Supplementary Product Disclosure Statement

Group Life and Group Salary Continuance Insurance

25 April 2015

This Supplementary Product Disclosure Statement (SPDS) is dated 25 April 2015, and supplements the Product Disclosure Statements (PDS) listed below. This SPDS is to be read together with the relevant PDS and any other SPDSs issued for the product.

Product and PDS Name	Date of PDS
Group Life Insurance Product Disclosure Statement	15 November 2010
Group Salary Continuance Product Disclosure Statement	15 November 2010

Terms defined in the PDS have the same meaning in this SPDS.

This SPDS and each product listed above is issued by OnePath Life Limited (**OnePath Life**) ABN 33 009 657 176, AFSL 238341.

Australia and New Zealand Banking Group Limited (**ANZ**) ABN 11 005 357 522 is an authorised deposit taking institution (Bank) under the *Banking Act 1959* (Cth). OnePath Life is owned by ANZ – it is the issuer of this product but is not a Bank. Except as set out in the issuer's contract terms (including the PDS), this product is not a deposit or other liability of ANZ or its related group companies. None of them stand behind or guarantee the issuer.

The purpose of this SPDS is to:

1. Insert a new 'Updated Information' section in the PDS;
2. Update the 'Duty of Disclosure' in the PDS;
3. Insert a new 'Sanctions Regulations' section in the PDS;
4. Update the 'Availability of cover' section in the PDS;
5. Update the 'Automatic Acceptance' section in the PDS; and
6. Update the 'Privacy' section in the PDS. Changes to the Privacy Statement are effective 12 March 2014.

1. Insert the following new section titled 'Updated Information' after the section 'Product Disclosure Statement':

Updated Information

Updated information will be available free of charge from onepath.com.au/adviser/group-risk-insurance.aspx

2. Replace the 'Duty of Disclosure' section in the PDS with that below:

Duty of Disclosure

Before you (as the policy owner) enter into, or an **eligible person** becomes insured under, a contract of insurance with us, you and the **eligible person** have a duty under the *Insurance Contracts Act 1984* (Cth) to disclose to us every matter that you or the **eligible person** knows or could reasonably be expected to know, is relevant to our decision whether to accept the risk of insurance and, if so, on what terms.

You and an **insured member** have the same duty to disclose those matters to us before you or an **insured member** renew, extend, vary or reinstate a contract of insurance. Your duty, however, does not require disclosure of a matter that:

- diminishes the risk to be undertaken by us;
- is of common knowledge;
- we know, or in the ordinary course of business, ought to know; or
- we have waived.

Non-disclosure

If you, an **eligible person** or an **insured member** do not disclose to us every matter that you, an **eligible person** or an **insured member** know or could reasonably be expected to know, that would be relevant to our decision whether to accept the risk of the insurance and if so, on what terms, we may avoid the contract, or avoid cover in respect of an individual **insured member** within three years of entering into it, provided that we would not have entered into that contract or accepted cover for the **insured member** had full disclosure been made.

If your non-disclosure is fraudulent we can avoid the contract, or the cover, at any time.

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Non-disclosure (continued)

Where we are entitled to avoid a contract of insurance or the **insured member's** cover, we may elect not to avoid it but apply either of the following options:

- reduce the sum that you or an **insured member** would have been insured for in accordance with a formula that takes into account the premium that would have been payable if you or the **eligible person** or **insured member** had disclosed all relevant matters to us; or
- vary the contract in such a way as to place us in a position that we would have been in, had you or the **eligible person** or **insured member** disclosed all relevant matters or not made a misrepresentation.

Where your contract or an **insured member's** cover is in respect of death cover, we may only apply the first of the two options and we must do so within three years of you entering into the contract or us providing cover to the **insured member**.

3. Insert the following new section in the PDS titled 'Sanction Regulations' after the section titled 'More information':

Sanction Regulations

We may delay or withhold paying a benefit where the payment of the benefit may breach any laws or regulations in Australia including any sanctions regulations. You must provide all information to OnePath Life which OnePath Life reasonably requires in order to manage its money-laundering, terrorism financing or economic and trade sanctions regulations.

4. Update the 'Minimum number of persons to commence a Policy' and 'Minimum annual premium' under the section 'Availability of cover' in the PDS with that below:

Minimum number of persons to commence a Policy	20
Minimum annual premium (excluding stamp duty)	$15,000

5. Delete the first bullet point under the section subtitled 'Automatic Acceptance Level':

- there are at least 75 **insured members** at the **policy start date** and at least 40 **insured members** at each annual **review date**

and replace with the following bullet point:

- there are at least 20 **insured members** at the **policy start date** and at least 20 **insured members** at each annual **review date** (unless we agree otherwise in writing)

6. Following changes to the Australian privacy laws, OnePath Life has replaced its Privacy Statement with that below. Changes to the Privacy Statement are effective 12 March 2014.

Privacy

In this section 'we', 'us' and 'our' refers to OnePath Life Limited and other members of the ANZ Group. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information. Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from onepath.com.au/privacy-policy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information to certain third parties.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information include:

- an organisation that assists us and/or ANZ to detect and protect against consumer fraud;
- any related company of ANZ which will use the information for the same purposes as ANZ and will act under ANZ's Privacy Policy;
- organisations performing administration and/or compliance functions in relation to the products and services we provide;
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- our solicitors or legal representatives;
- organisations maintaining our information technology systems;
- organisations providing mailing and printing services;
- persons who act on your behalf (such as your agent or financial adviser);
- the policy owner;
- regulatory bodies, government agencies, law enforcement bodies and courts.

Providing your information to others (continued)

We will also disclose your personal information in circumstances where we are required by law to do so.

Examples of such laws are:

- *The Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- There are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

ANZ may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at onepath.com.au/privacy-policy

Life risk – sensitive information

For life risk products, where applicable, we may collect health information with your consent. Your health information will only be disclosed to service providers or organisations providing medical or other services for the purpose of underwriting, assessing the application or assessing any claim.

Privacy consent

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions please notify us in writing.

If you give us or ANZ personal information about someone else, please show them a copy of this document so that they may understand the manner in which their personal information may be used or disclosed by us or ANZ in connection with your dealings with us or ANZ.

Privacy Policy

Our Privacy Policy contains information about:

- when we or ANZ may collect information from a third party;
- how you may access and seek correction of the personal information we hold about you; and
- how you can raise concerns that we or ANZ has breached the Privacy Act or an applicable code and how we and/or ANZ will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing:

GPO Box 75
Sydney NSW 2001
Email: privacy@onepath.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 133 667.

More information can be found in our Privacy Policy onepath.com.au/privacy-policy

Privacy law changes from 12 March 2014

From 12 March 2014, we and the ANZ Group must provide you with the following information about overseas recipients of personal information.

Overseas recipients

We or ANZ may disclose information to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in ANZ's Privacy Policy at anz.com/privacy

Group Risk Administration
OnePath Life

Phone 1800 648 921
Email group.risk@onepath.com.au

Address
GPO Box 4129, Sydney NSW 2001
242 Pitt Street, Sydney NSW 2000

OnePath Life Limited (OnePath Life)
ABN 33 009 657 176 AFSL 238341

OnePath

Group Salary Continuance Insurance

Product Disclosure Statement

15 November 2010

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About OnePath

Helping you shape and protect your future

OnePath Life Limited (OnePath Life) is one of Australia's leading providers of wealth, insurance and advice solutions. We have been helping Australians grow and protect their wealth for over 130 years, previously as Mercantile Mutual and more recently as ING Australia.

Now as a wholly owned subsidiary of Australia and New Zealand Banking Group Limited (ANZ), OnePath Life operates as ANZ's Australian specialist wealth management and protection business.

ANZ is a leading global and local bank with operations in more than 32 countries including Australia, New Zealand, Asia, the Pacific, the Middle East, Europe and America. ANZ provides products and services to more than 5.7 million retail customers worldwide and employs over 39,000 people.

OnePath Life has a comprehensive range of wealth and insurance products available through intermediaries, financial advisers or direct to customers making it easier for you to find the solution that best suits your needs.

At OnePath Life we value and appreciate our customers, our staff and the communities we operate in. We are committed to acting with the highest standards and to meeting our corporate responsibilities. We also encourage and support staff involvement in volunteering and charitable activities supporting the wider community.

OnePath Life actively participates in forums looking at regulatory and industry change. We also regularly review and conduct research to ensure we are attuned to changing customer and market needs.

Contents

Introduction

Product Disclosure Statement

This Product Disclosure Statement (PDS), which is issued by OnePath Life, describes the main features and benefits of OnePath Life's Group Salary Continuance (GSC) Insurance. The information in this PDS will help you to decide whether this product is suitable to you, as well as assist you in comparing products available from other life insurers that you may be considering.

The information provided is of a general nature and does not take into account your personal needs and financial circumstances. It is not advice and you should consider obtaining independent advice before making any financial decisions. You should consider the appropriateness of any advice, having regard to your objectives, financial situation and needs.

The **Policy** contains the full terms and conditions of the GSC Insurance. A copy of the **Policy** document is available free of charge from onepath.com.au or by calling 1800 648 921. Should there be an inconsistency between the information contained in this PDS and the **Policy**, the terms of the **Policy** will prevail.

The amount of any benefits payable, how benefits are payable and whether or not optional benefits are included, are determined on a plan by plan basis and set out in the **Quotation Summary** which will be generated for you if you request a quotation.

The information in this PDS, including taxation information, is based on the continuance of present laws and our interpretation of those laws.

The information in this PDS may change from time to time. We will issue a supplementary or replacement PDS if there is a material change to or omission from the information in this PDS. You can request a paper copy of any updated information free of charge from onepath.com.au or by calling 1800 648 921.

How to read this PDS

Throughout this PDS, the following words have the meanings set out below:

References to	To be read as
we, our, us, OnePath Life	OnePath Life Limited.
you, your	The applicant(s) for GSC insurance, i.e. the policy owner, generally an employer or a trustee of a complying superannuation fund.
insured member	The person whose life is to be insured under the **Policy**. This can be either an employee of an employer, a partner of a partnership or a member of a complying superannuation fund. All references to **insured member** assume the **Policy** is in force and cover in respect of that **insured member** continues under the **Policy**.
PDS	This GSC Insurance Product Disclosure Statement

Interpretation

Some expressions and words throughout this PDS and the GSC Proposal Form, have a special meaning. These words and expressions are shown in **bold** type and are defined in the Dictionary on page 28 of this PDS.

Headings appear in this PDS as an aid to interpretation of the relevant section or provision.

Policy Terms

This PDS does not constitute a legally binding contract of insurance with OnePath Life. A contract is formed when:

- we accept your application for GSC Insurance and issue a **Policy Schedule** to you (the **Policy Schedule** confirms your cover and contains important details of your insurance)
- we issue an 'On-risk' letter in accordance with the requirements imposed by the *Corporations Act 2001* (Cth) and
- you have paid the premium.

The specific benefits that apply to your plan are outlined in the **Policy Schedule**.

GSC Insurance to be held in superannuation

OnePaths Life's GSC Insurance can be owned through superannuation. It is important to note however, that superannuation law limits the circumstances when superannuation funds can pay benefits. This may mean that if the **Policy** is to be owned by a superannuation fund trustee, any **insured benefit** that we pay to the superannuation fund trustee can only be released by the superannuation fund trustee if it can be paid under superannuation law. If you are a superannuation fund trustee and wish to hold the **Policy** for superannuation fund members, we recommend that you seek independent expert advice as to whether **insured benefits** under the **Policy** will be able to be paid from the fund.

What is GSC Insurance?

At a glance

GSC Insurance can be a great way to add value to employees' remuneration packages or offer competitive insurance through a superannuation fund. OnePath Life's GSC Insurance provides cover for a group of people with a united commonality, usually employees of an employer or members of a complying superannuation fund. The cover provided is a monthly benefit of up to 75% of **salary** for an **insured member** who is unable to work due to illness or injury. The flexible nature of OnePath Life's GSC Insurance allows you to tailor insurance cover for the group by choosing the most appropriate benefit design.

The built-in benefits, features and options are summarised in the table below. Further information on each item can be found on the pages listed.

