My Protection Plan

PRODUCT DISCLOSURE STATEMENT & POLICY DOCUMENT

ISSUE DATE: 22 JUNE 2020

ali PROTECTING HOME & PROPERTY BUYERS

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ISSUED BY: HANNOVER LIFE RE OF AUSTRALASIA LTD
DATED: 22 JUNE 2020 • DISTRIBUTED BY: ALI GROUP

Contents

ALI PROTECTING HOME & PROPERTY BUYERS

Why you should read this document

This document should help you decide if My Protection Plan is right for you. It contains the terms and conditions of My Protection Plan so that you can be clear on the cover you are being offered and how you may benefit from it.

Read it carefully, along with any other documents we've given you.

Keep in mind that this is general information. It doesn't take into account your individual objectives, financial situation or personal needs.

If you're still not sure whether My Protection Plan meets your needs after reading this, you may want to seek professional financial advice.

This PDS is issued by Hannover Life Re of Australasia Ltd ABN 37 062 395 484. Hannover takes full responsibility for this PDS.

My Protection Plan

ALI Group's My Protection Plan provides a lump sum payment to you or your estate if:

- you die (Death Benefit).
- you're diagnosed as **terminally ill** (Terminal Illness Benefit).
- you suffer one of 13 serious medical conditions (Trauma Benefit).

As an added bonus and with no additional premium payable, My Protection Plan also provides a monthly benefit for up to three months if you suffer a **disabling injury** (Accidental Injury Benefit).

All benefits are paid on the terms set out in this document and all amounts we refer to are in Australian Dollars.

My Protection Plan is not a savings plan. It provides risk insurance cover only. You won't get any money back if you terminate your cover and you will not share in any profits of the insurer or distributor, or of the statutory fund of the insurer.

WHO PROVIDES THE COVER?

The issuer of the insurance cover is Hannover Life Re of Australasia Ltd ("Hannover") ABN 37 062 395 484 of Tower 1, Level 33, 100 Barangaroo Avenue, Sydney NSW 2000. The insurance cover is written out of the Hannover Australian Statutory Fund.

My Protection Plan is distributed by Australian Life Insurance Distribution Pty Ltd ("ALI Group") ABN 31 103 157 811 AFSL 226403.

ALI Group doesn't underwrite or guarantee the insurer's obligations under the policy.

ALI Group has consented to statements made by it in this **PDS** in the form and context in which such statements appear and has not withdrawn this consent before the date of the **PDS**.

If you have any questions about My Protection Plan or your policy, contact ALI Group:

1800 006 776 (toll free)

service@aligroup.com.au

GPO Box 4737, Sydney NSW 2001

You can find out more details at aligroup.com.au.

DEFINED WORDS

Some words or expressions in this **PDS** have special meaning. We have bolded these words and their meanings are explained in the 'Glossary' on page 20 of this **PDS**:

- "Us", "our" and "we" means Hannover.
- "You" and "your" means either the **insured person** or the **policy owner**, as the context allows.

Policy conditions

BENEFITS OF MY PROTECTION PLAN

Death Benefit

We pay a Death Benefit if you die.

The amount we pay can change over the term of your cover as a result of automatic increases, payment of a Trauma Benefit or your requests for changes to your benefit amounts. We pay the amount that applies on the date of your death.

When your cover starts, your Death Benefit may be calculated on the amount of your loan, rounded up to the nearest $10,000. The maximum amount of cover is $750,000 and the minimum is $100,000.

If you apply to increase an existing loan, your Death Benefit may be calculated on your new full loan amount, not just the increase.

If you're insuring two people, you don't have to both be insured for the same amount.

Once we've paid your Death Benefit, your cover automatically ends.

EXAMPLE

You take out a home loan for $600,000 and request a Death Benefit of $600,000 when you apply for cover. Two years later you borrow an extra $250,000 to renovate your home and you ask us to take account of this increase under your cover. Your new Death Benefit now goes up to the maximum $750,000. Your premiums will increase too.

Terminal Illness Benefit

We pay a Terminal Illness Benefit if you suffer a **terminal illness**.

Your Terminal Illness Benefit is the same amount as your Death Benefit, but we pay it before you die. The amount we pay is the same as the Death Benefit that applies on the date **terminal illness** is diagnosed, not the date we're told about the illness.

If you die before we pay the Terminal Illness Benefit, we'll pay a Death Benefit instead.

Once your Terminal Illness Benefit is paid, your cover automatically ends.

