Accelerated Protection

COMBINED PRODUCT DISCLOSURE STATEMENT AND POLICY DOCUMENT

ISSUE DATE 5 AUGUST 2022

TAL / ACCELERATED PROTECTION

Important information about this document

This section describes the purpose of this document, the Accelerated Protection Combined Product Disclosure Statement and Policy Document (PDS), and how it should be used.

This PDS together with the Policy Schedule form the terms and conditions of your Policy. To obtain a paper copy of this PDS, you can ask your financial adviser or you can call us to request a copy at no additional charge. We will provide you with your Policy Schedule if your application is accepted by us.

We are here to help

If you have any questions, contact us on:

1300 209 088

customerservice@tal.com.au

tal.com.au

GPO Box 5380, Sydney NSW 2001

About this PDS

This PDS contains information about Accelerated Protection, the various insurance options you can choose from as well as the terms and conditions which will apply to your Policy if your application is accepted by us. A financial adviser can help you decide which option will suit you. You should read this PDS carefully before you decide about acquiring or continuing to hold this insurance cover. Accelerated Protection is only available to person(s) receiving the PDS in Australia.

The information in this PDS is current as at the date of issue of this PDS. From time to time we may change or update information in this PDS. If there is a significant or materially adverse change to, or omission of, the information in this PDS, you will be notified in writing. Changes that are not materially adverse will be made available by providing a notice of any such changes at www.tal.com.au. If you'd like a free printed copy of the updated information, please contact our Customer Service Centre on 1300 209 088.

The information contained in this PDS is of a general nature only and has been prepared without taking into account your individual objectives, financial situation or needs. You should consider the information in this PDS and whether this insurance is appropriate for you, having regard to your objectives, financial situation and needs. You can seek advice from a financial adviser before making a decision or acting on any information in this PDS.

This PDS and the life insurance products described in it are issued by TAL Life Limited (ABN 70 050 109 450, AFSL 237848) (TAL). TAL is responsible for this PDS and the Policy Schedule that set out the terms and conditions of Accelerated Protection and the payments to be made under those documents.

If you make an application and we accept it, you'll receive a Policy Schedule outlining your specific cover details. Together, the Policy Schedule and the PDS sets out the terms and conditions of a contract of life insurance between the Policy Owner and TAL. Please note that no contract of insurance is established unless we accept your application (which we are not bound to do) and we receive the required premium. If you choose to structure your Accelerated Protection cover through superannuation, you must be a member of the superannuation fund through which your cover is intended to be structured.

Please read this PDS together with the Policy Schedule carefully to ensure you understand all the terms and conditions and the cover meets your needs. These are important documents and should be kept in a safe place. If the Policy is altered, you will receive a new Policy Schedule or confirmation reflecting the agreed changes.

Insurance through superannuation

You can choose to have Accelerated Protection structured through superannuation or outside of superannuation. Different terms and conditions apply depending on your choice, as outlined in this PDS.

If you choose to structure your Accelerated Protection cover through superannuation, TAL will issue the Policy to the trustee of the superannuation fund. You can choose to have the cover structured through TAL Super, a complying retail superannuation fund or your self-managed superannuation fund.

Any benefit payable under the Policy when structured through superannuation will be paid to the trustee of the fund. The trustee is responsible for paying benefits out of the fund in accordance with the governing rules of the fund and superannuation laws.

If you choose to structure your Accelerated Protection cover through TAL Super, you must also read the Accelerated Protection through TAL Super Product Disclosure Statement.

Terms and headings used in this PDS

There are a number of terms in this PDS which have a particular meaning. Where a defined term is used in this PDS, the first letter of each word is capitalised (e.g. 'Policy Owner'). The only exceptions are 'you', 'your', 'we', 'us', 'our' and 'structured through superannuation' which are not capitalised. You can seek advice from a financial adviser if you are unsure of any part of the PDS or its definition or what they mean.

Headings in the Plan conditions have been included to assist understanding, but they do not alter how clauses are to be interpreted (unless stated otherwise or the context indicates the contrary). Where the context provides for it, words indicating the singular can be taken to mean the plural and vice versa.

Life Insurance Code of Practice

As a member of the Financial Services Council, we have adopted the Life Insurance Code of Practice (the Code). The Code sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest. It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers. The Code covers many aspects of a customer's relationship with their insurer, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support.

The Code can be found at: **www.fsc.org.au**

FIND OUT MORE

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1 Introducing Accelerated Protection

Having the right kind of life insurance gives you and your family more power to make life plans, and more confidence that you can achieve them. We've developed a range of options to suit the way you live. We call it Accelerated Protection and you can mix and match its options to fit in with your own life plans - for now and for the future.

Accelerated Protection is an insurance policy between us and you, under which you can select a number of Plans comprising Life Insurance, Total and Permanent Disability (TPD) Insurance, Critical Illness Insurance, Child's Critical Illness Insurance and Income Protection. Each of these Plans contains included benefits and optional benefits that can be added at an additional cost. Each of these Plans and optional benefits form a separate part of the Policy.

Please read the PDS and the Policy Schedule carefully to ensure the terms and conditions meet your needs.

This PDS tells you about the various Accelerated Protection insurance options you can choose from. A financial adviser can help you decide which options will suit you. You should read this PDS carefully before you make a decision about purchasing or to continue to hold this insurance cover.

Distribution of TAL Accelerated Protection

TAL Accelerated Protection may be acquired via various distributors with or without personal advice.

Not all options, benefits, sum insured limits may be available from your distributor.

Your distributor can inform you if any features (such as options, benefits or sum insured limits) you seek are not available to you via that distributor.

Paying claims is why we're here

We're committed to paying all genuine claims as fast as possible, in a compassionate way. Last financial year we paid **$2.7 billion** in claims to 39,628 customers[1]. That's equivalent to over $52 million a week.

1 Claims statistics based on total claims paid under TAL Life Limited insurance products between 1 April 2021 and 31 March 2022.

Interim Cover

We provide you with limited Interim Cover at no additional cost while your application is being assessed. Limitations and conditions apply to Interim Cover. Refer to the 'Interim Cover' section for details.

Interim Rollover Cover Benefit

If you have chosen to structure your Policy through TAL Super and fund your premiums via rollover, we provide cover while we are waiting to receive payment of the premium from your nominated superannuation fund, once we have accepted your application. Refer to the 'Interim Rollover Cover Benefit' section for details.

30-day 'cooling off' period

If you feel that the Policy does not meet your needs and as long as you have not made a claim, you can request for it to be cancelled. Your premium will be refunded in full unless your Policy was structured through superannuation. Your request must be in writing and be made within 30 days of the Policy being issued (the 'cooling off' period).

If your Policy is structured through superannuation, refunded premiums are subject to preservation rules. This means that refunded premiums may be rolled over to another superannuation arrangement rather than be paid in cash.

If you nominate a superannuation arrangement that does not accept the payment, the trustee can only pay the refund to the Australian Taxation Office (ATO).

No refund can be made if a claim has been made under the Policy.

Who we pay

If the Policy is structured outside superannuation and you have nominated one or more beneficiaries to receive a benefit under Life Insurance, we will pay the benefit in accordance with your valid nomination. Otherwise, all payments made by us under the Policy will be made to you, or if you have died, to your legal personal representative or a person we are permitted to pay under any relevant law.

If the Policy is owned by more than one person (joint ownership), it is owned on a joint tenancy basis. This means that if one Policy Owner dies, the remaining Policy Owner(s) will own the policy and receive any benefits payable.

Where the Policy is structured through superannuation, benefits will be paid to the trustee.

Where the Policy is structured through TAL Super, the governing rules of TAL Super set out the rules pertaining to the nomination of beneficiaries.

Your duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

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

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

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

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

Refer to Section 5 of this PDS for details of your duty to take reasonable care not to make a misrepresentation.

Your cover – when it starts and ends and some important things for you to do

If we accept your application and we issue you a Policy Schedule, your cover will commence on the Plan start date as shown in the Policy Schedule. Cover for some benefits does not commence immediately and a Waiting Period or qualifying period may apply.

The Policy Owner at the date the Policy is issued is shown in the Policy Schedule. Cover is provided on the Life Insured shown in the Policy Schedule.

The Policy Schedule shows the Plan start date, identifies the Policy Owner, the Life Insured and outlines the benefits, options, special conditions and adjustments that apply to you. You may need to provide the Policy Schedule to us if you make a claim under Accelerated Protection.

Please read the PDS and the Policy Schedule carefully to ensure the terms and conditions meet your needs. These are important documents and should be kept in a safe place.

If the Policy is altered at any time you will receive a new Policy Schedule or confirmation reflecting the agreed changes.

Where cover being applied for with TAL is to replace existing cover with either TAL or another life insurance company, you must cancel the existing cover. No claim will be paid in respect of this Policy unless the previous cover has been cancelled. If the previous cover is not cancelled and a claim occurs, any premiums paid to TAL will be refunded and no benefit will be paid.

You may not be entitled to a refund of premium where the Policy has been structured through superannuation.

The relevant Plan end dates are explained in the following sections for each Plan:

Life Insurance: Section 2.1.3.

TPD Insurance: Section 2.2.4.

Critical Illness Insurance: Section 2.3.5.

Child's Critical Illness Insurance: Section 2.5.3.

Income Protection: Section 2.6.6.

Special conditions

During the Underwriting process, we may apply special conditions on the Policy that we issue to address the increase in risk, based on your personal situation. For example, we may exclude a medical condition or pastime, increase your premium payment or reduce the benefit amount.

If special conditions have been applied to your Policy, it will be stated in the Policy Schedule. We may be able to remove or reduce these special conditions if your health or lifestyle improves in the future.

Where we have relied on medical evidence to make our decision and you would like a copy of this, we will provide this either directly to you or your doctor within 10 business days of receiving your request.

Other important information

You should be aware that certain limitations and exclusions will apply under the Policy. This means that in some cases we will not pay a claim or will pay a claim only in limited circumstances; cover may be reduced; and cover will end in certain circumstances. Full details of these limitations and exclusions can be found in this PDS.

There are risks you should consider carefully when deciding to purchase insurance cover provided under the Policy. These include:

- that the insurance cover you have chosen might be inadequate to protect you and your family, including but not limited to the risks of selecting inadequate Benefit Amounts, selecting inadequate Plans and options, and suffering an event that is not covered by your Policy;
- that the Policy does not contain a savings or investment component, which means that if you cancel your Policy, you will not receive any money back unless a refund applies;
- that applications for new insurance or changes to your insurance may not be accepted by us;
- that your Plans under the Policy will expire;
- that claims may not be paid and the cover under your Policy may be cancelled, or the terms may be changed or an insured benefit may be reduced, where you or the Life Insured do not take reasonable care not to make a misrepresentation, or you have made a fraudulent claim;
- that claims will not be paid if the criteria and requirements to make a claim are not met, or an exclusion applies;
- that your cover may be altered by a limitation, adjustment, exclusion, or change in terms at a specified date, which may reduce an amount you are paid if you claim or result in no claim being paid;
- that the cost of your Policy can increase. For both level and stepped premiums, the premiums and the cost of your Policy can increase due to a range of factors, please see Section 1.3 "What are the costs?" for more information;
- that it is possible to pay more in premiums than the amount you are covered for;
- that the insurance cover under the Policy may be cancelled if you have failed to pay your premium by the due date; and
- if you structure Accelerated Protection through superannuation, the risks are described in Section 8.6 of this PDS.

You can discuss these risks with a financial adviser, seek their assistance in selecting the appropriate Plans, options and structure for you, and ensure you have read and understood this PDS before making an application for cover.

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1.1 Accelerated Protection at a glance

This 'Accelerated Protection at a glance' section provides information on eligibility requirements and a summary of some of the important benefits and features available in each Plan. These summaries are intended to give you an idea of what each Plan can provide, and to help you navigate this PDS, but do not contain the full details of the included and optional benefits, exclusions or limitations of each Plan. Full details, terms and conditions of each Plan are set out in further sections of this PDS.

In order to be eligible for a claim, the following must be fulfilled:

- the full requirements of the benefit or option as set out in Section 2 for the applicable Plan;
- the claim requirements in Section 3; and
- the criteria set out in any applicable definition(s) in Section 9.

A claim will not be paid if you only meet the brief description of the benefit or option in the table below or if you do not fulfil the applicable requirements in Sections 2, 3 and 9. A claim may also be denied if you have not complied with your 'duty to take reasonable care' (refer to Section 5 for details).

Included benefits are built into each Plan and do not attract additional cost. Optional benefits are benefits that you can add to your Plan for an additional cost. Optional benefits that you select will be shown in the Policy Schedule.

1.1.1 Life Insurance at a glance

Where selected, the Life Insurance Benefit Amount is payable in the event of death or a Terminal Illness.

This section contains some information about Life Insurance. Full details of Life Insurance can be found in Section 2.1.

You must also refer to Section 1.1.4 for a summary of other applicable benefits and options applicable to Life Insurance.

When we won't pay	Death or Terminal Illness resulting from: • an intentional self-inflicted act is excluded for the first 13 months (refer to Section 2.1.2 for details). • a special condition. If applicable, the special condition will be shown in the Policy Schedule.
Premium type/Entry age	• Stepped premiums: 19 – 74 (age next birthday) • Level premiums: 19 – 60 (age next birthday) Where level premiums to age 65 or age 70 is selected, the premiums will change to stepped premiums on the Policy anniversary prior to age 65 or age 70 respectively.
Maximum Benefit Amount	• Any financially justifiable amount
Plan end date	• Policy anniversary before your 100th birthday • Policy anniversary before your 75th birthday when structured through TAL Super or a retail superannuation fund.
Ownership	• Individual • Superannuation (TAL Super, eligible retail superannuation fund, SMSF) • Trust • Company/business • Joint ownership
Plan structure	• Standalone Life Insurance • TPD Insurance and/or Critical Illness Insurance can be Attached or Linked to Life Insurance. The TPD Insurance and/or Critical Illness Insurance Benefit Amount cannot exceed the Life Insurance Benefit Amount. (Refer to Section 1.2.2 for information on Plan structures)

Included benefits	Brief description	Refer to section	Structured outside superannuation	Structured through superannuation
Death Benefit	The Benefit Amount is paid if you die.	2.1.1	✔	✔
Terminal Illness Benefit	Early payment of the Benefit Amount if you are Terminally Ill.	2.1.1	✔	✔
Advanced Payment Benefit	An advanced payment of 10% of the Benefit Amount, up to a maximum of $25,000 as soon as we receive the death certificate or medical certificate confirming death.	2.1.1	✔	✔
Repatriation Benefit	The Advanced Payment Benefit capped at a maximum of $35,000 if you die overseas.	2.1.1	✔	✔

1.1.2 TPD Insurance at a glance

Where selected, the TPD Insurance Benefit Amount is payable in the event of Total and Permanent Disablement.

This section contains some information about TPD Insurance. Full details of TPD Insurance can be found in Section 2.2.

You must also refer to Section 1.1.4 for a summary of other applicable benefits and options applicable to TPD Insurance.

When we won't pay	Total and Permanent Disablement resulting from: • an intentional self-inflicted act is excluded (refer to Section 2.2.3). • a special condition. If applicable, the special condition will be shown in the Policy Schedule.
TPD definitions available	• 'Own occupation' • 'Any occupation' • Activities of Daily Living (ADL) (Occupational restrictions may apply)
Premium type/Entry age	• Stepped premiums: 19 – 62 (age next birthday) • Level premiums: 19 – 60 (age next birthday)
Maximum Benefit Amount	• Up to $3 million • Restrictions apply depending on your occupation, age or when Attached or Linked to another Plan. • Where Attached or Linked to Life Insurance, the TPD Insurance Benefit Amount cannot exceed the Life Insurance Benefit Amount. • Where Attached to Critical Illness Insurance, the TPD Insurance Benefit Amount cannot exceed the Critical Illness Benefit Amount.
Plan end date	• Policy anniversary before your 65th birthday
Ownership	• Individual • Superannuation (TAL Super, eligible retail superannuation fund, SMSF) • Trust • Company/business • Joint ownership
Plan structure	• Standalone TPD Insurance • TPD Insurance Attached or Linked to Life Insurance • TPD Insurance Attached to Critical Illness Insurance • Superlink TPD (Refer to Section 1.2.2 for information on Plan structures)

Included benefits	Brief description	Refer to section	Structured outside superannuation	Structured through superannuation
TPD Benefit	The Benefit Amount is paid if you become Totally and Permanently Disabled, depending on the applicable TPD definition.	2.2.1	✔	✔
Advanced Payment Benefit	An advanced payment of 25% of the TPD Insurance Benefit Amount, up to a maximum of $500,000 if you suffer Loss of use of a Single Limb (permanent) or Loss of Sight in One Eye (permanent).	2.2.1	✔	✖
Death Benefit (only available with Standalone TPD Insurance structured through TAL Super)	Pays the lesser of $10,000 or the Benefit Amount if you die and the TPD Benefit is not payable.	2.2.1	✖	✔

Optional benefits	Brief description	Refer to section	Structured outside superannuation	Structured through superannuation
Death Buy-Back Option (only available if TPD Insurance is Attached or Linked to Life Insurance)	If 100% of the TPD Insurance Benefit Amount is paid, you can repurchase Life Insurance in 12 months' time, up to the TPD Insurance Benefit Amount paid. The request must be made in writing within the specified time frame.	2.2.2	✔	✔
Double TPD Option (only available if TPD Insurance is Attached or Linked to Life Insurance)	If 100% of the TPD Insurance Benefit Amount is paid, the Life Insurance Benefit Amount will not be reduced. The premium for the portion of Life Insurance equivalent to the TPD Benefit paid, will be waived and will not be eligible for increases under the Inflation Protection Benefit, Guaranteed Future Insurability Benefit and Business Insurance Option (if applicable).	2.2.2	✔	✔

We require confirmation of diagnosis by a Medical Practitioner and in addition, the specified severity threshold criteria also need to be met, in order for a benefit to be payable. The severity threshold criteria are defined for each event in Section 9.

1.1.3 Critical Illness Insurance at a glance

Where selected, Critical Illness Insurance pays a benefit if you suffer a specified serious event listed in Section 2.3.

For many specified serious events this means the condition will be required to progress beyond a diagnosis, where diagnosis means the process of a Medical Practitioner determining which Sickness or Injury explains an individual's symptoms.

You must also satisfy our claim requirements in Section 3 of this PDS.

This section contains some information about Critical Illness Insurance. You must also refer to Section 1.1.4 for a summary of other applicable benefits and options applicable to Critical Illness Insurance.

Plan types available	• Critical Illness Insurance Plan Standard • Critical Illness Insurance Plan Premier
When we won't pay	• No benefits will be paid under Critical Illness Insurance unless you suffer a specified serious event listed under Critical Illness Insurance as defined in Section 9.3. This means that the requisite level of Severity as set out for the event in Section 9.3 must be met for a benefit to be payable. • No benefits under Critical Illness Insurance will be paid if the specified serious event resulted from an intentional, self-inflicted act (refer to Section 2.3.4). • A claim for some Critical Illness Events (e.g. Cancer (of specified criteria), Heart Attack (of specified severity), Stroke (resulting in neurological deficit)) will not be paid if the condition or the symptom of the condition occurred during the first three months from when the Plan started, cover was increased, or cover was reinstated (refer to Section 2.3.4). • A claim resulting from a special condition. If applicable, the special condition will be shown in the Policy Schedule.
Premium type / Entry age	• Stepped premiums: 19 – 62 (age next birthday) • Level premiums: 19 – 60 (age next birthday) Where level premiums 'to age 65' is selected, the premiums will change to stepped premiums on the Policy anniversary before your 65th birthday.
Maximum Benefit Amount	• Up to $2 million across all insurers • Where Attached or Linked to Life Insurance, the Critical Illness Insurance Benefit Amount cannot exceed the Life Insurance Benefit Amount.
Plan end date	• Policy anniversary before your 70th birthday
Ownership	• Individual • Trust • Company/business • Joint ownership
Plan structure	• Standalone Critical Illness Insurance • Critical Illness Insurance Attached or Linked to Life Insurance (Refer to Section 1.2.2 for information on Plan structures)

Included benefits	Brief description	Refer to section	Standard	Premier
Critical Illness Benefit	A benefit is payable if you suffer a Critical Illness Event. You must also meet the requirements as defined in the Critical Illness Event definition in Section 9.3.	2.3.1	✔	✔
Paralysis Support Benefit	The Critical Illness Insurance Benefit Amount will be doubled (up to $2 million) if you become permanently paralysed.	2.3.1	✔	✔
Death Buy-Back Benefit (only available if Critical Illness Insurance is Attached or Linked to Life Insurance)	If 100% of the Critical Illness Insurance Benefit Amount is paid, you can repurchase Life Insurance in 12 months' time, up to the Critical Illness Insurance Benefit Amount paid. The request must be made in writing within the specified time frame.	2.3.1	✔	✔
Advancement Benefit	Pays a portion of the Critical Illness Insurance Benefit Amount for Advancement Benefit Events. Payment of this benefit will reduce the Benefit Amount by the amount paid.	2.3.2	✘	✔
Female Critical Illness Benefit	Pays 20% of the Critical Illness Insurance Benefit Amount, up to $50,000, for conditions such as Pregnancy Complications and Congenital Abnormalities. Payment of this benefit will reduce the Benefit Amount by the amount paid. This benefit only applies if the Life Insured is a female.	2.3.2	✘	✔
Needlestick Benefit	Pays up to $1 million if you suffer Occupationally Acquired HIV or Occupationally Acquired Hepatitis B or C. This benefit only applies if your occupation class is AA+ as specified in the Policy Schedule.	2.3.2	✘	✔

Optional benefits	Brief description	Refer to section	Standard	Premier
Double Critical Illness Option (only available if Critical Illness Insurance is Attached or Linked to Life Insurance)	If 100% of the Critical Illness Insurance Benefit Amount is paid, the Life Insurance Benefit Amount will not be reduced. The premium for the portion of Life Insurance equivalent to the Critical Illness Benefit paid will be waived and will not be eligible for increases under the Inflation Protection Benefit, Guaranteed Future Insurability Benefit and Business Insurance Option (if applicable).	2.3.3	✔	✔
Critical Illness Reinstatement Option	If the Critical Illness Benefit, Advancement Benefit, Needlestick Benefit or Female Critical Illness Benefit is paid, you can repurchase Critical Illness Insurance in 12 months' time, up to the Critical Illness Insurance Benefit Amount paid. The request must be made in writing within the specified time frame. The repurchased cover will be subject to the limitations and conditions of the Option and any special conditions or loadings applicable to the original Plan.	2.3.3	✔	✔

1.1.4 Additional benefits and options applicable to Life, TPD and Critical Illness Insurance at a glance

The following included benefits and optional benefits are available with Life Insurance, TPD Insurance and Critical Illness Insurance. Please note that some benefits are not included and some options are not available when the Plan is structured through superannuation.

Included benefits	Brief description	Refer to section	Structured outside superannuation	Structured through superannuation
Inflation Protection Benefit	Automatically increases the Benefit Amount on the Policy anniversary by the greater of 5% and the Indexation Factor to help keep pace with inflation. Increased cover affects your premium, so you have the option to remove this benefit.	2.4.1	✔	✔
Premium Freeze Benefit	Your premiums stay the same and the Benefit Amount will reduce at each Policy anniversary. This benefit can only be exercised if stepped premiums have been selected and you are at least 30 years of age.	2.4.1	✔	✔
Guaranteed Future Insurability Benefit	Allows you to apply to increase your cover without providing additional health information when a significant life event occurs such as getting married, childbirth and taking out a mortgage.	2.4.1	✔	✔
Financial Planning Benefit	Reimburses up to $5,000 on fees for professional financial planning advice incurred when we pay 100% of the Benefit Amount. Your financial plan must be prepared by a financial adviser within 12 months of the date we paid your claim and we must receive evidence of the financial plan.	2.4.1	✔	✖
Long Distance Accommodation Benefit	Reimburses up to $250 per day, up to 14 days, for accommodation costs of an Immediate Family Member when they are required to travel more than 100 km to be with you. To be eligible, you must be Bed Confined more than 100 kilometres from your usual place of residence and the Terminal Illness Benefit, 100% of the TPD Insurance Benefit Amount or 100% of the Critical Illness Insurance Benefit Amount has been paid.	2.4.1	✔	✖
Grief Support Benefit	This benefit is available to you or your Immediate Family Member who need support when we pay 100% of the Benefit Amount. We will reimburse the cost of up to three grief support sessions, to a total maximum cost of $1,000 for all three sessions, with an accredited health provider approved by us, acting reasonably (the health provider should be competent, recognised and appropriately qualified to provide the support).	2.4.1	✔	✖
Child's Critical Illness Benefit	Pays a benefit of $10,000, if your child (aged between two and 19 next birthday) suffers a Child's Critical Illness Event listed under the Child's Critical Illness Insurance. The severity criteria set out for the events in Section 9.3 must be met for a benefit to be payable. Pre-existing conditions are excluded, and certain conditions are excluded if they occur or were diagnosed within three months of the Policy commencing or being reinstated.	2.4.1	✔	✖

Optional benefits	Brief description	Refer to section	Structured outside superannuation	Structured through superannuation
Premium Relief Option	We'll waive your premiums if you're totally unable to work for at least three consecutive months due to Sickness or Injury. This will end on the earlier of when you are either capable of working or earning an income, or the Policy anniversary before your 65th birthday.	2.4.2	✔	✔
Business Insurance Option	Allows you to apply to increase the Benefit Amount of your Life Insurance and any attached TPD Insurance and Critical Illness Insurance without providing additional health information on the occurrence of a specified business event.	2.4.2	✔	✖

We require confirmation of diagnosis by a Medical Practitioner and in addition, the specified severity threshold criteria also need to be met, for a benefit to be payable. The severity threshold criteria are defined for each event in Section 9.

1.1.5 Child's Critical Illness Insurance at a glance

Where selected, the Child's Critical Illness Insurance Benefit Amount is payable in the event of a Child's Critical Illness Event listed in Section 2.5.

For many specified serious events this means the condition will be required to progress beyond a diagnosis, where diagnosis means the process of a Medical Practitioner determining which Sickness or Injury explains an individual's symptoms.

You must also satisfy our claim requirements in Section 3 of this PDS.

This section contains some information about Child's Critical Illness Insurance.

When we won't pay	• No benefits will be paid under Child's Critical Illness Insurance unless the Child Insured suffers a listed Child's Critical Illness Event under Child's Critical Illness Insurance as defined in Section 9.3. This means that the requisite level of Severity as set out for the event in Section 9.3 must be met in order for a benefit to be payable. • A claim for some Child's Critical Illness Events will not be paid if the condition or the symptom of the condition occurred during the first three months from when the Plan started, cover was increased or cover was reinstated (refer to Section 2.5.2). • A claim resulting from a special condition. If applicable, the special condition will be shown in the Policy Schedule.
Premium type / Entry age	• Level premiums: 2 – 18 (age next birthday)
Maximum Benefit Amount	• Up to $200,000
Plan end date	• Policy anniversary before the Child Insured's 23rd birthday
Ownership	• Parent or legal guardian of the Child Insured (the Child Insured must be financially dependent on the Policy Owner) • Trust • Joint ownership
Plan structure	• Standalone – can be a Policy on its own or included as part of a Policy with multiple Plans

Included benefits	Brief description	Refer to section
Critical Illness Benefit	The Benefit Amount is paid if the Child Insured suffers a Child's Critical Illness Event.	2.5.1
Grief Support Benefit	This benefit is available to the Immediate Family Member of the Child Insured who need support in the event we pay the Child's Critical Illness Benefit. We will reimburse the cost of up to three grief support sessions, to a total maximum cost of $1,000 for all three sessions, with an accredited health provider approved by us, acting reasonably (the health provider should be competent, recognised and appropriately qualified to provide the support).	2.5.1
Cover Continuation Benefit	Allows the Child's Critical Illness Plan to convert to a Life Insurance Plan with Attached Critical Illness Insurance Standard Plan. The Benefit Amount for Life Insurance and Critical Illness Insurance cannot exceed the Benefit Amount of the Child's Critical Illness Insurance.	2.5.1

1.1.6 Income Protection at a glance

This section contains a summary of the benefits and features of Income Protection. In the event of a claim under Income Protection, your eligibility to receive a benefit will be assessed against the terms and conditions detailed in Section 2.6 (Income Protection), Section 3 (Claims) and Section 9 (Definitions).

When you are Totally Unable to Work or Partially Unable to Work as a result of a Sickness or Injury, Income Protection is here to help.

Income Protection provides a benefit if you suffer a loss of income due to a Sickness or Injury. It does not provide a benefit if you are not working solely due to redundancy or an economic downturn. For those who are Self-Employed, Income Protection does not provide a benefit if your business is not generating a profit due to reasons other than you being Totally Unable to Work or Partially Unable to Work as a result of Sickness or Injury.

There are some circumstances when we will not pay a claim (refer to Section 2.6.4 for details), when the benefit payable is adjusted (refer to Section 2.6.1 for details) or reduced if an offset applies (refer to Section 2.6.5 for details). This includes if you receive or are entitled to income from other sources and/or if you are not working to your full capacity. Please read this document carefully. You can contact us or a financial adviser if you need help to understand the terms of cover and limitations.

While you are unable to work and receiving claim payments from us, your case manager will help you to understand your policy and any benefits you may be entitled to so you can focus on getting well and where possible, return to work. In order to qualify for claim payments, you are required to undertake reasonable treatment as recommended by an appropriate Medical Practitioner and you may also be required to undertake reasonable retraining to help you prepare to return to work.

Review your cover if your income changes

Income Protection claim payments are calculated based on your Pre-Claim Earnings. If you are an Employee, this means your Earnings in the 12 months prior to claim, or if you are Self-Employed, your average Earnings over the last two full financial years. If your income has reduced significantly since your cover started or was last reviewed, you can discuss this with us or a financial adviser to make sure that your level of cover is appropriate. For example, a reduction of your income could result in a benefit payment below the amount you are insured for.

Employment or occupational changes after taking out cover

If you have been on Long Term Leave or were Unemployed for more than 12 months prior to the start of the Waiting Period, Pre-Claim Earnings will be based on your Earnings in the period immediately before the start of the Waiting Period.

This could result in a reduction in the benefit payable or no benefit being payable, depending on your circumstances.

The Super Contribution Option is only available if you are an Employee. If you are no longer an Employee and you have the Super Contribution Option, you may not be entitled to claim on the Super Contribution Option.

If your employment or occupational circumstances have changed, you should review your cover or speak to a financial adviser to make sure that your level of cover is appropriate.

The information in the tables below contains some information about Income Protection. Details of Income Protection can be found in Section 2.6 and Section 9.

Plan types available	• Income Protection
Income replacement options	• Income Protection Focus (IP Focus) • Income Protection Enhance (IP Enhance) • Income Protection Focus Extend (IP Extend)
	• Each income replacement option has different features. For a summary of the different features, refer to the 'Income replacement option summary' table below on page 21. • Full details of each Income replacement option can be found in Section 2.6.
Maximum Benefit Amount (at time of application)	**Income Protection** • Up to $30,000 per month (includes Super Contribution Benefit Amount if applicable) (Restrictions may apply when applying for new Income Protection cover or when you increase your Income Protection cover depending on your occupation)
	Super Contribution Option • Up to 100% of the Employer Superannuation Contribution amount, capped at 15% of your Pre-Claim Earnings (i.e. base salary excluding superannuation). Benefits paid under the Super Contribution Option may impact your tax status and/or your superannuation contribution cap. Refer to Section 7 for more information on tax. • The total of the Income Protection Benefit Amount and the Super Contribution Benefit Amount cannot exceed $30,000 per month. • Not available if Self-Employed or if the Policy Owner is a company (that is not a trustee of a superannuation fund).
Premium type / Entry age	Stepped and level premiums: • 19 – 60 (age next birthday) for occupation class AAA, AA+, AA & A • 19 – 55 (age next birthday) for occupation class BBB, BB, B & SRA.
Waiting Period options	• 4 weeks • 13 weeks • 8 weeks • 26 weeks
	• Occupational restrictions may apply when applying for new Income Protection cover or when you increase your Income Protection cover.
Benefit Period options	**IP Focus:** • 1 year • 2 year • 5 year **IP Enhance:** • To age 65 **IP Extend:** • To age 65
	• Availability of the 'to age 65' Benefit Period options may be restricted when applying for new Income Protection cover or when you increase your Income Protection cover depending on your occupation.
Plan end date	• Policy anniversary before your 65th birthday.
Ownership	• Individual • Company/Business • Superannuation/SMSF/Platform
Plan structure	• Standalone outside of superannuation • Standalone through superannuation • Superlink IP

Some limitations and exclusions

- All benefit payments under Income Protection are limited by the terms and conditions set out in Section 2.6, Section 3 and Section 9.
- The benefit payable may be reduced or stopped as a result of the following:
  - If you are not working or earning to your full capability (refer to 'How much is payable and what are the ongoing benefit payments?' and 'When will we adjust your benefit payments?' in Section 2.6.1 for details).
  - If you are receiving other payments (refer to Section 2.6.5 for details).
  - The Totally Unable to Work Benefit or Partially Unable to Work Benefit will stop after three months if you are overseas (refer to Section 2.6.4 for details).
- A claim will not be paid if the claim arises from any of the following (refer to Section 2.6.4 for details):
  - Intentional self-inflicted act.
  - Normal and uncomplicated pregnancy.
  - War or act of war.
  - Deregistration, disqualification or restriction which prevents or restricts you from performing your occupation.
  - Participation in a criminal act and/or for any period that you are incarcerated due to your participation in a criminal act.
- A claim may not be paid or paid at a reduced amount, if a special condition applies. If applicable, the special condition will be shown in the Policy Schedule.

Other important information

- At time of claim, you will need to provide proof of your Pre-Claim Earnings to support the Benefit Amount. If your Pre-Claim Earnings do not justify your monthly insured Benefit Amount, any benefit payable to you will be reduced. If your income has reduced since you purchased your Policy, you may want to review your Income Protection cover and/or speak to a financial adviser.
- The Totally Unable to Work Benefit and the Partially Unable to Work Benefit only become payable after the end of the Waiting Period. The only benefits that are potentially payable for an event that occurred during the Waiting Period are the Bed Confinement Benefit and the Death Benefit.
- The Totally Unable to Work Benefit and the Partially Unable to Work Benefit are paid monthly in arrears after the Waiting Period ends. For example, if you have a 4 week Waiting Period, the first monthly benefit will be paid to you around the end of the second month from when the Waiting Period started and monthly thereafter (unless we agree to an alternative).

Income replacement option summary

The information in the table below shows a summary of the differences between the income replacement options available. Details of each income replacement option can be found in Section 2.6 and Section 9.

	IP Focus	IP Enhance	IP Extend
What is the maximum proportion of your income that can be covered?	• 70% of the first $20,000 per month ($240,000 per annum) of your Earnings; • 50% of the next $20,000 per month ($240,000 per annum) of your Earnings; and • 20% of your remaining Earnings.		
How long can benefits be payable for a claim?	Choice of Benefit Period: • 1 year; • 2 years; or • 5 years. No benefit payable beyond the Plan end date.	To age 65	To age 65
How much is payable if you are Totally Unable to Work[1]?	Benefit Amount[3]	• 1 – 24 months on claim: Benefit Amount • After 24 months on claim: 2/3rd of the Benefit Amount	Benefit Amount[3]
How much is payable if you are Partially Unable to Work[1, 2]?	Benefit Amount[3] less 75% of Earnings while on claim	• 1 – 24 months on claim: Benefit Amount less 75% of Earnings while on claim • After 24 months on claim: 2/3rd of Benefit Amount less 100% of Earnings while on claim	• 1 – 24 months on claim: Benefit Amount less 75% of Earnings while on claim • After 24 months on claim: Benefit Amount[3] less 100% of Earnings while on claim
Permanent Incapacity Reset Benefit	Not Applicable	• 1 – 24 months on claim: Not applicable • After 24 months on claim: 1/3rd of Benefit Amount if Seriously and Permanently Incapacitated	Not Applicable
Occupation definition used in Totally Unable to Work definition	Own Occupation	• 1 – 24 months on claim: Own Occupation • After 24 months on claim: Any Occupation	• 1-24 months on claim: Own Occupation • After 24 months on claim: Any Occupation

Refer to the 'Claim examples' on pages 23 to 26 for examples of how a claim may work under each income replacement option.