Benefit/Feature	Brief description	Available in superannuation?	Refer to page
Built-in benefits			
Total Disability Benefit*	If an **insured member** is unable to work due to illness or injury, we will pay you the monthly benefit for the **benefit period**.	Yes	10
Partial Disability Benefit*	If an **insured member** has reduced working capacity after a period of **total disability**, we will pay you a portion of the monthly benefit for the **benefit period.**	Yes	10
Death Benefit	If an **insured member** dies while a Disability Benefit is being paid, we will pay you an amount up to three times the monthly benefit.	Yes	11
Specific Injury Benefit*	If an **insured member** suffers a specific injury within 180 days of the event which caused it, we will pay you the monthly benefit for a nominated payment period.	Yes	11
Recurring Disablement Benefit	If the **insured member** suffers a relapse of the injury or illness that caused the **insured member** to obtain a Disability Benefit within six months, no further **waiting period** will apply and Disability Benefits will continue until the end of the **benefit period**.	Yes	12
Early Notification Incentive Benefit	If we are notified of a claim within 30 days of the event which causes the claim, we will pay you an amount equal to 25% of the first month's Disability Benefit.	Yes	12
Emergency Domestic Travel Benefit	If an **insured member** requires **emergency transport** within Australia to a hospital whilst in receipt of a Total Disability Benefit, we will reimburse the expenses incurred for **emergency transportation** of the **insured member** up to $1,000.	No	12
Built-in features			
Transfer Terms	We may agree to take over the level of insurance benefits provided by your previous insurer and provide equivalent benefits on certain terms.	Yes	7
Worldwide cover	Where an **insured member** is covered, the cover provided will be anywhere and any time.	Yes	13
Cover during paid and unpaid leave	We provide cover for a maximum period of two years if the **insured member** is on paid or unpaid leave.	Yes	13
Cover during overseas employment	We automatically cover **insured members** working overseas for up to five years.	Yes	13
Extended Cover	We provide cover for up to a maximum of 60 days if an **insured member** ceases to satisfy the **eligibility criteria**.	Yes	13

Benefit/Feature	Brief description	Available in superannuation?	Refer to page
Built-in features			
Continuation Option	If an **insured member's** cover ends because they cease to satisfy the **eligibility criteria**, they may be able to apply to us for an individual policy providing Disability Benefits without medical underwriting.	Yes	13
Limited Cover	While we consider an **insured member's** application, we will provide cover for **disability** that occurs as a result of an **accident** for up to 90 days.	Yes	14
Return to work assistance	We may pay some or all of the expenses incurred by an **insured member** participating in a return to work program, if we believe that such a program may help the **insured member** return to work.	Yes	14
Workplace modification assistance	We may pay some or all of the expenses required to modify an **insured member's** place of employment if we believe such modification is necessary to enable the **insured member** to return to work.	Yes	14
Premium waiver	You do not have to pay premiums while the **insured member** is **on claim**.	Yes	14
Discounts	A discount will apply if the annual premium is paid within 30 days of the annual due date or if you purchase OnePath Life's Group Life Insurance simultaneously with GSC Insurance.	Yes	15
Guaranteed continuing cover	The **Policy** will continue each year upon payment of the premium, regardless of changes to the number of **insured members** or changes to their health or circumstances.	Yes	25
Options available at extra cost			
Superannuation Contribution Benefit	You may choose to insure an additional amount of your **insured members'** salaries in the form of a Superannuation Contribution Benefit.	Yes	16
Enhanced Bereavement Benefit	If an **insured member** dies or is diagnosed with a **terminal illness** while covered, we will pay you three times the **insured member's** monthly benefit as a lump sum up to a maximum of $60,000.	Yes	16
Alternative Benefit Expiry Age Benefit	Age-based terms of 'to age 67' or 'to age 70' are available subject to certain conditions.	Yes	16
Escalation Benefit	You can elect for an **insured member's** monthly benefit to increase each year when a claim is being paid by the lesser of the annual **CPI** increase and the **escalation factor** at the anniversary of the claim's commencement date.	Yes	16
Nurse Care Benefit*	If an **insured member** is confined to bed and receiving **full-time** nursing care during the **waiting period**, we will pay you an additional amount.	No	16
Recovery Assistance Benefit	If an **insured member** becomes **totally and permanently disabled** within 12 months of the **insured member's total disability,** we will pay you an additional lump sum amount.	No	16
Early Cash Benefit*	If an **insured member** suffers an early cash benefit event (of which there are eight), we will pay the **insured member's** monthly benefit for a maximum of six months. Not available if the Trauma Recovery Benefit is selected.	No	17

Benefit/Feature	Brief description	Available in superannuation?	Refer to page
Options available at extra cost			
Trauma Recovery Benefit*	If an **insured member** suffers a trauma recovery event (of which there are 42), we will pay you the **insured member's** monthly benefit for a maximum of six months. Not available if the Early Cash Benefit is selected.	No	17
Immediate Family Member Benefit	If, while in receipt of the Total Disability Benefit, the **insured member** has been confined to bed and he or she requires care from an **immediate family member**, we may pay you an additional amount of up to $3,000 per month, for a maximum period of three months.	No	18
Relocation Benefit	We will reimburse the cost of a single standard economy airfare up to three times the **insured member's** monthly benefit if the **insured member** returns to Australia while **totally** or **partially disabled**.	No	19

* These benefits can only be paid one at a time. Refer to page 20 for more details.

Availability of cover

The below table sets out the limits and choices that apply to OnePath Life's GSC Insurance:

Minimum benefit entry age	15 years of age
Maximum benefit entry age	64 years of age
Minimum number of persons to commence a Policy	75
Minimum annual premium (excluding stamp duty)	$30,000
Maximum monthly benefit level	$30,000
Maximum benefit expiry age	70
Maximum Superannuation Contribution Benefit	Up to 12%
Waiting periods available	30, 60, 90, 180 and 365 days
Benefit periods	Fixed term periods: 1 year, 2 years or 5 years. Age-based terms: to age 65, to age 67 and to age 70.
Premium payment frequency	Yearly, half-yearly, quarterly or monthly

Who is eligible for cover?

Only an **eligible person** can become an **insured member** under the **Policy**.

An **eligible person** is a person who is a member of a complying superannuation fund, a partner of a partnership or an employee or **contractor** of an employer and:

- is aged less than the **maximum benefit entry age** on the day he or she is first eligible for cover, or the date that he or she applies for cover
- is an **Australian resident** or holder of a **visa**
- resides in Australia (unless the person is working overseas as set out under the heading 'Cover during overseas employment' on page 13 of this PDS)
- is employed and working at least 15 hours per week on a permanent basis (including an eligible **contractor**)
- is working in an occupation that we do not class as an **excluded occupation** and
- satisfies the eligibility rules chosen by you and agreed by us.

How is cover provided?

An **eligible person** can become an **insured member** and be covered for GSC Insurance by one of three ways:

- automatic acceptance
- operation of our transfer terms
- applying to us in writing.

Automatic acceptance

Automatic Acceptance Level

When you establish your plan, we may agree to provide an **Automatic Acceptance Level (AAL)**. An **AAL** is the maximum amount of cover available without **eligible persons** needing to give us any evidence of good health. The amount of any **AAL** we agree to provide depends on a number of factors and will only be provided where all of the following conditions are met:

- there are at least 75 **insured members** at the **policy start date** and at least 40 **insured members** at each annual **review date** (unless we agree otherwise in writing)
- you provide an **At Work Certificate** where one is required (if you are a trustee of a superannuation fund, you must provide an **At Work Certificate** for each participating employer under your superannuation fund)
- we are your sole insurer for this type of insurance
- at least 75% of all **eligible persons** (unless we agree otherwise in writing), shall become **insured members** at the **Policy start date**.

Cover under automatic acceptance

An **eligible person** may be automatically accepted for the applicable type of cover under the **Policy** up to the **AAL**, without needing to give us any evidence of good health, providing all of the following conditions are met:

- the **AAL** shown in the **Policy Schedule** is for an amount other than nil
- there are clearly defined and objective eligibility rules that do not allow an individual to choose to become an **insured member** on a discretionary basis, i.e. as a result of the person's individual choice
- the eligible person is **at work** with you or a participating employer on the **policy start date** or the day he or she first satisfies the **eligibility criteria**, as confirmed by an **At Work Certificate**
- the **eligible person** satisfies any other terms that apply to your plan
- the **eligible person** must not be entitled to payment of an insurance benefit for illness or injury or be in a waiting period for such a benefit and
- the **eligible person** must not have previously been accepted for cover under the **AAL** of your plan.

Automatic acceptance and eligible persons not at work

An **eligible person** who is not **at work** as a result of an illness or injury on the **policy start date** or on the day the **eligibility criteria** was first met, shall become an **insured member** covered for **New Events Cover** only.

When the **insured member** returns to the pre-disability duties (working the same hours and in the same capacity without limitation) he or she performed when he or she was last **at work**, the **insured member's New Events Cover** will cease and the **insured member** will be covered on the same basis as an **insured member** who was **at work** on the relevant day.

Variations in the AAL

If the number of **insured members** falls below 75% (unless we agree otherwise in writing) of persons eligible for cover based on the **eligibility criteria**, we may remove the **AAL**, after consultation with you. Where this occurs, the cover we provide for existing **insured members** as at the date the **AAL** is removed will not be impacted.

When an **AAL** increases, the higher **AAL** may apply to all existing **insured members** irrespective of whether they have been declined, excluded or loaded for cover above the previous lower **AAL**. Any loading, limitation or exclusion that previously applied to the lower **AAL** will only apply above the new higher **AAL**. We will advise you in writing if we agree to do this.

Transfer terms

Transfer terms may be available if you had similar insurance cover before choosing to transfer the insurance to us. Transfer terms will only apply to those persons who were members of your previous plan as at the date immediately prior to the **transfer date**.

All transferring members will be covered for an **insured benefit** on underwriting terms no less favourable than those provided by the previous insurer, including **forward underwriting limits**, premium loadings, restrictions, exclusions and any limitations imposed in respect of an individual **insured member** providing all of the following conditions are met:

- the following information is provided to us no later than 90 days after the **transfer date**, unless we agree otherwise in writing:
  - all information we need about the operation and terms of the previous policy are provided to us in writing including, but not limited to, individual names, level and type of **insured benefits** and the applicable underwriting acceptance terms and
  - an **At Work Certificate** from you certifying the names of all transferring members who were not **at work** due to an illness or injury on the **transfer date**.
- premiums are paid for all transferring members we are to cover
- cover is provided in accordance with our quotation including, but not limited to, our maximum monthly benefit level.

We will provide GSC Cover from the **transfer date** for transferring members insured under the previous policy who are **eligible persons** and who were **at work** on the last **normal business day** immediately before the **transfer date**.

For any transferring member insured under the previous policy who was not **at work** on the last **normal business day** immediately before the **transfer date**, for reasons other than illness or injury, we will take over the same amount of Total and/or Partial Disability Cover and/or Specific Injury Cover provided by the previous insurer, provided:

- on the day before the first day of the relevant absence,
  the transferring member was **at work** and
- during the period where the transferring member was not **at work**, he or she was not **disabled** due to an illness or injury prior to the **transfer date**.

Transferring members insured under the previous policy that were not **at work** due to illness or injury on the last **normal business day** before the **transfer date** will be provided with **New Events Cover** from the **transfer date**.

When the transferring member returns to the pre-disability duties they (working the same hours and in the same capacity without limitation) last performed when they were **at work**, the **insured member** will be covered on the same basis as an **insured member** who was **at work** on the last **normal business day** immediately before the **transfer date**.

The **eligible person** must not have been paid or have been entitled to receive a benefit under the previous insurer's policy.

Transfer terms and AALs

When a plan is transferred to us and we apply a higher **AAL**, the higher **AAL** may apply to all members of the plan including those who were declined cover above the previous insurer's **AAL**, or who had loadings or exclusions applied to their cover above the previous insurer's **AAL**. Any loading or exclusions that previously applied in respect of an **insured member** will only apply above the new higher **AAL**. We will advise you in writing if we agree to do this.

Applications

An **eligible person** or **insured member** will be required to submit an application online or in writing for GSC Insurance if:

- automatic acceptance terms do not apply to your plan
- they are not eligible for automatic acceptance
- they require cover in excess of the **AAL**
- they require cover that is not **New Events Cover**
- transfer terms do not apply
- they require an increase in their monthly benefit (if an increase is not automatically provided see page 14 of this PDS)
- their cover stops under the **Policy** for any reason or
- the **eligible person** joins the plan at age 61 or older and wishes to be covered under the **Policy** beyond age 65.

