



Sickness Policy

Product Disclosure Statement

Sickness Policy

Product Disclosure Statement and Policy

This document contains the following Parts:

- **The Product Disclosure Statement (“PDS”)** is contained in Part 1 and provides an outline of all the important information you should know about our Sickness Policy and the available Plans. The PDS is not the insurance agreement. That agreement is set out in the Policy terms and conditions contained in Part 2 of the document (“The Policy”).
- **The Policy** is the insurance agreement between you and us, and is the basis under which claims are paid.

Preparation Date :

This PDS was prepared on August 13th, 2010.

Version : 10PDSCIHC01

THIS IS AN IMPORTANT DOCUMENT, PLEASE READ THE DOCUMENT AND RETAIN IT IN A SAFE PLACE.

Welcome to Combined Insurance

Since our beginnings in 1919, Combined Insurance has grown to become a global brand that provides personal sickness insurance. Our motto is “Service, Strength and Security” and our goal is to provide you with peace of mind should you be unfortunate enough to suffer a Covered Sickness.

Combined Insurance is part of the ACE Group of Companies®, one of the leading global providers of insurance and reinsurance. Combined Insurance operates in Australia as a division of ACE Insurance Limited.

Friendly and Reliable Service

We pride ourselves on providing you with friendly and reliable service. If you have any questions, you can call our toll free Customer Service Hotline on **1300 300 480** or email us at customer@combined.com.au and our staff will be happy to help you.

We are service oriented and take pride in our commitment to provide you with the benefits promised under your coverage. We will always endeavour to serve you with fast, friendly and efficient claims service.

Contents

Welcome to Combined Insurance	1
Part 1 - Product Disclosure Statement.....	3
PDS Definitions	3
Policy Definitions	3
Disclaimer	3
The Sickness Policy Benefits	3
Notification of Variation from Standard Cover.....	4
Premiums	4
Instalments	5
Commission.....	5
Other Charges	5
PLAN 1: Sickness Disability Plan.....	5
PLAN 2: Sickness Confinement Plan	6
PLAN 3: Critical Illness Plan	6
PLAN 4: Cancer Plan	6
Increasing Your Cover	7
Exclusions	7
Endorsements - Sickness Disability Plan	7
How to Make a Claim.....	7
When Your Policy will End.....	8
Duty of Disclosure	8
Appropriate Coverage	8
Confirmation of Transaction	8
Cooling-off Period and Cancellation of Policy	8
Code of Practice.....	9
Complaints.....	9
Financial Claims Scheme and Compensation Arrangements	10
Your Privacy	10
Combined Insurance Contact Details.....	10

Part 2 - Sickness Policy Terms and Conditions.....11

Section 1 - Your Sickness Policy	11
Section 2 - Definitions.....	12
Section 3 - Sickness Disability Plan	
- Benefits	14
Section 4 - Sickness Confinement Plan	
- Benefits	14
Section 5 - Critical Illness Plan	
- Benefits	14
Section 6 - Cancer Plan	
- Benefits	15
Section 7 - Exclusions	15
Section 8 - Claims.....	16
Section 9 - General Policy Conditions	16

APPENDIX

PLAN 1: Sickness Disability Plan	
- Benefits & Premiums Tables.....	18
PLAN 2: Sickness Confinement Plan	
- Benefits & Premiums Tables.....	20
PLAN 3: Critical Illness Plan	
- Benefits & Premiums Tables.....	21
PLAN 4: Cancer Plan	
- Benefits & Premiums Tables.....	23

Part 1 - Product Disclosure Statement

In this PDS, Combined Insurance a division of ACE Insurance Limited is called “we”, “our” or “us”. The Person named in the policy schedule as the Insured is referred to as “you”, or “your”.

PDS Definitions

The following definitions apply in the Product Disclosure Statement. Some terms appearing in the Product Disclosure Statement in title case are defined in the Policy. Those terms have the meaning set out in the Policy.

“**Fact Find Document**” means a document which includes questions and answers about your health, occupation and financial circumstances. Your answers to our questions will determine whether you are insurable under the Policy and if so the level of insurance cover that we can offer you.

“**Family Plan**” means in relation to the Cancer Plan, a Cancer Plan that covers you and Covered Persons (as defined in the Policy, page 13).

“**FOS**” means the Financial Ombudsman Service.

“**FSG**” means the Financial Services Guide.

“**IDR**” means our free internal disputes resolution process.

“**PDS**” means the Product Disclosure Statement set out in Part 1 of this document.

“**Plans**” means the four optional plans offered under the Policy which you may choose to purchase, each offering cover for different types of sickness events.

“**SoA**” means the Statement of Advice.

This PDS has been prepared by us as the underwriter of the Policy. However, in many circumstances the PDS may be provided to you by one of our contracted “Authorised Representatives”, who are authorised to sell this product and provide advice on our behalf.

Policy Definitions

Please note that the important definitions applying to the Policy are included in Section 2 of the Sickness Policy Terms and Conditions on page 11 of this document.

Disclaimer

The Policy is not a life insurance policy, income protection policy, nor a health insurance policy. It does not cover expenses that may only be covered by a health insurance policy, but is intended to assist in meeting extra costs which may result from sickness such as an inability to work and earn an income, meeting living costs, travel and other costs not related to the health expenses incurred by you or Covered Persons. It does not provide cover in circumstances where we are not permitted by law to provide cover.

The Sickness Policy Benefits

The Policy offers cover for different types of sickness events through the Plans. These are the “Sickness Disability Plan”, the “Sickness Confinement Plan”, the “Critical Illness Plan” and the “Cancer Plan”. You can purchase any combination of Plans that best suits your needs.

1. The **Sickness Disability Plan** provides benefits for Total and Partial Disability due to a Covered Sickness.
2. The **Sickness Confinement Plan** provides a benefit if, due to a Covered Sickness, you are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you require the Full Time Care of a Professional Carer during this confinement.
3. The **Critical Illness Plan** provides a benefit if either you, or an Eligible Child, suffer a Covered Condition as specified in this Policy. Covered Conditions are any of the following events: Covered Cancer, Heart Attack, Coronary Artery Bypass Surgery, Stroke, Kidney Failure, Parkinson’s Disease, Coma, or Major Organ Transplant – Heart, Kidney, Liver, Lung, or Pancreas. A Skin Cancer benefit is also payable if either you, or an Eligible Child, is diagnosed with a Skin Cancer.
4. The **Cancer Plan** provides:
 - (a) a benefit for the first diagnosis of a Covered Cancer;
 - (b) a benefit if you or a Covered Person are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you or a Covered Person require the Full Time care of a Professional Carer during this confinement;
 - (c) a convalescence benefit following the abovementioned confinement;
 - (d) a diagnosis of Skin Cancer benefit;
 - (e) transportation and family lodging benefits.

The Cancer Plan may be purchased as an Individual or Family Plan.

The Policy provides benefits for sickness only and not injury, unless injury results in Coma under the Critical Illness Plan.

You will only be eligible to purchase the Policy if you:

- are age 16 or over (or age 18 or over for the Critical Illness and Cancer Plans); and
- are under age 65; and
- qualify in accordance with our underwriting requirements.

The Policy will not have a cash value on termination at any time.

The benefits you can receive under the Plan(s) you have selected and the cost of the Plan(s) are set out in the benefits and premiums tables set out on pages 18 to 24 of this document.

Notification of Variation from Standard Cover

This Policy varies from the standard cover specified in the *Insurance Contracts Act 1984* (Cth), (“Standard Cover”) for sickness and accident insurance contracts. In particular, it is important for you to note that:

- (a) policy benefits are as specified in the Policy document and the amounts in the benefits and premiums tables on pages 18 to 24 and in the policy schedule we will send to you;
- (b) Section 7 - Exclusions sets out the circumstances in which this Policy will not cover a loss;
- (c) policy benefits are not payable in respect of death, only in the event of a Covered Sickness, a Covered Condition or Covered Cancer. Should you die before a benefit that arose prior to your death was paid, any remaining benefit will be payable to your estate;
- (d) Disability benefits in the policy schedule are expressed as a monthly amount. We calculate the daily benefit by dividing the monthly benefit by 30 days; and
- (e) Not all Plans cover Total or Partial Disability.

Premiums

Payment of Premiums and Changes in Premiums or Benefits

For the Policy to remain in force, you must pay the premium (plus taxes detailed in this PDS) when due. If we have not received full payment of the premium due, by the date due (“Premium Due Date”), you will have 31 days in which to pay your premium before the Policy is cancelled in accordance with applicable law.

The premium for the Policy is fixed for the Policy term of one year, subject to the indexation amount referred to below. We reserve the right to vary the premium for any subsequent renewal term. We will notify you of any change in the premium or the benefits at least 30 days before the end of the Policy term or subsequent renewal term.

Premium Structure

Your premium will depend on a range of factors including the Plan or Plans you choose, your age at entry, the level of cover you choose (set out in the benefits and premiums tables on pages 18 to 24 of this document), whether you choose for premium to be direct debited from a bank account or credit card, or paid by cheque, the Waiting Period you choose, whether you are a smoker or a non-smoker (Critical Illness Plan), and whether you purchase an Individual or Family Cancer Plan. Benefits and premiums are shown in the benefits and premiums tables set out on pages 18 to 24 of this document.

If you choose to renew the Policy, both the benefits and premiums are indexed to increase on the annual renewal of the Policy for the first ten renewals. The benefits and premiums are indexed to increase upon renewal at the rate of 5% of the initial Policy benefit and premium values respectively (that is, 5% of the Policy benefit and premium values that applied during the first year of cover – the increase is not compounded).

