Cashback Flexi

Product Disclosure Statement
Version 2.1, Issued 24 June 2009

AIA.COM.AU

It just makes sense.

Please read this Product Disclosure Statement carefully.
It contains important information about the product.

Issued by: AIA Australia Limited (ABN 79 004 837 861 AFSL 230043).

In the Cashback Flexi Product Disclosure Statement (PDS) and Application form, any reference to 'we', 'us', 'our', 'the insurer' or 'AIA Australia' means AIA Australia Limited.

It pays to be protected

It's important to protect your family's financial future.
You wouldn't risk leaving your car uninsured…
so why risk leaving yourself and your family unprotected?

Now AIA Australia offers a new way to insure you and your family's financial future – protection that pays. With Cashback Flexi you not only have access to a range of flexible cover options that provide peace of mind and security – but we also guarantee a full premium refund at the end of the plan term if you don't make a claim.

Peace of mind plus your money back…
it just makes sense.

Selecting the Cashback Flexi policy that best suits your needs

To apply for a Cashback Flexi policy all you need to do is follow 5 easy steps.

Step 1. Choose your type of cover

Step 2. Decide on your plan term

Step 3. Select your premium term

Step 4. Complete your application

Step 5. Submit your application

Step 1. Cover

You can choose to apply for just one or a combination of the following plans:

- **Term Life Plan**

  This plan is designed to provide financial security to your family in the event of your death, or diagnosis of a terminal illness.

  Please refer to pages 5 to 7 for more information about the Term Life Plan.

- **Crisis Plan**

  This plan eases the financial burden of the costs associated with recovering from a medical crisis (e.g. heart attack, cancer or stroke). The plan covers 36 Crisis (medical) Events, plus also contains inbuilt death cover.

  Please refer to pages 8 to 12 for more information about the Crisis Plan.

Step 2. Plan term

When applying for cover you will have a choice of either a:

- 10 year term,
- 15 year term,
- 20 year term.

The term you choose will determine the benefit expiry date of the Cashback Flexi cover you have selected.

Step 3. Premium term

You can select one of the following premium terms:

- **Standard**

  Premiums are payable on your policy anniversary every year up to the benefit expiry date. For example, if you choose a 15 year plan term you will pay premiums for 15 years.

- **Accelerated**

  Premiums are payable on your policy anniversary every year up to premium cease date. For example, if you choose a 15 year plan term you will only pay premiums for 8 years.

The following tables outline the difference between each premium payment option.

Standard	
Plan term	**Years premiums paid**
10 Year	10
15 Year	15
20 Year	20

Accelerated	
Plan term	**Years premiums paid**
10 Year	5
15 Year	8
20 Year	10

For more information on how premiums are calculated on your policy and when they are due, please refer to pages 22 to 24.

Step 4. Completing your application

To apply for a Cashback Flexi policy you will need to complete a current Application form.

What information is required?

We will ask for medical and other information about the person to be insured such as health, income, occupation, residency, travel details, lifestyle and pastimes. This information will assist us to assess:

- your eligibility for the type of cover you have selected,
- if any exclusions or special conditions should apply to your policy,
- the correct premium for your policy.

In some instances it may be necessary for you to complete additional forms or we may ask for further medical or financial requirements depending on your personal situation or the amount of cover you are applying for. Your adviser will be able to assist you with these requests.

What happens if I fail to provide information or give incomplete information or inaccurate information?

If you and/or the life insured provide incomplete or inaccurate information you may not be eligible to receive a benefit or claim under your policy.

It is essential that you, and the life insured read and understand your duty of disclosure when completing an Application form. Please refer to pages 20 to 21 for information about your duty of disclosure and what may happen in the event of non disclosure of information.

Your privacy

We will keep all information provided in your application confidential. Please refer to our Privacy Statement on pages 29 to 30 for more information regarding our privacy procedures.

Step 5. Submitting your application

Once you have completed and signed your application including any additional forms and questionnaires, all you need to do is return it with the first premium to:

AIA Australia
PO Box 6111
St Kilda Road Central
Melbourne VIC 8008

REMEMBER – Don't forget to keep your Complimentary Interim Accidental Death Cover Certificate.

Information on your policy

Once we have assessed and approved your application for cover, we will mail or deliver to you:

- A policy document, containing policy terms and conditions; and
- A policy schedule which sets out the regular premium payable and the benefits purchased under your policy.

You should read these documents carefully and contact your adviser or us directly if you have any concerns.

Once you have received your policy document, you will have a 14 day 'cooling-off' period to ensure the cover you have selected meets your needs. Within this period you may cancel your policy and we will refund any premiums paid. For more information about the cooling-off period, please refer to page 26.

24 hour worldwide cover

Once your policy commences, full cover is provided 24 hours a day, 7 days a week, anywhere in the world.

The Term Life Plan provides you with:

- a lump sum benefit upon death, or diagnosis of a terminal illness, of the life insured; or
- a Guaranteed Premium Refund at the end of the nominated 10, 15 or 20 year plan term.

The following information outlines the important terms and conditions of each of these benefits.

What benefits are covered under my plan?

Payment on death

We will pay a lump sum upon death. The amount we pay, prior to the benefit expiry date, is the sum insured outlined in your policy schedule.

Payment on terminal illness

We will pay an advanced payment of the sum insured up to $1,000,000, across all cover held with us, upon diagnosis of a terminal illness (as defined on page 19). Any balance in the sum insured not paid under this benefit will be payable upon the life insured's death prior to the benefit expiry date.

Overview

What are the entry ages*?

For the life insured:
10 year plan: Age 2 to 60
15 year plan: Age 2 to 55
20 year plan: Age 2 to 50

For the policy owner:
10 year plan: Age 16 to 60
15 year plan: Age 16 to 55
20 year plan: Age 16 to 50

What premium options are available?

Standard or Accelerated

What is the minimum sum insured?

$10,000

What is the maximum sum insured?

