ahm life insurance

Product Disclosure Statement

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About ahm life insurance

ahm life insurance is issued by Swiss Re Life & Health Australia Limited ABN 74 000 218 306, Australian Financial Services Licence No. 324908, Level 36, Tower Two, International Towers Sydney, 200 Barangaroo Avenue, Sydney, NSW 2000.

ahm life insurance is promoted by ahm health insurance, a business of Medibank Private Limited, ABN 47 080 890 259, Authorised Representative No. 286089, 720 Bourke Street, Docklands VIC 3008.

Medibank Private Limited is acting as the authorised representative of Greenstone Financial Services Pty Ltd (GFS), ABN 53 128 692 884, Australian Financial Services Licence No. 343079, 58 Norwest Boulevard, Bella Vista NSW 2153.

ahm life insurance is distributed by GFS.

About this Product Disclosure Statement (PDS)

This PDS is designed to help you decide if the cover provided is right for you.

The PDS, which is provided by the insurer, Swiss Re, describes the main features and benefits and sets out the terms and conditions of ahm life insurance. Swiss Re is responsible for this PDS.

Any advice given in this PDS is general only and doesn't take into account your individual objectives, financial situation or needs. You should consider whether this product is right for you, having regard to your objectives, financial situation and needs.

You should carefully read this PDS and any other documentation we send you before making a decision whether to acquire ahm life insurance.

ahm life insurance is issued by the insurer, Swiss Re Life & Health Australia Limited. Swiss Re has sole responsibility for this PDS, the Policy Schedule and the assessment and payment of claims.

In this PDS, some words or expressions have a special meaning. They normally begin with capital letters and their meaning is explained in the **Glossary** (page 14) of this PDS.

In the PDS, references to 'we', 'us' and 'our' means Swiss Re.

In the PDS, 'ahm' and 'ahm health insurance' are references to Medibank Private Limited ABN 47 080 890 259, trading as ahm health insurance.

ahm life insurance isn't issued, guaranteed or underwritten by ahm, and ahm isn't involved, nor liable, in any manner in respect of the assessment and payment of benefits under ahm life insurance.

Information contained in this PDS may be updated or changed. Any changes or updates that aren't materially adverse to you will be available at **ahm.com.au/life** or by calling us on **1300 052 589** Monday to Friday, 8am - 8pm (AEST).

What's inside

Introducing ahm life insurance

ahm has partnered with Swiss Re, one of the world's leading insurance groups, to offer ahm life insurance – affordable life insurance for your peace of mind.

ahm life insurance offers a range of product options to suit your needs.

- Life cover – lump sum cover in the event of death, Terminal Illness or Accidental injury; and
- Optional benefits:
  - Permanently Unable to Work cover* – lump sum cover if you suffer Permanent Inability to Work;
  - Trauma cover* – lump sum cover if you suffer a specified trauma event; and
  - Children's Insurance cover – lump sum cover in the event an Insured Child suffers a specified trauma event or death.

* Any payment of the Permanently Unable to Work Benefit Amount and Trauma cover Benefit Amount, as a result of a claim, will reduce (or in some instances end) the Life Benefit Amount which remains on your Insurance Policy. The benefits are constructed in this way in order to minimise the additional cost of the options whilst providing you with valuable cover. Further explanation of how this works is provided in **Reducing Benefit Amounts** on page 7.

These benefits and the terms and conditions of ahm life insurance are explained in this PDS.

Your Insurance Policy

If your application for ahm life insurance is accepted by us, we'll issue you a Policy Schedule. Your Insurance Policy consists of your Policy Schedule and:

- this PDS;
- the application (and any future application accepted by us); and
- any special conditions, amendments or endorsements we issue you.

Please keep your Policy Schedule, this PDS and all documents we send to you in a safe place for future reference. The insurance provided by ahm life insurance is written out of the Swiss Re Statutory Fund.

Who can apply for ahm life insurance?

You can apply for a single plan on your own life or you can apply to include your spouse, partner and/or de facto (Partner Life Insured) under an ahm life insurance Policy.

You (and your Partner Life Insured, if applying) must be an Australian Resident/s and meet the following age requirements:

Age eligibility	Life cover	Permanently Unable to Work cover	Trauma cover
Minimum age	16	16	18
Maximum age	65	60	60

In addition, for Permanently Unable to Work cover, you (and your Partner Life Insured if applying) must be working on a permanent basis in an eligible occupation for at least 20 hours per week. Most occupations are eligible but work that involves hazardous activities may be excluded.

You can apply for Children's Insurance cover for a natural child, stepchild or adopted child of yours (and/or of a Partner Life Insured) if the child is aged from 2 to 18 years inclusive and the child is an Australian Resident.

Your Policy Schedule will state which Life Insured/s and Insured Child/ren (if applicable) are covered and which optional benefits apply (if any).

We reserve the right to accept or decline applications for ahm life insurance (including optional benefits, Life Insured/s and Insured Child/ren) at our absolute discretion.

Complimentary interim Accidental Death cover

If you apply by phone and we need further information to assess your application, you'll be provided with interim cover for up to 30 days against Accidental Death while we assess your application. The amount of interim Accidental Death insurance cover is the Life Benefit Amount you apply for, subject to the maximum limits indicated in **The Benefit Amounts you can apply for** on page 5. This cover is provided at no additional cost to you and is subject to the terms explained and conditions in this PDS.

Your interim Accidental Death insurance cover will cease after 30 days from the date of your phone application, or on the date we notify you that we have accepted or declined your application, whichever occurs first.

The Benefit Amounts you can apply for

The minimum Life Benefit Amount is $100,000.

You can apply for a Benefit Amount which is more than the minimum, in increments of $50,000, up to the maximum Benefit Amount shown below:

Maximum Benefit Amount

Age at application	Life cover	Permanently Unable to Work cover*	Trauma cover*
16-45	$1,500,000**	$1,250,000**	$500,000 (from age 18)
46-55	$1,000,000**	$750,000**	$200,000
56-60	$500,000	$200,000	$75,000
61-65	$500,000	N/A	N/A

* The Life Benefit Amount is reduced by the amount paid under these optional benefits – see explanation in **Reducing Benefit Amounts** on page 7.