EXAMPLE

You're insured for a Death Benefit of $600,000 and are diagnosed with stage 4 cancer that reduces your life expectancy to six months. We pay you the full amount as a lump sum Terminal Illness Benefit so that you can spend it as you wish, even if you outlive your life expectancy. Your cover now ends and no Death Benefit will be payable if you die.

Trauma Benefit

We pay a Trauma Benefit if you suffer:

- **cancer***
- **cardiomyopathy***
- **heart attack***
- **stroke***
- **coronary artery bypass surgery***
- **surgery to the aorta***
- **kidney failure**
- **Alzheimer's Disease (dementia)**
- **paralysis**
- **severe burn**
- **loss of independent existence**
- **total loss of sight**
- **total loss of hearing**

*You'll need to wait three months from the start of the policy before you're eligible to claim a Trauma Benefit for these conditions. For full definitions of these conditions, see the 'Glossary' (page 20).

The amount we pay can change over the term of your cover as a result of automatic increases or your requests for changes to your benefit amounts. We pay the amount that applies on the date the condition is suffered (not the date we're told about the condition). The time you are deemed to suffer the condition is the date of initial diagnosis, or of the medical trauma (as appropriate).

At the start of the policy your Trauma Benefit is equal to 30% of your Death Benefit unless you ask us to amend it. It can't ever be increased to more than 50% of your Death Benefit.

We only pay one Trauma Benefit for each **insured person**. Once the Trauma Benefit is paid, we reduce your Death and Terminal Illness Benefits by the same amount. This means your premiums will also go down.

EXAMPLE

You're insured for a Death Benefit of $600,000 and have a Trauma Benefit of 30%. Eleven months later you suffer a **heart attack**. We pay you $180,000. Your Death Benefit is now reduced by the same amount and becomes $420,000.

Complimentary Accidental Injury Benefit

We pay an Accidental Injury Benefit if you suffer a **disabling injury** and remain continuously **disabled** both during and after the 30-day waiting period. During the 30-day waiting period no benefits are payable.

At your policy **start date**, your Accidental Injury Benefit is 1% of the Death Benefit, capped at $2,500 per month. Until your Accidental Injury Benefit ends, your benefit will increase and/or decrease in line with automatic increases and/or requested increases or decreases in your Death Benefit. Please refer to "Changes to your Cover" on page 15. The amount of the benefit you receive is the amount of your Accidental Injury Benefit at the time you are deemed to suffer a **disabling injury** which is the date the **disabling injury** occurred.

We'll pay the Accidental Injury Benefits for only one **disabling injury** each **policy year**, and will pay up to three months benefits for each **disabling injury**.

Where the Accidental Injury Benefit is payable for less than one whole month, we will calculate each day's benefit as 1/30th of the monthly benefit for each day you remain **disabled**.

If you return to work before we have paid three months benefit and then become **disabled** again within six months of returning to work due to the same **disabling injury**, you may still be eligible for the balance of your Accidental Injury Benefit.

If we pay you an Accidental Injury Benefit, this won't affect your other benefits.

EXAMPLE

You're working full-time and are insured for a Death Benefit of $600,000. You fall down the stairs at home and injure yourself so severely that you can't work for three months. After 30 days away from work (the waiting period), we'll pay you an Accidental Injury Benefit of $2,500 a month, so you receive a total of $5,000. If you can't work again within six months because of that same **disabling injury** you may still have $2,500 left to claim.

ARE YOU ELIGIBLE FOR COVER?

You're eligible for My Protection Plan if you've received this **PDS** in Australia and one of the following applies:

- you've applied for a loan (as a borrower, co-borrower or guarantor) or a loan increase in the last 12 months. Your cover is independent of your loan, which means you can still be covered if your loan application isn't approved, or it's approved but you don't draw it down; or
- you've completed a loan review with your mortgage broker in the last 12 months; or
- you're associated with and have been nominated by a company that's a borrower or co-borrower on a loan application or loan increase application lodged within the last 12 months (i.e. a shareholder, officer or employee); or
- you're the spouse of someone who has applied for My Protection Plan.

In each case, the loan must be a home, investment property, equity access or personal loan.

When your policy starts, you must also be:

- an Australian or New Zealand citizen or permanent resident;
- residing in Australia; and
- between 18 and 59 years of age.

You must not be:

- insured under two or more policies underwritten by Hannover and distributed by ALI Group where the total of your Death and Terminal Illness Benefit amounts is more than $750,000 when your policy starts.

If you don't meet these requirements, or if you're not sure whether you do, please contact us.
We may be able to waive some of the eligibility requirements. If we do, we'll record it on your policy. If you think we've waived a requirement but it's not recorded in your **policy schedule**, please contact us immediately.