1 The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).
2 The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' in Section 2.6.1 for details).
3 If the claim started after the Policy anniversary before your 60th birthday, the amount used to calculate the benefit payable will be 2/3rd of the Benefit Amount after the Claim Period exceeds 24 months.

Included benefits	Brief description	Section
Totally Unable to Work Benefit	Pays a benefit after the end of the Waiting Period and monthly in arrears if you are Totally Unable to Work because of a Sickness or Injury.	2.6.1
Partially Unable to Work Benefit	Pays a portion of the benefit after the end of the Waiting Period and monthly in arrears if you are Partially Unable to Work because of a Sickness or Injury.	2.6.1
Recurrent Claim Benefit	If you become Totally Unable to Work or Partially Unable to Work because of the same or related cause of claim within 12 months from the date the claim was last paid to, we will recommence payments without a further Waiting Period.	2.6.1
Permanent Incapacity Reset Benefit (only applies to IP Enhance option)	Pays 1/3rd of the Benefit Amount in addition to the Totally Unable to Work Benefit if you are Seriously and Permanently Incapacitated. This benefit only becomes available after the Claim Period exceeds 24 months.	2.6.1
Inflation Protection Benefit	Automatically increases the Benefit Amount on the Policy anniversary date by the Indexation Factor to help keep pace with inflation when you're not on claim. Your premiums will also increase as a result of the Benefit Amount increasing. You can opt out of this benefit by contacting us. The Inflation Protection Benefit does not apply when you are on claim.	2.6.2
Bed Confinement Benefit	Pays a benefit if you are Totally Unable to Work and Bed Confined for at least 72 consecutive hours during the Waiting Period.	2.6.2
Waiver of Premium Benefit	Waives your Income Protection premiums when the Totally Unable to Work Benefit or Partially Unable to Work Benefit is payable.	2.6.2
Work Assistance Benefit (not available when structured through superannuation)	Reimburses the cost of an approved Rehabilitation Program to help you return to work. The maximum amount for this benefit is 12 times the Benefit Amount. This benefit does not pay for the costs of medical consultations and treatments.	2.6.2
Death Benefit	Pays $10,000 if you die.	2.6.2
Overseas Assistance Benefit (not available when structured through superannuation)	Reimburses the cost of returning to Australia if the Totally Unable to Work Benefit or the Partially Unable to Work Benefit are payable when you are overseas. The maximum reimbursement is three times the Benefit Amount.	2.6.2
Premium Pause Benefit	Suspend your Income Protection Plan for up to 12 months if you become Unemployed or are on Long Term Leave.	2.6.2
Elective Surgery Benefit	Allows you to make a claim if you are Totally Unable to Work because of undergoing an elective surgery. This benefit is not available within six months of the Plan start date, the date your Policy was reinstated or the date of any increase you applied for (but only in respect of the increased portion).	2.6.2
Blood Borne Diseases Benefit	If you are a healthcare professional and you contract a blood borne disease such as HIV, Hepatitis B or Hepatitis C and it prevents you from performing Exposure Prone Procedures or you suffer a reduction in income as a result of this, we may assess you to be disabled even if you are physically able to work. The SIS definition of Temporary Incapacity or Permanent Incapacity must be satisfied if Income Protection is structured through superannuation.	2.6.2

Optional benefit	Brief description	Section
Increasing Claim Option	Increases the Benefit Amount by the Indexation Factor at each anniversary of the commencement of eligible benefit payments.	2.6.3
Super Contribution Option (not available if Self-Employed)	Makes a personal contribution to your nominated superannuation fund on your behalf when the Totally Unable to Work Benefit or Partially Unable to Work Benefit is payable.	2.6.3

Through the PDS we will provide examples to show how Income Protection cover works. These examples are illustrative only and do not form part of your Income Protection policy terms and conditions.

Income replacement options

Income Protection offers three different income replacement options, and each has different features and conditions. It is important that you understand the features of your selected option, as claim requirements and the benefit payable may change over the duration of a claim. An adviser can help you understand which option meets your needs.

The income replacement options available are:

- Income Protection Focus (IP Focus)
- Income Protection Enhance (IP Enhance)
- Income Protection Extend (IP Extend)

This section contains some information about the different income replacement options. Details of Income Protection can be found in Section 2.6 and Section 9.

Income Protection Focus (IP Focus)

How long can benefits be payable for a claim?	Choice of Benefit Period: 1 year, 2 years or 5 years
What is the maximum proportion of your income that can be covered?	• 70% of the first $20,000 per month ($240,000 per annum) of your Earnings; • 50% of the next $20,000 per month ($240,000 per annum) of your Earnings; and • 20% of your remaining Earnings.
Occupation definition used in Totally Unable to Work definition:	Own Occupation
How much is payable if you are:	
Totally Unable to Work[1]	Benefit Amount[3]
Partially Unable to Work[1,2]	Benefit Amount[3] less 75% of Earnings while on claim

[1]The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).

[2]The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' in Section 2.6.1).

[3]If the Benefit Period which applies is 5 year and the claim started after the Policy anniversary before your 60th birthday, the amount used to calculate the benefit payable will be 2/3rd of the Benefit Amount after the Claim Period exceeds 24 months.

The claim example below is not real and should only be used to help you understand how the IP Focus option works at time of claim. Please also refer to the conditions set out in the table above, along with the example to assist you to understand how IP Focus works. All relevant terms and conditions must be met for a claim to be payable.

Example

- Lee has IP Focus with a 2 year Benefit Period with a Benefit Amount of $5,000 per month (the Increasing Claim Option was not selected by Lee so does not apply).
- Lee suffered a Sickness or Injury and was medically certified Totally Unable to Work in his Own Occupation. For the first 18 months of the Claim Period, the Totally Unable to Work Benefit payable is:
  Benefit Amount
  = $5,000 per month
- After the first 18 months of the Claim Period, Lee was able to return to work three days a week earning $3,500 a month. The Partially Unable to Work Benefit payable is:
  Benefit Amount – 75% of Earnings
  = $5,000 – (75% X $3,500)
  = $2,375 per month
- After the end of the 24th month of the Claim Period, Lee remained Partially Unable to Work but the claim was finalised and no Income Protection benefit is payable because the total Claim Period (i.e. 24 months) equalled the maximum 2 year Benefit Period.

Income Protection Enhance (IP Enhance)

How long can benefits be payable for a claim?	to age 65	
What is the maximum proportion of your income that can be covered?	• 70% of the first $20,000 per month ($240,000 per annum) of your Earnings; • 50% of the next $20,000 per month ($240,000 per annum) of your Earnings; and • 20% of your remaining Earnings.	
Claim Period	**1-24 months on claim**	**After 24 months on claim**
Occupation definition used in Totally Unable to Work definition:	Own Occupation	Any Occupation
How much is payable if you are:		
Totally Unable to Work[1]	Benefit Amount	2/3rd of the Benefit Amount
Partially Unable to Work[1, 2]	Benefit Amount less 75% of Earnings while on claim	2/3rd of Benefit Amount less 100% of Earnings while on claim
Permanent Incapacity Reset Benefit	Not applicable	1/3rd of Benefit Amount if Seriously and Permanently Incapacitated

[1]The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).

[2]The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' in Section 2.6.1).

The claim examples below are not real and should only be used to help you understand how the IP Enhance option works at time of claim. Please also refer to the conditions set out in the table above, along with the examples to assist you to understand how IP Enhance works. All relevant terms and conditions must be met for a claim to be payable.

Example 1

- Eve has IP Enhance with a Benefit Amount of $7,500 per month (the Increasing Claim Option was not selected by Eve so does not apply).
- Eve suffered a Sickness or Injury and is medically certified to be Totally Unable to Work in her Own Occupation for the first 12 months of the Claim Period. Eve is paid $7,500 per month under the Totally Unable to Work Benefit for the first 12 months.
- From the 13th month to the 24th month of her Claim Period, Eve was able to return to work in a part-time capacity working one day a week, earning $2,200 per month. This means that Eve is no longer Totally Unable to Work but is Partially Unable to Work. The Partially Unable to Work Benefit payable for this period is:

  Benefit Amount – 75% of Earnings

  = $7,500 – (75% x $2,200)

  = $7,500 - $1,650

  = $5,850 per month
- From the 25th month to the 30th month of her Claim Period, Eve was able to increase her work to two days a week earning $4,400 per month. The Partially Unable to Work Benefit payable for this period is:

  (2/3rd of Benefit Amount) – 100% of Earnings

  = (2/3 X $7,500) - $4,400

  = $5,000 - $4,400

  = $600 per month

Example 2

- Adam has IP Enhance with a Benefit Amount of $6,000 per month (the Increasing Claim Option was not selected by Adam so does not apply).
- Adam suffered a Sickness or Injury and is medically certified Totally Unable to Work in his Own Occupation.
- For the first 24 months of the Claim Period, Adam is paid the Totally Unable to Work Benefit at $6,000 per month.
- From the 25th month to the 36th month of the Claim Period, Adam remained Totally Unable to Work in Any Occupation but does not meet the requirement for Permanent Incapacity Reset Benefit. The Totally Unable to Work Benefit payable is:

  2/3 x Benefit Amount

  = 2/3 x $6,000

  = $4,000 per month
- From the 37th month of the Claim Period, Adam's condition deteriorates, and he now meets the requirements for the Permanent Incapacity Reset Benefit. The Permanent Incapacity Reset Benefit payable is:

  1/3 X Benefit Amount

  = 1/3 X $6,000

  = $2,000 per month

  Total benefits payable = Totally Unable to Work Benefit + Permanent Incapacity Reset Benefit

  = $4,000 + $2,000

  = $6,000 per month
- Adam will continue to be paid the Totally Unable to Work Benefit and the Permanent Incapacity Reset Benefit until the end of his Benefit Period (to age 65), as long as he meets the requirements for the Totally Unable to Work Benefit and the Permanent Incapacity Reset Benefit.

Example 3

- Jack has IP Enhance with a Benefit Amount of $9,000 per month (the Increasing Claim Option was not selected by Jack so does not apply).
- Jack suffered a Sickness or Injury and is medically certified Totally Unable to Work in his Own Occupation. Jack was paid $9,000 per month under the Totally Unable to Work Benefit.
- For the first 24 months of the Claim Period, Jack remained Totally Unable to Work in his Own Occupation. However, Jack is medically certified to be capable of full-time work in another reasonable occupation which he is suited for.
- From the 25th month onwards, Jack's claim was finalised and no Income Protection benefit is payable because he is capable of work in Any Occupation on a full-time basis.

Income Protection Extend (IP Extend)

How long can benefits be payable for a claim?	to age 65	
What is the maximum proportion of your income that can be covered?	• 70% of the first $20,000 per month ($240,000 per annum) of your Earnings; • 50% of the next $20,000 per month ($240,000 per annum) of your Earnings; and • 20% of your remaining Earnings.	
Claim Period	**1-24 months on claim**	**After 24 months on claim**
Occupation definition used in Totally Unable to Work definition:	**Own Occupation**	**Any Occupation**
How much is payable if you are:		
Totally Unable to Work[1]	Benefit Amount[3]	
Partially Unable to Work[1,2]	Benefit Amount[3] less 75% of Earnings	Benefit Amount[3] less 100% of Earnings

1 The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).

2 The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' section in Section 2.6.1).

3 If the claim started after the Policy anniversary before your 60th birthday, the amount used to calculate the benefit payable will be 2/3rd of the Benefit Amount after the Claim Period exceeds 24 months.

The claim example below is not real and should only be used to help you understand how the IP Extend option works at time of claim. Please also refer to the conditions set out in the table above, along with the example to assist you to understand how IP Extend works. All relevant terms and conditions must be met for a claim to be payable.

Example 1

- Sam has IP Extend with a Benefit Amount of $5,000 per month (the Increasing Claim Option was not selected by Sam so does not apply).
- Sam was 45 years old when he suffered a Sickness or Injury and was medically certified Totally Unable to Work in his Own Occupation.
  For the first 24 months of the Claim Period, the Totally Unable to Work Benefit payable is:
  Benefit Amount
  = $5,000 per month
- From the 25th month to the 30th month of the Claim Period, Sam remained Totally Unable to Work in Any Occupation. The Totally Unable to Work Benefit payable is:
  = $5,000 per month
- On the 31st month of the Claim Period, Sam was able to return to work two days a week earning $2,800 per month. The Partially Unable to Work Benefit payable is:
  Benefit Amount – 100% of Earnings
  = $5,000 – (100% x $2,800)
  = $2,200 per month
- From the 35th month onwards, Sam returned to full-time work and his claim was finalised.

Example 2

- Michael has IP Extend with a Benefit Amount of $7,000 per month (the Increasing Claim Option was not selected by Michael so does not apply).
- Michael was 61 years old when he suffered a Sickness or Injury and was medically certified Totally Unable to Work in his Own Occupation.
- For the first 24 months of the Claim Period, Michael remained Totally Unable to Work in his Own Occupation. He was paid the Totally Unable to Work Benefit at $7,000 per month.
- From the 25th month to the 28th month of the Claim Period, Michael remained Totally Unable to Work in Any Occupation.
  Since the claim started after the Policy anniversary before Michael's 60th birthday, the Totally Unable to Work Benefit payable was:
  2/3 x Benefit Amount
  = 2/3 x $7,000
  = $4,666.67 per month
- Michael will continue to be paid the Totally Unable to Work Benefit until the end of his Benefit Period (to age 65), as long as he meets the requirements for the Totally Unable to Work Benefit.

1.2 Structuring your Plan

Once you've decided on the type of Plan(s) you need, you need to decide:

- Whether the ownership is through superannuation or outside superannuation.
- How to structure your Plan(s) – Standalone, Attached, Linked or Superlink.

1.2.1 Ownership structure

There are a few different ownership options available depending on the Plan you choose. The different types of ownership determine how the premiums are funded and may have different tax implications in respect of the premiums and benefits paid. An adviser can help you decide which ownership option is suitable to meet your needs. More information on tax and structuring insurance through superannuation can be found in Section 7 and Section 8. If you are structuring your Accelerated Protection insurance through TAL Super, you must also read the 'Accelerated Protection through TAL Super PDS'.

Ownership structure	Life Insurance	TPD Insurance	Critical Illness Insurance	Child's Critical Illness Insurance	Income Protection
Individual	✓	✓	✓	✗	✓
Superannuation	✓	✓	✗	✗	✓
Trust	✓	✓	✓	✓	✗
Company/business	✓	✓	✓	✗	✓
Joint	✓	✓	✓	✓	✗
Parent/guardian	✗	✗	✗	✓	✗

1.2.2 Plan structure

There are several different ways you can structure your Plans. An adviser can help you decide which Plan structure is suitable for your needs. The Plans structures available are:

- **Standalone**: A claim paid under a Standalone Plan will not reduce the Benefit Amount of another Standalone Plan.
- **Attached/Attaching**: When a Plan is Attached to another Plan, a claim paid under a Plan will reduce the Benefit Amount on all other Plans that it is Attached to. All Attached Plans have the same Policy Owner(s) and are issued under one Policy.
- **Linked/Linking**: When a Plan is Linked to another Plan, a claim paid under a Plan will reduce the Benefit Amount on all other Plans that it is Linked to. Linked Plans have different Policy Owners and the Plans are issued under multiple policies. This allows you to package Plans that cannot be structured through superannuation with Plans that are structured through superannuation.
- **Superlink**: Two policies are issued, one structured through superannuation and the other outside of superannuation. The Benefit Amount for both policies must be the same and the maximum benefit payable is the equivalent to the Benefit Amount of one Policy. This allows a portion of the premium to be funded through superannuation, thereby reducing out-of-pocket cost while still providing access to benefits that are not available when insurance is structured through superannuation.

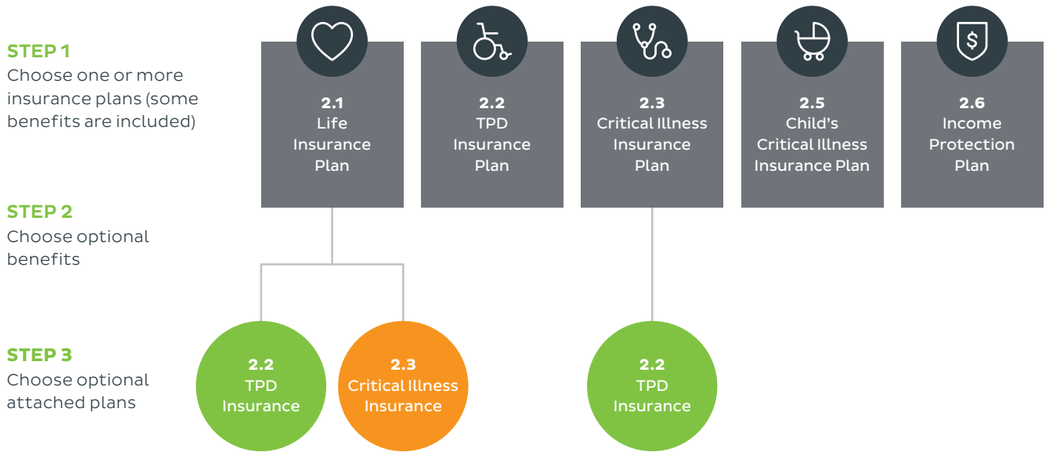
If you make a claim and Superlink applies, we will assess the claim against the Policy structured through superannuation first. If a benefit is payable and the SIS legislation and rules are met, we will pay the benefits from the Policy structured through superannuation. If a benefit is payable but the SIS legislation and rules are not met, we will pay the benefits from the Policy structured outside superannuation.

	Life Insurance	TPD Insurance	Critical Illness Insurance	Child's Critical Illness Insurance	Income Protection
Standalone	✓	✓	✓	✓	✓
Attached	✗	✓[2]	✓[1]	✗	✗
Linked	✗	✓[1]	✓[1]	✗	✗
Superlink	✗	✓	✗	✗	✓

[1]Can only be Attached/Linked to Life Insurance
[2]Can be Attached/Linked to Life Insurance or Critical Illness Insurance

Structuring insurance outside superannuation
The following diagram describes the Plan structures available where you structure Accelerated Protection outside of superannuation. Terms, conditions and limitations apply to these benefits.

STRUCTURING YOUR INSURANCE OUTSIDE SUPERANNUATION

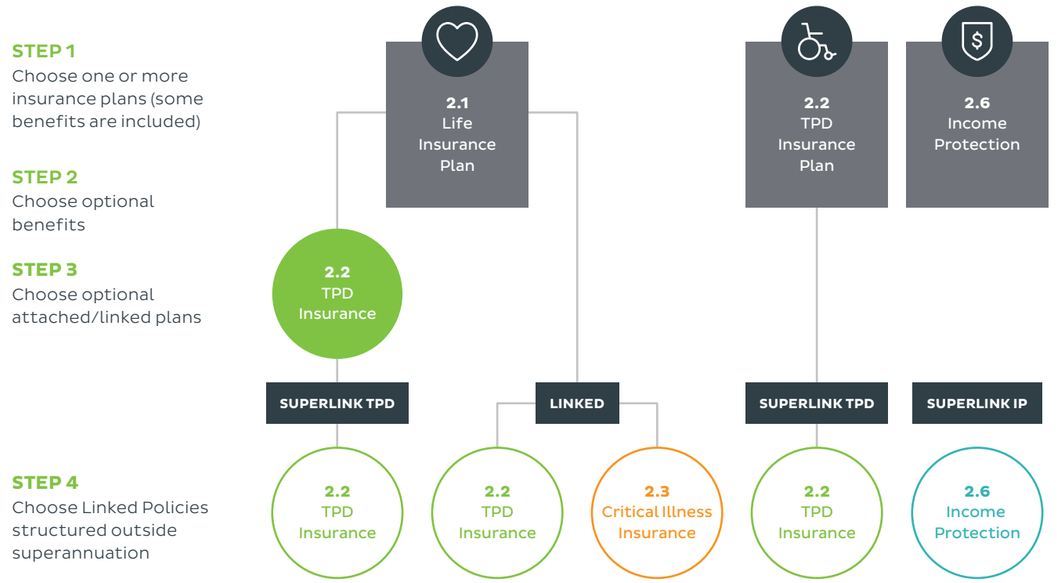


Structuring insurance through superannuation
You should be aware of the following if you structure Accelerated Protection through superannuation:

- You will need to be a member of the superannuation fund through which your Policy is structured.
- The trustee of the fund owns the Policy.
- Premiums and benefit payments are made through the fund and are subjected to restrictions under the governing rules of the fund and in accordance with superannuation law.
- Some features of Accelerated Protection will not be available or will not apply.
- For a claim to be paid, you must fulfil the SIS rules and regulation, and the applicable SIS definitions (refer to Section 9.1).
- A claim under TPD Insurance must meet the SIS definition of Permanent Incapacity.
- A claim under Income Protection must meet the SIS definition of Temporary Incapacity.

The following diagram describes the Plans structures available when Accelerated Protection is structured through superannuation.

STRUCTURING YOUR INSURANCE THROUGH SUPERANNUATION



More information on structuring insurance through superannuation can be found in Section 8. Where you structure your insurance through TAL Super, you must also read the 'Accelerated Protection through TAL Super PDS'.

1.3 What are the costs?

The cost of your Policy depends on a range of factors, including but not limited to the type of cover, your age and sex, whether you smoke, the length of time you have had your Policy and how often you choose to pay your premiums. We may also take your occupation, health, income, personal pastimes, lifestyle, the number or type of Plans you hold across one or more policies, and other factors into account in determining insurance premium amounts.

We ask for this information so that the premiums we charge take into account the different levels of risk presented by different customer groups.

Sometimes discounts may apply to certain Plans; however, these may not apply for the full term of your Policy.

Once we know a little bit about you and the cover you require, we can provide you with an indicative quote for your premium. The quoted premium may change once we have all the information we require to complete our Underwriting assessment.

All premiums are payable in advance, by the due date shown in your Policy Schedule. We will inform you of the premium payable in subsequent years before each Policy anniversary.

1.3.1 You can choose to pay stepped or level premiums.

Stepped premium
If you choose stepped premium, the premium is calculated based on your total Benefit Amount, the length of time you have had your Policy and your age as at each Policy anniversary. This means your premium will generally increase at each Policy anniversary. There are a range of other reasons why your stepped premium may increase, including if we change our premium rates. Please see Section 1.3.2 and 1.3.3 below for more information.

Level premium
Level premiums are not fixed. They can change. If you choose level premiums, the premium is based on your age at the Plan start date. Where you choose to increase your cover or the Inflation Protection Benefit applies, the premium rates used to calculate premiums for the alteration will be based on the Life Insured's age at that time. There are a range of other reasons why your level premium may increase, including if we change our premium rates. Please see sections 1.3.2 and 1.3.3 below for more information.

Where level premium 'to age 65' is shown in your Policy Schedule, premiums will change to stepped premiums on the Policy anniversary before the Life Insured's 65th birthday. Where level premium 'to age 70' is shown in your Policy Schedule, premiums will change to stepped premiums on the Policy anniversary before the Life Insured's 70th birthday.

1.3.2 Changes in premiums

For both stepped and level premium, your premiums and the amount you pay will change if:

- you vary your Policy, for example when you add or remove a Plan or benefit option;
- there is a change in your Benefit Amount, for example when your Benefit Amount increases (including through the Inflation Protection Benefit and Guaranteed Future Insurability Benefit);
- a discount no longer applies or changes because you varied your Policy, or another policy held with us;
- government duties or charges change; or
- we change our premium rates or Policy fee (refer to Section 1.3.3 for details).

Premiums for your Policy may change if there are any variations to other Accelerated Protection plans or policies you hold or have cover under. This includes, but is not limited to, the following variations - increases or decreases in sums insured, addition or cancellation (including due to non-payment of premium) of other plans or policies. When determining premiums, we take into account a number of factors which may include the number or type of policies or plans that you hold or have cover under.

If your premiums change there may be options available to help you manage the cost of your cover, please speak to us or a financial adviser for assistance.

1.3.3 We can change our premium rates

The cost of your cover is not guaranteed to remain the same each year. It can change for both stepped and level premium cover. In the past we have changed the premium rates used to calculate the cost of cover and Policy fees, including changing the premium rates we use to determine level premiums.

We can change our Policy fees or the premium rates we use to determine your premium. However, the premium rates we use to determine your premiums are guaranteed not to change before the first Policy anniversary.

Decisions to change premium rates or Policy fees do not occur because of changes to an individual customer's own circumstances, but rather are determined in relation to the group of customers that we insure.

We will act reasonably when making decisions to change our premium rates or Policy fees and will only make changes to the extent reasonably necessary to protect our legitimate business interests.

Our premiums and Policy fees are determined so that the total premium and Policy fees for our group of insured customers is enough to cover our expected future claims costs, meeting our associated costs of doing business and margins in providing cover to you.

We review associated factors on an ongoing basis which may include, but are by no means limited to, our assessment of regulatory or legislative requirements, our operating costs or the commercial environment. These are only some examples of factors that we may consider and others may apply. The outcome of any premium review performed by us may result in a change to the premium rates and Policy fees we charge you. If we change the premium rates or Policy fees, you will be advised of the change to your premiums or Policy fees at least 30 days before the change takes effect.

If your premiums increase, you will always have the option to reduce the premium by reducing your cover, subject to any minimum premiums or sum insured applicable to your Policy.

You will also always have the right to cancel your cover, at any time and for any reason, including a premium increase. There may be other options available to help you manage the cost of your cover. Please speak to us or a financial adviser for assistance.

Your Policy cannot be singled out for a change in how premium is charged because of an adverse change in the health or circumstances of the Life Insured after the Policy start date.

1.3.4 Commissions

We may pay commission or other remuneration (such as referral fees) to your financial adviser or other distributors of the Accelerated Protection product. Any amounts paid are factored into the cost of the Policy. Your financial adviser or the distributor will provide details of the payments they will receive from us in the Financial Services Guide and, if applicable statement of advice that they will give to you. In general, these amounts will be calculated by reference to your premium and will be subject to commission caps imposed by law.

1.3.5 Policy fee

The Policy fee is included as part of each premium instalment. The Policy fee will be increased on each Policy anniversary by the greater of the Indexation Factor or three percent.

The amount of the Policy fee depends on which premium frequency option is selected:

Premium frequency	Per instalment	Annual equivalent
Yearly	$88.00	$88.00
Half-Yearly	$44.00	$88.00
Quarterly	$24.00	$96.00
Monthly	$8.00	$96.00

1.3.6 Payment method and frequency options

Payment method options:	Payment frequency options:
• Direct debit • Credit card (MasterCard or Visa) • Rollover when structured through TAL Super (annual payments only) • Employer contribution through SuperStream • BPAY® • From a retail superannuation account or investment account that we have an agreement with	• Monthly (not available if paying by BPAY) • Quarterly • Half yearly* • Annually* *premium frequency discount may apply

2 Accelerated Protection in detail

2.1 Life Insurance

Life Insurance only applies if indicated in the Policy Schedule.

A benefit under Life Insurance will only be paid if death or Terminal Illness occurs after the Plan start date and before the Plan end date.

When we refer to a benefit payment, the statement is made on the basis that the benefit referred to is payable under the terms and conditions of the Policy. We will not pay a benefit if an exclusion applies. You must also satisfy our claim requirements, explained in Section 3.

2.1.1 Included benefits

Death Benefit
The Benefit Amount is payable when the Life Insured dies.

Terminal Illness Benefit
The Benefit Amount is payable when the Life Insured is diagnosed as Terminally Ill.

If the Terminal Illness Benefit is paid, we will cancel any Attached or Linked Plans.

Advanced Payment Benefit
The Advanced Payment Benefit is an advance payment of 10% of the Benefit Amount, up to a maximum of $25,000. This benefit will be paid when the death certificate or a medical certificate confirming death of the Life Insured is provided to us.

In the first three years from the Plan start date, the Advanced Payment Benefit will only be paid if the Life Insured's death resulted from an Accident. After the first three years, the Advanced Payment Benefit will apply for all causes of death unless the cause of death is excluded.

Payment of the Advanced Payment Benefit does not mean any admission or acceptance of any claim or liability regarding current or future payments under Life Insurance.

If we pay the Advanced Payment Benefit and our assessment of the claim determines that the Death Benefit will not be paid due to breach of the duty to take reasonable care not to make a misrepresentation, we will require the Advanced Payment Benefit to be repaid to us.

If the Advanced Payment Benefit is paid, it will reduce the Benefit Amount by the amount paid under the Advanced Payment Benefit.

Repatriation Benefit
If the Life Insured dies outside Australia, we will increase the maximum amount payable under the Advanced Payment Benefit to 10% of the Benefit Amount up to a maximum of $35,000. This benefit will be paid when the death certificate or a certified medical certificate by a Medical Practitioner, confirming death of the Life Insured outside of Australia is provided to us. All other terms and conditions of the Advanced Payment Benefit apply to the Repatriation Benefit.

2.1.2 When we will not pay

No payments will be made under Life Insurance, and any included or optional benefits (if applicable), if the claim arises directly or indirectly because of an intentional, self-inflicted act by the Life Insured:

- within 13 months after the Plan start date;
- within 13 months after the date of any increase applied for, but only in respect of the increase amount; and
- within 13 months after the most recent date we agreed to reinstate either the Plan or Policy.

We will waive the above exclusion if you had death cover on the Life Insured that was in force for at least 13 consecutive months immediately before the Plan start date (without the death cover being cancelled and/or reinstated) with TAL or another insurer, and you have replaced the death cover with Life Insurance under this Policy. The waiver will only apply up to the level of death cover you had with TAL or the other insurer.

If the Life Insurance Plan is reinstated, the exclusion above will recommence from the date of reinstatement.

Any cover bought back under the Death Buy-Back Option or Death Buy-Back Benefit will be issued subject to the limitations and conditions, exclusions and loadings which were applicable to the original Policy. If Accelerated Protection is no longer available when the Death Buy-Back Option or Death Buy-Back Benefit is exercised, we will issue a death cover comparable to Accelerated Protection Life Insurance. Any additional benefits under the new death cover which are not available with Accelerated Protection Life Insurance will not apply.

2.1.3 When Life Insurance ends

Life Insurance ends and our liability to pay a benefit under the Plan ceases on the earlier of the:

- Policy anniversary before the Life Insured's 100th birthday;
- Policy anniversary before the Life Insured's 75th birthday if structured through TAL Super or a retail superannuation fund (at which point you can apply to transfer the ownership outside of superannuation and continue until the Policy anniversary before the Life Insured's 100th birthday. An application to transfer ownership must be received before the Plan end date);
- date we receive the Policy Owner's written request to cancel the Policy;
- Policy being cancelled because of non-payment of premiums;
- date we cancel or avoid the Policy because of a misrepresentation made by you or the Life Insured before our acceptance of the Policy or because you made a fraudulent claim;
- death of the Life Insured; or
- full Benefit Amount being paid or reduced to nil (when this occurs, the Financial Planning Benefit and Grief Support Benefit will remain available for 12 months after the Benefit Amount was paid).

When structured through a retail superannuation fund, Life Insurance will end when you cease to be a member of the retail superannuation fund. This means that your Policy will be cancelled from the date you cease to be a member of the retail superannuation fund. You can apply within 60 days of the date your Policy was cancelled to continue the Plan with no further medical or financial requirement. Any special conditions or loadings which applied to the original Plan will also apply to the new Plan.

2.2 TPD Insurance

TPD Insurance only applies if indicated in the Policy Schedule. The TPD definition and any applicable options are shown in the Policy Schedule.

A benefit under TPD Insurance will only be paid if the conditions and requirements for a claimable event are met after the Plan start date and before the Plan end date.

When we refer to a benefit payment, the statement is made on the basis that the benefit referred to is payable under the terms and conditions of the Policy. You must also satisfy our claim requirements, explained in Section 3.

2.2.1 Included benefits

TPD Benefit
The TPD Benefit is payable if the Life Insured becomes Totally and Permanently Disabled. The applicable TPD definition is shown in the Policy Schedule.

The following TPD definitions are available:

- 'Any Occupation';
- 'Own Occupation' (not available when structured through superannuation); or
- Activities of Daily Living (ADL).

If the TPD Benefit is paid, it will reduce the Benefit Amount of any Attached and/or Linked Plans by the amount paid.

Advanced Payment Benefit
Not available when structured through superannuation.

We will pay 25% of the Benefit Amount, up to a maximum of $500,000 if the Life Insured suffers one of the following:

- Loss of use of a Single Limb (permanent); or
- Loss of Sight in One Eye (permanent).

This is only payable once and the TPD Insurance Benefit Amount and the Benefit Amount under any Attached or Linked Plan, will be reduced by the amount paid under the Advanced Payment Benefit.

Death Benefit
Only available with Standalone TPD Insurance structured through TAL Super.

If the TPD Benefit has not been paid and the Life Insured dies, we will pay the lesser of $10,000 and the TPD Insurance Benefit Amount.

2.2.2 Optional benefits

The options listed below only apply if indicated in your Policy Schedule.

Death Buy-Back Option
Only available if TPD Insurance is Linked or Attached to Life Insurance.

If we pay 100% of the TPD Insurance Benefit Amount, TPD Insurance will end. When this occurs, under the Death Buy-Back Option, you can buy-back Life Insurance on the Life Insured.

The amount of cover you may repurchase is the amount of the TPD Insurance Benefit Amount paid. The Death Buy-Back Option can be exercised without having to provide evidence of health, occupation, income or pastimes, or any other Underwriting information.

You must notify us in writing of your intention to exercise the Death Buy-Back Option. Notification must occur during the 30 days following the 12-month anniversary of the date we were notified formally of a claim in accordance with our claim requirements (see Section 3), and in relation to a claim which was subsequently paid. Any further requirements must be submitted to us within 30 days of the date we received your notification, or the Death Buy-Back Option will expire.

If payment of the claim occurs more than 12 months after the formal notification was made to us, buy-back will be available for 30 days from the date of payment. If you fail to exercise the Death Buy-Back during this 30-day period, the Death-Buy Back Option will expire.

The Death Buy-Back Option will expire if not exercised before the Policy anniversary before the Life Insured's 65th birthday.

The premium for the repurchased Life Insurance will be calculated using our standard premium rates for the age of the Life Insured at the time the option is exercised and will take into account any extra premiums charged and special provisions that apply to the Life Insurance Plan for the Life Insured.

The repurchased Life Insurance will not be eligible for the following benefits and options:

- Inflation Protection Benefit;
- Guaranteed Future Insurability Benefit;
- Premium Relief Option; or
- Business Insurance Option (if applicable).

The Death Buy-Back Option does not apply where 'Double TPD' or 'Double Critical Illness' is shown in your Policy Schedule.

Double TPD Option
Only available if TPD Insurance is Attached or Linked to Life Insurance.

If 'Double TPD' is indicated in your Policy Schedule, and 100% of the TPD Insurance Benefit Amount becomes payable:

- the Life Insurance Benefit will not be reduced;
- future premiums due in respect of that part of the Life Insurance Benefit Amount equal to the TPD Insurance Benefit Amount paid will be waived;
- the Life Insurance Benefit Amount equal to the TPD Insurance Benefit Amount paid will continue until the Life Insurance Plan end date; and
- in the event cover is transferred to non-superannuation ownership, future premiums due in respect of that part of the Life Insurance Benefit Amount equal to the TPD Insurance Benefit Amount paid will be waived until the Life Insurance Plan end date.

The portion of Life Insurance where the premiums are waived will not be eligible for the following benefits and options:

- Inflation Protection Benefit;
- Guaranteed Future Insurability Benefit;
- Premium Relief Option; or
- Business Insurance Option (if applicable).

