# Zurich Ezicover Income Protection
# **Welcome**

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Policy number

Dear

Welcome and thank you for choosing Zurich to assist you with your financial needs. We look forward to providing insurance solutions that fit your financial needs and aspirations, now and into the future. Your Ezicover Income Protection - Essentials policy has been established and the following documentation is enclosed:

- Policy schedule confirming your policy details
- Policy document detailing the terms applicable to your policy
- Frequently Asked Questions
- Direct debit service agreement

**Please review these documents carefully to ensure all your details are correct and keep them in a safe place as you will need them if you make a claim.** Your policy number is noted above. Please keep this number in a convenient place. Quoting it whenever you contact us will ensure you receive efficient service.

If you have any questions or should you wish to change any of the details, please contact the Zurich Client Service Centre on 131 551 - we will be happy to assist.

Yours sincerely,

Sasho Briskoski
Head of Customer Services

Zurich Ezicover Income Protection - Essentials

# Policy schedule

Policy number

**This Policy schedule forms part of the Policy.**

**Policy commencement date:**
**Document issue date:**

## Policy details

**Policy owner/s:**
**Life insured:**
**Date of birth:**
**Smoker status:**
**Occupation class:**
**Cover type:** Essentials
**Benefit period:** 1 year
**Waiting period:** 30 day Waiting period

## Insurance coverage details

**Life insured:**

| Item | Benefit type | Benefit amount | Start date | Expiry date | Premium type |
|---|---|---|---|---|---|
| 1 | Monthly sum insured | | | | stepped |

## Premiums

**Premium frequency:** monthly
**Instalment premium:**
**Stamp Duty:**

**Total instalment premium:**
**Next premium due date:**
**Payment method:**

# Zurich Ezicover Income Protection
# **Policy document**

## Contents





BVEI-010455-2015

## Contents (continued)



This policy is a legal document. It is important that you read it carefully and keep it in a safe place. It is your record of the terms and conditions of the policy.

# 1. General information

## 1.1 Introduction

This document sets out the terms and conditions applicable to the Ezicover Income Protection policy and explains how the policy operates. The policy also includes the *Policy schedule*, which shows ownership details, the *life insured*, the level of cover and any special conditions particular to your policy. Please check both this document and the *Policy schedule* carefully to ensure that the policy provides you with the cover you want and has been established in accordance with your wishes.

In this document, a reference to "you" is a reference to the owner of the policy as shown on the *Policy schedule*, while any reference to "Zurich", "we", "our" or "us" is a reference to Zurich Australia Limited, the issuer of this product. All terms appearing in *italics* (other than in headings) are defined terms with special meanings. Detailed definitions are in section 7. Product features are capitalised for ease of identification.

If you have any questions about the policy contact the Zurich Client Service Centre on 131 551. We will be happy to explain any matter to you.

## 1.2 Overview

This policy provides the insurance benefits explained in sections 3 and 4. You can apply to increase levels of cover, or change the *benefit period* or *waiting period*, but only if we accept your application after considering the *life insured's* health and personal circumstances including occupation and pastimes.

## 1.3 Cooling off period

This policy provides valuable insurance protection. However, if you have received this Policy document as a result of a new application and you are not completely satisfied with it you can, within 30 days, return this Policy document and the *Policy schedule* to us with a letter asking us to cancel the policy.

We will cancel the policy and promptly send you a full refund of any *premiums* paid provided you have not made a claim under the policy.

The "30 day" period commences from the date you receive this Policy document. Unless you can prove otherwise, we will assume it was received by you within five business days of us issuing it.

## 1.4 Contract and statutory fund

The contract is between Zurich Australia Limited and you. The *premiums* paid for this policy form part of the Zurich No. 2 Statutory Fund. Any benefits you receive under this policy will be paid from that fund.

## 1.5 Currency

All payments made in connection with this policy will be in Australian currency to an Australian Bank or Financial Institution account.

## 1.6 Surrender value

This policy does not acquire a cash surrender value.

## 1.7 Application summary

Please advise us immediately if there are any discrepancies between your application and the information in your *Policy schedule*.

## 1.8 Guaranteed to continue

As long as each premium due is paid within the grace period allowed (see part 5.2) and you comply with your obligations under this policy, the policy can be continued up to the benefit expiry date (shown on the *Policy schedule*) regardless of changes in the *life insured's* personal circumstances.

## 1.9 Changes to the policy

You must submit a written request if you want to make a change to the policy. In order to consider your request, we may ask for further information. If we agree, we will confirm any changes in writing. Only an authorised member of our staff can agree to change or waive any condition of the policy.

## 1.10 Government duties

We reserve the right to charge you for any government duties, taxes or other charges that are or become payable by us or you in respect to this policy.

## 1.11 Termination of policy

This policy ends on the first to occur of:

- the non-payment of any *premium* within 30 days of its due date;
- the *policy anniversary* after the *life insured's* 65th birthday (shown as the benefit expiry date in the *Policy schedule*);
- our receipt of your written notification to terminate this policy; or
- the death of the *life insured*.

