Corporate Group Life

Product Disclosure Statement | 1 July 2019

Insurer
TAL Life Limited
ABN 70 050 109 450 AFSL 237848

Including TAL Risk Only Super Plan

Issuer and Trustee for the TAL Risk Only Super Plan
TAL Superannuation Limited
ABN 69 003 059 407 AFSL 237851 RSE L0000642

TAL

Important Information

This Product Disclosure Statement (PDS) provides important information about the following products:

1. Corporate Group Life (superannuation and non-superannuation) – issued by TAL Life Limited (the Insurer). When structured as superannuation, Corporate Group Life can only be owned by a trustee of a standard employer-sponsored superannuation fund, as defined in section 16(4) of the *Superannuation Industry (Supervision) Act 1993* (Cth).
2. TAL Risk Only Super Plan (ROSP) – issued by TAL Superannuation Limited (the Trustee).

Insurance Cover is available for death only or death and Total and Permanent Disablement, and also includes Interim Cover and Terminal Illness. Permanent Employees, Casual Employees, Contractors and Spouses may also be eligible to be covered.

This PDS is divided into 3 parts.

Part 1 contains information relating to the Corporate Group Life (superannuation and non-superannuation) for prospective Corporate Policy Owners and their Employees or superannuation trustees and their members. This section sets out the terms and conditions relating to Benefits provided under any Policy issued to the Policy Owner by the Insurer. It explains who can be covered, when Insurance Cover is provided automatically and when Employees and Members will need to apply for Insurance Cover. It also details when Voluntary Cover may be applied for.

Some sections of Part 1 are also applicable to ROSP. Where a section in Part 1 is marked with this symbol, the content in that section is NOT applicable to ROSP Members.

Part 2 contains important additional product information for ROSP.

Part 3 contains the definitions of key terms applicable to both Corporate Group Life and ROSP which are capitalised throughout this PDS. For ease of reference, regularly used terms are listed below.

Please note throughout this PDS:

- 'Fund' refers to the TAL Superannuation and Insurance Fund;
- 'Insured Person' refers to the person whose life is insured under the Policy and in respect of ROSP includes a Member;
- 'Insurer' and 'TAL' refers to TAL Life Limited;
- 'Member' refers to a member of the Fund whose life is insured under the Policy;
- 'Policy Owner' refers to the purchaser of the Policy and in respect of ROSP means the Trustee;
- 'ROSP' refers to the Risk Only Super Plan;
- 'TAL Group', 'We', 'Us', 'Our' refers to TAL group of companies;
- 'Trustee' refers to TAL Superannuation Limited as trustee for the TAL Superannuation and Insurance Fund; and
- 'You' refers to the reader of this PDS.

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

From time to time the information in this PDS which is not materially adverse may be updated by publishing a note of the change on Our website www.tal.com.au. Free paper copies of the updated information are available by calling 1800 130 869.

For ROSP, the Trustee reviews its products regularly to ensure that they continue to meet the current needs and future expectations of Members. As a result, the Trustee may make changes to the terms and conditions of the ROSP product in the future. Where required by law, the Trustee will give the Employer and/or Insured Person prior written notice of the change. Otherwise, the Trustee will notify the change in either Your annual statement or the Fund's Annual Report.

Details of the Insurer for both Corporate Group Life and ROSP are as follows:

TAL Life Limited
ABN 70 050 109 450
AFSL 237848

363 George Street
Sydney NSW 2000

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

www.tal.com.au

Details of the Trustee of ROSP are as follows:

TAL Superannuation Limited
ABN 69 003 059 407
AFSL 237851 RSE L0000642

TAL Superannuation and Insurance Fund
363 George Street
Sydney NSW 2000

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

www.tal.com.au

Need help?

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

If You have any questions You can contact TAL on 1800 130 869, or visit Our website, www.tal.com.au.

If You do not have a financial adviser, please contact Us and We can put You in touch with someone who can help.

Any information contained in this PDS is of a general nature only. It does not take into account individual financial situations, needs or objectives. Full details of the Policy terms and conditions can be found in the Policy document.

Corporate Group Life

Issued by TAL Life Limited (the Insurer)
ABN 70 050 109 450 AFSL 237848

Once the Insurer has agreed to issue group life insurance, this PDS together with the Policy Schedule and any Endorsements (for later amendments to the Policy) will form the Policy, as stated in Section 3.3. The Insurer will send the Policy Schedule which will reflect the agreed terms and conditions.

Where the Policy Owner is the trustee of a superannuation fund, Benefit payments are made through the superannuation fund and subject to restrictions under superannuation law.

Risk Only Super Plan (ROSP)
Issued by TAL Superannuation Limited (the Trustee)
ABN 69 003 059 407 AFSL 237851

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

The Policy and Trustee

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

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

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

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

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

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

A GUIDE TO READING THIS PRODUCT DISCLOSURE STATEMENT (PDS)

- *I'm interested in Corporate Group Life Insurance Cover for my employees or superannuation fund members…*
  You should read Parts 1 and 3.
- *I'm interested in ROSP Insurance Cover for my employees…*
  You should read Parts 2 and 3. There is additional information relating to ROSP in Part 1 however some sections in Part 1 do not apply to ROSP and these are clearly marked by (R).

If You are still unsure, speak to Your financial adviser, or contact Us.

Interpretation
In this PDS:

- there are a number of words which are capitalised throughout this PDS. These words have a particular definition when used in this PDS. These definitions are found in Part 3 of this PDS. It is important to read these definitions carefully because their meanings may be relevant to the decision to hold or apply for Insurance Cover, continue to be a Member (for ROSP), the assessment of any application for Insurance Cover, eligibility for Insurance Cover, ability to make a claim and any decision that the Insurer makes in relation to any claim; and
- words expressed in the singular include the plural and vice versa.

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1 About TAL

Insuring This Australian Life

TAL is a leading life insurance specialist and for over 140 years We've been protecting people, not things. Together with Our partners We protect almost four million Australians and their families, helping them look after what matters most, so they have the freedom to keep living the life they planned.

As Australia's leading life insurance specialist We've learnt that the most important part of life isn't the stuff we own, but the experiences we share with the people we love. It's living life. This Australian Life.

That's why We do what We do, protect people, not things, to help you look after what matters most. From covering your children's education, to keeping up the mortgage payments for the family home or rehabilitation to get you back on track sooner, We help you and your family keep living the life you planned, should the unplanned happen.

TAL's commitment to claims

Making a real difference to your life at a difficult time is the most important thing We do. We'll ensure that if you need to make a claim it is as easy as possible. You'll receive:

- a dedicated claims manager for the whole process;
- a near paper-less approach - We do as much as possible on the phone; and
- personalised rehabilitation services like exercise plans.

Awards and recognition

We're proud of Our achievements and Our people who've helped Us earn them. While We're not in the business of winning awards, We're grateful that Our customers and the industry have recognised Our commitment to protecting what matters most. Here are some of Our most recent awards from 2017:

- **AB+F Australian Insurance Awards** – Australian Insurance Executive of the Year (Brett Clark) and Marketing Campaign of the Year
- **Money Magazine Best of the Best Awards** – Best Featured Income Protection Insurance
- **Strategic Insight Direct Life Insurance Awards** - Overall Direct Life Insurance Excellence Winner, Term Life Product Winner, Omnibus Product Winner, Customer Service Winner, Marketer Customer Service Winner
- **CANSTAR Outstanding Value Life Insurance Awards** – Income Protection Insurance Award Winner
- **ANZIIF Australian Insurance Industry Awards Winner** - Women's Employer of the Year
- **SMA Innovation in Action Awards** – Insurance Winner
- **iCMG ANZ & Asia Pacific Architecture Excellence Awards** – Winner for Architecture Excellence in the Banking, Financial Services and Insurance category
- **Money Management/DEXX&R Risk Company of the Year Awards** – Disability Income Product Award Winner for TAL Accelerated Protection Income Protection Premier
- **TDI Asian Insurance Innovation Awards** – Top Asian insurance innovator (TAL and Qantas)
- **Roy Morgan Satisfaction with Risk and Life Insurer Customer Survey** - Top life insurer for customer satisfaction (InsuranceLine)

Codes of Practice

TAL has adopted the Financial Services Council Life Insurance Code of Practice. This Code sets out expectations of Insurers in respect of claims handling for Insured Persons.

The Trustee has adopted the Insurance in Superannuation Voluntary Code of Practice.

For a copy of either or both Codes, please contact the Financial Services Council or consult their website at fsc.org.au. For the avoidance of doubt, Trustee's and Trustee's agreement to adhere to the Codes does not create a contractual relationship between TAL and/or TASL and the Policy Owner or Insured Person(s) and the terms of the Codes do not form part of the insurance contract or the Fund's governing rules in its Trust Deed.

2 Part 1: Corporate Group Life and Risk Only Super Plan (ROSP) Information

Insurance at a glance

What types of Insurance Cover are available?

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

There are three types of TPD definitions available:

- TPD (Standard);
- TPD (Own Occupation) ® (Not available for ROSP or within superannuation); and
- TPD (Alternate).

There is no TPD (Own Occupation) available within superannuation. The TPD (Own Occupation) definition is generally only available upon request for Employees or members who meet certain Eligibility Criteria agreed with the Policy Owner. For example, the Eligibility Criteria may be that the Employee or Spouse has to be a Professional or a Senior Manager.

