NOBLEOAK

Product Disclosure Statement

My Protection Plan

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Issued by: NobleOak Life Limited
ABN: 85 087 648 708 AFSL No. 247302

In this Product Disclosure Statement

Welcome to My Protection Plan

Insurance Cover Types

General Information

Welcome to My Protection Plan

Customer Value

Award-winning Insurer

NobleOak is an award-winning insurer delivering value to its members. This value is provided through quality cover you can trust with better service and competitive premiums.

Comprehensive Life Insurance product

Life Insurance is an important tool for people who have financial dependants, allowing you to help provide for your loved ones if you die.

This is one part of My Protection Plan, but there is so much more.

My Protection Plan offers several different insurance types, each providing a benefit for different scenarios. You can choose one or more of the following insurance types:

Life Cover

Covering death and terminal illness

Total and Permanent Disability

If you're unable to work again due to sickness or injury

Trauma

Covering specific diagnosed diseases, e.g. cancer

Income Protection and/or Business Expenses

If you're unable to work due to sickness or injury and are required to take extended leave from work, or away from your business.

Life Insurance is a long-term product, but you can cancel your My Protection Plan insurance at any time without an exit fee. We'll refund any premium you've paid in advance of the next month.

How are my premiums calculated?

Premiums for your insurance are called Variable Age -Stepped Premiums (previously known as Stepped Premiums). This means the premiums are based on your age at each policy anniversary and will generally increase each year as you get older. We will calculate the premiums based on several factors such as your age, sex, occupation, and smoking status.

Future premium rates are not guaranteed and may change. Further information on how premiums are calculated and when premiums can change is included starting from page 66.

Guaranteed Renewability

We guarantee to renew your insurance cover each year up until the expiry age that applies for your cover, provided you continue to pay your premiums.

Benefit Upgrade Guarantee

Whenever we improve the terms of this product, we'll make the enhancements available to you (except where they would result in an increase in premium).

Please note that once available, the improvements will apply to future claims only. They won't apply to current claims or to claims arising from any event (including any injury, sickness or disability) which occurred before the improvement became effective.

How do I know how much insurance I need?

There are various online calculators you can use to help work out how much life insurance you would need to cover your responsibilities and financial liabilities.

They usually consider your income, mortgage, and other debts, living expenses, children, and other dependants.

We provide a calculator you can use at www.nobleoak.com.au/tools-guides/insurance-calculator

There are others available online, such as the MoneySmart needs calculator at www.moneysmart.gov.au/how-life-insurance-works/life-insurance-calculator

Some people are only looking to replace their existing insurance held elsewhere. It's always worth checking that the insurance amounts are still right for your needs, to prevent paying for more than you need. If you are replacing an existing insurance cover, it's also important to remember that your cover must first be accepted under your My Protection Plan application. For more information see page 72 - Important - if you are replacing your cover.

Peace of mind starts when you apply

My Protection Plan is a fully underwritten life insurance contract. That means we ask you about your health, occupation, income, and recreational pursuits at the start, and will adjust your cover and your premium according to the answers provided. We may issue special acceptance terms in respect of your cover.

Once issued, your insurance cover provides worldwide protection 24-hours a day, subject to any special terms and conditions we may apply to your cover.

The people behind your cover

NobleOak Life Limited (NobleOak) is an Australian life insurance company that was established in 1877 and has been protecting Australians for over 145 years. NobleOak is a friendly society regulated by the Australian Prudential Regulation Authority (APRA). It holds an Australian Financial Services Licence issued by the Australian Securities and Investments Commission (ASIC).

When you're with NobleOak, you can feel secure knowing you're with a leading friendly society, synonymous with trust and integrity. We pride ourselves on personalised, friendly service and our experienced claims specialists are based here in Australia.

As a friendly society, our core philosophy is to put our members' needs first. It's all about looking after our members – ensuring you receive excellent value, comprehensive products and great service.

NobleOak has adopted the Life Insurance Code of Practice (Code). The Code sets out the minimum standards for dealing with, communicating with, and servicing our members. It is built around the principles of clarity and transparency, fairness and respect, honesty and timeliness of communication.

At NobleOak, we pride ourselves on exceeding minimum standards. Our Client Guides set out the standards you can expect from the team at NobleOak when taking out and managing your cover, and are available at: www.nobleoak.com.au/about-us/code-of-practice/

At NobleOak we offer genuine value, quality cover, and strive to make Life Insurance more accessible and affordable to more Australians.

NobleOak is a member of the Council of Australian Life Insurers (CALI), a body which supports the Australian life insurance industry and its members through dedicated representation and engagement. CALI advocates to drive positive outcomes for customers, insurers, and their partners.

If you have a concern about your insurance cover or any aspect of our service, please tell us about it. In the first instance, it's best to talk with the person you have been dealing with at NobleOak to resolve your concern.

You can contact us on 1300 551 044 or email enquiry@nobleoak.com.au.

Managing your concerns

It's important to us to provide you with a high standard of customer service at every stage.

We have been helping Australians for over 145 years to protect their loved ones and lifestyle. Our core philosophy is to always put our members' needs first.

We offer genuine value, provide quality cover, and strive to make Life Insurance more accessible and affordable to more Australians.

If you have a complaint

If you are not satisfied with your insurance policy or the service we've provided, please contact us to let us know your concerns and the details of your complaint. We will do all we can to resolve your complaint as quickly as possible.

You can contact the Client Care team to register your complaint.

Online: www.nobleoak.com.au/complaints
Email: clientcare@nobleoak.com.au
Phone: 1300 396 455
Mail: PO Box 4793, Sydney NSW 2001

To help us deal with your complaint quickly, please include the following information:

- your name and contact details, including your daytime phone number and email address
- details of your complaint, and
- your desired outcome.

Our Client Care team will contact you to acknowledge receipt of your complaint in writing within 1 business day.

We will always aim to resolve your complaint as quickly as possible. If we are unable to resolve your complaint within 30 days, we will inform you of the reasons for the delay and let you know when we expect to provide a response to your complaint.

A Client Care team member will listen to your concerns and confirm the nature of your complaint with you.

They will outline the actions NobleOak will take to consider or investigate your complaint and provide you with an agreed time frame to respond. The Client Care team member will oversee the internal investigation at NobleOak to review your complaint. If we find any errors or mistakes have been made in the handling of your matter, we will address these promptly.

We'll check if you need any other support in progressing your complaint, such as a support person you nominate to help you.

Finally, the Client Care team member will provide you with a written confirmation of your complaint including the agreed resolution.

You can view our Complaints Policy on our website at www.nobleoak.com.au/complaints

External Dispute Resolution Service

If we haven't been able to resolve your complaint within 30 days of lodging, or if you are unhappy with the handling, or resolution, of your complaint you can escalate your complaint to the Australian Financial Complaints Authority (AFCA). AFCA provides a fair and independent financial services complaint resolution service that is free to consumers.

There are some circumstances where AFCA cannot deal with your complaint, and time limits may apply to complaints to AFCA. However, they can inform you of these circumstances. The complaints procedure is free of charge and decisions made by AFCA are binding on us.

Before you ask AFCA to help you, please try to resolve the issue with us first.

AFCA's contact details are:
Mail: GPO Box 3, Melbourne VIC 3001
Phone: Toll Free Number 1800 931 678
Email: info@afca.org.au
Online: afca.org.au

We pay claims

We want to hear from you

If you think you may be able to claim, please let us know as soon as possible (ideally within 14 days). We know it's a difficult time, but we will guide you through the process and help you work out what you might be entitled to.

We pay all eligible claims promptly once processed, under the condition that the Member answered all questions truthfully and completely during the application process and at claim time. All claims will be paid in Australian dollars.

Paying genuine claims is our ultimate service and we are proud of how we can help our members in their time of need. You can see how we compare using the MoneySmart claims comparison tool at Life insurance claims comparison tool - Moneysmart.gov.au

If you have fully disclosed all your information accurately when you applied, you can rest assured that, should you make a claim in the future, your claim will be paid on meeting the terms and conditions in this PDS.

We'll only ask for information we need

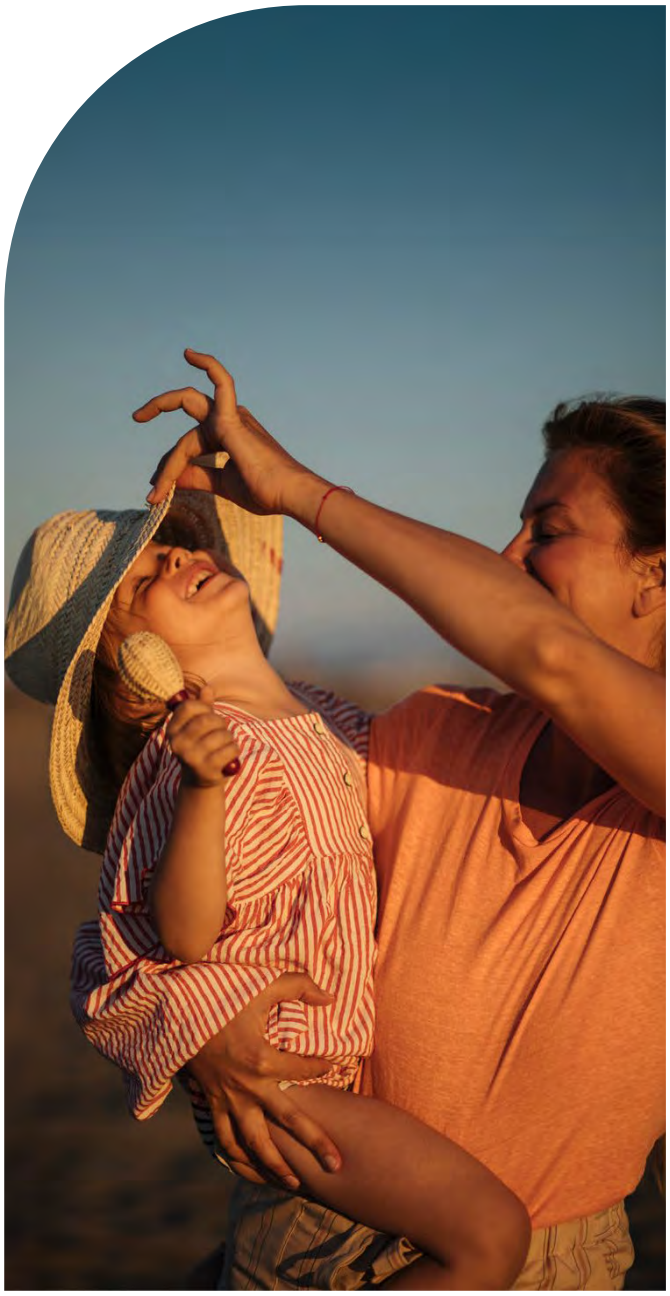
We need to gather information at claim time to verify your condition and fact-check the information you provided when you applied for cover.

The information we need to assess the claim will depend on the insurance cover type. For example, for Income Protection claims, we'll ask for proof of income with the required medical evidence together with the completed claim form.

We may need a report of your medical history for the period before your insurance started to verify your health history from your application, and we'll arrange and pay for this. Before we do, we'll ask for your (or your beneficiary's) permission to approach the medical practitioners or other people who may have information we may need to assess your claim.

You will need to arrange and pay for your own medical and related evidence to substantiate your claim. However, we'll pay for any expenses we incur when we are seeking our own independent opinion.

If you are overseas at the time of claim, we'll consider the advice you receive from a qualified and equivalent medical health care practitioner where you're located at the time. If there isn't anyone suitably qualified or reasonably available, you'll need to return to Australia at your own expense.



The claims we don't pay

We pay genuine claims, we also have a responsibility to our members to decline certain claims.

If there are material differences between a member's actual details including date of birth, gender, smoking status, medical history, occupation, lifestyle and recreational pursuits, and what we asked and were advised by the member during the application, we have the right to vary their cover and review their claim against the insurance we would have offered. If we would not have offered insurance, we may avoid the cover (treat the cover as if it never existed) and/or cancel the benefit(s) within 3 years of entering into it. If there is a fraudulent misrepresentation, we may refuse to pay a claim and may avoid your insurance cover or any part of it, irrespective of the type of cover, at any time.

Further information about your duty to take reasonable care not to make a misrepresentation can be found starting from page 74.

If we receive a fraudulent claim, we will have no liability in respect of that claim and we may cancel the cover altogether.

You should let us know of a claim as early as you can. It is much more straightforward to assess a claim when we can get the information we need.

When does cover end?

Your insurance cover, and our liability to pay claims, will end if any of the following events occur:

- You don't pay your premiums when they are due. In this case, we may agree to reinstate your cover if you pay the outstanding premium. Reinstatement of any cover which has ceased will only be effective if we agree to reinstate the cover in writing and is subject to any terms and conditions that we consider appropriate at that time.
- We pay the full Sum Insured.
- You die.
- You join the armed forces of any country.
- You cancel your insurance by letting us know in writing.
- Legal proceedings are commenced for your winding up.
- Your insurance ends, as set out for each cover type under 'Exclusions and Limitations.'

When all your cover under the insurance plan ceases, your membership of the Benefit Fund also ends.

The PDS and your contract

Deciding if this product is right for you

This Product Disclosure Statement (PDS) describes the key features, benefits, and limitations of My Protection Plan contained in NobleOak's Benefit Fund known as Risk Fund No. 1, to help you decide if it's right for you. It also sets out the options that are available for each insurance type.

Any advice given in this PDS is of a general nature only and doesn't account for your individual circumstances. You should consider whether this product is right for your own objectives, financial situation, and needs.

Throughout this PDS, we use 'you' to mean the applicant and, if we agree to issue the insurance, the cover holder and member of NobleOak's Benefit Fund known as Risk Fund No.1. We also use 'you' to refer to the Life Insured when the context applies. You can apply for cover for yourself as the Life Insured or for someone else. We don't issue policies in joint names.

Reference to 'our,' 'us,' 'we,' 'NobleOak' all refer to NobleOak Life Limited.

The benefits described in this PDS are for members joining from the Issue Date of this PDS. If you have any questions, please call us on 1300 551 044.

Documents that make up your contract

When you apply for insurance and we accept your application for cover, you have a contract of insurance with us.

You'll receive a welcome pack with a Benefit Schedule setting out your cover, your premiums and any special terms agreed with you.

Your contract is the Benefit Fund Rules (which are described in this PDS), your application for insurance, any special acceptance terms applying to your cover, your policy certificate and the most recent Benefit Information notice (annual renewal statement) we've sent you. Please keep these documents in a safe place for future reference.

We provide your insurance by way of a master insurance policy that is issued to NobleOak Services Limited ABN 66 112 981 718 AFSL Number 286798 as the Trustee of the My Protection Plan Trust. You may request at any time to view the Risk Fund No.1 Benefit Fund Rules that govern your cover.

My Protection Plan held in super

A self-managed superannuation fund (SMSF) trustee or an Approved Superannuation Fund trustee can purchase this product on behalf of the Life Insured as a member of the fund. We refer to the trustees who hold the insurance cover as 'Trustee Members' under the Benefit Fund Rules.

Only Life Cover, Total and Permanent Disability and Income Protection are available through super.

If you wish to change your policy later to be non-super, we'll need to do this by way of issuing you a replacement policy. You won't need to complete a full application for insurance or provide further health information. If you're already on claim, or you're eligible to claim, your claim must be made under your existing insurance. This is also the case if you are looking to change your non-super policy to a superannuation policy.

Terms used in this PDS

Words or terms that are in *italics* for an insurance type have a special meaning that you can reference at the end of the relevant insurance type section.

All other defined terms are Capitalised.

You can find the meaning for these in the General Definitions starting on page 78.

Insurance Cover Types

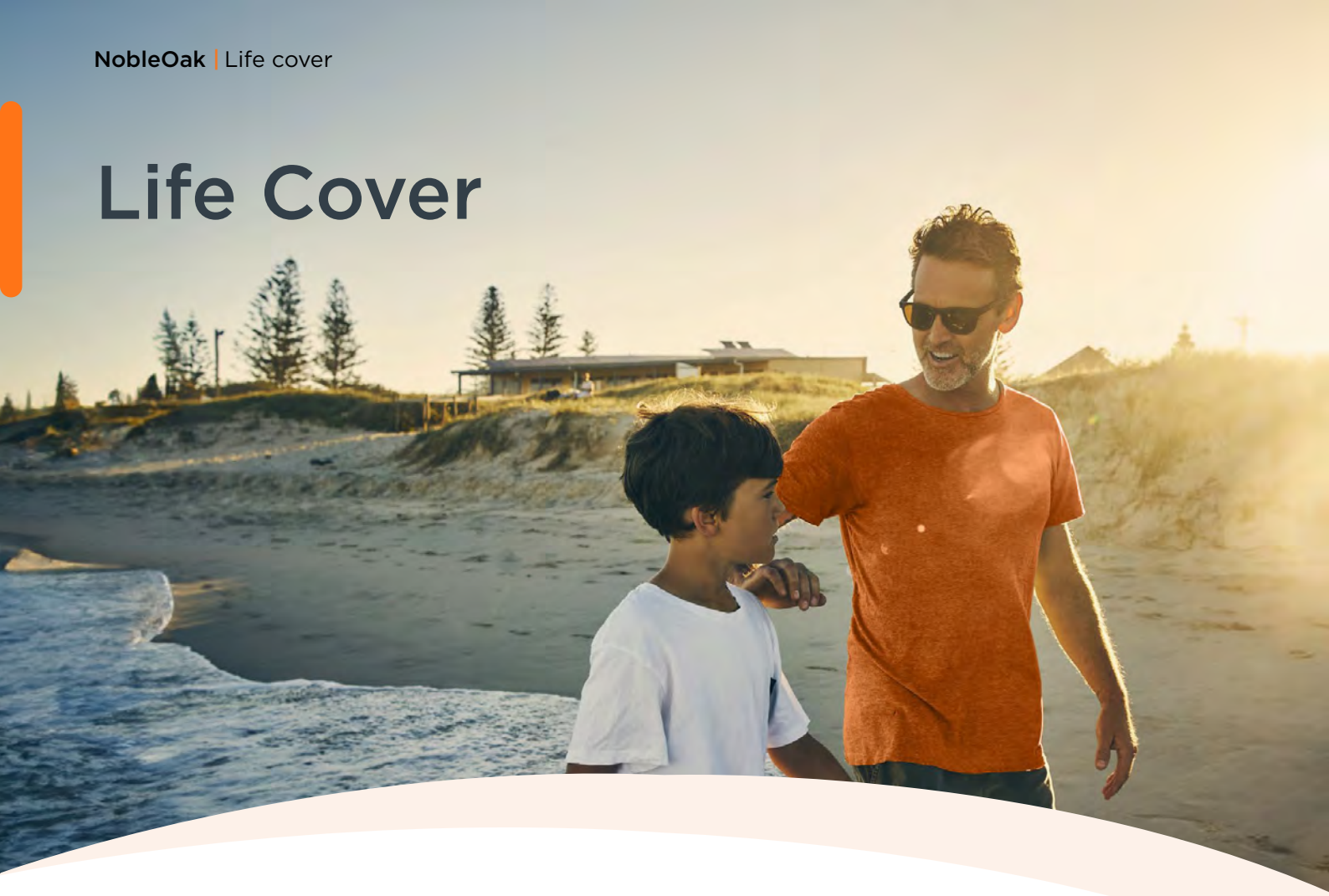
As an Australian-owned company, our diverse and passionate team are committed to helping protect what matters most to you, backed by a legacy of trust and excellence.

