ahm Life Insurance

Product Disclosure Statement and Policy Document (PDS)

4 July 2023

What is this product and who is it issued by?

ahm Life Insurance is a death and disability insurance product issued by Integrity Life Australia Limited ABN 83 089 981 073 AFSL No. 245492 (**Integrity Life**), of Wharf 10, Level 1, 50-52 Pirrama Road, Pyrmont NSW 2009. Integrity Life has sole responsibility for this PDS and the *policy schedule*.

Integrity Life receives insurance premiums and pays claims from its Statutory Fund No. 1.

This *policy* has no surrender value. This means you cannot access any value on cancellation of the *policy* other than a premium refund payable under the terms of this PDS.

Who is NEOS Direct?

NEOS Direct, a registered business name of NDLI Pty Limited ABN 70 665 747 277 AFSL No. 547119, of Tower 3, Darling Park, 201 Sussex Street, Sydney, NSW 2000, is a business focussed on distributing and administering quality life insurance products to Australians. NEOS Direct is the distributor of this life insurance product. NEOS Direct is also the administrator of this life insurance product. ahm Life Insurance is not issued by NEOS Direct.

About ahm

ahm Life Insurance is an insurance product promoted by Medibank Private Limited trading as ahm health insurance ABN 47 080 890 259 Corporate Authorised Representative No. 286089 (**Medibank Private**) of 720 Bourke Street, Docklands, Victoria 3008. In promoting this life insurance product, Medibank Private is acting as the authorised representative of NEOS Direct.

This life insurance product is not issued, guaranteed or underwritten by ahm health insurance, and ahm health insurance is not involved, nor liable, for the assessment and payment of benefits under this insurance product.

Target Market Determination

The Target Market Determination (**TMD**) is provided by Integrity Life, which sets out the target market for ahm Life Insurance, the conditions under which cover can be sold, and the events or circumstances under which the TMD may be reviewed or updated.

The TMD for ahm Life Insurance is available at **www.ahmlife.com.au/TMD** or you can request a free paper copy by contacting us on **1300 508 940** Monday to Friday, between 8am and 8pm (AEST/AEDT).

Life Insurance Code of Practice

Integrity Life is a signatory to the Financial Services Council's Life Insurance Code of Practice (**Code**). This means that we will comply with all our obligations as outlined within the Code as we interact with you. For more information, please refer to www.fsc.org.au/life-code

Explaining this document

This Product Disclosure Statement and Policy Document (**PDS**) explains what you need to know about the benefits, features, options, risks and costs of ahm Life Insurance, to help you make decisions on the types of cover available.

The information and any advice given in this PDS, is general in nature and doesn't take into account your individual objectives, financial situation and needs. You should therefore consider the appropriateness of this information to your situation before acting on it.

The information in this PDS is current as at the date of issue. However, from time to time we may change or update information that is not materially adverse. We'll provide a notice of any such changes at **www.ahm.com.au/life-insurance**. If you'd like a free printed copy of the updated information, please email ahm life insurance at **sales@ahmlife.com.au**.

Understanding what we mean

While our aim is to always provide straightforward explanations, some words we use have specific meanings. These words appear throughout the PDS in *italics* and are explained within the text or in the Definitions section. The different types of cover and benefits are capitalised.

In addition, there are some terms used throughout this PDS which are not capitalised or in italics, but which have a special meaning:

'you' or **'your'** means the *policy owner*.

'us', **'we'**, **'our'** or the **'insurer'** means Integrity Life.

You can change your mind

If for any reason you feel that your *policy* doesn't meet your needs, you can cancel it by notifying us within 30 days of your *policy* commencement date. This is known as the cooling-off period.

Provided you have not made a claim, if you cancel your *policy* during the cooling-off period your *policy* will be cancelled from the commencement date and we'll refund any premiums you've paid.

You can also cancel your insurance *policy* at any time after the cooling-off period by calling ahm life insurance on **1300 867 125**. Your insurance will end when we receive your request to cancel your *policy*. Any premium paid by you for a period after that date will be refunded to you.

Contact ahm life insurance

Phone: 1300 508 940

Email: sales@ahmlife.com.au

Website: www.ahm.com.au/life-insurance

Mail: GPO Box 239, Sydney NSW 2001

Hours: Monday to Friday 8:00am – 8:00pm (AEST/AEDT)

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About ahm Life Insurance

ahm Life Insurance offers a range of cover options. These are summarised in the table below. This is a summary only and conditions, limitations and exclusions apply, which are described later in this PDS.

Type of Cover	What you're covered for
Life Cover	Life Cover provides a lump sum payment if the *insured person* dies or is diagnosed with a *terminal illness*.
Optional Covers	
— Total and Permanent Disability (TPD) Cover	TPD Cover provides a lump sum payment if the *insured person* suffers a *total and permanent disability*.
— Critical Illness Cover	Critical Illness Cover provides a lump sum payment if the *insured person* suffers a specified *critical illness event* that is listed in this PDS.
— Child Cover	Child Cover provides a lump sum payment if the *insured child* dies, is diagnosed with a *terminal illness* or suffers a specified *child critical illness event* that is listed in this PDS.

Your insurance *policy*

Your *policy* starts when your application has been assessed and approved by us. Until then, we may ask for more information to fully assess your application.

As soon as your cover is approved, a welcome letter will be sent to you via email, along with your *policy schedule* outlining the full details of your cover, including your *policy*'s commencement date. Your insurance *policy* consists of:

- your most recent *policy schedule*; and
- this policy document / PDS.

Please keep these documents, and all documents we send you, in a safe place for future reference. Your *policy schedule* will outline the specifics of your ahm Life Insurance *policy*, including the *insured person*, *policy owner*, *sum(s) insured* and any optional benefits that apply to you.

We reserve the right to accept or decline applications for ahm Life Insurance (including optional cover) at our reasonable discretion.

Who can apply and who can own the *policy*?

The *insured person* (and the *insured child* for Child Cover) must meet the following age requirements in order to be eligible to apply for ahm Life Insurance:

Age eligibility	Life Cover, TPD Cover & Critical Illness Cover	Child Cover
Minimum age	18	2
Maximum age	55	15

The *policy owner* of an ahm Life Insurance *policy* can be the *insured person*, the *insured person*'s partner or another individual who would be financially impacted by the death, *illness* or *injury* of the *insured person*.

Both the *insured person* and *policy owner* must be an *Australian resident* aged 18 or over. For TPD Cover, the *insured person* must be *gainfully employed* and working a minimum of 20 hours per week at the time the application is made.

Any *insured child* must also be an *Australian resident* and the child of the *policy owner*.

Unless we state otherwise, benefits are paid to the *policy owner*. If you are both the *policy owner* and the *insured person* and you die while owning your ahm Life Insurance *policy*, the Life Cover *sum insured* will be paid to your legal personal representative (or other person that we are legally permitted to pay) except where you have made a valid beneficiary nomination. Where a valid beneficiary nomination exists, we will pay the benefits to your nominated beneficiary (see 'Beneficiary nomination' on page 19).

We pay all benefits and amounts payable under your *policy* in Australian dollars.

The application process

During the application process, you will be asked for information about the person to be insured's age, gender, occupation and health information.

The person to be insured's:

- Age will determine whether or not you can have cover, how much cover you can have, the types of cover you can have and how much it will cost.
- Occupation will determine what cover types you can have and the applicable cost, and for certain occupations, whether or not you are able to take out cover.
- Gender will influence the cost of the various cover types.
- Health information will determine what cover types you can have and whether any special terms, including exclusions and/or loadings, will apply to your cover.

The amount you can apply for

Minimum *sum insured*

The minimum *sum insured* for Life Cover, TPD Cover and Critical Illness Cover is $50,000, and for Child Cover is $10,000.

Maximum *sum insured*

The maximum *sum insured* you can apply for, for each type of cover is as follows:

- Life Cover: $1,500,000.
- TPD Cover*: $1,000,000.
- Critical Illness Cover*: $500,000.
- Child Cover: $200,000 per *insured child*.

* Neither your TPD Cover nor your Critical Illness Cover *sum insured* can exceed your Life Cover *sum insured* at any time.

The maximum *sum insured* available to you is also dependent on the *insured person's* annual income at the time of application.

Increasing or decreasing your *sum insured*

You can decrease your *sum insured* for any of your cover types at any time by contacting ahm life insurance on 1300 867 125 and requesting a decrease. Note you cannot have TPD Cover, Critical Illness Cover or Child Cover without Life Cover and your Life Cover *sum insured* must be equal to or greater than your TPD Cover and/or Critical Illness Cover *sum insured*.

If you wish to increase your *sum insured*, or add any additional cover types, you can contact ahm life insurance on 1300 867 125 to request an increase.

You will need to complete an application which may require information relating to for example, the *insured person's* health, occupation and pastimes.

If you increase your *sum insured*, any cover that you already hold will remain in place. Any special terms, including limitations, loadings or exclusions applied as part of your new application will only apply to the newly added cover amount or types.

Note: if you have included the Indexation Benefit in your *policy* your cover will increase automatically. See page 14 for further details.

Adding another *insured child*

You can add another *insured child* to your *policy* at any time, so long as they meet the eligibility criteria. To add another *insured child* to your *policy*, contact ahm life insurance on **1300 867 125**.

When we will pay a benefit

Life Cover

Death Benefit

We will pay the Life Cover *sum insured* as a lump sum if the *insured person* dies while the Life Cover is in place.

Terminal Illness Benefit

We will pay the Life Cover *sum insured* as a lump sum if the *insured person* is diagnosed with a *terminal illness* while the Life Cover is in place.

Death Advancement Benefit

We will advance $15,000 of the Life Cover *sum insured* to assist with the costs associated with a funeral or other similar expenses, upon receipt of the *insured person's* death certificate. Your Life Cover *sum insured* as well as any TPD Cover and/or Critical Illness Cover *sum insured* will be reduced by the amount paid under this benefit.

Payment of this benefit is not an admission of our liability to pay a Death Benefit, and we may not make a payment under the Death Advancement Benefit where we reasonably consider there is a reasonable doubt as to whether a Death Benefit will be payable.