** The maximum Benefit Amount detailed in the table above, may be reduced based on the information you provide during the application process about your income.

The Benefit Amounts for Permanently Unable to Work cover and Trauma cover can't in aggregate exceed the chosen Life cover.

When you apply with a Partner Life Insured, you each apply for individual Benefit Amounts based on the limits above for the relevant age group.

For Children's Insurance, for any child aged from 2 to 18 years inclusive, you can apply for a Benefit Amount of either $50,000 or $25,000. The maximum Children's Insurance Benefit Amount for a child is $50,000.

When we'll pay the Benefit Amounts

We'll pay the benefits explained below if the Life Insured or Insured Child suffers an insured event while covered for that insured event under the Insurance Policy, except in the circumstances explained in **When will a Benefit Amount not be payable?** on page 7.

The Benefit Amounts for each Life Insured and Insured Child are set out in the Policy Schedule. Unless otherwise indicated, payment of a benefit is subject to the provision of claim proofs, which are explained in **Making a claim** on page 12.

Life cover

We'll pay the Life Benefit Amount as a lump sum under the Insurance Policy if a Life Insured dies while the Insurance Policy is in force.

We'll advance $15,000 of the Life Benefit Amount to help with the costs associated with funeral or other similar expenses without waiting for all claim proofs, but we must have satisfactory evidence of the deceased Life Insured's age, cause and date of death. This advancement isn't payable if the Life Insured's death is the result of suicide within 13 months of the Policy Start Date, is the result of anything that's excluded under the Insurance Policy, or if there's reasonable doubt about whether the Life Benefit Amount may become payable. If we make an advance payment in this way, this isn't an admission of our liability to pay the balance of the Life Benefit Amount, which is subject to the provision of all claim proofs.

Terminal Illness

We'll pay the Life Benefit Amount as a lump sum if you're diagnosed with a Terminal Illness while your Insurance Policy is in force.

Payment of the Life Benefit Amount, as a result of a Terminal Illness claim, will end cover under this Insurance Policy in respect of the relevant Life Insured.

Accidental injury

We'll pay the Life Benefit Amount as a lump sum if, as the direct result of an Accident, the Life Insured suffers:

- Permanent Loss of Use of Limbs or Paralysis; or
- Permanent Loss of Sight.

We'll pay 25% of the Life Benefit Amount if, as the direct result of an Accident, the Life Insured suffers:

- the total and Permanent Loss of Use of One Limb; or
- Permanent Partial Loss of Sight.

When an Accidental injury claim is paid, the Life Benefit Amount is reduced by the amount paid.

Permanently Unable to Work cover

Permanently Unable to Work cover in respect of a Life Insured is only available if we have agreed to provide Life cover for that Life Insured.

We'll pay you the Permanently Unable to Work Benefit Amount if, while the cover is in force (see **When your cover starts and ends** on page 7), the Life Insured is Permanently Unable to Work.

Permanently Unable to Work means:

- the Life Insured, solely because of sickness or injury, has been continuously absent from work for a period of at least three consecutive months; and

- in our opinion after consideration of all relevant evidence, due to that sickness or injury, the Life Insured is unlikely ever to be able to work again in any occupation for which the Life Insured is suited based on work experience, education or any training;

or

- the Life Insured suffers Permanent Loss of Hearing or Severe Burns.

If the Life Insured was engaged in full time Domestic Duties at the time of the injury, additional conditions will apply.

Please refer to the **Glossary** on page 14 for full details.

When the Permanently Unable to Work Benefit Amount is paid, the Life Benefit Amount is reduced by the amount paid.

Trauma cover

Trauma cover in respect of a Life Insured is only available if we have agreed to provide Life cover for that Life Insured.

We'll pay the Trauma Benefit Amount if, while the Trauma cover is in force (see **When your cover starts and ends** on page 7), the Life Insured suffers one of the following trauma events:

- Cancer (excluding specified early stage cancers)
- Heart Attack
- Loss of Independent Living
- Open Heart Coronary Artery Bypass Surgery
- Stroke.

When the Trauma Benefit Amount is paid, the Life Benefit Amount is reduced by the amount paid.

Children's Insurance cover

We'll pay the benefits explained below if an Insured Child suffers death or an insured trauma event while the Insurance Policy is in force (see **When your cover starts and ends** on page 7) except in the circumstances explained in **When will a Benefit Amount not be payable?** on page 7.

Unless otherwise indicated, payment of a benefit is subject to the provision of claim proofs, which are explained in **Making a claim** on page 12.

We'll pay the Children's Insurance Benefit Amount for an Insured Child as a lump sum if that Insured Child suffers one of the following trauma events:

- Cancer (excluding specified early stage cancers)
- Encephalitis (resulting in Permanent Neurological Deficit)
- Major Head Trauma (resulting in Permanent Neurological Deficit)
- Meningitis (resulting in Permanent Neurological Deficit)
- Permanent Loss of Hearing
- Permanent Loss of Sight
- Permanent Loss of Use of Limbs or Paralysis
- Severe Burns

while covered under the Insurance Policy and survives for 14 days after the day that the trauma event occurs or is contracted. If the Children's Insurance Benefit Amount is paid or payable because the Insured Child suffers a trauma event, the Insurance for that Insured Child ends and there's no further payment if the Insured Child subsequently dies.

We'll pay 20% of the Children's Insurance Benefit Amount as a lump sum under the Insurance Policy on the death of an Insured Child while the Insurance Policy is in force.

We'll pay you up to $1,000 as reimbursement of costs you incur for consultations with an independent, qualified counselling organisation for counselling immediate family members of the Insured Child following an insured trauma event or death. This reimbursement is in addition to any payment of the Children's Insurance Benefit Amount.

