist medical practitioner** with carcinoma in situ of the breast, cervix uteri, vagina, vulva, fallopian tubes, ovary, corpus uteri, anus, perineum, penis or testicle. Tumours must be classified as Tis according to the TNM classification or FIGO stage 0 with supporting histological evidence.

Chronic lymphocytic leukaemia.

We will pay 25% of the **sum insured** up to a maximum of $50,000, the first time the **insured person** is positively diagnosed by a **specialist medical practitioner** with chronic lymphocytic leukaemia of Rai stage 0.

Colostomy and/or ileostomy.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** undergoes the creation of a permanent non-reversible opening, linking the colon or ileum to the external surface of the body.

Dementia diagnosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with dementia by a **specialist medical practitioner**.

Early stage prostate cancer.

We will pay 25% of the **sum insured** up to a maximum of $50,000, the first time the **insured person** is positively diagnosed by a **specialist medical practitioner** with supporting histological evidence of early stage prostate cancer of TNM classification T1 (all categories) or Gleason score less than or equal to 5.

Hydrocephalus.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** requires a shunt to remove an excessive accumulation of cerebrospinal fluid or to relieve increased pressure within the cranium.

Loss of one limb.

We will pay 25% of the **sum insured** up to a maximum of $25,000, if the **insured person** suffers the total and permanent loss of use of one hand or one foot.

Loss of sight in one eye.

We will pay 25% of the **sum insured** up to a maximum of $25,000, if the **insured person** suffers the permanent and irreversible loss of sight in one eye.

The permanent and irreversible loss of sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Major burns.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** suffers tissue damage caused by thermal, electrical or chemical agents that results in third degree burns to at least:

- 9% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or
- 50% of either hand, or combined over both hands, requiring surgical debridement and/or grafting.

Malignant melanoma diagnosis.

We will pay 25% of the **sum insured** up to a maximum of $50,000, the first time the **insured person** is positively diagnosed by a **specialist medical practitioner** with supporting histological evidence of malignant melanoma that is Clark Level 1 or 2 depth of invasion, and less than 1mm in thickness as measured using the Breslow method.

Multiple sclerosis diagnosis.

We will pay 25% of the **sum insured** up to a maximum of $25,000, if the **insured person** is unequivocally diagnosed with **multiple sclerosis** confirming more than one episode of well-defined neurological abnormalities by an appropriate **specialist medical practitioner**.

Parkinson's disease diagnosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with Idiopathic **Parkinson's disease** by a **specialist medical practitioner**.

Severe osteoporosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** before **their** 50th birthday:

- suffers at least two vertebral body fractures or a fracture of the neck of the femur, due to osteoporosis, and

- has bone mineral density reading with a T-score of less than -2.5. This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** before **their** 50th birthday is diagnosed with severe rheumatoid arthritis by an appropriate **specialist medical practitioner**. The diagnosis must confirm all the following:

- morning stiffness of the joints, and

- swelling and pain in the joints of at least three joint groups, involving the corresponding joints on both sides of the body. One of the groups must be joints on the fingers or toes, or the knuckles of the hand or wrist, and

- small nodular swelling beneath the skin, and

- a positive rheumatoid factor test, and

- x-ray evidence showing multiple and extensive changes to joints typical of rheumatoid arthritis, and

- diffuse osteoporosis with severe hand and spinal deformity.

Systemic lupus erythematosus.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with systemic lupus erythematosus by a **specialist medical practitioner**. The diagnosis must be made in a clinical setting based on the American College of Rheumatology (ACR) revised criteria and have evidence of lupus nephritis as confirmed by:

- grade 3 to 5 nephritis (WHO classification of lupus nephritis), and

- persisting proteinuria (more than 2+).

Total deafness in one ear.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** suffers the total and irreversible loss of hearing, both natural and assisted, in one ear as a result of sickness or injury as confirmed by an appropriate **specialist medical practitioner**.

Mortgage Protector. Trauma multi cover.

Your cover in detail.

1. Introduction.

This Trauma multi cover provides **you** with a lump sum payment if an **insured person** suffers from a **trauma condition**, for up to a maximum of five full payments for each **insured person** for each unrelated **trauma condition**.

The **policy schedule** will show which **insured person** this Trauma multi cover applies to and any Additional options that may apply.

2. Built-in benefits.

2.1 Trauma conditions.

Trauma condition means any one of the conditions listed in the below sections and meeting the respective definition in section 8.

2.1.1 The conditions covered for a full benefit payment.

The conditions **we** will pay the **full benefit** for are as follows:

Accidentally acquired HIV

Alzheimer's disease

Angioplasty – triple vessel

Aorta surgery

Aplastic anaemia

Benign brain tumour or benign spinal tumour

Cancer

Carcinoma in situ – major treatment

Cardiomyopathy

Chronic kidney failure (renal failure)

Chronic liver failure

Chronic lung disease

Cognitive impairment

Coma

Coronary artery bypass surgery

Creutzfeldt-Jakob disease (CJD)

Dementia

Encephalitis

Heart attack

Heart valve surgery

Intensive care

Loss of independent existence

Loss of limb and eye

Loss of limbs

Loss of sight in both eyes

Loss of speech

Major head trauma

Major organ transplant

Meningitis and/or meningococcal disease

Motor neurone disease

Multiple sclerosis

Muscular dystrophy

Occupationally acquired HIV

Open heart surgery

Out of hospital cardiac arrest

Paralysis

Parkinson's disease

Peripheral neuropathy

Pneumonectomy

Primary pulmonary hypertension

Severe burns

Severe diabetes

Severe inflammatory bowel disease

Stroke

Systemic sclerosis

Total deafness in both ears

2.1.2 The conditions covered for a partial benefit payment.

The conditions **we** will pay a **partial benefit** for are as follows:

Adult onset type 1 insulin dependent diabetes mellitus

Alzheimer's disease diagnosis

Aneurysm

Angioplasty – two vessels or less

Carcinoma in situ without major treatment

Chronic lymphocytic leukaemia

Colostomy and/or ileostomy

Dementia diagnosis

Early stage prostate cancer

Hydrocephalus

Loss of one limb

Loss of sight in one eye

Major burns

Malignant melanoma diagnosis

Multiple sclerosis diagnosis

Parkinson's disease diagnosis

Severe osteoporosis

Severe rheumatoid arthritis

Systemic lupus erythematosus

Total deafness in one ear

2.2 How much do we pay?

2.2.1 First claim for a trauma condition.

When the **insured person** suffers a **trauma condition** for the first time after the **start date** and after the **stand-down period** (where applicable), **we** will pay **you** either:

- the **full benefit**, one fifth (20%) of the **sum insured**, or
- a **partial benefit**, one tenth (10%) of the **sum insured** up to $25,000.

2.2.2 Subsequent claims.

a. **Same trauma condition.**

- **After a partial benefit claim.**

  We will pay a claim for a **full benefit** if a **partial benefit** claim has been paid and the **insured person** subsequently meets the **full benefit** definition for that **trauma condition**.

  The **full benefit** payment will be reduced by the amount of the **partial benefit** paid so that no more than 20% of the **sum insured** is paid for that **trauma condition**.

- **Other payments.**

  We will pay more than one claim for a **trauma condition** if it meets the following:

  - at least six consecutive months have passed since the last diagnosis of the **trauma condition**, and
  - it isn't a recurrence of the original **trauma condition**, and
  - it isn't directly or indirectly caused by or related to the original **trauma condition**, or the symptoms or conditions which caused the **trauma condition** to occur.

b. **Different trauma condition.**

We will pay a claim for a different **trauma condition** if it meets the following:

- it isn't directly or indirectly caused by or related to any previous **trauma condition**, or the symptoms or conditions which caused any previous **trauma condition** to occur, or
- it's a **loss of independent existence** claim (see section 2.2.3 or if the **policy schedule** shows the Loss of independent existence option see section 3.2).

Only one claim can be made per **trauma condition** where the definition requires **permanent incapacity**.

2.2.3 Loss of independent existence.

If the **policy schedule** shows Trauma multi cover – accelerated applies to an **insured person**, **we** will pay more than one payment of the **full benefit** for **loss of independent existence** if:

- the **insured person** continues to meet the **loss of independent existence** definition, and
- there has been at least 12 consecutive months since the last payment for **loss of independent existence**, and
- the cover hasn't ended (see section 6).

If **they** meet the definition of one **trauma condition** and at the same time meets the definition of **loss of independent existence**, then **we** will make one **full benefit** payment.

2.2.4 Maximum amount of cover.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), **we** will reduce the **sum insured** and our payment so that when added to any amount paid or payable under the existing policy, the total for that **insured person** does not exceed $2,000,000.

2.2.5 Trauma multi cover – accelerated.

If the **policy schedule** shows Trauma multi cover – accelerated applies to an **insured person**, payment of the **sum insured** is an advance payment of the Life cover this Trauma multi cover – accelerated is attached to. **We** will reduce that Life cover by the amount **we** pay for the **trauma condition** and adjust the premium accordingly.

Their Trauma multi cover – accelerated **sum insured** can't exceed **their** Life cover **sum insured** unless a claim has been paid for that **insured person**.

2.2.6 Trauma multi cover – standalone.

If the **policy schedule** shows Trauma multi cover – standalone applies to an **insured person, we** will only pay a claim for the Trauma multi cover – standalone if **they** survive for at least 14 days after the diagnosis of the **trauma condition**.

2.3 Stand-down period.

If a **trauma condition** stated below, occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the **insured person**, or would have become apparent to a reasonable person in **their** position, within three months of:

- the **start date** or the date of reinstatement, then no benefit will ever be payable for that **trauma condition** under this cover, or
- the date of any increase in the **sum insured** (excluding increases due to the CPI option), then no benefit will ever be payable for that **trauma condition** for that increase in **sum insured**.

The stand down applies to the following conditions:

a. **Cancer condition**, **heart attack**, **out of hospital cardiac arrest** or **stroke**.

b. **Angioplasty – two vessels or less** or a**ngioplasty – triple vessel** if there was narrowing or blockage of one or more arteries.

c. **Coronary artery bypass surgery** if there existed disease of the arteries.

d. **Aorta surgery** if there was narrowing, dissection or aneurysm of the abdominal or thoracic aorta.

e. **Heart valve surgery** if there was heart valve defects or abnormalities.

The **stand-down period** won't apply if an **insured person** had similar cover with **us** or another insurance company and this cover replaced that cover, up to the lesser of:

- 20% of the **sum insured** under the replaced cover, or
- the **sum insured** on the previous policy,

provided the previous policy had been in force for at least three months.

2.4 Inbuilt child's trauma benefit.

The Inbuilt child's trauma benefit will be payable if:

- a **child** aged between two and 20 (inclusive) suffers a **trauma condition** defined in section 8 (apart from **adult onset type 1 insulin dependent diabetes mellitus)**, and
- the **trauma condition** occurs for the first time after the **start date** and after the **stand-down period** (where applicable), and
- the **child** survives for 14 days after suffering the **trauma condition**.

Where the **trauma condition** directly results from **known congenital conditions** or any **child pre-existing conditions**:

- At the **start date** or reinstatement date, no benefit will ever be payable for that **trauma condition** for that **child**.
- At the **start date** the **parent's sum insured** is increased, no benefit will ever be payable for the Inbuilt child's trauma benefit for the amount that relates to that increase in **sum insured**.

We will pay **you** per **child** the lesser of:

- 20% of the **parent's sum insured** up to $50,000, or
- If the **trauma condition** is a **partial benefit**, 10% of the **parent's sum insured** up to $25,000.