A copy of the standard Group Risk Personal Statement can be found at onepath.com.au. Once completed, it should be submitted to:

Group Risk Insurance Administration
OnePath Life
GPO Box 4129, Sydney NSW 2001
Fax 02 9234 8072
Email group.risk@onepath.com.au

Will other information be required?

Our standard underwriting requirements are outlined in our 'Underwriting Guide', which can be downloaded from onepath.com.au or obtained by calling Group Risk Insurance Administration on 1800 648 921.

In some circumstances, we will require information from the **insured member** in addition to the Group Risk Personal Statement. Where this is the case, we shall advise the **insured member**. We may also request additional medical, personal, or financial information on a case-by-case basis.

How much cover is available?

An application can be made for cover up to the maximum monthly benefit level.

If we accept an application, we will notify you of the **insured member's** new cover details. Premiums will be charged from the effective date of any cover we approve.

Limited Cover may be provided whilst the application is being assessed. Limited Cover is described on page 14 of this PDS.

When does cover start?

Cover for **insured members** accepted under automatic acceptance will start on the later of the **policy start date** and the date the **eligible person** first meets the **eligibility criteria**.

Cover for **insured members** accepted under transfer terms commences on the **transfer date**.

Cover obtained on individual application will start from the date we accept the application.

When does cover end?

An **insured member's** cover will end and our liability to pay any benefit under the **Policy** will cease automatically, on the earlier of:

- the date the **Policy** ends as set out in the **Policy Schedule**
- the date the **insured member** who is not an **Australian resident** is no longer permanently in Australia, or not eligible to work in Australia (whether that is because they no longer hold a **visa** or for any other reason)
- the date the **insured member** attains the **benefit expiry age**
- the date the **insured member** commences **active service** with the armed forces of any country (except where the **insured member** is a member of the Australian Defence Force Reserves, in which case, cover for all benefits will cease only when the Reservist becomes the subject of a call out order under the *Defence Act 1903* (Cth))
- the date we cancel and/or avoid the **Policy**, or cover in respect of an **insured member**, in accordance with our legal rights
- the date we cancel and/or avoid the **Policy**, or cover in respect of an **insured member**, because you have not paid the premium when due
- the date the **insured member** dies
- the date the **insured member** permanently retires from employment
- when we receive written advice from the **insured member** to cancel cover
- in relation to an **insured member** who ceases to meet the **eligibility criteria**, on the earlier of:
  - the date the **insured member** reaches the **benefit**

expiry age

- 60 days after the date the **insured member** ceases to meet the **eligibility criteria**
- the date the **insured member** commences employment with a new employer or commences work as a **contractor**
- the date we issue a retail policy of insurance to the **insured member** pursuant to the Continuation Option

- from the date the **insured member** is on leave for longer than we have agreed to provide cover for
- from the date the **insured member** is employed overseas for a period longer than we have agreed to provide cover for
- the date the **Policy** is terminated, except to the extent discussed below.

If the **Policy** terminates and the **insured member** is not **at work** due to illness or injury, the **insured member** will continue to have cover under the **Policy** until the earliest of the following times:

- the date the **insured member** returns to the **pre-disability** duties (working the same hours and in the same capacity without limitation) they last performed when they were **at work**, free from any limitation due to illness or injury and they are not entitled to receive income support benefits (including government income support benefits) of any kind
- the date we make a determination in respect of the **insured member's disability** claim
- the date the **insured member** attains the **benefit expiry age**
- the date the **insured member** dies.

Duration of the Policy

The **Policy** starts on the **policy start date** and generally, will continue for as long as the premium is paid on time and the terms of the **Policy** are observed, until the earlier of:

- the policy expiry date outlined in the **Policy Schedule**
- the date you terminate the **Policy** by giving us at least 30 days written notice
- the date we terminate the **Policy** by giving you at least 30 days written notice after your failure to pay the premium on the due date
- the date we terminate the **Policy** in accordance with our legal rights.

As this is a group policy that covers multiple lives, the **Policy** may remain in force even after an individual **insured member's** cover has stopped.

Varying the Policy

If we agree with you to vary the terms of the **Policy**, we shall do so in writing.

Changing your cover

You may apply to us in writing to change the benefits that apply to your plan or make any other changes at any time. Any insurance already in place will be unaffected by such an application. If you apply to make such changes and we approve the change, we will provide confirmation by issuing a new **Policy Schedule**. We will also issue a new **Policy Schedule** at the expiry of the **premium rate guarantee period**.

What are the built-in benefits of GSC Insurance?

Monthly benefit

The monthly benefit is the amount you will be paid under the benefits provided by the **Policy** while the **insured member** is **on claim**. The amount of the monthly benefit is calculated as a percentage of the **insured member's salary**. Generally, the monthly benefit is equivalent to 75% of an **insured member's salary** divided by 12, however, you can decide on the percentage of the **salary** that will be used to calculate the monthly benefit when you establish the **Policy**. It is subject to an overriding maximum monthly benefit (indicated in your **Quotation Summary** and the **Policy Schedule** if we issue a **Policy** to you). In some cases, we may agree to pay a fixed monthly benefit for a group of **insured members** where we have verified (in advance) their **salaries** support such a benefit. Where we do this, it will be outlined in the **Policy Schedule**.

If a payment is for part of a month, then it will be calculated on the basis of 1/30 of the monthly benefit amount for each day the benefit is payable.

Minimum hours requirement

In order to be eligible for a Disability Benefit, the **insured member** will be required to be **gainfully employed** for an average of 15 hours or more per week over a period of six consecutive months immediately prior to the date of the **disability**.

If, at the time of the **disability**, the **insured member** has been working for their current employer for less than six months, they will only be eligible for a Disability Benefit if they have worked an average of 15 hours or more per week since their cover commenced.

If the **insured member** does not satisfy the minimum hours requirement set out above at any time, he or she will not be eligible for a Total or Partial Disability Benefit.

Waiting period

The **waiting period** is the number of days for which an **insured member** must be **totally** or **partially disabled** before the Total or Partial Disability Benefit begins to accrue.

Benefits are only payable where the **insured member** is **totally** or **partially disabled** for at least the **waiting period**.

The **waiting period** that applies to your plan will be outlined in the **Policy Schedule**.

During the **waiting period** an **insured member** may return to work once for up to five consecutive days without having to re-start the **waiting period**. The days worked will be added to the **waiting period**.

A separate **waiting period** applies for each separate illness or injury of the **insured member** which causes **disability** for which the **insured member** can claim under this **Policy** unless the **insured member** is claiming under the Recurring Disablement Benefit.

Total Disability Benefit

We will pay the monthly benefit to you during the **benefit period** if an **insured member** is **totally disabled** for longer than the **waiting period**. To be eligible for the Total Disability Benefit, the **insured member** must have been:

- **totally disabled** for at least seven days out of the first 12 consecutive days of the **waiting period**
- continuously **totally** or **partially disabled** for the balance of the **waiting period** and
- at the expiry of the **waiting period**, **totally disabled**.

No payment is made during the **waiting period**.

The Total Disability Benefit is payable monthly in arrears and stops at the earlier of:

- the end of the **benefit period**
- the **insured member** reaching the **benefit expiry age**
- the **insured member's** death
- the **insured member** ceasing to be **totally disabled**
- for an **insured member** on a **visa**, the date the **insured member's** employment contract and/or **visa** expires or is otherwise terminated, or the date the **insured member** departs Australia.

Partial Disability Benefit

We will pay you a portion of the monthly benefit during the **benefit period** when an **insured member** is **partially disabled** at the expiry of the **waiting period**. To be eligible for the Partial Disability Benefit, the **insured member** must have been:

- **totally disabled** for at least seven days out of the first 12 consecutive days of the **waiting period**
- **totally** or **partially disabled** for the balance of the **waiting period** and
- continuously **disabled** since the end of the **waiting period**.

No payment is made during the **waiting period**. The Partial Disability Benefit is calculated as follows:

$$\frac{A - B}{A} \times \text{monthly benefit}$$

where:

A = the **insured member's pre-disability salary**

B = the greater of the **salary** of the **insured member**:

- earns for the month that the Partial Disability Benefit is payable
- is capable of earning for the month in which they are **partially disabled**.

If the **insured member** is not working to their assessed capacity then 'B' will be the amount they could expect to earn if they were. When we assess capacity, consideration will be given to medical evidence, and other factors related to the **insured member's** condition. 'B' must be less than the amount of 'A'. If 'B' is negative in a month, we will treat 'B' as zero.

The Partial Disability Benefit begins to accrue from the day after the **insured member** is no longer **totally disabled** or after the end of the **waiting period**, whichever is later.

The Partial Disability Benefit is payable monthly in arrears and stops at the earlier of:

- the end of the **benefit period**
- the **insured member** reaching the **benefit expiry age**
- the **insured member's** death
- the **insured member** ceasing to be **partially disabled**
- the **insured member** earning, or being capable of earning, a monthly **salary** equal to or greater than the **insured member's pre-disability salary**
- for an **insured member** on a **visa**, the date the **insured member's** employment contract and/or **visa** expires or is otherwise terminated, or the date the **insured member** departs Australia.

Death Benefit

If an **insured member** dies while a Disability Benefit is being paid in respect of them, we will pay you an amount equal to three times the monthly benefit amount that was payable or paid in respect of the **insured member** in the month immediately preceding his or her death.

Specific Injury Benefit

If an **insured member** suffers a specific injury as set out in the table 'Specific injuries covered under the Policy' within 180 days of the event which caused it, we will pay you the monthly benefit for the corresponding nominated payment period. This payment will cease when the **insured member** reaches the **benefit expiry age**.

Only one Specific Injury Benefit is ever payable for an **insured member**, irrespective of the number of claims made. If an **insured member** suffers more than one specific injury at the same time, we will pay the monthly benefit for the longer of the relevant nominated payment periods. No Disability Benefit is payable in respect of a period during which the Specific Injury Benefit is being paid or applies.

If an **insured member** continues to be **disabled** at the end of the nominated payment period during which a Specific Injury Benefit was paid and the **insured member** is eligible for a Disability Benefit, we will waive the **waiting period**.

If the **insured member** dies during the nominated payment period, we will pay you a lump sum equal to the greater of the total remaining monthly benefits payable under this benefit and the Death Benefit.

The diagnosis of the specific injury must be made by an appropriate specialist **medical practitioner** and confirmed by our medical adviser.

Specific injuries covered under the Policy

Specific injury	Nominated payment period
Paralysis*	60 months†
Loss of both feet or both hands or sight in both eyes‡	24 months
Loss of any combination of two of: • a hand • a foot • sight in one eye‡	24 months
Loss of one leg or one arm‡	12 months
Loss of one foot or one hand or sight in one eye‡	12 months
Loss of thumb and index finger of the same hand‡	6 months
Fractures§ of the:	
• thigh or pelvis	3 months
• leg (between knee and foot) or knee cap	2 months
• upper arm including the elbow and shoulder bone	2 months
• skull (except bones of the nose or face)	2 months
• lower arm (including wrist but excluding the elbow, hand and fingers)	1.5 months
• jaw or collarbone	1.5 months

* Paralysis means the total and permanent loss of function of two or more limbs.

† If you have selected a two-year **benefit period**, this payment period is reduced to 24 months.

‡ Loss means either:

- total and permanent loss of the use and control of the hand from the wrist, or the foot from the ankle joint
- complete severance of the thumb and index finger from the first phalangeal joint
- irrecoverable total loss of an eye or the sight of an eye.

§ Fracture means any fracture that requires a pin, traction, a plaster cast or other immobilising structure.

Recurring Disablement Benefit

If:

- the **insured member** was engaged in full-time or part-time work prior to a period of **disability** and then returns to full-time or part-time work after such period of **disability** and
- the **insured member** suffers a recurrence of the **disability** which was the cause of the previous claim within six months of the claim ending,

then the **waiting period** will not apply and the further claim will be regarded as a continuation of the earlier claim.

The monthly benefit payment will recommence without a further **waiting period** applying.

The monthly benefit will continue to be paid until the end of the **benefit period** under the **insured member's** first claim i.e. both periods of the **insured member's disability** are added together to work out when the **benefit period** for the **disability** ceases.

If the **insured member's disability** recurs more than six months after the earlier claim ended, any subsequent claim will be considered as a new claim. A new **waiting period** and **benefit period** will apply.

Early Notification Incentive Benefit

We will pay you the Early Notification Incentive Benefit once during a claim period if the **insured member**:

- notifies us of their intention to make a claim before the expiration of the **waiting period** and
- provides to us the information required by us to establish the occurrence of the event giving rise to the claim no later than 30 days after the occurrence of the event.

