Sports Personal Accident Insurance

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Product Disclosure Statement and Policy Wording

The insurer of this product is:

Wesfarmers General Insurance Limited, ABN 24 000 036 279, trading as Lumley Insurance

AFS Licence No. 241461

Preparation Date: 01/07/09

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IMPORTANT CUSTOMER INFORMATION

Who is the Insurer

The insurer is Wesfarmers General Insurance Limited, ABN 24 000 036 279 AFS Licence No. 241461, trading as Lumley Insurance. We are authorised to issue and deal in this product. In this PDS unless otherwise stated, the insurer is called 'we', 'us', or 'our' and/or 'Lumley Insurance'.

About our Product Disclosure Statement and Policy Wording

This booklet (which is our Product Disclosure Statement and policy wording ('PDS')) contains important information to help the Insured and Insured Persons understand this Sports Personal Accident insurance. Before making a decision, please read this booklet carefully.

Other documents may form part of our PDS. Any such documents will include a statement identifying them as part of this PDS and will be provided at the same time as this PDS.

How this insurance works

This insurance is entered into with the Insured and is designed to provide cover in relation to certain Insured Persons who fall within the Eligibility Criteria specified in the Schedule.

When the Insured applies for this insurance they complete an application and we use the information supplied to decide the terms of cover we will provide. We provide cover on the terms contained in this document and the Schedule that we issue to the Insured.

The Schedule contains important information relevant to the insurance including who the Insured is, who the Insured Persons will be, the Period of Insurance, the premium we charge for this Policy, the applicable benefits and limits, and whether any standard terms have been varied by way of endorsement.

All of these make up the Insured's "Policy" with us.

Before expiry, we will send the Insured a renewal notice which states whether we will renew and on what terms. The renewal notice will state what is required.

Insured Persons who fall within the agreed Eligibility Criteria specified in the Schedule, get automatic access to the cover we have agreed to provide under this Policy by way of a statutory right under section 48 of the Insurance Contracts Act 1984 (Cth). They are not contracting Insureds (e.g. they cannot cancel or vary the Policy – Only the Insured can do this), do not enter into any agreement with us and neither we nor the Insured hold anything on trust or for the benefit of such persons under this Policy.

Insured Persons have the same obligations in relation to a claim made by them that the Insured would have to us (e.g. complying with claims conditions such as subrogation) and may discharge the Insured's obligations in relation to a loss. We have the same defences to an action by them as they would have against the Insured. For when access to cover by Insured Persons starts and ends see the General Conditions Section.

The Insured does not act as our agent, the Insured acts independently from us in entering into this insurance to provide cover to Insured Persons, does not hold an Australian Financial Services Licence and is not authorised to provide any recommendations or opinions about the insurance or other financial services to an Insured Person.

Any notices of non renewal, variation, avoidance or cancellation will be sent by us to the insured not insured persons. The insured will notify insured persons when this occurs.

The Insured and Insured Persons should contact us if they have any queries.

Where an Insured Person has an option to elect whether to access this cover or not by performing an act which brings them within the Eligibility Criteria, the Insured is required to ensure that the Insured Person is given a copy of this booklet and any other documents which comprise part of our PDS. The PDS must be given to the Insured Person before they make the election to ensure that they understand the cover they are accessing and their rights and obligations. If this hasn't been done, the Insured Person should contact us.

Even if the Insured Person has not elected to access the cover and obtains access automatically by falling within the agreed Eligibility Criteria, they can still ask the Insured to provide them with a copy of the PDS. The Insured must provide this documentation free of charge and if it does not do this, the Insured Person should contact us.

IMPORTANT CUSTOMER INFORMATION (continued)

What you need to read

It is important that both the Insured and Insured Persons carefully read this and other documents provided and keep them together in a safe place for future reference.

In order to determine whether the cover that the Insured and an Insured Person can access under this insurance provides the cover required for the Insured Person's or the Insured's individual personal objectives, financial situation and needs, it is important that the Insured Person and the Insured read:

- this Important Customer Information Section - it contains information on important matters the Insured Person needs to be aware of;
- the Definitions Section - it sets out what we mean by certain defined terms in this insurance;
- the Cover Section - it set out the cover we can provide under this insurance;
- the Policy Exclusions Section – it sets out what we do not cover;
- the General Conditions Section – it sets out the details of the Insured's, the Insured Person's and our rights and obligations under this insurance, including what an Insured Person needs to do if they need to make a claim; and
- any other documents we provide about the insurance which may change the standard cover.

If the Insured or Insured Person do not meet their obligations in relation to the Policy, we may cancel this insurance and/or reduce our liability in respect of a claim to the extent permitted by law.

Services Provided by Lumley Insurance and General Advice Warning

Lumley Insurance is an Australian Financial Services Licensee (No. 241461) and are authorised under our licence to deal in and provide general advice on this insurance.

Any advice we or our representatives provide is general only and does not take into account the Insured's or the Insured Persons' personal objectives, financial situation or needs. Because of this the Insured and Insured Persons should, before acting on the advice, decide if it is right for them and consider the information contained in this document carefully.

Our employees are paid an annual salary and possibly bonuses on achievement of company goals. They are not otherwise remunerated for any advice or dealing service that they provide unless they advise otherwise.

