Company Funded Income Protection

Northern Star Resources provide an important insurance benefit to their employees. If you have received this flyer from Human Resources you may be eligible for income protection, providing you and your family peace of mind in case of illness, accident & injury.

Please confirm with your appropriate HR personnel if you are covered by this policy and refer to the Policy Document for specific details.

NORTHERN STAR
RESOURCES LIMITED

Key Benefits

- Employees are covered up to 75% of salary plus 10.5% super
- 90 day waiting period
- Benefit paid up to 2 years
- 24 hour worldwide cover
- Maximum entry age is 64, cover ceases at age 65

Additional Benefits

- Automatic cover up to a salary of $210,526 pa (base plus super). If your cover exceeds this amount, contact Gallagher for medical underwriting forms
- Total & Partial disability cover for Injury or Illness
- Workplace modification
- Emergency transport
- Rehabilitation expense benefit
- Family care
- Bereavement benefit if an insured member dies while on claim to three times their monthly benefit
- Continuation option available on leaving employer, conditions apply

For more information or a copy of your policy, contact Anthony Warman at Gallagher or speak with your employer.

T (08) 6250 8308 | **E** anthony_warman@ajg.com.au

P 1300 557 782
E super-service@ajg.com.au
gallagherbenefits.com.au

Please note the above information is provided as a simplified summary of the Company Group Salary Continuance Insurance policy.

The Policy Document remains the definitive authority on all policy matters. In the event that there is a discrepancy between the details provided above and the Policy Document the latter will prevail.

Gallagher

Insurance | Risk Management | Consulting

MLC Group Salary Continuance

Policy document

Version 2: 3 October 2016

MLC Limited
ABN 90 000 000 402
AFSL 230694

Registered Office:
105-153 Miller Street
North Sydney NSW 2060

Telephone: 02 8908 6111

Website: mlc.com.au
Email: groupsales@mlc.com.au

Contents

Important information

- Your contract of insurance with us comprises:
  - the terms contained in this document and the accompanying Schedule; and
  - any annexures issued under this Policy.
- Certain terms commencing with capital letters are terms that are defined in the definitions section of the Policy.
- The details of your cover are set out in the Schedule. The Schedule contains, but is not limited to, the Policy Commencement Date, your Policy name and number, the Eligibility Terms described on page 6, the Annual Renewal Date, the Premium rates, whether a profit share rebate applies and any special terms attached to the Policy.

  Where special terms are noted in the Schedule and they differ from this Policy document, the terms as set out in the Schedule will prevail.
- A reference to 'you' or 'your' means the Policy owner set out in the Schedule who will receive payment of all Benefits and pay all Premiums under the Policy.
- References to 'we', 'our' or 'us' means MLC Limited – ABN 90 000 000 402 AFSL 230694 whose Head Office is at 105–153 Miller St, North Sydney NSW, 2060.
- The minimum numbers to set up a Group Insurance Policy is 10 insured lives, but if the group is a manufacturing group the minimum is 100 insured lives. If the group falls below the minimum of 10 insured lives, Automatic Acceptance may be withdrawn from the Policy. The minimum annual Premium for a Policy is $10,000.
- The maximum Monthly Benefit, including the Employer superannuation contribution Benefit (if applicable), that may be offered is $30,000. (note: the maximum Monthly Benefit may increase in excess of $30,000 by indexation (if applicable) while an Insured Member is claiming a Benefit, (refer to 'increasing benefits/indexation' on page 3)
- Superannuation Law limits the circumstances when superannuation funds can pay Benefits. This may mean that a Benefit payment will need to be kept in the fund until it can be paid under Superannuation Law.

  Where the Policy Owner is a superannuation fund, as indicated in the Schedule, we recommend that you seek independent expert advice if you have any concerns about whether a payment may be paid from the fund.
- If takeover terms are noted as applicable in the Schedule then takeover terms apply as per IFSA Guidance Note No. 11.00, 'Group Insurance Takeover Terms', unless otherwise agreed.
- There may be different categories of Insured Members under this Policy. These are described in the Schedule, and any Eligibility Terms applying to each category are set out in the Schedule.

  A person who meets Eligibility Terms applying to a category, and who is nominated by you for that category, may become an Insured Member in that category. If there is more than one category under this Policy, the terms of cover and maximum levels of cover may vary depending on the particular category. Where this is the case, it is noted in the Schedule.
- All headings in this Policy are for ease of reference only.
- While insurance Benefits generally do help reduce financial loss, there is a risk that an insurance product may not be suitable or adequate for your employees' or members' needs. To help prevent this you should read this Policy document carefully and consult your financial adviser to assess your insurance needs. When replacing insurance, it is recommended you do not cancel an existing insurance arrangement until the replacement insurance is in place.
- Any stamp duty or other government charges levied from time to time in relation to this Policy (including any duty or charges on Premiums) must be paid by you. We will advise you of any amount payable.
- This Policy is designed purely for insurance protection. Unlike some other types of life insurance that have investment or savings components, it will never have a surrender or cash value.
- No authorised representative, broker or financial adviser may change this Policy without our consent or the consent of the Policy owner. Any requested changes will only be valid if we confirm the changes in writing.
- The Premiums are placed in our Statutory Fund No 1.

  An MLC Group Insurance Policy does not represent a deposit with or a liability of National Australia Bank Limited ABN 12 004 044 937 AFSl 230686 or any of its related bodies corporate. Neither National Australia Bank Limited, nor any of its related bodies corporate guarantees or accepts liability in respect of MLC Group Insurance.

Policy Terms – Insurance Benefits

Total Disability Benefit

If an Insured Member becomes Totally Disabled while this Policy is in force in respect of that Insured Member, we will, subject to the terms of this Policy (including the Schedule), pay the Insured Member's Monthly Benefit. The Total Disability Benefit will accrue from the end of the Waiting Period and be paid monthly in arrears or as otherwise agreed by us, until the earliest of the following:

- the date Total Disability ceases;
- the date the Insured Member attains the Ceasing Age stated in the Schedule;
- the date of death of the Insured Member;
- the end of the Benefit Period stated in the Schedule;

If the Insured Member attempts to return to work during the Waiting Period and;

- the return to work proves unsuccessful due to the injury or Illness causing Total Disability; and
- the period of return to work is less than five (5) days in total within the Waiting Period,

then the original Waiting Period will continue and will be extended by the number of days the Insured Member returned to work within the Waiting Period.

Partial Disability Benefit

If an Insured Member becomes Partially Disabled while this Policy is in force in respect of that Insured Member, we will, subject to the terms of this Policy (including the Schedule), pay a Partial Disability Benefit

The Partial Disability Benefit will accrue at the end of the Waiting Period and is payable monthly in arrears or as otherwise agreed by us.

The Partial Disability Benefit will be calculated according to the formula;

$$\frac{A-B}{A} \times C$$

where:

A: is the Insured Member's Monthly Income, or Restricted Monthly Income, immediately prior to Total Disability commencing.

B: is the actual Monthly Income earned by the Insured Member during the month in which he or she is Partially Disabled.

C: is the Insured Member's Monthly Benefit.

The Partial Disability Benefit will cease on the earliest of the following:

- the date the Insured Member ceases to be Partially Disabled;
- the Insured Member reaches the Ceasing Age stated in the Schedule;
- the date of death of the Insured Member;
- the end of the Benefit Period stated in the Schedule;
- the date the Monthly Income earned by the Insured Member equals or exceeds their Monthly Income, or Restricted Monthly Income, immediately prior to Total Disability commencing.