Insurance Cover Types

My Protection Plan provides flexibility for you to select the life insurance products you want, within a range of cover levels. It lets you choose the types and amounts of cover you'd like, and you only pay for what you are underwritten and covered for.

Type of Insurance	What does it cover?	Who can apply?	When does the cover expire?	Page no.
Life Cover	This cover pays a lump sum (the Sum Insured) if you die or become terminally ill. Choose an amount of cover from $50,000 up to $25 million.	Australian residents, ages 16 - 74.	The policy anniversary after your 99th birthday, or the expiry date stipulated on the policy certificate.	12
Total and Permanent Disability (TPD) Insurance (Optional with Life Cover)	This cover pays a lump sum if you're unlikely ever to work again because of sickness or injury. Choose an amount of cover between $50,000 and $5 million.	Australian residents, ages 16 - 59.	The policy anniversary after your 75th birthday.	20
Trauma Insurance (Stand Alone or Optional with Life Cover)	This cover pays a lump sum benefit if you suffer a serious listed medical condition. Choose an amount of cover from $50,000 up to $2 million.	Australian residents, ages 18 - 59.	The policy anniversary after your 70th birthday.	27
Income Protection Cover	This cover pays a monthly benefit if you cannot work due to sickness or injury. You can apply to insure up to 70% of your income. The minimum monthly benefit is $1,500 and the maximum monthly benefit is $30,000.	Australian residents, ages 18 – 60, working at least 20 hours per week.	The policy anniversary after your 65th birthday.	42
Business Expenses Insurance	This insurance can help you cover the fixed running costs of your business if you can't work due to Sickness or Injury. You can apply for a monthly benefit up to $25,000 per month to cover your Allowable Business Expenses.	Australian residents, available for self-employed between the ages of 21 and 59.	The policy anniversary after your 65th birthday.	61

Life Cover



Purpose

This cover pays a lump sum (the Sum Insured) if you die or become terminally ill.

Sum Insured

Choose an amount of cover from $50,000 up to $25 million. If you are aged 70 - 74, the maximum you can apply for is $500,000.

Options

Add Total and Permanent Disability and/or Trauma Insurance, with claim payments advanced from your Life Insurance sum insured.

Who can apply?

Australian residents, ages 16 - 74.

Benefits

Death Benefit

If you die while your insurance is in force, we'll pay the Sum Insured as a lump sum to your nominated beneficiaries or estate.

Funeral Advance Benefit

We will advance $30,000 of your Death Benefit as soon as we receive the death certificate and proof of age. If a death certificate isn't available, we'll consider other equivalent evidence, acting reasonably.

Terminal Illness Benefit

If you become terminally ill, we'll advance the Death Benefit. To be eligible:

- Two Medical Practitioners (at least one being a Specialist Medical Practitioner in an area related to your Sickness or Injury) must certify (either in two individual reports or one joint report) that you suffer from a Sickness or Injury which is likely to result in death within 24 months of the most recent certification.

Where certification is issued by way of individual reports from two separate Medical Practitioners, both certifications must include diagnosis and life expectancy. The date of certification shall be taken to be the date of the most recent certification.

Family and Carer Support Benefit

This is a package of benefits to help support you and your family upon payment of a terminal illness or death benefit, should you or your family be eligible. The Family and Carer Support Benefit is payable on meeting the below criteria, in addition to your Sum Insured. The maximum and total payable under the Family and Carer support benefit is $25,000 per Life Insured on satisfaction of the benefits and conditions below, with necessary evidence at claim time. The Family Carer Support Benefit includes:

- **Family Care Support**
  If you're confined to bed for at least 3 consecutive days as a result of a terminal illness and an Immediate Family Member needs to travel more than 100km, stay away from their home to be with you, and suffers a loss in income to provide care for you, we'll reimburse their travel and accommodation costs and/or loss of income while they're with you providing care – up to $250 per day – for a maximum of 30 days (subject to a maximum of $7,500).

- **Home Care Support**
  If you are unable to perform any Domestic Duties for at least 7 consecutive days, we'll reimburse up to $250 per day, for a maximum of 30 days, for paid professional housekeeping and/or childcare, or travel costs to medical appointments. This benefit doesn't apply if it's an Immediate Family Member who provides the service (subject to a maximum of $7,500).

- **Nursing Care Support**
  If you're confined to bed for at least 3 consecutive days and required to be under the continuous care of a registered nurse, we'll pay you $250 per day, for a maximum of 30 days (subject to a maximum of $7,500).

- **Terminal Illness Care Support**
  If you're terminally ill and receiving palliative care we will support you and your family with holistic well-being expenses and family home care by paying $500 per day, for a maximum of 30 days (subject to a maximum of $15,000).

- **Funeral Attendance**
  If an Immediate Family Member needs to travel more than 100km and stay away from their home to attend your funeral, we'll reimburse their travel and accommodation costs and/or loss of income – up to $250 per day – for a maximum of 7 days for up to 4 Immediate Family Members (subject to a maximum of $7,500).

For the above, 'confined to bed' must be on the advice of a Medical Practitioner while you are Terminally Ill. Each type of Family and Carer Support Benefit is payable only once.

You or your immediate family must send us your claim for payment within 90 days of the Family and Carer Support Benefit costs being incurred – including a copy of paid invoices, travel, and accommodation receipts (as applicable), and any other reasonable evidence we request. We cannot pay for expenses that are usually available under health insurance or that are restricted due to other laws. We also are unable to pay for medical treatment due to related legislation. See page 15.

Financial Advice Benefit

We'll reimburse the cost of you or your spouse/partner engaging a licensed financial adviser, up to $5,000, to prepare a financial plan if we pay a benefit of more than $200,000 for death or terminal illness.

If your Sum Insured is more than $1 million and your insurance has been in place for at least 2 years, the upper limit on this benefit is increased to $10,000.

You must send us suitable evidence of paid invoices within 12 months of the claim payment. The financial adviser must be operating under an appropriate Australian Financial Services License. This benefit is payable once only.

Grief Counselling Benefit

We'll reimburse the cost of grief counselling services for you or your Immediate Family Member, up to $2,000, if we pay a benefit for death or terminal illness.

You or your family must send us suitable evidence of the paid invoices within 12 months of the claim payment. The service provider must be appropriately qualified and registered to provide grief counselling services. This benefit is payable once only.

Exclusions and limitations

Exclusions

We won't pay any Life Cover claim if the claim:

- is caused or contributed to by a suicide or suicide attempt (whether sane or insane) occurring within 13 months following the commencement, reinstatement, or voluntary increase of the insurance cover (but only to the extent of that increase), or
- results from any exclusion which is specific to you and noted in any special acceptance terms agreed with you in connection with your cover.

Where assisted dying is legal for your state or territory, we won't treat it as suicide if it's conducted in compliance with that law.

The 13-month suicide exclusion will not apply to your cover if it replaced existing life cover issued by us or another insurer and if each of the following applies:

- The insurance under the replaced cover was in place for a minimum of 13 consecutive months immediately prior to the commencement of this cover.
- The replaced cover was cancelled after the issue of this cover.
- Any suicide exclusion period has expired under the replaced cover.
- The cover amount being issued by us is the same or less than that under the replaced policy.
- No claim is payable, pending, or entitled to be made under the replaced cover.

Where your Sum Insured is greater than your replaced cover, we'll apply the suicide exclusion to the difference in the sums insured.

We won't be able to reimburse any expenses that are usually available under health insurance or that are restricted due to other laws (which may include the National Health Act 1953 (Cth) or the Private Health Insurance Act 2007 (Cth)).

In the event of Invasion or War, your cover may be subject to an exclusion if you don't pay the increased premium. For more information see page 67 - Changes to your Premium.

Special Acceptance Terms

Benefits will be subject to any exclusion or limitation which is specific to you and noted in any special acceptance terms applying in respect of your cover.

Benefit reductions

We will reduce the Sum Insured by any amounts we pay under the optional Total and Permanent Disablement insurance cover and/or the optional Trauma Insurance cover.

Compliance with superannuation law

There are special rules from superannuation law on which benefits we can pay for insurance in super. We are unable to pay the Funeral Advance Benefit, Financial Advice Benefit, Family Care Support Benefit or Grief Counselling Benefit for a Trustee Member.

End date

This insurance ends, along with our liability to pay any claim, at the policy anniversary after your 99th birthday, or the expiry date stipulated on the policy certificate.

See also 'When does cover end?' on page 8.

Features to manage your cover over time

Indexation

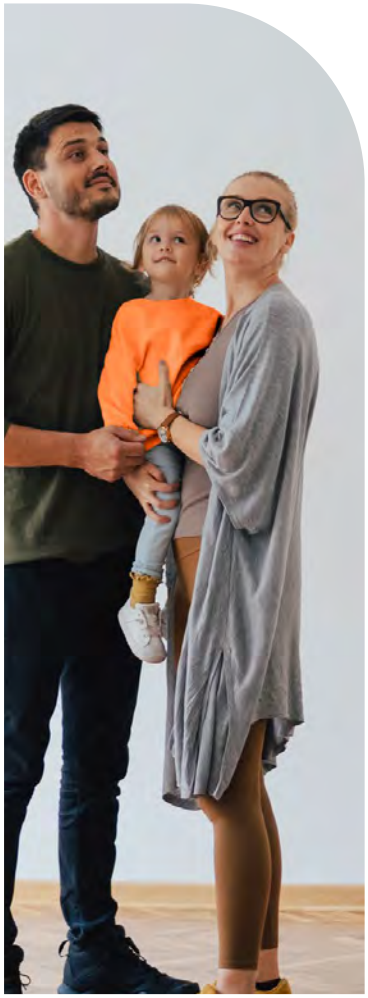
We increase your Sum Insured at each anniversary of your cover to guard against inflation. The increase applies automatically and is the increase in the Consumer Price Index or 3%, whichever is more. Your premium will automatically adjust to reflect the increase in cover.

You can refuse each year's increase or cancel these automatic increases by letting us know in writing. If you decline 3 consecutive increases, we won't make any further increases. Indexation increases stop at age 99, or when your policy term expires. There will be an increase to the premium due to the indexed Sum Insured each year. You can choose to cancel the indexation on your cover at any time.

Future Increases Benefit

You can increase your Sum Insured without the need to provide further medical evidence if a future increase event occurs while you are less than 60 years of age.

The future increase events are specified life events that are connected with an increased insurance need, such as taking out a new or increasing a mortgage or having a child. Refer to page 18 and 19 for the allowable events.



You must let us know within 90 days of the allowable event, or within the 30 days of the next anniversary of your cover which follows the allowable event, supplying the relevant supporting evidence.

The increase can be the lesser of the following:

- 25% of the original Sum Insured
- 50% of the original Sum Insured in the case of a new or increased mortgage
- your new mortgage amount or increased mortgage amount
- 10 times the annual amount of your salary increase if you are employed (in the case of a salary increase), or
- $250,000.

During the first six months after exercising the Future Increases Benefit, the added amount only covers death due to Accident.

You can only use the Future Increases Benefit once in any 12-month Anniversary Period. The total value of increases cannot exceed 100% of the original cover amount provided to you when your cover started. Nor can it exceed $1 million for all increases during your period of membership.

You cannot exercise the Future Increases Benefit:

- while we are waiving your premiums at your request, or we are considering a request to waive your premiums
- if you have a medical loading or medical exclusion on your Life Insurance cover, or
- if you're eligible to make a claim, or are seeking payment of a claim, with us or any other insurer.

Premium Freeze Benefit

You can freeze the cost of your Life Insurance cover at any time by contacting us with your request to exercise the Premium Freeze Benefit. This means that:

- Your future premiums will stay the same as they are when you make the request; and
- we'll reduce your Sum Insured each year to the amount that premium amount will pay for.

You can contact us at any time to end the Premium Freeze Benefit and the premium freeze will end on the next anniversary of your cover.

Premium Pause

If you become Involuntarily Unemployed or need to take extended leave from employment (other than for travel) because of full time study, parental leave, or compassionate leave, you can contact us and ask us to pause payment of your premiums for up to 12 months.

If you pause your Life Insurance cover, it will also pause any attached optional benefits or covers (TPD or Trauma Insurance).

When you restart your cover, we will not pay any claim arising from an event which occurs during the premium pause or within 90 days after the end of your premium pause and restarting your premium payments. This means that we won't pay for death occurring, or any Terminal Illness being diagnosed, during the premium pause or within 90 days after the end of the premium pause and restarting your premium payments.

The premium pause is only available once your cover has been in place for more than 2 years. You are not covered during the premium pause period and cannot claim during that period.

Waiver of Premium While Involuntarily Unemployed

If you become Involuntarily Unemployed for longer than 30 consecutive days (other than as a direct result of any Sickness or Injury), we'll waive the premium for up to 3 months in total while you're Involuntarily Unemployed. The waived premium starts from your next premium due date, at least 31 days after you become Involuntarily Unemployed.

The waiver of premium is only available:

- for monthly premiums
- if your cover has been in place for at least 12 consecutive months
- if you are an employee (excluding self-employment, including partners in a partnership), and
- in respect of future premiums (those that are due to become payable).

You must let us know in writing no later than 14 days before the relevant premium payment due date for which you are applying to have the premium waived under this benefit.

You must provide us with any suitable evidence that shows you are Involuntarily Unemployed, e.g. a separation letter from your employer.

Premium payments will resume at the end of the waiver period.

Allowable Events for the Future Increases Benefit

Future Increase Event	Evidence required
Birth of a child.	A copy of the birth certificate that shows you are the parent of the child.
You adopt a child.	A copy of the adoption certificate that shows you and/or your spouse/partner as an adopting parent.
Your child starts secondary school.	Evidence of enrolment in secondary school.
You marry, or you officially register a partnership or start a de facto relationship which is recognised by law.	A copy of the marriage certificate or evidence of the registration of the partnership or de facto relationship with an Australian State or Territory. Or satisfactory evidence of the partnership or de facto relationship, such as a statutory declaration or similar sworn statement.
You divorce, or you legally separate or register a separation from a marriage or registered de facto relationship, or you end a de facto relationship which is recognised by law.	A copy of the relevant Family Court or supporting legal document, or satisfactory evidence of the end of a partnership or de facto relationship such as a statutory declaration or similar sworn statement.
Death of your spouse or de facto partner.	A copy of the death certificate.
Your annual salary increases by at least $10,000.	A copy of the salary review letter from your employer.
You complete your first undergraduate degree at a recognised Australian university, or you complete a postgraduate degree.	Documentation from the Australian university such as a testamur or completion notice.
You take out or increase a mortgage on your primary place of residence (either alone or jointly with another person).	A copy of the mortgage documents.

Future Increase Event	Evidence required
You become a carer.	A letter of confirmation from a Medical Practitioner treating the person you are a carer for.
You have a change in tax dependency status because you ceased to have any tax dependents as defined by Australian taxation law.	Written confirmation from a registered accountant or taxation agent of the change in taxation status.
You qualify as a fellow in your profession.	Written confirmation of fellowship registration by the professional body.
You become a partner in a professional services organisation.	Written confirmation of admission as a partner by the professional service firm partnership, managing partner or authorised representative of the partnership.
You start private practice in a recognised profession.	Written confirmation from the professional registration or accreditation body confirming registration of the private practice.

Total and Permanent Disablement (TPD) Insurance

Purpose

As an optional extra with Life Insurance, this cover pays a lump sum if you're unlikely ever to work again because of sickness or injury.

Sum Insured

You can apply for an amount between $50,000 and $5 million, provided it is not higher than your Life Insurance Sum Insured.

Options

The TPD definitions available are Own Occupation, Any Occupation and Domestic Duties.

Who can apply?

Australian residents, ages 16 - 59. If working less than 15 hours a week, only the Domestic Duties definition is available.

Getting set up

Choice of TPD definition

When you apply for TPD Insurance you will need to select the TPD definition you want.

The choices available to you will depend on your occupation:

Any Occupation – this is our most broadly available definition. We consider your current occupation and any other suited occupation (given your education, training, and experience) in deciding whether you are 'totally and permanently disabled.' This is the only TPD definition that fits with superannuation law and can be used for Trustee Members.

Own Occupation – this definition is available for a select range of occupations, typically professional and white collar. We consider only your current occupation in deciding whether you're 'totally and permanently disabled'. This definition costs more than *Any Occupation*.

Domestic Duties – this definition is only used for those who are not working when they apply for insurance. If you're also not working (or working less than 15 hours) when you claim, we'll consider your ability to do home duties from our set list of domestic activities in deciding whether you're 'totally and permanently disabled'. If you are working just prior to claim, we can use the *Any Occupation* definition.

Benefits

TPD Insurance is available as an optional extra with Life Insurance. Any claim paid under TPD Insurance will reduce the Life Insurance amount (and Trauma Insurance if also taken as an option with Life Insurance) by the amount of TPD benefit paid.

Total and Permanent Disablement (TPD) Benefit

If you become totally and permanently disabled due to Sickness or Injury, we will pay you the agreed cover amount as a lump sum.