Maximum Benefit Amount limit

The maximum aggregate Benefit Amount payable for a Life Insured or Insured Child can't exceed the maximum Benefit Amount set out in **The Benefit Amounts you can apply for** on page 5 plus any automatic increases as described in **Automatic increases of your Benefit Amounts** on page 9. If the Life Insured or Insured Child is covered under more than one ahm life insurance and/or ahm accidental death insurance Policy, we'll apply this limit to the aggregate of the Benefit Amounts for that Life Insured or Insured Child under all such Policies and, if necessary, we'll reduce the applicable Benefit Amount under the Insurance Policy or Policies most recently commenced. If we reduce the Benefit Amount insured under an Insurance Policy, any overpayment of premiums resulting from the reduction in benefits will be refunded.

Reducing Benefit Amounts

The Life Benefit Amount for a Life Insured will be reduced by the amount of:

- any Benefit Amount paid as the result of an Accidental injury; and
- any advancement of the Life Benefit Amount paid; and
- any Permanently Unable to Work Benefit Amount paid; and
- any Trauma Benefit Amount paid,

in respect of that Life Insured.

If the Life Benefit Amount for a Life Insured is reduced, any unpaid Permanently Unable to Work Benefit Amount and any unpaid Trauma Benefit Amount for that Life Insured can't exceed the remaining Life Benefit Amount. If the Permanently Unable to Work Benefit Amount and/or Trauma Benefit Amount for that Life Insured does exceed the reduced Life Benefit Amount, the Permanently Unable to Work Benefit Amount and Trauma Benefit Amount will be reduced to equal the remaining Life Benefit Amount. We'll also adjust your premiums to reflect the reduced cover.

When your cover starts and ends

If your application for ahm life insurance is accepted by us, cover starts for a Life Insured or Insured Child on the Policy Start Date set out in the Policy Schedule. Your first premium is deducted on the First Premium Due Date, which is also set out in your Policy Schedule.

We guarantee to continue cover for a Life Insured under your Insurance Policy (provided you pay your premiums when due) until the earlier of the death of the Life Insured or such time as the Life Benefit Amount in respect of that Life Insured is reduced to nil as a result of the payment of claims.

When a Life Insured reaches age 99, the premium will stay the same for the remaining term of the Insurance Policy in respect of that Life Insured unless we change the premium rates as explained in **The cost of your cover** on page 10.

If a Life Insured has Permanently Unable to Work cover or Trauma cover, we guarantee to continue this cover for the Life Insured (as long as the Insurance Policy remains in force and you pay premiums when due) until the Policy Anniversary after the Life Insured's 65th birthday or such time as the Benefit Amount in respect of that Life Insured is reduced to nil as a result of the payment of claims. Permanently Unable to Work cover and Trauma cover for a Life Insured end on the Policy Anniversary after the Life Insured's 65th birthday.

As long as the Insurance Policy remains in force and you pay premiums when due, we guarantee to continue the Children's Insurance cover for an Insured Child until:

- the date of payment of a benefit in respect of the Insured Child; or
- the Policy Anniversary after the Insured Child attains age 21

whichever occurs first. Your Insurance Policy ends when the first of the following occurs:

- the date of payment of the total Life Benefit Amount in respect of a Life Insured and there's no surviving Partner Life Insured; or
- the date you cancel your Insurance Policy; or
- the date we cancel your Insurance Policy if you don't pay your premium when due, in accordance with our rights.

If your premiums remain unpaid for more than one month, your Insurance Policy could be cancelled. If we cancel your Insurance Policy, it may be reinstated within six months of the date that your Insurance Policy was cancelled, but only if we agree and subject to any terms and conditions we require.

You can cancel your Insurance Policy at any time in writing by giving us 30 days notice. You'll need to send your written request for cancellation, including your full name and policy number, to:

Policyowner Services
ahm life insurance
PO Box 6728
Baulkham Hills NSW 2153

To chat about cancelling or making changes to your Insurance Policy, give us a call on **1300 052 589** Monday to Friday, 8am - 8pm (AEST).

When will a Benefit Amount not be payable?

We won't pay a Life Benefit Amount in respect of a Life Insured if the Life Insured dies, or is diagnosed with a Terminal Illness, directly or indirectly as a result of an intentional or deliberate self-inflicted injury, occurring on or after the Policy Start Date and before the date that's 13 months after:

- the Policy Start Date of your Insurance Policy;
- the date that any increase in Benefit Amount is requested (but only in respect of the increase); or
- the date on which we reinstate your Insurance Policy (where we have agreed to reinstate your Insurance Policy after it was cancelled).

We won't pay an Accidental injury benefit, a Permanently Unable to Work benefit or a Trauma benefit where the condition is a result, directly or indirectly, of an intentional or deliberate self-inflicted injury.

For Trauma cover, we won't pay the Trauma Benefit Amount in the case of Cancer (excluding specified early stage cancers), Stroke, Open Heart Coronary Artery Bypass Surgery or Heart Attack if the condition was diagnosed, or the circumstances leading to diagnosis became apparent, after the Policy Start Date and within 90 days after:

- the Policy Start Date; or
- the date that an increase in Benefit Amount is requested in respect of the Life Insured (but only in respect of the increase); or
- the date on which we reinstate your Insurance Policy (where we have agreed to reinstate your Insurance Policy after it was cancelled).

We won't pay any benefits where we have agreed with you a special term in respect of your cover that specifically excludes the event or condition leading to the claim. Any such special term will be agreed with you before your Insurance Policy is issued and will appear on your Policy Schedule.

We won't pay a Children's Insurance Benefit Amount if the claim arises (either directly or indirectly) from:

- the intentional or deliberate act of:
  - the Insured Child;
  - the Policyowner or person who will otherwise be entitled to all or part of the Benefit Amount; or
  - the Insured Child's parents, guardian, relative or someone who lives with the Insured Child;
- a congenital condition, i.e. a condition which is present at birth as a result of either hereditary or environmental influences; or
- a pre-existing medical condition for which the Insured Child has been under the care of a medical practitioner or undergone a medical-related investigation before the Policy Start Date of the Insurance Policy.

Who receives the Benefit Amount?

We generally make all Benefit Amount payments to the Policyowner. However, if you die while owning your Insurance Policy, the Life Benefit Amount will be paid to your validly-nominated beneficiary or beneficiaries, and distributed in the proportions noted in the nomination form most recently lodged with us (see **Beneficiary nomination** on this page).