Summary of Cover and other significant matters

(Read the full terms, conditions and exclusions of the Policy for a full explanation of the cover)

By way of summary, the principal cover provided under this insurance is Injury Cover:

If an Insured Person suffers a defined Injury (which must occur during the Period of Insurance and Scope of Cover) and this results in one of the covered conditions set out in the Table of Conditions occurring within twelve (12) consecutive calendar months of the Insured Person's Injury, we will pay the Insured Person (or such other persons we specify in this Policy) the applicable lump sum or Weekly Compensation listed for the relevant condition.

Certain pre existing medical conditions are excluded. See the Exclusions Section for details.

Some Additional Benefits for Exposure and Disappearance are provided and in certain cases an Injury Assistance Benefit and cover for Non Medicare Medical Expenses can be applied for by the Insured. If these apply, they will be noted in the Schedule.

Refer to each cover section for details of the basis on which we settle any claim.

We only cover the events specified as covered in the Schedule up to the amount(s), limits and sum(s) insured and for the period of time specified in this Policy and subject to its other terms, conditions and exclusions. All amounts insured exclude GST.

The Insured and Insured Persons need to make sure that they are happy with the extent of the cover provided by this insurance. If not they may not get the cover they require.

Waiting Period

A "Waiting Period" applies for disability claims.

If an Insured Person is continuously Temporarily Totally Disabled for the whole Waiting Period and they are entitled to Weekly Compensation under this insurance, we will begin our payments at the end of the Waiting Period subject to the terms of this Policy. No payment is made for or during the Waiting Period.

We agree on the Waiting Period with the Insured and it is specified in the Schedule.

The Waiting Period applies to all claims made under the Cover Sections of this Policy as a result of a recurrence of the same Injury referred in "Specific limitations on Weekly Compensation" of the Benefit Limits section of this document on page 15.

When we you may not be covered

We may refuse to pay or reduce the amount we pay under a claim in certain circumstances. In particular, where an exclusion applies and if you do not comply with the terms and conditions of the Policy.

An insured person's access to cover may end before the Period of Insurance ends. For example, if they reach a certain age, or if the insured cancels the Policy. Insured persons need to make sure they understand when this can occur.

We may cancel the Policy in certain circumstances permitted by law e.g. if the insured fails to comply with a condition or breaches its duty of disclosure. See the General Conditions for details. If this happens, the cover for insured persons will also cease, but this will not affect the rights of any person which arose before cancellation.

If the insured fails to comply with its duty or disclosure or makes a misrepresentation when applying for cover which is:

- fraudulent, we may treat the Policy as if it was never effected and the insured and insured persons, will not be entitled to cover.
- not fraudulent (or we choose not to exercise the above right), we may reduce our liability under the Policy in respect of a claim made under the Policy. We will, however, be entitled to cancel the Policy in accordance with our cancellation rights (see the General Conditions for details).

Cost of the insurance

The insurance provided is subject to the Insured's payment or agreement to pay the premium we require by the agreed time. In order to calculate the premium, we take various factors into consideration, including:

- the type and amount of cover requested;
- the type of Insured Persons who can access the cover;
- the sum(s) insured and limits; and
- the Insured's previous insurance history.

Factors that increase the risk generally increase the premium (e.g. extra cover or higher sums insured or a high claims experience) and those that lower the risk, reduce the premium payable (e.g. less cover, a longer Waiting Period or low claims experience).

The premium also includes amounts that take into account our actual or estimated obligation to pay any relevant compulsory government charges, taxes or levies (for example, Stamp Duty and GST where applicable) in relation to this Policy. We tell the Insured when they apply what premium is payable, when it needs to be paid and how it can be paid.

Insured Persons may need to pay the Insured an amount in order to access the cover. The Insured will inform the Insured Person if any amount is payable and how and when it must be paid before they access cover. Any such amount payable is not premium and is not received by us as Insured Persons are not contracting parties to this Policy.

Duty of Disclosure

Before a person enters into a contract of general insurance with us, they have a duty under the Insurance Contracts Act 1984 to disclose to us every matter that they know, or a reasonable person in the circumstances could be expected to know, is relevant to our decision whether to accept the risk of the insurance and, if so, on what terms.

The Act imposes a different duty the first time that a person enters into a contract of insurance with us, to that which applies when they renew, vary, extend or replace it.

The Insured's Duty of Disclosure when they enter into this contract of insurance with us for the first time

We will ask the Insured various questions when they first apply for this contract of insurance that are relevant to our decision whether to accept the risk of insurance and if so, on what terms. When the Insured answers those questions, they must:

- give us honest and complete answers;
- tell us everything they know; and
- tell us everything that a reasonable person in the circumstances could be expected to know.

The Insured's Duty of Disclosure when they renew, vary, extend, reinstate or replace this contract of insurance

When the Insured renews, extends, varies or reinstates their contract of insurance with us, the Insured's duty is to disclose to us before the renewal, extension, variation or reinstatement, every matter that they know, or a reasonable person in the circumstances could be expected to know, is relevant to our decision whether to accept the risk of the insurance and, if so, on what terms.

What the Insured does not need to tell us

The duty however does not require disclosure of a matter:

- that diminishes the risk to be undertaken by us;
- that is of common knowledge;
- that we know or, in the ordinary course of business, ought to know; or
- as to which compliance with the duty is waived by us.