Where an **insured member** suffers **disability** after the expiration of the **waiting period**, the Early Notification Incentive Benefit that we will pay you is 25% of the first month's Disability Benefit amount (or if this is for less than one month, a pro-rata amount for each day the **insured member** is **disabled**).

This benefit is payable in addition to any other benefit (with the exception of the Specific Injury Benefit) and only becomes payable at the expiration of the **waiting period**.

Emergency Domestic Travel Benefit

This benefit is not available if the Policy is to be held within superannuation.

If the **insured member** is in receipt of a Total Disability Benefit and requires **emergency transportation** within Australia to a hospital, we will reimburse the expenses incurred for **emergency transportation** by the **insured member**.

The amount we will pay you is the lesser of:

- the expenses actually incurred for the **emergency transportation**
- the **insured member's** monthly benefit
- $1,000.

The Emergency Domestic Travel Benefit will be reduced by the amount of any payments made by, or recoverable from, another source in respect of the same **emergency transportation** expense. The **insured member** is obliged to inform us if he or she has the right to apply for, or has received, a similar benefit from any other source. Where the **insured member** refuses to provide such information, we may refuse to pay the benefit.

This benefit is only payable once in respect of each claim for **total disability** made by an **insured member,** is payable in addition to any other benefit that becomes payable and is not payable during the **waiting period**.

Additional information

In limited circumstances, we may agree with you to pay some or all of the benefits directly to the **insured member**, for example where the **insured member's** employer no longer operates, the **insured member** has been terminated as an employee, or the **insured member** is no longer a member of a complying superannuation fund. This is at our sole discretion.

What are the built-in features of GSC Insurance?

Worldwide cover

The cover provided by the **Policy** provides worldwide insurance cover 24 hours a day. There are, however, some restrictions on **insured members** working overseas and taking leave, as set out below.

Cover during paid and unpaid leave

Provided the premiums continue to be paid, an **insured member** is automatically covered for 24 months whilst on paid or unpaid leave including **parental leave**, subject to the following conditions:

- the **insured member's** employer must approve the period of paid or unpaid leave, prior to the date the **insured member** commences leave
- the **insured member's** employer must hold appropriate leave records in respect of that **insured member**, which include:
  - the date the paid or unpaid leave is to commence and
  - the date the **insured member** is expected to return to work.

  These records must be provided to us upon request.

The number and identity of **insured members** on leave must be provided to us when requested, and annually with the **member information**.

Cover during overseas employment

Provided the premiums continue to be paid, cover for **Australian residents** continues automatically while they are seconded overseas for up to five years.

We may impose conditions on the cover, and review cover, at the end of the **premium rate guarantee period**. If we impose such terms we will do so in writing.

For cover beyond five years, an application is required.

You must retain records in relation to **insured members** working overseas, including location, and provide these to us upon request and annually with the **member information**.

Cover for non-Australian residents

Non-**Australian residents** are eligible for cover whilst they reside in Australia if they are eligible to work in Australia and hold a **visa**. All cover will cease upon the non-**Australian resident's** departure from Australia unless the overseas trip is for three months or less.

Extended Cover

Cover continues under the **Policy** for a maximum period of 60 days after the date an **insured member** ceases to meet the **eligibility criteria** provided the **insured member** had not received, nor is entitled to receive, a benefit under the **Policy**, nor was in a **waiting period** for a benefit.

Extended Cover will cease on the earlier of:

- the date, the **insured member** reaches the **benefit expiry age**
- 60 days after the date the **insured member** ceases to meet the **eligibility criteria**
- the date, cover for the **insured member** commences under a retail policy of insurance issued by us under the Continuation Option (see below) and
- the date the **insured member** commences employment with a new employer or commences work as a **contractor**.

Continuation Option

The option to continue cover provided by OnePath Life's GSC Insurance under an individual policy is available as a built-in feature of the **Policy**. This means that the **insured member** may apply to us for an individual disability indemnity policy on his or her life with a **waiting period**, **benefit period** and monthly benefit that are no more favourable than those that applied to the **insured member** under the **Policy**.

We will not require medical evidence to be provided, however, to exercise the Continuation Option the person must:

- apply in writing by completing an application for the individual policy within 60 days from the date he or she ceases to be an **eligible** person under the **Policy** as a result of ceasing **gainful employment** with you (if the **Policy** is held outside of superannuation) or with a participating employer (where the **Policy** is held within superannuation)
- be less than 60 years of age
- provide any information we consider relevant (that does not relate to medical information)
- be an **Australian resident** or holder of a **visa** and not residing outside Australia
- acknowledge that any restrictions, limitations or loadings that apply to the **insured member's** cover under the **Policy** will apply to the new policy
- apply for an indemnity contract only
- not be eligible to receive benefits under the **Policy** or any other policy issued by an insurer providing similar benefits, nor any previous policy that the **Policy** replaced under transfer terms and

- be engaged in an occupation which is acceptable as an insurable occupation under the new contract and working the minimum number of hours required under the new contract.

If the **Policy** is terminated or is transferred, including as a result of a successor fund transfer where you are a trustee of a complying superannuation fund, a Continuation Option will not be available to any **insured member**.

If we provide a Continuation Option, cover under the individual policy commences in accordance with the terms of that individual policy. The premium rate under the individual policy may be more than under the **Policy**. The individual policy issued will be OnePath Life's OneCare policy. If it is no longer available, the policy issued will be the individual policy available at that time that we deem provides the same or similar benefits.

Limited Cover

Whilst an application for cover is being assessed by us, we provide cover for **disability** arising as the result of an **accident** (Limited Cover), at no extra cost.

Limited Cover starts from the date an application for cover is received by us and it will end upon the earlier of:

- the date we notify you or the **insured member** that we accept or reject the application for cover
- 90 days after the date Limited Cover starts
- when the **insured member** withdraws or cancels their application
- cover otherwise ceasing in respect of that **insured member** under the **Policy** (refer to pages 8 and 9 of this PDS).

The amount of Limited Cover

The Limited Cover Benefit we will pay you will be the lesser of:

- the benefit amount applied for in the application for cover
- the difference between the level of increased cover applied for and the current level of cover
- the maximum monthly benefit level.

Limited Cover does not include the payment of a Specific Injury Benefit or any other built-in benefits, built in features or extra cost options.

Return to work assistance

Once we receive notice of an illness or injury which may give rise to a claim for a Disability Benefit, if we are of the opinion that participation in a return to work program may help an **insured member** return to work, we may pay some or all of the expenses incurred for their participation in that program. We will pay only where the program expenses have been approved by us. We will pay the service provider directly. Any payment will be made at our discretion.

Workplace modification assistance

If the **insured member** is receiving Disability Benefits and we agree that his or her place of employment requires modification in order for him or her to return to work, we may pay all or some of the modification expenses to a service provider. The maximum payment is three times the **insured member's** monthly benefit, and all payments will be made at our discretion.

Premium Waiver

We will waive the payment of any premium for an **insured member** while they are receiving a Disability Benefit, the Specific Injury Benefit, the Early Cash Benefit, the Recovery Assistance Benefit or the Trauma Recovery Benefit.

Forward Underwriting Limits

If increases in the monthly benefit are not accepted under automatic acceptance or transfer terms, we may agree with you to accept increases up to a **forward underwriting limit**. We will notify you when it applies.

We will only agree to a **forward underwriting limit** in respect of an **insured member** when we have provided our written acceptance of the **insured member's** application for cover or increased cover. We may impose lower **forward underwriting limits** at our discretion.

Automatic increases to the monthly benefit

An **insured member** who became covered by automatic acceptance may have their monthly benefit increase in line with changes to their **salary** provided they are **at work** on either the **review date** or another date during a 12 month period, which is specified in the **Policy Schedule**.

The **insured member** will not need to apply to us in writing if the increase in the **insured benefit** is up to the lesser of:

- the **AAL**
- 25% of the **insured member's insured benefit,** as applied immediately before the increase.

Unless we agree otherwise, we will require the **insured member** to be underwritten for that part of the monthly benefit that is in excess of the above limitations.

Discounts

Early payment discount

A premium discount will apply if the annual premium is paid within 30 days of the annual due date. All details will be outlined in the **Policy Schedule**.

Combined plan discount

If you install a OnePath Life Group Life Policy with the same **policy start date** and annual **review date** at the same time as this plan, we will reduce the premium for this plan by 2.5%. This discount will only continue to apply while the annual **review date** of the OnePath Life Group Life Policy remains the same as the annual **review date** chosen for the **Policy**, and both policies remain in force.

What optional benefits are available?

At a glance

You may select optional benefits to apply to your plan at an extra cost. Cover for an optional benefit can apply in respect of an **insured member**, or a category of **insured members**. Any optional benefits that apply will be shown in the **Policy Schedule**. The optional benefits available are set out below.

Superannuation Contribution Benefit (SCB)

If the SCB applies when a Disability Benefit is payable in respect of an **insured member**, the **insured member** will also be provided with a benefit calculated as set out below.

The SCB is:

- calculated based on 1/12 of the percentage factor set out in the **Policy Schedule** of the **insured member's salary**
- paid in addition to the monthly benefit and
- subject to the maximum monthly benefit level.

The SCB may be reduced proportionally where the **insured member** is entitled to a Partial Disability Benefit.

The terms that apply to the payment of a Disability Benefit in the **Policy** also apply to the payment of the SCB. No SCB is payable during the **waiting period**.

We will pay the SCB directly to a superannuation provider nominated by you for the **insured member's** benefit, or we will pay it to you subject to proof we may request that the amount is subsequently forwarded to a superannuation provider for the **insured member's** benefit.

This benefit will only be paid in circumstances permitted by the relevant laws relating to superannuation contributions and taxation. The superannuation provider must be either a complying superannuation fund or retirement savings account as defined in the relevant superannuation and taxation laws.

Enhanced Bereavement Benefit

The Enhanced Bereavement Benefit is payable where an **insured member** dies or is diagnosed with a **terminal illness**.

If selected, the Enhanced Bereavement Benefit is payable regardless of whether an **insured member** is **on claim**. The amount payable is three times the monthly benefit amount, paid as a lump sum, subject to a maximum of $60,000.

We will pay this benefit once only. If we pay the Enhanced Bereavement Benefit for a **terminal illness**, we will not pay an additional amount upon the death of the **insured member**.

Alternative Benefit Expiry Age Benefit

If the **benefit expiry age** requested by you and accepted by us is an age other than age 65 (Alternative Benefit Expiry Age), as shown in the **Policy Schedule,** an **insured member** may have cover under the **Policy** up to the Alternative Benefit Expiry Age subject to the following conditions:

- a specific category may have cover up to the Alternative Benefit Expiry Age so long as the number of **insured members** in that category exceeds 20 **insured members** and
- an **eligible person** who joins the plan at age 61 or older must apply to us in writing and we must accept that **eligible person's** application if the **eligible person** is to have the **benefit period** extend beyond age 65 or be covered to the Alternative Benefit Expiry Age.

Escalation Benefit

Twelve months after a Disability Benefit has been continuously paid in respect of the **insured member**, the **insured member's** monthly benefit will be increased by the lesser of the annual CPI and the **escalation factor**.

The adjusted benefit will be similarly increased after each 12 month period for which a Disability Benefit is continuously paid.

Nurse Care Benefit

This benefit is not available if the Policy is to be held within superannuation.

An amount equal to 1/30 of the monthly benefit is payable to you for each day, after the first three consecutive days, an **insured member** is:

- **totally disabled** during the **waiting period**
- confined to bed for more than three consecutive days on the advice of their **medical practitioner** and
- in receipt of **full-time** nursing care which is certified by their **medical practitioner** as necessary for the treatment of their **disability**, provided the nursing care is performed by a registered and qualified nurse who does not normally reside in the same household and who is not their relative.

The Nurse Care Benefit is payable until the earlier of:

- 30 days
- the expiry of the **waiting period**.

Recovery Assistance Benefit

The benefit amount set out in the table 'Recovery Assistance Benefit Amounts' is payable to you as a lump sum if:

- the Total Disability Benefit is being paid in respect of an **insured member** and
- the **insured member** becomes **totally and permanently disabled** within 12 months of the date he or she first ceased work due to the illness or injury giving rise to the **total disability**.

The Recovery Assistance Benefit is payable in addition to any other benefits which may be payable under the **Policy**. Only one Recovery Assistance Benefit is ever payable for each **insured member**.