For the life insured:
Age 2 to 11 – $100,000
Age 12 to 60 – No limit. Financial Underwriting will apply to any large sum insured.

Am I eligible for a premium discount?

You may be eligible for the following discounts:

- non-smoker
- AAA or AA professional occupation categories
- sums insured of $500,000 or greater

Can I increase or decrease my sum insured?

No. Once your cover commences it will not be possible to increase or decrease the sum insured.

**Age next birthday*

How does the guaranteed premium refund work?

When am I entitled to a premium refund?

We will pay a lump sum, equal to 100% of the Total Premium Paid, at the benefit expiry date provided:

- premiums are paid in full when due,
- no Terminal Illness benefit has been paid, and
- no Death benefit has been paid.

If multiple benefits are attached to a policy, only one policy fee will be refunded. This will occur at the expiry date of the last benefit under the Cashback Flexi policy.

What happens if I terminate my plan before the benefit expiry date?

If you cancel your plan, it is converted to another plan, or it is terminated prior to the benefit expiry date you will not get anything back.

What is the Total Premium Paid?

Total Premium Paid includes:

- insurance premium,
- policy fee,
- any pastime, health or other loadings,
- any stamp duty (if applicable), and
- any premium frequency charges (applying to monthly and half-yearly premium payments).

Can I convert my sum insured under this plan?

At or before the end of the nominated benefit term you will have the option of converting your Term Life benefit to another Term Life benefit (excluding another Cashback Flexi benefit) from us, provided there has not been a claim under the policy. The Conversion Option must be exercised before the 70th birthday of the life insured.

The replacement policy must provide a benefit not greater than the sum insured under the Cashback Flexi Term Life benefit.

The conversion to the replacement Term Life benefit must be effective from a policy anniversary of your Cashback Flexi Term Life benefit, and:

- written notice must be provided to us before the policy anniversary or within 30 days after the anniversary;
- will be subject to our Term Life premium rates and plan entry rules at the time of the conversion;
- will be written on either a stepped or level premium basis;
- will be available without evidence of health; and
- will be provided on the same underwriting acceptance terms as were applied to the original Cashback Flexi Term Life benefit.

You will not be eligible for a Guaranteed Premium Refund if the Conversion Option is exercised prior to the Term Life benefit expiry date.

What exclusions apply to my plan – events for which the life insured is not covered?

Suicide of the life insured within 13 months from the commencement date or date of last reinstatement of the policy is excluded under your plan.

When does my cover stop?

Your cover will stop on the earliest to occur of the;

- death of the life insured;
- payment of the full Term Life sum insured due to Terminal Illness;
- exercise of the Conversion Option under this plan;
- the expiry date of the benefit;
- cancellation of the benefit; and
- lapse of the policy for any reason.

Overview

What are the entry ages*?

For the life insured and policy owner:

10 year plan: Age 16 to 50
15 year plan: Age 16 to 45
20 year plan: Age 16 to 40

What premium options are available?

Standard or Accelerated

What is the minimum sum insured?

$10,000

What is the maximum sum insured?

For the life insured:
$2,000,000#

Am I eligible for a premium discount?

You may be eligible for the following discounts:

- non-smoker discount,
- sums insured of $300,000 or greater

Can I increase or decrease my sum insured?

No. Once your cover commences it will not be possible to increase or decrease the sum insured.

**Age next birthday*
#Applies to the total sums insured for the Crisis Plan and other similar benefits with us and other insurers.

The Crisis Plan provides you with:

- a lump sum benefit if the life insured is diagnosed as having sustained at least one of the 36 Crisis (medical) Events as defined, and we confirm the diagnosis;
- a lump sum benefit upon death, or diagnosis of a terminal illness, of the life insured; or
- a Guaranteed Premium Refund at the end of the nominated 10, 15 or 20 year plan term.

The following information outlines the important terms and conditions of each of these benefits.

What benefits are covered under my Plan?

The following benefits are covered under the Crisis Plan:

- Crisis Events – refer to page 9
- Chronic Diagnosis Advancement benefit – refer to page 10
- Death benefit – refer to page 11
- Terminal Illness benefit – refer to page 11

Crisis Events

Each event is defined on pages 13 to 19.

- Accidental HIV Infection
- Aplastic Anaemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer*
- Cardiomyopathy
- Chronic Liver Disease
- Chronic Lung Disease
- Coma
- Coronary Artery Angioplasty#
- Coronary Artery By-pass Surgery
- Dementia/Alzheimer's Disease
- Diplegia
- Heart Attack
- Heart Valve Surgery
- Hemiplegia
- Kidney Failure
- Loss of Hearing
- Loss of Independence
- Loss of Limbs and Sight of One Eye
- Loss of Speech
- Major Burns
- Major Head Trauma
- Major Organ Transplant
- Motor Neurone Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Other Serious Coronary Artery Disease
- Paraplegia
- Parkinson's Disease
- Pulmonary Arterial Hypertension (primary)
- Quadriplegia
- Stroke
- Surgery to Aorta
- Viral Encephalitis

*For 'carcinoma in situ of the breast', the benefit payable will be limited to 25% of the Crisis sum insured, subject to a maximum payment of $25,000 under all policies we have issued covering the life insured.

For Coronary Artery Angioplasty the benefit payable for angioplasty of one or two coronary arteries is limited to 25% of the Crisis sum insured subject to a maximum of $25,000 under all policies we have issued covering the life insured. 100% of the Crisis sum insured, subject to a maximum of $100,000 under all policies we have issued covering the life insured, will be payable for three or more coronary arteries.

Once total payments under the Crisis benefit reach the full Crisis sum insured your plan will cease.

Where a partial benefit has been paid for 'carcinoma in situ of the breast' or Coronary Artery Angioplasty, you will still be eligible for a Guaranteed Premium Refund. The amount payable will be equal to the reduced Total Premium Paid.