This means that upon renewal 5% of the benefit and premium values respectively that applied during the first year of cover will be added to the respective benefit and premium values that applied during the period of cover immediately prior to that renewal. This indexation amount ceases to apply after ten annual renewals (total eleven years of cover). This indexation of benefits and premiums does not limit our right to vary the rate of renewal premium for any renewal term including those renewal terms in which the indexation amount applies.

For example, at the start of the second year while you hold the Sickness Disability Plan (Silver Level), the Total Disability benefit will increase from \$1,000 per month to \$1,050 per month. Should you renew the Plan for a third year, the benefit will increase to \$1,100 per month. The premium will also increase in the same manner.

The amount of benefit payable for a loss is the benefit applicable at the date of diagnosis or first treatment, whichever occurs first.

Instalments

Premiums are payable during the term of the Policy by instalment. Your first instalment is payable immediately and will cover the first two, six or twelve months. After that time, if you have chosen to pay the first instalment for the first two months, you may then pay monthly instalments. If you have chosen to pay the first instalment by a six monthly payment, you may then pay six monthly. Instalments (other than the first instalment but including instalments for any renewal term) may be paid by direct debit from your financial institution account or by automatic credit card payment or by cheque six monthly or annually. We will cancel your Policy in accordance with applicable law if a premium is not paid by the end of the 31st day after it is due. We will not deny a claim covered by the Policy on the grounds of non payment of premium if the premium is received by us within this 31 day period.

Commission

Our Authorised Representative will receive a commission from us should you purchase the Policy. The Authorised Representative has to meet their expenses from this commission and also relies on it to provide them with an income. This commission is paid from the premium you pay - it is not an additional cost to you. The amount of the commission will depend on which Plan(s) you purchase. In addition, our Authorised Representative may receive other benefits such as bonuses and incentive prizes should a certain volume of sales of the Policy be achieved. For more information relating to commission amounts or other benefits, please refer to the Financial Services Guide ("FSG") and Statement of Advice ("SoA") that have been provided with this PDS.

Other Charges

The following charges may apply to your Policy and are in addition to the premiums set out in the benefits and premiums tables on pages 18 to 24 of this document.

Stamp Duty

A government stamp duty is imposed on your Policy. The amount varies depending on your State/Territory of residence. The government may change the rate or basis of stamp duty and if it does, we may adjust the premium to reflect the change.

Goods And Services Tax

Currently, we require you to pay Goods and Services Tax ("GST") on your premium. The rate of GST is currently 10%. The government may change the rate or basis of GST and if it does so, we may adjust the premium to reflect the change.

Plan 1: Sickness Disability Plan

The different levels of cover are set out in the Sickness Disability Plan - Benefits and Premiums Table on pages 18 to 24 of this document. The policy schedule we will send to you after your Policy is issued will set out the specific level of sickness disability cover (if any) that you have selected.

Sickness Disability Plan Benefits

Total Disability

If due to a Covered Sickness that first manifested after 30 days from the Commencement Date of the Policy, you are Totally Disabled, we will pay you the benefit set out in your policy schedule. Depending on your Waiting Period selection, we will pay you either from the first, fifteenth, or thirty-first day of Total Disability and for a specified benefit period of up to twelve months while you remain Totally Disabled. (Please see the Policy for details - Page 14, Section 3.1.1).

Partial Disability

If due to a Covered Sickness that first manifested after 30 days from the Commencement Date of the Policy, you are Partially Disabled, we will pay you the benefit set out in your policy schedule. Depending on your Waiting Period selection, we will pay you either from the first, fifteenth, or thirty first day of Partial Disability and for a specified benefit period of up to one month while you remain Partially Disabled. Should a period of Partial Disability immediately follow a period of Total Disability for which you have already been subject to a Waiting Period, then we will pay you the Partial Disability benefit from the first day of such disability. (Please see the Policy for details - Page 14, Section 3.1.2).

Recurrent Disability

Successive periods of Total or Partial Disability will be considered one period of disability unless such periods are separated by at least six months, or the disabilities resulted from different or unrelated sicknesses.

Payment of Benefits

When you are claiming for ongoing Total Disability or Partial Disability, we will pay benefits on a monthly basis (calculated per day of Total Disability or Partial Disability) in arrears upon the receipt of certification from a Medical Practitioner, satisfactory to us, of your continuing disability. Monthly benefits are calculated on the basis of a 30 day month. That is, the daily benefit is calculated by dividing the monthly benefit by 30.

For example, if you were Totally Disabled for a period of 20 days under the Sickness Disability Plan (Platinum Level) in the first year, your payment would be calculated as follows:

\$2,000 per month divided by 30 days multiplied by 20 = \$1,333.33.

Benefits are paid to you. In the event of your death, any remaining benefits will be payable to your Estate.

Plan 2: Sickness Confinement Plan

The different levels of cover are set out in the Sickness Confinement Plan - Benefits and Premiums Table on page 20 of this document. The policy schedule we will send to you after your Policy is issued will set out the specific level of sickness confinement cover (if any) that you have selected.

Sickness Confinement Benefit

If due to a Covered Sickness that first manifested after 30 days from the Commencement Date of the Policy, you are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you require the Full Time Care of a Professional Carer during such confinement, we will pay you a daily benefit, starting with the first day of this confinement and continuing for up to 100 days. (Please see the Policy for details - Page 14, Section 4.1).

Plan 3: Critical Illness Plan

The different levels of cover are set out in the Critical Illness Plan - Benefits and Premiums Table on pages 21 to 22 of this document. The policy schedule we will send to you after your Policy is issued will set out the specific level of Critical Illness cover (if any) that you have selected.

Critical Illness Benefit

If while this Policy is in force, you suffer a Covered Condition, and provided this Covered Condition, its diagnosis or initial treatment (whichever occurs first) takes place after this Policy has been in force for at least 30 days from the Commencement Date, we will pay you the benefit set out in your policy schedule. Covered Conditions are Covered Cancer, Heart Attack, Coronary Artery Bypass Surgery, Stroke, Kidney Failure, Parkinson's Disease, Coma, or Major Organ Transplant - Heart, Kidney, Liver, Lung, or Pancreas. These terms are defined on page 12 of this document. The benefit is payable once only under this Policy and will be payable by us for the first claim accepted for one of the Covered Conditions. The Critical Illness Plan will terminate after payment of such a claim. (Please see the Policy for details - Pages 14 and 15, Sections 5.1 and 5.3).

Eligible Children's Cover

The Plan provides for payment of a benefit to you if an Eligible Child suffers a Covered Condition as specified above. The benefit is payable once only under this Policy in respect of the Eligible Child for the first claim, accepted for one of the Covered Conditions. The Critical Illness Plan will not terminate after payment of such a claim. (Please see the Policy for details - Pages 14 and 15, Sections 5.1 and 5.3).

Who is an Eligible Child?

An Eligible Child is any child who is aged 3 to 17 years (inclusive) at the date of the event giving rise to the claim and whose natural or legally adoptive mother or father is the Insured.

Skin Cancer Benefit

We will pay you the benefit set out in your policy schedule upon the medical diagnosis of Skin Cancer while this Policy is in force. Only one Skin Cancer benefit will be payable for you or any Eligible Child during any six month period under this Plan and will only be paid once in respect to the diagnosis of any one Skin Cancer. (Please see the Policy for details - Page 14, Section 5.2).

Payment of Benefits

The Critical Illness benefit will be paid when we receive written proof, satisfactory to us, of your Covered Condition.

Benefits are paid to you. In the event of your death, any remaining unpaid benefits will be payable to your estate. The Skin Cancer benefit will be payable when we receive written proof, satisfactory to us, of the medical diagnosis of Skin Cancer.

Plan 4: Cancer Plan

The different levels of cover are set out in the Cancer Plan - Benefits and Premiums Table on page 23 and 24 of this document. The policy schedule we will send to you after your Policy is issued will set out the specific level of cover (if any) that you have selected.

Individual or Family Cancer Plans

You may choose to purchase a Cancer Plan covering you only ("Individual Plan"); or a Cancer Plan for your family ("Family Plan") covering you, your Spouse, and any of your unmarried children who are dependent upon you for care and support and are aged 3 to 17 years inclusive ("Covered Person"). If you select the Family Plan, any of your children who turn age 3 while this Policy is in force will be automatically covered under the Plan from that time.

First Diagnosis Benefit

Upon the first diagnosis of a Covered Cancer, we will pay you the benefit set out in your policy schedule. Only one benefit will be payable to you, or in respect of any one Covered Person during their lifetime. (Please see the Policy for details - Page 15, Section 6.1).

Confining Cancer Benefit

If, due to a Covered Cancer, you or a Covered Person are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you or a Covered Person require the Full Time Care of a Professional Carer during such confinement, we will pay you the daily benefit set out in your policy schedule, starting with the first day of this confinement and for up to a lifetime maximum of 500 days. (Please see the Policy for details - Page 15, Section 6.2).

Non-Confining Cancer Benefit

If due to a Covered Cancer, you or a Covered Person remain Totally Disabled immediately following a period of continuous confinement to bed for which we have already paid benefits under the confining cancer benefit above, we will pay you the daily benefit set out in your

policy schedule while you or a Covered Person remain Totally Disabled, and for up to twice the number of days paid under the “confining cancer benefit”. (Please see the Policy for details - Page 15, Section 6.3).

Skin Cancer Benefit

We will pay you the benefit set out in your policy schedule upon the medical diagnosis of Skin Cancer while this Policy is in force. Only one Skin Cancer benefit will be payable for you or any Covered Person during any six month period under this Plan and will only be paid once in respect to the diagnosis of any one Skin Cancer. (Please see the Policy for details - Page 15, Section 6.4).