A maximum of one Inbuilt child's trauma benefit will be paid irrespective of the number of **trauma conditions** that **child** suffers or the number of covers a **parent(s)** has with **us** with the Inbuilt child's trauma benefit or equivalent type child's trauma benefit.

Payment of the Inbuilt child's trauma benefit doesn't reduce the **parent's sum insured**.

The Inbuilt child's trauma benefit ends for a **child** on the earliest of the date:

a. the **child's parent(s)** no longer have any cover with **us** that provides this Inbuilt child's trauma benefit, or

b. of that **child's** 21st birthday, or

c. **we** pay an Inbuilt child's trauma benefit, or equivalent type child's trauma benefit claim for that **child**.

2.4.1 Conversion of Inbuilt child's trauma benefit.

A **child** covered under the Inbuilt child's trauma benefit can apply for a Policy with **our** then Life cover and Trauma multi cover – accelerated without having to provide additional health information within the 30 days before and after reaching the **child's** 21st birthday.

The maximum amount of Life cover and Trauma multi cover – accelerated that can be applied for is 20% of one of the **parent's sum insured** on the day immediately before that **child's** 21st birthday up to $50,000.

We will calculate the premium for the Life cover and Trauma multi cover – accelerated at age 21, based on the **sum insured**, gender and smoking status of that **child**.

The Life cover and Trauma multi cover – accelerated will exclude any claim if the **trauma condition** directly results from any:

- **known congenital conditions**, or
- **child pre-existing conditions**.

The conversion of Inbuilt child's trauma benefit isn't available if the **child** had either had a claim paid or is entitled to make a claim under the Inbuilt child's trauma benefit.

This conversion of Inbuilt child's trauma benefit ends for a **child** on the earliest of:

a. the **child's parent(s)** no longer have any cover with **us** that provides the Inbuilt child's trauma benefit, or

b. 30 days after that **child's** 21st birthday.

2.5 Financial planning benefit.

If **we** pay a lump sum benefit of at least $100,000 to a beneficiary under this Policy, **we** will reimburse, up to a maximum of $2,500, the cost of a fully documented financial plan prepared by a financial advice provider providing a financial planning service for the beneficiary.

Where there is more than one beneficiary, **we** will divide the Financial planning benefit equally between those beneficiaries who each receive a benefit of at least $100,000.

The reimbursement must be claimed within six months of receiving the lump sum benefit and will be payable only once in respect of all policies with **us** covering the same **insured person**.

We will require evidence to show that the financial plan has been provided, the qualifications of the financial adviser and the costs charged by the financial advice provider.

2.6 Special events.

You can increase an **insured person's sum insured** once in any 12-month period before **their** 55th birthday without providing additional health information if one of the circumstances shown below occurs.

a. **You** can increase that **their sum insured** by up to the lesser of $250,000 or 25% of **their sum insured** at the **start date** of the cover, if any of the following events apply to **them**:

- marriage, civil union, divorce or being subject to a separation agreement or order, or
- birth or adoption of a **child**, or
- dependent **child** starting secondary school, or
- reaching ages 25, 30, 35, 40, or 45, or
- death of a spouse, defacto partner, **child** or civil union partner, or
- **they** permanently stop work to provide full time physical care for the first time for a dependant **relative** who didn't require full time physical care before the **start date**.

b. If **they** take out or increase a mortgage on **their** own home, **you** can increase **their sum insured** by up to the lesser of:

- 50% of the **sum insured** at the **start date**, or
- the increase in the value of the existing mortgage or the amount of a new mortgage, or
- $250,000.

c. If **they** have a **salary** increase of at least $10,000 or a **salary** increase of at least 10% of **their salary**, **you** can increase **their sum insured** by up to the lesser of:

- 25% of the **sum insured** at the **start date**, or
- five times the increase in **their salary**, or
- $250,000.

Conditions.

a. **You** must exercise a Special events increase in writing with supporting evidence within the later of either:

- six months following the event, or
- 30 days of the following **policy anniversary**.

b. An increase under Special events isn't available if:

- The **sum insured** at the **start date** includes a premium loading greater than 100%.

- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.

- The premiums aren't up to date or are being waived for any reason.

c. Any special terms and loadings that applied to the **sum insured** at the **start date** will also apply to the increase on that **cover**.

d. **Your** premiums will increase in line with the increased **sum insured**. **We** will calculate the premium for the increase using the **insured person's** age at the date **you** exercise a Special events increase. The increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional premium.

e. The maximum increase for an **insured person** for all events is the lesser of:

- $1,000,000, or

- the **sum insured** at the **start date**.

f. If **they** have Trauma multi cover – accelerated **their** Trauma multi cover **sum insured** can't exceed the Life cover **sum insured**.

g. The total cover when added to all other trauma type covers with any insurer after an increase can't exceed $2,000,000.

2.8 Conversion option for the Trauma multi cover – standalone – age-rated.

If a Trauma multi cover – standalone is shown in the **policy schedule** for an **insured person**, then before **their** 65th birthday **you** may convert that Trauma multi cover – standalone to a Trauma multi cover – accelerated for up to the **sum insured** with an equal amount of Life Cover without providing additional health information.

Conditions.

a. The conversion isn't available if

- The **sum insured** at the **start date** includes a premium loading or an exclusion.

- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.

- The premiums aren't up to date or are being waived for any reason.

- The **insured person** has suffered from or is suffering from a **terminal illness** at the **conversion date**.

- The **insured person** is under the age of 16.

b. **We** will calculate the premiums for the Life cover and the converted Trauma multi cover – accelerated for **them** based on **their** age at the **conversion date**.

c. If **they** die within three months of the **conversion date**, other than by **accident**, the converted Life cover with the Trauma multi cover – accelerated will not apply. Where this happens, **we** will assess the claim under the Trauma multi cover – standalone terms and conditions.

2.9 Relocation benefit.

If an **insured person**:

a. has been residing outside New Zealand for more than three consecutive months, and

b. **they** then suffer from a **trauma condition** while residing outside of New Zealand, and

c. **we** have accepted a claim for a **full benefit**,

we will reimburse **you** the lesser of:

- $10,000, or
- the actual cost of a single standard economy airfare from **their** location to New Zealand for **them** and one support person (where medically necessary), by the most direct route available plus any additional transport costs to an approved medical facility in New Zealand.

We will pay this Relocation benefit once only for each **insured person** regardless of other covers which may include this Relocation benefit. The Relocation benefit is paid in addition to the **sum insured**. **You** will need to provide **us** with the original invoice and receipt for payment before **we** pay a claim.

This Relocation benefit isn't payable:

- for a **child** under the Inbuilt child's trauma benefit, or
- as a result of any **partial benefit** payment.

3. Additional options.

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

How **we** apply the CPI option is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** will be applied on the earliest of:

- the **policy anniversary** before **their** 65th birthday, or
- the total **sum insured** for all trauma type cover/s for them with **us** and any other insurer, reaches $2,000,000.

3.2 Loss of independent existence option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

We will pay **you** a **full benefit** for **loss of independent existence** where at least 12 consecutive months have passed since the last **full benefit** was paid for **them** and the **loss of independent existence** definition is satisfied before the cover ends (see section 6).

Each claim paid for **them** under this Loss of independent existence option will count as one claim towards the maximum of five claims for **them**.

3.3 Buy back option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

12 months after payment of the **full benefit** under the Trauma multi cover – accelerated **you** may buy back the Life cover without providing additional health information.

The maximum amount of Life cover that **you** can buy back is the Trauma multi cover – accelerated **full benefit** amount **we** paid. **We** will contact **you** to let **you** know that the option is able to be exercised.

If **we** pay the **full benefit** amount for a **trauma condition** listed below, **you** may buy back the Life cover six months after **we** pay the **full benefit** amount:

Paralysis, Alzheimer's disease, dementia, loss of limb and eye, loss of limbs, loss of sight in both eyes, multiple sclerosis or Parkinson's disease.

You may exercise this Buy back option once only within 90 days after the end of either the six or 12-month period and before the **insured person's** 70th birthday.

Once the Life cover has been bought back, the portion of the Life cover which has been bought back can't be bought back again at any time.

We will calculate the premium based on the rates applicable for their age and the Life cover **sum insured** bought back at the time **you** exercise the Buy back option.

Any Life cover bought back under the Buy back option will be subject to the same terms and conditions that applied to the Life cover when issued.

3.4 Total and permanent disability option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

Full benefit.

3.4.1 Total and permanent disability before age 65.

Total and permanent disability means that **we** are satisfied that one of the following events occurs before the **insured person's** 65th birthday:

a. **Own occupation.**

If own occupation is shown in the **policy schedule** for an **insured person,** then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months, and in **our**

reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever be able to work in any capacity in **their own occupation**, or

b. **Any occupation.**

If any occupation is shown in the **policy schedule** for an **insured person**, then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever be able to perform **their own occupation** or **any occupation**, or

c. **Home duties.**

If the **insured person** wasn't **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, regardless of whether own occupation or any occupation is shown in the **policy schedule**, **total and permanent disability** shall mean that **they** for an uninterrupted period of at least three months:

- has been under medical supervision with the complete inability to perform all normal **home duties**, and
- has been unable to leave the home without assistance, and
- in **our** reasonable opinion based on medical and other relevant evidence, is unlikely to ever again be able to perform all normal **home duties**.

3.4.2 Total and permanent disability from age 65 to age 70.

If **we** are satisfied that after the **insured person's** 65th birthday **they** were continuing to perform **their** usual occupational duties without limitation or restriction due to sickness or injury for at least 25 hours per week, then **we** will assess any claim for **total and permanent disability** made before **their** 70th birthday under the definition that applied before **their** 65th birthday.

If **they** were performing **their** occupational duties with limitations or restrictions due to sickness or injury, **we** will assess the claim under the definition applying under section 3.4.4.

3.4.3 Home duties from age 65.

If the **insured person** wasn't **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, and the event causing the **total and permanent disability** happens after **their** 65th birthday, **we** will assess the claim under the definition applying under section 3.4.4.

3.4.4 Total and permanent disability from age 70.

Where the event causing the **total and permanent disability** happens after the **insured person's** 70th birthday, or where sections 3.4.2 or 3.4.3 apply, the following definition applies:

Total and permanent disability means that **we** are satisfied that **they** are totally and permanently unable to perform at least two **activities of daily living** as a result of sickness or injury without the assistance of an adult.

3.4.5 Total and permanent disability partial benefit.

We will pay a **partial benefit** if the **insured person** suffers the total and permanent loss of use of one hand, one foot or the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

3.4.6 How much do we pay?

When the **insured person** suffers a **total and permanent disability**, **we** will pay **you** either:

- the **full benefit**, less any **partial benefit** payments **we** have paid **you** in respect of that **total and permanent disability**, or
- if the **total and permanent disability** is a **partial benefit,** 10% of the **sum insured** up to $75,000.

Where a **trauma condition** and **total and permanent disability** result from the same sickness or injury, **we** will pay either a claim for a **trauma condition** or a **total and permanent disability** not both.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), then **we** will reduce the **sum insured** and **our** payment so that when added to any amount paid or payable under the existing policy, the total for that **insured person** doesn't exceed $5,000,000.

If the **policy schedule** shows Trauma multi cover – accelerated applies to an **insured person**, payment of the Total and permanent disability option is an advance payment of the Life cover this Trauma multi cover – accelerated is attached to. **We** will reduce that Life cover by the amount **we** pay for the **total and permanent disability** and adjust the premium accordingly.