Rehabilitation Expense Benefit

If Total or Partial Disability Benefits are being paid for an Insured Member, we may meet any expense incurred on behalf of the Insured Member as a result of their participation in a rehabilitation program. The conditions of payment of this Benefit are:

- the rehabilitation program must be approved by us in writing before the program expenses are incurred;
- the rehabilitation program must be approved by the Insured Member's Doctor; and
- the maximum amount that may be payable shall not exceed twenty-four (24) x the Monthly Benefit, less any amount that can be claimed from any other source for those expenses.

The expenses must be incurred to directly assist the Insured Member in returning to work in a gainful occupation or in undertaking a vocational retraining program because of their disability. Any payment of this expense will be made at our discretion.

Bereavement Benefit

If an Insured Member dies while either Total or Partial Disability Benefits are being paid, then we will pay you a lump sum amount equivalent of three (3) times the Insured Member's Monthly Benefit from the date of the Insured Member's death.

Policy Terms – Insurance Benefits

Family Carer Benefit

The family carer Benefit will be paid if a member of the Insured Member's family leaves permanent employment to care for an Insured Member who is suffering a Total Disability, for which Benefits are being paid. This additional Benefit may be payable for a maximum period of six (6) months. The Benefit amount will be the lesser of:

- the amount we estimate the carer would have earned if the Insured Member had not been disabled; or
- a maximum Benefit amount of $2,000 per month.

This Benefit accrues and payment will commence from the later of the end of the Waiting Period and the date the family member terminates employment to care for the Insured Member. This Benefit is only payable while the Insured member continues to receive Total Disablility Benefits.

The family member must not have been employed by the Insured Member or be an employee of an entity under the control of the Insured Member or of which the Insured Member is a Principal or Director.

Workplace Modification Benefit

If Total or Partial Disability Benefits are being paid for an Insured Member we may pay you an additional Benefit up to a maximum amount of two and a half (2.5) times the Insured Member's Monthly Benefit for the purpose of modifying the Insured Member's workplace to facilitate their return to work.

Any payment of this Benefit will be made at our discretion and the expense must be approved by us in writing before the expense has been incurred.

Emergency Transport Benefit

If an Insured Member has an Illness or injury which results in Total or Partial Disability we will reimburse the emergency transportation costs incurred up to a maximum amount of $500. This Benefit will not be payable if the emergency transport costs are payable from any other source.

Bed Confinement Benefit

If the bed confinement Benefit is applicable as set out in the Schedule, we will pay you an additional Benefit if the Insured Member is suffering a Total Disability, and during the Waiting Period, the Insured Member is:

- confined to bed for more than three (3) consecutive days on the advice of a Doctor; and
- during the period of bed confinement the Insured Member receives full time nursing care which is certified by a Doctor to be necessary for the treatment of an injury or Illness; and
- the nursing care is given by a registered nurse who is acceptable to us and who is not the Insured Member or spouse, family member, business partner, employee or Employer of the Insured Member.

This Benefit will be payable for each period of bed confinement in excess of three (3) consecutive days during the Waiting Period, up to a maximum of 180 days or the applicable Waiting Period, whichever is lesser.

The amount payable will be one-thirtieth of the Insured Member's Monthly Benefit for each consecutive day of confinement in excess of the initial three (3) days for each period of bed confinement.

This Benefit will not be paid if the specified illness Benefit or advance payment for specific injuries Benefit is payable or has been paid for the Insured Member.

Increasing Benefits/ Indexation

If increasing Benefits/indexation is applicable as set out in the Schedule, the indexation of Benefits will apply if we have been continuously paying you a Monthly Benefit for an Insured Member for 12 months. After 12 consecutive months, we will then increase the Monthly Benefit payable by the lower of the annual percentage increase in the Consumer Price Index (CPI) and 5 per cent or 7.5 per cent, as set out in the Schedule. We will increase the amount by the same method again after each 12 month period as long as we are continuously paying a Monthly Benefit because the Insured Member is suffering a disability.

When we stop Benefit payments for that Insured Member, the Monthly Benefit will revert to the Monthly Benefit determined in accordance with the Schedule, or as otherwise varied from time to time.

Specified Illness Benefit

If a specified illness Benefit is applicable as set out in the Schedule, the specified illnesses covered under this Benefit are:

- Heart Attack
- Coronary Artery Bypass Surgery
- Malignant Cancer
- Stroke
- Chronic Kidney Failure
- Multiple Sclerosis
- Blindness
- Major Brain Injury
- Burns
- Major Organ Transplant

Please refer to definitions section on page 16 for the meaning of these terms. In some cases a condition must progress to a certain level before it meets the definition.

If an Insured Member is Totally Disabled due to any of the above listed specified illnesses, we will pay an amount equivalent to the Insured Member's Monthly Benefit during the Waiting Period and as an additional amount from the end of the Waiting Period to a maximum period being six (6) months less the Waiting Period.

This Benefit is only available on a Policy with a 30, 60 or 90 day Waiting Period.

The payment of this Benefit is subject to the following conditions:

- the specified illness Benefit is not payable where the specified illness was in any way caused by, or related to or required to, due to an Illness that had been diagnosed, or of which the Insured Member should have been reasonably aware of, prior to cover commencing in respect of the Insured Member
- the specified illness Benefit is not payable where any of the following specified illnesses first appeared, first happened or were first diagnosed during the first three (3) months after cover commenced in respect of the Insured Member:

  1. Heart Attack
  2. Coronary Artery Bypass Surgery
  3. Malignant Cancer
  4. Stroke

The specified illness must be diagnosed by a Doctor who is an appropriate specialist and may be required to be confirmed by our medical adviser.

This Benefit is payable only once in respect of any specified illness. If an Insured Member sustains two (2) or more specified illnesses (which are related or arose directly or indirectly from the same cause) we will only pay this Benefit once and no further payment of this Benefit will be made.

This Benefit will not be paid if the bed confinement Benefit or advance payment for specific injuries Benefit is payable or has been paid for the Insured Member.

Policy Terms – Insurance Benefits

Advance payment for specific injuries

If the advance payment for specific injuries Benefit is applicable as set out in the Schedule and an Insured Member suffers one of the specific injuries shown in the following tables, while the Policy remains in force, in respect of that Insured Member, we will make a lump sum payment in advance even if the Insured Member continues to work.

The Waiting Period does not have to end before payment can be made.

If one incident causes more than one of the injuries outlined in the following tables, we will pay only for the single injury which entitles an Insured Member to the largest Benefit.

The advance payment will be an amount equal to the Insured Member's Monthly Benefit multiplied by the period of months shown as the applicable specific injury Benefit Period in the following tables. Note where the Waiting Period is greater than thirty (30) days the advance payment is calculated by deducting the relevant Waiting Period from the specific injury Benefit Period.

