SIGNIFICANT EVENT NOTICE

We've updated your cover from 2nd May 2022

April 2022

HEALTHIER, LONGER, BETTER LIVES

Thank you for continuing your insurance protection with us

Your Cashback Flexi Product Disclosure Statement (PDS) and Policy Document has been updated.

Important Note

It is important to read this Significant Event Notice (Notice) together with your existing PDS and Policy Document, and any other policy notices previously provided in relation to your Cashback Flexi policy. The updates outlined in this document now form part of your policy. A copy of the Cashback Flexi PDS and Policy Document v2.1 dated 24 June 2009 can be downloaded from the AIA Australia website at www.aia.com.au/en/individual/help-support/policyholder-information.html and is located in the '2012 and prior' tab'.

It is important to note that the updates in this Notice do not apply to any medical conditions or events which the life insured had as at 2nd May 2022. The updates will also not apply to any policy where a claim is pending or where a claim is the process of being paid. The updates override your existing policy terms and conditions (except to the extent where you are disadvantaged in any way, in which case the previous policy wording will apply) and for Crisis Plan are subject to Pre-existing medical conditions or events.

The updates outlined in the tables below show the existing terms of your policy prior to this update (Prior to update) and the updated terms of your policy (After update).

We're here to help

No action from you is required, however, if you have any questions about the updates contained in this Notice please contact your financial advisor or contact our Client Services Team on **1800 333 613** Monday to Friday, 8am - 6pm AEDT or email us at **au.customer@aia.com**

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TABLE 1. Updates to benefits and general policy terms – Policy Document

The terms that have been updated in your Policy Document are detailed in Table 1 below.

Change number	Section and page	Prior to update	After update
1	**Contents** Pg. 1	AIA Australia Limited ABN 79 004 837 861 AFSL 230043 PO Box 6111 St Kilda Road Central MELBOURNE 8008 Freecall: 1800 333 613 Freefax: 1800 832 266 AIA .COM .AU	AIA Australia Limited ABN 79 004 837 861 AFSL 230043 PO Box 6111 MELBOURNE VIC 3004 Email: au.customer@aia.com Phone: 1800 333 613 Fax: 1800 832 266 or 03 9009 4824
2	**General Terms and Conditions** 3.4 Renewal Statement Pg. 11	**3.4 Renewal Statement** Each year You will receive a Renewal Statement showing the level of Your selected benefits. Any change to the fees and charges and to the taxation treatment of the Policy and any other matter relevant to the Policy over the preceding year will also be shown in the Renewal Statement. If there are any material changes to the circumstances described in the Product Disclosure Statement, the Policy Document, or any subsequent communication, You will be notified in the Renewal Statement following the change. However, any material change related to fees and charges will be notified in writing prior to the change taking effect. Any change, which is initiated by You, will be confirmed in writing by Us.	**3.4 Policy Information we send you** Each year You will receive policy information showing the level of Your selected benefits. Any change to the fees and charges and to the taxation treatment of the Policy and any other matter relevant to the Policy over the preceding year will be communicated to you. If there are any material changes to the circumstances described in the Product Disclosure Statement, the Policy Document, or any subsequent communication, You will be notified of these as well. However, any material change related to fees and charges will be notified in writing prior to the change taking effect. Any change, which is initiated by You, will be confirmed in writing by Us.
3	**General Terms and Conditions** 3.5.1 Payment of premiums Pg. 12	Premiums are only available on a level premium basis and are payable yearly in advance on the Policy Anniversary.	Premiums are only available on a level premium basis and are payable yearly in advance on the Policy Anniversary. Level premiums are based on your age at the start of your policy and premiums will not increase by the reason of you getting older. While your premium will not change based on your age, the actual amount of premium payable by you may still change where we adjust the applicable premium rates in accordance with "Premium rates not guaranteed" section. Your premiums can also change (even if your premium rates do not change) if there is an increase to the Policy Fee, Premium Frequency Charge, State or Territory government stamp duty and Tax or imposts.

