PRODUCT DISCLOSURE STATEMENT

TAL Risk Only Super Plan

Product Disclosure Statement | 1 June 2021

Important information

This Product Disclosure Statement (**PDS**) provides important information about the TAL Risk Only Super Plan (**ROSP**)

This PDS is jointly issued by:

1. Mercer Superannuation (Australia) Limited (ABN 79 004 717 533, AFSL 235906) (**MSAL**) as trustee for the Mercer Super Trust (ABN 19 905 422 981) (**Fund**). ROSP is held within TAL Super (the **Product**), a section within the Retail Division of the Fund; and
2. TAL Life Limited (**Insurer**) (ABN 70 050 109 450, AFSL 237848).

Insurance Cover is available for death only or death and Total and Permanent Disablement, and also includes Interim Cover and Terminal Illness. Permanent Employees, Casual Employees and Contractors may be eligible to be covered. Contributions made to the Product are only used for the purposes of paying insurance premiums. Members do not have an account balance in the Product and therefore there is no investment component.

The Insurer is the issuer of the life insurance product structured through TAL Super but is not responsible for TAL Super and does not issue, underwrite or guarantee the superannuation interest described in this PDS. MSAL is the trustee (the **Trustee**) for the Product and is responsible for the superannuation interest Members hold in the Fund.

As the insurance cover is structured through the Fund, the Trustee will be noted as the Policy Owner and will hold the Policy on behalf of all members of ROSP. Your interest in the Fund is governed by the Trust Deed of the Fund as well as the terms and conditions of the policy (**Policy**) issued by TAL Life Limited (ABN 70 050 109 450, AFSL 237848) as the provider of the insurance cover to the Trustee.

Any benefit payable under the Policy will be paid by the Insurer to the Trustee. The Trustee is responsible for paying the benefits out of the Fund. Restrictions may apply to these benefit payments under the Trust Deed, governing rules and superannuation law.

A copy of the Trust Deed can be obtained, free of charge at www.mercersuper.com/documents

This PDS is divided into 2 parts.

Part 1 contains information for prospective Employers and their Employees. This section sets out the terms and conditions relating to Benefits provided through a ROSP Employer Plan issued by the Insurer. It explains who can be covered, when Insurance Cover is provided automatically and when Employees and Members will need to apply for Insurance Cover. It also details when Voluntary Cover may be applied for.

Part 2 contains the definitions of key terms applicable to ROSP which are capitalised throughout this PDS. For ease of reference, regularly used terms are listed below.

Please note throughout this PDS:

- 'Fund' refers to the Mercer Super Trust;
- 'Insured Member' refers to the person whose life is insured under the Policy and relevant Employer Plan ;
- 'Insurer', refers to TAL Life Limited;
- 'Member' refers to a member of the Product;
- 'Policy Owner' means the Trustee;
- 'ROSP' refers to the Risk Only Super Plan;
- Trustee' refers to Mercer Superannuation (Australia) Limited as trustee for the Mercer Super Trust;
- 'We', 'Us', 'Our' refers to the Trustee; and
- 'You', 'Your' refers to the reader of this PDS.

It is recommended that this PDS is read fully before making any decision to purchase or continue to hold ROSP. The information within this PDS is current as at the date of issue.

From time to time the information in this PDS which is not materially adverse may be updated by publishing a note of the change on Our website at tal.com.au/talsuper

Free paper copies of the updated information are available by calling 1800 130 869.

For ROSP, the Trustee reviews its products regularly to ensure that they continue to meet the current needs and future expectations of Members. As a result, the Trustee may make changes to the terms and conditions of the ROSP product in the future. Where required by law, the Trustee will give the Employer and/or Insured Member prior written notice of the change.

Otherwise, the Trustee will notify the change in either Your annual statement or the Fund's Annual Report.

Details of the Trustee of ROSP are:

Mercer Superannuation (Australia) Limited
GPO Box 4303, Melbourne, VIC, 3001

TAL Life Limited is the Insurer for ROSP and both TAL Life Limited and TAL Services Limited provides the Trustee with administration services in relation to ROSP and TAL Super.
The details for TAL Life Limited and TAL Services Limited are:

363 George Street
Sydney NSW 2000

T: 1800 130 869
F: 02 9465 2065
E: corporateadmin@tal.com.au

www.tal.com.au/talsuper

Need help?

If You need help in deciding whether to hold this product or any financial product in general, it is recommended that You speak to a licensed financial adviser.

The information contained in this PDS is general information only. TAL and the Trustee have not taken into account Your objectives, financial situation or needs. You should consider the appropriateness of the information in this PDS, taking into account Your objectives, financial situation and needs, before acting on any information in this PDS. Information about tax provided in this PDS is a guide only and is based on the Trustee's understanding of the tax laws that were current at the date of the PDS. These laws can change and the Trustee recommends You speak to Your tax adviser regarding the tax consequences of holding insurance cover through superannuation.

This PDS provides a summary of the Insurance Cover. In the event of any inconsistency between this PDS and the Policy, the terms and conditions of the Policy will prevail to the extent of the inconsistency. Details of Insurance Cover will be provided to the Member by the Trustee on commencement of Insurance Cover under their Employer Plan. Each year a personalised annual statement will be provided to the Members detailing the level of Insurance Cover. A copy of the Policy may be inspected by contacting the Trustee.

The Policy and Trustee

The Policy covering death and Total and Permanent Disablement (**TPD**) Benefits is owned by Mercer Superannuation (Australia) Limited, as Trustee of the Fund.

Although insurance is provided to Members, they do not actually own the Policy. If a claim needs to be made by or in respect of a Member, the Trustee must be contacted. The Trustee then claims on the Policy and if the claim is accepted by the Insurer, the Trustee will determine if a Benefit is payable from the Fund and if so pay the proceeds to the Member or their dependant or legal personal representative as a superannuation disability or death Benefit (as appropriate) from the Fund.

Benefit payments through the Fund are subject to the Fund's governing rules in its Trust Deed and to restrictions under superannuation law.

A Member's Benefits in the Fund shall (unless otherwise determined by the Trustee) be reduced:

- To the extent to which the Trustee is unable to effect Insurance Cover on terms acceptable to the Trustee; or
- By the amount of the Insurance Cover or part thereof which, having been effected, the Insurer declares void, or refuses liability for, for any reason.

Rules relating to when superannuation benefits can be accessed are complex and financial advice should be sought to consider any personal circumstances.

A GUIDE TO READING THIS PRODUCT DISCLOSURE STATEMENT (PDS)

Interpretation

In this PDS:

- there are a number of words which are capitalised throughout this PDS. These words have a particular definition when used in this PDS. These definitions are found in Part 2 of this PDS. It is important to read these definitions carefully because their meanings may be relevant to the decision to hold or apply for Insurance Cover, continue to be a Member, the assessment of any application for Insurance Cover, eligibility for Insurance Cover, ability to make a claim and any decision that the Insurer makes in relation to any claim; and
- words expressed in the singular include the plural and vice versa.

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1 About TAL

Insuring This Australian Life

TAL is a leading Australian life insurer who protects people, not things.

With over 150 years of experience, TAL has learnt that the most important part of life isn't the stuff we own, but the experiences we share with the people we love. It's living life. This Australian life.

Together with its partners, TAL protects 4.5 million Australians and their families, helping them look after what matters most, so they have the freedom to keep living the life they planned.

Supporting customers through claims is the most important thing TAL can do. In 2020, TAL paid $2.7 billion in claims, to 36,901 customers and their families.

TAL's commitment to claims

If You need to make a claim, You can be confident TAL will be there to help You every step of the way. TAL understands that no two claims are the same, and that making a claim can be an unfamiliar experience at a difficult time.

For most people, making a claim is the start of a journey they have never encountered before. TAL's dedicated Claims Consultants work in partnership with You throughout Your claim, looking after You in a personal, genuine and empathetic way that reflects Your unique circumstances and condition.

TAL's commitments to You:

- Claim with confidence
- Ensure You're understood
- Remove complication
- Provide clear steps
- Treat You fairly
- Guiding You through Your claim, every step of the way

When the unexpected happens, TAL understands it's only human to need a bit of extra help. That's why, if You need to make a claim with TAL, they can help with much more than just payments. Your heath is a priority, and TAL is committed to supporting You to reach your best possible state of health.

TAL's Claims and Health teams tailor their approach to Your needs to ensure You get the support You need during Your recovery. Working alongside Your medical team, carer or employer they'll make things easier for You, and when You're ready, they can connect You with the support services relevant to your individual health needs and return to work goals.

Awards and recognition

As a leading Australian life insurer, TAL is honoured to have received the following awards. To see all of TAL's awards please visit https://www.tal.com.au/about-us/who-we-are/awards-and-recognition

- **Plan for Life/AFA Life Company of the Year Awards** – Overall Platinum Life Company of the Year Winner
- **Financial Services Council (FSC) Life Insurance Awards** - Best Life Insurance Awareness Campaign Winner (COVID Support Awareness Campaign)
- **Commonwealth Workplace Gender Equality Agency (WGEA)** - Employer of choice
- **Momentum Media Women in Finance Awards** – Employer of the Year
- **Plan for Life Health & Wellness Life Insurance Excellence Awards** – Rehabilitation & Claims Support Winner, Outcomes Experience Winner, Innovation, Market View of Health & Wellness Programs Winner

Codes of practice

TAL is proud to have adopted the Life Insurance Code of Practice and to have played a leading role in its creation. This code is the life insurance industry's commitment to mandatory customer service standards and it's designed to protect You.

To access a copy of this code, please contact the Financial Services Council or visit their website at fsc.org.au.

The Trustee has also adopted the Insurance in Superannuation Voluntary Code of Practice. The purpose of this code is to improve superannuation member value and protection. It is a strong step towards enhancing member interests and helping build confidence in life insurance through superannuation.

Learn more about the Insurance in Superannuation Voluntary Code of Practice by visiting: https://www.superannuation.asn.au/policy/insurance-in-superannuation-voluntary-code-of-practice

Part 1: Risk Only Super Plan (ROSP) Information

Insurance at a glance

What types of Insurance Cover are available?

Death or death and TPD cover is available. The Policy also provides Terminal Illness as a built-in Benefit.

There are two types of TPD definitions available:

- TPD (Standard); and
- TPD (Alternate).

The TPD (Standard) and TPD (Alternate) definitions are available to eligible Employees and Members. However, the TPD (Alternate) definition must be approved by the Trustee.

The TPD definitions the Insurer has agreed to provide under the Policy will be stated in the Employer Plan Schedule or Member Benefit Certificate.

The easy reference table below provides a quick summary of the Insurance Cover. Please read the terms and conditions outlined in this PDS for a full explanation of Insurance Cover and limits.