This option will expire on the Policy anniversary before the Life Insured's 65th birthday.

Superlink TPD
Superlink TPD allows you to structure TPD Insurance as follows:

- TPD 'Any Occupation' definition structured through superannuation; and
- TPD 'Own Occupation' definition structured outside superannuation.

Two Policies will be issued, one of which will be issued to the trustee of a superannuation fund, and the other will be issued outside of superannuation. These policies will be Linked and the following additional conditions apply:

- the TPD Insurance Benefit Amount, any optional benefits selected, and any loadings or exclusions (if applicable) of each Policy must always be the same;
- if TPD Insurance is reduced or increased under one Policy, TPD Insurance on the other Policy will be reduced or increased (as applicable) at the same time;
- if the Policy structured through superannuation is cancelled (not because of a claim payment), the Policy structured outside superannuation will also be cancelled unless you notify us in writing to retain the Plan structured outside superannuation before cancellation;
- if TPD Insurance structured outside superannuation is cancelled, cover will continue under the Policy structured through superannuation, and Superlink TPD will no longer apply; and
- the maximum benefits payable under both Policies will never exceed that which would be payable under a single TPD Policy.

Claims will first be assessed using the 'Any Occupation' definition under TPD Insurance Plan structured through superannuation and the SIS definition of Permanent Incapacity. If these definitions are satisfied the Benefit Amount will be paid to the trustee. If these definitions are not satisfied, the claim will be assessed using the 'Own Occupation' definition under the TPD Insurance Plan structured outside superannuation and any Benefit Amount payable will be paid to the Policy Owner.

The Policy Schedules will indicate if Superlink TPD applies.

2.2.3 When we will not pay

No payment will be made under TPD insurance and any included or optional benefits (if applicable) if the claim arises directly or indirectly because of an intentional, self-inflicted act by the Life Insured.

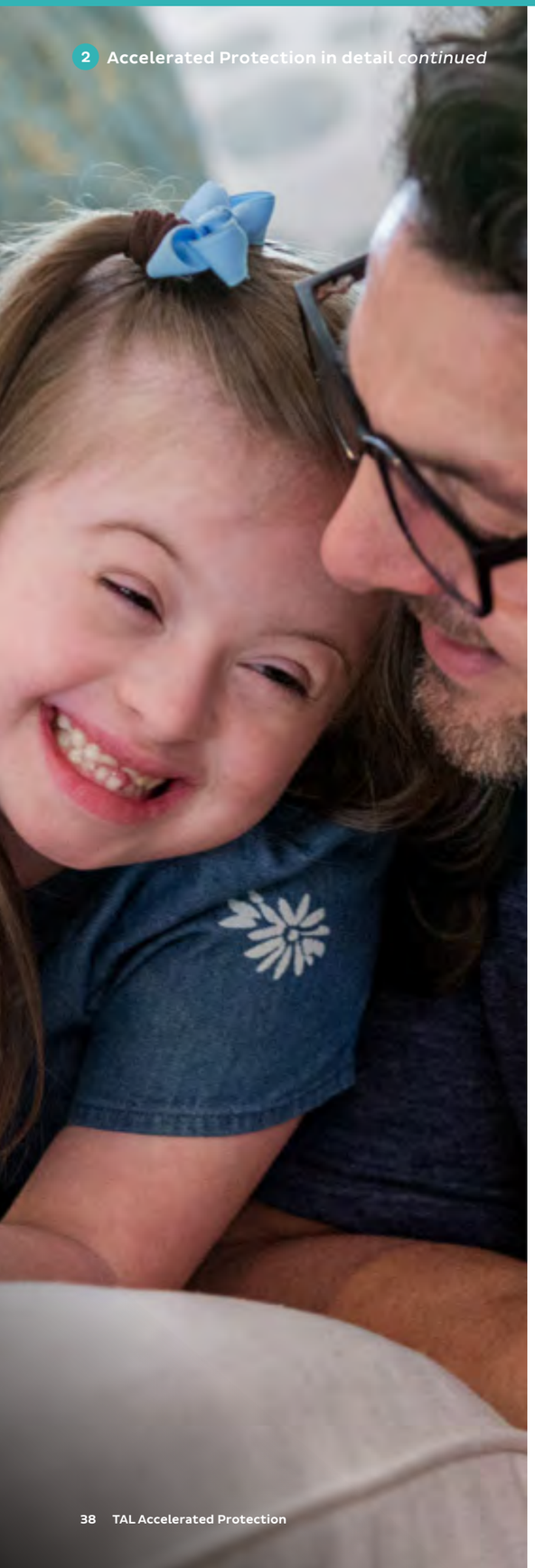
If TPD Insurance is Attached or Linked to Life Insurance, the TPD Benefit will not be paid if you are also eligible for the Terminal Illness Benefit under Life Insurance.

If TPD Insurance is not Attached or Linked to Life Insurance, no payment will be made under TPD Insurance unless the Life Insured survives the Sickness or Injury which resulted in Total and Permanent Disability, for at least 14 days.

2.2.4 When TPD Insurance ends

TPD Insurance will also end and our liability to pay a benefit under the Plan will cease on the earlier of the:

- Policy anniversary before the Life Insured's 65th birthday;
- date we receive the Policy Owner's written request to cancel the Plan or Policy;
- Policy being cancelled because of non-payment of premiums;
- date we cancel or avoid the Policy because of a misrepresentation made by you or the Life Insured before our acceptance of the Policy or because you made a fraudulent claim;
- death of the Life Insured; or
- full Benefit Amount being paid or reduced to nil (when this occurs, the Financial Planning Benefit and Grief Support Benefit will remain available for 12 months after the Benefit Amount was paid).



The following conditions also apply to TPD Insurance:

- If TPD Insurance is Attached to Life Insurance or Critical Illness Insurance, cancellation of Life Insurance or Critical Illness insurance will also cancel TPD Insurance unless you tell us in writing that you want to retain TPD Insurance as a Standalone Plan. The terms and conditions for Standalone TPD Insurance will apply.
- If TPD Insurance is Linked to Life Insurance, TPD Insurance will become a Standalone Plan if you cancel Life Insurance.
- If TPD Insurance and Critical Illness Insurance are both Attached to Life Insurance and you cancel Life Insurance, both TPD Insurance and Critical Illness Insurance will also be cancelled unless you tell us in writing that you want to retain either or both TPD Insurance and/or Critical Illness Insurance. If you choose to keep both TPD Insurance and Critical Illness Insurance, the TPD Insurance will be Attached to Critical Illness Insurance. If the TPD Insurance Benefit Amount is greater than the Critical Illness Insurance Benefit Amount, the Attached TPD Insurance Benefit Amount will be reduced so that it is not greater than the Critical Illness Insurance Benefit Amount and the remainder of the TPD Insurance Benefit Amount can be setup as a Standalone TPD Insurance Plan.

If you cancel a Plan but choose to keep at least one of the Plans that was Attached or Linked, your premium rates will change for the remaining Plan(s). The premium will be calculated using our premium rates for the age of the Life Insured at the time of the change and will take into account any extra premiums charged and special provisions that apply to the original Plan. Any changes that increase our liability to pay claims will require full Underwriting.

When structured through a retail superannuation fund, TPD Insurance will end when you cease to be a member of the retail superannuation fund. This means that your Policy will be cancelled from the date you cease to be a member of the retail superannuation fund. You can apply within 60 days of the date your Policy was cancelled to continue the Plan with no further medical or financial requirement. Any special conditions or loadings which applied to the original Plan will also apply to the new Plan.

2.3 Critical Illness Insurance

Critical Illness Insurance only applies if indicated in the Policy Schedule. Critical Illness Insurance is available as 'Standard' or Premier'. The type of Critical Illness Insurance and any applicable options is stated in your Policy Schedule. Critical Illness Insurance cannot be structured through superannuation.

A benefit under Critical Illness Insurance will only be paid if the conditions and requirements for a claimable event are met after the Plan start date but before the Plan end date and the Life Insured suffers a specified serious event as described in the sections below. We require confirmation of diagnosis by a Medical Practitioner and the specified severity threshold criteria to be met, for a benefit to be payable. The severity threshold criteria are defined for each event in Section 9.

For many specified serious events this means the condition will be required to progress beyond a diagnosis, where diagnosis means the process of a Medical Practitioner determining which Sickness or Injury explains an individual's symptoms. You must also satisfy our claim requirements in Section 3 of this PDS.

When we refer to a benefit payment, the statement is made on the basis that the benefit referred to is payable under the terms and conditions of the Policy.

2.3.1 Included benefits

The following benefits, in addition to the benefits set out in Section 2.4, are included in Critical Illness Insurance Standard and Premier, unless otherwise indicated.

Critical Illness Benefit
The Benefit Amount is payable if the Life Insured suffers a Critical Illness Event listed in the table below.

If the Life Insured suffers more than one Critical Illness Event, the Benefit Amount is only payable for the first occurring Critical Illness Event, unless the first to occur is Angioplasty. If Angioplasty occurs and a claim is paid, the remaining Benefit Amount will be the basis used to determine payment in accordance with the Critical Illness insurance terms and conditions if the Life Insured suffers another Critical Illness Event.

More than one payment can be made for Angioplasty, as long as the first Angioplasty procedure ever undergone by the Life Insured occurred after the Plan start date.

The following conditions apply to Critical Illness Insurance Standard Plan for Angioplasty:

- each Angioplasty procedure occurring at least six months after the previous Angioplasty; and
- a maximum of three payments.

If the Critical Illness Benefit is paid, it will reduce the Critical Illness Insurance Benefit Amount and the Benefit Amount of any Attached and/or Linked Plans, by the amount paid.

Critical Illness Events applicable to Standard and Premier

Heart conditions	Neurological conditions	Permanent conditions	Organ disorders
• Angioplasty[1,2] • Angioplasty for Triple Vessel Disease[1] • Aortic Surgery (for specified conditions) • Cardiomyopathy (permanent) • Heart Attack (of specified severity)[1] • Heart Valve Surgery[1] • Coronary Artery Bypass Surgery[1] • Open Heart Surgery[1] • Out of Hospital Cardiac Arrest (requiring cardiopulmonary resuscitation)[1] • Idiopathic Pulmonary Arterial Hypertension (of specified severity)	• Coma (of specified severity) • Dementia including Alzheimer's Disease (permanent) • Encephalitis (resulting in permanent neurological deficit) • Major Head Trauma (with permanent neurological deficit) • Meningitis (resulting in permanent neurological deficit) • Meningococcal Septicaemia (resulting in significant permanent impairment) • Multiple Sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities)[1] • Muscular Dystrophy • Paralysis (permanent) • Parkinson's Disease (permanent) • Progressive and Debilitating Motor Neurone Disease • Stroke (resulting in neurological deficit)[1]	• Blindness (permanent) • Deafness (permanent) • Loss of Independent Existence (permanent) • Loss of use of Limbs (permanent) • Loss of Speech (permanent)	• Chronic Kidney Failure (undergoing permanent dialysis) • Chronic Liver Failure (resulting in permanent symptoms) • Chronic Lung Failure (on permanent oxygen therapy) • Major Organ Transplant (of specified organs) • Pneumonectomy • Severe Burns (covering at least 20% of the body's surface area)

Blood disorders	Cancer
• Aplastic Anaemia (requiring treatment) • Medically-Acquired HIV (contracted from a medical procedure or operation) • Occupationally-Acquired HIV	• Benign Brain Tumour (resulting in irreversible neurological deficit)[1] • Cancer (of specified criteria)[1]

Critical Illness Events applicable to Premier:

Organ disorders	Blood disorders
• Severe Diabetes Mellitus (of specified severity)	• Occupationally-Acquired Hepatitis B or C[3]

[1]A three-month qualifying period applies. Refer to the 'When we will not pay' Section 2.3.4 for details.
[2]The amount to be paid is reduced to 25% of the Benefit amount to a maximum of $50,000.
[3]Only payable under the Needlestick Benefit.

Paralysis Support Benefit
If the Life Insured suffers Paralysis (permanent), the Critical Illness Insurance payment will be:

- two times the Benefit Amount, to a maximum of $2,000,000; or
- the Benefit Amount, if it is greater than $2,000,000.

If the Paralysis Support Benefit is paid, it will reduce the Benefit Amount of any Attached or Linked Plans by the Critical Illness Insurance Benefit Amount.

Death Buy-Back Benefit
Only available when Critical Illness Insurance is Attached or Linked to Life Insurance.

If we pay 100% of the Critical Illness Benefit, Paralysis Support Benefit or TPD Benefit, Critical Illness Insurance will end. When this occurs, under the Death Buy-Back Benefit, you can repurchase Life Insurance on the Life Insured. The amount you can repurchase is the amount of Critical Illness Benefit paid or the Benefit Amount, in the case of the Paralysis Support Benefit. The Death Buy-Back Benefit can be exercised without having to provide evidence of health, occupation, income or pastimes, or any other Underwriting information.

You must notify us in writing of your intention to exercise the Death Buy-Back Benefit during the 30 days after the 12 month anniversary of the date we were notified formally of a claim in accordance with our claim requirements (see Section 3) in relation to a claim which was subsequently paid. Any further requirements must be submitted to us within 30 days of the date we received your notification or the Death Buy-Back Benefit will expire.

If payment of the claim occurs more than 12 months after the formal notification was made to us, repurchase will be available for 30 days from the date of payment. If you fail to exercise the Death Buy-Back during this 30 day period, the Death-Buy Back Benefit will expire.

The Death Buy-Back Benefit will expire if not exercised before the Policy anniversary before the Life Insured's 70th birthday.

The premium for the repurchased Life Insurance will be calculated using our standard premium rates for the age of the Life Insured at the time the option is exercised and will take into account any extra premiums charged and special provisions that apply to the Life Insurance Plan for the Life Insured.

The repurchased Life Insurance will not be eligible for increases under the Inflation Protection Benefit, Guaranteed Future Insurability Benefit, or Business Insurance Option (if applicable).

The Death Buy-Back Benefit does not apply:

- unless Critical Illness insurance is Attached or Linked to Life Insurance; or
- when 'Double Critical Illness' or 'Double TPD' is shown in your Policy Schedule.

2.3.2 Premier benefits

The following benefits only apply if 'Premier' is shown in your Policy Schedule.

Advancement Benefit
If the Life Insured suffers an Advancement Benefit Event listed in the table below, the Advancement Benefit will be payable. The amount payable is shown in the following table.

The Advancement Benefit is payable only once for each Event. The total Benefit Amount will be reduced by the amount paid for each of these Events. If the Life Insured is eligible for more than one Critical Illness Event and/or Advancement Benefit Event at the same time, the events will be treated as occurring consecutively. We will consider the event with the highest amount payable to have taken place first.

The Advancement Benefit will only be paid if the condition or the circumstances leading to the claim first occurs after the Plan start date.

If the Advancement Benefit is paid, it will reduce the Critical Illness Insurance Benefit Amount and the Benefit Amount of any Attached or Linked Plans by the amount paid.

Advancement Benefit Events	Maximum payment
• Loss of Hearing in One Ear (permanent) • Loss of use of a Single Limb (permanent) • Loss of Sight in One Eye (permanent)	10% of the Benefit Amount to a maximum of $100,000
• Carcinoma In Situ (of specified site)[1]	• 25% of the Benefit Amount to a maximum of $100,000 • If the Life Insured is diagnosed with a cervical lesion which has been classified as Carcinoma In Situ of the cervix or Cervical Intraepithelial Neoplasia (CIN) 3, we will pay 10% of the Benefit Amount to a maximum of $100,000.
• Diagnosed Benign Brain Tumour (of specified severity)[1] • Early Stage Chronic Lymphocytic Leukaemia[1] • Early Stage Skin Melanoma (excluding melanoma in situ)[1] • Early Stage Prostate Cancer[1]	25% of the Benefit Amount to a maximum of $100,000
• Type 1 Diabetes diagnosed after age 30 • Severe Ulcerative Colitis (unresponsive to therapy) • Severe Crohn's Disease (unresponsive to therapy)	20% of the Benefit Amount to a maximum of $100,000
• Diagnosed Dementia	25% of the Benefit Amount to a maximum of $50,000

[1]A three-month qualifying period applies. Refer to the Section 2.3.4 for details.

Female Critical Illness Benefit

The Female Critical Illness Benefit will be payable upon the occurrence of a Female Critical Illness Benefit Event listed in the table below and only apply if the Life Insured is female. The payment for each event is 20% of the Benefit Amount, up to a maximum of $50,000. Each Female Critical Illness Benefit Event can only be paid once.

If the Female Critical Illness Benefit is paid, it will reduce the Critical Illness Insurance Benefit Amount and the Benefit Amount of any Attached or Linked Plans by the amount paid.

	Female Critical Illness Event
Pregnancy complications	• Eclampsia of Pregnancy • Disseminated Intravascular Coagulation (pregnancy related) • Ectopic Pregnancy (occurring in the fallopian tube) • Hydatidiform Mole • Stillbirth
Congenital abnormalities[1]	• Down's Syndrome • Spina Bifida Myelomeningocele • Tetralogy of Fallot • Transposition of Great Vessels • Congenital Blindness (permanent) • Congenital Deafness (permanent)
Other events	• Severe Osteoporosis (of specified severity) • Lupus (of specified severity)

[1]The condition and symptoms must have first occurred after the Plan started and the child must survive at least 30 days from birth.

Coverage for Pregnancy Complications and Congenital Abnormalities ends at the Policy anniversary before the Life Insured's 45th birthday. No payments will be made for Pregnancy Complications or Congenital Abnormalities:

- within 12 months after the Plan start date;
- within 12 months after the date of an approved applied-for increase but only in respect of the increase; and
- within 12 months after the most recent date we agreed to reinstate either the Plan or Policy.

No payments will be made for 'Other events' (listed in the table above):

- within three months after the Plan start date;
- within three months after the date of an applied-for increase but only in respect of the increase; and
- within three months after the most recent date we agreed to reinstate either the Plan or Policy.

Needlestick Benefit

If the occupation class of the Life Insured is AA+ as specified in the Policy Schedule, the Needlestick Benefit will be payable when the Life Insured suffers Occupationally-Acquired Hepatitis B or C. The amount payable is the Benefit Amount, to a maximum of $1 million across all policies issued by TAL in the event of Occupationally-Acquired Hepatitis B or C.

2.3.3 Optional benefits

The options listed below only apply if indicated in your Policy Schedule.

Double Critical Illness Option

Only available if Critical Illness Insurance is Attached or Linked to Life Insurance.

The Life Insured must survive a Critical Illness Event for at least 14 days to be eligible to claim under this option.

If the Double Critical Illness Option is indicated in your Policy Schedule, and 100% of the Critical Illness Insurance Benefit Amount becomes payable:

- the Life Insurance Benefit Amount will not be reduced;
- all future premiums due in respect of that part of the Life Insurance Benefit Amount equal to the Critical Illness Insurance Benefit Amount paid will be waived; and
- the Life Insurance Benefit Amount equal to the Critical Illness Insurance Benefit Amount paid will continue until the Life Insurance Plan end date.

The portion of Life Insurance where the premiums are waived will not be eligible for the following benefits and options:

- Inflation Protection Benefit;
- Guaranteed Future Insurability Benefit;
- Premium Relief Option; or
- Business Insurance Option (if applicable).

The Double Critical Illness Option will expire on the Policy anniversary before the Life Insured's 70th birthday.

Critical Illness Reinstatement Option

If we pay a Critical Illness Benefit, Advancement Benefit, Needlestick Benefit, or Female Critical Illness Benefit, the Critical Illness Insurance Benefit Amount will reduce by the amount paid. The Critical Illness Reinstatement Option allows you to repurchase this amount of Critical Illness cover on the Life Insured. The repurchased cover will be the same type of Critical Illness cover held immediately before the claim.

The Critical Illness Reinstatement Option can be exercised without having to provide evidence of health, occupation, income or pastimes, or any other Underwriting information.

You must notify us in writing of your intention to exercise the Critical Illness Reinstatement Option. Notification must occur during the 30 days following the 12-month anniversary of the date we were notified formally of a claim, and in relation to a claim which was subsequently paid. Any further requirements must be submitted to us within 30 days of the date we received your notification, or the Critical Illness Reinstatement Option will expire. If payment of the claim occurs more than 12 months after the formal notification was made to us, reinstatement will be available for 30 days from the date of payment. If you fail to exercise the Critical Illness Reinstatement Option in the prescribed period, the Critical Illness Reinstatement Option will expire.

The Critical Illness Reinstatement Option will expire on the Policy anniversary before the Life Insured's 65th birthday.

The premium for the reinstated Critical Illness Insurance will be calculated using our standard premium rates for the age of the Life Insured at the time the option is exercised and will take into account any extra premiums charged and special provisions that previously applied to the Critical Illness Insurance Plan for the Life Insured.

If your Policy includes this option, we will allow you to repurchase the Critical Illness Insurance cover on the following basis:

- the repurchased Critical Illness Insurance Benefit Amount will be the same as the Critical Illness Benefit, Advancement Benefit, Needlestick Benefit, or Female Critical Illness Benefit paid;
- Death Buy-Back Benefit, Critical Illness Reinstatement Option, Double Critical Illness Option, Business Insurance Option and Premium Relief Option will not be available under the repurchased cover; and
- the repurchased cover will not be eligible for increases under the Inflation Protection Benefit, the Guaranteed Future Insurability Benefit or the Business Insurance Option (if applicable).

If the Life Insured is subsequently diagnosed with a Critical Illness Event, Advancement Benefit Event, Needlestick Benefit or Female Critical Illness Event, we will pay a claim under the repurchased cover provided the Critical Illness Event, Advancement Benefit Event, Needlestick Benefit or Female Critical Illness Event occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the Life Insured or would have become apparent to a reasonable person in the position of the Life Insured, after the Critical Illness Insurance cover was repurchased subject to the following conditions.

We will not pay a claim under the repurchased cover if the Critical Illness Event, Advancement Benefit Event, Needlestick Benefit or Female Critical Illness Event is:

- the same as the original Critical Illness Event, Advancement Benefit Event, Needlestick Benefit or Female Critical Illness Event for which we have already paid a benefit;
- directly or indirectly caused by or related to the Critical Illness Event, Advancement Benefit event, Needlestick Benefit or Female Critical Illness event for which we have already paid a benefit;
- directly or indirectly caused by or related to the symptom(s) or condition(s) which caused the occurrence of the original Critical Illness Event, Advancement Benefit Event, Needlestick Benefit or Female Critical Illness Event for which we have already paid a benefit;
- a Loss of Independent Existence (permanent);
- a Heart Condition and the Critical Illness Event for which we have already paid a benefit was also a Heart Condition;
- a Cancer Condition and the Critical Illness Event or Advancement Benefit Event for which we have already paid a benefit was also a Cancer Condition; or
- a Stroke (resulting in neurological deficit) or Paralysis (permanent), directly or indirectly resulting from a Stroke, and the Critical Illness Event for which we have already paid a benefit was a Heart Condition.

Under Critical Illness Reinstatement Option, Heart Condition means:

- Angioplasty;
- Angioplasty for Triple Vessel Disease;
- Aortic Surgery (for specified conditions);
- Cardiomyopathy (permanent);
- Coronary Artery Bypass Surgery;
- Heart Attack (of specified severity);
- Heart Valve Surgery;
- Idiopathic Pulmonary Arterial Hypertension (of specified severity) and any other condition we include in the meaning of Heart Condition at the time the Critical Illness Insurance is repurchased;
- Open Heart Surgery; and
- Out of Hospital Cardiac Arrest (requiring cardiopulmonary resuscitation).

Under Critical Illness Reinstatement Option, Cancer Condition means:

- Cancer (of specified criteria);
- Carcinoma in Situ (of specified site);
- Early Stage Chronic Lymphocytic Leukaemia;
- Early Stage Skin Melanoma (excluding Melanoma In Situ);
- Early Stage Prostate Cancer; and
- any other condition we include in the meaning of Cancer Condition at the time the Critical Illness Insurance is repurchased.

The Critical Illness Reinstatement Option cannot be exercised when an Attached TPD Benefit or Terminal Illness Benefit is paid.

2.3.4 When we will not pay

No payments will be made under any included or optional benefits (if applicable) if the claim arises directly or indirectly because of an intentional, self-inflicted act by the Life Insured.

If Critical Illness Insurance is Attached or Linked to Life Insurance, the Critical Illness Benefit will not be paid if you are also eligible for the Terminal Illness Benefit under Life Insurance.

If Critical Illness Insurance is not Attached or Linked to Life Insurance, no benefits will be paid under Critical Illness Insurance unless the Life Insured survives the Critical Illness Event for at least 14 days.

Qualifying period

No payment will be made if a claim arises directly or indirectly because of any one of the Critical Illness Events listed in the table below if the condition occurred or was diagnosed, or the signs or symptoms leading to the diagnosis became apparent to the Life Insured or would have become apparent to a reasonable person in the position of the Life Insured:

- within three months after the Plan start date;
- within three months after the date of any approved increase applied for, but only in respect of the increase portion; or
- within three months after the most recent date we agreed to reinstate the Plan or Policy.

Critical Illness Events where qualifying period applies

- Angioplasty
- Angioplasty for Triple Vessel Disease
- Benign Brain Tumour (resulting in irreversible neurological deficit)
- Carcinoma In Situ (of specified site)
- Cancer (of specified criteria)
- Coronary Artery Bypass Surgery
- Diagnosed Benign Brain Tumour (of specified severity)
- Early Stage Chronic Lymphocytic Leukaemia
- Early Stage Skin Melanoma (excluding melanoma in situ)
- Early Stage Prostate Cancer
- Heart Attack (of specified severity)
- Heart Valve Surgery
- Multiple Sclerosis (with episodes of neurological deficit and persisting neurological abnormalities)
- Open Heart Surgery
- Out of Hospital Cardiac Arrest (requiring cardiopulmonary resuscitation)
- Stroke (resulting in neurological deficit)
- Type 1 Diabetes diagnosed after age 30

We will waive this three-month period if:

- you were insured with us or another insurer for the same events immediately before your cover starts; and
- you transferred your cover after any similar three month period.

The waiver will only apply up to the level of critical illness cover that you had with us or the other insurer. Should you reinstate your cover, the three-month period will recommence from the date of reinstatement.

2.3.5 When Critical Illness Insurance ends

Critical Illness Insurance will end and our liability to pay a benefit under the Plan will end on the earlier of the:

- Policy anniversary before the Life Insured's 70th birthday;
- date we receive the Policy Owner's written request to cancel the Plan or Policy;
- Policy being cancelled because of non-payment of premiums;
- date we cancel or avoid the Policy because of a misrepresentation made by you or the Life Insured before our acceptance of the Policy or because you made a fraudulent claim;
- death of the Life Insured; or
- full Benefit Amount being paid or reduced to nil (when this occurs, the Financial Planning Benefit and Grief Support Benefit will remain available for 12 months after the Benefit Amount was paid).

The following conditions apply to Critical Illness Insurance:

- If Critical Illness Insurance is Attached or Linked to Life Insurance, the Critical Illness Benefit will not be paid if you are also eligible for the Terminal Illness Benefit under Life Insurance.
- If Critical Illness Insurance is Attached to Life Insurance, cancellation of Life Insurance will also cancel Critical Illness Insurance unless you tell us in writing that you want to retain Critical Illness Insurance as a Standalone Plan.
- If Critical Illness Insurance is Linked to Life Insurance, Critical Illness Insurance will become a Standalone Plan if you cancel Life Insurance.

If you cancel a Plan but choose to keep at least one of the Plans that was Attached or Linked, your premium rates will change for the remaining Plan(s). The premium will be calculated using our premium rates for the age of the Life Insured at the time of the change and will take into account any extra premiums charged and special provisions that apply to the original Plan. Any changes that increase our liability to pay claims will require full Underwriting.

2.4 Additional Benefits and Options applicable to Life, TPD and Critical Illness Insurance

The following benefits and options are only available to Life Insurance, TPD Insurance and Critical Illness Insurance. Please note that some benefits are not included when the Plan is structured through superannuation.

2.4.1 Included Benefits

Inflation Protection Benefit
We will increase the Benefit Amount by the greater of the Indexation Factor and five per cent at each Policy anniversary unless:

- you tell us not to apply the Inflation Protection Benefit to your Plan;
- the premiums are being waived under the Premium Relief Option; or
- if Life Insurance resulted from exercising the Death Buy-Back Option, Double TPD Option, Death Buy-Back Benefit or Double Critical Illness Option.

For information on how this will impact your premium, please refer to Section 1.3.

The Inflation Protection Benefit doesn't apply to Child's Critical Illness Benefit and Child's Critical Illness Insurance.

Premium Freeze Benefit
The Premium Freeze Benefit can only be activated if we are charging premiums on a stepped premium basis and the Life Insured is older than age 30. You may elect to activate the Premium Freeze Benefit by notifying us in writing.

If you choose to exercise the Premium Freeze Benefit, your premium will remain unchanged, but the Benefit Amount will reduce on a yearly basis at each Policy anniversary. This is because insurance generally becomes more expensive as you get older. The reduction of the Benefit Amount will be calculated based on your age and the premium rate applicable to you.

If you notify us that you wish to apply the Premium Freeze Benefit, the Inflation Protection Benefit will not apply. If you notify us that the Premium Freeze Benefit is to cease within three years of it starting, the Inflation Protection Benefit will then recommence but only if it was applicable before the Premium Freeze Benefit being activated.

Guaranteed Future Insurability Benefit
You can apply to increase your Benefit Amount under the Guaranteed Future Insurability Benefit for Life Insurance, TPD Insurance and Critical Illness Insurance without providing evidence of your health or pastimes when one of the following personal or business events occur:

Personal events	Business events
• The birth of a child where the Life Insured is the parent. • The adoption of a child by the Life Insured. • A dependent child of the Life Insured starting primary or secondary school. • Marriage of the Life Insured. • Divorce of the Life Insured. • The Life Insured's base salary increases by at least $10,000 (this only applies if you're an Employee). • The Life Insured completes a post graduate degree. • The Life Insured taking out a new mortgage or increasing the existing mortgage. • The Life Insured becoming a Carer. • The Life Insured has a change in tax dependency status as a result of the Life Insured ceasing to have any tax dependents as defined by current law.	• An increase in the Life Insured's value to the business, where the Life Insured is a key person in that business. • An increase in the Life Insured's financial interest in the business, whether as a partner, shareholder or unit holder, and the Policy forms part of a buy-sell, share purchase or business succession agreement. • An increase in the loan liability of the business for which the Life Insured is the primary guarantor.

The Guaranteed Future Insurability Benefit is limited by the following:

- You must apply in writing within 30 days from when the event (described in the table above) first occurred or within 30 days before the next Policy anniversary following the event.
- You can only exercise the Guaranteed Future Insurability Benefit once in any 12-month period.
- You must provide evidence which (in our reasonable opinion) establishes that the event has occurred.
- The event occurring while the Policy is in-force.
- The event occurred when the Life Insured is under age 55.

The maximum amount that you can apply for to increase the Benefit Amount under the Guaranteed Future Insurability Benefit is the lesser of:

- 25% of the Benefit Amount at the Plan start date of the corresponding Plan which you are applying for an increase;
- the amount of mortgage or business loan taken out or increased (if applicable);
- five times the amount of the base salary increase (if applicable); and
- $200,000.

If TPD Insurance and/or Critical Illness Insurance is Attached to Life Insurance, the Benefit Amount for TPD Insurance and/or Critical Illness Insurance after the increase under the Guaranteed Future Insurability Benefit cannot exceed the Life Insurance Benefit Amount.

The total maximum amount for all increases under the Guaranteed Future Insurability Benefit cannot exceed the lesser of:

- the Benefit Amount at the Plan start date; or
- $1,000,000.

If the Benefit Amount has been increased using the Guaranteed Future Insurability Benefit, the total cover (including cover with TAL and any other organisation) must not exceed:

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

During the first six months after exercising the Guaranteed Future Insurability Benefit, the increased portion of the Benefit Amount will only be paid in the event of the Life Insured suffering:

- Accidental death;
- TPD caused by Accident; or
- any of the listed Critical Illness Events caused by Accident.

You cannot exercise the Guaranteed Future Insurability Benefit if:

- premiums are being waived under the Premium Relief Option;
- an exclusion or an increase in premiums due to the Life Insured's medical history or pastimes has been applied to the Plan;
- cover under Life Insurance has resulted from applying the Death Buy-Back Option under TPD Insurance or the Death Buy-Back Benefit under Critical Illness insurance;
- cover under Critical Illness insurance has resulted from applying the Critical Illness Reinstatement Option;
- you did not undergo Underwriting when you applied for this Plan; or
- you are entitled to make, or are receiving or seeking payment of, a claim under any life insurance policy with TAL or another insurer.

Financial Planning Benefit
Not available when structured through superannuation.

If we pay 100% of the Benefit Amount under Life Insurance, Critical Illness Insurance or TPD Insurance, we will reimburse the costs associated with the preparation of a financial plan by a financial adviser for the person(s) to whom we paid 100% of the Benefit Amount, or to their Immediate Family Member.

The following conditions apply to the Financial Planning Benefit:

- the maximum amount payable under the Financial Planning Benefit is $5,000 and this amount will only be paid once per Life Insured across all policies issued by us in respect of that Life Insured;
- the Financial Planning Benefit is only payable for the reimbursement of fees actually paid to the financial adviser for the preparation of the financial plan where the fees were paid by the person(s) to whom we paid 100% of the Benefit Amount, or by their Immediate Family Member;
- we must receive evidence which (in our reasonable opinion) establishes the financial planning advice received and the financial plan must be received within 12 months of 100% of the Benefit Amount being paid; and
- the financial adviser who provides the financial plan must be an Australian Financial Services Licensee or an Authorised Representative of an Australian Financial Services Licensee.

Long Distance Accommodation Benefit

Not available when structured through superannuation.

If we pay 100% of the Terminal Illness Benefit, TPD Benefit or Critical Illness Benefit, we will reimburse the accommodation costs of the Life Insured's Immediate Family Member up to a maximum of $250 per day, for a maximum of 14 days for each day:

- the Life Insured is Bed Confined due to the reason for which we paid 100% of the Terminal Illness Benefit, TPD Benefit or Critical Illness Benefit;
- the Life Insured is Bed Confined more than 100 kilometres from their usual place of residence; and
- the Immediate Family Member remains away from their home, having been required to travel more than 100 kilometres from their usual place of residence to be with the Life Insured.

The following conditions also apply to the Long Distance Accommodation Benefit:

- This benefit must be claimed within six weeks of the Terminal Illness Benefit, TPD Benefit or Critical Illness Benefit being paid in full (100% of the Benefit Amount).
- You must provide evidence which (in our reasonable opinion) establishes the Life Insured's Bed Confinement and payment of the accommodation costs.
- If the Life Insured is eligible for this benefit and there is more than one Plan, we will only pay up to a maximum of $250 per day, across all Plans.

Grief Support Benefit

This benefit is not available when structured through superannuation.

If we pay 100% of the Benefit Amount under Life Insurance, Critical Illness Insurance, or TPD Insurance, we will reimburse the costs of up to three grief counselling sessions for the Life Insured, and/or an Immediate Family Member with a counsellor approved by us, acting reasonably (the counsellor should be competent, recognised and appropriately qualified to provide the support). The maximum total amount we will reimburse under the Grief Support Benefit for the Life Insured is $1,000.

This benefit must be exercised within 12 months of 100% of the Benefit Amount being paid.

Child's Critical Illness Benefit

This benefit is not available when structured through superannuation.

A benefit payment of $10,000 will be payable under the Child's Critical Illness Benefit if your child suffers a Child's Critical Illness Event listed under Child's Critical Illness Insurance (Section 2.5). Each event is defined in Section 9. For a benefit to be paid, the specified serious event must meet the full criteria and severity requirements for that event.

A three month qualifying period applies to certain Child's Critical Illness Events. See Section 2.5.2 for details.