Who does the duty of disclosure apply to?

The duty of disclosure applies to every Insured under the contract of insurance.

What happens if an Insured does not comply with the duty of disclosure?

If an Insured fails to comply with the duty of disclosure, we may be entitled to reduce our liability under this Policy in respect of a claim or cancel this Policy. If the non-disclosure is fraudulent, we may be able to treat this Policy as if it was never effected.

Cooling off rights

Even after making a decision to purchase this insurance, the Insured still has cooling off rights. The Insured can return this Policy by notifying us in writing within 21 days of cover commencing and we will refund the premium paid less any government taxes and charges that we cannot recover unless something has occurred for which a claim may be payable under this insurance. Even after this cooling off period ends, the Insured still has cancellation rights (See the General Conditions Section).

The Insured will advise each Insured Person of their refund policy when they apply to access cover and if this Policy ends or if the Insured Person wants to cease its access to the cover.

IMPORTANT CUSTOMER INFORMATION (continued)

Confirming Transactions

The Insured may contact us in writing or by phone to confirm any transaction under this Policy if they do not already have the required policy confirmation details.

Insured Persons should contact the Insured for confirmation of their access to cover.

Code of Practice

The Insurance Council of Australia Limited has developed the General Insurance Code of Practice, which is a self regulatory code for use by all insurers. The Code aims to raise the standards of practice and service in the insurance industry.

We have adopted and endorse the Code and abide by it. For details please contact us.

How to Make a Claim

If an Insured or an Insured Person wishes to make a claim, they should in the first instance contact us.

Details about making a claim are set out in the General Conditions.

Before we pay any claim, we may require receipts or reports from one or more Medical Practitioners and other documentary evidence. Please ensure that these are kept in a safe place.

Complaints - Internal and External Complaints Procedure

If the Insured or an Insured Person has a complaint, they should contact us and explain what the complaint is and the reasons behind it.

We will then either resolve or attempt to resolve the complaint immediately and if it is unresolved, we will refer the matter to our Internal Dispute Resolution Committee (IDRC).

If the Insured or the Insured Person who has made the complaint is not satisfied with the decision of the IDRC, they may be able to access the services of an independent external dispute resolution body called Financial Ombudsman Service (FOS).

For further information about our dispute resolution process, please contact us.

Privacy

In this Privacy clause, “you” and “your” refers to the Insured and each Insured Person.

We are bound by the National Privacy Principles under the Privacy Act 1988 (Cth) when we collect and handle personal information provided by you (this includes the personal information of the Insured and any Insured Person).

We collect personal information for the purpose of providing insurance, including arranging insurance, policy administration and claims handling. We also collect your personal information to conduct market or customer satisfaction research and to develop and identify products and services that may interest you. If necessary, we may collect your health and other sensitive information, but we will obtain your consent before doing so unless the collection is required or permitted by or under law.

We disclose personal information to reinsurers, insurance intermediaries, insurance reference bureaus, credit reference agencies, our and your advisers and those involved in the claims handling process, as well as our related bodies corporate, for the purposes of assisting us and them in providing relevant services and products, and for the purposes of litigation. We limit the use and disclosure of any personal information provided by us to them to the specific purpose for which we supplied it. By providing your personal information to us or our agent, you consent to us making these disclosures.

Without this information, we may not be able to provide you with the services you require.

When you give us personal information about other individuals, we rely on you to have made or make them aware that you will or may provide their information to us and the types of third parties we may provide it to, the relevant purposes we and the third parties will use it for, and how they can access it. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

IMPORTANT CUSTOMER INFORMATION (continued)

If you would like a copy of our Privacy Policy, would like to seek access to or correct your personal information, or opt out of receiving materials we send, please contact us.

Updating our Product Disclosure Statement

We may need to update this PDS from time to time if certain changes occur where required and permitted by law. We will issue the Insured with a new PDS or a Supplementary PDS or other compliant document to update the relevant information except in limited cases. Where the information is not something that would be materially adverse from the point of view of a reasonable person considering whether to buy this insurance, we may issue the Insured with notice of this information in other forms or keep an internal record of such changes (the Insured can get a paper copy free of charge by calling us).

Where an Insured Person has an option to elect whether to access this cover or not by performing an act which brings them within the Eligibility Criteria, the Insured is required to provide the above documents to the Insured Person before they make the election to ensure that they understand the cover they are accessing and their rights and obligations. If this hasn't been done, the Insured Person should contact us.

Our contact details

If the Insured, an Insured Person or their adviser needs to contact us, have any questions or would like any further information regarding this insurance, please contact us using the contact details provided in this document or where relevant, at our local office.

COVER

DEFINITIONS

In this Policy some words have a special meaning (whether expressed in the singular or plural) and we define them below:

"we", "us", "our", and/or **"Lumley Insurance "** means the insurer, Wesfarmers General Insurance Limited,
ABN 24 000 036 279, trading as Lumley Insurance.

To assist in reading this document, the following words have been printed in Title Case wherever they appear in this Policy.

"Accident" means a sudden, unexpected, external, violent, visible, unusual and specific event that is unforseen or unintended by the Insured Person and which occurs at a single identifiable time and place during the Period of Insurance and independently of all other causes, results directly, immediately and solely in physical bodily injury.