TPD Cover (optional)

TPD Cover is an option you must apply for in addition to your Life Cover and only applies if TPD Cover appears on your *policy schedule*.

TPD Cover is available at an additional cost.

TPD Benefit

We'll pay your TPD Cover *sum insured* if the *insured person* suffers a *total and permanent disability* while the TPD Cover is in place.

If the *insured person* is not *totally and permanently disabled* but suffers:

- *loss of use of a single limb (total and irrecoverable); or*
- *loss of sight in one eye (total and irrecoverable);*

we'll pay 25% of your TPD Cover *sum insured*. Once paid, we'll reduce your TPD Cover *sum insured*, and the *sum insured* for any Life Cover or Critical Illness Cover (if applicable), by the amount paid under this benefit.

Critical Illness Cover (optional)

Critical Illness Cover is an option you must apply for in addition to your Life Cover and only applies if Critical Illness Cover appears on your *policy schedule*.

Critical Illness Cover is available at an additional cost.

Critical Illness Benefit

We'll pay your Critical Illness Cover *sum insured* if the *insured person* suffers one of the following *critical illness events* while this cover is in place;

- *acute stroke (requiring specified impairment lasting more than 24 hours and excluding the retina)^.*
- *cancer (excluding early stage cancers)^.*
- *chronic lung failure (requiring long-term oxygen therapy).*
- *end stage chronic kidney failure (requiring regular renal dialysis or kidney transplantation).*
- *end stage chronic liver failure.*
- *heart attack (with evidence of heart muscle damage)^.*
- *loss of independence (total and permanent).*
- *major burns of the skin (of specified severity and requiring specified treatment).*
- *major head trauma (with significant permanent neurological impairment).*
- *major organ transplant (of specified organs or being put on a transplant waiting list).*
- *open heart surgery^.*
- *paralysis (total and permanent).*

^ These conditions are subject to a 90-day qualifying period as explained below.

The *insured person* must meet our definition of the *critical illness event*, as detailed in the 'Definitions' section on page 28 of this PDS. If the *insured person* suffers more than one *critical illness event*, your *sum insured* is only payable for the first occurring *critical illness event*. This is because once the *sum insured* is reduced to zero, the cover will end.

90-day qualifying period

No benefit will be paid for any of the *critical illness events* marked with a ^ above, if the event first occurred, was diagnosed, or symptoms leading to the event first became *apparent* within 90 days of:

- the Critical Illness Cover commencement date as detailed on the *policy schedule*;
- an increase in your Critical Illness Cover *sum insured* other than any increase in cover as a result of the Indexation Benefit (but this exclusion only applies in respect of the increased amount); or
- if applicable, the date your cover was last reinstated.

Child Cover (optional)

Child Cover is an option you must apply for in addition to your Life Cover and only applies if Child Cover appears on your *policy schedule*.

Child Cover is available at an additional cost.

Child Cover provides a lump sum payment if the *insured child* dies, becomes *terminally ill* or is diagnosed with one of the specified *child critical illness events* included under this cover as described below.

Death Benefit

We'll pay the Child Cover *sum insured* if the *insured child* dies while this cover is in place.

Terminal Illness Benefit

We'll pay the Child Cover *sum insured* if the *insured child* becomes *terminally ill* while this cover is in place.

Child Critical Illness Benefit

We'll pay the Child Cover *sum insured* if the *insured child* is diagnosed with, or suffers, one of the *child critical illness events* listed in the following table while this cover is in place.

Heart conditions	
– *cardiomyopathy (permanent and irreversible).*	– *heart attack (with evidence of heart muscle damage)^.*
Nervous system conditions	
– *acute stroke (requiring specified impairment lasting more than 24 hours and excluding the retina)^.* – *coma (of specified severity and duration).* – *encephalitis (resulting in serious and permanent functional impairment).*	– *major head trauma (with significant permanent neurological impairment).* – *meningococcal disease (resulting in significant permanent impairment).* – *paralysis (total and permanent).* – *subacute sclerosing panencephalitis.*
Body organ disorders	
– *benign brain tumour (resulting in irreversible neurological deficit).* – *cancer (in children, excluding early stage cancers)^.* – *end stage chronic kidney failure (requiring regular renal dialysis or kidney transplantation).*	– *major burns of the skin (of specified severity and requiring specified treatment).* – *major organ transplant (of specified organs or being put on a transplant waiting list).*
Blood conditions	
– *aplastic anaemia (requiring specified treatment).*	– *medically-acquired HIV (contracted from a medical procedure or operation).*
Other conditions	
– *blindness (total and irrecoverable).* – *deafness in both ears (total and permanent including requiring a cochlear implant).* – *loss of independence (total and permanent).*	– *loss of speech (total and irrecoverable).* – *loss of use of limbs (total and irrecoverable).* – *prolonged intensive care.*

^ These conditions are subject to a 90-day qualifying period as explained below.

90-day qualifying period

No benefit will be paid for any of the *child critical illness events* marked with a ^ in the previous table, if the event first occurred, was diagnosed, or symptoms leading to the event first became *apparent* within 90 days of:

- the Child Cover commencement date as detailed on the *policy schedule*;
- an increase in your Child Cover *sum insured* other than any increase in cover as a result of the Indexation Benefit (but this exclusion only applies in respect of the increased amount); or
- if applicable, the date your Child Cover was last reinstated.

Child Death Advancement Benefit

We will advance $10,000 of the Child Cover *sum insured* to assist with the costs associated with funeral or other similar expenses, upon receipt of the *insured child's* death certificate. Your Child Cover *sum insured* for the particular *insured child* will be reduced by the amount paid under this benefit. Payment of this benefit is not an admission of our liability to pay a Child Cover claim, and we may not make a payment under the Child Death Advancement Benefit where we reasonably consider there is a reasonable doubt as to whether a Death Benefit will be payable in respect of the *insured child*.

Conversion of Child Cover Benefit

When the *insured child* approaches the expiry age for Child Cover, they have the option of converting their existing cover to Life Cover (Death and Terminal Illness Benefits). They may also choose to include Critical Illness Cover, without having to reapply or supply medical evidence to us. This benefit does not allow the *insured child* to apply for TPD Cover without supplying a full application.

To be eligible for this option, the *insured child* must exercise it before their Child Cover expires or is cancelled, however they must also meet the eligibility requirements in relation to age for Life Cover and Critical Illness Cover.

In addition, the conversion of a Child Cover Benefit will not be available where a claim has been made, or the *insured child* is eligible to make a claim, on the Child Cover.

The *sum insured* on their new cover can be up to the same *sum insured* that applied under their Child Cover at the time it expired.

Their new premium will be based on their age and the current premium rates at the time the new cover is issued.

Any exclusions which applied to their Child Cover, as outlined on page 11, will also apply to their new cover.

Exclusions

We will not pay any benefit under Life Cover, TPD Cover, Critical Illness Cover or Child Cover if the event giving rise to the claim is:

- caused or contributed by anything that is specifically excluded on your *policy schedule*; or
- a result of travel to an overseas location against the advice issued by the Australian Government to the Australian public. This includes travelling to regions classified by the Department of Foreign Affairs and Trade as Advice Level 3 ('reconsider your need to travel') and Advice Level 4 ('do not travel'). These Advice Levels and destinations they apply to can be found at smartraveller.gov.au/destinations.

We are also unable to pay any benefit where the recipient is subject to sanctions and laws prevent us from paying a benefit. See page 17 for further information.

Other specific exclusions apply to the different cover types under ahm Life Insurance as outlined below.

Life Cover

We will not pay any benefit under Life Cover if the event giving rise to the claim is caused or contributed to by suicide, attempted suicide or any intentional self-inflicted act by the *insured person*, within 13 months of:

- the Life Cover commencement date as detailed on the *policy schedule*;
- an increase in your *sum insured* other than any increase in cover as a result of the Indexation Benefit (but this exclusion only applies in respect of the increased amount); or
- if applicable, the date on which your cover was last reinstated.

If you have increased your *sum insured* under the Future Increase Benefit, within the first six months of any increase, the increased amount of the *sum insured* will only be payable for death or *terminal illness* where the *injury* or *illness* that is the cause of the claim is the result of an *accident*.

In addition, the payment of a Terminal Illness Benefit under Life Cover is dependent upon the *insured person* having followed the reasonable advice of a *medical practitioner* (for more information see page 26).

TPD Cover

We will not pay any benefit under TPD Cover if the event giving rise to the claim is caused or contributed to by attempted suicide, or any intentional self-inflicted act by the *insured person*.

If you have increased your *sum insured* under the Future Increase Benefit, within the first six months of any increase, the increased amount of the *sum insured* will only be payable where the *injury* or *illness* that is the cause of the *insured person's total and permanent disability* is the result of an *accident*.

In addition, the payment of a TPD Benefit under the *policy* is dependent upon the *insured person* following the reasonable advice of a *medical practitioner* (for more information see page 26).

Critical Illness Cover

We will not pay any benefit under Critical Illness Cover:

- if the event giving rise to the claim is caused or contributed to by attempted suicide, or any intentional self-inflicted act by the *insured person*; or
- for *critical illness events* subject to the 90-day qualifying period (as explained on page 7), if the event first occurred, was diagnosed, or symptoms leading to the event first became *apparent* within the 90-days of:
  - the Critical Illness Cover commencement date as detailed on the *policy schedule;*
  - an increase in your Critical Illness Cover *sum insured* other than any increase in cover as a result of the Indexation Benefit (but this exclusion only applies in respect of the increased amount); or
  - if applicable, the date your cover was last reinstated.

In addition, if you have increased your *sum insured* under the Future Increase Benefit, within the first six months of any increase, the increased amount of the *sum insured* will only be payable where the *critical illness event* is the result of an *accident*.