'Totally and permanently disabled' means solely because of your Sickness or Injury you meet one of the following criteria:

A) You have been absent from work (or have not performed Domestic Duties) for a continuous period of at least 3 months, and at the end of those 3 months, we're reasonably satisfied that your Sickness or Injury makes it unlikely that you will:

- ever again be able to engage in your Own Occupation (if the *'Own Occupation'* definition applies)
- ever again engage in any gainful employment for which you are reasonably qualified by education, training or experience (if the *'Any Occupation'* definition applies)
- ever again be able to perform your usual unpaid Domestic Duties (if the *'Domestic Duties'* definition applies).

B) You have suffered *Loss of Limbs and/or Sight - total and permanent*.

C) You have suffered *Loss of Independence - total and permanent*.

However:

- If you are a Trustee Member, you must meet the criteria for the *'Any Occupation'* definition.
- If you have a *'Domestic Duties'* definition due to being a homemaker when you apply for cover, we will assess you under the *'Any Occupation'* definition if you had been working for more than 6 consecutive months – and more than 15 hours per week on average – immediately prior to claim.
- If you are under the age of 65 and permanently retired from the workforce at the time of disablement, the *'Domestic Duties'* definition will apply.
- If you are age 65 or older, you must meet the criteria for 'B' or 'C' above.

Financial Advice Benefit

We'll reimburse the cost of you or your spouse/partner engaging a financial adviser, up to $5,000, to prepare a financial plan if we pay a TPD Insurance Benefit more than $200,000.

If your Sum Insured is more than $1 million and your insurance has been in place for at least 2 years, the upper limit on this benefit is increased to $10,000.

You must send us suitable evidence of the paid invoices within 12 months of the claim payment. The financial adviser must be operating under an appropriate Australian Financial Services License. This benefit is payable once only.

Exclusions and limitations

Exclusions

We won't pay any TPD insurance claim if the claim is caused or contributed to by any attempted self-inflicted injury, suicide attempt (whether sane or insane) within 13 months from the commencement, reinstatement or increase of the insurance cover (but only to the extent of that increase).

Compliance with superannuation law

There are special rules from superannuation law on which benefits we can pay for insurance inside superannuation. If you are a Trustee Member, we will only be able to pay a benefit if you meet the *'Any Occupation'* definition (in addition to any other criteria used to assess your claim).

Special Acceptance Terms

Benefits will be subject to any exclusion or limitation, which is specific to you and noted in any special acceptance terms applying in respect of your cover.

End date

This insurance ends, along with our liability to pay any claim, at the policy anniversary after your 75th birthday.

See also 'When does cover end?' on page 8.

Features to manage your cover over time

Indexation

We increase your sum insured at each policy anniversary to guard against inflation. The increase applies automatically and is the increase in the Consumer Price Index or 3%, whichever is more. Your premium will automatically adjust to reflect the increase in cover.

You can refuse each year's increase or cancel these automatic increases by letting us know in writing. If you decline 3 consecutive increases, we won't make any further increases. Indexation increases stop at age 64.

Future Increases Benefit

You can increase your Sum Insured without the need to provide further medical evidence if a future increase event occurs while you are less than 60 years of age.

The future increase events are specified life events that are connected with an increased insurance need, such as taking out or increasing a mortgage, or having a child. Refer to page 18 and 19 for the allowable events.

You must let us know within 90 days of the allowable event, or within the 30 days of the next anniversary of your cover which follows the allowable event, supplying the relevant supporting evidence.

The increase can be the lesser of the following:

- 25% of the original Sum Insured
- 50% of the original Sum Insured in the case of a new or increased mortgage
- your new mortgage amount or increased mortgage amount
- 10 times the amount of your salary increase if you are employed (in the case of a salary increase), or
- $250,000.

During the first six months after exercising the Future Increases Benefit, the added cover amount only covers TPD due to Accident.

You can only use the Future Increases Benefit once in any 12-month Anniversary Period. The total value of increases cannot exceed 100% of the original cover amount provided to you when your cover started. Nor can it exceed $1 million for all increases during your period of membership.

You can't exercise the Future Increases Benefit:

- while we are waiving your premiums at your request
- if you have a medical loading or medical exclusion on your TPD Insurance cover, or
- if you're eligible to make a claim, or seeking payment of a claim, with us or any other insurer.

Benefit reduction after age 65

After you turn age 65, we reduce your Sum Insured at each anniversary by 10% (of the value at age 65) until expiry by age 75, when the Sum Insured will be exhausted. We calculate your premiums each year against the reduced Sum Insured.

Premium Freeze Benefit

You can freeze the cost of your TPD cover at any time by contacting us with your request to exercise the Premium Freeze Benefit. This means that:

- Your future premiums will stay the same as they are when you make the request; and
- We'll reduce your Sum Insured each year to the amount that premium amount will pay for.

You can contact us at any time to end the Premium Freeze Benefit and the premium freeze will end on the next anniversary of your cover.

Premium Pause

If you become Involuntarily Unemployed or need to take extended leave from employment (other than for travel) because of full time study, parental leave, or compassionate leave, then you can contact us and ask us to pause payment of your premiums for up to 12 months.

When you restart your cover, we will not pay any claim arising from an event which occurs during the premium pause or within 90 days of after the end of your premium pause and restarting your premium payments. This means that we will not pay any benefit for Total & Permanent Disablement arising from a Sickness or Injury occurring, or for a Terminal Illness being diagnosed, during a premium pause or within 90 days after the end of your premium pause and restarting your premium payments.

The premium pause is only available once your cover has been in place for more than 2 years. You are not covered during the premium pause period and cannot claim during that period.

Waiver of Premium While Involuntarily Unemployed

If you become Involuntarily Unemployed for longer than 30 consecutive days (other than as a direct result of any Sickness or Injury), we'll waive the premium for up to 3 months in total while you're Involuntarily Unemployed. The waived premium starts from your next premium due date, at least 31 days after you become Involuntarily Unemployed.

The waiver of premium is only available:

- for monthly premiums
- if your cover has been in place for at least 12 consecutive months
- if you are an employee (excluding self-employment, including partners in a partnership), and
- in respect of future premiums (those that are due to become payable).

You must let us know in writing no later than 14 days before the relevant premium payment due date for which you are applying to have the premium waived under this benefit.

You must provide us with any suitable evidence that shows you are Involuntarily Unemployed, e.g. a separation letter from your employer.

Premium payments will resume at the end of the waiver period.

TPD defined terms

Any Occupation
means any occupation, business, or employment for which the Life Insured is reasonably suited by education, training or experience.

Domestic Duties
means the following five activities performed by a Life Insured unassisted by another person, where the Life Insured's sole occupation is to maintain the family home:

1. Cleaning of the home, i.e. the ability to carry out basic internal household chores using various tools such as a mop or vacuum cleaner.

2. Cooking meals, i.e. the ability to prepare meals using basic ingredients and normal kitchen appliances.

3. Doing the family laundry, i.e. the ability to maintain the household's laundry by using the washing machine and being able to hang clothes on a washing line or clothes airer.

4. Shopping for the family's groceries, i.e. the ability to physically purchase general household grocery items with either the use of a shopping basket or trolley.

5. Taking care of dependant children (where applicable), i.e. if the Life Insured normally looks after a child or children up to the age of 12 as part of their everyday activities. Taking care of dependent children means the ability to care for and supervise the children, including preparation of meals, bathing, dressing and getting the children to and from school by the usual mode of transport.

Loss of Independence - total and permanent
means a condition, as a result of a Sickness or Injury, that results in the Life Insured:

- being totally and permanently unable to perform at least 2 of the 5 Activities of Daily Living without the standby assistance of another person, or
- suffering Severe Cognitive Impairment - permanent.

'Severe Cognitive Impairment – permanent' means you have suffered a total and permanent deterioration of intellectual capacity that has required you to be under continuous care and supervision by another adult person for at least 6 consecutive months, and:

- This has been measured and validated by a recognised assessment instrument such as a Mini-Mental State Examination (MMSE) with a score of 20 or less out of 30, or other appropriate tool with equivalent level of severity.
- At the end of the six-month period, in the reasonable opinion of an appropriate Specialist Medical Practitioner, you require permanent ongoing continuous care and supervision by another adult person.

Loss of Limbs and/or Sight - total and permanent
means the total and permanent loss of any of the following:

- the use of both hands
- the use of both feet
- the sight in both eyes (to the extent of 6/60 or less*)
- the use of one hand and one foot
- the use of one hand and the sight of one eye (to the extent of 6/60 or less), or
- the use of one foot and the sight of one eye (to the extent of 6/60 or less).

*'to the extent of 6/60 or less' means that even with the use of visual aids, the Life Insured needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.

Own Occupation
means the occupation, business, or employment in which you were gainfully employed at the time of the Sickness or Injury for which the claim for total and permanent disablement is made. If not gainfully employed at that time, it is the occupation, business, or employment in which you were most recently gainfully employed.

Trauma Insurance

Purpose

This cover pays a lump sum benefit if you suffer a serious listed medical condition. Available as stand-alone cover, or optional with Life Insurance cover.

Sum Insured

You can apply for an amount between $50,000 and $2 million. If taken as an optional extra to Life Insurance, it can be no higher than your Life Insurance Sum Insured.

Options

Includes 6 Main Trauma Events and 31 Other Trauma Events.

Who can apply?

Australian residents, ages 18 - 59.

Benefits

Where Trauma Insurance is an optional extra with Life Insurance, any claim paid will reduce the Life Insurance cover amount (and TPD Insurance cover amount if also taken) by the amount of the Trauma Benefit paid.

For stand-alone Trauma Insurance, any claim paid will have no impact on any other insurance cover you hold with NobleOak.

Trauma Benefit

If you suffer one of the specified *Main Trauma Events* or *Other Trauma Events* while covered for Trauma Insurance, we will pay you the Sum Insured as a lump sum.

The *Main Trauma Events* are:

- Cancers – excluding specified early-stage cancers
- Coronary Artery Angioplasty – through specific procedures*
- Coronary Artery By-Pass through open chest surgery
- Heart Attack – with evidence of severe heart muscle damage
- Stroke – in the brain resulting in specified permanent impairment
- Three Vessel Coronary Artery Disease – requiring specific treatment

The claim criteria for each of the *Main Trauma Events* is in the Medical Definitions Dictionary starting from page 35.

Your Trauma Insurance includes 31 *Other Trauma Events*. These trauma events are less commonly claimed.

The full list of the *Other Trauma Events* and their claim criteria is in the Medical Definitions Dictionary starting from page 37.

A 90-day qualifying period applies on each of the Main Trauma Events and any of the *Other Trauma Events* denoted with a # symbol.

The terms for the 90-day qualifying period are on page 31.

A Survival Period applies to stand-alone Trauma Insurance, being a period of at least 14 days that you must survive after a Trauma Event without the aid of an artificial life support system.

*This benefit pays 25% of the Sum Insured to a maximum of $25,000. Once paid, the Sum Insured will reduce by the amount of the benefit paid, with a corresponding reduction to premium. You can claim again if the event occurs again in a future year (but not again in the same year).

Funeral Benefit

For stand-alone Trauma Insurance, we'll pay a benefit of $5,000 if you die and no other benefits are payable under stand-alone Trauma Insurance.

Financial Advice Benefit

We'll reimburse the cost of you or your spouse/partner engaging a financial adviser, up to $5,000, to prepare a financial plan if we pay a Trauma Insurance Benefit more than $200,000.

If your Sum Insured is more than $1 million and your insurance has been in place for at least 2 years, the upper limit on this benefit is increased to $10,000.

You must send us suitable evidence of the paid invoices within 12 months of the claim payment. The financial adviser must be operating under an appropriate Australian Financial Services License. This benefit is payable once only.

Medical Advancement Protection

The Life Insurance Code of Practice holds minimum standard definitions for 3 of the most common trauma events. They are:

- Cancers – excluding specified early-stage cancers.
- Heart Attack – with evidence of severe heart muscle damage.
- Stroke – in the brain resulting in specified permanent impairment.

The definition sets out any tests or diagnosis that show a level of severity for the insurance purpose. As medical practices change over time, the minimum standard definitions are also reviewed and revised regularly.

We reference the Life Insurance Code of Practice and consult medical specialists to regularly review the definitions for all the trauma events included with My Protection Plan.

If the criteria set out in the Medical Definitions for diagnosing a Trauma Event are superseded, inconclusive or impractical to apply because of medical advances, we will consider other medically recognised methods that conclusively diagnose the listed Trauma Event to at least the same severity.

We'll consider other diagnostic methods under the following conditions:

- They are not considered experimental.
- They are medically necessary, and they are equivalent or superior to the original diagnostic techniques or investigations.
- They are recognised by medical specialists in Australia as medically acceptable in accordance with relevant medical practice standards and guidelines.

Exclusions and limitations

Exclusions

A benefit will not be payable for Trauma Insurance for the following cases:

- You have selected stand-alone Trauma Insurance, and the Life Insured does not survive for a period of at least 14 days after the Trauma Event without the aid of an artificial life support system.
- A Trauma Event is caused or contributed to by intentional self-inflicted injury, attempted suicide, or suicide by the Life Insured, whether sane or insane, within 13 months following the commencement, reinstatement or increase of the insurance cover (but only to the extent of that increase).

90-day qualifying period

Each of the *Major Trauma Events* and any of the *Other Trauma Events* denoted with a # in the Medical Definitions have a 90-day qualifying period.

Refer to the Medical Definitions starting on page 35.

This means that a Trauma Benefit will not be payable if it is first diagnosed or occurs within 90 days of:

- the Trauma Insurance start date
- reinstatement of your Trauma Insurance, or
- an increase in your Trauma Insurance cover amount (but only to the extent of that increase).

The 90-day qualifying period exclusion will not apply to your cover if it replaced an existing Trauma cover issued by us or another insurer, as long as:

- The insurance under the replaced cover was in place for at least 90 days immediately prior to the commencement of this policy.
- The replaced cover provided similar cover for the same trauma conditions or events that are expressed to be subject to the 90-day qualifying period under this cover.
- The replaced cover was cancelled immediately after the issue of this cover.
- Any similar qualifying period has expired under the replaced cover (including exclusions which were applied to the cover after its commencement due to, for example, reinstatements or increases).
- The cover amount under this cover is the same or less than the cover amount under the replaced cover.
- No claim is payable or pending under the replaced cover.

Where your Sum Insured is greater than your replaced cover, we'll apply the 90-day qualifying period exclusion to the difference in the sums insured.

Special Acceptance Terms

Benefits will be subject to any exclusion or limitation, which is specific to you and noted in any special acceptance terms applying in respect of your cover.

End date

This insurance ends, along with our liability to pay any claim, at the policy anniversary after your 70th birthday.

See also 'When does cover end?' on page 8.

Features to manage your cover over time

Premium Freeze Benefit

You can freeze the cost of your Trauma Insurance at any time by contacting us with your request to exercise the Premium Freeze Benefit. This means that:

- Your future premiums will stay the same as they are when you make the request; and
- We'll reduce your Sum Insured each year to the amount that premium amount will pay for.

You can contact us at any time to end the Premium Freeze Benefit and the premium freeze will end on the next anniversary of your cover.

Indexation

We increase your Sum Insured at each policy anniversary to guard against inflation. The increase applies automatically and is the increase in the Consumer Price Index or 3%, whichever is more. Your premium will automatically adjust to reflect the increase in cover.

You can refuse each year's increase or cancel these automatic increases by letting us know in writing. If you decline 3 consecutive increases, we won't make any further increases. Indexation increases stop at age 59.

Premium Pause

If you become Involuntarily Unemployed or need to take extended leave from employment (other than for travel) because of full time study, parental leave, or compassionate leave, then you can contact us and ask us to pause your premiums for up to 12 months.

When you restart your cover, we will not pay any claim arising from an event which occurs during the premium pause or within 90 days after the end of your premium pause and restarting your premium payments.

The premium pause is available once your cover has been in place for more than 2 years. You are not covered during the premium pause period and cannot claim during that period.

Waiver of Premium While Involuntarily Unemployed

If you become Involuntarily Unemployed for longer than 30 consecutive days (other than as a direct result of any Sickness or Injury), we'll waive the premium for up to 3 months in total while you're Involuntarily Unemployed. The waived premium starts from your next premium due date, at least 31 days after you become Involuntarily Unemployed.

The waiver of premium is only available:

- for monthly premiums
- if your cover has been in place for at least 12 consecutive months
- if you are an employee (excluding self-employment, including partners in a partnership), and
- in respect of future premiums (those that are due to become payable).

You must let us know in writing no later than 14 days before the relevant premium payment due date for which you are applying to have the premium waived under this benefit.

You must provide us with any suitable evidence that shows you are Involuntarily Unemployed, e.g. a separation letter from your employer.

Premium payments will resume at the end of the waiver period.

Medical Definitions

Main Trauma Events

Each Trauma Event needs an unequivocal diagnosis by a Medical Practitioner (or by a Specialist Medical Practitioner if noted in the medical definition for the Trauma Event) before we make a payment.

A 90-day qualifying period applies on each of the Main Trauma Events, noted with a #.

See exclusion details on page 31.

Cancers – excluding specified early-stage cancers#
means any malignant tumour diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and the invasion and destruction of normal tissue beyond the basement membrane.

The term malignant tumour includes:

- leukaemia
- sarcoma
- lymphoma
- multiple myeloma and malignant bone marrow disorders, and
- inaccessible brain tumours described as malignant on neuroimaging.

The following are not covered:

- All tumours which are histologically classified as any of the following:
  a) pre-malignant
  b) non-invasive
  c) high-grade dysplasia
  d) borderline or low malignant potential.
- Carcinoma in situ except carcinoma in situ of the breast where a total mastectomy with full removal of the breast has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
- All cancers of the prostate unless:
  a) histologically classified as having a Gleason score of 7 or above
  b) having progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system, or
  c) where a total prostatectomy has been undertaken where the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment.
- All cancers of the thyroid unless:
  a) having progressed to at least TNM classification T2N0M0; or
  b) where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
- All cancers of the bladder unless having progressed to at least TNM classification T1N0M0.
- Cutaneous lymphoma confined to the skin.
- Chronic lymphocytic leukaemia unless having progressed to at least Rai stage I.
- All non-melanoma skin cancers unless greater than 4cm or having invaded perineural tissue or beyond the subcutaneous fat, or where there is evidence of spread to bone, lymph nodes or other distant organs.
- All melanoma skin cancers unless having progressed to at least TNM classification T2bN0M0.
- Pituitary Neuroendocrine Tumours (PitNETs) unless invasion of surrounding structures or metastasis is unequivocally proven histologically and/or radiologically by Magnetic Resonance Imaging (MRI).

