Cashback Flexi

Policy Document
Version 2.1, Issued 24 June 2009

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It just makes sense.

Who issues Cashback Flexi?

Cashback Flexi is issued by AIA Australia Limited (ABN 79 004 837 861 AFSL 230043).
Freecall: 1800 333 613.

This Policy Document should be read in conjunction with the attached Policy Schedule.

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

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1. Introduction

The Policy Document and the application for this insurance including any declaration and statements relating to this insurance, constitute the entire contract ('the Policy'). The term 'the Policy' also includes any applicable endorsements. Any variation of this contract must be evidenced in writing bearing the signature of one of Our authorised officials.

The Policy is issued, on the date the Policy Schedule was sent, by AIA Australia to the Policy Owner named on the attached Policy Schedule:

(i) in consideration of the payment of the premium and stamp duty as stated on the Policy Schedule, and

(ii) on the basis of the application, declaration and any other statements made by the Policy Owner and the Life Insured to Us in connection with the Policy.

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 extend, 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 premium that would have been payable if you had disclosed all relevant matters to the insurer.

2. Definitions

Wherever used in the Policy:

‘BENEFIT EXPIRY DATE’ means the expiry date shown on the Policy Schedule for that benefit.

‘LIFE INSURED, HIS, HER, HIMSELF, HERSELF’ means the person named as the Life Insured on the Policy Schedule.

‘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.

‘NON-SMOKER’ at a point in time, means, not having smoked tobacco or any other substance for a continuous period of 12 months ending at that point in time.

‘OUR, US, WE,’ relate to AIA Australia Limited.

‘POLICY ANNIVERSARY’ means an anniversary of the due date of the first premium shown on the Policy Schedule.

‘POLICY OWNER’ means the person or persons named on the Policy Schedule as the ‘Policy Owner’ and any successor in title of that Policy Owner.

‘PREMIUM CEASE DATE means the date that premiums are no longer payable as shown on the Policy Schedule for that benefit.

‘YOU, YOUR’ relate to the Policy Owner.

‘SUM INSURED’ for a benefit means the Sum Insured for that benefit stated on the Policy Schedule.

‘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 1cm 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.

'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.

3. General terms and conditions

3.1 Your Cashback Flexi Policy

We have issued the Policy in accordance with the contents of Your application and any supporting documents We have obtained. The contract between You and Us is based completely on the accuracy of these documents, and You have a duty to disclose in them any information which is material to the risks We are insuring.

The Policy Document is evidence of the contract between You and Us. The contract is completed after Your application has been accepted, Your premium received and the Policy Document issued by Us.

3.2 Policy Schedule

The Policy Schedule sets out the benefits purchased under the Policy. The Policy Schedule should be read in conjunction with the Policy Terms and Conditions.

The enclosed Policy Schedule is a summary of the premium and benefit amounts under Your Policy and form part of the contract.

3.3 Cooling-off period

Please read the Policy Document carefully. If You are not happy that the policy and benefits meet Your needs You may return the policy within the 14-day cooling-off period and receive the 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 cancel the 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.

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.

*Note: You will lose the right to return Your policy within the cooling-off period when You first exercise any right or power, other than this right to return Your policy, that You have under the policy.

3.5 Premiums

3.5.1 Payment of premiums

Premiums are only available on a level premium basis and are payable yearly in advance on the Policy Anniversary.

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 for a plan will cease in accordance with the Standard or Accelerated premium term selected.

3.5.1.1 Standard premium term

Premiums are payable on the Policy Anniversary every year up to the Benefit Expiry Date as outlined in the table below:

Plan term	Years premiums paid
10 years	10 years
15 years	15 years
20 years	20 years

3.5.1.2 Accelerated premium term

Premiums are payable on the Policy Anniversary every year up to the Premium Cease Date as outlined in the table below:

Plan term	Years premiums paid
10 years	5 years
15 years	8 years
20 years	10 years

3.5.2 If you stop paying premiums

60 days of grace are allowed for the payment of premiums during which the Policy will remain in force. If You do not pay premiums within 60 days from the premium due date the Policy will lapse and its benefits will cease.

