AFA INSURANCE

WAGEguard™

Income protection insurance for plumbing trades

Product Disclosure Statement

WORKPLACE TRAUMA & INJURY, WORKCOVER/TAC TOP-UP & SICKNESS COVER

Preparation Date: 1 March 2021
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WAGEGUARD WORKPLACE TRAUMA & INJURY,
WORKCOVER/TAC TOP-UP & SICKNESS COVER

Part A: About this insurance

This Product Disclosure Statement (PDS) is an important document about this product and includes the policy wording which starts on page 7. You should read it carefully before making a decision to purchase this product.

This PDS will help you to:

- decide whether this product will meet your needs; and
- compare this product with other products you may be considering.

The information contained in this PDS is general information only. It is important you read your *policy* to ensure you have the cover you need.

ABOUT THE INSURER

The insurer of this product is Zurich Australian Insurance Limited (ZAIL), ABN 13 000 296 640, AFS Licence Number 232507. In this document, ZAIL may also be expressed as 'Zurich'.

ZAIL is part of the Zurich Insurance Group, a leading multi-line insurer that serves its customers in global and local markets. Zurich provides a wide range of general insurance and life insurance products and services in more than 210 countries and territories. Zurich's customers include individuals, small businesses, and mid-sized and large companies, including multinational corporations.

ABOUT AFA

AFA Pty Ltd (ABN 83 067 084 333 and AFS Licence No. 247122) is an Underwriting Agency, specialising in the design and marketing of Accident & Health insurance products. *AFA* has been provided with a binding authority by the insurer authorising it to enter into, vary and cancel this insurance as well as settle any claims on behalf of the insurer as if it were the insurer.

AFA acts on behalf of the insurer in relation to this insurance not you.

CONTACT DETAILS

AFA Pty Ltd

PO Box R1852, Royal Exchange, NSW 1225

Telephone 02 9259 8222
Facsimile 02 9259 8200

www.afainsurance.com

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ABOUT MARSH

Marsh Pty Ltd (ABN 86 004 651 512 and AFS Licence No. 238983) is the world leader in delivering risk and insurance services and solutions to clients. Our mission is to create and deliver risk solutions and services that make its clients more successful. Marsh provides global risk management, risk consulting, insurance broking, financial solutions and insurance program management services for businesses, public entities, associations, professional services organisations, and private clients.

Marsh is an operating unit of Marsh & McLennan companies (MMC), a global professional-services firm with 63,000 employees and annual revenues exceeding US$11 billion.

Marsh acts on behalf of the *insured* and not *AFA* or the insurer.

HOW TO APPLY FOR THIS INSURANCE

Throughout this document when we are referring to your insurance broker or adviser, we simply refer to them as your intermediary.

If you are interested in buying this product or have any inquiries about it, you should contact your intermediary, who should be able to provide you with all the information and assistance you require.

If you are not satisfied with the information provided by your intermediary, you can contact us at the address or telephone number shown on page 1 of this document. However, we are only able to provide factual information or general advice about the product. We do not give advice on whether the product is appropriate for your personal objectives, needs or financial situation.

OUR WORKPLACE TRAUMA AND INJURY ACCIDENT AND SICKNESS INSURANCE

Group 24 Hour Sickness, Accident and Journey Cover allows you to tailor the cover for your requirements. Cover can be arranged by you (referred to as the *insured*) to cover yourself or some other person(s) (referred to as the *insured person*(s)).

The *policy* generally operates 24 hours a day, seven days a week, anywhere in the world, however this can be customised for your requirements and the *scope of cover* will be shown on your *policy schedule*.

OUR CONTRACT WITH YOU

This *policy* is a contract of insurance between the *insured* and us and contains all the details of the cover that we provide. The *policy* is made up of:

- the policy wording which begins at page 7 of this document. It tells you what is covered, sets out the claims procedure, exclusions and other terms and conditions of cover;
- the proposal, which is the information you provide to us when applying for insurance cover;
- your most current *policy schedule* issued by us;
- The *policy schedule* is a separate document unique to *you*, which shows the insurance details relevant to *you*. It includes any changes, exclusions, terms and conditions made to suit *your* individual circumstances and may amend the *policy*; and
- any other change otherwise advised by us in writing (such as an endorsement or a supplementary PDS). These changes vary or modify the above documents.

Please note, only those covers shown as covered in your *policy schedule* are *insured*.

This document is also the PDS for any offer of renewal we may make, unless we tell you otherwise. Please keep your *policy* in a safe place. We reserve the right to change the terms of this product where permitted to do so by law.

ABOUT AN INSURED PERSON

An *insured person* has a right to recover under this *policy* only through Section 48 of the Insurance Contracts Act 1984 (Cth) and is not a party to the contract of insurance. Only the *insured* is able to vary or cancel the *policy*.

Insured persons are not charged for the right to make a claim under this *policy*.

Any person who may be *insured* under this *policy* should consider obtaining their own advice from an appropriately licensed person to determine if the benefits provided by this *policy* are suitable to their needs. No advice is provided by either you or us as to the suitability of these benefits to the needs of anyone who may be entitled to benefits under it.

When the insured person's cover starts and ends

An *insured person's* ability to access cover:

- starts at the time the relevant person becomes an insured person; and
- ends at the earliest happening of the following:
  (a) the relevant person is no longer meeting the criteria specified in the schedule for an *insured person*;
  (b) the date and time you request that such *insured person* ceases to have access to the benefits under this *policy*; or
  (c) the date and time this *policy* ends in accordance with the *policy* terms, either because the *period of insurance* has ceased and the *policy* has not been renewed with us, or this *policy* has been cancelled in accordance with the *policy* terms.