Coronary Artery Angioplasty - through specific procedures#
means the treatment of the narrowing or blockage of one or more coronary arteries by balloon angioplasty (or similar intra-arterial catheter procedure) with or without the use of a stent.

Angiographic evidence is required to confirm the need for this procedure.

This benefit is payable once in any 12-month period.

Coronary Artery By-Pass Graft Surgery#
means the actual undergoing of coronary artery by-pass graft surgery, either through an open-heart operation or through a keyhole surgical technique, for the treatment of coronary artery disease.

The operation must be for the treatment of one or more coronary arteries and angioplasty contra-indicated and must be considered necessary by an appropriate Specialist Medical Practitioner.

Endovascular procedures are specifically excluded.

Heart Attack – with evidence of severe heart muscle damage#
means the death of a portion of the heart muscle as a result of ischaemia (inadequate blood supply to the heart muscle), where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least 3 of the following:

a) Symptoms of ischaemia consistent with a heart attack.
b) New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block(LBBB).
c) Development of new pathological Q waves in the ECG.
d) Imaging evidence of new regional wall motion abnormality present at least six weeks after the event.
e) Identification of a coronary thrombus by angiography or other intracoronary imaging.

If the tests specified in a) to e) above are inconclusive or unable to be met, then the definition will be met if at least 3 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 as a result of an elective percutaneous procedure for coronary artery disease.
- Other acute coronary syndromes including but not limited to angina pectoris.
- Other causes of increased troponin levels in non-obstructive coronary arteries including myocarditis or coronary spasm where there is no evidence of infarction.
- Any cardiomyopathy including Takotsubo cardiomyopathy (Takotsubo Syndrome).

Stroke – in the brain resulting in specified permanent impairment#
means death of brain tissue caused by one of the following:

- Ischaemic infarction of brain tissue.
- Intracranial haemorrhage (cerebral, intraventricular, or subarachnoid).

The diagnosis must be supported by both of the following:

- Evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event; and
- Findings on MRI, CT, or other reliable imaging evidence consistent with the diagnosis of a new stroke.

The following are not covered:

- transient ischaemic attacks;
- brain damage due to an accident, injury, infection, or non-vasculitic inflammatory disease;
- vascular disease affecting the eye or optic nerve;
- ischaemic disorders of the vestibular system;
- strokes caused by or related to illicit drug use or substance abuse;
- migraine; or
- hypoxic events.

Words within the definition that have special meaning:

'Permanent neurological deficit with persisting symptoms' means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. It includes outcomes such as: numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function.

The following do not constitute 'permanent neurological deficit with persisting symptoms':

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

Three Vessel Coronary Artery Disease – requiring specified treatment#
means undergoing angioplasty (with or without stent insertion) on 3 or more different coronary arteries within a single procedure, or in two procedures no more than two months apart, as considered necessary by a Specialist Medical Practitioner in the field to treat severe coronary artery disease.

Angiographic evidence of triple vessel coronary artery disease prior to the first procedure is required to confirm the need for the procedure(s).

Other Trauma Events

Each Trauma Event needs an unequivocal diagnosis by a Medical Practitioner (or by a Specialist Medical Practitioner if noted in the medical definition for the Trauma Event) before we make a payment.

A 90-day qualifying period applies on the Other Trauma Events, noted with a #.

See exclusion details on page 31.

Accidental HIV Infection – contracted through occupation or medical procedures#
means infection with the human immunodeficiency virus (HIV) acquired by accident or violence during the course of the Life Insured's normal occupation or through the medium of a blood transfusion, transfusion of blood products, organ transplant, assisted reproduction technique or other medical procedure or operation performed by a doctor or at a recognised medical facility.

Seroconversion evidence of the HIV infection must occur within 6 months of the accident. HIV infection transmitted by any other means, including but not limited to sexual activity or non-medical intravenous drug use, is not Accidental HIV Infection under this policy.

You are encouraged to report an accident or violent incident giving rise to a potential claim to us within 30 days. The Life Insured's infection needs to be supported by a negative HIV Antibody Test taken within 7 days after the accident or violent incident. We require a statement from the appropriate Statutory Health Authority that provides documented proof of the incident and confirms that the infection is medically acquired.

The definition will not be met if:

- The Australian government or relevant government body has approved a medical treatment or cure which renders the virus inactive and non-infectious.
- The infection arises from a deliberate, self-inflicted, or induced cause, or from sexual activity (whether as part of your occupational duties or otherwise), or from the use of drugs not medically prescribed to you.
- In practising your own occupation, you have not made reasonable efforts to comply with relevant State and Commonwealth guidelines in relation to preventing infection of health care workers.
- You have not taken an approved vaccine that is recommended by the relevant government body for use in your own occupation and is available prior to the event which causes infection.

Alzheimer's Disease – permanent and of specified severity
means an irreversible state of cognitive decline with loss of intellectual capacity, mental and social functioning, and/or having abnormal behaviour, arising from Alzheimer's disease.

The unequivocal diagnosis must be clinically confirmed by a Specialist Medical Practitioner in the field and be supported with a Mini-Mental State Examination score of 24 or less (or an equivalent level of severity assessed under another clinically appropriate cognitive assessment instrument).

Neurosis and other psychiatric illnesses are excluded.

Aplastic Anaemia – requiring specified treatment
means chronic persistent bone marrow failure, which results in anaemia, neutropenia and thrombocytopenia requiring treatment over a period of at least 2 months by at least one of the following:

- blood product transfusion
- marrow-stimulating agents
- immunosuppressive agents
- bone marrow transplantation (including stem cell transplantation).

Bacterial Meningitis – resulting in significant permanent impairment
means bacterial infection of the meninges (the thin layers surrounding the brain and spinal cord) causing permanent and significant functional impairment as evidenced by a permanent inability to perform at least one of the Activities of Daily Living without the standby assistance of another person.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field. All other forms of meningitis, including viral, are excluded.

Blindness – severe and irreversible in both eyes
means severe irreversible loss of sight in both eyes, as certified by a Specialist Medical Practitioner in the field. Loss of sight means that best corrected visual acuity is reduced to at least 6/60 visual acuity, or the visual field is reduced to at least 20 degrees of arc.

For clarity:

- Any loss of sight that is reversible through treatment or visual aids, including (but not limited to) cataracts, is excluded as it would not be considered irreversible.

- 'Best corrected visual acuity is reduced to at least 6/60' means that even with the use of visual aids, the Life Insured needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.
- 'Visual field is reduced to at least 20 degrees of arc' means that the Life Insured's field of vision is less than 20 degrees in diameter.

Cardiomyopathy (heart failure) – resulting in permanent and significant impairment
means a condition of impaired ventricular function resulting in:

- permanent physical impairment to the extent of at least Class 3 on the New York Heart Association classification of cardiac impairment, or
- a persistent left ventricular ejection fraction of less than or equal to 35% despite optimal medical therapy.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Chronic Liver Failure – of specified severity
means end-stage liver failure, resulting in two of the following being permanent:

- jaundice (yellow discolouration of the skin or eyes)
- refractory ascites (abnormal build-up of fluid in the abdomen), or
- hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease).

Chronic Lung Disease – of specified severity or requiring long-term oxygen therapy
means end-stage respiratory failure requiring long-term oxygen therapy, or with a PaO2 consistently less than 55mmHg.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Coma (impaired consciousness) – of specified severity and requiring specific treatment
means a state of unconsciousness with abnormal response to external stimuli or internal needs with a Glasgow Coma Scale of 6 or less, requiring mechanical ventilation for a continuous period of at least 72 hours.

Dementia – resulting in significant cognitive impairment
means the unequivocal diagnosis of dementia resulting in significant cognitive impairment, as confirmed by a Specialist Medical Practitioner in the field. Significant cognitive impairment means deterioration in the Life Insured's Mini-Mental State Examination scores to 20 or less, or an equivalent level of deterioration assessed under another clinically appropriate cognitive assessment instrument.

Diplegia – total and permanent
means the total and permanent loss of function of both sides of the body (such as both arms or both sides of the face) due to spinal cord injury or disease, or brain injury or disease.

Heart Valve Replacement – through specific procedures#
means the actual undergoing of either open heart surgery or a minimally invasive keyhole procedure to replace or repair cardiac valves, as a consequence of heart valve defects or abnormalities.

Hemiplegia – total and permanent-
means the total and permanent loss of function of one side of the body (such as one arm and one leg of the same side of the body) due to spinal cord injury or disease, or brain injury or disease.

Kidney Failure – requiring regular renal dialysis or renal transplantation
means end-stage renal failure, which presents as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation is carried out.

The definition will be met if, despite the need for regular dialysis or a kidney transplant as confirmed by a Specialist Medical Practitioner in the field, the Life Insured chooses renal supportive care.

Loss of Hearing – irreversible and of specified severity (except by Cochlear implant)
means a confirmed diagnosis of profound, irreversible hearing loss in both ears with any one of the following:

- best corrected hearing threshold of 81 decibels or greater in the better ear, averaged at frequencies from 500Hz to 3,000Hz; or
- requiring or undergoing cochlear implant due to loss of hearing in both ears.

The diagnosis must be made by an appropriate Specialist Medical Practitioner.

Loss of Independence - total and permanent
means a Sickness or Injury that results in the Life Insured:

- being totally and permanently unable to perform at least 2 of the Activities of Daily Living without the standby assistance of another person, or
- suffering Severe Cognitive Impairment – permanent.

For the purposes of this definition 'Severe Cognitive Impairment – permanent' means you have suffered a total and permanent deterioration of intellectual capacity that has required you to be under continuous care and supervision by another adult person for at least 6 consecutive months, and:

- this has been measured and validated by a recognised assessment instrument such as a Mini-Mental State Examination (MMSE) with a score of 20 or less out of 30, or other appropriate tool with equivalent level of severity; and
- at the end of the six-month period, in the reasonable opinion of an appropriate Specialist Medical Practitioner, the Life Insured requires permanent ongoing continuous care and supervision by another adult person.

Loss of Limbs and/or Sight – total and permanent
means the total and permanent loss of any of the following:

- the use of both hands
- the use of both feet
- the sight in both eyes (to the extent of 6/60 or less*)
- the use of one hand and one foot
- the use of one hand and the sight of one eye (to the extent of 6/60 or less), or
- the use of one foot and the sight of one eye (to the extent of 6/60 or less).

*'to the extent of 6/60 or less' means that even with the use of visual aids, the Life Insured needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.

Loss of Speech – total and irrecoverable
means the total and irrecoverable loss of the ability to produce intelligible speech due to Sickness or Injury, which must be established, and the diagnosis reaffirmed after a continuous period of 3 months of such loss by a Specialist Medical Practitioner in the field. Loss of speech due to any psychological cause is excluded.

Major Brain Injury – resulting in significant permanent impairment
means an accidental head injury resulting in permanent neurological deficit causing:

- the total and permanent inability to perform any 1 of the Activities of Daily Living without the assistance of another person; or
- a Montreal Cognitive Assessment (MoCA) test with a persistent score of 17 or less, or other standardised cognitive assessment test with an equivalent severity.

'Accidental head injury' means a bump, blow, or jolt to the head, or penetrating head injury.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Major Burns – of specified severity and requiring specific treatment
means thermal, electrical, or chemical injury causing deep partial thickness burns or full thickness burns to the skin requiring surgical debridement and skin grafting or flap reconstruction to at least:

- 20% of the total body surface area as measured by the Lund-Browder Chart or 'Rule of Nines'
- 50% of both hands
- 50% of both feet, or
- any part of the face.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Major Organ Transplant of specified organs from a human donor, or placement on a waiting list#
means having received, from a human donor, a medically necessary transplant involving one or more of the following organs or tissues:

- kidney
- heart
- liver
- lung
- pancreas
- small bowel, or
- bone marrow/haematopoietic (stem) cells.

The definition will also be met upon being placed on the Australian or New Zealand Transplant Society waiting list (such as OrganMatch) to receive a major organ or tissue transplant of the kind described above.

The transplantation of all other organs or parts of any organ or any other tissue or grafts is excluded.

Motor Neurone Disease
means a group of progressive neurodegenerative diseases that specifically affect motor neurones and result in permanent rapid weakening of the muscles that enable a person to move, speak, breathe, and swallow.

This means the unequivocal diagnosis of any of the following types of motor neurone disease, made by a Specialist Medical Practitioner in the field and supported with appropriate tests:

- Amyotrophic lateral sclerosis (ALS)
- Progressive muscular atrophy (PMA)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Flail arm (or leg) syndrome
- ALS-plus syndrome

Multiple Sclerosis
means an immune-mediated inflammatory disease, causing neurological impairment, due to an immune system attack on myelinated nerves in the brain, spinal cord, and/or optic nerves.

The unequivocal diagnosis of multiple sclerosis must be confirmed by a Specialist Medical Practitioner in the field and supported by:

- relevant clinical/neurological findings, and
- radiological evidence of lesions in the central nervous system (such as Magnetic Resonance Imaging).

Clinically isolated syndrome is excluded.

Muscular Dystrophy
means a hereditary condition marked by progressive weakness and wasting of the muscles. The unequivocal diagnosis must be made by a Specialist Medical Practitioner in the field.

Paraplegia – total and permanent
means the total and permanent loss of function of both the lower limbs due to spinal cord injury or disease, or brain injury or disease.

Parkinsons Disease and specified Parkinson Plus Syndromes – with specified severity
means a confirmed diagnosis of any one of the following progressive neurodegenerative disorders characterised clinically by the presence of parkinsonism:

- Idiopathic Parkinson's Disease
- Progressive Supranuclear Palsy
- Dementia with Lewy Bodies
- Multiple System Atro
- Corticobasal Degeneration;

and resulting in the Life Insured being unable to perform at least 1 of the Activities of Daily Living without the standby assistance of another person.

'Parkinsonism' means the presence of both of the following:

- Bradykinesia (slowness of movement plus a decrement in speed or progressive hesitations as movements are continued); and
- Rigidity (extreme stiffness or resistance with passive movement of the major joints whilst in a relaxed position) or slow resting tremor (observed in a fully resting limb and suppressed when initiating movement).

All other forms of parkinsonism are excluded, including drug-induced parkinsonism.

Pulmonary Arterial Hypertension (idiopathic and familial) – resulting in significant right heart failure#
means a confirmed diagnosis of idiopathic or familial pulmonary arterial hypertension (meaning of a spontaneous or unknown cause, or inherited), with evidence of right ventricular enlargement resulting in permanent physical impairment of at least Class III of the World Health Organisation Functional Classification of Pulmonary Hypertension.

All other causes of pulmonary arterial hypertension are specifically excluded.

Quadriplegia – total and permanent
means the total and permanent loss of function of both arms and both legs due to spinal cord injury or disease, or brain injury or disease.

Repair to the thoracic or abdominal aorta (excluding its branches and with specified treatment)
means the correction of any narrowing, dissection, or aneurysm of the thoracic or abdominal aorta (but not any of its branches) either through open thoracic or abdominal surgery or Endovascular Aneurysm Repair (EVAR). Angioplasty and other non-surgical techniques are excluded.

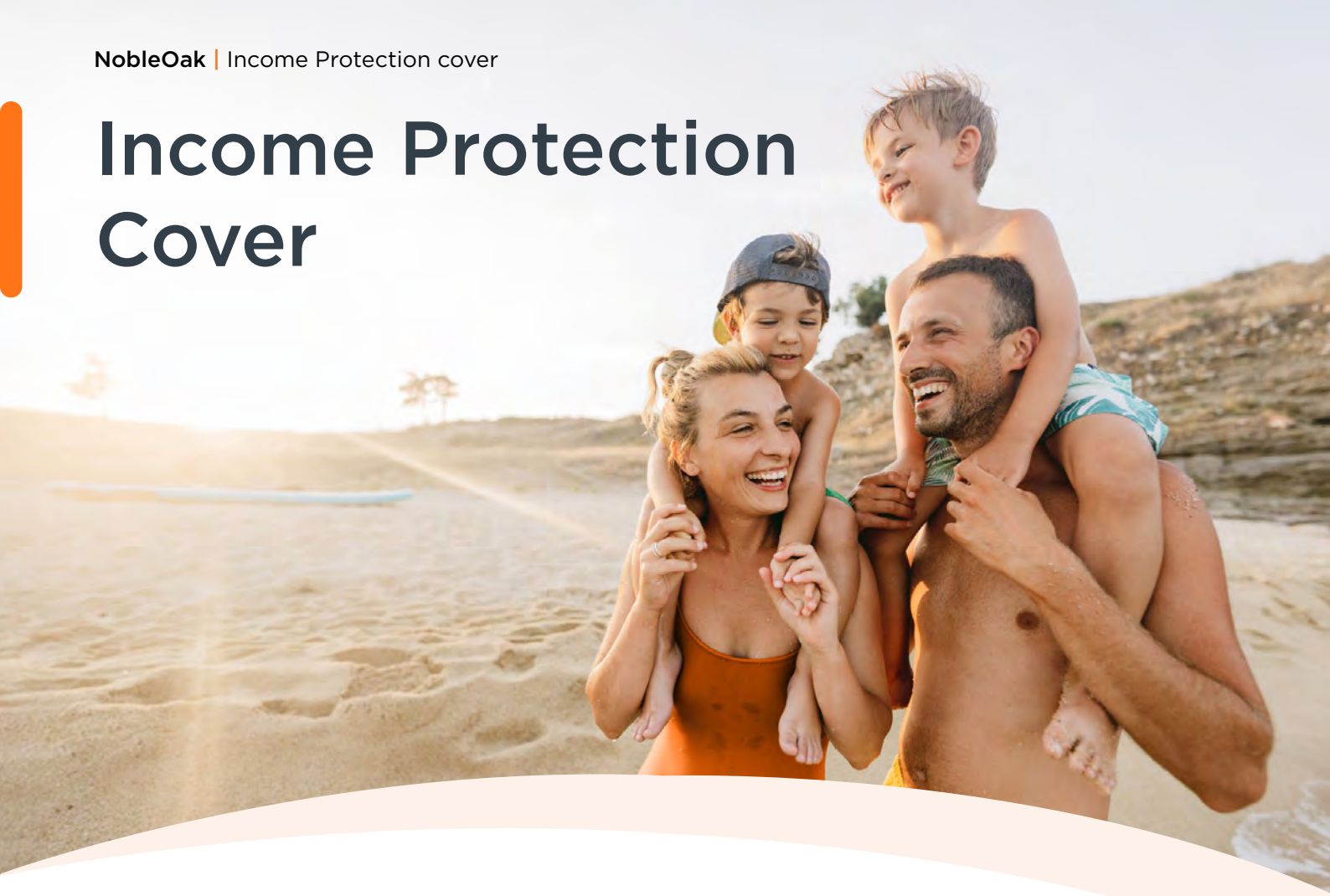
Terminal Illness
means that two Medical Practitioners (one of which is a specialist practising in an area related to the illness or injury suffered by the Life Insured) must certify (either in two individual reports or one joint report) that the Life Insured suffers from an illness, or has incurred an injury, that is likely to result in death of the Life Insured within a period that ends not more than 24 months after the date of certification.