Change number	Section and page	Prior to update	After update
4	**General Terms and Conditions** 3.5.1 Payment of premiums Pg.12	Premiums can also be paid in monthly or half-yearly instalments by a method approved by Us. If We agree to accept premiums in instalments We will add a premium frequency charge (see condition 3.6.2).	Premiums can also be paid in monthly or half-yearly instalments. If premiums are paid in instalments We will add a premium frequency charge (see condition 3.6.2).
5	**General Terms and Conditions** 3.5.3 Premium rating factors Pg. 12	The premiums You pay depend on the Life Insured's age, sex, smoking habits, occupation, pastimes and state of health and on the level of cover and benefit features chosen by You. The premium rates allow for the cost of cover and Our expenses.	The premiums You pay depend on factors such as the Life Insured's age, sex, smoking habits, occupation, pastimes and state of health. Premium rates also take into account the level of cover and benefit features chosen by You. Premium rates allow for the cost of insurance and Our reasonable expenses, including, but not limited to costs incurred in administering Your policy.
6	**General Terms and Conditions** 3.5.4 Premium rates not guaranteed Pg. 12	The premium rates under the Policy are not guaranteed and may be varied by Us from time to time. A table of premium rates is available on request. Premium rates may not be altered for an individual policy but only for all policies in a group. Your Policy cannot be singled out for an increase. You will be notified in writing of any change in the premium prior to the change taking effect.	We may vary your premium rates from time to time provided that any such variations are reasonably necessary to protect our legitimate business interests. A table of premium rates is available on request. Premium rates may not be altered for an individual policy but only for all policies in a group. Your Policy cannot be singled out for an increase. You will be notified in advance of any changes that are, or result in, an increase in premiums, fees or charges impacting your policy. We will advise you in writing prior to any change.
7	**General Terms and Conditions** 3.6.1 Policy fee Pg. 13	The Policy fee is currently $60 per year. The Policy fee is subject to a Premium Frequency Charge (see below). The Policy fee may be changed at Our discretion. However, the Policy fee at any time cannot exceed $60 increased by the percentage increase in the CPI since 1 October 2001 up to that time. You will be notified in writing of any change in the amount of the Policy fee prior to the change taking effect.	The Policy fee is currently $60 per year. The Policy fee is included in the calculation of the Premium Frequency Charge. We may vary your Policy fee from time to time provided that any such variations are reasonably necessary to protect our legitimate business interest. However, the Policy fee at any time cannot exceed $60 increased by the percentage increase in the CPI since 1 October 2001 up to that time. We will advise you in writing prior to any change to Your Policy fee.
8	**General Terms and Conditions** 3.6.2 Premium Frequency Charge (Third Paragraph) Pg. 13	You will be notified in writing of any change in the amount of this charge prior to the change taking effect.	The Premium Frequency Charge may be reviewed and varied from time to time provided that any such variations are reasonably necessary to protect our legitimate business interests. We will advise you in writing prior to any change to Your Premium Frequency Charge.
9	**General Terms and Conditions** 3.6.4 Lost Policy Document charge Pg. 13	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.	**Section 3.6.4 *Lost Policy Document charge* is deleted**