Feature	Brief Description	Section
Death Insurance Cover	A lump sum Benefit is paid to the Policy Owner if an Insured Member dies.	10.2 23.2
Terminal Illness Insurance Cover	A lump sum Benefit is paid to the Policy Owner if the Insured Member suffers a Terminal Illness.	10.3, 23.2
TPD Insurance Cover	A lump sum Benefit is paid to the Policy Owner if the Insured Member becomes Totally and Permanently Disabled.	10.4, 10.5 23.2
Automatic Acceptance	Insurance Cover without Underwriting up to the AAL.	5
Voluntary Cover	An amount of Insurance Cover which is not based on the Insurance Formula and includes Life Events Cover.	8.1, 8.2
Life Events Cover	Voluntary 'top up Insurance Cover' available as a result of a change to individual circumstances e.g. marriage, new child, and mortgage.	8.3 - 8.6
Interim Cover	Provides Insurance Cover for an injury during Underwriting.	9
Insurance Cover during paid and unpaid leave	Up to 24 months continuous Insurance Cover whilst on Employer approved leave, without the need to be approved by the Insurer.	11
Overseas cover	Insurance Cover is provided 24 hours a day, 7 days per week, with no restrictions on location or time spent overseas, subject to certain conditions.	12
Extended Cover	Up to 60 days additional Insurance Cover after the Insured Member ceases to be an Employee.	14
Continuation option	When Insurance Cover ends for an Insured Member, they may be able to apply for a death only or death and TPD individual policy with the Insurer without medical Underwriting.	15
AAL uplifts	Insured Members may automatically receive any increase in AAL, including those that have been previously Underwritten and have been declined, loaded or excluded, for Insurance Cover above the previous lower AAL, unless otherwise stated in the Employer Plan Schedule.	5
Underwriting loadings	For Insurance Cover subject to Takeover Terms, premiums in respect of Underwriting loadings are waived for Insurance Cover which is not Voluntary Cover, reducing costs and simplifying administration.	7
Premium frequency	Monthly, quarterly, half-yearly or annually.	19

Availability of cover

The below table sets out the limits and choices that apply to the Insurance Cover unless otherwise stated in the Employer Plan Schedule or Member Benefit Certificate:

Minimum entry age	16
Maximum entry age	64
Maximum Benefit Limit	Death: Unlimited Terminal Illness: Unlimited TPD: $3,000,000
Benefit Expiry Age	Death: 75 Terminal Illness: 75 TPD: 70

Section 1: About ROSP

1.1 Introduction

The purpose of this Part is to provide Employers and Members with details of the Benefits available in ROSP and important additional product information about ROSP so that they can understand the Policy held in trust for Members by the Trustee.

The documents that make up the Policy are the ROSP Group Life Insurance Policy No. GR682-GL, the Employer Plan Schedule signed by the Insurer, and the Endorsement(s) if any.

It is important that this PDS is read together with the Member Welcome Letter and Member Benefit Certificate.

For further information, please contact the Trustee on 1800 130 869 or visit www.tal.com.au/talsuper.

1.2 How ROSP works

ROSP is designed to provide Benefits to Employees of Employers. The Benefits are provided through a Policy which is owned by the Trustee and held in the Fund, where the Insured Members are Members of the Product.

As the Policy Owner, the Trustee pays the premiums due under the Policy from the Fund. The Employer makes superannuation contributions to the Fund to meet the cost of these premiums. ROSP only accepts Employer contributions.

Please note that as ROSP does not provide an accumulation account in the Fund, the Trustee cannot accept contributions above the amount required to pay the insurance premiums. Membership of the Product is for the provision of Benefits only.

The Federal Government's *Treasury Laws Amendment (Putting Members' Interests First) Act 2019* **(PMIF)** was introduced in April 2020. As all Employees in a ROSP Employer Plan are employer-sponsored, the Trustee intends to use the employer-paid exemption to the legislation.

Under the legislation, for the exemption to take effect, Employers are required to provide an annual, formal notice to the Trustee confirming the contributions that are paid on behalf of their Employees in the Employer Plan are:

- totally funded by the Employer and do not come from Employee's salary package, nor are Employees asked to pay in any way for their Insurance Cover under the Employer Plan; and
- the contribution made by the Employer for Employees in their Employer Plan is in addition to the Employer's Superannuation Guarantee obligations for their Employees.

If this declaration is not received by the Trustee on time, then the Trustee cannot provide insurance to Employees in the Employer Plan and the Employer Plan will terminate and all Insurance Cover will cease for all Employees in the Employer Plan.

Employers are also required to notify the Trustee of any new eligible Employees that commenced employment with the Employer within the previous year. This will enable the Trustee to provide Insurance Cover to Employees as at the date they commenced employment with the Employer, subject to the terms of the Policy and Employer Plan Schedule. If the Trustee is not notified within the year that the Employee commenced, then Insurance Cover will not commence until the day after the notification is received.

The Trustee will write to Employers on an annual basis at each Annual Review requesting a letter providing information around current Employees be returned to the Trustee within 30 days. If the letter is not received by the Trustee by the required date, then all Insurance Cover for Employees in the Employer Plan will cease and the Employer Plan will terminate. Employees will then receive an Exit Statement as a result of the termination of the Employer Plan.

Should this occur and the Employer later request for their Employer Plan to be reinstated, the Trustee will require a new application and quotation, and for a deposit premium to be paid. The Trustee will be unable to reinstate the entire Employer Plan from the date cover ceased as Members would have exited the Product.

1.3 Identification requirements

We have obligations under the *Anti-Money Laundering and Counter Terrorism Financing Act 2006* (Cth) (the **AML/CTF Act**) which include obtaining and verifying information about the identity of individuals prior to making payments from superannuation accounts.

Generally, We require individuals to provide certain information to confirm their identity using electronic methods prior to making payments and there are a range of alternative methods to complete this process.

The AML/CTF Act also imposes other obligations such as monitoring certain transactions and reporting certain matters to the Australian Transaction Reports and Analysis Centre (AUSTRAC).

If We are not satisfied that an individual has confirmed their identity, or We form a suspicion that an individual is using Our products and services for financial crime activities We may delay or decline to process a transaction and report it to AUSTRAC. If We take this step, We will not incur any liability to You. More information about anti-money laundering and counter-terrorism financing obligations is available on AUSTRAC's website at www.austrac.gov.au.

1.4 Unpaid contributions

Under the Federal Government's "Protecting Your Super" legislation, the Trustee cannot provide insurance cover to a member of an Employer Plan if their account in the Product becomes inactive. A Member's account is inactive if no contributions (i.e. premiums) have been received for a continuous period of 16 months.

To comply with this requirement, the Trustee will write to the Employer prior to the Annual Review date for their Employer Plan requesting the Annual Review information and premium payment within 30 days.

If the Employer does not pay the superannuation contributions that the Product requires to cover the cost of premiums, the Insurer and Trustee shall provide the Member(s) with written notice that their Insurance Cover through the Product will terminate if the required superannuation contributions are not received within a further 30 days.

If, following this further 30 day period the required superannuation contributions are not received, Insurance Cover for all members in the Employer Plan will cease in accordance with the existing Policy terms and the Employer Plan will be terminated accordingly. Should this occur and the Employer later request for the Employer Plan to be reinstated, the Insurer and Trustee will require a new application and quotation, and for a deposit premium to be paid. The Trustee will be unable to reinstate the entire Employer Plan from the date cover ceased as Members would have exited the Product.

1.5 Cooling off period

If the Employer is not satisfied with the Benefits under ROSP once the Employer Plan is issued, or they feel that it does not meet their Employees' needs, they may request to cancel their Employer Plan in writing and return it to the Trustee within 28 days from the date it was received. Any contributions will be repaid into another superannuation fund nominated by the Employer.

If no nomination is made within 30 days of the Trustee receiving notice of the cancellation, the Trustee may transfer any contributions received in respect of the Employer Plan to an eligible rollover fund.

The Trustee will then return the Employer Plan document to the Insurer and the Employer Plan will be cancelled.

If the Employer Plan is cancelled during the cooling off period, no claim can be made and no Benefits will be payable in respect of that period.

Section 2: Policy information

2.1 The Insurer

TAL Life Limited (ABN 70 050 109 450) (AFSL 237848) is registered as a life insurer under the *Life Insurance Act 1995* (Cth) and is the provider of Insurance Cover under the Policy.

2.2 The Administrator

TAL Life Limited and TAL Services Limited provide administration services to the Trustee for ROSP.

2.3 The Policy Owner

All Benefits payable under the Policy are paid to the Policy Owner.

Subject to the superannuation law and the Fund's governing rules, the Trustee will pay a corresponding benefit from the Fund to or in respect of the Member.

2.4 Benefits

Subject to the Maximum Benefit Limits, the Benefits provided for Insured Members under the terms and conditions of the Policy and Employer Plan Schedule are for death, as well as any applicable TPD, stated in the Employer Plan Schedule. The Policy also provides Terminal Illness as a built-in Benefit of death Insurance Cover.

2.5 Changes to the Employer Plan

Once the Employer Plan Schedule is issued by the Insurer, any subsequent changes or variations to the terms and conditions of the Employer Plan Schedule must be issued by the Insurer in the form of an Endorsement.

2.6 Employer obligations

In relation to the applicable Employer Plan, the Employer agrees to:

- pay premiums as required by, and in accordance with the Employer Plan as outlined in Section 19;
- abide by the Eligibility Conditions set out in Section 3.2;
- provide the Insurer in writing on or before the next Annual Review, the following requirements:
  - details of all Eligible Persons who meet the Eligibility Conditions (if details of particular people are not provided, they will not be eligible for Insurance Cover under Automatic Acceptance);
  - details of each person who no longer meets the Eligibility Conditions;
  - changes in any Eligible Person's employment status which results in a change from their current Membership Category;
  - any request for a change to the Eligibility Conditions;
  - any request to provide Insurance Cover for the Employees of any new company or business acquired by the Employer;
- supply the Insurer with all information it asks for at the commencement of the Policy, at each Annual Review, and on termination of the Policy, within 30 days of receiving its request (as per sections 1.2 and 1.4);
- execute and return Endorsements within 30 days of receipt; and
- provide the Insurer with all information and notices it requires under the Policy and Employer Plan.

Where the Employer does not comply with these obligations the Insurer may provide the Employer with notice to terminate the Policy in accordance with Section 17.1, and the entitlement to a Benefit may be affected.

Section 3: ROSP Membership

3.1 Commencement of membership

An Eligible Person becomes a Member when all of the following apply:

- the Employer provides the Trustee with the Eligible Person's valid TFN; and
- the Insurer provides or agrees to provide Insurance Cover for the Eligible Person under the Policy.

3.2 Eligibility Conditions

Insurance Cover will be provided under the Policy for all Employees who are Members of the Fund and meet the Eligibility Criteria and the Age Criteria of their Employer Plan and the conditions for the relevant types of Insurance Cover. This Insurance Cover is only granted if the Insurer is provided with the relevant information with respect to that Member or Employee (see Section 1.2). Where the Member or Employee meets all these conditions they will be an Eligible Person under the Policy.