# 2. World wide coverage

## 2.1 Coverage

Subject to the terms of this policy, cover is provided to you 24 hours a day, seven days a week, worldwide.

## 2.2 Residency and compliance with laws

This policy is designed for people who are resident in Australia. If you or the *life insured* move to another country outside of Australia you may no longer be eligible to make payments into your policy. The local laws and regulations of the jurisdiction to which you or the *life insured* move may affect our ability to continue to service your policy in accordance with its terms and conditions.

You need to tell us of any planned change in residency before the change happens.

We do not offer tax advice, so if you or the *life insured* decide to live outside Australia, we recommend you obtain advice on the tax consequences of any change in residence in relation to your policy. We will not be held liable for any adverse tax consequences that arise in respect of you or your policy as a result of such a change in residence.

We and other companies within the worldwide Zurich group of companies have obligations under Australian and foreign laws. Regardless of any other policy terms and conditions, we reserve the right to take any action (or not take any action) which could place us or another company within the group at risk of breaching Australian laws or laws in any other country.

All financial transactions, including but not limited to acceptance of premium payments, claim payments and other reimbursements, are subject to compliance with applicable trade or economic sanctions laws and regulations. We reserve the right not to provide any service or benefit under this policy to you or any other party if we determine this places us at risk of violating applicable trade or economic sanctions laws or regulations. We may terminate the policy if we consider you or any person entitled to receive benefits under the policy as sanctioned persons, or conduct an activity which is sanctioned, according to trade or economic sanctions laws and regulations.

This policy has been concluded based on the legal and regulatory requirements in force and applicable at the time the policy is issued. Should the legal and regulatory requirements change and the change affects or influences the contractual terms and condition in a material way, Zurich is entitled to adapt the contractual terms and condition to the changed legal and regulatory requirements. Zurich is not entitled to make such changes if the changes in regulation would preclude Zurich to make such changes.

# 3. Benefits

**The *Policy schedule* attached to this document shows the *life insured* covered under this policy, lists your *cover type*, the *monthly sum insured*, the *benefit period* and the *waiting period*. Your *Policy schedule* also shows the benefit expiry date applying to the cover.**

## 3.1 Sickness and Injury cover

If you have Sickness and Injury cover, as shown under *cover type* on your *Policy schedule*, we will pay a *monthly benefit* if the *life insured* has been *disabled* for the entire *waiting period*. The *monthly benefit* starts to accrue from the end of the *waiting period* and will continue until it ends in accordance with part 3.6.

### 3.1.1 Waiting period waiver

If you have Sickness and Injury cover, as shown under *cover type* on your *Policy schedule*, and the *life insured* is diagnosed with one of the following conditions (as defined in part 7 of this document) whilst the *life insured* is aged between 19 and 65 years of age (inclusive) and while this policy is in force, we will waive the *waiting period* and we will pay a lump sum equivalent to three times the *monthly benefit* for:

- *Cancer;*
- *Stroke; or*
- *Heart attack.*

We must be satisfied that the *life insured* meets the definition of the condition (as set out in part 7 of this document) and if so, the *monthly benefit* will accrue from the date of diagnosis. The Waiting period waiver does not apply if the Cancer, Stroke or Heart attack is diagnosed in the first 90 days of the start of the policy or any reinstatement of the policy.

If, after the end of the 3 month period, the *life insured* is disabled, we will pay the *monthly benefit* in accordance with the terms of this policy. The 3 month payment of the *monthly benefit* counts towards the total *benefit period*. If, after the 3 month period, the *life insured* is not *disabled*, benefits will cease and any further claim in relation to the same or related condition will be subject to a *waiting period* and the same terms and conditions as under part 3.1.

## 3.2 Essentials cover

If you have Essentials cover, as shown under *cover type* on your *Policy schedule*, we will pay a *monthly benefit* if the *life insured* has been *disabled* for the entire *waiting period*. The *monthly benefit* starts to accrue from the end of the *waiting period* and will continue until it ends in accordance with part 3.6.

## 3.3 Injury only cover

If you have Injury only cover, as shown under *cover type* on your *Policy schedule*, we will pay a *monthly benefit* if the *life insured* has been *disabled* for the entire *waiting period*. The *monthly benefit* starts to accrue from the end of the *waiting period* and will continue until it ends in accordance with part 3.6.

## 3.4 Monthly benefit and waiting period

The *monthly* benefit is payable whilst the *life insured* is *disabled* up to the maximum *benefit period* as shown on your *Policy schedule*.

We will pay the *monthly benefit* monthly, with the first payment due 15 days after the end of the *waiting period*, unless the *waiting period* has been waived in accordance with part 3.1.1, in which case, the first payment will be due 15 days after the insured event occurs. For any partial months that the *life insured* is *disabled*, the amount paid will be at the rate of 1/30th of the *monthly benefit* for each day the *life insured* is *disabled* during that partial month.
You must be *disabled* for the duration of the *waiting period* as shown on your *Policy schedule* (subject to part 3.1.1) before any benefit is payable.