Change number	Section and page	Prior to update	After update
10	**General Terms and Conditions** 3.7 Tax or imposts Pg. 13	Where We are, or believe We will become, liable for any tax or other imposts levied by any Commonwealth, State or Territory 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.	Where We are, or believe We will become, liable for any tax or other imposts levied by any Commonwealth, State or Territory 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 which is reasonably necessary to take account of the tax or impost.
11	**General Terms and Conditions** 3.8 Guaranteed Renewable Pg. 14	**3.8 Guaranteed Renewable** The Policy runs for 12 months. It may be renewed annually, by payment of the renewal premium within the 60 days of grace, until the Premium Cease Date shown on the Policy Schedule. Provided You pay the appropriate premium in full when due, each benefit under the Policy is guaranteed renewable each year to the Expiry Date of that benefit regardless of changes in the Life Insured's health, occupation or pastimes.	**Section 3.8 *Guaranteed Renewable* is deleted**
12	**General Terms and Conditions** 3.9 Lapse and reinstatement Pg.14	**3.9 Lapse and reinstatement** The Policy will cease to be in force if a premium is not paid within the 60 days of grace. If the Policy ceases to be in force it may be reinstated with Our consent upon such proof as We may require of the continued good health and eligibility for insurance of the Life Insured and upon payment of the unpaid premium or premiums with compound interest as We determine. After reinstatement, the Policy shall not cover any event the symptoms leading to which were apparent prior to such reinstatement. The Policy may be cancelled by Us in accordance with the provisions of the Life Insurance Act or any other relevant legislation.	**3.8 Lapse and reinstatement** If premiums are not paid within 60 days of the premium due date, Your Policy will lapse, and Your cover will cease. You can apply for your Policy to be reinstated after it has lapsed, however, You may be required to provide evidence of continued good health and eligibility prior to reinstatement of Your Policy. You will also need to pay any unpaid premiums. After reinstatement the Policy will not cover any event where the symptoms leading to that event were apparent after the Policy lapsed and prior to reinstatement.
13	**General Terms and Conditions** 3.10 – 3.20 Multiple sub sections are re-numbered due to deletion of earlier subsections. Pg.14 – 17	3.10 Assignment of Policy 3.11 Nomination of beneficiaries 3.12 Misstatement of age 3.13 Suicide 3.14 Claims 3.14.1 Claim requirements and conditions 3.14.2 Medical examination 3.15 Non-smoker – incorrect declaration 3.16 Statutory Fund 3.17 Currency 3.18 Policy upgrade 3.19 Choice of benefits 3.20 Any questions or concerns	3.9 Assignment of Policy 3.10 Nomination of beneficiaries 3.11 Misstatement of age 3.12 Claims 3.12.1 Claim requirements and conditions 3.12.2 Medical examination 3.13 Non-smoker – incorrect declaration 3.14 Statutory Fund 3.15 Currency 3.16 Policy Upgrade 3.17 Choice of benefits 3.18 Any questions or concerns

Change number	Section and page	Prior to update	After update
14	**General Terms and Conditions** 3.13 Suicide Pg. 15	3.13 Suicide This condition applies to a benefit if the Life Insured, dies as a result of suicide committed within 13 months of the date of: • commencement of that benefit; • the last reinstatement of the Policy. In that event, the Policy shall be voidable at Our option and any premiums paid in respect of it shall be forfeited to Us . However, should any other person have obtained for value a genuine interest in the Policy at least two months before the death of the Life Insured and has notified Us in writing, We will pay them: • an amount equal to the value of the interest; or • the amount which would have been payable had the Life Insured died otherwise than by suicide; whichever is the lesser.	**Section 3.13 *Suicide* is deleted**
15	**General Terms and Conditions** 3.14.1 Claim requirements and conditions Pg. 15	**3.14.1 Claims requirements and conditions** All conditions necessary to entitle a claim to be made must be met during the currency of the Policy. Written notice containing full particulars of any circumstances in respect of which a claim is to be made must be given to Us as soon as possible. Claim forms can be requested by writing to AIA Australia's Claims Department (visit www.aia.com.au for the most up to date contact details). All certificates and evidence required by Us will be furnished at Your expense within 30 days of the date of the written notice and will be in the form and of the nature as We may request.	**3.12.1 Claims requirements and conditions** You or your beneficiaries should notify us as soon as practicable of any claim or potential claim against the Policy. The event giving rise to your claim must have occurred while the Policy was in force. Following our receipt of your written notice of a claim, we will provide you with the appropriate forms so that proof of your claim can be filed with us. The forms can also be obtained by contacting our Claims Team on 1800 333 613. The completed claim forms (where relevant) and any other particulars We reasonably request as proof of any entitlement to claim must be provided to us, where applicable. All certificates and evidence required will be in the form and of the nature as we may request.
16	**General Terms and Conditions** 13.4.2 Medical examination Pg. 15	**13.4.2 Medical examination** We, at Our discretion, may have the Life Insured medically examined (including blood tests and other tests), when and as often as is reasonable, in connection with a claim.	**3.12.2 Medical examination** Where appropriate and reasonably necessary in connection with your claim, We may require you to be medically examined by our medical practitioners or undergo other relevant medical examinations (including blood tests and other tests).