Transportation Benefit

If due to a Covered Cancer a Medical Practitioner certifies that you or a Covered Person require Medically Necessary Treatment and you or a Covered Person must travel more than 50 kilometres to receive such treatment, we will pay you a Transportation benefit for the travel expenses incurred, up to the Maximum Lifetime Benefit shown in your policy schedule. (Please see the Policy for details - Page 15, Section 6.5).

Family Lodging Benefit

If, due to a Covered Cancer, you or a Covered Person are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you or a Covered Person require the Full Time Care of a Professional Carer, and such confinement necessitates one family member staying at a hotel or motel in close proximity to the place of such confinement, we will pay you the daily family lodging benefit shown in your policy schedule for up to 100 days. This benefit is payable for hotel or motel stays only during the period of time of such confinement. (Please see the Policy for details - Page 15, Section 6.6).

Increasing Your Cover

Subject to you and a Covered Person meeting our underwriting requirements and the payment of an additional premium, if you do not hold the maximum level of cover offered by us from time to time, we will allow you to increase your cover to the limit offered by us. The additional cover will take effect from the Commencement Date stated in the revised policy schedule we will send to you subject to the payment in full of any additional premium payable.

Exclusions

The Policy does not cover you, an Eligible Child, or a Covered Person, for loss that is in any way caused or contributed to by:

- (i) bodily injuries (unless Coma results from injury, under the Critical Illness Plan);
- (ii) mental or emotional disorders;
- (iii) normal and uncomplicated pregnancy or childbirth;
- (iv) any complications of pregnancy or childbirth that first manifested within 12 months after the Commencement Date of the Policy;
- (v) a Pre-existing Condition (as defined on page 14);
- (vi) a Pre-existing Cancer (as defined on page 14).

In addition, no benefit will be payable for a Covered Sickness (Sickness Disability and Sickness Confinement Plans), a Covered Condition (Critical Illness Plan) or a Covered Cancer (Cancer Plan) unless medical reports and evidence satisfactory to us, are provided by suitably qualified Medical Practitioner(s) or hospital(s) in Australia, New Zealand, European Union Member States, the United States of America, or Canada. (Please see the Policy for details - Page 15, Section 7).

Endorsements - Sickness Disability Plan

In some instances if you suffer from, or have suffered from a chronic health problem over recent years, you may still be eligible for the Sickness Disability Plan. However, as a condition of the Plan, we may issue you with an attachment to the Plan known as an “endorsement” which precludes you from claiming for this condition, or any similar condition for either a period of time after you have recovered from the condition, or for the term of the Policy. If we do not issue you with an endorsement, you are still subject to the exclusion for Pre-existing Conditions set out above.

How to Make a Claim

If you need to make a claim, you should tell us about the circumstances giving rise to the claim as soon as possible, and complete our claim form (available from our Authorised Representatives, from our website, or from our Australian Head Office upon request) within 30 days after your loss has occurred, or as soon as reasonably possible.

When Your Policy will End

Your Policy will end as soon as one of the following occurs:

- (i) an instalment premium remains unpaid after 31 days from the Premium Due Date during the Policy term;
- (ii) you cancel your Policy;
- (iii) we do not offer to renew the Policy at the expiry of the Policy term or any subsequent renewal term, or should you choose not to renew the Policy for a further term and the Policy term elapses;
- (iv) you die;
- (v) on the first Premium Due Date after you have reached age 70;
- (vi) we cancel your Policy in accordance with applicable law.

The Critical Illness Plan will terminate upon the payment of a benefit to you under the Critical Illness Plan (excluding the Skin Cancer benefit). An Eligible Child's cover under the Critical Illness Plan ceases on the termination of cover, or upon the payment of a benefit for a Covered Condition suffered by the Eligible Child, or upon the child reaching age 18.

Under the Family Cancer Plan, cover for your children will cease when the child reaches age 21, marries, or when the Family Cancer Plan terminates, whichever comes first. Cover for your Spouse under the Family Cancer Plan ceases upon the divorce (or separation for a de facto Spouse) of you and your Spouse, or when your Spouse reaches age 70, or when the family Cancer Plan terminates, whichever comes first.

Duty of Disclosure

We rely on the information you provide us with to decide whether to insure you and the terms on which we will insure you. This is called your Duty of Disclosure.

What must you tell us?

When answering our questions, you must be honest and you have a duty under the law to tell us anything known to you, and which a reasonable person in the circumstances, would include in answer to the question. We will use the answers in deciding whether to insure you and anyone else to be insured under the Policy, and on what terms.

Who needs to tell us?

It is important that you understand you are answering our questions in this way for yourself and anyone else whom you want to be covered by the Policy.

If you do not tell us?

If you do not answer our questions in this way, we may reduce or refuse to pay a claim, or cancel the Policy. If you answer our questions fraudulently, we may refuse to pay a claim and treat the Policy as never having commenced.

The information that you provide in the Application Form and Fact Find document helps us to assess the level of risk that we are being asked to cover. You should contact us if you have any questions about what you should disclose.

Appropriate Coverage

It is important that you consider whether the terms, cover, and conditions of the Policy are relevant and suitable to your needs and circumstances. You should continue to review your cover for its relevance and suitability on a regular basis.

Confirmation of Transaction

The *Corporations Act 2001* (Cth) requires us to provide you with written or electronic confirmation of the premium payment for your Policy as soon as is reasonably practicable after the payment transaction or, alternatively, we are required to inform you about our facility by which you can, for yourself, get a written confirmation of the transaction.

Our customer service staff are able to provide you with written confirmation of any payment transaction upon request. If you wish to obtain written confirmation of your payment, including details such as the date, premium payable and your 14 day cooling-off period, call our toll free number **1300 300 480** to obtain this information at no cost to you. If you would prefer to use an alternative facility as a means of obtaining confirmation, please write to us or telephone us and we will provide you with written confirmation as soon as reasonably practicable after each payment transaction.

Cooling-off Period and Cancellation of Policy

After you have applied for the Policy and paid your first premium, you have 14 days to check that the Policy meets your needs. This is known as the cooling-off period.

If you decide that the Policy does not meet your needs, we will cancel the Policy and refund your money without any charges as long as you have not made a claim under the Policy and notify us in writing or electronically at our address as notified to you within 14 days of the Commencement Date of the Policy. Please quote the Application number located on your Application in any correspondence.

You may also cancel the Policy within 14 days of any subsequent payment of the Policy, by notifying us in writing or electronically or otherwise, of your request to cancel. We will refund to you the last premium payment

collected and the Policy will terminate from the Premium Due Date. You cannot exercise these rights of cancellation if a claim has been made during a period of cover to which this 14 day cooling-off period applies.

After the 14 day cooling-off period, you may cancel your Policy at any time by writing to us and advising us to cancel your Policy. If you are paying premiums by six monthly or annual instalment, we will refund any unearned premium on a pro-rata basis and cancellation will take effect on the date that your written instruction is received by us. We will not refund any remaining premium if you are paying by monthly instalment, and cancellation will take effect from the next Premium Due Date.

Issue of this Policy is subject to our review of your medical history and information. If any such information does not meet our requirements, then we may cancel this Policy.

Code of Practice

We have adopted the General Insurance Code of Practice. The Code was designed to promote understanding between insurers, agents, and consumers by setting standards for insurers to follow in their dealings with the public. It has a lot to say about your rights as a consumer to receive communications from your insurer promptly and in plain language. It also says that you should have access to a free internal disputes resolution process if you have a complaint. Our Disputes Officer will review your complaint in a timely manner and if you are not satisfied, will advise you of the option of the free external disputes resolution process outlined below, for any disputes relating to a claim under the Policy. If you would like more information about the Code, call us on our toll free number **1300 300 480** or visit www.codeofpractice.com.au

Complaints

Internal Disputes Resolution Process

You have access to our free internal disputes resolution (IDR) process. Our IDR process relates to any aspect of our service, including claims handling, or any problems you have experienced in dealing with our staff or authorised representatives.

Our Disputes Officer is available to review any complaints that you may have about our service. If you would like to make a complaint, the following steps should be taken:

Step 1 - Making a Complaint

Phone, write to, fax, or email our customer service department and advise us of your complaint. It is important that you let us know that you are not happy and the reason(s) why, so that we can attempt to find a solution that appropriately addresses your concerns.

Customer Service Department

c/o Combined Insurance
PO Box 403
North Sydney NSW 2059
Toll Free: 1300 300 480
Fax: (02) 9922 2096
Email: complaints@combined.com.au

We will respond to your complaint within 15 business days, or if further investigation or information is required, we will work with you to agree on reasonable alternative timeframes.

Step 2 - Lodging a Dispute

If your complaint is not resolved to your satisfaction and so becomes a dispute, please write to our Disputes Officer or advise a customer service representative that you would like the complaint to be referred to our Disputes Officer. Please outline your concerns and the reasons why you feel that we should review the original decision.

You may forward your dispute in writing to:

The Disputes Officer

c/o Combined Insurance
PO Box 403
North Sydney NSW 2059
Fax: (02) 8912 9699
Email: complaints@combined.com.au

In handling your dispute, our Disputes Officer is obliged to be fair and timely. In most cases, you will receive a reply within 15 business days from our receipt of your dispute. If further investigation or information is required, we will work with you to agree on reasonable alternative timeframes.

Step 3 - External Review

If you are unhappy with our final decision, or we have been unable to resolve your original complaint within 45 days, you may seek an external review of our decision concerning your complaint through the Financial Ombudsman Service ("FOS").