Specific injury	30 day Waiting Period	30+ day Waiting Period
Loss of use of[1]:	**Specific Injury Benefit Period**	**Specific Injury Benefit Period**
Both hands or both feet or the sight of both eyes	24 months	24 months less the relevant Waiting Period
A hand and a foot	24 months	24 months less the relevant Waiting Period
A hand or foot and the sight of one eye	24 months	24 months less the relevant Waiting Period
An arm or a leg	18 months	18 months less the relevant Waiting Period
A hand or foot or the sight in one eye	12 months	12 months less the relevant Waiting Period
Thumb and index finger on the same hand	6 months	6 months less the relevant Waiting Period

1 The loss of use of must be complete and permanent and it must occur within 181 days of the injury.

Payment in respect of the following fractures will not apply where the Waiting Period, as shown in the Schedule, is greater than 60 days.

If the Insured Member has a complete fracture[2] of any of the following:	30 day Waiting Period	60 day Waiting Period
	Specific Injury Benefit Period	**Specific Injury Benefit Period**
Thigh (shaft)	3 months	1 month
Pelvis (except the coccyx)	3 months	1 month
Skull (except face or nose bones)	2 months	n/a
Upper arm (shaft)	2 months	n/a
Shoulder blade	2 months	n/a
Lower leg (shaft)	2 months	n/a
Kneecap	2 months	n/a
Collar Bone	1.5 months	n/a
Forearm (shaft)	1.5 months	n/a

2 A 'complete' fracture is a fracture which extends through the entire thickness of the bone. The fracture must be diagnosed within thirty (30) days of the injury that caused it.

If the Insured Member continues to suffer Total Disability or Partial Disability after the end of the applicable specific injury Benefit Period shown in the above tables, Monthly Benefits will accrue from the later of the end of the specified injury Benefit Period or the end of the Insured Member's Waiting Period and will be payable monthly in arrears. The Insured Member's maximum Benefit Period will be reduced by the period for which advanced payments were made.

This Benefit will not be paid if the bed confinement Benefit or specific illness Benefit is payable or has been paid for the Insured Member.

Employer Superannuation Contribution Benefit

If an employer superannuation contribution Benefit is applicable as set out in the Schedule, we will increase the Monthly Benefits otherwise payable by the percentage amount stated in the Schedule of the Insured Member's Monthly Income. The maximum employer superannuation contribution Benefit that is available is 15% of the Insured Member's Monthly Income.

This additional payment is to cover the cost of any employer superannuation contributions payable by you or the Employer to the superannuation fund in respect of the Insured Member. This Benefit is payable in addition to the Monthly Benefit provided under this Policy, subject to our maximum Benefit limits and may also be proportionally reduced where Partial Disability Benefits apply.

The employer superannuation contribution Benefit will cease from the earlier of the time the Insured Member's employment ceases and/or you would otherwise cease to make contributions to the superannuation fund in accordance with the terms of the superannuation fund trust deed or by law and when Total or Partial Disability Benefit payments cease for the Insured Member. The terms that apply to the payment of Total and Partial Disability Benefits in this Policy also apply to the payment of this Benefit.

Worldwide Cover

The cover described in this Policy is provided to Insured Members 24 hours a day on a worldwide basis. However, unless the Insured Member is continuously residing in Australia or one of the following approved countries; Belgium, Canada, Denmark, France, Germany, Hong Kong, Italy, Japan, the Netherlands, New Zealand, Singapore, Sweden, Switzerland the United Kingdom, the United States of America or any other country we may agree to in writing, the payment of Benefits to the Insured Member will be subject to the following conditions:

- payment of continuous Benefits will be limited to 12 months from the date of the Insured Member's disability; and
- after expiration of the 12 month period, no additional Benefits will be payable to you unless and until the Insured Member returns to Australia or one of the approved countries.

If the Insured Member returns to Australia or an approved country and they are still Totally or Partially Disabled in accordance with the terms of the Policy, Benefits may be reinstated effective from the date they return to Australia or one of the approved countries.

Parental Leave / Leave of Absence

Insurance cover under this Policy may be continued for up to twenty-four (24) months while an Insured Member is on Employer approved leave of absence or parental leave, providing:

- immediately prior to commencing the period of leave the Insured Member was 'At Work';
- the Insured Member does not join the armed forces (excluding Australian Defence Force Reservists not deployed overseas);
- Premiums continue to be paid in respect of that Insured Member;
- the Insured Member remains Employed by the Employer or remains a member of the superannuation fund.

Any Benefit payable will be based on the Monthly Income notified by you and accepted by us before commencement of such leave by the Insured Member. If an Insured Member applies for additional cover while on leave, Underwriting Terms apply and the increased cover does not commence until we provide written acceptance and the Insured Member returns to work.

Should cover need to be extended beyond the initial twenty-four (24) month period our written approval will be required at least 60 days before the expiry of the initial twenty-four (24) month period. We have discretion on whether to approve an extension of cover beyond twenty-four (24) months.

If any of the events on page 10, 'Cessation of Cover/Extended Cover' occur in respect of the Insured Member before the end of the proposed period of Parental Leave or Leave of Absence, cover will cease in respect of that Insured Member and we will refund any portion of the overpaid Premium.

If an Insured Member suffers a Total Disability while on such leave the Benefit will become payable from the later of:

(a) the end of the Waiting Period; or
(b) the nominated date of return to work of the Insured Member.

Exclusions

Benefits are not payable under this Policy in respect of an Insured Member for disability or loss arising directly or indirectly from:

- any intentional self-inflicted injury or attempted suicide, whether the Insured Member was sane or insane;
- normal and uncomplicated pregnancy or childbirth;
- war or warlike operations;
- service in the armed forces (excluding Australian Defence Force Reservists not deployed overseas); or
- any other event or matter referred to in the Schedule or otherwise by way of a special condition noted in the Schedule.

Automatic Acceptance and Eligibility Terms

Automatic Acceptance Level ('AAL')

'Automatic Acceptance' means that we will agree to accept Eligible Persons for cover not exceeding the AAL, without the need for medical or other evidence, provided they meet the Eligibility Terms noted on this page.

Automatic Acceptance Levels may be granted by us under this Policy subject to at least 75% of all persons in the group actually becoming Insured Members. If overall membership of the Policy falls below 75% we may withdraw Automatic Acceptance on the Policy.

Eligibility Terms

The Eligibility Terms for determining who you can nominate for automatic insurance cover under this Policy are set out below and in the Schedule. To be considered as eligible for cover under this Policy an Eligible Person must be:

- 'At Work' and performing the normal duties of their Occupation on the date they are eligible for cover. If the Eligible Person is not 'At Work' on this date, you must provide us with written notification advising the dates and reason they were not 'At Work';
- under the Ceasing Age;
- Employed by the Employer or a member of the Fund;
- nominated to join within 30 days of first becoming eligible for cover;
- engaged in permanent Employment or Fixed Term Employment and working 15 hours or more per week; and
- an Australian resident unless otherwise agreed with us. For the purposes of this term, an "Australian resident" means a person who:
  - has always lived in Australia or has come to Australia to live; and
  - is eligible to work in Australia.

If the person goes overseas temporarily and does not set up a permanent home in another country, the person may continue to be treated as an Australian resident.

An Insured Member engaged in Fixed Term Employment will be entitled to a minimum Benefit Period of two (2) years or the term of their contract, whichever is the greater. Seasonal workers or contractors who are not Fixed Term employees are not eligible for any insurance cover.

When does an Eligible Person become an Insured Member?

If an Eligible Person meets the terms for Automatic Acceptance they become an Insured Member when we advise you in writing, with effect from the date they are eligible for cover.