3.4.7 Total and permanent disability early payment benefit.

If the cause of the **insured person's total and permanent disability** is due to one of the below conditions, **we** will waive the requirement for **them** to be absent from employment or unable to undertake full-time **home duties** for an uninterrupted period of three months. The conditions are:

- Alzheimer's disease
- Cardiomyopathy
- Chronic lung disease
- Dementia
- Major head trauma
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease
- Severe rheumatoid arthritis
- Systemic sclerosis

4. Claims.

4.1. Notice.

You or the **insured person** must notify **us** in writing immediately or as soon as practically possible if **you** or **they** become aware of any claim or potential claim under this Trauma multi cover.

We will advise **you** of the requirements **we** need to assess **your** claim.

We won't pay any claim until **we** receive all the requirements **we** need to assess the claim and confirm that **they** meet the definition of a **trauma condition**.

4.2 Obligations.

You and the **insured person** (if possible) must:

- Complete **our** claim form in full and send it to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of **their** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of **their** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require. This may include financial and occupational evidence.

The **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the occurrence of the **trauma condition**.
- Undergo one or more medical examinations if **we** reasonably request **them** at our expense. This may include blood tests and medical testing.
- **We** may also request other additional claim proofs necessary to complete our assessment of the claim including an independent opinion from an appropriate **medical practitioner** or **specialist medical practitioner** approved by us.

You must pay any expenses incurred in proving **your** claim.

5. Exclusion.

You can't claim under this cover in connection with an intentional self-inflicted act or injury.

6. When this cover ends.

This Trauma multi cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Trauma multi cover, or

b. this Policy ends for any reason, or

c. **we** have paid an amount equal to the **sum insured**, or

d. **they** die, or

e. if **they** have Trauma multi cover - standalone, on **their** 70th birthday.

7. General definitions.

The definitions shown below apply to all derivatives of the words defined. Where applicable, an **insured person** will include a **child**.

Accident.

Bodily injury caused solely and directly by violent, accidental, external or visible means. The injury must be unintended and unexpected.

Any occupation.

An occupation for which the **insured person** is suited to by education, training or experience, which would remunerate at a rate greater than 25% of **their** earnings over the last 12-month period of employment.

Cancer condition.

Cancer, carcinoma in situ – major treatment, carcinoma in situ – without major treatment, chronic lymphocytic leukaemia, malignant melanoma diagnosis and **early stage prostate cancer.**

Child pre-existing condition.

Any illness, sickness, disease, injury or medical condition existing that:

- the **parent** or **child** was aware of, or
- the **child** had signs or symptoms of, or
- the **child** had investigations or sought medical advice for, or
- a reasonable person or **parent** in the circumstances would seek diagnosis, care or treatment for,

on or before the date the Inbuilt child's trauma benefit starts for a **child**.

Conversion date.

The later of the:

- date the conversion of the Trauma multi cover – standalone to Trauma multi cover – accelerated becomes effective, or
- actual date **we** receive the first premium for the Life cover and the Trauma multi cover – accelerated.

The conversion date can't be backdated.

Full benefit.

Payment of one fifth (20%) of the **sum insured**.

Gainfully employed.

Working in an occupation or job as an employee for reward, salary, commission or any other income. For an **insured person** who's self-employed, working in any business or professional practice which could produce income for that business or professional practice.

Home duties.

The duties normally associated with a person who is engaged in full time unpaid home duties within the family home, and isn't employed in any occupation or working outside the **insured person's** home for salary, reward or profit and includes:

a. Cleaning the family home, such as using a vacuum cleaner, sweeping with a broom, using a mop and cleaning dishes (automatic or manual).

b. Cooking the family meals, such as preparing fresh and frozen food and using an oven, stove or microwave oven.

c. Doing the family's laundry, such as loading and unloading a washing machine, hanging out clothes or using a dryer, folding clothes and ironing.

d. Shopping, such as attending shops or using the phone or internet to purchase food for the family.

e. Taking care of **their** dependent children (where applicable) such as supervising, lifting, transporting, feeding and bathing.

We won't consider an **insured person** who's actively seeking employment or is performing less than full time unpaid **home duties** to be performing **home duties**.

Known congenital condition.

A health anomaly, medical condition or defect which is:

- present at birth, and
- known by the **parent** or **child** at the date the Inbuilt child's trauma benefit starts for a **child**.

New York Heart Association Classification of Cardiac Impairment.

Class 1 – no limitation of physical activity, no symptoms with ordinary physical activity.

Class 2 – slight limitation of physical activity, symptoms occur with ordinary physical activity.

Class 3 – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity.

Class 4 – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.

Own occupation.

The field of work in which the **insured person** has trained in, specialises in and was engaged in immediately before becoming **totally and permanently disabled**.

Partial benefit.

A part payment for the **sum insured** as set out in section 2.2 for a **trauma condition** and if applicable sections 3.4.5 and 3.4.6 for **total and permanent disability**.

Permanent incapacity.

The **insured person** is suffering permanent incapacity if **they** have neurological damage and functional impairment causing permanent and irreversible:

- inability to perform at least one of the **activities of daily living** without assistance of an adult, or
- at least 25% permanent impairment of **whole person function**.

Stand-down period.

The period set out in section 2.3 where no benefit will ever be payable under this **cover.**

Terminal illness.

An illness where, after considering the current or future treatment the **insured person** would be reasonably expected to receive, death is likely to occur within 12 months.

Total and permanent disability.

A sickness or injury resulting in the **insured person** meeting the definition as outlined in section 3.4.

Trauma condition.

A condition as defined in section 8.

Whole person function.

The evaluation of whole person function derived from the most recent edition of the American Medical Association's book Guides to the Evaluation of Permanent Impairment (Guides) as assessed by an appropriately qualified **medical practitioner**.

8. Trauma definitions.

Trauma conditions covered for a full benefit payment.

Accidentally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV), acquired via blood transfusion or accidental means, with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to **us** within thirty days of the incident. The report must be supported by a negative HIV antibody test within seven days of the incident.

Transmission via any form of sexual activity or deliberate injection of a drug not prescribed by a **medical practitioner** is excluded.

Alzheimer's disease.

The confirmed diagnosis by a **specialist medical practitioner** of Alzheimer's disease with the permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety. Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Angioplasty – triple vessel.

Undergoing a coronary artery angioplasty to correct narrowing or blockage of three or more coronary arteries within one or more procedures within a two-month period.

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Aorta surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to correct any narrowing, dissection or aneurysm of the abdominal or thoracic aorta by repair or its replacement.

Aplastic anaemia.

Bone marrow failure that results in anaemia, neutropenia and thrombocytopenia and requires treatment with at least one of the following:

- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplant
- Peripheral blood stem cell transplant
- Blood product transfusions.

Benign brain tumour or benign spinal tumour.

A non-cancerous tumour in the brain or spinal cord that gives rise to characteristic symptoms of intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment and results in:

- permanent neurological damage and functional impairment diagnosed by an appropriate **specialist medical practitioner**, or
- surgical treatment for its removal where this is considered the appropriate and medically necessary treatment.

A tumour in the pituitary gland will be covered if results in:

- permanent neurological damage and functional impairment diagnosed by an appropriate **specialist medical practitioner**, or
- requires a craniotomy to remove it.

Neurological damage and functional impairment include but aren't limited to: memory loss, impaired speech, vision loss and paralysis on one side of the body.

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

Cysts, granulomas, malformations in or of the arteries or veins of the brain and haematomas are excluded.

Cancer.

The confirmed presence of one or more invasive malignant tumours diagnosed by a **specialist medical practitioner** with supporting histological evidence of uncontrolled growth of malignant cells and invasion of normal tissue beyond the basement membrane. The term malignant tumour also includes leukaemia, sarcoma, malignant bone marrow disorders, and malignant lymphomas.

In addition to the above, only cancers meeting the following specified level of advancement for that cancer are covered:

- Hodgkin's and Non-Hodgkins lymphoma (all stages)
- Chronic lymphocytic leukaemia of Rai stage 1 or higher
- Malignant melanomas meeting any of the following criteria:
  - at least Clark Level 3 depth of invasion, or
  - 1mm Breslow thickness or greater, or
  - showing evidence of ulceration.
- Prostatic cancers meeting any of the following:
  - at least TNM classification T2, or
  - a Gleason score greater than or equal to 6, or
  - the entire prostate has been removed through a prostatectomy, or
  - **medically necessary** treatment by radiotherapy or chemotherapy has been performed.
- Papillary and follicular carcinoma of thyroid of at least TNM classification T2
- Squamous cell carcinomas of the skin where the carcinomas have spread to other organs, bones or lymph nodes
- Other cancers not listed above of at least TNM classification T1

This definition doesn't include the following:

- Tumours showing the malignant changes of carcinoma-in-situ (including cervical dysplasia CIN1, CIN2 and CIN3)
- Tumours histologically classified as pre-malignant or having low-malignant potential
- All hyperkeratoses or basal cell carcinomas of the skin

Carcinoma in situ – major treatment.

The actual undergoing of treatment for pre-invasive carcinoma in situ. The tumour must be positively diagnosed by a **specialist medical practitioner** as Tis according to the TNM classification or FIGO stage 0, with supporting histological evidence and resulting in one of the following being performed:

- **radical surgery**, or
- **medically necessary** treatment by radiotherapy or systemic chemotherapy.

Radical surgery means the actual undergoing of **medically necessary** surgery to remove an entire affected organ or breast. Where surgery involves the colon, radical surgery means partial or full colectomy.

Cardiomyopathy.

Impaired ventricular function of variable aetiology, resulting in physical impairments to the degree of at least class 3 of the **New York Heart Association Classification of Cardiac Impairment**.

Chronic kidney failure (renal failure).

End stage renal failure diagnosed by an appropriate **specialist medical practitioner** and presenting as chronic irreversible failure of both kidneys to function and resulting in regular renal dialysis being started.

Chronic liver failure.

End stage liver failure diagnosed by an appropriate **specialist medical practitioner** based on any of the following symptoms: permanent jaundice, ascites and encephalopathy.

Chronic lung disease.

End stage lung disease requiring permanent oxygen therapy and with:

- FEV1 test results of consistently less than one litre, or
- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Cognitive impairment.

Injury or illness of the brain resulting in permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety. Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

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Coma.

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continually with the use of a life support system for at least 72 hours.

The Trauma multi cover – standalone benefit for **coma** will only be paid where the **insured person** survives for at least a further fourteen days without the use of a life support system.

Coma related to alcohol or drug abuse is excluded.

Coronary artery bypass surgery.

Medically necessary coronary artery bypass graft surgery to correct coronary artery disease that is causing inadequate myocardial blood supply.

Angioplasty, intra-arterial procedures and other non-surgical techniques are excluded.

Creutzfeldt-Jakob disease (CJD).

The unequivocal diagnosis of CJD by a **specialist medical practitioner** with signs and symptoms of cerebellar dysfunction, severe progressive dementia, uncontrolled muscle spasm, tremor and athetosis resulting in the **insured person** requiring permanent and continual supervision for **their** safety.

Dementia.

The confirmed diagnosis by a **specialist medical practitioner** of dementia with the permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Encephalitis.

Severe inflammation of the brain diagnosed by a **specialist medical practitioner** as resulting in:

- significant and permanent neurological sequelae, or
- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Heart attack.