External Disputes Resolution

At any time you may contact the Financial Ombudsman Service ("FOS"). The FOS is an independent organisation offering free and accessible dispute resolution services to financial services consumers across Australia. The General Insurance division of FOS resolves general insurance disputes that are covered by its "Terms of Reference". If you wish your dispute to be reviewed by FOS you must refer your dispute to FOS within two years of receiving our IDR decision and you can do this by contacting FOS at:

Financial Ombudsman Service

GPO Box 3
Melbourne VIC 3001
Toll Free: 1300 780 808
Ph: (03) 9613 7366
Fax: (03) 9613 6399
Email: info@fos.org.au
Website: www.fos.org.au

If your complaint cannot be reviewed by the FOS, we will endeavour to refer you to an appropriate external body.

Financial Claims Scheme and Compensation Arrangements

We are an insurance company authorised under the Insurance Act 1973 (Insurance Act) to carry on general insurance business in Australia by the Australian Prudential Regulation Authority (APRA) and are subject to the prudential requirements of the Insurance Act. The Insurance Act contains prudential standards and practices designed to ensure that, under all reasonable circumstances, financial promises made by us are met within a stable, efficient and competitive financial system.

Because of this:

- the protection provided under the Financial Claims Scheme legislation applies in relation to us and the Policy. If ACE were to fail and were unable to meet our obligations under the Policy, a person entitled to claim under insurance cover under the Policy may be entitled to payment under the Financial Claims Scheme (access to the Scheme is subject to eligibility criteria). Information about the Financial Claims Scheme can be obtained from the APRA website at <http://www.apra.gov.au> and the APRA hotline on 1300 13 10 60; and
- we are exempted by the Corporations Act 2001 from the requirement to meet the compensation arrangements Australian financial services licensees must have in place to compensate retail clients for loss or damage suffered because of breaches by the licensee or its representatives of Chapter 7 of that Act. We have compensation arrangements in place that are in accordance with the Insurance Act.

Your Privacy

We are committed to protecting your privacy. We collect, use and retain your personal information in accordance with the National Privacy Principles.

Our detailed privacy policy is available on our website at www.combined.com.au.

We and our Authorised Representatives collect your personal information (which may include health information and banking details) when you are applying for, changing or renewing an insurance policy with us or when we are processing a claim. We collect the information to assess your application for insurance, to provide you or your organisation with competitive insurance products and services and administer them and to handle any claim that may be made under a policy. If you do not provide us with this information, we may not be able to provide you with insurance or to respond to any claim.

We may disclose the information we collect to third parties. These include contractors and contracted service providers engaged by us to deliver our services or carry out certain business activities on our behalf (such as

assessors and call centres), other companies within the ACE Group, our reinsurers, and government agencies (where we are required to by law). These third parties may be located outside Australia.

You agree to us using and disclosing your personal information as set out above. This consent remains valid unless you alter or revoke it by giving written notice to our Privacy Officer.

From time to time, we may use your personal information to send you offers or information regarding our products that may be of interest to you. If you have previously provided us with permission to show your name for marketing purposes, you may revoke this permission at any time in writing to us, or by calling our customer service centre toll free on 1300 300 480.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our Privacy Officer c/o Combined Insurance, PO Box 403, North Sydney NSW 2059.

Combined Insurance Contact Details

The Policy is issued by ACE Insurance Limited, ABN 23 001 642 020, AFSL 239687.

Combined Insurance is a division of ACE Insurance Limited.

Combined Insurance contact details are as follows:

Street Address

51 Berry St
North Sydney NSW 2060

Postal Address

PO Box 403
North Sydney NSW 2059

Ph: (02) 9922 5033 or Toll Free: 1300 300 480

Fax: (02) 9922 2096

Email: customer@combined.com.au

Website: www.combined.com.au

Part 2 - Sickness Policy Terms and Conditions

This Policy document contains the details of the legal agreement between the Insured (“you” or “your”) and Combined Insurance a division of ACE Insurance Limited (“we”, “our” or “us”). We call this part the “Policy” and it provides information concerning the type and extent of the cover being provided under each Plan, restrictions, exclusions, special conditions and any mutual obligations. Please read your Policy carefully and retain it in a safe place for future reference.

Section 1 - Your Policy

1.1 Benefits

Your Policy is a legal agreement between you and us. In return for the payment of the applicable premium, and on the basis of the statements made in the Fact Find Document and the Application, we will pay you, subject to the terms, conditions, and exclusions of your Policy, a benefit (as stated in the policy schedule we will send to you) for a Covered Sickness (if you have selected the Sickness Disability Plan or Sickness Confinement Plan), or a Covered Condition (if you have selected the Critical Illness Plan), or a Covered Cancer (if you have selected the Cancer Plan).

1.2 Policy Documents

Your Policy is made up of the following documents:

- (i) The Policy terms and conditions which are set out in this Part 2 of the document.
- (ii) The Application form and Fact Find Document which form the basis on which we decide whether to provide you with cover, and if so, on what terms, and in which you have disclosed all relevant information and selected your level of cover.
- (iii) The policy schedule which shows the details of the Plan(s) you have chosen.
- (iv) Any endorsement to this Policy which is signed by our Authorised Officer.

Together these documents set out the full terms and conditions that apply to your Policy. None of our other representatives apart from our Authorised Officer is authorised to amend or change your Policy.

1.3 Eligibility

You will only be eligible to purchase the Policy if you:

- are 16 years of age or over (or age 18 or over if you select the Critical Illness or Cancer Plans); and
- are under the age of 65 (all Plans); and
- qualify in accordance with our other underwriting requirements.

1.4 Paying Your Premium

The premium for the Policy is fixed for the Policy term of one year, subject to the indexation amount referred to in clause 1.6 that applies if you choose to renew the Policy.

After you have paid your first instalment, future instalments may be payable by direct debit or credit card from your bank, credit union or building society account, or by cheque. The first instalment of your premium is due on the Commencement Date. Subsequent instalment premiums are due at the intervals following the Commencement Date shown in the policy schedule.

If your first instalment is dishonoured or not received by the due date, this Policy will not commence and will be taken to have never commenced. This means you will not be covered if you make a claim. If any subsequent instalment premium is paid by a cheque, credit card or bank debit that is not honoured, your Policy will terminate in accordance with clause 1.5.

1.5 Non-Payment of Renewal Premium or Instalments

If an instalment remains unpaid for 31 days after the relevant Premium Due Date, your Policy will be cancelled from the end of the last day of that 31 day period. If the premium is received during this 31 day period, we will not refuse to pay any claim covered by the Policy on the basis that the premium was not paid by the Premium Due Date.

1.6 Premiums and Benefits are Indexed

If you choose to renew the Policy, both the benefits and premiums are indexed to increase on the annual renewal of the Policy for the first ten renewals. The benefits and premiums are indexed to increase upon renewal at the rate of 5% of the initial Policy benefit and premium values respectively (that is, 5% of the Policy benefit and premium values that applied during the first year of cover – the increase is not compounded).

This means that upon renewal 5% of the benefit and premium values respectively that applied during the first year of cover will be added to the respective benefit and premium values that applied during the period of cover immediately prior to that renewal. This indexation amount ceases to apply after ten annual renewals (total eleven years of cover). This indexation of premiums and benefits does not limit our right under Clause 9.4 to vary the rate of renewal premium for any renewal term including those renewal terms in which the indexation amount applies.

The amount of benefit payable for a loss is the benefit applicable at the date of diagnosis or first treatment, whichever occurs first.

1.7 Notification of Variation from Standard Cover

The Policy varies from the standard cover specified in the *Insurance Contracts Act 1984* (Cth), (“Standard Cover”) for sickness and accident insurance contracts. In particular, it is important for you to note that:

- (a) policy benefits are as specified in the Policy document and the amounts are set out in the benefit and premiums tables set out on pages 18 and 24 of this document and in the policy schedule we will send to you;
- (b) Section 7 - Exclusions sets out the circumstances in which this Policy will not cover a loss;
- (c) policy benefits are not payable in respect of death, only in the event of a Covered Sickness, Covered Condition or Covered Cancer. Should you die before all relevant benefits are paid, any remaining benefit will be payable to your estate;
- (d) Disability benefits in the policy schedule are expressed as a monthly amount. We calculate the daily benefit by dividing the monthly benefit by 30 days; and
- (e) not all plans cover Total or Partial Disability.

Section 2 - Definitions

Some words are used frequently and have a special meaning in your Policy. The meanings are explained below.

“**Application**” means the document by which you apply for the Policy and shows the Plans and level of cover selected.

“**Authorised Officer**” means an officer authorised by us to amend your Policy or sign an endorsement to your Policy.

“**Commencement Date**” means the date that cover commences as shown in the Application and the policy schedule, subject to the payment of the premium on or before the relevant Premium Due Date.

“**Covered Cancer**” means a malignant tumour that first manifested after 30 days from the Commencement Date of this Policy and while the Policy is in force, and is characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue, and is diagnosed by a Medical Practitioner who is a consultative oncologist. This includes leukaemia, lymphomas, and Hodgkin’s disease, but excludes non-invasive cancer in situ, tumours in the presence of HIV, all squamous cell carcinomas of the skin (unless there has been a spread to other organs), all hyperkeratoses, and basal cell carcinomas of the skin. “Covered Cancer” does not include Pre-existing Cancer or Skin Cancer.

“**Covered Condition**” means:

One condition as described below that is diagnosed or treated while this Policy is in force in accordance with the requirements prescribed for each condition, excluding bodily injuries (except where Coma results from such injuries) and Pre-existing Conditions.

1. “**Covered Cancer**” (as defined above).
2. “**Heart Attack**” means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
 - heart attack symptoms
 - new electrocardiogram (ECG) changes consistent with a heart attack
 - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
 - ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.
3. “**Coronary Artery Bypass Surgery**” means the undertaking of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist.
 4. “**Kidney Failure**” means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.
 5. “**Stroke (Cerebrovascular Accident)**” means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:
 - acute onset of new neurological symptoms, and

- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms must be corroborated by diagnostic imaging testing.