If a valid beneficiary nomination hasn't been made, the Life Benefit Amount will be paid to your estate, and managed by your legal personal representative (we may also make payment to any other person that we're permitted to pay under the Life Insurance Act 1995).

The Life Benefit Amount won't automatically be paid to the Partner Life Insured unless they're a nominated beneficiary.

Beneficiary nomination

The Policyowner may, at any time during the term of the Insurance Policy, nominate one or more beneficiaries to receive a specified percentage of the Life Benefit Amount on his or her death. To make a valid nomination, the following rules and procedures apply:

- Up to five beneficiaries can be nominated with a specified percentage share for each beneficiary that must total 100%;
- Only natural persons can be nominated (not, for example, companies or organisations);
- The Policyowner must make the nomination/s by completing and signing a valid nomination form which must be lodged with us. A nomination takes effect when it's received and processed by us;
- Nominations may be varied by properly completing, signing and lodging a new, valid nomination form with us. A new nomination takes effect when it's received and processed by us;
- If the nominated beneficiary is a minor when the benefit is payable, his or her specified share will be paid to a trustee or legal guardian for the benefit of the minor during his/her minority;
- If the nominated beneficiary dies before the Policyowner, the nomination in favour of that beneficiary fails and the share specified for the deceased beneficiary will be paid to the Policyowner's estate, and managed by the Policyowner's legal personal representative (or other person that we're permitted to pay under the Life Insurance Act 1995). The remaining nominations, if any, will continue to be effective; and
- If the Insurance Policy ownership changes e.g. due to assignment, any existing nomination will be invalidated.

If the Policyowner dies and there's a surviving Partner Life Insured, the Insurance Policy will continue for the surviving Partner Life Insured in his or her name as the new Policyowner.

The payment of the Benefit Amount to or in respect of a Life Insured, including payment made pursuant to a valid beneficiary nomination, is full and final discharge of our liability under your Insurance Policy for that benefit.

Any benefits paid in connection with ahm life insurance will be made in Australian dollars.

Automatic increases of your Benefit Amounts

To help your level of insurance keep up with the cost of living, the Benefit Amount for each Life Insured will automatically increase on each Policy Anniversary by 5%. This means your premiums will increase in line with the increased level of insurance. Automatic increases don't apply to Children's Insurance cover. Automatic increases will continue even where the maximum Benefit Amount (as shown in the table on page 5) is met or exceeded.

We'll send you an updated Policy Schedule each year your Insurance Policy remains in force 30 days prior to your Policy Anniversary setting out your updated Benefit Amount and premium. You can decline the automatic increase by giving us a call on **1300 052 589** Monday to Friday, 8am - 8pm (AEST) or by writing to us before your Policy Anniversary at:

Policyowner Services
ahm life insurance
PO Box 6728
Baulkham Hills NSW 2153

If you decline the automatic increase, the updated Policy Schedule we sent you won't be valid and we'll send you a replacement Policy Schedule.

Even if you choose not to accept an automatic increase in any given year, the automatic increase will be applied in the following year unless you again choose to decline it.

The final automatic increase will be made on the Policy Anniversary after your 75th birthday. After this date, no more automatic increases will be offered.

Guaranteed Life Benefit Amount increases

The Life Benefit Amount can be increased for a Life Insured without our further assessment of the Life Insured's health, within 90 days of any of the specified events described in the table below, as long as a benefit in respect of that Life Insured hasn't been paid and isn't payable under your Insurance Policy.

Other than for an increase as a result of the birth or adoption of a child, for the first six months after an increase applies, the Life Benefit Amount in respect of the increase will only be payable in the event of the Life Insured's Accidental Death.

The minimum amount by which cover for a Life Insured can be increased under this benefit is $10,000.

Specified event	We guarantee to increase Life Benefit Amount by the least of the following*
The Life Insured marries or divorces or the Life Insured or his/her spouse gives birth to, or adopts, a child.**	• **$200,000; or** • **50% of the Life Benefit Amount at the Policy Start Date of the Insurance Policy.**
The Life Insured takes out for the first time, or increases, a mortgage on his/her principal place of residence with a licensed mortgage provider.	• **$200,000; or** • **50% of the Life Benefit Amount at the Policy Start Date of the Insurance Policy; or** • **the amount of the mortgage or increase in the mortgage.**
The Life Insured has any single increase to his/her total salary package of 20% or more.	• **$100,000; or** • **25% of the Life Benefit Amount at the Policy Start Date of the Insurance Policy; or** • **five times the amount of the salary package increase.**

* The Life Benefit Amount can't be increased to an amount greater than the maximum Life Benefit Amount for your age at the time of the increase, as shown in the table on page 5.

** This means legal husband or wife, or someone living with the Life Insured as a de facto spouse on a genuine domestic basis. For the purposes of this benefit, the spouse may be of the same gender as the Life Insured.

Changing your cover

To chat about changing your ahm life insurance cover, give us a call on **1300 052 589** Monday to Friday, 8am - 8pm (AEST). We may require you to confirm changes in writing if you want to:

- decrease the Life Benefit Amount for a Life Insured (subject to the minimum Benefit Amount noted on page 5); or
- increase the Life Benefit Amount for a Life Insured (subject to the Maximum Benefit Amounts set out in **The Benefit Amounts you can apply for** on page 5), or add additional benefits for a Life Insured. Any insurance already in place will be unaffected by future applications for increases, even where we decline the increase or agree to cover subject to special terms; or

- change the status of a Life Insured from smoker to non-smoker for the purpose of determining the Insurance premium rating.

You may also apply to us to include a Partner Life Insured. If you apply to make these changes and we approve the change, we'll provide confirmation by issuing a new Policy Schedule.

The cost of your cover

Premiums are the cost of your insurance cover. Your premium is shown in your Policy Schedule.

Your premium is calculated at each Policy Anniversary and is based on:

- the age of each Life Insured at that time;
- the benefits provided for each Life Insured (Life cover or Life and Permanently Unable to Work cover and/or Trauma cover);
- the benefits provided for each Insured Child (if applicable);
- the Benefit Amounts for each Life Insured;
- your smoking status; and
- various other factors which affect the premium rating for each Life Insured, as assessed before your Policy Start Date, such as gender, state of health, family history, occupation and participation in hazardous activities.