If an Eligible Person does not meet the terms of Automatic Acceptance, eg: is not 'At Work' on the date that the insurance cover would otherwise have become effective, then we may require Evidence of Insurability in respect of that Eligible Person and cover would only take effect when we notify you that the request for insurance in respect of that Eligible Person has been accepted from the date of that notice.

Evidence of Insurability / Underwriting Terms

Where an Eligible Person is not eligible for Automatic Acceptance or an Insured Member's cover exceeds the Automatic Acceptance Level (AAL) and they apply for cover or an increase in cover above the AAL, we will only agree to accept the Eligible Person or Insured Member on certain conditions. We refer to this as "Underwriting Terms".

Underwriting Terms apply when:

- the person does not meet the Eligibility Terms;
- the amount of the cover, or any increase in the cover, exceeds the AAL shown in the Schedule. Underwriting Terms apply in respect of the amount that is in excess of the AAL;
- the increase in cover exceeds the Insured Member's Forward Underwriting Level (FUL). Underwriting Terms apply in respect of the amount in excess of the FUL;
- the Insured Member's salary increases by more than 30% in any 12 month period. Any increase in excess of 30% may be subject to Underwriting Terms;
- the AAL is nil. In this case Underwriting Terms apply in respect of the total amount of cover;
- the Eligible Person does not comply with the terms for Automatic Acceptance set out on page 6 and in the Schedule. In this case Underwriting Terms apply in respect of the total amount of cover and any subsequent increases in cover;
- an increase in cover is other than as a result of the Policy's agreed Benefit Formula;
- the insured amount for an Insured Member is reduced to nil for a period of time, and subsequently reinstated. In this case Underwriting Terms apply in respect of the total amount of cover and any subsequent increases in cover.

What happens if Underwriting Terms apply?

If Underwriting Terms apply, we will only consider whether to provide the cover, or an increase in cover, if the Eligible Person or Insured Member completes the Evidence of Insurability forms and provides information requested by us for our assessment. We will tell you what information we need and will meet any medical costs for requirements we have requested, provided a request for insurance has been submitted to us.

We have the discretion whether to approve the cover, and/or any increase in the cover and we will notify you of our decision after assessment of the Evidence of Insurability forms and information has been completed. If we accept the cover, we will also tell you:

- of any special terms applied to the cover;
- when the cover starts;
- if we have agreed to the Automatic Acceptance of future increases of cover and the amount of the increase. If we do this, additional underwriting will not apply to those increases up to the agreed higher amount. We call this higher amount the 'Forward Underwriting Level'.

Any application for cover for an Eligible Person or an increase in cover in excess of the AAL for an Insured Member, will only take effect when we notify you that the application in respect of the cover for an Eligible Person or increase in cover for the Insured Member, has been accepted.

We will notify you of any nomination for membership, or application for cover in excess of any AAL that is rejected or which will only be accepted by us on special terms.

General information

Claims

You must notify us in writing as soon as is reasonably practicable of any event entitling you to a Benefit under this Policy including the diagnosis of an Insured Member as having an injury or Illness likely to give rise to that Insured Member's Total Disability:

On receipt of notification of a claim we will provide you with our standard claim forms. The claim forms must be fully completed by the Insured Member, their treating Doctor and the Employer and returned to us as soon as possible. We may request and obtain other such information and documentation that we require to consider and process the claim. A claim will not be processed until all the relevant documentation is received by us.

If the claim is notified to us in writing more than one year after the event giving rise to the claim, and the delay results in our interests being prejudiced, we may not accept liability for the claim or alternatively, we may reduce our liability in respect of the claim to the extent of the prejudice we have suffered. The Policy must have been in force when the events leading to the claim occurred, or we must have agreed in writing otherwise.

You must ensure for the assessment and payment of the claim, that:

- we are provided with satisfactory proof of age of an Insured Member;
- if required by us, we are provided with reports from a Doctor on the medical condition of the Insured Member at such times as we may reasonably require;
- we are provided with any additional information or any other requirements we need to assess the claim.

When a claim is ongoing, entitlements under this Policy will be regularly reviewed monthly or at intervals determined by us and further evidence must be provided by you or the Insured Member on request. We may also ask for further proof if we need to satisfy ourselves that you are entitled to a Benefit payment. Different types of claims may set out special claim requirements.

Any proof or information provided to us is at the Insured Member's cost However, if we require a financial audit, factual interview or a medical examination by a third party we appoint, we will pay for it.

In addition to the above, we reserve the right to conduct an annual review of Benefit payments to ensure the correct Benefits have been paid.

We may deduct taxes, duties or imposts that may apply to Benefits paid under this Policy.

Total or Partial Disability Benefits will only be paid directly to the Insured Member once the Insured Member's employment has been terminated by the Employer and verification of this arrangement has been confirmed to us in writing.

If we don't approve a claim we will tell you in writing the reasons why the claim has been declined.

We reserve the right to list all claims with an insurance reference bureau for the purpose of establishing and obtaining an insurance reference from an insurance claims database.

Recurrent Disability

If a Total or Partial Disability claim recurs within six (6) months of the Insured Member returning to full time work, we will treat the claim as a continuation of the original claim. There is no new Waiting Period so you can claim as soon as the disability recurs. The cause of the disability must be the same or related to the cause of the original disability. This Policy must be in force when the disability recurs. The maximum Benefit Period will apply to the original disability including continuation of that disability.

Limitation of Benefits

The Total Disability and Partial Disability Benefits payable under this Policy will be reduced by any other income which the Insured Member may be entitled to from other sources, whether that income was actually received or not. Income from other sources includes:

- any other income derived as a result of disability from employment under any other insurance policy; and
- any Benefit under any workers' compensation or other similar compensation under state or federal legislation or common law, but not including payments in respect of medical treatment, rehabilitation and permanent impairment or permanent loss of use of a body part; and
- monies paid in respect of any claim for past or future economic loss arising from any claim by the Insured Member for personal injury.

Any income from other sources which is in the form of a lump sum or is commuted for a lump sum, will be treated as a monthly equivalent of one sixtieth (1/60) of the lump sum over a period of sixty (60) months, to calculate the reduction in Monthly Benefits under this Policy.

Income from other sources does not include:

- income earned from investments; and
- any lump sum total and permanent disablement benefit.

The reduction will be sufficient to ensure that the amount we pay in Total Disability or Partial Disability Benefits, together with the aggregate of the other payments or entitlements, will not exceed the Insured Member's Monthly Benefit entitlement.

Benefits payable under the specified illness Benefit under this Policy are not affected by this clause.

When an Insured Member's entitlement to workers' compensation payments is in dispute, we will pay the full amount of the Benefits due under this Policy on a conditional basis until the dispute is resolved. If the Insured Member is declared entitled to workers' compensation payments it is a condition of this Policy that you will repay to us that part of any Benefit payment representing the proceeds received by way of compensation which would otherwise not have been paid, if not for the conditional payment. We may at our discretion obtain payment of this amount by offsetting it against any amounts that may subsequently become due to you.

When and how we will pay Benefits

We will pay a claim for a Total or Partial Disability Benefit and any other Benefits (if any) under this Policy, as applicable, in respect of an Insured Member once we have received satisfactory proof of an entitlement to such a Benefit. Satisfactory proof may include additional information as required by us.