The TPD (Standard) and TPD (Alternate) definitions are available to eligible Employees, Spouses or members.

For ROSP, the TPD (Alternate) definition must be approved by the Trustee. ® For ROSP, Insurance Cover is not available to spouses. Any reference to any Insurance Cover for a Spouse is for Corporate Group Life only.

Section 4 explains in more detail how the definitions apply to each type of Employee and member. The TPD definitions the Insurer has agreed to provide under the Policy will be stated in the Policy Schedule, Employer Plan Schedule or Member Benefit Certificate.

The easy reference table below provides a quick summary of the Insurance Cover. Please read the terms and conditions outlined in this PDS for a full explanation of Insurance Cover and limits. See Part 2 for information about the Benefits available under ROSP.

Feature	Brief Description	Section
Death Insurance Cover	A lump sum Benefit is paid to the Policy Owner if an Insured Person dies.	11.2
Terminal Illness Insurance Cover	A lump sum Benefit is paid to the Policy Owner if the Insured Person suffers a Terminal Illness.	11.3, 30.1.2
TPD Insurance Cover	A lump sum Benefit is paid to the Policy Owner if the Insured Person becomes Totally and Permanently Disabled.	4.2, 11.4, 11.5
Automatic Acceptance	Insurance Cover without Underwriting up to the AAL.	6, 26
Voluntary Cover	An amount of Insurance Cover which is not based on the Insurance Formula and includes Life Events Cover.	9.1, 9.2
Life Events Cover	Voluntary 'top up Insurance Cover' available as a result of a change to individual circumstances e.g. marriage, new child, and mortgage.	9.3 - 9.6
Interim Cover	Provides Insurance Cover for an injury during Underwriting.	10
Insurance Cover during paid and unpaid leave	Up to 24 months continuous Insurance Cover whilst on Employer approved leave, without the need to be approved by the Insurer.	12
Overseas cover	Insurance Cover is provided 24 hours a day, 7 days per week, with no restrictions on location or time spent overseas, subject to certain conditions.	13
Extended Cover	Up to 60 days additional Insurance Cover after the Insured Person ceases to be an Employee.	15
Continuation option	When Insurance Cover ends for an Insured Person, they may be able to apply for a death only or death and TPD individual policy with the Insurer without medical Underwriting.	16
No minimum hours	Standard death and TPD Insurance Cover is available to Permanent Employees irrespective of minimum hours worked.	4.2
AAL uplifts	Insured Persons may automatically receive any increase in AAL, including those that have been previously Underwritten and have been declined, loaded or excluded, for Insurance Cover above the previous lower AAL, unless otherwise stated in the Policy Schedule or Employer Plan Schedule.	6
Underwriting loadings	For Insurance Cover subject to Takeover Terms, premiums in respect of Underwriting loadings are waived for Insurance Cover which is not Voluntary Cover, reducing costs and simplifying administration.	8
Variable TPD definitions	Flexible TPD definitions are available to cover Contractors, Spouses and Casual Employees.	4.2
Premium frequency	Monthly, quarterly, half-yearly or annually.	20

Availability of cover

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

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

Section 1: Before a Corporate Group Life Policy starts

This section does not apply to ROSP

1.1 Who can apply for group insurance?

Australian based organisations, including corporations, incorporated associations and superannuation fund trustees can apply to the Insurer for a Corporate Group Life Policy to provide Insurance Cover for their Employees, members and their Spouses. Under these circumstances, the applicant will be the Policy Owner and a Policy will be issued to the Policy Owner.

1.2 Information required for a quotation

For the Insurer to provide group insurance, a quotation must be produced. The Insurer will require certain information on the group of persons to be insured. This information includes age, gender, occupation, location (including outside Australia if applicable), plan and claims history (if insured previously), as well as insurance requirements for them.

In addition, further information may be required to enable the Insurer to assess the risk more accurately and provide the most reasonable and sustainable price for the insurance. Once the Insurer has the information required, it will issue the Policy Owner with a quotation.

It is important that the information provided to the Insurer is accurate. The Insurer reserves the right to alter or withdraw its quotation, should the information be found to be inaccurate or incomplete. Please also refer to Section 21.5 which has information about the Duty of Disclosure.

1.3 Accepting the insurance quotation

To apply for group insurance, the applicant must complete the prescribed application form (including any information required by the Insurer) and submit it, together with the premium requested by the Insurer, on or before the requested date for commencement of the Policy.

Please make sure the completed application form is consistent with the quotation provided by the Insurer. The commencement of the Policy is subject to acceptance by the Insurer.

1.4 Other important information

There are important risks which should be considered when deciding to purchase this insurance, including:

- selected Benefits may not provide adequate financial protection for the Insured Persons covered under the Policy;
- Benefits may be reduced, excluded, limited or withheld under circumstances described in Section 14;
- the Policy or Insurance Cover may be avoided or terminated where there is a failure to comply with the Policy Owner obligations (see Section 3.7) or the Duty of Disclosure (see Section 21.5), or under the circumstances described in Section 18; and
- any Special Conditions agreed between the Insured Person, Policy Owner and the Insurer will be stated in the Policy Schedule when it is issued.

Accordingly, it is important that this PDS is read together with:

- the Policy Schedule; and
- the relevant quotation received prior to making an application for Insurance Cover.

Section 2: When the Corporate Group Life Policy starts

This section does not apply to ROSP

2.1 Policy Commencement Date

Insurance Cover will be provided under the Policy from the Policy Commencement Date once all the following events have occurred:

- the Insurer has accepted the completed application and issued an On Risk Letter, advising the Policy Commencement Date;
- the Insurer has issued the Policy Schedule, executed by them;
- You have executed the Policy Schedule and returned it to the Insurer; and
- You have paid the Insurer the requested deposit premium.

2.2 Cooling off period

The Insurer offers a 14 day cooling off period. This period starts on the date from which the Insurer agrees to provide Insurance Cover to the Policy Owner.

This will be the Policy Commencement Date stated in the On Risk Letter and the Policy Schedule the Insurer will issue.

If the Policy is cancelled before the expiry of the cooling off period and provided there have not been any claims, the Insurer will refund any premiums paid if the request is made in writing.

See Section 22.5 for information on the cooling off period for ROSP.

Section 3: Policy information

3.1 The Insurer

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

3.2 The Policy Owner

All Benefits payable under the Policy are paid to the Policy Owner, unless otherwise instructed in writing by the Policy Owner.

For Members of ROSP, the Policy Owner is the Trustee. All Benefits payable under the Policy are paid to the Trustee. Subject to the superannuation law and the Fund's governing rules, the Trustee will pay a corresponding benefit from the Fund to or in respect of the Member.

3.3 The Policy

This section does not apply to ROSP

The Policy is a legal contract of life insurance between the Insurer and the Policy Owner.

The documents issued by the Insurer that make up the Policy are:

- this PDS as at the Policy Commencement Date;
- the Policy Schedule executed by the Insurer;
- the Policy Schedule executed by You and returned to Us; and
- any Endorsements or written amendments to the terms and conditions of the Policy agreed between the Policy Owner and the Insurer and executed by the Policy Owner and the Insurer.

Whether the Policy is superannuation or non-superannuation business will be shown in the Policy Schedule as 'Policy Type'. See Section 22.1 for ROSP Policy information.

3.4 Benefits

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

3.5 Changes to the Policy

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

3.6 Policy Owner acknowledgements

In applying for the Policy, the Policy Owner acknowledges:

- the Insurer has relied on information provided by the Policy Owner or their appointed representative;
- they have the authority to enter into the Policy;
- their appointed representative (if applicable) is their agent in entering into the Policy; and
- if entering into a Policy as a trustee, the trust instrument authorises entry into an insurance policy.

3.7 Policy Owner obligations

Under the terms and conditions of the Policy, the Policy Owner agrees to:

- comply with the Duty of Disclosure set out in Sections 21.5 and 25;
- pay premiums in accordance with the Policy as outlined in Section 20;
- abide by the Eligibility Conditions set out in Section 4.1;
- provide the Insurer in writing on or before the next Annual Review of details of all Eligible Persons who meet the Eligibility Conditions (if details of particular people are not provided, they will not be eligible for Insurance Cover under Automatic Acceptance);
- provide the Insurer in writing details of each person who no longer meets the Eligibility Conditions on or before the next Annual Review;
- notify the Insurer in writing of a change in any Eligible Person's employment status which results in a change from their current Membership Category on or before the next Annual Review;
- provide the Insurer in writing any request for a change to the Eligibility Conditions;
- provide the Insurer in writing any request to provide Insurance Cover for the Employees of any new company or business acquired by the Employer;
- supply the Insurer with all information it asks for at the commencement of the Policy, at each Annual Review, and on termination of the Policy, within 30 days of receiving its request;
- execute and return Policy Schedules and Endorsements within 30 days of receipt; and
- provide the Insurer with all information and notices it requires under the Policy.

Where the Policy Owner does not comply with these obligations the Insurer may provide the Policy Owner with notice to terminate the Policy in accordance with Section 18.1, and the entitlement to a Benefit may be affected.

3.8 Policy assignments

This section does not apply to ROSP

The Policy can be assigned in accordance with the *Life Insurance Act* 1995 (Cth) with the Insurer's prior written consent. If the Insurer allows the assignment, the assignee will be recorded as the new Policy Owner with all the rights, powers, duties, obligations and privileges of the original Policy Owner.