Change number	Section and page	Prior to update	After update
17	**General Terms and Conditions** 3.18 Policy upgrade Pg. 16	**3.18 Policy upgrade** Over time We will review the benefits provided under the Policy. When the benefits under a plan change We may upgrade Your plan with the new benefits. The policy upgrade will be made automatically, and no action is required by You. We will replace Your current Policy Document with a new Policy Document incorporating the upgrade. The new policy will be effective from Your next Policy Anniversary. Your rights and obligations are then 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 upgrade under the new policy, these will apply to future claims only 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 the upgrade.	**3.16 Policy upgrade** Over time We will review the benefits provided under the Policy. When the benefits under a plan are improved We will administer Your plan on the basis that such improvements apply to it from Your next Policy Anniversary. The policy upgrade will be made automatically, and no action is required by You. We will replace Your current Policy Document with a new Policy Document incorporating the upgrade. The new policy will be effective from Your next Policy Anniversary. Your rights and obligations are then determined by the new Policy Document. Should a situation arise where You are disadvantaged in any way as a result of the benefit improvements being applied in relation to Your plan, the previous policy wording will apply. We will apply these benefit improvements to the assessment of future claims only and not to past or current claims or any claims resulting from health conditions or events which began or took place before the date on which these improvements took effect.
18	**General Terms and Conditions** 3.20 Any questions or concerns Pg. 17	**3.20 Any questions or concerns** If You should have any questions or concerns about Your policy please contact 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 are as follows: Financial Ombudsman Service (FOS) GPO Box 3 MELBOURNE VIC 3001 Telephone: 1300 78 08 08 Fax: (03) 9613 6399 Email: info@fos.org .au	**3.18 Any questions or concerns** If you have any questions or concerns about your Policy, you should firstly contact your financial adviser. You can also contact us directly in writing to AIA Australia Customer Complaints , PO Box 6111, Melbourne VIC 3004 or by email to au.customerresolutions@aia.com. We will promptly investigate your matter and, if necessary, refer your matter to our Internal Dispute Resolution Committee. Internal complaints are normally resolved within 30 days. You may also wish to lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers. You can contact AFCA online at afc.org.au, by email to info@afc.org.au, by mail to Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001, or by phone on 1800 931 678.

Change number	Section and page	Prior to update	After update
19	**Term Life Plan** 4.1.2 Terminal Illness Pg.18	If the Life Insured is diagnosed with a Terminal Illness as defined in condition 2, We will pay a lump sum amount of 100% of the Term Life Sum Insured up to a maximum payment of $1,000,000, or such other larger amount as We may determine from time to time. The maximum amount payable includes the total amount payable under this benefit and other death benefits with Us in respect of the Terminal Illness of the Life Insured. Payment of the Terminal Illness benefit will reduce the Term Life Sum Insured by the amount of the payment made under the Term Life benefit. The reduced Term Life Sum Insured will be subsequently payable upon the Life Insured's death prior to the Term Life Benefit Expiry Date. The premium for the benefit will be adjusted to reflect any reduction in the Sum Insured for that benefit. When a Terminal Illness benefit has been paid there will be no subsequent Guaranteed Premium Refund payable under the Term Life benefit.	If you are diagnosed with a Terminal Illness, we will pay a lump sum equal to the Term Life Sum Insured. When a Terminal Illness benefit has been paid there will be no subsequent Guaranteed Premium Refund payable under the Term Life benefit.
20	**Crisis Plan** 5.1.1.3 Pre-existing medical condition Pg. 22	If the Life Insured has consulted a Medical Practitioner or undergone an investigation in relation to a Crisis Event before the benefit commencement date and has not disclosed full details to Us before the benefit commencement date or reinstatement of the benefit, then the Crisis benefit will not be paid in respect of that Crisis Event and any associated Crisis Event(s).	The Crisis benefit will not be paid in respect of any Crisis Event that occurred or was diagnosed, or where symptoms occurred which to a reasonable person in the circumstances would have indicated the presence of that Crisis Event or the need to seek medical treatment or investigation that would have revealed the presence of that Crisis Event, before the benefit commencement date or reinstatement of the benefit, unless disclosed to Us before the benefit commencement date or reinstatement of the benefit.