Recovery Assistance Benefit Amounts

Age next birthday when ceased work	Amount of Recovery Assistance Benefit
Up to age 56	$50,000
57	$45,000
58	$40,000
59	$35,000
60	$30,000
61	$25,000
62	$20,000
63	$15,000
64	$10,000
65	$5,000
66	$0

If the Escalation Benefit applies, the amount of the Recovery Assistance Benefit will be increased on each **review date** by the lesser of the annual **CPI** increase and the **escalation factor**.

Early Cash Benefit

This benefit is not available if the Policy is to be held within superannuation or if you select the Trauma Recovery Benefit.

The Early Cash Benefit will be payable monthly in advance from the date the **insured member** is diagnosed with an early cash condition. The duration of the period for which we pay an Early Cash Benefit is determined by the **waiting period** that applies to your plan, as set out below:

Waiting period applicable to your plan	Payment period
30 days	6 months
60 days	4 months
90 days	3 months

If an **insured member** suffers more than one early cash condition at the same time, we will only pay for one early cash condition. We will not pay you any other benefit under the **Policy** while we are paying you the Early Cash Benefit.

The following early cash conditions are included under the Early Cash Benefit and are defined in the Dictionary on page 30 of this PDS:

- **cancer**
- **chronic kidney failure**
- **coronary artery by-pass surgery**
- **heart attack**
- **heart valve surgery**
- **stroke**
- **major organ transplant**
- **severe burns**.

Benefits after expiry of the Early Cash Benefit

If the **insured member** is **disabled** after the Early Cash Benefit payment period ends, due to an early cash condition for which we have paid this benefit, we will pay a Total or Partial Disability Benefit from the date at which the Early Cash Benefit payment period ends. There is no **waiting period** in this circumstance.

Trauma Recovery Benefit

This benefit is not available if the Policy is to be held within superannuation or if you select the Early Cash Benefit.

We will pay the monthly benefit to you if a trauma recovery event happens to the **insured member**.

This benefit is payable whether or not the **insured member** is **disabled**. This benefit is payable during the **waiting period**.

The **insured member's** monthly benefit will be paid in advance each month until the earlier of the:

- end of the payment period of six months for that trauma recovery event
- **insured member's** cover ceasing under the **Policy**
- date of the **insured member's** death.

If the **insured member** suffers either another trauma recovery event or a specific injury while we are paying a Trauma Recovery Benefit, we will pay the benefit that provides for the longest payment period. The Trauma Recovery Benefit is payable only once in respect to any **insured member**.

The following trauma recovery events are included under the Trauma Recovery Benefit and are defined in the Dictionary on page 28 of this PDS:

Trauma recovery events	
Alzheimer's disease†	**loss or paralysis of limb**
aortic surgery*	**major head trauma**†
aplastic anaemia	**major organ transplant**
benign brain tumour†	**medically acquired HIV**
blindness	**meningitis and/or meningococcal disease**
cancer*†	**motor neurone disease**†
cardiomyopathy	**multiple sclerosis**†
chronic kidney failure	**muscular dystrophy**†
chronic liver disease	**occupationally acquired HIV**
chronic lung disease†	**open heart surgery***
cognitive loss	**Parkinson's disease**†
coma	**pneumonectomy**†
coronary artery by-pass surgery*†	**primary pulmonary hypertension**
deafness	**severe burns**
dementia†	**severe diabetes***†
encephalitis	**severe osteoporosis***†
heart attack*†	**severe rheumatoid arthritis***†
heart valve surgery*	**stroke***†
intensive care	**systemic sclerosis***
loss of independent existence	**terminal illness**†
loss of speech	**triple vessel angioplasty***

* There is no Trauma Recovery Benefit payable if this trauma recovery event first occurs or is first diagnosed, or the symptoms leading to the trauma recovery event occurring or being diagnosed first become **reasonably apparent**, during the first 90 days that cover under the **Policy** commences in respect of the **insured member**.

† This trauma recovery event must be diagnosed and certified by a **medical practitioner** who is an appropriate specialist physician approved by us.

Benefits after expiry of Trauma Recovery Benefit

If the **insured member** is **disabled** at the end of the payment period of six months, due to the trauma recovery event for which we have paid this benefit, we will pay a Total or Partial Disability Benefit (as applicable) from the later of the:

- end of the payment period for the trauma recovery event
- end of the **waiting period**.

If the **benefit period** is two years or five years, the maximum period for which we will pay **disability** benefits is reduced by the number of months for which we have already paid the Trauma Recovery Benefit.

Immediate Family Member Benefit

This benefit is not available if the Policy is to be held within superannuation.

If:

- a **medical practitioner** certifies that the **insured member** is confined to bed due to illness or injury and they require care
- the **insured member** is in receipt of Total or Partial Disability Benefits and
- as a direct result of the **insured member's** illness or injury, an **immediate family member** ceases to earn any **income** solely because the **insured member** needs the **immediate family member** to care for them,

we will pay you up to an additional 50% of the monthly benefit of which the **insured member** is receiving, subject to a maximum payment of $3,000 per month, under the **Policy** for a maximum of three months.

Payment of the Immediate Family Member Benefit will be made monthly in arrears.

This benefit is payable in addition to any other benefits that become payable and is not payable during the **waiting period**.

Evidence that may be required from the immediate family member

The **immediate 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 an entity of which the **insured member** is a Principal or Director and
- provide the proof that we reasonably require to confirm that the **immediate family member** ceased to earn any income solely to provide the **insured member** with care.

We may refuse to make any payments where proof to our satisfaction is not provided.

Relocation Benefit

This benefit is not available if the Policy is to be held within superannuation.

We will pay the Relocation Benefit to you once whilst an **insured member** is **on claim** if the **insured member:**

- becomes **totally disabled** whilst outside of Australia
- remains **totally disabled** for at least 30 days and
- chooses to return to Australia while **disabled**.

The amount we will reimburse is the lesser of:

- the cost of a single standard economy airfare for a scheduled commercial flight by the most direct route to the airport in Australia nearest to where the **insured member** resides, which is reasonable in the circumstances
- expenses actually incurred by the **insured member** in changing previously made air travel arrangements
- three times the **insured member's** monthly benefit.

This benefit is only payable once in respect of each claim for **total disability**, is payable in addition to any other benefit that becomes payable and is payable during the **waiting period**.

This benefit is conditional upon proof from you that:

- there is no more than 15% of **insured members** working overseas at any one time and
- at the last **review date**, with the provision of **member information**, we have been advised of the number of **insured members** working overseas and the countries that such **insured members** reside in.

We may refuse to pay this benefit where proof to our satisfaction is not provided.

What are the limitations and risks?

One benefit payable at a time

We pay one monthly benefit at a time, even if the **insured member** suffers more than one illness or injury. This applies to the Total Disability Benefit, Partial Disability Benefit, Specific Injury Benefit, Trauma Recovery Benefit, Early Cash Benefit, and the Nursing Care Benefit.

Benefit reductions

Benefits payable will be reduced in the following circumstances:

- the Total or Partial Disability Benefit is reduced by other amounts payable (including settlement or commutation amounts) in respect of the **insured member**:
  - by way of compulsory insurance schemes such as Workers' Compensation or Accident Compensation for loss of income
  - in respect of loss of income (whether under legislation or otherwise)
  - by way of any paid parental leave, where the **insured member** suffers **disability** during a period of **parental leave**
  - as benefits under any other disability, injury or sickness insurance policy (except for lump sum benefits received for total and permanent disablement under such an insurance policy)
  - sick leave, long service leave entitlements and investment income are not taken into account.
- the Specific Injury Benefit is reduced by any amount you or the **insured member** receives by way of Workers' Compensation or Accident Compensation (including a settlement or commutation amount) in respect of the applicable nominated period.

If a lump sum payment is received, with all or a part of that lump sum as a payment in compensation for loss of earnings that cannot be allocated to specific months, we will covert that part of the compensation for loss of earnings to income on the basis of 1% of the loss of earnings component for each month that we pay the monthly benefit, for a maximum of eight years. The balance of the lump sum, if any, will not be offset.

In addition, the **Policy** may contain certain exclusions or limitations. We will not pay any benefits under the **Policy** for anything we have specifically excluded as shown in the **Policy Schedule** or the **Decision Note**.

Reductions if the benefit period is beyond age 65

If the **insured member's disability** commences when the **insured member** is age 65 or older, the **insured member's** maximum monthly benefit level is reduced to the maximum monthly benefit level that corresponds to the **insured member's** age when **disability** commenced as set out in the table below, or 75% of the **insured member's salary**, whichever is the lesser:

Age at commencement of disability	Maximum monthly benefit payable
65	$10,000
66	$8,000
67	$6,000
68	$4,000
69	$2,000

Repayment of benefits

If, for any reason, it is determined that a benefit paid was not actually payable under the **Policy**, all or the part of the benefit that was not payable, must be repaid to us by you (the policy owner).

Pre-existing conditions

If the **Policy** allows members to be accepted under automatic acceptance or transfer terms (as described on pages 6 and 7), cover for **pre-existing conditions** is excluded if a similar benefit can be claimed under a policy from another insurer, or under another plan.

Insurance risks

There are a number of insurance risks you should be aware of:

- if the premium is not received by us within 30 days of the due date, we may cancel or terminate your **Policy** after we give you 30 days written notice and we may charge interest on any amount due. In addition we may not accept an **insured member's** claim that arises after the due date
- the maximum amount of the insurance cover you select for your plan may not be sufficient to provide adequate insurance cover for an **insured member** in the event of their illness or injury
- we are not bound to accept your proposal and
- if you or an **insured member** do not comply with the Duty of Disclosure (see page 25 of this PDS) or makes a misrepresentation, we may avoid the contract, or avoid cover in respect of an individual **insured member**.

Change in risk profile

If any aspect of the membership profile (number, gender, age, occupation) changes by more than 25% from that existing at the **policy start date**, or the last **review date**, we may:

- stop accepting new **insured members**
- increase the premium rate (including during the **premium rate guarantee period)**
- vary the automatic acceptance terms and/or
- vary or remove the **AAL**.

If the number of **insured members** covered under the **Policy** falls below 75% of **eligible persons** (or as otherwise agreed to by us in writing) the **AAL** may automatically revert to nil as described on page 7 of this PDS.

Overseas travel

If an **insured member** travels or resides overseas for over six months (or such period as we agree to with you in writing) whilst **on claim** we will cease payment of any further benefits. Payments will resume only if further entitlement is established during a period the **insured member** resides in Australia.

Exclusions

Benefit payments will not be made if the event giving rise to the claim is caused directly or indirectly, wholly or partially by either:

- **war**, or an act of **war**, in Australia, New Zealand or an **insured member's** country of residence
- if an **insured member** dies on **war service**
- an **insured member's** intentional self-inflicted act or
- pregnancy, unless the **insured member** is **disabled** for more than three months after the end of the pregnancy (in which case the **waiting period** is deemed to start on the later of the date **total disability** begins and the end of the pregnancy).

We may reduce or refuse to pay any benefits:

- while the **insured member** is imprisoned or on remand in a correctional or rehabilitational facility
- if you or the **insured member** do not comply with our claim requirements, including compliance with any obligations arising from your, or the **insured member's**, duty of disclosure
- where we have not received notice at the time the **insured member's disability** started, to the extent our assessment or management of the **insured member's** claim is prejudiced.

In addition, we cannot reimburse any expenses which:

- we are not permitted by law to reimburse or
- are regulated by the *National Health Act 1953 (Cth) or the Private Health Insurance Act 2007* (Cth).

What are the costs?

Payment of premiums

If we agree to accept your Proposal, the **Policy** commences when the first premium due has been paid or we accept a deposit premium from you.

We calculate the premium using the premium rate schedule set out in the **Quotation Summary**. We will calculate the premiums which apply to your **Policy** based on the **member information** we are initially provided. Thereafter, we will calculate the annual premium based on **member information** you must provide at each annual **review date**. The premium will be at least the minimum annual premium, which will be set out in the **Quotation Summary.**

We can change the premium rates:

- at the expiration of the **premium rate guarantee period** or if expired, any time after the **review date**
- during the **premium rate guarantee period** in limited circumstances (see heading titled 'Guarantee of premium rates' on this page)
- at any time in the event of **war**, or an act of **war**, in Australia, New Zealand or an **insured member's** country of residence
- by written notice to you, at any time if any aspect of the membership profile of **insured members** (including number, gender, age, occupation and country of residence) changes by more than 25% from that existing at the **policy start date,** or the date on which we last reviewed the premium rates or
- if there is a change in any government charge, licence fee, tax or any other impost that is directly attributable to the **Policy**.