"Act of Terrorism" means an act, including but not limited to the use of force or violence and or threat thereof, of any person or group of persons, whether acting alone or on behalf of or in connection with any organisation or government which from its nature or context is done for, or in connection with, political, religious, ideological, ethnic or similar purposes or reasons, including the intention to influence any government and or to put the public, or any section of the public, in fear

"Aggregate Limit of Liability" means the maximum amount we will pay for all claims arising under this Policy from any one event during the Period of Insurance.

"Aggregate Period" means the maximum period of time for which we will pay any Weekly Compensation for any one Injury, irrespective of whether claims are made under this Policy or another policy held by the Insured or Insured Person with us, unless we have agreed to provide that cover in excess of this one. The relevant Aggregate Period is specified in the Schedule.

"Earnings" means with respect to an Insured Person who:

1. is an employee, the Insured Person's gross weekly rate of pay exclusive of bonuses, commission, overtime payments and all other allowances, derived from the personal exertion of the Insured Person in their usual occupation, averaged over the number of weeks so engaged during the twelve month period immediately preceding the date Temporary Total Disablement (with respect to which we have agreed to pay a claim under this Policy) commences;
2. is not an employee, the Insured Person's gross weekly income derived from the personal exertion of the Insured Person in their usual occupation, after deducting any expenses necessarily incurred in deriving that income averaged over the number of weeks so engaged during the twelve (12) consecutive calendar months immediately preceding the date of Temporary Total Disablement (with respect to which we have agreed to pay a claim under this Policy).

Earnings do not include any income earned from training for, or participating in any sport by the Insured Person and does not include income earned as a result of the personal exertion or labour of other persons unless we specifically agree otherwise in writing. It also does not include any income earned by the Insured Person as a result of any employment or services provided on a seasonal or temporary basis only unless notified in the Schedule.

"Effective Date of Individual Cover" means for each Insured Person the latter of the commencement of the Period of Insurance stated in the Schedule or the date and time an Insured Person falls within the Eligibility Criteria specified in the Schedule, provided such date falls within the Period of Insurance. Cover continues on a 24 hour a day basis or as stated in the Scope of Cover in the Schedule for as long as the Insured Person continuously comes within the Eligibility Criteria, provided this Policy is still in force and the premiums in respect to that Insured Person are being paid, until cover ceases as set out in the General Conditions.

"Excess" means the amount stated in the Schedule which will be deducted from each and every claim under the event shown.

"Fingers or Toes" means the digits of a hand or foot.

DEFINITIONS (continued)

"Injury" means an identifiable physical bodily injury:

- caused solely by an Accident and which occurs independently of any other cause or condition, including, but not limited to any other bodily injury or any sickness, illness, disease, congenital or other condition where both the Accident and the bodily injury occur during the Scope of Cover and the Period of Insurance, and
- which results in any of the Conditions set out in the Table of Conditions within twelve (12) consecutive calendar months from the date of the Injury.

Injury does not include any consequences of a bodily injury that are ordinarily described as being a sickness, illness or disease, a Pre-Existing Condition or any degenerative, congenital or other condition that does not result solely and directly from the Accident that caused the Injury;

Injury shall include collapse or disability that is directly related to the cardiovascular system, but only for Insured Persons who are under 35 years of age and provided the condition was not a Pre-Existing Condition.

"Injury Assistance Benefit" means additional expenses that

a) are not medical expenses or related to medical expenses; and

b) are as a direct result of an Injury covered by this Policy and

c) are incurred within twelve (12) consecutive calendar months from the date of the Injury; and

d) are reasonably and necessarily incurred by an Insured Person or paid for on the Insured Person's behalf; and

e) are deemed necessary by the treating Medical Practitioner.

No expenses are payable under this benefit unless those expenses are as a direct result of the Injury or are necessarily incurred in the recovery from the Injury, and do not include any expenses for the prevention of future Injury(ies).

"Insured" is the Insured named in the Schedule.

"Insured Person" means any eligible person who meets the Eligibility Criteria specified in the Schedule and who has access to the cover under this Policy in accordance with the terms and conditions of this Policy pursuant to section 48 of the Insurance Contracts Act (See when access starts and ends in General Conditions Section "When an Insured Person's Access to cover begins and ends").

"Limb" means the entire limb between the hip and the ankle or between the shoulder and the wrist.

"Loss of Use" means loss of, by physical severance, or total and permanent loss of the effective use of the part of the body referred to in the Table of Conditions.

"Medical Practitioner" means a legally qualified and registered medical practitioner who is not the Insured or an Insured Person or a relative of an Insured Person and who is acting within the scope of their qualification and registration and in accordance with the relevant laws.

"Medicare Gap" means any expenses or part of any expenses for which a Medicare benefit is paid or is payable including the balance of monies due or payable by the Insured or Insured Person after the deduction of any Medicare benefit or rebate from the actual expenses incurred.

DEFINITONS (continued)

"Non Medicare Medical Expenses" means expenses reasonably and necessarily incurred by the Insured Person up to twelve (12) consecutive calendar months from the date of the Injury and are as a direct result of an Injury covered by this Policy from:-

a) private hospitals (including accommodation), dentists, ambulance or emergency transport services; or

b) orthotists services prescribed by a surgeon; or

c) physiotherapy, chiropractic, osteopath, naturopath and massage services after referral by the treating Medical Practitioner.

d) no expenses are payable in respect of the Medicare Gap

e) No expenses are payable under this benefit unless those expenses are as a direct result of the Injury or are necessarily incurred in the recovery from the Injury, and do not include any expenses for the prevention of future Injury(ies).