SOME WORDS HAVE SPECIAL MEANINGS

We capitalise or italicise terms in this PDS, to show that words are abbreviations or have a particular defined meaning.

You should refer to the Definitions in this document to obtain the full meaning of such terms.

In some cases, certain words may be given a special meaning in a particular section of the *policy* when used or in the other documents making up the *policy*.

HEADINGS

Headings are provided for reference only and do not form part of the *policy* for interpretation purposes.

SIGNIFICANT ISSUES TO CONSIDER

Insurance contracts contain *policy* exclusions, *policy* terms and conditions and *policy* limits and sub–limits that you should be aware of when deciding to purchase our product. These things may affect the amount of the payment that we will make to you if you have a claim.

We may express some *policy* terms, *policy* limits or sub-limits as being either a dollar amount or a percentage of your sum insured shown in your schedule or some other amount, factor or item specified in the relevant clause or this document. You should be aware of the following matters in considering whether this product is suitable for your needs.

Excesses can apply

An excess may apply to claims made under each of these Sections. An excess is not an additional fee, charged by us at the time of making a claim. Rather, it is the uninsured first portion of a loss for which you are otherwise covered, i.e. the amount that you must contribute towards each claim.

We are able to provide options to quote higher or lower excess or *excess period* alternatives in certain circumstances, which will either decrease or increase your premium, depending upon the options requested.

The *excess period* applicable to your *policy* is specified in the schedule.

What you should read

To determine if this insurance is right for you, it is important that you read:

- About this Workplace Trauma & Injury, Workcover/ TAC Top-Up & Sickness Insurance section which contains important information that you need to be aware of;
- Sections 1–6 the Your Cover Sections, which set out the cover available under this insurance;
- Section 7 — General Conditions, which sets out the terms and conditions that apply to this whole *policy* such as how the *insured* and we can cancel the *policy*;
- Section 8 — Exclusions, which sets out what we do not cover under any of the Cover Sections;
- Section 9 — Claiming a Benefit Section, which tells you how to make a claim;
- Section 10 — Definitions, which defines some of the important words which we use in the *policy*; and
- any other document(s) we provide which we tell you will form part of the insurance contract, such as the *policy schedule* or an endorsement. These may change the standard cover in this document.

Important matters

It is important to note that:

- we only provide cover up to the amount(s) and limit(s) and for the period(s) of time specified in the *policy*, including the *policy schedule* and subject to its other terms, conditions and exclusions.
- all amounts *insured* exclude GST.
- in the event of a claim, no payment will be made for *total disablement* or *partial disablement* until the *excess period* has expired. No amount is payable for or during the *excess period*.
- a weekly benefit is only payable under this insurance while the *insured person* is a legal resident of Australia who is physically residing in Australia.

When does cover begin and end?

Cover begins

For the *insured*, the *policy* begins at 4pm on the commencement date shown on the *policy schedule*, subject to our receipt of the first payment of applicable *insurance contributions*.

For *insured persons*, access to cover begins when the *insurance contributions* for the *insured person* has been paid or agreed to be paid and the *insured person* meets any eligibility criteria as set out on the *policy schedule* under the description of *insured persons* or any other document issued by us. For example, the eligibility criteria may require a person to be an employee of the *insured* or be named in the *policy schedule*.

Cover ends

The *insured person's* access to cover ends on the earlier of the following:

- at the time that the *insured person* no longer meets the eligibility criteria;
- at the time that the *insured person's insurance contributions* are overdue;
- at the time the *insured* requests that such *insured person* no longer be covered under the *policy* as an *insured person*;
- at the time that the *insured person* asks us in writing to terminate their access to insurance cover;
- unless otherwise agreed, on the date that such *insured person* leaves or is dismissed from the *insured's* employment (not applicable to self-employed persons or if the *insured person* is not an employee, contractor or representative of the *insured*) or is retired or pensioned; or
- on the day that the *insured person* attains the age of 70;
- 4pm on the date shown on the *policy schedule* as the end of the *period of insurance*;
- the date the *policy* is cancelled by the *insured* or us (see the "Cancellation Rights" section under Section 7 — General Conditions);
- 4:00pm EST of the 3rd (third) business day after the day on which we advise the *insured* in writing that the *insured person* is no longer eligible for access or such later time as we may specify in the notice.

For the cancellation rights of the *insured* and us, see Section 7 — General Conditions.

What do you pay?

The cover provided to each *insured person* under the *policy* is subject to the payment or agreement to pay the *insurance contributions* for each *insured person* by the agreed time. The *insurance contributions* are a fixed amount for each *insured person*. When the *insured* enters into the *policy* with us it has to pay an agreed amount for all *insured persons* who enter into the *policy* in each calendar month based on a declaration made by it. If a contract of insurance is entered into with us, the initial amount payable and amount applicable to each *insured person* under the *policy* is shown on the *policy schedule*.

Subject to any instalment payment terms and conditions, the *insured* must pay all *insurance contributions* to us by the 30th day of each calendar month or within Marsh's credit terms advised by them.

DUTY OF DISCLOSURE

For *insureds* who are not a natural person, before you enter into an insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you renew, extend, vary or reinstate an insurance contract.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

Individuals

If you are the *insured* and you are a natural person, a different duty of disclosure to the one set out above applies to you. Contact your intermediary or us to ensure you are notified of your duty.