Child Cover

We will not pay any benefit under Child Cover:

- if the event giving rise to the claim is caused or contributed to by an intentional, self-inflicted act, or attempted suicide, within the first 13 months of:
  - the commencement date of Child Cover in relation to the particular *insured child* (as detailed on the *policy schedule*);
  - an increase in the *sum insured* in relation to the particular *insured child* other than any increase in cover as a result of the Indexation Benefit (but this exclusion only applies in respect of the increased amount); or
  - if applicable, the date on which cover in relation to the particular *insured child* was last reinstated; or
- if the event giving rise to the claim is caused or contributed to by a *congenital condition;*
- for any *illness* or *injury* that first became *apparent* before the commencement date of Child Cover in relation to the particular *insured child* (as detailed on the *policy schedule*);
- if the event giving rise to the claim is caused or contributed to by any illegal act inflicted on the *insured child* by you or the *insured child's* guardian; or
- for *child critical illness events* subject to the 90-day qualifying period (as explained on page 9), if the event first occurred, was diagnosed, or symptoms leading to the event first became *apparent* within 90 days of:
  - the commencement date of Child Cover in relation to the particular *insured child* (as detailed on the *policy schedule*);
  - an increase in the *sum insured* in relation to the particular *insured child,* other than any increase in cover as a result of the Indexation Benefit (but this exclusion only applies in respect of the increased amount); and
  - if applicable, the date your Child Cover in relation to the particular *insured child* was last reinstated.

In addition, the payment of a Terminal Illness Benefit under Child Cover is dependent upon the *insured child* having followed the reasonable advice of a *medical practitioner* (for more information see page 26).

Adjustments to your *sum insured*

Payment of a benefit under one cover type will reduce your *sum insured*, or end cover under that cover type and your other cover types as follows:

Life Cover	Payment of the Death Benefit or Terminal Illness Benefit will reduce the *sums insured* for all cover types to zero, and end the Life Cover, and if applicable, the TPD Cover and Critical Illness Cover. Payment of these benefits does not impact the *sum insured* for any *insured child*.
TPD Cover and Critical Illness Cover	Payment of the TPD Benefit or Critical Illness Benefit will reduce your *sum insured* for Life Cover, TPD Cover and Critical Illness Cover (as applicable) by the amount paid. If a *sum insured* reduces to zero, the cover will end. Payment of these benefits does not impact the *sum insured* for any *insured child*.
Death Advancement Benefit	Payment of the Death Advancement Benefit will reduce the Life Cover *sum insured* by the amount paid and if applicable, the TPD Cover and/or Critical Illness Cover *sums insured*.
Child Cover	Payment of the Child Cover Death Benefit or Child Cover Terminal Illness Benefit will reduce the *sum insured* for the relevant *insured child* to zero, and cover will end for that *insured child*. Payment of the Child Critical Illness Benefit will reduce your *sum insured* for the Child Cover Death Benefit or Child Cover Terminal Illness Benefit Cover (as applicable) for the relevant *insured child* by the amount paid. If a *sum insured* for the relevant *insured child* reduces to zero, the cover will end.
Child Death Advancement Benefit	Payment of the Child Death Advancement Benefit will reduce the Child Cover *sum insured* for the relevant child.

In addition, your TPD Cover or Critical Illness Cover *sum insured* can never be higher than your Life Cover *sum insured*. As such, your TPD Cover and/or Critical Illness Cover *sum insured* may be decreased (including down to zero) where your Life Cover *sum insured* decreases, so that each of your TPD Cover and Critical Illness Cover *sums insured* are equal to or less than your Life Cover *sum insured*. If we do this, we will refund any premiums paid in relation to your TPD Cover or Critical Illness Cover for a period in which the cover has been reduced.

Cover in relation to any *insured child* can remain in place where the Life Cover *sum insured* is reduced to zero as the result of a claim being paid. Should the Life Cover *sum insured* be reduced to zero for any other reason, cover in relation to each *insured child* will also cease. If we do this, we will refund any premiums paid in relation to the *insured child* cover for a period in which cover is not provided.

Example Case Study

Max took out an ahm Life Insurance *policy* on 3 September 2023 with the following cover types;

- Life Cover: $500,000 *sum insured;*
- TPD Cover: $250,000 *sum insured; and*
- Critical Illness Cover: $100,000 *sum insured.*

On 4 April 2024, Max was in a car accident, resulting in serious injuries to his head. As he met the definition of *major head trauma (with significant permanent neurological impairment)*, he qualified for, and was paid, his Critical Illness Cover *sum insured* of $100,000.

After the payment of his Critical Illness Cover *sum insured*, Max's Critical Illness Cover ended, and his Life Cover and TPD Cover *sums insured* were reduced to:

- Life Cover $400,000; and
- TPD Cover $150,000.

When your cover ends

Life Cover, TPD Cover and/or Critical Illness Cover (as appropriate) will end on the earlier of:

– the date we receive your request to cancel the relevant cover;
– the full *sum insured* for the relevant cover is paid or reduced to zero;
– the *policy* anniversary immediately after:
  - the *insured person* turns 99 for Life Cover; and
  - the *insured person* turns 65 for TPD Cover and Critical Illness Cover;
– the *insured person's* death;
– Critical Illness Cover will end after the first occurring *critical illness event*; or
– the date we cancel the *policy* because premiums were not paid when due (see page 23).

When Life Cover ends all TPD Cover and Critical Illness Cover will also end.

Child Cover will end on the earlier of:

– the date we receive your request to cancel Child Cover;
– the *insured child's* death;
– the full Child Cover *sum insured* is paid or reduced to zero;
– the *policy* anniversary immediately after the *insured child* turns 19;
– when Life Cover ends (except where it ends as the result of a claim, in this instance any Child Cover *sums insured* will remain in place); or
– the date we cancel the *policy* because premiums were not paid when due (see page 23).

If we cancel or avoid your *policy,* we will refund the premium received (on a pro rata basis) for cover that has been cancelled or avoided.

Reinstatement of cover

If your *policy* ends due to non-payment of premiums, you can apply to have your cover reinstated within 60 days of your *policy* cancellation date.

If you make this request within 60 days of the cancellation date, your *policy* may be reinstated, depending upon your individual circumstances. If your *policy* is reinstated it will be done such that there is no gap in cover. As a result, you will be required to pay all outstanding premiums.

A *policy* cannot be reinstated if more than 60 days have elapsed. If after 60 days you wish to take out cover again, you will need to apply for a new *policy*, where you will need to meet all our underwriting requirements.

If the *insured person's* health or occupation status has changed, you may no longer be eligible for the cover amount or types you held previously.

Other features of your *policy*

Indexation Benefit

To help your level of insurance keep up with the cost of living, the *sum insured* for all cover types will automatically increase on each *policy* anniversary by 3%. This means your premiums will increase in line with the increased level of insurance.

Indexation Benefit increases will continue until your *sum insured* for each cover type reaches the following levels:

Cover type	Maximum *sum insured*
Life Cover	$1,800,000
TPD Cover	$1,200,000
Critical Illness Cover	$600,000
Child Cover	$240,000

If your *sum insured* for a particular cover type has reached the above maximum, but other cover types have not, any cover type that has not reached the maximum will continue to be indexed until the maximum is reached.

We will send you an updated *policy schedule* each year your cover remains in place setting out your updated *sum insured* and premium. You can decline the Indexation Benefit increase before your *policy* anniversary by contacting ahm life insurance on **1300 867 125** Monday to Friday, between 8am and 8pm (AEST/AEDT).

If you cancel or decline the Indexation Benefit, for this benefit to be reinstated the *policy owner/insured person* would need to reapply for this benefit and the *insured person* would need to undergo full underwriting.

Any premium loadings, exclusions, limitations or varied terms that apply to your Life Cover, TPD Cover or Critical Illness Cover will apply to any increases under the Indexation Benefit.

The final Indexation Benefit increase will be made on the *policy* anniversary after the *insured person's* 60th birthday. After this date, no more Indexation Benefit increases will be offered, even if the maximum amount has not been reached for any cover type(s).

For Child Cover, Indexation Benefit increases will apply until Child Cover ends or the maximum *sum insured* is reached. Child Cover increases do not end when the *insured person* turns 60.

Future Increase Benefit

The Future Increase Benefit allows you to increase your Life Cover, TPD Cover and/or Critical Illness Cover *sum insured* after the occurrence of specified events without having to supply further medical evidence to us.

You may only apply to increase the *sum insured* under this benefit once in any 12 month period, and the application to increase must be made within 90 days of the occurrence of the event.

For each increase applied for under the Future Increase Benefit, the maximum amount you can increase your *sum insured* by is detailed in the table on page 15 but subject always to the limitation that the *sum insured* cannot exceed the benefit maximums outlined in the section titled 'The amount you can apply for' on page 6. The total of all increases to your *sum insured* as a result of the Future Increase Benefit over the life of your *policy* cannot exceed the original *sum insured* at your cover commencement date (as detailed on the *policy schedule*).

The minimum increase is $10,000.

Specified events	Evidence required	Maximum *sum insured* increase per event
The *insured person* takes out or increases a *mortgage* on their primary place of residence.	Written confirmation from the *mortgage* provider showing the *mortgage* amounts before and after the increase, or for a new loan, a copy of the loan agreement.	The lesser of: – 25% of *sum insured* at cover commencement; – the amount of the *mortgage* or increase in the *mortgage*; and – $100,000.
The *insured person* marries, registers a partnership, or commences a de facto relationship recognised at law.	Copy of the marriage certificate, partnership registration, or de facto agreement.	The lesser of: – 25% of *sum insured* at cover commencement; and – $100,000.
The *insured person* or their partner gives birth to or adopts a child.	Copy of the birth/adoption certificate.	
The *insured person's* child starts secondary school.	Written confirmation of the child's enrolment in secondary school.	
The *insured person's* spouse dies.	Copy of the death certificate.	
The *insured person* gets divorced, deregisters a partnership, or ends a de facto relationship recognised at law.	Copy of the divorce certificate, partnership deregistration certificate or cancelled de facto agreement.	

To apply for an increase under this benefit, you must provide the evidence noted above to demonstrate that the event has occurred. Once accepted, your premiums will increase in line with the increased level of insurance.

Important things to note: Future Increase Benefit

Within the first six months of an increase to a *sum insured* under the Future Increase Benefit, the increased amount of the *sum insured* will only be payable for death, *total and permanent disability* or a *critical illness event* (as applicable) which results from an *accident*.