The death of a portion of heart muscle as a result of inadequate blood supply. The basis of diagnosis must be confirmed by an appropriate **specialist medical practitioner** and evidenced by a typical rise and/or fall of cardiac biomarkers (Troponin I, Troponin T or CK-MB) and must also be supported by one of the following changes consistent with a heart attack:

- new cardiac symptoms and signs, or
- electrocardiogram (ECG) tests showing new significant changes, or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, **we** will consider other appropriate and medically recognised tests provided in support of the diagnosis.

The following are excluded:

- other acute coronary and other non-coronary syndromes, including but not limited to angina pectoris, and

- a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease.

Heart valve surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to replace or repair a cardiac valve or valves as a consequence of heart valve defects or abnormalities.

Intensive care.

An **accident** or sickness, which at the recommendation of an appropriate **specialist medical practitioner**, has resulted in the **insured person**:

- requiring continuous mechanical ventilation by means of tracheal intubation for at least five consecutive days (24 hours per day), or
- being admitted to the intensive care ward of an appropriately certified hospital for at least five consecutive days (24 hours per day).

Intensive care as a direct or indirect result of drug or alcohol abuse is excluded.

Loss of independent existence.

As a result of disease, sickness or injury, the **insured person** is totally and permanently unable to perform at least two of the **activities of daily living** without the assistance of an adult.

Loss of limb and eye.

The **insured person** suffers the total and permanent loss of the use of:

- one foot or one hand, and
- the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Loss of limbs.

The **insured person** suffers the total and permanent loss of the use of either both feet, both hands or one foot and one hand.

Loss of sight in both eyes.

The **insured person** suffers the permanent and irreversible loss of sight in both eyes.

The permanent and irreversible loss of sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in both eyes after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Loss of speech.

The total and permanent 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, whether caused by injury, tumour or sickness.

Loss of speech due to psychological reasons is excluded.

Major head trauma.

Permanent neurological deficit caused by an external accidental injury to the head which is confirmed by a **specialist medical practitioner** as resulting in either:

- at least 25% permanent impairment of **whole person function**, or

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- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Major organ transplant.

The actual transplant, or placement on an official waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit, of one or more of the following organs or tissues:

- Kidney
- Heart
- Lung
- Liver (including live donor liver transplants)
- Pancreas
- Small bowel
- Bone marrow
- Blood-forming stem cell transplant.

The transplant must be confirmed by an appropriate **specialist medical practitioner** as being **medically necessary** and treatable only by a transplant. The transplant of all other organs, parts of organs (except for liver transplant) or any other tissue transplant is excluded.

Meningitis and/or meningococcal disease.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of meningitis and/or meningococcal disease including meningococcal septicaemia that results in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Motor neurone disease.

The unequivocal diagnosis of motor neurone disease by two appropriate **specialist medical practitioners**.

Multiple sclerosis.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of multiple sclerosis confirming more than one episode of well-defined neurological abnormalities and:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability to perform at least one of the **activities of daily living** without the assistance of an adult, or
- Expanded Disability Status Scale (EDSS) level of 7.5 or higher.

The diagnosis must be based on confirmatory neurological investigations e.g. lumbar puncture, evoked visual responses, evoked auditory responses and NMR (Nuclear Magnetic Resonance) evidence of lesions of the central nervous system.

Muscular dystrophy.

The unequivocal diagnosis of muscular dystrophy by an appropriate **specialist medical practitioner**.

Occupationally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV), acquired via blood transfusion or accidental means during the course of carrying out the **insured person's** normal occupation, with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to **us** within thirty days of the incident. The report must be supported by a negative HIV antibody test within seven days of the incident.

Transmission via any form of sexual activity or deliberate injection of a drug not prescribed by a **medical practitioner** is excluded.

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Open heart surgery.

Undergoing open heart surgery to treat a cardiac defect, cardiac aneurysm or benign cardiac tumour.

Repair via catheter surgery, minimally invasive 'keyhole' or similar techniques are excluded.

Out of hospital cardiac arrest.

A sudden unexpected stoppage of effective heart action which:

- isn't associated with any medical procedure, and
- is documented by an electrocardiogram, and
- occurs outside a hospital, and
- is due to either cardiac asystole (complete failure of the heart causing cardiac arrest) or ventricular fibrillation (heart abnormality with ineffective twitching of the heart chambers).

Paralysis.

The total and permanent loss of use of one or more limbs resulting from injury or disease.

Limb means an entire arm or leg and included in this definition is monoplegia, diplegia, hemiplegia, paraplegia, quadriplegia and tetraplegia. The diagnosis must be confirmed by a **specialist medical practitioner**.

Parkinson's disease.

The unequivocal diagnosis of Idiopathic **Parkinson's disease** by a **specialist medical practitioner** resulting in:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Peripheral neuropathy.

Irreversible loss of function of peripheral nerves, diagnosed by a **specialist medical practitioner** and resulting in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Peripheral neuropathy related to alcohol or drug use is excluded.

Pneumonectomy.

The removal of an entire lung. This must be considered the **medically necessary** treatment by an appropriate **specialist medical practitioner**.

Primary pulmonary hypertension.

Irreversible raised pressure in the pulmonary arteries with right ventricular enlargement established by investigations including cardiac catheterisation.

Severe burns.

Tissue injury caused by thermal, electrical or chemical agents that results in third degree burns to at least:

- 20% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or
- 50% of both hands requiring surgical debridement and/or grafting, or
- 25% of the face requiring surgical debridement and/or grafting.

Severe diabetes.

The confirmation by an appropriate **specialist medical practitioner** that the **insured person** has experienced at least two of the following complications as a direct result of diabetes:

- retinopathy that results in corrected visual acuity of 6/36 or worse in both eyes, or
- neuropathy causing:
  - irreversible autonomic neuropathy that results in postural hypotension and/or motility problems in the gut with intractable diarrhoea, or
  - polyneuropathy leading to severe mobility problems due to sensory and/or motor deficits, or
- chronic infection or gangrene that results in amputation of a whole hand or foot, or
- nephropathy causing chronic, irreversible kidney impairment for at least three months where the glomerular filtration rate has reduced to less than 28ml/min (chronic kidney disease stage 4, International Chronic Kidney Disease classification).

Severe inflammatory bowel disease.

The confirmed diagnosis by an appropriate **specialist medical practitioner** of either:

- Crohn's disease, or
- ulcerative colitis,

that has failed surgical treatment, is resistant to conventional medical intervention, and requires either:

- permanent immunosuppressive therapy, or
- surgical removal of the entire large bowel (colon and rectum).

Stroke.

A cerebrovascular incident including infarction of brain tissue, intracranial or subarachnoid haemorrhage, or embolisation from an intracranial source as evidenced by CT, MRI or similar scan.

Transient ischaemic attacks and cerebral symptoms due to migraine are excluded.

Systemic sclerosis.

The unequivocal diagnosis of systemic sclerosis, as confirmed by an appropriate **specialist medical practitioner**, causing:

- skin thickening accompanied by various degrees of tissue fibrosis, and
- chronic inflammatory infiltration in visceral organs, and
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Total deafness in both ears.

The total and irreversible loss of hearing both natural and assisted, in both ears as a result of sickness or injury as confirmed by a **specialist medical practitioner**.

Trauma conditions covered for a partial benefit.

Adult onset type 1 insulin dependent diabetes mellitus.

The diagnosis by a **specialist medical practitioner** after the **insured person's** 30th birthday with type 1 diabetes mellitus which requires insulin.

Alzheimer's disease diagnosis.

The unequivocal diagnosis of Alzheimer's disease by a **specialist medical practitioner**.

Aneurysm.

The **insured person** has either:

- a cerebral aneurysm of any size that is treated by a **specialist medical practitioner** surgically via clipping or endovascular surgery, or
- an aortic aneurysm that has been definitely identified through MRI or CT scanning and:
  - is larger than 5.5cm in diameter, or
  - is larger than 3.5cm in diameter and growing at a rate faster than 0.5cm in diameter per year, or
  - has ruptured.

Angioplasty – two vessels or less.

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

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Carcinoma in situ – without major treatment.

The first time diagnosis by a **specialist medical practitioner** with carcinoma in situ of the breast, cervix uteri, vagina, vulva, fallopian tubes, ovary, corpus uteri, anus, perineum, penis or testicle. Tumours must be classified as Tis according to the TNM classification or FIGO stage 0 with supporting histological evidence.

Chronic lymphocytic leukaemia.

The first time positive diagnosis by a **specialist medical practitioner** with chronic lymphocytic leukaemia of Rai stage 0.

Colostomy and/or ileostomy.

The undergoing of the creation of a permanent non-reversible opening, linking the colon or ileum to the external surface of the body.

Dementia diagnosis.

The unequivocal diagnosis with dementia by a **specialist medical practitioner**.

Early stage prostate cancer.

The first time positive diagnosis by a **specialist medical practitioner** with supporting histological evidence of early stage prostate cancer of TNM classification T1 (all categories) or Gleason score less than or equal to 5.

Hydrocephalus.

The requirement of a shunt to remove an excessive accumulation of cerebrospinal fluid or to relieve increased pressure within the cranium.

Loss of one limb.

The total and permanent loss of use of one hand or one foot.

Loss of sight in one eye.

The permanent and irreversible loss of sight in one eye must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Major burns.

Tissue damage caused by thermal, electrical or chemical agents that results in third degree burns to at least:

- 9% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or

- 50% of either hand, or combined over both hands, requiring surgical debridement and/or grafting.

Malignant melanoma diagnosis.

The first time positive diagnosis by a **specialist medical practitioner** with supporting histological evidence of malignant melanoma that is Clark Level 1 or 2 depth of invasion, and less than 1mm in thickness as measured using the Breslow method.

Multiple sclerosis diagnosis.

The unequivocal diagnosis with **multiple sclerosis** confirming more than one episode of well-defined neurological abnormalities by an appropriate **specialist medical practitioner**.

Parkinson's disease diagnosis.

The unequivocal diagnosis with Idiopathic **Parkinson's disease** by a **specialist medical practitioner**.

Severe osteoporosis.

The diagnosis with severe osteoporosis by an appropriate **specialist medical practitioner** before the **insured person's** 50th birthday: The diagnosis must confirm the following:

- suffers at least two vertebral body fractures or a fracture of the neck of the femur, due to osteoporosis, and
- has bone mineral density reading with a T-score of less than -2.5. This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis.

The diagnosis of severe rheumatoid arthritis by an appropriate **specialist medical practitioner** before the **insured person's** 50th birthday. The diagnosis must confirm all the following:

- morning stiffness of the joints, and
- swelling and pain in the joints of at least three joint groups, involving the corresponding joints on both sides of the body. One of the groups must be joints on the fingers or toes, or the knuckles of the hand or wrist, and
- small nodular swelling beneath the skin, and
- a positive rheumatoid factor test, and
- x-ray evidence showing multiple and extensive changes to joints typical of rheumatoid arthritis, and
- diffuse osteoporosis with severe hand and spinal deformity.

Systemic lupus erythematosus.

The unequivocal diagnosis of systemic lupus erythematosus by a **specialist medical practitioner**. The diagnosis must be made in a clinical setting based on the American College of Rheumatology (ACR) revised criteria and have evidence of lupus nephritis as confirmed by:

- grade 3 to 5 nephritis (WHO classification of lupus nephritis), and
- persisting proteinuria (more than 2+).

Total deafness in one ear.

The total and irreversible loss of hearing, both natural and assisted, in one ear as a result of sickness or injury as confirmed by an appropriate **specialist medical practitioner**.