We will only pay one *monthly benefit* at any one time, regardless of the number of events (*sickness or injury*) leading to *disability*.
If the *life insured* returns to work for no more than 5 consecutive days during the *waiting period* but then becomes *unable to work* again, the *waiting period* will not start again. We will simply extend the *waiting period* by the number of days that the *life insured* was able to work. If the life insured returns to work for more than 5 consecutive days during the *waiting period* and then becomes *unable to work* again, the waiting period will start again.

You are not entitled to a refund of any part of the *premiums* you have paid if the *monthly benefit* paid to you is less than the *monthly sum insured*.

## 3.5 Exclusions

No benefit is payable under this policy if the *life insured's disability* is caused directly or indirectly by:

- a *mental health disorder;*
- an intentional self-inflicted act or attempted suicide;
- *uncomplicated pregnancy or childbirth;*
- unemployment for reasons other than *sickness* or *injury*;
- an act of war, whether declared or not;
- the *life insured* committing, being involved in or attempting to commit, a criminal offence or the use of illegal illicit substances;
- the *life insured* being incarcerated or lawfully detained;
- elective surgery (including cosmetic surgery) unless the *life insured* is disabled for more than 90 days;
- *Cancer, Stroke* or *Heart attack* diagnosed in the first 90 days of the start of the policy or any reinstatement of the policy;
- any *sickness* or *injury* which is the direct or indirect result of elective or donor transplant surgery within six months of the start of the policy or any reinstatement of the policy;
- events occurring during travel in countries outside Australia, if the Australian government has advised against travel to that country at the time of starting the trip;
- any other exclusion agreed with you at the time of application, and shown on your *Policy schedule*; or

## 3.6 When benefits end

If you are eligible for a benefit, we will pay you the *monthly benefit* until the first to occur of the following:

- we consider, based on reasonable medical and other evidence, the *life insured* is able to return to work;
- we consider the life insured able to perform the regular daily activities (Essentials cover);
- we consider the life insured is no longer under the regular care of or not following the advice of a medical practitioner for treatment of the sickness or injury;
- the benefit period has ended;
- the policy has ended;
- death of the *life insured*;
- the policy has ended in accordance to condition 1.11.

We seek the opinion of the *life insured's medical practitioner* to determine whether the *life insured* is capable of returning to work.

# 4. Ancillary benefits and features

## 4.1 Return to work benefit

If a *monthly benefit* is being paid under this policy and the *life insured* is *unable to work*, when the *life insured* is ready to return to work and benefits cease, we will make a one-off payment to you of $500. This payment will only apply on new claims and not on recurring claims (as referred to at part 6.9). The Return to work benefit is not applicable if you have Essentials cover.

## 4.2 Premium holiday

### 4.2.1 Conditions of Premium holiday

A Premium holiday can be activated by request to us, on any policy which has been continuously in force for a period of at least 12 months. A Premium holiday can be activated for a 3, 6, 9 or 12 month period starting from the latest unpaid premium due date.

When a Premium holiday is activated we will confirm in writing:

- the Premium holiday start date;
- the Premium holiday end date;
- the next *premium* due date after the Premium holiday end date; and
- the *premium* due at the next *premium* due date.

From the Premium holiday start date until the Premium holiday end date ('Premium holiday period'):

- the policy is not in force and no cover is provided;
- no *premiums* are required in respect of the Premium holiday period; and
- if applicable, Inflation protection increases will continue to be offered if a *policy anniversary* passes.

No cover is provided under the policy for any insured event which:

- is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) before the Premium holiday start date, unless all elements of the insured event are already fully satisfied before the Premium holiday start date or
- occurs or is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) at any time during the Premium holiday period.

If we receive the requested *premium* within 30 days of the next premium due date after the end of the Premium holiday period, the policy will be put back in force automatically on the Premium holiday end date, subject to the above exclusion. The *premium* will recommence and become payable from the Premium holiday end date. The *premium* payable will be calculated as if the Premium holiday had not occurred. If the requested *premium* is not paid within 30 days of the next premium due date after the end of the Premium holiday period, the policy will terminate.

### 4.2.2 Varying a Premium holiday

Subject to our approval and on any additional terms we determine, a Premium holiday which has already started can be extended or reduced. We must receive the request 14 days before the earlier of the original or proposed Premium holiday end date and the variation is not effective until we confirm our acceptance in writing.

If the Premium holiday period is reduced, it must be reduced by a minimum of 4 months and, in addition to the conditions of this policy, no cover is provided under the policy for any insured event which occurs or is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) in the first 90 days after the revised Premium holiday end date.

### 4.2.3 Restrictions and limitations - Premium holiday

A Premium holiday cannot be used in relation to *premiums* that have already been paid. We will not refund any paid *premiums* under this provision.

Any subsequent Premium holiday must be separated by 12 months during which all required *premiums* are paid on the policy.