We may change the premium rates applying to your Insurance Policy, but only if we change the premium rate applying to all ahm life insurance policies. We'll send written notice of any change to you (at your last address notified to us) at least 90 days before the effective date of the change.

For a premium quote, go to **ahm.com.au/life** or call us on **1300 052 593**.

If you're an ahm health insurance member, you're eligible for a 10% premium discount on your Insurance Policy.

You should note that the actual cost of your premiums may vary from any indicative quote provided online or by phone.

Paying for your Insurance Policy and when your premium is deducted

Your premium will be debited by us on the date of your choice, either fortnightly, monthly or annually. You can pay either by direct debit from your bank, credit union or building society account, or from your credit card. You can apply at any time to change the method of payment of premiums.

Premiums must be paid in Australian dollars.

Financial hardship

If you're suffering from financial hardship and having difficulty meeting your premium payments, we may agree to a short-term arrangement to help. It's important that you let us know about your circumstances so we can provide you with the available arrangement. We may ask you to provide us with reasonable evidence of your financial hardship.

Your 30-day cooling off period

You've got 30 days from the First Premium Due Date of your Insurance Policy, or the date any additional benefit starts, to decide whether you want to keep your Insurance Policy or the additional benefit. If you want to cancel your Insurance Policy, or additional benefit, within this 30-day period, you can do so provided you haven't made a claim under your Insurance Policy. Within the 30-day cooling off period, you'll need to send your written request for cancellation, including your full name and policy number, to:

Policyowner Services
ahm life insurance
PO Box 6728
Baulkham Hills NSW 2153

When we receive your request, we'll cancel your Insurance Policy or the additional benefit, as applicable, and refund any premiums you may have paid.

Your duty of disclosure

When applying for an ahm life insurance Policy, you (and your Partner Life Insured if applicable) have a duty of disclosure under the Insurance Contracts Act 1984, to tell us anything you (and your Partner Life Insured if applicable) know, or could reasonably be expected to know, which is relevant to our decision as to whether to insure the Life Insured/s or Insured Child/ren (if applicable) and on what terms. You've got this duty until we agree to insure you. You (and your Partner Life Insured if applicable) have the same duty to disclose those matters when applying to increase a Benefit Amount or include additional benefits, or when applying to reinstate your Insurance Policy.

You (and your Partner Life Insured if applicable) don't need to tell us anything that:

- reduces our risk;
- is of common knowledge;
- we know, or as an insurer, should know; or
- we indicate we don't want to know.

If the insurance is for the life of another person and that person doesn't tell us everything he or she should have, this may be treated as a failure by you to tell us something that you must tell us. If you (and your Partner Life Insured if applicable) fail to comply with the duty of disclosure, and we wouldn't have issued the Insurance Policy (or accepted an application to extend, vary or reinstate the Insurance Policy) if the duty had been complied with, we may avoid the relevant part/s of the Insurance Policy within three years of the Policy Start Date of your Insurance Policy (or the date we agreed to increase a Benefit Amount, include additional benefits, or reinstate your Insurance Policy, as applicable). This means we could refuse to pay a benefit.

If the non-disclosure is fraudulent, we may avoid the relevant part/s of your Insurance Policy at any time.

Alternatively, we may be able to reduce the amount of cover under the relevant part/s of your Insurance Policy to reflect the premium that would have been payable if all relevant matters had been disclosed to us. However, in respect of your Life cover only, we may only exercise this right within three years of the Policy Start Date (or the date we agree to increase a Benefit Amount, include additional benefits or reinstate your Insurance Policy, as applicable).

If we haven't cancelled your Insurance Policy or varied the cover amount, we can vary your Insurance Policy (including any of the terms and conditions of the relevant part/s of your Insurance Policy) in a way that places us in the same position we would have been if the non-disclosure or misrepresentation hadn't occurred.

In exercising our rights outlined above, we may consider whether different types of cover can constitute separate contracts of life insurance. If they do, we may apply the above rights separately to each type of cover.

Your duty of disclosure continues to apply after your application for cover, extension, variation or reinstatement until such time as we notify you that the risk has been accepted.

Please note: ahm doesn't provide any information it may have about your health, medical and claims history, occupation or pastimes to us. In addition, we won't consider any other disclosures you may have made when applying for other ahm products. Therefore, you must act in accordance with your duty of disclosure explained above, and you (and your Partner Life Insured if applicable) must provide complete and accurate answers when applying for Insurance, or when applying to increase a Benefit Amount, or when applying to include additional benefits or reinstate your Insurance Policy. You (and your Partner Life Insured if applicable) must provide all information even if you think (or are aware) that such information is or may already be held by ahm.

Life Insurance Code of Practice

The Life Insurance Code of Practice has been developed by the life insurance industry through the Financial Services Council and is the life insurance industry's commitment to provide quality products and a high standard of service to customers. A copy of the Code is available at **fsc.org.au**

The risks you should know about

It's important to select the correct insurance product and apply for the appropriate level of cover for your needs. If you don't have enough cover, it might cause you or your family to suffer financial hardship even after receiving the benefit payment. You should assess your needs carefully to ensure that this doesn't occur.

ahm life insurance is designed purely for protection (unlike some other types of life insurance that have savings and investment components), which means that if you cancel your ahm life insurance Policy (after the 30-day cooling off period), you won't receive any of the premiums you've paid back.

If you're replacing a contract or contracts, or a policy or policies with an ahm life insurance Policy, you should consider all the terms and conditions of each policy before making a decision to change.

Making a claim

If you (or your legal personal representative on your death) wish to claim under your Insurance Policy, please phone **1300 052 584** Monday to Friday, 8am - 8pm (AEST) or write to:

Claims Services
ahm life insurance
PO Box 6728
Baulkham Hills NSW 2153

We'll send you, your nominated beneficiary, or your legal personal representative, a form to be completed, signed and returned. We may also require your treating doctor or specialist to complete a form at your (or your estate's) expense.