Change number	Section and page	Prior to update	After update
21	**Crisis Plan** 5.1.1.4 Chronic Diagnosis Advancement Benefit Pg. 23	The Chronic Diagnosis Advancement benefit is an advanced payment of the Crisis benefit, payable when certain Crisis Events have been diagnosed, but have not yet met the definition of that Crisis Event as described in condition 2 of the Policy. The payment is 25% of the Crisis Sum Insured, to a maximum of $25,000 under all policies issued by Us covering the Life Insured. The Chronic Diagnosis Advancement benefit will be paid if an appropriate specialist Medical Practitioner confirms, to Our satisfaction, that the Life Insured: (a) has suffered or been medically diagnosed with one of the following Crisis Events: • Motor Neurone Disease, • Multiple Sclerosis, • Muscular Dystrophy, and • Parkinson's Disease but has not yet met the definition of that Crisis Event in condition 2 of the Policy; 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 condition 2) and that the procedure is unrelated to any previous procedure or surgery undergone by 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 payment of the Crisis benefit, the reduced Crisis benefit will be paid. Only one Chronic Diagnosis Advancement benefit payment will be made in respect of the Life Insured. Where a Chronic Diagnosis Advancement benefit has been paid, You will still be eligible for a Guaranteed Premium Refund. The amount payable will be equal to the reduced Total Premium Paid at the end of the Benefit Expiry Date.	The Chronic Diagnosis Advancement benefit is an advanced payment of the Crisis benefit, payable when certain Crisis Events have been diagnosed, but have not yet met the definition of that Crisis Event as described in condition 2 of the Policy. The payment is 25% of the Crisis Sum Insured, to a maximum of $25,000 under all policies issued by Us covering the Life Insured. The Chronic Diagnosis Advancement benefit will be paid if an appropriate specialist Medical Practitioner confirms, that the Life Insured: (a) has suffered or been medically diagnosed with one of the following Crisis Events: • Motor Neurone Disease, • Multiple Sclerosis, • Muscular Dystrophy, and • Parkinson's Disease but has not yet met the definition of that Crisis Event in condition 2 of the Policy; 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 condition 2) and that the procedure is unrelated to any previous procedure or surgery undergone by 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 payment of the Crisis benefit, the reduced Crisis benefit will be paid. Only one Chronic Diagnosis Advancement benefit payment will be made in respect of the Life Insured. Where a Chronic Diagnosis Advancement benefit has been paid, You will still be eligible for a Guaranteed Premium Refund. The amount payable will be equal to the reduced Total Premium Paid at the end of the Benefit Expiry Date.

Change number	Section and page	Prior to update	After update
22	**Crisis Plan** 5.1.1.5 Proof of positive diagnosis of a Crisis Event required Pg. 23	Written proof of positive diagnosis of a Crisis Event must be provided to Us at Our head office in the case of claim within 90 days after the date of such diagnosis. Failure to provide such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is provided as soon as is reasonably possible. We shall at Our own expense have the right and opportunity to examine the Life Insured when and as often as We may reasonably require in connection with a claim. The Crisis benefit will not be payable unless the Crisis Event and the date thereof is confirmed in writing by a Medical Practitioner(s) and/or legally qualified pathologist(s), and who shall base their diagnosis solely on the definition contained herein of the particular Crisis Event after a study of the histological material and clinical presentation based on the medical history, physical examination, radiological studies, and the results of any other diagnostic procedures performed on the Life Insured. Any such diagnosis must be confirmed by Us.	Once you have notified us in writing by mail, fax, phone or email that you are submitting a claim on your policy, we will provide you with the appropriate forms, including a proof of positive diagnosis form. You must return proof of the positive diagnosis form to us. We have the right and opportunity to examine the Life Insured when and as often as we may reasonably require in connection with a claim. We will do this at our own expense.
23	**Crisis Plan** 5.1.1.6 Claim forms Pg. 24	Following receipt of a written notice of claim, We shall supply You with the appropriate form(s) to enable proof of positive diagnosis to be filed with Us.	**Section 5.1.16 *Claim forms* is deleted**
24	**5.1.1.7 – 5.1.1.8** sub sections are re- numbered due to deletion of earlier subsections. Pg.24	5.1.1.7 Limitations 5.1.1.8 Benefit reduction	5.1.1.6 Limitations 5.1.1.7 Benefit reduction
25	**Crisis Plan** 5.1.3 Terminal Illness Pg. 24	If the Life Insured is diagnosed with a Terminal Illness as defined in condition 2, We will pay a lump sum amount of 100% of the Crisis Sum Insured up to a maximum payment of $1,000,000, or such other larger amount as We may determine from time to time . The maximum amount payable includes the total amount payable under this benefit and other death benefits with Us in respect of the Terminal Illness of the Life Insured.	If the Life Insured is diagnosed with a Terminal Illness we will pay a lump sum equal to the Crisis Sum Insured. When a Terminal Illness benefit has been paid there will be no subsequent Guaranteed Premium Refund payable under the Crisis benefit.