Qualifying period

The Crisis benefit under this plan will not be paid if the life insured sustains one of the following Crisis Events within three months after the plan commencement date or reinstatement of the benefit. These Crisis Events are:

- Accidental HIV Infection
- Benign Brain Tumour
- Cancer
- Coronary Artery Angioplasty
- Coronary Artery By-pass Surgery
- Heart Attack
- Heart Valve Surgery
- Major Organ Transplant
- Other Serious Coronary Artery Disease
- Pulmonary Arterial Hypertension (primary)
- Stroke
- Surgery to Aorta

The three months qualifying period will be waived provided this is a replacement policy from a previous insurer and the full qualifying period under the in force policy to be replaced has elapsed.

Pre-existing medical condition

If the life insured has consulted a medical practitioner or undergone an investigation in relation to a Crisis Event before the plan commencement date (or reinstatement date) and has not disclosed full details to us, the Crisis benefit under this plan will not be paid in respect of that Crisis Event and any associated Crisis Events.

Chronic Diagnosis Advancement benefit

The Chronic Diagnosis Advancement benefit is an advanced payment of the Crisis benefit. This benefit is payable if an appropriate specialist medical practitioner acceptable to us confirms that the life insured:

(a) has suffered or been medically diagnosed with one of the following events:
- Motor Neurone Disease;
- Multiple Sclerosis
- Muscular Dystrophy; or
- Parkinson's Disease

but has not yet met the definition of that Crisis Event (see pages 17 to 18); or

(b) has been placed on a waiting list to receive a major organ transplant of the kind described in the definition of the Major Organ Transplant Crisis Event (see page 17) and that the procedure is unrelated to any previous procedure or surgery undergone by the life insured.

The payment is 25% of the Crisis sum insured, subject to a maximum of $25,000 under all policies issued by us covering the life insured.

If the Chronic Diagnosis Advancement benefit is paid, the Crisis sum insured will be reduced by the amount paid. If the life insured subsequently qualifies for the Crisis benefit as defined in the policy document, the reduced Crisis benefit will be paid.

Only one Chronic Diagnosis Advancement benefit payment will be made in respect of the life insured under the policy.

Where a benefit has been paid under the Chronic Diagnosis Advancement benefit you will still be eligible for a Guaranteed Premium Refund. The amount payable will be equal to the reduced Total Premium Paid.

Payment on death

We will pay a lump sum upon death. The amount we pay, prior to the benefit expiry date, is the sum insured outlined in your policy schedule.

If the death benefit is paid, the Crisis Plan will cease.

Payment on terminal illness

We will pay an advanced payment of the sum insured up to $1,000,000, across all cover held with us, upon diagnosis of a terminal illness (as defined on page 19).

If the Terminal Illness benefit is paid, the Crisis sum insured will be reduced by the amount paid. Any balance in the sum insured not paid under this benefit will be payable upon the life insured's death prior to the benefit expiry date.

How does the guaranteed premium refund work?

When am I entitled to a premium refund?

We will pay a lump sum, equal to 100% of the Total Premium Paid, at the benefit expiry date provided:

- premiums are paid in full when due,
- the full Crisis benefit sum insured has not been paid,
- no Terminal Illness benefit has been paid, and
- no Death benefit has been paid.

We will also pay a Guaranteed Premium Refund where a Chronic Diagnosis Advancement benefit, or partial Crisis payment has been made for 'carcinoma in situ of the breast' or Coronary Artery Angioplasty' has been paid under the plan. The amount payable will be equal to the reduced Total Premium Paid.

If multiple benefits are attached to a policy, only one policy fee will be refunded. This will occur at the expiry date of the last benefit under the Cashback Flexi policy.

What happens if I terminate my plan before the benefit expiry date?

If you cancel your plan, it is converted to another plan, or it is terminated prior to the benefit expiry date you will not get anything back.

What is the Total Premium Paid?

Total Premium Paid includes:
- insurance premium,
- policy fee,
- any pastime, health or other loadings,
- any stamp duty (if applicable), and
- any premium frequency charges (applying to monthly and half-yearly premium payments).

Can I convert my sum insured under this plan?

At or before the end of the nominated benefit term you will have the option of converting your Crisis benefit to a Term Life benefit (excluding a Cashback Flexi benefit) from us, provided there has not been a claim under the policy. The Conversion Option must be exercised before the 60th birthday of the life insured.

The replacement Term Life policy will provide cover for death and terminal illness only, not Crisis Events, and must provide a benefit not greater than the sum insured under the original benefit.

The conversion to the replacement Term Life benefit must be effective from a policy anniversary of your Cashback Flexi Crisis benefit, and:
- written notice must be provided to us before the policy anniversary or within 30 days after the anniversary;
- will be subject to our Term Life premium rates and plan entry rules at the time of the conversion;
- will be written on either a stepped or level premium basis;
- will be available without evidence of health; and
- will be provided on the same underwriting acceptance terms as were applied to the original Cashback Crisis benefit.

You will not be eligible for a Guaranteed Premium Refund if the Conversion Option is exercised prior to the Crisis benefit expiry date.

What exclusions apply to my plan – events for which the life insured is not covered?

Suicide of the life insured within 13 months from the commencement date or date of last reinstatement of the policy is excluded under your plan.

Any Crisis Event directly or indirectly, wholly or partly, caused by the intentional self-inflicted injury or any such attempt by the life insured is also excluded.

When does my cover stop?

Your cover will stop on the earliest to occur of the;
- payment of the full Crisis sum insured; or
- death of the life insured; or
- payment of the full Crisis sum insured due to Terminal Illness; or
- exercise of the Conversion Option under this plan; or
- the expiry date of the benefit; or
- cancellation of the benefit; or
- lapse of the policy for any reason;

whichever is the earliest to occur.