We will pay you the relevant Benefit in respect of an Insured Member monthly in arrears. When only part of a month is being paid, we will calculate this as one thirtieth (1/30th) of the Monthly Benefit for each day the Insured Member is entitled to be paid under the Policy.

Where we are required by law to deduct any tax, duty, impost or the like in connection with the payment of a Benefit, we will deduct the required amount from the payment and forward it to the relevant authority.

When we stop payments

We will stop paying benefits in respect of an Insured Member at the earliest of one of the following events:

- the Insured Member is no longer Totally or Partially Disabled;
- the Insured Member dies, subject to payment of the bereavement benefit;
- the maximum Benefit Period expires;
- the Insured Member attains the maximum insurable age;
- the Insured Member is no longer under the regular and continuous care of a Doctor;
- you or the Insured Member fail to provide us with all requested information and other evidence reasonably required to assess the Insured Member's claim.

When incorrect information is provided to us

We rely on the information provided to us by you and the Insured Member to assess whether we will provide cover for an Eligible Person or pay a Benefit for an Insured Member. If any information provided is not correct or there is a failure on your part or the Eligible Person's or Insured Member's part to comply with the duty of disclosure as described on page 13 of this Policy, we may:

- avoid the Policy if the failure to comply with the duty of disclosure or the misrepresentation of information was fraudulent;
- avoid the Policy within 3 years of the Commencement Date, if we would not have entered into the Policy on any terms had the duty of disclosure been complied with or the misrepresentation not been made;
- vary the Benefit provided under this Policy; or
- if the misrepresentation is in relation to the age of the Eligible Person or Insured Member we may vary the Benefit and/or Premiums payable under this Policy.

General Information

Cessation of Cover / Extended Cover

All insurance cover under this Policy for an Insured Member will cease on the earliest of the following:

- sixty (60) days after the date the Insured Member retires or ceases to be Employed;
- sixty (60) days after the date the Insured Member no longer qualifies as an Insured Member under this Policy;
- the date the Insured Member effects a continuation option under this Policy;
- the date the Insured Member attains the Ceasing Age stated in the Schedule;
- the day before the Insured Member commences service with the armed forces of any country (excluding Australian Defence Force Reservists not deployed overseas);
- the date of the Insured Member's death;
- twenty-four (24) months from the commencement of Employer approved leave of absence by the Insured Member, if such Insured Member has not returned to work or an extension of cover has not been approved by us in writing at least 60 days prior to the expiry of the twenty-four (24) month period; except where the reason why the Insured Member has not returned to work is because he or she has made a claim under this Policy, or is eligible to do so;
- if the Policy is a superannuation Policy, the date the Insured Member ceases to be a contributing member of the Superannuation fund for which this Policy is held;
- the date this Policy terminates or is cancelled.

Termination of this Policy, or the cessation of cover for an Insured Member, shall not prejudice any entitlement to make a claim for an event which happened prior to the cessation of cover.

Where cover has ceased due to the Insured Member effecting a continuation option, any claims arising under this Policy may only be made pursuant to the Policy effected under the continuation option.

Continuation Option

Where an Insured Member who has not attained the age of sixty (60) years ceases to be Employed and is no longer covered under this Policy and is not entitled to, nor is claiming a Benefit under this Policy, then, provided an application for a continuation of cover is made to us within sixty (60) days after the termination of employment, we may issue to the Insured Member an individual policy that is guaranteed to renew annually.

If the Insured Member exercises a continuation option, all cover under this Policy and/or extended cover ceases on commencement of cover under the individual income protection insurance policy.

However, income protection insurance will only be available where the Insured Member has ceased employment to follow employment in a similar occupation in a capacity that would have entitled the Insured Member to an MLC income protection insurance policy.

The following terms will apply to the Insured Member's option to continue cover under an individual MLC income protection insurance policy:

- the Insured Member's cover must have ceased as a consequence of the Insured Member ceasing employment with the Employer or membership of the superannuation fund, and not for reasons of ill health. Continuation of cover is not available where the Insured Member leaves a superannuation fund and there is no change in employment;
- the Insured Member must be commencing full time employment within 90 days of terminating employment;
- the Insured Member has not ceased to be an Insured Member because of duty in the armed forces (excluding Australian Defence Force Reservists not deployed overseas);
- the Benefit will be no more than the entitlement under this Policy and with the same Benefit Periods and Waiting Periods (if available) for individual income protection cover. Any special terms and conditions applying to the Insured Member under the Policy, including loadings or exclusions, will also apply under the individual policy;
- the cover will be provided on the terms, conditions and rates that are current for this type of insurance at the time, and must satisfy our underwriting criteria in relation to occupation, pastimes, smoking status and residency status;
- the individual policy premium will be subject to our normal minimum premium;
- the Insured Member must not have received, nor be eligible to receive, any disability benefits (under a group disability policy) or similar payments under any other policy.
- the Insured Member must be a permanent resident of Australia.

We retain the discretion to refuse to provide cover under the continuation

option where we do not have a retail product which covers the occupational risk of the individual applying for the continuation option.

The premium payable for the individual policy will be based on our standard premium for similar policies taking into account, but not limited to, the Insured Member's Benefit, age, sex, occupation, pastimes and smoking status, residency status and any special terms that apply to the person under this Policy.

Premiums

The initial Premium will be payable on the Commencement Date of the Policy and must be paid within 30 days. Subsequent Premiums will be payable annually in advance on the Annual Renewal Date, although you may vary the terms for payment of Premiums by agreement with us. The frequency of payment of Premiums will be set out in the Schedule. Premiums must be calculated using the Premium rates as set out in the Schedule.

Premium adjustments will be made to the Premium at each Annual Renewal Date to take into account the number of Insured Members at the Annual Renewal Date and any variation in the level of Benefits insured under this Policy over the period since the Policy commenced, or the last Annual Renewal Date.

If as a result of the re-calculation of the Premium, you have paid too much we will refund you the overpayment.

If you have not paid enough, we will notify you in writing of the additional Premium due. We refer to this as the adjustment Premium.

If you have not advised us of any Eligible Persons or Insured Members in the renewal information, they will not be covered by this Policy until:

- you have advised us that the person should have been included; and
- we have agreed to cover the person on such terms as we may determine (including, but not limited to, subjecting the person to Underwriting Terms).

We require you to provide us with Policy renewal information necessary to determine Premiums within a reasonable time frame each year. You must pay a deposit premium equal to the previous year's Premium within 30 days of the Annual Renewal Date, until you provide us with sufficient renewal data for us to determine the updated Premium.

If Premiums are not paid within thirty (30) days of the date they fall due, we will give you notice of our intention to cancel the Policy. If the overdue Premiums have not been paid within a further twenty-eight (28) days of that notice, the Policy will be cancelled and all cover will cease, unless otherwise agreed by us.

All premiums under this Policy must be paid in Australian currency.

You must pay the Premiums for all periods during which the Policy has been in force, including any period of interim accident insurance cover.

A Premium loading will apply if you elect to pay Premiums by any frequency other than annually, as set out in the Schedule.

We reserve the right to recover from you the cost of any duty, tax, excise or other charge of the Commonwealth or any State or Territory Government in respect of this Policy. The Federal Government passed a Goods and Services Tax (GST) legislation effective from 1 July 2000, under which our products are input-taxed. While this means that no explicit GST charge will be directly applied to this Policy, but we do have to pay GST on some of the goods and services involved in its provision. We are not entitled to claim input tax credits for all of the GST we pay, and this will result in increased costs which may be reflected in Premium rates.