Claims should be made as soon as possible after the claimable event. If you don't notify us within 120 days after the event giving rise to the claim, and we're disadvantaged by the delay, we may be able to reduce the amount we would otherwise pay, or we may be able to refuse to pay the claim.

Before a claim is fully assessed, we must receive proof, provided at your (or your estate's) expense and to our satisfaction, that the insured event has occurred. This includes all relevant information, including any test, examination, or laboratory results and certification from one or more appropriate specialist medical practitioners whom we approve. Only medical practitioners registered in Australia or New Zealand (or in another country approved by us) will be considered for approval.

We reserve the right to require the Life Insured or Insured Child to undergo, at our expense, examinations or other reasonable tests (including, where necessary, a post-mortem examination) to confirm the occurrence of an insured event. In addition we may conduct investigations to assess the validity of the claim. This could involve the use of investigation agents and surveillance, legal advisers and the collection of personal data.

Your Insurance Policy and the insurance for the benefit of the Life Insured, or Insured Child, must be in force when the insured event occurs.

Tax

Premiums generally aren't tax-deductible and tax won't generally be payable on any benefit paid to individuals under your Insurance Policy.

Please note: You don't have to pay GST on your premiums or any benefits you receive.

The information in this section is based on continuation of present tax laws and their interpretation and is a general statement only. As individual circumstances will vary, you should consult your professional tax adviser for advice regarding your personal circumstances.

Your privacy

We collect personal information (including sensitive information) for the purpose of processing insurance applications, administering your Insurance Policy, and assessing and paying claims under your Insurance Policy. Where possible, we'll collect personal information directly from you or, where that isn't reasonably practical, from other sources.

We may also use your personal information to consider any other application you may make to us, designing or underwriting new insurance products, for research and analytical purposes, to perform administrative functions (including for example accounting, risk management, staff training, etc.), and to comply with our legal obligations. If you don't provide this information in whole or in part, we may not be able to provide the services you require, or you may be deemed to not have complied with your duty of disclosure, which could affect the outcome of any claim you submit.

We may disclose personal information to:

- agents, third party service providers, and related companies who assist us in processing any application or claim for insurance, such as GFS, reinsurers, our advisers, persons involved in claims, medical service providers, external claims data collectors, investigators and verifiers and your employer;
- agents and third party service providers who perform functions or services on our behalf, such as IT services and mailing functions;
- ahm to assist them in developing, identifying and promoting to you ahm products and services which may be of interest to you. Please contact ahm if you wish to withdraw your consent to receiving information about their products and services; and

where otherwise required by law.

Some of the related companies we may disclose personal information to may be located overseas, including the United Kingdom, India, the United States of America and Switzerland.

To access or update your personal information or to make a complaint about a breach of privacy, get in touch with us. For further information about privacy, read our Privacy Policy at **ahm.com.au/life** or give us a call on **1300 052 589.**

Got a question or a complaint?

For more information about ahm life insurance, to confirm policy transactions, or if you've got any questions about the information contained in this PDS, give us a call on **1300 052 589** Monday to Friday, 8am - 8pm (AEST) or you can write to:

Policyowner Services
ahm life insurance
PO Box 6728
Baulkham Hills NSW 2153

We hope that you never have reason to complain, but if you do, we'll do our best to work with you to resolve it. You can call or write to us (our details are shown above) to make a complaint. If we can't resolve your complaint to your satisfaction, you can contact the Financial Ombudsman Service (FOS) at:

Financial Ombudsman Service

Phone:	1800 367 287 Monday to Friday 9am - 5pm (AEST/AEDT)
Fax:	03 9613 6399
Web:	fos.org.au
Email:	info@fos.org.au
Post:	GPO Box 3 Melbourne VIC 3001

FOS is an independent complaint review service.

A decision of FOS is binding on us (up to specified limits) but not on you. It's a service provided without cost to you.

Glossary

In this PDS and the Policy Schedule, some words have a special meaning, as explained below:

Accident/Accidental means an unexpected event resulting in bodily injury occurring while your Insurance Policy is in force, where the injury is directly and solely caused by accidental, violent, external, and visible means without any other contributing causes and where the injury isn't self-inflicted.

Accidental Death means death occurring as a direct result of an Accident and where death occurs within 90 days of the Accident.

Australian Resident means a person who resides full time in Australia and:

- holds Australian or New Zealand citizenship; or
- 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.

Benefit Amount/s means the amount/s you apply for and which is accepted by us in respect of each Life Insured and Insured Child. It includes increases which you've requested and that we have accepted and automatic increases. The Benefit Amount/s at the Policy Start Date is shown in your first Policy Schedule issued.

Cancer (excluding specified early stage cancers) means the diagnosis of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells with invasion of normal tissue. The diagnosis of cancer must be verified by provision of the histopathological report.

Cancer includes: Leukaemia, Hodgkins disease, malignant bone marrow disorders, sarcoma and malignant lymphoma including cutaneous lymphoma.

The following are excluded:

- Carcinoma in situ or cancer in situ, dysplasis, and all pre-malignant conditions;
- Carcinoma in situ of the breast unless a total mastectomy with full removal of the breast is undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
- Prostate cancer unless:
  - Histologically classified as having a Gleason Score of 7 or above; or
  - having progressed to at least clinical stage classification of T2N0M9 on the TNM clinical staging system; or
  - Where total prostatectomy has been undertaken and the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment.
- Any primary skin cancer other than:
  - malignant melanoma that has invaded beyond the epidermis (outer layer of the skin); or
  - all other non-melanoma skin cancer progressed to at least AJCC stage III (eight edition).
- Cutaneous lymphoma unless having progressed to at least stage II; or
- All papillary cancers of the thyroid unless having progressed to at least TNM classification T2N0M0.

Children's Insurance Benefit Amount means the Benefit Amount payable in respect of Children's Insurance cover, as set out in the Policy Schedule (if applicable).