WHEN WON'T WE PAY A BENEFIT?

There are times when we can't pay you a benefit.

We will not pay a benefit if, at the **start date**, you did not meet the eligibility requirements set out on this page under 'Are you eligible for cover?'.

We will not pay a benefit for any event for which an exclusion is listed on your **policy schedule**. Please refer to "Exclusions for pre-existing conditions" on page 11.

Death or Terminal Illness Benefit

We won't pay a Death or Terminal Illness Benefit if you:

- die before the **start date** or after your cover has ended.
- die or suffer a **terminal illness** that's caused by an intentional or self-inflicted act by you or the **policy owner** (regardless of whether sane or insane at the time) that happens within 13 months of your **start date** or cover being reinstated.

If you suffer a self-inflicted death or **terminal illness** within 13 months of you increasing your cover, we won't pay the amount of the increase you requested. However, we'll pay any automatic increase.

Trauma Benefit

We won't pay a Trauma Benefit if you:

- caused your condition through an intentional act by you or the **policy owner** (regardless of whether sane or insane at the time).
- suffered, or sought or intended to seek professional health advice about your condition before the **start date**; or in the case of **cancer**, **cardiomyopathy**, **coronary artery bypass surgery**, **heart attack**, **surgery to the aorta** or **stroke**, within three months after the **start date**.
- suffer the condition after your cover has ended.

We'll only pay a Trauma Benefit once. You won't be covered if you're diagnosed with one of these conditions a second time.

If you're suffering, or intended to seek professional medical advice about **cancer**, **cardiomyopathy**, **coronary artery bypass surgery**, **heart attack**, **surgery to the aorta** or **stroke** within three months of increasing your Trauma Benefit we won't pay the amount of the increase you requested. However, we'll pay any automatic increase.

Accidental Injury Benefit

We won't pay an Accidental Injury Benefit if your injury is the result of:

- an intentional, deliberate or self-inflicted act by you or the **policy owner** (regardless of whether sane or insane or under any mental distress at the time).
- intoxication of the **insured person** resultant from:
  a. **excessive alcohol consumption**;
  b. recreational drug use; or
  c. prescription drug use not adhering to medical advice.
- flying, other than as a fare-paying passenger on a commercial airline on a regularly scheduled flight.
- an activity engaged in more than 20 metres above ground or 30 metres below it.
- willingly and knowingly exposing yourself to the risk of injury or danger for gain or reward.
- war or war-like activity, taking part in riot or civil commotion, or engaging or serving in the armed forces.
- criminal or illegal activities.

An Accidental Injury Benefit will also not be paid if:

- benefits have already been paid for a disabling injury in the same policy year;
- the **disabling injury** did not occur independently of a pre-existing condition.

Increased benefits

Except as a result of automatic annual increases, we will not pay the amount of any increase in:

- Death and Terminal Illness Benefit if your death or **terminal illness** is caused directly or indirectly by you or the **policy owner** (regardless of whether sane or insane at the time) within 13 months of the increase.
- Trauma Benefit if you suffer or intend to seek professional health advice about **cancer**, **cardiomyopathy**, **coronary artery bypass surgery**, **heart attack**, **surgery to the aorta** or **stroke** within 3 months of the increase.
- any benefit if the insured event occurred prior to the increase or a pre-existing condition applies to the increase.

Reinstatement of cover

We will not pay any benefits for a condition you suffered, sought or intended to seek professional health advice about, or treatment for, prior to the date your cover was reinstated. We will also not pay any benefits if any exclusion were to apply if "**start date**" was replaced by "**reinstatement date**".

Exclusions for pre-existing conditions

When you apply for My Protection Plan we won't ask any personal medical questions, ask you to take any medical examinations or ask you for any medical reports. The only information we base your cover on is what you provide.

There are two types of exclusions that can apply to your Death Benefit, Terminal Illness Benefit, Trauma Benefit and Accidental Injury Benefit when your cover starts: Type A (a list of ongoing and **chronic** conditions – see page 12) and Type B (family medical history – see page 12).

If your policy covers two people, pre-existing condition exclusions only apply to the person who has the pre-existing condition. This means, for example, that your partner's pre-existing condition doesn't affect your cover.