Premiums waived during Total or Partial Disability

While Benefits are being paid in respect of an Insured Member's Total or Partial Disability, we will not charge any Premium for cover under this Policy for that Insured Member.

General Information

When we can change the Premium Rates / Automatic Acceptance Levels

We may vary the Premium rates and Automatic Acceptance Level (AAL) at any time if we give you one month's prior notice in writing. Unless otherwise specified in the Schedule, Premium rates will generally remain fixed for a period of three years from the commencement of the Policy. Any variation resulting in higher rates or a reduction in the AAL will not be made within the Premium Rate Guarantee Period set out in the Schedule, unless:

- the number of Insured Members changes by more than 25% within any 12 month period; or
- there are changes to the occupations, countries in which Insured Members are located, or other circumstances affecting Insured Members which leads, in our opinion, to a major change in the risk insured by this Policy; or
- there is a change in any government charge, licence fee, tax or any other impost that is directly attributable to the Policy; or
- there is an invasion or outbreak of war (whether declared or not) in Australia, New Zealand or the Insured Member's country of residence. If you do not pay any such increase we will not pay any Benefits under the Policy in respect of an Insured Member where the event giving rise to the claim arose either directly or indirectly from the invasion or war.

In such cases the changed Premium rates and AAL will apply from the date of our written notice to you. Any alteration to the Premium rates and AAL can only be made once in any 12 month period.

Profit Share Option

You can request to participate in profit sharing by selecting the profit share option in the proposal form. Profit sharing involves us returning some of the Premium paid on the Policy where claims experience has been favourable to us. The availability of profit sharing is at our discretion and subject to the group meeting our criteria and on terms we set out in the Policy Schedule.

Changing the Profit Share Rebate

We may vary the profit share basis and terms on any Annual Renewal Date, including withdrawing the profit share option, provided we give you thirty days written notice. We will not make any variation resulting in a decrease in your profit share within the Premium Rate Guarantee Period set out in the Schedule unless;

- the number of Insured Members changes by more than 25% within the Premium Rate Guarantee Period;
- in our opinion, changes in occupations, countries in which Insured Members are located, or other circumstances affecting the Insured Members leads to a major change in the risk insured by this Policy;
- in our opinion there is a change in any government charge, licence fee, tax or other impost that is directly attributable to this Policy.

In such cases the changed profit share basis and terms will apply from the date of our written notice to you.

Reinstatement

If the Policy is cancelled due to non-payment of Premiums we may at our discretion reinstate it on such terms as we may determine.

Guaranteed Renewal

We guarantee that we will renew this Policy at each Annual Renewal Date, subject to:

- receipt of renewal information satisfactory to us;
- the due observance of all the terms of this Policy;
- payment of Premiums by the due date.

When the Policy ends

You can end this Policy by giving us written notice or we can agree on an earlier termination date with you. If the date of cancellation falls prior to the Annual Renewal Date, we will calculate and may deduct Premiums due and payable for the period the Policy was in force (including any administration expenses) from any Premium refund due to you.

If the Policy is cancelled, we will only consider a claim if:

- the event which gave rise to the claim occurred before the Policy was cancelled;
- the Insured Member has not been engaged in any paid employment since cover ceased under this Policy;
- cover for the event which gave rise to the claim has not been taken over by a new insurer;
- any Premium arrears have been paid up to the date the Policy was cancelled.

When we can end the Policy

We may cancel a Policy by giving written notice if you fail to pay a Premium on the Premium due date (refer to 'Premiums' on page 11 for further details), or as otherwise permitted by law.

General questions you may have

Takeover Terms

Takeover terms may be offered at our discretion to groups transferring to MLC Group Insurance from other insurers, providing the previous group insurance policy is similar in scope of cover to this Policy. The information we request about the operation and terms of the previous policy (including the underwriting decisions of the insurer of the previous policy), are to be provided within 90 days of the Policy Commencement Date, unless otherwise agreed by us. The claims experience under the previous policy must have been satisfactory to us. We will generally follow IFSA Guidance Note No. 11.00 'Group Insurance Takeover Terms', unless otherwise agreed.

Takeover terms may be offered on the same basis, including any Forward Underwriting Levels, provided by the previous insurer.

Where takeover terms are offered they will be confirmed in writing and form part of the Policy. If we provide Group Salary Continuance under takeover terms, we will cover the Insured Member(s) from the commencement of this Policy, however the Insured Member(s) will not be covered for disability which arises from an Illness or injury which caused them to not be 'At Work' on the last working day immediately before this Policy commenced.

However, this limitation will cease to apply if the Insured Member:

- returns to work and is actively performing all the duties and work hours of their usual Occupation with their Employer, free of any limitation due to injury or Illness; and
- is not entitled to or receiving income or Benefits from any other source.

Duty of Disclosure

When you apply for a life insurance policy, you have a duty to tell us anything that you know, or could reasonably be expected to know, that 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 policy.

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 someone other than you will be the life insured under the policy, any failure by that person to comply with the above duty will be treated as failure by you.

If you request life insurance inside super, the Trustee obtains this insurance from us in relation to you. In this circumstance, we rely on the disclosures that you or the Trustee makes to us.

If you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate policies 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 policy within 3 years of entering into it.

If we choose not to avoid the policy, 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 policy provides cover on death, we may only exercise this right within 3 years of entering into the policy.

If we choose not to avoid the policy or reduce the amount you have been insured for, we may, at any time vary the policy 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 policy provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the policy as if it never existed.

General questions you may have

Cooling off period

A 14 day cooling off period applies for Employers who apply to establish a group Policy with us for their employees or members of a Fund. The insurance cover may be cancelled and Premiums paid will be refunded, provided notification is received by us within 14 days of the commencement of the cooling off period. The cooling off period commences for the Employer upon receipt of the Policy Schedule or at the end of the fifth business day after the Policy Schedule was issued, whichever occurs first. If notice is received within the cooling off period, we will cancel the Policy in accordance with the request.

The cooling off period terminates immediately if the Employer or an Insured Member acts in a manner confirming an interest or rights under the Policy.

Right to inspect records

We reserve the right, upon giving you reasonable notice, to inspect your books and records in relation to this Policy and to take and carry away copies of any relevant records. This right shall continue notwithstanding the termination of this Policy for any reason for a period of two (2) years after termination or until final settlement of all claims made under the Policy, whichever is the latter. We will try to minimise any inconvenience to your operations during such reviews.

Notices

Any notice we give you, or any notice you are required to give us, must be in writing. We can give you a notice personally or send it to you at your address last known to us, or send it to someone else nominated by you. A posted notice will be taken to be received on the third day after posting. A notice sent by facsimile is taken to be received at the time the facsimile transmission report indicates that it was sent in its entirety to the facsimile number of the recipient. An email notice is taken to be received at the time it appears in the recipients email inbox.

You should send notices to us as follows:

- By post or delivery to MLC Group Insurance, 105–153 Miller Street, North Sydney, NSW 2060, or PO Box 200, North Sydney NSW 2059; or
- Send by facsimile to (02) 9966 3502 (Sydney); or
- By email to **groupsales@mlc.com.au**

Currency

All monetary amounts referred to in this Policy and the attached Schedule are in Australian dollars and all transactions will be made in Australian dollars.