3.3 Who is eligible for Insurance Cover under ROSP?

If the prospective Member is an Australian Resident and an Employee on or after the commencement date of their Employer Plan and they meet the Eligibility Criteria under the Policy, they are eligible to join ROSP and have Insurance Cover.

A person who is a non-Australian Resident but satisfies all other conditions for eligibility for ROSP may still be eligible to join ROSP and have Insurance Cover provided:

- the Insurer has agreed in writing to provide Insurance Cover in respect of the non-Australian Resident; and
- the non-Australian Resident has a valid Australian TFN.

Insurance Cover for Eligible Persons starts in accordance with Section 4.

Section 4: When Insurance Cover starts in ROSP

4.1 Commencement of Insurance Cover

Cover under an Employer Plan will only be provided to an Employee where the Trustee is satisfied the employer sponsor contribution exception applies in respect of that Employee.

Where the Insurer has agreed to provide Insurance Cover to the Trustee for a Member, it will commence on the latest of the following:

- the day after the Trustee has been notified by the Employer (see Section 1.2);
- the date the Member first becomes an Eligible Person and meets the conditions for Automatic Acceptance (see Section 5);
- the Takeover Date if the Insurer has agreed to provide Insurance Cover under Takeover Terms (see Section 6);
- the date the Insurer advises the Member they have been Underwritten and accepted for Insurance Cover (see Section 7); or
- the date from which there is an increase in the Member's Insurance Cover (in respect of the increased amount).

When the Member obtains Insurance Cover under their Employer Plan they will be an Insured Member under the Policy and the Trustee will be the Policy Owner.

Section 5: Automatic Acceptance

5.1 What is Automatic Acceptance?

Automatic Acceptance means the Insurer will provide Eligible Persons with Insurance Cover up to the Automatic Acceptance Limit (AAL) without Underwriting.

5.2 Conditions for Automatic Acceptance of Insurance Cover

For Automatic Acceptance to be provided the following conditions must apply:

- the Insurance Cover is calculated according to the Insurance Formula;
- the Eligible Person is in a Membership Category for which an AAL applies as stated in the Employer Plan Schedule;
- the AAL (other than "nil") is stated in the Employer Plan Schedule;
- at least 75% of Eligible Persons have been nominated by the Employer (and are covered) for Insurance Cover under the Policy; and
- the Special Conditions stated in the Policy or Employer Plan Schedule (if any) regarding the provision of Automatic Acceptance are satisfied.

5.3 When are Eligible Persons entitled to Automatic Acceptance?

Automatic Acceptance applies to Eligible Persons at the earliest of:

- the Policy Commencement Date where the Eligible Person was entitled to be covered at that date; or
- the date the Member became an Eligible Person although the Employer must inform the Insurer at the next Annual Review of the Employer Plan that the Member was an Eligible Person.

However, where the Eligible Person is not At Work on the Policy Commencement Date or at the date that they first become an Eligible Person under the Policy (whichever is the later), they will be provided Limited Cover. Limited Cover will apply from that date until they have returned to work and have remained At Work for 60 consecutive days, at which time Full Cover will be provided.

Any Eligible Person who does not obtain Insurance Cover under Automatic Acceptance by not meeting the conditions of this section will need to be Underwritten and accepted by the Insurer in writing before Insurance Cover can commence.

5.4 Future automatic increases in Insurance Cover

Where an increase in an Insured Member's Insurance Cover is activated by the Insurance Formula, e.g. due to a salary increase, the increase in the Insurance Cover will be restricted to the higher of the AAL and any Forward Underwriting Limit that the Insurer has granted to the individual.

5.5 When can the AAL be changed?

The AAL will apply for the duration of the Premium Rate Guarantee Period. However, if there has been a change in the Eligibility Criteria, Benefit structure or a change of 25% or more in the number or occupational profile of Insured Members under the Employer Plan or a particular Membership Category, the Insurer reserves the right to increase or decrease the amount of the AAL, by giving the Employer written notice. Any Insurance Cover already provided will not be reduced or adversely affected by any change in the AAL.

5.6 How do changes in AAL affect existing Insurance Cover?

Where there has been an increase in the AAL, the AAL applicable for all existing Insured Members may be automatically increased to the new level subject to the following conditions:

- If the Insurance Cover an Insured Member receives under Automatic Acceptance increases as a result of the increase in the AAL, any existing exclusions or loadings will only apply to any Insurance Cover above the new AAL; and
- Any specific exclusions or loadings which apply to the Voluntary Cover will continue to apply.

Section 6: Takeover of Insurance Cover

6.1 What are Takeover Terms?

Takeover Terms generally apply for a new group of Eligible Persons who have previously been provided Insurance Cover by another insurer.

Under Takeover Terms the levels of cover under the previous policy may be continued without further Underwriting.

The Insurer's practice is to adhere to FSC Group Insurance Takeover Terms under FSC Guidance Note No. 11.00.

However, there may be certain circumstances where alternate Takeover Terms may be required. In either case, where Takeover Terms apply to any Transferring Members, the terms will be stated in the Employer Plan Schedule.

6.2 Conditions for providing Takeover Terms

Where Takeover Terms apply, the provision of Insurance Cover under Takeover Terms will be subject to all of the following conditions:

- the Employer provides the Insurer with all the information the Insurer needs about the operation and
- terms of the previous policy in writing including, but not limited to, names, type and amount of insurance cover and any individual Underwriting acceptance terms provided by the previous insurer no later than 90 days after the Takeover Date, unless the Insurer agrees otherwise;
- the Employer provides the Insurer with the names of Eligible Persons who are not At Work due to an illness or injury on the last working day immediately prior to the Takeover Date, unless the Insurer agrees otherwise;
- the terms and conditions of the Policy including the Maximum Benefit Limit and conditions for Automatic Acceptance (see Section 5.2) of the Insurance Cover, if any, will apply;
- where the AAL applicable to the previous policy is the same as the AAL applicable to the Policy, any specific exclusions and loadings applied to Insurance Cover provided by the previous insurer will continue to apply under the Policy; and
- where the AAL applicable to the previous policy is lower than the AAL applicable to the Policy, the AAL applicable for all persons insured under the previous policy may be automatically increased to the new AAL level and any specific exclusions and loadings which applied to Insurance Cover provided by the previous insurer will only apply to Insurance Cover above the AAL applicable to the Policy.

Takeover Terms will not be available if the cover with the previous insurer included TPD cover provided through superannuation under an own occupation definition.

There is no TPD (Own Occupation) available within superannuation for TPD cover first taken out on or after 1 July 2014.

6.3 Waiver of Underwriting premium loadings on takeover

For Insurance Cover subject to Takeover Terms, the Insurer will not charge any additional premiums for any loadings on Underwritten Insurance Cover based on the Insurance Formula. However, any applicable loadings will continue to be recorded and additional premiums may be charged for these loadings for other purposes such as for a Continuation Option. Additional premiums will be charged for any loadings on Voluntary Cover.

Section 7: Underwriting

7.1 When Underwriting is required

An Eligible Person must be Underwritten for Insurance Cover under any one or more of the following circumstances:

- no AAL is applicable to the Eligible Person under the Policy;
- an AAL applies but the Eligible Person does not satisfy the conditions for Automatic Acceptance set out in Sections 5.2 and 5.3;
- the Eligible Person is seeking Insurance Cover based on the Insurance Formula above the AAL, including when the Insurance Cover above the AAL is being reinstated (see Section 11.3) or any Forward Underwriting Limit, in which case Underwriting will only apply to the Insurance Cover above that amount; or
- the Eligible Person is applying for Voluntary Cover.

7.2 Applications for Insurance Cover requiring Underwriting

If Underwriting is required, the Eligible Person must complete a Personal Statement and provide the Insurer with any information or undergo any medical examinations requested.

While being Underwritten, an Eligible Person will be provided Interim Cover (see Section 9).

Underwriting will be completed once the Insurer received all the additional information the Insurer might request to assess the application.

The Insurer will pay all costs associated with obtaining the Underwriting information it has requested, provided these costs are incurred in Australia. Any Underwriting costs incurred outside Australia will not be paid by the Insurer.

However, the Insurer may reimburse some or all of these costs at their discretion.

7.3 Acceptance terms of Underwritten Insurance Cover

Once Underwriting is completed the Insurer will notify the Eligible Person in writing via the Employer Plan adviser of the outcome. When the Insurer does this the Eligible Person will also be advised if any of the following applies:

- the Insurance Cover which has been Underwritten has been provided without any Special Conditions;
- any Forward Underwriting Limit has been provided;
- a loading has been applied to any of the Insurance Cover which has been Underwritten;
- any specific exclusion has been applied to the Insurance Cover which has been Underwritten; or
- the Insurer has declined the application.

The Insurer will also notify the Eligible Person in writing via the Employer Plan adviser if:

- the Underwriting has not proceeded due to the request of the Eligible Person; or
- the Underwriting has been discontinued because the Insurer did not receive the information it had requested to allow it to assess the application.

7.4 Waiver of Underwriting premium loadings

The Insurer will not charge any additional premiums in respect of any loadings advised for Underwritten Insurance Cover based solely on the Insurance Formula. Additional premiums will be charged in respect of loadings advised for Voluntary Cover.

Section 8: Voluntary Cover and Life Events Cover

8.1 What is Voluntary Cover?

Voluntary Cover is an amount of Insurance Cover which is not based on the Insurance Formula and includes Life Events Cover. It is only available where it is stated in the Employer Plan Schedule and Member Benefit Certificate. It is chosen by the Eligible Person. All applications for Voluntary Cover, with the exception of Life Events Cover, require full Underwriting and are subject to acceptance by the Insurer. While Life Events Cover does not require medical Underwriting it still needs to be accepted by the Insurer.

8.2 Applying for Voluntary Cover

An application can be made by an Eligible Person for an amount of Insurance Cover which is in addition to any amount provided under the Insurance Formula. Voluntary Cover will commence when the Insurer provides written notice of acceptance.

8.3 Life Events Cover

Life Events Cover is Voluntary Cover without the need for medical Underwriting. Insured Members may apply for Life Events Cover which will enable them to increase their death or TPD Insurance Cover.

8.4 When is Life Events Cover available?

Life Events Cover is available to Insured Members in any of the following circumstances, subject to the conditions set out in Section 8.5:

- the birth of the Insured Member's child/children;
- the adoption of a child/children by the Insured Member;
- the marriage of the Insured Member; or
- effecting a mortgage on the purchase or construction of the Insured Member's primary place of residence (either alone or jointly with another person).