3.5.3 Premium rating factors

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.

3.5.4 Premium rates not guaranteed

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.

3.6 Fees and charges

All the charges of Your Policy are fully described in this section. We shall not apply any other charges without Your specific consent.

In addition to the premiums for each benefit, We will charge a policy fee and stamp duty (if applicable).

3.6.1 Policy fee

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.

3.6.2 Premium Frequency Charge

There is no Premium Frequency Charge on yearly premiums.

Premiums payable more frequently than yearly (i.e. 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 payment frequency	Charge as a percentage of yearly premium
Half-yearly	5%
Monthly	8%

You will be notified in writing of any change in the amount of this charge prior to the change taking effect.

3.6.3 State or Territory government stamp duty

Stamp duty is a government charge that varies depending on the State/Territory of residence of the Life Insured. Stamp duty is payable according to the relevant State or Territory stamp duty legislation.

If the amount of the stamp duty payable is changed the stamp duty charged to You will be changed accordingly (up or down) for future premium payments.

3.6.4 Lost Policy Document charge

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.

3.7 Tax or imposts

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.

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.

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.

3.10 Assignment of Policy

At any time, You may transfer ownership of the Policy to another person (subject to the minimum and maximum age of entry rules that apply) or legal entity. This is achieved by assigning the Policy using the Memorandum of Transfer included in this Policy Document. You should be aware that by assigning the Policy, You forfeit all rights to benefits payable under the Policy. Assignment will revoke any previous nomination of beneficiary.

No assignment of the Policy or the benefits under it shall bind Us unless and until it has been registered by Us. We take no responsibility as to the validity of any assignment.

3.11 Nomination of beneficiaries

You may nominate a beneficiary (person or legal entity) to receive all death claim benefits under the Policy, subject to the following rules:

- Contingent nominations cannot be made;
- You may change a nominated beneficiary or revoke a previous nomination at any time prior to the occurrence of an event giving rise to a claim;
- The nominated beneficiary will receive any money payable under the Policy. If the nominated beneficiary dies before the occurrence of an event giving rise to a claim under the Policy and no change in nomination has been made, then any money payable will be paid to the nominated beneficiary's legal personal representative;

- If ownership of the Policy is assigned to another person or entity, then any previous nomination is automatically revoked;
- A nominated beneficiary has no rights under the Policy, other than to receive the Policy proceeds after a claim has been admitted by Us. The nominated beneficiary cannot authorise or initiate any policy transaction;
- The nomination, change or removal of a beneficiary must be advised in writing and sent to Us.

3.12 Misstatement of age

If the age of the Life Insured on issue of the Policy is different from that stated on the application the sum payable under the Policy shall be reduced to that which would have been payable if the age had been correctly stated on the basis of premiums actually paid.

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.

3.14 Claims

3.14.1 Claim 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.

3.14.2 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.

3.15 Non-smoker – incorrect declaration

'NON-SMOKER' at a point in time, means, not having smoked tobacco or any other substance for a continuous period of 12 months ending at that point in time.

Where it is declared that the Life Insured is a Non-smoker and We have charged a premium based on such declaration, it is a condition of this insurance that if an incorrect non-smoker declaration has been made, the Sum(s) Insured shown on the Policy Schedule will be reduced to the amount(s) which the premium paid would have purchased had a correct declaration been made.

3.16 Statutory Fund

The Policy forms part of Our Statutory Fund No. 1 which alone shall be liable under the Policy. The Policy does not participate in bonus distributions.

3.17 Currency

All amounts under the Policy whether payable by Us or by You are payable in Australian currency.

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.

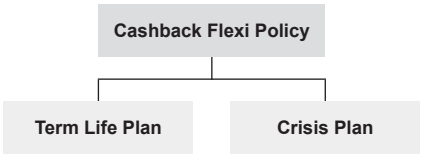
Your rights and obligations are then determined by the new Policy Document. Should a situation arise where You are disadvantaged in any way as a result of the upgrade, the previous policy wording will apply.