The diagnosis of Stroke must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- Transient Ischaemic Attacks; or,
- Intracerebral vascular events due to trauma; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.

6. **“Parkinson’s Disease”** means a definite diagnosis of primary idiopathic Parkinson’s Disease, which is characterised by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses). You or an Eligible Child must require substantial physical assistance from an adult to perform at least 2 of the following 6 Activities of Daily Living. The diagnosis of Parkinson’s Disease must be made by a Specialist.

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene.
- Bladder and Bowel Continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Exclusion: No benefit will be payable under this Covered Condition for all other types of Parkinsonism.

7. **“Coma”** means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4

or less. The diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

- A medically induced coma; or
- A coma which results directly from alcohol or drug use; or,
- A diagnosis of brain death.

8. **“Major Organ Transplant – Heart, Kidney, Liver, Lung, or Pancreas”** means a definite diagnosis of the irreversible failure of the heart, kidney, liver, lung, or pancreas, and transplantation must be medically necessary. To qualify under Major Organ Transplant, you or an Eligible Child must undergo a transplantation procedure as the recipient of a heart, kidney, liver, lung, or pancreas and limited to these entities. The diagnosis of Major Organ Failure must be made by a Specialist.

“Covered Sickness” (Sickness Disability and Sickness Confinement Plans only) means a bodily illness or disease that first manifested after 30 days from the Policy Commencement Date while this Policy is in force, but does not include bodily injuries or a Pre-existing Condition. We will cover you for loss caused by a Pre-existing Condition where your loss begins after you have held this Policy for 24 months from the Commencement Date of the Policy, unless you have been issued with an endorsement to this Policy which excludes you from claiming for a Pre-existing Condition.

“Covered Person” (Family Cancer Plan only) means your Spouse and your unmarried dependant children (including stepchildren and legally adopted children) aged 3 to 17 years (inclusive) at the Commencement Date of the Policy or such children who are automatically added when the child turns 3 years of age.

“Eligible Child” or **“Eligible Children”** (Critical Illness Plan only) means any child who is aged 3 to 17 years (inclusive) at the date of the event giving rise to the claim, and who is your natural or legally adopted child or stepchild.

“Full Time Care of a Professional Carer” means 24 hour a day care provided by a Professional Carer.

“Insured” means the person named as the Insured on the Application Form and policy schedule, and to whom benefits will be made payable.

“Medically Necessary Treatment” means treatment which according to a Medical Practitioner who is also a consultative oncologist is necessary for the care of a Covered Cancer. The treatment must be widely accepted professionally as effective, appropriate, and essential, based on recognised standards of health care prevailing at the time of treatment.

“Medical Practitioner” means a medical practitioner licensed in Australia, New Zealand, European Union Member States, the United States of America, or Canada

and operating within the scope of his or her licence in the relevant country (ies), who is not a member of your immediate family and is acceptable to us.

“Partially Disabled” means the ability to perform one or more, but not all of the substantial duties of your business or occupation (or usual activities if you are not currently employed).

“Pre-existing Cancer” means Covered Cancer (or the symptoms of Covered Cancer) for which you or a Covered Person received medical advice or treatment for within 5 years prior to the Commencement Date of the Policy.

“Pre-existing Condition” means a bodily illness or disease for which you or an Eligible Child received medical advice or treatment for within 24 months prior to the Commencement Date of the Policy.

“Premium Due Date” means the due date for receipt of renewal or instalment premiums payable for this Policy.

“Professional Carer” means a person (who is not a family member of you or a Covered Person) who provides assistance with bathing, toileting, eating and dressing, in return for payment made by or on behalf of you.

“Skin Cancer” means a cutaneous neoplasm or lesion that does not metastasise to other body sites.

“Spouse” means your partner in a legally recognised marriage or de-facto relationship.

“Totally Disabled” means the inability to perform each of the substantial duties of your business or occupation (or usual activities if you are not currently employed).

“Waiting Period” means the period for which you must be disabled before any benefits for any type of disability will begin and is shown in the policy schedule.

“we”, “our”, or “us” means Combined Insurance a division of ACE Insurance Limited.

“you” or “your” means the Insured named in the policy schedule.

Section 3 - Sickness Disability Plan Benefits

The following benefits apply to the Sickness Disability Plan

3.1 Sickness Disability Benefit

The Sickness Disability Plan covers you, subject to the Policy terms and conditions, for both Total and Partial Disability due to a Covered Sickness. The monthly benefits payable for Total or Partial Disability will be set out in the policy schedule.

3.1.1 Total Disability Benefit

If due to a Covered Sickness that first manifested after 30 days from the Commencement Date of the Policy, you are Totally Disabled, we will pay you the benefit set out in your policy schedule. Depending on your Waiting Period selection, we will pay you either from the first, fifteenth, or thirty first day of

Total Disability and for a specified benefit period of up to twelve months while you remain Totally Disabled.

3.1.2 Partial Disability Benefit

If due to a Covered Sickness that first manifested after 30 days from the Commencement Date of the Policy, you are Partially Disabled, we will pay you the benefit set out in your policy schedule. Depending on your Waiting Period selection, we will pay you either from the first, fifteenth or thirty first day of Partial Disability and for a specified benefit period of up to one month while you remain Partially Disabled. Should a period of Partial Disability immediately follow a period of Total Disability for which you have already been subject to a Waiting Period, then we will pay you the Partial Disability benefit from the first day of such disability.

Section 4 - Sickness Confinement Plan Benefit

The following benefit applies to the Sickness Confinement Plan.

4.1 Sickness Confinement Benefit

If due to a Covered Sickness that first manifested after 30 days from the Commencement Date of the Policy, you are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you require the Full Time Care of a Professional Carer during such confinement, we will pay you the daily benefit set out in your policy schedule, starting with the first day of this confinement and continuing for up to 100 days.

Section 5 - Critical Illness Plan Benefits

The following benefits apply to the Critical Illness Plan.

5.1 Critical Illness Benefit for Covered Conditions

If while this Policy is in force, you or an Eligible Child suffer a Covered Condition, and provided this Covered Condition, its diagnosis or initial treatment (whichever occurs first), takes place after this Policy has been in force for at least 30 days from the Commencement Date, we will pay you the benefit set out in your policy schedule. Covered Conditions are Covered Cancer, Heart Attack, Coronary Artery Bypass Surgery, Stroke, Kidney Failure, Parkinson’s Disease, Coma, or Major Organ Transplant – Heart, Kidney, Liver, Lung, or Pancreas.

5.2 Skin Cancer Benefit

If while this Policy is in force you, or an Eligible Child are medically diagnosed with Skin Cancer, we will pay you the benefit set out in your policy schedule. Only one Skin Cancer benefit under this Plan will be payable during any six month period and will only be paid once in respect to the diagnosis of any one Skin Cancer.

5.3 Benefit Payment

The lump sum benefit for Critical Illness is payable once only under this Plan for any Covered Condition you incur, and will be payable by us for

the first claim accepted for one of the Covered Conditions. The Plan will terminate after payment of such a claim.

The benefit for Critical Illness is payable once only under this Plan for any Covered Condition an Eligible Child suffers, and will be payable by us for the first claim accepted for one of the Covered Conditions suffered by an Eligible Child. The Plan will not terminate after payment of an Eligible Child's claim, however, cover will cease for the relevant Eligible Child.

5.4 Eligible Child's Benefit Payable Under One Critical Illness Plan Only

In the event that an Eligible Child is covered by more than one of our Critical Illness Plans, a benefit will only be paid under one Plan, (the Plan which provides the highest benefit).

Section 6 - Cancer Plan - Benefits

The following benefits apply to the Cancer Plan.

6.1 First Diagnosis Benefit

Upon the first diagnosis of a Covered Cancer, we will pay you the first diagnosis benefit set out in your policy schedule. Only one first diagnosis benefit will be payable for you or any one Covered Person during their lifetime.

6.2 Confining Cancer Benefit

If due to a Covered Cancer, you or a Covered Person are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you or a Covered Person require the Full Time Care of a Professional Carer during such confinement, we will pay you the daily benefit set out in your policy schedule, starting with the first day of this confinement and for up to a lifetime maximum of 500 days.

6.3 Non-Confining Cancer Benefit

If due to a Covered Cancer, you or a Covered Person remain Totally Disabled immediately following a period of continuous confinement to bed for which we have already paid benefits under the confining cancer benefit above, we will pay you the daily benefit set out in your policy schedule while you or a Covered Person remain Totally Disabled, and for up to twice the number of days paid under the "confining cancer benefit".

6.4 Skin Cancer Benefit

If while this Policy is in force you or a Covered Person are medically diagnosed with Skin Cancer, we will pay you the benefit set out in your policy schedule. Only one Skin Cancer benefit under this Plan will be payable for you or any Covered Person during any six month period and will only be paid once in respect to the diagnosis of any one Skin Cancer.

6.5 Transportation Benefit

If due to a Covered Cancer a Medical Practitioner certifies that you or a Covered Person require

Medically Necessary Treatment and you or a Covered Person must travel more than 50 kilometres to receive such treatment, we will pay you a Transportation benefit for the travel expenses incurred, up to the Maximum Lifetime Benefit shown in your policy schedule.

6.6 Family Lodging Benefit

If due to a Covered Cancer, you or a Covered Person are Totally Disabled and continuously confined to bed (without interruption) and a Medical Practitioner certifies that you or a Covered Person require the Full Time Care of a Professional Carer, and such confinement necessitates one family member staying at a hotel or motel in close proximity to the place of such confinement, we will pay you the daily family lodging benefit shown in your policy schedule for up to 100 days. This benefit is payable for hotel or motel stays only during the period of time of such confinement.