A Premium holiday may only be used once in any 12 month period and a maximum total period of 12 months of Premium holiday is available over the life of the policy.

For the purposes of these policy conditions, when the policy is back in force following a period of Premium holiday, it is considered a reinstatement of the policy and any terms and conditions under this policy that apply to a reinstatement will apply to the cover after the end of a Premium holiday period.

## 4.3 Reducing income feature

### 4.3.1 Conditions of Reducing income feature

The Reducing income feature can be activated by request, on a Sickness and Injury cover or an Injury only Cover policy which has been continuously in force for a period of at least 12 months. It can be activated for a 3, 6, 9 or 12 month period starting from the latest unpaid premium due date. The Reducing income feature is not available on Essential Cover policies.

When the Reducing income feature is activated, we will confirm in writing:

- the Reducing income feature start date;
- the Reducing income feature end date;
- the next *premium* due date after the Reducing income feature end date; and
- the *premium* due at the next *premium* due date.

# 4. Ancillary benefits and features (continued)

From the Reducing income feature start date until the Reducing income feature end date ('Reducing income feature period'):

- the policy is in force for a reduced *monthly sum insured* nominated by you at the Reducing income feature start date, subject to a minimum *monthly sum insured* of $1,000;
- reduced *premiums*, reflective of the reduced *monthly sum insured*, are payable; and
- if applicable, Inflation Protection increases will continue to be offered if a *policy anniversary* passes.

The Reducing income feature option does not affect your *waiting period* or your *benefit period* which will remain unchanged.

The reduced *monthly sum* insured applies to any insured event occurring during the Reducing income feature period. At the end of the Reducing income feature period, your *monthly sum* insured that applied prior to the Reducing income feature start date, plus any increases due to Inflation protection for the period, will be automatically reinstated. Your *premiums* will increase accordingly from the Reducing income feature end date and your revised *premium* is due within 30 days of the next *premium* due date after the Reducing income feature end date. If the requested *premium* is not paid within 30 days of the next premium due date, the policy will terminate.

### 4.3.2 Varying a Reducing income feature period

Subject to our approval and on any additional terms we determine, a Reducing income feature period which has already started can be extended or reduced. We must receive the request 14 days before the earlier of the original or proposed Reducing income feature end date and the variation is not effective until we confirm our acceptance in writing.

If the Reducing income feature period is reduced, it must be reduced by a minimum of 4 months and, in addition to the conditions of this policy, the reduced *monthly sum insured* is provided under the policy will apply to any insured event which occurs or is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) in the first 90 days after the revised Reducing income feature end date.

### 4.3.3 Restrictions and limitations - Reducing income feature

A Reducing income feature cannot be used in relation to a period where premiums have already been paid. We will not refund any paid *premiums* under this provision.

A Reducing income feature may only be used once in any 12 month period and a maximum total period of 12 months of the Reducing income feature is available over the life of the policy.

## 4.4 Waiver of premium

While we are paying you a *monthly benefit*, we will waive your *premiums*. This means during any period when the *monthly benefit* is payable, all *premiums* payable will be waived or refunded. Furthermore, if you are eligible for a *monthly benefit*, we will refund the *premiums* you have paid during the *waiting period*, if we receive your completed claim form within 30 days from the date of *disability*.

## 4.5 Inflation protection option

You can choose to have your *monthly sum* insured increased each year to protect against the impact of inflation. Selecting the Inflation protection option means your cover is increased every year and your *premiums* will reflect this increase in cover. It's important to consider your *cover type* and whether your income also increases annually, as your income will be verified at claim time to calculate the *monthly benefit*.

When you apply for your policy, you can select the Inflation protection option at that time.

If you have selected the Inflation protection option, your *monthly sum insured* will be increased on each *policy anniversary* by the lesser of:

- 3% and
- the percentage increase in the *Consumer Price Index*.

You have the option of rejecting our offer to increase the *monthly sum insured*.

# 5. Premium and reinstatement

## 5.1 Payment of premium

The *premium* is payable by you, the policy owner, on the due dates shown on your *Policy schedule*. *Premiums* must be paid to keep your policy in force. All *premiums* must be paid in Australian dollars.

## 5.2 Unpaid premium

If any *premium* is not paid within 30 days of its due date, regardless of the method of payment chosen, your policy will lapse and no benefits are payable.

## 5.3 Reinstatement

In the first 30 days after lapse, we will reinstate the cover immediately if we receive a request and all outstanding *premiums* are paid. If the policy is reinstated in this period, no benefits will be paid for an event which occurred or was apparent while the policy was lapsed. After 30 days, the policy can be considered for reinstatement if we receive a signed reinstatement application. We will consider a request for reinstatement within 12 months of the due date of the first unpaid *premium* but we may decline to reinstate or impose conditions. If the policy is reinstated in this 12 month period, the cover recommences from the date that we accept the application for reinstatement and no cover is provided during the period of lapse. This means that no payments will be made for an event which occurred or became apparent while the policy was lapsed.