'ACCIDENTAL HIV INFECTION' means infection with the human immunodeficiency virus (HIV) acquired by accident or violence during the course of the life insured's normal occupation or through the medium of a blood transfusion, transfusion of blood products, organ transplant, assisted reproduction technique or other medical procedure or operation performed by a doctor or at a recognised medical facility. Sero-conversion evidence of the HIV infection must occur within 6 months of the accident. HIV infection transmitted by any other means, including but not limited to sexual activity or non-medical intravenous drug use, is not Accidental HIV Infection under the policy.

Any accident giving rise to a potential claim must be reported to us within 30 days and be supported by a negative HIV antibody test taken within 7 days after the accident. We must be given access to test independently all blood samples used, if we require. We retain the right to take further independent blood tests or other medically accepted HIV tests.

'APLASTIC ANAEMIA' means permanent bone marrow failure that results in anaemia, neutropenia and thrombocytopenia requiring treatment by at least one of the following:

- Blood product transfusion
- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplantation.

'BACTERIAL MENINGITIS' means the diagnosis of the life insured with bacterial meningitis. The meningitis must produce neurological deficit causing permanent and significant functional impairment. 'Significant' shall mean at least a 25% impairment of whole person function as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association. Diagnosis must be confirmed by a consultant neurologist. Bacterial meningitis in the presence of HIV infection is excluded. All other forms of meningitis including viral, are excluded.

'BENIGN BRAIN TUMOUR' means a non-cancerous tumour on the brain giving rise to symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory or motor skills impairment as confirmed by a consultant neurologist. The tumour must result in permanent neurological deficit, resulting in either:

(a) at least 25% impairment of whole person function, as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association,

Or

(b) The life insured being totally and permanently unable to perform any one of the following 'Activities of Daily Living':
    (i) Bathing,
    (ii) Dressing,
    (iii) Eating,
    (iv) Toileting,
    (v) Transferring.

The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI (Magnetic Resonance Imaging).

Cysts, granulomas, cholesteatomas, malfunctions in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.

'BLINDNESS' means total irreversible loss of sight in both eyes certified by an ophthalmologist and as a result of disease or accident.

'CANCER' means the presence of one or more malignant tumours including Hodgkin's disease, leukaemia and other malignant bone marrow disorders, and characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue, but does not include the following:

- tumours which are histologically described as premalignant or showing the changes of 'carcinoma in situ';
- 'carcinoma in situ of the breast' is not excluded if the entire breast is removed specifically to arrest the spread of malignancy, and this procedure is the appropriate and necessary treatment as confirmed by an appropriate specialist acceptable to us;
- melanomas of less than 1.5 mm thickness as determined by histological examination and which are also less than Clark Level II depth of invasion, without ulceration;
- All hyperkeratoses or basal cell carcinomas of the skin;
- All squamous cell carcinomas of the skin, unless there has been spread to other organs;
- T1 N0 M0 papillary carcinoma of the thyroid less than 1 cm in diameter;
- Polycythemia Rubra Vera requiring treatment by venesection alone; and
- Tumours treated by endoscopic procedures alone.

'CARDIOMYOPATHY' means a condition of impaired ventricular function of variable aetiology (often not determined) resulting in significant physical impairment i.e. Class III on the New York Heart Association classification of cardiac impairment.

The New York Heart Association classifications are:

Class I – no limitation of physical activity, no symptoms with ordinary physical activity.

Class II – slight limitation of physical activity, symptoms occur with ordinary physical activity.

Class III – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity.

Class IV – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.

'CHRONIC LIVER DISEASE' means end stage liver failure, together with permanent jaundice, ascites, and hepatic encephalopathy. Such disease directly related to alcohol or drug abuse is excluded.

‘CHRONIC LUNG DISEASE’ means end stage respiratory failure requiring permanent oxygen therapy with FEV 1 test results consistently showing less than one litre.

‘COMA’ means total failure of cerebral function characterised by total unarousable, unresponsiveness to external stimuli, persisting continually with the use of a life support system for a period of at least 96 hours. It must result in significant permanent loss of cerebral function as determined by a recognised consultant neurologist acceptable to us.

For the purposes of this definition, ‘significant’ shall mean at least a 25% impairment of whole person function as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association.

Excluded from this definition is coma induced medically or resulting from alcohol or drug abuse.

‘CORONARY ARTERY ANGIOPLASTY’ means the actual undergoing for the first time of either:

- Balloon angioplasty;
- Insertion of a stent;
- Atherectomy; or
- Laser therapy

to correct a narrowing or blockage of three or more coronary arteries within the same procedure. Angiographic evidence, indicating obstructions of three or more coronary arteries is required to confirm the need for this procedure.

The procedure must be considered necessary by a cardiologist to correct or treat coronary artery disease.

‘CORONARY ARTERY BY-PASS SURGERY’ means the actual undergoing of by-pass surgery (including saphenous vein or internal mammary graft(s) for the treatment of coronary artery disease. The operation must be for the treatment of one or more coronary arteries and angioplasty contra-indicated and must be considered necessary by a consultant cardiologist.

‘DEMENTIA/ALZHEIMER’S DISEASE’ means the unequivocal diagnosis of Alzheimer’s disease or other dementia as confirmed by a consultant neurologist, geriatrician, psychiatrist or psycho-geriatrician. The diagnosis must confirm dementia due to failure of global brain function for which no other recognisable cause has been identified. The condition must result in significant cognitive impairment and the permanent inability to perform at least two of the five Activities of Daily Living (see definition of ‘LOSS OF INDEPENDENCE’).

Dementia or Alzheimer’s disease as a result of alcohol or drug abuse is excluded.

‘DIPLEGIA’ means the total and permanent loss of function of both sides of the body due to spinal cord injury or disease, or brain injury or disease.

‘HEART ATTACK’ (Myocardial Infarction) means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this must be evidenced by:

- New and permanent ECG changes consistent with Myocardial Infarction; and

- Elevation of biochemical markers (such as troponin or cardiac enzymes) consistent with Myocardial Infarction.