6.7 Individual or Family Cancer Plan

If you have selected the Individual Cancer Plan, this Plan covers you only. If you have selected the Family Cancer Plan, this plan covers you, your Spouse, and any of your unmarried children who are dependent upon you for care and support and are aged 3 to 17 years inclusive. (Please refer to the definition of "Covered Person" – Section 2 on page 13 of this Policy).

6.8 Important notes relating to benefits payable under the Cancer Plan

6.8.1 Diagnosis of Cancer

In order to qualify for the benefits above due to a Covered Cancer, we will first require a copy of one or more pathology report(s), satisfactory to us, as proof of diagnosis of Covered Cancer.

6.8.2 Post Mortem Diagnosis

If a positive diagnosis of a Covered Cancer is first made post-mortem, the confining cancer benefit payable will be limited to the period of time beginning with the date of your terminal confinement to bed.

Section 7 - Exclusions

Exclusions are those events and happenings for which cover is not included in your Policy. This means that you, an Eligible Child or a Covered Person are not covered for loss that is in any way caused or contributed to by:

- (i) bodily injuries (unless Coma results from injury under the Critical Illness Plan);
- (ii) mental or emotional disorders;
- (iii) normal and uncomplicated pregnancy or childbirth;
- (iv) any complications of pregnancy or childbirth that first manifested within 12 months after the Commencement Date of this Policy;
- (v) a Pre-existing Condition (as defined on page 14);
- (vi) a Pre-existing Cancer (as defined on page 14).

In addition, no benefit will be payable for a

Covered Sickness (Sickness Disability and Sickness Confinement Plans), a Covered Condition (Critical Illness Plan) or a Covered Cancer (Cancer Plan) unless medical reports and evidence satisfactory to us, are provided by one or more Medical Practitioner(s) or hospital(s) in Australia, New Zealand, European Union Member States, the United States of America, or Canada.

Section 8 - Claims

8.1 How to Make a Claim on Your Policy

If you need to make a claim, you should tell us about the circumstances giving rise to your claim under your Policy as soon as possible and complete a claim form within 30 days after your loss has occurred, or as soon as reasonably possible.

Our claim form is available from our Authorised Representatives, from our website or by calling the Australian Head Office on our toll free number **1300 300 480**. If you cannot complete our claim form, you should still provide us with whatever proof and documentation supporting this claim as we may reasonably require.

8.2 Proof of Loss

To claim for Total Disability, Partial Disability, Covered Sickness confinement or Covered Cancer confinement, written proof acceptable to us must be provided to us at our Australian Head Office within three months of the end of each period of loss for which you are claiming.

To claim a lump sum benefit for a Covered Condition, Covered Cancer, or Skin Cancer, written proof acceptable to us must be given to us within six months of the Covered Condition, Covered Cancer, or the Skin Cancer being diagnosed or initially treated (whichever occurs first), or as soon after as is reasonably possible.

To claim the transportation benefit or family lodging benefit, written proof acceptable to us of transportation or accommodation expenses incurred must be provided to us within three months of the period in which the expenses were incurred.

If you are unable to provide us with the proof we require within the time frame specified, you must provide it as soon as reasonably possible. However, the proof must be received by us no later than one year from the time specified, or we may refuse the claim.

8.3 Claim Forms Completed at Your Expense

While a claim continues, any claim form or progress form completed by a Medical Practitioner or Specialist to support the claim will be supplied at your own expense.

8.4 Medical Examination at Our Expense

We may request that you, or an Eligible Child, or a Covered Person undergo one or more medical examination(s) at our expense at a time and by any Medical Practitioner we may choose. Failure to comply with our request may result in the claim being refused.

8.5 How Do We Pay Claims?

For ongoing Total or Partial Disability, we will pay benefits on a monthly basis upon the receipt of written proof, satisfactory to us, of continuing disability. Monthly benefits are calculated on the basis of a 30 day month. That is, the daily benefit is calculated by dividing the monthly benefit by 30.

Benefits for any other loss covered by the Policy will be paid when we receive written proof, satisfactory to us, of loss.

8.6 Who are Benefits Paid to?

Benefits are paid to you. In the event of your death, any remaining benefit will be payable to your estate.

Section 9 - General Policy Conditions

9.1 Variations to the Terms and Conditions of Your Policy

No term or condition of your Policy may be waived or modified unless this change is approved in writing by our Authorised Officer.

9.2 Misrepresentations and Non-Disclosures

Subject to the provisions of the *Insurance Contracts Act 1984*, (Cth), if you do not comply with your duty of disclosure provided for by the *Insurance Contracts Act 1984* (Cth) and outlined in this Document, then we, at our option, can reduce our liability under the Policy or cancel the Policy and treat it as if it never commenced.

9.3 Policy Term

This Policy is issued for a term of one year starting on the Commencement Date, beginning and ending at 12 noon, standard time at the place where you reside.

9.4 Renewal Term

At the expiry of the Policy Term, we may offer to renew the Policy for a further annual term. We do not guarantee the amount of premiums or benefits at the time of any renewal of the Policy, but will advise you of any change to the premiums or benefits at least 30 days prior to renewal.

9.5 No Waiver

If we accept a premium payment (or part of a premium payment) in error, when the Policy has lapsed, this does not mean that we have waived any of these Policy provisions, and in these circumstances we will refund the amount of premium received by us if your Policy has not been reinstated.

9.6 Concurrent Disability

If you suffer Total or Partial Disability as a result of more than one Covered Sickness or Covered Cancer, benefits will be paid as if your Disability were the result of only one Covered Sickness or Covered Cancer.

9.7 Recurrent Disability

Successive periods of Total Disability or Partial Disability will be considered to be one period of disability unless such periods are separated by at least six months, or the disabilities resulted from different or unrelated sicknesses.

9.8 Premium Correction and Adjustment

In the event the premium amount written in the Application does not correspond to the Plan selected in the Application, we will correct the amount of premium to correspond to the Plan selected in the Application. We will then advise you of any correction or adjustment.

9.9 Your Right to Cancel

After you have applied for the Policy and paid your first premium, you have 14 days to check that the Policy meets your needs. This is known as the cooling-off period. If you decide that the Policy does not meet your needs, we will cancel the Policy and refund your money without any charges as long as you notify us in writing or electronically at our address as notified to you within 14 days of the Commencement Date of the Policy. Please quote the Application Number in any correspondence.

You may also cancel the Policy within 14 days of any subsequent payment of the Policy, by notifying us in writing or electronically, of your request to cancel. We will refund to you the last premium payment collected and the Policy will terminate from the Premium Due Date.

You cannot exercise these rights of cancellation if a claim has been made during a period of cover to which this 14 day cooling-off period applies.

After the 14 day cooling-off period, you may cancel your Policy at any time by writing to us and advising us to cancel your Policy. If you are paying premiums by semi-annual or annual instalment, we will refund any unearned premium on a pro-rata basis and cancellation will take effect on the date that your written instruction is received by us. We will not refund any remaining premium if you are paying by monthly instalment and cancellation will take effect from the next Premium Due Date.

9.10 Our Right to Cancel

Issue of this Policy is subject to our review of your medical history and other information. If any such information does not meet our underwriting requirements then we may cancel this Policy. We may also decline to offer to renew this Policy.

9.11 Termination of your Policy

Your Policy will terminate when the first of the following events occurs:

- (i) you do not pay the instalment premium and your Policy lapses in accordance with clause 1.5;
- (ii) you cancel your Policy in accordance with clause 9.9;
- (iii) at the expiry of the Policy term or any subsequent Renewal term if we do not offer to renew this Policy in accordance with Clause 9.10, or should you choose not to renew this Policy for a further term;
- (iv) you die;
- (v) upon the first Premium Due Date after you reach age 70;
- (vi) we cancel your Policy in accordance with applicable law.

The Critical Illness Plan will terminate upon the payment of a benefit to you under the Critical Illness Plan (excluding the diagnosis of Skin Cancer benefit).

An Eligible Child's cover under the Critical Illness Plan ceases on the termination of cover, upon payment of a claim for a Covered Condition suffered by the Eligible Child, or upon the child reaching age 18.

Under the Family Cancer Plan cover for your children will cease when the child reaches age 21, marries, or when this Plan terminates, whichever comes first. Your Spouse's cover will cease upon the divorce (or separation for a de facto Spouse) of you and your Spouse, or when your Spouse reaches age 70, or when this Plan terminates, whichever comes first.

9.12 Conformity with Federal, State and Territory Laws

Your Policy is governed by the laws of the Commonwealth, States or Territories and any provisions of your Policy which on the Commencement Date of the Policy are in conflict with the laws of the place in which you live on that date are amended to conform with the minimum requirements of these laws.