Non Medicare Medical Expenses:-

a) must be incurred as a result of an Injury which occurs while :

(i) the Insured Person is:

A engaged in a sporting activity in the capacity of a participant, adjudicator, judge, referee or umpire or in a similar capacity;

B acting as an official at, or otherwise assisting in the conduct of a sporting activity; or

C acting in his or her capacity as an elected or appointed official of a sporting organisation;

or while the Insured Person is travelling to or from:

D that activity; or

E the place where that person acts in that capacity

b) are limited to expenses incurred during the period following Injury that the Insured Person remains Temporary Totally Disabled on medical advice, and

c) are reduced by any recovery made from any private health insurance fund, ambulance service or from any other source.

d) are reduced by any Excess as shown in the Schedule per event.

f) are limited to the benefit amount shown in the Schedule.

"Paraplegia" means total paralysis of both legs and part or whole of the lower half of the body.

"Period of Insurance" means:

In respect of the Insured, the period stated in the Schedule, or:

In respect of an Insured Person, the period from the Effective Date of Individual Cover to the end of the Period of Insurance stated in the Schedule.

In respect of both the Insured and an Insured Person, Period of Insurance does not refer to any prior period of insurance if this Policy is a renewal of a previous policy and with respect to an Insured Person the Insured Person was eligible for cover under the previous policy.

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 at least twelve (12) consecutive calendar months and at the expiry of that period is certified by a medical practitioner as beyond hope of improvement.

DEFINITIONS (continued)

"Permanent Total Disablement" means a Total Disablement which has lasted for at least twelve (12) consecutive calendar months from the date of the Injury and at the expiry of that period is certified by an independent Medical Practitioner as being beyond hope of improvement and which entirely prevents the Insured Person forever from engaging in any occupation, profession, business or employment that he/she is reasonably fitted for by way of education, training and experience,

"Policy" means this document and the 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.

"Pre-Existing Condition" means any sickness, illness, disease, injury, disability or other condition including any symptoms or side effects of these:

a) of which the Insured Person is aware or a reasonable person in the circumstances would be expected to have been aware; or

b) for which the Insured Person has sought or received medical attention, undergone tests or taken prescribed medication,

in the twelve (12) month prior to that Insured Person's Effective Date of Individual Cover under this Policy.

"Quadriplegia" means permanent, total paralysis of both legs and both arms.

"Schedule" means the current schedule, certificate and endorsements we provide to the Insured which contains details of the cover specific to the Insured.

"Scope of Cover" means the operative time of the cover under this Policy as specified in the Schedule.

"Temporary Total Disablement" means Total Disablement which lasts for longer than the Waiting Period and which is not Permanent Total Disablement

"Total Disablement" means that the Insured Person is wholly and continuously prevented from engaging in their usual occupation, profession, business or employment or any other occupation, profession, business or employment for which they are reasonably qualified by experience, education or training, and they are under the regular care of and acting in accordance with the instructions or professional advice of a Medical Practitioner.

"Waiting Period" is the period of consecutive days specified in the Schedule for or during which no Weekly Compensation is payable by us, commencing on the first day of Temporary Total Disablement for which medical treatment was sought in respect of an Injury.

"Weekly Compensation" means the weekly compensation payable for the Weekly Benefit Events specified in Item 19 of the Table of Conditions.

COVER SECTIONS

COVER

The following covers only apply if the relevant premium has been paid by the Insured to us, if they are specified as applicable in the Schedule and only in relation to the activities specified as applicable in the Schedule and not otherwise specifically excluded.

If, an Insured Person suffers an Injury which solely and directly results in any of the Conditions specified in Section A of the Table of Conditions we will pay the Insured Person (or in the case of death, their legal personal representative, or such other person or entity as we may specify in this Policy) the Benefits specified in the Table of Conditions for the relevant disablement or Condition, subject to the other terms, limits and conditions of this Policy. Any disablement must occur within twelve consecutive (12) calendar months of the date of the Injury.

Where as a result of an Injury a benefit is payable for a Condition under Section A of the Table of Conditions, we will also pay the Other Benefits set out in Section B of the Table of Conditions.

TABLE OF CONDITIONS

Section A. - Lump Sum Benefits

Specified as a percentage of Lump Sum Insured stated in the Schedule:

As a result of Injury Only	Compensation Percentage
1. Death	100%
2. Permanent Total Disablement	100%
3. Paraplegia/Quadriplegia	100%
4. Permanent and incurable paralysis of all Limbs.	100%
5. Permanent Total Loss of sight of both eyes.	100%
6. Permanent Total Loss of sight of one eye.	100%
7. Permanent Total Loss of Use of two Limbs.	100%
8. Permanent Total Loss of Use of one Limb.	100%
9. Permanent and incurable insanity.	100%
10. Permanent Total Loss of hearing in	
(a) both ears	75%
(b) one ear	15%
11. Permanent Total loss of the lens of one eye	50%
12. Permanent Total Loss of four fingers and thumb of either hand	70%
13. Permanent Total Loss of four fingers of either hand	40%
14. Permanent Total Loss of Use of one thumb of either hand	
(a) both joints	30%
(b) one joint	15%
15. Permanent Total Loss of Use of fingers of either hand	
(a) three joints	10%
(b) two joints	7.5%
(c) one joint	5%
16. Permanent Total Loss of Use of toes of either foot	
(a) all - one foot	15%
(b) great - both joints	5%
(c) great - one joint	3%
(d) other than great, each one	1%
17. Fractured leg or patella with established non-union	10%