8.5 Conditions for Life Events Cover

Life Events Cover can be provided to an Insured Member in any of the circumstances set out in Section 8.4 above, subject to all the following conditions:

- the Insured Member is already covered for the Benefits for which the Life Events Cover relates;
- the Insurer receives a Life Events Cover application completed by the Insured Member to the Insurer's satisfaction together with satisfactory / certified evidence of the occurrence of the relevant event set out in Section 8.4 above, within 90 days of the relevant circumstance and prior to their death, Terminal Illness or Date of Disablement;
- the Insured Member is less than 60 years of age at the date the Insurer receives a completed application for Life Events Cover;
- the Insured Member has not previously had an application for Insurance Cover declined;
- the Life Events Cover application being accepted by the Insurer in writing;
- the payment of the applicable additional premiums;
- during the first 6 months after the Insurer has accepted the application, Limited Cover only will apply to the Life Events Cover provided as a result of the application; and
- an application for Life Events Cover can only be made by an Insured Member once in any 12 month period.

8.6 Conditions relating to amount of Life Events Cover which can be applied for

The following conditions apply to the amount of Life Events Cover applied for:

- the minimum amount of Life Events Cover which can be applied for is $25,000; and
- the maximum amount of Life Events Cover which can be applied for by an Insured Member is the lesser of 25% of their Insurance Cover and $200,000 provided this does not cause the total of any existing Insurance Cover and any Life Events Cover applied for to exceed the Maximum Benefit Limit.

Section 9: Interim Cover

9.1 What is Interim Cover?

If an Eligible Person needs Underwriting, the Insurer will provide Interim Cover for the amount being Underwritten.

Interim Cover means the Insurer will provide an Eligible Person with the Benefits applied for in their application form for up to 90 days while they are being Underwritten, subject to the relevant terms and conditions of the Policy.

Interim Cover is only payable for claims arising directly from an injury which first occurs during the period of Interim Cover.

9.2 Interim Cover limits

The Interim Cover will be limited to the lesser of:

- the amount being Underwritten; and
- $1 million for death and TPD Insurance Cover;

less any amount of Insurance Cover already provided under the Policy to the Eligible Person.

9.3 When Interim Cover starts

Interim Cover starts in respect of an Eligible Person on the date the Insurer receives a completed Personal Statement from them.

9.4 When Interim Cover ceases

Interim Cover ceases in respect of an Eligible Person on the earliest of:

- 90 days after the Insurer receives a completed Personal Statement;
- the date the Insurer provides notice to the Insured Member of the Underwriting decision in respect of the Underwritten Insurance Cover;
- the date the Insured Member withdraws their application for Insurance Cover;
- the date the Insured Member ceases to be an Eligible Person;
- the date the Insured Member reaches the Benefit Expiry Age;
- the date a Benefit under Interim Cover becomes payable for the Insured Member;
- the date the Insured Member dies or becomes Totally and Permanently Disabled;
- the date a Terminal Illness Benefit becomes payable for the Insured Member; and
- the Policy Termination Date.

9.5 When an Interim Cover Benefit isn't payable

A Benefit under Interim Cover is not payable:

- for a claim arising directly or indirectly from an injury which occurred at any time prior to the date the Insurer receives a completed Personal Statement; or
- where the death, Terminal Illness or TPD of the Eligible Person is caused directly or indirectly by suicide or self-inflicted act or injury.

Section 10: Benefits

10.1 Benefits payable

Where a Benefit is payable under the Employer Plan, it will be payable subject to the terms and conditions of the Policy. The Benefit is paid to the Trustee as the Policy Owner.

The amount payable in respect of the Insured Member will be the lesser of:

- Insurance Cover based on the Insurance Formula calculated at the date set out in Sections 10.2, 10.3 or 10.4 plus any Voluntary Cover; and
- the Maximum Benefit Limit.

10.2 Payment of a death Benefit

If an Insured Member dies while covered under the Policy, the Insurer will pay their Insurance Cover for death calculated at the date of their death to the Trustee. When the Insurer becomes liable to pay a death Benefit for an Insured Member, all Insurance Cover for that person ceases.

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

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

Where after reasonable searches the Trustee cannot locate any of these people, it may pay the death benefit to an individual non-dependant such as a parent or sibling.

10.3 Payment of a Terminal Illness Benefit

If an Insured Member is determined to be suffering from a Terminal Illness while covered under the Employer Plan and Policy, the Insurer will pay a Terminal Illness Benefit equal to the amount of death Insurance Cover applicable at the date the person is certified as suffering from a Terminal Illness, to the Trustee. When the Insurer becomes liable to pay a Terminal Illness Benefit for an Insured Member, all Insurance Cover for that person ceases.

10.4 Payment of a TPD Benefit

If an Insured Member is Totally and Permanently Disabled while covered under the Policy, the Insurer will pay their TPD Benefit to the Trustee, calculated at their Date of Disablement. When the Insurer becomes liable to pay a TPD Benefit, all Insurance Cover for that person ceases.

10.5 Tapering of TPD Benefits

Tapering of TPD Benefits may apply to the TPD Insurance Cover which has been calculated in accordance with the Insurance Formula. If tapering applies it will gradually reduce the TPD Benefit to zero by the Benefit Expiry Age. The method of tapering and the ages at which tapering applies will be stated in the Employer Plan Schedule.

Section 11: Employer-approved leave

11.1 Continuation of Insurance Cover during paid leave

Insurance Cover will continue while an Employee is on paid leave approved by their Employer without the need for the Insurer's prior approval, subject to continued payment of premiums and compliance with other conditions of the Policy.

11.2 Continuation of Insurance Cover during unpaid leave

An Insured Member's death and applicable TPD Insurance Cover will be provided for a continuous period of up to 24 months while they are on Employer-approved unpaid leave for any reason, subject to all of the following conditions (where applicable):

- for Employees and Contractors, there is documented agreement with the Employer, of a return to work date;
- in the case of a Contractor, when they commenced the leave they had an existing contract with the Employer providing for a period of service of no less than 6 continuous months;
- the period of Employer-approved unpaid leave commences on the first day of that leave;
- continued payment of premiums during the period of unpaid leave; and
- the conditions of cessation of Insurance Cover (see Section 16).

The Insured Member must notify the Insurer of and receive the Insurer's written agreement to extensions of Insurance Cover for any unpaid leave beyond the 24 month period. Otherwise, Insurance Cover will not be extended beyond the 24 month period.

If any of the above conditions are not met, Insurance Cover will cease for the Insured Member on the day prior to the commencement of the agreed period of leave, subject to the Extended Cover (see Section 14).

The applicable TPD definition will be determined at the time of claim and hence may differ from the TPD definition which applied to the Insured Member at the time Insurance Cover commenced in respect of the Insured Member (see Section 3.2).

In respect of any claim arising for an Insured Member during a period of unpaid leave, both the Salary used to calculate any Insurance Cover based on the Insurance Formula, and the TPD definition, will be those which applied to that Insured Member on their last working day prior to the commencement of their unpaid leave period.

Subject to the conditions above, where the Insured Member does not return to work by the end of the 24 month period, or the end of any extended period beyond the 24 month period agreed in writing by the Insurer, all Insurance Cover will cease at the end of the relevant period (see Section 16). If the person would like to reinstate their Insurance Cover, they will need to be Underwritten.

11.3 Insurance Cover when premiums were not paid during unpaid leave

If an Insured Member goes on a period of unpaid leave and premiums are not paid in respect of all or part of that period, then Insurance Cover will cease on the day prior to the commencement of the period of unpaid leave, unless cover has ceased earlier (see Section 16).

If the Insured Member returns to work with their Employer on the agreed return to work date after a period of unpaid leave during which the relevant premiums had not been paid (and hence Insurance Cover did not continue), then Insurance Cover will be reinstated subject to both of the following conditions:

- Limited Cover will apply to Insurance Cover up to the AAL from the date of return to work until they have been At Work for 60 consecutive days, after which time Full Cover will apply; and
- Underwriting is required for any Insurance Cover above the AAL (see Section 7).

The applicable TPD definition will be determined at the time of claim and hence may differ from the TPD definition which applied to the Insured Member at the time cover commenced.

11.4 After operational deployment on active service as a reservist

If an Eligible Person returns to work with the Employer within 12 months of their Insurance Cover ceasing because of their operational deployment on active service as a reservist with the Australian Defence Force, their Insurance Cover, not including any Interim Cover at the date it ceased, will be reinstated once they have been At Work for 60 consecutive days.

If the Eligible Person returns to work more than 12 months after their Insurance Cover ceased, Underwriting will be required.

The applicable death and TPD definition will be determined at the time of claim and hence may differ from the death and TPD definition which applied to the Insured Member at the time Insurance Cover commenced.

Section 12: Overseas cover

12.1 Overseas cover

Insurance Cover is provided 24 hours per day, 7 days per week, regardless of the Insured Member's location as long as:

- the Insured Member continues to be employed by the Employer or a Related Entity;
- the Insured Member's premium continues to be paid to the Insurer by the Trustee;
- Insurance Cover has not ended (see Section 16). Overseas cover is subject to compliance with the terms and conditions of the Policy (see Sections 12.2 and 12.3).

Where the Employer or Related Entity starts to pay the premium in respect of an Insured Member after a period during which the relevant premiums had not been paid (and hence Insurance Cover did not continue), then Insurance Cover will be reinstated subject to both of the following conditions:

- Limited Cover will apply to Insurance Cover up to the AAL from the date the premium is paid until they have
- been At Work for 60 consecutive days, after which time Full Cover will apply; and
- Underwriting is required for any Insurance Cover above the AAL (see Section 7).

12.2 Underwriting overseas

In addition to the Underwriting requirements set out in Section 7, the Insurer does not require an Insured Member overseas to return to Australia to be Underwritten.

The Insurer may reimburse part or all of these costs at their discretion.

12.3 Assessment of a claim overseas

In addition to the claim requirements set out in Section 18 where a claim for a Terminal Illness or TPD Benefit payment arises for an Insured Member and they are overseas during the assessment of the claim, the Insurer will require them to provide supporting medical evidence to the Insurer's satisfaction to enable assessment of their eligibility for payment.

The Insurer may require the Insured Member to return to Australia for claims assessment. Any costs incurred in returning to Australia, for this purpose will not be paid by the Insurer.

The Insurer may, at their discretion, reimburse part or all of the costs relating to tests or medical information, in respect of a claim by the Insured Member.

Section 13: Restrictions on Benefit payments

13.1 Exclusions on Voluntary Cover and Life Events Cover

Benefits will not be payable in respect of any Voluntary Cover or Life Events Cover for death, Terminal Illness or TPD if the death, Terminal Illness or TPD is caused directly or indirectly by a self-inflicted act or injury of the Insured Member within 13 months of the following:

- the date of acceptance of the Voluntary Cover or Life Events Cover;
- the date the Voluntary Cover or Life Events Cover was reinstated, in respect of the reinstated amount; or
- the date the Voluntary Cover or Life Events Cover increased, in respect of the increased amount.