## 5.4 Amount of premium

The *premium* payable from the start of the policy is set out in the *Policy schedule*.

The *premium* payable changes on each *policy anniversary*. At that time, the *premium* is calculated in respect of the *life insured* based on our current standard premium rates on the basis of:

- the gender, age next birthday and smoking status of the *life insured;*
- the level of cover, *waiting period* and *benefit period*;
- the *life insured's* occupation;
- any stamp duty charged by State governments or taxes levied by State or Federal governments;
- the frequency of payment; and
- any extra *premium* or loading applying.

## 5.5 Premium review

We cannot change the premium rates applying to a benefit provided by this policy unless we change the premium rates applicable to that benefit under this class of policy generally. We will notify you of any changes in premium rates applying to this policy at least 30 days prior to the change taking effect.

## 5.6 Taxes

Your *premium* will include any government charges, duties or taxes imposed on insurance premiums under applicable laws. Should any changes to the law or to any relevant person (eg. change in residency) result in additional or increased charges, duties or taxes in relation to the policy, we may accordingly add these amounts to the *premium* or deduct them from any insurance benefits.

# 6. Making a claim

## 6.1 How to claim

You must advise us of an insured event occurring as soon as reasonably possible after the event by sending us a completed claim form. You can access claim forms on our website www.zurich.com.au or by contacting the Zurich Client Service Centre who will forward a claim form to you. You must complete, sign and return the claim form to us.

## 6.2 Claim requirements

We need the following items in a form satisfactory to us before we can assess any claim:

- the *Policy schedule* ;
- proof of claimable event or condition and when it occurred;
- supporting evidence from appropriate specialist *medical practitioners* and confirmatory investigations including, as appropriate (but not limited to) any clinical, radiological, histological and laboratory evidence that we reasonably require to substantiate the claim;
- proof of the *life insured's* age.
- proof of *pre-disability income:*
    - the *life insured* may be asked to provide copies of personal and business tax returns, assessment notices and/or other financial evidence to substantiate the *life insured's* income;
    - when it is necessary to enable us to calculate the amount of the benefit payable, the *life insured* must allow us to examine the *life insured's* business and personal financial circumstances;
- if a claim is a result of a surgical procedure, we will require evidence that the procedure was medically necessary, or if the procedure was not medically necessary, evidence that the disablement persisted for more than 90 days.

Our medical advisers must support the occurrence of the insured events. We reserve the right to require the *life insured* to undergo an examination or other reasonable tests to confirm the occurrence of the insured event.

## 6.3 Assessing the claim

In assessing the claim we will also rely on any information you or the *life insured* disclosed to us as part of the application. Where information was not verified at the time of application we reserve the right to verify it at the time of claim.

## 6.4 Medical examination

We may require the *life insured* to undergo an examination, and reasonable tests, necessary to enable the diagnosis to be confirmed by a specialist *medical practitioner* appointed by us. If we request a medical examination by a *medical practitioner* we select, we will pay for it.

## 6.5 Claim payments

Benefits are payable to you, the policy owner. All benefits are paid in Australian dollars.

## 6.6 Following the advice of a medical practitioner and travelling overseas while on claim

Claim payments will be contingent on the *life insured* being under the regular care of and following the advice of a *medical practitioner*, including recommended courses of treatment and rehabilitation. If, while *disabled*, a *life insured*, under the regular care of and following the advice of a *medical practitioner*, travels to or resides overseas:

- we will require the *life insured* to have a medical examination in Australia or in another country by a doctor nominated or approved by us; and
- *monthly benefit* payments will only be made for a maximum of 3 months while the *life insured* remains outside Australia.

## 6.7 Misstatement of Age

If the age of the *life insured* has been understated on the application for this policy then the benefit payable under this policy will be calculated on the basis of the benefit that the *premium* would have purchased if it had been calculated on the correct age. If the age of the *life insured* has been overstated, we will refund any excess *premium* paid.

Where the terms and conditions of a benefit vary by the age of the *life insured*, the correct age of the *life insured* will be used to determine whether a benefit is payable.

## 6.8 Concurrent claims

If a *life insured* suffers multiple *sicknesses* or *injuries*, we will only pay the benefit once for the period of *disability*.

## 6.9 Recurrent claims

If within 12 months of the end of a claim, the *life insured* suffers from the same or related *sickness* or *injury* which caused the initial claim, the recurrence will be treated as a continuation of the original claim. This means that subject to the terms and conditions of the policy:

- the *waiting period* does not apply to the recurrent *disability*;
- subject to ongoing evidence that the *life insured* is disabled, benefit payments will recommence monthly in arrears;
- all periods of claim will be added together for the purpose of determining the remaining *benefit period;* and
- if already paid, the Waiting period waiver or Return to work benefit will not be paid again;
- once benefits have been paid for the duration of the *benefit period* in respect of the recurrent *disability*, the *benefit period* will end;
- the *benefit period* is only payable once per claimed condition, including any recurrences, and it expires when the end of the *benefit period* is reached.