COVER SECTIONS (continued)

18.	Shortening of leg by at least 5cm	7.5%

Section A - Weekly Benefits

19.	Temporary Total Disablement caused directly and solely by Injury and occurring within twelve (12) consecutive calendar months of the date of the Injury	During such disablement, the Insured Person's Weekly Benefit or percentage of Earnings as specified in the Schedule, whichever is the lesser and commencing from the first treatment by a Medical Practitioner.

Section B - 1. Injury Assistance Benefit As shown in the Schedule

Section B - 2. Non Medicare Medical Expenses As shown in the Schedule

Benefits shall only be payable under Section B Conditions B -1 and/or B - 2, if the expenses are incurred within twelve (12) consecutive calendar months from the date of the Injury.

ADDITIONAL BENEFITS

Exposure

If by reason of an Injury occurring during the Period of Insurance and during the Scope of Cover and while they are an Insured Person, an Insured Person is exposed to the elements and as a direct result of that exposure they suffer from any of the Conditions set out in the Table of Conditions, such condition will be treated as though it were caused by an Injury for the purpose of this Policy.

Disappearance

If the Insured Person disappears following the disappearance, sinking or wrecking of a conveyance in which they were travelling during the Period of Insurance and during the Scope of Cover and while they were an Insured Person, and their body has not been found within twelve (12) consecutive calendar months after the date of their disappearance, we will pay the Death Benefit under Section A – Condition 1 of the Table of Conditions on the assumption that the Insured Person died as a result of Injury at the time of the disappearance, sinking or wrecking of the conveyance. This disappearance benefit is subject to the receipt by us of a signed undertaking by the person to whom the claim is paid, that any payment will be refunded if it is later demonstrated that the Insured Person did not die as a result of an Injury.

COVER SECTIONS (continued)

BENEFIT LIMITS

Specific limitations on Lump Sum Benefits

1. No benefit shall be payable for more than one of Condition under Section A in respect of the same Injury, in which case the highest compensation will be payable.
2. Any benefit payable under Section A for Conditions 1 to 18 shall be reduced by any Weekly Compensation already paid for Section A – Condition 19 in respect of the same Injury.
3. Benefits shall only be payable under Section A if the Condition occurs within twelve (12) consecutive calendar months of the date of Injury.
4. Benefits shall only be payable under Section B Conditions B -1 and/or B - 2, if the expenses are incurred within twelve (12) consecutive calendar months of the date of Injury.

Specific limitations on Weekly Compensation

1. We will pay one-seventh (1/7th) of the Weekly Compensation for each day disablement lasts for less than a week. All weekly benefits shall be paid fortnightly in arrears.
2. No weekly benefits shall be payable for disablement during the Waiting Period stated in the Schedule.
3. No Benefits are payable unless as soon as possible after the happening of any Injury the Insured Person obtains, follows and continues to follow medical advice from a Medical Practitioner.
4. Benefit Payments will cease if the Insured Person stops following medical advice or refuses or delays medical treatment (other than experimental treatment), which in the opinion of an independent Medical Practitioner could reduce the period of disablement.
5. Weekly benefits payable for Temporary Total Disablement will be reduced by the amount of any Worker's Compensation and/or Transport Accident compensation entitlement or any other benefits or compensation the Insured Person is entitled to receive or entitled to claim for lost income (whether a periodical payment, lump sum or otherwise but not including any payment in respect of pain and suffering) from any other source as a result of the same condition. If the Insured Person surrenders, commutes, redeems or releases such claim or entitlement (whether in whole or in part), the total amount of benefits under this Policy will reduce by the amount of payment to which the Insured Person would have been entitled or had the right to claim. Benefits or entitlements received from other sources after weekly benefits have been paid under this Policy must be refunded by the Insured Person to us.
6. If, while the Policy is in force the Insured Person suffers a recurrence of Temporary Total Disablement from the same or related cause or causes, the subsequent period of disablement will be deemed a continuation of the prior period unless between such periods the Insured Person has worked on a full-time basis for at least 6 consecutive months, in which case the subsequent period of disablement shall be deemed to have resulted from a new Injury and a new Waiting Period shall apply and the continuing period of disablement will accumulate to the prior claim period.
7. No further compensation shall be paid to an Insured Person, under this Policy, if that Insured Person:
   (a) becomes entitled to the payment of Weekly Compensation for the Aggregate Period stated in the Schedule;
   (b) becomes entitled to the payment of 100% of the Lump Sum Insured stated in the Schedule; or
   (c) reaches 65 years of age, unless otherwise shown in the Schedule.

General limitations on Benefits

The following general limits apply in relation to the benefits:

1. No benefits shall be payable beyond the date of the Insured Person's death with the exception of the death benefit if this is included in the Schedule.
2. The total liability for all claims arising under this Policy from any one event during the Period of Insurance shall not exceed the Aggregate Limit of Liability stated in the Schedule. In the event that claims made under this Policy exceed the Aggregate Limit of Liability, then the amount by which claims exceed this limit will be proportionally reduced.