Section 4: Who can have Insurance Cover under the Policy?

4.1 Eligibility Conditions

Insurance Cover will be provided under the Policy for all Members and Employees and their Spouses who meet the Eligibility Criteria, the Age Criteria and the conditions for the relevant types of Insurance Cover, detailed in Section 4.2. This Insurance Cover is only granted if the Insurer is provided with the relevant information with respect to that Member, Employee or Spouse (if Insurance Cover is applicable).

Where the person meets all these conditions they will be an Eligible Person under the Policy.

See Sections 24.1 and 24.2 for more information about the Eligibility Conditions for ROSP.

Insurance Cover for Eligible Persons starts in accordance with Section 5.

4.2 What TPD insurance options are available?

The TPD definition available to Eligible Persons may vary according to the specific categories of employment status and the Benefit type chosen. The following table is a general guide to eligibility criteria for particular TPD definitions. These eligibility criteria may be tailored.

	TPD Definitions		
The Eligible Person is:	**TPD (Standard)**	**TPD (Alternate)**	**TPD (Own Occupation)#**
1. Applying for insurance under ROSP and is a Member	✔	Must be approved by the Trustee	Not available
2. Applying for insurance under Corporate Group Life and is:			
2.1 A Permanent Employee	✔	✔	✔
2.2 A Contractor contracted to the Employer for a minimum of 15 hours each week for a continuous 6 month period.	✔	✔	Not available
2.3 A Spouse who is Gainfully Employed: • on a permanent full-time or permanent part-time basis; or • under a written contract of services for a minimum of 15 hours each week for a continuous six month period, and is paid salary and Superannuation Guarantee Contributions under their contract.	✔	✔	Not available
2.4 A Casual Employee, contractor* or Spouse not meeting the criteria in 2.1 to 2.3 above.	Not available	✔	Not available

* These are Eligible Persons who are employed under a contract for services with the Employer but do not meet the definition of Contractor set out in Part 3.
The TPD definition(s) and the applicable Eligibility Criteria which apply under the Policy will be stated in the Policy Schedule or Employer Plan Schedule.
The applicable TPD definition will be determined by examining at the time of claim the claimant's employment status in accordance with the Policy Schedule or Employer Plan Schedule.

\# Own Occupation TPD definition not available if policy owned by a superannuation trustee.

Section 5: When Insurance Cover starts

This section does not apply to ROSP

5.1 Commencement of Insurance Cover

For Corporate Group Life, the Insurer will provide Insurance Cover for an Eligible Person and it will commence on the latest of the following:

- the date they first become an Eligible Person and meet the conditions for Automatic Acceptance (see Section 6);
- the Takeover Date if the Insurer has agreed to provide them Insurance Cover under Takeover Terms (see Section 7);
- the date the Insurer advises the Eligible Person they have been Underwritten and accepted for Insurance Cover (see Section 8); or
- the date from which there is an increase in the Eligible Person's Insurance Cover (in respect of the increased amount).

Where the Eligible Person obtains Insurance Cover under the Policy they will be an Insured Person.

See Section 23 for more information about when membership of the Fund for the purposes of ROSP commences. Additionally, see Section 26 for information about when Insurance Cover under ROSP commences.

Section 6: Automatic Acceptance

6.1 What is Automatic Acceptance?

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

6.2 Conditions for Automatic Acceptance of Insurance Cover

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

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

6.3 When are Eligible Persons entitled to Automatic Acceptance?

Automatic Acceptance applies to Eligible Persons at the earliest of:

- the Policy Commencement Date where the Eligible Person was entitled to be covered at that date; or
- the date the Member, Employee or Spouse became an Eligible Person although the Policy Owner or Trustee must inform the Insurer at the next Annual Review of the Policy that the Member, Employee or Spouse was an Eligible Person. For ROSP, the Employer has a corresponding duty to provide this information to the Trustee.

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

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

6.4 Future automatic increases in Insurance Cover

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

6.5 When can the AAL be changed?

The AAL will apply for the duration of the Premium Rate Guarantee Period. However, if there has been a change in the Eligibility Criteria, Benefit structure or a change of 25% or more in the number or occupational profile of Insured Persons under the Policy or a particular Membership Category, We reserve the right to increase or decrease the amount of the AAL, by giving the Policy Owner written notice.

Any Insurance Cover already provided will not be reduced or adversely affected by any change in the AAL.

6.6 How do changes in AAL affect existing Insurance Cover?

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

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

Section 7: Takeover of Insurance Cover

7.1 What are Takeover Terms?

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

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

The Insurer's practice is to adhere to FSC Group Insurance Takeover Terms under FSC Guidance Note No. 11.00. However, there may be certain circumstances where alternate Takeover Terms may be required. In either case, where Takeover Terms apply to any Transferring Members, the terms will be stated in the Policy Schedule or Employer Plan Schedule.

7.2 Conditions for providing Takeover Terms

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

- the Policy Owner provides the Insurer with all the information the Insurer needs about the operation and terms of the previous policy in writing including, but not limited to, names, type and amount of insurance cover and any individual Underwriting acceptance terms provided by the previous insurer no later than 90 days after the Takeover Date, unless the Insurer agrees otherwise;
- the Policy Owner provides the Insurer with the names of Eligible Persons who are not At Work due to an illness or injury on the last working day immediately prior to the Takeover Date, unless the Insurer agrees otherwise;
- the terms and conditions of the Policy including the Maximum Benefit Limit and conditions for Automatic Acceptance (see Section 6.2) of the Insurance Cover, if any, will apply;
- where the AAL applicable to the previous policy is the same as the AAL applicable to the Policy, any specific exclusions and loadings applied to Insurance Cover provided by the previous insurer will continue to apply under the Policy; and
- where the AAL applicable to the previous policy is lower than the AAL applicable to the Policy, the AAL applicable for all persons insured under the previous policy may be automatically increased to the new AAL level and any specific exclusions and loadings which applied to Insurance Cover provided by the previous insurer will only apply to Insurance Cover above the AAL applicable to the Policy.

Takeover Terms will not be available if the cover with the previous insurer included TPD cover provided through superannuation under an own occupation definition. There is no TPD (Own Occupation) available within superannuation for TPD cover first taken out on or after 1 July 2014.

7.3 Waiver of Underwriting premium loadings on takeover

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

Section 8: Underwriting

8.1 When Underwriting is required

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

- no AAL is applicable to the Eligible Person under the Policy;
- an AAL applies but the Eligible Person does not satisfy the conditions for Automatic Acceptance set out in Sections 6.2 and 6.3;
- the Eligible Person is seeking Insurance Cover based on the Insurance Formula above the AAL, including when the Insurance Cover above the AAL is being reinstated (see Section 12.3) or any Forward Underwriting Limit, in which case Underwriting will only apply to the Insurance Cover above that amount; or
- the Eligible Person is applying for Voluntary Cover.

8.2 Applications for Insurance Cover requiring Underwriting

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

While being Underwritten, an Eligible Person will be provided Interim Cover (see Section 10).

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

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

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

8.3 Acceptance terms of Underwritten Insurance Cover

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

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

The Insurer will also notify the Eligible Person in writing if:

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

8.4 Waiver of Underwriting premium loadings

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

Section 9: Voluntary Cover and Life Events Cover

9.1 What is Voluntary Cover?

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

9.2 Applying for Voluntary Cover

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

9.3 Life Events Cover

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

9.4 When is Life Events Cover available?

Life Events Cover is available to Insured Persons in any of the following circumstances, subject to the conditions set out in Section 9.5:

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

9.5 Conditions for Life Events Cover

Life Events Cover can be provided to an Insured Person in any of the circumstances set out in Section 9.4 above, subject to all the following conditions:

- the Insured Person is already covered for the Benefits for which the Life Events Cover relates;
- the Insurer receives a Life Events Cover application completed by the Insured Person to the Insurer's satisfaction together with satisfactory / certified evidence of the occurrence of the relevant event set out in Section 9.4 above, within 90 days of the relevant circumstance and prior to their death, Terminal Illness or Date of Disablement;
- the Insured Person is less than 60 years of age at the date the Insurer receives a completed application for Life Events Cover;
- the Insured Person has not previously had an application for Insurance Cover declined;
- the Life Events Cover application being accepted by the Insurer in writing;
- the payment of the applicable additional premiums;
- during the first 6 months after the Insurer has accepted the application, Limited Cover only will apply to the Life Events Cover provided as a result of the application; and
- an application for Life Events Cover can only be made by an Insured Person once in any 12 month period.

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

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

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

Section 10: Interim Cover

10.1 What is Interim Cover?

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

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

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

10.2 Interim Cover limits

The Interim Cover will be limited to the lesser of:

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

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

10.3 When Interim Cover starts

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

10.4 When Interim Cover ceases

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

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

10.5 When an Interim Cover Benefit isn't payable

A Benefit under Interim Cover is not payable:

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

Section 11: Benefits

11.1 Benefits payable

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

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

- Insurance Cover based on the Insurance Formula calculated at the date set out in Sections 11.2, 11.3 or 11.4 plus any Voluntary Cover; and
- the Maximum Benefit Limit.