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.

3.19 Choice of benefits

Cashback Flexi offers a choice of benefits under two insurance plans. The Policy Schedule details the benefits purchased under the Policy.

The Plans are:
Term Life Plan – refer pages 18 to 20
Crisis Plan – refer pages 21 to 27



The terms and conditions of each benefit within each plan are provided in the sections listed above.

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

4. Term Life Plan

This condition applies if the Term Life Plan has been selected and this benefit is shown on the Policy Schedule.

Important notice

This is not a savings plan and is without profits. The primary purpose of this Term Life Plan is to provide a lump sum payment in the event of the Life Insured's death.

If You terminate Your plan after the cooling-off period You will not receive any termination payment or refund of premium.

4.1 Term Life benefits

4.1.1 Death

If the Life Insured dies prior to the Benefit Expiry Date (see 4.2) We will pay a lump sum equal to the Term Life Sum Insured.

When a Death benefit has been paid there will be no subsequent Guaranteed Premium Refund payable under the Term Life benefit.

4.1.2 Terminal Illness

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.

4.1.3 Guaranteed 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,
- no Death benefit has been paid, and
- the Plan has not been cancelled, terminated or converted to a Term Life benefit before the Benefit Expiry Date.

If multiple benefits are attached to a Policy, only one Policy fee will be refunded. This will occur at the Benefit Expiry Date of the last benefit under the Policy.

4.1.3.1 Total premium paid

For the purposes of this calculation the Total Premium Paid for the Term Life benefit includes insurance premium, policy fee, any pastime, health or other loadings, stamp duty and any premium frequency charges (applying to monthly and half-yearly premium payments).

4.1.4 Conversion option

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.

4.2 Benefit expiry date

Cover for the benefit ceases at the Benefit Expiry Date that appears on the Policy Schedule.

4.3 Exclusion

The benefit under the Term Life benefit is not payable in the event of suicide of the Life Insured within 13 months from the commencement date or date of last reinstatement of the benefit.

4.4 Termination

The Term Life benefit will terminate on the:

- death of the Life Insured;
- payment of the full Sum Insured under this benefit due to Terminal Illness;
- date the conversion option is exercised;
- the Benefit Expiry Date of the benefit;
- date the benefit is cancelled; or
- date the Policy lapses or is cancelled;

whichever is the earliest to occur.

4.5 Maximum Sum Insured

Ages 2 to 11 next birthday – the maximum Sum Insured is $100,000

Age 12 to 60 next birthday – No limit but financial underwriting will apply to any large Sum Insured.

4.6 Premiums

Please see condition 3.5 of the Policy Terms & Conditions.

4.7 Worldwide protection

The Life Insured is covered under the Term Life Plan anywhere in the world, 24 hours a day.

5. Crisis Plan

This condition applies if the Crisis Plan has been selected and this benefit is shown on the Policy Schedule.

Important notice

This is not a savings plan and is without profits. The primary purpose of this Crisis Plan is to provide a lump sum payment in the event of the Life Insured sustaining a crisis event, or death, whichever is the earliest to occur.

If You terminate Your plan after the cooling-off period You will not receive any termination payment or refund of premium.

5.1 Crisis benefits

5.1.1 Crisis benefit

If the Life Insured is diagnosed with one of the Crisis Events listed below and as defined in condition 2, We will pay a lump sum equal to the Crisis Sum Insured.

After the payment of a claim for the full Crisis Sum Insured in respect of a Crisis Event, the Crisis Plan will cease and no further amount will be payable under the Plan.

5.1.1.1 Crisis Events covered

The Crisis Events covered are listed below and are defined on pages 3 to 10:

- 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

Once total payments under the Crisis benefit reach the Crisis Sum Insured the Crisis Plan will cease.

* 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.

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 Total Premium Paid at the end of the Benefit Expiry Date.

5.1.1.2 Qualifying period on commencement or reinstatement

The Crisis benefit will not be paid if the Life Insured sustains one of the Crisis Events listed below within three months after the benefit 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 Replacement
- 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.

