

Homeowner Protection

Combined Product Disclosure Statement and Policy Document

ISSUE DATE 27 NOVEMBER 2025

TAL



Important information about Homeowner Protection

This Combined Product Disclosure Statement (PDS) and Policy Document contains important information about Homeowner Protection.

Homeowner Protection is optional

Homeowner Protection is an optional insurance product that provides lump sum payments if you die or are diagnosed with a terminal illness as defined under Decreasing Life Cover or a specified injury, illness or event as defined under optional Major Illness Cover. This insurance product is not a requirement when you apply for a home loan and is not a requirement to qualify for a home loan.

Whether or not you buy Homeowner Protection will not impact or alter the terms of any home loan you currently have or are eligible for.

Your Homeowner Protection Decreasing Life Cover Benefit Amount reduces automatically over time

Your Decreasing Life Cover Benefit Amount will automatically reduce at each Policy Anniversary by 5%. When your Policy commences, we will provide you with a schedule that outlines how your Benefit Amount will reduce over your Policy term.

If you make any changes to your Decreasing Life Cover Benefit Amount after you take out your Policy, your Decreasing Life Cover Benefit Amount will continue to reduce automatically at each Policy Anniversary by 5%. If this happens, we will provide you with an updated schedule that outlines how your Benefit Amount will reduce over the remaining term of your Policy.

See **Section 2.1.2** for more information.

Homeowner Protection benefits are paid to you – they are not paid by us to your home loan lender

The benefit payments under Homeowner Protection are not paid by us to your home loan lender. The benefit payments will be paid directly to you or your loved ones you nominate. You or your loved ones can choose to use the benefit payments for any purpose, including to contribute to medical or living expenses or to repay debt.

Your Homeowner Protection Policy does not automatically end if your home loan is repaid or ends

Your Policy does not end automatically when you repay your home loan, your home loan ends or you make changes to your home loan (e.g., refinance your home loan with another lender).

If you repay your home loan, your home loan is cancelled or ends, or you make changes to your home loan, you should review your Policy to make sure it continues to meet your individual objectives, financial situation and needs.

You may cancel your Homeowner Protection Policy at any time, for any reason.

Homeowner Protection is not consumer credit insurance – your insurance is not linked to the amount outstanding on your home loan over time

Homeowner Protection is not a form of consumer credit insurance under *the National Consumer Credit Protection Act 2009* (Cth).

Your Decreasing Life Cover Benefit Amount is not linked to and does not track the amount outstanding on your home loan or your home loan repayments over time. The automatic decreases to your Decreasing Life Cover Benefit Amount we apply each year are not designed to match the actual amount of outstanding debt on your home loan or your home loan repayments over time. You should regularly consider whether your Benefit Amount under this insurance is appropriate and sufficient for you to meet your individual objectives, financial situation and needs over time.

Any benefits paid under your Policy may be used at your discretion for any purpose and do not have to be used to make home loan repayments or as additional repayments to reduce the amount outstanding on your home loan.

Your premiums can change

Your premiums will not reduce even though your Decreasing Life Cover Benefit Amount automatically reduces by 5% at each Policy Anniversary.

Your premiums may change in future for a range of reasons which include:

- we change our premium rates;
- you vary your Policy, for example when you add a Plan, or you make changes to your Benefit Amount (including through the Cover Review Benefit);
- a discount no longer applies or changes (this includes when you vary your Policy); or
- government duties or charges change.

See **Section 1.2** for more information.

About this PDS

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

This section describes the purpose of this document.

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

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

This PDS contains information about Homeowner Protection, the various options you can choose from as well as the terms and conditions which will apply to your Policy if your application is accepted by us. You should read the PDS carefully before you decide to acquire or continue to hold this insurance cover. Homeowner Protection is only available to Australian Residents receiving the PDS in Australia.

If you apply for Homeowner Protection and we accept your application, you will receive a Policy Schedule outlining your specific cover details. Together, the Policy Schedule and the PDS sets out the terms and conditions of a contract of life insurance between you and TAL. Please note that no contract of insurance is established unless we accept your application (which we are not bound to do) and we receive the required premium.

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

If you have any questions, contact us on:

- 1300 683 816
- customerservice@tal.com.au
- www.tal.com.au
- GPO Box 5380, Sydney NSW 2001

How we communicate with you – Important updates and communications about your Policy will only be available on our self-service website

Important updates and communications about your Policy will only be made available to you on our self-service website. This includes your welcome letter and Policy Schedule, anniversary letters, correspondence relating to non-payment of premium, policy changes and cancellation confirmations.

You will not be able to elect to receive any communications about your Policy by post.

When new communications about your Policy are made available on our self-service website, we will send you an email or SMS notification to the email address or mobile number you provided to us, to let you know that a new communication is available for you to access on our self-service website. These communications contain important information about your Policy so it is important that you access and read these documents. You should save and download the documents for your own records and safe-keeping.

When your Policy starts, we will provide you with details about how to access communications about your Policy on our self-service website including the website link and your registration/ login instructions.

When your login details and password are used to access your Policy information, make any changes relating to your Policy or to otherwise communicate with us on our self-service website, you agree that we will assume that the action or communication is performed by you. You will be responsible for all such actions and communications performed via your login details.

It is your responsibility to let us know if any of your contact details are incorrect or change, including your email address and mobile number. You can update your details by contacting us.

If you need any help or have any questions about accessing your documents on our website, you can call us on 1300 683 816 or email us at customerservice@tal.com.au.

Changes to this PDS

The information in this PDS is current as at the date of issue of this PDS. From time to time, we may change or update information to the PDS. If there is a significant or materially adverse change to, or omission of information in this PDS, you will be informed by a notice available on our website. We will send you an email or SMS notification to the email address or mobile number you provided to us, to let you know that these changes or updates to the PDS are available for you to access on our website.

Changes that are not materially adverse will be made available by providing notice of any such changes at www.tal.com.au/homeowner-protection. If you would like a free digital copy of the updated information, please contact our Customer Service Centre.

Terms and headings used in this PDS

In this PDS, there are a number of terms which have a particular meaning. Where a defined term is used in this PDS, the first letter of each word is capitalised (e.g. 'Policy Owner'). The only exceptions are 'you', 'your', 'we', 'us' and 'our' which are not capitalised. In this document, references to 'you' and 'your' mean the Life Insured and/or Policy Owner as applicable or as the context requires, unless indicated otherwise. References to 'we', 'us' and 'our' mean TAL.

You can contact us if you are unsure of the meaning of any definition or part of this PDS.

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

Other important information about limitations and exclusions

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

Risks

There are risks with taking out Homeowner Protection that you should be aware of. These include:

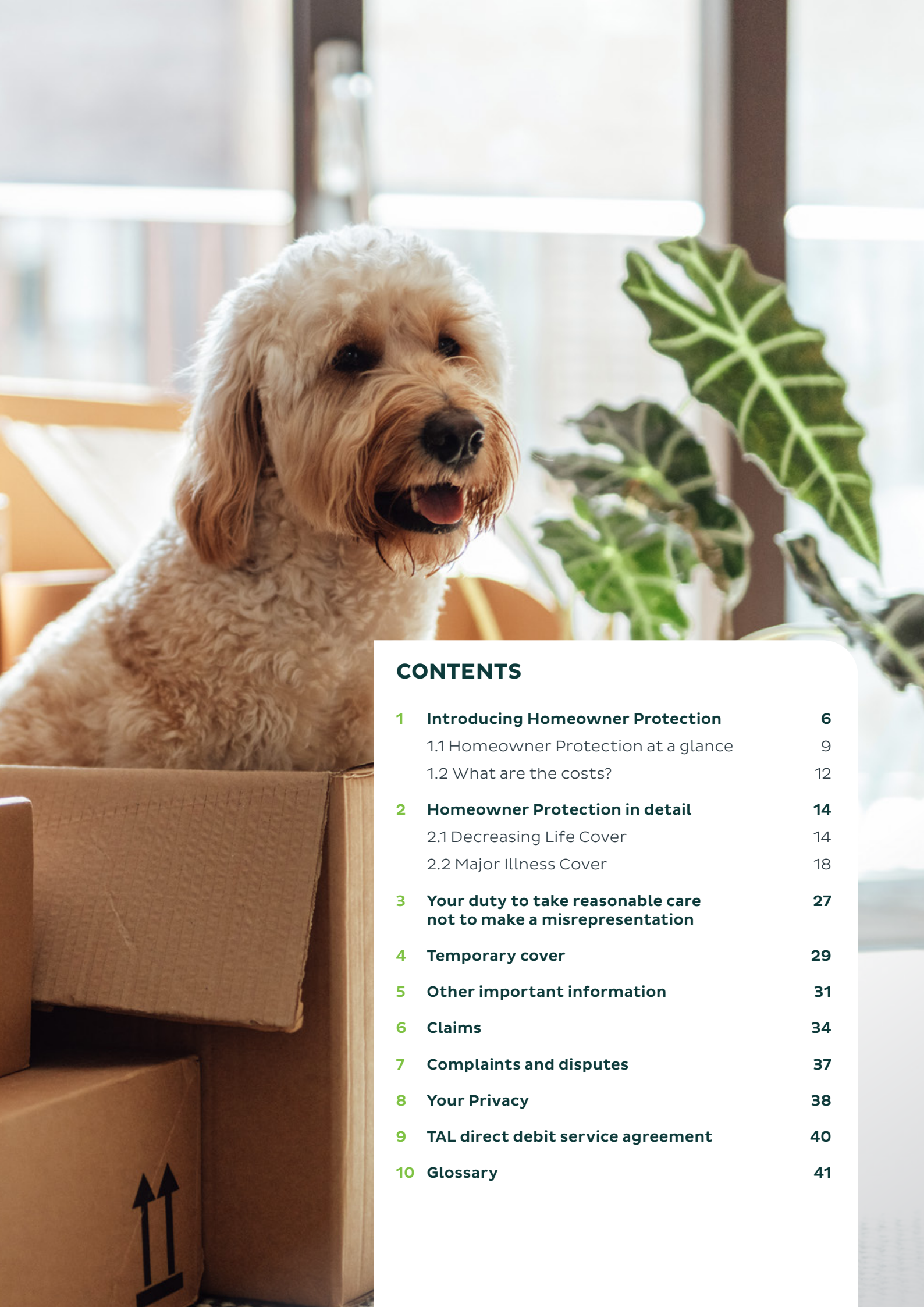
- That it may not be suitable for your needs or you may not select the right type of cover or level of cover for your needs.
- Your life insurance cover under Decreasing Life Cover will decrease automatically over time. This may mean that over time you may not have the right level of cover to meet your needs, and that you should review your cover over time to make sure it meets your individual objectives, financial situation, and needs. Please refer to **Section 2.1** for more information.
- Your life insurance cover under Decreasing Life Cover is not linked to and does not track the amount outstanding on your home loan over time. Your Policy does not automatically end when you repay your home loan, your home loan ends or you make changes to your home loan. You should regularly consider whether your Policy is appropriate and sufficient for you to meet your individual objectives, financial situation and needs.
- The Policy does not contain a savings or investment component, which means that if you cancel your Policy after the 30-day cooling off period, you will not receive any money back.
- Claims may not be paid and your cover under the Policy may be avoided (which means treated as if it never existed), or the terms may be changed or an insured benefit may be reduced, where you do not take reasonable care not to make a misrepresentation, when applying for or changing cover. Refer to **Section 3** for more information.
- Claims may not be paid, and your Policy may be cancelled to the extent permitted by law if you have made a fraudulent claim under your Policy or another policy you have with us.
- Claims will not be paid if the criteria and requirements to make a claim are not met, including where an exclusion applies.
- The cost of your Policy can increase in the future due to a range of factors, and these increases might be significant. Your premiums will not reduce over the term of your Policy, even though your life insurance cover under Decreasing Life Cover automatically reduces over the term of your Policy. Please refer to **Section 1.2** for more information.
- It is possible to pay more in premiums than the amount you are covered for.
- You should consider if you have the financial capacity to fund the costs of cover, over the period you intend to hold the cover. This includes periods in which your financial capacity may change such as, but not limited to, changing employment circumstances, entering retirement or another change in your financial situation. You should form your own assessment of your capacity to fund premiums.
- The Policy will be cancelled if you have failed to pay your premiums by the due date and we have given you notice required by law.
- If you are replacing another insurance contract, you may lose valuable benefits so you should consider the terms and conditions of each insurance contract before deciding to make the change.

We encourage you to consider these risks. You should consider if your Policy meets your needs both now and in the future. You may need to seek advice from a financial adviser to understand these risks and the appropriate Policy, options, and structure for you. You should also read and ensure you understand this PDS before making an application for cover.

Life Insurance Code of Practice

We have adopted the Life Insurance Code of Practice (the Code) which sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest. It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers as well as how insurers will assess your claim if your policy has a medical definition which specifies an obsolete method of diagnosis or treatment that is no longer used in mainstream medical practice in Australia. The Code covers many aspects of a customer's relationship with their insurer, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support.