The following conditions apply to the Child's Critical Illness Benefit:

- The child must be financially dependent on the Policy Owner.
- The child's age at their next birthday must be between two and 19.
- This benefit will only be paid once for an individual child across all Life Insurance, TPD Insurance or Critical Illness Insurance Plans issued by us.
- This benefit is only payable once under each Plan.
- This benefit is not payable on a Critical Illness Event which occurred, was diagnosed, or signs and symptoms leading to the diagnosis became apparent on or before the child's first birthday.
- This benefit is not payable on a Child's Critical Illness Event which occurred, was diagnosed, or signs and symptoms leading to the diagnosis became apparent before the Plan or Policy start date.
- The Child's Critical Illness Benefit ends on the Policy anniversary before the Life Insured's youngest child's 19th birthday
- The Child's Critical Illness Benefit is not payable if the Plan ends or is cancelled.

2.4.2 Optional benefits

These options only apply if stated in the Policy Schedule.

Premium Relief Option

Under the Premium Relief Option, premiums due in relation to a Life Insured will be waived when, because of Sickness or Injury, the Life Insured is for three consecutive months:

- totally unable to work in any occupation for which he or she is suited by training, education or experience;
- not earning an income; and
- following the advice of a Medical Practitioner.

You must notify us in writing of your intention to exercise the Premium Relief Option. You will also be required to provide to us the necessary evidence which (in our reasonable opinion) confirms your health/medical, employment and financial status.

The amount waived will be the daily proportion of premiums due. The Premium Relief Option will stop on the earlier of:

- the Life Insured is capable of working in any occupation for which he or she is suited by training, education or experience;
- the Life Insured generating Earnings; or
- the Policy anniversary before the Life Insured's 65th birthday.

No premiums will be waived under the Premium Relief Option if the claim is caused:

- directly or indirectly by an intentional, self-inflicted act by the Life Insured; or
- by normal and uncomplicated pregnancy, miscarriage or childbirth. Normal and uncomplicated pregnancy includes, but is not limited to morning sickness, backache, varicose veins, ankle swelling, bladder problems, carpal tunnel syndrome, multiple pregnancy, or participation in an IVF or similar program.

The Premium Relief Option is not available after any of the following have been exercised:

- Death Buy-Back Option;
- Death Buy-Back Benefit; or
- Critical Illness Reinstatement Option.

Business Insurance Option

Not available when structured through superannuation.

The Business Insurance Option is available under Life Insurance and is only applicable to Critical Illness Insurance and/or TPD Insurances when Attached to Life Insurance.

Under the Business Insurance Option, you can apply to increase the Benefit Amount without the need for further evidence of health, or pastimes, subject to acceptable financial evidence being provided.

The Business Insurance Option is available when one of the following business events occurs:

Business event	Description
Business value	• An increase in the Life Insured's share or value of the business entity for which this cover was originally established.
Key-person value	• An increase in the value of the Life Insured key person to the business entity for which the cover was originally established.
Loan guarantee	• An increase in the level of a business loan for which the Life Insured is a guarantor.

The total Benefit Amount after all increases cannot exceed three times the Benefit Amount (including cover with TAL and any other organisation) at the Plan start date and following limits:

- Life Insurance: $15 million.
- TPD Insurance: $3 million.
- Critical Illness Insurance: $2 million.

The following conditions also apply to Business Insurance Option:

- Increases for TPD Insurance and Critical Illness Insurance will not be allowed if the business event occurred or the application for increase is submitted to us after the Policy anniversary before the Life Insured's 60th birthday.
- You must apply in writing within 30 days of the business event occurring or within 30 days of the Policy anniversary following the business event.
- Any application for an increase will be assessed using the same valuation method used in the application for the Business Insurance Option. The assessment of the application to increase the Benefit Amount will also include an analysis of the business's growth and business profitability trends. Your application for increase may be declined if the business trend indicates that the business has not grown, is in decline or net profit is decreasing.
- If the application for increase is due to a 'loan guarantee', the increased Benefit Amount cannot exceed the amount by which the 'loan guarantee' has increased.
- The application to increase the Benefit Amount must not exceed the increase in value resulting from the business event. If the application to increase the Benefit Amount is less than the increase in value resulting from the business event, any subsequent applications to increase the Benefit Amount will only be allowed if the subsequent valuation of the business is greater than the last valuation that was used to increase the Benefit Amount under Business Insurance Option.
- Any application to increase the Benefit Amount under the Business Insurance Option must be for the same business event for which the Policy was originally established as determined by us.
- If the Benefit Amount at the Plan start date is less than 100% of the value associated with the purpose of the business insurance, we will limit any future increases made under the Business Insurance Option such that the amount insured, as a proportion of the value associated with the business insurance purpose, does not increase above that which applied at the Plan start date.

- If the Benefit Amount for TPD Insurance and/or Critical Illness Insurance is increased under Business Insurance Option, the Benefit Amount of the Attached Life Insurance must also increase by the same amount.
- The Business Insurance Option cannot be exercised if the Life Insured suffers a Sickness or Injury which results in an entitlement to a claim or has made a claim under any life insurance, total and permanent disability insurance or critical illness insurance policy (including cover with TAL and any other insurer).
- Business Insurance Option cannot be exercised if the Life Insured is entitled to make a claim or is entitled to a payment from any income protection insurance (including cover with TAL and any other insurer) at the time of application, up to when we approve the increase.
- The Business Insurance Option can only be exercised once in any 12-month period.

Any application to increase the Benefit Amount under Business Insurance Option must be accompanied with the following information:

- Confirmation the Life Insured is actively at work in their usual occupation at the time of application.
- A current valuation of the business provided by a qualified accountant or business valuer, which we reasonably consider to be acceptable. The business valuation method used must be consistent across all valuations.
- Financial or occupational evidence in support of the application.

The Business Insurance Option ends on the earlier of the following:

- If the option is cancelled by you.
- A benefit being paid under Life Insurance, TPD Insurance or Critical Illness Insurance as a result of the Life Insured suffering a Sickness or Injury.
- The maximum increase limit has been reached.
- The death of the Life Insured.
- Life Insurance is cancelled.
- The Policy anniversary prior to the Life Insured attaining age 65.
- The third Policy anniversary, if the Business Insurance Option is not exercised within the first three years from the Plan start date.
- The third Policy anniversary from the date Business Insurance Option was last exercised. However, we will extend the Business Insurance Option for another three years (from the date we accept the financial evidence) if you provide financial evidence, which we reasonably consider to be acceptable, that the Business Insurance Option could not be exercised because none of the business events described above occurred. The evidence must be provided to us within 30 days of the end of the option expiring.

If the Business Insurance Option is shown in the Policy Schedule, the following benefits will not apply:

- Inflation Protection Benefit (but will apply on the first anniversary after the Business Insurance Option was cancelled);
- Guaranteed Future Insurability Benefit;
- Premium Relief Option;
- Death Buy-Back Option under TPD Insurance;
- Double TPD Option;
- Death Buy-Back Benefit under Critical Illness Insurance; and
- Double Critical Illness Option.

2.5 Child's Critical Illness Insurance

Child's Critical Illness Insurance only applies if indicated in your Policy Schedule. Child's Critical Illness Insurance cannot be structured through superannuation.

A benefit under Child's Critical Illness Insurance will only be paid if the conditions and requirements for a claimable event are met after the Plan start date and before the Plan end date.

A benefit under Child's Critical Illness Insurance will only be paid if the Child Insured suffers a specified serious event as described in the sections below. We require confirmation of diagnosis by a Medical Practitioner and the specified severity threshold criteria to be met, for a benefit to be payable. The severity threshold criteria are defined for each event in Section 9.

For many specified serious events this means the condition will be required to progress beyond a diagnosis, where diagnosis means the process of a Medical Practitioner determining which Sickness or Injury explains an individual's symptoms. You must also satisfy our claim requirements in Section 3 of this PDS.

When we refer to a benefit payment, the statement is made on the basis that the benefit referred to is payable under the terms and conditions of the Policy.

2.5.1 Included benefits

Child's Critical Illness Benefit
The Benefit Amount will be paid if the Child Insured suffers a Child's Critical Illness Event listed below after the Plan start date and before the Plan end date.

The sum of all payments per child under the Child's Critical Illness Insurance and Child's Critical Illness Benefit (where applicable), including cover with TAL and any other organisation will be limited to $250,000.

If the Child Insured suffers more than one Child's Critical Illness Event, the Benefit Amount is only paid for the Child's Critical Illness Event that occurs first.

Child's Critical Illness Events

Heart conditions	Neurological conditions	Permanent conditions
• Cardiomyopathy (permanent) • Heart Attack (of specified severity)[1]	• Coma (of specified severity) • Encephalitis (resulting in permanent neurological deficit) • Major Head Trauma (with permanent neurological deficit) • Meningitis (resulting in permanent neurological deficit) • Meningococcal Septicaemia (resulting in significant permanent impairment) • Paralysis (permanent) • Stroke (resulting in neurological deficit)[1]	• Blindness (permanent) • Deafness (permanent) • Loss of use of Limbs (permanent) • Loss of Speech (permanent)
Cancer	**Organ Disorder**	**Other events**
• Benign Brain Tumour (resulting in irreversible neurological deficit)[1] • Cancer (of specified criteria)[1]	• Chronic Kidney Failure (undergoing permanent dialysis) • Major Organ Transplant (of specified organs) • Severe Burns (covering at least 20% of the body's surface area)	• Aplastic Anaemia (requiring treatment) • Death • Terminal Illness

[1]A three month qualifying period applies. Refer to the 'When we will not pay' Section 2.5.2 for details.

Grief Support Benefit
If we pay the Child's Critical Illness Benefit, we will reimburse the costs of up to three grief counselling sessions for an Immediate Family Member of the Child Insured with a counsellor approved by us, acting reasonably (the counsellor should be competent, recognised and appropriately qualified to provide the support). The maximum total amount we will reimburse under the Grief Support Benefit is $1,000.

This benefit must be exercised within 12 months of the Benefit Amount being paid.

Cover Continuation Benefit
If the Child's Critical Illness Insurance Plan has not ceased prior to the Plan end date, the Child Insured can apply for a new Life Insurance Plan with Attached Critical Illness Insurance Standard Plan without requiring further medical information, except for smoking status, height, weight and occupation. The application must be made to us in writing within 30 days of the Plan end date. If Critical Illness Insurance Standard is not available, we will provide a Plan we believe is most like Critical Illness Insurance Standard.

The Life Insurance with Attached Critical Illness Insurance Standard (or other replacement cover) can be purchased on the following basis:

- The Benefit Amount will be the same or less than the Child's Critical Illness Insurance Benefit Amount. Any increase to the Benefit Amount will be subject to full Underwriting.
- No options will be available. Selection of optional benefits will be subject to full Underwriting.
- The Inflation Protection Benefit (or equivalent) and the Guaranteed Future Insurability Benefit (or equivalent) will not apply.
- A new premium rate will apply based on the premium rates and rating factors applicable to Life Insurance and Critical Illness Insurance Standard at the time the option is exercised.
- Any special conditions or loadings applied to Child's Critical Illness Insurance will continue to apply.

These conditions override the terms of any new or continued Policy arising from the exercising of the continuation option under the Child's Critical Illness Option.

2.5.2 When we will not pay

No payment will be made if the Child's Critical Illness Event arises directly or indirectly because of an intentional act of a person who stands to derive a benefit from the claim payment.

Qualifying period
No payment will be made if a claim arises directly or indirectly because of any one of the Child's Critical Illness Events listed in the table below if the condition or event occurred or was diagnosed, or signs or symptoms leading to the diagnosis became apparent:

- within three months after the Plan start date;
- within three months after the date of an approved applied-for increase, but only in respect of the increase portion; or
- within three months after the most recent date we agreed to reinstate the Plan.

Child's Critical Illness Events where qualifying period applies
• Benign Brain Tumour (resulting in irreversible neurological deficit) • Cancer (of specified criteria) • Heart Attack (of specified severity) • Stroke (resulting in neurological deficit);

2.5.3 When Child's Critical Illness Insurance ends

Critical Illness Insurance ends and our liability to pay a benefit under the Plan ceases on the earlier of the:

- Policy anniversary before the Child Insured's 23rd birthday;
- date we receive the Policy Owner's written request to cancel the Plan or Policy;
- Policy being cancelled because of non-payment of premiums;
- date we cancel or avoid the Policy because of a misrepresentation made by you or the Child Insured before our acceptance of the Policy or because you made a fraudulent claim;
- death of the Child Insured; or
- full Benefit Amount being paid.

2.6 Income Protection

Income Protection only applies if 'Income Protection Plan' is indicated in your Policy Schedule. Any applicable options are shown in your Policy Schedule.

Income Protection conditions are set out in this section of this PDS.

A benefit under Income Protection will only be paid if the condition and requirements for a claimable event are met after the Plan start date and before the Plan end date, unless stated otherwise.

Income Protection can be structured through superannuation or outside superannuation. When Income Protection is structured through superannuation, the SIS legislation and rules will apply, and some benefits may not be payable if your circumstances do not meet the SIS legislation and rules requirements. When this occurs, we will assess any eligibility to a benefit payment under the additional Policy structured outside superannuation if Superlink IP applies.

When we refer to a benefit payment, we mean a benefit payment which is paid in accordance with the terms and conditions of this Policy. We will not make a benefit payment if an exclusion or special condition applies. You must also satisfy the claim requirements in Section 3 of this PDS.

2.6.1 Main benefits

The main benefits under Income Protection are:

- Totally Unable to Work Benefit;
- Partially Unable to Work Benefit;
- Permanent Incapacity Reset Benefit (only applicable to IP Enhance after the Claim Period has reached at least 24 months – refer to the 'Permanent Incapacity Reset Benefit' section below for details).

What does Totally Unable to Work mean?
Totally Unable to Work means that solely because of Sickness or Injury, the Life Insured is:

- not working in any capacity (this includes full-time, part-time and casual, whether or not for remuneration);
- following the advice and treatment plan of a Medical Practitioner in relation to the Sickness or Injury, and
- unable to perform all the duties necessary to generate income in the Life Insured's Own Occupation* (if the Life Insured is able to perform any duties necessary to generate income in their Own Occupation*, they are not Totally Unable to Work).

*If the 'to age 65' Benefit Period applies, following the first 24 months of the Claim Period, Own Occupation will be replaced with Any Occupation.

Where Income Protection has been structured through superannuation, the Life Insured must also satisfy the SIS definition for Temporary Incapacity or Permanent Incapacity.

What does Partially Unable to Work mean
Partially Unable to Work means that solely because of Sickness or Injury, the Life Insured is:

- working (whether or not for remuneration) in a reduced capacity or capable of working in a reduced capacity;
- following the advice and treatment plan of a Medical Practitioner in relation to the Sickness or Injury; and
- not capable of working more than 80% of the Life Insured's usual average working hours in the 12 months immediately before the start of the Waiting Period. The usual average working hours immediately before the start of the Waiting Period will be limited to 40 hours a week (if the Life Insured is working more than 40 hours a week).

Where Income Protection has been structured through superannuation, the Life Insured must also satisfy the SIS definition for Temporary Incapacity or Permanent Incapacity.

How do you qualify for the benefits?

Occupation class AAA, AA+, AA and A (as indicated in the Policy Schedule)
To qualify for the Totally Unable to Work Benefit, the Life Insured must:

- be Totally Unable to Work for at least 7 consecutive days during the Waiting Period;
- remain Totally Unable to Work or Partially Unable to Work for the balance of the Waiting Period; and
- remain Totally Unable to Work at the end of the Waiting Period.

To qualify for the Partially Unable to Work Benefit, the Life Insured must:

- be Totally Unable to Work for at least 7 consecutive days during the Waiting Period;
- remain Totally Unable to Work or Partially Unable to Work for the balance of the Waiting Period; and
- remain Partially Unable to Work at the end of the Waiting Period.

Occupation class BBB, BB, B and SRA (as indicated in the Policy Schedule)
To qualify for the Totally Unable to Work Benefit, the Life Insured must:

- be Totally Unable to Work for at least 14 consecutive days during the Waiting Period;
- remain Totally Unable to Work or Partially Unable to Work for the balance of the Waiting Period; and
- remain Totally Unable to Work at the end of the Waiting Period.

To qualify for the Partially Unable to Work Benefit, the Life Insured must:

- be Totally Unable to Work for at least 14 consecutive days during the Waiting Period;
- remain Totally Unable to Work or Partially Unable to Work for the balance of the Waiting Period; and
- remain Partially Unable to Work at the end of the Waiting Period.

When will the benefits start to accrue and become payable?

The Totally Unable to Work Benefit or the Partially Unable to Work Benefit:

- start to accrue after the Waiting Period ends; and
- are payable monthly in arrears.

How much is payable and what are the requirements for ongoing benefit payments?

Once you qualify for the Totally Unable to Work Benefit or the Partially Unable to Work Benefit, the amount payable depends on the income replacement option selected (refer to the applicable table below). The income replacement options available are:

- Income Protection Focus;
- Income Protection Enhance; and
- Income Protection Extend.

The income replacement option selected is shown in the Policy Schedule. In calculating the Partially Unable to Work Benefit, the benefit payable cannot exceed the Totally Unable to Work Benefit.

The amount payable under the Totally Unable to Work Benefit and the Partially Unable to Work Benefit may be reduced if an offset applies (refer to Section 2.6.5 for details) and/or an adjustment (refer to 'When we will adjust your benefit payments' section below).

The tables below shows:

- Changes to the occupation definition used to determine the Life Insured's capacity to work as the duration of the Claim Period increases.
- The benefit payable under the Totally Unable to Work Benefit, including changes to the Benefit Amount as the duration of the Claim Period increases.
- The benefit payable under the Partially Unable to Work Benefit, including changes to the Benefit Amount and formula as the duration of the Claim Period increases.

Income Protection Focus (IP Focus)

		Claim Period	
		1 – 24 months	**After 24 months (5 year Benefit Period only)**
Occupation definition used in Totally Unable to Work definition		Own Occupation	
When the Waiting Period starts before Policy anniversary before 60th birthday	**Totally Unable to Work Benefit Payable**[1]	Benefit Amount	
	Partially Unable to Work Benefit payable[1, 2]	Benefit Amount less 75% of Earnings	
When the Waiting Period starts after Policy anniversary before 60th birthday	**Totally Unable to Work Benefit payable**[1]	Benefit Amount	2/3rd of Benefit Amount
	Partially Unable to Work Benefit payable[1, 2]	Benefit Amount less 75% of Earnings when Partially Unable to Work	2/3rd of Benefit Amount less 75% of Earnings when Partially Unable to Work

[1]The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).
[2]The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' section below).

Income Protection Enhance (IP Enhance)

	Claim Period	
	1 – 24 months	**After 24 months**
Occupation definition used in Totally Unable to Work definition	Own Occupation	Any Occupation
Totally Unable to Work Benefit payable[1]	Benefit Amount	2/3rd of Benefit Amount
Partially Unable to Work Benefit payable[1, 2]	Benefit Amount less 75% of Earnings when Partially Unable to Work	2/3rd of Benefit Amount less 100% of Earnings when Partially Unable to Work
Permanent Incapacity Reset Benefit[1, 3]	Not applicable	1/3rd of Benefit Amount

[1]The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).
[2]The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' section below).
[3]Refer to the 'Permanent Incapacity Reset Benefit' section below for details.

Income Protection Extend (IP Extend)

		Claim Period	
		1 – 24 months	**After 24 months**
Occupation definition used in Totally Unable to Work definition		Own Occupation	Any Occupation
When the Waiting Period starts before Policy anniversary before 60th birthday	**Totally Unable to Work Benefit Payable**[1]	Benefit Amount	
	Partially Unable to Work Benefit payable[1, 2]	Benefit Amount less 75% of Earnings	Benefit Amount less 100% of Earnings
When the Waiting Period starts after Policy anniversary before 60th birthday	**Totally Unable to Work Benefit payable**[1]	Benefit Amount	2/3rd of Benefit Amount
	Partially Unable to Work Benefit payable[1, 2]	Benefit Amount less 75% of Earnings when Partially Unable to Work	2/3rd of Benefit Amount less 100% of Earnings when Partially Unable to Work

[1]The amount payable may be reduced if an offset applies (refer to Section 2.6.5 for details).
[2]The amount payable may be subject to an adjustment (refer to 'When we will adjust your benefit payments' section below).

Permanent Incapacity Reset Benefit
Only available if IP Enhance option is shown in your Policy Schedule.

The purpose of the Permanent Incapacity Reset Benefit is to provide an additional support payment in the event that the Life Insured suffers Serious and Permanent Incapacity.

The Permanent Incapacity Reset Benefit is only available once the total Claim Period has reached 24 months or more for a claim.

The Permanent Incapacity Reset Benefit is payable when the Life Insured:

- has achieved Maximum Medical Improvement of the Sickness or Injury;
- is entitled to the Totally Unable to Work Benefit; and
- is Seriously and Permanently Incapacitated* (see Section 9 for definition).

*Any claim for a mental illness under the Permanent Incapacity Reset Benefit will only be assessed under the 'mental illness' category under the Serious and Permanent Incapacity definition.

For the Life Insured to qualify for the Permanent Incapacity Reset Benefit on an ongoing basis, the Life Insured must continuously meet the requirements for the Permanent Incapacity Reset Benefit.

The Permanent Incapacity Reset Benefit payable will be 1/3rd of the Benefit Amount for each month the Life Insured is eligible for the Permanent Incapacity Reset Benefit and is payable monthly in arrears. The Permanent Incapacity Reset Benefit will be paid in addition to the Totally Unable to Work Benefit, less any other payments (see Section 2.6.5).

The Permanent Incapacity Reset Benefit will stop on the earlier of the following events:

- the date the Life Insured is no longer Seriously and Permanently Incapacitated;
- the date the Life Insured is no longer Totally Unable to Work;
- the end of the Benefit Period; or
- the Life Insured's 65th birthday.

Example

- Sera has Income Protection IP Enhance with a monthly benefit of $7,500, with no Increasing Claim Option.
- Sera was involved in a motor vehicle accident and suffered spinal cord injury which resulted in paralysis from her waist down.
- After being on claim for 24 months, Sera remains Totally Unable to Work in Any Occupation and her paralysis is expected to be permanent.
- For the first 24 months of the Claim Period, Sera was paid the Totally Unable to Work Benefit at $7,500 per month. From the 25th month onwards, the Totally Unable to work Benefit payable is:

  2/3 X Benefit Amount

  = 2/3 X $7,500

  = $5,000 per month
- At the 25th month of claim, Sera meets the requirements for the Permanent Incapacity Reset Benefit because she remains Totally Unable to Work in Any Occupation, she has achieved Maximum Medical Improvement and she is Seriously and Permanently Incapacitated. The Permanent Incapacity Reset Benefit payable is:

  1/3 X Benefit Amount

  = 1/3 X $7,500

  = $2,500 per month
- The total monthly benefit payable to Sera from month 25 onwards is:

  $5,000 + $2,500 = $7,500 per month

When will we adjust your benefit payments?
Income Protection only covers loss of Earnings solely as a result of a Sickness or Injury. It does not cover losses due to economic circumstances. In certain circumstances, the Partially Unable to Work Benefit will be adjusted if loss of Earnings is not solely due to a Sickness or Injury.

The Partially Unable to Work Benefit payable will be adjusted if:

- the Life Insured's Earnings (when Partially Unable to Work) do not align to the amount of work being performed by the Life Insured (i.e. the Earnings are not commensurate with the work performed) for at least three consecutive months; and/or
- the Life Insured is not working to their full capability, including:
  - the Life Insured is not working but capable of working for at least three consecutive months; or
  - the Life Insured is working but not to their full capability for at least three consecutive months.

An adjustment to the Partially Unable to Work Benefit payable will be based on the Life Insured's potential Earnings. The potential Earnings is the amount that the Life Insured could reasonably earn after taking into account their capability to work. When calculating the benefit payable, we will substitute Earnings with what we consider is the Life Insured's potential Earnings.

The potential Earnings will take into consideration the Life Insured's Earnings compared to the number of hours worked, and the Life Insured's capability to work compared to their average weekly working hours in the 12 months immediately before the start of the Waiting Period. The average working hours immediately before the start of the Waiting Period will be limited to the lesser of:

- the Life Insured's normal average weekly working hours (excluding overtime); or
- 40 hours a week.

If we adjust the benefit payment, we will act reasonably when determining the adjusted Partially Unable to Work Benefit payable.

Where we adjust the benefit payment under this clause, we will notify and explain our decision to you before we apply the adjustment.

The examples below are not real and should only be used to help you understand how we may apply an adjustment.

Example 1

- John regularly works 60 hours a week and earns an average of $15,000 per month before coming on claim.
- John has IP Focus option with a Benefit Amount of $10,000 per month.
- After receiving the Totally Unable to Work Benefit for six months, the Medical Practitioner certifies John as having the capacity to work 20 hours a week. John decides to work 10 hours a week.
- John's full-time hours are calculated as the lesser of his pre-claim full-time hours (60) and 40 hours per week.
- John is capable of working 20 hours per week. He is deemed capable of earning 20/40 = 50% of his current full-time equivalent Earnings.
- John's potential Earnings are calculated as:

  $15,000 x 50% = $7,500 per month
- John's adjusted Partially Unable to Work Benefit payable is:

  Benefit Amount – 75% potential Earnings

  = $10,000 – (75% x $7,500)

  = $4,375 per month

Example 2

- Jane is a self-employed accountant. Prior to claim, Jane worked 32 hours a week and the business was earning an average of $10,000 a month (net profit).
- Jane has IP Enhance option with a Benefit Amount of $7,000 per month.
- While on claim, Jane is medically certified as fit to work 20 hours a week, performing all her work duties. However, Jane reports that her business is making a loss (for reasons other than a Sickness or Injury) despite working more than 50% of her pre-claim work hours.
- Jane's Earnings do not align to the amount of work she is performing. Her potential Earnings are calculated as:

  20 hours / 32 hours x $10,000 = $6,250 per month
- Jane's adjusted Partially Unable to Work Benefit is:

  Benefit Amount – 75% of potential Earnings

  = $7,000 – (75% X $6,250)

  = $2,312.50 per month
- After 9 months Jane returns to work (32 hours per week). Her claim is finalised.

When do the benefits stop?
The Totally Unable to Work Benefit will stop on the earlier of the following events:

- the Life Insured is no longer Totally Unable to Work;
- the Life Insured's Earnings exceed their Pre-Claims Earnings;
- the end of the Benefit Period; or
- the Plan end date (if you have a 'to age 65' Benefit Period, refer to Section 2.6.6 for more details of when a benefit can be paid to age 65).

The Partially Unable to Work Benefit will stop on the earlier of the following events:

- the Life Insured is no longer Partially Unable to Work;
- the Partially Unable to Work Benefit is not payable for at least three consecutive months (except where the Partially Unable to Work Benefit is not payable due to applying an offset described in Section 2.6.5);
- the end of the Benefit Period; or
- the Plan end date (if you have a 'to age 65' Benefit Period, refer to Section 2.6.6 for more details of when a benefit can be paid to age 65).

What happens if your claim was finalised but the condition reoccurs?
If a claim has been paid under the Totally Unable to Work Benefit or the Partially Unable to Work Benefit, we understand in certain circumstances the condition may reoccur from the same or a related cause during the term of the Plan. Where this happens within 12 months from the date the claim was last paid to, the reoccurrence will be considered a continuation of the initial claim. The Waiting Period will not be reapplied.

If the above applies, the Claim Period does not reset. All periods where the person qualifies for a Totally Unable to Work Benefit or Partially Unable to Work Benefit from any recurrent claims count towards the Claim Period and the Benefit Period.

Example

- David has Income Protection with the IP Enhance option with a Benefit Amount of $7,500 per month (the Increasing Claim Option has not been selected by David so does not apply).
- David suffered a Sickness or Injury and was medically certified Totally Unable to Work in his Own Occupation.
- David was paid the Totally Unable to Work Benefit for 19 months before he returned to full time work (total Claim Period of 19 months) and his claim was finalised. The Benefit Amount for this Claim Period is $7,500 per month.
- Two months after returning to full-time work, the condition which he previously claimed under reoccurred and David had to stop work again completely.
- David's claim was restarted, and benefits became payable from the day he ceased work because of the same condition. The Waiting Period did not apply due to the reoccurrence of the same claim condition within 12 months.
- David had to remain on claim for another nine months before returning to full time work again.
- For the first five of the nine months, the monthly benefit payable will be calculated based on $7,500 (the Benefit Amount). The total Claim Period is 19 + 5 = 24 months.
- From the 25th month onwards, the benefit payable will be calculated based on 2/3rd of the Benefit Amount. For the remaining four months, the monthly benefit payable will be calculated based on:

  2/3 X Benefit Amount

  = 2/3 X $7,500

  = $5,000 per month

What happens if another Sickness or Injury occurs while you are already on claim?
If the Life Insured becomes Totally Unable to Work or Partially Unable to Work because of separate and distinct Sicknesses or Injuries during the same period, only one benefit will be payable and only one Claim Period will apply. The Life Insured will be eligible for benefit payments from the end of the Waiting Period relating to the first Sickness or Injury and the Claim Period starts from the end of the Waiting Period relating to the first Sickness or Injury.

For 1 year, 2 year and 5 year Benefit Periods, once the maximum Benefit Period has been reached, you will not be able to make another claim for the same or related Sickness or Injury. If you make another claim for a distinct and separate Sickness or Injury, you must have returned to work for at least six consecutive months, working at least 20 hours per week on average.

Example

- Jill has IP Focus option with a 2 year Benefit Period.
- Jill suffered a Sickness and was medically certified Totally Unable to Work in her Own Occupation.
- While she was on claim, she suffered an Injury which also prevented her from working. Immediately before the Injury, Jill had already received 20 months of Totally Unable to Work Benefit due to her Sickness. An additional benefit will not be paid for Jill's Injury while she is already on claim.
- Jill remained Totally Unable to Work due to both the Sickness and Injury for another six months. However, her claim will be finalised once her Claim Period has reached 24 months because Jill selected to have a 2 year Benefit Period.
- For Jill to be eligible to make another claim on her Income Protection, she must return to work for at least 6 consecutive months, working at least 20 hours per week on average. Jill will not be able to make another claim for the same Sickness/Injury or related Sickness/Injury for which the maximum Benefit Period has already been paid for.

2.6.2 Ancillary benefits

Inflation Protection Benefit

We will increase the Benefit Amount (and the Super Contribution Benefit Amount if applicable) by the Indexation Factor at each Policy anniversary.

This increase will occur on each Policy anniversary unless:

- you tell us the Inflation Protection Benefit is not to apply to your Plan;
- premiums are being waived under the Waiver of Premium Benefit; or
- cover is suspended under the Premium Pause Benefit.

Bed Confinement Benefit

The Bed Confinement Benefit is payable when the Life Insured is:

- Bed Confined during the Waiting Period for at least 72 consecutive hours; and
- Totally Unable to Work.

The amount payable will be 1/30th of the Benefit Amount for each day of Bed Confinement, less any other payments (refer to Section 2.6.5).

The Bed Confinement Benefit is paid monthly in arrears.

The Bed Confinement Benefit will stop on the earlier of the following event:

- the Life Insured is no longer Bed Confined;
- the Life Insured is no longer Totally Unable to Work;
- the end of the Waiting Period;
- the Plan end date; or
- the payments equalling 28 days having occurred.

Waiver of Premium Benefit

The Waiver of Premium Benefit applies when the Totally Unable to Work Benefit and/or the Partially Unable to Work Benefit are payable. If the Waiver of Premium Benefit applies, the daily proportion of premiums due in respect of the Life Insured under Income Protection will be waived.

The Waiver of Premium Benefit:

- starts to accrue from the first day of the Waiting Period; and
- applies immediately after the Waiting Period for any premiums paid during the Waiting Period and monthly in arrears for subsequent premiums.

The Waiver of Premium Benefit will stop on the earlier of:

- the Totally Unable to Work Benefit or Partially Unable to Work Benefit are no longer payable; or
- the end of the Benefit Period.

For 1 year, 2 year and 5 year Benefit Periods, this will mean premium payments will recommence once you have reached the end of the Benefit Period for any one condition or related condition, even if you are still Totally Unable to Work or Partially Unable to Work.

If Superlink IP applies, the Waiver Of Premium Benefit will apply to both Income Protection Policies.

Work Assistance Benefit

Not available when Income Protection is structured through superannuation.

The Work Assistance Benefit reimburses the cost of an approved Rehabilitation Program that assists in the effective rehabilitation of the Life Insured to return to work, less amounts reimbursed from elsewhere. Payment of Work Assistance Benefit is subject to:

- our approval of the expenditure; and
- a maximum allowable reimbursement of 12 times the Benefit Amount at the start of the Waiting Period.

The cost of medication, medical consultations or medical therapy consultations, including but not limited to, physiotherapy, psychotherapy and hydrotherapy, are not covered under the Work Assistance Benefit.

This benefit will only be paid once across all Income Protection Plans issued by us for each claim event or concurrent claim.

Death Benefit

If the Life Insured dies, we will pay $10,000. If you receive any death benefits from other income protection cover with TAL, these amounts will reduce the death benefit paid under this Policy.

This benefit will not be paid if the death arises directly or indirectly as a result of an intentional, self-inflicted act by the Life Insured:

- within 13 months after the Plan start date;
- within 13 months after the date of any increases applied for, but only in respect of the increase amount; or
- within 13 months after the most recent date we agreed to reinstate the Plan or Policy.

Overseas Assistance Benefit

Not available when Income Protection is structured through superannuation.

If the Life Insured is outside Australia and qualifies for the Totally Unable to Work Benefit or Partially Unable to Work Benefit, we will pay for the cost for the Life Insured to return to Australia.

The amount paid will be a reimbursement of the costs directly incurred by the Life Insured in returning to Australia, less amounts reimbursed from elsewhere, to a maximum of three times the Benefit Amount for any one claim. The amount we reimburse excludes the cost of any premier, business or first class seat.

This benefit will only be paid once across all Income Protection Plans issued by us for each claim event or concurrent claim.

Premium Pause Benefit

You may apply to temporarily suspend paying Income Protection premiums and cover for up to 12 months. The following conditions apply to the Premium Pause Benefit:

- It only applies if Income Protection premiums have been paid for at least 12 consecutive months immediately prior to applying for the Premium Pause Benefit.
- You must provide us with evidence which establishes (in our reasonable opinion), that the Life Insured has stopped working due to Unemployment or Long Term Leave.
- No premiums are due, no Benefit Amount is payable, and no indexation occurs, while premium suspension continues.
- No benefit is payable for any Sickness or Injury (whichever is applicable) that occurs while Income Protection is suspended or during the 90 days following the end of the Premium Pause Benefit.
- It does not apply to any period where premiums have already been paid.
- We will not require evidence of the Life Insured's health, occupation, income or pastimes, or any other Underwriting information if premium payments for Income Protection restart before the end of the 12 months from when premiums were suspended.
- You must contact us to recommence cover and restart premium payments. If premiums are not restarted within 12 months from the start of the Premium Pause Benefit, the option to recommence cover will no longer be available and the Plan will be cancelled.

Elective Surgery Benefit

Under the Elective Surgery Benefit, the following will be considered a Sickness for the purpose of assessing entitlement to the Totally Unable to Work Benefit:

- the Life Insured undergoes surgery to transplant part of the Life Insured's body to someone else;
- the Life Insured undergoes surgery to improve the Life Insured's appearance; or
- the Life Insured undergoes elective surgery performed on the advice of a medical practitioner.

The Elective Surgery Benefit will not apply if the surgery took place:

- within six months after the Plan start date;
- within six months after the date of any increase applied for, but only in respect of the increase amount; or
- within six months after the most recent date we agreed to reinstate the Plan.

Where Income Protection is structured through superannuation (as indicated in the Policy Schedule), the Life Insured must also satisfy the SIS legislation and rules.

Blood Borne Diseases Benefit

If the Life Insured is a health care professional, for example a medical doctor, surgeon or dentist, and they contract a blood borne disease such as HIV, Hepatitis B or C, their ability to work can be affected by factors other than physical inability due to the illness.