11.2 Payment of a death Benefit

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

11.3 Payment of a Terminal Illness Benefit

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

11.4 Payment of a TPD Benefit

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

11.5 Tapering of TPD Benefits

Tapering of TPD Benefits may apply to the TPD Insurance Cover which has been calculated in accordance with the Insurance Formula.

If tapering applies it will gradually reduce the TPD Benefit to zero by the Benefit Expiry Age. The method of tapering and the ages at which tapering applies will be stated in the Policy Schedule or Employer Plan Schedule.

Section 12: Employer-approved leave

12.1 Continuation of Insurance Cover during paid leave

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

12.2 Continuation of Insurance Cover during unpaid leave

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

- for Employees and Contractors, there is documented agreement with the Employer, or for Spouses with their own employer, of a return to work date;
- in the case of a Contractor, when they commenced the leave they had an existing contract with the Employer providing for a period of service of no less than 6 continuous months;
- the period of Employer-approved unpaid leave commences on the first day of that leave;
- continued payment of premiums during the period of unpaid leave; and
- the conditions of cessation of Insurance Cover (see Section 17).

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

If any of the above conditions are not met, Insurance Cover will cease for the Insured Person on the day prior to the commencement of the agreed period of leave, subject to the Extended Cover (see Section 15).

The applicable TPD definition will be determined at the time of claim and hence may differ from the TPD definition which applied to the Insured Person at the time Insurance Cover commenced in respect of the Insured Person (see Section 4.2).

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

Subject to the conditions above, where the Insured Person does not return to work by the end of the 24 month period, or the end of any extended period beyond the 24 month period agreed in writing by the Insurer, all Insurance Cover will cease at the end of the relevant period (see Section 17). If the person would like to reinstate their Insurance Cover, they will need to be Underwritten.

12.3 Insurance Cover when premiums were not paid during unpaid leave

If an Insured Person goes on a period of unpaid leave and premiums are not paid in respect of all or part of that period, then Insurance Cover will cease on the day prior to the commencement of the period of unpaid leave, unless cover has ceased earlier (see Section 17).

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

- Limited Cover will apply to Insurance Cover up to the AAL from the date of return to work until they have been At Work for 60 consecutive days, after which time Full Cover will apply; and
- Underwriting is required for any Insurance Cover above the AAL (see Section 8).

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

12.4 After operational deployment on active service as a reservist

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

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

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

Section 13: Overseas cover

13.1 Overseas cover

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

- the Insured Person continues to be employed by the Employer or a Related Entity;
- the Insured Person's premium continues to be paid to the Insurer by the Policy Owner;
- where the Insured Person is a Spouse, the Spouse has not commenced employment overseas with a new employer unless otherwise agreed by the Insurer; and
- Insurance Cover has not ended (see Section 17).

Overseas cover is subject to compliance with the terms and conditions of the Policy (see Sections 13.2 and 13.3).

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

- Limited Cover will apply to Insurance Cover up to the AAL from the date the premium is paid until they have been At Work for 60 consecutive days, after which time Full Cover will apply; and
- Underwriting is required for any Insurance Cover above the AAL (see Section 8).

13.2 Underwriting overseas

In addition to the Underwriting requirements set out in Section 8, the Insurer does not require an Insured Person overseas to return to Australia to be Underwritten. The Insurer may reimburse part or all of these costs at their discretion.

13.3 Assessment of a claim overseas

In addition to the claim requirements set out in Section 19 where a claim for a Terminal Illness or TPD Benefit payment arises for an Insured Person and they are overseas during the assessment of the claim, the Insurer will require them to provide supporting medical evidence to the Insurer's satisfaction to enable assessment of their eligibility for payment.

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

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

Section 14: Restrictions on Benefit payments

14.1 Exclusions on Voluntary Cover and Life Events Cover

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

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

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

14.2 Reduction of Benefit payments in certain circumstances

If the Insurance Formula takes the Superannuation Account Balance into account in determining an Insured Person's Insurance Cover and the Insured Person transfers all or part of their Superannuation Account Balance to another superannuation fund, the Insurer will reduce the Insured Person's Benefit by the amount of the Superannuation Account Balance transferred from the superannuation fund.

14.3 Misstatement of age

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

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

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

14.4 Maximum Benefit Limit

The Insurer will limit any Benefit payable to an Insured Person to the Maximum Benefit Limit stated in the Policy Schedule.

14.5 Non-compliance with Duty of Disclosure

The Insurer may be legally entitled to limit or withhold Benefits, or to adjust Benefits or premiums, if the Policy Owner or any Insured Person has not complied with the Duty of Disclosure as set out in Sections 21.5 and 25.

14.6 Unpaid premiums

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

Section 15: Extended Cover

15.1 What is Extended Cover?

Extended Cover is Insurance Cover which continues to be provided, without charge, for up to 60 days after the Insured Person ceases to be an Employee. Extended Cover is subject to the conditions set out in this Section 15.

15.2 When does Extended Cover start?

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

15.3 When Extended Cover ceases

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

- 60 days after the Insured Person ceases to be an Employee;
- the Benefit Expiry Age;
- the date an application for a Continuation Option is accepted or declined by the Insurer (see Section 16);
- the date they obtain insurance for the same or similar Benefits; and
- the date Insurance Cover ends (see Section 17).

15.4 Extended Cover for Spouses

This section does not apply to ROSP

Spouses will be eligible for Extended Cover subject to the conditions set out in Sections 15.1, 15.2 and 15.3 when their spouse (who is employed by the Employer) ceases to be an Employee.

Section 16: Continuation of Insurance Cover option

16.1 What is a continuation of Insurance Cover option?

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

16.2 Conditions for a continuation of Insurance Cover option

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

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

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

16.3 Continuation of Insurance Cover option for Spouses

This section does not apply to ROSP

Spouses who have Insurance Cover will be eligible to apply for a Continuation Option, subject to the conditions set out in Sections 16.1 and 16.2 as though these conditions are applicable to them, when their spouse (who is employed by the Employer) ceases to be an Employee.

Section 17: When Insurance Cover for an Insured Person ceases

17.1 Cessation of Insurance Cover

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

- the date they reach the Benefit Expiry Age;
- subject to the Extended Cover (see Section 15.3), the date they cease to be an Employee;
- for Spouses, subject to Extended Cover (see Section 15.4), the date their spouse ceases to be an Employee;
- for Spouses, the date they commence employment overseas with a new employer unless otherwise agreed by the Insurer;
- the date they ceased to be a Contractor with a written contract of services to the Employer for a minimum of 15 hours each week for a continuous 6 month period;
- the date any Extended Cover ceases (see Section 15);
- the date of their death;
- the date a Terminal Illness Benefit becomes payable for them;
- the date a TPD Benefit becomes payable for them;
- the date they do not meet the conditions for continuation of Insurance Cover during unpaid leave (see Section 12.2);
- the date they no longer meet the conditions for continuation of Insurance Cover while overseas (see Section 13);
- the date before they commence active service in the armed forces of any country, not including normal activities as a reservist with the Australian Defence Force, but including operational deployment on active service with the Australian Defence Force;
- the date an individual life insurance policy is issued to them by the Insurer under a Continuation Option (see Section 16);
- in respect of any Interim Cover provided under Section 10, the date any Interim Cover ceases for them;
- the date they change to a new Membership Category which offers a lower level of Insurance Cover than their previous Membership Category, for the amount in excess of their new Insurance Cover;
- the date the Insurer is advised that the Insured Person no longer wishes to be an Insured Person under the Policy;
- the date the Insurer is advised that the Insured Person wishes to have their Insurance Cover reduced, in respect of the amount reduced;
- when premiums are unpaid (see Section 20.4);
- the Policy Termination Date (see Section 18.2); or
- the date the relevant Employer Plan terminates (for ROSP); or
- the date they no longer meet the Eligibility Criteria.

Section 18: When the Policy ends

18.1 Duration of the terms and conditions of the Policy

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

- the Policy Owner terminating the Policy by providing the Insurer with 30 days' written notice prior to the Policy Termination Date;
- the Insurer terminating the Policy, after having provided the Policy Owner at least 30 days' written notice of its intention to do so, due to the Policy Owner's failure to pay the required premiums (see Section 20);
- the Insurer terminating the Policy, after having provided the Policy Owner at least 30 days' written notice of its intention to do so, due to the Policy Owner's failure to provide the Insurer with adequate information at the Annual Review of the Policy to allow the Insurer to calculate the correct premiums;
- the Insurer terminating the Policy, after having provided the Policy Owner with at least 30 days' written notice of the Insurer's intention to do so, if less than 10 persons have Insurance Cover (in which case the Insurer would allow those persons to apply for a Continuation Option within 60 days of the Policy Termination Date);
- payment of the last Benefit of the last Insured Person;
- the Insurer terminating the Policy, after providing the Policy Owner at least 30 days' written notice of the Insurer's intention to do so, due to the Policy Owner's failure to comply with the Policy Owner's obligations set out in Section 3.7; or
- Insurance Cover ends for all Insured Persons.

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

18.2 End of Insurance Cover when the Policy ends

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

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

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

- the date the Insured Person is next At Work; and
- the date Insurance Cover would end under Section 17, excluding the Policy Termination Date.

18.3 No value on termination

The Policy has no value on termination.