More information can be found on our website, at tal.com.au/code-of-practice



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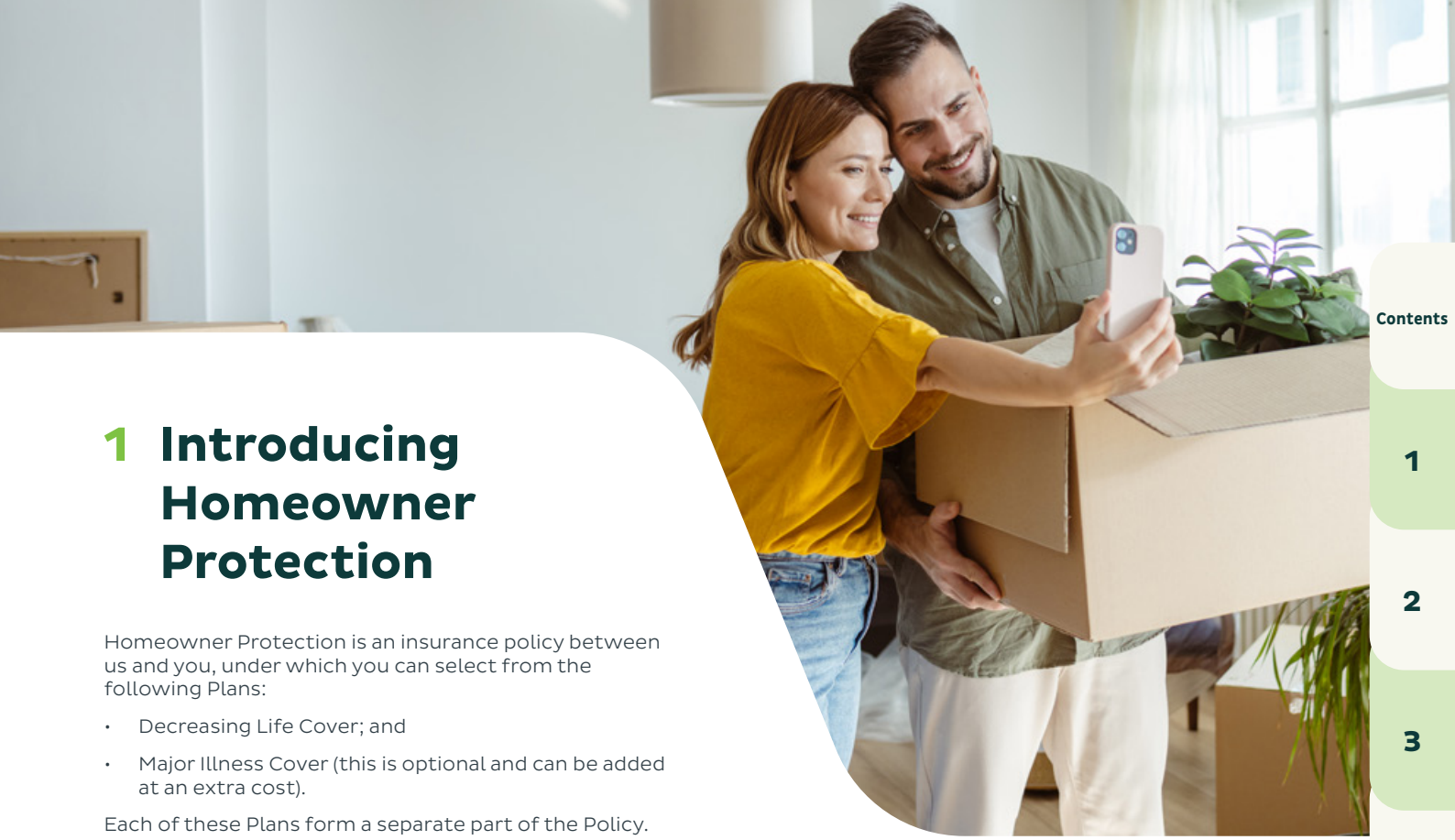


1 Introducing Homeowner Protection

Homeowner Protection is an insurance policy between us and you, under which you can select from the following Plans:

- Decreasing Life Cover; and
- Major Illness Cover (this is optional and can be added at an extra cost).

Each of these Plans form a separate part of the Policy.

Who is Homeowner Protection designed for?

Homeowner Protection is designed for customers with certain objectives, financial situations or needs.

We have prepared a target market determination (TMD) for this product, which is separate to, and not part of, this PDS. The TMD includes information about the likely objectives, financial situation and needs of consumers that the product is designed for, and information about the distribution of this product. You can find the TMD for this product here www.tal.com.au/homeowner-protection

Convenient

Homeowner Protection is designed to provide you with a quick decision on the outcome of your application, based on the information provided by you in a short application and you are not required to undergo any medical tests or exams to apply for this product.

Homeowner Protection is not linked to your home loan or your lender

Any benefit payments under Homeowner Protection will not be paid by us to your home loan lender. Benefit payments will be paid directly to you, or the remaining Policy owner, your nominated beneficiaries, or your estate as applicable. You or your beneficiaries can use the benefit payments for any purpose, including to repay your home loan or other debts, or to contribute to household or medical expenses.

Your life insurance cover, under Decreasing Life Cover, reduces automatically over your Policy term. The amount of your life insurance cover will reduce by 5% at each Policy Anniversary. When your Policy commences, we will provide you with a schedule that outlines how your Decreasing Life Cover Benefit Amount reduces over the term of your Policy. The rate at which your life insurance cover reduces is not linked to and does not track your home loan or any outstanding home loan debt or home loan repayments over time.

Your Policy will not automatically end if your home loan is repaid or ends, you make changes to your home loan or you decide to change lenders throughout the course of your home loan. If you repay your home loan, or your home loan ends or changes, you may need to review your Policy to make sure it continues to meet your individual objectives, financial situation and needs. You can cancel your Homeowner Protection Policy at any time, for any reason.

You do not have to buy this insurance

Please note that Homeowner Protection is optional insurance, and you are not required to take out this Policy when you apply for a home loan. You do not need to buy this insurance for your home loan application to be approved.

Whether or not you buy Homeowner Protection will not impact or alter the terms of any home loan you currently have or are eligible for.

Distribution of Homeowner Protection

You can apply for Homeowner Protection through distributors that have an agreement with us to distribute it. These distributors do not offer personal advice to you about Homeowner Protection. Your distributor can inform you of the types of financial services they can provide you with.

If you require, a distributor may be able to refer you to a financial adviser who provides personal advice and who can consider the suitability of this product based on your individual objectives, financial situation and needs.

Not all benefits and sums insured are necessarily available through each distributor. Your distributor can inform you of whether any benefits or sums insured you seek are available to you via that distributor.

TAL cannot provide you with credit assistance and does not recommend or endorse any credit product or credit provider (or home loan product or lender)

In this document and in the distribution of Homeowner Protection, TAL does not provide credit assistance or engage in any credit activities that are regulated by the *National Consumer Credit Protection Act 2009* (Cth). TAL does not make recommendations, opinions or endorsements of any home loan product or home loan provider (or any other credit product or credit provider).

30-day 'cooling off' period

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

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

Who we pay

If a claim is paid, the payment will be made to the surviving Policy Owner of the Policy. Where there is no living Policy Owner, the benefit will be paid to the nominated beneficiary or beneficiaries, or the estate of the Policy Owner.

The Policy Owner can nominate to whom a death benefit will be paid – these people are called the beneficiaries. Any nomination of a beneficiary or beneficiaries is binding on us once we receive it and provide confirmation of the nomination to you. You can ask us to change or revoke a nomination at any time.

If a nomination is made, details of each beneficiary will be shown in the Policy Schedule. If a change or revocation is made in relation to a nomination, a new Policy Schedule will be issued as confirmation of the change or revocation.

If you have validly nominated one or more beneficiaries to receive a death benefit under Decreasing Life Cover, we will pay the benefit in accordance with your nomination. In the event a beneficiary dies before the Life Insured, the nomination of that beneficiary is no longer valid. If there are other surviving beneficiaries, benefits will be paid to the remaining beneficiaries.

If there are no surviving beneficiaries, then the benefit will be paid to your estate or legal personal representative or a person we are permitted to pay under any relevant law.

If a nomination is not made, all payments made by us under the Policy will be made to you, or if you have died, to your estate or legal personal representative or a person we are permitted to pay under any relevant law.

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

Your duty to take reasonable care

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

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

When determining whether you have taken reasonable care not to make a misrepresentation, we may have regard to a range of matters. This will include your particular characteristics or circumstances of which we were aware or ought to have been reasonably aware of.

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

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

Refer to **Section 3** of this PDS for details of your duty to take reasonable care not to make a misrepresentation.

If you need to make a claim

At TAL, a claims consultant is assigned to each claim to provide support through the process of making a claim – which includes following up on documentation, right through to assessment and processing of the claim. We keep in touch with you about the progress of the claim.

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

If we accept your application, receive the premium and we issue you a Policy Schedule, your Plan will commence on the Plan Commencement Date as shown in the Policy Schedule that will be sent to you. If your application includes cover for optional Major Illness Cover, be aware that cover for some Insured Events under optional Major Illness Cover does not commence immediately because a 90-day qualifying period applies – see **Section 2.2.6** for more information.

The Policy Owner at the date the Policy is issued is shown in the Policy Schedule. Cover is provided on the Life Insured shown in the Policy Schedule. The Policy Schedule shows the Plan Commencement Date for each Plan and outlines the benefits, options, and any special terms, and adjustments that apply to you.

Please read the PDS and the Policy Schedule carefully to ensure the terms and conditions meet your needs. These are important documents and should be kept in a safe place. If the Policy is altered at any time, you will receive a new Policy Schedule or confirmation reflecting the agreed changes.

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

- Decreasing Life Cover: **Section 2.1.8**;
- Major Illness Cover: **Section 2.2.7**.

Your information and privacy

We understand that the privacy of your information is important to you. We recognise the importance of protecting your personal information that is collected and used by us, and we respect the confidentiality of your information. Information about why we collect and use your information, along with our commitment to privacy can be found in **Section 8**.

Special terms

As a result of the Underwriting process, we may apply special terms to the Policy that we issue to address the increase in risk, based on your personal situation. For example, we may exclude claims arising from a medical condition or pastime, increase your premium or reduce the Benefit Amount.

If special terms have been applied to your Policy, they will be stated in the Policy Schedule. Subject to an eligibility assessment, we may be able to remove or reduce these special terms if your circumstances change in the future. Where we have relied on medical evidence to make our decision and you would like a copy of this, we will provide this either directly to you or your doctor within 10 business days of receiving your request.



1.1. Homeowner Protection at a glance

1.1.1 Decreasing Life Cover at a glance

This section contains some information about Decreasing Life Cover.

Full details of Decreasing Life Cover can be found in **Section 2.1**.

Decreasing Life Cover

What's covered	We will pay a benefit if a Life Insured either dies or is diagnosed with a Terminal Illness.
When we won't pay	There are some events or circumstances where claims will not be paid. A benefit will not be paid for any claim if an exclusion applies. See **Section 2.1.6** for full details of the exclusions relating to: • intentional self-inflicted acts; • not following government travel warnings; and • any special terms that may apply following Underwriting.
Who can apply	Australian Residents aged 18 to 55. You must receive the PDS in Australia.
Maximum Benefit Amount at application	For each Life Insured, up to $1.5 million. The maximum benefit amount for each application may be subject to our underwriting assessment and your home loan amount.
Decreasing Benefit Amount	On each Policy Anniversary, your Benefit Amount will automatically decrease by 5%. However, these automatic reductions will stop if your Benefit Amount reaches $10,000 and there will be no further automatic reductions to your Benefit Amount. When you buy Homeowner Protection or make changes to your Benefit Amount, we will provide you with a schedule detailing your Benefit Amount at each Policy Anniversary. See **Sections 2.1.1** and **2.1.2** for more information.
Plan Expiry Date	30 years after your Policy Commencement Date.
Policy Ownership	A Policy can be owned by one person or two people (joint ownership). Only a Life Insured can be a Policy Owner. Where there are joint Lives Insured covered by a single Policy, each Life Insured will be covered under a separate Decreasing Life Cover Plan. We do not permit policy ownership by a superannuation fund, a company or a trust.

Included benefits	**Brief description**
Cover Review Benefit	You can apply to increase your Benefit Amount without providing additional health and lifestyle information when Life Events occur, for example when you refinance your home loan, increase your home loan, get married or have a child. Some limitations apply. See **Section 2.1.7** for more information.

1.1.2 Optional Major Illness Cover (severity based) at a glance

You can add optional Major Illness Cover to your Policy if you are taking out or have Decreasing Life Cover. Major Illness Cover pays a benefit if you satisfy the definition of an Insured Event. For a benefit to be paid, the Insured Event must meet the full criteria and severity requirements for that condition. For many Insured Events, this means the condition will be required to progress beyond a diagnosis, where diagnosis means the process of a Medical Practitioner determining which Sickness or Injury explains an individual's symptoms.

You must also satisfy our claim requirements in **Section 6** of this PDS.

This section contains some information about Major Illness Cover. Full details of Major Illness Cover can be found in **Section 2.2**.