This Future Increase Benefit is not available:

- from the *policy* anniversary immediately after the *insured person* turns 60;
- if the *insured person* has made, or is eligible to make, a claim under any Life Cover, TPD Cover or Critical Illness Cover issued by us; or
- if a medical loading or exclusion applies to your cover, as stated on your *policy schedule*.

Premium and Cover Pause Benefit

If you've held your cover for a continuous period of at least 12 months, you can pause your cover due to hardship for a period of time. During this period, you won't need to pay premiums, however you'll also be unable to make a claim in respect of any event, *illness* or *injury* that occurs during the period the *policy* is paused.

To exercise this benefit:

- you must notify us at least 30 days before the premium due date (fortnightly, monthly or yearly) from which you wish to pause your cover; and
- you acknowledge that both premiums and cover will be paused.

Your cover will be paused for three consecutive months from the date your cover is paid to. At the end of your pause period, we'll continue your cover and your premium payments will resume. If the resumed premiums cannot be collected, then your *policy* will be cancelled (see page 23).

If you choose to pause your cover under this benefit, the pause will apply to all covers on your *policy*.

Please note: where you hold cover under ahm Income Protection under the same *policy*, this cover and the premiums will also pause in the same way.

Your cover may be paused under this benefit for a maximum of 12 months in total over the life of your *policy*, and the Premium and Cover Pause Benefit may only be exercised once in any 12 month period. If applicable, the Indexation Benefit will continue to apply to your cover while cover is paused, however no other changes can be made to your *policy* while it is paused under this benefit.

Interim Accident Cover

Interim Accident Cover is designed to provide you with limited cover while your application is being assessed by us.

This cover is provided at no additional cost.

It applies to your initial application for cover, and for applications to increase your cover.

Interim Accident Cover is payable upon the death of the person to be insured as the result of an *injury* caused by an *accident*. The *accident* causing the death and death must have occurred while Interim Accident Cover is in place.

Your Interim Accident Cover will start as soon as we receive your fully completed application form and a completed personal statement.

Your Interim Accident Cover will cease on the earliest of:

- 28 days after commencement of the Interim Accident Cover;
- the date your *policy* is issued;
- when you withdraw your application; or
- when your application for cover is declined by us.

The benefit payable is the lesser of:

- the Life Cover *sum insured* applied for;
- the reduced benefit amount that would be offered where, under our underwriting assessment guidelines, we would offer a lower benefit amount than the *sum insured* applied for; and
- $500,000.

If the cover being applied for is to replace existing cover, we'll reduce the Interim Accident Cover Benefit amount payable by the amount payable under your existing cover.

To be eligible for this benefit, both the *accident* and death must have occurred while the Interim Accident Cover is in place.

An Interim Accident Cover Benefit will not be paid for:

- any *illness;*
- any *accident* that first occurred prior to your application date;
- any reason that would make the person to be insured ineligible for Life Cover under the eligibility requirements applicable at underwriting or within this PDS;
- an *injury* that is the result of war or an act of war (whether declared or not); or
- any *injury* related to any exclusion that we would have applied through our usual underwriting and assessment guidelines.

Other than as varied by these terms, the standard conditions, waiting periods, limitations and exclusions subject to any options you applied for in your application for ahm Life Insurance shall apply to this Interim Accident Cover.

Other important information about your *policy*

Sections of this document

This document is not a product disclosure statement for the Interim Accident Cover set out from page 16 or the Direct Debit Service Agreement set out from page 24.

Guaranteed continuity of cover

We guarantee to renew your *policy* each year until your *policy* expires, provided you pay your premiums when due. This means we can't cancel your cover, place further restrictions on it or increase your individual premium (before applicable discounts) because of changes to the *insured person's* health, occupation or pastimes.

Changes to the policy terms and conditions

If we change the terms and conditions of our ahm Life Insurance product in the future, and those changes mean your benefits are the same or are improved and where this change does not result in an increase to your premiums, we'll pass on the improvements to you by updating the terms of your *policy*. We'll make these changes to your *policy* on the basis that you will not be disadvantaged by the update.

We will provide a notice of any such changes at **www.ahm.com.au/life-insurance** and tell you of the effective date of any improvements to your *policy* within 12 months of the update. Each new improvement will only apply to claims where the *illness* or *injury* causing the claim first became *apparent* after the effective date of the change.

This means the improvements won't apply to past or existing claims, or claims resulting from an *illness* or *injury* that first became *apparent* or events which took place before the effective date.

In the event that any changes to our ahm Life Insurance product in the future may disadvantage you, we will apply the prior, more favourable terms.

We may also vary your *policy* where:

- the variation is to benefits, the variation improves those benefits and you accept that improvement by continuing to pay your premiums after we notify you of the improvement; or
- the variation is to your premium rates provided that the premium is being varied for all contracts of the same kind on a simultaneous and consistent basis. (If this happens we'll give you notice as set out at page 22).

Sanctions

No benefit is payable if doing so will contravene or violate any sanction, prohibition, restriction, proscription or prevention under any sanctions, laws or regulations, including but not limited to sanctions, laws or regulations of Australia, New Zealand, the European Union, the United Kingdom or the United States of America or those set out in any United Nations resolutions.

Duty to take reasonable care

When applying for insurance, you have a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into. A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and in certain circumstances when reinstating insurance.

If the cover being applied for is not on your life, it is crucial that the person whose life is being insured also reads this 'Duty to take reasonable care' section and gives complete and accurate information to you so you are able to provide the information to us in accordance with your duty to take reasonable care.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced. We explain below 'What can we do if the duty is not met'.

When you are not the *insured person*, and the *insured person* does not take reasonable care not to make a misrepresentation to us, this may be treated as a failure of your duty to take reasonable care.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made or if you request further underwritten cover.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, a family member or friend), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. Please let us know if you would answer any of our questions differently. The information might impact how we decide whether we can cover you, and if so on what terms and at what cost. If you do not do this, you may not have met your duty.

About your application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and at what cost. We will ask questions we need to know the answers to. These will be about the person to be insured's personal circumstances, such as their health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please contact us immediately and we'll let you know whether it has any impact on the cover and cost. If we decide that your disclosure has no impact on your cover, we will not change our mind at a later time.

What can we do if the duty is not met?

If the person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

For example we may, acting reasonably and to the extent permitted by law:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

Whether we can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was;
- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you have difficulty understanding the process of buying insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. If you want, you can have a support person you trust with you.

Notices

Any notice you give us under your *policy* will be effective from the date your call or email is received by a customer service agent. In circumstances where we require you to send us a notice in writing (including via email) we will inform you of this.

Any notice which we give you must be in writing, and will be sent to the last contact address you provided (including email address).

Making changes to your *policy*

If you wish to make changes to your *policy*, including:

- increasing or decreasing your *sum insured*;
- changing the status of the *insured person* from a 'smoker' to a 'non-smoker';
- changing the *policy owner*; or
- adding a cover type (e.g. TPD Cover, Critical Illness Cover or Child Cover);

please contact ahm life insurance on **1300 867 125** Monday to Friday, between 8am and 8pm (AEST/AEDT).

Any requested variation to your *policy* which affects your benefits must be agreed to by us and you. If we agree to a variation that affects your benefits, we will provide confirmation by issuing a new *policy schedule*.

We may require that you apply for these changes in writing, specifically where there is a change in ownership or an increase in risk, or where legally required. We will advise you of your increased premium (if any) and if you wish to proceed and we approve the change, we will provide confirmation by issuing a new *policy schedule*.

Beneficiary nomination

Where you are also the *insured person*, you may, at any time during the term of the *policy*, nominate one or more beneficiaries (up to a maximum of five) to receive a specified percentage of the Death Benefit. To make a valid nomination after the commencement of the *policy*, you must complete a 'Nomination of Beneficiary' form and follow all relevant instructions.

Risks

Before applying for any form of insurance, it's important to understand the potential risks. You should consider the below risks before making your decision to purchase an ahm Life Insurance *policy*.

- The cover type, or amount of cover, may not be appropriate for your needs. You should consider the Target Market Determination (available at **www.ahmlife.com.au/TMD**) and the options you select carefully.
- If you become unable to pay your premium in the future, your cover may be cancelled (see page 23) and, if your circumstances have changed, you may not be able to take out equivalent cover.
- If you and the *insured person* don't take reasonable care not to make a misrepresentation to us, we may avoid your cover or reduce the benefit amount payable (refer to page 18 for more information).
- Should an exclusion apply to your *policy*, a benefit will not be paid to you should the claim relate to the stated exclusion.
- Premium rates are not guaranteed, and we may increase or decrease your premium in the future. The premium rates are influenced by a number of factors including your age and will generally increase as you get older.

ahm Income Protection

You are able to combine cover offered under our 'ahm Income Protection' which provides Income Protection Cover with cover under this 'ahm Life Insurance' *policy*. If you would like to consider additional cover under ahm Income Protection, you should read and consider the ahm Income Protection PDS (available at **www.ahmlife.com.au/income-PDS)** and the Target Market Determination (available at **www.ahmlife.com.au/income-TMD**), before making any decisions about ahm Income Protection.

Complaints

If you have a query or complaint about your *policy*, you can contact ahm life insurance on **1300 867 125** or via email at **service@ahmlife.com.au**. They will acknowledge your complaint in writing and endeavour to resolve your complaint.

If you need additional assistance lodging your complaint, for example due to illness, disability or English as a second language, please contact us and we will assist you through the complaints resolution process.

Your complaint will be assigned to one of our staff who is independent of the cause of complaint, and we will keep you up to date on the progress of your complaint resolution.

We will endeavour to provide you with a written response informing you of our final decision within thirty (30) days of receiving your complaint. If we are unable to resolve your complaint within that period, we will let you know the reasons for the delay and when we expect to be able to provide you with a response.

If your issues are not resolved, or ahm life insurance's resolution to your complaint is not to your satisfaction, you can refer your complaint to the Australian Financial Complaints Authority (AFCA). Contact details for AFCA are:

Australian Financial Complaints Authority

GPO Box 3,
Melbourne VIC 3001
Phone: 1800 931 678
Email: info@afca.org.au
Website: www.afca.org.au

Privacy

Integrity Life Privacy Statement

In this section 'you/your' means an *insured person*, the *policy owner* or a potential *insured person* or *policy owner* as the context indicates.