Section 19: Claims

19.1 Conditions for payment of a claim

Payment of a claim under the Policy is conditional upon all of the following conditions:

- the Insurer's claim requirements being met (see Section 19.3);
- any legislative requirements being met; and
- the person making the claim is entitled to the Benefit under the terms and conditions of the Policy.

19.2 Notification of a claim

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

19.3 Claim requirements

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

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

19.4 Claim review

If the Insured Person or Policy Owner is not satisfied with a decision to deny a claim, they may have the claim reviewed.

Please see information on complaints under Sections 21.3 and 21.4.

19.5 Fraudulent claims

The Insurer may cancel the cover of an Insured Person or Policy Owner if either party makes a fraudulent claim.

Section 20: Premiums

20.1 Premium Rates

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

The Policy Owner must pay at least the Minimum Premium, if any.

20.2 Calculation and payment of premiums

The Insurer will advise the Policy Owner of the premium payable at the commencement of the Policy.

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

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

If, as a result of the recalculation of the premium, the Policy Owner has paid too much, the Insurer will use the overpayment to offset the amount against the next premium due, assuming the Policy is to be renewed. Otherwise, the Insurer will return the amount the Policy Owner has overpaid.

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

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

20.3 When the premiums must be paid

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

20.4 When premiums are unpaid

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

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

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

See Section 22.4 for information about unpaid premiums under a ROSP Policy.

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

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

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

20.5 When the Insurer can change the premium

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

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

- the information the Policy Owner has provided the Insurer (see Section 1.2) is not accurate, in which case the Insurer will give the Policy Owner at least 30 days' prior written notice and any change would be effective from the date specified in the written notice;
- the Insurer reserves the right to re-rate the Policy if the premiums are deducted from the Employee's annual base Salary, therefore the Policy is not fully funded by the Employer; and
- a Minimum Premium of $15,000 per annum applies to the Policy, irrespective of annual premium calculated based on the age and/or unit rate at each Annual Review. The Minimum Premium excludes all forms of third-party payments and all form of government taxes and/or levies.

Section 21: Additional information

21.1 Privacy

The way in which We collect, use, secure and disclose personal and sensitive information about individuals (including an Eligible Person or Insured Person) is explained in Our Privacy Policy which is available at www.tal.com.au/privacy.aspx or is free of charge on request. Our Privacy Policy contains details about the following:

- the kinds of personal and sensitive information ("personal information") that We collect and hold;
- the purposes for which We collect, hold, use and disclose personal information;
- how individuals 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 individuals may have regarding privacy issues.

We take reasonable steps to protect and secure the information that We hold against unauthorised access, loss, unauthorised disclosure, interference and misuse. We have processes in place to identify, remediate, manage and, where required, to report privacy and data breaches in accordance with current privacy legislation, Our data breach response plan and the requirements of the Office of the Australian Information Commissioner.

Personal and sensitive information will be collected from or about individuals 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 an individual wants to make a claim and We need to collect health and/or financial information. If individuals do not supply the required information, We may not be able to provide the requested product or service or pay the claim.

Individuals are generally entitled to access the personal information We hold about them with limited exceptions, including but not limited to, if We reasonably believe that giving access would pose a serious threat to the life, health or safety of any individual, or to public health or public safety.

Any privacy related questions or complaints can be sent to Us using the contact details at the end of this document or to Our customer service team using the details below:

1300 351 133

customerservice@tal.com.au

www.tal.com.au

GPO Box 5380, Sydney NSW 2001

Additional information about privacy rights and obligations can be found at the website of the Privacy Commissioner at www.oaic.gov.au including their processes for handling privacy related complaints.

21.2 Queries regarding the Policy

This section does not apply to ROSP

The Insurer will always aim to quickly and satisfactorily answer any questions and resolve any problems or complaints regarding the Policy.

From time to time questions may arise about insurance. The Insurer's customer service consultants are familiar with the product and are happy to answer any questions. A customer service consultant is available by calling 1800 130 869.

21.3 Complaints on a non-superannuation Corporate Group Life Policy

This section does not apply to ROSP

If You, as an Insured Person, have a complaint in relation to a Policy that is not owned by a superannuation fund, You can write to:

Complaints Manager
TAL Life Limited
GPO Box 5380, Sydney NSW 2001

The Complaints Manager will attempt to resolve the complaint within 45 days from the date it is received. If the complaint is unable to be resolved within that period, the Complaints Manager will inform You of the delay and ask for consent to resolve the complaint within 90 days from the date it was received.

If the complaint has not been resolved to Your satisfaction within 45 days of the Insurer receiving the initial complaint (or, if agreed, within 90 days) You may contact the Australian Financial Complaints Authority (AFCA).

AFCA provides fair and independent financial services complaint resolution that is free to consumers.

Online: www.afca.org.au

Email: info@afca.org.au

Phone: 1800 931 678 (free call)

In writing:
Australian Financial Complaints Authority
GPO Box 3, Melbourne VIC 3001

21.4 Complaints on a Corporate Group life Policy owned by a superannuation fund

This section does not apply to ROSP

If You as a member of a superannuation fund have a complaint in relation to a Policy that is owned by a superannuation fund, You should address Your complaint to the trustee of that fund. That trustee will provide You with details of its complaints-handling procedures.

21.5 Duty of Disclosure

Before You enter into a life insurance contract, You have a duty to tell Us anything that you know, or could reasonably be expected to know, may affect Our decision to insure You and on what terms.

You have this duty until We agree to insure You.

You have the same duty before You extend, vary or reinstate the contract.

You do not need to tell Us anything that:

- reduces the risk We insure You for; or
- is common knowledge; or
- We know or should know as an insurer; or
- We waive Your duty to tell Us about.

If the insurance is for the life of another person and that person does not tell Us everything they should have, this may be treated as a failure by You to tell Us something that You must tell Us.

In exercising the following rights, We may consider whether different types of cover can constitute separate contracts of life insurance. If they do, We may apply the following rights separately to each type of cover.

If You do not tell Us anything You are required to, and We would not have insured You if You had told Us, We may avoid the contract within 3 years of entering into it.

If We choose not to avoid the contract, We may, at any time, reduce the amount You have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if You had told Us everything You should have. However, if the contract has a surrender value, or provides cover on death, We may only exercise this right within 3 years of entering into the contract.

If We choose not to avoid the contract or reduce the amount you have been insured for, We may, at any time vary the contract in a way that places Us in the same position We would have been in if You had told Us everything You should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If Your failure to tell Us is fraudulent, We may refuse to pay a claim and treat the contract as if it never existed.

See Section 25 for further details of the Duty of Disclosure for Members and/or Employers in relation to ROSP.

21.6 Ongoing electronic disclosure

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

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

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

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

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

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

21.7 Notices

Any notice the Insurer gives to the Policy Owner or the Policy Owner gives to the Insurer, must be:

- in writing, by email or facsimile; and
- to the address most recently advised by You or Us, as relevant.

A notice which is delivered personally, electronically (email) or sent by facsimile is treated as being given on the day it was received and a notice which is posted is treated as being given 3 days from the date of posting.

If the Policy Owner advises the Insurer that they have appointed an agent or broker to act on their behalf in respect of the Policy, the Insurer will give notices to the agent or broker, including premium notices, and they will be deemed to have been given to the Policy Owner. Any notice provided to the Insurer by their agent or broker will be deemed to have been given by the Policy Owner.

21.8 Currency

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

21.9 The Insurer may inspect the Policy Owner's records

The Insurer may inspect and take copies of any records the Policy Owner, their agents or representatives have, which the Insurer believes are relevant to the Policy. If the Insurer does this, it will do so during normal working hours and give reasonable notice of the inspection.

The Insurer will continue to reserve this right after termination of the Policy until the later of:

- 2 years after the Policy Termination Date; and
- the settlement of all claims under the Policy.

21.10 Statutory Fund

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

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

21.11 Governing law

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

The Policy is valid and effective only to the extent that it complies with any laws, regulations or licensing requirements (whether Australian or otherwise) that may apply to Us, including but not limited to the *Life Insurance Act 1995* (Cth) and *Insurance Contracts Act 1984* (Cth).

21.12 Government taxes and charges

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

21.13 Taxation – points to consider

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

A superannuation fund should consider whether certain TPD definitions are tax deductible when choosing TPD insurance options.

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

3 Part 2: Risk Only Super Plan (ROSP) Information

Section 22: About ROSP

22.1 Introduction

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

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

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

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

Please refer to the following sections in Part 1 for information on:

- the Policy and Policy Owner: Inside front cover under the heading 'The Policy and Trustee';
- the Insurer: Inside front cover;
- the Statutory Fund: Section 21.10.

22.2 How ROSP works

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

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

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

22.3 Identification requirements

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

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

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

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

22.4 Unpaid contributions

If the Employer does not pay the superannuation contributions that the Fund requires to cover the cost of premiums payable under the Policy within 30 days after the premium due date advised by the Insurer to the Trustee, the Insurer and Trustee shall provide the Member(s) with written notice of termination of their Insurance Cover through the Fund if the required superannuation contributions are not received within a further 30 days.

If the required superannuation contributions are not received, the Member's Insurance Cover will cease on the date immediately after the end of the period for which all premiums have been paid. Members should speak with their Employer to ensure that superannuation contributions are made by the required date.

22.5 Cooling off period

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

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

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

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

Section 23: ROSP membership

23.1 Commencement of membership

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

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

See Section 26 for information about when a Member's Insurance Cover commences.