Major Illness Cover	
What's covered	The following specified Insured Events are covered: • Cancer (of a specified criteria); • Coronary Artery Bypass Surgery; • Heart Attack (of specified evidence) – partial payment; • Heart Attack (with specified evidence of severe heart muscle damage) – full payment; • Major Head Trauma (with permanent neurological deficit); • Major Organ Failure (of specified organs); • Major Organ Transplant (of specified organs); • Paralysis; • Permanent Major Physical Impairment; • Severe Burns (of specified severity); • Stroke (resulting in a new neurological deficit).
When we won't pay	There are some events or circumstances where claims will not be paid. A benefit will not be paid for any claim if an exclusion or qualifying period applies. A 90-day qualifying period applies for Cancer (of a specified criteria), Coronary Artery Bypass Surgery, Heart Attack (of specified evidence) – partial payment, Heart Attack (with specified evidence of severe heart muscle damage) – full payment and Stroke (resulting in a new neurological deficit). See **Section 2.2.6** for full details of the qualifying period and exclusions relating to: • intentional self-inflicted acts; • participating in criminal or unlawful activity; • not following government travel warnings; and • any special terms, including exclusions, that may apply following Underwriting.
Who can apply	Australian Residents aged 18 to 55. You must receive the PDS in Australia.

Major Illness Cover cont.

Maximum Benefit Amount at application	For each Life Insured, up to: • $250,000; or • your Decreasing Life Cover Benefit Amount at the time you apply for Major Illness Cover, whichever is the lower for each Life Insured. Your Benefit Amount for Major Illness Cover will not automatically decrease at each Policy Anniversary, it will only decrease if a claim is paid or you've requested a change to your Benefit Amount. The benefit payable for Heart Attack (of specified evidence) – partial payment is the greater of: • $10,000; and • 10% of your total Major Illness Cover Benefit Amount. The benefit for Heart Attack (of specified evidence) – partial payment is only payable once across all Homeowner Protection Plans and Policies for which you are the Life Insured.
Major Illness Cover Expiry Date	The earlier of: • the Policy Anniversary after the Life Insured's 65th birthday; or • 30 years after the Policy Commencement Date. Note: Your Policy Commencement Date is the date your Homeowner Protection Policy commences. If you take out Major Illness Cover after the Policy Commencement Date, your Major Illness Cover Plan cannot continue beyond your Decreasing Life Cover Plan Expiry Date. For example: • You take out your Policy (with Decreasing Life Cover) on 1 January 2026 and your Policy Commencement Date is 1 January 2026. Your Decreasing Life Cover Plan Expiry Date is 1 January 2056 (30 years after the Policy Commencement Date). • On 1 January 2040 you add Major Illness Cover to your Policy. Your Major Illness Cover will end on the earlier of 1 January 2056 (30 years after the Policy Commencement Date) or the Policy Anniversary following your 65th birthday.
Policy Ownership	A Policy can be owned by one person or two people (joint ownership). Only a Life Insured can be a Policy Owner. We do not permit policy ownership by a superannuation fund, a company or a trust. Where there are joint Lives Insured covered by a single Policy, each Life Insured will be covered under a separate Major Illness Cover Plan.

1.2 What are the costs?

1.2.1 Cost of your Policy

The cost of your Policy depends on a range of factors, including but not limited to the type and amount of cover, your age, sex and whether or not you smoke. We may also take into account your occupation, health, income, personal pastimes, lifestyle, and other factors in determining insurance premium amounts. We ask for this information so that the premiums we charge take into account the different levels of risk presented by different customer groups.

Premiums are inclusive of government charges.

Sometimes discounts may apply. The size of a discount may depend on a range of factors. Discounts may not apply for the full term of your Policy and may change.

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

All premiums are payable in advance by the due date. We will inform you of the premium payable in subsequent years before each Policy Anniversary.

You should consider if you have the financial capacity to fund the costs of cover over the period you intend to hold the cover.

Premiums for Decreasing Life Cover

Your premium for Decreasing Life Cover is based on your age and your Benefit Amount at the Plan Commencement Date.

> Your premium **will not reduce** even though your Decreasing Life Cover Benefit Amount automatically reduces at each Policy Anniversary by 5%.

Your premium will change if you make changes to your cover. Each additional amount of cover, whether it be from the Cover Review Benefit or if you request to increase your cover, will be priced based on the Life Insured's age at the date of increase. This will generally have a higher premium rate than the original cover because premium rates generally increase with the Life Insured's age.

There are a range of other reasons why your premium may change, including if we change our premium rates. Please see **Sections 1.2.2** and **1.2.3** for more information.

Optional Major Illness Cover premiums

Your Major Illness Cover premium is based on your age and your Benefit Amount at the Plan Commencement Date.

Your premium will change if you make changes to your cover. Each additional amount of cover, if you request to increase your cover, will be priced based on the Life Insured's age at the date of increase. This will generally have a higher premium rate than the original cover.

There are a range of other reasons why your premium may change, including if we change our premium rates. Please see **Sections 1.2.2** and **1.2.3** for more information.

1.2.2 Changes applying to your premiums

In addition to **Section 1.2.1**, your premiums and the amount you pay will change if:

- we change our premium rates (refer to **Section 1.2.3** for details);
- you vary your Policy, for example when you add or remove a Plan, or you make changes to your Benefit Amount (including through the Cover Review Benefit);
- a discount no longer applies or changes (this includes when you vary your Policy); or
- government duties or charges change.

1.2.3 We can change our premium rates

The cost of your cover can change. In the past, for life insurance policies, we have changed the premium rates used to calculate the cost of cover.

We can change the premium rates we use to determine your premium. If we do this, the cost of your cover will change.

Decisions to change premium rates do not occur because of changes to an individual customer's own circumstances but rather are determined in relation to the group of customers that we insure. We apply all changes to premium rates on a simultaneous and consistent basis and your Policy will not be singled out for a change.

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

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

We review associated factors on an ongoing basis which may include, but are by no means limited to, our assessment of regulatory or legislative requirements, our operating costs or the commercial environment.

These are only some examples of factors that we may consider, and others may apply. The outcome of any premium review performed by us may result in a change to the premium rates we charge you. If we change the premium rates, you will be advised of the change to your premiums at least 30 days before the change takes effect.

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

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

1.2.4 Commissions

We may pay commission or other remuneration (such as referral fees) to your mortgage broker or other distributors for the distribution of the Homeowner Protection product. Any amounts paid are factored into the cost of the Policy.

Your mortgage broker or other distributor will provide details of the payments they will receive from us in the Financial Services Guide. In general, these amounts will be calculated by reference to your premium and will be subject to commission caps imposed by law.

1.2.5 What if I'm unable to afford paying my premiums?

If you are experiencing financial hardship, please call us on 1300 683 816 to discuss options that may be available to help you. You may also need to provide supporting documentation to assist with your financial hardship application.

1.2.6 Payment of premiums - frequency

Premiums can only be paid monthly. If we do not receive your monthly premium payment when due, we may change your premium frequency to quarterly. You may contact us if you seek to change your premium frequency back to monthly.

1.2.7 Payment method

Premiums may be paid by:

- Direct debit; or
- Credit card (MasterCard or Visa).





2 Homeowner Protection in detail

2.1 Decreasing Life Cover

2.1.1 The benefit we pay

A benefit under Decreasing Life Cover will only be paid if you die or are diagnosed with a Terminal Illness after the Plan Commencement Date and before your Plan ends. The amount we pay is the Benefit Amount applicable at the date the Life Insured dies or is diagnosed with Terminal Illness. Your Benefit Amount reduces by 5% at each Policy Anniversary.

The Benefit Amount is payable as a lump sum.

You must meet the terms and conditions of the Policy and satisfy our claim requirements (explained in **Section 6**) for a Benefit Amount to be paid. We will not pay a Benefit Amount if an exclusion applies. Please see **Section 2.1.6** for further information.

2.1.2 Your Decreasing Life Cover Benefit Amount will reduce automatically

Your Decreasing Life Cover Benefit Amount will automatically reduce by 5% at each Policy Anniversary. However, these automatic reductions will stop if your Benefit Amount reaches $10,000 and there will be no further automatic reductions to your Benefit Amount.

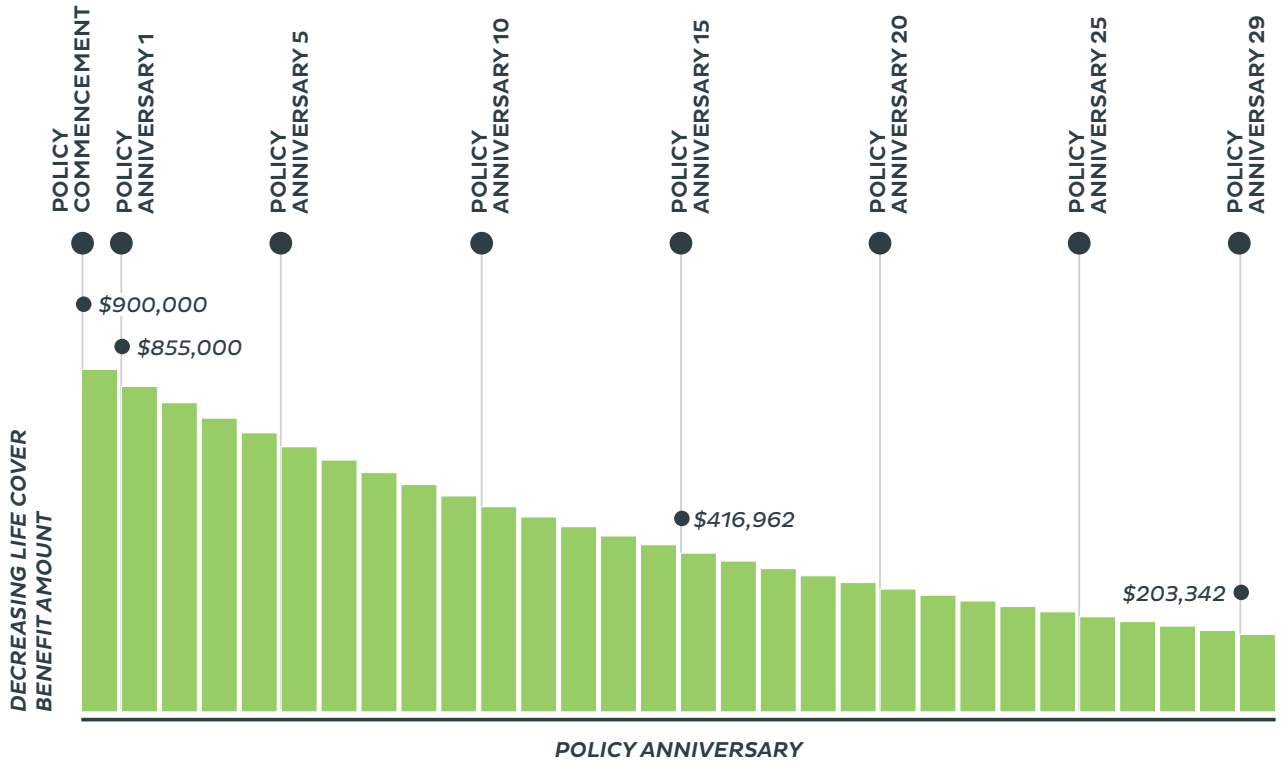
The Decreasing Life Cover Benefit Amount at each Policy Anniversary will be shown in your Policy Schedule.

For example, if your Policy starts on 15 December 2025 with a Benefit Amount of $900,000, your Benefit Amount on the following dates will be:

Decreasing Life Cover (Date)	Benefit Amount	Calculation
Policy Commencement (15 December 2025)	$900,000	N/A
1st Policy Anniversary (15 December 2026)	$855,000	$900,000 – ($900,000 x 5%)
2nd Policy Anniversary (15 December 2027)	$812,250	$855,000 – ($855,000 x 5%)
15th Policy Anniversary (15 December 2040)	$416,962	$438,907 – ($438,907 x 5%)
29th Policy Anniversary (15 December 2054)	$203,342	$214,044 – ($214,044 x 5%)

The table above only includes the Benefit Amount for the first two and fifteenth Policy Anniversaries. It also includes the Benefit Amount in the final year of cover. The Benefit Amount will continue to reduce at each Policy Anniversary over the 30-year term of a Decreasing Life Cover Plan.

The graph below illustrates how a Benefit Amount of $900,000 at Policy Commencement Date automatically reduces at each Policy Anniversary over the **30-year term (29 Policy Anniversaries)** of a **Decreasing Life Cover Plan**.



Benefit Amount at Policy Commencement	$900,000
Policy Term	30 years (29 Policy Anniversaries)
Rate of reduction	5%

The example above and other examples used in this Product Disclosure Statement are illustrative only, and are not a guarantee, recommendation or forecast of your cover amount under this insurance or of your insurance needs. We have not taken into account your individual objectives, financial situation or needs in preparing the examples or any other information in this PDS.

Your Benefit Amount is not linked to the amount outstanding on your home loan or your home loan repayments over time. The automatic decreases to your Benefit Amount we apply each year are not designed to match or track the actual amount of the outstanding debt on your home loan or your home loan repayments over time. You should regularly consider whether your cover amount under this insurance is appropriate and sufficient for you to meet your individual objectives, financial situation and needs over time.

2.1.3 What is the minimum Benefit Amount per Life Insured for Decreasing Life Cover?

The minimum Benefit Amount you can apply for at the Policy Commencement Date is $50,000 for each Life Insured.

Your Policy can cover up to two Lives Insured. You can have different Benefit Amounts for each Life Insured your Policy covers.

2.1.4 What is the maximum Benefit Amount per Life Insured for Decreasing Life Cover?

You can apply for a Benefit Amount of up to $1.5 million. This maximum Benefit Amount may be subject to our Underwriting assessment and your home loan amount.

2.1.5 Can I change the Benefit Amount for my Decreasing Life Cover

You can request to increase or decrease your Decreasing Life Cover Benefit Amount to a:

- maximum of $1.5 million;
- minimum of $50,000.