Where certification is issued by way of individual reports from two separate Medical Practitioners, both certifications must include diagnosis and life expectancy. The date of certification shall be taken to be the date of the most recent certification.

Viral Encephalitis – resulting in significant permanent neurological impairment
means the diagnosis of acute inflammatory disease of the brain tissue (viral, bacterial, or autoimmune) resulting in neurological deficit causing significant functional impairment as evidenced by a permanent inability to perform at least 1 of the Activities of Daily Living without the standby assistance of another person.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Income Protection Cover



Purpose

This cover pays a monthly benefit if you cannot work due to sickness or injury.

Sum Insured

You can apply to insure up to 70% of your income. The maximum monthly benefit is $30,000

Options

Waiting Periods: 30, 60, 90 or 730 days from the date of Disability during which no benefit is paid.

Benefit Periods: 1, 2, 5 or 10 years, or to age 65.

Two extra cost options available, Claim Increase Benefit and Monthly Superannuation Benefit.

Who can apply?

Ages 18 – 60, working at least 20 hours per week (only 1 or 2 year Benefit Periods are available if you are over age 55 when you apply).

Getting set up

Set your Sum Insured

Your *sum insured* is based on your application and your eligibility for up to:

- 70% of the first $25,000 per month ($300,000 per annum) of your *regular income*; plus
- 50% of the next $25,000 per month ($300,000 per annum) of your *regular income* (and 0% thereafter).

You may choose to insure a lower amount. The monthly benefit together with the *Monthly Superannuation Benefit* (if applicable, see below) cannot exceed $30,000 per month.

At the time of application, our underwriting team will consider your income level, income sources (including passive income that would continue if you could not work), and other insurance cover you hold which supports or replaces income. This information will affect how much you can insure.

At the time of claim, we calculate your *monthly benefit* based on the lesser of the *income replacement amount* and your *Sum Insured*.

Your *Sum Insured is* the maximum *monthly benefit* you can claim.

The amount we pay for a claim could be lower for a few reasons:

- We will apply the same calculation of your maximum monthly benefit against your recent earnings, which could be lower if your income has reduced since the time you applied or if you overstated your income.
- The amount we pay could be reduced further if you are working, or able to work, or you have other sources of income replacement.
- For Benefit Periods of 10 years or to age 65, we lower the maximum monthly benefit by 1/7th after 2 years on claim.

The monthly benefit we pay at claim depends on your income and earnings situation at the time of your disability. The Sum Insured is the maximum amount we will pay. This means you could be insured for more than you can claim if:

- your income hasn't increased with inflation, but your insurance has, or
- your income has reduced, and you haven't updated your Sum Insured.

If your income has reduced since taking out your insurance cover, you should consider whether you should also reduce your Sum Insured. Alternatively, if you will be off work for some time, you may wish to suspend your cover. Please contact us if you want to apply to make changes.

Similarly, if your income has increased, you may consider whether you wish to increase your Sum Insured (any increase is subject to our usual underwriting requirements). You should also note the Future Income Increase Benefit, which can apply to eligible members who apply for the increase within 60 days of a salary increase. See page 54 for more information.

In your annual renewal statement, we include a reminder for you to consider your income and earnings regularly.

Contact us if you feel you want to change your Sum Insured or need help working out your maximum benefit.

Choose from the optional extras

These options are available at an extra cost:

- Claim Payment Increase Benefit – for the monthly benefit *on claim* to increase with inflation (up to 3%)
- Monthly Superannuation Benefit – an added Sum Insured to continue super contributions if you claim. It is paid directly to your super fund.

Choose a Benefit Period

You select a Benefit Period when you apply for this product.

The Benefit Period is the maximum period of time that you can receive a monthly benefit (and a *Monthly Superannuation Benefit* if it applies) while you are continuously *Disabled*. The choices are:

- 1, 2, 5 or 10 years – the total number of years you can receive the benefit for any one claim event, or
- To age 65 – the Benefit Period ends at the policy anniversary while you are age 65.

The Benefit Period starts at the end of the Waiting Period.

Premiums for shorter Benefit Periods are generally lower than those for a longer Benefit Period.

Choose a Waiting Period

You select a Waiting Period when you apply for this product.

You become eligible to receive benefits only after meeting the requirements of the Waiting Period. The Waiting Period is the number of days from the *Disability Date* during which no claim for *Total Disability* or *Partial Disability* is payable. The *Waiting Period* starts on the *Disability Date*.

Waiting Periods of 30, 60 or 90 days are available. A *Waiting Period* of 730 days is available if you also have group salary continuance with another insurer attached to your superannuation.

To be eligible to receive a benefit you must remain either *Totally Disabled* or *Partially Disabled* for the duration of the *Waiting Period*. If we classify your occupation as 'medium blue' or 'heavy blue' (using our standard guidelines) you must also be *Totally Disabled* for 5 working days.

If you return to work, or are capable of working, more than 32 hours in 5 consecutive working days during the *Waiting Period*, the *Waiting Period* will start again.

Benefits

Call or email us if you're unable to work or are expected to be unable to work due to sickness or injury for 14 or more consecutive days. This allows us to assign a dedicated case manager who can help you lodge a claim if you decide to lodge one.

Where you have selected the 2-Year Waiting Period, you must notify us within 30 days of Disability, or as soon as reasonably practicable, to access any rehabilitation benefits available during the Waiting Period.

Your dedicated case manager will provide you with a personalised service during the claims process, arranging payment of monthly benefits once we accept the claim. They can also guide you through the occupational rehabilitation, retraining and reskilling benefits that may be suitable for you while you recover.

Disability Benefit

We will pay a monthly benefit while you're *Totally Disabled* or *Partially Disabled*, provided:

- Your *Disability Date* occurs while your insurance is in force.
- You have met the requirements of the *Waiting Period*.
- You continue to be either *Totally Disabled* or *Partially Disabled*.

Benefit calculation ('monthly benefit amount')

Your monthly benefit is the lesser of:

- your *Income Replacement Amount*, and
- your *Sum Insured*.

It is then reduced by 75% of any *Post-Disability Income* (if applicable) and by any *Other Payments*.

Your benefits are calculated on a per-day basis (assuming 30 days in a month) and payable monthly in arrears. If we have sufficient evidence, it may be paid monthly in advance.

Varied benefit calculation after 2 years on claim

The above benefit calculation is varied after 2 years *on claim* if your *Benefit Period* is 10 years or to age 65.

As a step reduction to the monthly benefit, the amount from the benefit calculation is reduced by 1/7th. For example, if the monthly benefit worked out from the benefit calculation was $7,000 the varied benefit calculation after 2 years on *claim* is $6,000.

How long are Disability Benefits paid?

The monthly benefit will continue until the earliest of:

- you ceasing to be *Totally* or *Partially Disabled*
- the expiry of the *Benefit Period*
- the expiry of the cover, and
- your death.

Waiver of Premium While on Claim

We will waive your Income Protection Cover premiums each month while you are *on claim*, including when the amount payable *on claim* is reduced to nil due to *Other Payments*. Premiums payable on an annual basis will be pro-rated.

Once you are no longer *on claim*, premium payment must recommence for you to keep the cover in force.

Recurring Disablement

If your claim is due to the same or related cause as an earlier Disability Benefit and occurs less than 6 months after your return to work, we'll treat the claim as a continuation of the original claim and won't apply another *Waiting Period* for this claim.

The *Benefit Period* picks up from the earlier claim, using the remaining part of the *Benefit Period* available.

Recovery at Work Benefit

If you are receiving Disability Benefit payments and have returned to work or are likely to return to work earning at least 40% of your *Pre-Disability Income*, we help cover the costs of:

- special equipment that makes it possible for you to re-enter the workforce and/or the costs of modifications to your workplace (including a workplace in your home) if a Medical Practitioner has recommended it. We'll reimburse up to 12 times the monthly benefit amount, and
- a support program for your return to work. We'll reimburse up to 3 times the monthly benefit amount, or up to 6 times the monthly benefit amount with reasonable evidence it is supporting your earning capacity.

We will only cover costs for a program that we have approved in writing before you incur the expenses. This is to ensure that any benefit paid is compliant with all relevant Australian laws and regulations and so that we may be reasonably satisfied that it will help your return to work.

We pay the third-party provider directly and will only reimburse you for costs incurred where this is not possible.

This benefit is not available for a Trustee Member, due to constraints under the superannuation laws.

Rehabilitation Program Expenses Benefit

If you have been *Totally Disabled* for at least 5 consecutive days during the *Waiting Period*, or you are receiving Disability Benefit payments, we'll help cover the costs of a rehabilitation program that your treating Medical Practitioner has recommended in writing. We may also recommend a program and seek approval from your treating medical practitioner.

This payment can be up to a further 50% of the monthly benefit amount each month for up to 12 months.

We will only cover costs for a program that we have approved in writing before you incur the expenses. This is to ensure that any benefit paid is compliant with all relevant Australian laws and regulations and so that we may be reasonably satisfied that the program is appropriate in the circumstances.

We pay the rehabilitation service provider directly and will only reimburse you for expenses incurred where this is not possible.

This benefit is not available for a Trustee Member, due to constraints under the superannuation laws.

Vocational Transition Program Benefit

If you are receiving a Disability Benefit and unable to return to your *regular occupation*, we can help cover the costs of vocational training that your treating Medical Practitioner has recommended in writing.

This payment can be up to a further 6 times the monthly benefit amount. We may pay a higher amount that you request if we are reasonably satisfied that an increase in the amount will help you return to work sooner.

We will only cover costs for a program that we have approved in writing before you incur the expenses. This is to ensure that any benefit paid is compliant with all relevant Australian laws and regulations and so that we may be reasonably satisfied that the program will help you return to work in the new occupation.

We pay the third-party provider directly and will only reimburse you for expenses incurred where this is not possible.

This benefit is not available for a Trustee Member, due to constraints under the superannuation laws.

Extra cost options

The following options are available at an extra cost when you apply for Income Protection Cover. They only apply to your claim if they show on your Policy certificate.

Claim Payment Increase Benefit

We will increase your *total benefit* after each year *on claim* by the most recently published annual increase in the Consumer Price Index up to a maximum of 3%.

When you're no longer *on claim*, the Sum Insured and *Superannuation Sum Insured* will be those shown on your most recent Policy certificate.

Monthly Superannuation Benefit

If your employer is making *Statutory Employer Superannuation Contributions*, you may also insure an amount of up to 11.5% of your Sum Insured for a *Superannuation Sum Insured*.

As at 1 July 2024, the superannuation guarantee contribution rate is 11.5% of earnings. If this is a higher percentage figure at the time you apply for cover, we will consider allowing you to insure up to that higher percentage, as your Superannuation Sum Insured.

If you choose this optional benefit, your *Superannuation Sum Insured* will show on your Policy certificate. The *Monthly Superannuation Benefit* will be payable if you are receiving a Disability Benefit. It is payable to a complying superannuation fund monthly in arrears, and is the lesser of:

- the *Superannuation Sum Insured* (as shown on your Policy certificate) multiplied by your monthly benefit as a proportion of your Sum Insured, and
- $2,000 per month

Your payments are calculated on a per day basis (assuming 30 days in a month) and payable monthly in arrears or, if we have sufficient evidence, it may be paid monthly in advance.

This benefit is not available for a Trustee Member, due to constraints under the superannuation laws.

14 Day Accident Accelerator Benefit

If you are in a white collar/professional occupation and applying for a 30-day waiting period, you may add this option for a benefit to apply earlier if you're claiming due to an accidental injury.

At the end of the 30-day Waiting Period, if you're *Totally Disabled* due to an Accident, we'll also pay a one-off benefit of 16/30th of the monthly benefit amount. This amount relates to your *Total Disablement* during the Waiting Period after the first 14 days, paid in arrears.

Severe Illness Booster Benefit

This optional benefit may be selected at application. If this optional benefit is selected, we will increase the Monthly Benefit payable by 20% for the first 6 months *On Claim*, if the Life Insured suffers from any of the following Severe Illness events or conditions . You must be *Totally Disabled* or *Partially Disabled* at the end of the *Waiting Period*.

The Severe Illness events are:

- *Advanced cancer – of specified severity*
- *Severe Heart Attack – with evidence of permanently impaired cardiac function*
- *Stroke – in the brain or spinal cord, resulting in severe permanent impairment*
- *Major Burns – of specified severity and requiring specific treatment.*

Refer to Severe Illness Booster Benefit definitions for this benefit on page 59.

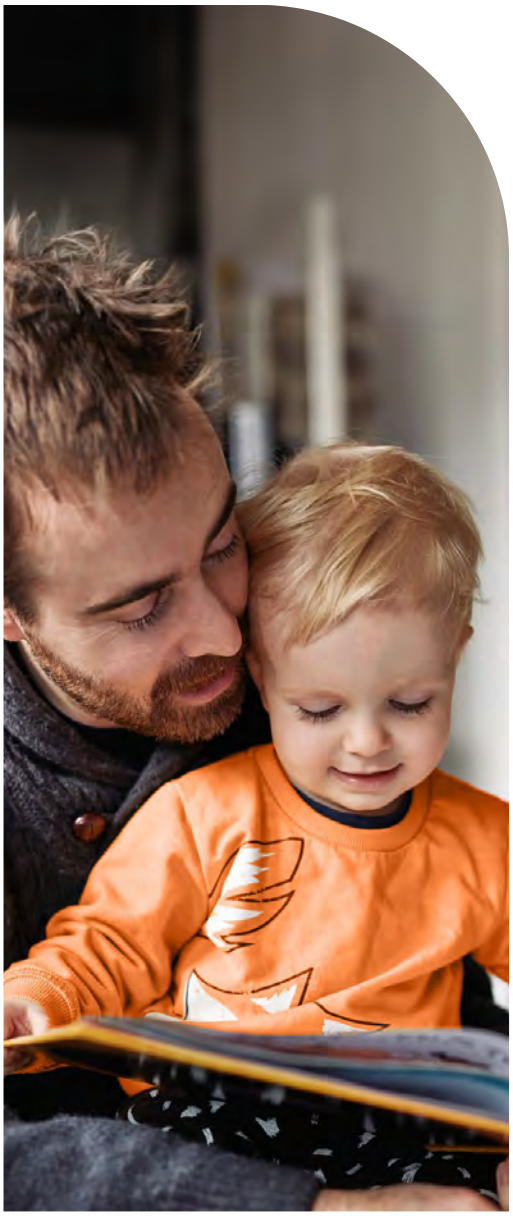
This benefit will not be payable for the condition if symptoms of the condition first appeared or happened, or the condition was diagnosed, during the first 3 months after the commencement date of the Income Protection Cover or the last reinstatement date of cover.

Exclusions and limitations

Self-inflicted injury and suicide exclusion

We won't pay any Income Protection Cover claim if the claim is caused or contributed to by a self-inflicted injury, attempted suicide or suicide (whether sane or insane) within the first 13 months following the commencement, reinstatement or increase of this insurance cover. Where this exclusion applies in respect of an increase to your insurance cover, the exclusion is limited to the increased part of the cover only.

Other exclusions



We won't pay any Income Protection Cover claim for Sickness or Injury as a result of, or related to:

- a normal and uncomplicated pregnancy, miscarriage, or childbirth (and for the purpose of this exclusion, the following are not considered complications of pregnancy, childbirth, or miscarriage:
  - multiple pregnancy
  - threatened or actual miscarriage
  - participation in an IVF or similar program, or
  - discomfort commonly associated with pregnancy such as morning sickness, backache, varicose veins, ankle swelling and bladder problems
- your participation in criminal activity or your incarceration
- a permanent or temporary banning, deregistration, disqualification, or restriction being placed on you (by any governing or industry body applicable to your trade, employment or profession) from performing all or some of the duties of your *regular occupation*, including by way of any permanent or temporary loss or restriction on any license, registration, permit or similar required in respect of your employment or profession
- war or an act of war (except in relation to a death claim benefit)
- any sickness or injury that occurred before the NobleOak Income Protection Cover commencement date, unless you clearly disclosed it, and we agreed to issue your cover (with or without loadings and/or exclusions). This exclusion also applies to any increases (in respect of that increase) prior to the increase date, and to any reinstatement prior to the reinstatement date.

We won't be able to reimburse any expenses that are usually available under health insurance or that are restricted due to other laws (which may include the National Health Act 1953 (Cth) or the Private Health Insurance Act 2007 (Cth)).

Reduction of other payments

We may reduce your monthly benefit amount if you are receiving any of the following:

- Any payments you receive or are entitled to receive in respect of your Injury or Sickness under state, territory or federal legislation, or as damages under common law, for a loss of income, loss of earning capacity or any other economic loss (including any benefits or payments for work Injury damages). For example, worker's compensation and motor accident claims payments.
- Any payments you receive, or are entitled to receive, in respect of your Injury or Sickness from any other individual or group disability insurance policy, benefits from credit or mortgage insurance, or superannuation pension plans you didn't tell us about when you applied for the cover or when you applied to increase your cover.
- Any payments you receive from your employer, including but not limited to sick leave and similar payments (other than earnings which we assess separately as *Post-Disability Income*).
- Any social security payments or other government grants or payments you receive or are entitled to receive in respect of your injury or sickness, to the extent allowed by law, except where Centrelink is offsetting the benefit received under this Plan.

If the payment is a lump sum payment, we treat this as a series of 60 monthly payments, with each monthly payment equal to 1/60th of the lump sum payment.

Maximum Sum Insured

The maximum Sum Insured is for all income protection policies you hold with us and any other insurer. If you don't tell us about your other income protection policies when you apply for insurance cover, we may reduce the monthly benefit we pay (and if applicable, any other benefit under this cover) if a claim occurs.