We may also apply loadings to individual **insured members** based on our assessment of individual risks. Where we apply a loading, it will be applied to the base rate table(s) or unit rate we advised you. It may be varied by any other factor (e.g. occupation) that is used to calculate the premium payable in respect of an individual **insured member**. Where we do this, we will notify you.

Irrespective of the premium payment frequency, we calculate the premium at the plan's annual **review date**. We then advise you of the amount of the annual premium. Where the **Policy** has been in force for longer than one year, we also calculate an adjustment premium to cover changes in membership and benefit levels that occurred over the previous period. To keep the **Policy** in force, you must pay the premium by the due date. If it is not paid, we may cancel the **Policy**, and cover will cease for all **insured members**, after we give you 30 days written notice.

If you have paid too much, we will apply the overpayment to the next premium due. If you have not paid enough, we will notify you of the additional premium owed (the adjustment premium).

Adjustments are also calculated if the **Policy** ends, so that any overpayment of premium is refunded or any adjustment premium is payable.

A range of factors are taken into account when the premium is calculated for your plan. The premium will be affected by significant factors such as the:

- sum insured – the larger the sum insured the larger the premium
- age spread of **insured members** – the premium generally increases with age
- gender spread of **insured members**
- occupation of **insured members** – generally occupations with hazardous duties or higher occupational risk have higher premium rates
- grouping of polices – refer to 'Discounts' on page 15 for further information
- the claims history of your plan and
- applicable commission levels agreed between you and an intermediary.

The premium rates will be indicated in the **Quotation Summary**.

Guarantee of premium rates

The premium rates will be guaranteed from the **policy start date** to the end of the **premium rate guarantee period** (this will be indicated in the **Quotation Summary**), unless any aspect of the membership profile (number, sex, age, occupation) changes by more than 25% from that existing at the **policy start date**, or the date on which we last reviewed the premium rates.

If we agree to any change in the method of calculating benefits or the **eligibility criteria**, we may change the **premium rate guarantee period**, and/or the premium rates.

Minimum annual premium

The minimum annual premium (exclusive of stamp duty) is outlined in the **Quotation Summary**. If the premium we calculate is less than this minimum, you must pay the minimum premium, plus stamp duty. If you do not pay the minimum annual premium, we may cancel or terminate the **Policy** by giving you at least 30 days written notice.

Taxes and expenses

Policies held in superannuation

The taxation implication of insurance benefits and premiums under non-superannuation and superannuation policies will differ depending on individual circumstances and you should consider all potential taxation consequences that may apply to the premiums and benefit payments under a GSC Insurance **Policy**.

Your specific circumstances are not taken into account in providing this information. It is important that you seek professional and independent taxation advice specific to your circumstances regarding the taxation implications of purchasing a non-superannuation or superannuation GSC Insurance **Policy**.

Stamp duty

Stamp duty is payable in addition to the premium rates. This is a charge levied by each state government and we pass it on to the appropriate Office of State Revenue. The amount of stamp duty payable varies according to the **insured member's** state or territory of residence and may change from time to time.

An up-to-date listing of the percentage or dollar amount of duty that applies to **insured members'** premiums can be obtained by contacting Group Risk Insurance Administration on 1800 648 921.

Other expenses

In addition to the premium you are required to pay any:

- federal, state or territory taxes and charges
- expenses we incur in administering any function required of us by a federal, state or territory government under any legislation in relation to the **Policy**.

We reserve the right to recoup these charges through the premium you pay for the **Policy**, and increase the premium to cover any increase in these charges.

Goods and Services Tax (GST) implications

There is no GST charged on the premium payable for your cover.

Interest

We may charge you interest on any amount due to us which is outstanding for more than 30 days. Interest will be calculated based on the five year Bond Yield plus 3% as at the date the premium initially became due, as published in the *Australian Financial Review*. If this rate is no longer published, we will determine a similar replacement rate.

Misstatement of age

If an **insured member's** age is misstated, we may adjust the premium and/or the monthly benefit based on their correct age.

What do you need to know about making a claim?

How to make a claim

We require you or an **insured member** to notify us in writing of any claim within 30 days of an **insured member** being **disabled**, or as soon as reasonably possible.

In the event of the death of an **insured member**, you or a representative acting on behalf of the **insured member** should notify us within 30 days of the death of the **insured member**, or as soon as reasonably possible.

We will generally send you or the **insured member** claim forms within seven days of receiving notice of a claim.

Claim forms must be completed within 30 days of the **insured member** first becoming **disabled** or as soon as it is reasonably possible for the **insured member** to do so.

Payment of the claim

For us to pay a claim, the **insured member** must provide a properly executed claim form and proof, in a form which is subject to our verification, of all of the following:

- where an **insured member** was accepted (or an increase of the **insured benefit** was accepted) under automatic acceptance or our transfer terms, that you and the **insured member** met all our requirements
- **disability** or other entitlement to claim the applicable **insured benefit**
- any relevant payments during the **benefit period**
- the **insured member's** age and
- the **insured member's salary** and, if applicable, **pre-disability salary**.

Payment of the claim is conditional upon you or the **insured member** establishing entitlement by:

- providing medical reports from treating **medical practitioners**
- providing financial documentation (including, without limitation, tax returns, notices of assessment, group certificates and the like)
- when reasonably required by us (and at our expense), being examined by a **medical practitioner** we nominate who must confirm the condition and
- providing pathology, blood tests, x-ray or other appropriate evidence.

Payment of the claim is conditional upon the **insured member** being under the regular care of, and following the advice and treatment recommended by, their **medical practitioner**.

When reasonably required by us (and at our expense) the **insured member** will also:

- undergo an employability assessment
- be interviewed
- agree to an audit of their financial circumstances and
- provide any other relevant information.

More information

If you want to know more about making a claim for a GSC Insurance benefit:

- contact Group Risk Insurance Claims on 1800 648 921
- visit the OnePath website at onepath.com.au

What else do you need to know about GSC Insurance?

Guaranteed continuing cover

You may continue the **Policy** each year upon payment of the premium, regardless of changes to the health or pastimes of **insured members** in your plan.

Events that result in the **Policy** ending can be found on page 8.

Administration

We will maintain records and establish administrative systems to enable the **Policy** to be administered efficiently. After each **review date**, we will calculate the premiums due for the year beginning at that **review date** and will give you a listing of **insured members** and **insured benefits** provided.

To enable us to properly administer the **Policy** you must notify us of the entry and exit of individual **insured members** throughout the year.

Profit sharing

Generally we do not offer profit sharing for GSC schemes. Most plans will be non-profit, but in some cases we may offer a self-experience profit sharing formula. Where we offer profit sharing, it will be detailed in the **Quotation Summary**.

Duty of Disclosure

Before you (as the policy owner) or an **eligible person** enter into a contract of insurance with us, you and/or the **eligible person** have a duty under the *Insurance Contracts Act 1984* (Cth) to disclose to us every matter that you and/or the **eligible person** knows or could reasonably be expected to know, is relevant to our decision whether to accept the risk of insurance and, if so, on what terms.

You and an **insured member** have the same duty to disclose those matters to us before you or an **insured member** renew, extend, vary or reinstate a contract of insurance cover. Your duty, however, does not require disclosure of a matter that:

- diminishes the risk to be undertaken by us
- is of common knowledge
- we know, or in the ordinary course of business, ought to know or
- we have waived.

If you, an **eligible person** or an **insured member** do not disclose to us every matter that you know or could reasonably be expected to know, that would be relevant to our decision whether to accept the risk of the insurance and if so, on what terms, we may avoid the contract, or avoid cover in respect of an individual **insured member**, within three years of entering into it, provided we would not have entered that contract or accepted cover for an **insured member** on any terms had full disclosure been made.

If your, an **eligible person's** or an **insured member's**, non-disclosure is fraudulent, we may avoid the contract, or cover in respect of an **insured member**, at any time.

The Duty of Disclosure continues to apply until formal notification of assessment and acceptance of cover, or of any change in cover is accepted by us and confirmation is issued in writing.

Changes to member and other information

You must notify us of any changes to **insured members'** information that may affect their membership in the plan.

Governing law

The **Policy** is governed by the law that applies in the state or territory of Australia in which the **Policy** is registered.

Currency

All payments to or from us are to be made in Australian dollars.

Statutory fund

The **Policy** is issued from the statutory fund stated in the **Policy Schedule**. The statutory fund from which the **Policy** is issued will depend on whether it is ordinary or superannuation business.

The Proposal Form will allow us to obtain the information we need to determine the statutory fund from which we will issue the **Policy**. Neither you nor the **insured members** have any rights of ownership of the assets of that fund. The **Policy** does not participate in any surplus arising in any of our statutory funds.

Cooling-off period

You may cancel your **Policy** within 14 days of the earlier of:

- the date you receive the **Policy**, including the **Policy Schedule**
- the date you receive an `On-risk' letter confirming our acceptance of your application
- the end of the fifth day after we issue the **Policy**.

You may cancel the **Policy** during the cooling-off period by giving us notice in writing and returning the **Policy**, including the **Policy Schedule**. If you do this, we will terminate the **Policy** and will refund any money paid (except any amounts of taxation which we are unable to recover). However, you cannot exercise your right to cancel the **Policy** or get a refund at any time after an **insured member** has made a claim for benefits under the **Policy**.

Customer concerns

If you or an **insured member** has any concerns or a complaint about the **Policy**, please refer them to us. Customer concerns should be directed to:

Complaints Resolution Officer
OnePath Life
GPO Box 5306, Sydney NSW 2001
Phone 1800 627 625
Fax 02 9234 8967

If concerns are not resolved to your satisfaction, a complaint may be lodged with the appropriate industry body.

The organisation to which your complaint should be referred depends on whether your plan is held inside or outside of superannuation.

Policy owners and members of employer plans

If the **Policy** is held outside of superannuation, the policy owner and **insured members** may contact the Financial Ombudsman Service Limited (FOS). FOS is independent and industry sponsored service that has been set up to advise and assist customers. If unresolved at Case Manager level, the Panel of FOS can make a determination that is binding on us.

Concerns to FOS can be directed to:

The Manager
Financial Ombudsman Service
GPO Box 3, Melbourne VIC 3001
Toll-free 1300 78 08 08
Fax 03 9613 6399
Email info@fos.org.au
Website www.fos.org.au

Members of superannuation plans

If a member of a superannuation plan has an enquiry or complaint about the operation or management of their plan, they may contact the Superannuation Complaints Tribunal (SCT). Concerns can be directed to:

Superannuation Complaints Tribunal
Locked Bag 3060
GPO Melbourne VIC 3001
Phone 1300 780 808
Fax 03 8635 5588

The SCT is an independent body established by the federal government that can assist with the resolution of certain types of complaints within superannuation funds and life insurance companies.

The fund's Complaints Resolution Officer must be contacted before calling the SCT.

Privacy

In this section 'we', 'us' and 'our' refers to OnePath Life and other members of the ANZ Group. We are committed to ensuring the confidentiality, security and privacy of your personal information. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information to provide you with the products and services you request. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

In order to manage and administer the products and services requested by you, we may need to disclose your personal information to certain third parties, including:

- other members within the ANZ Group, to the extent necessary to service our relationship with you and carry on business as a group
- organisations performing administration or compliance functions in relation to the products and services
- organisations maintaining our information technology systems
- authorised financial institutions
- organisations providing services such as mailing, printing or data verification
- a person who acts on your behalf (such as your financial adviser or your agent)
- the policy owner (where you are a life insured who is not the policy owner).

For life risk products we collect health information with your consent. Your health information will only be disclosed to service providers, reinsurers or organisations providing medical or other services for the purpose of underwriting, assessing the application or assessing any claim.

We may also disclose your personal information in circumstances where we are required to do so by law.

We may send you information about our financial products and services from time to time. You may elect not to receive such information at any time by contacting Customer Services on 133 667.

You may access the personal information OnePath holds about you, subject to permitted exceptions and subject to OnePath still holding that information, by contacting OnePath at:

Privacy Officer – OnePath
GPO Box 75
Sydney NSW 2001
Phone 02 9234 8111
Fax 02 9234 8095
Email privacy@onepath.com.au

If any of your personal information is incorrect or has changed, please let OnePath know by contacting Customer Services.

More information can be found in OnePath's Privacy Policy which can be obtained from its website at onepath.com.au

How do you establish a Policy?