If the Voluntary Cover or Life Events Cover has expired and has subsequently been reinstated, the 13 month period will recommence from the date of reinstatement.

13.2 Misstatement of age

If the age of an Insured Member has been understated, the Benefit in respect of that person will be recalculated and reduced based on the amount of premium already paid and the amount of Insurance Cover that premium would have purchased if the Insurance Cover had been calculated using the correct age.

If the age of the Insured Member has been overstated, the Benefit will not change and the Insurer will return any excess premium paid.

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

13.3 Maximum Benefit Limit

The Insurer will limit any Benefit payable to an Insured Member to the Maximum Benefit Limit stated in the Employer Plan Schedule.

13.4 Unpaid premiums

Where the death or Date of Disablement for TPD occurs for an Insured Member during a period where premiums owing for that period remain outstanding, any Benefit payments will not be made until such time as any premiums owing have been received.

Section 14: Extended Cover

14.1 What is Extended Cover?

Extended Cover is Insurance Cover which continues to be provided, without charge, for up to 60 days after the Insured Member ceases to be an Employee. Extended Cover is subject to the conditions set out in this Section 14.

14.2 When does Extended Cover start?

Extended Cover for an Insured Member starts on the date they cease to be an Employee.

14.3 When Extended Cover ceases

Extended Cover ceases for an Insured Member on the earliest of:

- 60 days after the Insured Member ceases to be an Employee;
- the Benefit Expiry Age;
- the date an application for a Continuation Option is accepted or declined by the Insurer (see Section 15);
- the date they obtain insurance for the same or similar Benefits; and
- the date Insurance Cover ends (see Section 16).

Section 15: Continuation of Insurance Cover option

15.1 What is a continuation of Insurance Cover option?

Where an Insured Member is no longer an Eligible Person under their Employer Plan, because they have ceased to be an Employee for reasons other than for illness or injury, they may apply for a Continuation Option. A Continuation Option allows the person to continue their Insurance Cover under an individual insurance policy issued by the Insurer, without the need to provide evidence of health.

A continuation option is not available where an Employer Plan has terminated.

15.2 Conditions for a continuation of Insurance Cover option

All of the following conditions need to be satisfied before an Insured Member can apply for a Continuation Option:

- they are under age 60;
- no Benefits have been paid or are payable to them under the Policy, or any other life insurance policy;
- they had not ceased employment due to illness or injury;
- they must be commencing employment in an Occupation considered by the Insurer to be an insurable risk under the individual insurance policy;
- the Insurer receives their application, completed to its satisfaction, for a Continuation Option, together with the relevant premium, within 60 days of them ceasing to be an Employee;
- the individual insurance policy issued will be one the Insurer considers contains the same or similar Benefits, to the Insurance Cover provided on the date they ceased to be an Employee;
- the premium for the individual insurance policy issued will be based on the Insurer's standard individual age-based rates, and will be subject to any specific exclusions and loadings applying to their Insurance Cover at the date they ceased to be an Employee;
- the application for the Continuation Option must include, but is not limited to:
  - occupational information, including Salary, if applying for TPD Insurance Cover; and
  - information regarding pastimes, residency, travel, smoking status and other insurance cover; and
- acceptance by the Insurer of any application.

Where a Continuation Option is granted while the Insured Member is applying for Underwritten Cover, their application and any Interim Cover they were entitled to will be cancelled.

Section 16: When Insurance Cover for an Insured Member ceases

16.1 Cessation of Insurance Cover

Insurance Cover will cease for an Insured Member immediately on the earliest of:

- the date they reach the Benefit Expiry Age;
- subject to the Extended Cover (see Section 14.3), the date they cease to be an Employee;
- the date they ceased to be a Contractor with a written contract of services to the Employer for a minimum of 15 hours each week for a continuous 6 month period;
- the date any Extended Cover ceases (see Section 14);
- the date of their death;
- the date a Terminal Illness Benefit becomes payable for them;
- the date a TPD Benefit becomes payable for them;
- the date they do not meet the conditions for continuation of Insurance Cover during unpaid leave (see Section 11.2);
- the date they no longer meet the conditions for continuation of Insurance Cover while overseas (see Section 12);
- the date before they commence active service in the armed forces of any country, not including normal activities as a reservist with the Australian Defence Force, but including operational deployment on active service with the Australian Defence Force;
- the date an individual life insurance policy is issued to them by the Insurer under a Continuation Option (see Section 15);
- in respect of any Interim Cover provided under Section 9, the date any Interim Cover ceases for them;
- the date they change to a new Membership Category which offers a lower level of Insurance Cover than their previous Membership Category, for the amount in excess of their new Insurance Cover;
- the date the Insurer is advised that the Insured Member no longer wishes to be an Insured Member under the Policy;
- the date the Insurer is advised that the Insured Member wishes to have their Insurance Cover reduced, in respect of the amount reduced;
- when premiums are unpaid (see Section 19.4);
- the Policy Termination Date (see Section 17.2);
- the date the relevant Employer Plan terminates;
- the date they no longer meet the Eligibility Criteria; or
- the date the Trustee is required to cease cover in order to meet their obligations under any statutory or legislative instrument.

Section 17: When the Employer Plan ends

17.1 Duration of the terms and conditions of the Employer Plan

The Employer Plan is effective from the Policy Commencement Date and remains in effect until the earliest of:

- the Employer or Policy Owner terminating the Employer Plan or Policy (as applicable) by providing the Insurer with 30 days' written notice prior to the Policy Termination Date;
- the Insurer terminating the Employer Plan, after having provided the Employer at least 30 days' written notice of its intention to do so, due to the Employer's failure to pay the required premiums (see Section 19);
- the Insurer terminating the Employer Plan, after having provided the Employer at least 30 days' written notice of its intention to do so, due to the Employer's failure to provide the Insurer with adequate information at the Annual Review of the Employer Plan to allow the Insurer to calculate the correct premiums;
- the Insurer terminating the Employer Plan, after having provided the Employer with at least 30 days' written notice of the Insurer's intention to do so, if less than 10 persons have Insurance Cover (in which case the Insurer would allow those persons to apply for a Continuation Option within 60 days of the Policy Termination Date);
- payment of the last Benefit of the last Insured Member;
- the Insurer terminating the Employer Plan, after providing the Employer at least 30 days' written notice of the Insurer's intention to do so, due to the Employer's failure to comply with their obligations set out in Section 2.6; or
- Insurance Cover ends for all Insured Members.

In the event the Insurer terminates the Employer Plan due to the Employer's failure to pay outstanding premiums, the Policy Termination Date will be the date immediately after the end of the period for which all premiums have been paid.

17.2 End of Insurance Cover when the Employer Plan ends

All Insurance Cover will end at the conclusion of the Policy Termination Date.

However, if an Insured Member is not At Work at the conclusion of the Policy Termination Date, the Insurer will continue to provide TPD Insurance Cover for that person on and from the Policy Termination Date but only for claims arising from an illness or injury which occurred on or prior to the Policy Termination Date. In addition, this illness or injury giving rise to the claim must be the same reason the Insured Member was not At Work at the conclusion of the Policy Termination Date.

In these circumstances, this TPD Insurance Cover provided by the Insurer on and from the Policy Termination Date will cease on the earliest of:

- the date the Insured Member is next At Work; and
- the date Insurance Cover would end under Section 16, excluding the Policy Termination Date.

17.3 No value on termination

The Policy has no value on termination.

Section 18: Claims

18.1 Conditions for payment of a claim

Payment of a claim under an Employer Plan is conditional upon all of the following conditions:

- the Insurer's claim requirements being met (see Section 18.3);
- any legislative requirements being met; and
- the person making the claim is entitled to the Benefit under the terms and conditions of the Policy and Employer Plan Schedule.

18.2 Notification of a claim

The Insurer should be advised of a claim for an Insured Member as soon as it is reasonably possible. The Insurer will then provide the necessary forms for completion in order to assess the claim.

18.3 Claim requirements

Payment of a claim is conditional upon the Insured Member providing proof of eligibility for a claim and assisting the Insurer with its determination of the Insured Member's eligibility to make a claim. This may include, but is not limited to, the following:

- the Insurer verifying that each of the conditions of Automatic Acceptance of Insurance Cover (where applicable) were met;
- providing the Insurer with an original or certified death certificate (if required), an original or certified birth certificate (or other proof of birth to the Insurer's satisfaction) and any other documentation the Insurer believes is relevant to the claim;
- the Insurer obtaining medical reports, as required, from any relevant Medical Practitioners;
- when reasonably required by the Insurer (and at the Insurer's expense), examination by a Medical Practitioner, undergoing a medical examination or other test or appraisal nominated by the Insurer or providing any other relevant information; and
- if overseas, and requested by the Insurer, where reasonably required by the Insurer, returning to Australia for assessment, at the Insured Member's expense.

18.4 Claim review

If the Insured Member or Employer is not satisfied with a decision to deny a claim, they may have the claim reviewed.

Please see information on complaints under Section 22.7.

18.5 Fraudulent claims

The Insurer may cancel the cover of an Insured Member if they make a fraudulent claim.

Section 19: Premiums

19.1 Premium Rates

The Premium Rates used to calculate the cost of Insurance Cover and the Premium Frequency selected (annually, half-yearly, quarterly or monthly), are each stated in the Employer Plan Schedule.

The Employer must pay at least the Minimum Premium, if any. A Minimum Premium of $15,000 per annum applies to the Employer Plan, irrespective of annual premium calculated based on the age and/or unit rate at each Annual Review. The Minimum Premium excludes all forms of third-party payments and all form of government taxes and/or levies.

19.2 Calculation and payment of premiums

The Insurer will advise the Employer of the premium payable at the commencement of the Employer Plan.

The Insurer will then calculate the premium payable up to and including the day before the next Annual Review using the information provided at the Policy Commencement Date. The Employer will then be advised of the amount they must pay based on the Premium Frequency chosen and taking into account any premium already paid for the period.

At each Annual Review and at the termination of the Employer Plan, the Insurer will recalculate the premium to reflect changes in the Insured Members and the Insurance Cover provided over the period since the Policy Commencement Date or the last Annual Review date, whichever is the later.

If, as a result of the recalculation of the premium, the Employer has paid too much, the Insurer will refund the difference back to the Employer.

If, as a result of the recalculation of the premium the Employer has not paid enough, the Insurer will advise the additional premium (called the adjustment premium) that is owed.

Premiums must be paid in respect of all Insured Members for any period for which Insurance Cover is provided.

19.3 When the premiums must be paid

Any premium or adjustment premium the Insurer advises the Employer is payable in respect of the Employer Plan, will be payable within 30 days of the Insurer's written notice to the Employer.

19.4 When premiums are unpaid

If the requested premium is not paid within 30 days of the due date, the Insurer may provide the Employer with written notice of termination of the Employer Plan if the requested premium is not received within a further 30 days. If the Employer Plan is terminated, Insurance Cover will cease on the date immediately after the end of the period for which all premiums have been paid.