The Disability Benefit together with the *Monthly Superannuation Benefit* (if applicable) cannot exceed $30,000 per month.

Compliance with superannuation law

There are special rules from superannuation law on which benefits we can pay for insurance in super. If you are a Trustee Member, the Recovery at Work, the Vocational Transition Program, and the Rehabilitation Expenses benefits are not available.

Under the superannuation laws, to be eligible for a benefit you must have ceased to be gainfully employed or ceased temporarily to receive any gain or reward under a continuing agreement to be gainfully employed. Trustee Members should contact us to discuss the options available to continue cover outside of superannuation or cancelling their cover if they have ceased working.

Unemployment and extended leave

If you haven't earned any income in the 12 months before the *Disability Date*, your *Pre-Disability Income* will be zero and you won't be eligible for a monthly benefit. It makes no difference if this is because you were unemployed or on leave for the 12 months.

Contravention with other laws

We won't be able to reimburse any expenses that are usually available under health insurance or that are restricted due to other laws (which may include the National Health Act 1953 (Cth) or the Private Health Insurance Act 2007 (Cth)). For example, we can help with occupational rehabilitation costs but not physiotherapy.

Special Acceptance Terms

Benefits will be subject to any exclusion or limitation which is specific to you and noted in any special acceptance terms applying in respect of your cover.

End date

This insurance ends, along with our liability to pay any claim, at the policy anniversary after your 65th birthday, or as stipulated on the policy certificate.

See also 'When does cover end?' on page 8.

NobleOak Customer Journey

"We are there for our customers at every life stage and claim event"

Jenny's claim*

Jenny took out an Income Protection policy with NobleOak when she started full time work as an office manager. Health and well-being were important to Jenny, and she could never imagine needing to claim, but her financial independence meant so much to her.

At Policy Time

Jenny's income replacement calculation:

- Jenny's monthly income – $10,000
- Jenny's Sum Insured – $7,000

Income replacement
= 70% of first $25,000 per month = $7,000

Claim Event

One weekend she was moving house and badly injured her back. She thought it would get better on its own, but it didn't. The pain just seemed to get worse. After multiple consultations with the doctor and her physiotherapist, it became clear it would be a long road to recovery. It was time to call NobleOak.

Claim

NobleOak assigned her a dedicated Australian based claims case manager, Alex, who checked her policy and saw that she had a waiting period of 90 days. She'd only been off work for 3 weeks, so she hadn't met her waiting period yet. But Alex reassured her that NobleOak would be able to help her even during the waiting period.

Alex let her know about the Rehabilitation Program Expenses Benefit, which was available to her straight away. This funded occupational rehabilitation, a specialised desk and home office equipment to allow her to work from home. The Rehabilitation Program Expenses Benefit meant that she was physically able to keep up a part time income while she wasn't yet eligible for a monthly benefit.

*This is a fictional case study for illustrative purposes only.

Claim Outcome

By the time the 90-day waiting period was up, Jenny was working 3 days a week and feeling happy to be busy with work again. At this time, she became eligible for a monthly benefit based on the shortfall in her income.

Disability Benefit calculation

- Jenny's income replacement amount
  – $7,000 (from the calculation above)
- Income earned while on claim
  – $6,000 (the benefit reduces by 75% of this amount)
- Other payments
  – $0 (the benefit further reduces by this amount)
- Monthly benefit amount
  = $7,000 – ($6,000 x 0.75) $4,500 – $0 = $2,500.

This helped to cover the bills until she was ready to return to work full time, almost 6 months later.

Features to manage your cover over time

Indexation

We increase your Sum Insured at each policy anniversary to guard against inflation. The increase applies automatically and is the increase in the Consumer Price Index or 3%, whichever is less. Your premium will automatically adjust to reflect the increase in cover.

You can refuse each year's increase or cancel these automatic increases by letting us know in writing. If you decline 3 consecutive increases, we won't make any further increases. Indexation increases stop at age 59.

Premium Pause

If you become unemployed or need to take extended leave from work because of full time study, parental leave, or compassionate leave, you can ask us to pause your premiums for up to 12 months.

We will not pay any claim arising from an event which occurs during the premium pause or within 90 days after the end of your premium pause and restarting your premium payments.

The premium pause is available once your cover has been in place for more than 2 years. You are not covered during the premium pause period and cannot claim during that period.

Future Income Increase Benefit

You can apply to increase your Sum Insured by up to 20% (and up to $5,000) if you receive a salary increase, and we will not ask further medical questions. You must make your application within 60 days of your salary increase.

This benefit is only available if you're an employee, the salary increase is permanent and you provide us with suitable evidence, e.g. a letter from your employer.

You can exercise this benefit up to once in any 12-month period, providing you don't exceed the maximum Sum Insured and the total of all increases to date using this benefit remains less than 100% of the original Sum Insured.

It is not available if any of the following is true:

- You were age 50 or older when your cover started.
- You have not been accepted on standard underwriting terms (that is a loading, special condition or exclusion applies to your cover).
- You are on *claim* or intend to make a claim.
- You are age 55 or older.

Waiver of Premium While Involuntarily Unemployed

If you become Involuntarily Unemployed for longer than 30 consecutive days (other than as a direct result of any Sickness or Injury), we'll waive the premium for up to 3 months in total while you're Involuntarily Unemployed. The waived premium starts from your next premium due date, at least 31 days after you become Involuntarily Unemployed.

The waiver of premium is only available:

- if your cover has been in place for at least 12 consecutive months
- if you are an employee (excluding self-employment, including partners in a partnership), and
- in respect of future premiums (those that are due to become payable). You must let us know in writing no later than 14 days before the relevant premium payment due date for which you are applying to have premium waived under this benefit.

You must provide us with any suitable evidence that shows you are Involuntarily Unemployed, e.g. a separation letter from your employer.

Premium payments will resume at the end of the waiver period.

This feature is not available where the life insured is receiving a benefit under a separate group salary continuance scheme and you have a 730 day waiting period.

Two Year Waiting Period Reduction

If you have a 730 day *Waiting Period* due to cover under a separate group salary continuance arrangement (such as cover arranged by an employer or a superannuation fund), you can reduce your *Waiting Period* to 90 days when the group salary continuance arrangement ends.

You must provide us with suitable evidence that the group salary arrangement and your insurance has ceased, e.g. a letter from your employer or the fund.

This is only available if:

- you are less than age 55
- you are not offered a continuation option by the other insurer, and
- you notify us within 30 days of your group salary continuance ending.

Your new premium will reflect the premium rates that apply for the 90 day *Waiting Period*.

Age Extension Benefit

You can use this benefit to extend your Income Protection Cover at age 65, until age 70 if you are still working and in a white collar/ professional occupation, recognised by us in our underwriting guidelines.

If you wish to exercise this benefit you need to apply within 30 days of your Income Protection Cover expiry (at the policy anniversary following your 65th birthday).

You must apply to us for the Age Extension benefit and provide the information we require to assess your eligibility for this benefit.

Eligibility criteria:

- You have been working in a professional occupation for at least 20 hours a week in the consecutive 6 months immediately before your Income Protection Cover expired.
- We assess your occupation as white collar or professional.
- You are not *On Claim* or eligible to make a claim under this Income Protection Cover or any similar income replacement insurance held with us.

The Age Extension Benefit replaces your existing Income Protection Cover and is a limited Income Protection Cover with the following terms:

- The Waiting Period is 30 days.
- The Benefit Period is 1 year.
- The maximum Sum Insured is the *Income Replacement Amount*, and is 50% of your monthly *Regular Income*, or up to $10,000, whichever is less.

The benefits available are:

- Disability Benefit for *Total Disability* claims only
- Waiver of Premium While On Claim
- Recurring Disablement benefit.

No other benefits continue to the extended cover under this benefit.

The following benefits do not apply to the Age Extension Benefit:

- There is no Indexation due to CPI, or Indexation to the *Total Disability* Benefit whilst *On Claim* nor do any other features to manage your cover over time apply. If you have the Claim Increase Benefit Option it does not apply to this benefit.
- *Partial Disablement* does not apply to this benefit.

The Age Extension Benefit ends at the earlier of when any of the following occur:

- the policy anniversary after your 70th birthday.
- You have been *On Claim* and claimed for 12 months of Total Disability Benefits (consecutive or not).
- You have not worked in gainful employment for at least 20 hours per week for 6 consecutive months (except where cessation of employment is due to Total Disablement).

Income Protection defined terms

Benefit Period
means the maximum period of time in aggregate that You can receive a *Monthly Benefit* while the Life Insured remains continuously *Totally Disabled* and/or *Partially Disabled*. The Benefit Period starts at the end of the *Waiting Period*.

The Benefit Period that applies to a Life Insured is shown in the policy certificate.

Disability
(and *'Disabled'* and *'Disablement'*) means either *Total Disability* or *Partial Disability* when not specifically *Total Disability* or *Partial Disability* in the context.

Disability Date
(and *'Disablement Date'*) means the earlier of:

- the date that the Life Insured was first certified by a Medical Practitioner as being *Disabled* as a result of a Sickness or Injury, or
- the date that the Life Insured first stopped working if *Gainfully Employed* and providing this was no more than 7 days prior to consulting a *Medical Practitioner* about the *Sickness* or *Injury* causing *Disability*.

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

Important Income Producing Duties
means duties of the Life Insured's occupation that can be considered primarily essential to producing the Life Insured's income and which:

- are normally required for the purposes of the Life Insured's occupation
- do not include exceptional duties which are not normally required to perform the duties of that occupation, and
- cannot be reasonably omitted, modified or substituted by the Life Insured or, where applicable, their employer.

Income Replacement Amount
means an amount calculated for the Life Insured whilst on claim.

The Income Replacement Amount used for the 1, 2 and 5-year Benefit Periods, and for the first 2 years of the 10 year and age 65 Benefit Periods is:

- 70% of the first $25,000 of your *regular income*; plus
- 50% of the next $25,000 of your *regular income* (and 0% thereafter).

The Income Replacement Amount used for the 10 year and age 65 Benefit Periods after 24 months *On Claim* is 6/7ths of the above calculation.

Monthly Benefit
means the actual amount payable to the Life Insured each month On Claim under this plan and is the lesser of:

(i) the *Sum Insured* less 75% of *Post-Disability Income* (if applicable) less *Other Payments*; and

(ii) The *Income Replacement Amount* less 75% of *Post-Disability Income* (if applicable) less *Other Payments*.

The *Monthly Benefit* may be paid in advance where supporting evidence is available (or payable monthly in arrears) and pro-rated for partial months using 30ths.

Monthly Superannuation Benefit
means the actual amount that will be paid into a complying superannuation fund in respect of a Life Insured in respect of each month *on claim*, which is the lesser of:

- the *Superannuation Sum Insured* multiplied by the monthly benefit as a proportion of the Sum Insured; and
- $2,000 per month

The Monthly Superannuation Benefit may be paid in advance where supporting evidence is available, or paid in arrears, and pro-rated for partial months using 30ths.

On Claim
means the period of time in which you are entitled to receive a benefit under these Rules due to Disability, even if the monthly benefit is nil due to the operation of benefit reduction provisions.

Other Payments
are other sources of income that may reduce your monthly benefit.
See 'Reduction of other payments' on page 51.

Partially Disabled
(and *'Partial Disability'* and *'Partial Disablement'*) means that solely because of Sickness or Injury, the Life Insured is not *Totally Disabled* and:

- is working (or capable of working) less than 32 hours per week in *suitable work*,
- has a current *Post-Disability Income* less than 80% of their *Pre-Disability Income*, and
- is under the regular care and following the advice of a treating Medical Practitioner in relation to the Sickness or Injury (including any care or recovery plan recommended by a treating Medical Practitioner).

Post-Disability Income
means the *regular income* (expressed monthly) earned by the Life Insured during the month of *Disability* for which the *monthly benefit* is being calculated.

If you have *work capacity* but are not working to that capacity, your Post-Disability Income will include what you could reasonably be expected to earn if you were working at your *work capacity*.

Acting reasonably, we may request suitable evidence of your income and earnings from time to time (including monthly if appropriate) while you are *on claim*. Our ongoing liability to pay the monthly benefit is conditional upon receipt of the evidence requested.

Pre-Disability Income
means the Life Insured's average *regular income* (expressed monthly) for the consecutive 12-month period immediately preceding the *Disability Date*.

If the Life Insured is self-employed and not earning a readily identifiable monthly salary or wage amount, we may determine their *Pre-Disability Income* based on their average *regular income* for the latest financial year preceding the *Disability Date*.

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

If the Life Insured is, immediately preceding the *Disability Date*, not *Gainfully Employed*, or is on sabbatical, parental or long service leave, or if the 12-month period referred to above includes a period of not being *Gainfully Employed* or a period of sabbatical, maternity, paternity or long service leave, *Pre-Disability Income* is based on their average regular income (expressed monthly) earned in the consecutive 12-month period prior to when that period of unemployment or leave commenced.

If, at the *Disability Date*, the Life Insured has been unemployed, on sabbatical leave, on parental leave, on long service leave, or on unpaid leave for 12 months or more, then *Pre-Disability Income* will be nil, and no benefit will be payable in the event of a claim.

Where the Life Insured's average *regular income* for the consecutive 12-month period immediately preceding the *Disability Date* is nil then their *Pre-Disability Income* will be nil, and no benefit will be payable in the event of a claim.

Regular Income
means:

- If the Life Insured is not self-employed or a working director, the gross monthly income earned from their personal exertion by way of total remuneration package including salary, share of profits, regular overtime, commissions, bonus payments, salary sacrifice amounts and other fringe benefits.
- If the Life Insured is self-employed or a working director, the Life Insured's share of the gross monthly income generated by the business or professional practice as a result of the Life Insured's personal physical exertion, less their share of the eligible business expenses necessarily incurred in generating that income.

In each case, regular income does not include *passive income*, *ongoing business income* or any *Statutory Employer Superannuation Contributions*.

Each of the following applies:

- Where the Life Insured's income includes single large amounts or amounts that are not reliably recurrent in nature (which, for example, includes bonuses, redundancy payments, over-time, one-off transaction fees or income which are large amounts not usual for the Life Insured's work or which are not reasonably considered recurring amounts), these will be excluded from their regular income.

- Where the Life Insured's income includes reasonable periodic payments for which there is a history of payment, such as commissions, bonuses or profit shares, these will be spread over the period to which they relate and will be capped so that they do not comprise more than of 20% of the regular income.
- If there is a delay between the time the Life Insured generates their income and when they receive it, we will deem their income to have been received in the month in which it was generated.

Regular income will be limited to that which can be earned by working up to 45 hours per week.

Regular Occupation
means the occupation in which the Life Insured was working immediately prior to the Sickness or Injury causing *Disability*, unless they:

- were working in that occupation for less than ten hours a week, or
- were unemployed or on sabbatical, long service, maternity or paternity leave for more than 6 months,

in which case *regular occupation* will be any occupation for which the Life Insured is reasonably suited or capable of performing based on education, training or experience, including any education, training or experience which has been acquired through occupational rehabilitation programs, re-skilling, retraining or employment during any period in which a benefit is payable under this insurance cover.

If the Life Insured had been working in more than one occupation that meets these criteria, *regular occupation* will include any of those occupations.
Regular occupation is not restricted to mean the Life Insured's employer at the *Disability Date*.

Severe Illness Booster Benefit

The Severe Illness events are:

Advanced cancer – of specified severity
means the confirmed diagnosis of any one of the following:

- Cancer at stage III or IV using the AJCC TNM classification
- Acute Myeloid Leukaemia
- Acute Lymphocytic Leukaemia
- Chronic Lymphocytic Leukaemia at stage III or IV using the Rai staging system
- Chronic Myeloid Leukaemia requiring bone marrow transplant
- Hodgkin's/non-Hodgkin's lymphoma stage III or IV using the Lugano Staging System
- Multiple Myeloma at stage III using the Revised International Staging System
- Any blood-related cancer requiring treatment with bone marrow transplantation
- Brain tumours classified as grade III or grade IV using the World Health Organization grading for tumours of the central nervous system.

Major Burns – of specified severity and requiring specific treatment
means thermal, electrical or chemical injury causing deep partial thickness burns or full thickness burns to the skin requiring surgical debridement and skin grafting or flap reconstruction to at least:

- 20% of the total body surface area as measured by the Lund-Browder Chart or 'Rule of Nines', or
- 50% of both hands, or
- 50% of both feet, or
- 50% of the face.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Severe Heart Attack – with evidence of permanently impaired cardiac function
means a 'Heart Attack – with evidence of severe heart muscle damage' (as defined on "Heart Attack – with evidence of severe heart muscle damage#" on page 36) resulting in one of the following:

- permanent physical impairment to the degree of at least Class IV on the New York Heart Association classification of cardiac impairment; or
- a permanent left ventricular ejection fraction (LVEF) of less than or equal to 35% despite optimal medical therapy.

Stroke – in the brain or spinal cord, resulting in severe permanent impairment
means a 'Stroke – in the brain or spinal cord, resulting in specified permanent impairment' (as defined on "Stroke – in the brain resulting in specified permanent impairment#" on page 36) resulting in one of the following:

- permanent inability to perform at least one of the Activities of Daily Living; or
- a permanent Modified Rankin Score of 4 or more.

Suitable Work
means the Life Insured's *regular occupation* for any period in respect of which monthly benefits are payable.

Sum Insured
means the dollar amount of monthly insurance cover under this Plan in relation to the Life Insured as set out in the policy certificate.

Statutory Employer Superannuation Contributions
means the monthly superannuation contributions paid or payable by the Life Insured's employer, as required by law. This does not include voluntary superannuation contributions that the Life Insured or their employer make above the minimum required by law.

Superannuation Sum Insured
means the dollar amount of superannuation monthly insurance cover for the Life Insured as set out in the policy certificate.

Totally Disabled
(and '*Total Disability*' and '*Total Disablement*') means solely because of Sickness or Injury, the Life Insured is:

- not working (whether paid or unpaid) and does not have any *work capacity*, and
- under the regular care and following the advice of a Medical Practitioner in relation to that Sickness or Injury (including any care or recovery plan recommended by a treating Medical Practitioner).

Total Benefit
means the monthly benefit plus the Monthly Superannuation Benefit.

Waiting Period
means the number of days from the *Disability Date* during which no claim for *Total Disablement* or *Partial Disablement* is payable. The *Waiting Period* starts on the *Disability Date*. The *Waiting Period* that applies to a Life Insured is shown in the policy certificate for that Life Insured.