Applying for the Policy

Step 1 – Obtaining a quotation

To establish a **Policy** you need to first obtain a quotation for GSC Insurance. In requesting a quotation, you will need to decide what level of monthly benefit **insured members** ought to be provided with, how soon the **Policy** should start, the **waiting period** that is to apply, the **benefit period** and what optional benefits should apply. If you wish to request a quotation, please contact us.

If you (or an intermediary acting on your behalf) have already provided us with information about your prospective plan, a **Quotation Summary** may be attached to this PDS. A **Quotation Summary** is guaranteed for 90 days unless we agree to extend or reduce this period.

It is important that you read and understand the information provided in this PDS before applying.

Step 2 – Accepting a quotation

Should you choose to accept our offer, you must notify us in writing before the end of the quotation guarantee period. You can do this by completing the form supplied to you with the **Quotation Summary** and returning it to us properly completed, along with the premium due.

In order for us to establish the **Policy**, the following information is required:

- a completed Proposal Form signed by you
- an **At Work Certificate** signed by you (or if you are a trustee of a superannuation fund, signed by each participating employer under your superannuation fund) in respect of each person to be covered
- a final list of persons to be covered under the **Policy** and the **member information** which includes details of all proposed **insured members** who have been seconded overseas by their employer to work. To assist you in providing the **member information**, we may give you a specific form or agree with you a basis to provide the **member information** electronically
- 'transfer terms' information, if relevant (refer to pages 7 and 8 for information on transfer terms) and
- the first annual premium or deposit premium we advise you is payable.

The documentation and premium is to be provided to:

Group Risk Insurance Administration
OnePath Australia
GPO Box 4129, Sydney NSW 2001
Email group.risk@onepath.com.au

Once all our requirements are met we shall also provide you with the **Policy** and the **Policy Schedule**.

Need help?

If you want to know more about obtaining a quotation for OnePath Life's GSC Insurance our dedicated Group Risk Development Managers can assist. For help:

- contact Group Risk Insurance Administration on 1800 648 921
- visit the OnePath website at onepath.com.au

Dictionary

Unless described here, terms in the Policy Schedule have the meaning shown in the Policy Schedule. Terms highlighted throughout this PDS are defined here.

Key terms

Accident means a fortuitous, external event which was unexpected and unintended causing injury or death of the **insured member**.

Exclusions – events that are not accidents

The following situations are not accidents, and any claims arising from these situations are excluded:

- one of the contributing causes of injury and death was any of the following conditions:
  - illness
  - disease
  - allergy
  - any gradual onset of a physical or mental infirmity.
- the injury or death, which was unintended and unexpected, was the result of an intentional act or omission
- the **insured member** was injured or died as a result of an activity in respect of which they assumed the risk or courted disaster, irrespective of whether he or she intended injury or death.

Active service refers to an **insured member's** occupation as part of a military force (including without limitation the defence force, the army, the navy, the air force). Reserve duty is excluded.

At work means the **insured member** is:

- actively performing all the duties of his or her usual occupation
- working his or her usual hours free from any limitation due to illness or injury and
- not in receipt of and/or entitled to claim income support benefits from any source including workers' compensation benefits, statutory motor accident benefits or disability income benefits (including government income support benefits).

An **insured member** who does not meet these requirements is correspondingly described as not at work.

At Work Certificate means the form we nominated in which you certify those **eligible persons** who were at **work** and **not at work** on the requisite date.

Australian resident means an Australian citizen or a New Zealand citizen living in Australia on a permanent basis.

Automatic Acceptance Level and ***AAL*** means the automatic acceptance level shown in the **Policy Schedule.**

Benefit expiry age means the age at which cover ceases as set out in the **Policy Schedule.**

Benefit period is the maximum period of time that a benefit will be paid for any one illness or injury while the **insured member** is Totally or Partially Disabled.

Contractor means a person is performing all the normal duties of his or her work and is working on a contracted basis for at least 15 hours per week and is under a fixed term contract of no less than one year.

Consumer Price Index or ***CPI*** means the Consumer Price Index (all groups: all capital cities) published by the Australian Bureau of Statistics or, if no longer published, a similar replacement index we select.

Decision Note means the document we issue in respect of an **insured member** when that **insured member's** application for cover, an increase in cover, or variation in cover has been accepted by us, setting out details of the following:

- the type and level of Disability Benefits provided for that **insured member**
- the date the cover starts or an increase in cover starts and
- any special conditions applying.

Disability or ***disabled*** means **total disability** or **partial disability** (as the context requires) in relation to an **insured member**.

Eligibility criteria means the rules for eligibility set out in the **Policy** and the **Policy Schedule**.

Eligible person means a person who meets the criteria set out in the section headed 'Who is eligible for cover?' on page 6 of this PDS.

Emergency transportation means emergency transportation where, in the opinion of a **medical practitioner**, an **insured member** requires immediate treatment in circumstances where there is a serious threat to the **insured member's** life or health. Ambulance transportation is excluded.

Escalation factor is defined in the **Policy Schedule**.

Excluded occupation is an occupation for which cover is not available under the **Policy**. A list of excluded occupations can be downloaded from onepath.com.au or can be obtained by calling Group Risk Administration on 1800 648 921.

Following the advice of a medical practitioner means the **insured member** is following the regular advice of their treating **medical practitioner** on an ongoing basis, including following all recommended courses of treatment and rehabilitation.

Forward underwriting limit means the amount up to which we will accept future increases in the monthly benefit, without application in respect of an **insured member**.

Full-time means a person is performing all the normal duties of his or her occupation and is working at least 30 hours per week.

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

Immediate family member means a:

- spouse
- son, daughter, father, mother, brother, sister, father-in-law or mother-in-law or
- person in a bona fide domestic living arrangement and is financially interdependent. You must provide us with satisfactory evidence that there is an established and ongoing interdependency.

Insured benefit means any benefit provided under the **Policy** as the context requires including, the Total Disability Benefit, the Partial Disability Benefit, the Specific Injury Benefit and any optional benefit as varied by any **Decision Note** that we issued in respect of an individual **insured member**.

Insured member refers to a person who is covered by the **Policy** and is either an employee of an employer or partner of a partnerhsip where the **Policy** is employer owned, or a member of a complying superannuation fund where the **Policy** is owned by the trustee of the relevant superannuation fund. All references to insured member assume the **Policy** is in force and cover in respect of that insured member continues.

Maximum benefit entry age means the maximum age at which an **eligible person** may become an **insured member** under the **Policy** as shown in the **Policy Schedule.**

Medical practitioner means a registered and qualified medical practitioner in Australia, or another country as approved by us, who is not the **insured member** or you and not related to the relevant **insured member.**

Member information means all information in respect of an **eligible person** which we advise you we require. This includes, but is not limited to, the following:

- name
- date of birth
- gender
- occupation
- state, territory and country of residence including details of persons who have been seconded overseas by their employer for work
- **salary** (in Australian currency)
- employee/member status (i.e. whether the person is on unpaid or paid leave)
- date the person joined the company
- date the person first satisfied the **eligibility criteria** and, if required, an **At Work Certificate.**

New Events Cover means the **insured member** will not be covered for a **pre-existing condition**. The **insured member** will only be covered for an illness which became apparent to the **insured member**, or any injury which occurred to the **insured member,** on or after the date that cover commenced, recommenced or increased (as applicable).

Normal business day means any day which is not a weekend or a public holiday, on which businesses normally operate.

On claim means the dates for which you are eligible to receive a benefit in respect of a particular **insured member** under the **Policy**.

Parental leave includes maternity leave, paternity leave and/or adoption leave.

Part-time means a person is performing all the normal duties of his or her occupation and is working at least 15 hours per week, but less than 30 hours per week.

Partial disability/partially disabled means solely as a result of illness or injury, the **insured member** is:

- incapable of performing one or more duties of his or her usual occupation necessary to produce income but has returned to work in their usual occupation or is working in another occupation and has a monthly **salary** less than their **pre-disability salary**, and
- is **following the advice of a medical practitioner** in relation to the illness or injury for which they are claiming.

Policy means the policy of Group Salary Continuance Insurance issued by OnePath Life to you and includes the proposal, each application for cover and associated documentation from an **eligible person** or **insured member**, the **Policy Schedule**, any notices issued or received by us under the **Policy**, the **Decision Note** and any written variation of the **Policy**. The **Policy** does not form part of this PDS. The **Policy** constitutes the legal agreement between the parties.

Policy Schedule means the document we send you which sets out the details of your **Policy**, including any special conditions, amendments or endorsements. A new Policy Schedule will be issued at any time there is a change in your **Policy** such as a variation of benefits. The new Policy Schedule will apply from the effective date shown on the Policy Schedule.

Policy start date means the policy start date shown in the **Policy Schedule**.

Pre-disability salary means the total monthly value of **salary** received by the **insured member** from his or her usual occupation, averaged over the lesser of:

- the 12 month period immediately prior to the **insured member** becoming **disabled**
- the actual period of work (provided the period of work occurred in the 12 month period preceding the date of **disability**) if less than 12 months.

Pre-existing condition means an injury which first occurred, or an illness which first became apparent, to the **insured member**, or any direct or indirectly related condition before the date cover in respect of that **insured member** commenced, recommenced or increased.

Premium rate guarantee period means the premium rate guarantee period shown in the **Policy Schedule.**

Quotation Summary means the GSC Insurance quotation summary we issue to you. It contains the premium rates and the terms on which we will offer cover to your prospective plan.

Reasonably apparent means a reasonable person in the circumstances could be expected to have been aware of the symptoms.

Review date means an annual date agreed to between you and us as shown in the **Policy Schedule**.

Salary or ***income*** means:

- where the **insured member** is employed, the annual cash salary remuneration which the **insured member** receives from their employer for the **insured member's** personal exertion immediately prior to the **insured member** becoming **disabled**. If salary or income includes non-cash benefits or fringe benefits provided as a direct substitute for salary or the inclusion of performance-related commission and bonuses, this will be shown in the **Policy Schedule** or
- where the **insured member** directly or indirectly owns all or part of the business from which he or she earns his or her usual income, the gross amount earned by the business in the 12 months immediately prior to the **insured member** becoming **disabled**, as a direct result of the **insured member's** personal exertion or activities through his or her usual occupation after allowing for the costs and expenses incurred in deriving that income.

Terminal illness means an illness or injury that in the opinion of at least two **medical practitioners** (one whom we may elect and require to be a specialist physician) is likely to lead to the death of the **insured member** within 12 months from the date of diagnosis.

Total disability/totally disabled means solely as a result of illness or injury, the **insured member** is:

- medically certified as being incapable of performing one or more duties of his or her usual occupation necessary to produce **income**
- not engaged in any occupation and
- **following the advice of a medical practitioner** in relation to their illness or injury for which they are claiming.

Totally and permanently disabled means, in relation to the optional Recovery Assistance Benefit, the **insured member** is **gainfully employed** when suffering an illness or injury and as a result of that illness or injury, he or she is:

- totally unable to engage in any occupation, business, profession or employment for a period of six consecutive months and
- determined by us at the end of that six month period (or such later time we agree with the policy owner) to be permanently incapacitated to such an extent as to render the **insured member** unlikely ever to engage in any **gainful employment** for which he or she is reasonably suited by education, training or experience.

Transfer date means the date the **Policy** commenced with OnePath Life.

Visa means a current and valid visa issued in accordance with the *Migration Act 1958* (Cth) or any amending or replacing Act which enables an **eligible person** or **insured member** to work in Australia.

Waiting period is the number of consecutive days for which an **insured member** must be **totally disabled** or **partially disabled**, as the case may be, before the Disability Benefit is payable.

War or ***war service*** includes but is not limited to:

- declared war, and armed aggression by one or more countries resisted by any country, combination of countries or international organisations
- participation in an action to defend a country or region from civil disturbance or insurrection, or in an effort to maintain peace in a country or region.

Early Cash Benefit Conditions and Trauma Recovery Events

Activity/Activities of daily living are:

- bathing and/or showering
- dressing and undressing
- eating and drinking
- using a toilet to maintain personal hygiene
- getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or with assistance of a walking aid.

Alzheimer's disease means the unequivocal diagnosis of Alzheimer's disease, made by a **medical practitioner** who is a consultant neurologist or geriatrician, confirming dementia due to failure of the brain function with cognitive impairment for which no other recognisable cause has been identified.