Des Bosnic
Executive Vice President
Australia and New Zealand

APPENDIX

PLAN 1: SICKNESS DISABILITY PLAN - BENEFITS AND PREMIUMS

SICKNESS DISABILITY PLAN BENEFITS (*Refer to note below)	BRONZE	SILVER	GOLD	PLATINUM	PLATINUM PLUS
Total Disability due to a Covered Sickness - per month, for up to twelve months	\$500	\$1,000	\$1,500	\$2,000	\$2,500
Partial Disability due to a Covered Sickness - per month, for up to one month	\$250	\$500	\$750	\$1,000	\$1,250

BENEFITS FROM 1st DAY		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
Premiums for Sickness Disability Plan cover payable from the FIRST DAY OF DISABILITY code 24966 (**, ## Refer to notes below)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE	Age at Entry 16-39	\$40	\$20	\$114	\$221	\$126	\$247
	Age at Entry 40-49	\$58	\$29	\$165	\$320	\$183	\$358
	Age at Entry 50-59	\$92	\$46	\$261	\$508	\$290	\$569
	Age at Entry 60-64	\$122	\$61	\$346	\$673	\$384	\$754
SILVER	Age at Entry 16-39	\$80	\$40	\$228	\$442	\$252	\$494
	Age at Entry 40-49	\$116	\$58	\$330	\$640	\$366	\$716
	Age at Entry 50-59	\$184	\$92	\$522	\$1,016	\$580	\$1,138
	Age at Entry 60-64	\$244	\$122	\$692	\$1,346	\$768	\$1,508
GOLD	Age at Entry 16-39	\$120	\$60	\$342	\$663	\$378	\$741
	Age at Entry 40-49	\$174	\$87	\$495	\$960	\$549	\$1,074
	Age at Entry 50-59	\$276	\$138	\$783	\$1,524	\$870	\$1,707
	Age at Entry 60-64	\$366	\$183	\$1,038	\$2,019	\$1,152	\$2,262
PLATINUM	Age at Entry 16-39	\$160	\$80	\$456	\$884	\$504	\$988
	Age at Entry 40-49	\$232	\$116	\$660	\$1,280	\$732	\$1,432
	Age at Entry 50-59	\$368	\$184	\$1,044	\$2,032	\$1,160	\$2,276
	Age at Entry 60-64	\$488	\$244	\$1,384	\$2,692	\$1,536	\$3,016
PLATINUM+	Age at Entry 16-39	\$200	\$100	\$570	\$1,105	\$630	\$1,235
	Age at Entry 40-49	\$290	\$145	\$825	\$1,600	\$915	\$1,790
	Age at Entry 50-59	\$460	\$230	\$1,305	\$2,540	\$1,450	\$2,845
	Age at Entry 60-64	\$610	\$305	\$1,730	\$3,365	\$1,920	\$3,770

The benefits you can receive under the Plan or Plans you have selected and the cost of the Plan or Plans are set out in the Benefits and Premiums Tables.

* These benefit tables are only a brief overview of the benefits and do not include definitions and exclusions. **MAKE SURE TO READ YOUR POLICY FOR DETAILS.**

** To calculate instalment premiums after the first Policy Year, just add 5% to the premium plus GST and Stamp Duty. We will send you an Annual Renewal Statement advising you of the increase.

The above premiums do not include Federal Government GST or State Stamp Duty. These are additional Government taxes and charges. These taxes and charges are applied in the following manner:

For example, GST is levied on the premium for a 37 year old Insured who purchases the Sickness Disability Plan (Silver Level - 14 Day Waiting Period, Direct Debit renewal) with an annual premium of \$332 at the rate of 10% or, \$33.20. The total premium including GST is \$365.20. An additional State or Territory Stamp Duty of currently between 5 and 11% (depending on the State) is then levied on the GST inclusive total. At a Stamp Duty rate of 5% or \$18.26, the premium, inclusive of Government taxes and charges would be \$383.46.

Premium Indexation Example

The Sickness Disability Plan (the same example as above) has an annual premium of \$332 (excluding GST and Stamp Duty). The premium for the first Policy term is \$332. In the second year and subsequent years, should you renew the Policy each year, the premium automatically increases by \$16.60 or the 5% indexation factor to \$348.60, (excluding GST and Stamp Duty). Indexation ceases to apply after 10 renewal periods (11 years).

BENEFITS FROM 15th DAY		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
Premiums for Sickness Disability Plan cover payable from the FIFTEENTH DAY OF DISABILITY code 24966 (* , ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE	Age at Entry 16-39	\$30	\$15	\$85	\$166	\$95	\$185
	Age at Entry 40-49	\$44	\$22	\$125	\$243	\$139	\$272
	Age at Entry 50-59	\$70	\$35	\$199	\$386	\$221	\$433
	Age at Entry 60-64	\$92	\$46	\$261	\$508	\$290	\$569
SILVER	Age at Entry 16-39	\$60	\$30	\$170	\$332	\$190	\$370
	Age at Entry 40-49	\$88	\$44	\$250	\$486	\$278	\$544
	Age at Entry 50-59	\$140	\$70	\$398	\$772	\$442	\$866
	Age at Entry 60-64	\$184	\$92	\$522	\$1,016	\$580	\$1,138
GOLD	Age at Entry 16-39	\$90	\$45	\$255	\$498	\$285	\$555
	Age at Entry 40-49	\$132	\$66	\$375	\$729	\$417	\$816
	Age at Entry 50-59	\$210	\$105	\$597	\$1,158	\$663	\$1,299
	Age at Entry 60-64	\$276	\$138	\$783	\$1,524	\$870	\$1,707
PLATINUM	Age at Entry 16-39	\$120	\$60	\$340	\$664	\$380	\$740
	Age at Entry 40-49	\$176	\$88	\$500	\$972	\$556	\$1,088
	Age at Entry 50-59	\$280	\$140	\$796	\$1,544	\$884	\$1,732
	Age at Entry 60-64	\$368	\$184	\$1,044	\$2,032	\$1,160	\$2,276
PLATINUM+	Age at Entry 16-39	\$150	\$75	\$425	\$830	\$475	\$925
	Age at Entry 40-49	\$220	\$110	\$625	\$1,215	\$695	\$1,360
	Age at Entry 50-59	\$350	\$175	\$995	\$1,930	\$1,105	\$2,165
	Age at Entry 60-64	\$460	\$230	\$1,305	\$2,540	\$1,450	\$2,845
BENEFITS FROM 31st DAY		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
Premiums for Sickness Disability Plan cover payable from the THIRTY FIRST DAY OF DISABILITY code 24966 (* , ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE	Age at Entry 16-39	\$22	\$11	\$62	\$121	\$69	\$136
	Age at Entry 40-49	\$30	\$15	\$85	\$166	\$95	\$185
	Age at Entry 50-59	\$48	\$24	\$136	\$265	\$151	\$297
	Age at Entry 60-64	\$62	\$31	\$176	\$342	\$195	\$383
SILVER	Age at Entry 16-39	\$44	\$22	\$124	\$242	\$138	\$272
	Age at Entry 40-49	\$60	\$30	\$170	\$332	\$190	\$370
	Age at Entry 50-59	\$96	\$48	\$272	\$530	\$302	\$594
	Age at Entry 60-64	\$124	\$62	\$352	\$684	\$390	\$766
GOLD	Age at Entry 16-39	\$66	\$33	\$186	\$363	\$207	\$408
	Age at Entry 40-49	\$90	\$45	\$255	\$498	\$285	\$555
	Age at Entry 50-59	\$144	\$72	\$408	\$795	\$453	\$891
	Age at Entry 60-64	\$186	\$93	\$528	\$1,026	\$585	\$1,149
PLATINUM	Age at Entry 16-39	\$88	\$44	\$248	\$484	\$276	\$544
	Age at Entry 40-49	\$120	\$60	\$340	\$664	\$380	\$740
	Age at Entry 50-59	\$192	\$96	\$544	\$1,060	\$604	\$1,188
	Age at Entry 60-64	\$248	\$124	\$704	\$1,368	\$780	\$1,532
PLATINUM+	Age at Entry 16-39	\$110	\$55	\$310	\$605	\$345	\$680
	Age at Entry 40-49	\$150	\$75	\$425	\$830	\$475	\$925
	Age at Entry 50-59	\$240	\$120	\$680	\$1,325	\$755	\$1,485
	Age at Entry 60-64	\$310	\$155	\$880	\$1,710	\$975	\$1,915

PLAN 2: SICKNESS CONFINEMENT PLAN - BENEFIT AND PREMIUMS

SICKNESS CONFINEMENT PLAN BENEFIT (*Refer to note on page 18)	BRONZE	SILVER	GOLD	PLATINUM	PLATINUM PLUS
Totally disabled and continually confined to bed (without interruption) and a Medical Practitioner certifies that you require the Full Time care of a Professional Carer during such confinement - Per day	\$50 100 Days Maximum	\$100 100 Days Maximum	\$150 100 Days Maximum	\$200 100 Days Maximum	\$250 100 Days Maximum

CONFINEMENT BENEFIT		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
Premiums for Sickness Confinement Plan Cover payable from the FIRST DAY OF DISABILITY code 24946 (**, ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE	Age at Entry 16-39	\$10	\$5	\$28	\$55	\$32	\$62
	Age at Entry 40-49	\$14	\$7	\$40	\$77	\$44	\$87
	Age at Entry 50-59	\$18	\$9	\$51	\$99	\$57	\$111
	Age at Entry 60-64	\$28	\$14	\$80	\$155	\$88	\$173
SILVER	Age at Entry 16-39	\$20	\$10	\$56	\$110	\$64	\$124
	Age at Entry 40-49	\$28	\$14	\$80	\$154	\$88	\$174
	Age at Entry 50-59	\$36	\$18	\$102	\$198	\$114	\$222
	Age at Entry 60-64	\$56	\$28	\$160	\$310	\$176	\$346
GOLD	Age at Entry 16-39	\$30	\$15	\$84	\$165	\$96	\$186
	Age at Entry 40-49	\$42	\$21	\$120	\$231	\$132	\$261
	Age at Entry 50-59	\$54	\$27	\$153	\$297	\$171	\$333
	Age at Entry 60-64	\$84	\$42	\$240	\$465	\$264	\$519
PLATINUM	Age at Entry 16-39	\$40	\$20	\$112	\$220	\$128	\$248
	Age at Entry 40-49	\$56	\$28	\$160	\$308	\$176	\$348
	Age at Entry 50-59	\$72	\$36	\$204	\$396	\$228	\$444
	Age at Entry 60-64	\$112	\$56	\$320	\$620	\$352	\$692
PLATINUM+	Age at Entry 16-39	\$50	\$25	\$140	\$275	\$160	\$310
	Age at Entry 40-49	\$70	\$35	\$200	\$385	\$220	\$435
	Age at Entry 50-59	\$90	\$45	\$255	\$495	\$285	\$555
	Age at Entry 60-64	\$140	\$70	\$400	\$775	\$440	\$865