Table 2. Updates to benefits and general policy terms – PDS

The terms that have been updated in your PDS are detailed in Table 2 below.

Change number	Section and page	Prior to update	After update
1	**Information on your policy** Pg. 4	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.	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. 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. 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.
2	**Payment on terminal illness** Pg.5	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.	We will pay a lump sum equal to the Term Life sum insured upon diagnosis of a terminal illness (as defined on page 19).
3	**Chronic Diagnosis Advancement benefit** Pg. 10	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:	The Chronic Diagnosis Advancement benefit is an advanced payment of the Crisis benefit. This benefit is payable if an appropriate specialist medical practitioner confirms that the life insured:
4	**Pre-existing medical condition** Pg. 10	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.	The Crisis benefit will not be paid in respect of any Crisis Event that occurred or was diagnosed, or where symptoms occurred which to a reasonable person in the circumstances would have indicated the presence of that Crisis Event or the need to seek medical treatment or investigation that would have revealed the presence of that Crisis Event, before the benefit commencement date or reinstatement of the benefit, unless disclosed to Us before the benefit commencement date or reinstatement of the benefit.

Change number	Section and page	Prior to update	After update
5	**Payment on terminal illness** Pg. 11	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.	We will pay a lump sum equal to the Crisis sum insured upon diagnosis of a terminal illness (as defined on page 19).
6	**Premium rates** Pg. 22	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.	A table of premium rates is available on request. The premiums you pay depend on factors such as the Life Insured's age, sex, smoking habits, occupation, pastimes, and state of health. Premium rates also take into account the level of cover and benefit features chosen by you. Premium rates allow for cost of insurance and Our reasonable expenses, including but not limited to costs incurred in administering your policy.
7	**Premium guarantees** Pg. 22	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.	We may vary your premium rates from time to time provided that any such variations are reasonably necessary to protect our legitimate business interests. Your premium rates may not be altered individually but only for all policies in a group.
8	**Policy fee** Pg. 25	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.	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. The policy fee is subject to any premium frequency charge/loading fee (see table). We may vary your Policy fee from time to time provided that any such variations are reasonably necessary to protect our legitimate business interest. 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. We will advise you in writing prior to any change to your policy fee.

<table>
<tr><th>Change number</th><th>Section and page</th><th>Prior to update</th><th>After update</th></tr>
<tr><td>9</td><td>Premium frequency charge
Pg. 25</td><td>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.

<table><tr><th>Premium frequency</th><th>Charge as a percentage of yearly premium</th></tr><tr><td>Half-yearly</td><td>5%</td></tr><tr><td>Monthly</td><td>8%</td></tr></table>
You will be notified of any change in the amount of the charges prior to the change taking effect.</td><td>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.