Domestic Duties means performing the following duties (with or without the use of assistive devices or another person):

- cleaning the family home, such as using a vacuum cleaner, sweeping with a broom, using a mop, cleaning dishes (automatic or manual);
- cooking the family meals, such as preparing fresh and frozen food and using an oven, stove or microwave oven;
- doing the family's laundry, such as loading and unloading a washing machine and hanging out clothes or using a dryer, folding clothes and ironing;
- shopping to meet family needs, such as going to the shops or using the phone or internet to purchase food; and
- taking care of dependent children (where applicable) such as supervising, lifting, transporting, feeding and bathing.

Encephalitis (resulting in Permanent Neurological Deficit) means severe inflammation of brain substance (cerebral hemisphere, brain stem or cerebellum), caused by viral infection. The encephalitis must produce Permanent Neurological Deficit causing significant functional impairment.

First Premium Due Date means the date your first premium is deducted, as set out in the Policy Schedule.

Heart Attack means the final diagnosis of acute myocardial infarction, which means death of heart muscle caused by obstruction of the blood supply. This must be confirmed by the typical rise and/or fall of a cardiac biomarker blood test (Troponin I, Troponin T or CK-MB) with at least one level above the 99th percentile of the upper reference limit plus one of the following:

- acute cardiac symptoms and signs consistent with a heart attack; or
- new serial 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.

Other acute coronary syndromes including but not limited to unstable angina are excluded.

Insurance means the insurance benefits that have been applied for and accepted by us in respect of a Life Insured or Insured Child (as applicable).

Insurance Policy/Policy means the legal contract between the Policyowner and us. This PDS, your application, any future application accepted by us, your Policy Schedule, and any special conditions, amendments, or endorsements we issue you, make up your Insurance Policy.

Insured Child/ren means a person named in the Policy Schedule with Children's Insurance cover. An Insured Child must be a natural child, stepchild or adopted child of the Policyowner and/or Partner Life Insured.

Leukaemia means the unequivocal diagnosis of leukaemia, confirmed by histology and requiring chemotherapy and/or radiotherapy treatment.

Life Benefit Amount means the Benefit Amount set out in the Policy Schedule (if applicable).

Life Insured means the person whose circumstances we assess and accept as a Life Insured and who is named as such in your Policy Schedule and, as applicable, a Partner Life Insured.

Limb means a whole hand or whole foot.

Loss of Independent Living means, as a result of sickness or injury, the Life Insured is totally and permanently unable to perform at least two of the following five **Activities of Daily Living**:

Bathing means the ability of the Life Insured to wash him/herself either in the bath or shower or by sponge bath without the assistance of another person. The Life Insured will be considered to be able to bathe him/herself even if the above tasks can only be performed by using equipment or adaptive devices.

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

Eating means the ability to get nourishment into the body by any means, once it has been prepared and made available to the Life Insured, without the assistance of another person.

Toileting means the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing without the assistance of another person. The Life Insured will be considered able to toilet him/herself even if he or she has an ostomy and is able to empty it him/herself, or if the Life Insured uses a commode, bedpan or urinal, and is able to empty and clean it without the assistance of another person.

Transferring means the ability to move in and out of a chair or bed without the assistance of another person. The Life Insured will be considered able to transfer him/herself even if equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices (including mechanical or motorised devices) are used.

Major Head Trauma (resulting in Permanent Neurological Deficit) means Permanent Neurological Deficit or loss of intellectual capacity as a result of brain damage sustained through an Accident.

Meningitis (resulting in Permanent Neurological Deficit) means the unequivocal diagnosis of meningitis where the condition is characterised by severe inflammation of the brain. The meningitis must produce Permanent Neurological Deficit causing significant functional impairment.

Open Heart Coronary Artery Bypass Surgery means the undergoing of open heart surgery to correct the narrowing of (or blockage to), one or more coronary arteries by means of a bypass graft. Percutaneous coronary interventions such as angioplasty and all other intra-arterial, catheter-based techniques, or laser procedures are excluded.

Partner Life Insured means a person whose circumstances we assess and accept as a Partner Life Insured and who is named as such in your Insurance Policy. A partner may be a legal husband or wife, or someone living with you as your de facto spouse on a genuine domestic basis. Your partner may be of the same gender as you.

Permanent Inability to Work/Permanently Unable to Work means:

- solely because of sickness or injury, the Life Insured has been continuously absent from work for a period of at least three consecutive months and in our opinion, after consideration of all relevant evidence, due to that sickness or injury, the Life Insured is unlikely to ever be able to work again in any occupation for which the Life Insured is suited based on work experience, education or any training; or
- the Life Insured suffers Permanent Loss of Hearing or Severe Burns; or
- where the Life Insured was engaged in full time Domestic Duties, and:
  - is unable to perform all of the Domestic Duties they were undertaking for an uninterrupted period of at least three consecutive months solely because of that sickness or injury; and
  - is unable to leave home unaided; and
  - is under the regular treatment and following the advice of a registered medical practitioner for the sickness or injury that prevents them from performing the Domestic Duties; and
  - hasn't engaged in any occupation or work outside the family home for salary, reward or profit, for a period of three consecutive months after the occurrence of the sickness or injury; and
  - at the end of the period of three months, in our opinion, after consideration of all relevant evidence, the Life Insured is disabled to such an extent as to render them unlikely to ever again be able to perform all the Domestic Duties they were undertaking before suffering the sickness or injury.

A Life Insured shall be considered to be engaged in full time Domestic Duties if the Life Insured is engaged in full time unpaid Domestic Duties within the family home, and isn't employed in any occupation or working outside the Life Insured's home for salary, reward or profit. A Life Insured who is actively seeking employment or is performing less than full time unpaid Domestic Duties won't be considered to be performing Domestic Duties.

Permanent Loss of Hearing means total and permanent loss of hearing in both ears and the loss is unable to be corrected by a hearing aid or other means.

Permanent Loss of Sight means the permanent loss of sight in both eyes as a result of sickness or injury such that visual acuity is 6/60 or less in both eyes, or such that the visual field is reduced to 20 degrees or less of arc, and the loss is unable to be corrected by glasses or any other means.

Permanent Loss of Use of Limbs or Paralysis means the total and permanent loss of function of two or more Limbs, or the total and permanent loss of function of one Limb and Permanent Partial Loss of Sight. Total and permanent loss of function of Limbs must be established for a continuous period of at least six months whilst policy is in force.