Government charges

Any stamp duty, tax or other charge levied from time to time by a government authority is payable by you in addition to premiums, unless mutually agreed otherwise

What if I have a complaint?

You are welcome to call Group Insurance on (02) 8908 6111. You can speak with one of our client service co-ordinators and in most cases we can deal with your complaint over the phone. If we cannot resolve your complaint over the phone, MLC Group Insurance has formal procedures for dealing with complaints and you will need to write to us. In addition to your address, please provide your phone number and/or email address if you would prefer that form of contact. Your correspondence should be addressed to:

The Manager
MLC Life Insurance
Complaints Resolution Team
PO Box 1086
North Sydney NSW 2059

Please mark the envelope "Notice of Complaint".

We will make every effort to resolve your complaint as quickly as possible. If there is anything that may prevent this from happening, we will notify you.

If your complaint has not been resolved within 45 days of lodgement, or if you are dissatisfied with our decision, you may seek assistance from the Financial Ombudsman Service (FOS). FOS is an independent complaints resolution scheme established to provide free assistance to customers of the financial services industry. You can contact them at:

The Manager
Financial Ombudsman Service
GPO Box 3
Melbourne VIC 3001
Phone: 1300 780 808
Fax: 03 9613 6399

More information about FOS is available at **www.fos.org.au**

Interim Accident Insurance

Interim Accident Cover

Interim Accident cover is provided in respect of an Eligible Person who does not satisfy the Automatic Acceptance conditions of the Policy or an Insured Member who has applied for cover in excess of the AAL, during the underwriting process.

The interim Accident Benefit will be paid for injury only. Interim Accident cover will commence on receipt of a fully completed request for insurance form and declaration of health in the form that we require. The interim Accident Benefit will be the lesser of the Monthly Benefit being applied for, the Monthly Benefit we would allow under our normal assessment guidelines and $15,000 per month.

We will pay you the Insured Member's Monthly Benefit or $15,000 per month, whichever is the lesser, if an Eligible Person or an Insured Member applying to increase their cover suffers a Total Disability as a result of an injury while they are covered by this interim Accident cover.

The amount payable in respect of the Eligible Person or Insured Member will be subject to:

- the terms and conditions of the Policy;
- the level of cover for the category of the Eligible Person or Insured Member, where applicable;
- a maximum amount up to $15,000 per month for any one Eligible Person or Insured Member.

Interim Accident cover will expire on the earliest of the following:

- 90 days after the commencement of the interim Accident cover;
- the date on which we give notice that the request for insurance under this Policy is accepted or declined;
- the date the Employer or the Insured Member or Eligible Person cancels or withdraws the request for insurance; or
- the date the Eligible Person ceases to be an Eligible Person or no longer satisfies the Eligibility Terms.

Exclusions for Interim Accident Insurance

No interim Accident Benefit will be payable for:

- injury to an Insured Member caused by engaging in hazardous pastimes or sports that would not be covered under our normal assessment guidelines;
- injury occurring prior to the date of becoming an Eligible Person.

Furthermore, we will not pay an interim Accident Benefit if:

- the cover applied for would have been declined under our current assessment guidelines; or
- the Eligible Person or the Insured Member lodges a claim for an event or condition that would have been excluded under our normal underwriting process.

We will not pay more than one Benefit under this interim Accident insurance for any one Accident to any person.

Definitions

For the purpose of this Policy the following important definitions apply:

'Accident' means an event where bodily injury is caused directly and solely by external and visible means, independently of all other causes.

'Annual Renewal Date' means each anniversary of the Commencement Date of this Policy unless otherwise agreed by you and us. This date is set out in the Schedule.

'Application' means an application for insurance cover under this Policy completed by you, via a proposal form to commence cover, or in the case of an Eligible Person or Insured Member, any information and any Evidence of Insurability required by us.

'At Work' means the person is at work for the normal daily hours of work and are actively performing the full, unrestricted or unmodified duties of their normal Occupation for which they were Employed or would have been had the day not been a day of leave (other than due to Illness or injury), public holiday or weekend day.

'Automatic Acceptance' means the acceptance for cover by us for certain members of a group without the need to provide medical evidence.

'Automatic Acceptance Level (AAL)' means the dollar limit of cover for Automatic Acceptance specified in the Schedule.

'Benefit' means the Total Disability, Partial Disability, interim Accident insurance, recurrent disability, rehabilitation expense, bed confinement, specific injury, specified illness, employer superannuation contribution, family carer, workplace modification, emergency transport and bereavement benefit described in the Policy and the Schedule.

'Benefit Formula' means the formula used for calculating the amount of cover for an Insured Member, as noted in the Schedule.

'Benefit Period' means the maximum period for which Total and/or Partial Disability Benefits may be payable in accordance with the Policy. The maximum period is stated in the Schedule.

'Blindness' means the permanent loss of all sight in both eyes, whether aided or unaided, due to Illness or injury to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 20 degrees or less of arc.

'Burns' means third degree Burns to 20% or more of the body surface, or to the whole of the face or the whole of both hands requiring surgical debridement and/or grafting.

'Ceasing Age' means the age at which cover under the Policy ceases for an Insured Member, as shown in the Schedule.

'Commencement Date' means the date of commencement of cover under this Policy, as set out in the Schedule.

'Chronic Kidney Failure' means the final stage of kidney disease that requires permanent dialysis or a transplant.

'Coronary Artery Bypass Surgery' means the surgical grafting of a bypass to a coronary artery to overcome narrowing or obstruction. It does not include coronary artery angioplasty, intra-arterial procedures or other non-surgical procedures.

'CPI' means the Consumer Price Index (All Groups Index Weighted Average for Eight Capital Cities, published by the Australian Bureau of Statistics). However, if this index is not available, we may use another price index that we consider appropriate. In determining the percentage increase of Benefits we use the CPI in respect of the twelve (12) months concluding at the end of the last quarter prior to the anniversary of the commencement of Total Disability Benefit payments.

'Doctor' means a registered medical practitioner who is acceptable to us and who is not the Insured Member or spouse, family member, business partner, employee or Employer of an Insured Member.

'Eligibility Terms' means the rules for eligibility set out in the Policy and the Schedule.

'Eligible Person' means a person who has been nominated by you for cover under the Policy and who meets the Eligibility Terms as set out in the Schedule.

'Employed' means engaged in Regular permanent employment for at least 15 hours per week but does not include any person engaged on a Casual Employment or Seasonal or Contract Employment basis.

'Employer' means the Employer named as the Policy owner in the Schedule or a participating Employer where a Fund is the Policy owner, and/or any associated entity of the Employer agreed to by us.

'Evidence of Insurability' means a completed personal statement or request for insurance form and any other evidence of health or insurability that we may require, such as medical examinations and reports, medical tests and health and activity statements.

'Fixed Term Employment' means the Insured Member is Employed for a fixed period of employment determined at the commencement of their employment and where they are in receipt of leave, sick leave, superannuation and other entitlements normally associated with full time employment.

'Forward Underwriting Level (FUL)' means the Benefit amount (if any) which we last notified to you up to which we will accept future increases in the amount of cover in accordance with the Benefit Formula, without further underwriting.

'Fund' means the superannuation fund trustee named as the Policy Owner in the Schedule (if any).