You can decrease your Benefit Amount at any time.

You can apply to increase your Benefit Amount under Decreasing Life Cover through the Cover Review Benefit after your Policy starts. See **Section 2.1.7** for details about the Cover Review Benefit.

Apart from the Cover Review Benefit, you may be able to increase your Benefit Amount, but only if agreed to by both you and us.

If we accept your application to change your Benefit Amount your premiums will change. Your revised Benefit Amount, after any changes, will automatically reduce by 5% at each Policy Anniversary for the remaining term of your Policy. We will provide you with an updated Policy Schedule that outlines how your revised Benefit Amount will reduce over the remaining term of your Policy.

If you increase or decrease your Benefit Amount, it will usually change your premiums. You will start paying a new premium once we have accepted your application. We will notify you if your application to change your Benefit Amount has been accepted and when the changes will be effective from.

2.1.6 When we will not pay a benefit under Decreasing Life Cover

Intentional self-inflicted act

No payments will be made under Decreasing Life Cover, if the claim arises directly or indirectly because of an intentional self-inflicted act (including attempted suicide and suicide, whether sane or not) by the Life Insured within 13 months after:

- the Plan Commencement Date;
- the date of any Benefit Amount increase applied for by you, including under the Cover Review Benefit feature, but only in respect of the increased amount;
- the date a Life Insured was added to the Policy, but only in respect of that Life Insured (if applicable); or
- the most recent date we agreed to reinstate the Plan or Policy.

Overseas travel

No payments will be made under Decreasing Life Cover if the event giving rise to the claim is caused by the Life Insured being in a country for which the Australian Department of Foreign Affairs and Trade or any successor government department or agency issued a 'Do Not Travel' warning advice prior to the Life Insured's travel to that country, and which continues to be in force during the time of their stay in that country.

Special terms

We will not pay any benefits where we have agreed with you a special term in respect of your Decreasing Life Cover that specifically excludes the event or condition leading to the claim. Any such special term will be agreed with you before your Policy is issued and will be shown in your Policy Schedule.



2.1.7 Cover Review Benefit – for Decreasing Life Cover

Under the Cover Review Benefit, you can apply to increase your Decreasing Life Cover Benefit Amount without providing evidence of your health or pastimes if you experience a specified Life Event.

The Cover Review Benefit does not apply to Major Illness Cover.

Life Events are:

- you refinance or increase your home loan;
- the birth or adoption of a child and you are the parent;
- your dependant starting primary or secondary school;
- you get married;
- you get divorced; or
- your base salary increases by at least $10,000 per annum.

Your new Benefit Amount, after the Cover Review Benefit has been applied will also reduce automatically at each Policy Anniversary, effective from your next Policy Anniversary date after the Cover Review Benefit has been applied.

Please note that if you increase your Benefit Amount under the Cover Review Benefit, your Benefit Amount will continue to automatically reduce by 5% at each Policy Anniversary for the remaining term of your Policy. We will provide you with a new Policy Schedule that outlines how your Benefit Amount will reduce over the remaining term of your Policy.

The maximum amount that you can apply for to increase the Benefit Amount under the Cover Review Benefit is:

- $200,000; or
- 25% of the original Benefit Amount at the Policy Commencement Date,

whichever is the lower.

The Cover Review Benefit is limited by the following:

- You must apply within 30 days from when the Life Event first occurred.
- You can only exercise the Cover Review Benefit once in any 12-month period.
- You must provide evidence which (in our reasonable opinion) establishes that the Life Event has occurred.
- The Life Event occurred when the Life Insured is under age 55.
- The Life Event occurred while the Policy is in force and within 20 years after the Policy Commencement Date.
- The Cover Review Benefit can only be exercised twice over your Policy term.
- You can only have a maximum Benefit Amount of $1.5 million per Life Insured, including any increases made under the Cover Review Benefit.

The Cover Review Benefit is not available if you have a Policy with a special term (such as, without limitation, an exclusion or premium loading based on underwriting – set out in your Policy Schedule), or if you have made a claim or are eligible to make a claim on this Policy or any other policy issued by us.

2.1.8 When Decreasing Life Cover ends

Decreasing Life Cover will end on the earlier of the:

- date which is 30 years from the Policy Commencement Date (this is the Plan Expiry Date shown in your Policy Schedule);
- date we cancel the Plan following a request from all Policy Owners;
- date we cancel the Policy because you did not pay your premiums and we have given you notice required by law;
- date we cancel the Policy because you made a fraudulent claim;
- death of the Life Insured for that Plan; and
- full Benefit Amount for the Life Insured for that Plan being paid.

If you have not complied with your duty to take reasonable care not to make a misrepresentation and we avoid the Plan, this will mean that we cancel the Plan from the start and treat it as if it never existed.

No benefits are payable for any event that occurs after your Plan ends.

Where there are joint Lives Insured covered by a single Policy, each Life Insured will be covered under a separate Decreasing Life Cover Plan.

Your Policy is not linked to and does not track your home loan. Your Policy does not end if your loan stops, you repay your loan or there are any changes to your loan. If your loan ends, is cancelled or changes, you should review your Policy to ensure it continues to meet your needs.



2.2 Major Illness Cover (severity based)

You have the option of adding Major Illness Cover. You can only apply for Major Illness Cover if you have or are applying for Decreasing Life Cover.

A benefit will only be paid under Major Illness Cover if the conditions and requirements for a claimable event are met and the Life Insured satisfies the definition of a specified Insured Event as described in the sections below. We require confirmation of the diagnosis by a Medical Practitioner and the specified severity threshold criteria to be met, for a benefit to be payable. The severity threshold criteria are defined for each Insured Event in **Section 2.2.8**.

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

For a benefit to be paid under Major Illness Cover, you must also satisfy our claim requirements in **Section 6**.

See **Section 2.2.8** for the Insured Events covered, their definitions and any exclusions that apply.



2.2.1 How optional Major Illness Cover works – payment of Benefit Amount

Payment of a benefit under Major Illness Cover will not affect the Benefit Amount of your Decreasing Life Cover.

The benefit we pay is the Benefit Amount applicable at the date the Insured Event occurred, unless the claim is for Heart Attack (of specified evidence) – partial payment. See below for details.

If a benefit for Heart Attack (of specified evidence) – partial payment is paid, it will reduce the Major Illness Cover Benefit Amount. For example, if you have Major Illness Cover with a Benefit Amount of $50,000 and you suffer a Heart Attack (of specified evidence) – partial payment, we will pay you $10,000. This means your Major Illness Cover Benefit Amount would reduce by $10,000 to $40,000.

Other than this, the Benefit Amount for Major Illness Cover will remain the same and does not automatically reduce over the term of your Policy. Your Benefit Amount for Major Illness Cover will only change if a claim is paid, or if you have requested a change that we have agreed to.

What is payable for Heart Attack (of specified evidence) – partial payment?

The benefit payable for Heart Attack (of specified evidence) – partial payment is the greater of:

- $10,000; and
- 10% of your total Major Illness Cover Benefit Amount

Example

Mary has Major Illness Cover with a Benefit Amount of $50,000 and Mary suffers a Heart Attack (of specified evidence) – partial payment.

We will pay Mary $10,000.
This is because the benefit payable for Heart Attack (of specified evidence) – **partial payment is the greater of $10,000 and 10%** of Mary's Major Illness Cover Benefit Amount.

10% of Mary's Major Illness Cover Benefit Amount is $5,000 (0.1 x $50,000).
The greater of the two amounts ($10,000 and $5,000) is $10,000.

The examples above and other examples in this PDS are illustrative only, and are not a guarantee, recommendation or forecast of your cover amount under this insurance or of your insurance needs. We have not taken into account your individual objectives, financial situation or needs in preparing the examples or any other information in this PDS.

2.2.2 What is covered under Major Illness Cover?

The following Insured Events are covered under Major Illness Cover:

- Cancer (of a specified criteria);
- Coronary Artery Bypass Surgery;
- Heart Attack (of specified evidence) – partial payment*;
- Heart Attack (with specified evidence of severe heart muscle damage) – full payment;
- Major Head Trauma (with permanent neurological deficit);
- Major Organ Failure (of specified organs);
- Major Organ Transplant (of specified organs);
- Paralysis;
- Permanent Major Physical Impairment;
- Severe Burns (of specified severity); and
- Stroke (resulting in a new neurological deficit).

*The benefit payable for Heart Attack (of specified evidence) – partial payment is explained in "What is payable for Heart Attack (of specified evidence) – partial payment?" section above.

These Insured Events are explained in more detail in **Section 2.2.8**

2.2.3 What is the Minimum Benefit Amount per Life Insured for Major Illness Cover?

The minimum Benefit Amount you can apply for at the Policy Commencement Date is $25,000 for each Life Insured.

Your Policy can cover up to two Lives Insured. You can have different Benefit Amounts for each Life Insured your Policy covers.

2.2.4 What is the Maximum Benefit Amount per Life Insured for Major Illness Cover?

The maximum Benefit Amount for Major Illness Cover that you can apply for at Plan Commencement Date is:

- $250,000; or
- your Decreasing Life Cover Benefit Amount at the time you apply for Major Illness Cover, whichever is the lower for each Life Insured. When your Major Illness Cover Plan starts, your Major Illness Cover Benefit Amount cannot be greater than your Decreasing Life Cover Benefit Amount.

2.2.5 Can I change the Benefit Amount for my Major Illness Cover?

You can request to increase or decrease your Major Illness Cover Benefit Amount to a:

- maximum of $250,000;
- minimum of $25,000.

You can request to decrease your Benefit Amount under Major Illness Cover after the Plan Commencement Date.

You may increase your Benefit Amount, but only if agreed to by both you and us.

If you increase or decrease your Benefit Amount, it will usually change your premiums. You will start paying a new premium once we have accepted your application. We will notify you if your application to change your Benefit Amount has been accepted and when the changes will be effective from.

2.2.6 When we will not pay a benefit under Major Illness Cover

Intentional self-inflicted act, or participation in criminal or unlawful activity

The Major Illness Cover benefit is not payable if the Insured Condition was directly or indirectly caused by:

- Any intentional self-inflicted act (including attempted suicide and suicide, whether sane or not).
- The Life Insured's participation in any criminal or unlawful activity.

Overseas travel

No payments will be made under Major Illness Cover if the event giving rise to the claim is caused by the Life Insured being in a country for which the Australian Department of Foreign Affairs and Trade or any successor government department or agency issued a 'Do Not Travel' warning advice prior to the Life Insured's travel to that country, and which continues to be in force during the time of their stay in that country.

Special terms

We will not pay any benefits where we have agreed with you a special term in respect of your Major Illness Cover that specifically excludes the event or condition leading to the claim. Any such special term will be agreed with you before your Policy is issued and will appear in your Policy Schedule.

90-day qualifying period for certain Insured Events

Major Illness Cover does not provide a benefit for certain Insured Events (listed below) which occurred or were diagnosed, or the signs or symptoms leading to the diagnosis became apparent to the Life Insured or would have become apparent to a reasonable person in the position of the Life Insured, within 90 days after:

- the Plan Commencement Date;
- the date of any approved increase to the Benefit Amount applied for, but only in respect of the increased portion;
- the date a Life Insured was added to the Policy, but only in respect of that Life Insured (if applicable); or
- the most recent date that we have agreed to reinstate the Plan or Policy.

The Insured Events where the 90-day qualifying period applies are:

- Cancer (of a specified criteria);
- Coronary Artery Bypass Surgery;
- Heart Attack (with specified evidence of severe heart muscle damage) – full payment;
- Heart Attack (of specified evidence) – partial payment; and
- Stroke (resulting in a new neurological deficit).

If Temporary Cover applies, the above Insured Events where the qualifying period applies, are not covered under Temporary Cover. However, the 90-day qualifying period for the above Insured Events will start when Temporary Cover starts. If your Major Illness Cover Plan has not started at the end of 90 days from your Temporary Cover start date, then the 90-day qualifying period will restart from the Major Illness Cover Plan Commencement Date.

2.2.7 When Major Illness Cover ends

Major Illness Cover ends on the earlier of the:

- date which is 30 years from the Policy Commencement Date* (this is the Plan Expiry Date shown in your Policy Schedule);
- Policy Anniversary following the Life Insured's 65th birthday;
- date we cancel the Plan following a request to cancel the Plan from all Policy Owners;
- date we cancel the Policy because you did not pay your premiums and we have given you notice required by law;
- date we cancel the Policy because you made a fraudulent claim;
- death of the Life Insured for that Plan;
- Decreasing Life Cover for the Life Insured for that Plan ends; and
- Major Illness Cover Benefit Amount for the Life Insured for that Plan being paid or reduced to nil.

If you have not complied with your duty to take reasonable care not to make a misrepresentation and we avoid the Plan, this will mean that we cancel the Plan from the start and treat it as if it never existed.

*Your Policy Commencement Date is the date your Homeowner Protection Policy first commences. If you take out Major Illness Cover after the Policy Commencement Date, your Major Illness Cover Plan cannot continue beyond your Decreasing Life Cover Plan Expiry Date.

Example

You take out your Policy with Decreasing Life Cover on 1 December 2025. Your Policy Commencement Date is 1 December 2025. Your Decreasing Life Cover Plan Expiry Date is 1 December 2055 (30 years after the Policy Commencement Date).