Mortgage Protector. Total and permanent disability cover.

Your cover in detail.

1. Introduction.

This Total and permanent disability cover provides **you** with a lump sum payment if an **insured person** suffers a **total and permanent disability**.

The **policy schedule** will show which **insured person** this Total and permanent disability cover applies to and any Additional options that may apply.

2. Built-in benefits.

2.1 Total and permanent disability.

2.1.1 Total and permanent disability before age 65.

Total and permanent disability means that **we** are satisfied that one of the following events occurs before the **insured person's** 65th birthday:

a. **Own occupation.**

If own occupation is shown in the **policy schedule** for an **insured person,** then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months, and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever again to be able to work in any capacity in **their own occupation**,

Or

b. **Any occupation.**

If any occupation is shown in the **policy schedule** for an **insured person**, then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever again to be able to perform **their own occupation** or **any occupation**,

Or

c. **Home duties.**

If the **insured person** was not **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, regardless of whether own occupation or any occupation is shown in the **policy schedule**, **total and permanent disability** shall mean that **they**, for an uninterrupted period of at least three months:

- have been under medical supervision with the complete inability to perform all normal **home duties**, and
- have been unable to leave the home without assistance, and
- in **our** reasonable opinion based on medical and other relevant evidence, is unlikely to ever again be able to perform all normal **home duties**,

Or

d. has suffered the total and permanent loss of the:

- sight of both eyes, or
- use of two limbs, or
- sight of one eye, and the loss of the use of either a whole hand, or a whole foot.

Loss of the sight in an eye must be confirmed by an ophthalmologist and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above,

Or

e. is totally and permanently unable to perform at least two **activities of daily living** as a result of sickness or injury without the assistance of an adult,

Or

f. has suffered a sickness or injury of the brain resulting in permanent and irreversible loss of cognitive function that requires the **insured person** to be under continuous full time care for **their** safety to prevent such situations including but not limited to wandering away from **their** usual place of residence, physical aggression, neglect of self-care, misjudging or causing situations that are dangerous for themselves or others.

   The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

   - Short or long term memory
   - Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
   - Deductive or abstract reasoning

2.1.2 Total and permanent disability from age 65 to age 70.

If **we** are satisfied that after the **insured person's** 65th birthday **they** were continuing to perform **their** usual occupational duties without limitation or restriction due to sickness or injury for at least 25 hours per week, then **we** will assess any claim for **total and permanent disability** made before **their** 70th birthday under the definition that applied before the **their** 65th birthday.

If the **insured person** was performing **their** occupational duties with limitations or restrictions due to sickness or injury, **we** will assess the claim under the definition applying under section 2.1.4.

2.1.3 Home duties from age 65.

If the **insured person** was not **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties** and the event causing the **total and permanent disability** happens after the **their** 65th birthday, **we** will assess the claim under the definition applying under section 2.1.4.

2.1.4 Total and permanent disability from age 70.

Where the event causing the **total and permanent disability** happens after the **insured person's** 70th birthday, or where sections 2.1.2 or 2.1.3 apply, the following definition applies:

Total and permanent disability means that **we** are satisfied that the **insured person**:

a. has suffered the total and permanent loss of the:

   - sight of both eyes, or
   - use of two limbs, or
   - sight of one eye, and the loss of the use of either a whole hand, or a whole foot.

Loss of the sight in an eye must be confirmed by a **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above,

Or

b. is totally and permanently unable to perform at least two **activities of daily living** as a result of sickness or injury without the assistance of an adult,

Or

c. has suffered a sickness or injury of the brain resulting in permanent and irreversible loss of cognitive function that requires the **insured person** to be under continuous full time care for the **insured person's** safety to prevent such situations including but not limited to wandering away from **their** usual place of residence, physical aggression, neglect of self-care, misjudging or causing situations that are dangerous for themselves or others.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

2.1.5 Partial benefit.

We will pay a **partial benefit** if the **insured person** suffers the total and permanent loss of use of one hand, one foot or the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of less than 6/60 in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

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2.2 How much do we pay?

When the **insured person** suffers a **total and permanent disability**, **we** will pay **you** either:

- the **sum insured**, or
- if the **total and permanent disability** is a **partial benefit,** 25% of the **sum insured** up to $75,000.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), then **we** will reduce the **sum insured** and **our** payment so that when added to any amount paid or payable under the existing policy, the total for that **insured person** does not exceed $5,000,000.

The Total and permanent disability cover **sum insured** will reduce by any partial payment of the **sum insured** payable under this cover. **We** will adjust the premium accordingly. If **we** pay the full **sum insured**, Total and permanent disability cover will end for that **insured person.**

2.2.1 Total and permanent disability cover – accelerated.

If the **policy schedule** shows Total and permanent disability cover – accelerated applies to an **insured person**, payment of the Total and permanent disability cover – accelerated **sum insured** is an advance payment of the Life cover this Total and permanent disability cover – accelerated is attached to. **We** will reduce that Life cover by the amount **we** pay for the **total and permanent disability** and adjust the premium accordingly.

Their Total and permanent disability cover – accelerated **sum insured** cannot exceed **their** Life cover **sum insured**.

2.3 Total and permanent disability early payment.

If the cause of the **insured person's total and permanent disability** is due to one of the below conditions, **we** will waive the requirement for **them** to be absent from employment or unable to undertake full-time **home duties** for an uninterrupted period of three months. The conditions are:

- Alzheimer's disease
- Cardiomyopathy
- Chronic lung disease
- Dementia
- Major head trauma
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease
- Severe rheumatoid arthritis
- Systemic sclerosis

2.4 Financial planning benefit.

When **we** pay a lump sum benefit of at least $100,000 to a beneficiary under this Policy, **we** will reimburse, up to a maximum of $2,500, the cost of a fully documented financial plan prepared by a financial advice provider providing a financial planning service for the beneficiary.

Where there is more than one beneficiary, **we** will divide the Financial planning benefit equally between those beneficiaries who each receive a benefit of at least $100,000.

The reimbursement must be claimed within six months of receiving the lump sum benefit and will be payable only once in respect of all policies with **us** covering the same **insured person**.

We will require evidence to show that the financial plan has been provided, the qualifications of the financial adviser and the costs charged by the financial advice provider.

2.5 Special events.

You can increase an **insured person's sum insured** once in any 12-month period before **their** 55th birthday without providing additional health information if one of the circumstances shown below occurs.

a. **You** can increase **their sum insured** by up to the lesser of $250,000 or 25% of **their sum insured** at the **start date** of the cover if any of the following events apply to **them**:

- marriage, civil union, divorce or being subject to a separation agreement or order, or
- birth or adoption of a **child**, or
- dependent **child** starting secondary school, or
- reaching ages 25, 30, 35, 40 or 45, or
- death of a spouse, defacto partner, **child** or civil union partner, or
- **they** permanently stop work to provide full time physical care for the first time for a dependant **relative** who did not require full time physical care before the **start date**.

b. If **they** take out or increase a mortgage on **their** own home, **you** can increase **their sum insured** by up to the lesser of:

- 50% of the **sum insured** at the **start date**, or
- the increase in the value of the existing mortgage or the amount of a new mortgage, or
- $250,000.

c. If **they** have a **salary** increase of at least $10,000 or a **salary** increase of at least 10% of **their salary**, **you** can increase **their sum insured** by up to the lesser of:

- 25% of the **sum insured** at the **start date**, or
- 5 times the increase in **their salary**, or
- $250,000.

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Conditions.

a. **You** must exercise a Special events increase in writing with supporting evidence within the later of either:

- six months following the event, or
- 30 days of the following **policy anniversary**.

b. An increase under Special events is not available if:

- The **sum insured** at the **start date** includes a premium loading greater than 100%.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums are not up to date or are being waived for any reason.

c. Any special terms and loadings that applied to the **sum insured** at the **start date** will also apply to the increase on that cover.

d. **Your** premiums will increase in line with the increased **sum insured**. **We** will calculate the premium for the increase using the **insured person's** age at the date **you** exercise a Special events increase. The increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional premium.

e. The maximum increase for an **insured person** for all events is the lesser of:

- $1,000,000, or
- the **sum insured** at the **start date**.

f. If the **insured person** has Total and permanent disability cover – accelerated, **their** Total and permanent disability **sum insured** cannot exceed the Life cover **sum insured**.

g. The total cover when added to all other total and permanent disability type covers with any insurer, after an increase cannot exceed $5,000,000.

2.6 Premium holiday option.

You can apply to **us** in writing once to ask **us** to suspend this Total and permanent disability cover and the premiums for an **insured person** for up to 12 consecutive months. The Premium holiday option is only available for the following reasons: redundancy, bankruptcy, tertiary studies or overseas travel.

You must advise **us** how long **you** want the cover and the premiums suspended. In applying for the Premium holiday option **you** acknowledge that reinstating this Total and permanent disability cover within the 12-month period is **your** sole responsibility. **You** can exercise this Premium holiday option during the days of grace by writing to **us** advising the reason why premium payments have stopped.

Conditions.

a. **We** will acknowledge the request, suspend this cover confirming that the Premium holiday option has been activated if a valid reason is given. **We** may require evidence of the reason for the suspension.

b. The maximum **sum insured** under this Premium holiday option is $500,000.

c. **You** can reinstate this Total and permanent disability cover without providing the **insured person's** health information.

d. From the date **you** reinstate this Total and permanent disability cover, premiums are payable on the same terms that applied before the premium holiday. **We** will base the premium on the **insured person's** current age and the premium rates that apply at that time.

3. Additional options.

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

How **we** apply the CPI is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** will be applied on the earlier of:

- the **policy anniversary** before **their** 65th birthday, or
- the total sum insured for all total and permanent disability type cover/s for that **insured person** with **us** and any other insurer, reaches $5,000,000.

3.2 Buy back option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

12 months after the payment of the full **sum insured** under the Total and permanent disability cover – accelerated **you** may buy back the Life cover without providing additional health information.

The maximum amount of Life cover that **you** can buy back is the Total and permanent disability cover – accelerated amount **we** paid. **We** will contact **you** to let **you** know that the option is able to be exercised.

You may exercise this Buy back option once only within 90 days after the end of the 12-month period and before the **insured person's** 65th birthday.

Once the Life cover has been bought back, the portion of the Life cover which has been bought back cannot be bought back again at any time.

We will calculate the premium based on the rates applicable for the **insured person's** age and the Life cover **sum insured** bought back at the time **you** exercise the Buy back option.

Any Life cover bought back under the Buy back option will be subject to the same terms and conditions that applied to the Life cover when issued.

4. Claims

4.1 Notice.

You or the **insured person** must notify **us** in writing immediately or as soon as practically possible if **you** or **they** become aware of any claim or potential claim under this Total and permanent disability cover.

We will advise **you** of the requirements **we** need to assess **your** claim.

We will not pay any claim until **we** receive all the requirements **we** need to assess the claim and confirm that the **insured person** meets the definition of **total and permanent disability**.

4.2 Obligations.

You and the **insured person** (if possible) must:

- Complete **our** claim form in full and send it to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of **their** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of **their** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require. This may include financial and occupational evidence.

The **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the occurrence of the **total and permanent disability**.
- Undergo one or more medical examinations if **we** reasonably request **them** at **our** expense. This may include blood tests and medical testing.
- **We** may also request other additional claim proofs necessary to complete **our** assessment of the claim including an independent opinion from an appropriate **medical practitioner** or **specialist medical practitioner** approved by us.