We will not pay for other causes of severe non-cardiac chest pain, heart failure or angina.

If the above tests are inconclusive, we will consider other appropriate and medically recognised tests in support of a diagnosis.

'HEART VALVE SURGERY' means the actual undergoing of open-heart surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities occurring after the commencement date or last reinstatement date of the policy. Valvotomy is specifically excluded.

'HEMIPLEGIA' means the total and permanent loss of function of one side of the body due to spinal cord injury or disease, or brain injury or disease.

'KIDNEY FAILURE' means end stage renal failure, which presents as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation carried out.

'LOSS OF HEARING' means complete and irrecoverable loss of hearing, both natural and assisted, from both ears as a result of injury or sickness, as certified by an appropriate medical specialist.

'LOSS OF INDEPENDENCE' means:

(a) A condition as a result of injury or sickness, where the life insured is totally and irreversibly unable to perform at least two of the following five 'Activities of Daily Living'. The condition should be confirmed by a consultant physician.

Bathing: the ability of the life insured to wash himself or herself either in the bath or shower or by sponge bath without the standby assistance of another person. The life insured will be considered to be able to bathe himself or herself even if the above tasks can only be performed by using equipment or adaptive devices.

Dressing: the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten and unfasten them, without the standby assistance of another person. The life insured will be considered able to dress himself or herself even if the above tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.

Eating: the ability to get nourishment into the body by any means once it has been prepared and made available to the life insured without the standby assistance of another person.

Toileting: the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing without the standby assistance of another person. The life insured will be considered able to toilet himself or herself even if he or she has an ostomy and

is able to empty it himself or herself, or if the life insured uses a commode, bedpan or urinal, and is able to empty and clean it without the standby assistance of another person.

Transferring: the ability to move in and out of a chair or bed without the standby assistance of another person. The life insured will be considered able to transfer himself or herself even if equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical.

(b) Cognitive impairment, meaning a deterioration or loss in the life insured's intellectual capacity which requires another person's assistance or verbal cueing to protect himself or herself or others as measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:
- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning.

'LOSS OF LIMBS AND SIGHT OF ONE EYE' means the total and irrecoverable loss by the life insured of any of the:
- Use of both hands
- Use of both feet
- Use of one hand and one foot
- Use of one hand and the sight of one eye
- Use of one foot and the sight of one eye.

'LOSS OF SPEECH' means the complete and irrecoverable loss of the ability to speak as a result of injury or sickness which must be established and the diagnosis reaffirmed after a continuous period of three months of such loss by an appropriate medical specialist.

'MAJOR BURNS' means third degree burns (full thickness skin destruction) to at least 20% of the body surface area.

'MAJOR HEAD TRAUMA' means an accidental head injury resulting in neurological deficit, as certified by a consultant neurologist acceptable to us, causing at least a permanent 25% impairment of whole person function as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association.

'MAJOR ORGAN TRANSPLANT' means having received, from a human donor, a medically necessary transplant involving one or more of the following organs: kidney, heart, liver, lung, bone marrow and pancreas.

'MEDICAL PRACTITIONER' means a legally qualified and registered medical practitioner other than the policy owner or the life insured, or a family member, business partner, employee or employer of either the policy owner or the life insured.

'MOTOR NEURONE DISEASE' means the unequivocal diagnosis of Motor Neurone Disease by at least two consultant neurologists with persistent neurological deficit resulting in at least a permanent 25% impairment of whole person function as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association.

'MULTIPLE SCLEROSIS' means the unequivocal diagnosis of multiple sclerosis by two consultant neurologists resulting in at least a permanent 25% impairment of whole person function as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association.

Diagnosis must be based on all of the following:

- symptoms referable to tracts (white matter) involving the optic nerves, brain stem, and spinal cord, producing well defined neurological deficits;
- a multiplicity of discrete lesions; and
- A well documented history of exacerbations and remissions of said symptoms/neurological deficits.

'MUSCULAR DYSTROPHY' means the unequivocal diagnosis of muscular dystrophy, confirmed by at least two consultant neurologists, based on a combination of some or all of the following:

- Clinical presentation including absence of sensory disturbance, abnormal cerebro-spinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram;
- Clinical suspicion confirmed by muscle biopsy, and which in our opinion confirms the diagnosis of muscular dystrophy.

'OTHER SERIOUS CORONARY ARTERY DISEASE' means the narrowing of the lumen of at least 3 coronary arteries by a minimum of 60%, as proven for the first time by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed.

'PARAPLEGIA' means the total and permanent loss of function of the lower limbs due to spinal cord injury or disease, or brain injury or disease.

'PARKINSON'S DISEASE' means unequivocal diagnosis of Parkinson's Disease by at least two consultant neurologists where the condition:

- cannot be controlled with medication;
- shows signs of progressive impairment;
- at least 25% impairment of whole person function, as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association, or
- 'Activities of Daily Living' assessment confirms the inability of the life insured to perform without assistance 2 or more of the following: bathing, dressing, eating, toileting, transferring in or out of a bed or a chair.

Only idiopathic Parkinson's Disease is covered. Drug induced or toxic causes of Parkinsonism are excluded.

'PULMONARY ARTERIAL HYPERTENSION (PRIMARY)' means primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation, resulting in significant irreversible physical impairment of at least Class III of the New York Heart Association classification of cardiac impairment.

Pulmonary Hypertension in association with chronic lung disease is specifically excluded.

Other forms of hypertension (involving increased blood pressure) are specifically excluded.

The New York Heart Association classifications are:

Class I – no limitation of physical activity, no symptoms with ordinary physical activity.

Class II – slight limitation of physical activity, symptoms occur with ordinary physical activity.

Class III – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity.

Class IV – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.

'QUADRIPLEGIA' means the total and permanent loss of function of the lower and upper limbs due to spinal cord injury or disease, or brain injury or disease.