If you do not tell us something

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay you if you make a claim, or both.

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

COOLING OFF PERIOD

After the *insured* applies for a *AFA* product and has received the *policy* document, they have 21 days to check that the *policy* meets their needs. Within this time they may cancel the *policy* and receive a full refund of any premium paid, unless they have:

- made a claim or become entitled to make a claim under your *policy*; or
- exercised any right or power you have in respect of your *policy* or the *policy* has ended.

Your request will need to be forwarded to us via your intermediary or to the address shown on page 1 of this document.

You can cancel your *policy* at any time after the cooling–off period. Please refer to 'Cancellation' under Section 7 — General Conditions on page 11.

PRIVACY NOTICE

In this Privacy Notice, 'We', 'Us', 'Our' means Zurich and *AFA*. 'You', 'Your' or 'Yours' means the *insured* or an *insured person* as applicable.

Zurich and *AFA* is bound by the Privacy Act 1988 (Cth). We collect, disclose and handle information, and in some cases personal or sensitive (eg health) information, about you ('your details') to assess applications, administer policies, contact you, enhance our products and services and manage claims ('Purposes'). If you do not provide your information, we may not be able to do those things. By providing us, our representatives or your intermediary with information, you consent to us using, disclosing to third parties and collecting from third parties your details for the Purposes.

We may disclose your details, including your sensitive information, to relevant third parties including your intermediary, affiliates of Zurich Insurance Group Ltd, affiliates of *AFA*, other insurers and reinsurers, our banking gateway providers and credit card transactions processors, our service providers, our business partners, health practitioners, your employer, parties affected by claims, government bodies, regulators, law enforcement bodies and as required by law, within Australia and overseas.

We may obtain your details from relevant third parties, including those listed above. Before giving us information about another person, please give them a copy of this document. Laws authorising or requiring us to collect information include the Insurance Contracts Act 1984 (Cth), Anti-Money Laundering and Counter-Terrorism Financing Act 2006 (Cth), Corporations Act 2001 (Cth), Autonomous Sanctions Act 2011 (Cth), A New Tax System (Goods and Services Tax) Act 1999 (Cth) and other financial services, crime prevention, trade sanctions and tax laws.

Zurich's Privacy Policy, available at www.zurich.com.au or by telephoning Zurich on 132 687 and AFA's Privacy Policy is available at www.afainsurance.com or by telephoning 1300 728 997, provides further information and lists service providers, business partners and countries in which recipients of your details are likely to be located. It also sets out how we handle complaints and how you can access or correct your details or make a complaint.

GENERAL INSURANCE CODE OF PRACTICE

We are signatories to the General Insurance Code of Practice (the Code) and support the Code.

The objectives of the Code are:

- to commit us to high standards of service;
- to promote better, more informed relations between us and you;
- to maintain and promote trust and confidence in the general insurance industry;
- to provide fair and effective mechanisms for the resolution of complaints and disputes you make about us; and
- to promote continuous improvement of the general insurance industry through education and training.

Further information about the Code and your rights under it is available at www.codeofpractice.com.au or by contacting us.

COMPLAINTS AND DISPUTES RESOLUTION PROCESS

We welcome every opportunity to resolve any concerns you may have with our products or service. Any enquiry or complaint relating to this insurance or AFA Pty Ltd should first be referred to:

In Writing to: AFA Pty Ltd
PO Box R1852,
Royal Exchange NSW 1225

Telephone: 02 9259 8222

Facsimile: 02 9259 8200

Email: enquiries@afainsurance.com

If you have a complaint about an insurance product we have issued or service you have received from us, please contact your intermediary to initiate the complaint with us. If you are unable to contact your intermediary, you can contact us directly on 1300 728 997.

We will acknowledge receipt of your complaint within 24 hours or as soon as practicable.

If this does not resolve the matter or you are not satisfied with the way a complaint has been dealt with, you may access our internal dispute resolution process. Please refer to the general insurance fact sheet available on our website for details of our internal dispute resolution process.

We expect that our internal dispute resolution process will deal fairly and promptly with your complaint, however, you may take your complaint to the Australian Financial Complaints Authority (AFCA) at any time.

AFCA is an independent external dispute resolution scheme. We are a member of this scheme and we agree to be bound by its determinations about a dispute. AFCA provides fair and independent financial services complaint resolution that is free to you.

FINANCIAL CLAIMS SCHEME

Zurich is an insurance company authorised under the *Insurance Act 1973* to carry on general insurance business in Australia. As such, we are subject to prudential requirements and standards, regulated by the Australian Prudential Regulation Authority (APRA).

This *policy* may be a protected *policy* under the Federal Government's Financial Claims Scheme, (FCS) which is administered by APRA.

The FCS may apply in the event that a general insurance company becomes insolvent. If the FCS applies, a person who is entitled to make a claim under this insurance *policy* may be entitled to a payment under the FCS. Access to the FCS is subject to eligibility criteria.

Further information about the FCS can be obtained at www.fcs.gov.au

UPDATING THIS PDS

The information in this PDS is up to date at the time it is prepared. Certain information in this PDS may change from time to time. If the updated information is not materially adverse from the point of view of a reasonable person deciding whether or not to purchase this product, we will update this information on our website at www.afainsurance.com. A paper copy of the updated information will be available free of charge upon request, by contacting your intermediary or us by using our contact details are on page 1 of this PDS. Please note that we may choose to issue a new or supplementary PDS in other circumstances.