5.1.1.3 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 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).

5.1.1.4 Chronic Diagnosis Advancement benefit

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.

5.1.1.5 Proof of positive diagnosis of a Crisis Event required

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.

5.1.1.6 Claim forms

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.

5.1.1.7 Limitations

- The maximum Crisis benefit to be paid in respect of any and all claims arising from coverage under this benefit will not exceed in total the Crisis Sum Insured.
- After the happening of one Crisis Event for which payment of the full Crisis Sum Insured has been made, no further amount will be payable under the Crisis benefit.
- The Crisis benefit does not cover any disease, sickness or incapacity other than a Crisis Event as defined herein which occurs during the period the Crisis benefit remains in force.

5.1.1.8 Benefit reduction

The Crisis Sum Insured will be reduced by the payment of a claim under the following benefits:

- Crisis Event,
- Chronic Diagnosis Advancement,
- Death,
- Terminal Illness.

The Crisis Sum Insured will be reduced by the amount of the claim paid. The premium for this benefit will be adjusted to reflect the reduction in the Crisis Sum insured.

5.1.2 Death

If the Life Insured dies prior to the Benefit Expiry Date (see 4.2) We will pay a lump sum equal to the Crisis Sum Insured.

When a Death benefit has been paid there will be no subsequent Guaranteed Premium Refund payable under the Crisis Plan.

5.1.3 Terminal Illness

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.

Payment of the Terminal Illness benefit will reduce the Crisis Sum Insured by the amount of the payment made under the Crisis benefit.

The reduced Crisis Sum Insured will be subsequently payable upon the Life Insured's death prior to the Crisis 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 Crisis benefit.

5.1.4 Guaranteed 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,
- no Death benefit has been paid, and
- the Plan has not been cancelled, terminated or converted to a Term Life benefit before the Benefit Expiry Date.

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 Premiums Paid.

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

5.1.4.1 Total premium paid

For the purposes of this calculation the Total Premium Paid for the Crisis benefit includes insurance premium, policy fee, any pastime, health or other loadings, stamp duty and any premium frequency charges (applying to monthly and half-yearly premium payments).

5.1.5 Conversion option

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.

5.2 Benefit Expiry Date

Cover for the benefit ceases at the Benefit Expiry Date that appears on the Policy Schedule.

5.3 Exclusion

The Crisis benefit is not payable in the event of:

A Crisis Event directly or indirectly, wholly or partly, caused by intentional self-inflicted injury or any such attempt by the Life Insured.

5.4 Termination

The Crisis benefit will terminate on the:

- payment of the full Sum Insured under this benefit due to a Crisis Event; or
- death of the Life Insured; or
- payment of the full Sum Insured under this benefit due to Terminal Illness; or
- date the conversion option is exercised; or
- Benefit Expiry Date of the benefit; or
- date the Policy lapses or is cancelled;

whichever is the earliest to occur.

5.5 Maximum Sum Insured

The maximum Sum Insured is $2,000,000 and includes the Sum Insured for all similar benefits on the Life Insured with Us and other Insurers.

5.6 Premiums

Please see condition 3.5 of the Policy Terms & Conditions.

5.7 Worldwide protection

The Life Insured is covered under the Crisis Plan anywhere in the world, 24 hours each day.

DATE OF TRANSFER				
SIGNATURE OF TRANSFEROR (Current Policy Owner)				
NAME OF WITNESS WITNESS SIGNATURE				
TRANSFEREE'S (New Policy Owner) FULL NAME				
TRANSFEREE'S (New Policy Owner) ADDRESS				
TRANSFEREE'S (New Policy Owner) OCCUPATION				
TRANSFEREE'S (New Policy Owner) DATE OF BIRTH				
SIGNATURE OF TRANSFEREE (New Policy Owner)				
NAME OF WITNESS WITNESS SIGNATURE				
DATE OF REGISTRATION OF TRANSFER BY COMPANY				
SIGNATURE OF PRINCIPAL OFFICER OF COMPANY OR AUTHORISED PERSON				

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