Your privacy is important to us. We have obligations under the Privacy Act 1998 (Cth) and procedures in place to comply with those obligations.

For more information on Integrity Life's privacy and information handling practices, you should read our Privacy Policy which can be found on our website at **www.integritylife.com.au** or call **1300 543 366** for a copy.

In order for us to administer insurance under the *policy*, we will need you to provide us with certain personal and sensitive information. If you do not provide all information requested, we may not be able to issue or administer the *policy* including managing any claims. You should be aware of the type of information which we will request from you, in addition to how we will request this information and to whom we may need to disclose it.

Personal information we collect

We collect your personal information including:

- name, address, gender, date of birth and contact details;
- occupation, income, date of commencement and cessation of employment;
- information specific to the product or service you decide to purchase from us; and
- financial details.

We may also collect sensitive information, which includes information about your health. We may be required to collect additional sensitive information when you make an application for certain insurance.

How we collect your personal information

Where possible, we'll collect personal information from you directly either through our online services or in writing, or over the phone. We'll obtain consent before collecting sensitive information, such as health information, unless we're required or permitted by law to collect it without consent.

We may, where required or permitted by law, also collect personal information and sensitive information about you from a third party including, for example when you are applying for a *policy*, increasing or decreasing your *sum insured* or making a claim.

These parties may include:

- our agents and service providers such as financial institutions;
- your family member who applies for a *policy* that covers you or is instructed by you to deal with us;
- people who are involved in a claim or assist us in assessing, investigating, processing or settling claims such as investigators, assessors, witnesses and medical service providers;
- law enforcement, dispute resolution, statutory and regulatory bodies; and
- publicly available sources such as the internet.

Sometimes we may be required to collect sensitive information about you from a third party. If you are providing information about a person who is to be covered by the *policy*, you must show them this document or a copy of our Privacy Policy available on our website at **www.integritylife.com.au** so they understand how we may use or disclose their personal information in relation to your dealings with us.

What we do with your personal information

We collect, hold, use and disclose personal information in ways people would reasonably expect and where it is reasonably necessary for our business, including:

- issuing, administering and managing insurance policies;
- assessing risk and underwriting insurance;
- processing claims and taking recovery action;
- improving our products and services, and the customer experience;
- handling complaints; and
- working with business partners and insurance intermediaries.

Disclosing personal information

To the extent permitted by law, and where reasonably necessary for the provision and administration of cover under this *policy*, we, or our agents, may disclose personal information to:

- any person authorised by you;
- our related bodies corporate;
- other insurers and reinsurers;
- our distributors and agents;
- mail houses, records management companies or technology services providers for printing and/or delivery of mail and email, including secure storage and management of our records;
- healthcare providers to establish medical status and arrange appropriate treatment and services. In an emergency we may also disclose information to employers and family members;
- organisations that provide banking or transactional services to facilitate payments to and from us;
- our advisers such as legal, actuary and accounting advisers;
- business partners and intermediaries who arrange insurance with us;
- co-insureds to confirm full disclosure has been made to us;
- Government, law enforcement, statutory, regulatory or enforcement bodies and agencies;
- service providers that perform data analytics;
- insurance reference bureaus;
- companies that conduct customer surveys on our behalf; and
- other parties as required by law.

In the case of a claim we may also disclose personal information to:

- investigators and assessors to investigate and assess claims and related matters;
- lawyers and recovery agents, to defend actions by third parties, to recover our costs (including amounts owed to us) or to seek a legal opinion;
- witnesses, to obtain witness statements;
- experts to provide us with opinions; and
- other parties to a claim to obtain statements from them, seek recovery or defend an action.

We also collect personal information from these people and organisations.

We do not store or disclose personal information outside of Australia or the United States of America. However, from time to time we may engage a service provider who does. You can find further information in our Privacy Policy available on our website at **www.integritylife.com.au**.

Disclosure to business partners and intermediaries

When you buy a *policy* arranged by one of our business partners or intermediaries, such as NEOS Direct, you consent to us providing all of your personal information to that business partner or intermediary, which may include sensitive information and claim information. That business partner or intermediary will also provide us with personal information that they have collected from you.

You should read the Privacy Policy of that business partner or intermediary to find out how they collect, hold, use and disclose your personal information. The NEOS Direct privacy policy is available at **www.neosgroup.com/privacy-policy**.

We may also disclose your personal information (but not sensitive information) to Medibank Private who may use that information to assist them in planning, researching, developing, identifying and notifying you of products and services which may be of interest to you. You may call or write to us or Medibank Private at any time to let us know that you do not want to receive any further communications from us.

Access, corrections and complaints

Our aim is to always have accurate, complete, up-to-date and relevant personal information. If you would like to seek access to, or revise, your personal information, or feel that the information we currently have on record is incorrect or incomplete, or wish to make a complaint about privacy, please contact ahm life insurance on **1300 867 125**, by email **service@ahmlife.com.au** or by writing to **GPO Box 239 Sydney NSW 2001**.

You may also elect to contact the Office of the Australian Information Commissioner if you have a complaint about the way we handle your personal information on 1300 363 992 or by writing to GPO Box 5288 Sydney NSW 2001.

Premiums and other costs

How much will it cost?

The cost of your *policy* depends on a range of factors, including:

- your cover types (the greater the number of cover types, the greater the premium);
- your *sum insured* (the higher the *sum insured*, the higher the premium);
- the *insured person's* gender;
- the *insured person's* age;
- whether or not the *insured person* smokes (smokers will have a higher premium than non-smokers);
- the *insured person's* health (adverse health may result in a higher premium);
- the *insured person's* family history (adverse family history may result in a higher premium);
- the *insured person's* occupation (occupations deemed as higher risk, for example those involving manual labour, may result in a higher premium);
- your premium frequency (the total premium paid in a year is lower if you pay yearly than if you pay monthly or fortnightly);
- whether you qualify for a discount (if you qualify for a discount, the premium will be reduced);
- stamp duty and any other Government charges (the greater the stamp duty rate or Government charges applicable to the premium, the higher the total cost of the *policy*); and
- increases under the Indexation Benefit.

During the assessment of your application, we may apply a premium loading (such as a percentage on top of the standard premium rate) as a result of the *insured person's* state of health, family history or pastimes at that time.

Each year we'll send you a *policy* anniversary notice outlining your premium payable. As noted on page 3, you may cancel your *policy* and your insurance will end when we receive your request to cancel your *policy*. Any premium paid by you for a period after that date will be refunded to you.

Your premium type

We calculate your premium on each *policy* anniversary based on the *insured person's* age at that anniversary, the various amounts of each cover type held, and your continued eligibility for discounts. Premiums will generally increase each year in line with the increase in age and any increase in your *sum insured* as a result of the Indexation Benefit. These types of premiums are called 'stepped premiums'.

Can premium rates change?

The premium you pay may increase each year due to a range of factors including regular age increases (as described above), if you increase your *sum insured* (including through the Indexation Benefit), and as a result of any increase in tax, duty or charge introduced by Government.

However, premium rates are not guaranteed, and as such we may increase or decrease your premium in the future. We may change our premium rates in the future if it is reasonably necessary including to reflect our insurance business experience, like the cost of claims, which will change the premiums you pay. Any change to premium rates will apply to all policies in a defined group (as discussed on page 22). We'll not single out an individual *policy*.

If we change the premium rates, we'll write to you to let you know at least 30 days before the change takes effect.

Premium discounts

If the *insured person* is an ahm health member, you may be eligible for a 10% discount on your premium whilst the *insured person* remains a member.

The benefit of any discount will be reflected in your *policy schedule* and *policy* anniversary notice. We don't guarantee premium discounts, and we may remove or vary the discounts applicable during the term of your *policy*.

We will provide you with at least 30 days prior notice of a removal of a premium discount. You may cancel your *policy* at any time.

Paying your premium

You have the option to pay your premium fortnightly, monthly or yearly. Premiums may be paid by credit card or direct debit. If you choose to pay by direct debit, the Direct Debit Service Agreement in this PDS will apply.

If you pay your premiums fortnightly or monthly, we'll apply a premium frequency loading to your premium. This loading is a percentage of the annual premium and helps cover the costs of collecting your premium on a more frequent basis.

If you stop paying your premiums

To ensure your cover continues, you must pay your premium when it's due. If you don't pay your premium within 30 days of the due date, we'll write to advise that your cover will be cancelled. If we cancel your *policy*, all cover will cease, and you'll be unable to make a claim for any event which occurs after the date cover stopped.

Government charges and tax

The information provided in this section is general in nature, and based on our interpretation of the tax laws and rulings current at the date this PDS was prepared. Individual circumstances can be quite different, and the law may change, so we recommend that you speak with a taxation professional with respect to your own situation.

Your premium may include allowances for current Government charges and taxes including stamp duty. Stamp duty is either incorporated into your base premium rate or added as an additional charge. If it's an additional charge, it will be shown on your *policy schedule*.

We may pass on to you any applicable new, or increased, Government taxes or charges. If this happens, we'll write to you to let you know at least 30 days before the change takes effect.

Premiums for Life Cover, TPD Cover, Critical Illness Cover and Child Cover are generally not tax-deductible and tax will generally not be payable on any benefit paid under your *policy*. You do not have to pay GST on your premiums or any benefits you receive.

Direct Debit Service Agreement

Definitions

The following special terms are capitalised and apply to this Direct Debit Service Agreement only:

Account means the account held at Your Financial Institution from which we're authorised to arrange for your Premium to be debited.

Agreement means the direct debit service agreement between you and us.

Banking Day means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.

Debit Day means the day that your Premium payment is due to us.

Debit Payment means a particular transaction where a debit is made to your Account.

Direct Debit Request means the direct debit request you've provided to us.

Premium means the premium payable for the cover provided by your ahm Life Insurance policy at the Debit Day.

Your Financial Institution is the financial institution where you hold the Account that you have authorised us to debit.