The following is our approach to claims.

There are three scenarios that could affect the Life Insured. For all three scenarios the Life Insured must notify the relevant governing body of their medical condition:

- the Life Insured chooses to disclose their condition to their patients which may lead to some of their patients seeking medical treatment elsewhere. It could also be difficult for the Life Insured to attract new patients;
- the Life Insured chooses to cease performing Exposure Prone Procedures as defined by the relevant governing body; or
- the Life Insured's governing body advises the Life Insured to cease performing Exposure Prone Procedures as defined by the relevant governing body.

In all of these scenarios it is likely that the Life Insured's income will reduce.

In all these cases we will assess whether the Life Insured is Totally Unable to Work or Partially Unable to Work in accordance with the terms and conditions of their Policy.

If the 'to age 65' Benefit Period applies, the Blood Borne Disease Benefit will cease when the Claim Period reaches 24 months.

Where Income Protection is structured through superannuation (as indicated in the Policy Schedule), the Life Insured must also satisfy the SIS legislation and rules.

2.6.3 Optional benefits

The options listed below only apply if indicated in your Policy Schedule.

Increasing Claim Option

If the Increasing Claim Option applies, the Benefit Amount will increase by the Indexation Factor on each anniversary when the Totally Unable to Work Benefit or the Partially Unable to Work Benefit first became payable. The Increasing Claim Option also applies to the Permanent Incapacity Reset Benefit and the Super Contribution Option (if applicable).

Super Contribution Option

If the Totally Unable to Work Benefit or Partially Unable to Work Benefit is payable, we will make a superannuation contribution on your behalf, which will be paid directly to the superannuation fund nominated by you.

The amount payable each month will be	Where
A ÷ B × C	A is the lesser of the following: • the Super Contribution Benefit Amount; • the average Employer Superannuation Contribution amount in the 12 months immediately before the start of the Waiting Period; and • 15% of your monthly Pre-Claim Earnings. B is the Benefit Amount (Income Protection) at the start of the Waiting Period, plus increases under the Increasing Claim Option, if applicable. C is the: • Totally Unable to Work Benefit plus Permanent Incapacity Reset Benefit (if applicable) payable; or • Partially Unable to Work Benefit payable. In calculating C, any offsets listed in Section 2.6.5 will not apply.

Payment of the Super Contribution Option:

- will start when the Totally Unable to Work Benefit or the Partially Unable to Work Benefit is payable; and
- is paid monthly in arrears.

Payments under the Super Contribution Option will stop on the earlier of the following events:

- the Totally Unable to Work Benefit or Partially Unable to Work Benefit is no longer payable; or
- the Policy anniversary before the Life Insured's 60th birthday.

The Super Contribution Option benefit payable will be paid on your behalf as a personal contribution to a superannuation fund nominated by you. The Super Contribution Option benefit can only be paid to an eligible complying superannuation fund and is subject to the standard superannuation rules relating to contributions, taxation and preservation. Your nominated fund may also have rules (or restrictions) on certain contribution types. Before nominating your fund for receipt of the Super Contribution Option benefit, you should check with your nominated fund that the fund rules permit receipt of the Super Contribution Option benefit.

The Super Contribution Option benefit should generally constitute assessable income and therefore you should keep a record of any Super Contribution Option benefit paid, to enable you to prepare your individual tax return. If you satisfy the tests for claiming a tax deduction in respect of the personal contributions and give the trustee of the nominated superannuation fund a valid notice of intent that is acknowledged, you may be entitled to a tax deduction in respect of some or all of the personal contributions. If you provide the trustee of the nominated superannuation fund with a valid notice that you intend to claim a tax deduction for the personal contributions, then the trustee should treat the contributions as concessional contributions which are generally subject to tax at 15% in the superannuation fund and this tax may be deducted from your account depending on the trustee's policy. There may be different tax treatment of your Super Contribution Option benefit and taxation issues that arise depending on whether you structure your Policy through superannuation. These matters are your responsibility, and you may wish to seek financial and tax advice.

In order to receive this benefit, you must provide us with your instructions and any necessary information we request to make the personal contribution on your behalf.

Benefits paid under the Super Contribution Option may impact your tax status and/or your superannuation contribution cap. Refer to Section 7 for more information on tax.

Where the trustee of a self-managed superannuation fund (SMSF) is the Policy Owner of the Income Protection Policy, the Super Contribution Option benefit can only be paid to the trustee of that SMSF and cannot be paid to a different nominated fund. The trustee of the SMSF is responsible for complying with superannuation and taxation legislation in respect of receiving the Super Contribution Option benefit.

Where Income Protection is structured through superannuation, the SIS legislation and rules must also be satisfied.

Example

- Phil is an Employee who has elected the IP Enhance income replacement option and the Super Contribution Option. Phil is the owner of the Income Protection Policy. The Increasing Claim Option has not been selected by Phil so does not apply.
- Phil has an insured monthly benefit of $7,000 per month and a Super Contribution Benefit Amount of $1,000 per month.
- Phil suffers a Sickness and satisfies the requirements of the Totally Unable to Work Benefit.
- Phil's Pre-Claim Earnings are $10,000 per month. His average Employer Superannuation Contribution amount in the 12 months immediately before the start of the Waiting Period was $1,000 per month.
- Phil's initial Super Contribution Benefit Amount is $1,000 per month (=A).
- Phil's initial Benefit Amount is $7,000 per month (=B).
- Phil remains Totally Unable to Work for 36 months.
  - During the first 24 months, Phil receives a Totally Unable to Work Benefit of $7,000 per month (=C). The amount paid under the Super Contribution Option is:

    A ÷ B x C = $1,000 ÷ $7,000 x $7,000 = $1,000 per month
  - From the 25th month onwards, Phil receives a Totally Unable to Work Benefit of $7,000 per month x 2/3 = $4,666.67 (=C). The amount paid under the Super Contribution Option is:

    A ÷ B x C = $1,000 ÷ $7,000 x $4,666.67 = $666.67 per month

Superlink IP

Superlink IP allows an Income Protection Policy structured outside superannuation to be Superlinked to an Income Protection Policy structured through superannuation.

If you select the Superlink option, two policies will be issued. An Income Protection Policy structured through superannuation will be issued to the trustee of the superannuation fund, and the other Income Protection Policy will be issued to the Life Insured and Superlink IP will apply. Your Policy Schedules will indicate when Superlink IP applies.

The following conditions apply for the two policies:

- the Income Protection Benefit Amount, Waiting Period, Benefit Period, and any loadings or special conditions (if applicable) of each Policy must always be the same;
- in the event Income Protection is reduced or increased under one Policy, the other Superlinked Income Protection Policy will be reduced or increased (as applicable) at the same time;
- if the Income Protection Policy structured through superannuation is cancelled, the Income Protection Policy structured outside superannuation will also be cancelled unless you notify us in writing to retain the Policy outside of superannuation before cancellation;
- if the Income Protection Policy structured outside superannuation is cancelled, cover will continue under the Income Protection Policy structured through superannuation, and Superlink IP will no longer apply; and
- the maximum benefits payable under both Policies will never exceed that which would be payable under a single Income Protection Policy.

If a benefit is payable and the SIS rules and regulations are met, we will pay the benefits from the Income Protection Policy structured through superannuation. If a benefit is payable but the SIS rules and regulations are not met, we will pay the benefits from the Income Protection Policy structured outside superannuation.

2.6.4 When we will not pay

No payment will be made under Income Protection and any included or optional benefits (if applicable), if the claim arises:

- directly or indirectly because of an intentional, self-inflicted act by the Life Insured;
- because of normal and uncomplicated pregnancy, miscarriage or childbirth. Normal and uncomplicated pregnancy includes, but is not limited to morning sickness, backache, varicose veins, ankle swelling, bladder problems, multiple pregnancy, carpal tunnel syndrome, or participation in an IVF or similar program;
- directly or indirectly because of War or an act of war, even if the disability manifests itself after the War or warlike activity;
- directly or indirectly as a result of the Life Insured's participation in a criminal act and/or for any period that they are incarcerated due to their participation in a criminal act; or
- directly or indirectly as a result of a permanent or temporary banning, deregistration, disqualification or restriction being placed on the Life Insured from performing all or some of the duties of their Working Occupation.

Travel outside Australia

If Life Insured is outside Australia, the Totally Unable To Work Benefit and/or the Partially Unable to Work Benefit will be limited to three months of payments. Entitlement to further and/or ongoing benefits will be assessed once the Life Insured returns to Australia and has met the necessary claim requirements (refer to Section 3 for details).

If we limit payment of the Totally Unable to Work Benefit and/or Partially unable to Work Benefit payment to three months and the Life Insured remains Totally Unable to Work or Partially Unable to Work, the Overseas Assistance Benefit may be available to assist the Life Insured to return to Australia.

This limitation will not apply during periods when the Life Insured is medically certified as unfit for air travel, or where air travel to Australia is not possible.

2.6.5 When we will reduce the benefit payment if an offset applies

How we will calculate your benefit when an offset applies

If an offset applies, the net amount payable for a claim will be calculated as follows (as applicable):

- Totally Unable to Work Benefit plus Permanent Incapacity Reset Benefit (if applicable), less 'other payments', less 'Earnings while Totally Unable to Work';
- Partially Unable to Work Benefit less 'other payments'; or
- Bed Confinement Benefit, less 'other payments', less ' Earnings while Totally Unable to Work'.

The types of offsets 'Earnings while Totally Unable to Work' and 'Other payments' are described below.

Earnings while Totally Unable to Work

We will reduce the Totally Unable to Work Benefit, Permanent Incapacity Reset Benefit and Bed Confinement Benefit if the Life Insured:

- receives any Earnings, or
- is entitled to any Earnings when the Life Insured is Self-Employed,

while the Totally Unable to Work Benefit is payable.

Other payments

We will also reduce the Totally Unable to Work Benefit, Partially Unable to Work Benefit, Permanent Incapacity Reset Benefit and Bed Confinement Benefit if the Life Insured receives other payments through:

- any other individual or group disability income insurance, credit or mortgage insurance not disclosed at the time of initial underwriting, any increase in benefits or reinstatement of the Policy;
- workers' compensation, common law or statute where payments are in respect of a disability of the Life Insured and in calculating the payment the relevant organisation did not, or could not, take into account payments due under the Income Protection Plan;
- any other payments which the Life Insured receives in relation to their employment/occupation, including payments or rebates relating to or referrable to loss of income, loss of earning capacity or any other economic loss. Some examples of the types of payments that we would not offset include one off retention payments and investment returns on shares as a result of employment; and
- any sick leave taken by the Life Insured.

If any of the other payments above are received as a lump sum, we will only reduce what we pay to you by the portion of the lump sum relating to loss of income, loss of earning capacity or any other economic loss, for the corresponding period you were entitled to the Totally Unable to Work Benefit or Partially Unable to Work Benefit. The lump sum amount will be converted to a monthly amount based on 1% of the lump sum per month. The disability payment will be calculated taking this figure into account for a maximum of eight years. You must provide to us the breakdown of the lump sum received as soon as reasonably practicable. This should include the portions of the lump sum relating to loss of income, loss of earning capacity or any other economic loss and any other information we reasonably require. Where you do not provide enough information for us to identify the portions of the lump sum relating to loss of income, loss of earning capacity or any other economic loss, we will, acting reasonably, determine the portions of the lump sum amount relating to or referrable to loss of income, loss of earning capacity or any other economic loss for the purpose of calculating the offset amount.

2.6.6 When Income Protection ends

Income Protection ends and our liability to pay a benefit under these Plans will cease (unless stated otherwise) on the earlier of the:

- date we receive the Policy Owner's or your written request to cancel the Plan or Policy;
- Policy being cancelled because of non-payment of premiums;
- Policy anniversary before the Life Insured's 65th birthday (refer to the paragraph below for 'to age 65' Benefit Period);
- date we cancel or avoid the Plan because of a misrepresentation made by you or the Life Insured before our acceptance of the Policy or because you made a fraudulent claim; or
- the death of the Life Insured.

If your Plan has a 'to age 65' Benefit Period and you were Totally Unable to Work or Partially Unable to Work immediately before the Plan end date as stated in the Policy Schedule, we will assess your claim until the earlier of the following:

- the Life Insured is no longer Totally Unable to Work or no longer Partially Unable to Work;
- the Life Insured's 65th birthday; or
- the death of the Life Insured.

When structured through a retail superannuation fund, Income Protection will end when you cease to be a member of the retail superannuation fund. This means that your Policy will be cancelled from the date you cease to be a member of the retail superannuation fund. You can apply within 60 days of the date your Policy was cancelled to continue the Plan with no further medical or financial requirement. Any special conditions or loadings which applied to the original Plan will also apply to the new Plan.

3 Claims

3.1 Notifying us of a claim

We will support you through the process of making a claim. If you wish to make a claim against the Policy, we strongly encourage you to contact us at the earliest possible opportunity. If you don't tell us about the life Insured's Sickness or Injury when it happens, and this affects our ability to gather evidence that we require to assess your claim, then this may potentially impact the time that it will take us to assess your claim.

Our contact details can be found on the back cover of this PDS. When we are notified that you wish to make a claim, we will provide the forms that need to be completed and explain in detail our requirements and what the next steps are.

3.2 Payment of premiums

While we assess your claim and unless we tell you otherwise, it is important to continue to pay premiums to ensure your cover is not cancelled.

If you are experiencing financial hardship, please call us on 1300 209 088 to discuss options that may be available to help you. You may also need to provide supporting documentation to assist with your financial hardship application. Alternatively, you can discuss this with your financial adviser.

3.3 Formal claim notification

For the purpose of:

- Critical Illness Insurance Death Buy-Back Benefit;
- Critical Illness Insurance Reinstatement Option; or
- TPD Insurance Death Buy-Back Option,

formal claim notification requirements consist of enough details of the claim to enable our assessment of the claim to commence including the Policy number, the condition claimed for and the date of the event or diagnosis.

3.4 Claim requirements

An event giving rise to a claim must occur when your insurance cover is in force and claim payments can only be made, start to accumulate or continue while your cover is in place.

Our assessment of your claim will involve determining whether your claim meets all relevant Policy terms and conditions and any applicable special condition shown in the Policy Schedule. This includes the terms and conditions that apply to the payment of any benefit under a Plan. It may also include investigating whether the duty to take reasonable care not to make a misrepresentation was complied with when the Policy or Plan was applied for, reinstated or changed. Our assessment of your claim will require obtaining the information, such as medical (for example Medicare, Pharmaceutical Benefits Scheme and private health insurance records), employment, lifestyle, pastime or financial evidence, that we require to make our decision. This may include information that relates to the period prior to the Policy or Plan start date, such as previous medical, employment, lifestyle, pastime or financial history, to determine whether you or the Life Insured took reasonable care not to make a misrepresentation when you applied for, reinstated or changed the Policy or Plan. In all circumstances we must be satisfied of our initial and ongoing liability to pay a benefit. Any information we require must be provided, and participation in the assessment activities we require must be undertaken, for us to assess your claim and before we will pay a benefit.

Administrative requirements
You may be required to provide the following information, as advised by your case manager, to support your claim:

- a completed claim form;
- a signed authority to allow us to collect information (including medical, occupational and financial information) about the Life Insured;
- proof of the event for which a claim is being made;
- proof of payment, when a claim for reimbursement is being made;
- proof of age (unless previously provided); and
- proof of probate and a death certificate for death claims.

You may also need to provide:

- proof of Policy ownership; and
- a signed discharge from an authorised person.

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

- examination of the Life Insured by a Medical Practitioner of our choice. This may involve imaging studies and clinical, histological and laboratory evidence;
- examination of the Life Insured by an appropriate specialist Medical Practitioner registered in Australia or New Zealand (or any other country approved by us, acting reasonably);
- proof that a surgical procedure was medically necessary and was the usual treatment for the underlying condition.

You will be required to provide an initial medical attendants report and medical certificates as reasonably required and determined by us. These medical reports must be completed by the appropriate Medical Practitioner to diagnose and certify the Insured's claimed condition.

For Terminal Illness Benefit claims, two treating Medical Practitioners must certify the extent of the Sickness or Injury, one of which must be by the appropriate specialist Medical Practitioner treating the condition. The assessment process will include review of medical information regarding treatment and response to treatment.

Financial requirements
For Income Protection and TPD Insurance we may require:

- verification of the Life Insured's Earnings stated in the application;
- verification of the Life Insured's Earnings the period before and after the event giving rise to your claim; and/or
- an audit of the Life Insured's business and personal financial circumstances as often as is required. This may include auditing documents that constitute a legal requirement such as business and personal taxation returns and profit and loss statements.

We will require you to provide us with copies of the tax returns lodged with the Australian Taxation Office (ATO) or other financial documentation which verifies your Pre-Claim Earnings and your Earnings during the period for which we have paid an Income Protection benefit. We must receive this information by any reasonable time frame we require.

We may recalculate the amount of the Income Protection benefit that we would have otherwise paid if your Earnings were averaged over the relevant claim period, and either:

- pay any underpayment of Income Protection Benefit(s);
- recover any overpaid Income Protection Benefit(s); or
- reduce the amount of any future Income Protection Benefits(s) payable until the excess amount paid has been recovered.

If required, the trustee will deduct any tax payable from any benefit payment made from the fund.

Occupation requirement
For Income Protection and TPD Insurance, you will be advised if you are required to provide verification of your occupation, including the breakdown of all the duties that you performed prior to ceasing work as a result of Sickness or Injury. If you are self-employed, your occupation will also take into consideration the duties required in running your business or a similar business. This information will be used to assess your ability to perform your occupation.

Interview requirements
You and the Life Insured (if applicable) may be required to attend interviews by a member of our staff or someone appointed by us as often as is required to fully consider your claim.

Other information requirements
We may also require:

- access to details of the Life Insured's previous medical consultations;
- assessment of current functional and vocational capacity by an appropriately qualified person selected by us; or
- information from various parties, including you and the Life Insured (if applicable), in relation to your claim, by a member of our staff or someone appointed by us, as often as is required. This may include, but not be limited to, details of any previous Injury or Sickness claims in relation to the Life Insured and details of previous occupation duties.

We reserve the right to require any information or documents not listed above but which are reasonably necessary to the assessment of your claim and establishing our liability to pay a benefit under the Policy.

Meeting the costs of claim requirements
Where we request an examination or assessment by a person we nominate, we will pay the cost for this service. You will be responsible for other costs which may be incurred for example, having your claim forms completed by your attending doctor, and providing financial information as required (e.g. the cost of completing tax returns, profit and loss statements).

Authority to obtain information
To obtain all relevant evidence to assess your claim and our liability under the Policy, we will require you or the Life Insured to provide us with written authority to receive information relevant to the assessment of the claim from third parties. For example, we may use this authority to seek information from medical practitioners who have treated you, including historical medical records which are relevant to determining whether the duty to take reasonable care not to make a misrepresentation was complied with when you applied for, reinstated or changed your Policy or Plan.

If you choose to withhold your consent and do not complete your authority, we may not be able to process your claim and your claim will be declined until we are able to obtain the information and evidence we reasonably require.

3.5 Obsolete criteria due to medical advancement

If the method for diagnosing the specified medical condition has been superseded by a revised clinical protocol, and the appropriate Australian medical body has recognised this revised criteria for diagnostic practice, we will apply the revised clinical protocol subject to our verification that the specified medical condition is conclusively diagnosed and to at least the same severity.

3.6 Treatment and rehabilitation requirement

Claim payments are dependent on the Life Insured being or having been under the care and following or having followed the reasonable advice of a Medical Practitioner and an appropriate specialist Medical Practitioner (where applicable). Following the advice of a Medical Practitioner or an appropriate specialist Medical Practitioner includes:

- following the treatment advice and actively engaging in the treatment plan developed by a Medical Practitioner, including any health and return to work plan, medication, specialist intervention and therapies; and
- following and actively participating in an accredited Rehabilitation Program or return to work program, where appropriate.

If there is no improvement of the Life Insured's symptoms where an improvement is generally expected in a person suffering from a similar condition, we may require:

- an assessment and confirmation of the diagnosis and severity of the signs and symptoms of the Life Insured's medical condition and treatment plan by an appropriate specialist Medical Practitioner; and
- where appropriate, that the Life Insured be under the care of an appropriate specialist Medical Practitioner after considering the opinion of the treating Medical practitioner and other medical information.

Benefit payments under Income Protection may be withheld if the Life Insured:

- is not following the advice or treatment plan as prescribed by the Medical Practitioner; or
- is not under the care of an appropriate specialist Medical Practitioner, where appropriate.

3.7 Fraudulent claim

If you make a fraudulent claim under your Policy or another policy you have with us, then we may cancel your Policy.

3.8 Your obligation regarding disability duration and severity

If we have provided you with a Policy, we have contracted to insure the Life Insured on the basis of the agreed cover. While we have accepted the risks associated with any potential loss, you and the Life Insured also have an obligation to mitigate your loss. You and the Life Insured must not knowingly contribute to the severity or longevity of the Life Insured's disablement or your claim may not be accepted.

We may reduce or decline to pay benefits where the condition resulting in a claim is caused or contributed to by your failure to seek and follow medical advice or treatment. We may waive this requirement if, in the opinion of the Medical Practitioner, continued or future treatment would be of no benefit.

3.9 Payment of claim

If you are legally competent to apply for a claim and your claim is accepted, all benefits will be paid to you or your legal personal representative. If your claim is accepted and you are judged to not be legally competent, we will pay any respective benefits to whomever we are legally permitted to make payments.

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

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

If a claimable event meets the requirements under the Terminal Illness Benefit, TPD Benefit and/or Critical Illness Benefit (where Plans are Attached or Linked), the Terminal Illness Benefit will be paid instead of the TPD Benefit or Critical Illness Benefit.

If cover is provided under Income Protection and a claim is made for a period of less than one month, it will be paid on a pro-rata basis. The payment will be made at a rate of 1/30th of the monthly amount payable for each day the Life Insured is entitled to any benefits payable under Income Protection.

3.10 When we will not pay a claim

We are not liable to pay a claim or may reduce a benefit arising from or in any way connected with anything we have specifically excluded or adjusted in the Policy Schedule.

If Accelerated Protection was purchased to replace an existing policy, until the other policy is cancelled, no claim will be paid under Accelerated Protection. If the previous policy is not cancelled and a claim occurs, any premiums paid to us will be refunded, and no benefit will be paid.

For the avoidance of doubt, we will also not pay a claim:

- where your claim does not meet the relevant Policy terms and conditions for a benefit to be paid;
- where you or the Life Insured did not comply with the duty to take reasonable care not to make a misrepresentation to the insurer (when you applied, reinstated or varied your Policy or Plan), and we apply a remedy available under the Insurance Contracts Act;
- where we do not receive all information we have reasonably requested to assess your claim;
- where there is insufficient evidence to support your claim;
- where we do not receive the authority that we require to obtain the information, records and evidence we reasonably require to assess your claim and compliance with the duty to take reasonable care not to make a misrepresentation.

3.11 Misstatement of age

If the age of the Life Insured has been incorrectly provided and the premium paid is lower than required, any claim payments that are subsequently made will be reduced. If the premium paid is higher than required, any overpaid premiums will be refunded.

If the date of birth of the Life Insured has been incorrectly provided and the expiry date of the Policy would have been different had the correct date of birth been provided, then we may vary the Policy by changing its expiry date to the date that would have been the expiry date if the Policy had been based on the correct date of birth.

4 General policy conditions

4.1 Coverage

Accelerated Protection provides cover 24 hours a day, every day of the year, worldwide.

Some benefits may only be payable if the event giving rise to the claim occurs in Australia. Where this is the case, this is explained in this PDS. Some conditions also apply to claims where the Life Insured is not in Australia. See Section 3 for more information.

For Income Protection, if you are overseas, benefit payment will be limited to three months. See Section 2.6.4 for details.

4.2 Guaranteed continuation of cover

If you or the Life Insured took reasonable care not to make a misrepresentation and answered all our questions accurately and you have paid all the premiums when due, Accelerated Protection will continue until the Plan end date. This guarantee of continuation applies regardless of any change in your health or personal circumstances.

4.3 Guarantee of upgrade

Where future improvements are made to benefits or definitions under the Policy without increasing the premium rates, these improvements will be passed on to you. You will be notified of the changes and improvements via one or more of notice in writing, on our website or your adviser. In the unlikely event you are unexpectedly disadvantaged in any way, the former wording of the condition will apply. If the Life Insured has any existing symptoms before an improved condition being included, the Life Insured will be assessed on the former wording of the condition (if applicable).

4.4 No cash value

All Plans and benefits outlined in this PDS don't have a cash value if the Policy is cancelled. The premiums paid represent the amounts due for us undertaking the risk of the insured event occurring.

4.5 Premiums and benefit payment

All premiums and benefits payable must be paid in Australian currency.

4.6 Statutory fund

The Policy will be issued from TAL's No. 1 Statutory Fund. The Policy will be non-participating which means that it does not entitle you to participate in the distribution of any surplus of the statutory fund.

4.7 Jurisdiction

This PDS and all Accelerated Protection Policies issued by us will be interpreted in accordance with New South Wales law and is subject to the exclusive jurisdiction of the Courts of Australia.

4.8 Changes to your Policy

The conditions of the Policy can be changed if required, but only if agreed to by both you and us. Changes to the Policy requested by you are subject to application. We reserve the right to require an Underwriting assessment to any Policy alteration that increases our obligation to pay a benefit. Any change must be confirmed in writing by an authorised member of our staff.

This section does not restrict our ability to change your Policy conditions as permitted under the Insurance Contracts Act if you or the Life Insured do not take reasonable care not to make a misrepresentation.

4.9 Additional increases to Benefit Amount

In some circumstances, we may agree to accept a voluntary increase in Benefit Amounts, even where a voluntary increase, if accepted, would result in the Benefit Amount exceeding the limits set out under the relevant Plan conditions. We may write to you from time to time to see if you wish to request a voluntary increase. Any request for voluntary increase is subject to the duty to take reasonable care not to make a misrepresentation to the insurer outlined in Section 5 and will involve a recalculation of your premium.

4.10 Cancellation and refunds

If you wish to cancel your Policy, you may be entitled to a refund of a proportion of the premium pursuant to our refund policy.

If your Policy is structured through superannuation, we may not be able to refund premiums to you but may be required to refund the premium as a contribution to an appropriate superannuation fund.

4.11 Can we cancel your Policy?

As long as your premium payments are received by the due date, your Policy will remain current until the Plan end date. This means your insurance Policy will continue regardless of any changes in your health, occupation, pastimes or income.

Your Policy may be cancelled if we do not receive a premium payment that is due. See Section 4.13 for more information.

Your Policy may be cancelled if you make a fraudulent claim or you do not comply with your duty to take reasonable care not to make a misrepresentation and we would not have provided you with the Policy had you complied with the duty to take reasonable care not to make a misrepresentation.

We will honour claim payments in line with the Policy terms and conditions if:

- The duty to take reasonable care not to make a misrepresentation has been complied with;
- You have answered all questions in your application honestly and accurately; and
- Your claim complies with relevant Australian laws.

4.12 Paying your premium

All premiums are payable by the due date shown in the Policy Schedule, unless we've offered an extension.

From the first Policy anniversary onwards, we'll advise you of your new premium before each Policy anniversary.

If you make a claim, it is important to continue to pay premiums while we assess your claim until we tell you otherwise. This is important to ensure your cover is not cancelled.

4.13 Non-payment or late payment of premiums

If we do not receive your premium payment by the due date, we'll let you know in writing and give you at least 30 days to pay the overdue premium. If we do not receive the overdue premium by the date stated in the overdue notice, we will cancel your Policy.

If a claim is payable after your premium is due, but before your Policy/Plan is cancelled, we will pay the claim in line with the respective Policy/Plan conditions. When this occurs, any outstanding premiums will be deducted from the claim amount.

4.14 What happens when your Policy is cancelled due to non-payment of premiums?

If the Policy is cancelled due to non-payment of premiums, we may permit you to reinstate your Policy. We do not guarantee that reinstatement will be available to you. We reserve the right to decline to reinstate, offer amended terms or impose conditions on any cover offered.

You may be required to complete an application form and this may be subject to Underwriting (for example, we may require information about your health, lifestyle, pastimes, occupation and income).

If we offer to reinstate the Policy:

- Any special conditions and/or loadings which applied to your original Policy will also apply to the reinstated Policy.
- You must agree to any additional or amended terms offered to reinstate the Policy.
- You must pay all outstanding premiums. We will inform you of the total outstanding premium amount as part of any offer of reinstatement we may make to you.
- Your duty to take reasonable care not to make a misrepresentation (see Section 5) applies to any application for reinstatement.
- Any reinstatement offered may be subject to additional terms and conditions other than those described in this clause. You will be informed of any additional terms and conditions at the time this option is offered to you.

If reinstatement is not available to you, you can choose to apply for a new policy. This will be subject to an underwriting assessment and if cover is offered, the terms and premiums that apply for the new policy will be based on the current on-sale product available at the time of application.

When we will not pay
If we reinstate the Policy, no benefit will be paid if the claim arises from:

- any condition or Sickness including Terminal Illness which occurred, or where symptoms develop or were apparent to the Life Insured; or
- any Injury or death that occurs,

from the date the Policy was cancelled up to the date the Policy was reinstated.

4.15 How to make a complaint

If you have a complaint about our services or your privacy you should direct your complaint depending on the product you hold:

Complaints about Accelerated Protection structured outside superannuation or SMSF
If you wish to make a complaint about Accelerated Protection you can contact us on:

1300 209 088
customerservice@tal.com.au
www.tal.com.au
Internal Dispute Resolution
GPO Box 5380, Sydney NSW 2001

We will attempt to resolve your complaint within 30 days of the date it is received. If we are unable to resolve your complaint within that period, we will inform you of the reasons for the delay and let you know when we expect to provide a response to your complaint.

Complaints about Accelerated Protection structured through superannuation
You should address your complaints to the trustee of your superannuation fund. The trustee will provide you with the details of its complaint-handling arrangements.

If your Policy is structured though TAL Super, please refer the 'How to make a complaint' section of the Accelerated Protection through TAL Super PDS.

Australian Financial Complaints Authority (AFCA)
If an issue has not been resolved to your satisfaction within 30 days of lodging your initial complaint, you can lodge a complaint with AFCA. AFCA provides fair and independent financial services complaint resolution that is free to consumers.

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

Time limits may apply to complaints to AFCA. You may wish to consult the AFCA website or contact AFCA directly to find out if there is a time limit on lodging a complaint with AFCA.

5 Duty to take reasonable care not to make a misrepresentation

When you apply for life insurance, we conduct a process called Underwriting. It's how we decide whether we can cover you, and if so on what terms and for what premium.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

If your application is accepted, the Policy will be a consumer insurance contract.

You can find details of how we treat your personal information in our privacy policy in Section 6.

5.1 The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

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

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

5.2 What can happen if the duty is not met?

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

For example, we may:

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

Whether we can exercise one of these remedies depends on a number of factors, including:

- whether you or the Life Insured took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances;
- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

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

5.3 We may require further information

In addition to the information you have disclosed to us, we may require further information, including but not limited to medical, employment, and financial records about the Life Insured, to determine whether we are able to offer you cover and on what terms. We may require you to provide this further information to us. Alternatively, we may require your authority to obtain this information from one or more third parties, for example a treating medical practitioner, your employer or accountant.

If you do not provide the information that we require, or you do not authorise us to obtain the information we require from one or more third parties, we may not be able to assess your application or provide you with a Policy or Plan.

5.4 We can verify your compliance with your duty

We have the right to verify whether what you have told us when you applied for your cover is accurate and complete. We may do this by comparing what you have told us to information contained in medical, financial, employment and other records about you.

We may require you to provide these records to us. Alternatively, we may require your authority to obtain these records from one or more third parties. If you do not provide the records we require, or you do not authorise us to obtain records about you that we require, we may refuse to assess or pay a claim you make against the Policy until the records are provided to us.

6 Privacy

In this section regarding your privacy, the words 'we', 'us' and 'our' refer to TAL and TAL Services Limited (ACN 076 105 130), and where your Policy is structured through TAL Super, Mercer Superannuation (Australia) Limited (ABN 79 004 717 533) (MSAL). TAL Services is the administrator of TAL Super, appointed by MSAL.

The way in which we collect, use and disclose your personal and sensitive information ('personal information') is explained in our respective Privacy Policies. Our Privacy Policies are available via the respective websites or free of charge on request. The contact details are provided in the table below.

Our Privacy Policies contain details about the following:

- the kinds of personal information that we collect and hold;
- how we collect and hold personal information (including sensitive information);
- the purposes for which we collect, hold, use and disclose personal information (including sensitive information);
- how our customers may access personal information about them which is held by us and how they can correct that information; and
- how we deal with any complaints that our customers may have regarding privacy issues.

If you would like a copy or if you have any questions about the way in which we collect, use, secure and disclose your information please contact us using the details below:

TAL

1300 209 088

customerservice@tal.com.au

www.tal.com.au

GPO Box 5380, Sydney NSW 2001

MSAL (TAL Super)

1300 209 088

customerservice@tal.com.au

www.tal.com.au/talsuper

GPO Box 4303, Melbourne, VIC 3001

Your personal and sensitive information will be collected to enable us to provide or arrange for the provision of our insurance products and services. We may request further personal information in the future, for example, if you want to make a claim and we need to collect health or financial information. If you do not supply the required information, we may not be able to provide the requested product or service or pay the claim.

In processing and administering your insurance benefits (including at the time of claim) we may disclose your personal information to other parties such as organisations to whom we outsource our mailing and information technology, government regulatory bodies and other related bodies corporate. We may also disclose your personal information (including health information) to other bodies such as reinsurers, your financial adviser, health professionals, investigators, lawyers and external complaints resolution bodies.

In administering your insurance benefits and in operating TAL Super (if applicable), your personal information may be disclosed to service providers in another country. In these circumstances we have robust operational processes to protect the information including due diligence, vendor management and a formal contract requiring adherence with Australian privacy laws. Details about the countries to which we disclose information are available in our Privacy Policy.

Generally, we do not use or disclose any customer information for a purpose other than providing our products and services unless:

- our customer consents to the use or disclosure of the customer information;
- the use or disclosure is required or authorised under an Australian law or a court/tribunal order;
- the purpose is related to improving our products and services and seeking customer input such as market research; or
- the use or disclosure of the information is reasonably necessary for one or more enforcement related activities conducted by, or on behalf of, an enforcement body e.g. the police.

From time to time we or our related bodies corporate and business partners may wish to contact you (where we have your valid consent) to provide you with information about other products and services in which you may be interested. These consents shall remain in effect in accordance with relevant law or unless and until you notify us that you do not want to receive direct marketing communications from us (or our related companies).

We rely on the accuracy of the information you provide. If you think that we hold information about you that is incorrect, incomplete or out of date, please let us know using the communication methods above.