'Heart Attack' means the death of part of the heart muscle because of inadequate blood supply. The diagnosis must be based on electrocardiogram changes and either:

- higher levels of cardiac enzyme (CK-MB) than normal; or
- an elevation (other than as a result of cardiac or coronary intervention or angina) of Troponin I in excess of 2.0ug/L (micro-grams per litre) or Troponin T in excess of 0.6 mg/L.

If a diagnosis based on the above criteria is inconclusive, then we will consider a claim based on conclusive evidence that the Insured Member has been diagnosed as having suffered a Heart Attack, resulting in either one of the following:

- New pathological Q waves; or
- A permanent left ventricular ejection fraction of 50% or less, measured three or more months after the event.

'Illness' means a sickness, disease or medical disorder.

'Important Duties' means the duties of the Insured Member's Occupation which are essential in producing a salary.

'Insured Member' means an Eligible Person who has been accepted by us for inclusion under and, in accordance with, the provisions of the Policy.

'Major Brain Injury' means a physical head injury that results in permanent loss of at least 25% of either the brain's mental function or its physical control function.

'Major Organ Transplant' means the transplant of any of the following whole organs from a human donor to an Insured Member:

(i) kidney

(ii) lung

(iii) liver

(iv) pancreas

(v) heart

(vi) bone marrow

(vii) small bowel.

'Malignant Cancer' means the presence of one or more malignant tumours, leukaemia or lymphomas (including Hodgkin's Disease). The following are **not** included:

- chronic lymphocytic leukaemia in its early stages (RAI stages 0 or 1)
- prostate cancer which is histologically described as TNM classification T1 or another equivalent or lesser classification
- carcinoma in situ (including cervical dysplasia CIN1, CIN2 and CIN3), or premalignant tumours. Carcinoma in situ of the breast is included where it leads to the removal of the breast by a mastectomy. The procedure must be performed as a direct result of the carcinoma in situ and specifically to arrest the spread of malignancy, and be considered the necessary and appropriate treatment
- skin cancer other than melanoma at least 1.5mm thick or at least Clark Level 3 of invasion
- hyperkeratosis or basal cell skin carcinoma
- squamous cell skin carcinoma unless it has spread to other organs.

Definitions

'Monthly Benefit' means the insured amount calculated as a percentage of the Insured Member's Monthly Income. At the time of establishing the Policy, you decide on the percentage of income that will be used by us to calculate the Insured Member's monthly benefit however, we must first agree in writing. The maximum percentage of income for the first $320,000 of the Insured Member's annual income is 75% and for the next $240,000 of annual income is 50%. This results in the maximum monthly benefit available of $30,000.

The maximum Monthly Benefit, including the Employer superannuation contribution Benefit (if applicable), that may be offered is $30,000.

(note: the maximum Monthly Benefit may increase in excess of $30,000 by indexation (if applicable) while an Insured Member is claiming a Benefit, (refer to 'increasing benefits/indexation' on page 3)

'Monthly Income' means one-twelfth of the Eligible Person's or Insured Member's annual pre-tax income derived from their Occupation, where;

(i) The Eligible Person or Insured Member is an employee, who does not directly or indirectly own part or all of a business or practice – the salary from their occupation which may include the value of all non-cash remuneration approved by us. Monthly Income does not include any director's fees, commissions, overtime payments, bonuses, penalty, shift or other allowances, investment income, income received from deferred compensation plans, disability income policies or retirement plans or income not derived from vocational activities, unless agreed by us and specified in the Schedule. Monthly Income is to be determined on the date cover commences under the Policy for an Eligible Person or Insured Member or where there has been a subsequently agreed alteration to the level of Monthly Benefit, then at the date of the most recent alteration.

(ii) Where the Eligible Person or Insured Member is self-employed, that is directly or indirectly owns part or all of a business or practice – the income of the business or practice generated by the personal efforts of the Eligible Person or Insured Member after the deduction of their appropriate share of business or practice expenses in generating that income, or any other income as approved by us.

'Multiple Sclerosis' means the progressive destruction of the insulating layer of myelin in the brain and spinal cord. The diagnosis of Multiple Sclerosis must be certain and supported by neurological investigations.

There must be more than one episode of brain dysfunction with persistent abnormalities and loss of at least 25% of either the brain's mental function or its physical control function.

'Occupation' means the employment or activity in which the Insured Member is Employed.

'Own Occupation' means the normal occupation in which the Insured Member is employed immediately prior to becoming Totally Disabled.

'Partial Disability' or **'Partially Disabled'** means that immediately following a period of at least 14 consecutive days of Total Disability and as a direct result of injury or Illness which caused the Total Disability, the Insured Member has returned to work in his or her own or another occupation and is:

- continuously unable to perform the Important Duties of his or her own occupation; and
- earning less than his or her Monthly Income prior to Total Disability; and
- under the continuous care and following the advice for treatment of a Doctor in relation to that Illness or injury.

'Policy' means this contract of insurance between you and us which includes the policy document and Schedule and any other documentation, including policy annexures, that we advise form part of the policy.

'Premium' means the payments made by you, calculated in accordance with the rates set out in the Schedule, or the amount advised by us from time to time, to provide cover under this Policy.

'Premium Rate Guarantee Period' means the period stated in the Schedule.

'Regular' means a period of continuous work history as measured over a three (3) month period.

'Renewal Date' means each anniversary of the Commencement Date of this Policy unless otherwise mutually agreed. This date is shown in the Schedule.

'Restricted Monthly Income' means the Monthly Income that would result in a Monthly Benefit equivalent to the AAL and applies where the Insured Member's Monthly Benefit is restricted to the AAL.

'Schedule' means the schedule to this Policy headed 'schedule', as amended from time to time and any annexures or other documentation we advise forms part of the schedule.

'Stroke' means an incident in the blood vessels of the brain or bleeding in the brain leading to neurological effects that last for at least 24 hours. There must be clear evidence on a CT, MRI or similar scan that a stroke has occurred.

Transient ischaemic attacks, symptoms due to migraine, vascular disease of the optic nerve, physical head injury, reversible neurological deficit or any blood vessel incident outside the cranium, except embolism resulting in stroke, are not included.

'Total Disability' or **'Totally Disabled'** means that solely as a result of injury or Illness, the Insured Member is continuously:

- unable to perform at least one of the Important Duties of his or her own Occupation; and
- under the care of and following the regular and continuous advice for treatment from a Doctor in relation to that Illness or injury; and
- not engaged in any occupation, paid or unpaid.

'Underwriting Terms' mean the terms on which we agree to provide cover described in 'Evidence of Insurability/ Underwriting Terms' on page 7.

'Waiting Period' means the period of continuous disability commencing from the first day of Total Disability of the Insured Member during which no Total or Partial Disability Benefits are payable. The Waiting Period is stated in the Schedule and starts on the date that the Insured Member first gets medical advice and is confirmed to have a Total Disability by a Doctor.

Group Insurance

Where to get help

MLC Group Insurance
For more information call
02 8908 6111.
Email: **groupsales@mlc.com.au**
or contact your Adviser.

Website

For details on our range of products and services visit our website at **www.mlc.com.au**

Postal Address

MLC Group Insurance
PO Box 200
North Sydney NSW 2059
105-153 Miller Street
North Sydney NSW 2060
Fax: **(02) 9966 3502**

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