The following terms also have a special meaning but are not capitalised:

we/us/our means Integrity Life Australia Limited ABN 83 089 981 073.

you/your means the person who provided the Direct Debit Request to us.

Debiting your Account

By providing a Direct Debit Request, you have authorised us to arrange for funds to be debited from your Account for the purpose of paying the Premium on your ahm Life Insurance policy. You should refer to the Direct Debit Request and this Agreement for the terms of the arrangement between us and you.

We will only arrange for funds to be debited from your Account for payment of the Premium as authorised in the Direct Debit Request. The amount of the Premium may vary from time to time. We will not notify you of this variation unless we're required to do so under the terms and conditions of your ahm Life Insurance policy.

We will not issue a billing notification prior to debiting your Account. If the Debit Day falls on a day that is not a Banking Day, we may direct Your Financial Institution to debit your Account on the following Banking Day. If you're unsure about which day your Account has or will be debited, you should ask Your Financial Institution.

Changes by us

We may vary any details of this Agreement or a Direct Debit Request at any time by giving you at least 14 days written notice.

Changes by you

You may change the arrangements under a Direct Debit Request by contacting us subject to:

- if you wish to stop or defer a Debit Payment you must notify us at least seven days before the next Debit Day. This notice should be given to us in the first instance; and
- you may also cancel your authority with us to debit your Account at any time by giving us at least seven days' notice before the next Debit Day. This notice should be given to us in the first instance.

You may also cancel a Direct Debit Request by contacting Your Financial Institution.

Your obligations

It's your responsibility to ensure that there are sufficient clear funds available in your Account to allow a Debit Payment to be made in accordance with the Direct Debit Request.

If there are insufficient clear funds in your Account to meet a Debit Payment:

- you may be charged a fee and/or interest by Your Financial Institution;
- you may also incur fees or charges imposed or incurred by us in relation to an unsuccessful direct debit, such as fees charged to us by Your Financial Institution; and
- you must arrange for the Debit Payment to be made by another method, or arrange for sufficient clear funds to be in your Account by an agreed time, so that we can process the Debit Payment.

You should check your Account statement to verify that the amounts debited from your Account are correct.

If we're liable to pay goods and services tax ("GST") on a supply made in connection with this Agreement, then you agree to pay us on demand an amount equal to the consideration payable for the supply, multiplied by the prevailing GST rate.

Disputes

If you believe that there has been an error in debiting your Account, you should notify us as soon as possible so that we can resolve your query.

If we conclude as a result of our investigations that your Account has been incorrectly debited, we will respond to your query by arranging for Your Financial Institution to adjust your Account (including interest and charges) accordingly. We will also notify you of the amount by which your Account has been adjusted.

If we conclude as a result of our investigations that your Account has not been incorrectly debited, we will respond to your query by providing you with reasons and any evidence for this finding.

Any queries you may have about an error made in debiting your Account should be directed to ahm life insurance (contact details below) so that they can attempt to resolve the matter. In addition, you may contact Your Financial Institution, who will obtain details from you of the disputed transaction and may lodge a claim on your behalf.

Accounts

You should check:

- with Your Financial Institution whether direct debiting is available from your Account, as direct debiting is not available on all accounts offered by financial institutions;
- your Account details which you provided to us are correct by checking them against a recent Account statement; and
- with Your Financial Institution before completing the Direct Debit Request if you have any queries about how to complete the Direct Debit Request.

Confidentiality

We will keep any information (including your Account details) in your Direct Debit Request confidential. We will make reasonable efforts to keep any such information that we have about you secure, and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

We will only disclose information that we have about you:

- to the extent specifically required by law; or
- for the purposes of this Agreement (including disclosing information in connection with any query or claim).

Notices

If you wish to notify us about anything relating to this Agreement, our contact details are below.

Where we're providing you with notification in writing, we'll send the notice via email.

Providing instructions

Your Direct Debit Request may be provided to us in writing, by calling us or by such other electronic means that we choose to accept from time to time.

Instructions from you in connection with this Agreement (including any change to the Account to which your Direct Debit Request applies) may be provided to us in writing, by calling us or by e-mail.

Contact ahm life insurance

Phone: 1300 867 125

Email: service@ahmlife.com.au

Website: wwww.ahm.com.au/life-insurance

Mail: GPO Box 239, Sydney NSW 2001

Hours: Monday to Friday 8:00am – 8:00pm (AEST/AEDT)

Making a claim

Notifying us of a claim

We're here to support you through the claims process. If you, your legal personal representative, or nominated beneficiaries, are eligible to make a claim or are unsure and would like some assistance, it's important that you contact us as soon as possible. We'll then explain the claims process and requirements, so we can get your claim underway as soon as possible.

You should notify us of a claim in a timely manner. If our assessment has been compromised by a delay in you notifying us of your intention to claim, your claim or benefit payment may be delayed or reduced. If we reduce your claim or benefit payment due to a delay in your claim notification, we will do so by an amount that proportionally represents the extent to which our interests were prejudiced as a result of the delay.

Payment of premiums

An event giving rise to a claim must occur while your cover is in place. Benefit payments will only be made in relation to an insured event that occurs when cover is in place.

It's important to continue paying your premiums while your claim is being assessed to ensure your cover is not cancelled (except in the case of Death Benefit claims).

General claim requirements

Our assessment of your claim will involve us, acting reasonably and to the extent permitted by law, determining whether your claim meets all relevant *policy* terms and conditions and any applicable special terms shown on your *policy schedule*.

To enable us to assess liability for your claim we may acting reasonably and to the extent permitted by law, need financial, medical, vocational and other relevant information, or an examination or assessment of the *insured person* by a person reasonably nominated by us. Where we reasonably require information, an examination or assessment, we will confirm the need and purpose of the request with you and will require your, and the *insured person's*, reasonable cooperation. Different types of insurance may have special claim requirements and we may, acting reasonably and to the extent permitted by law, ask for further proof or information to help in assessing your claim.

To help support your claim we may also need the following (including certified copies where appropriate):

- a completed claim form;
- proof of the event which resulted in a claim being made;
- proof of payment, when a claim for reimbursement is being made;
- proof of age (unless previously provided);
- medical information (for example, reports from your treating doctors, Medicare/Pharmaceutical Benefits Scheme and private health insurance records);
- the *insured person* to attend medical examinations by a *medical practitioner* arranged by us, undertaking functional capacity tests; and / or undertaking vocational assessments;
- proof of probate and a death certificate for all Death Benefit claims; and/or
- an interview with our representative.

Our assessment of your claim may also require obtaining reasonable information relating to lifestyle, pastimes or financial evidence so that we can make our decision. Following a reasonable assessment of your claim, we must be satisfied of our initial and ongoing liability to pay a benefit. We will tell you if we need any of the above outlined information.

If we need an examination or assessment, we'll pay for the cost. However, costs which you may incur as a result of completing claim forms or providing other information to us, are payable by you.

Following the advice of a *medical practitioner*

The payment of a Terminal Illness Benefit (under Life Cover or Child Cover), or a benefit under TPD Cover will be dependent on the *insured person* (or *insured child* if relevant) following the reasonable advice of a *medical practitioner*. This includes reasonably:

- following, and actively participating in, a recommended course of treatment and rehabilitation for any conditions for which the claim is being made;
- complying with reasonable requests for occupational therapy, retraining and accepting reasonable job modifications that would allow a return to work (if relevant); and
- actively participating in recommended return to work trials or job placements (if relevant).

Confirmation of information provided in your application for insurance

In the assessment of your claim, we may, acting reasonably and to the extent permitted by law, confirm the accuracy of information you provided in:

- your application for insurance;
- a request to reinstate your insurance; or
- a request to make any other changes to your insurance;

in order to verify your entitlement to the insurance cover, re-instatement of cover, or other change to cover. This may include reasonable information that relates to previous medical, employment, lifestyle, pastime or financial history, to determine whether you and the *insured person* took reasonable care not to make a misrepresentation when you applied for, reinstated or changed the *policy*. We will advise you if this is required.

We, acting reasonably and to the extent permitted by law, may require written authorities from the *insured person*, permitting third parties, (e.g., other insurers, doctors, medical practices, hospitals, other health service providers, accountants, former employers, Medicare and other relevant third parties) to provide us with reasonable information to confirm your original entitlement to the insurance cover, re-instatement of cover, or other change to cover, when we are assessing your claim. We will advise you if this is required.

Fraudulent claims

If you fraudulently make a claim we may reduce or decline to pay you benefits and we may cancel your *policy*.

Payment of claims

If you make a claim and the claim is approved, all benefits will be paid to the *policy owner* or their legal personal representative.

Definitions

<table>
<tr><td>accident and accidental</td><td>Means a random and unforeseen event independent of all other causes.</td></tr>
<tr><td>activities of daily living</td><td>Means the following five activities:
– Dressing – The ability to put on and take off all garments. If the person is using modified clothing or adaptive devices including but not limited to tape fasteners or zipper pulls to perform this task, we will consider them able to dress themselves.
– Toileting – The ability for the person to get on and off the toilet and clean themselves. If the person can care for a stoma or catheter or uses adaptive devices to perform this task, we will consider them able to toilet themselves.
– Bathing – The ability for the person to wash themselves either in the bath or shower. If the person performs these tasks by using equipment or adaptive devices, we will consider them able to bathe themselves.
– Eating – The ability to get food from a plate into the mouth once it has been prepared. If the person is able to perform this task using assistive devices including but not limited to modified utensils and adaptive dinnerware, we will consider them able to feed themselves.
– Transferring – The ability to move in and out of bed and a chair. If the person uses motorised equipment and supportive devices including but not limited to bed rails, grab bars, walkers, transfer platforms and canes, we will consider them able to transfer themselves.</td></tr>
<tr><td>acute stroke (requiring specified impairment lasting more than 24 hours and excluding the retina)</td><td>Means the death of brain or spinal cord tissue caused by one of the following:
– focal ischaemia (infarction) of brain or spinal cord tissue; or
– haemorrhage (intracerebral, intraventricular, subarachnoid, or any haemorrhage into the spinal cord).
The diagnosis must be supported by both of the following:
– evidence of ongoing neurological deficit with persisting signs lasting more than 24 hours; and
– findings on Magnetic Resonance Imaging (MRI), computerized tomography (CT) scan or other reliable imaging evidence consistent with the clinical findings and/or with the diagnosis of a new stroke.
The following are not covered:
– Any vascular cause resulting in transient neurological symptoms or signs (including transient ischaemic attacks) lasting less than 24 hours regardless of any neuroimaging evidence of a stroke.
– Brain damage due to accident, injury, infection, demyelination or non-vasculitic inflammatory disease.
– Any vascular disease affecting the eye, retina or optic nerve (including retinal artery and venous occlusive events).
– Migraine.
– Subdural and/or epidural haematoma.
– Silent stroke or silent intracranial haemorrhage (or any abnormality on imaging) that has not resulted in neurological deficit.</td></tr>
</table>