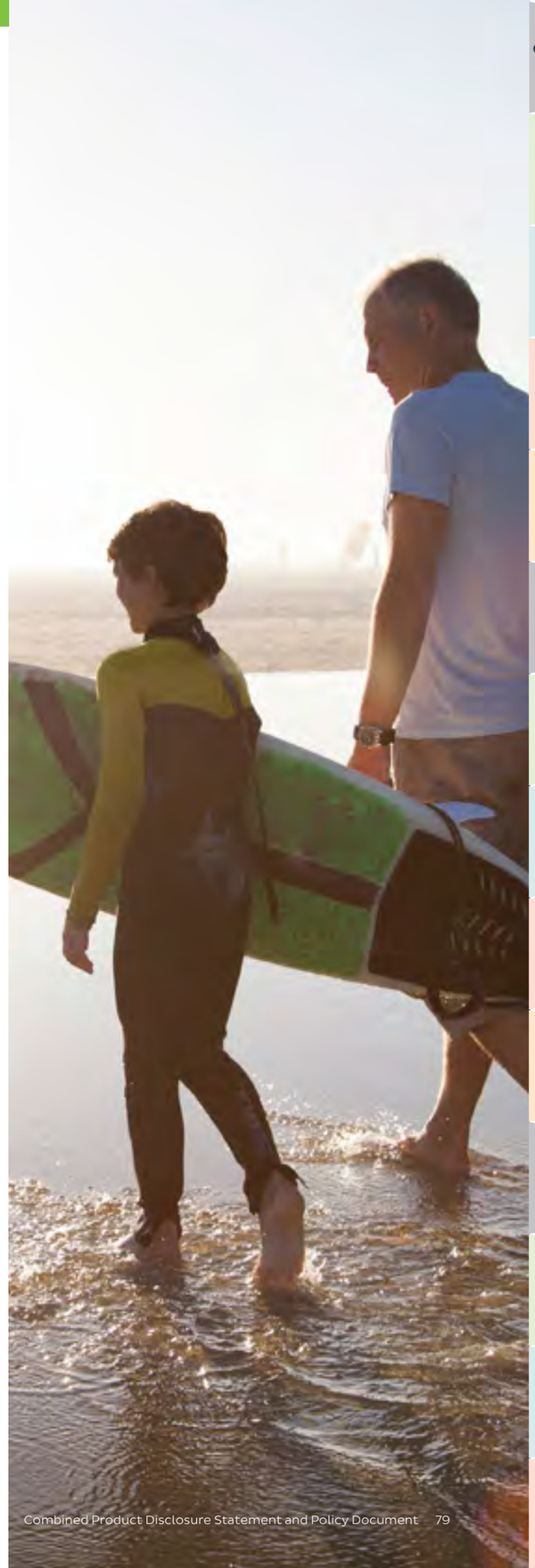
Under the current privacy law, you are generally entitled to access the personal information we hold about you. To access that information, simply make a request in writing. This process enables us to confirm your identity for security reasons and to protect your personal information from being sought by a person other than yourself.

There are some limited exemptions where we would be unable to provide the personal information that we hold about you in response to your request. These circumstances include, but are not limited to, where we reasonably believe the following:

- giving access would pose a serious threat to the life, health or safety of any individual, or to public health or public safety;
- giving access would have an unreasonable impact on the privacy of other individuals;
- the request for access is frivolous or vexatious;
- the information relates to existing or anticipated legal proceedings between you and us and the information would not be accessible by the process of discovery in those proceedings;
- giving access would reveal our intentions in relation to negotiations with you in such a way as to prejudice those negotiations;
- the information should be provided directly by us to your doctor or healthcare professional;
- giving access would be unlawful; or
- giving access would reveal evaluative information generated by us in connection with a commercially sensitive decision making process.

If, for any reason we decline your request to access and/or update your information, we will provide you with details of the reasons and where appropriate, a list of the documents that are not being provided directly to you. In some circumstances it may be appropriate to provide you with access to information that you've requested via an intermediary, such as providing medical information to a treating GP rather than directly to yourself. If this is the case, we will let you know.

Additional information about privacy rights and how to make a privacy related complaint can be found at the website of the Privacy Commissioner (www.oaic.gov.au) including sensible steps that you can take to protect your information when dealing with organisations and when using modern technology.



7 Tax

If you're considering the tax implications of purchasing and receiving benefits under Accelerated Protection, it is important you seek independent, professional taxation advice. The complexity of taxation laws and rulings is such that this advice should be specific to your circumstances. This should include any tax implications of purchasing insurance cover structured through superannuation or outside of superannuation. The following general information only applies to Australian resident individuals and is based on the Australian tax law and rules as at the date of issue of this PDS.

7.1 Goods and services tax (GST)

Accelerated Protection is treated as input taxed under the GST law and the premium will not be subjected to GST. The premium rates are inclusive of any GST costs incurred in relation to the Policy. An input tax credit will not be available to the Policy Owner.

7.2 Insurance held outside superannuation

The following general information relates only to Australian resident individuals who are both the Policy Owner and the Life Insured. Superannuation law and tax law are complex, so it is important to seek professional advice specific to your circumstances.

Income tax
For Income Protection, premiums paid for insuring against loss of income and for benefits which are considered assessable income, should generally be tax deductible. Benefit payments which substitute for income, or are in the nature of ordinary income, are generally considered assessable income. This should not be the case for Life Insurance, TPD Insurance, Critical Illness Insurance, Child's Critical Illness Insurance and certain benefits under Income Protection. This may vary if insurance is taken out for business purposes and you should seek professional taxation advice.

Capital gains tax
Benefits payable under the Policy that are not assessable as ordinary income may be assessed under the capital gains tax provisions if you are not the original owner of the Policy and you acquired an interest in the Policy for consideration, or you received benefit payments from the Policy and fall outside of the exemption provisions.

As noted above, benefit payments which are paid in substitute for income, or are in the nature of ordinary income, are generally considered assessable income and therefore should not also be subject to capital gains tax.

Tax withholding
We usually do not deduct or remit tax from benefit payments unless required to do so by law.

7.3 Insurance structured through superannuation

The following general information relates only to complying superannuation funds. Superannuation law and tax law are complex, so it is important to seek professional advice specific to your circumstances. From 1 July 2022, there have been changes to the eligibility age for downsizer contributions and in respect of the work test for personal superannuation contributions. From 1 July 2022, the minimum age to make downsizer contributions decreased to 60 years. This will allow some members aged 60 to 64 to potentially contribute $630,000 (or $1.26 million combined in the case of a couple) at one time by combining a downsizer contribution with the three-year non-concessional contributions bring-forward rule.

Individual members
You may be eligible for a tax deduction for your personal voluntary superannuation contributions.

From 1 July 2022, if you are aged from 67 and 74 years, you will be able to make personal superannuation contributions without satisfying the work test, subject to existing contribution caps. However, you will still be required to meet the work test or work test exemption to claim a deduction for personal contributions. This test requires that you are gainfully employed for at least 40 hours in any consecutive 30 day period in the income year in which the contributions are made. The work test exemption applies to members aged from 67 and 74 who have a total super balance below $300,000 at the prior 30 June and meet other conditions. It is your responsibility to ensure that you satisfy the work test or work test exemption for any personal contributions that you are claiming.

To meet the work test exemption criteria, you must have:

- satisfied the work test in the income year preceding the year in which you made the contribution;
- a total super balance of less than $300,000 at the end of the previous income year; and
- not relied on the work test exemption in a previous financial year.

Personal contributions which are claimed as a tax deduction are concessional contributions and are subject to the concessional contributions cap discussed below. Employer and salary sacrifice contributions are also concessional contributions.

The concessional contributions cap for the 2022/2023 financial year is $27,500 for members of all ages. From the 2019/2020 financial year, individuals with total superannuation balances of less than $500,000 on 30 June of the previous financial year, may be able to use their unused concessional contributions cap space to increase their concessional contributions cap.

Concessional contributions are generally included in the fund's assessable income and may be subject to tax at the rate of 15% in the fund's hands. However, where the member's personal adjusted taxable income exceeds $250,000, the ATO will issue an assessment to the member assessing all or part of their concessional contributions to an additional 15% of tax.

Where concessional contributions in excess of the applicable cap are made in a financial year the ATO will issue the member an assessment taxing the excess at the member's marginal tax rate (plus the Medicare levy). The member will be entitled to a tax offset equal to 15% of their excess concessional contribution (reflecting generally the tax already assessed to the recipient fund). An interest charge also applies for the deferral of tax.

If you are a low income earner and have eligible concessional superannuation contributions, you may be eligible for the low income superannuation tax offset, which is paid to your superannuation fund.

There are also limits on the amount of post-tax or 'non-concessional contributions' that can be made on behalf of a member. Personal contributions for which you do not claim an income tax deduction and any excess concessional contributions that are not refunded by the fund, are non-concessional contributions.

For the 2022/2023 financial year, the annual cap for non-concessional contributions is $110,000 and members with total superannuation balances of $1.7 million or more are not eligible to make non-concessional contributions. There is a 'bring-forward' option as discussed below. You will be taxed on non-concessional contributions over the cap at the rate of 45%, plus the Medicare levy where they cannot be released from a fund (and this is the case for TAL Super as stated below).

Under the 'bring-forward' option, generally people under 75 years of age for at least one day during the year and have not accessed this option in prior years, can make non concessional contributions of up to three times the annual cap limit (explained above) in one year (other conditions apply).

However, from 1 July 2022 members with total superannuation balances of $1.48 million or more have reduced (or no) access to the bring-forward rule.

If you receive an excess concessional or non-concessional contribution determination from the ATO, you should not elect for amounts to be released from TAL Super. TAL Super is unable to process a release authority from the ATO because you will not have an accumulation interest in TAL Super. In these circumstances if you require an amount to be released, you should nominate another superannuation fund in which you have a sufficient accumulation interest to make the release from.

If your income is less than $57,016 (for the 2022/2023 financial year), you may also benefit from government co-contributions if you make a personal after tax (non-concessional) contribution to your superannuation.

The government co-contribution is a payment made by the Federal Government to the superannuation account of eligible members who make personal non-concessional contributions. For more information contact your financial adviser or the Australian Tax Office (ATO) Superannuation Infoline on 13 10 20.

Employers
Employer contributions are tax deductible to the employer where they are made to provide superannuation benefits for an employee or the employee's dependants.

Employers can make contributions to complying superannuation funds for employees aged:

- under 75; or
- 75 and over, where contributions are required under legislation (such as the Superannuation Guarantee) or by relevant industrial awards.

Tax payable on death benefits
Lump sum death benefits are tax free if paid to a dependant for tax purposes or the member's estate where the beneficiaries of the estate are dependants of the member for tax purposes. Lump sum death benefits paid to non-dependants for tax purposes or the member's estate to the extent the beneficiaries are not dependants for tax purposes, are taxed at different rates depending on whether the elements are from taxed or untaxed sources. For elements taxed in the fund, the rate is the lower of the recipient's marginal tax rate and 15%, plus the Medicare levy. For elements untaxed in the fund, the rate is the lower of the recipient's marginal tax rate and 30%, plus the Medicare levy. The trustee of the member's estate does not bear the Medicare levy.

Tax payable on Terminal Illness benefits
Terminal illness benefits paid to members are tax free.

Tax payable on TPD benefits
Total and Permanent Disablement (TPD) benefits are taxed at different rates, depending on the amount, the member's age when they were disabled and their age at the date of payment.

Tax payable on Income Protection benefits
Income Protection benefits, including the Super Contribution Option benefit, that substitute for lost income or are in the nature of ordinary income, should constitute assessable income of the claimant and should be taxed at the recipient's marginal tax rate, plus the Medicare levy where applicable.

Withholding tax
Where TAL or the trustee is required by law to deduct any tax, duty, impost or the like in connection with the payment of a benefit, TAL or the trustee will deduct the required amount from the payment and forward it to the relevant authority. For example, we will withhold tax from the Income Protection benefits that are in the nature of income (including the Super Contribution Option benefit), before the amounts are paid by us to the member or their nominated superannuation fund. This withholding tax arrangement applies for policies structured through TAL Super or certain retail superannuation funds. In other cases, the Policy Owner needs to consider the income and withholding tax implications upon receiving the Income Protection benefits and allocating the Super Contribution Option benefit to a nominated superannuation fund. We will also withhold tax from TPD and death benefits where required by law.

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8 Important information on structuring insurance through superannuation

You can choose to structure your Accelerated Protection through a complying superannuation fund. This means the trustee of the superannuation fund becomes the Policy Owner and you become a member of the fund.

When benefits are paid, they will be received by the trustee who will then distribute them in accordance with the governing rules of the superannuation fund and superannuation law.

Check with the trustee of your superannuation fund to see whether they can pay TAL your insurance premiums from your member account. This would be the case for most self-managed superannuation funds.

If you are not a member of a complying superannuation fund, or you are a member of a fund which cannot pay us insurance premiums from your member account, you can still take out Accelerated Protection through superannuation by becoming a member of TAL Super (see Accelerated Protection through TAL Super PDS). This applies to Life Insurance, TPD Insurance and Income Protection.

If you structure your Accelerated Protection through superannuation the taxation impacts may differ from holding insurance outside of superannuation, so it's important to seek financial and taxation advice before you make this decision. Superannuation law is complex, so this advice should be specific to your circumstances. Please refer to the 'Tax' section for more information.

There are some important differences between owning your insurance yourself and purchasing your insurance through superannuation. For example, some benefits will not apply where insurance is held through superannuation (as set out in this PDS). However, in some circumstances purchasing insurance through superannuation may be more advantageous.

When Income Protection is structured through superannuation:

- A claim may not be payable if you were not 'gainfully employed' (as set out in SIS) immediately before your disability started.
- If you're not 'gainfully employed' (as set out in SIS), you can apply to have your Plan suspended for up to 12 months.

If you are concerned or have any questions about the potential complications of structuring Income Protection through superannuation, you should speak to your financial adviser.

The following information is provided to assist you in understanding your options. It is general information only and is not intended to be a comprehensive statement of the laws applying to superannuation. You should talk to a financial adviser about your personal circumstances.

8.1 Contributions to a superannuation fund

Contributions can only be made to the superannuation fund in accordance with superannuation law. Superannuation law stipulates the way in which employer, personal, spousal and child contributions can be made, as well as work requirements and age limits in relation to the acceptance of superannuation contributions for members.

8.2 Payment of the death benefit

Superannuation law specifies that a death benefit can only be paid to the following:

- Member's spouse (married or de facto, including same sex couples).
- Child of the member of any age (including adopted child, stepchild and ex-nuptial child).
- The member's legal representative.
- Any person who was financially dependent on the member at the time of death.
- Any person with whom the member had an interdependency relationship.

If the trustee cannot locate any of these persons after conducting reasonable searches, the death benefit may be paid to an individual non-dependant such as a parent or sibling.

8.3 Payment of superannuation benefits

Other than death benefits, a superannuation benefit can only be paid where the member meets a condition of release under applicable superannuation law. In a general sense, these circumstances include Permanent Incapacity, Temporary Incapacity, Terminal Medical Condition, retirement (or the person has reached their preservation age), the termination of employment after age 60, leaving Australia after holding an eligible temporary resident visa, and on financial hardship or compassionate grounds. Rules relating to when superannuation benefits can be accessed are complex, so you should consult a financial adviser for further information.

8.4 Superannuation and family law

Provisions in the Family Law Act enable parties who are married to require superannuation fund trustees to carry out certain actions in relation to superannuation entitlements. Members should note that their spouse or de-facto will be able to request the trustee to disclose information about the member's benefit entitlements ('Request for Information').

The trustee is prohibited by law from informing members that such a request was made. The trustee will not pass any information about your present whereabouts to the person making the Request for Information.

8.5 Payment by rollover

Some superannuation funds are prevented from making rollovers to pay for insurance cover through superannuation – you should check whether your superannuation fund is able to pay a rollover.

8.6 Risk of holding insurance through superannuation

There are risks you should consider before deciding to hold insurance through superannuation, including:

- Except for Income Protection benefits, a benefit paid from a policy structured through superannuation is a superannuation benefit for tax purposes and it may be subject to more tax than would otherwise apply if the benefit was paid from the same insurance held outside of superannuation.
- Limits apply to the amount you can contribute to superannuation each year. Any contributions you make to a superannuation fund in order to pay premiums will reduce the amount you may be able to contribute to other superannuation accounts you hold for retirement savings purposes.
- Where you choose to pay premiums by rollover from another superannuation fund, your retirement savings will be reduced so that you may have less available to you on retirement than otherwise may have been the case. You should ensure that the cost of premiums do not inappropriately erode your retirement savings.
- Taxation or superannuation laws may change in the future, altering the suitability of holding insurance through superannuation.

8.7 Structuring insurance through TAL Super

If you're structuring Accelerated Protection through TAL Super, you should also read the 'Accelerated Protection through TAL Super PDS' together with this PDS. It contains specific information about to structuring Accelerated Protection through TAL Super.

9 Definitions

Where a defined term is used in this PDS, the first letter of each word is capitalised (e.g.'Policy Owner'). The only exceptions are 'you', 'your', 'we', 'us', 'our' and 'structured through superannuation' which are not capitalised. The meaning of each defined term can be found in this section.

9.1 General definitions

Accident or **Accidental** means an accident caused wholly by violent, accidental, external and visible means.

Activities of daily living (ADL) are:

- Bathing – The ability for the Life Insured to wash themselves either in the bath or shower. If the Life Insured performs these tasks by using equipment or adaptive devices, we will consider them able to bathe themselves.
- Dressing – The ability for the Life Insured to put on and take off all garments. If the Life Insured is using modified clothing or adaptive devices including but not limited to tape fasteners or zipper pulls to perform this task, we will consider the Life Insured able to dress themselves.
- Feeding – The ability for the Life Insured to get food from a plate into the mouth once it has been prepared. If the Life Insured is able to perform this task using assistive devices including but not limited to modified utensils and adaptive dinnerware, we will consider the Life Insured able to feed themselves.
- Toileting – The ability for the Life Insured to get on and off the toilet and clean themselves. If the Life Insured can care for a stoma or catheter or uses adaptive devices to perform this task, we will consider them able to toilet themselves.
- Mobility – The ability for the Life Insured to move in and out of bed and a chair. If the Life Insured uses motorised equipment and supportive devices including but not limited to bed rails, grab bars, walkers, transfer platforms and canes, we will consider the Life Insured able to mobilise themselves.

Any Occupation under Income Protection means an occupation that the Life Insured is suited for after considering the Life Insured's work experience, training, education and transferable skills regardless of whether the work or employment is available.

An occupation that a Life insured is reasonably suited for includes suitable alternate occupations where up-skilling is required, and the training course/program can be completed within 12 months on a full-time basis or 24 months on a part-time basis.

Attached or **Attaching** means where under one Policy:

- Critical Illness insurance is added as a benefit to Life insurance;
- TPD insurance is added as a benefit to Life insurance; or
- TPD insurance is added as a benefit to Critical Illness insurance.

A payment under one will affect a corresponding reduction in the Benefit Amount payable under the other (Attached) insurance and a reduction in the total premium payable.

Bed Confined and **Bed Confinement** mean the Life Insured has been advised by a Medical Practitioner to remain in or near a bed for a substantial part of each day and under the continuous care of a Registered Nurse.

Benefit Amount under Income Protection means the monthly amount as calculated below.

Benefit Amount at the start of the Waiting Period is the lesser of the following:

- the Benefit Amount shown in your Policy Schedule, plus any increases under the Inflation Protection Benefit (if applicable); or
- 70% of the first $20,000 per month ($240,000 per annum) of your Pre-Claim Earnings; 50% of the next $20,000 per month ($240,000 per annum) of your Pre-Claim Earnings; and 20% of the remainder of your Pre-Claim Earnings.

If you have more than one income protection cover with us, the Benefit Amount will be adjusted so that the accumulated total income replacement benefit that you receive cannot exceed 70% of the first $20,000 per month ($240,000 per annum) of the Pre-Claim Earnings; 50% of the next $20,000 per month ($240,000 per annum) of the Pre-Claim Earnings; and 20% of the remainder of the Pre-Claim Earnings.

Benefit Amount will incorporate increases under the Increasing Claim Option (if applicable).

Benefit Amount under Life Insurance, TPD Insurance, Critical Illness Insurance and Child's Critical Illness Insurance is the respective lump sum amount shown in the Policy Schedule as applicable, after taking into account increases or reductions, applied:

- Under the conditions of Life Insurance, TPD Insurance, Critical Illness insurance and Child's Critical Illness Insurance or options; or
- In line with a request by you that is agreed to by us.

Benefit Period under Income Protection means the maximum Claim Period for any one Sickness or Injury or related Sickness or Injury. The maximum Benefit Period is shown in your Policy Schedule.

Carer means the Life Insured provides everyday care to an Immediate Family Member due to disability or injury to enable them to live at home. The care must be necessary for medical reasons and have not been required before the Policy commencement. It must also be, in the opinion of a Medical Practitioner, likely to be required for a continuous period of at least six months.

Child Insured means the child insured under the Child's Critical Illness Insurance Plan.

Claim Period means the total length of time that the Life Insured qualifies for the Totally Unable To Work Benefit or the Partially Unable to Work Benefit after the Waiting Period.

Earnings means:

- if the Life Insured is Self-Employed, their share of the total of all net profits and all net losses generated or accrued in the normal conduct of the business or businesses, after excluding business expenses which were not necessarily incurred or normally required in the usual and normal conduct of the business/ businesses; or
- if the Life Insured is an Employee (and is not Self-Employed), salary, wages, regular bonuses and any other income considered part of the Life Insured's remuneration package (excluding any Employer Superannuation Contribution).

Income paid from other disability income policies, retirement plans, lump sum disability payments, rental income and investment income are some examples of income we would not consider as Earnings.

Employer Superannuation Contribution means the employer superannuation guarantee contribution mandated under the *Superannuation Guarantee Administration Act* and any employer contribution made as part of the Life Insured's remuneration package. It excludes any other type of superannuation contribution.

Employee means the Life Insured is hired for a wage, salary, fee or payment to perform work for an employer, whereby they have no direct or indirect ownership interest in the employing entity (ignoring shares in publicly listed companies).

Exposure Prone Procedures means contact by the skin with sharp surgical instruments, needles, or splinters of bone or teeth in poorly visualised or confined body sites.

Immediate Family Member means spouse, partner, de-facto, children, parents and siblings.

Indexation Factor is the percentage change in the Consumer Price Index (Weighted Average All Capital Cities) as last published by the Australian Bureau of Statistics in respect of the 12-month period finishing on 30 September of each year.

This factor will be determined at 30 November each year and applied, where indicated, for the following calendar year. If it is not published by 30 November, the Indexation Factor will be calculated based upon a retail price index we consider replaces it.

If the percentage change in the Consumer Price Index, or any substitute for it, is negative, the Indexation Factor will be taken as zero.

Injury means a bodily injury suffered by the Life Insured or Child Insured.

Life Insured means the person whose life is insured under the Life Insurance Plan, TPD Insurance Plan, Critical Illness Insurance Plan or Income Protection Plan.

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

Linked or **Linking** means the connection of two separate Policies whereby the payment under a Plan purchased under one Policy effects a corresponding reduction in the Benefit Amount payable under the other (Linked) Policy and a reduction in the total premium payable.

Long Term Leave is any leave period longer than four weeks such as any unpaid leave, maternity or paternity leave, a sabbatical, or leave taken to allow you to work for a charitable organisation.

Loss of Independent Existence (permanent) means that solely because of Sickness or Injury, the Life insured:

- is totally and permanently unable to perform at least two of the five Activities of Daily Living without the physical assistance of another person; or
- suffers permanent Significant Cognitive Impairment.

Loss of use of a Single Limb (permanent) means the total and irrecoverable loss of use of one Limb.

Loss of use of Limbs (permanent) means the total and irrecoverable loss of use of two or more Limbs.

Loss of Sight in One Eye (permanent) means the permanent and irrecoverable loss of sight (whether aided or unaided) in one eye, because of Sickness or Injury to the extent that visual acuity in the eye, on a Snellen Scale after correction by a suitable lens is less than 6/60, or to the extent that the visual field is reduced to 20 degrees or less of arc.

Maximum Medical Improvement means that the Life Insured's recovery from the Sickness or Injury has reached a point where no further recovery or functional improvement is expected even with additional intervention or treatment (medical and non-medical). We will consider all medical information from the Life insured's medical providers and will seek independent medical specialist opinion if required, to determine whether Maximum Medical Improvement has been achieved.

Medical Practitioner means a person who is legally qualified and registered as a Medical Practitioner, other than:

- you or the Life Insured;
- a business partner of yours or the Life Insured; or
- an Immediate Family Member of you or the Life Insured.

If practising other than in Australia, the Medical Practitioner must be approved by us, acting reasonably, and have qualifications equivalent to Australian standards.

Note: Chiropractors, physiotherapists, psychologists and alternative therapy providers are not regarded as Medical Practitioners.

MSAL refers to Mercer Superannuation (Australia) Limited (ABN 79 004 717 533) (AFSL 235906) as the trustee of TAL Super.

Own Occupation under Income Protection means the occupation or business in which the Life Insured was working immediately before the start of the Waiting Period, unless the Life Insured:

- was Unemployed or on Long Term Leave for more than 12 consecutive months immediately before the start of the Waiting Period, 'Own Occupation' will be replaced with 'Any Occupation'; or
- was Unemployed or on Long Term Leave for less than 12 consecutive months immediately before the start of the Waiting Period, 'Own Occupation' means the most recent occupation in which the Life Insured was working prior to the start of the Waiting Period.

If you are Self-Employed or work on a contract basis and you have not performed any duties that directly generate income, or your business has not generated any income for more than 12 consecutive months before the start of the Waiting Period, 'Own Occupation' has the same meaning as 'Any Occupation'.

If the Life Insured had been working in more than one occupation that meets these criteria, 'Own Occupation' will include all of those occupations.

Own Occupation under Life Insurance, Critical Illness Insurance and TPD Insurance is the occupation in which the Life Insured was working immediately before the Sickness or Injury causing disability.

If the Life Insured had been working in more than one occupation that meets these criteria, 'Own Occupation' will include all of those occupations.

Partially Unable to Work means that solely because of Sickness or Injury, the Life Insured is:

- working (whether or not for remuneration) in a reduced capacity or capable of working in a reduced capacity;
- following the advice and treatment plan of a Medical Practitioner in relation to the Sickness or Injury; and
- not capable of working more than 80% of the Life Insured's usual average working hours in the 12 months immediately before the start of the Waiting Period. The usual average working hours immediately before the start of the Waiting Period will be limited to 40 hours a week (if the Life Insured is working more than 40 hours a week).

Where Income Protection has been structured through superannuation, the Life Insured must also satisfy the SIS definition for Temporary Incapacity or Permanent Incapacity.

Plan means the insurance benefits and applicable options under Life Insurance, TPD Insurance, Critical Illness Insurance, Child's Critical Illness Insurance and Income Protection, depending on the terms of the applicable Policy Schedule, that apply to you when your Policy is in force.

Policy means the Accelerated Protection Policy under the terms and conditions set out in this PDS.

Policy Owner means the person or company that legally owns the Policy. Where Accelerated Protection is structured through a superannuation fund, the trustee of that superannuation fund will be the Policy Owner that holds the Policy on behalf of the member.

Policy Schedule refers to the documentation that identifies the Policy Owner, the Life Insured, the type of Plan(s) and options applicable to the Policy, the amount of coverage, the special conditions that apply, the Plan start and end date and premium details (amount and payment frequency). The Policy Schedule is a legal document and forms part of the insurance contract.

Pre-Claim Earnings under Income Protection means:

- if Self-Employed, the Life Insured's average Earnings over the last two financial years that have ended immediately before the start of the Waiting Period; or
- if an Employee (and the Life Insured is not Self-Employed), the Life Insured's average Earnings over the consecutive 12-month period immediately before the start of the Waiting Period.

Pre-Claim Earnings will increase by the Indexation Factor on each anniversary from the start of the Totally Unable to Work Benefit or the Partially Unable to Work Benefit becomes payable.

If the Life Insured has been on Long Term Leave or was Unemployed for up to 12 months prior to the start of the Waiting Period, Pre-Claim Earnings will be calculated based on the period immediately before the Life Insured went on Long Term Leave or became Unemployed.

If Income Protection is structured through superannuation, the SIS rules and regulation must be met.

Rehabilitation Program means a program or plan:

- designed to assist the Life Insured in returning to a Working Occupation; and
- developed by an appropriately qualified vocational or occupational rehabilitation specialist.

General medical consultations and medical therapy consultations, including but not limited to, physiotherapy, psychotherapy and hydrotherapy, are excluded.

Self-Employed means the Life Insured directly or indirectly owns all or part of the business in which their work is performed including where the business operates under a company structure (ignoring shares in publicly listed companies).

Serious and Permanent Incapacity or **Seriously and Permanently Incapacitated** means that solely because of Sickness or Injury, in our opinion, the Life Insured suffers permanent incapacity to the severity of at least one of the categories listed in the table below. The following conditions also apply in addition to the serious incapacity requirement:

- all mental illness will only be assessed under the mental illness category;
- for chronic pain conditions, the Life Insured must also have participated in an accredited multi-disciplinary pain management program and been under the care of a pain specialist for at least six months and is not expected to gain any further functional improvement.

Category	Serious Incapacity requirement
Cardiac and respiratory condition	The Life Insured meets one of the following: • suffers an irreversible respiratory condition and is on permanent oxygen therapy; or • suffers an irreversible cardiac condition to the degree of at least Class 3 of the New York Heart Association Classification.
Mental illness	The Life Insured has a diagnosed mental disorder, and solely due to the mental disorder meets at least four of the following: • Self-care and independent living: Cannot live independently without regular support. Needs prompting to shower daily and wear clean clothes. Is not able to prepare own meals and frequently misses meals if not prompted to eat. Requires family member or community nurse visits 3 times every week to ensure minimum level of hygiene and nutrition. • Social and/or recreational activities: Rarely goes out to social and/or recreational events, and only when prompted by family member or close friend. Not actively involved, remains quiet and withdrawn. • Travel: Cannot travel away from own residence without support person due to severe anxiety or cognitive impairment. • Social functioning: Unable to form or sustain long term relationships and loss of most pre-existing relationships (e.g. lost partner, close friends). Unable to care for dependants (e.g. own children, elderly parent). • Concentration: Can only read a few lines of text before losing concentration. Has difficulty following simple instructions. Concentration deficits obvious even during brief conversation. Needs regular assistance from relatives or community services.
Cognitive impairment (impairment as a result of Sickness or Injury other than mental illness)	The Life Insured suffers a deterioration or loss of intellectual capacity that results in a requirement for a full-time permanent caregiver.
Blindness	The Life Insured has permanent and irrecoverable loss of sight in of both eyes as a result of Sickness or Injury to the extent that visual acuity in both eyes, on a Snellen Scale after correction by suitable lens is less than 6/60, or to the extent that the visual field is reduced to 20 degrees or less of arc. Visual acuity cannot be improved with corrective lenses or surgery.
Terminal conditions	The Life Insured has an incurable Sickness or Injury and: • has a life expectancy of less than 12 months; or • requires palliative care (i.e. care or treatment to improve the quality of living). The palliative care must be provided by an accredited medical provider/facility.
Universal	The Life Insured is totally and permanently unable to perform at least two of the five Activities of Daily Living without the physical assistance of another person. The Life Insured is considered capable of performing the task if they can perform the task using or wearing any prosthesis or assistive device that is appropriate.
Specified conditions	The Life Insured has been unequivocally diagnosed by an appropriate specialist Medical Practitioner with one of the following: • paraplegia, diplegia, hemiplegia or quadriplegia • end stage chronic kidney, lung, heart or liver failure • motor neurone disease • dementia • Parkinson's disease

Sickness means an illness or disease suffered by the Life Insured or Child Insured, as confirmed by a Medical Practitioner.

Significant Cognitive Impairment means a deterioration or loss of intellectual capacity that results in a requirement for a full-time permanent caregiver.

SIS means the *Superannuation Industry (Supervision) Act 1993 (Cth)* or *the Superannuation Industry (Supervision) Regulation 1994 (Cth)*, as applicable.

SMSF means self-managed superannuation fund.

Standalone means Plans which are held independently of each other and when a benefit is paid under one Plan, it does not reduce the Benefit Amount for any other Standalone Plans held.

Structured through superannuation means Accelerated Protection is owned by the trustee of a fund (which may be TAL Super, a retail superannuation fund which we have an agreement with or a self-managed superannuation fund) for one or more members of the fund.

Super Contribution Benefit Amount under the Super Contribution Option means the monthly benefit shown in your Policy Schedule plus any increases under the Inflation Protection Benefit.

Superlink or **Superlinked** means the connection of two separate Policies, one issued to the trustee of a superannuation fund and the other issued outside of superannuation. In the event no amount is payable under the Policy structured through superannuation, or the amount payable is restricted, a payment may be made through the Policy structured outside superannuation, subject to the Life Insured meeting the terms and conditions. The maximum benefits payable under both Policies will never exceed the amount that would have been payable under a single Policy structured outside superannuation.

TAL Services means TAL Services Limited (ACN 076 105 130), a related body corporate of TAL that provides administration and other services in relation to TAL Super.

TAL Super means a plan within the Retail Division in the Mercer Super Trust (ABN 19 905 422 981) sponsored by TAL Services Limited.

Terminally Ill and **Terminal Illness** means an illness or condition where, after having regard to the current treatment or such treatment as the Life Insured may reasonably be expected to receive, the Life Insured has a life expectancy of less than 12 months.

When Life Insurance is structured through superannuation, the Life Insured must also satisfy the SIS definition of Terminal Medical Condition.

Total and Permanent Disability and **Totally and Permanently Disabled** when 'Any Occupation' is shown in your Policy Schedule means that solely because of Sickness or Injury and after all reasonable treatment and rehabilitation has been undertaken:

- the Life Insured has not been working in any occupation for three consecutive months and, in our opinion, after consideration of medical and any other evidence, is incapacitated to such an extent as to render the Life Insured unlikely ever to be able to work in any occupation for which they are reasonably suited by training, education or experience which would pay remuneration at a rate greater than 25% of the Life Insured's Earnings during their last 12 months of work;
- the Life Insured has suffered permanent Whole Person Impairment of at least 25% and has not been working in any occupation, and, in our opinion, after consideration of medical and any other evidence, is incapacitated to such an extent as to render the Life Insured unlikely ever to be able to work in any occupation for which they are reasonably suited by training, education or experience which would pay remuneration at a rate greater than 25% of the Life Insured's Earnings during their last 12 months of work; or
- the Life Insured is Totally and Permanently Disabled under the 'ADL' definition.

When cover is structured through superannuation, the Life Insured must also satisfy the SIS definition of Permanent Incapacity.

Total and Permanent Disability and **Totally and Permanently Disabled** when 'Own Occupation' is shown in your Policy Schedule means that solely because of Sickness or Injury and after all reasonable treatment and rehabilitation has been undertaken:

- the Life Insured has not been working in their Own Occupation for three consecutive months and in our opinion, after consideration of medical and any other evidence, is incapacitated to such an extent as to render the Life Insured unlikely ever to be able to work in their Own Occupation;
- the Life Insured has suffered permanent Whole Person Impairment of at least 25% and has not been working in any occupation, and, in our opinion, after consideration of medical and any other evidence, is incapacitated to such an extent as to render the Life Insured unlikely ever to be able to work in any occupation for which they are reasonably suited by training, education or experience which would pay remuneration at a rate greater than 25% of the Life Insured's Earnings during their last 12 months of work; or
- the Life Insured is Totally and Permanently Disabled under the 'ADL' definition.

Total and Permanent Disability and **Totally and Permanently Disabled** when 'ADL' (Activities of Daily Living) is shown in your Policy Schedule or when the 'TPD ADL' definition is applicable, means that solely because of Sickness or Injury the Life Insured:

- is totally and permanently unable to perform at least two of the five Activities of Daily Living without the physical assistance of another person;
- suffers Blindness (permanent);
- suffers Loss of use of Limbs (permanent);
- suffers Significant Cognitive Impairment; or
- suffers a mental disorder based on a recognised diagnostic system, and solely due to the mental disorder permanently satisfies or meets at least four of the Mental Illness categories after reaching Maximum Medical Improvement.

Mental illness categories:
The Life Insured has a diagnosed mental disorder and meets at least four of the following:

- Self-care and independent living: Cannot live independently without regular support. Needs prompting to shower daily and wear clean clothes. Is not able to prepare own meals and frequently misses meals if not prompted to eat. Requires family member or community nurse visits at least 3 times every week to ensure minimum level of hygiene and nutrition.
- Social and/or recreational activities: Rarely goes out to social and/or recreational events, and only when prompted by a family member or a close friend. Not actively involved, remains quiet and withdrawn.
- Travel: Cannot travel away from own residence without support person due to severe anxiety or cognitive impairment.
- Social functioning: Unable to form or sustain long term relationships and loss of most pre-existing relationships (e.g. lost partner, close friends). Unable to care for dependants (e.g. own children, elderly parent).
- Concentration: Can only read a few lines of text before losing concentration. Has difficulty following simple instructions. Concentration deficits obvious even during brief conversation. Needs regular assistance from relatives or community services.