# 7. Definitions

***annual income*** is different based on whether the *life insured* is self employed or not. It consists of the income earned through personal exertion and:

- if the *life insured* does not directly or indirectly own all or part of the business or professional practice from which he or she earns his or her regular income: "annual income" means the salary, wages, fees, regular commissions, regular bonuses and other income earned from personal exertion by the *life insured*, plus the value of any company benefits received by the *life insured* (for example superannuation contributions or a company car), less any deductions for expenses directly incurred in earning this income; or
- if the *life insured* does directly or indirectly own all or part of the business or professional practice from which he or she earns his or her regular income: "annual income" means the revenue generated by the *life insured's* business as a result of the *life insured's* personal exertion, plus income earned by the *life insured* from any other source as a result of personal exertion, less eligible business expenses.

***any occupation*** means any occupation the life insured is suited to by reason of his or her education, training or experience.

## 7. Definitions (continued)

***benefit period*** is the maximum total length of time that we will pay a *monthly benefit*, when the *life insured* suffers from the same or related *sickness* or *injury* during the life of the policy (this includes all periods of *disability* for the same or related *sickness* or *injury*). The *benefit period* is shown on your *Policy schedule*.

***Cancer*** means the presence of a malignant tumour, including leukaemia, malignant lymphoma and other haemopoietic malignancies.
The tumour must be confirmed by histological examination and:

- the *life insured* must require major interventionist therapy including surgery, radiotherapy, chemotherapy, biological response modifiers or any other major treatment; or
- the tumour must be sufficiently advanced such that major interventionist therapy is no longer recommended.

The following cancers are specifically excluded from this definition:

- chronic lymphocytic leukaemia less than RAI Stage 1;
- all cancers described as carcinoma in situ. Carcinoma in situ of the breast is covered only if it requires:

- the removal of the entire breast; or
- breast conserving surgery and radiotherapy; or
- breast conserving surgery and chemotherapy

(chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells).
Carcinoma in situ of the breast treated by breast conserving surgery and other forms of adjuvant systemic therapy, including endocrine manipulation therapy, hormonal manipulation therapy or non-endocrine adjuvant therapy, is not covered;

- skin cancers unless:

- they have metastasised to other organs; or
- the tumour is a malignant melanoma of Clark Level 3 and above; or
- the tumour is a malignant melanoma with invasion greater than 1mm thickness; or
- the tumour is a malignant melanoma where melanoma is showing signs of ulceration as determined by histological examination;

- prostate cancers diagnosed as T1 with a Gleason score of 5 or less, unless major interventionist therapy is performed.

***Consumer Price Index or CPI*** means the Consumer Price Index for "Weighted Average of Eight Capital Cities Index" as published by the Australian Bureau of Statistics (or, if that index ceases to be published or is substantially amended, such other appropriate index we will select), published for the quarter ending immediately prior to 3 months before the policy anniversary, over that published for the quarter ending immediately prior to 15 months before that policy anniversary.

***cover type*** means either Sickness and Injury cover, Essentials cover or Injury only Cover, as shown on the *Policy schedule.*

***disabled, disability*** or ***disablement*** means that:

- if you have Sickness and Injury cover, as shown on your *Policy schedule,* the *life insured* is, solely due to *sickness* or *injury* occurring after policy commencement, *unable to work*; or
- if you have Injury only Cover, as shown on your *Policy schedule*, the *life insured* is, solely due to an *injury* occurring after policy commencement, unable to work; or
- if you have Essentials cover, as shown on your *Policy schedule*, the *life insured* is, solely due to *sickness* or *injury* occurring after policy commencement, *unable to work* and unable to perform at least three of the *Regular Daily Activities*.

***Heart attack*** means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following:

- signs and symptoms of ischaemia consistent with myocardial infarction; or
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]); or
- development of pathological Q waves in the ECG; or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive or our noted diagnostic techniques are impractical to apply or have been superseded, we will consider other appropriate and medically recognised tests. A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease is excluded. Also excluded are other acute coronary syndromes including but not limited to angina pectoris.

***injury*** means bodily injury caused by accidental, violent, external and visible means, inflicted after the policy begins and while the policy is in force.

***life insured*** means the person named as the life insured on your Policy schedule.

## 7. Definitions (continued)

***medical practitioner*** means a medical practitioner legally qualified and registered to practise in Australia or New Zealand or a medical practitioner legally qualified and registered to practise in another country approved by us, but does not include the policy owner, the *life insured* or a relative, business partner or employee of the policy owner or *life insured*. Medical practitioners do not include other paramedical professionals such as chiropractors, physiotherapists or naturopaths.

***mental health disorder*** is any disorder classified in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current at the start of the period of *disability* (or such replacement or successor publication or if none then such comparable publication as selected by us).
Such mental health disorders include, but are not limited to, stress (including post traumatic stress disorder), physical symptoms of a psychiatric illness, anxiety, depression, psychoneurotic, psychotic, personality, emotional or behavioral disorders or disorders related to substance abuse and dependency which includes alcohol, drug and chemical abuse dependency. A *mental health* disorder does not include dementia (except where the dementia is related to any substance abuse or dependency) and Alzheimer's Disease.