Aortic surgery means the undergoing of surgery that is considered necessary to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta, but does not include angioplasty, intra-arterial procedures or non-surgical techniques.

Aplastic anaemia means the acquired bone marrow failure that:

- results in anaemia, neutropenia and thrombocytopenia and
- requires treatment with one or more of the following:
  - marrow stimulating agents
  - bone marrow transplantation
  - peripheral blood stem cell transplantation
  - blood product transfusions
  - immunosuppressive agents.

Benign brain tumour means a non-malignant tumour in the brain giving rise to characteristic symptoms of increased intracranial pressure such as papilledema, mental symptoms, seizures and sensory impairment as confirmed by a **medical**

practitioner who is a consultant neurologist. The tumour must result in permanent neurological deficit causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment*, 4th edition, or an equivalent guide to impairment approved by us
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

The presence of the underlying tumours must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.

Blindness means the permanent loss of sight in both eyes, whether aided or unaided, as a result of illness or injury such that visual acuity is ‰ or less in both eyes, or such that the visual field is reduced to 20 degrees or less of arc.

Cancer means the presence of one or more malignant tumours including leukaemia, lymphomas and Hodgkin's disease characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

The following cancers are not covered:

- melanomas of less than 1.5mm maximum Breslow thickness and which are also less than Clark Level 3 depth of invasion as determined by histological examination
- all hyperkeratoses or basal cell carcinomas of the skin
- all squamous cell carcinomas of the skin unless there has been a spread to other organs
- low level prostatic cancers which are:
  - histologically described as TNM Classification T1a or T1b or lesser classification
  - characterised by a Gleeson score less than 7 and
  - appropriate and necessary 'major interventionist treatment' has not been performed specifically to arrest the spread of malignancy.

    'Major interventionist treatment' includes removal of the entire prostate, radiotherapy, chemotherapy, hormone therapy or any other similar interventionist treatment.
- chronic lymphocytic leukaemia less than Rai Stage 1
- tumours showing the malignant changes of carcinoma in situ* (including cervical dysplasia CIN-1, CIN-2, and CIN-3), or which are histologically described as pre malignant, or which are classified as FIGO Stage 0, or which have a TNM classification of Tis. 'FIGO' refers to the staging method of the International Federation of Gynaecology and Obstetrics.

* Carcinoma in situ is covered in the following circumstances where the procedures are performed specifically to arrest the spread of malignancy and are considered the appropriate and necessary treatment:

- carcinoma in situ of the breast if it results directly in the removal of the entire breast
- carcinoma in situ of the testicle if it results directly in the removal of the testicle
- carcinoma in situ of the prostate if it results directly in the removal of the prostate or where characterised by a Gleeson score of 7 or greater.

Cardiomyopathy means impaired ventricular function of variable aetiology resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Chronic kidney failure means end stage renal disease which requires permanent dialysis or renal transplantation.

Chronic liver disease means end stage liver failure together with permanent jaundice, ascites or encephalopathy.

Chronic lung disease means end stage lung disease requiring permanent supplementary oxygen, as confirmed by a specialist **medical practitioner.**

Chronic lymphocytic leukaemia means the presence of chronic lymphocytic leukaemia diagnosed as Rai Stage 0, which is defined to be in the blood and bone marrow only.

Cognitive loss means we have determined a total and permanent deterioration or loss of intellectual capacity that has required the **insured member** to be under continuous care and supervision by another adult person for at least six consecutive months and, at the end of that six month period, they are likely to require ongoing continuous care and supervision by another adult person, provided at least two **medical practitioners** have certified that to be the case.

Coma means total failure of cerebral function characterised by total unconsciousness and unresponsiveness to all external stimuli, persisting continuously with the use of a life support system for a period of at least 72 hours and resulting in a neurological deficit causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment*, 4th edition, or an equivalent guide to impairment approved by us
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Coronary artery by-pass surgery means the undergoing of coronary artery by-pass surgery that is considered necessary to treat coronary artery disease causing inadequate myocardial blood supply. Surgery does not include angioplasty, intra-arterial procedures or non-surgical techniques.

Deafness means the total, irreversible and irreparable loss of hearing, in both ears, whether aided or unaided.

Dementia means the unequivocal diagnosis of dementia, made by a **medical practitioner** who is a consultant neurologist or geriatrician, confirming dementia due to failure of the brain function with cognitive impairment for which no other recognisable cause has been identified. A Mini-Mental State Examination score of 24 or less is required.

Encephalitis means the severe inflammatory disease of the brain resulting in neurological deficit causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment*,

4th edition, or an equivalent guide to impairment approved by us

- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Heart attack means death of a portion of heart muscle arising from inadequate blood supply to the relevant area. The basis for diagnosis shall be supported by both of the following clinical features being present and consistent with myocardial infarction (and not due to medical intervention):

- new electrocardiographic (ECG) changes and
- diagnostic elevation of cardiac enzyme CK-MB or Troponin I greater than 2.0 µg/L or Troponin T greater than 0.6µg/L.

If the above is inconclusive, then we will consider a claim based on conclusive evidence that the **insured member** has been diagnosed as having suffered a myocardial infarction, resulting in either:

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

Heart valve surgery means the undergoing of surgery that is considered necessary to correct or replace cardiac valves as a consequence of heart valve defects or abnormalities but does not include angioplasty, intra-arterial procedures or non-surgical techniques.

Hydrocephalus means excessive cerebrospinal fluid within the brain resulting from injury, infection or tumour, which causes increased intra-cranial pressure requiring surgical intervention of a shunt.

Intensive care means the **insured member** requires continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital. Intensive care as a result of drug or alcohol intake is excluded.

Loss of independent existence means a condition whereby we have determined the **insured member** is totally and irreversibly unable to perform at least two of the five activities of daily living without the assistance of another adult person.

Loss of speech means the total and permanent loss of the ability to produce intelligent speech due to permanent damage to the larynx or its nerve supply or a disorder affecting the speech centres of the brain. Loss of speech related to any psychological cause is excluded.

Loss or paralysis of limb means the total and permanent loss of use of a whole hand or a whole foot as a result of illness or injury, or the total and permanent loss of the use of one arm or one leg as a result of paralysis.

Major head trauma means cerebral injury resulting in permanent neurological deficit, as confirmed by a **medical practitioner** who is a consultant neurologist and/or an occupational physician, causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment* 4th edition, or an equivalent guide to impairment approved by us
- a total and irreversible inability to perform at least one **activity of daily living** with out the assistance of another adult person.

Major organ transplant means the **insured member** undergoes, or has been placed on an Australian waiting list approved by us for, an organ transplant from a human donor to the **insured member** for one or more of the following organs:

- kidney
- heart
- lung
- liver
- pancreas
- small bowel
- the transplant of bone marrow.

This treatment must be considered medically necessary and the condition affecting the organ deemed untreatable by any other means other than organ transplant, as confirmed by a specialist physician.

Medically acquired HIV means the accidental infection with Human Immunodeficiency Virus (HIV) which we believe, on the balance of probabilities, arose from one of the following medically necessary events which must have occurred to the **insured member** in Australia as a result of a procedure authorised by a recognised health professional:

- a blood transfusion
- transfusion with blood products
- organ transplant to the **insured member**
- assisted reproductive techniques or
- a medical procedure or operation performed by a doctor or a dentist.

Notification and proof of the incident will be required via a statement from the appropriate Statutory Health Authority that the infection is medically acquired.

We must have open access to all blood samples and be able to obtain independent testing of such blood samples.

There will be no cover and no benefit payable if a medical 'cure' is found for AIDS or the effects of HIV, or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any Australian Government approved treatment which renders HIV inactive and non-infectious.

HIV infection acquired by any other means, including infection as a result of sexual activity or recreational intravenous drug use, is excluded.

Meningitis and/or ***meningococcal disease*** mean meningitis or meningococcal septicaemia causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment*, 4th edition, or an equivalent guide to impairment approved by us
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Motor neurone disease means the unequivocal diagnosis of a progressive form of debilitating motor neurone disease, as confirmed by a **medical practitioner** who is a consultant neurologist.

Multiple sclerosis means the unequivocal diagnosis of multiple sclerosis made by a **medical practitioner** who is a consultant neurologist on the basis of confirmatory neurological investigation. There must be more than one episode of confirmed neurological deficit.

Muscular dystrophy means the unequivocal diagnosis of muscular dystrophy, as confirmed by a **medical practitioner** who is a consultant neurologist on the basis of confirmatory neurological investigation.

Occupationally acquired HIV means infection with the Human Immunodeficiency Virus (HIV) where the virus was acquired as a result of an **accident** occurring during the course of your normal occupation and sero-conversion of the HIV infection must occur within six months of the **accident**.

HIV infection acquired by any other means including sexual activity or recreational intravenous drug use is excluded.

Any **accident** giving rise to a potential claim must be reported to us within seven days of the incident and supported by a negative HIV antibody test taken after the **accident**.

We must have open access to all blood samples and be able to obtain independent testing of such blood samples.

There will be no cover and no benefit payable if a medical 'cure' is found for AIDS or the effects of HIV, or a medical treatment is developed that results in the prevention of the occurrence of AIDS. 'Cure' means any Australian Government approved treatment which renders HIV inactive and non-infectious.

Open heart surgery means the undergoing of open heart surgery that is considered necessary to correct a cardiac defect, cardiac aneurysm or cardiac tumour.

Parkinson's disease means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of:

- rigidity
- tremor
- akinesia from degeneration of the nigrostriatal system.

All other types of parkinsonism, including secondary parkinsonism due to medication, are excluded.

Pneumonectomy means the undergoing of surgery to remove an entire lung. This treatment must be deemed the most appropriate treatment and medically necessary.

Primary pulmonary hypertension means primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation and resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Severe burns means tissue injury caused by thermal, electrical or chemical agents causing third degree burns to one of the following:

- 20% or more of the body surface area as measured by the 'Rule of Nines' or the Lund and Browder Body Surface Chart
- the whole of both hands, requiring surgical debridement and/or grafting
- the whole of both feet, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting
- the whole of the face, requiring surgical debridement and/or grafting.

Severe diabetes means that a **medical practitioner** who is a specialist physician has confirmed that at least two of the following complications have occurred as a direct result of diabetes:

- nephropathy requiring regular dialysis or a kidney transplant
- proliferative retinopathy
- peripheral vascular disease leading to chronic infection or gangrene, requiring a surgical procedure
- neuropathy including either:
  - irreversible autonomic neuropathy resulting in postural hypotension, and/or motility problems in the gut with intractable diarrhoea
  - polyneuropathy leading to severe mobility problems due to sensory and/or motor deficits.

Severe osteoporosis means prior to the age of 50, the **insured member** is unequivocally diagnosed with osteoporosis and suffers at least two vertebral body fractures or a fracture of the neck of femur due to osteoporosis.

Severe rheumatoid arthritis means a definite diagnosis of severe rheumatoid arthritis by a consultant rheumatologist, with ineffectiveness of the first line of treatment leading to further treatment with certain biological immunosuppressive agents (such as monoclonal anti-bodies targeting the tumour necrosis factor). The diagnosis must confirm all of the following:

- small nodular swelling beneath the skin
- multiple and extensive changes to joints typical of rheumatoid arthritis as evidenced by X-ray

- diffuse osteoporosis with severe hand and spinal deformity.

Stroke means a cerebrovascular accident or event producing a neurological deficit lasting more than 24 hours. There must be clear evidence of all of the following:

- of the onset of objective neurological deficit
- on a CT, MRI or similar scan that a stroke has occurred
- of infarction of brain tissue, intracranial or subarachnoid haemorrhage or embolisation from an extracranial source.

Transient ischaemic attacks, cerebral events due to reversible neurological deficits, migraine, hypoxia or trauma, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Systemic sclerosis means the unequivocal diagnosis of systemic sclerosis, made by a **medical practitioner** who is a consultant physician, characterised by skin thickening accompanied by various degrees of tissue fibrosis and chronic inflammatory infiltration in visceral organs, causing either:

- a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication *Guides to the Evaluation of Permanent Impairment*, 4th edition, or an equivalent guide to impairment approved by us or
- a total and irreversible inability to perform at least one **activity of daily living** without the assistance of another adult person.

Triple vessel angioplasty means the undergoing of angioplasty (with or without an insertion of a stent or laser therapy) to three or more coronary arteries during a single surgical procedure that is considered necessary on the basis of angiographic evidence to correct the narrowing or blockage of three or more coronary arteries.

Notes

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