Section 24: Who can have Insurance Cover in ROSP?

24.1 Eligibility Conditions

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

Please refer to the following sections of Part 1 for information on:

- AAL: Sections 6.1, 6.3 and 6.4;
- Applying for Insurance Cover: Section 8;
- Interim Cover: Section 10.

24.2 Who is eligible for Insurance Cover under ROSP?

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

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

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

Section 25: Duty of Disclosure

25.1 Duty of Disclosure for Members and/or Employers

The Trustee has a duty to disclose to the Insurer every matter that it knows, or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk of insurance and, if so, on what terms. The same duty applies before the Insurance Cover is renewed, extended, varied or reinstated. A Member and/or Employer has a corresponding duty to disclose such matters to the Trustee.

See Section 21.5 for further information.

Section 26: When Insurance Cover starts in ROSP

26.1 Commencement of Insurance Cover

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

- the date the Member first becomes an Eligible Person and meets the conditions for Automatic Acceptance (see Section 6);
- the Takeover Date if the Insurer has agreed to provide Insurance Cover under Takeover Terms (see Section 7);
- the date the Insurer advises the Member they have been Underwritten and accepted for Insurance Cover (see Section 8); or
- the date from which there is an increase in the Member's Insurance Cover (in respect of the increased amount).

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

Please refer to the following sections in Part 1 for information on:

- Eligibility: Section 4;
- When Insurance Cover ceases: Section 17;
- Continuation Option: Section 16.

Section 27: Benefits

27.1 Benefits payable

When a Benefit is payable under the Policy, it will be payable subject to the terms and conditions of the Policy. The Benefit is paid to the Trustee as the Policy Owner. Subject to superannuation law and the Fund's governing rules, the Trustee will pay a corresponding benefit from the Fund to or in respect of the Member.

See Section 11 for information about Benefit payments.

Please refer to the following sections in Part 1 for information on:

- Death Benefit: Section 11.2;
- Terminal Illness Benefit: Section 11.3;
- TPD Benefit: Section 11.4;
- TPD tapering: Section 11.5;
- Limit on Benefit increases: Section 6.4;
- When Benefits are excluded or withheld: Section 14;
- Overseas cover: Section 13;
- Insurance Cover during Employer approved leave: Section 12;
- How to make a claim: Section 19;
- Overseas claim assessment: Section 13.

Section 28: Payments

28.1 Additional premiums for Voluntary Cover

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

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

28.2 Employer reserve accounts in ROSP

An Employer reserve account is established in the Fund for each Employer to receive Employer contributions which are to cover the cost of premiums payable from the Fund in respect of its Employees.

On the review date for the Employer Plan, the contributions are allocated to Members and an adjustment is then made based on the Members employed at the end of the review period. The details of contributions and adjustments are shown on a Member's annual statement each year.

28.3 Fees and other costs

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

Section 29: Additional superannuation information

29.1 Joining the Fund

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

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

29.2 Trust Deed

The Fund is governed by rules set out in the Trust Deed dated 1 June 1989 as amended. The Trust Deed and the superannuation law govern the Trustee's relationship with Members. In the event of any inconsistency between the Trust Deed and this PDS, the Trust Deed will prevail to the extent of the inconsistency.

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

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

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

A copy of the Trust Deed is available free of charge upon request by contacting the Trustee on 1800 130 869. The Trustee may amend the Trust Deed at any time. The Trustee may include any changes in the Fund's Annual Report. The latest Annual Report is available free of charge by calling 1800 130 869 or visiting www.tal.com.au.

29.3 Contributions to the Fund

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

Only Employer contributions are accepted for Members in ROSP. Such contributions may be in addition to any superannuation guarantee, salary sacrifice, or any other mandated contributions for Members.

Where a Member has opted to have Voluntary Cover or Life Events Cover they will need to arrange for the additional contributions to be paid by the Employer.

29.4 Policy Committees

The SIS Act requires the Trustee to take all reasonable steps to ensure that certain Employer Plans with 50 or more Members establish a Policy Committee with equal Member and Employer representation. The Policy Committee solely acts in an advisory capacity and does not take over the duties and responsibilities of the Trustee. The Policy Committee provides an opportunity for Members to enquire about the operation of the Fund and can also act as a communication channel between the Members, Employer and Trustee. A Policy Committee, if formed, must meet at least once every year.

29.5 Beneficiary nomination

Deciding who receives the lump sum superannuation benefit in the event of the Insured Person's death is an important decision.

Members have two options for telling the Trustee to whom and in what proportions they would like their superannuation death Benefit to be paid in the event of their death:

1. Binding nomination; and
2. Trustee discretion; unless otherwise noted on the Member Benefit Certificate.

In either option, a Member may only select dependants under superannuation law to receive their Benefit in the event of their death. The definition of a 'Dependant' includes:

- any spouse, including a de facto spouse of a Member;
- any child including an adopted child or stepchild (under 18 years for taxation purposes);
- any person financially dependent on the Insured Person at the date of the Insured Person's death;
- a person with whom the Member has an 'Interdependency Relationship'.

29.5.1 What is an 'Interdependency Relationship'?

An 'Interdependency Relationship' is defined as where two people (whether or not related by family): have all of the following:

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

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

It is recommended that any beneficiary nomination made by Members be reviewed regularly, particularly if their circumstances change (eg. marriage or divorce). Please refer to Our brochure 'Superannuation Death Benefits at TAL' which can be found on www.tal.com.au, for more information.

29.5.2 Binding nomination
If a Member makes a binding nomination, the Trustee will pay their Benefit from the Fund to each nominee entitled to receive a superannuation death benefit at the time of death. If no binding nomination is held at the time of death, the Trustee will pay the Benefit in accordance with the rules of the Fund.

When making (or amending) a binding nomination, superannuation law requires the application to be signed in the presence of two witnesses. Both of these witnesses need to be over the age of 18 and cannot be beneficiaries under the binding nomination. Members can nominate a spouse, child (regardless of age), person they have an 'Interdependency Relationship' with, or any other person who is dependent on them.

Each binding nomination is only valid for three years, so if this option is chosen, it is the Member's responsibility to renew their nomination and advise the Trustee of appropriate changes. The binding nomination along with the date of expiry will be confirmed to Members on their Annual Statement each year. If a portion of their Benefit cannot be paid to a specified beneficiary for any reason, then that portion of the Benefit will be paid in accordance with the rules of the Fund.

29.5.3 Trustee discretion
In the event of a Member's death, Benefits will be paid to one or more of their 'Dependants' or to their personal representative as determined by the Trustee.

Members can advise the Trustee to whom they would prefer their death Benefit to be paid, however the Trustee has absolute discretion in determining to whom any death benefit will be paid to and is not bound by a Member's preferred beneficiary nomination. However, when making the determination, the Trustee will take into account their preference.

The nomination will be confirmed to Members on their annual statement each year.

29.6 Superannuation and family law

If a Member is married or in a de facto relationship, they and their spouse can split their superannuation interests in the same way other property of the relationship is divided upon a relationship breakdown. Regarding ROSP, the family law allows:

- a Member's Spouse to obtain information about their Benefits in the Fund from the Trustee without the Member's knowledge (the Trustee is prohibited by law from informing the Member that such a request was made and will not pass any information in relation to the Member's present whereabouts to their Spouse); and
- by agreement of the parties to the relationship or by Order of the Family Court, to flag the Member's benefits in the Fund to prevent them from being paid.

If a payment flag still applies to a Member's Benefits at the time they become entitled to a Benefit under ROSP, the Trustee will write to both the Member (or their legal personal representative) and the Member's Spouse to notify them of the situation.

29.7 Superannuation – points to consider

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

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

As circumstances change, so may the tax treatment of Member contributions and any other payments made through the Fund.

29.8 Complaints

From time to time Members may have questions about their Insurance Cover through the Fund.

Procedures are in place to deal with any queries and complaints about the operation and management of the Fund. The opportunity exists for Members to have their complaint dealt with in an appropriate manner should the need arise.

As an initial step, Members should contact the Trustee with their query. If a Member is not satisfied with the response received from the Trustee they can lodge a complaint in writing to:

TAL Superannuation Limited
Complaints Resolution Manager
GPO Box 5380, Sydney NSW 2001

The Complaints Resolution Manager will attempt to resolve the complaint within 90 days from the date it is lodged. If there are special circumstances the Trustee will seek the Member's agreement to extend this time frame.

29.8.1 Australian Financial Complaints Authority (AFCA)
As the Policy has been issued through the Fund, Members may also choose to have their complaint addressed by AFCA. If a Member is not satisfied with the response to their complaint, or after 90 days they have not received a response to their complaint, they may make a complaint to AFCA.

AFCA provides fair and independent financial services complaint resolution that is free to consumers.

Online: www.afca.org.au

Email: info@afca.org.au

Phone: 1800 931 678 (free call)

In writing:
Australian Financial Complaints Authority
GPO Box 3, Melbourne VIC 3001

Section 30: Summary of taxation information for ROSP

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

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

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

30.1 Contributions

Employer contributions are generally tax deductible to the employer where they are made for the purpose of providing superannuation benefits for an employee or the employee's 'Dependants' (see Section 29.5).