***monthly benefit*** is the maximum monthly amount you are eligible to receive under this policy in respect of a *life insured* and is based on your *cover type*. The *monthly benefit* is equal to:

- if you have either Sickness and Injury cover or Injury only Cover, as shown on your *Policy schedule*, the lesser of:
  - the *monthly sum insured* and
  - 75% of the *life insured's pre-disability income, reduced by any amount of offsets* applicable; or
- if you have Essentials cover, as shown on your *Policy schedule*, the *monthly sum insured*,

***monthly sum insured*** means the amount shown as the monthly sum insured on your *Policy schedule*, and if applicable, increased by the Inflation protection option or reduced by any Reducing income feature selected.

***offsets*** are payments received by the life insured from other sources by which we are entitled to reduce your eligible benefit in order to calculate the *monthly benefit payable*. "Offsets" are entitlements received from any of the following sources:

- an employer as sick leave or other paid leave;
- workers' compensation;
- social security where the payment relates to inability to work;
- any other legislation that provides income type payments;
- other insurance policies providing income benefits; or
- superannuation benefits relating to inability to work;
- any other payments related to employment or business controlled by you or the *life insured* or the immediate family of either you or the *life insured*, for the same period, in relation to the *disability*.

If any of these payments are made in a lump sum, we will divide the amount by 60 to convert the value to a monthly amount. *Offsets* do not include investment income and policy payments for business expenses or compensation for pain and suffering.

***policy anniversary*** means the anniversary of the commencement date of your policy as shown in your *Policy schedule*.

***Policy schedule*** means the document which will be provided to you by us, containing details of the *life insured* under this policy, the *monthly sum insured*, the *waiting period*, the *benefit period* and other important details about your policy. Your *Policy schedule* will be updated by us as a result of:

- any changes you make to your policy and agreed to by us; and
- any changes made by us in accordance with these policy terms.

A reference in this document to your *Policy schedule* is a reference to the most recent *Policy schedule* issued by us to you.

***pre-disability income*** means the *life insured's* average monthly income calculated from the *life insured's annual income* in the financial year in which the *life insured* reported the highest earning from the last two complete financial years immediately prior to the onset of his or her *disability*.

***premium*** means the amount payable for the benefits applicable under this policy, including any increase in benefit, stamp duty and any other government charges, duties or taxes that may be levied from time to time.

## 7. Definitions (continued)

***Regular Daily Activities*** means:

- Cooking meals - using kitchen and cooking utensils, appliances and equipment to prepare a meal;
- Cleaning the home - using domestic appliances and equipment to clean and maintain a home;
- Shopping for household items - physical ability to purchase everyday household items, by using a shopping basket or trolley;
- Caring for dependents - providing care for children or dependent adults; and
- Driving a car and using public transport - the physical ability to drive a car for any distance, and the ability to catch a bus, train or ferry without the assistance of another person.

***sickness*** is an illness or disease that first manifests itself after the policy begins and while the policy is in force.

***Stroke*** is a cerebrovascular event producing a neurological sequela lasting at least 24 hours. This requires clear evidence on a Computerised Tomography (CT), Magnetic Resonance Imaging (MRI) or similar scan that a stroke has occurred and of:

- infarction of brain tissue, or
- intracranial or subarachnoid haemorrhage.

Cerebral symptoms due to transient ischaemic attacks, reversible neurological deficit, migraine, cerebral injury resulting from trauma or hypoxia, disturbances of vision or balance due to disease of the eye, optic nerve or the vestibular apparatus of the ear are excluded.

***unable to work*** means in our opinion, and confirmed by a medical practitioner acceptable to us, the *life insured*:

- has stopped working in the life insured's usual occupation solely as a result of a sickness or injury; and
- is unable to work in any occupation (whether paid or unpaid); and
- is not earning any income from personal exertion; and
- is under the regular care of, and following the advice of, a medical practitioner.

***uncomplicated pregnancy or childbirth*** is a pregnancy, childbirth or termination which does not result in any serious medical complication. It includes participation in an IVF or similar program, normal discomforts such as morning sickness, backache, varicose veins, ankle swelling or bladder problems, giving birth, miscarrying or having an abortion.

***usual occupation*** means the paid occupation the *life insured* predominantly performed in the 12 months prior to the *sickness* or *injury*. If the life insured has been on long service, maternity or paternity leave for more than 12 consecutive months immediately prior to the *sickness* or *injury* then his or her usual occupation is any *occupation*.

***waiting period*** is the number of days the *life insured* must be *disabled* before being eligible for a benefit. The waiting period is shown on your *Policy schedule.*

Zurich Ezicover Income Protection

# Frequently Asked Questions

ZURICH

**How can I change the direct debit details on my policy?**

You can amend a direct debit arrangement on your policy:

1. By completing a Direct debit request form and returning the form to Zurich. The form is available online at www.zurich.com.au.
2. Over the phone by contacting Zurich on 131 551.