On 1 December 2040 you add Major Illness Cover to your Policy. Your Major Illness Cover Policy Expiry Date is **the earlier of 1 December 2055 (30 years after the Policy Commencement Date) or the Policy Anniversary following your 65th birthday.**

No benefits are payable for any event that occurs after your Plan ends.

Where there are joint Lives Insured covered by a single Policy, each Life Insured will be covered under a separate Major Illness Cover Plan.

Your Major Illness Cover is not linked to your home loan and your Policy does not end if your loan stops, you repay your loan or there are any changes to your loan. If your loan ends, changes or is cancelled, you should review your Policy to ensure it continues to meet your needs.

2.2.8 Insured Events

In order for a benefit to be paid, you must meet the full criteria and severity requirements for the Insured Event.

For many Insured Events this means the condition will be required to progress beyond a diagnosis. Diagnosis means the process of a Medical Practitioner or specialist Medical Practitioner determining which Sickness or Injury explains an individual's symptoms.

Severity means the seriousness of an Insured Event in order for a benefit to be paid. Details of the Insured Events and exclusions under Major Illness Cover are explained below.

You must also satisfy our claim requirements in **Section 6**.

The Life Insurance Code of Practice (the Code) sets out how insurers will assess your claim if your policy has a medical definition which specifies an obsolete method of diagnosis or treatment that is no longer used in mainstream medical practice in Australia. Information about the Code can be found in the 'Important information about this document' section of the PDS.



Insured Event	What's covered	What's not covered
Cancer (of a specified criteria)	**Cancer (of a specified criteria)** means any malignant tumour diagnosed with histological or cytological confirmation and characterised by: • the uncontrolled growth of malignant cells; and • invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders. **Carcinoma in situ of the breast** which requires: • the removal of the entire breast due to any malignant tumour diagnosed with histological or cytological confirmation; or • breast conserving surgery with either radiotherapy or chemotherapy. **Carcinoma in situ of the testicle** that requires the removal of the entire testicle and malignant tumour that requires histological and cytological confirmation. **Skin melanoma that:** • has evidence of metastasis; • is at least Clark level 3; • is showing signs of ulceration; or • is greater than 1.0mm maximum thickness using the Breslow method. **Non-melanoma skin cancers** that have spread to the bone, lymph node or other distant organs. **Chronic lymphocytic leukaemia** that has progressed to Rai stage 1 or more. **Prostate cancer:** • that is histologically classified as having a Gleason score of 7 or above; • that has progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system; or • where a total prostatectomy has been undertaken where the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. **Section 2.2.6** includes a qualifying period for Cancer (of a specified criteria) which covers a Cancer (of specified criteria) that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of: • the Plan Commencement Date; or • an increase in the Benefit Amount applied for by you, but only in respect of the increased portion; or • the date a Life Insured was added to the Policy, but only in respect of that Life Insured; or • the date of any reinstatement of the Plan or Policy. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6** the following are also not covered: • All tumours which are histologically described as any of the following: a) pre-malignant; b) non-invasive (including tumours that are classified as Tis, Cis or pTa unless stated otherwise); c) high-grade dysplasia; or d) borderline or low malignant potential. • All Carcinoma in situ except the examples provided in the 'What's covered' column. • All skin melanomas except the examples provided in the 'What's covered' column. • All non-melanoma skin cancers except the examples provided in the 'What's covered' column. • Chronic lymphocytic leukaemia that has not progressed to Rai stage 1 or more. • All prostatic cancers except the examples provided in the 'What's covered' column.

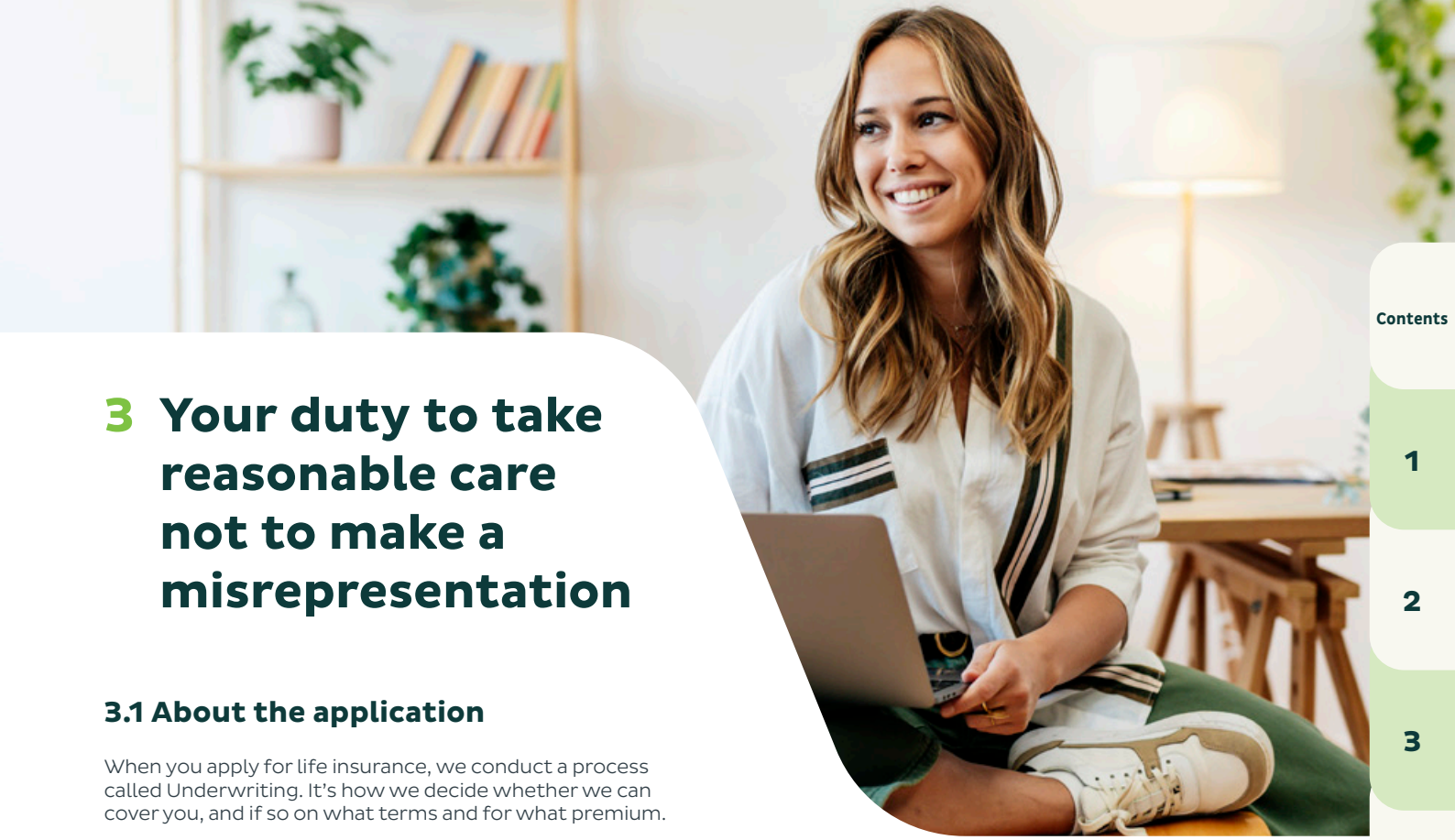
Insured Event	What's covered	What's not covered
Coronary Artery Bypass Surgery	**Coronary Artery Bypass Surgery** means bypass grafting surgery performed to correct or treat coronary artery disease.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. **Section 2.2.6** includes a qualifying period for Coronary Artery Bypass Surgery which covers a Coronary Artery Bypass Surgery that takes place or the circumstances leading to the procedure become apparent within the first 90 days of: • the Plan Commencement Date; or • an increase in the Benefit Amount applied for by you (for the increased portion only); or • the date a Life Insured was added to the Policy, but only in respect of that Life Insured; or • the date of any reinstatement of the Plan or Policy.
Heart Attack (of specified evidence) – partial payment The benefit payable for Heart Attack (of specified evidence) – partial payment is the greater of: • $10,000; and • 10% of your total Major Illness Cover Benefit Amount	Heart Attack (of specified evidence) – partial payment means the death of a portion of the heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following: • Symptoms of ischaemia. • New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB). • Development of new pathological Q waves in the ECG. • Imaging evidence of new regional wall motion abnormality present at least six weeks after the event. If the tests specified above are inconclusive, other appropriate and medically recognised tests will be considered.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. **Section 2.2.6** includes a qualifying period for Heart Attack (of specified evidence) – partial payment, which covers a Heart Attack (of specified evidence) – partial payment that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of: • the Plan Commencement Date; or • an increase in the Benefit Amount applied for by you, but only in respect of the increased portion; or • the date a Life Insured was added to the Policy, but only in respect of that Life Insured; or • the date of any reinstatement of the Plan or Policy. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6** the following are also not covered: • Any heart attack which is caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner. If alcohol and/or drugs have contributed to the heart attack, it must be confirmed by an appropriate specialist Medical Practitioner; • A rise in biomarkers because of an elective percutaneous procedure for coronary artery disease; or • Other acute coronary syndromes including but not limited to angina pectoris.

Insured Event	What's covered	What's not covered
Heart Attack (with specified evidence of severe heart muscle damage) – full payment	**Heart Attack (with specified evidence of severe heart muscle damage) – full payment** means the death of a portion of the heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least three of the following: • Symptoms of ischaemia. • New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB). • Development of new pathological Q waves in the ECG. • Imaging evidence of new regional wall motion abnormality present at least six weeks after the event. If the tests specified above are inconclusive, other appropriate and medically recognised tests will be considered or the definition will be met if at least three months after the event the Life Insured's left ventricular ejection fraction is less than 50 per cent.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. **Section 2.2.6** includes a qualifying period for any Heart Attack (with specified evidence of severe heart muscle damage) – full payment, which covers a Heart Attack (with specified evidence of severe heart muscle damage) – full payment that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of: • the Plan Commencement Date; or • an increase in the Benefit Amount applied for by you, but only in respect of the increased portion; or • the date a Life Insured was added to the Policy, but only in respect of that Life Insured; or • the date of any reinstatement of the Plan or Policy. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6** the following are also not covered: • Any heart attack which is caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner. If alcohol and/or drugs have contributed to the heart attack, it must be confirmed by an appropriate specialist Medical Practitioner; • A rise in biomarkers because of an elective percutaneous procedure for coronary artery disease; or • Other acute coronary syndromes including but not limited to angina pectoris.
Major Head Trauma (with permanent neurological deficit)	**Major Head Trauma (with permanent neurological deficit)** means head Injury due to an accident resulting in permanent neurological deficit. This requires at least a permanent 25% of Whole Person Impairment as defined in the latest edition of the 'Guides to the evaluation of Permanent Impairment, American Medical Association'.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6**, we will also not cover Major Head Trauma resulting from the Life Insured being under the influence of alcohol (over the prescribed legal limit according to the relevant state or territory limit), or any drug not prescribed by a Medical Practitioner, or any drug prescribed by a Medical Practitioner and not taken in the correct dosage.

Insured Event	What's covered	What's not covered
Major Organ Failure (of specified organs)	**Major Organ Failure (of specified organs)** means any of the following: • Chronic lung failure (on permanent oxygen therapy): means end-stage lung disease with a consistent pulmonary function test result of: – FEV1 less than 40% predicted; or – a DLCO less than 40% predicted; and – on permanent oxygen therapy; • Chronic liver failure (resulting in permanent symptoms): means end-stage liver failure resulting in permanent jaundice, ascites and/or encephalopathy; or • Chronic kidney failure – (undergoing permanent dialysis): means undergoing permanent dialysis treatment prescribed by a renal physician due to impairment of total kidney function to a severity constituting end stage kidney failure.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. In addition to 'When will we not pay Major Illness Cover?' in **Section 2.2.6**, we will also not cover conditions which are caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner.
Major Organ Transplant (of specified organs)	**Major Organ Transplant (of specified organs)** means either the undergoing of a Major Organ Transplant (of specified organs) or upon the advice of an appropriate specialist Medical Practitioner, the placement on a waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit for the human to human transplant from a donor (who is not the Life Insured) to the Life Insured of: • bone marrow; • kidney; • heart; • lung; • liver; • pancreas; or • small bowel.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6** the following are also not covered: • Major Organ Transplant of the liver which is caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner; or the transplant of any organs, part or parts of an organ or any other tissue transplant which is not listed in the 'What's covered' column.
Paralysis	**Paralysis** means the total and permanent loss of function of two or more Limbs through Sickness or Injury causing permanent damage to the nervous system. This includes, but is not limited to, quadriplegia, paraplegia, diplegia and hemiplegia.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6**, we will also not cover conditions which are caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner.