'STROKE' means an acute neurological event caused by a cerebral or subarachnoid haemorrhage, cerebral embolism or cerebral thrombosis, where the following conditions are met:

- There is an acute onset of objective and ongoing neurological signs that last more than 24 hours, and
- Findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques, demonstrate a lesion consistent with the acute haemorrhage, embolism or thrombosis.

Brain damage due to an accident, infection, reversible ischaemic neurological deficit, transient Ischaemic attack, vasculitis or an inflammatory disease is excluded.

'SURGERY TO AORTA' means the actual undergoing of surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

'TERMINAL ILLNESS' means the diagnosis of the life insured with an illness which in Our opinion, will result in the death of the life insured within 12 months of the diagnosis regardless of any treatment that may be undertaken.

'VIRAL ENCEPHALITIS' means the diagnosis of the life insured with encephalitis due to direct viral infection of the central nervous system. The encephalitis must produce neurological deficit causing permanent and significant functional impairment certified by a consultant neurologist.

'Significant' shall mean at least a 25% impairment of whole person function as defined in *Guides to the Evaluation of Permanent Impairment 5th edition*, American Medical Association. Encephalitis in the presence of HIV infection is excluded.

It is recommended that you read the following information before applying for cover as there are some significant risks associated with life insurance:

Insurer fails

Your insurer may become insolvent and therefore may not pay your claims. Life insurers are supervised by the Australian Prudential Regulation Authority and are regulated under the Life Insurance Act 1995. As at the date of this PDS, the reserves in our Statutory Fund No. 1, which back this product, are in excess of the solvency and capital adequacy requirements that apply to life insurers.

Selection of the wrong product

You may choose an insurance product that does not meet your needs. You should read the PDS and policy document for an insurance product carefully to prevent this. You may wish to consult an adviser for assistance.

Inadequate amount of insurance

You may select the correct insurance product for your needs, but you might not choose enough cover. This might cause you to suffer financial hardship after receiving your benefit payment. You will need to assess your needs carefully to ensure that this does not occur. Again, an adviser may be able to help you.

Alterations to your policy

Once your policy commences, it will not be possible for you to increase or decrease the sum insured.

Policy terms and conditions

Please note that this PDS provides only a basic outline of the coverage. For precise terms and conditions, you should refer to the policy document. This should be done within the cooling-off period, to satisfy yourself that the policy meets your expectations and needs, as discussed with the person who recommended it to you.

Your duty of disclosure

Before you enter into a contract of insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, which is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you vary or reinstate this contract of insurance.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time. An insurer who is entitled to avoid a contract of insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum insured that you have been insured for in accordance with a formula that takes into account the contribution that would have been payable if you had disclosed all relevant matters to the insurer.

Premiums

Minimum premium

The minimum premium is $500 per annum per policy. This includes the premium for all selected benefits chosen, the policy fee and any loadings, premium frequency charge and stamp duty.

Premium rates

A table of premium rates is available on request.
Different premium rates apply to males and females and to non-smokers and smokers. The premium rates allow for the cost of cover and the life insurer's expenses, including commission payable to your adviser.

Premium guarantees

The premium rates under all plans are not guaranteed and may be varied from time to time. Your premium rates may not be altered individually but only for all policies in a group.
Your policy cannot be singled out for an increase.

Premium discounts

Term Life Plan

If you purchase a Term Life Plan, you may be entitled to a premium rate discount based on the sum insured for the benefit and the age of the life insured at the commencement date of the plan. Please refer to the table below for the discount that may be applicable.

Discount to rate per $1,000 sum insured			
Sum insured	Age next birthday at entry		
	44 or lower	45 – 54	55 or greater
$500,000 to $999,999	$0.07	$0.15	$0.50
$1,000,000 or greater	$0.15	$0.25	$0.60

Also, a 5% discount applies to Term Life premium rates for lives rated as occupation category AAA and AA. This discount is calculated prior to the above discounts. A description of each occupation category is available in the table below.

Please consult your adviser for details of all discounts that may apply.

Occupation categories

Category AAA

Professional white collar workers, other than those in medical and allied occupations, who must have tertiary qualifications, e.g. lawyers and accountants. Other successful high income earning white collar workers such as senior executives who have long-standing experience in their field of business are also considered as category AAA.

Category AA

Professionals who must have tertiary qualifications in the medical and allied occupations. e.g. doctors, dentists, optometrists, physiotherapists and domestic veterinary surgeons.

Category A

Other white collar occupations that involve clerical and administrative work only (no manual work). These workers are generally office bound, e.g. managers, secretaries, sales people (no deliveries), clerical staff. The working environment must present minimal injury or sickness risk.

Crisis Plan

If you purchase a Crisis Plan, you may be entitled to a premium rate discount based on the sum insured for each benefit and the age of the life insured at the commencement date of the plan. Please refer to the table below for the discount that may be applicable.

Discount to rate per $1,000 sum insured			
Sum insured	Age next birthday at entry		
	30 – 35	36 – 44	45 or greater
$300,000 to $499,999	$0.10	$0.15	$0.50
$500,000 to $999,999	$0.10	$0.20	$0.55
$1,000,000 or greater	$0.15	$0.25	$0.60

Payment of premiums

Premiums must be paid monthly, half-yearly or yearly. Premium payments made more frequently than yearly are subject to a premium frequency charge (see page 25).

The first premium must be paid in advance and submitted together with the Application form.

Category B

Those occupations which are not classified as white collar and which may involve some light manual work. e.g. shopkeepers, supervisors, hairdressers, beauticians. This category also includes supervisors of manual workers and persons in a totally administrative job within an industrial environment. The working environment may present slight injury or sickness risk.

Category C

Fully qualified, skilled tradespersons of various occupations who perform light to medium manual work. e.g. qualified electricians, chefs, mechanics. The working environment may present a moderate injury or sickness risk.

Category D

Unqualified tradespersons who perform light to medium manual work. e.g. cleaners, drivers, fencing contractors. The working environment may present a significant injury or sickness risk.