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

There is an annual cap for the amount of concessional contributions which may be made to a superannuation fund by, or on behalf of, a Member. The concessional contributions cap for the 2018/2019 financial year is $25,000 for individual Members regardless of their age. From 1 July 2019, Members with superannuation account balances less than $500,000 who have not fully used their concessional contributions cap in previous years, may make extra concessional contributions above the cap. The unused cap can be carried forward on a rolling basis for up to five years. Members should obtain independent professional advice regarding this.

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

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

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

If a Member is a low income earner and has eligible concessional superannuation contributions, the Fund may be eligible for the low income superannuation tax offset. If the offset is received by the Fund, the amount needs to be transferred to another superannuation fund where the Member has an accumulation interest.

30.1.1 Death and TPD Benefits

Premiums paid by the Fund should be deductible to the Fund.

If there is a claim on the Policy and a death or TPD Benefit is paid to the Fund, this payment should not be assessable to the Fund and the subsequent payment to the Member or their beneficiary or estate will be non-deductible.

If a lump sum death Benefit is received by a beneficiary who is considered a dependant of the deceased Member for tax purposes, or the deceased Member's estate where the beneficiaries are dependants for tax purposes of the deceased, the amount paid is tax free.

Lump sum death Benefits paid to non-dependants for tax purposes are taxed at 15% plus the Medicare levy (for elements taxed in the Fund) or taxed at 30% plus the Medicare levy (for elements untaxed in the Fund, such as insurance proceeds).

As the taxation law upon which the information in this section is subject to change, Members should obtain their own independent taxation advice in relation to this.

Where a TPD Benefit is received by a Member, it will be taxed as a superannuation lump sum. This lump sum may be made up of two components:

- Tax-Free - this amount is tax free when taken as a lump sum;
- Taxable - comprising the total payment reduced by the Tax-Free component. The taxable component is split into taxed and untaxed elements. The tax treatment of the taxed element depends on the Member's age at the date of payment and the amount withdrawn, which at the date of this PDS is as follows:

Age	Tax 2018-2019 Financial Year
Aged 60 and above	Tax Free
Your preservation age up to age 59	The first $205,000* is tax free. The amount over $205,000* is taxed at the Member's marginal tax rate up to a maximum tax rate of 15% (plus Medicare Levy).
Below Preservation Age	The whole amount is taxed at the Member's marginal tax rate up to a maximum tax rate of 20% (plus Medicare Levy)

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

30.1.2 Terminal Illness

Members under the age of 60 who are diagnosed with a Terminal Illness may access their superannuation and will be exempt from tax on their lump sum payment if it is withdrawn within 24 months of certification.

Members should obtain their own independent advice in relation to this.

30.2 Providing a TFN

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

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

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

Section 31: Member details

31.1 Keeping Member details up to date

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

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

4 Part 3: Definitions

The following definitions apply to Corporate Group Life and ROSP.

Definition	Meaning
Administration Fee	means the fee for administering a Member's ROSP account in the Fund and can be up to $3.85 per Member per week (indexed). This fee is in addition to the premiums for Insurance Cover and is paid by the Employer.
Age Criteria	means the minimum and maximum entry ages stated in the Policy Schedule.
Annual Review	means the date stated in the Policy Schedule or Employer Plan Schedule.
At Work	means i) where the Eligible Person is: a) a Permanent Employee, a Casual Employee or Spouse who is working at the relevant time and not on leave - he or she is actively performing all the normal duties of their Occupation with the Employer or employer (as applicable) without restriction or limitation due to illness or injury; or b) a Permanent Employee, a Casual Employee or Spouse who is not working at the relevant time or is on leave approved by the Employer or employer (as applicable) - he or she is, in the Insurer's opinion, capable of performing all the normal duties of their Occupation with their Employer or employer (as applicable) without restriction or limitation due to illness or injury; and ii) not receiving or not entitled to receive income support benefits from any source including workers' compensation benefits, statutory transport accident benefits or disability income benefits. An Eligible Person who does not meet these requirements will be described as not At Work.
Australian Resident	means a person who permanently resides in Australia or resides in Australia on a temporary working visa as agreed by the Insurer.
Automatic Acceptance	see Section 6.
Automatic Acceptance Limit (AAL)	means the maximum amount of Insurance Cover based on the Insurance Formula, provided without Underwriting. The AAL will be stated in the Policy Schedule or Employer Plan Schedule.
Benefit	means the death and/or TPD Insurance Cover as stated in the Policy Schedule or Employer Plan Schedule (for ROSP). Terminal Illness and Interim Cover are Benefits provided under the terms and conditions of the Policy but will not be stated in the Policy Schedule or Employer Plan Schedule.
Benefit Expiry Age	means the maximum age to which a Benefit will be provided as set out in the Policy Schedule or Employer Plan Schedule.
Casual Employee	means an Eligible Person who is Gainfully Employed by the Employer on a casual basis.
Continuation Option	see Section 16.
Contractor	means an Eligible Person under a written contract of service with the Employer (or for Spouse with their employer) for a minimum of 15 hours each week for a continuous 6 month period and is, under the contract, having Salary and Superannuation Guarantee Contributions paid in respect of them.
Corporate Group Life	means group life insurance provided by the Insurer, including group life insurance issued to a superannuation fund trustee other than ROSP.
Date Of Disablement	means the date which a Medical Practitioner certifies in writing as the date that the Insured Person ceased work as a result of an illness or injury which is the principal cause of the TPD for which a claim is made, and the Insurer is satisfied, on medical or other evidence, that this is the date that the Insured Person ceased work as a result of an illness or injury which is the principal cause of the TPD for which that claim is made.
Duty Of Disclosure	see Section 21.5. For ROSP, see Sections 21.5 and 26.
Eligibility Conditions	mean the conditions stated in Sections 4.1 and 4.2 which need to be met in order for Insurance Cover to be provided under the Policy.
Eligibility Criteria	means the criteria for a Membership Category stated in the Policy Schedule or Employer Plan Schedule.
Eligible Person	means a person who meets all the conditions of Sections 4.1 and 4.2 and other requirements to be eligible for Insurance Cover as stated in the Policy Schedule or Employer Plan Schedule when their Insurance Cover commences.
Employee	means a person who is Gainfully Employed by the Employer.
Employer	means the entity stated in the Policy Schedule or Employer Plan Schedule employing Eligible Persons under the Policy.
Employer's Default Superannuation Fund	means the superannuation fund recognised as such for the purposes of the Superannuation Guarantee (Administration) Act 1992 or successor statutes.
Employer Plan	For ROSP, means a group of Members employed by an Employer.
Employer Plan Schedule	means for ROSP only, the document issued by the Insurer to the Employer, stating specific details relating to the Employer Plan, including any Special Conditions.

Definition	Meaning
Endorsement	means any written amendment to the terms and conditions of the Policy the Insurer agrees with and provides to the Policy Owner.
Extended Cover	see Section 15.
Forward Underwriting Limit	means the maximum level, advised after Underwriting, to which Insurance Cover for an Eligible Person can increase, based on the Insurance Formula, without further Underwriting.
FSC	means Financial Services Council.
Full Cover	means Insurance Cover for any illness or injury after the person was nominated for Insurance Cover, where the Insurance Cover is not affected by the date the illness became apparent or the injury occurred.
Fund	means TAL Superannuation and Insurance Fund.
Gainfully Employed	means working for reward in an Occupation (which can include a contract for services) without restriction due to illness and injury.
Insurance Cover	means the Benefits provided under the terms and conditions of the Policy.
Insurance Formula	means the calculation method for Insurance Cover elected by the Employer or Policy Owner and agreed by the Insurer as stated in the Policy Schedule or Employer Plan Schedule.
Insured Person	means any Eligible Person for whom Insurance Cover has been provided by the Insurer.
Interim Cover	see Section 10.
Life Events Cover	see Section 9.
Limited Cover	means Insurance Cover is only payable for claims arising directly from an illness or injury which first occurs or is diagnosed or the signs or symptoms first become apparent, after the date the Insurance Cover commenced, was reinstated or increased under the Policy. Benefits arising directly or indirectly by a self-inflicted act are not payable under Limited Cover.
Maximum Benefit Limit	means • an amount as determined by the Insurance Formula as stated in the Policy Schedule or Employer Plan Schedule; and • the maximum Benefit amount the Insurer will pay in respect of an Insured Person as set out in Part 1 under 'Availability of cover' on page 4.
Medical Practitioner	means, unless the Insurer agrees otherwise: a) a medical practitioner legally qualified and registered to practice in Australia; or b) if the claimed condition is a mental health condition, it is to be diagnosed in accordance with the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the definition of a medical practitioner means a person who is legally qualified and registered as a practising psychiatrist by the relevant medical registration boards and/or the Specialist Recognition Advisory Committee coordinated through the Australian Health Insurance Commission. Chiropractors, physiotherapists, psychologists or alternative health providers are not regarded as Medical Practitioners. The Medical Practitioner cannot be: i) the Insured Person; ii) the Insured Person's spouse/partner in a de facto relationship; iii) a close family relative of the Insured Person; iv) business associates or partners of the Insured Person; v) fellow security holders in the same company/trust (ignoring publically listed entities); or vi) an employer or employee of the Insured Person.
Member	means a person admitted by the Trustee as a member of the Fund under the Fund's governing rules.
Member Benefit Certificate	means, for Members, a part of the welcome letter that outlines the features that their Employer has chosen.
Membership Category	means the common group set out in the Policy Schedule or Employer Plan Schedule to which Insured Persons belong because of their Occupation and/or their employment status, or because they are a Spouse.
Minimum Average Hours	means an Insured Person who is a Contractor or a Spouse and has worked a minimum of 15 hours per week for the 3 months immediately prior to the Date of Disablement. The 3 month period may be adjusted as follows: • where an Insured Person returns from an agreed period of leave, it will include time prior to the commencement of the agreed period of unpaid leave if 3 complete months have not elapsed prior to the Date of Disablement; • where an Insured Person has been working for less than 3 months, the equivalent period will be the time since commencement with the Employer to the Date of Disablement.