Insured Event	What's covered	What's not covered
Permanent Major Physical Impairment	**Permanent Major Physical Impairment** means any of the following: • The total and permanent loss of the use of two or more Limbs due to an Injury. • The total and irrecoverable loss of sight in both eyes (whether aided or unaided) as a result of Sickness or Injury to the extent that: – visual acuity in both eyes, on a Snellen Scale after correction by suitable lens is less than 6/60; or – the visual field is reduced to 20 degrees or less of arc. • The irrecoverable profound loss of all hearing in both ears, resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500, 1000 and 3000 hertz, both natural and assisted, as a result of Sickness or Injury. The condition must be diagnosed by an appropriate specialist Medical Practitioner.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. In addition to 'When will we not pay Major Illness Cover?' in **Section 2.2.6**, we will also not cover conditions which are caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner.
Severe Burns (of specified severity)	**Severe Burns (of specified severity)** means tissue injury caused by thermal, electrical or chemical agents resulting in full thickness burns and must be a result of an Injury. This requires: • 20% of the body surface area as measured by the Lund and Browder Body Surface Chart; • 50% of both hands requiring surgical debridement and/or grafting; or • 50% of the face requiring surgical debridement and/or grafting.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6**, any burns resulting from the Life Insured being under the influence of alcohol (over the prescribed legal limit according to relevant state or territory legislation, or any drug not prescribed by a Medical Practitioner, or any drug prescribed by a Medical Practitioner and not taken in the correct dosage.

Insured Event	What's covered	What's not covered
Stroke (resulting in a new neurological deficit)	**Stroke (resulting in a new neurological deficit)** means a cerebrovascular event producing a new neurological deficit confirmed through clinical examination. This requires clear evidence on a CT, MRI or similar, appropriate Scan or investigation that a Stroke (resulting in neurological deficit) has occurred with evidence of infarction of brain tissue, intracranial haemorrhage and/or subarachnoid haemorrhage.	Refer to 'When will we not pay Major Illness Cover' in **Section 2.2.6**. **Section 2.2.6** includes a qualifying period for any Stroke (resulting in a new neurological deficit), which covers a Stroke (resulting in a new neurological deficit) that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of: • the Plan Commencement Date; or • an increase in the Benefit Amount applied for by you, but only in respect of the increased portion; or • the date a Life Insured was added to the Policy, but only in respect of that Life Insured; or • the date of any reinstatement of the Plan or Policy. In addition to 'When will we not pay Major Illness Cover' in **Section 2.2.6** the following are also not covered: • transient ischaemic attacks; • non-stroke related reversible neurological deficit; • cerebral symptoms due to migraine; • cerebral injury resulting from trauma or hypoxia; • vascular disease affecting the eye or optic nerve; • ischaemic disorders of the vestibular system; • migraine; or • hypoxic events.



3 Your duty to take reasonable care not to make a misrepresentation

3.1 About the application

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

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

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

You can find details of how we treat your personal information in our privacy policy. See **Section 8** for more information.

3.2 The duty to take reasonable care

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

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

When determining whether you have taken reasonable care not to make a misrepresentation, we may have regard to a range of matters. This will include your particular characteristics or circumstances of which we were aware or ought to have been reasonably aware of.

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

3.3 What can happen if the duty is not met?

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

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

3.4 What can we do if the duty is not met?

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

For example we may:

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

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

- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, the type of cover and how long it has been since the cover started.

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

3.5 We may require further information

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

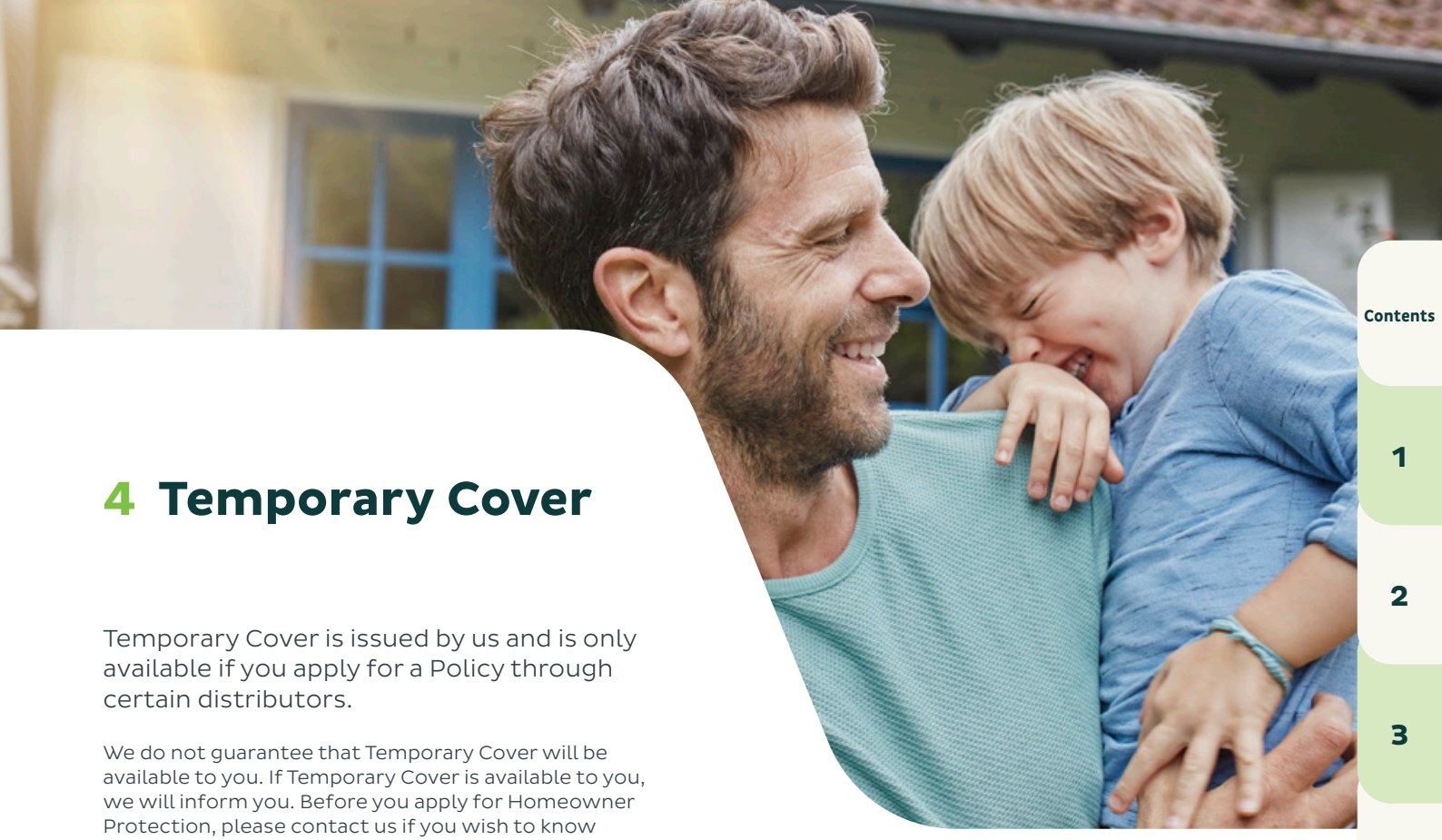
If you or the Life Insured do not provide the information that we require, or do not authorise us to obtain the information we require from one or more third parties, it may impact our ability to assess the application or provide you with a Policy or Plan.

3.6 We can verify your compliance with your duty

We have the right to verify whether what you or the Life Insured told us when applying for cover was accurate and complete. For example, we may do this by comparing what you told us with information contained in medical, financial, employment and other records.

We may require you or the Life Insured to provide these records to us. Alternatively, we may require an authority to obtain these records from one or more third parties. If the records we require are not provided, or we do not receive the necessary authority to obtain the records that we require, it may impact our ability to assess or pay a claim made against the Policy until the records are provided to us.





4 Temporary Cover

Temporary Cover is issued by us and is only available if you apply for a Policy through certain distributors.

We do not guarantee that Temporary Cover will be available to you. If Temporary Cover is available to you, we will inform you. Before you apply for Homeowner Protection, please contact us if you wish to know whether Temporary Cover is available to you.

This section sets out important information about Temporary Cover. In this section references to 'you' or 'your' includes the life to be insured.

We provide limited Temporary Cover at no additional cost.

Temporary Cover is subject to the terms and conditions which apply to the Plan(s) being applied for as set out in the Homeowner Protection Combined PDS and Policy Document and the additional terms and conditions for Temporary Cover in this section.

When does Temporary Cover start and end?

Temporary Cover will start from the date all of the following have been met:

- we have received your completed application form, which is signed (including by electronic means) and dated, and you confirm your application is true and accurate; and
- we inform you that your Temporary Cover has commenced.

Temporary Cover will end on the earliest of:

- the Policy Commencement Date;
- the date you withdraw your application;
- the expiration of 90 days from when Temporary Cover starts;
- the date that we inform you that your application has been declined or has not been accepted; and
- the Temporary Cover Benefit Amount for Decreasing Life Cover for the life to be insured being paid.

In addition to the circumstances above, Temporary Cover for Major Illness Cover will end if the Temporary Cover Benefit Amount for Major Illness Cover for the life to be insured is paid.

When a claim is paid under Temporary Cover

If a Benefit Amount is paid under Temporary Cover, it will impact your Policy.

If the Temporary Cover Benefit Amount for Decreasing Life Cover is paid, your Temporary Cover will end and your Policy will not commence.

If the Temporary Cover Benefit Amount for Major Illness Cover is paid, only the Major Illness Cover plan of your Policy will not commence. In this case you will not have Major Illness Cover under your Policy and will not be entitled to payment of the Major Illness Cover Benefit Amount. Your Decreasing Life Cover under your Policy may commence and continue until it ends in accordance with the terms set out in this PDS.

Temporary Cover Benefit Amount Payable

The Temporary Cover Benefit Amount that is payable for Decreasing Life Cover is the Homeowner Protection Decreasing Life Cover Benefit Amount you have applied for and that has been accepted by us.

For those Insured Events that are covered by Temporary Cover (see the table next page), the Temporary Cover Benefit Amount for Major Illness Cover payable is the Homeowner Protection Major Illness Cover Benefit Amount you have applied for and that has been accepted by us. Temporary Cover does not cover Cancer (of a specified criteria), Coronary Artery Bypass Surgery, Heart Attack (with specified evidence of severe heart muscle damage) – full payment, Heart Attack (of specified evidence) – partial payment and Stroke (resulting in a new neurological deficit).

Benefits under Temporary Cover

Plan type	Temporary Cover Benefit
Decreasing Life Cover	If the life to be insured dies or is diagnosed with Terminal Illness, we will pay the Temporary Cover Benefit Amount for Decreasing Life Cover.
Major Illness Cover (Temporary Cover Benefit applies only to some, not all, Insured Events)	**Insured Events that are covered under Temporary Cover:** If the life to be insured satisfies the definition of any of the following Insured Events, we will pay the Temporary Cover Benefit for Major Illness Cover: • Major Organ Failure (of specified organs); • Major Head Trauma (with permanent neurological deficit); • Major Organ Transplant (of specified organs); • Paralysis; • Permanent Major Physical Impairment; • Severe Burns (of specified severity). See **Section 2.2.8** for the definitions of the above Insured Events covered under the Temporary Cover Benefit. **Insured Events that are not covered under Temporary Cover:** Temporary Cover Benefit does not cover the following Insured Events: • Cancer (of a specified criteria); • Coronary Artery Bypass Surgery; • Heart Attack (of specified evidence) – partial payment; • Heart Attack (with specified evidence of severe heart muscle damage) – full payment; • Stroke (resulting in a new neurological deficit). See **Section 2.2.8** for the definitions of the above Insured Events that are not covered under the Temporary Cover Benefit.

When we will not pay under Temporary Cover

The **Decreasing Life Cover** benefit under Temporary Cover is not payable:

- If the Insured Condition was directly or indirectly caused by any intentional self-inflicted act (including attempted suicide and suicide, whether sane or not).
- If the event giving rise to the claim is caused by the life to be insured being in a country for which the Australian Department of Foreign Affairs and Trade or any successor government or agency issued a 'Do Not Travel' warning advice prior to their travel to that country, and which continues to be in force during the time of their stay in that country.

The **Major Illness Cover** benefit under Temporary Cover is not payable if the Insured Condition was directly or indirectly caused by:

- Any intentional self-inflicted act (including attempted suicide and suicide, whether sane or not); or
- The life to be insured participation in any criminal or unlawful activity.

The Major Illness Cover benefit under Temporary Cover is also not payable if the event giving rise to a claim is caused by the life to be insured being in a country for which the Australian Department of Foreign Affairs and Trade or any successor government; or agency issued a 'Do Not Travel' warning advice prior to their travel to that country, and which continues to be in force during the time of their stay in that country.

90-day qualifying period and Temporary Cover for Major Illness Cover

If Temporary Cover applies, the 90-day qualifying period for certain Insured Events for Major Illness Cover will start when Temporary Cover starts. If your Major Illness Cover Plan has not started at the end of 90 days from the Temporary Cover start date, then the 90-day qualifying period will restart from the Major Illness Cover Plan Commencement Date.



5 Other Important Information

5.1 Guaranteed continuation of cover

Provided you have paid all the premiums when due, your Policy will continue until all Plans under the Policy end. This guarantee of continuation applies regardless of any change in your health or personal circumstances.

5.2 Changes to your Policy

You can request that we make changes to your Policy after it has commenced. We may require you to make this request in a particular form and/or provide more information. Any changes to your Policy are subject to our agreement. Please contact us to understand the possible alterations that can be made to your Policy.

We reserve the right to require an Underwriting assessment for any request for a Policy alteration that increases the Benefit Amount or our insurance risk in providing the insurance cover. Any change must be confirmed by an authorised member of our staff.

This section does not restrict our ability to change your Policy conditions as permitted under the *Insurance Contracts Act 1984* (Cth) if you or the Life Insured do not take reasonable care not to make a misrepresentation.