The Insurer reserves the right to charge interest on any premium amount due to them, which is outstanding for more than 30 days.

Interest will be calculated on an annual basis as at the date the premium amount first became due.

See Section 1.4 for information about unpaid contributions.

Benefits will not be paid until all outstanding premiums are paid.

To avoid such an event occurring, a Direct Debit Agreement for premium payment should be considered.

If the Employer pays premiums using a Direct Debit Agreement, the Insurer may reduce any Premium Frequency loadings applicable to the Employer Plan.

19.5 When the Insurer can change the premium

The Premium Rates will not change prior to the end of the Premium Rate Guarantee Period, if one is stated in the Employer Plan Schedule, unless:

- the Insurer agrees to the Employer's request for a change in the terms or conditions of the Employer Plan, in which case the Insurer will give the Employer at least 30 days' prior written notice and any change would be effective from the date specified in the written notice;
- Australia is involved in War, whether declared or not, or the armed invasion of Australia, and the Insurer provides the Employer written notice of such a change, in which case the Insurer will give the Employer immediate written notice and the effective date of such a change would be the date of written notice to the Employer;
- there has been a change in the Eligibility Criteria, Benefit structure or a change of 25% or more in the number or occupational profile of Insured Members under the Employer Plan or a particular Membership Category since the start of the Premium Rate Guarantee Period, in which case the Insurer will give the Employer at least 30 days' prior written notice and any change would be effective from the date specified in the written notice;
- a change to the Premium Rate is required in respect of Insurance Cover provided for any or all Insured Members under the Employer Plan due to any change to past (i.e. a retrospective change by Government), current or future Government charges relating to the Employer Plan, in which case the Insurer will give the Employer immediate written notice and any change would be effective from the effective date of the change in Government charges even if that change precedes any written notice provided to the Employer;
- the number of Insured Members under the Employer Plan falls below 10, in which case the Insurer will give the Employer Owner at least 30 days' prior written notice and any change would be effective from the date specified in the written notice;
- the information the Employer has provided the Insurer at the time of quotation (see is not accurate, in which case the Insurer will give the Employer at least 30 days' prior written notice and any change would be effective from the date specified in the written notice;
- the Insurer reserves the right to re-rate the Employer Plan if the premiums are deducted from the Employee's annual base Salary, therefore the Employer Plan is not fully funded by the Employer.

Section 20: Additional information

20.1 Privacy

In this section regarding your privacy, the words 'we', 'us' and 'our' refer to TAL Life Limited (ABN 70 050 109) and TAL Services Limited (ACN 076 105 130), and Mercer Superannuation (Australia) Limited (ABN 79 004 717 533) (MSAL). TAL Life Limited and TAL Services Limited are the administrator of the Product, appointed by MSAL.

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

Our Privacy Policies contain details about the following:

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

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

TAL

1800 130 869

corporateadmin@tal.com.au

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MSAL (TAL Super)

1800 130 869

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

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

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

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

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

From time to time we or our related bodies corporate and business partners may wish to contact You to provide You with information about other products and services in which you may be interested. If You prefer not to receive direct marketing communications from us (or our related companies) You can let us know using any of the communication methods above.

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

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

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

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

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

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

20.2 Ongoing electronic disclosure

Australian Securities and Investment Commission (ASIC) Regulatory Guide 221 Facilitating online financial services disclosure (RG221) enables financial product providers (including superannuation trustees) to provide ongoing disclosure to Members through electronic or digital delivery methods, including by:

- sending the information to an email address the Member or their Employer has provided to the financial product provider; and
- publishing or hosting the information on a website the financial product provider has nominated for that purpose.

As a result of this, We may communicate with You by:

- using any email address nominated by You, Your Employer or financial adviser; or
- making a communication or other information available to You on Our website at www.tal.com.au/talsuper

If You would like to update Your email address, please complete a Change of Details form or contact Us on 1800 130 869.

Any email address provided to Us for these purposes should be an email address which You access regularly. You, Your Employer or financial adviser must notify Us if You change this email address. By providing Your email address, You acknowledge that it is Your responsibility to regularly check Your email address to access ongoing disclosure in relation to Your account.

20.3 Currency

All payments made in connection with the Policy must be made in Australian dollars.

20.4 Statutory Fund

The Policy is issued in the TAL Life Limited Statutory Fund Number 1.

The Policy or Employer Plan does not share in the distribution of any surplus of this fund or give any Insured Member any rights of ownership of the assets of this or any statutory fund.

20.5 Governing law

The Policy and Employer Plans are subject to and governed by the laws of New South Wales. Australian courts have exclusive jurisdiction to hear all disputes arising from it.

The Policy and Employer Plans are valid and effective only to the extent that it complies with any laws, regulations or licensing requirements.

20.6 Government taxes and charges

If the Insurer is required by law to withhold or pay any tax, duty or other charges in connection with a Benefit paid to the Policy Owner or Insured Member, which are not included in the Premium Rates, the Insurer will deduct the relevant amount from the Benefit and pay it to the proper authority.

20.7 Taxation – points to consider

The taxation treatment in respect of both the premiums and the Benefits payable on insurance policies are different depending on whether or not the relevant insurance Policy is under superannuation and on each individual circumstance.

Because of the differing taxation implications it is important that independent professional taxation advice is sought in determining whether a superannuation or a non-superannuation Policy is purchased and regarding the taxation implications for the Policy Owner and Insured Member of paying premiums or contributions, receiving insurance cover and Benefits under the Policy.

Section 21: Payments

21.1 Additional premiums for Voluntary Cover

Members will need to arrange for their Employer to make additional superannuation contributions to the Product to cover the cost of the additional premium payable from the Fund to the Insurer for their Voluntary Cover.

The relevant Member's Employer is advised of the additional premium payable for Voluntary Cover once that cover is accepted by the Insurer.

21.2 Fees and other costs

The cost of a Member's Insurance Cover is charged to the Fund by the Insurer and paid by the Employer via an employer superannuation contribution to the Product. The total cost of a Member's Insurance Cover is the premium (which includes an allowance for any stamp duty that may be payable by the Insurer) and the Administration Fee based on relevant laws and regulations and disclosed in the quotation and Employer Plan Schedule.

Section 22: Additional superannuation information

22.1 Joining the Fund

The Fund is a regulated public offer fund, in accordance with the *Superannuation Industry (Supervision) Act 1993* (Cth) **(SIS Act**), in which the Member's Employer participates. For the purpose of providing Insurance Cover, the Employer will enroll all eligible Employees into ROSP.

Providing an eligible Employee meets the Eligibility Criteria, and once they are recorded as a Member and once they meet the conditions for Automatic Acceptance, they will be considered an Insured Member under ROSP.

22.2 Trust Deed

The Product is governed by rules set out in the Trust Deed. The Trust Deed and the superannuation law govern the Trustee's relationship with Members. In the event of any inconsistency between the Trust Deed and this PDS, the Trust Deed will prevail to the extent of the inconsistency.

While the Trustee is able to amend the Trust Deed, (subject to certain restrictions) the Trust Deed may not be amended to reduce Members' Benefits without their consent. The only exception to this is if the reduction is allowed under superannuation law.

The Trustee will give members 30 days' prior written notice of material changes or significant events that affect their membership of the Product.

Under the Trust Deed, the Trustee is not generally liable to Members for any act or omission other than where the Trustee has failed to act honestly, or where the Trustee has intentionally and/or recklessly failed to exercise the degree of due care and diligence that it was required to exercise.

A copy of the Trust Deed is available free of charge at www.mercersuper.com/documents or by contacting the Trustee on 1800 130 869.

The Trustee may amend the Trust Deed at any time.

The Trustee may include any changes in the Fund's Annual Report. The latest Annual Report is available free of charge by calling 1800 130 869 or visiting www.mercersuper.com/documents

22.3 Contributions to the Fund

Contributions can only be made to the Fund in accordance with superannuation law. Superannuation law stipulates the way in which Employer contributions can be made as well as work requirements and age limits in relation to the Member for which the contribution has been made.

Only Employer contributions are accepted for Members in ROSP. Such contributions are in addition to any superannuation guarantee, salary sacrifice, or any other mandated contributions for Members. Where a Member has opted to have Voluntary Cover or Life Events Cover they will need to arrange for the additional contributions to be paid by the Employer.

22.4 Beneficiary nomination

Understanding who receives Your benefit in the event of Your death is important. Under the Trust Deed, the Trustee has the discretion to determine to whom and in what proportions any death benefit is payable (see Below for binding nominations). You may nominate Your legal personal representative and/or dependants as Your preferred beneficiaries and the Trustee will consider Your wishes in the event of Your death.

In the event of Your death, benefits will be paid to one or more of Your dependants or to Your legal personal representative as determined by the Trustee.

For superannuation and tax purposes, the definition of 'dependant' includes any of the following:

a) A spouse, which includes a person (whether of the same or different sex) with whom the member is in a relationship that is registered under a law of a State or territory, or a person who, although not legally married to the member, lives with the member on a genuine basis in a relationship as a couple;
b) A child of the member, including adopted child, stepchild, ex-nuptial child or child of the member's spouse (for tax purposes a child must be under age 18);
c) A person who is financially dependent on the member;
d) A person with whom the member has an 'interdependency relationship'.

It is recommended that any nomination of beneficiaries made by You be reviewed regularly, particularly if a change in circumstances has occurred (e.g. marriage or divorce). If You would like to nominate a beneficiary, please complete the Nomination of Beneficiary form at www.tal.com.au/talsuper and return it to the Trustee at the address on the form. The nomination will be confirmed to You on Your annual statement each year.

22.4.1 What is an interdependency relationship?
An interdependency relationship is defined as where two people (whether or not related by family):

a) live together; and
b) have a close personal relationship; and
c) one or each of them provides the other with financial support; and
d) one or each of them provides the other with domestic support and personal care.

An interdependency relationship can also exist where there is a close personal relationship between two people who do not satisfy all other criteria for interdependency because either or both of them suffer from a physical, intellectual, psychiatric or other disability.

22.4.2 Binding nominations
Generally, Your nomination is only a guide. The Trustee is obliged to pay Your death benefit in accordance with the Trust Deed and superannuation laws. If You wish to make Your nomination binding, the Trust Deed and superannuation laws require special conditions to be met.

When making (or amending) a binding nomination, the nomination must be signed in the presence of two witnesses. Both witnesses need to be over the age of 18 and cannot be beneficiaries under the binding nomination.

Each binding nomination remains valid for only three years. If You choose this option, it is Your responsibility to renew Your nomination and advise the Trustee of appropriate changes.

If Your nomination expires or is invalid at the time of Your death, the Trustee has the discretion to determine to whom and in what proportions any death benefit is payable.