See also the Exclusions, General Conditions and the Schedule for other limits that may apply.

Limitation of weekly benefits outside Australia

If an Insured Person has made a claim and they are in receipt of Weekly Compensation under this Policy and the Insured Person travels or resides outside Australia for a period of more than three (3) consecutive calendar months (unless otherwise agreed with us in writing), then the Weekly Compensation payable under this Policy will cease at the end of the three (3) consecutive calendar months taken from the date the Insured Person left Australia or the remaining unpaid Aggregate Period, whichever occurs first. If the Insured Person returns to reside in Australia prior to the expiry of the three (3) consecutive calendar month period (or other period as agreed by us in writing) then Weekly Compensation payments can continue for any remaining Aggregate Period left under this Policy, subject to all other terms, conditions and exclusions of this Policy.

EXCLUSIONS

No compensation is payable under this Policy for any Injury or event caused by, resulting from or in any way connected with:

1. war, riot, civil commotion, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, terrorism, revolution, insurrection or military or usurped power;
2. taking part in, or training for, any professional sport of any kind (where the majority of the person's income is derived directly or indirectly from the sport);
3. taking part in or training for flying or other aerial activities, otherwise than as a fare paying passenger in a licensed aircraft that is part of a commercial airline with scheduled flights;
4. a deliberately self inflicted or intentionally caused injury or suicide, self harm or attempted suicide;
5. sexually transmitted disease or Human Immunodeficiency Virus (HIV) or any variance including Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC) or hepatitis C
6. the Insured Person or a person who as beneficiary has received the Insured Person's benefits under this Policy engaging in any illegal conduct or criminal act;
7. the Insured Person being under the influence of or addiction to alcohol or any drug, other than a drug prescribed or administered by and taken in accordance with the advice of a Medical Practitioner;
8. the use, existence or escape of nuclear weapons materials or ionising radiation from or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
9. a Pre-Existing Condition as herein defined.
10. resulting from loss or damage to any prosthesis, spectacles, contact lenses, hearing aids, dental appliances or false teeth or any artificial aids, brace or protective device, whether it be expenses directly or indirectly incurred in as a result of Injury.
11. any psychiatric or psychological disorder, stress, stress-related disorders, including, but not limited to depression, anxiety, physical fatigue or associated disorders whether or not as result of an Injury.
12. any Act of Terrorism;

We will also not pay:

- any benefit that if the benefit were paid, that payment would constitute the carrying on of a "Health Insurance Business" as defined under the National Health Act, 1953 (Cth), the Private Health Insurance Act, 2007 (Cth) or any succeeding legislation to those Acts or would result in a breach of the provisions of the Health Insurance Act, 1973 (Cth); or
- for any Injury or event under this Policy if the Insured Person has agreed not to seek compensation from another person(s) or organisation(s) that are or may be liable to compensate the Insured Person for any loss that is covered by this Policy.

GENERAL CONDITIONS

1. Insured Person complying with terms and conditions of Policy

All Insured Persons must comply with the terms and conditions of this Policy relevant to them. If there is a breach of any of the terms and conditions of this Policy, we shall be entitled to reject a claim to the extent permitted by law. However a breach by an individual Insured Person will not affect the cover or claims of other Insured Persons.

2. When an Insured Person's Access to cover begins and ends

Access shall not commence until the Effective Date of Individual Cover.

Access ends from the earlier of one of the following:

(a) the Period of Insurance ends or this Policy is cancelled by us or the Insured;

(b) the Insured Person is paid Weekly Compensation for the maximum Aggregate Period stated in the schedule or 100% of the Lump Sum Insured specified in the Schedule;

(c) the Insured Person retires or stops actively seeking work;

(d) the Insured Person no longer falls within the Eligibility Criteria specified in the Schedule.

(e) the Insured Person dies;

(f) the Insured Person reaches 65 years of age, unless otherwise shown in the Schedule;

(g) the Insured Person ends their access by giving the Insured written notice of their intent to end their access;

(h) 4:00pm Eastern Standard Time of the third business day after the day on which we advise the Insured in writing that the person is no longer eligible for access or such later time as we may specify in the notice.

(i) if the Insured Person's payment to access cover is not made by the Insured within 30 days from the date due other than as a result of inadvertent error on the part of the Insured;

(j) the time the Insured notifies us in writing that the Insured Person's access is to cease.

3. Cancellation by Insurer and Insured

(a) The Insured may cancel this Policy at any time by telling us in writing.

If the Insured cancels this Policy, we shall retain and be entitled to the proportional premium for the period (subject to the cooling off period) during which this Policy has been in force plus our cancellation

Cancellation by the Insured will be effective when we receive the request.

(b) We may cancel this Policy by giving the Insured written notice and in accordance with the provisions contained in the Insurance Contracts Act 1984, including where the Insured has:

(i) made a misrepresentation to us before this Policy was entered into;

(ii) failed to comply with the Duty of Disclosure;

(iii) failed to comply with a provision of this Policy including failure to pay the Premium;

(iv) made a fraudulent claim under this Policy or any other Policy during the time this Policy has been in effect;

(v) failed to notify us of a specific act or omission as required by this Policy,

(vi) failed to tell us about any changes in the circumstances of the risk during the Period of Insurance.