<table><tr><th>Premium frequency</th><th>Charge as a percentage of yearly premium</th></tr><tr><td>Half-yearly</td><td>5%</td></tr><tr><td>Monthly</td><td>8%</td></tr></table>
The premium frequency charge may be reviewed and varied from time to time provided that any such variations are reasonably necessary to protect our legitimate business interests. We will advise you in writing prior to any change to Your premium frequency charge.</td></tr>
<tr><td>10</td><td>Policy upgrades
Pg. 26</td><td>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.</td><td>Over time we will review the benefits provided under the policy. When the benefits under the policy improve, 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 benefit improvements being applied in relation to your policy, the previous policy wording will apply.

We will apply these benefit improvements to the assessment of future claims and not to past or current claims or any claims resulting from health conditions or events which began or took place before the date on which these improvements took effect.</td></tr>
<tr><td>11</td><td>Lost policy documentation</td><td>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.</td><td>The Lost policy documentation section is deleted</td></tr>
<tr><td>12</td><td>Tax changes
Pg. 27</td><td>Any material change to the taxation position of the policy will be notified to you in the first Renewal Statement following the change.</td><td>Any material change to the taxation position of the policy will be notified to you in the information we send you on your next policy anniversary following the change.</td></tr>
</table>

Change number	Section and page	Prior to update	After update
13	**Tax or other government imposts** Pg. 27	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.	Where We are, or believe We will become, liable for any tax or other imposts levied by any Commonwealth, State or Territory 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 which is reasonably necessary to take account of the tax or impost.
14	**Questions and concerns** Pg. 28	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	If you have any questions or concerns about your Policy, you should firstly contact your financial adviser. You can also contact us directly in writing to AIA Australia Customer Complaints, PO Box 6111, Melbourne VIC 3004 or by email to **au.customerresolutions@aia.com** We will promptly investigate your matter and, if necessary, refer your matter to our Internal Dispute Resolution Committee. Internal complaints are normally resolved within 30 days. You may also wish to lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers. You can contact AFCA online at afc.org.au, by email to info@afc.org.au, by mail to Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001, or by phone on 1800 931 678.

Change number	Section and page	Prior to update	After update
15	**Any questions or concerns on privacy?** Pg. 30	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	If you have a complaint about our handling of your personal information, including whether we have handled your personal information in accordance with the National Privacy Principles, you can submit a complaint to our Customer Complaints team in writing to AIA Australia Customer Complaints, PO Box 6111, Melbourne VIC 3004, or by email to **au.customerresolutions@aia.com** We will promptly investigate your matter and, if necessary, refer your matter to our Internal Dispute Resolution Committee. Internal complaints are normally resolved within 30 days. Should your 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 Australian Information Commissioner GPO Box 5218 Sydney, NSW 2001 Email: enquiries@aic.gov.au Phone: 1300 363 992 www.oaic.gov.au You may also wish to lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers. You can contact AFCA online at afc.org.au, by email to info@afc.org.au, by mail to Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001, or by phone on 1800 931 678.

Table 3. Updates to Medical Definitions – Policy Document and PDS

Updates made to medical definitions contained in both your Policy Document and PDS are outlined in Table 3 below.:

Change number	Section and page	Prior to update	After update
1	**Definitions** (PD) Pg. 3 (PDS) Pg. 13 'ACCIDENTAL HIV INFECTION'	'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.	'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 six 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 this Policy. Any accident giving rise to a potential claim must 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.
2	**Definitions** (PD) Pg. 4 (PDS) Pg. 13 'BACTERIAL MENINGITIS'	'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.	'BACTERIAL MENINGITIS WITH SIGNIFICANT FUNCTIONAL IMPAIRMENT' 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. All other forms of meningitis including viral, are excluded.