Payments made easy

Acceptable methods of payment that can be used are:

- Deposit Premium Only
  - Cheque, Money Order
  - Direct Debit (credit card)
  - Direct Debit (financial institution)
- All Future Premiums
  - Direct Debit (credit card)
  - Direct Debit (financial institution)
  - Bpay (half-yearly and yearly)
  - POSTbillpay (half-yearly and yearly)

Notes

1) Acceptable credit cards are: MasterCard, Visa Card, Diners Card and American Express.
2) Direct Debit (financial institution) will cover both the deposit premium and all future premiums.

What happens if I stop paying premiums?

If you do not pay premiums in full within 60 days from the premium due date your policy will lapse and cover will cease.

Can I reinstate my policy once it has lapsed?

Reinstatements can occur within 6 months from the latest premium due date for the first unpaid premium. Underwriting will be required in some circumstances.

Fees and charges

What are the fees and charges?

All the fees and charges of your Term Life Plan and Crisis Plan are fully described in this section. We undertake not to apply any other charges without notifying you.

We will charge a policy fee and any appropriate government stamp duty (see page 27).

Policy fee

A policy fee is charged per policy in addition to the premiums applicable per benefit and any stamp duty. The policy fee is currently $60 per annum regardless of the number of plans or benefits purchased under the one policy and may be changed at our discretion. The policy fee is subject to any premium frequency charge/loading fee (see table).

The policy fee may be changed at our discretion. However, the policy fee at any date cannot exceed $60 increased by the percentage increase in the CPI since 1 October 2001 up to that date. You will be notified of any change in the amount of the policy fee prior to the change taking effect.

Premium frequency charge

There is no premium frequency charge on yearly premiums.

Premiums payable half-yearly or monthly are subject to a charge to cover increased costs. This charge is expressed as a percentage of the yearly premium in the following table.

Premium frequency	Charge as a percentage of yearly premium
Half-yearly	5%
Monthly	8%

You will be notified of any change in the amount of the charges prior to the change taking effect.

General information once your application has been accepted

What is a cooling-off period?

After we have assessed and approved your application you will receive the policy document and policy schedule from us. You will then have 14 days to check that the policy and benefits meet your needs. This is known as the cooling-off period. Within this period you may cancel the policy and receive a full refund of all premiums paid. The cooling-off period starts from when you received the policy document from us or from the end of the 5th day after the day on which we sent the policy document to you, whichever is the earlier to occur.

To return your policy in the cooling-off period, please send us:

- Your request to cancel the policy either by letter, fax or email or in any other manner permitted by law, and
- The policy document.

Policy upgrades

Over time we will review the benefits provided under the policy. When the benefits under the policy change we may tell the policy owner that new benefits are available under the plan and upgrade the plan to the new plan. The upgrade will be done automatically and no action is required by you. We will replace the policy document with a new policy document incorporating the upgrade. The new policy will be effective from the next policy anniversary.

The rights and obligations will be determined by the new policy document. Should a situation arise where you are disadvantaged in any way as a result of the upgrade, the previous policy wording will apply.

In terms of any changes under the new policy terms, these will only apply to future claims and not past or current claims or any claims resulting from health conditions or events which began or took place before the effective date of changes.

Nomination of beneficiaries

It will be possible to nominate a beneficiary (person or any other legal entity) to receive all death claim benefits under the policy at anytime prior to the occurrence of an event giving rise to a claim.

Transfer of ownership

At any time, you may transfer ownership of the policy to another person (minimum and maximum ages of entry rules will apply) or legal entity. This is achieved by assigning the policy to the other person or entity. You should be aware that by assigning the policy, you forfeit all rights to benefits payable under the policy and it may give rise to tax implications. Also assignment will revoke any previous nomination of beneficiary.

Please contact us if you wish to assign the policy. We will advise you of the process required to do so.

Lost policy documentation

If your policy document is lost or damaged we will replace it but may charge to recover the costs involved. This charge is currently not greater than $100 and covers the cost of reissuing the lost document, including advertising the loss – a statutory requirement. We may vary this charge from time to time.

Taxation

Are there any tax benefits?

Usually tax is not payable upon death on any lump sum payment that may be made under this policy, as long as the ownership of the policy does not change. Conversely, premiums for a policy that provides lump sum benefits are not usually tax deductible. Different rules may apply in some circumstances. A tax professional will be able to clarify your particular position.

If the policy is owned in a business environment then the premiums may in some situations be deductible and the proceeds may then be assessable for taxation purposes.

This information is based on the continuance of present laws affecting taxation and our interpretation of them.

Tax changes

Any material change to the taxation position of the policy will be notified to you in the first Renewal Statement following the change.

Tax or other government imposts

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

GST

The premium applicable to this policy is input taxed for the purposes of the Goods & Services Tax (GST). No GST is payable by you in respect of the purchase of this policy.

Stamp duty

Stamp duty may be payable on this policy by us in accordance with the stamp duty rates applicable in the State or Territory in which the life insured is ordinarily resident. For some benefits the amount of stamp duty payable is included in the premium and is not an additional charge to you. For others, it is not included in the premium and is an additional charge to you. Your adviser can provide you with a personalised premium quotation showing the amount of any stamp duty payable as an additional charge to you.

How to contact us

Questions and concerns

If you should have any questions or concerns about your policy please contact your adviser in the first instance or us direct on 1800 333 613 and we will promptly investigate your enquiry, referring it if necessary to our Internal Dispute Resolution Committee.

Internal complaints are normally resolved within 45 days. In special circumstances we may take longer. If this is the case we will advise you.