If the Life Insured permanently satisfies or meets the Mental Illness categories above, it must be solely due to a mental disorder diagnosed on a recognised diagnostic system.

When cover is structured through superannuation, the Life Insured must also satisfy the SIS definition of Permanent Incapacity.

Totally Unable to Work means that solely because of Sickness or Injury, the Life Insured is:

- not working in any capacity (this includes full-time, part-time and casual, whether or not for remuneration;
- following the advice and treatment plan of a Medical Practitioner in relation to the Sickness or Injury, and
- unable to perform all the duties necessary to generate income in the Life Insured's Own Occupation* (if the Life Insured is able to perform any duties necessary to generate income in their Own Occupation*, they are not Totally Unable to Work).

  *If the 'to age 65' Benefit Period applies, following the first 24 months of the Claim Period, Own Occupation will be replaced with Any Occupation.

Where Income Protection has been structured through superannuation, the Life Insured must also satisfy the SIS definition for Temporary Incapacity or Permanent Incapacity.

Underwriting is a process by which we assess risks associated with your application for insurance. The Underwriting process is based on the life to be insured's health and other relevant factors, such as occupation, pursuits and income.

Unemployed and **Unemployment** mean that the Life Insured is not employed or working in any Working Occupation. It does not include sick leave, sabbatical, long service, maternity or paternity leave.

Waiting Period means the period between the Life Insured becoming Totally Unable to Work or Partially Unable to Work, and the Totally Unable to Work Benefit or the Partially Unable to Work Benefit becoming payable.

If the Life Insured does not consult a Medical Practitioner concerning the Sickness or Injury causing disability within seven days of the Sickness starting or the Injury occurring, the Waiting Period will start when the Life Insured consults a Medical Practitioner.

War or an **act of war** means armed aggression, whether declared or not, by a country or organisation, resisted by any other country or organisation.

We, us and **our** mean TAL Life Limited (ABN 70 050 109 450) (AFSL 237848).

Whole Person Impairment means where a payment depends on the Life Insured meeting criteria based on the Whole Person Impairment, the calculation is to be based on the latest edition of the American Medical Association publication titled Guides to the Evaluation of Permanent Impairment until an equivalent Australian guide, sanctioned by the Australian Medical Association, has been produced, at which time the calculation in the relevant Australian guide will apply.

Working Occupation means an occupation in which the Life Insured is working and as a result, is expected to generate Earnings.

You and **your** means the Policy Owner and/or the Life Insured as applicable or as the context requires, unless indicated otherwise.

9.2 Superannuation/SIS definitions

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

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

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

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

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

9.3 Critical Illness events and specified condition definition

Angioplasty means the actual undergoing of Coronary Artery Angioplasty to correct a narrowing or blockage of one or more coronary arteries.

Angioplasty for Triple Vessel Disease means the actual undergoing for the first time of coronary artery angioplasty to correct a narrowing and/or blockage in three or more of the following major arteries in a single procedure:

- left main coronary artery;
- left anterior descending coronary artery;
- left circumflex coronary artery;
- right coronary artery.

In the event that not all coronary arteries can be corrected in a single procedure and a second procedure is required, a benefit will be payable provided the second procedure occurs no more than two months after the first.

Aortic Surgery (for specified conditions) means surgery to repair or correct an aortic aneurysm, an aortic dissection, an obstruction of the aorta, a coarctation of the aorta or traumatic Injury to the aorta. For the purpose of this definition, aorta means aortic arch, ascending aorta and descending aorta, but not its branches.

Aplastic Anaemia (requiring treatment) means bone marrow failure resulting in at least two of the following:

- anaemia;
- neutropenia; or
- thrombocytopenia; and

requiring one of the following:

- blood product transfusion;
- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

Benign Brain Tumour (resulting in irreversible neurological deficit) means a non-cancerous tumour in the brain (excludes cranial nerves), meninges, pituitary gland or spinal cord, resulting in an irreversible neurological deficit which has caused:

- permanent Whole Person Impairment of at least 25%; or
- the Life Insured to be totally and permanently unable to perform any one of the Activities of Daily Living.

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

Cysts, granulomas, vascular aneurysms or haematomas are not covered.

Blindness (permanent) means the permanent and irrecoverable loss of sight (whether aided or unaided) in both eyes as a result of Sickness or Injury to the extent that visual acuity in both eyes, on a Snellen Scale after correction by suitable lens is less than 6/60, or to the extent that the visual field is reduced to 20 degrees or less of arc.

Cancer (of specified criteria) means any malignant tumours diagnosed with histological or cytological confirmation and characterised by:

- the uncontrolled growth of malignant cells; and
- invasion and destruction of normal tissue beyond the basement membrane.

The term malignant tumour includes lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders.

The following are not covered:

- All tumours which are histologically described as any of the following:
  a. pre-malignant;
  b. non-invasive (includes tumours that are classified as Tis, Cis or pTa unless stated otherwise);
  c. low-grade or high-grade dysplasia; or
  d. borderline or low malignant potential.
- All carcinoma in situ except the following:
  a. Carcinoma in situ of the breast which requires the removal of the entire breast.
  b. Carcinoma of the breast which requires breast conserving surgery with either radiotherapy or chemotherapy.
  c. Carcinoma in situ of the testicle that requires removal of the entire testicle.
- All skin melanomas unless the melanoma:
  a. has evidence of metastasis;
  b. is at least Clark level 3;
  c. is showing signs of ulceration; or
  d. is greater than 1.0mm maximum thickness using the Breslow method.
- All non-melanoma skin cancers unless they have spread to the bone, lymph node or other distant organs.
- Chronic lymphocytic leukaemia unless it has progressed to Rai stage 1 or more.
- All prostatic cancers unless the prostate cancer:
  a. has a Gleason score of 6 or more; or
  b. requires major interventional therapy including radiotherapy, chemotherapy, biological response modifiers or any other major treatment to arrest the spread of malignancy.

If a surgical procedure is performed, it must be considered appropriate and necessary to arrest the spread of malignancy.

Carcinoma In Situ (of specified site) means the Life Insured has a carcinoma in situ, characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion and destruction of normal tissues beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method or FIGO Stage 0.

Only Carcinomas In Situ of the following sites are covered:

- Breast
- Cervix (Cervical Intraepithelial Neoplasia (CIN) classified as CIN-1 and CIN-2 are excluded).
- Endometrium
- Fallopian Tube (the tumour must be limited to the tubal mucosa)
- Ovary
- Penis
- Perineum
- Testicle
- Vagina
- Vulva

Cardiomyopathy (permanent) means a disease of the heart muscle characterised by structural, functional and/or electrophysiological dysfunction of the heart muscle, resulting in significant permanent and irreversible cardiac impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Chronic Kidney Failure (undergoing permanent dialysis) means undergoing permanent dialysis treatment prescribed by renal physician due to impairment of total kidney function to a severity constituting end stage kidney failure.

Chronic Liver Failure (resulting in permanent symptoms) means end-stage decompensated liver failure characterised by the presence of liver cirrhosis and development of complications of cirrhosis, including jaundice, ascites and/or encephalaopathy.

Chronic Lung Failure (on permanent oxygen therapy) means end-stage lung disease with a consistent pulmonary function test result of:

- FEV1 less than 40% predicted; or
- a DLCO less than 40% predicted; and
- on permanent oxygen therapy.

Coma (of specified severity) means a state of unconsciousness which requires mechanical ventilation by means of tracheal intubation for at least three consecutive days (72 hours).

Congenital Blindness (permanent) means a congenital, total and permanent loss of sight in both eyes whether aided or unaided, confirmed by an appropriate specialist Medical Practitioner.

Congenital Deafness (permanent) means irrecoverable profound loss of all hearing in both ears, resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500, 1000 and 3000 hertz, both natural and assisted, as a result of a congenital condition. The condition must be diagnosed by an appropriate specialist Medical Practitioner.

Coronary Artery Bypass Surgery means bypass grafting performed to correct or treat coronary artery disease.

Deafness (permanent) means the irrecoverable profound loss of all hearing in both ears, resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500, 1000 and 3000 hertz, both natural and assisted, as a result of Sickness or Injury. The condition must be diagnosed by an appropriate specialist Medical Practitioner.

Dementia including Alzheimer's Disease (permanent) means the unequivocal diagnosis of dementia by a consultant neurologist or geriatrician. The diagnosis must confirm dementia or Alzheimer's Disease due to permanent failure of brain function with associated cognitive impairment. A Mini-Mental State Examination score of 24 or less out of 30 is required.

Diagnosed Benign Brain Tumour (of specified severity) means a non-cancerous tumour in the brain (excludes cranial nerves), pituitary gland, meninges or spinal cord giving rise to symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures, sensory impairment or motor impairment. The presence of the tumour must be confirmed by CT Scan, MRI or other imaging studies.

Cysts, granulomas, vascular aneurysms and haematomas are not covered.

Diagnosed Dementia means the unequivocal diagnosis of dementia by a neurologist or geriatrician.

Disseminated Intravascular Coagulation (pregnancy related) means due to pregnancy, an over-activation of the coagulation and fibrinolytic system occurs, resulting in thrombosis, consumption of platelets and coagulation factors causing life threatening haemorrhage or thrombosis at multiple sites.

Down's Syndrome means a specific genetic condition caused by an extra chromosome 21, which causes intellectual disability and characteristic physical features.

Early Stage Chronic Lymphocytic Leukaemia means the diagnosis of chronic lymphocytic leukaemia with pathological confirmation of Rai Stage 0, which is defined to be in the blood and bone marrow only.

Early Stage Skin Melanoma (excluding melanoma in situ) means the diagnosis of one or more malignant skin melanomas with histological confirmation of the tumour which are:

- 1.0mm or less maximum thickness using the Breslow method; or
- classified as Clark level 2 (Clark level 1 is not covered).

Early Stage Prostate Cancer means the diagnosis of a malignant tumour confined within the prostate with pathological confirmation of a Gleason Score of 2, 3, 4, or 5.

Eclampsia of Pregnancy means the occurrence of new-onset generalised tonic-clonic seizures or coma in a woman with pre-eclampsia (including HELLP syndrome) or gestational hypertension.

Ectopic Pregnancy (occurring in the fallopian tube) means a fertilised ovum has implanted outside the uterine cavity resulting in the rupturing or haemorrhaging of a fallopian tube, which results in a laparotomy or laparoscopic surgery removing the involved fallopian tube.

Encephalitis (resulting in permanent neurological deficit) means the unequivocal diagnosis of encephalitis where the condition is characterised by severe inflammation of the brain resulting in permanent neurological deficit causing:

- permanent Whole Person Impairment of at least 25%; or
- the Life Insured being totally and permanently unable to perform any one of the Activities of Daily Living.

The diagnosis must be confirmed by structural brain imaging, EEG and/or cerebrospinal fluid analysis.

Heart Attack (of specified severity) means the death of a portion of the heart muscle because of inadequate blood supply to the relevant area.

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

- signs and symptoms of ischaemia consistent with acute myocardial infarction;
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]);
- development of pathological Q waves in the ECG; or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, other appropriate and medically recognised tests will be considered or, if at least three months after the event the insured's left ventricular ejection fraction is less than 50%.

The following are not covered:

- A rise in biological markers because of an elective percutaneous procedure for coronary artery disease.
- Other acute coronary syndromes including but not limited to angina pectoris.

Heart Valve Surgery means surgery to replace or repair a cardiac valve because of a cardiac valve abnormality or other cardiac defects.

Hydatidiform Mole means abnormal fertilisation which results in abnormal development and proliferation of placental tissue in the absence of normal embryonic development confirmed by histopathological evidence.

Idiopathic Pulmonary Arterial Hypertension (of specified severity) means idiopathic pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in physical permanent impairment to the degree of at least Class 3 of New York Heart Association classification of cardiac impairment. The condition must be diagnosed by an appropriate specialist Medical Practitioner.

Loss of use of a Single Limb (permanent) means the total and irrecoverable loss of use of one Limb.

Loss of Hearing in One Ear (permanent) means:

- the irrecoverable profound loss of all hearing in one ear, resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500, 1000 and 3000 hertz, both natural and assisted, as a result of Sickness or Injury; or
- the irrecoverable profound loss of hearing (resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500, 1000 and 3000 hertz) as a result of Sickness or Injury, requiring the Life Insured to undergo cochlear implantation (includes unilateral or bilateral implantation).

The condition must be diagnosed by an appropriate specialist Medical Practitioner.

Loss of Independent Existence (permanent) means that solely because of Sickness or Injury, the Life insured:

- is totally and permanently unable to perform at least two of the five Activities of Daily Living without the physical assistance of another person; or
- suffers permanent Significant Cognitive Impairment.

Loss of use of Limbs (permanent) means the total and irrecoverable loss of use of two or more Limbs.

Loss of Sight in One Eye (permanent) means the permanent and irrecoverable loss of sight (whether aided or unaided) in one eye, because of Sickness or Injury to the extent that visual acuity in the eye, on a Snellen Scale after correction by a suitable lens is less than 6/60, or to the extent that the visual field is reduced to 20 degrees or less of arc.

Loss of Speech (permanent) means the total and irrecoverable loss of the ability to produce intelligible speech, because of permanent damage to the larynx or its nerve supply or to the speech centres of the brain, due to Sickness or Injury.

Lupus (of specified severity) requires diagnosis confirmed by an appropriate specialist Medical Practitioner and such diagnosis must be based on the current diagnostic criteria established by the American College of Rheumatology or Systemic Lupus International Collaborating Clinics Classification Criteria. Pathological evidence of such diagnosis must be provided. There must also be evidence-based involvement of one of the following systems:

- cardiac;
- pulmonary;
- nervous system; or
- renal.

Major Head Trauma (with permanent neurological deficit) means Accidental head Injury resulting in neurological deficit causing:

- permanent Whole Person Impairment of at least 25%; or
- the Life Insured or Child Insured being totally and permanently unable to perform any one of the Activities of Daily Living.

Major Organ Transplant (of specified organs) means either the undergoing of, or upon the advice of a specialist Medical Practitioner the placement on a waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit for, the human to human transplant from a donor (who is not the Life Insured or Child Insured) to the Life Insured or Child Insured of one of the following:

- bone marrow;
- kidney;
- heart;
- lung;
- liver;
- pancreas; or
- small bowel.

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

Medically-Acquired HIV (contracted from a medical procedure or operation) means accidental infection, after the Plan start date, with the human immunodeficiency virus (HIV) where the virus was acquired in Australia by the Life Insured from one of the following medically necessary events conducted by a recognised and registered health professional:

- a blood transfusion;
- transfusion with blood products;
- organ transplant to the Life Insured;
- assisted reproductive techniques; or
- a medical procedure or operation performed by a Medical Practitioner or dentist.

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

HIV infection transmitted by any other means including sexual activity or the use of drugs, other than as prescribed by a Medical Practitioner for the Life Insured is excluded.

This Critical Illness event will not apply and no payment will be made where:

- the Life Insured has not followed the advice of a Medical Practitioner; or
- a *functional cure* has become available.

A *functional cure* is where the Life Insured had:

- been fully cured from the HIV infection; or
- achieved a level of health where the HIV infection does not prevent the Life Insured from working in their Own Occupation. We will make this assessment based on the opinion from the relevant medical specialist and/or relevant governing body of the Life Insured's profession, if applicable.

Meningitis (resulting in permanent neurological deficit) means the unequivocal diagnosis of meningitis where the condition is characterised by severe inflammation of the meninges of the brain resulting in permanent neurological deficit causing:

- permanent Whole Person Impairment of at least 25%; or
- the Life Insured being totally and permanently unable to perform any one of the Activities of Daily Living.

The diagnosis must be confirmed by structural brain imaging, EEG and/or cerebrospinal fluid analysis.

Meningococcal Septicaemia (resulting in significant permanent impairment) means the unequivocal diagnosis of meningococcal septicaemia causing:

- permanent Whole Person Impairment of at least 25%; or
- the Life Insured being totally and permanently unable to perform any one of the Activities of Daily Living.

The diagnosis must be confirmed by blood culture analysis.

Multiple Sclerosis (with multiple episodes of neurological deficit and persisting neurological abnormalities) means a disease characterised by demyelination in the brain and/or spinal cord. Multiple Sclerosis must be unequivocally diagnosed by an appropriate specialist Medical Practitioner. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities.

Neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, and evoked auditory responses are required to confirm diagnosis.

Muscular Dystrophy means the unequivocal diagnosis of muscular dystrophy by an appropriate specialist Medical Practitioner. The diagnosis must be supported by appropriate clinical investigations including genetic test, muscle biopsy or electromyography.

Occupationally-Acquired Hepatitis B or C means infection, after the Plan start date, with Hepatitis B or C where the infection is acquired because of:

- an accident arising out of the life insured's normal occupation; or
- a malicious act of another person or persons arising out of the Life Insured's normal occupation.

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

Any incident giving rise to a potential claim must be:

- reported to the relevant authority or employer within seven days of the incident;
- reported to us with proof of the incident within 30 days after the incident; and
- supported by a negative Hepatitis B or C test taken within seven days of the incident.

The infection must manifest itself within six months of the accident or malicious act.

This Critical Illness Event will not apply, and no payment will be made if:

- the infection occurred directly or indirectly, as a result of an intentional self-inflicted act by the Life Insured;
- the Life Insured has not followed the advice of a Medical Practitioner;
- the Hepatitis B or C infection resulted from sexual activity or drug use not medically prescribed for the Life Insured; or
- the Life Insured achieves a *functional cure*.

A *functional cure* is where the Life Insured had:

- been fully cured from the infection; or
- achieved a level of health where the infection does not prevent the Life Insured from working in their Own Occupation. We will make this assessment based on the opinion from the relevant medical specialist and/or governing body of the Life Insured's profession, if applicable.

Occupationally-Acquired HIV means infection after the Plan start date, with the human immunodeficiency virus (HIV) where the infection is acquired because of:

- an accident arising out of the Life Insured's normal occupation; or
- a malicious act of another person or persons arising out of the Life Insured's normal occupation.

The infection must be diagnosed with a positive anti-HIV antibody test result within six months of the reported occurrence. Proof of the new HIV infection must be reported and registered within six months of the accident or malicious act.

Any incident giving rise to a potential claim must be:

- reported to the relevant authority or employer within seven days of the incident;
- reported to us with proof of the incident within 30 days after the incident; and
- supported by a negative HIV test taken within seven days of the incident.

This Critical Illness event will not apply and no payment will be made if:

- the infection occurred directly or indirectly, as a result of an intentional self-inflicted act by the Life insured;
- the Life Insured has not followed the advice of a Medical Practitioner;
- the HIV infection resulted from sexual activity or drug use not medically prescribed for the Life Insured; or
- the Life Insured achieves a *functional cure*.

A *functional cure* is where the Life Insured has:

- been fully cured from the infection; or
- achieved a level of health where the infection does not prevent the Life Insured from working in their Own Occupation. We will make this assessment based on the opinion from the relevant medical specialist and/or governing body of the Life Insured's profession, if applicable.

Open Heart Surgery means the undergoing of open chest surgery for the surgical treatment of a cardiac defect, cardiac aneurysm or benign cardiac tumour.

Out of Hospital Cardiac Arrest (requiring cardiopulmonary resuscitation) means a loss of cardiac output resulting in unresponsiveness and requiring cardiopulmonary resuscitation intervention, that is not associated with any medical procedure and is due to:

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

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

If ECG evidence is not available, other medical evidence that unequivocally confirms a cardiac arrest has occurred will be considered. Such evidence may include ambulance or hospital medical records.

Cardiac arrest resulting from alcohol or drug abuse is excluded.

Paralysis (permanent) means the total and permanent loss of function of two or more limbs through Sickness or Injury causing permanent damage to the nervous system. This includes, but is not limited to, quadriplegia, paraplegia, diplegia and hemiplegia.

Parkinson's Disease (permanent) means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease by an appropriate specialist Medical Practitioner, caused by degeneration of the nigrostriatal system and as characterised by the clinical manifestation of bradykinesia in combination with at least one of the following:

- rigidity; or
- rest tremor.

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

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

Progressive and Debilitating Motor Neurone Disease means the unequivocal diagnosis of a progressive form of debilitating Motor Neurone Disease by an appropriate specialist Medical Practitioner.

The diagnosis must be supported by ancillary testing (e.g. clinical neurophysiology) and exclusion of other causes by imaging and appropriate investigations.

Severe Burns (covering at least 20% of the body's surface area) means tissue Injury caused by thermal, electrical or chemical agents causing full thickness burns to at least:

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

Severe Crohn's Disease (unresponsive to therapy) means the unequivocal diagnosis of Crohn's disease that has failed to be controlled by standard therapy including steroid treatment, immunosuppressive medication and biologic therapies.

The diagnosis must be confirmed by an appropriate specialist Medical Practitioner.

Severe Diabetes Mellitus (of specified severity) means that an appropriate specialist Medical Practitioner has confirmed that at least two of the following complications have occurred as a direct result of diabetes:

- severe diabetic retinopathy resulting in visual acuity (whether aided or unaided) of 6/36 or worse in both eyes;
- severe diabetic neuropathy causing motor and/or autonomic impairment;
- diabetic gangrene leading to surgical intervention; or
- severe diabetic nephropathy causing chronic irreversible renal impairment as demonstrated with a glomerular filtration rate of 15 to 30 ml/min (stage 4 kidney disease).

Severe Osteoporosis (of specified severity) means, where the bone mineral density has a T-score of less than -2.5 (i.e. 2.5 standard deviations below the adult mean for bone density) measured in at least two sites by dual-energy x-ray densitometry (DEXA) or quantitative CT scanning is consistent with severe osteoporosis with:

- at least two vertebral body fractures occurring before the age of 65; or
- fracture of the neck of the femur.

Severe Ulcerative Colitis (unresponsive to therapy) means the unequivocal diagnosis of ulcerative colitis that has failed to be controlled by standard therapy including steroid treatment, immunosuppressive medication and biologic therapies.

The diagnosis must be confirmed by an appropriate specialist Medical Practitioner.

Spina Bifida Myelomeningocele means a defective closure of the spinal column resulting in a neural tube deficit with a resultant myelomeningocele or meningocele and associated neurological deficit confirmed by a Medical Practitioner. Spina bifida occulta is excluded.

Stillbirth means the foetal death in utero or during delivery, after at least 20 weeks gestation and confirmed by an appropriate specialist Medical Practitioner. Elective pregnancy termination is excluded.

Stroke (resulting in neurological deficit) means a cerebrovascular event producing a new neurological deficit confirmed through clinical examination. This requires clear evidence on a CT, MRI or similar, appropriate scan or investigation that a stroke has occurred and of infarction of brain tissue, intracerebral and/or subarachnoid haemorrhage.

The following are not covered:

- transient ischaemic attacks;
- non-stroke related reversible neurological deficit;
- cerebral injury resulting from trauma;
- cerebral injury resulting from hypoxia;
- vascular disease affecting the eye or optic nerve;
- ischaemic disorders of the vestibular system;
- migraine or neurological deficit due to migraine.

Tetralogy of Fallot means an anatomical defect with severe or total right-ventricular outflow tract obstruction and a ventricular septal defect allowing right- ventricular deoxygenated blood to bypass the pulmonary artery and enter the aorta directly.

The diagnosis must be supported by an echocardiogram, and invasive surgery must be performed to correct the condition.

Transposition of Great Vessels means a congenital heart defect where the aorta arises from the right ventricle and the pulmonary artery from the left ventricle.

The diagnosis must be based on an echocardiogram and invasive surgery must be performed to correct the condition.

Type 1 Diabetes diagnosed after age 30 means the diagnosis of Type 1 diabetes mellitus after the age of 30 for which insulin is required, diagnosed by an appropriate specialist Medical Practitioner.

10 Interim cover

Interim Cover
Interim Cover is issued by us.

This section sets out important information about Interim Cover. In this section references to 'you' or 'your' includes the life to be insured.

We provide you with limited Interim Cover at no additional cost while your application is being assessed.

Interim Cover is subject to:

- the terms and conditions which apply to the Plan(s) being applied for as set out in the Accelerated Protection Policy Document; and
- the additional terms and conditions for Interim Cover, as follows.

Interim Cover is subject to the Accelerated Protection Underwriting guidelines. This means we may be unable to verify the amount of Interim Cover (if any) until our assessment of your application is completed. Any conditions or restrictions that would have applied to your Policy based on our Underwriting guidelines will also apply to any Interim Cover claim you may make.

A claim during the Interim Cover period will affect our assessment of your application and the terms of any Policy that we may subsequently issue to you or the Policy Owner. Any benefits payable under Interim Cover are payable to the Policy Owner, except where the Policy is structured through superannuation. If the Policy is to be structured through superannuation, we will pay the Benefit Amount directly to you. If Death benefit is payable, it will be paid to your legal personal representative. For Superlink IP and Superlink TPD applications, any benefits payable will be paid under the non-superannuation Policy.

If you suffer a Sickness or Injury before your application being accepted by us (but after we receive your application), that Sickness or Injury will be taken into account in our assessment of your application once a decision on your Interim Cover claim is finalised.

When does Interim Cover start?
Cover will start from the date we receive your fully completed, signed and dated application form.

If you are applying for cover through a financial adviser and your adviser has requested that we obtain the answers to the health and lifestyle questions in the electronic application form directly from you, cover will start from the date we receive the answers to these questions.

For Income Protection insurance, you must be Totally unable to Work at the end of the applied for Waiting Period to be eligible for the Interim Cover benefit.

When does Interim Cover end?
Interim Cover will end for each Plan applied for upon the earliest of:

- the Plan start date;
- the date you withdraw your application;
- the expiration of 90 days from when we receive a fully completed application form; or
- we inform your financial adviser that your Plan has not been accepted.

Interim Cover Benefit

Plan type	Benefit
Life Insurance	If the life to be insured dies we will pay the Interim Cover Benefit for Life insurance.
TPD Insurance	If the life to be insured becomes Totally and Permanently Disabled, we will pay the Interim Cover Benefit for TPD insurance. The definition of TPD will be that applied for in the application except that where an 'Own Occupation' definition is sought the 'Any Occupation' definition will apply to Interim Cover. Unless TPD insurance is Attached or Linked the life to be insured must survive for at least 14 days after the event that caused Total and Permanent Disability.
Critical Illness Insurance	If the life to be insured suffers a Critical Illness Standard condition listed in Section 2.3.1 of this PDS that does not have a [1] next to the named condition, we will pay the Interim Cover Benefit for Critical Illness insurance. Unless Critical Illness insurance is Attached or Linked the life to be insured must survive for at least 14 days after suffering the Critical Illness Event.
Child's Critical Illness Insurance	If the child to be insured suffers a Critical Illness condition listed in Section 2.5.1 of this PDS that does not have a [1] next to the named condition, we will pay the Interim Cover Benefit for Child's Critical Illness insurance.
Income Protection	If the life to be insured becomes Totally Unable to Work, we will pay the Interim Cover Benefit for Income Protection insurance. Interim Cover applies to the Totally Unable to Work Benefit and Super Contribution Option only. Interim Cover does not apply to any other benefits or any optional benefits under Income Protection.

Benefit Amount Payable

The Interim Cover Benefit we will pay will be the lesser of:

- the Benefit Amount applied for;
- the difference between the Benefit Amount applied for and any existing insurance with TAL or any other insurer which you stated on your application form is to be replaced;
- the reduced Benefit Amount that would be offered where, under our Underwriting rules, we would offer a lower Benefit Amount to that applied for;
- the reduced Benefit Amount the premium would purchase where we would apply a premium adjustment under our Underwriting rules; and
- the maximum amount payable under Interim Cover for each type of cover as specified below:

Plan type	Maximum Benefit payable
Life Insurance	$1,000,000
TPD Insurance	$500,000
Critical Illness Insurance	$500,000
Child's Critical Illness Insurance	$50,000
Income Protection	$10,000 per month, subject to adjustments, offsets and limited to a maximum of 12 months

The maximum amount payable is limited to a total amount payable of $1,000,000 for any one life to be insured in respect of all insurances, with TAL or any other insurer, under Interim Cover.

If an electronic application form is submitted by your financial adviser and your cover is accepted by our online Underwriting engine, these maximums do not apply, and we will cover the life to be insured based on the Benefit Amount applied for.

When we will not pay the Interim Cover

We will not pay any benefits under the Interim Cover where:

- a claim is paid under the Interim Rollover Cover Benefit;
- the Underwriting decision appropriate at the time immediately preceding the Sickness or Injury for which the Interim Cover claim is made, would have been to decline cover or exclude that Sickness or Injury;
- we are unable to complete our Underwriting assessment and your Interim Cover claim is due to Sickness;
- the Sickness or Injury resulted from participation in any travel, occupation, sport or pastime which we would not normally provide cover (or accepted cover only with a loading or restriction) to the insured person during their participation in such travel, occupation, sport or pastime; or
- the condition being claimed for was caused by, or in any way contributed to by:
  - — suicide;
  - — an intentional self-inflicted act;
  - — use of alcohol, recreational or non-prescription drugs, or any drug taken other than as medically directed;
  - — participation in a criminal act and/or for any period that they are incarcerated due to their participation in a criminal act;
  - — a permanent or temporary banning, deregistration, disqualification or restriction from performing all or some of the duties of their Working Occupation; or
  - — any Sickness, Injury or medical condition you were aware of, or a reasonable person in your position would have been aware of, at any time before the date of the application.

Cover will also be restricted or may not be available if you or the life to be insured have not complied with the duty to take reasonable care not to make a misrepresentation or would not have been entitled to the amount of cover applied for in your application.

11 Interim Rollover Cover Benefit

The Interim Rollover Cover Benefit provides you with cover on the same terms as your accepted Accelerated Protection application while we are waiting for your nominated superannuation fund to transfer premium payment via rollover.

The Interim Rollover Cover Benefit is applicable where:

- the policy owner is Mercer Superannuation (Australia) Limited ABN 79 004 717 533, AFSL 235906, as the trustee for TAL Super; and
- the premiums are paid via rollover from your nominated superannuation fund.

The Interim Rollover Cover Benefit starts when we agree to insure you and have received all the necessary requirements to enable us to issue your Policy (including any superannuation fund payment details).

The Interim Rollover Cover Benefit will cease upon the earliest of:

- the expiration of 30 days from the Interim Rollover Cover Benefit start date;
- the Plan start date as stated in the Policy Schedule; or
- the date you withdraw your application with us.

If your Policy has not been issued after the expiration of 30 days from the Interim Rollover Cover Benefit start date, the remaining balance of your Interim Cover will continue. Please refer to Section 10 to understand when your Interim Cover ends.

The Interim Rollover Cover Benefit is subject to the terms and conditions which apply to the Plan(s) being applied for as set out in this PDS. Please note some additional terms and conditions as follows:

- It applies to a Plan which is funded by rollover and all Plans included in the same application.
- All claims will be subjected to the terms and conditions of the applicable Accelerated Protection Plan you applied for and where applicable, the special condition(s) that you've agreed to.
- If Life Insurance and/or TPD Insurance is structured through superannuation, any benefit payable under Interim Rollover Cover Benefit will be paid to the Life Insured or to the estate of the Life Insured as applicable.
- If Income Protection is structured through superannuation, any benefits payable under Interim Rollover Cover Benefit will be paid to the Life Insured or to the estate of the Life Insured as applicable. Benefits payable from the Policy start date will be paid to the Policy Owner.
- Any claim paid because of the Interim Rollover Cover Benefit will not affect our offer of insurance provided you have complied with your duty to take reasonable care not to make a misrepresentation.
- The Interim Rollover Cover Benefit does not apply where a policy being replaced is not cancelled.

12 Direct debit arrangements

This Direct Debit Request Service Agreement (DDR Agreement) is issued by TAL (as an agent of MSAL in relation to TAL Super), to enable you to understand your rights and responsibilities as a new customer when making premium payments by direct debit. It allows TAL to debit your nominated account to meet the premiums for your Policy.

Please keep this DDR Agreement in a safe place for future reference.

Our commitment to you
We ensure that we:

- will give you at least 14 days written notice if there are any changes to the terms of this DDR Agreement; and
- will keep all information relating to your nominated financial institution account confidential, except where required for conducting direct debits with your financial institution, or otherwise as required by law.

Your commitment to us
If you do commit to a DDR Agreement, please ensure that:

- the account you have nominated can accept direct debits;
- all account holders for this nominated account agree to this Agreement; and
- that there are enough funds available in the nominated account, on the due dates, to cover the premiums. If there isn't, you may incur dishonour fees from your financial institution and your Policy may be cancelled. Dishonour fees will not be charged by TAL.

If a premium due date falls on a weekend or a public holiday, we will automatically debit the payment on the next business day.

If you provide us, directly or indirectly, with new or updated bank account details (for payment through the direct debit system), these conditions will also apply to that request.

How to make changes
Please give us at least 7 days' notice before your next premium due date for either:

- altering any of your direct debit or financial institution details; or
- stopping or suspending any debits or cancelling the DDR Agreement completely.

If you do any of these, you will need to make alternative arrangements for future premiums to continue your Policy.

If you prefer you may contact your financial institution directly to alter, stop, cancel or dispute any debit. If you alter your direct debit details with your financial institution, your financial institution may alter your debit payment only to the extent of advising us of your new account details.

Contacting us
If you wish to make any of the changes, as outlined above, or wish to dispute a debit you can do so in writing or by phone. The contact details are:

TAL Life Limited or the trustee for TAL Super
GPO Box 5380, Sydney NSW 2001
1300 209 088

We will always respond to your query or dispute in the first instance.

Please refer to our website at www.tal.com.au to obtain a copy of our current Payment Authority form.

About us

TAL is a **leading life insurer**, here to help Australians protect what matters most: the experiences we share with those we love

Our **150 years' experience** ensures we can protect you, your loved ones and the future you've planned together

Get in touch

Customer Service Centre:
1300 209 088

Adviser Service Centre:
1300 286 937

Monday to Friday 8am – 7pm AEST

www.tal.com.au

Accelerated Protection through TAL Super

PRODUCT DISCLOSURE STATEMENT

Accelerated Protection Combined Product Disclosure Statement and Policy Document
Issue date 5 August 2022

TAL Life Limited | ABN 70 050 109 450 | AFSL 237 848
GPO Box 5380 Sydney NSW 2001

TALR7983/0822

ISSUE DATE 5 AUGUST 2022

TAL / ACCELERATED PROTECTION

Important information about this document

This Product Disclosure Statement (PDS) gives you important information about structuring Accelerated Protection through TAL Super.

This PDS is jointly issued by TAL Life Limited (ABN 70 050 109 450, AFSL 237848) (TAL) and Mercer Superannuation (Australia) Limited (ABN 79 004 717 533, AFSL 235906) (MSAL). You should read this PDS in conjunction with the Accelerated Protection Combined Product Disclosure Statement and Policy Document (AP Combined PDS and Policy Document) which contains detailed information about the benefits, options, conditions and limitations of Accelerated Protection.

TAL Super is a plan within the Retail Division in the Mercer Super Trust (ABN 19 905 422 981) and is sponsored by TAL Services Limited (ACN 076 105 130) (TAL Services). TAL Services is a related body corporate of TAL that provides administration services, insurance services and indemnities to MSAL.

TAL Super provides members with access to life insurance through superannuation. Contributions and rollovers made to TAL Super are only used for the purposes of paying insurance premiums. Members do not have an account balance in TAL Super and therefore there is no investment component.

TAL is the issuer of the life insurance product structured through TAL Super but is not responsible for TAL Super and does not issue, underwrite or guarantee the superannuation interest described in this PDS. MSAL is the Trustee (the Trustee) of TAL Super and is not responsible for the life insurance product or the payments to be made under the life insurance product.