aplastic anaemia (requiring specified treatment)	Means the unequivocal diagnosis of a chronic persistent bone marrow failure, confirmed by bone marrow biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following: – blood product transfusion; – bone marrow stimulating agents; – immunosuppressive agents; or – bone marrow/stem cell transplantation.
apparent	Means the person was aware of, or a reasonable person in the circumstances could be expected to have been aware of, the *illness* or *injury*.
Australian resident	Means a person that permanently resides in Australia and: – holds an Australian or New Zealand citizenship; – holds an Australian permanent residency visa; or – is eligible to apply for an Australian permanent residency visa and will submit an application within the next 12 months.
benign brain tumour (resulting in irreversible neurological deficit)	Means a non-cancerous tumour on the brain or spinal cord that gives rise to symptoms of permanent neurological deficit and: – results in the total and permanent inability to perform any one of the *activities of daily living*; or – requires the tumour to be surgically removed on the advice of a consultant neurologist/neurosurgeon or ear, nose and throat surgeon. The presence of the underlying tumour must be confirmed on imaging studies such as computerised tomography (CT) scan or Magnetic Resonance Imaging (MRI), and any neurological deficit must be confirmed by a relevant *specialist medical practitioner*. The following are excluded: – Pituitary gland tumours unless surgically removed by open craniotomy. – Pituitary gland haematomas. – Cysts and granulomas. – Cholesteatomas. – Malfunctions in or of the arteries or veins of the brain.
blindness (total and irrecoverable)	Means the *loss of sight (permanent)* in both eyes.

cancer (excluding early stage cancers)	Means any malignant tumour diagnosed with histological confirmation and characterised by: – the uncontrolled growth of malignant cells; and – invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes carcinoma, sarcoma, lymphoma, leukaemia and other malignant bone marrow disorders. The following specified early stage cancers are not covered under this definition: – All tumours which are histologically classified as carcinoma in situ, pre-malignant, non-invasive, high-grade dysplasia, borderline or low malignant potential. – Chronic lymphocytic leukaemia. – Polycythaemia Rubra Vera. – Melanoma skin cancer. – Non-melanoma skin cancer. – Hyperkeratosis. – Bladder cancer. – Prostate cancer. – Thyroid cancer. – Cutaneous lymphoma confined to the skin. – Brain tumours. The following specified early stage cancers are covered under this definition: – Carcinoma in situ of the breast which has resulted in: - the removal of the entire breast; - breast conserving surgery and radiotherapy; or - breast conserving surgery and chemotherapy. These procedures must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment. – Chronic lymphocytic leukaemia with Rai classification stage 1 or greater. – Polycythaemia Rubra Vera where there has been: - failure to be controlled on venesection only; - rising platelet counts; or - increasing primitive blood cells (blasts) in the circulation. – Melanoma skin cancer with a Breslow thickness of greater than 1mm or where ulceration is present (T1b or greater) or with a Clark Level 3 or greater depth of invasion. – Non-melanoma skin cancer - squamous cell carcinoma or basal cell carcinoma: - with extensive cortical or medullary bone involvement; - with invasion of the base of the cranium; - with any distant spread to another organ; or - measuring greater than 4cm or with erosion of the muscle, cartilage, bone, lymphatics or peri neural invasion. – Bladder cancer that has progressed to at least TNM classification T1N0M0.

cancer (excluding early stage cancers) continued	– Prostate cancer that has progressed to at least TNM classification:
	  - T2N0M0 (Gleason score >6); or
	  - T1N0M0 (Gleason score ≤6) requiring radical prostatectomy or other adjuvant therapy (such as radiotherapy and/or chemotherapy) and considered to be the appropriate and necessary treatment.
	– Thyroid cancer that has progressed to at least TNM classification:
	  - T2N0M0; or
	  - where total thyroidectomy was done and considered to be the appropriate and necessary treatment.
	– Cutaneous lymphoma that has spread to lymph nodes or other organs.
	– Malignant brain tumours with a WHO grade III or higher.

cancer (in children, excluding early stage cancers)	Means any malignant tumour diagnosed with histological confirmation and characterised by:
	– the uncontrolled growth of malignant cells; and
	– invasion and destruction of normal tissue beyond the basement membrane.
	The term malignant tumour includes carcinoma, sarcoma, lymphoma, leukaemia and other malignant bone marrow disorders.
	The following specified early stage cancers are not covered under this definition:
	– All tumours which are histologically classified as carcinoma in situ, pre-malignant, non-invasive, high-grade dysplasia, borderline or low malignant potential.
	– Chronic lymphocytic leukaemia.
	– Melanoma skin cancer.
	– Non-melanoma skin cancer.
	– Hyperkeratosis.
	The following specified early stage cancers are covered under this definition:
	– Chronic lymphocytic leukaemia with Rai classification stage 1 or greater.
	– Melanoma skin cancer with a Breslow thickness of greater than 1mm or where ulceration is present (T1b or greater) or with a Clark Level 3 or greater depth of invasion.
	– Non-melanoma skin cancer - squamous cell carcinoma or basal cell carcinoma:
	  - with extensive cortical or medullary bone involvement;
	  - with invasion of the base of the cranium;
	  - with any distant spread to another organ; or
	  - measuring greater than 4cm or with erosion of the muscle, cartilage, bone, lymphatics or perineural invasion.

cardiomyopathy (permanent and irreversible)	Means a permanent and irreversible condition of the heart muscle with impaired ventricular function of variable aetiology (often not determined) resulting in: – significant physical impairment to the degree of at least Class III on the New York Heart Association classification of cardiac impairment; or – a persistent left ventricular ejection fraction of less than or equal to 35% despite optimal medical therapy.
child critical illness event	Means the medical events outlined on page 8.

chronic lung failure (requiring long-term oxygen therapy)	Means chronic irreversible lung disease that has progressed to an advanced stage with either a Pa02 consistently less than 55mmHg or requiring long term oxygen therapy of at least 15 hours per day, as certified by the relevant *specialist medical practitioner*.
coma (of specified severity and duration)	Means a prolonged state of unconsciousness characterised by abnormal response to external stimuli, with a Glasgow Coma Score (GCS) of less than 7 and requiring mechanical ventilation for a continuous period of at least 72 hours. The diagnosis of coma must be made by an appropriate *specialist medical practitioner*. Excluded from this definition is intensive care as a result of excessive alcohol use or illicit substance use.
congenital condition	Means a condition present at birth as a result of either hereditary or environmental influences. A condition will be considered as a congenital condition even if discovered at any time after birth (during childhood and into adulthood), but was present at the moment of birth.
critical illness event	Means the medical events outlined on page 7.
deafness in both ears (total and permanent including requiring a cochlear implant)	Means a confirmed diagnosis of profound, irreversible hearing loss in both ears with any one of the following: – best corrected hearing threshold of 91 decibels or greater in the better ear, averaged at frequencies from 500 hertz to 3,000 hertz; or – requiring or undergoing cochlear implant due to loss of hearing in both ears. The diagnosis must be made by an appropriate *specialist medical practitioner*.
encephalitis (resulting in serious and permanent functional impairment)	Means severe acute inflammation of the brain tissue (cerebral hemisphere, brainstem or cerebellum) caused by viral or bacterial infection resulting in either: – the total and permanent inability to perform any one of the *activities of daily living*; or – permanent impairment of at least 25% in *whole person function*, attributable to the above condition. The diagnosis must be confirmed by a consultant neurologist.
end stage chronic kidney failure (requiring regular renal dialysis or kidney transplantation)	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. The definition will also be met if both of the following are present: – regular renal dialysis or kidney transplantation is clinically indicated in the person as confirmed by the treating nephrologist but the person has chosen renal supportive care; and – the person has an estimated glomerular filtration rate (eGFR) of less than 15ml/min/1.73m2.
end stage chronic liver failure	Means the irreversible deterioration in liver function that has progressed to end stage liver failure resulting in two of the following: – permanent jaundice (yellow discolouration of the skin or eyes); – ascites (abnormal build-up of fluid in the abdomen); or – hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease).