Part B: Your Cover

SECTION 1 — WEEKLY BENEFIT — SICKNESS COVER

If an *insured person* suffers a *sickness* that first *manifests* itself during the *period of insurance* and the *scope of cover* and this *sickness* results in the *insured person* becoming *totally disabled*:

- within 12 calendar months of the first *manifestation* of the *sickness*; and
- for a continuous period that is longer than the *excess period*;

we will pay the *insured person* the lesser of:

- the percentage of the *insured person's pre disability earnings* shown on their *policy schedule*; and
- the Weekly Sickness Benefit amount shown on the *insured person's policy schedule*,

for the period the *insured person* is *totally disabled* up to the Maximum Benefit Period shown on the *policy schedule* less any income the *insured person* is able to derive from any gainful occupation.

No payment is made for the *excess period*.

For *insured persons* who are not also the *insured*, the payment of weekly benefits will not commence until the *insured person* has used any available sick leave available from the *insured* as the *insured person's* current employer and all other sick leave available to the *insured person*.

The *insured person* will not be considered to be *totally disabled* before they consult a *medical practitioner* for the claimed disability. If the *insured person* is capable of returning to work in any occupation, profession or business which they are in the opinion of a *medical practitioner* qualified to perform (based on your education, training or experience) on a full time, part time or any other basis, they are not *totally disabled*.

SECTION 2 — WEEKLY BENEFIT — INJURY COVER

If an *insured person* suffers an *injury* that first *manifests* itself during the *period of insurance* and the *scope of cover* and this *injury* results in the *insured person* becoming *totally disabled*:

- within 12 calendar months of the first *manifestation* of the *injury*; and
- for a continuous period that is longer than the *excess period*,

we will pay the *insured person* the lesser of:

- the percentage of the *insured person's pre disability earnings* shown on their *policy schedule*; and
- the Weekly Injury Benefit amount shown on the *insured person's policy schedule*,

for the period the *insured person* is *totally disabled* up to the Maximum Benefit Period shown on the *policy schedule* less any income the *insured person* is able to derive from any gainful occupation.

No payment is made for the *excess period*.

For *insured persons* who are not also the *insured*, the payment of weekly benefits will not commence until the *insured person* has used any available sick leave available from the *insured* as the *insured person's* current employer and all other sick leave available to the *insured person*.

The *insured person* will not be considered to be *totally disabled* before they consult a *medical practitioner* for the claimed disability. If the *insured person* is capable of returning to work in any occupation, profession or business which they are in the opinion of a *medical practitioner* qualified to perform (based on your education, training or experience) on a full time, part time or any other basis, they are not *totally disabled*.

SECTION 3 — WEEKLY BENEFIT — WORKERS COMPENSATION TOP UP — INJURY

If an *insured person* suffers an *injury* that first *manifests* itself during the *period of insurance* and the *scope of cover* and this *injury* results in the *insured person* becoming *totally disabled*:

- within 12 calendar months of the first *manifestation* of the *injury*; and
- for a continuous period that is longer than the *excess period*,

provided the *injury* also results in an entitlement to weekly workers compensation benefits, we will pay the *insured person* the lesser of:

- the difference between the *insured person's pre disability earnings* and the weekly workers compensation benefits; and
- the Maximum Weekly Workers Compensation Top Up Benefit shown on the *policy schedule*,

this Weekly Benefit will be reduced by any income that the *insured person* receives from any gainful occupation.

No payment is made for the *excess period*.

This Weekly Benefit will end on the eariler of:

- the date when the *insured person* ceases receiving weekly workers compensation benefits; and
- the Maximum Benefit Period shown on the *policy schedule* for this Section 3 — Weekly Benefit — Workers Compensation Top Up — Injury is reached.

The *insured person* will not be considered to be *totally disabled* before they consult a *medical practitioner* for the claimed disability. If the *insured person* is capable of returning to work in any occupation, profession or business which they are in the opinion of a *medical practitioner* qualified to perform (based on your education, training or experience) on a full time, part time or any other basis, they are not *totally disabled.*

SECTION 4 — TAC TOP UP — INJURY COVER

If an *insured person* suffers an *injury* that first *manifests* itself during the *period of insurance* and the *scope of cover* and this *injury* results in the *insured person* becoming *totally disabled*:

- within 12 calendar months of the first *manifestation* of the *injury*; and
- for a continuous period that is longer than the *excess period*,

provided the *injury* also results in an entitlement to transport accident compensation benefits, we will pay the *insured person* the lesser of:

- the difference between the *insured person's pre disability earnings* and the weekly transport accident compensation benefits; and
- the Maximum Weekly TAC Top Up Benefit shown on the *policy schedule*,

this Weekly Benefit will be reduced by any income that the *insured person* receives from any gainful occupation.

No payment is made for the *excess period*.

This Weekly Benefit will end on the eariler of:

- the date when the *insured person* ceases receiving weekly transport accident compensation benefits; and
- the Maximum Benefit Period shown on the *policy schedule* for this Section 4 — TAC Top Up — Injury Cover is reached.

The *insured person* will not be considered to be *totally disabled* before they consult a *medical practitioner* for the claimed disability. If the *insured person* is capable of returning to work in any occupation, profession or business which they are in the opinion of a *medical practitioner* qualified to perform (based on your education, training or experience) on a full time, part time or any other basis, they are not *totally disabled*.