During the *Waiting Period*, the Life Insured must remain *Disabled* for the duration of the Waiting Period. Where the Life Insured's occupation is 'medium blue' or 'heavy blue' collar (according to our underwriting guidelines), they must also be *Totally Disabled* for 5 consecutive working days.

If the Life Insured works, or is capable of working, more than 32 hours in 5 consecutive working days the *Waiting Period* will start again.

Work Capacity
means our assessment (acting reasonably) of the Life Insured's capacity to work in *suitable work* expressed in hours per week. We'll consider:

- available medical evidence (including the opinion of the Life Insured's Medical Practitioner) and any other relevant evidence directly related to the Life Insured's medical condition (including information provided by the Life Insured and any independent medical or rehabilitation examinations or reports arranged by us), and
- the extent to which the Life Insured can perform the *Important Income Producing Duties of suitable work*, as applicable, without substantial risk of exacerbating their Sickness or Injury.

We will not consider non-medical factors such as the availability of suitable employment.

Business Expenses Insurance

Purpose

Insurance to help cover the fixed running costs of your business if you can't work due to Sickness or Injury.

Sum Insured

You can apply for a monthly benefit up to $25,000 per month to cover your Allowable Business Expenses.

Options

Business Expenses insurance provides a Waiting Period of 30 days, and a Benefit Period of 12 months.

Who can apply?

Available for self-employed between the ages of 21 and 59.

Benefits

Disability Benefit

If you become *Totally Disabled* or *Partially Disabled*, we'll pay you the Insured Monthly Benefit to help cover your share of the ongoing business expenses while you're not working or working in a reduced capacity.

The Insured Monthly Benefit payments start after the 30-day Waiting Period, in which you have been *Totally Disabled* for at least the first 14 days.

Your payments are calculated on a daily basis (assuming 30 days in a month) and payable monthly in arrears, so your first payment will generally occur 2 months after your Sickness or Injury commenced.

The monthly amount you receive following a claim will be the lesser of:

- the Sum Insured, and
- 1/12th of the *allowable business expenses* actually incurred in the 12 months immediately preceding the Waiting Period, reduced by:
    - your share of the gross business income of the business for that period, and
    - any *Business Expense claim offsets*.

We will determine your share of the *allowable business expenses* actually incurred or share of gross *business income* in line with the usual manner of apportioning profits and/or losses of the business between you and any co-owners of the business.

The benefit payable will be proportionate to the loss of *business income* sustained. When you are *Partially Disabled* and not working, we will determine the gross income of the business. We will consider the opinion of your Medical Practitioner and any Medical Practitioners we have nominated.

The Insured Monthly Benefit can continue while you continue to be *Totally Disabled* or *Partially Disabled* and for a maximum of 12 months.

Extended Benefit Period

If you are still *Totally Disabled* or *Partially Disabled* at the end of the *Benefit Period*, and the total benefit paid is less than 12 times the Insured Monthly Benefit, we will continue to pay the monthly benefit until (whichever comes first):

- the total of all benefits paid is 12 times the Insured Monthly Benefit,
- a further 12 months have expired,
- you cease to be *Partially Disabled* or *Totally Disabled*, or
- the insurance cover has expired.

Waiver of Premium

If you are receiving a claim payment for Business Expenses Insurance, we will waive the premiums for the period the claim payments relate to, for Business Expenses Insurance.

Exclusions and limitations

Self-inflicted injury and suicide exclusion

We won't pay any Business Expenses insurance claim if the claim is caused or contributed to by any attempted self-inflicted injury, suicide attempt or suicide (whether sane or insane) within the first 13 months following the later of the commencement, reinstatement or increase of this insurance cover.

Where this exclusion applies in respect of an increase to your insurance cover, the exclusion is limited to the increased part of the cover only.

Other exclusions

Benefits will not be payable by us if your Sickness or Injury is caused, or contributed to, by normal and uncomplicated pregnancy, childbirth or miscarriage, (and in this respect, we will not pay benefits if the claim is caused or contributed to by multiple pregnancy, threatened or actual miscarriage, participation in an IVF or similar programme, or discomfort commonly associated with pregnancy such as morning sickness, backache, varicose veins, ankle swelling, or bladder problems).

Reductions for other insurance

We may reduce your monthly benefit by any other Income Protection or Business Expenses Insurance policy (in force or proposed) that you had but didn't tell us about when you applied for Business Expenses Insurance. We will only reduce the monthly benefit to the extent that we would have if we had been aware of the other insurance.

Special Acceptance Terms

Benefits will be subject to any exclusion or limitation, which is specific to you and noted in any special acceptance terms applying in respect of your cover.

End date

This insurance ends, along with our liability to pay any claim, at the policy anniversary after your 65th birthday, or the expiry date stipulated on the policy certificate.

See also 'When does cover end?' on page 8.

Business Expenses defined terms

Allowable Business Expenses

Allowable Business Expenses refers to the Life Insured's share of business expenses as listed below, and any others that have been specifically approved:

- **Premises expenses:** Cleaning, insurance, interest, and fees on loan to finance the premises, property rates/ taxes, rent, repairs and maintenance and security costs.
- **Services expenses:** Electricity, fixed telephone and fax lines, gas, internet service provider, mobile telephone, postage and couriers, water, and sewerage.
- **Equipment:** Depreciation, motor vehicle leasing, insurance of vehicles and equipment, registration of vehicles, repairs, and maintenance.
- **Salaries and related costs:** Salaries of employees who do not generate any business income, payroll tax and superannuation (SGC) contributions for these same employees.
- **Other eligible expenses:** Account-keeping fees, accounting and auditing fees, bank fees and charges, business insurances, professional association membership fees and regular advertising costs.

Business Expenses Claim Offsets

In the event of a Business Expense claim, we will reduce the amount otherwise payable, by:

- your portion of the income of the business derived from trading during the period of disablement,
- the income generated by an employee hired after you became Totally Disabled to perform the work normally performed by you, and
- any amount received from any other insurance policy for reimbursement of business expenses that was not disclosed to the Insurer when the present level of cover was applied for. The amount will be reduced only to the extent that the combined claim payments from the Business Expenses Insurance and other insurance could otherwise exceed 100% of the Insured Monthly Benefit.

Business Income

Business Income means the monthly income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses, for the last 12 months.

Pre-Disability Business Income

Pre-Disability Business Income means for Business Expenses Insurance, the average monthly Business Income earned over the 12 months immediately prior to the Sickness or Injury.

For the sake of clarity, if the person's Business Income over the 12 months is nil, then the person's Pre-Disability Business Income will be nil, and no benefit will be payable in the event of a claim.

Partially Disabled/Partial Disablement

means that due to your Sickness or Injury, all the following are true:

- You are working in your usual occupation or another occupation, in a reduced capacity.
- You are not Totally Disabled.
- Your monthly *Business Income* is less than your *Pre-Disability Business Income*.
- You are under the regular care and attendance of a Medical Practitioner.

Totally Disabled/Total Disablement

means due to Sickness or Injury, you are:

- unable to perform one or more duties of your occupation (that you were engaged in immediately prior to your Sickness or Injury) that is important or essential in producing your Business Income
- not working (whether paid or unpaid), and
- following the advice of a Medical Practitioner.

Waiting Period

The Waiting Period is stated in your policy certificate and means the number of days from the beginning of a period of *Total Disablement* or *Partial Disablement* during which no claim for *Total Disablement* or *Partial Disablement* is payable.

During the Waiting Period the Life Insured must be *Totally Disabled* for at least the first 14 days of the Waiting Period. Following the first 14 days, the Life Insured may return to work for any number of days throughout the Waiting Period as long as the Life Insured remains either *Totally* or *Partially Disabled*.

Any days worked will not be added to the Waiting Period.

The Waiting Period begins on the date the Life Insured first ceases work due to the Injury or Sickness causing the *Total Disablement* or subsequent *Partial Disablement* as long as it is not more than seven days before the Life Insured consults a Medical Practitioner about the Injury or Sickness and provides reasonable medical evidence about when the period of *Total Disablement* began.

General information

Our claims philosophy is built on our fundamental desire to put our members first at all times. When making a claim, all claimants are assigned a dedicated claims consultant, based in Australia, to help you through the process.

Premiums, charges, and taxes

Premium structure

The premiums you will pay for your cover are variable age-stepped premiums. This means your premium will be based on your age when you apply for cover, and then will generally increase each year at the policy anniversary as your age increases. Premiums may be varied over time as outlined in the 'Changes to your premium' section below.

How premiums are calculated

We take several factors into account to calculate your premium.

Age

Under variable age-stepped premiums, premium rates will generally increase with age, as the probability of making a claim generally increases as you get older. This means the premium you will need to pay for the same level of cover will increase as you get older.

Sex

Premium rates differ by sex – as the claim rates for different benefits and conditions differ between males and females.

Benefit Types

Premium rates differ by benefit type – as claim rates differ by benefit type.

Amount of Cover

Premium rates are applied to your sum insured – therefore the higher your level of cover, the higher the premium that will be payable. This includes any increases in your sum insured each year due to indexation.

We may also apply a discount factor for higher sums insured.

Benefit options

Optional benefits and features can attract an additional premium - you will only pay for these benefits while you have them.

Some benefit choices you make will cost more than others, for example on Income Protection cover, a shorter waiting period will attract a higher premium than a longer waiting period and a longer benefit period will attract a higher premium than a shorter benefit period.

Personal circumstances

The total premium you pay will also depend on your personal circumstances, including but not limited to:

- Your occupation – premiums are higher for higher risk and hazardous occupations.
- Your smoking status – premiums are higher for smokers due to the associated health risks.
- Your state of health, family medical history, lifestyle, leisure activities and other relevant factors considered during the assessment of your application - premium loadings may apply where your health status or hobbies impact the probability of making a claim.

When your cover commenced	New customers that have recently applied for cover and have been fully underwritten are generally less likely to claim than those underwritten years ago. We may apply a discount factor for new customers in earlier years, that reduces over time.
Premium payment frequency	Monthly premium payments will include a 5% loading. There is no loading if you pay your premium annually.
Policy fees	A policy fee is a flat fee added to the premium. We currently don't charge a policy fee and if we do so in the future, we will let you know.
Stamp duty and other government charges	Insurance premiums may attract state Stamp Duty or other government charges at different rates for different products. This charge is covered by your premium and we will be responsible for these payments.

Other fees and charges included in the premium

Your premium includes all fees and charges for providing you insurance cover, including (where applicable):

- Distribution Partner remuneration: when you purchase your insurance through a distribution partner or in response to a partner marketing campaign, we may pay remuneration to that partner.
- Administration fees: the Trustee receives a fee (being a percentage of the premium) for providing administrative services.

Changes to your premium

Premium rates are not guaranteed to remain unchanged. We regularly review premium rates and premium factors to determine whether they are set at the right level to continue meeting future claim costs and other costs of providing the insurance cover.

We will act reasonably when making decisions to change our premium rates or policy fees.
As a friendly society and Insurer, when we set our premium rates, we are required to consider many risk factors that go towards the ongoing management of the Benefit Fund and the interests of all members, along with the cost of administering the Benefit Fund. This includes the sustainability of the premium rates we charge our members for the risks we insure and the cost of administering the policies.

Some of the main reasons we may need to increase the premium rates are due to changes in:

- claims costs – for example, due to changes in the number, amount, or duration of claims received
- the length of time that customers keep their insurance cover
- economic conditions such as interest rates
- operating costs and expenses, including cost of capital, reinsurance, and third-party providers, and
- laws or regulation that we must comply with.

If there is an invasion or an outbreak of war (whether declared or not) in which Australia is involved, we may also increase the premiums payable under your cover for the elevated risk. The increased premium will be payable by the due date to be covered for any claims arising due to the war or invasion.

Any change to premium rates will apply to all policies in a particular category. We will not single you out for a change in premiums.

If we change our premium rates, the new rate will apply to you from your next policy anniversary date after the change. We'll write to you to let you know at least 30 days before the change takes effect.

Other reasons your premiums may change include:

- a change in your sum insured, including as a result of benefit indexation
- a change in the benefits or options selected
- a change in eligibility for discounts applied, or if a discount previously applied ends or is reduced

Options are available to help you manage the cost of your cover, as described in the section below.

What options are available to manage the cost?

If you need to manage the cost of your insurance, there are several ways you can do so. You can ask us to:

- Switch off automatic indexation increases. This means your Sum Insured will no longer increase for inflation at each policy anniversary date.
- Activate the Premium Freeze Benefit. This means we'll reduce your Sum Insured each year as you get older to an amount that allows your premium to stay the same.
- Reduce your Sum Insured.
- Alter the benefit features on your policy, or
- Reduce your optional benefits.

Financial hardship provisions

We understand that at times paying your insurance premium may become difficult or your needs may change.

If you are experiencing financial hardship, we may be able to waive your premiums for up to a maximum of 3 consecutive months. This can help you to keep your insurance cover in place at a difficult time. You may need to provide supporting documentation. A premium waiver for financial hardship will not be available more than once.

If we grant a financial hardship waiver, no benefits under your policy will be provided, and we will not pay for any claimable event arising during the period.

Certain eligibility conditions apply:

- Your cover needs to have been in place for at least 24 months.
- You must not have increased your Sum insured in the last 12 months other than by indexation.
- Your policy is not held through superannuation.
- You're paying premiums monthly.
- You're not receiving income protection monthly benefits from us, nor have you claimed such benefits in the last 12 months or lodged a claim for such benefits.

The waiver is only available in limited financial hardship circumstances. These circumstances may be any of the following:

- You were retrenched or made redundant from your employment.
- You have been declared bankrupt.
- You are suffering financial hardship because of family or domestic violence or the death of a spouse, partner, or child.
- A natural disaster or health pandemic has inhibited your ability to undertake your usual work, and you have not found alternative work.

Please call us on 1300 551 044 to discuss whether you may be eligible for a premium waiver based on financial hardship. We reserve the right, acting reasonably, to require specific evidence of your financial hardship circumstances.

Importantly, a premium waiver for financial hardship is for future premiums due. It doesn't waive an overdue payment or refund premiums already paid prior to your request.

You need to keep paying premium while we consider your situation. If we do grant a waiver, we'll tell you the date from which it is effective, and how long it applies for.

Experiencing Vulnerability

We recognise that everyone may experience vulnerability at some point in their lives. Vulnerability can come in many unique forms such as illness, age, loss of income, changes in community, family, or personal circumstance. Other factors can include disability, financial hardship, language and literacy barriers, mental health concerns, family domestic violence and the loss of a loved one.

We understand that asking for help isn't always easy. Our employees are trained in identifying and supporting customers experiencing vulnerability. We have a specialist Client Care team dedicated to working with customers who may need additional support.

Our website (https://www.nobleoak.com.au/about-us/how-can-nobleoak-support-you/) has a range of useful links and services to support you. Please contact the Client Care Team on 1300 551 044 or at clientcare@nobleoak.com.au if you would like to speak with one of our specialists about your unique support requirements.

Tax treatment

You generally won't be able to claim a tax deduction for premiums paid for Life, TPD and Trauma Insurance. Any benefits you receive from these insurances will, in most instances, be tax-free.

Your premiums for Income Protection Cover and Business Expenses Insurance are generally tax-deductible. You'll receive any benefits as a gross payment which is tax assessable to you.

Of course, individual circumstances can be different. For example, the tax treatment will be different for insurance benefits released from a superannuation fund. We recommend that you seek professional taxation advice if in doubt about your situation.

There is no GST payable on your premiums.

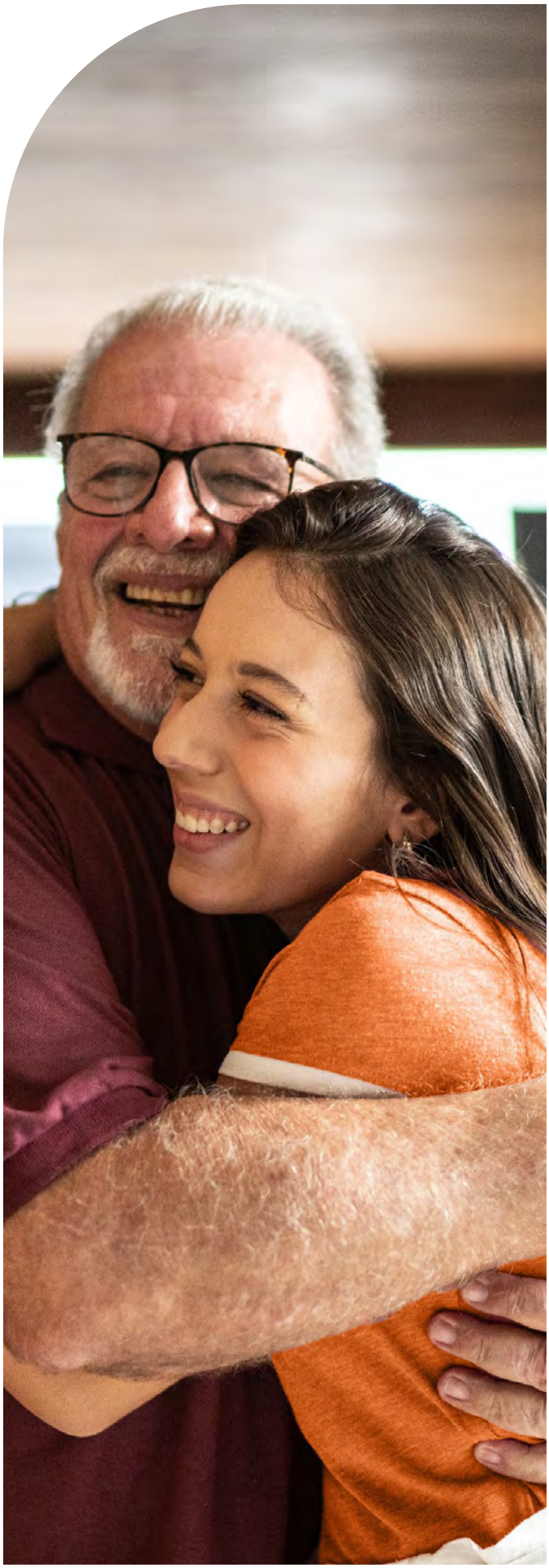
This tax information is necessarily general in nature. It is based on the continuation of present taxation laws and their interpretation.