If we are unable to successfully identify the caller we cannot proceed with changes over the phone and a Direct debit form will be required.

**How can I remove my direct debit details?**

You can change or remove a direct debit arrangement on your policy:

1. By written request. The request must include the policy number and be signed by either the policy owner or payor.
2. Over the phone by contacting Zurich on 131 551.

If we are unable to successfully identify the caller we cannot proceed with changes over the phone and a written request will be required. Where there is more than one policy owner, we cannot accept an instruction over the phone and a written request signed by all policy owners will be required.

**How can I change my address or contact details on my policy?**

You can change the address or contact details on your policy:

1. By written request. The request must include the policy number, the old and new contact details and be signed by the policy owner (or the member in the case of Superannuation policies).
2. Over the phone by contacting Zurich on 131 551.
3. Via your financial adviser. Your financial adviser can call us to update these details on your behalf (where applicable).

If we are unable to successfully identify the caller we cannot proceed with changes over the phone and a written request will be required. Where there is more than one policy owner, we cannot accept an instruction over the phone and a written request signed by all policy owners will be required.

**Who can access information on my Zurich policy?**

The following parties have the authority to access your policy information:

1. You, as the policy owner (or the member in the case of Superannuation policies).
2. Your appointed financial adviser (where applicable).
3. The payor, but only in relation to the payment of premiums.

In addition, a policy owner (or the member) can provide Zurich with an authority for any third party to access information in relation to their policy. An authority can be provided verbally over the phone by the policy owner (subject to Zurich being able to successfully identify the caller as the policy owner), giving the nominee access to policy information for a 24 hour period. A written request will provide a nominee the authority to access policy information until such time as the authority is revoked by the policy owner in writing. Where there is more than one policy owner, a written request signed by all policy owners will be required.

**All written requests must be signed by all policy owners and should provide the following information about the nominee: name, date of birth and address.**

## DIRECT DEBIT REQUEST SERVICE AGREEMENT

**This agreement sets out the terms and conditions on which the Account Holder has authorised Zurich to debit money from their account and the obligations of Zurich and the Account Holder under this Agreement.**

**The Account Holder understands and agrees that:**

- Direct debiting may not be available on all accounts. The Account Holder is responsible for ensuring the specified account can accept direct debits and there are sufficient cleared funds available in the nominated account to permit payments under the Direct Debit Request on the due date for payments.
- Zurich accepts no responsibility for issues arising where incorrect details have been provided. The Account Holder should check the account details provided to Zurich are correct. If uncertain, check with your financial institution before completing the Direct Debit Request.
- Zurich will debit the account for the sum of the amounts due at the debit date for all specified policies.
- Changes to bank account details must be provided in writing, or by telephoning Zurich (or by such other means as we approve).
- Zurich will give the Account Holder at least 14 days notice in writing if there are any changes to the terms of this Service Agreement.

**Zurich agrees that:**

- When the due date for payment is not a business day, the debit will be processed on the next business day.
- The Account holder can cancel, change*, defer or suspend the Direct Debit Request on a policy by providing notice to Zurich in writing or by telephone (or by such other means as we approve), or directly with the Account Holder's financial institution (which is required to act promptly on the instructions).
  * The Account Holder's financial institution can "change" the Direct Debit Request only to the extent of advising Zurich of new account details. Notification must be received by Zurich at least 14 days before the next drawing date in order to process your instructions.
- Upon request, Zurich will forward a copy of the current terms and conditions for direct debits to the Account Holder by post, facsimile or other agreed method.
- Zurich will provide details of this Direct Debit, on request.

**Disputes**

The Account Holder should give notice of any disputed debit to Zurich. Zurich will respond within 7 working days of receiving your letter. Alternatively, the Account Holder can take it up directly with the Account Holder's financial institution.

**Dishonoured debits**

If a debit is unsuccessful, Zurich will cancel the payment in respect of the dishonoured debit. In some instances, such as where your account has insufficient funds, Zurich may notify you and attempt a second deduction from your account within 14 days. You should ensure that your account has sufficient funds before any second deduction. If we receive new information from you after a dishonour, Zurich will process a one-off debit to pay the policy up to date. If two consecutive dishonours occur, Zurich may cancel the authority. Zurich may charge a dishonour fee to the relevant policy. Currently the fee is nil. The financial institution may also charge fees relating to the dishonour to the account, which is the Account Holder's responsibility.

**Confidential information**

Zurich may disclose information about your account to its banker (in connection with a claim made against it relating to an alleged incorrect or wrongful debit made from the account), your financial institution, your adviser and to other companies within the Zurich Financial Services Australia Group of companies. Zurich will not disclose information about you or the account to any other person, except where you have given consent or where the disclosure is required by law.

**Notices to Zurich**

The Account Holder may give notice to Zurich by telephone on 131 551. Alternatively, you may write to us at Locked Bag 994, North Sydney NSW 2059.