5.3 Additional increases to Benefit Amount

In some circumstances, we may agree to accept a voluntary increase to your Benefit Amount.

Any request for voluntary increase is subject to the duty to take reasonable care not to make a misrepresentation to the insurer outlined in **Section 3** and will involve a recalculation of your premium.

5.4 Joint lives

You can cover up to two Lives Insured under one Policy when you apply for insurance and each Life Insured can choose their own Benefit Amount. For a joint Policy, each Life Insured under a single Policy has separate Plans under the Policy.

If you no longer wish to hold a joint Policy with your partner, you can contact TAL to discuss your options to change this to a single ownership Policy.

5.5 No cash value

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

5.6 Cancellation

If you wish to cancel your Policy, your Policy will end at your next premium due date, after you have informed us of your cancellation. This is because premiums are paid monthly for your Policy.

5.7 Can we cancel your Policy?

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

Your Policy may be cancelled if we do not receive a premium payment that is due and we provide relevant notice under the law. See **Section 1.2** for more information on premiums and **Section 5.10** for information on cancellation for non-payment of premiums.

Your Policy may be avoided (which means treated as if it never existed) if you do not comply with your duty to take reasonable care not to make a misrepresentation and we would not have provided you with the Policy had you complied with the duty to take reasonable care not to make a misrepresentation.

We may also not pay your claim and cancel your Policy if you make a fraudulent claim under your Policy or another policy you have with us.

5.8 Premium and benefit payment

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

5.9 Paying your premium

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

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

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

5.10 Non-payment or late payment of premiums

If we do not receive your premium payment by the due date, we'll let you know and give you at least 30 days to pay the overdue premium. If we do not receive the overdue premium by the date stated in the overdue notice, we will cancel your Policy. If we have cancelled your policy due to non-payment of premiums, we will provide you confirmation of cancellation.

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

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

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

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

If we offer to reinstate the Policy:

- Any special terms and/or loadings which applied to your original Policy will also apply to the reinstated Policy.
- You must pay all outstanding premiums. We will inform you of the total outstanding premium amount as part of any offer of reinstatement we may make to you.
- Your duty to take reasonable care not to make a misrepresentation (see **Section 3**) applies to any application for reinstatement.
- Any reinstatement offered may be subject to additional terms and conditions other than those described in this clause. You will be informed of any additional terms and conditions at the time this option is offered to you.

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

When we will not pay

If we reinstate the Policy, no benefit will be paid if the claim arises from:

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

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

5.12 What happens if we make an error?

We work hard to make sure you receive accurate information and that your Policy and any claim you make will be administered correctly. However, from time to time we do make and identify errors. If this happens, we will try to make things right. If you think we have made an error, please tell us right away so that we can investigate and take action.

5.13 Taxation

If you are considering the tax implications of purchasing and receiving benefits under Homeowner Protection, it is important you seek independent, professional taxation advice. The complexity of taxation laws and rulings is such that this advice should be specific to your circumstances. For comprehensive advice regarding the taxation implications of paying premiums or receiving any of the benefits under the Policy that takes into account your personal circumstances, please contact a registered tax agent, tax (financial) adviser or the Australian Taxation Office.

The following general information only applies to Australian resident individuals who are both the Policy Owner and the Life Insured and the recipient of any benefits and who are not taking out the insurance for business purposes. It is based on the Australian tax law as at the date this PDS was prepared. The tax law and its interpretation are subject to change. Where the law requires an amount to be withheld or deducted from a benefit payment, we will withhold or deduct the required amount from the payment and forward it to the relevant authority.

Generally, the premiums you pay will not be tax deductible. Benefits payable under the Policy may be assessed under the capital gains tax provisions, if you are not the original Policy Owner and you acquired the interest in the Policy for consideration.

This taxation information is based on the continuation of present laws and their current interpretation and is a general statement only. For advice regarding taxation please contact your registered accountant or the Australian Taxation Office.

Homeowner Protection is treated as input taxed under the Australian Goods and Services Tax (GST) law and premiums are not subject to GST. The premium rates are inclusive of any GST costs incurred in relation to the Policy. An input tax credit will not be available to the Policy Owner.

5.14 Statutory fund

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

5.15 Jurisdiction

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

5.16 Government duties

We reserve the right to pass on to you any government duties, taxes or other charges that are or become payable by us or by you in respect of this Policy.

5.17 Sanctions

In limited cases, Australian and overseas laws prohibit ("sanction") payments to or from certain persons, and dealings in certain assets (including insurance policies).

Where any law requires us, we will not provide cover under, accept premium for, or make a claim or other payment under the Policy, if any Policy Owner, Life Insured or nominated beneficiary:

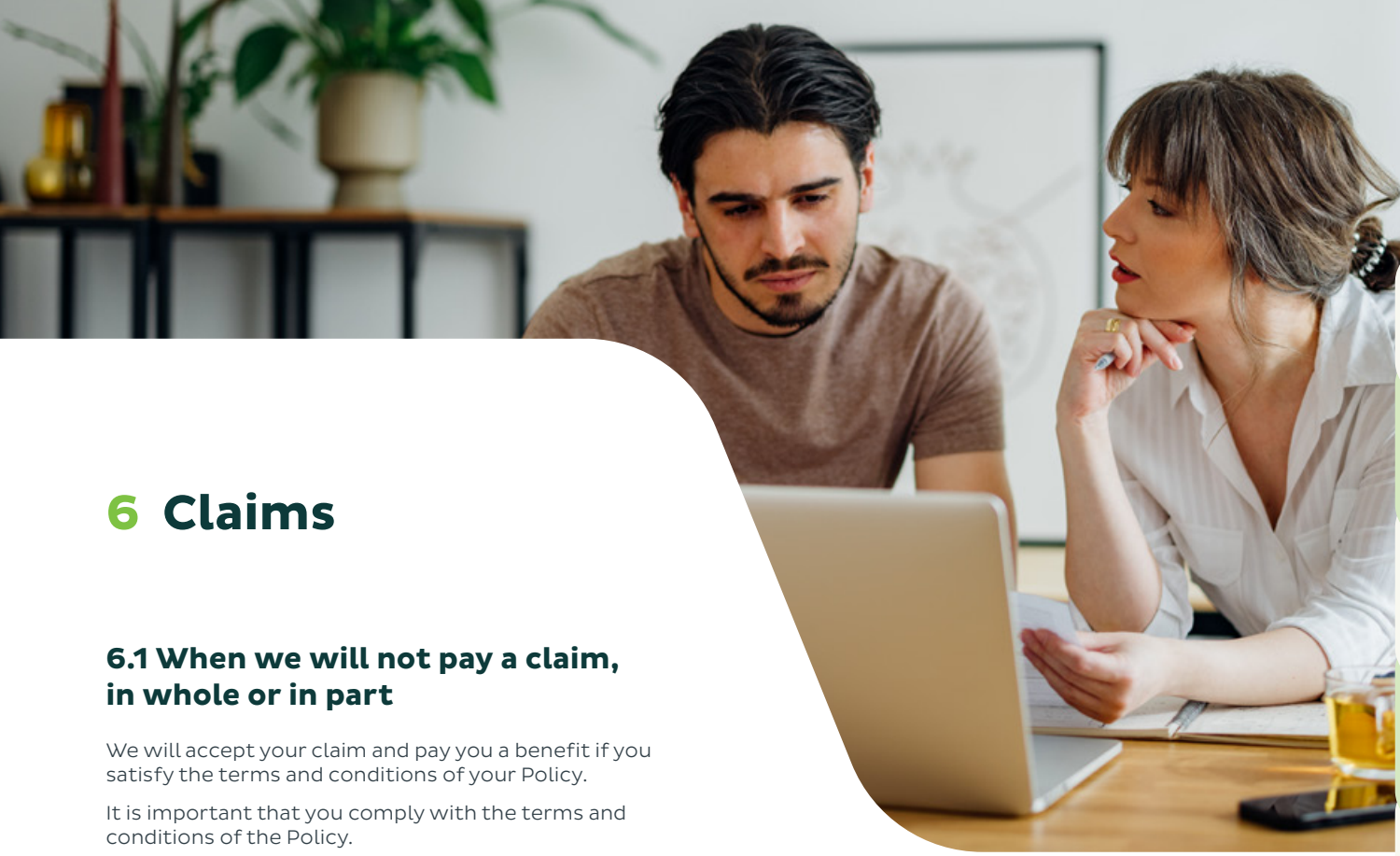
- is listed on the Australian Department of Foreign Affairs and Trade or other applicable Australian or overseas sanctions list, or where dealing with such person or asset is otherwise unlawful;
- live in a sanctioned country; or
- requests payment to an account of a bank listed on any Australian or relevant overseas sanctions list or if such bank is located in a sanctioned country.

We are not liable to provide cover, accept premium, or make a claim or other payment if that would expose us to any prohibited sanction under any applicable law.

5.18 Duty of utmost good faith

Both us and you have a duty of utmost good faith under this contract, which means that both of us must act with honesty and fairness when dealing with each other in relation to your Policy. Under the *Insurance Contracts Act 1984* (Cth), neither of us may rely on a term of your Policy, if such reliance would be to fail to act with utmost good faith.





6 Claims

6.1 When we will not pay a claim, in whole or in part

We will accept your claim and pay you a benefit if you satisfy the terms and conditions of your Policy.

It is important that you comply with the terms and conditions of the Policy.

We may refuse to pay your claim, in whole or in part, or reduce the amount of your benefit where:

- Your claim does not meet the relevant Policy terms and conditions (including any applicable special terms shown in the Policy Schedule);
- You did not comply with the duty to take reasonable care not to make a misrepresentation to the insurer (when you applied, reinstated or varied your Policy or Plan), and we apply a remedy available under the *Insurance Contracts Act 1984* (Cth). See **Section 3** for more information;
- You make a fraudulent claim under your Policy or another policy you have with us. See **Section 6.7** for more information;
- We do not receive all information we reasonably require to assess your claim or compliance with the duty to take reasonable care not to make a misrepresentation;
- There is insufficient evidence to support your claim.

Your Policy is subject to the applicable laws of Australia including the *Insurance Contracts Act 1984* (Cth). For example, under section 54 of the *Insurance Contracts Act 1984* (Cth), if the effect of your Policy is that we may refuse to pay your claim or reduce your benefit due to some act or omission by you or someone else that occurs after your Policy commences, we may:

- Refuse to pay your claim, but only to the extent that such act or omission could reasonably be regarded as having caused or contributed to the loss which gives rise to your claim; or
- Reduce the amount of your benefit, but only by an amount that fairly represents the extent to which our interests are prejudiced by the act or omission.

There may be circumstances where the act or omission was necessary to protect a person or property, or it was not reasonably possible to avoid the act or omission. In those circumstances we may not refuse to pay the claim, only because of that act or omission.

6.2 Notifying us of a claim

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

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

6.3 Payment of Premiums

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

If you are experiencing financial hardship, please call us on **1300 683 816** to discuss options that may be available to help you. You may also need to provide supporting documentation to assist with your financial hardship application. Alternatively, you can discuss this with your financial adviser.

6.4 Claim Requirements

An event giving rise to a claim must occur when your Policy is in force.

Our assessment of your claim will involve determining whether your claim meets all relevant Policy terms and conditions and any applicable special term shown in the Policy Schedule. This includes the terms and conditions that apply to the payment of any benefit under a Plan. It may also include investigating whether the duty to take reasonable care not to make a misrepresentation was complied with when the Policy or Plan was applied for, reinstated or changed.

Our assessment of your claim will require obtaining the information, such as medical (for example Medicare, Pharmaceutical Benefits Scheme and private health insurance records), employment, lifestyle, pastime or financial evidence, that we require to make our decision. This may include information that relates to the period prior to the Policy or Plan start date, such as previous medical, employment, lifestyle, pastime or financial history, to determine whether you or the Life Insured took reasonable care not to make a misrepresentation when you applied for, reinstated or changed the Policy or Plan. In all circumstances we must be satisfied of our initial and ongoing liability to pay a benefit. Any information we require must be provided, and participation in the assessment activities we require must be undertaken, for us to assess your claim and before we will pay a benefit.

Administrative requirements

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

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

You may also need to provide:

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

Medical requirements

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

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

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

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

Interview requirements

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

Other information requirements

We may also require:

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

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

6.5 Meeting the costs of claim requirements

Where we request an examination or assessment by a person we nominate, we will pay the cost for this service. You will be responsible for other costs which may be incurred for example, having your claim forms completed by your attending doctor.

6.6 Authority to obtain information

To obtain all relevant evidence and records to assess your claim and our liability under your Policy, we will request you or the Life Insured to provide us with an authority to receive information relevant to the assessment of the claim from third parties. For example, we may require information and records from Medical Practitioners who have treated you in relation to a condition giving rise or contributing to your claim, and historical medical records which are relevant to determining whether you complied with your duty to take reasonable care not to make a misrepresentation when you applied for, reinstated or modified your Policy.

If you do not provide the relevant records or you do not provide consent or authority for us to obtain the relevant records, it may impact our ability to process your claim and your claim may be declined until we are able to obtain the information and evidence we reasonably require.

For Major Illness Cover claims, we will require proof of the Sickness or Injury for which a claim is being made, supported by (but not limited to):

- evidence of the date and location of where the event leading to the Injury occurred (if applicable); and
- appropriate evidence from a Medical Practitioner, including confirmatory investigations such as clinical, radiological, histological and laboratory evidence.