You must pay any expenses incurred in proving **your** claim.

5. Exclusions.

You cannot claim under this cover in connection with an intentional self-inflicted act or injury.

6. When this cover ends.

This Total and permanent disability cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Total and permanent disability cover, or

b. this Policy ends for any reason, or

c. **we** pay the **sum insured** for that **insured person**, or

d. **they** die, or

e. of **their** 100th birthday.

7. General definitions.

The definitions shown below apply to all derivatives of the words defined.

Any occupation.

An occupation for which the **insured person** is suited to by education, training or experience, which would remunerate at a rate greater than 25% of **their** earnings over the last 12-month period of employment.

Gainfully employed.

Working in an occupation or job as an employee for reward, salary, commission or any other income. For an **insured person** who is self-employed, working in any business or professional practice which could produce income for that business or professional practice.

Home duties.

The duties normally associated with a person who is engaged in full time unpaid home duties within the family home, and is not employed in any occupation or working outside the **insured person's** home for salary, reward or profit and includes:

a. Cleaning the family home, such as using a vacuum cleaner, sweeping with a broom, using a mop and cleaning dishes (automatic or manual).

b. Cooking the family meals, such as preparing fresh and frozen food and using an oven, stove or microwave oven.

c. Doing the family's laundry, such as loading and unloading a washing machine, hanging out clothes or using a dryer, folding clothes and ironing.

d. Shopping, such as attending shops or using the phone or internet to purchase food for the family.

e. Taking care of the **insured person's** dependent children (where applicable) such as supervising, lifting, transporting, feeding and bathing.

We will not consider an **insured person** who is actively seeking employment or is performing less than full time unpaid **home duties** to be performing **home duties**.

Own occupation.

The field of work in which the **insured person** has trained in, specialises in and was engaged in immediately before becoming **totally and permanently disabled**.

Partial benefit.

A part payment of the **sum insured**.

Total and permanent disability.

A sickness or injury resulting in the **insured person** meeting the definition as outlined in section 2.1.

Mortgage Protector.
Monthly mortgage repayment cover.

Your cover in detail.

1. Introduction.

This Monthly mortgage repayment cover provides **you** with a monthly payment while the **insured person** is **totally disabled** or **partially disabled**.

The **policy schedule** will show which **insured person** this Monthly mortgage repayment cover applies to and any Additional options that may apply.

2. Built-in benefits

2.1 Total disability benefit.

If the **insured person**:

- has been **totally disabled** or **partially disabled** for the **waiting period**, and
- is **totally disabled** at the end of the **waiting period**,

we will pay **you** the **monthly benefit** monthly in advance from the end of the **waiting period** until the earliest of:

- **they** are no longer **totally disabled**, or
- the **benefit period** ends, or the cover ends (see section 7).

Any payment for a period of less than one month is calculated on a pro-rata basis.

2.1.1 Monthly benefit over $5,000 at claim time.

If the **insured person**:

a. Doesn't have a **mortgage**, the amount of **monthly benefit** in excess of $5,000 will be reduced by **other income**.

b. Has a **mortgage**:

- if the amount insured at time of application is the total mortgage repayment, the amount of **monthly benefit** in excess of $5,000 will be reduced by any **gross income**, or
- if the amount insured at the time of application is the total mortgage repayment less **gross income**, the amount of **monthly benefit** in excess of $5,000 will be reduced by any increase in the **gross income** between application time and claim time.

2.2 Partial disability benefit.

If the **insured person**:

- has been **totally disabled** or **partially disabled** for the **waiting period**, and
- is **partially disabled** either:
  - at the end of the **waiting period**, or
  - following a period of **total disability**,

we will pay **you** the Partial disability benefit monthly in arrears until the earliest of:

- **they** are no longer **partially disabled**, or
- the **benefit period** ends, or
- the cover ends (see section 7).

Any payment for a period of less than one month is calculated on a pro-rata basis.

2.2.1 How much do we pay?

We will pay the lesser of:

- the **monthly benefit**, or
- (A - B) / A x **monthly benefit**

'A' is **pre-disability income**.

'B' is the **monthly earned income**.

If the percentage loss of **monthly earned income** is 75% or more, **we** will consider the loss to be 100%.

The amount **you** receive including **other income** will not exceed 75% of the **insured person's pre-disability income**.

Capacity to work.

When the **insured person** is **partially disabled** and has the capacity to work more hours than **they** are working, **we** will calculate **their** benefit based on what **they** could reasonably be expected to earn. In this situation, **we** will pay:

((A – B) / A) x the **monthly benefit** less **other income**

- 'A' is **pre-disability hours**.
- 'B' is **post-disability hours**.

2.3 Family member support benefit.

We will pay **you** this benefit when all the following apply to an **insured person**:

a. **they** are **totally disabled** and confined to bed, and

b. a **medical practitioner** certifies that **they** require full time care, and

c. the income of one **immediate family member** stops as a result of that person providing **them** care.

We will pay an additional amount for a maximum of three months of the least of:

- one half of the **monthly benefit**, or
- $3,000 per month, or
- the income foregone by the **immediate family member.**

The benefit is payable once only for the **insured person** and any amounts payable under the Hospitalisation/nursing care benefit will be deducted when calculating the benefit amount.

2.4 Hospitalisation/nursing care benefit.

We will pay **you** the **monthly benefit** on a pro-rata basis for each full day an **insured person** is **totally disabled** in the **waiting period** and:

a. is under the care of a Registered Nurse (on the advice of a **medical practitioner**) visiting at least once a day, and

b. remains in or near a bed for a substantial part of each day, and

c. has received that nursing care for at least 72 hours.

We will pay this benefit for the lesser of:

- the **waiting period**, or
- 90 days.

Subsequent claims under this benefit during the same **waiting period** do not require condition c. of this benefit to be satisfied again.

2.5 Rehabilitation and retraining benefit.

Where the **insured person** is **totally disabled** for longer than the **waiting period**, **we** may work with **them** to put a rehabilitation plan in place to help **them** return to paid work.

If the rehabilitation plan **we** agree to requires **them** to participate in a rehabilitation, retraining or re-education program to assist **them** to return to paid work for a minimum of 20 hours per week, then **we** will reimburse the costs approved by **us** provided they are not reimbursed, or able to be reimbursed, from any other source.

The reimbursement will be 50% of the approved costs incurred each month, up to a maximum of 50% of the **monthly benefit**, upon proof that **they** continue to fully participate in the program. The remaining 50% of costs, up to a maximum of 50% of the **monthly benefit**, will be reimbursed once **they** have returned to paid work for a minimum of 20 hours per week.

The maximum amount **we** will pay for each sickness or injury is equal to 12 times the **monthly benefit**. If **they** experience a recurrence of that sickness or injury either under the Recurring claim benefit under section 2.8 or Benefit period reset under section 2.9, **we** will only reimburse expenses up to the remainder of the maximum period not previously paid. If **they** experience a new disablement, **we** may consider reimbursement of further rehabilitation and re-training costs.

2.6 Recovery support benefit.

We will pay the costs, up to a maximum of six times the **monthly benefit**, of purchasing specialist equipment or completing home alterations which are reasonably necessary based on an external specialist assessment.

The costs under this Recovery support benefit include (but are not limited to) wheelchairs, artificial limbs, prosthetic devices, travel, and house and car modifications.

The Recovery support benefit will be reduced by any costs reimbursed from any other source.

The Recovery support benefit is paid in addition to the **monthly benefit**.

2.7 Relocation benefit.

If an **insured person**:

a. has been residing outside New Zealand for more than three consecutive months, and

b. is **totally disabled** while outside New Zealand, and

c. a **medical practitioner** advises that **they** are likely to remain **totally disabled** for at least three months,

we will reimburse **you** the lesser of:

- $5,000, or
- the actual cost of a single standard economy airfare from **their** location to New Zealand by the most direct route, less any amounts reimbursable from other sources.

We will pay this Relocation benefit once only for each **insured person** regardless of other covers which may include this Relocation benefit. This benefit is paid in addition to the **monthly benefit**. **You** will need to provide **us** with the original invoice and receipt for payment before **we** pay a claim.

2.8 Recurring claim benefit.

We will waive the **waiting period** on a recurrent claim if:

a. an **insured person** was no longer **totally disabled** or **partially disabled**, and

b. during the first 12 months after the claim ends, **they** become **totally disabled** or **partially disabled** again because of a recurrence of the same or related injury or sickness.

We will treat the recurrent claim as a continuation of the previous claim and these payments together with the payments made under the previous claim will be added together when applying the **benefit period**.

We will pay the Total disability benefit or Partial disability benefit from the date of the recurrence of the **total disability** or **partial disability** under the terms of section 2.1 or 2.2.

2.9 Benefit period reset.

The **waiting period** and a new **benefit period** will apply where an **insured person**:

a. was no longer **totally disabled** or **partially disabled**, and

b. has returned to full time paid work performing all the important income producing duties without limitation for at least:

- 12 continuous months, where the full **benefit period** has not been used at the date of that recurrence, or
- six continuous months where the full **benefit period** has been used at the date of that recurrence, and

c. is not eligible for the Recurring claim benefit, and

d. becomes **totally disabled** or **partially disabled** because of a recurrence of the same or related injury or sickness for which **we** have previously paid a **total disability** or **partial disability** claim under this Monthly mortgage repayment cover.

This Benefit period reset does not apply to **them** where **they** are **totally disabled** or **partially disabled** as a result of a **mental disorder** or **back disorder** where the Mental and back disorder limitation is shown in the **policy schedule** for **them**.

2.10 Waiver of waiting period.

We will not apply the **waiting period** on a new claim for an **insured person** resulting from a sickness or injury unrelated to a previous claim provided that:

- a **waiting period** applied to the previous claim, and
- the new claim occurs within 12 months of **their** return to work from the previous unrelated

claim, and

- the new claim is for a continuous period of 30 days or more.

We will pay the Total disability benefit or Partial disability benefit from the date of that **disability** or **partial disability** under the terms of section 2.1 or 2.2.

2.11 Reduction in waiting period.

You can apply to reduce an **insured person's waiting period** without providing any health, occupation or financial information if a Key person cover or Business expenses cover **they** are the **insured person** on with **us** is cancelled. The **waiting period** on this Monthly mortgage repayment cover will be reduced to match the **waiting period** on the cancelled cover. The reduced **waiting period** on this cover will apply to the lesser of:

- the monthly benefit for the Key person cover or Business expenses cover when it was cancelled, or
- the **monthly benefit** for this cover.

If **they** resign from a job which results in either a reduction in sick leave entitlement or the loss of income insurance provided by **their** previous employer, **you** can apply for a reduction in **waiting period** without providing any health information. To support this application, **you** will need to provide **us** with the following:

- Details of the change in circumstance which supports the need for a shorter waiting period
- Occupation and financial information

Conditions.

a. **You** must make the application in writing with supporting evidence within 60 days of the cancellation of cover or resignation from job.

b. The **insured person's** resignation must not be due to retirement, ill health or incapacity.

c. The **insured person** must be under the age 59 at the time of the reduction.

d. The **insured person** must not have either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.

e. The premiums must be up to date and not being waived for any reason.

f. **Your** premiums will increase with any reduction in **waiting period**.

g. Once the **waiting period** has been reduced under this benefit, no further reductions will be allowed without evidence of health.

2.12 Future insurability.

You can increase an **insured person's monthly benefit** if **they** take out a new **mortgage** or increases **their** existing **mortgage** without providing additional health information in respect **them**, subject to the conditions below.