How to pay

You can pay your premiums by direct debit from your nominated bank account or by Visa or MasterCard. If you wish to pay by cheque, this is only available with annual premiums.

A direct debit service agreement is in place for payments made by direct debit.

You can read more about this on page 70.



Direct Debit Request Service Agreement

Definitions

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

'Agreement' means this Direct Debit Request Service Agreement between you and us.

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

'Debit Day' means the day that payment by you to us is due.

'Debit Payment' means a particular transaction where a debit is made.

'Direct Debit Request' means the Direct Debit Request between us and you.

'Us' or 'we' means NobleOak Services Limited (the Debit User) you have authorised by signing a direct debit request.

'You' means the customer who signed the direct debit request.

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

1. Debiting your account

1.1 By signing a direct debit request, you have authorised us to arrange for funds to be debited from your account. You should refer to the direct debit request and this agreement for the terms of the arrangement between us and you.

1.2 We will only arrange for funds to be debited from your account as authorised in the direct debit request.

1.3 If the debit day falls on a day that is not a Banking Day, we may direct your financial institution to debit your account on the following Banking Day. If you are unsure about which day your account has or will be debited, you should ask your financial institution.

2. Changes by us

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

3. Changes by you

3.1 Subject to 3.2 and 3.3, you may change the arrangements under a direct debit request by contacting us on the Client Service Line on 1300 551 044.

3.2 If you wish to stop or defer a debit payment, you must notify us in writing at least seven (7) days before the next debit day. This notice should be given to us in the first instance.

3.3 You may also cancel your authority for us to debit your account at any time by giving us seven (7) days' notice in writing before the next debit day. This notice should be given to us in the first instance.

4. Your obligations

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

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

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

4.4 If NobleOak Services Limited is liable to pay goods and services tax (GST) on a supply made in connection with this agreement, then you agree to pay NobleOak Services Limited on demand an amount equal to the consideration payable for the supply multiplied by the prevailing GST rate.

5. Dispute

5.1 If you believe that there has been an error in debiting your account, you should notify us directly on the Client Service Line on 1300 551 044 and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly.

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

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

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

6. Accounts

You should check:

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

7. Confidentiality

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

7.2 We will only disclose information that we have about you:

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

8. Notice

8.1 If you wish to notify us in writing about anything relating to this agreement, you should write to:
NobleOak Services Limited,
GPO Box 4793, Sydney NSW 2001.

8.2 We will notify you by sending a notice in the ordinary post to the address you have given us in the direct debit request.

8.3 Any notice will be deemed to have been received on the third banking day after posting.

Getting started

Arrange your quote

To arrange your quote on your selected covers, visit www.nobleoak.com.au or call us on 1300 041 494. We can provide general information about the product features and answer any questions you may have.

We can even send you a quote while you're still on the phone. Once you're happy with the quote, you can apply for My Protection Plan or take some time to compare other insurers.

These steps also apply for applications to increase your Sum Insured.

Apply

Allow 15 to 30 minutes to complete your application for My Protection Plan. We'll ask a set of questions to help decide if we can offer the standard cover and pricing, or whether we can only offer cover with a loading or specific exclusion.

You have a duty to take reasonable care to answer these questions truthfully. You can read more about this duty starting on page 74.

Our privacy policy governs all information that we collect. You can read more about our privacy policy on page 76.

Once we have your full application and payment details, we'll provide you with free Interim Accidental Cover while we complete our assessment. You can read more about the Interim Accidental Cover on page 77.

If we approve your application, we'll activate your cover and provide you with a welcome pack that outlines the details of your cover.

When does your cover start?

Your cover will start once we have accepted your application and communicated to you in writing. Until then, we may ask for more information to fully assess your application.

Your duty to take reasonable care not to make a misrepresentation continues right up the point we accept your application.

When your insurance cover begins, you will be issued with an acceptance letter outlining the full details of your insurance. Please keep your letter together with this PDS for future reference.

You will also receive an annual renewal statement from us confirming your insurance details, including your insured benefits (as indexed) and premium payable.

Important – if you are replacing existing cover

If you told us that you are replacing existing insurance cover, your replacement insurance with us could be void if you don't cancel that other cover. This could be the case for certain types of insurance where the combined insurance is more than we would have agreed to insure.

You shouldn't cancel the other cover until we have accepted your application. This is in case we are unable to offer the cover due to a change in your health or circumstances. But once your insurance with us starts, you should cancel the other cover straight away.

What are the risks in taking out insurance?

You should consider any risks that might apply before making an application under this PDS. Some of the risks may include:

- The insurance you take out may not meet your needs.
- The level of cover, or the terms that apply, may not be sufficient to give you the protection you need or desire.
- You may not be able to increase cover to the desired level because of health or other issues.
- Claims will not be paid if the criteria to make a claim are not met or an exclusion applies. Claims may not be paid, or we may cancel and/or avoid your cover (treat the cover as if it never existed), the terms may be varied, or a benefit may be reduced where there is a failure to comply with the duty to take reasonable care to not make a misrepresentation.

- No surrender value. My Protection Plan isn't a savings plan. The only way it provides a financial benefit is through an insurance claim. Note, that none of the insurances in this PDS have a surrender or cash value at any time.
- As an insurance product, there is no guarantee that you will receive a benefit or receive a benefit more than you have paid in premiums.

Your insurance cover may be cancelled if you have failed to pay premium by the due date.

Cooling off period

Once you receive your welcome pack, you have a 30-day cooling off period to ensure your cover suits your needs.

If you need to make any changes, please contact us as soon as possible.

During the cooling off period, you may cancel your insurance cover, and we will refund any premiums paid. Otherwise, please keep your documentation in a safe place for future reference and in case of any future claims.

Your duty to take reasonable care

Before entering into a contract with us for your insurance cover, you have a legal duty to take reasonable care not to make a misrepresentation to us before we issue your cover. 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 applies not only to new applications for insurance, but also when you are extending or amending existing insurance and when you are reinstating insurance, up until your application, amendment or reinstatement is submitted and accepted by us.

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

Please keep in mind that we may investigate whether the answers and information given to us was true (including following a claim being made).

If you do not meet your duty

If you do not meet your duty to take reasonable care not to make a misrepresentation, this can have serious impacts on your insurance. The terms of your insurance may be changed, or your cover could even be avoided altogether (treated as if it never existed). This may also result in a claim being declined or a benefit being reduced. Please make sure you read the section 'What we can do if the duty is not met,' which appears below.

Guidance for answering our questions

Keep in mind that you are responsible for the information provided to us, including information provided in response to any questions we ask during the application process or when you make changes to your insurance or reinstate your insurance. When answering our questions, please:

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

Changes before your cover starts

Before your cover starts (or before insurance cover is extended, changed, or reinstated), we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

What we can do if the duty is not met

If you do not take reasonable care not to make a misrepresentation, there are different remedies which may be available to us. We may exercise our rights (under the Benefit Fund Rules and/or otherwise available to us legally) to put us in the position we would have been if you had met your duty.

Failure to meet your duty to take reasonable care may result in the following:

If you fail to comply with your duty and we would not have entered into the insurance contract if you had told us, we may avoid (treat the cover as if it never existed), or cancel your insurance cover within 3 years of entering into it.

If we choose not to cancel your insurance cover, we may elect to vary your insurance cover at any time by:

- Reducing the amount of your cover. This would be worked out using a formula that considers the premium that would have been paid if you had met your duty to take reasonable care not to make a misrepresentation (for any Death Benefit under Life Insurance, we may only reduce your cover amount within 3 years of the commencement date of your cover).
- Varying the terms of your insurance cover in a way that places us in the same position we would have been in if you had met your duty to take reasonable care not to make a misrepresentation.

If your failure to meet your duty is fraudulent, we may refuse to pay a claim and may avoid your insurance cover or any part of it, irrespective of the type of cover, at any time.

Please note that a failure by the Life Insured (or the life to be insured, as the case may be) to meet the duty will be treated as a failure by the applicant (if a different person to the life to be insured/Life Insured) to comply with their duty.

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

- whether the person who answered our questions took reasonable care not to make a misrepresentation, depending on all the relevant circumstances
- whether the misrepresentation or the failure to meet the duty was fraudulent, and
- in some cases, how long it has been since the cover started.

It may also depend on what we would have done, had the duty been met (for example, whether we would have offered cover, and if so, on what terms).

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

Notifying us

If, once your cover is in place, you think you may not have met your duty, please contact us immediately to let us know.

Privacy Statement

We recognise the importance of protecting your personal information that we collect and use. At all times we will safeguard your personal information as required by the Privacy Act 1988.

This Privacy Statement is a summary of our Privacy Policy. Please refer to our website for the full Privacy Policy at www.nobleoak.com.au/privacy-policy.

Your consent

By applying for cover under My Protection Plan, you will be consenting to the collection, use and disclosure of your personal information in the manner set out below. We need this information to provide you with a quote for the insurance, consider your application and provide you with any insurance cover.

Collection of personal information

We collect your personal information that is necessary for the purposes of:

- providing premium quotes
- assessing and processing your application
- managing and administering the products and services you obtain
- assessing and processing any claims made under your insurance
- identifying you and protecting against fraud
- improving our insurance products, and
- advising you about other products or services that we may offer.

The type of personal information we may collect includes your name, date of birth, address, banking details, beneficiaries, health, and employment information.

In most instances your personal information is collected directly from you when you apply for cover or request a variation in your cover. In some situations, we may collect personal information from a third party, such as an alliance partner or lead provider, as well as health or similar professionals.

Please advise us promptly of any changes to your name or contact details.

Disclosure and use of personal information

We may share the personal information we collect from (or about) you with the following parties:

- Any doctor, hospital, clinic, or other medical service in respect of whom you have provided us with a medical authority for the purpose of obtaining details about your medical history.
- The reinsurer and any Medical Practitioners, legal advisers, claims investigators or other professionals that we may appoint to consider your application or to assess or assist in determining any claim.
- Any person we consider requires access to your information in order to process your application, manage or administer your plan, assess any claim or resolve any complaint.
- Any person or entity to whom we outsource tasks or use as a service provider who do something on our behalf.
- The licensed distributor of your insurance, but only necessary information.
- Your legal adviser or any other representative acting on your behalf (including your financial planner or adviser or any insurance broker).
- Any person as is needed or authorised by law or where you have given consent to the disclosure.
- Any third party with whom we have marketing or distribution arrangements for our insurance products if we obtain your consent.
- In the case of information collected through online forms or via chatbot on our website, we provide information about this in our Privacy Policy.

All persons engaged to do something on our behalf will only be allowed to use the information to perform the tasks which we have asked them.

Marketing

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

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

Interim Accidental Cover

We provide Interim Accidental Cover when you apply for My Protection Plan and meet the eligibility requirements.

Note that the application may be for a new benefit or an increase to an existing benefit. If the application is for an increase, then the cover described here only applies to that increased amount.

Our refusal of any claim for payment of Interim Accident Cover will not affect any later claim on your insurance.

When Interim Accidental Cover starts

Interim Accidental Cover starts on the date we have received both your fully completed application and payment information (direct debit or credit card authority or deposit premium).

Interim Accidental Death Benefit

If you are applying for Life Insurance, and you die due to an accident between the application date and termination of the Interim Accidental Cover, we will pay the cover amount applied for up to a maximum of $1.5 million.

Interim Accidental Disablement Benefit

If you are applying for Total and Permanent Disablement Insurance, and you first become Accidentally Disabled between the application date and termination of the Interim Accidental Cover, we will pay the cover amount applied for up to a maximum of $500,000.

'Accidentally Disabled' means that, due to an Accident, you have suffered one or more of the following:

- Quadriplegia - total and permanent
- Major Brain Injury - resulting in significant permanent impairment, or
- the total and irreversible inability to perform at least 2 Activities of Daily Living.

See page 39 and page 40 for the definition of these events.

We will only pay one Interim Accidental Disablement Benefit. This benefit is not available for Trustee Members.

Interim Accidental Trauma Benefit

If you are applying for Trauma Insurance, and you first suffer an Accidental Trauma event between the application date and termination of the Interim Accidental Cover, we will pay the cover amount applied for up to a maximum of $500,000.

We'll reduce the Trauma Insurance Sum Insured applied for by the amount of any Interim Accidental Trauma Benefit paid.

Accidental Trauma means that, due to an Accident, you have suffered one or more of the following:

- Blindness - total and irreversible in both eyes.
- Coma (impaired consciousness) - of specified severity and requiring specific treatment.
- Diplegia - total and permanent.
- Hemiplegia - total and permanent.
- Major Brain Injury - resulting in significant permanent impairment.
- Major Burns - of specified severity and requiring specific treatment.
- Paraplegia - total and permanent.
- Quadriplegia - total and permanent.
- Loss of Independence - total and permanent.

See page 35 to 41 for the definition of these events.
We will only pay one Interim Accidental Trauma Benefit.

Interim Accidental Disability Cover

If you are applying for Income Protection Cover and you first suffer (and continue to suffer) Total Disablement due to an Accident between the application date and termination of the Interim Accidental Cover we will pay the Sum Insured applied for, up to 24 months, to a maximum of $4,000 per month.

When Interim Accidental Cover ends

Interim Accidental Cover ends on the earliest of:

- 90 days after it starts.
- The date we approve, decline, or defer your application or you withdraw your application.
- The date we pay a claim or admit a claim for any interim accident benefits.
- The date that the My Protection Plan Plan would otherwise terminate for that eligible life insured.

General Definitions

Accident
Accident means bodily injury caused solely and directly by accidental, violent, external, and visible means and independently of all other causes.

Activities of Daily Living
Activities of Daily Living means the following five (5) activities of daily living:

1. Bathing means the ability to wash oneself either in a bath or shower or by sponge bath, without the standby assistance of another person. A person will be considered able to bathe themself even if the above tasks can only be performed by using equipment or adaptive devices.

2. Dressing means the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten and unfasten them, without the standby assistance of another person. A person will be considered able to dress themself even if the above tasks can be performed only by themself using modified clothing or adaptive devices such as tape fasteners or zipper pulls.

3. Eating means the ability to get nourishment into the body by any means once it has been prepared and made available to you without the standby assistance of another person.

4. Toileting means the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing without the standby assistance of another person. A person will be considered able to toilet themself even if they have an ostomy and is able to empty it themself, or uses a commode, bedpan, or urinal, and is able to empty and clean it without the standby assistance of another person.

5. Transferring means the ability to move in and out of a chair or bed without the standby assistance of another person. A person will be considered able to transfer themself even if equipment such as canes, quad canes, walkers, crutches, grab bars or other support devices (including mechanical or motorised devices) is used.

Anniversary Period
Anniversary Period means the 12-month period effective from the commencement date of the insurance and each anniversary following.

Approved Superannuation Fund
An Approved Superannuation Fund is a superannuation fund in respect of which we have entered into an agreement with its trustee whereby certain My Protection Plan insurance products are available for its members.

Domestic Duties
Domestic Duties means the following five (5) activities performed by a Life Insured unassisted by another person, where the Life Insured's sole occupation is to maintain the family home:

1. Cleaning of the home, i.e. the ability to carry out basic internal household chores using various tools such as a mop or vacuum cleaner.

2. Cooking meals, i.e. the ability to prepare meals using basic ingredients and normal kitchen appliances.

3. Doing the family laundry, i.e. the ability to maintain the household's laundry by using the washing machine and being able to hang clothes on a washing line or clothes airer.

4. Shopping for the family's groceries, i.e. the ability to physically purchase general household grocery items with either the use of a shopping basket or trolley.

5. Taking care of dependent children where applicable, i.e. if the Life Insured normally looks after a child or children up to the age of 12 as part of their everyday activities. Taking care of dependent children means the ability to care for and supervise the children, including preparation of meals, bathing, dressing, and getting the children to and from school by the usual mode of transport.

Domestic Duties do not include duties performed outside the Life Insured's home for remuneration or reward.

Immediate Family Member
An Immediate Family Member means a spouse or former spouse, de facto partner or former de facto partner, child, parent, grandparent, grandchild, or sibling; or a child, parent, grandparent, grandchild or sibling of the Life Insured's spouse or de facto partner. It includes step-relations (e.g. stepparents and stepchildren) as well as adoptive relations.

Injury
Injury means bodily injury occurring after the commencement of cover. It also includes any injury which was fully disclosed to us, and we accepted in connection with your application for cover or application for increase in cover (and subject to any special acceptance terms or exclusions advised by us).

Involuntarily Unemployed
Involuntarily Unemployed means, in respect of a Life Insured, that the Life Insured is unemployed due to redundancy (but not a voluntary redundancy) or retrenchment, or as a result of the Life Insured's employer being in administration or liquidation. Being Involuntarily Unemployed does not include instances such as the Life Insured failing to successfully complete a probation period, reaching the end of a fixed term employment contract, being engaged for a specific task or project which is completed early resulting in the Life Insured no longer being employed, resigning from their employment or retiring from the workforce, or being dismissed from their employment for cause.

Life Insured
Life Insured means a person covered for insurance under a My Protection Plan policy accepted by us in writing.

Medical Practitioner
Medical Practitioner means any Medical Practitioner registered with the Australian Health Practitioner Regulation Agency (AHPRA) who is not you or the cover holder, a member of your or their family, your or their business partner, or your or their employee or employer.

Reinstatements
If you cancel your cover or the cover ceases because of non-payment of premiums, you can apply to us to have it reinstated. Such reinstatement will depend on our terms and conditions at the time.

Sickness
Sickness (whether physical or mental) means illness or disease which manifests itself after the commencement of cover. It also includes any sickness which was fully disclosed to us, and we accepted in connection with your application for cover or application for increase in cover (and subject to any special acceptance terms or exclusions advised by us).

Specialist Medical Practitioner
Specialist Medical Practitioner means a Medical Practitioner who practices in a specialty field and is listed on the Australian Health Practitioner Regulation Agency (AHPRA) Specialist Register who is not you or the cover holder, a member of your or their family, your or their business partner, or your or their employee or employer.

Sum Insured
Sum Insured means the dollar amount insurance cover under the relevant insurance cover. When we accept the insurance cover, the Sum Insured is set out in your Policy certificate.

Trustee Member
Trustee Member means either the person or company that has the legal responsibility to ensure that the trust or superannuation fund is operated in accordance with the trust deed and has been accepted as a Member of the Fund through My Protection Plan.

NOBLEOAK

Contact us at NobleOak
Quotes & Applications: 1300 041 494
All other enquiries: 1300 551 044
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