PLAN 3: CRITICAL ILLNESS PLAN - BENEFITS AND PREMIUMS

CRITICAL ILLNESS PLAN BENEFITS (*Refer to note on page 18)	BRONZE	SILVER	GOLD
1. Critical Illness Benefit - Covered Condition For the Insured being diagnosed with any of the following: Covered Cancer, Heart Attack, Coronary Artery Bypass Surgery, Stroke, Kidney Failure, Parkinson's Disease, Coma, or Major Organ Transplant - Heart, Kidney, Liver, Lung, or Pancreas.	\$10,000	\$20,000	\$30,000
2. Skin Cancer Benefit Medically diagnosed with Skin Cancer - Lump sum	\$50	\$100	\$150

PREMIUM ALTERNATIVES		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
NON-SMOKER PREMIUM RATES code 24947 (* , ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE	Age at Entry 18-39	\$26	\$13	\$74	\$144	\$82	\$161
	Age at Entry 40-44	\$40	\$20	\$114	\$221	\$126	\$247
	Age at Entry 45-49	\$44	\$22	\$125	\$243	\$139	\$272
	Age at Entry 50-54	\$58	\$29	\$165	\$320	\$183	\$358
	Age at Entry 55-59	\$76	\$38	\$216	\$420	\$239	\$470
	Age at Entry 60-64	\$96	\$48	\$273	\$530	\$302	\$593
SILVER	Age at Entry 18-39	\$52	\$26	\$148	\$288	\$164	\$322
	Age at Entry 40-44	\$80	\$40	\$228	\$442	\$252	\$494
	Age at Entry 45-49	\$88	\$44	\$250	\$486	\$278	\$544
	Age at Entry 50-54	\$116	\$58	\$330	\$640	\$366	\$716
	Age at Entry 55-59	\$152	\$76	\$432	\$840	\$478	\$940
	Age at Entry 60-64	\$192	\$96	\$546	\$1,060	\$604	\$1,186
GOLD	Age at Entry 18-39	\$78	\$39	\$222	\$432	\$246	\$483
	Age at Entry 40-44	\$120	\$60	\$342	\$663	\$378	\$741
	Age at Entry 45-49	\$132	\$66	\$375	\$729	\$417	\$816
	Age at Entry 50-54	\$174	\$87	\$495	\$960	\$549	\$1,074
	Age at Entry 55-59	\$228	\$114	\$648	\$1,260	\$717	\$1,410
	Age at Entry 60-64	\$288	\$144	\$819	\$1,590	\$906	\$1,779

PREMIUM ALTERNATIVES		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
SMOKER PREMIUM RATES code 24947 (**, ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE	Age at Entry 18-39	\$46	\$23	\$131	\$254	\$145	\$284
	Age at Entry 40-44	\$70	\$35	\$199	\$386	\$221	\$433
	Age at Entry 45-49	\$78	\$39	\$222	\$431	\$246	\$482
	Age at Entry 50-54	\$102	\$51	\$290	\$563	\$321	\$630
	Age at Entry 55-59	\$134	\$67	\$381	\$740	\$422	\$828
	Age at Entry 60-64	\$170	\$85	\$484	\$938	\$536	\$1,051
SILVER	Age at Entry 18-39	\$92	\$46	\$262	\$508	\$290	\$568
	Age at Entry 40-44	\$140	\$70	\$398	\$772	\$442	\$866
	Age at Entry 45-49	\$156	\$78	\$444	\$862	\$492	\$964
	Age at Entry 50-54	\$204	\$102	\$580	\$1,126	\$642	\$1,260
	Age at Entry 55-59	\$268	\$134	\$762	\$1,480	\$844	\$1,656
	Age at Entry 60-64	\$340	\$170	\$968	\$1,876	\$1,072	\$2,102
GOLD	Age at Entry 18-39	\$138	\$69	\$393	\$762	\$435	\$852
	Age at Entry 40-44	\$210	\$105	\$597	\$1,158	\$663	\$1,299
	Age at Entry 45-49	\$234	\$117	\$666	\$1,293	\$738	\$1,446
	Age at Entry 50-54	\$306	\$153	\$870	\$1,689	\$963	\$1,890
	Age at Entry 55-59	\$402	\$201	\$1,143	\$2,220	\$1,266	\$2,484
	Age at Entry 60-64	\$510	\$255	\$1,452	\$2,814	\$1,608	\$3,153

PLAN 4: CANCER PLAN - BENEFITS AND PREMIUMS

CANCER PLAN BENEFITS (*Refer to note on page 18)	BRONZE	SILVER	GOLD
1. First Diagnosis Benefit Upon the first diagnosis of Covered Cancer	\$1,000	\$1,500	\$3,000
2. Confining Cancer Benefit Totally disabled and continually confined to bed (without interruption) and a Medical Practitioner certifies that you require the Full Time Care of a Professional Carer during this confinement - Per day	\$100 500 Days Maximum	\$150 500 Days Maximum	\$300 500 Days Maximum
3. Non-Confining Cancer Benefit Remain Totally Disabled immediately following a period of continual confinement to bed, and for up to twice the number of days paid under the Confining Cancer Benefit - Per day	\$50	\$75	\$150
4. Skin Cancer Benefit Medically diagnosed with Skin Cancer - Lump sum	\$100	\$150	\$300
5. Transportation Benefit A Medical Practitioner certifies that you require Medically Necessary Treatment and you must travel more than 50 kilometres to receive such treatment - up to a lifetime maximum of:	\$1,000 maximum	\$1,500 maximum	\$3,000 maximum
6. Family Lodging Benefit Totally Disabled and continually (without interruption) confined to bed and a Medical Practitioner certifies that you require the Full Time Care of a Professional Carer, and such confinement necessitates one family member staying at a hotel or motel in close proximity to the place of such confinement - Per day	\$100 100 Days Maximum	\$150 100 Days Maximum	\$300 100 Days Maximum

PREMIUM ALTERNATIVES		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
CANCER PLAN PREMIUM RATES - INDIVIDUAL PLAN code 24665 (* , ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE*	Age at Entry 18-39	\$18	\$9	\$51	\$99	\$56	\$110
*UPGRADE	Age at Entry 40-49	\$30	\$15	\$86	\$165	\$93	\$183
	Age at Entry 50-59	\$46	\$23	\$132	\$253	\$143	\$281
	Age at Entry 60-64	\$76	\$38	\$218	\$419	\$237	\$465
SILVER	Age at Entry 18-39	\$27	\$13.50	\$76.50	\$148.50	\$84	\$165
	Age at Entry 40-49	\$45	\$22.50	\$129	\$247.50	\$139.50	\$274.50
	Age at Entry 50-59	\$69	\$34.50	\$198	\$379.50	\$214.50	\$421.50
	Age at Entry 60-64	\$114	\$57	\$327	\$628.50	\$355.50	\$697.50
GOLD	Age at Entry 18-39	\$54	\$27	\$153	\$297	\$168	\$330
	Age at Entry 40-49	\$90	\$45	\$258	\$495	\$279	\$549
	Age at Entry 50-59	\$138	\$69	\$396	\$759	\$429	\$843
	Age at Entry 60-64	\$228	\$114	\$654	\$1,257	\$711	\$1,395

PREMIUM ALTERNATIVES		DIRECT DEBIT / CREDIT CARD				MAIL RENEWAL	
CANCER PLAN PREMIUM RATES - FAMILY PLAN code 24666 (**, ## Refer to notes on page 18)		Two Months first payment only	Monthly instalment payments for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year	Six Monthly instalment payments for the first year	Annual instalment payment for the first year
BRONZE*	Age at Entry 18-39	\$32	\$16	\$92	\$176	\$99	\$195
*UPGRADE	Age at Entry 40-49	\$56	\$28	\$161	\$309	\$174	\$342
	Age at Entry 50-59	\$86	\$43	\$247	\$474	\$268	\$526
	Age at Entry 60-64	\$142	\$71	\$408	\$783	\$443	\$869
SILVER	Age at Entry 18-39	\$48	\$24	\$138	\$264	\$148.50	\$292.50
	Age at Entry 40-49	\$84	\$42	\$241.50	\$463.50	\$261	\$513
	Age at Entry 50-59	\$129	\$64.50	\$370.50	\$711	\$402	\$789
	Age at Entry 60-64	\$213	\$106.50	\$612	\$1,174.50	\$664.50	\$1,303.50
GOLD	Age at Entry 18-39	\$96	\$48	\$276	\$528	\$297	\$585
	Age at Entry 40-49	\$168	\$84	\$483	\$927	\$522	\$1,026
	Age at Entry 50-59	\$258	\$129	\$741	\$1,422	\$804	\$1,578
	Age at Entry 60-64	\$426	\$213	\$1,224	\$2,349	\$1,329	\$2,607



**Combined Insurance is a division
of ACE Insurance Limited**

ABN 23 001 642 020
AFSL Number 239687

Customer Service

Toll Free 1300 300 480

Email

customer@combined.com.au

Website

www.combined.com.au

Street Address

51 Berry Street, North Sydney
NSW Australia 2060

Postal Address

PO Box 403, North Sydney
NSW Australia 2059

Version : 10PDSCIHC01

99045 08/10