Should you not be satisfied with our response to your concerns after they have been ruled upon by the Committee, then you may take the matter up with the independent Financial Ombudsman Service (FOS) (formerly known as the Financial Industry Complaints Service Ltd). Details as follows:

Financial Ombudsman Service (FOS)
GPO Box 3
MELBOURNE VIC 3001
Telephone: 1300 78 08 08
Facsimile: (03) 9613 6399
Email: info@fos.org.au

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043) follows the National Privacy Principles developed under the Privacy Amendment (Private Sector) Act 2000. We provide you with the following information regarding our privacy procedures and your rights. Our privacy policies and procedures may be found at: www.aia.com.au

Purpose of collection

We collect personal information about you to:

a) Process your application(s);
b) Administer and manage your policy including claims;
c) Facilitate our business operations; and
d) Market promotional material about services we believe you may be interested in (the Privacy Declaration contained in your Application allows you to elect whether you wish to receive direct marketing material from us).

If you do not wish to provide us with all or part of the personal information we request from you, we may not be able to provide you with insurance cover.

Access to your information

You are entitled at any time to request access to your personal information held by us. All requests should be made in writing to:

Policy Services Manager
AIA Australia
PO Box 6111, St Kilda Road Central
Melbourne, VIC 8008

You can ask us to update your personal information at any time if it is inaccurate, incomplete or out of date.

In some circumstances, we may not permit access to your personal information. Circumstances where access may be denied include where access would be unlawful or denying access is authorised by law.

In these cases, we will provide you with written reasons for denial of access or a refusal to correct personal information.

Disclosure of information

We may disclose your personal information to:

a) Another member of the AIA group of companies (whether in Australia or overseas);
b) Your adviser;
c) Our contractors and third party service providers. e.g. medical practitioners and reinsurers
d) Financial institutes you nominate; and
e) Mail houses and archive companies

We will only disclose your personal information to these parties for the primary purpose for which it was collected. In some circumstances we are entitled to disclose your personal information to third parties without your authorisation, such as law enforcement agencies or government authorities to protect our interests or to report illegal activities.

Any questions or concerns on privacy?

If you have any questions or concerns about your personal information, please write to:

Compliance Manager
AIA Australia
PO Box 6111, St Kilda Road Central
Melbourne, VIC 8008

We have established an internal dispute resolution process for handling customer complaints about our compliance with the National Privacy Principles. This dispute resolution mechanism is designed to be fair and timely to all parties and is free of charge.

If you have a complaint about our National Privacy Principles, you should submit it in writing to the Compliance Manager. You will receive a letter from us within 5 working days which documents our complaints handling process. Your complaint will be referred to our Internal Disputes Resolution Committee who will try to resolve your complaint within 45 days of receipt.

Should complaint not be resolved to your satisfaction by our internal dispute resolution process, you may take your complaint to the Privacy Commissioner. The Privacy Commissioner's contact details are:

Office of the Federal Privacy Commissioner
GPO Box 5218
Sydney, NSW 1042
or call the Privacy Hotline
on 1300 363 992

Complimentary Interim
Accidental Death Cover

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
will provide

.....
(name of proposer)

with Interim Accidental Death Cover
in the event of the life to be insured's accidental death.*
(The amount payable is explained overleaf.)

This certificate is valid for 90 days from

.....
(date of application)

or
until the policy is issued or the application is declined or withdrawn,
whichever is the earliest to occur.

.....
Adviser's Signature

*Refer to back of certificate for definition

AIA Australia grants COMPLIMENTARY INTERIM ACCIDENTAL DEATH COVER on the life to be insured without any extra premium being charged.

This cover is provided from the EFFECTIVE DATE until an assessment decision is made or until 90 days after the date the application is signed or until the policy is issued or the application is withdrawn by the proposer, whichever is the earliest to occur. A deposit equal to the first yearly premium or instalment of premium must have been paid or be payable on issue of the policy.

This interim cover certificate is issued to you after completion of the application.

Complimentary Interim Accidental Death Cover

1. The lump sum amount payable on accidental death under this cover is:

   (a) **Term Life Plan**

   The lesser of:
   - The Term Life sum insured proposed; and
   - $1,000,000

   (b) **Crisis Plan**

   The lesser of:
   - The Crisis sum insured proposed; and
   - $1,000,000

   The maximum payment under the Complimentary Interim Accidental Death Cover is $1,000,000.

2. Accidental death means death which is caused solely and directly by violent, accidental, external and visible means and results solely and directly and independently of any other cause.

3. The following risks are NOT covered.

   Death directly or indirectly caused by:
   (a) war (whether declared or not), invasion or civil war; and
   (b) intentional self-inflicted injury or suicide.

Effective date

Complimentary Interim Accidental Death Cover is effective from the issue date of the interim certificate if the application is received at our head office within five working days of the issue date with payment of the first instalment of premium. Otherwise cover commences once the application and payment are actually received at our head office.

Claims procedure

All the usual proofs in relation to a claim will be required (eg: death certificate, etc).

To contact AIA Australia, please visit www.aia.com.au.

About AIA Australia

AIA Australia has been operating in Australia for over 30 years. AIA Australia is a subsidiary of American International Assurance Company, Ltd (AIA Group) and a specialist provider of risk management products aimed at protecting the financial health and welfare of Australians.

About the AIA Group

The AIA Group is a leading pan-Asian life insurance organisation with a unique heritage of serving the world's most dynamic region for 90 years. It provides consumers and businesses with products and services for life insurance, retirement planning, accident and health insurance as well as wealth management solutions. Through an extensive network of 250,000 agents and 20,000 employees across 14 geographical markets, the AIA Group serves over 20 million customers in the region.

The AIA Group has branch offices, subsidiaries and affiliates located in jurisdictions including Australia, Brunei, China, Hong Kong, India, Indonesia, Macau, Malaysia, New Zealand, Singapore, South Korea, Taiwan, Thailand and Vietnam. Subject to regulatory approvals, AIG intends to incorporate the Philam Group of Companies, based in the Philippines into the AIA Group.

Customer Freecall: 1800 333 613
Adviser Freecall: 1800 033 490

AIA.COM.AU

AIA06001v2.1 – 6/09