Permanent Loss of Use of One Limb means the total and permanent loss of functions of one limb, which must be established for a continuous period of at least six months whilst your Insurance Policy is in force.

Permanent Neurological Deficit means symptoms of dysfunction of the nervous system that are present on clinical examination and expected to last throughout the person's life. These:

- include numbness, paralysis, dysarthia (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma; and
- exclude an abnormality seen on the brain or other scans without definite related clinical symptoms, neurological signs occurring without symptomatic abnormality (e.g. brisk reflexes without other symptoms), lesser symptoms such as lethargy, localised weakness, hyperaesthesia (increasing sensitivity), and symptoms of psychological or psychiatric origin.

Permanent Partial Loss of Sight means the permanent loss of sight in one eye as a result of sickness or injury such that visual acuity is 6/60 or less in that eye and the loss is unable to be corrected by glasses or any other means.

Permanently Unable to Work Benefit Amount means the Benefit Amount payable in respect of Permanent Inability to Work/Permanently Unable to Work cover, as set out in the Policy Schedule (if applicable).

Policy Anniversary means the anniversary of the First Premium Due Date of your Insurance Policy.

Policy Schedule means the document we send you which sets out the details of your Insurance Policy, including any special conditions, amendments, or endorsements. A new Policy Schedule will be issued at any time there's a change in your Insurance Policy such as:

- a change to the Life Insured;
- the addition or removal of a Partner Life Insured;
- a change to the Partner Life Insured;
- a variation in the Benefit Amount;
- a variation of benefits; or
- a change of nominated beneficiaries.

Your new Policy Schedule will apply from the Policy Schedule date shown on your new Policy Schedule.

Policy Start Date means the date your application for an Insurance Policy is accepted by us and cover starts, as set out in the Policy Schedule.

Policyowner, you, your and **yours** means the Life Insured who is the person who applies and is accepted as the owner of the Insurance Policy and is so named in the Policy Schedule. The Policyowner is the sole owner of the Insurance Policy and the only person who may extend, vary, cancel, transfer or otherwise exercise any rights under the Insurance Policy. If the Primary Life Insured dies while owning the Insurance Policy leaving a surviving Partner Life Insured, the Insurance Policy continues in the name of the Partner Life Insured as the owner of the Insurance Policy. The Partner Life Insured then becomes the new Policyowner.

Primary Life Insured means a person named in the Policy Schedule as the Primary Life Insured who is also the Policyowner when the Insurance Policy starts.

Severe Burns means Accidental full thickness burns to at least 20% of the body surface area as measured by the Lund & Browder Body Surface Chart.

Stroke means death of brain tissue due to inadequate blood supply or haemorrhage resulting in all of the following:

- Onset of new neurological symptoms consistent with a stroke;
- New objective neurological deficits on clinical examination persisting continuously for at least 24 hours following the diagnosis of the stroke; and
- New findings on CT scan or MRI, if done, consistent with the clinical diagnosis.

The following aren't covered:

- Transient ischaemic attack (TIA);
- Traumatic injury to brain tissue or blood vessels;
- Secondary haemorrhage into a pre-existing cerebral lesion; and
- An abnormality seen on brain or other scans without clearly related clinical symptoms and neurological signs.

Swiss Re, we, us and **our** means Swiss Re Life & Health Australia Limited.

Terminal Illness means a confirmed diagnosis by a medical practitioner approved by us of a terminal illness where life expectancy, after taking into account all reasonably available treatment, is 12 months or less.

Trauma Benefit Amount means the Benefit Amount payable in respect of Trauma cover, as set out in the Policy Schedule (if applicable).

You, your, yours and **Policyowner** means the owner of the Insurance Policy named in the Policy Schedule as the Policyowner.

Direct Debit Service Agreement

1. Swiss Re Life & Health Australia Limited ABN 74 000 218 306 ('Debit User') will initiate direct premium debit payments in the manner referred to in the Policy Schedule (the Direct Debit Request) through the Bulk Electronic System (BECS).

2. Debit payments will be made when due. The Debit User won't issue individual confirmation of payments made.

3. The Debit User will give the customer at least 14 days written notice if the Debit User proposes to vary details of this arrangement, including the amount and frequency of debit payments.

4. If the customer wishes to defer any payment or alter any of the details referred to in the Policy Schedule, they must either contact the Debit User on **1300 052 589** or write to the Debit User at the following address:

   Swiss Re Life & Health Australia Limited
   c/o PO Box 6728
   Baulkham Hills NSW 2153

5. Customer queries concerning disputed debit payments must be directed to the Debit User in the first instance. Details of the dispute resolution process that applies to the Debit User are described in this PDS. Queries about claims in regards to disputed debit payments should also be directed to the Debit User and may also be directed to the customer's financial institution nominated in the Policy Schedule.

6. Direct payment debiting through BECS isn't available on the full range of accounts at all financial institutions. If in doubt, the customer should check with their financial institution before completing the Direct Debit Request.

7. The customer should ensure that their account details given in the Policy Schedule are correct by checking against a recent statement or enquiring directly with their financial institution at which their account is held.

8. It's the customer's responsibility to have sufficient cleared funds available, by the premium due date, in the account to be debited to enable debit payments to be made in accordance with the Direct Debit Request.

9. By authorising the Direct Debit Request, the customer warrants and represents that he's/she's/they're duly authorised to request and instruct the debiting of premium payments from the account described in the Policy Schedule.

10. If a debit payment falls due on any day which isn't a business day, the payment will be made on the next business day. If you're uncertain as to when a debit payment will be processed to your account, you should make enquiries directly with the financial institution nominated in the Policy Schedule.

11. If a debit payment is returned unpaid, the customer may be charged a fee by the financial institution nominated in the Policy Schedule for each returned item.

12. Customers wishing to cancel the Direct Debit Request or to stop individual payments must give at least seven days written notice to the Debit User at the address referred above.

13. Except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required by law, the Debit User and its service providers will keep details of the customer's account and debit payments confidential.

Notes

For more information about
ahm life insurance or to apply:

1300 052 589

ahm.com.au/life

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