<table>
<tr><td>gainfully employed</td><td>Means to be employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment.</td></tr>
<tr><td>heart attack (with evidence of heart muscle damage)</td><td>Means the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area.
The diagnosis must be:
– confirmed by a cardiologist or relevant medical practitioner; and
– evidenced by typical rise and/or fall of a cardiac biomarker blood test (Troponin T, Troponin I or CK-MB) with at least one value above the 99th percentile of the upper reference limit; and
– any one of the following:
  - acute symptoms of coronary ischaemia (e.g. chest pain);
  - new significant ECG changes with the development of any of the following:
    - ST elevation or depression;
    - T wave inversion;
    - Pathological Q waves; or
    - left bundle branch block (LBBB);
  - imaging evidence of new loss of viable myocardium or new regional wall motion abnormality; or
  - identification of a coronary thrombus or severe coronary artery stenosis by angiography or other intracoronary imaging.
If the above tests are inconclusive we will consider other appropriate and medically recognised tests.
The following are excluded:
– Other acute coronary syndromes including but not limited to angina pectoris.
– Other causes of troponin increase in non-obstructive coronary arteries including myocarditis or coronary spasm where there is no evidence of infarction.
– Heart muscle injury as a result of an elective procedure for coronary artery disease.
– Any cardiomyopathy including Takotsubo cardiomyopathy (Takotsubo Syndrome).</td></tr>
<tr><td>illness</td><td>Means an illness or disease.</td></tr>
<tr><td>immediate family member</td><td>Means spouse, child, sibling, parent, father in-law or mother in-law, de facto partner, or a person in an interdependent relationship. An interdependent relationship exists where two people have a close personal relationship, live together, one or each of them provides the other with financial support, and one or each of them provides the other with domestic support and personal care.</td></tr>
<tr><td>injury</td><td>Means an injury to the body caused by an accident.</td></tr>
<tr><td>insured child</td><td>Means the child whose life is insured under Child Cover. The insured child (or children) are shown on your policy schedule. There may only be a maximum of five insured children under any one policy.</td></tr>
<tr><td>insured person</td><td>Means the person whose life is insured under your policy. The insured person is shown on your policy schedule.</td></tr>
<tr><td>limb</td><td>Means an arm, leg, hand or foot. The hand or foot starts from the wrist or ankle joint, respectively.</td></tr>
</table>

loss of independence (total and permanent)	Means any *illness* or *injury* that results in the permanent inability to perform two or more *activities of daily living* without total dependence on another person. The person must be under continuous care and supervision by another adult person for at least six consecutive months. At the end of that six-month period, the person must, on the basis of medical evidence, require ongoing continuous care and supervision by another adult person.
loss of sight in one eye (total and irrecoverable)	Means the *loss of sight (permanent)* in one eye.
loss of sight (permanent)	Means the complete and irreversible loss of sight in an eye due to *injury* or *illness* with any of the following: – best corrected visual acuity is 6/60 or less (this means that even with visual aids the person needs to be at 6 metres or less to see what someone with normal vision can see at 60 metres); or – visual field is reduced to 20 degrees or less of arc (this means that the person's field of vision is less than 20 degrees in diameter). The diagnosis must be confirmed by an ophthalmologist. Loss of sight due to cataracts is excluded.
loss of speech (total and irrecoverable)	Means the total and irrecoverable loss of the ability to produce intelligible speech, because of permanent damage to the larynx or its nerve supply or to the speech centres of the brain, due to *injury* or *illness* and confirmed by an appropriate *specialist medical practitioner*.
loss of use of a single limb (total and irrecoverable)	Means the total and irrecoverable loss of use of one *limb*.
loss of use of limbs (total and irrecoverable)	Means the total and irrecoverable loss of use of two or more *limbs*.
major burns of the skin (of specified severity and requiring specified treatment)	Means thermal, electrical or chemical *injury* causing deep partial-thickness burns or full thickness burns to the skin requiring surgical debridement and skin grafting or flap reconstruction. The burns must involve one of the following: – 20% of the total body surface area as measured by the Lund-Browder Chart or 'Rule of Nines'; – 50% of both hands; – 50% of both feet; or – the face. The diagnosis must be confirmed by a *specialist medical practitioner* in that field.
major head trauma (with significant permanent neurological impairment)	Means an *accidental* head *injury* resulting in permanent neurological deficit, resulting in either: – the total and permanent inability to perform any one of the *activities of daily living*; or – a Montreal Cognitive Assessment (MoCA) test with a persistent score of 17 or less, or other standardised cognitive assessment test with an equivalent severity. For the purposes of this definition *accidental* head *injury* means a bump, blow, or jolt to the head, or penetrating head *injury*. Diagnosis must be confirmed by a consultant neurosurgeon or neurologist.

major organ transplant (of specified organs or being put on a transplant waiting list)	Means having received, from a human donor, a medically necessary transplant involving one or more of the following organs or tissues: – Kidney; – Heart; – Liver; – Lung; – Pancreas; – Small bowel; or – Bone marrow/haematopoietic (stem) cells. The definition will also be met if the person has been placed on the Australian or New Zealand Transplant Society waiting list (such as OrganMatch) to receive a major organ or tissue transplant of the kind described above. The transplantation of all other organs or parts of any organ or any other tissue or grafts is excluded.
medical practitioner	Means a medical practitioner who is legally qualified and registered to practice in Australia (or for overseas practitioners, have the equivalent medical qualifications and are approved by us, acting reasonably, as having such qualifications) that is not the *insured person*, the *policy owner* or an *immediate family member*, business partner, employee or employer of the *insured person*, an *insured child* or the *policy owner.* Note: for the avoidance of doubt, persons qualified in occupations such as (but not limited to) chiropractic, physiotherapy, psychology and alternative therapies are not regarded as medical practitioners.
medically-acquired HIV (contracted from a medical procedure or operation)	Means *accidental* infection with the human immunodeficiency virus (HIV) where the virus was acquired in Australia from one of the following medically necessary events conducted by a recognised and registered health professional: – a blood transfusion; – transfusion with blood products; – organ transplant; – assisted reproductive techniques; or – a medical procedure or operation performed by a *medical practitioner* or dentist. Notification and proof of the incident will be required via a statement from the appropriate Statutory Health Authority that the infection was medically acquired. HIV infection transmitted by any other means including sexual activity or the use of drugs, other than as prescribed by a *medical practitioner*, is excluded. This event will not apply, and no payment will be made, when a cure has become available or where the person doesn't take any vaccine available prior to the event. 'Cure' means an Australian Government-approved treatment, which renders the HIV inactive and non-infectious, or results in there being little or no impact on life expectancy. 'Vaccine' means a preparation approved by the Australian Government and recommended for use by the Government authority to produce immunity to the HIV.
meningococcal disease (resulting in significant permanent impairment)	Means the unequivocal diagnosis of meningococcal septicaemia resulting in: – at least a permanent 25% impairment of *whole person function*; or – total and permanent inability to perform any one of the *activities of daily living* without the physical assistance of another person.
mortgage	Means a loan secured by a first mortgage over the *insured person's* home.

normal domestic duties	Means all of the following activities, unassisted by another person: – Cleaning the home – the ability to carry out basic internal household chores using various tools such as a mop or vacuum cleaner. – Cooking meals – the ability to prepare meals using basic ingredients and normal kitchen appliances. – Washing laundry – the ability to do laundry by using the washing machine and being able to hang clothes on a washing line or clothes airer. – Shopping for groceries – the ability to physically purchase general household grocery items with either the use of a shopping basket or trolley. – Taking care of dependent children (where applicable) – if the *insured person* normally looks after a child or children up to the age of 12 as part of their everyday activities, taking care of dependent children means the ability to care for and supervise the children, including preparation of meals, bathing, dressing and getting the children to and from school by the usual mode of transport. Normal domestic duties do not include duties performed outside of the person's home for salary, reward or profit.
open heart surgery	Means the undergoing of open chest surgery for the surgical treatment of a cardiac defect (including heart valve defect) cardiac aneurysm or benign cardiac tumour.
paralysis (total and permanent)	Means the total and permanent loss of function of two or more *limbs* through *illness* or *injury* as a result of permanent damage to the nervous system. This includes, but is not limited to, quadriplegia, paraplegia, diplegia and hemiplegia.
policy	Means our contract of insurance with you, which provides one or more cover types to you. Your policy consists of this PDS and your *policy schedule*.
policy owner	Means the person who owns the *policy*. The policy owner is shown on your *policy schedule*.
policy schedule	Means the most recent schedule to the *policy* which outlines the types of cover that you have and other details of your specific cover. The policy schedule forms part of your *policy*.
prolonged intensive care	Means an *injury* or *illness* has resulted in the *insured child* requiring continuous mechanical ventilation by means of tracheal intubation for seven consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital. Intensive care as a result of excessive alcohol use or illicit substance use is excluded.
specialist medical practitioner	Means a *medical practitioner* who practices in a specialty field related to the relevant *illness* or *injury* and is listed on the Australian Health Practitioner Regulation Agency (AHPRA) Specialist Register who is not the *insured person*, the *policy owner* or an *immediate family member* or business partner, employee or employer of the *insured person*, *insured child* or the *policy owner*.
subacute sclerosing panencephalitis	Means the unequivocal diagnosis of this disorder.
sum insured	Means the amount of cover you're insured for, as shown in your *policy schedule*. This may reduce when benefits are paid.

terminal illness **and** ***terminally ill***	Means an *illness* or *injury* that even with appropriate medical treatment, is likely to lead to the death of the *insured person* or *insured child* within 12 months of certification. This certification must be provided by a *specialist medical practitioner*, and where reasonable, a further *specialist medical practitioner* approved by us. We must, acting reasonably, agree with one or both medical opinions.
total and permanent disability / totally and permanently disabled	Means that, as a result of *illness* or *injury*, the *insured person*: – has been absent from, and unable to work, for three consecutive months and at the end of those three months is, in our reasonable opinion, and after consideration of medical and any other evidence, disabled to such an extent that the *insured person* is unlikely ever again to be able to: - engage in any occupation for which they are reasonably suited by education, training or experience; and - engage in an occupation which is likely to generate a regular income of more than 25% of the average regular income they were earning in the 12 months prior to their *illness* or *injury*; OR – is totally and permanently unable to perform at least two of the five *activities of daily living* without the physical assistance of another person; OR – suffers: - *blindness (total and irrecoverable);* - *loss of use of limbs (total and irrecoverable); or* - *loss of sight in one eye (total and irrecoverable)* and *loss of use of a single limb (total and irrecoverable)*; OR – has been solely performing *normal domestic duties* for more than 12 consecutive months immediately prior to the *illness* or *injury* that gave rise to the claim, and as a result of that *illness* or *injury*: - the *insured person* hasn't been able to perform the *normal domestic duties* for three consecutive months; and - in our reasonable opinion after consideration of medical and any other evidence, the *insured person* is incapacitated to such an extent that they are unlikely ever again to be able to perform all the *normal domestic duties*.
we, us, our, or insurer	Means Integrity Life.
whole person function	Has the meaning given to it in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' current as at the date of impairment.
you or your	Means the *policy owner.*

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To find out more about ahm Life Insurance, please visit the website at:
www.ahm.com.au/life-insurance

For assistance, please contact ahm life insurance on the below details:

Phone: 1300 867 125
Email: service@ahmlife.com.au