(c) If we cancel this Policy, we will advise the Insured in writing (the Insured must notify Insured Persons of cancellation of this Policy. We will not) and cancellation will take effect at whatever is the earlier of the following times:

(i) when another contract of insurance is taken out by the Insured to replace this Policy, or

(ii) at 4.00p.m. Local Standard Time of the third day after the day on which notice was given to the Insured or such later time as we may specify in the notice.

(d) If we have paid any benefit under this Policy to an Insured Person, return premium shall be at our discretion (subject to the cooling off rights).

4. Other insurance (applicable to Insured Persons)

To the extent permitted by law, when other insurance applies to a covered loss, we will pay only in excess of the other insurance that may apply, limited to the indemnity being provided under this Policy.

Should an Insured Person make a claim under this Policy they must advise us of any other insurance which may cover the loss.

5. How to make a claim

An Insured Person or their representative must:

(a) provide written notice to us at any of our offices in Australia within thirty (30) days after the occurrence of any Condition set out in the Table of Conditions in respect of which a claim has arisen or may arise.

(b) compensation may not be payable unless the Insured Person shall as soon as possible after the happening of any Injury or Sickness giving rise to a claim under this Policy procure and follow proper medical advice from a Medical Practitioner.;

(c) as often as reasonably required by us, submit to medical examination by a Medical Practitioner, including, but not limited to any Medical Practitioner we direct the Insured Person to use, on our behalf and at our expense;

(d) provide all information, certificates and evidence required by us at the Insured Person's expense in such form and of such nature as we shall prescribe;

(e) In the case of the Insured Person's death entitle us to have a post-mortem examination at our expense.

(f) provide written proof of loss to us at our office within 30 days after the date of the occurrence of the relevant Condition set out in the Table of Conditions.

If the Insured Person does not meet these requirements we may, to the extent permitted by law, refuse to pay a claim.

6. Claims Payment Procedure

(a) **Report of Claim Forms**

We will, upon receipt of a notice of claim furnish such forms as are usually required by us for filing proof of loss.

(b) **Time of the Payment of Claim**

Compensation other than periodic payments will be paid immediately upon acceptable and verifiable written proof of the event. Periodic payment will be paid fortnightly, after the Waiting Period or any other such period that may apply and all documentation required by us is provided to us.

(c) **Subrogation**

We have the right to exercise the legal rights of the Insured or Insured Person to conduct, defend or settle any legal recovery action that we consider necessary and to do so in the Insured's, an Insured Person's name. The Insured or Insured Person must not take any action to prejudice any such right of recovery and must co-operate and do all things necessary to enable the recovery action to be prosecuted. This includes providing any statements, documents or assistance we require, including the giving of evidence in court.

7. Renewing this Policy

This Policy may be renewed by the Insured with our consent from term to term, by payment of the premium in advance at our premium rate in force at the time of renewal. Each renewal shall be a new contract between the Insured and us.

8. Notices to the Insured

We will give the Insured any notice in writing. It will be effective from the earlier of the time of:

(a) delivery to the Insured personally; or

(b) posted to the Insured's address last known to us.

It is important that the Insured tells us of any change of address as soon as possible.

9. Changing this Policy

Any change to this Policy we agree with the Insured becomes effective when:

(a) we tell the Insured we have agreed to it, or

(b) we give the Insured a new Schedule or endorsement detailing the change.

10. Audit

If premium on this Policy has been calculated on any payroll estimates or number of insured persons to be covered given by the Insured, the Insured will allow us to inspect such records as we may require and following the expiry of each Period of Insurance supply us with an updated statement of the payroll or declaration of insured persons relevant to this insurance so that the premium for that period may be calculated and the difference paid or allowed to the Insured as the case may be.

11. Transfer of interests

No interest in the policy can be transferred without our written consent.

12. Jurisdiction and service of notice

We agree that in the event of a dispute arising under this insurance, at the request of the Insured, we will submit to the jurisdiction of any competent Court in the Commonwealth of Australia. Such dispute shall be determined in accordance with the law and practice applicable in such Court. Any summons notice or process to be served upon us may be served at: 309 Kent Street, Sydney 2000.

13. GST/ Tax or Imposts

All amounts insured by this Policy exclude GST. The Insured and Insured Persons should ensure that the amounts are appropriate for them and will cover their potential loss.

Any claim settlements, up to the total of all amounts insured, will exclude GST. However, if there is a shortfall between the GST applicable to the claim settlement (being the claim settlement multiplied by the GST rate) and the amount of input tax credit the Insured Person is entitled to for that GST, we will pay this shortfall in addition to the claim settlement.

We will not be liable to pay any GST, or any fine, penalty or charge that the Insured or an Insured Person is liable for, arising out of their misrepresentation of, or failure to disclose, their proper input tax credit entitlement in the settlement of any claim or payment of any premium relating to this Policy.

Where we believe we will become liable for any tax or other imposts levied by any Commonwealth or State government, authority or body in connection with this Policy, we may reduce, vary or otherwise adjust any amounts (including but not limited to premiums, charges and benefits), under this Policy in the manner and to the extent we determine to be appropriate to take account of the tax or impost.