Table of Benefits

Condition	Compensation Insured Person	
	With Dependents	No Dependents
1. Death	$400,000	$200,000
2. *Permanent total disablement*	$400,000	$200,000
3. *Permanent* and incurable paralysis of all limbs	$400,000	$200,000
4. Third degree burns which cover more than 50% of the entire body	$200,000	$100,000
5. *Permanent* total loss of sight in one / both eyes	$400,000	$200,000
6. *Permanent* total loss of the hearing in both ears	$250,000	$150,000
7. *Permanent* total loss of lens of the one eye	$100,000	$50,000
8. *Permanent* total loss of the hearing in one ear	$100,000	$50,000
9. *Permanent* physical severance or *permanent* total loss of use of the following:		
9.1. Both hands	$400,000	$200,000
9.2 Both arms	$400,000	$200,000
9.3 Both feet	$400,000	$200,000
9.4 Both legs	$400,000	$200,000
9.5 One hand and one foot	$400,000	$200,000
9.6 One hand or one arm	$200,000	$100,000
9.7 One foot or one leg	$200,000	$100,000
9.8 Four fingers and one thumb	$150,000	$75,000
9.9 Both joints of one thumb	$60,000	$30,000
9.10 One joint of one thumb	$30,000	$15,000
9.11 Three joints of one finger	$30,000	$15,000
9.12 Two joints of one finger	$20,000	$10,000
9.13 One joint of one finger	$10,000	$5,000
9.14 All toes of one foot	$30,000	$15,000
9.15 Great toe - both joints	$15,000	$7,500
9.16 Great toe - one joint	$10,000	$5,000
9.17 Each toe other than great	$10,000	$5,000
10. Fractured leg or patella with established non-union	$20,000	$10,000
11. Third degree burn which covers between 20% and 49% of the entire body	$100,000	$50,000
12. Loss of at least 50% of all sound and natural teeth including capped or crown teeth - per tooth	$2,500	$1,500
Permanent total disablement (payable where no payment is made under items 1 to and aligned to *Accident Compensation Act 1985* Section — Compensation of Maims)	10% of a lump sum impairment benefit as paid by WorkCover to a maximum of $50,000	5% of a lump sum impairment benefit as paid by WorkCover to a maximum of $25,000

SECTION 5 — WORKPLACE TRAUMA COVER

If an *insured person* suffers an *injury* that first *manifests* itself during the *period of insurance* and the *scope of cover* and this *injury* results in the *insured person* being entitled under:

- Condition 1 as set out in the Table of Benefits on page 9 of this document within 12 calendar months of the first *manifestation* of the *injury*; or
- Conditions 2–12 as set out in the Table of Benefits on page 9 of this document within 12 calendar months of the first *manifestation* of the *injury*,

provided the *injury* also results in an entitlement to workers compensation, we will pay the *insured person* the lesser of:

- the compensation specified for the Condition in the Table of Benefits; or
- the amount specified as applying to Section 5 — Workplace Tauma Cover on the *policy schedule*

This benefit will be reduced by any other capital benefit we have paid or are liable to pay in connection with the same *injury*.

The amout we will pay will depend on whether the *insured person* has any *dependents* at the date of the *injury* first *manifests*.

Except in the case of death, the *insured person* will not be considered to have suffered a Condition before they consult a *medical practitioner* for the claimed disability.

SECTION 6 — ADDITIONAL BENEFITS

The following additional benefits will only apply while the *insured person* is receiving weekly benefits under sections 1,2,3,4 of the *policy* for a *sickness* or *injury*.

Vocational training/retraining

If a *medical practitioner* certifies that the *insured person's total* or *partial disablement* will be assisted by the following, we will also pay up to an additional $10,000 for:

- vocational assessment advice and assistance; and
- retraining to enable employment in another occupation if it is appropriate.

Assistance for spouses

If from the commencement of the *insured person's total disablement* as a result of a *sickness* or *injury* a *medical practitioner* certifies that the *insured person* requires continuous care and:

- the *insured person* is confined to bed for at least 14 days; and
- the *insured person's spouse* or *partner* ceases employment to provide the continuous care certified as required by the *medical practitioner*,

We will provide a benefit to the *insured person's spouse* or *partner* for income lost as a result of providing the continuous care up to an amount of $200 per week for a period of up to 10 weeks, while they provide this care.

This benefit will not be paid for *partial disablement* and will be paid in arrears only while the *insured person* is confined to bed and entitled to weekly benefits for *total disablement* under the *policy*.

This Additional Benefit does not cover any nursing related costs or expenses.

Rehabilitation assistance

If a *medical practitioner* certifies that the *insured person's total* or *partial disablement* will be assisted by the following, we will also pay up to an additional $10,000:

- A return to work program.

Child care expense

If, an *insured person* becomes entitled to payment for Condition 1 under Section 5 — Workplace Trauma Cover, we will pay the reasonable expenses incurred by the *insured person* for the services of a registered childcare provider.

The maximum amount we will pay is $5,000 provided that the additional childcare expenses would not otherwise have occurred.

Escalation of claim benefit

Under Sections 1,2,3 or 4 of this *policy*, after payment of a benefit for temporary *total disablement* or temporary *partial disablement* continuously for 12 months, the benefit will be increased by 5%.

Disappearance benefit

If, during the *period of insurance* and the *scope of cover* for Section 5 — Workplace Trauma Cover, an *insured person* disappears in any manner whatsoever and their body has not been found within 12 months after the date of that disappearance, they will for the purpose of this *policy* be deemed to have died as a result of an *injury* at the time of their disappearance.