Change number	Section and page	Prior to update	After update
3	**Definitions** (PD) Pg. 4 (PDS) Pg. 14 'BLINDNESS'	'BLINDNESS' means total irreversible loss of sight in both eyes certified by an ophthalmologist and because of disease or accident.	'BLINDNESS' means that as a result of disease or accident and certified by an ophthalmologist: a) the visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes, or b) the field of vision is constricted to 20 degrees or less of arc around central fixation in the better eye irrespective of corrected visual activity (equivalent to 1/100 white test object).
4	**Definitions** (PD) Pg. 4. & 5 (PDS) Pg. 14 'CANCER'	'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 hyperkertoses 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 1cm in diameter; • Polycythemia Rubra Vera requiring treatment by venesection alone; and • tumours treated by endoscopic procedures alone.	'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 the malignancy and this procedure is the appropriate and necessary treatment as confirmed by an appropriate specialist; • 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; • non-melanoma skin cancers, unless there has been spread to other organs; • T1 N0 M0 papillary carcinoma of the thyroid less than 1cm in diameter; • Polycythemia Rubra Vera requiring treatment by venesection alone; and • tumours treated by endoscopic procedures alone.
5	**Definitions** (PD) Pg. 5 (PDS) P. 14 'CHRONIC LIVER DISEASE'	'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.	'END STAGE 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.
6	**Definitions** (PD) Pg. 5 (PDS) Pg. 15 'CHRONIC LUNG DISEASE'	'CHRONIC LUNG DISEASE' means end stage respiratory failure requiring permanent oxygen therapy with FEV 1 test results consistently showing less than one litre.	'END STAGE LUNG FAILURE' means end stage respiratory failure requiring permanent, long term oxygen therapy as certified by the relevant medical specialist, excluding Intermittent Oxygen Therapy.

Change number	Section and page	Prior to update	After update
7	**Definitions** (PD) Pg. 5. (PDS) Pg. 15. 'COMA'	'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.	'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.
8	**Definitions** (PD) Pg. 6 (PDS) Pg. 15. 'DIPLEGIA'	'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.	'DIPLEGIA' means the total and permanent loss of use of both arms or both legs, resulting from sickness or injury of the brain or spinal cord.
9	**Definitions** (PD) Pg. 7 (PDS) Pg. 16 'LOSS OF HEARING'	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 HEARING' means irreversible loss of hearing in the better ear, that: • has an auditory threshold of greater than 90 decibels at all frequencies from 500 hertz to 3,000 hertz, even with amplification, and • is diagnosed and certified by an appropriate specialist Medical Practitioner, using standardised equipment.
10	**Definitions** (PD) Pg. 8 (PDS) Pg. 17 'MAJOR HEAD TRAUMA'	'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 HEAD TRAUMA' means an accidental head injury resulting in neurological deficit, as certified by a consultant neurologist 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.
11	**Definitions** (PD) Pg. 8 (PDS) Pg. 17 'MOTOR NEURONE DISEASE'	'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.	'MOTOR NEURONE DISEASE' means the unequivocal diagnosis of Motor Neurone Disease confirmed by a consultant neurologist 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.

Change number	Section and page	Prior to update	After update
12	**Definitions** (PD) Pg. 8. & 9 (PDS) Pg. 18 'MUTIPLE SCLEROSIS'	'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.	'MULTIPLE SCLEROSIS' means the unequivocal diagnosis of Multiple Sclerosis confirmed by a relevant medical specialist 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.
13	**Definitions** (PD) Pg. 9 (PDS) Pg. 18 'MUSCULAR DYSTROPHY'	'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.	'MUSCULAR DYSTROPHY' means the unequivocal diagnosis of Muscular Dystrophy confirmed by a consultant neurologist, 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 the reasonable opinion of a relevant medical specialist confirms the diagnosis.
14	**Definitions** (PD) Pg. 9. (PDS) Pg. 18. 'PARKINSONS 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.	'PARKINSON'S DISEASE' means the unequivocal diagnosis of Parkinson's Disease by a consultant neurologist 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 the 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.

Change number	Section and page	Prior to update	After update
15	**Definitions** (PD) Pg. 10. (PDS) Pg. 19. 'TERMINAL ILLNESS'	'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.	'TERMINAL ILLNESS' means the diagnosis of an illness which, in the reasonable opinion of an appropriate specialist Medical Practitioner, is likely to result in you passing away within 12 months of the diagnosis regardless of any treatment that may be undertaken.
16	Definitions (PD) Pg. 5 & (PDS) Pg. 14. 'CARDIOMYOPATHY'	'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.	'CARDIOMYOPATHY' means a condition of impaired ventricular function of variable aetiology (often not determined) resulting in significant physical impairment to the degree of at least 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.