22.5 Superannuation and family law

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

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

22.6 Superannuation – points to consider

The laws governing the application of superannuation are complex and the statements provided here are general in nature and based on current law.

Members should obtain their own independent advice on the taxation implications of joining the Product, beneficiary nominations and maintaining Insurance Cover through the Product.

22.7 How to make a complaint

If You are dissatisfied with Your Insurance Cover through the Fund, You should address Your complaint to:

TAL Super plan in the Mercer Super Trust
C/- The Manager, Complaints Resolution
TAL Life Limited
GPO Box 5380, Sydney NSW 2001

The Trustee has 45 days to resolve your complaint from receipt. For complaints about superannuation death benefit distributions, you have up to 28 calendar days from the date of the death benefit distribution to object and the Trustee has up to 90 calendar days after the expiry of the 28 calendar day period for objecting to resolve your complaint.

If your complaint is not resolved to your satisfaction or within the relevant 45 or 90 day period, you can lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides a fair and independent financial services complaint resolution that is free to consumers.

Australian Financial Complaints Authority (AFCA)
1800 931 678
www.afca.org.au
info@afca.org.au
Australian Financial Complaints Authority
GPO Box 3,
Melbourne VIC 3001

Section 23: Summary of taxation information for ROSP

The taxation treatment in respect of both the premiums and the Benefits payable on insurance policies within superannuation is complex and depends on a Member's individual financial circumstances. Because of the differing taxation implications it is important that Members seek independent professional taxation advice relevant to their particular circumstances in determining how taxation affects them.

In the 2021-22 Federal Budget, proposed changes to the eligibility age for downsizer contributions and in respect of the work test for personal superannuation contributions were announced. At the date of issue of this PDS, these announced changes have not been legislated and for this reason they have not been included in the information below.

This Australian taxation information is a general statement only and is based on the continuance of present Australian taxation laws and rulings and their interpretation. A Member's specific circumstances may be different and have not been taken into account in providing this information. Information regarding the application of any foreign tax laws, for example where a Member is a non-Australian Resident, is not provided in this document and Members or Employers should obtain professional taxation advice in this regard if relevant to their circumstances.

The Policy is treated as input taxed under the *Goods and Services Tax (GST) Act 1999* (Cth) and any applicable cost of GST will be included in the Premium Rates. An input tax credit will not be available to the Trustee. The Insurer reserves the right to make changes to the Premium Rates in response to any taxation or other legal changes.

23.1 Contributions

Employer contributions are generally tax deductible to the employer where they are made for the purpose of providing superannuation benefits for an employee or the employee's 'Dependants' (see Section 22.5).

Employer contributions are 'concessional contributions', as are salary sacrifice contributions.

There is an annual cap for the amount of concessional contributions which may be made to a superannuation fund by, or on behalf of, a Member. The concessional contributions cap for the 2021/2022 financial year is $27,500 for Members regardless of their age.

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

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

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

There are also limits on the amount of post-tax or 'non-concessional contributions' that can be made on behalf of a Member. Non-concessional contributions include personal contributions for which You do not claim an income tax deduction and any excess concessional contributions that are not refunded.

For the 2021/2022 financial year, the annual cap for non-concessional contributions is $110,000 and individuals with total superannuation balances of $1.7 million or more are not eligible to make non-concessional contributions. There is a 'bring-forward' option as discussed below. You will be taxed on non-concessional contributions over the cap at the rate of 45%, plus the Medicare levy.

Under the 'bring-forward' option, generally people under 65 years of age at the start of the financial year can bring forward three years' entitlements to non-concessional contributions based on the annual cap limits above. However, from 1 July 2021 individuals with total superannuation balances of $1.48 million or more (2021/22) have reduced or no access to the bring forward rule.

If You receive an excess concessional or non-concessional contribution determination from the ATO, You should not elect for amounts to be released from the Fund. The Fund is unable to process a release authority from the ATO because You will not have an accumulation interest in the Product.

If Your income is less than $56,112 (for the 2021/2022 financial year), You may also benefit from government co-contributions if You make a personal after tax (non-concessional) contribution to Your superannuation (other than the Fund, which cannot accept personal contributions from You.)

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

From 1 July 2018, individuals with superannuation balances of $500,000 or less at the end of 30 June of the previous financial year will be allowed to access their unused concessional cap space (on a rolling basis for a maximum of 5 years) to make additional concessional contributions. The first year You will be entitled to carry forward unused amounts is the 2019–20 financial year. Unused amounts are available for a maximum of five years, and after this period will expire. Superannuation and taxation laws are complex. It is important You seek independent professional taxation advice that takes into account Your specific circumstances. For up-to-date tax information visit www.ato.gov.au/super or call the Australian Taxation Office on 13 10 20.

23.2 Tax on benefit payments

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

23.2.2 Tax on Terminal Illness benefits
Where you receive a Terminal Illness benefit, the amount paid is tax free. You should obtain your own independent advice in relation to this.

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

Where You receive a TPD benefit, it will be taxed as a superannuation lump sum. This lump sum may be made up of two components:

Tax-Free - the tax-free amount depends on factors including the number of days between the day when you ceased being capable of being gainfully employed and either, the day on which you would turn 65 years of age, or the date on which your employment would terminate if your employment arrangement provides a termination date based on age or period of service; and

Taxable - taxed element. The tax treatment of the taxable component (taxed) depends on your age at the date of payment and the amount paid, as follows:

Age	Tax 2021/2022 Financial Year
Aged 60 and above	Tax Free
Your preservation age up to age 59	The first $225,000* is tax free.
	The amount over $225,000* is taxed at your marginal tax rate up to a maximum tax rate of 15% (plus Medicare Levy).
Below preservation age	The whole amount is taxed at your marginal tax rate up to a maximum tax rate of 20% (plus Medicare Levy)

* This amount is indexed annually. It is a lifetime cap which is reduced for the taxable component of all superannuation lump sum payments received by you and is increased by the indexation amount at the start of each income year.

23.3 Providing a TFN

The Trustee is authorised to collect a Member's TFN under the SIS Act. The Trustee requires that Eligible Persons or their Employers supply their TFNs to the Fund as a prerequisite of membership. If the Trustee does not hold an Eligible Person's TFN, they are not a Member and the Trustee will refund any contributions received on their behalf to their Employer and no Insurance Cover will be provided.

A Member's TFN will only be used for lawful purposes which include administering the Fund. A TFN may only be disclosed as permitted by the applicable laws. The purposes for which the Trustee is able to use a Member's TFN may change in the future as a result of legislative change. Members are under no obligation to provide their TFN and declining to quote a TFN is not an offence, but membership of the Fund and Insurance Cover will only commence upon receipt of the TFN.

Members should notify their Employer if they do not wish to disclose their TFN to the Trustee.

Due to the complexity of TFN laws, the Insurer has agreed with the Trustee of the Fund not to issue any cover in respect of a Member who has not provided the Trustee with their TFN. This means that to be eligible for cover through the Fund a Member must be prepared to quote their TFN to the Trustee.

Section 24: Member details

24.1 Keeping Member details up to date

Please let the Trustee know promptly if any of Your personal or contact details, as a Member, have changed.

Life circumstances may mean that Your name and/ or address change from time to time and it's also important that the Trustee keeps up to date records of Your telephone number/s if the Trustee needs to contact You about Your account. Changing Your details is easy – simply contact Your Human Resources Team, Your Employer Plan's financial adviser or call the Trustee on 1800 130 869.

3 Part 2: Definitions

The following definitions apply to ROSP.

Definition	Meaning
Administration Fee	means the fee for administering a Member's ROSP account in the Fund and can be up to $3.85 per Member per week (indexed). This fee is in addition to the premiums for Insurance Cover and is paid by the Employer.
Age Criteria	means the minimum and maximum entry ages stated in the Employer Plan Schedule.
Annual Review	means the date stated in the Employer Plan Schedule.
At Work	means a. where the Eligible Person is: i. a Permanent Employee, Contractor or a Casual Employee who is working at the relevant time and not on leave - he or she is actively performing all the normal duties of their Occupation with the Employer without restriction or limitation due to illness or injury; or ii. a Permanent Employee, Contractor or a Casual Employee or who is not working at the relevant time or is on leave approved by the Employer - he or she is, in the Insurer's opinion, capable of performing all the normal duties of their Occupation with the Employer without restriction or limitation due to illness or injury; and b. not receiving or not entitled to receive income support benefits from any source including workers' compensation benefits, statutory transport accident benefits or disability income benefits. An Eligible Person who does not meet these requirements will be described as not At Work.
Australian Resident	means a person who permanently resides in Australia or resides in Australia on a temporary working visa as agreed by the Insurer.
Automatic Acceptance	see Section 5.
Automatic Acceptance Limit (AAL)	means the maximum amount of Insurance Cover based on the Insurance Formula, provided without Underwriting. The AAL will be stated in the Employer Plan Schedule.
Benefit	means the death and/or TPD Insurance Cover as stated in the Employer Plan Schedule. Terminal Illness and Interim Cover are Benefits provided under the terms and conditions of the Policy but will not be stated in the Employer Plan Schedule.
Benefit Expiry Age	means the maximum age to which a Benefit will be provided as set out in the Employer Plan Schedule.
Casual Employee	means an Eligible Person who is Gainfully Employed by the Employer on a casual basis.
Continuation Option	see Section 15.
Contractor	means an Eligible Person under a written contract of service with the Employer for a minimum of 15 hours each week for a continuous 6 month period and is, under the contract, having Salary and Superannuation Guarantee Contributions paid in respect of them.
Date Of Disablement	means the date which a Medical Practitioner certifies in writing as the date that the Insured Member ceased work as a result of an illness or injury which is the principal cause of the TPD for which a claim is made, and the Insurer is satisfied, on medical or other evidence, that this is the date that the Insured Member ceased work as a result of an illness or injury which is the principal cause of the TPD for which that claim is made.
Eligibility Conditions	mean the conditions stated in Sections 3.1 and 3.2 which need to be met in order for Insurance Cover to be provided under the Policy.
Eligibility Criteria	means the criteria for a Membership Category stated in the Employer Plan Schedule.
Eligible Person	means a person who meets all the conditions of Sections 3.1 and 3.2 and other requirements to be eligible for Insurance Cover as stated in the Employer Plan Schedule when their Insurance Cover commences.
Employee	means a person who is Gainfully Employed by the Employer.
Employer	means the entity stated in the Employer Plan Schedule employing Eligible Persons under the Policy.
Employer's Default Superannuation Fund	means the superannuation fund recognised as such for the purposes of the *Superannuation Guarantee (Administration) Act 1992* or successor statutes.
Employer Plan	means a group of Insured Members employed by an Employer and for which Insurance Cover is provided under the Policy and is assigned, for reference, an Employer Plan number as indicated on the Employer Plan Schedule.
Employer Plan Schedule	means , the document issued by the Insurer to the Policy Owner for the benefit of the Employer, stating specific details relating to the Employer Plan, including any Special Conditions.