Definition	Meaning
Minimum Premium	means the minimum annualised premium, as detailed in Section 20.5 and stated in the Policy Schedule or Employer Plan Schedule.
Occupation	means the primary duties for which the Eligible Person is paid a Salary.
On Risk Letter	means written advice issued by the Insurer advising agreement to provide Insurance Cover.
Own Occupation	means the Occupation in which the Insured Person has spent the majority of their time undertaking with the Employer immediately prior to the Date of Disablement.
Permanent Employee	means the Eligible Person is Gainfully Employed by the Employer on a permanent full-time or permanent part-time basis.
Personal Statement	means an application form issued by the Insurer for the purpose of Underwriting an Eligible Person for Insurance Cover.
Policy	For Corporate Group Life, means the terms and conditions in this PDS together with the other documents specified in Section 3.3 such as the Policy Schedule. For ROSP, means the documents as specified in Section 22.1.
Policy Commencement Date	means the Policy Commencement Date stated in the Policy Schedule or Employer Plan Schedule and the On Risk Letter.
Policy Owner	means the Policy Owner stated in the Policy Schedule or Employer Plan Schedule.
Policy Schedule	means the document issued by the Insurer to the Policy Owner, stating specific details relating to the Policy, including any Special Conditions.
Policy Termination Date	means the date the Policy ends on the earlier of when the Insurer receives written notice from the Policy Owner and as set out in Section 18.1.
Premium Frequency	means the frequency of premium payments, that is, annually, half-yearly, quarterly or monthly, as stated in the Policy Schedule or Employer Plan Schedule.
Premium Rate Guarantee Period	means the period stated in the Policy Schedule or Employer Plan Schedule during which Premium Rates will not be increased by the Insurer other than in the circumstances set out in Section 20.5.
Premium Rates	means the cost of the Insurance Cover stated in the Policy Schedule or Employer Plan Schedule and used to calculate the premiums for Insurance Cover.
Professional	means an Insured Person who: • has recognised tertiary qualifications relevant to their Own Occupation; • is a member, or eligible to be a member of a professional or government body where that membership is needed for engaging in their Own Occupation; • has a base Salary of at least $100,000 per annum; and • works in a sedentary capacity, primarily in an office environment.
Related Entity	means a related body corporate of the Employer.
ROSP	means Risk Only Super Plan.
Salary	means the remuneration components paid by the Employer to an Eligible Person at the relevant time, as stated in the Policy Schedule or Employer Plan Schedule (for ROSP). The following conditions apply: • where the Policy Schedule or Employer Plan Schedule (for ROSP) states that bonuses and/or commissions are included, they will be averaged over the 3 years preceding the last Annual Review date or any shorter period during which they have been paid for the Eligible Person, unless otherwise stated in the Policy Schedule or Employer Plan Schedule; • where the Insured Person owns (either indirectly or directly) all or part of the business including all or part ownership through another legal entity, Salary shall mean the regular income earned from the Insured Person's personal exertion after the deduction of all attributable business expenses incurred in earning the income. Income will not include investment income, profit distributions or similar payments that may continue in the event of disability, unless otherwise stated in the Policy Schedule or Employer Plan Schedule. For the purposes of determining the amount of cover used in the premium calculation in respect of an Insured Person, the relevant time is the last Annual Review. For the purposes of determining the amount of Benefit a person can claim with respect to an illness or injury which occurred whilst they had Insurance Cover under the Policy, the relevant time is the date immediately prior to the Date of Disablement.
SIS Act	means *Superannuation Industry (Supervision) Act 1993* (Cth).
Special Conditions	means variations and modifications to the Policy or Employer Plan agreed by the Insurer and stated in the Policy Schedule or Employer Plan Schedule.

Definition	Meaning
Spouse	means for Corporate Group Life, a person, including a person of the same sex, who is legally married to an Eligible Person or in a legally recognised de facto relationship with the Eligible Person. A spouse of an Insured Person is also an Eligible Person where the Insured Person elected for their spouse to have Insurance Cover for the type of Insurance Cover determined by the Policy Owner, as stated in the Policy Schedule.
Superannuation Account Balance	means the dollar amount of the Insured Person's superannuation account to which the Employer makes contributions on the Insured Person's behalf.
Takeover Date	means the date stated in the Policy Schedule or Employer Plan Schedule where Takeover Terms apply.
Takeover Terms	means the Takeover Terms, if any, stated in the Policy Schedule or Employer Plan Schedule, under which the Insurer agrees to provide Insurance Cover as was provided for Transferring Members by a previous Insurer.
Terminal Illness	means an Insured Person suffers any condition that: a) two appropriate Medical Practitioners approved by the Insurer (at least one of whom is a specialist) certifies in writing, having regard to the current treatment or such other treatment as the Insured Person may reasonably be expected to receive, will despite reasonable medical treatment likely lead to the Insured Person's death within 12 months of the date of certification; and b) the Insurer is satisfied, on medical or other evidence, will despite reasonable medical treatment lead to the Insured Person's death within 12 months of the certification referred to in paragraph a).
TFN	means Tax File Number.
We, Us, Our	means the TAL group of companies.

Definition	Meaning
TPD, Total and Permanent Disablement, Totally and Permanently Disabled	means one of the following: 1. TPD (Own Occupation) – if selected, not available to ROSP or within superannuation. An Insured Person to whom the TPD (Own Occupation) applies as stated in the Policy Schedule, employed in a Permanent Employee capacity in their Own Occupation at the Date of Disablement, and has since been unable to work solely because of illness or injury for a continuous period of at least 6 months, and is in the Insurer's opinion unlikely ever to be able to work in his or her Own Occupation; or otherwise satisfies the definitions below of TPD (Standard) or TPD (Alternate). 2. TPD (Standard) An Insured Person to whom the TPD (Standard) applies as stated in the Policy Schedule or Employer Plan Schedule, employed in a Permanent Employee capacity, or as a Contractor or a Spouse for the Minimum Average Hours per week, at the Date of Disablement, and has since been unable to work solely because of illness or injury for a continuous period of at least 6 months, and is in the Insurer's opinion unlikely ever to be able to work in any occupation for which they are reasonably suited by training, education or experience; or otherwise satisfies the definition below of TPD (Alternate). 3. TPD (Alternate) A. An Insured Person is, in the Insurer's opinion, totally and permanently unable to perform at least two of the following five activities of daily living without the physical assistance of another person: a) bathing – to shower or bathe; b) dressing – to dress or undress; c) feeding – to eat and drink; d) toileting – to use a toilet; e) mobility – to get in and out of bed or a chair or move from place to place without using a wheelchair. or B. An Insured Person has suffered the total and permanent loss of the use of: a) both feet, both hands or sight in both eyes; or b) any combination of two of, a hand, a foot, or sight in an eye. Where "loss of the use of" means: i) the loss of the use of the whole hand or the whole foot, from the wrist or ankle joint; or ii) sight to the extent that visual acuity in the eye, on a Snellen Scale after the correction by a suitable lens, is less than 6/60. or C. The Insurer has determined, directly or indirectly as a result of illness or injury a total and permanent deterioration or loss of mental capacity has required the Insured Person to be under continuous care and supervision by another adult for at least 6 consecutive months and, at the end of that 6 month period, the Insurer considers that they are likely to require permanent ongoing continuous care and supervision by another adult person. And for TPD Standard and TPD Alternate, when structured through superannuation, the Insured Person must also satisfy the SIS Regulations definition of Permanent Incapacity. Current as at the date of this PDS, the SIS definition of Permanent Incapacity is as follows: Permanent Incapacity in relation to a member of a superannuation fund means ill-health (whether physical or mental), where the trustee is reasonably satisfied that the member is unlikely, because of the ill-health, to engage in gainful employment for which the member is reasonably qualified by education, training or experience. Note: For those Insured Persons who had taken out TPD cover through superannuation prior to 1 July 2014, the Total and Permanent Disablement/Totally and Permanently Disabled definition as set out in the PDS dated 1 December 2012 will continue to apply.
Transferring Member	means any Eligible Person for whom the Insurer agrees to provide Insurance Cover under Takeover Terms.
Trustee	means TAL Superannuation Limited.
Underwriting And Underwritten	means the process the Insurer undertakes to assess an application by an Eligible Person for Insurance Cover including reference to information concerning their medical, health and employment.
Voluntary Cover	means Insurance Cover which is not based on the Insurance Formula and for which an Eligible Person makes an application, if stated as being provided in the Policy Schedule or Employer Plan Schedule.
War	means an act of war, whether declared or not, armed aggression by a country or organisation resisted by any country or organisation or civil disturbance.
You, Your	means the reader of this PDS.

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