Where the death benefit under the Table of Benefits is payable because of a disappearance, we will only pay if the legal representatives of the *insured person's* estate give us:

(a) a signed undertaking that these amounts will be repaid to us, if it is later found that the *insured person* did not die or did not die as a result of an *injury*; and

(b) where the cause of the *insured person's* disappearance is unknown, a death certificate from the relevant jurisdiction's Registry of Births, Deaths and Marriages or equivalent, if one is able to be or has been issued within 12 months of the disappearance.

Conditions applicable to disappearance cover

Where the cause of the *insured person's* disappearance is unknown, the disappearance must be reported;

(i) to the local police and a report obtained; and

(ii) where the disappearance occurs outside the *insured person's* country of residence, to the applicable embassy,consulate or other representative of the country of residence and a report obtained.

SECTION 7 — GENERAL CONDITIONS

Limits

Where an *insured person* is entitled to receive a benefit under Section 2 — Weekly Benefit — Injury and Section 3 — Weekly Benefit – Workers Compensation Top Up – Injury, during the period when both benefits are payable, we will not pay in the aggregate more than a weekly benefit of the difference between the *insured person's pre disability earnings* and the weekly workers compensation benefits received by the *insured person* up to a maximum of the combined weekly benefits that we pay under Section 2 — Weekly Benefit — Injury and Section 3 — Weekly Benefit – Workers Compensation Top Up – Injury per week.

Inspection

You must at regular intervals enter the name and earnings of every *insured person* in a proper wages book. We shall be permitted to examine all the earnings records and wages books of the *insured*, relating to the *policy* at any reasonable time, and from time to time until two years after expiration of the *policy* or until final adjustment (if applicable) and settlement of all claims hereunder, whichever is the later.

Aggregate limit of liability

We will not pay more than the Aggregate Limit of Liability shown in the *policy schedule* for any one event involving more than one *insured person* under this *policy*. If this amount is not enough to pay all claims in full then we will reduce each *insured person's* benefit proportionately.

Age restriction

We will not pay benefits under the *policy* for any *sickness* or *injury* that first *manifests* itself or occurs or reoccurs after the *insured person* has attained the age of 70 years.

Continuous period of insurance

If the weekly benefit has been paid for a period less than the relevant Maximum Benefit Period shown on your *policy schedule* for any of cover Sections 1 to 4 and you again become *totally disabled* or *partially disabled* within 6 months of your previous *total disability* or *partial disability* ending, as a result of the same *injury* or *sickness*, then any weekly benefit otherwise payable for the *total disablement* or *partial disablement* is only payable for the balance (if any) of the Maximum Benefit Period shown on your *policy schedule*.

The *excess period* applies to all claims made under Sections 1 to 4 as a result of a recurrence of the same *injury* or *sickness*.

The insured's contact details

Notices and other information concerning the *policy* will be sent to the *insured* at the address last advised to us. It is important that we be advised of any changes to the *insured's* contact information.

Notices

Notices should be sent to *AFA* at the address shown on page 1. If either the *insured* or *AFA* or the insurer send a notice by post, the notice is regarded as having been received at the time it would have been delivered in the ordinary course of the post

Cancellation

(a) You may cancel this *policy* at any time by notifying us. Notice of cancellation has the effect of cancelling this *policy* at 4.00pm on the day we receive your notice or such later date you request.

(b) We may cancel this *policy* by notifying you in writing, if you are in breach of any of the terms or conditions, or for any other reason available at law.

Notice of cancellation has the effect of cancelling this *policy* at 4.00pm on the 30th business day, after the day on which notice was sent to you.

(c) (i) After cancellation by you, we will be entitled to retain:

(1) the pro rata premium for the period during which the *policy* has been in force; and

(2) any tax or duty paid or owing for which we are unable to obtain a refund.

(ii) After cancellation by us, you will be entitled to a refund on a pro rata basis in relation to the unexpired *period of insurance*.

You will not receive a refund if you have made a claim or you become entitled to make a claim under the *policy* which is greater than 65% of the premium paid.

Sanctions regulation

Notwithstanding any other terms or conditions under this *policy*, we shall not be deemed to provide coverage and will not make any payments nor provide any service or benefit to you or any other party to the extent that such cover, payment, service, benefit and/or any business or activity of yours would violate any applicable trade or economic sanctions, law or regulation.

Proper law and jurisdiction

The construction, interpretation and meaning of the provisions of this *policy* will be determined in accordance with the laws of the State or Territory of Australia in which the *policy* was issued.

In the event of any dispute arising under this *policy*, including but not limited to its construction, interpretation, validity or performance, the parties to the *policy* submit to the exclusive jurisdiction of the courts of Australia.

A reference to any statute, regulation or subordinate legislation includes any amendment, replacement, successor or equivalent to or of that statute, regulation or subordinate legislation.

SECTION 8 — EXCLUSIONS

No compensation or benefit is payable under the *policy* for any event caused by, arising out of, or in any way connected with:

(a) the use, existence or escape of nuclear material or ionizing radiation, or contamination by radioactivity from any nuclear fuel or other nuclear substance;

(b) the *insured person's* own criminal or illegal act;

(c) the *insured person* being under the influence of a prescription drug (unless it was prescribed by, and taken in accordance with the instructions of a *medical practitioner*), or having taken any other medication in any manner other than as recommended by the drug's manufacturer;

(d) the *insured person* having any illicit drug in your breath, blood or urine at the time and place of the *accident*;

(e) the *insured person* being in control of a vehicle, and having alcohol in their breath, blood, or urine in excess of the prescribed legal driving limit at the time and place of the *accident;*

(f) the *insured person* having a blood alcohol content (BAC) greater than 0.08 percent in their breath, blood or urine at the time of the *accident*;

(g) pregnancy, childbirth or miscarriage or any complication arising from any of those conditions;

(h) flying, parachuting, hang gliding, or any other aerial activity except as a fare paying passenger on an airline with scheduled flights;

(i) suicide or attempted suicide; intentional self-injury or attempted intentional self-injury;

(j) any *pre existing condition* (see definition of Pre Existing in Section 10 Definitions);

(k) any other exclusion set out in the *policy schedule* or other document that forms part of the *policy*;

(l) war, civil war, invasion, insurrection, revolution, use of military power or usurpation of government or military power in Australia or any of the following countries: Afghanistan, Chechnya, Iraq, North Korea or Somalia.