An application for insurance can be submitted by your adviser acting on your behalf. Applications to the Trustee for membership of TAL Super are made along with the application for insurance.

Where Accelerated Protection is structured through TAL Super, the Trustee will be noted as the Policy Owner and will hold the Policy on behalf of the Life Insured member. Your interest in TAL Super is governed by the Master Deed of the Mercer Super Trust dated 28 June 1995, as amended from time to time (Trust Deed) as well as the terms and conditions of the Policy. Any benefit payable under the Policy will be paid by TAL to the Trustee. The Trustee is responsible for paying the benefits out of TAL Super. Restrictions may apply to these benefit payments under the Trust Deed and superannuation law. A copy of the Trust Deed can be obtained, free of charge at www.mercersuper.com.au/documents/governance-and-trustee-documents/ under *Designated rules*.

The information contained in this PDS is general information only. TAL and the Trustee have not taken into account your objectives, financial situation or needs. You should consider the appropriateness of the information in this PDS, taking into account your objectives, financial situation and needs, before acting on any information in this PDS. Information about tax provided in this PDS is a guide only and is based on our understanding of the tax laws that were current at the date of the PDS. These laws can change and the Trustee recommends you speak to your tax adviser regarding the tax consequences of holding insurance cover through superannuation.

The information in this PDS may change from time to time. You can obtain update information that is not materially adverse to you at www.tal.com.au/talsuper Please contact us if you'd like a free printed copy of the updated information. Changes that are materially adverse to you will be advised as required by law.

We are here to help

If you have any questions, contact us on:

TAL

1300 209 088

customerservice@tal.com.au

www.tal.com.au

GPO Box 5380, Sydney NSW 2001

MSAL

1300 209 088

customerservice@tal.com.au

www.tal.com.au/talsuper

GPO Box 4303, Melbourne, VIC 3001

Terms used in this document

There are a number of terms in this PDS which have a particular meaning. Where a defined term is used in this PDS, the initial letter(s) is capitalised (e.g. 'Policy Owner'). The only exceptions are 'you', 'your', 'we', 'us and 'our' which are not capitalised. Defined terms include the following:

Life Insured means the person(s) whose life is insured under the Policy.

Mercer refers to Mercer (Australia) Pty Ltd (ABN 32 005 315 917).

MSAL refers to Mercer Superannuation (Australia) Limited (ABN 79 004 717 533) (AFSL 235906) as the trustee of TAL Super.

Plan means insurance benefit and applicable options under Accelerated Protection.

Policy means the Plans and options listed in the Policy Schedule and the applicable terms and conditions in the Accelerated Protection Combined PDS and Policy Document.

Policy Owner means the person, company or trustee who legally owns the Policy.

Policy Schedule refers to the legal document that states the Plan start and end date and states the Plans' options and special conditions applicable to you.

SIS refers to the Superannuation Industry (Supervision) Act 1993 and/or the Superannuation Industry (Supervision) Regulations 1994, as applicable.

TAL refers to TAL Life Limited (ABN 70 050 109 450) (AFSL 237848).

TAL Services refers to TAL Services Limited (ACN 076 105 130).

TAL Super is a plan within the Retail Division in the Mercer Super Trust (ABN 19 905 422 981).

Trust Deed means the Master Deed of the Mercer Super Trust, dated 28 June 1995 (as amended from time to time), together with the governing rules applicable to TAL Super.

Trustee refers to MSAL.

We, us and **our** refers to TAL and/or MSAL.

You and **your** means the Life Insured or the person (excluding the Trustee) applying for insurance on behalf of the Life Insured, as applicable.

Contents

1 Accelerated Protection through TAL Super

The following information is provided to assist you in understanding your membership in TAL Super. It is general information only and is not intended to be a comprehensive statement of the laws applying to superannuation. You should talk to your financial adviser about your personal circumstances.

TAL Super provides members with insurance benefits within superannuation. Some of the key features are:

- Members can obtain Life Insurance, Total and Permanent Disability (TPD) Insurance and Income Protection through TAL Super.
- TAL Super does not offer a superannuation savings facility that has an investment component. You will not receive an investment return on contributions made to your account.
- MSAL will only accept contributions and rollovers to pay the premiums for insurance policies held through TAL Super.
- Membership of TAL Super is for the provision of insurance benefits only.
- The Trustee may reduce your contributions if it has claimed a tax deduction for the premiums funded by the payment.
- The Trustee will only accept your application for membership of TAL Super if your application for insurance is accepted by TAL.

This PDS provides important information about structuring your Accelerated Protection insurance through TAL Super, the tax treatment that may apply, your options for meeting the costs of the insurance, and the potential risks of holding insurance through TAL Super. If you structure Accelerated Protection through TAL Super and pay via rollover, the cost of premiums paid will gradually reduce your superannuation over time. You should consider your retirement needs and insurance protection objectives when structuring your insurance through TAL Super.

Once your application has been accepted, TAL will issue a Policy to MSAL and you will be the Life Insured. You will receive a copy of the Accelerated Protection Combined PDS and Policy Document as well as the Policy Schedule. The AP Combined PDS and Policy Document contains the full terms and conditions. The Policy Schedule will list the applicable Plans and options that you've selected and any special conditions that are applicable to the Policy. You should be aware that limitations and exclusions will apply under the Policy. This means that in some cases we will not pay a claim or will pay a claim only in limited circumstances.

You will only be entitled to a benefit if an insured event occurs while you are covered under the Policy, and you have satisfied a condition of release under SIS. The insured events under the policies offered in TAL Super are consistent with the conditions of release. If a benefit is payable under a policy the Trustee will direct TAL to pay it to you or your beneficiaries as a superannuation benefit.

You can change your mind

If you change your mind about purchasing insurance with us within 30 days of the date we issue your Policy, you can cancel the Policy and the Trustee will receive a full refund. However, your refund may be subject to superannuation preservation rules. So instead of a cash payment, your refund may be returned to the trustee of the superannuation fund from which the premium originally came. This only applies if you haven't made a claim. To receive your refund, simply provide us with a written signed request to cancel the Policy within the 30 days. And you don't have to tell us why you've changed your mind.

If you nominate a superannuation arrangement that does not accept the premium refund, the Trustee can only pay the refund to the Australian Taxation Office (ATO).

Contributions to TAL Super

Contributions can only be made to TAL Super in accordance with superannuation law. Superannuation law stipulates the way in which employer and personal contributions can be made as well as work requirements and age limits in relation to the acceptance of superannuation contributions for members.

Please note that the Trustee only accepts contributions to pay for insurance premiums. In circumstances agreed by the Trustee and TAL, an overpayment of premium may be held and applied to reduce future premiums. You will not receive interest or an investment return on contributions made.

How to make contributions to TAL Super

- Direct debit;
- Credit card;
- BPAY®; or
- Rollover (yearly payments only).

Payment of insurance premiums by rollover

- If you are funding your insurance premiums from another superannuation account, you should ensure that the cost of premiums do not erode your retirement savings.
- Some superannuation funds are prevented from making rollovers to pay for insurance cover through superannuation – you should check whether your superannuation fund is able to pay a rollover.

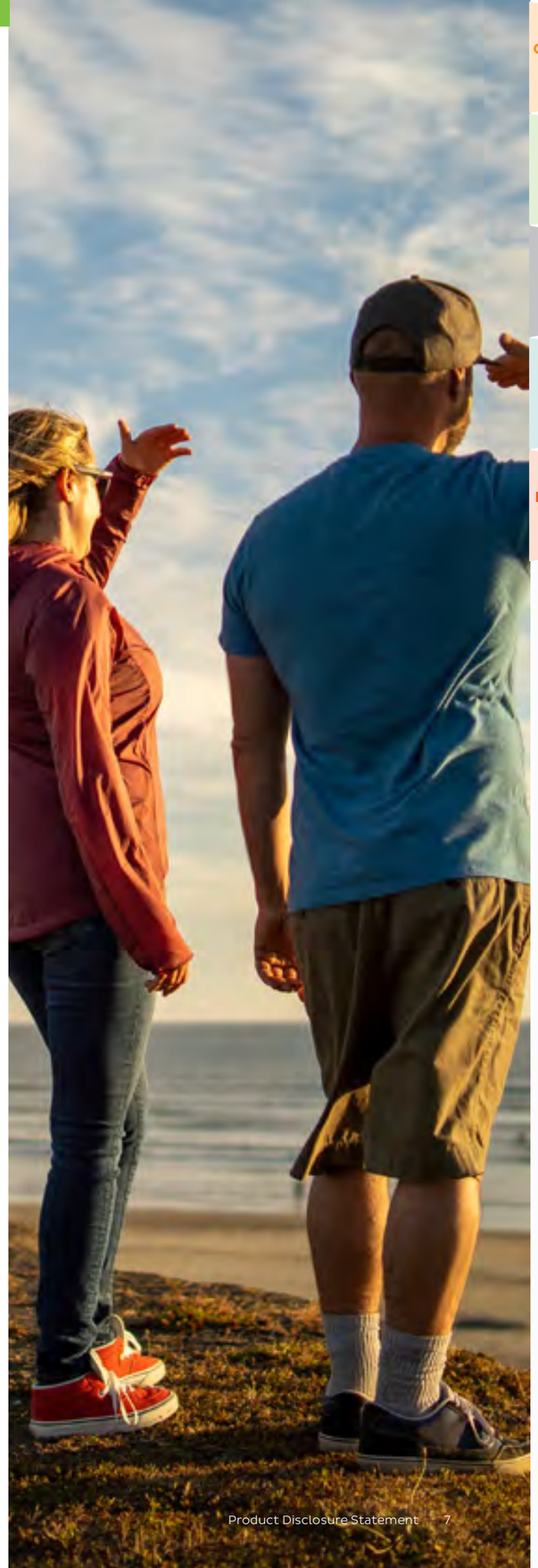
Superannuation – Further points to consider

- The laws governing superannuation are complex and the statements provided here are general in nature and based on current law;
- You should obtain your own independent advice on the taxation implications of joining TAL Super and in maintaining insurance cover through TAL Super; and
- As your circumstances change, so may the tax treatment of your contributions and any other payments made through TAL Super.

Risks of holding insurance through superannuation

There are risks you should consider before deciding to hold insurance through superannuation, including:

- Except for Income Protection benefits, a benefit paid from TAL Super is a superannuation benefit for tax purposes and it may be subject to more tax than would otherwise apply if the benefit was paid from the same insurance held outside of superannuation.
- Limits apply to the amount you can contribute to superannuation each year.
- Where you choose to pay premiums by rollover from another superannuation fund, your retirement savings will be reduced so that you will have less available to you on retirement than otherwise would have been the case.
- Taxation or SIS laws may change in the future, altering the suitability of holding insurance in superannuation.
- Any contributions you make to TAL Super in order to pay premiums will reduce the amount you may be able to contribute to other superannuation accounts you hold for retirement savings purposes.



2 Structuring Accelerated Protection through TAL Super

When you structure Accelerated Protection through TAL Super, your Policy is owned by the Trustee under TAL Super in the Mercer Super Trust. The Mercer Super Trust is a regulated superannuation fund regulated by the Australian Prudential Regulation Authority (APRA) under the *Superannuation Industry (Supervision) Act 1993 (Cth)*. Mercer pays for the Trustee's costs of running TAL Super. TAL makes payments to Mercer towards the costs of running TAL Super. These costs are not an additional cost to you.

TAL Super is governed by the Trust Deed. The Trustee can amend these governing rules at any time if superannuation law permits.

Under the Trust Deed, the Trustee is not generally liable to you for any act or omission other than where it has failed to act honestly or has intentionally and/or recklessly failed to exercise the degree of due care and diligence that it was required to exercise.

The Trustee has the right to indemnity from TAL Super for all liabilities it may incur, unless prevented by superannuation law.

Joining TAL Super

The first step in the joining process is for your financial adviser to submit your application. If your application for insurance is accepted by TAL, and the Trustee is able to accept contributions or rollovers for you, you will then become a member of TAL Super.

Insurance through TAL Super

The insurance products available through TAL Super are Life Insurance, Total and Permanent Disability (TPD) Insurance, and Income Protection (IP) Insurance Plans as set out in the Accelerated Protection Combined PDS and Policy Document. You should read the Accelerated Protection Combined PDS and Policy Document carefully as it sets out important information about:

- eligibility for insurance cover;
- various ways to structure your insurance cover;
- your duty to take reasonable care not to make a misrepresentation when completing an application for insurance;
- insurance benefit provided including when cover starts and ends and maximum insured amounts;
- the cost of cover including any discounts available;
- how to make a claim for a benefit;
- the terms and conditions of those benefits, including important definitions; and
- exclusions and restrictions on the payment of those benefits.

Once you are a member of TAL Super and TAL has agreed to issue the cover, the Trustee will be the Policy Owner and you will then be the Life Insured. You will not have an accumulation account in TAL Super, as the Trustee will immediately pay all contributions and rollovers received for you to the Mercer Super Trust (TAL Super) Application Moneys Account to pay your Accelerated Protection insurance premiums. Your membership of TAL Super only provides insurance benefits.

The Trustee may reduce your contributions if it is able to claim a tax deduction for the premiums funded by that payment and the contributions are not assessable income to the fund. To reflect the most common tax outcome to TAL Super, the Trustee will assume:

- you will be claiming a tax deduction for any personal contributions you make. This means we will assume that 15% tax will be payable on the contribution and the premium funded by your contribution will be deductible, resulting in no net tax impact for TAL Super; and
- any rollover you make is non-taxable, meaning that no tax is payable on the rollover, but the premium funded by the rollover is deductible to TAL Super for tax purposes, so there will be a net 15% tax impact; i.e. your rollover will only need to fund 85% of the premium.

It's not possible to later adjust those outcomes to reflect your individual tax circumstances. These outcomes do not change the premiums paid or the amount of cover.

Providing your Tax File Number (TFN)

TAL has agreed with the Trustee not to issue any Policy when a member has not provided their TFN to the Trustee as part of their TAL Super membership application. Your TFN will only be used for lawful purposes and may only be disclosed as permitted by the applicable laws. The purposes for which TAL and the Trustee can use your TFN may change in the future as a result of law changes.

Superannuation and family law

Provisions in the Family Law Act enable parties who are married or in a de-facto relationship to require superannuation fund trustees to carry out certain actions in relation to superannuation entitlements. Members should note that their spouse or de-facto will be able to request the trustee to disclose information about the member's benefit entitlements ('Request for Information').

The trustee is prohibited by law from informing members that such a request was made. The trustee will not pass any information about your present whereabouts to the person making the Request for Information.

Payment of benefits

If you become eligible for a benefit under the Policy, Life Insurance and TPD Insurance benefits will be paid as a lump sum, Income Protection Insurance benefits will be paid by income stream. A benefit payment will not be made under the Policy until the Trustee has determined to whom the benefit must be paid. This might be you, your beneficiary, your legal personal representative or one or more of your dependants.

Payment of a death benefit

Superannuation law specifies that a death benefit can only be paid to the following:

- member's spouse (married, de facto or same sex couples);
- child of the member of any age (including adopted child, stepchild and ex-nuptial child);
- the member's legal personal representative;
- any person who was financially dependent on the member at the time of death; and
- any person with whom the member had an interdependency relationship.

Where after reasonable searches the Trustee cannot locate any of these persons, it may pay the death benefit to an individual non-dependant such as a parent or sibling.

Payment of superannuation benefits

Other than death benefits, a superannuation benefit can only be paid where the member meets a condition of release under SIS. Generally, these circumstances include permanent incapacity, temporary incapacity, terminal medical condition, retirement (or the person has reached their preservation age), the termination of employment after age 60, leaving Australia after holding an eligible temporary resident visa, and on financial hardship or compassionate grounds. Rules relating to when superannuation benefits can be accessed are complex, so you should consult your financial adviser for further information.

Please note that not all the above conditions are relevant to your membership in TAL Super. You will only receive a benefit from TAL Super for one of the following conditions of release:

- death;
- permanent incapacity;
- temporary incapacity; or
- terminal medical condition.

Nominating a beneficiary

Understanding who receives your superannuation and insurance benefit in the event of your death is important. Under the Trust Deed, the Trustee has the discretion to determine to whom and in what proportions any death benefit is payable (see below for binding nominations). You may nominate your legal personal representative and/or dependants as your preferred beneficiaries and the Trustee will consider your wishes in the event of your death.

In the event of your death, benefits will be paid to one or more of your dependants or to your legal personal representative as determined by the Trustee.

For superannuation and tax purposes, the definition of 'dependant' includes any of the following:

- A spouse, which includes a person (whether of the same or different sex) with whom the member is in a relationship that is registered under a law of a State or territory, or a person who, although not legally married to the member, lives with the member on a genuine basis in a relationship as a couple;
- A child of the member, including adopted child, stepchild, ex-nuptial child or child of the member's spouse (but for tax purposes a child must be under age 18);
- A person who is financially dependent on the member; or
- A person with whom the member has an 'interdependency relationship'.

It is recommended that any nomination of beneficiaries made by you be reviewed regularly, particularly if a change in circumstances has occurred (e.g. marriage or divorce).

What is an interdependency relationship?

An interdependency relationship is defined as where two people (whether or not related by family):

- live together;
- have a close personal relationship;
- one or each of them provides the other with financial support; and
- one or each of them provides the other with domestic support and personal care.

An interdependency relationship can also exist where there is a close personal relationship between two people who do not satisfy all other criteria for interdependency because either or both of them suffer from a physical, intellectual, psychiatric or other disability.

Binding nominations

Generally, your nomination is only a guide. The Trustee is obliged to pay your death benefit in accordance with the Trust Deed and superannuation laws. If you wish to make your nomination binding, the Trust Deed and superannuation laws require special conditions to be met.

When making (or amending) a binding nomination, the nomination must be signed in the presence of two witnesses. Both witnesses need to be over the age of 18 and cannot be beneficiaries under the binding nomination.

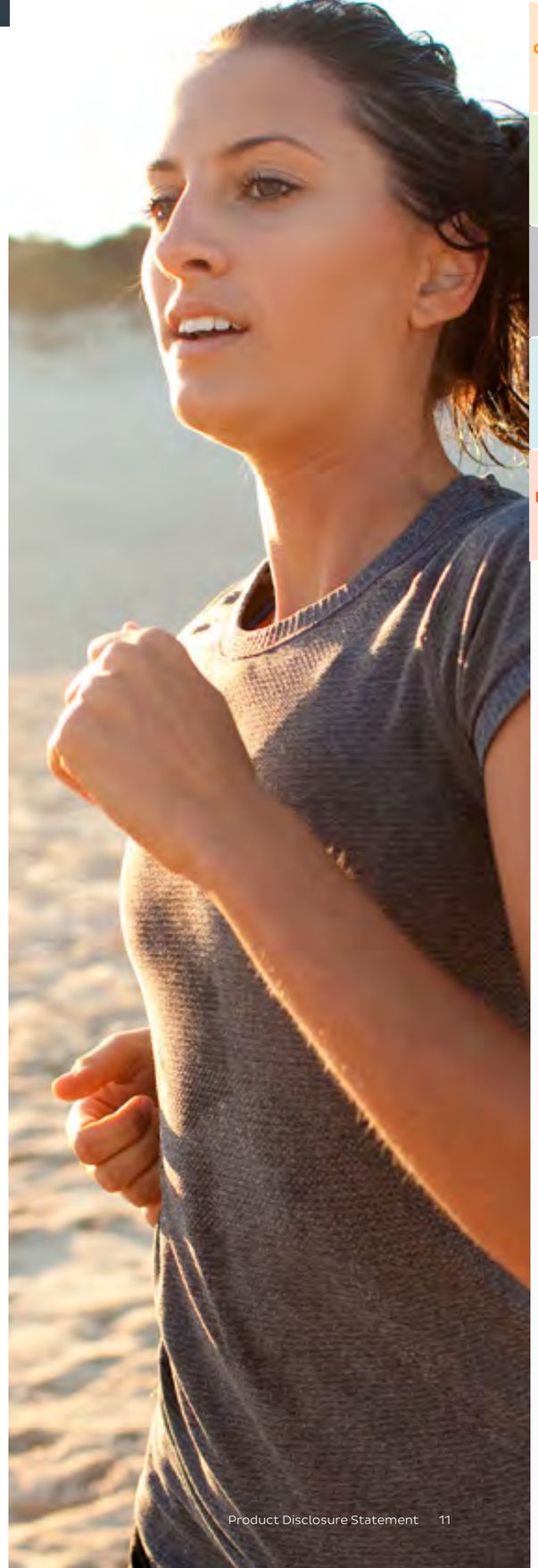
Each binding nomination remains valid for only three years. If you choose this option, it is your responsibility to renew your nomination and advise the Trustee of appropriate changes.

If your nomination expires or is invalid at the time of your death, the Trustee has the discretion to determine to whom and in what proportions any death benefit is payable.

Transfer of benefits to the ATO in certain circumstances

The Trustee is required by superannuation law to transfer your benefits in certain circumstances. The Trustee will transfer your benefits to the ATO (after providing you prior written notice of its intention to do so) if you do not inform the Trustee of an alternative superannuation arrangement within the time frame set out in the notice.

If we pay your benefit to the ATO, you cease to be a member of TAL Super. On transfer to the ATO, your insurance protection in TAL Super ceases. You can transfer or withdraw your benefit from the ATO as the governing legislation permits.



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3 Other important information

Refer to the Accelerated Protection Combined PDS and Policy Document for full terms and conditions in respect of the insurance available through TAL Super, including further details on the below.

3.1 What are the costs?

The cost of insurance is referred to as the premium and is determined by TAL. The cost of your Policy depends on a range of factors, including but not limited to the type of cover, your age and gender, whether or not you smoke, the length of time you have had your Policy and how often you choose to pay your premiums. We may also take your occupation, health, income, personal pastimes, lifestyle and other factors into account in determining insurance premium amounts.

We ask for this information so that the premiums we charge take into account the different levels of risk presented by different customer groups. Sometimes discounts may apply to certain Plans; however, these may not apply for the full term of your Policy.

Once we know a little bit about you and the cover you require, we can provide you with an indicative quote for your premium. The quoted premium may change once we have all the information we require to complete our Underwriting assessment.

All premiums (monthly, half-yearly, quarterly and annually) are payable in advance, by the due date shown in your Policy Schedule. We will inform you of the premium payable in subsequent years before each Policy anniversary.

You can choose to pay Stepped or Level premiums.

Stepped premium
If you choose stepped premium, the premium is calculated based on your total Benefit Amount, the length of time you have had your Policy and your age as at each Policy anniversary. This means your premium will generally increase at each Policy anniversary.

Level premium
Level premiums are not fixed. They can change. If you choose level premiums, the premium is based on your age at the Plan start date. Where you choose to increase your cover or the Inflation Protection Benefit applies, the premium rates used to calculate premiums for the alteration will be based on the Life Insured's age at that time.

Where level premium 'to age 65' is shown in your Policy Schedule, premiums will revert to stepped premiums on the Policy anniversary before the Life Insured's 65th birthday. Where level premium 'to age 70' is shown in your Policy Schedule, premiums will revert to stepped premiums on the Policy anniversary before the Life Insured's 70th birthday.

Changes in premiums
For both stepped and level premium, your premiums and the amount you pay will change if:

- you vary your Policy, for example when you add a new Plan or benefit option;
- there is a change in your Benefit Amount, for example when your Benefit Amount increases (including through the Inflation Protection Benefit and Guaranteed Future Insurability Benefit);
- a discount no longer applies or changes because you varied your Policy;
- government duties or charges change; or
- we change our premium rates or Policy fee (see below).

If your premiums change, there may be options available to help you manage the cost of your cover. Please speak to your adviser for assistance.

We can change our premium rates
The cost of your cover is not guaranteed to remain the same each year. It can change for both stepped and level premium cover. In the past we have changed the premium rates used to calculate the cost of cover and Policy fees, including changing the premium rates we use to determine level premiums.

We can change our Policy fees or the premium rates we use to determine your premium. However, the premium rates we use to determine your premiums are guaranteed not to change before the first Policy anniversary.

Decisions to change premium rates or Policy fees do not occur because of changes to an individual customer's own circumstances, but rather are determined in relation to the group of customers that we insure.

We will act reasonably when making decisions to change our premium rates or Policy fees and will only make changes to the extent reasonably necessary to protect our legitimate business interests.

Our premiums and Policy fees are determined so that the total premium and Policy fees for our group of insured customers is sufficient to cover our expected future claims costs, meeting our associated costs of doing business and margins in providing cover to you.

We review associated factors on an ongoing basis which may include, but are by no means limited to, our assessment of regulatory or legislative requirements, our operating costs or the commercial environment. These are only some examples of factors that we may consider, and others may apply. The outcome of any premium review performed by us may result in a change to the premium rates and Policy fees we charge you. If we change the premium rates or Policy fees, you will be advised of the change to your premiums or Policy fees at least 30 days before the change takes effect.

If your premiums increase, you will always have the option to reduce the premium by reducing your cover, subject to any minimum premiums or sum insured applicable to your Policy.

You will also always have the right to cancel your cover, at any time and for any reason, including a premium increase. There may be other options available to help you manage the cost of your cover. Please speak to your adviser for assistance.

Your Policy cannot be singled out for a change in how premium is charged because of an adverse change in the health or circumstances of the Life Insured after the Policy start date.

Non-payment or late payment of premiums
If the premium is not received by the due date, you will be sent a notice and provided at least 30 days to pay the overdue premium. If we do not receive the overdue premium by the date stated in the notice, your Policy will be cancelled.

If a claim is payable after your premium is due, but before your Policy/Plan is cancelled, we will pay the claim in line with the respective Policy/Plan conditions. When this occurs, any outstanding premiums will be deducted from the claim amount.

3.2 When does your cover and membership start and end

We are not bound to accept an application for membership into TAL Super. If we accept your application and then we issue a Policy Schedule and your cover will start and you will become a member of TAL Super. The invitation to apply is only made to persons receiving the PDS in Australia. The Policy Schedule shows the Plan start date, Plan end date, the Policy Owner, and the benefits, options and special conditions that apply to you.

Your membership with TAL Super will end when your Accelerated Protection Policy ends, is cancelled or transferred.

The Accelerated Protection Combined PDS and Policy Document sets out the details of when your cover under Accelerated Protection starts and ends.

If the Policy is altered at any time you will receive a new Policy Schedule or confirmation reflecting the agreed changes.

3.3 Tax

Unless otherwise stated, the general information provided below is based on Australian law that is in force at the time this document was prepared and relates to Australian resident individuals only.

We recommend that you obtain independent, professional tax advice that takes into account your specific circumstances regarding the tax and superannuation implications of investing in or contributing to superannuation and of joining and obtaining insurance cover through TAL Super.

The complexity of taxation laws and rulings is such that any advice should be specific to your circumstances. This should include any tax implications of purchasing insurance cover structured through superannuation or outside of superannuation.

A benefit payment will not be made under a Policy through TAL Super until the Trustee has determined to whom the benefit must be paid. This might be you, your beneficiary, your legal personal representative or one or more of your dependants. Except for benefits paid under Income Protection, benefits paid from TAL Super are treated as superannuation benefits for tax purposes. Where TAL or the Trustee is required by law to withhold any tax from a benefit, TAL or the Trustee will withhold the required amount before paying the benefit.

Individuals have different options to contribute to superannuation to fund the acquisition of insurance cover. Below is a general summary of the Australian tax implications of making contributions to a complying superannuation fund and receiving the types of benefits that are insured under Accelerated Protection. From 1 July 2022, there have been changes to the eligibility age for downsizer contributions and in respect of the work test for personal superannuation contributions. From 1 July 2022, the minimum age to make downsizer contributions decreased to 60 years.

This will allow some members aged 60 to 64 to potentially contribute $630,000 (or $1.26 million combined in the case of a couple) at one time by combining a downsizer contribution with the three-year non-concessional contributions bring-forward rule.

Individual members
You may be eligible for a tax deduction for your personal voluntary superannuation contributions.

From 1 July 2022, if you are aged from 67 and 74 years, you will be able to make personal superannuation contributions without satisfying the work test, subject to existing contribution caps. However, you will still be required to meet the work test or work test exemption to claim a deduction for personal contributions. This test requires that you are gainfully employed for at least 40 hours in any consecutive 30 day period in the income year in which the contributions are made. The work test exemption applies to members aged from 67 and 74 who have a total super balance below $300,000 at the prior 30 June and meet other conditions. It is your responsibility to ensure that you satisfy the work test or work test exemption for any personal contributions that you are claiming.

To meet the work test exemption criteria, you must have:

- satisfied the work test in the income year preceding the year in which you made the contribution;
- a total super balance of less than $300,000 at the end of the previous income year; and
- not relied on the work test exemption in a previous financial year.

Personal contributions which are claimed as a tax deduction are concessional contributions and are subject to the concessional contributions cap discussed below. Employer and salary sacrifice contributions are also concessional contributions.

The concessional contributions cap for the 2022/2023 financial year is $27,500 for members of all ages. From the 2019/2020 financial year, individuals with total superannuation balances of less than $500,000 on 30 June in the previous financial year, may be able to use their unused concessional contributions cap space to increase their concessional contributions cap.

Concessional contributions are generally included in the fund's assessable income and may be subject to tax at the rate of 15% in the fund's hands. However, where the member's personal adjusted taxable income exceeds $250,000, the ATO will issue an assessment to the member assessing part or all of their concessional contributions to an additional 15% of tax.

Where concessional contributions in excess of the applicable cap are made in a financial year the ATO will issue the member an assessment taxing the excess at the member's marginal tax rate (plus the Medicare levy). The member will be entitled to a tax offset equal to 15% of their excess concessional contribution (reflecting generally the tax already assessed to the recipient fund). An interest charge also applies for the deferral of tax.

If you are a low income earner and have eligible concessional superannuation contributions, you may be eligible for the low income superannuation tax offset, which is paid to your superannuation fund.

There are also limits on the amount of post-tax or 'non-concessional contributions' that can be made on behalf of a member. Non-concessional contributions and any excess concessional contributions that are not refunded include personal contributions for which you do not claim an income tax deduction.

For the 2022/2023 financial year, the annual cap for non-concessional contributions is $110,000 and members with total superannuation balances of $1.7 million or more are not eligible to make non-concessional contributions. There is a 'bring-forward' option as discussed below. You will be taxed on non-concessional contributions over the cap at the rate of 45%, plus the Medicare levy where they cannot be released from a fund (and this is the case for TAL Super as stated below).

Under the 'bring-forward' option, generally people under 75 years of age for at least one day during the year and have not accessed this option in prior years, can make non concessional contributions of up to three times the annual cap limit (explained above) in one year (other conditions apply).

However, from 1 July 2022 members with total superannuation balances of $1.48 million or more have reduced (or no) access to the bring-forward rule.

If you receive an excess concessional or non-concessional contribution determination from the ATO, you should not elect for amounts to be released from TAL Super. TAL Super is unable to process a release authority from the ATO because you will not have an accumulation interest in TAL Super. In these circumstances if you require an amount to be released, you should nominate another superannuation fund in which you have sufficient accumulation interest to make the release from.

If your income is less than $57,016 (for the 2022/2023 financial year), you may also benefit from government co-contributions if you make a personal after tax (non-concessional) contribution to your superannuation.

The government co-contribution is a payment made by the Federal Government to the superannuation account of eligible members who make personal non-concessional contributions. For more information contact your financial adviser or the Australian Tax Office (ATO) Superannuation Infoline on 13 10 20.

Employers
Employer contributions are tax deductible to the employer where they are made to provide superannuation benefits for an employee or the employee's dependants.

Employers can make contributions to complying superannuation funds for employees aged:

- under 75; or
- 75 and over, where contributions are required under legislation (such as the Superannuation Guarantee) or by relevant industrial awards.

Tax payable on death benefits
Lump sum death benefits are tax free if paid to a dependant for tax purposes or the member's estate where the beneficiaries of the estate are dependants of the member for tax purposes. Lump sum death benefits paid to non-dependants for tax purposes or the member's estate to the extent the beneficiaries are not dependants for tax purposes, are taxed at different rates depending on whether the elements are from taxed or untaxed sources. For elements taxed in the fund, the rate is the lower of the recipient's marginal tax rate and 15%, plus the Medicare levy. For elements untaxed in the fund, the rate is the lower of the recipient's marginal tax rate and 30%, plus the Medicare levy. The trustee of the member's estate does not bear the Medicare levy.

Tax payable on Terminal Illness benefits
Terminal illness benefits paid to members are tax free.

Tax payable on TPD benefits
Total and Permanent Disablement (TPD) benefits are taxed at different rates, depending on the amount, the member's age when they were disabled and their age at the date of payment.

Tax payable on Income Protection benefits
Income Protection benefits including the Super Contribution Option benefit, that substitute for lost income or are in the nature of ordinary income should constitute assessable income of the member and should be taxed at the member's marginal tax rate, plus the Medicare levy where applicable.

Withholding tax
Where TAL or the Trustee is required by law to deduct any tax, duty, impost or the like in connection with the payment of a benefit, TAL or the Trustee will deduct the required amount from the payment and forward it to the relevant authority. For example, TAL will withhold tax from the Income Protection benefits that are income in nature and the Super Contribution Benefit before the amounts are paid to the member or their nominated superannuation fund respectively, as required by the tax law. TAL will also withhold tax from TPD and death benefits where required by law.

3.4 Anti-money laundering and counter terrorism financing

TAL and MSAL are required to satisfy various regulatory and compliance obligations, including the *Anti-Money Laundering/Counter-Terrorism Financing Act 2006 (Cth)*.

TAL may, from time to time, require additional information from you, which you must provide. We may also be required to disclose information about you to a regulator or law enforcement body.

3.5 Privacy

The way in which we collect, use and disclose your personal and sensitive information (personal information) is explained in TAL's and Mercer's respective Privacy Policies. Protecting your personal information is very important to us. Please refer to the Accelerated Protection Combined PDS and Policy Document on information on how your personal information will be used. If you would like a copy or if you have any questions about the way in which we manage your information, please contact us using the details below:

TAL

1300 209 088
1300 351 133
customerservice@tal.com.au
www.tal.com.au
GPO Box 5380, Sydney NSW 2001

MSAL

1300 209 088
1300 351 133
customerservice@tal.com.au
www.tal.com.au/talsuper
GPO Box 4303, Melbourne, VIC 3001

3.6 How to make a complaint

If you are dissatisfied with your Policy which is structured through TAL Super, you should address your complaint to:

1300 209 088

customerservice@tal.com.au

www.tal.com.au

Internal Dispute Resolution
GPO Box 5380, Sydney NSW 2001

The trustee always seeks to resolve any complaints to the satisfaction of all concerned and in the best interests of all members of TAL Super. We will acknowledge your complaint as soon as practicable. We will provide you a response no later than 45 calendar days after receiving your complaint, unless another time frame is allowed or required under the relevant legislation. If we are unable to provide you a response within this time frame, we will provide you a delay notification advising you the reasons for the delay, as well as your rights to complain to the Australian Financial Complaints Authority (AFCA).

If you have made a complaint and are not satisfied with the outcome, or we have not resolved your complaint within the required time frame, you can complain to AFCA. AFCA provides a fair, free and independent body that can assist you with further resolving your complaint at no cost to you.

www.afca.org.au

info@afca.org.au

1800 931 678 (free call)

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

Some complaints must be lodged with AFCA within set timeframes or may be outside of AFCA's jurisdiction. Contact AFCA directly for more information about their time limits and other requirements.

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About us

TAL is a **leading life insurer**, here to help Australians protect what matters most: the experiences we share with those we love

Our **150 years' experience** ensures we can protect you, your loved ones and the future you've planned together

Get in touch

Customer Service Centre:
1300 209 088

Adviser Service Centre:
1300 286 937 (Monday to Friday 8am – 7pm AEST)

www.tal.com.au

Accelerated Protection through TAL Super Product Disclosure Statement
Issue date 5 August 2022

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GPO Box 5380 Sydney NSW 2001

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ABN 79 004 717 533 | AFSL 235 906

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