6.7 Fraudulent claims

We may refer any suspected fraudulent claims or illegal activity to the relevant law enforcement authorities and will, to the extent permissible by law, seek to recover any monies paid, expenses or damages incurred in obtaining such evidence as may be required to protect our rights.

If you make a fraudulent claim under your Policy or another policy you have with us, then to the extent permitted by law, we may cancel your Policy and may refuse payment of your claim.

6.8 Payment of claims

If you are legally competent to apply for a claim and your claim is accepted, all benefits will be paid to you, your nominated beneficiary(s) or your legal personal representative. If your claim is accepted and you are judged to not be legally competent, we will pay any respective benefits to whomever we are legally permitted to make payments. We will not be liable to you for any loss you suffer (including consequential loss) caused by the fact that we are required by law to delay, block, freeze or refuse to process a transaction.

6.9 Maximum benefit payable per Life Insured

If a Life Insured is covered under more than one Homeowner Protection Plans and / or Policies, the maximum total Benefit Amount that can be paid under all Homeowner Protection Plans and Policies issued by TAL in respect of that Life Insured is $1.5 million for Decreasing Life Cover and $250,000 for Major Illness Cover.

6.10 Misstatement of age

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

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





7 Complaints and disputes

If you have a complaint about our services or your privacy you should direct your complaint to:

- 1300 683 816
- Reply Paid GPO Box 5380, Sydney NSW 2001
- customerservice@tal.com.au

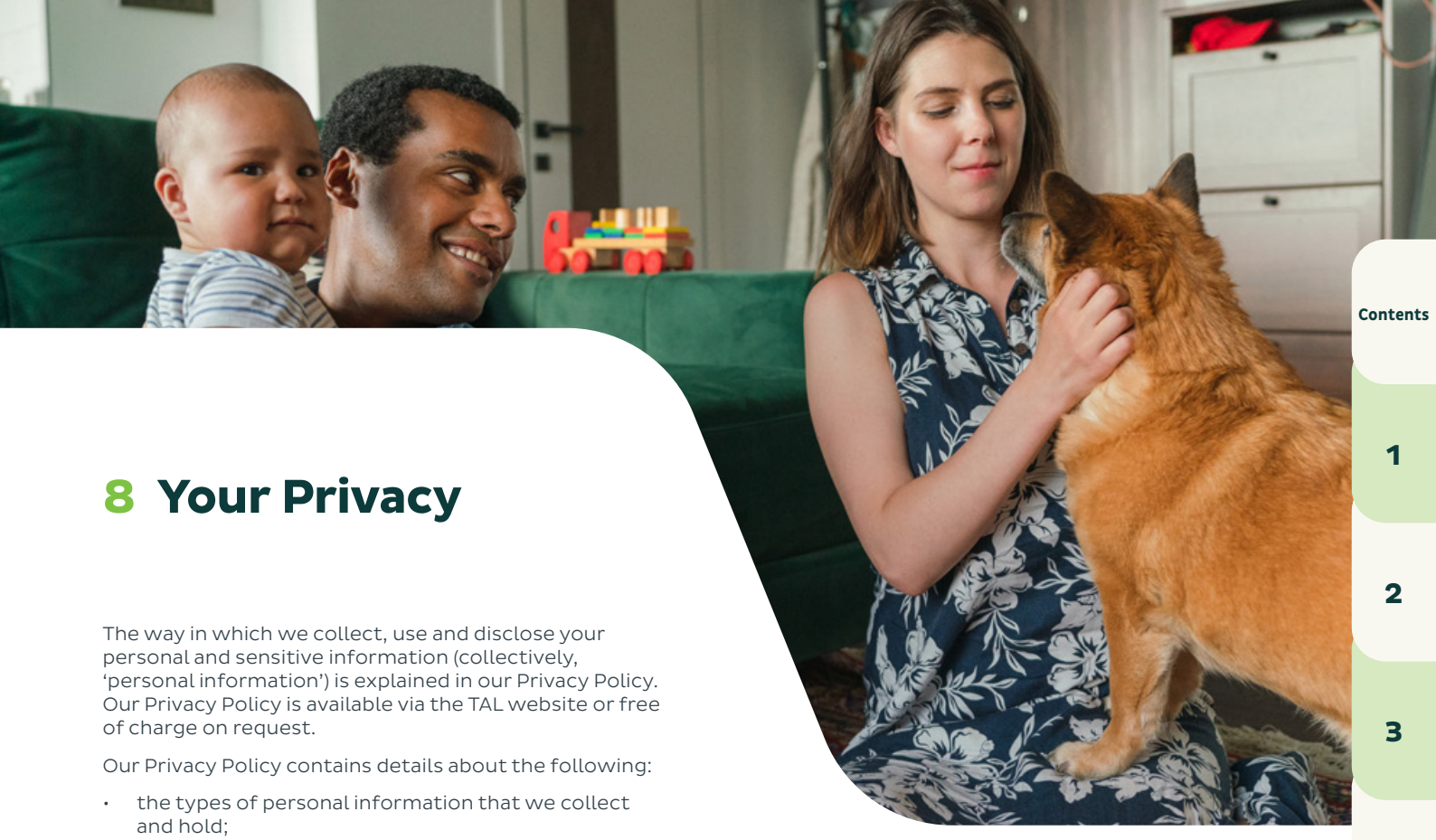
We will attempt to resolve your complaint within 30 days of the date it is received. If we are unable to resolve your complaint within that period, we will inform you of the reasons for the delay and let you know when we expect to provide a response to your complaint.

Australian Financial Complaints Authority (AFCA)

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

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

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



8 Your Privacy

The way in which we collect, use and disclose your personal and sensitive information (collectively, 'personal information') is explained in our Privacy Policy. Our Privacy Policy is available via the TAL website or free of charge on request.

Our Privacy Policy contains details about the following:

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

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

TAL

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

Your personal 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 your health or financial information. If you do not supply the required information, we may not be able to provide the requested product or service to you 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 our related bodies corporate. We may also disclose your personal information (including health information) to other bodies or persons such as reinsurers, your financial adviser and/or their authorising licensee, your mortgage broker and/or their credit licensee, health professionals, investigators, lawyers and external complaints resolution bodies.

In administering your insurance benefits, 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 personal information for a purpose other than providing our products and services, unless:

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

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

We rely on the accuracy of the information you provide. If you think that we hold information about you that is incorrect, incomplete or out of date, please let us know using the communication methods detailed 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 to us. 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. 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. Please also refer to our privacy policy for further information.

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.

Security and storage of personal information

We understand the importance of ensuring that the personal information you entrust to us is safe and secure. We take steps to protect the personal information we hold about you from unauthorised access, unauthorised disclosure, loss, misuse or interference by implementing a range of electronic, physical and technological safeguards.

We have processes in place to identify, manage and remediate privacy and data breaches in accordance with our obligations under the Notifiable Data Breaches scheme.

Please also refer to our Privacy Policy on our website at www.tal.com.au for further information.

Direct marketing opt out

From time to time we and our related entities or business partners may use your personal information for the purposes of marketing our products and services, together with the products and services of third parties that we think may be of interest to you. We may do this by phone (where we have your valid consent), mail, email and SMS or other electronic messages. If you do not want to receive further marketing communications from us, or if you do not want us to disclose your personal information for marketing purposes please contact us on **1300 209 088** or email customerservice@tal.com.au

Contact from us

From time to time we may contact you by telephone about your Policy.

If you do not want to receive calls from us at all, please contact us by calling **1300 683 816** or write to TAL, GPO Box 5380, Sydney NSW 2001.





9 TAL direct debit service agreement

The Direct Debit Request Service Agreement (DDR Agreement) is issued by TAL to enable you to understand your rights and responsibilities as a new customer when making premium payments by direct debit. It allows TAL to debit your nominated account to meet the premiums for your Policy.

Please keep this DDR Agreement in a safe place for future reference.

Our commitment to you

We ensure that we will:

- give you at least 14 days' notice if there are any changes to the terms of this DDR Agreement; and
- keep all information relating to your nominated financial institution account confidential, except where required for conducting direct debits with your financial institution, or otherwise as required by law.

Your commitment to us

If you do commit to a DDR Agreement, please ensure that:

- the account you have nominated can accept direct debits;
- all account holders for this nominated account agree to this DDR Agreement; and
- there are enough funds available in the nominated account, on the due dates, to cover the premiums. If there isn't, you may incur dishonour fees from your financial institution and your Policy may be cancelled. Dishonour fees will not be charged by TAL.

If a premium due date falls on a weekend or a public holiday, we will automatically debit the payment on the next business day.

If you provide us, directly or indirectly, with new or updated payment details (for payment through the direct debit system), these conditions will also apply to that request.

How to make changes

Please give us at least 7 days' notice before your next premium due date for either:

- altering any of your direct debit or financial institution details; or
- stopping or suspending any debits or cancelling the DDR Agreement completely.

If you do any of these, you will need to make alternative arrangements for future premiums to continue your Policy.

If you prefer you may contact your financial institution directly to alter, stop, cancel or dispute any debit. If you alter your direct debit details with your financial institution, your financial institution may alter your debit payment only to the extent of advising us of your new account details.

Contacting us

If you wish to make any of the changes, as outlined above, or wish to dispute a debit you can do so by email or by phone. The contact details are:

TAL

customerservice@tal.com.au

1300 683 816

We will always respond to your query or dispute in the first instance.

Please refer to our website at www.tal.com.au to obtain a copy of our current Payment Authority form.



10 Glossary

Australian Resident means you are currently residing in Australia, received the PDS in Australia and you are a/an:

- Australian citizen;
- New Zealand citizen; or
- Australian permanent resident.

Benefit Amount under Decreasing Life Cover and Major Illness Cover means the respective lump sum amount shown in your Policy Schedule as applicable, taking into account:

- any decreases or increases in line with a request by you that is agreed to by us; and
- any decreases that we have automatically applied to your Decreasing Life Cover Plan, under the conditions of Decreasing Life Cover.

Your Benefit Amount for Decreasing Life Cover will automatically reduce by 5% at each Policy Anniversary.

Immediate Family Member means a spouse, partner (including a same-sex partner or de facto partner), child, parent and/or sibling of a Life Insured or Policy Owner.

Insured Event means the medical condition, injury or medical procedure covered under Major Illness Cover as specified and defined in **Section 2.2.8**.

Injury means a bodily injury suffered by the Life Insured.

Life Events are:

- you refinance or increase your home loan;
- the birth or adoption of a child and you are the parent;
- your dependant starting primary or secondary school;
- you get married;
- you get divorced; or
- your base salary increases by at least $10,000 per annum.

Life Insured means the person whose life is insured under the Policy, and who is named as such in the Policy Schedule.

Limb means an arm, hand, leg or foot.

Medical Practitioner means a person who is registered as a Medical Practitioner in Australia, other than:

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

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

Unless registered as a Medical Practitioner, physiotherapists, nurse practitioners, and/or alternative therapy providers, chiropractors and acupuncturists, for example, are not regarded as Medical Practitioners.

Plan means the insurance benefits under Decreasing Life Cover or Major Illness Cover, depending on the terms of the applicable Policy Schedule that apply to you when your Policy is in force. The relevant Plan(s) applicable to you will be set out in your Policy Schedule. Decreasing Life Cover and Major Illness Cover are each a separate Plan under the Policy.

Plan Commencement Date means the date your Plan first commences (this date will be shown in your Policy Schedule).

Plan Expiry Date means the date at which each Plan ends. The Plan Expiry Date for each Plan and your Policy will be set out in your Policy Schedule.

Policy means the Homeowner Protection Policy under the terms and conditions set out in this PDS, your Policy Schedule and any special terms or endorsements.

Policy Anniversary means each anniversary from the Policy Commencement Date.

Policy Commencement Date means the date your Policy first commences (this date will be shown in your Policy Schedule)

Policy Owner means the person that legally owns the Policy and who is so named in the Policy Schedule.

Policy Schedule means the document we send you titled "Policy Schedule" which sets out the details of your particular Policy including who is the Policy Owner, who is the Life Insured, the type of Plans applicable to the Policy, the amount of coverage, the special terms that apply, and your Plan Commencement Date and Plan Expiry Date and premium details (amount and payment frequency). The Policy Schedule is a legal document that forms part of the insurance contract.

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

Terminal Illness and Terminally Ill means an illness where, after having regard to the current treatment or such treatment as the Life Insured may reasonably be expected to receive, the Life Insured will not survive more than 12 months.

Two treating Medical Practitioners, at least one of whom is a specialist Medical Practitioner specialising in the Life Insured's Illness, or an area related to the Illness, must certify in writing (either jointly or separately), that despite reasonable medical treatment, the Life Insured is suffering a Terminal Illness which will lead to death within 12 months of the date of certification. The Terminal Illness and certification must occur while the Plan is in place.

Underwriting is a process by which we assess risks associated with your application for insurance. The Underwriting process is usually based on the life to be insured's health and other relevant factors, such as occupation, pastimes, and income.

We, **us**, **our** and **TAL** mean TAL Life Limited, ABN 70 050 109 450 AFSL 237848.

You, and **your** mean the Policy Owner and/or Life Insured as the context requires.



Contacting TAL

customerservice@tal.com.au

1300 683 816

tal.com.au/homeowner-protection

mytal.tal.com.au/login

TAL Life Limited ABN 70 050 109 450 | AFSL Number 237848

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