We will not pay any benefit:

(m) where our payment would result in our contravening the Health Insurance Act 1973 (Cth), the Private Health Insurance Act 2007 (Cth), the Private Health Insurance (Health Insurance Business) Rules as updated form time to time, or the National Health Act (Cth) or any amendment to, or consolidation, or re-enactment of, those Acts;

(n) for any period during which the *insured person* is serving a prison sentence.

SECTION 9 — CLAIMING A BENEFIT

Notification

We need to be notified as soon as reasonably possible after you sustain an *injury* or a *sickness* which may give rise to a claim under the *policy*. We may reduce the amount of a benefit, or may refuse to pay the claim to the extent that we are prejudiced by late notification of the claim.

Claim procedures

- When you notify us of a potential claim, we will send you claim forms which need to be completed and returned to us within 30 days.
- A medical certification will be required by your *medical practitioner* in the format we provide to you so your claim can be assessed. You need to meet the cost of these medical certifications.
- For weekly benefits, ongoing medical certifications will be required. You will need to meet the cost of these medical certifications.
- We may also require you to undergo medical examinations, and vocation and/or rehabilitation assessments but, if this is required, we will meet those costs.

Other information

We may ask you to provide such evidence to support your entitlement to a benefit as we may reasonably request. This evidence may include, but is not limited to the following:

- written authorities allowing us to access medical, financial or other relevant information, which may include personal and sensitive information;
- in the case of a weekly benefit, evidence of your *pre disability earnings*, details of income or periodic payments you received from other sources. We may require verification of this information by way of a financial audit;
- details of any other insurance covering the same or similar, condition for which you are making the claim;

Your co-operation

When making a claim under the *policy* you are under a duty to act with utmost good faith. We owe the same duty to you in assessing the claim. You need to therefore make every practicable effort to co-operate with us and comply with our requests in assessing the claim.

Subrogation

You will at any time, at our request and expense, permit all steps required to enforce any rights to which we would be entitled, including but not limited to any necessary steps required to prosecute a person or group responsible for any unauthorised acts against you.

Currency

All amounts under this *policy* are expressed and payable in Australian currency.

Except as otherwise provided, if a judgment is rendered, settlement is denominated or another element of loss under this *policy* is stated in a currency other than Australian dollars, payment under this *policy* will be made in Australian dollars at the cash rate of exchange for the purchase of Australian dollars in accordance with the Reserve Bank of Australia on the date the final judgment is reached, the amount of the settlement is agreed upon or the other element of loss is due, respectively.

SECTION 10 — DEFINITIONS

Word	Definition
Accident	means a sudden, unexpected, unusual, specific event, which occurs fortuitously at an identifiable time and place and is unforseen or unintended by the *insured person*.
AFA	means AFA Pty Ltd acting as agent of the insurer.
Dependent	means an *insured person's*: • legal or defacto *spouse* or *partner* with whom the *insured person* has cohabited for not less than 3 consecutive calendar months whose gross earnings are less than $25,000 per year in the 12 calendar months immediately prior to the date that a weekly benefit becomes payable as a result of the *insured person* suffering an *injury* that results in a covered Condition; or • financially *dependent* children who are unmarried and who are 16 and under years of age or 26 and under years of age if they are a full time student.
Excess Period	*excess period* means the *excess period* expressed in days, before we make a payment. The period of days relevant to your *excess period* is specified under *excess period* in the schedule.
Injury	means a bodily *injury* resulting from an *accident*, where the *injury* and *accident* occur during the *period of insurance* and the *scope of cover*. For the avoidance of doubt, the following would not be an *injury*: • any bodily *injury* that arises from or is connected with the surgical treatment of a *pre existing condition*; • a *sickness* or a condition ordinarily described as being a *sickness*; • a *pre existing condition*; • the aggravation of a condition which existed before the start of the period during which cover is provided under the *policy*; or • any degenerative or congenital condition or other condition which does not result from an *accident*.
Insurance Contributions	are the agreed weekly amounts payable to obtain and maintain access to this *policy* for *insured persons*.
Insured	means the person or entity named as the *insured* in the *policy schedule*.
Insured Person	means any person who comes within the class of persons described as *insured persons* in the *policy schedule* and for whom *insurance contributions* have been paid or agreed to be paid.
Journey	means travel between the *insured person's* usual place of residence or temporary accommodation (where the *insured person* is temporarily absent from their usual place of residence) and their place of employment (provided there is no substantial deviation from the most reasonably direct route) for the purpose of attending or returning from work with the *insured*.
Manifest or Manifestation	means having: (a) required an emergency department visit, hospitalisation, or day surgery procedure; (b) required prescription medication from a *medical practitioner* or dentist; (c) had regular reviews or check-ups with a *medical practitioner*; (d) a chronic or ongoing condition which is medically documented, under investigation, pending diagnosis and/or test results; or (e) symptoms which would cause an ordinary person to seek the advice of a *medical practitioner*.
Medical Practitioner	means a legally qualified doctor (including a general practitioner, physician, or specialist) currently registered to practice in Australia, who is not the *insured person's spouse*, or a member of the *insured person's* family or their business associate and is acting within the scope of their registration and pursuant to the relevant laws.
Partial Disablement, Partial Disability, Partially Disabled	means disablement that prevents an *insured person* from substantially attending to their usual occupation, profession or business.