We will calculate the premium increase based on the **insured person's** age, occupation and premium rates at the time of the increase.

a. **You** must apply for this benefit:

   - within 90 days of the **insured person** taking out a new **mortgage** or increasing **their** existing **mortgage**. **We** will require evidence of the new **mortgage** or increase in the existing **mortgage**, and
   - before **their** 50th birthday.

b. The maximum for any one increase is the lesser of:

   - 110% of the increase in the **mortgage** repayment in excess of the **monthly benefit**, or
   - $300 per month.

c. The total of all increases under this option is 50% of the initial **monthly benefit**.

d. This Future insurability benefit is not available if the **insured person** is in the process of claiming or has claimed any benefit under this Policy.

2.13 Leave without pay.

You can apply to **us** in writing to ask **us** to suspend this Monthly mortgage repayment cover and its premiums for an **insured person** for up to 12 consecutive months. Leave without pay is only available for the following reasons: compassionate leave, maternity leave, paternity leave, sabbatical leave, study leave at a registered educational centre or involuntary unemployment. The period of leave without pay from **their** occupation must be for reasons other than disability.

You must advise **us** how long **you** want the cover and the premiums suspended. In applying for the Leave without pay benefit **you** acknowledge that reinstating this Monthly mortgage repayment cover within the 12-month period is **your** sole responsibility.

While this cover is suspended there will be no cover. This means **we** will not pay a claim for any event that would have been covered if this Monthly mortgage repayment cover was not suspended for any sickness or injury:

- which first existed, or
- where its direct cause first existed, or
- where the **insured person** first had knowledge, signs or symptoms of, whether or not medical treatment was sought, or
- where any test or investigation first showed its likely presence,

while **their** Monthly mortgage repayment cover was suspended.

You cannot make any claim for **them** unless **you** have restarted making premium payments and **they** have:

- returned to **their** usual occupation, and

- worked for at least 25 hours per week for at least one month after returning to work, and
- been continuously employed since returning to work, and
- returned to work within 12 months of the period of leave without pay starting.

We will pay a pro rata **monthly benefit** if **you** make a claim where **they** have returned to work part-time.

Conditions.

a. This cover must have been in place for at least 12 consecutive months.

b. **We** will acknowledge the request and suspend this cover confirming that the Leave without pay benefit has been activated if a valid reason is given. **We** may require evidence of the reason for the suspension.

c. Involuntary unemployment must not have occurred within six months of **their** Monthly mortgage repayment cover's **start date** or the date it or this Policy is reinstated. Involuntary unemployment does not include bankruptcy.

d. The maximum **monthly benefit** that can be suspended under this leave without pay benefit is $8,000 per month.

e. **You** can reinstate this Monthly mortgage repayment cover without providing **their** health information.

f. From the date **you** reinstate this Monthly mortgage repayment cover, premiums are payable on the same terms that applied before the period of leave without pay or involuntary unemployment. **We** will base the premium on **their** current age at the date of reinstatement and the premium rates that apply at that time.

g. **They** must have had a continuous period of at least 12 months employment since the previous period of leave without pay or involuntary unemployment before **you** can use this leave without pay benefit again.

h. The maximum period of leave without pay or involuntary unemployment is 12 months over the entire term of this Policy.

3. Additional options.

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

How **we** apply the CPI option is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** will be applied on the **policy anniversary** before **their** 65th birthday.

If **we** are paying **you** a Total disability benefit or a Partial disability benefit under this cover, **your** claim payments won't be increased by CPI unless the Claims escalation option is included in this cover.

3.2 Claims escalation option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

If the **monthly benefit** is paid continuously for more than three months, **we** will increase the **monthly benefit** on each quarter of the date payment started, by a rate **we** determine based on the percentage increase of the consumer price index. The amount of the increase in the **monthly benefit** will be the quarterly equivalent of the annual rate of the increase in the consumer price index **we** determine.

3.3 Extra benefits option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

The following benefits are included in this Extra benefits option:

3.3.1 Death benefit.

If the **insured person** dies while this cover is in place, **we** will pay an additional amount equal to three times the **monthly benefit** to **their** legal personal representative.

3.3.2 Specified medical condition benefit.

If the **insured person** suffers a specified medical condition as listed below and defined in section 9, **we** will consider **them** to be **totally disabled**.

Angioplasty – triple vessel

Aorta surgery

Cancer

Chronic kidney failure (renal failure)

Coronary artery bypass surgery

Heart attack

Heart valve surgery

Major organ transplant

Multiple sclerosis

Paralysis

Severe burns

Stroke

We will pay the **monthly benefit** for six months following **them** being diagnosed for the first time as having suffered from any of the above conditions, whether or not **they** are working. The benefit can be paid as a monthly benefit or a lump sum calculated by multiplying the **monthly benefit** by six.

The payment is instead of any other benefit under this cover. If **they** are **totally disabled** or **partially disabled** at the end of the six months, any further benefits will be determined under sections 2.1 or 2.2. If **they** die before the end of the payment period, and **we** were paying the benefit as a monthly benefit, **we** will pay the remainder of the monthly payments in a lump sum.

Stand-down period.

If the conditions stated below occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the **insured person**, or would have become apparent to a reasonable person in **their** position, within three months of:

- the **start date** or the date of reinstatement, then no benefit will ever be payable for that **condition** under this benefit or
- the date of any increase in the **monthly benefit**, (excluding increases due to the CPI option), then no benefit will ever be payable for that condition for that increase in **monthly benefit**.

The stand down applies to the following conditions:

a. **Cancer**, **heart attack**, or **stroke**

b. **Angioplasty – triple vessel** if there was narrowing or blockage of one or more arteries

c. **Coronary artery bypass surgery** if there existed disease of the arteries

d. **Aorta surgery** if there was narrowing, dissection or aneurysm of the abdominal or thoracic aorta

e. **Heart valve surgery** if there was heart valve defects or abnormalities

The **stand-down period** will not apply if **they** had similar cover with **us** or another insurance company and this cover replaced that cover, up to the **monthly benefit** under the replaced cover, provided the previous cover had been in force for at least three months.

3.3.3 Specific injury benefit.

If an **insured person** suffers an injury listed below, **we** will pay the **monthly benefit** for the lesser of the payment period shown in the table below or the **benefit period**, whether or not **they** are working. This benefit is paid in advance from the date **they** suffer the injury and is not subject to **other income**.

If **they** suffer more than one listed injury, the injury that provides the longest payment period will be paid. The payment is instead of any other benefit under this cover.

If **they** are **totally disabled** or **partially disabled** at the end of the payment period, any further benefits will be determined under sections 2.1 or 2.2. If **they** die before the end of the payment period, **we** will pay the remainder of the monthly payments in a lump sum.

Specific Injury means:	Payment Period
Fracture of skull, jaw	30 days
Fracture of forearm, collarbone	30 days
Fracture of wrist, hand (excluding fingers)	45 days
Fracture of upper arm, shoulder bone, elbow	60 days
Fracture of vertebrae	60 days

Fracture of kneecap	60 days
Fracture of ankle, heel	60 days
Fracture of leg below the knee (tibia or fibula)	60 days
Fracture of leg above the knee (femur), pelvis	90 days
Loss of thumb and index finger of the same hand	6 months
Loss of one foot or one hand or sight in one eye	12 months
Loss of one leg or arm	18 months
Loss of any combination of two of the following: a hand, a foot, sight in one eye	24 months
Loss of both feet or both hands or sight of both eyes	24 months
Paralysis (Diplegia, Hemiplegia, Paraplegia, Quadriplegia, Tetraplegia)	60 months

Fracture means the disruption in the continuity of bone, with or without displacement, as a result of an accident. The fracture must be shown by radiographic or scanning techniques and must be diagnosed by a **medical practitioner** within 30 days of the incident giving rise to the fracture.

Fracture does not include:

- osteoporotic fractures, or
- an avulsion fracture, or
- a hairline fracture, or
- a stress fracture, or
- bone bruising.

Loss means the total and permanent:

- loss of the use of the hand from the wrist or the foot from the ankle joint, or
- loss of the use of the arm from the elbow or leg from the knee joint, or
- complete severance of the thumb and index finger from the metacarpophalangeal joint, or
- irrecoverable total loss of an eye or sight in the eye.

3.3.4 Total and permanent disability.

If the **insured person** suffers a total and permanent disability, **we** will pay 24 times the **monthly benefit** as a lump sum if a **monthly benefit** has been paid for 12 consecutive months in respect of **them**.

Total and permanent disability means that based on medical evidence and other relevant evidence, **they** are:

- unlikely to ever be able again to perform at least two of the **activities of daily living** without the assistance of an adult, or
- unable to perform one of the **activities of daily living** without the assistance of an adult and **their** intellectual capacity has deteriorated to such an extent that requires **them** to be under continuous full time care for **their** safety to prevent such situations including but not limited to wandering away from **their** usual place of residence, physical aggression, neglect of self-care, misjudging or causing situations that are dangerous for themselves or others.

3.4 Booster benefit option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

The following are included in this Booster benefit option:

3.4.1 Total disability booster.

If **we** are paying **you** a Total disability benefit as set out in section 2.1, **we** will increase the amount **we** pay **you** for that **insured person** by one third for a maximum of three months from the end of the **waiting period** for any one continuous period of **total disability**.

This Total disability booster applies to a continuous period of **total disability** for an injury or sickness and does not apply to any other benefit payments for **them** under this Policy.

3.4.2 Partial disability booster.

If **we** are paying **you** a Partial disability benefit as set out in section 2.2, **we** will increase the amount **we** pay **you** for that **insured person** by 25%, until the earliest of the following:

- 12 months from the date **you** are entitled to the Partial disability booster payment for that injury or sickness, or
- **we** have paid the Partial disability booster for a total of 12 months for that injury or sickness, including any period **you** receive the Partial disability booster due to **them** suffering a recurrence of that same or related injury or sickness, or
- **they** are no longer **partially disabled**.

This Partial disability booster applies to a continuous period of **partial disability** for an injury or sickness under this Monthly mortgage repayment cover and does not apply to any other benefit payments for **them** under this Policy.

The amount **you** receive including **other income** will not exceed 100% of **their pre-disability income**.

3.5 Extended benefit option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

If:

a. **they** meet the **occupation class** 5 definition of **total disability**, and

b. **they** have reached age 65, and

c. The **monthly benefit**, subject to the limitations of section 2.1.1 of this cover was payable for at least three months before **their** 65th birthday,

then a benefit will be paid until the earlier of:

- **they** die, or
- **they** no longer being **totally disabled** to the extent of the **occupation class** 5 definition.

The benefit payable after **their** 65th birthday will be equal to the monthly benefit paid before **their** 65th birthday and the Claims escalation option, if applicable, will not apply.

3.6 Mental and back disorder limitation.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

If an **insured person** has this limitation and suffers from a **mental disorder** and/or a **back disorder**, **we** will pay benefits for a maximum period of 24 months regardless of the **benefit period**.

We will consider successive periods of **total disability** or **partial disability** due to the same or a related **mental disorder** and/or **back disorder** as an extension of the previous period of **total disability** or **partial disability**. **We** will reduce the maximum period under this clause by the length of time for which benefits have already been paid for **them**.

This Mental and back disorder limitation does not apply if **they** are unable to perform at least two **activities of daily living** without the assistance of an adult.

4. Claims.

4.1 Notice.

You or the **insured person** must notify **us** in writing immediately if **you** or **they** become aware of any circumstance likely to lead to a claim.