Definition	Meaning
Endorsement	means any written amendment to the terms and conditions of the Employer Plan the Insurer agrees with and provides to the Employer.
Extended Cover	see Section 14.
Forward Underwriting Limit	means the maximum level, advised after Underwriting, to which Insurance Cover for an Eligible Person can increase, based on the Insurance Formula, without further Underwriting.
FSC	means Financial Services Council.
Full Cover	means Insurance Cover for any illness or injury after the person was nominated for Insurance Cover, where the Insurance Cover is not affected by the date the illness became apparent or the injury occurred.
Fund	means the the Mercer Super Trust.
Gainfully Employed	means working for reward in an Occupation (which can include a contract for services) without restriction due to illness and injury.
Inactive	means no contributions (i.e. premiums) have been received by the Trustee for a Member of an Employer Plan for a continuous period of 16 months.
Insurance Cover	means the Benefits provided under the terms and conditions of the Policy and Employer Plan Schedule.
Insurance Formula	means the calculation method for Insurance Cover elected by the Employer and agreed by the Insurer as stated in the Employer Plan Schedule.
Insured Member	means any Eligible Person for whom Insurance Cover has been provided by the Insurer.
Insurer	means TAL Life Limited.
Interim Cover	see Section 9.
Life Events Cover	see Section 8.
Limited Cover	means Insurance Cover is only payable for claims arising directly from an illness or injury which first occurs or is diagnosed or the signs or symptoms first become apparent, after the date the Insurance Cover commenced, was reinstated or increased under the Policy. Benefits arising directly or indirectly by a self- inflicted act are not payable under Limited Cover.
Maximum Benefit Limit	means • an amount as determined by the Insurance Formula as stated in the Employer Plan Schedule; and • the maximum Benefit amount the Insurer will pay in respect of an Insured Member as set out in Part 1 under 'Availability of cover' on page 2.
Medical Practitioner	means, unless the Insurer agrees otherwise: a medical practitioner legally qualified and registered to practice in Australia; or if the claimed condition is a mental health condition, it is to be diagnosed in accordance with the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the definition of a medical practitioner means a person who is legally qualified and registered as a practising psychiatrist by the relevant medical registration boards and/or the Specialist Recognition Advisory Committee coordinated through the Australian Health Insurance Commission. Chiropractors, physiotherapists, psychologists or alternative health providers are not regarded as Medical Practitioners. The Medical Practitioner cannot be: a. the Insured Member; b. the Insured Member's /partner in a de facto relationship; c. a close family relative of the Insured Member; d. business associates or partners of the Insured Member; e. fellow security holders in the same company/trust (ignoring publicly listed entities); or f. an employer or employee of the Insured Member.
Member	means a person admitted by the Trustee as a member of the Product under the Fund's governing rules.
Member Benefit Certificate	means, for Members, a part of the welcome letter that outlines the features that their Employer has chosen.
Membership Category	means the common group set out in the Employer Plan Schedule to which Insured Members belong because of their Occupation and/or their employment status.

Definition	Meaning
Minimum Average Hours	means an Insured Member who is a Contractor and has worked a minimum of 15 hours per week for the 3 months immediately prior to the Date of Disablement. The 3 month period may be adjusted as follows: • where an Insured Member returns from an agreed period of leave, it will include time prior to the commencement of the agreed period of unpaid leave if 3 complete months have not elapsed prior to the Date of Disablement; • where an Insured Member has been working for less than 3 months, the equivalent period will be the time since commencement with the Employer to the Date of Disablement.
Minimum Premium	means the minimum annualised premium, as detailed in Section 19.5 and stated in the Employer Plan Schedule.
Occupation	means the primary duties for which the Eligible Person is paid a Salary.
On Risk Letter	means written advice issued by the Insurer advising agreement to provide Insurance Cover.
Own Occupation	means the Occupation in which the Insured Member has spent the majority of their time undertaking with the Employer immediately prior to the Date of Disablement.
Permanent Employee	means the Eligible Person is Gainfully Employed by the Employer on a permanent full-time or permanent part-time basis.
Personal Statement	means an application form issued by the Insurer for the purpose of Underwriting an Eligible Person for Insurance Cover.
Policy	means the documents GR682-GL between issued by the Insurer to the Trustee.
Policy Commencement Date	means the Policy Commencement Date stated in the Employer Plan Schedule and the On Risk Letter.
Policy Owner	means the Trustee as stated in the Employer Plan Schedule.
Policy Schedule	means the document issued by the Insurer to the Policy Owner, stating specific details relating to the Policy, including any Special Conditions.
Policy Termination Date	means the date the Employer Plan ends on the earlier of when the Insurer receives written notice from the Employer and as set out in Section 17.1.
Premium Frequency	means the frequency of premium payments, that is, annually, half-yearly, quarterly or monthly, as stated in the Employer Plan Schedule.
Premium Rate Guarantee Period	means the period stated in the Employer Plan Schedule during which Premium Rates will not be increased by the Insurer other than in the circumstances set out in Section 19.5.
Premium Rates	means the cost of the Insurance Cover stated in the Employer Plan Schedule and used to calculate the premiums for Insurance Cover.
Product	means TAL Super.
Related Entity	means a related body corporate of the Employer.
ROSP	means Risk Only Super Plan.
Salary	means the remuneration components paid by the Employer to an Eligible Person at the relevant time, as stated in the Employer Plan Schedule. The following conditions apply: • where the Employer Plan Schedule states that bonuses and/or commissions are included, they will be averaged over the 3 years preceding the last Annual Review date or any shorter period during which they have been paid for the Eligible Person, unless otherwise stated in the Employer Plan Schedule; • where the Insured Member owns (either indirectly or directly) all or part of the business including all or part ownership through another legal entity, Salary shall mean the regular income earned from the Insured Member's personal exertion after the deduction of all attributable business expenses incurred in earning the income. Income will not include investment income, profit distributions or similar payments that may continue in the event of disability, unless otherwise stated in the Employer Plan Schedule. For the purposes of determining the amount of cover used in the premium calculation in respect of an Insured Member, the relevant time is the last Annual Review. For the purposes of determining the amount of Benefit a person can claim with respect to an illness or injury which occurred whilst they had Insurance Cover under the Policy, the relevant time is the date immediately prior to the Date of Disablement.
SIS Act	means *Superannuation Industry (Supervision) Act 1993* (Cth).
Special Conditions	means variations and modifications to the Policy or Employer Plan agreed by the Insurer and stated in the Employer Plan Schedule.

3 Part 2: Definitions *(continued)*

Definition	Meaning
Takeover Date	means the date stated in the Employer Plan Schedule where Takeover Terms apply.
Takeover Terms	means the Takeover Terms, if any, stated in the Employer Plan Schedule, under which the Insurer agrees to provide Insurance Cover as was provided for Transferring Members by a previous Insurer.
TAL Super	means a plan within the Retail Division of the Fund.
Terminal Illness	means an Insured Member suffers any condition that: a. two appropriate Medical Practitioners approved by the Insurer (at least one of whom is a specialist) certifies in writing, having regard to the current treatment or such other treatment as the Insured Member may reasonably be expected to receive, will despite reasonable medical treatment likely lead to the Insured Member's death within 12 months of the date of certification; and b. the Insurer is satisfied, on medical or other evidence, will despite reasonable medical treatment lead to the Insured Member's death within 12 months of the certification referred to in paragraph a).
TFN	means Tax File Number.
TPD, Total and Permanent Disablement, Totally and Permanently Disabled	means one of the following: 1. TPD (Standard) An Insured Member to whom the TPD (Standard) applies as stated in the or Employer Plan Schedule, employed in a Permanent Employee capacity, or as a Contractor for the Minimum Average Hours per week, at the Date of Disablement, and has since been unable to work solely because of illness or injury for a continuous period of at least 6 months, and is in the Insurer's opinion unlikely ever to be able to work in any occupation for which they are reasonably suited by training, education or experience; or otherwise satisfies the definition below of TPD (Alternate). 2. TPD (Alternate) A. An Insured Member is, in the Insurer's opinion, totally and permanently unable to perform at least two of the following five activities of daily living without the physical assistance of another person: a) bathing – to shower or bathe; b) dressing – to dress or undress; c) feeding – to eat and drink; d) toileting – to use a toilet; e) mobility – to get in and out of bed or a chair or move from place to place without using a wheelchair. or B. An Insured Member has suffered the total and permanent loss of the use of: a) both feet, both hands or sight in both eyes; or b) any combination of two of, a hand, a foot, or sight in an eye. Where "loss of the use of" means: i) the loss of the use of the whole hand or the whole foot, from the wrist or ankle joint; or ii) sight to the extent that visual acuity in the eye, on a Snellen Scale after the correction by a suitable lens, is less than 6/60. or C. The Insurer has determined, directly or indirectly as a result of illness or injury a total and permanent deterioration or loss of mental capacity has required the Insured Member to be under continuous care and supervision by another adult for at least 6 consecutive months and, at the end of that 6 month period, the Insurer considers that they are likely to require permanent ongoing continuous care and supervision by another adult person. And for TPD Standard and TPD Alternate, when structured through superannuation, the Insured Member must also satisfy the SIS Regulations definition of Permanent Incapacity. Current as at the date of this PDS, the SIS definition of Permanent Incapacity is as follows: Permanent Incapacity in relation to a member of a superannuation fund means ill-health (whether physical or mental), where the trustee is reasonably satisfied that the member is unlikely, because of the ill-health, to engage in gainful employment for which the member is reasonably qualified by education, training or experience. Note: For those Insured Members who had taken out TPD cover through superannuation prior to 1 July 2014, the Total and Permanent Disablement/Totally and Permanently Disabled definition as set out in the PDS dated 1 December 2012 will continue to apply.
Transferring Member	means any Eligible Person for whom the Insurer agrees to provide Insurance Cover under Takeover Terms.
Trustee	means Mercer Superannuation (Australia) Limited.

Definition	Meaning
Trust Deed	means the Mercer Master Fund Deed of the Mercer Super Trust dated 28 June 1995 (as amended from time to time), together with the governing rules applicable to TAL Super.
Underwriting and Underwritten	means the process the Insurer undertakes to assess an application by an Eligible Person for Insurance Cover including reference to information concerning their medical, health and employment.
Voluntary Cover	means Insurance Cover which is not based on the Insurance Formula and for which an Eligible Person makes an application, if stated as being provided in the Employer Plan Schedule.
War	means an act of war, whether declared or not, armed aggression by a country or organisation resisted by any country or organisation or civil disturbance.
We, Us, Our	means the Trustee.
You, Your	means the reader of this PDS.

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TAL Risk Only Super Plan
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Current as at: June 2021

TAL Life Limited (ABN 70 050 109 450) (AFSL 237 848)

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