Word	Definition
Period of Insurance	means, with respect to the *insured*, the period during which cover is provided under the *policy* as set out in the *policy schedule*. With respect to an *insured person*, *period of insurance* means the period from the date the *insurance contribution* for the *insured person* is paid and the *insured person* meets any other eligibility criteria agreed with the *insured* as set out on the *policy schedule* or any other document issued by us to the end of the *period of insurance* stated in the *policy schedule*. With respect to both the *insured* and an *insured person*, *period of insurance* does not refer to any prior *period of insurance* if the *policy* is a renewal of a *previous policy* and with respect to an *insured person* the *insured person* was eligible for cover under that *previous policy*. Each period is treated as separate. *Period of insurance* also does not include any future *period of insurance* for any *policy* the *insured* may enter into with us upon renewal and under which an *insured person* may be covered.
Permanent	means lasting for 12 consecutive months from the date of the *injury* and at the expiry of that time a *medical practitioner* advises it is unlikely to improve.
Permanent Total Disablement	• *total disablement* which has lasted for at least 12 consecutive calendar months from the date of the *injury* and which is certified by a *medical practitioner* as beyond hope of improvement and which in all probability will entirely prevent the *insured person* forever from engaging in any occupation, profession, business or employment that they are reasonably fitted for by way of education, training and experience and for which the *insured person* has been paid weekly statutory workers compensation benefits for a continuous period of 24 months; and • at the end of the continuous period of 24 months during which the *insured person* has been paid such weekly statutory workers compensation benefits, the *insured person* has as a result of such *injury* a degree of impairment of the whole person of more than 30% as assessed in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment – Fifth Edition. Successive periods during which the *insured person* has been paid weekly statutory workers compensation benefits in respect of the same *injury* and that are not separated by a return to active full time employment for 6 months or more and that are within 48 months of the date upon which the *insured person* first became *totally disabled* will be considered as one continuous period.
Policy	means this document and the *policy schedule* and any other documents we issue to the *insured* which are expressed to form part of the *policy* terms, which set out the cover we provide for the *period of insurance*. For the sake of clarity, it does not include any prior *policy* that this is a renewal of or any future *policy* that is a renewal of this *policy*.
Policy Schedule	means the most current *policy schedule* and endorsements that we provide to the *insured* which contains details of the cover provided by this *policy*.
Pre Existing Condition	means any *injury*, or physical or mental defect, condition, illness, disease or syndrome for which the *insured person* in the six months prior their commencement date of cover under this *policy* has: • required an emergency department visit, hospitalisation or day surgery procedure; • required prescription medication from a *medical practitioner* or dentist; • had regular reviews or check-ups with a *medical practitioner* a chronic or ongoing condition which is medically documented, under investigation, pending diagnosis and/or test results; or • exhibited symptoms which would cause an ordinary person to seek the advice of a *medical practitioner*
Pre Disability Earnings	means the weekly equivalent of *insured person's* gross annual income from their personal exertion less any costs and or expenses incurred in deriving that income in the 12 months prior to the *injury* or any shorter period that the *insured person* has been engaged in their occupation which caused their disability.
Previous Policy	means the *policy* under which an *insured person* was covered before accessing cover under this *policy*.

Word	Definition
Sickness	means an illness, *sickness* or disease, condition, syndrome, or mental illness that is not an *injury* which first *manifests* during the *period of insurance* and which occurs solely, directly and independently of any other cause or condition (including, but not limited to any *injury* or *pre existing condition*, other *sickness*, illness, disease, syndrome, mental illness, congenital or degenerative condition) which existed prior to the *period of insurance.*
Scope of Cover	means the operative time of the cover under each Cover Section of this *policy* as specified in the *policy schedule*.
Spouse or Partner	means a person who is married to the *insured person* or a *partner* of an *insured person* who has been co-habiting with the *insured person* for a period of at least three continuous months.
Terrorist activity	means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the use of force or violence and/or the threat of such use. Furthermore, the perpetrators of *terrorist activity* can either be acting alone, or on behalf of, or in connection with any organisation(s) or government(s).
Total Disablement, Totally Disabled, Total Disability	means the *insured person* is entirely and continuously unable to engage in the *insured person's* usual occupation, profession or business or from any other occupation, profession or business which in the opinion of a *medical practitioner* the *insured person* is qualified to perform based on their education, training or experience and the *insured person* is: • not working in any employment or occupation; and • under the regular care and attendance of and following the advice and treatment recommended by, a *medical practitioner*. The *insured person* will not be considered to be *totally disabled* before they consult a *medical practitioner* for the claimed disability. If the *insured person* is capable of returning to work in the *insured person's* usual occupation, profession or business which the *insured person* is in our opinion, qualified to perform (based on their education, training or experience) on a full time, part time or any other basis, the *insured person* is not *totally disabled*.
We, Us and Our	means AFA Pty Ltd acting as agent of Zurich Australian Insurance Limited (ZAIL), ABN 13 000 296 640, AFS Licence Number 232507.

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