We will advise **you** or **them** of the requirements **we** need to assess **your** claim.

If **we** receive notification of a claim more than 60 days after the date **they** were **totally disabled** or **partially disabled**, **we** reserve the right to start benefits from the date of notification.

4.2 Obligations.

You and the **insured person** must throughout the life of the claim:

- Complete **our** claim forms in full and send it to **us** as soon as reasonably possible.
- Authorise the disclosure to **us** of **their** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of **their** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require. This may include but is not limited to financial, medical and occupational evidence.

The **insured person** must throughout the life of the claim:

- Obtain medical treatment as soon as reasonably possible from a **medical practitioner** and follow their advice including medical treatment, surgical treatment and rehabilitation plans.
- Undergo one or more medical examinations and attend any specialist **medical practitioner** or other appointments arranged by **us** at **our** expense if **we** reasonably request **them** for the purposes of assessing and managing **your** claim. This may include blood tests and medical testing.
- Co-operate with **us** in development and implementation of any rehabilitation plan.

You must pay any expenses incurred in proving **your** claim.

If **you** or **they** do not meet any of the above when reasonably requested by **us**, **we** have the right to either decline or stop the claim. **We** will give **you** notice in writing of **our** intention to stop the claim and set out **our** requirements to restart payment. Payments will not be made for any time the claim was stopped and will only recommence from the date **we** receive all the outstanding requirements

4.3 Payments.

Benefits are paid monthly in arrears unless otherwise specified. Any payment for a period of less than one month is calculated on a pro-rata basis.

5. Exclusions.

You cannot claim under this cover for sickness or injury in connection with:

a. The normal effects of pregnancy or childbirth.

b. Self-inflicted act or injury.

c. Any specific event or cause agreed between **you** and **us** and endorsed on the **policy schedule**.

6. Limitations.

6.1 Concurrent disability.

For each **insured person you** can only claim for one **total disability** or **partial disability** under this cover at any one time.

6.2 Unemployment.

If the **insured person** has been unemployed or on parental leave for 12 months or more immediately before a period of **total disability**, then **we** will consider the **occupation class** to be **occupation class** 5 and will pay the claim on that basis.

Long service or sabbatical leave is not considered as unemployment.

Other income will be deducted from any benefits payable.

7. When this cover ends.

This Monthly mortgage repayment cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Monthly mortgage repayment cover, or

b. this Policy ends for any reason, or

c. **their** 65th birthday, or

d. **they** die.

8. General definitions.

The definitions shown below apply to all derivatives of the words defined.

Back disorder.

Any disease, disorder or injury to the spine, its intervertebral discs, nerve roots, supporting musculature or ligaments, which is caused by any disease or is as a result of any accident.

Benefit period.

The period shown in the **policy schedule** adjacent to Benefit period.

Immediate family member.

Spouse, de facto spouse, partner, son or daughter.

Gross income.

The rental income from an investment property before expenses relating to that investment property are deducted.

Mental disorder.

A manifestation of any disorder classified in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is most current on the date the **total disability** or **partial disability** began.

Mental disorders include, but are not limited to, the following disorders or combination of disorders:

- Anxiety, depression, behavioural disorder, psychoneurosis or psychosis
- Stress, fatigue, exhaustion, chronic fatigue syndrome
- Any psychiatric complication of physical disorders
- Drug or alcohol abuse
- Any other physical disorder related or attributable to stress or any other mental or nervous disorder

Monthly earned income.

Earnings per month from:

- the **insured person's** share of income (before tax) from any business, derived from **their** personal exertions, after deduction of **their** share of business expenses, and
- any other sources of income (before tax) including salary, wages, fees, commission, bonuses and fringe benefits.

This does not include income from deferred compensation plans, disability income policies, retirement plans or any other income not derived from **their** personal exertions.

Mortgage.

A mortgage on a residential property and/or investment property.

Occupation class.

The Occupation class shown in the **policy schedule** unless stated otherwise in this Policy.

Other income.

Income an **insured person** receives or is entitled to receive during a period of **total disability** or **partial disability** from any:

- other insurance policy covering the same risk,
- government funded source (such as ACC payments or any benefit) or a statutory source.

It does not include a lump sum payment (unless it is a commutation of a periodic benefit), interest, dividends from investments, rent or other similar payments.

Partially disabled/partial disability.

The **insured person** is partially disabled, if as a direct result of sickness or injury **they** are:

- under the regular and personal care of a **medical practitioner** who has provided **them** with written confirmation of the need to reduce **their** hours, and
- is working (or could work) but is:
    a. unable to earn (or incapable of earning) more than 75% of **their pre-disability income**, or
    b. unable to work (or incapable of working) more than 75% of the average hours **they** worked before the partial disability.

Post-disability hours.

The number of hours per week the **insured person** could reasonably be expected to work taking into account:

- available medical evidence (including the opinion of **their** treating **medical practitioner**), and
- any other relevant considerations directly related to **their** medical condition (including an independent assessment arranged by **us**).

Pre-disability hours.

The average number of hours per week the **insured person** worked in the twelve months immediately before becoming **totally disabled** or **partially disabled** subject to a maximum of 40 hours.

Pre-disability income.

The **insured person's** average **monthly earned income** for any 12 consecutive months in the three years immediately before the **total disability** or **partial disability** started. **We** will not include any period during which **they** have received a Total disability benefit or Partial disability benefit in the three-year period and will extend the three-year period by that period.

While the **insured person** is **totally disabled** or **partially disabled**, pre-disability income will be increased on the claim anniversary by a rate **we** determine based on the percentage increase of the **consumer price index**.

Totally disabled/total disability.

For **occupation classes** 1, 2, 3 and 4:

The **insured person** is totally disabled if as a direct result of sickness or injury **they** are:

- under the regular and personal care of a **medical practitioner**, and
- unable to:
  a. perform at least one important income producing duty, or
  b. engage in **their** own occupation for more than 10 hours per week, and
- not engaging in any occupation other than up to 10 hours per week in **their** own occupation.

For **occupation class** 5:

The **insured person** is:

- disabled to such an extent that necessitates confinement to the home under medical supervision or to a recognised medical institution and necessitates receiving regular medical care, or
- as a result of sickness or injury, **they** are unable to perform at least two of the **activities of daily living** without the assistance of an adult, and
- not working in any gainful occupation.

Waiting period.

The period shown in the **policy schedule** that must have passed before a benefit can be paid under this Policy unless stated otherwise. The waiting period starts from the date the **insured person** receives written notification from an appropriate **medical practitioner** confirming **they** are unable to work due to **total disability** or need to reduce hours of work due to **partial disability**.

Whole person function.

The evaluation of whole person function derived from the most recent edition of the American Medical Association's book Guides to the Evaluation of Permanent Impairment (Guides) as assessed by an appropriately qualified **medical practitioner**.

9. Specified medical condition definitions.

Angioplasty – triple vessel.

Undergoing a coronary artery angioplasty to correct narrowing or blockage of three or more coronary arteries within one or more procedures within a two-month period.

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Aorta surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to correct any narrowing, dissection or aneurysm of the abdominal or thoracic aorta by repair or its replacement.

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Cancer.

The confirmed presence of one or more invasive malignant tumours diagnosed by a **specialist medical practitioner** with supporting histological evidence of uncontrolled growth of malignant cells and invasion of normal tissue beyond the basement membrane. The term malignant tumour also includes leukaemia, sarcoma, malignant bone marrow disorders, and malignant lymphomas.

In addition to the above, only cancers meeting the following specified level of advancement for that cancer are covered:

- Hodgkin's and Non-Hodgkins lymphoma (all stages)
- Chronic lymphocytic leukaemia of Rai stage 1 or higher
- Malignant melanomas meeting any of the following criteria:
  - at least Clark Level 3 depth of invasion, or
  - 1mm Breslow thickness or greater, or
  - showing evidence of ulceration
- Prostatic cancers meeting any of the following:
  - at least TNM classification T2, or
  - a Gleason score greater than or equal to 6, or
  - the entire prostate has been removed through a prostatectomy, or
  - **medically necessary** treatment by radiotherapy or chemotherapy has been performed.
- Papillary and follicular carcinoma of thyroid of at least TNM classification T2
- Squamous cell carcinomas of the skin where the carcinomas have spread to other organs, bones or lymph nodes
- Other cancers not listed above of at least TNM classification T1

All other cancers are not covered. Specifically excluded are:

- Tumours showing the malignant changes of carcinoma-in-situ (including cervical dysplasia CIN1, CIN2 and CIN3).
- Tumours histologically classified as pre-malignant or having low-malignant potential.
- All hyperkeratoses or basal cell carcinomas of the skin.

Chronic kidney failure (renal failure).

End stage renal failure diagnosed by an appropriate **specialist medical practitioner** and presenting as chronic irreversible failure of both kidneys to function and resulting in regular renal dialysis being started.

Coronary artery bypass surgery.

Medically necessary coronary artery bypass graft surgery to correct coronary artery disease that is causing inadequate myocardial blood supply.

Angioplasty, intra-arterial procedures and other non-surgical techniques are excluded.

Heart attack.

The death of a portion of heart muscle as a result of inadequate blood supply. The basis of diagnosis must be confirmed by an appropriate **specialist medical practitioner** and evidenced by a typical rise and/or fall of cardiac biomarkers (Troponin I, Troponin T or CK-MB) and must also be supported by one of the following changes consistent with a heart attack:

- new cardiac symptoms and signs, or
- electrocardiogram (ECG) tests showing new significant changes, or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, **we** will consider other appropriate and medically recognised tests in support of the diagnosis.

The following are excluded:

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

Heart valve surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to replace or repair a cardiac valve or valves as a consequence of heart valve defects or abnormalities.

Major organ transplant.

The actual transplant, or placement on an official waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit, of one or more of the following organs or tissues:

- Kidney
- Heart
- Lung
- Liver (including live donor liver transplants)
- Pancreas
- Small bowel
- Bone marrow
- Blood-forming stem cell transplant

The transplant must be confirmed by an appropriate **specialist medical practitioner** as being medically necessary and treatable only by a transplant. The transplant of all other organs, parts of organs (except for liver transplant) or other tissue transplant is excluded.

Multiple sclerosis.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of multiple sclerosis confirming more than one episode of well-defined neurological abnormalities and:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability to perform at least one of the **activities of daily living** without the assistance of an adult, or
- Expanded Disability Status Scale (EDSS) level of 7.5 or higher.

The diagnosis must be based on confirmatory neurological investigations e.g. lumbar puncture, evoked visual responses, evoked auditory responses and NMR (Nuclear Magnetic Resonance) evidence of lesions of the central nervous system.

Paralysis.

The total and permanent loss of use of one or more limbs resulting from injury or disease. Limb means an entire arm or leg and included in this definition is monoplegia, diplegia, hemiplegia, paraplegia, quadriplegia and tetraplegia. The diagnosis must be confirmed by a **specialist medical practitioner**.

Severe burns.

Tissue injury caused by thermal, electrical or chemical agents that results in third degree burns to at least:

- 20% or more of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or
- 50% of both hands requiring surgical debridement and/or grafting, or
- 25% of the face requiring surgical debridement and/or grafting.

Stroke.

A cerebrovascular incident including infarction of brain tissue, intracranial or subarachnoid haemorrhage, or embolisation from an intracranial source as evidenced by CT, MRI or similar scan.

Transient ischaemic attacks and cerebral symptoms due to migraine are excluded.