Type A Exclusions

A Type A Exclusion will apply if, before the **start date**, you suffered, sought or intended to seek professional health advice about, or treatment for, any of the following:

a) Diabetes (excluding diabetes only during pregnancy), chest pain, heart condition, stroke, high cholesterol (that is not **well managed**), conditions of the aorta or a circulatory condition (excluding **controlled** high blood pressure).

b) A lump or growth that has not been confirmed benign (non-cancerous) or any form of cancer, leukaemia, lymphoma or melanoma (excluding other skin cancer).

   For the purpose of the Type A Exclusion, all tumours excluded within the cancer benefit will be considered to be pre-existing except for hyperkeratosis, basal cell carcinoma and squamous cell carcinoma.

c) Any **chronic** condition of the kidney.

d) Any **chronic** condition of the bladder.

e) Any **chronic** condition of the liver (including hepatitis).

f) Any **chronic** lung condition (excluding **controlled** asthma).

g) Paralysis.

h) Multiple sclerosis or other nervous system condition.

i) A **serious mental condition**.

j) Any sight impairment (excluding long or short sightedness corrected by glasses or contact lenses).

k) Any hearing impairment.

l) A blood condition (including, but not limited to, HIV or AIDS).

If at the **start date**, you had previously suffered, sought or intended to seek professional health advice about, or treatment for one of these conditions, then all of the conditions referred to in the same paragraph will be excluded conditions. This means that we won't pay a benefit for any condition in the same paragraph or any complication arising from the treatment of any condition in the same paragraph.

EXAMPLE

If you have suffered from cancer before the **start date**, then all conditions in paragraph (b) will be excluded conditions. If you had also previously suffered from a major depressive disorder, then all conditions in paragraphs (b) and (i) will be excluded conditions.

Type B Exclusions

A Type B1 Exclusion applies if two or more of your natural parents, brothers or sisters were diagnosed with bowel cancer (for all **insured persons**), or breast or ovarian cancer (for female **insured persons** only) before they turned 55 years old.

If a Type B1 Exclusion applies to your cover, we won't pay any benefits for any event caused, or contributed to, by cancer or any complications arising from its treatment.

EXAMPLE

Your natural mother and natural father were both diagnosed with bowel cancer before the age of 55 years. We won't pay you a benefit if you also suffer from cancer, nor for any events your cancer causes or contributes to.

A Type B2 exclusion applies if two or more of your natural parents, brothers or sisters were diagnosed with cardiomyopathy before they turned 55 years old.

If a Type B2 exclusion applies to your cover, we won't pay any benefits for any event caused, or contributed to, by cardiomyopathy or any complications arising from its treatment.

EXAMPLE

Both your natural brother and your natural sister were diagnosed with cardiomyopathy before the age of 55 years. We won't pay you a benefit if you also suffer from cardiomyopathy, nor for any events your cardiomyopathy causes or contributes to.

Want more certainty around pre-existing conditions?

Within 30 days of the **start date**, you can choose to answer a series of short Personal Medical History questions. Your answers will enable us to replace or remove the pre-existing condition exclusion.

If you answer 'no' to all the questions, your cover won't be subject to any Type A or Type B Exclusions for pre-existing conditions. Even if you can't answer 'no' to all the questions, we may still replace the standard exclusions for pre-existing conditions with an agreed exclusion.

The structure of the Type A and Type B Exclusions and the Personal Medical History questionnaire means you shouldn't ever be worse off for completing the questionnaire.

It's important to answer the Personal Medical History questions honestly and accurately. We rely on this information to set the terms and conditions of your cover. If you don't answer the questions honestly and you have to make a claim, we may reduce your benefit or avoid paying a benefit.

If you reinstate or increase your cover, you'll need to complete another Personal Medical History questionnaire. Otherwise, the standard list of exclusions for pre-existing conditions will apply to the increase or reinstatement of your cover.

WHEN DOES MY COVER START?

Your cover **start date** is the date we issue your policy and is listed as the Commencement Date in your **policy schedule**.

WHEN DOES MY COVER END?

Your My Protection Plan isn't tied to your loan, so your cover keeps going even if your loan stops or you pay it off.

Regardless of any changes to your health, occupation or past times, your cover is guaranteed renewable. This means that your cover continues until the policy anniversary after you turn 99 years (for Death and Terminal Illness Benefits) and 65 years (for Trauma and Accidental Injury Benefits), unless your policy has ended earlier because:

- you die.
- we've paid a Terminal Illness Benefit.
- you've cancelled your cover.
- we have cancelled your policy (for reasons including that you did not pay your premium on time).
- you failed to comply with your duty of disclosure and we avoided your policy in accordance with the law.

Important information

COMPLIMENTARY COVER FOR THE FIRST 30 DAYS

Your first 30 days of cover are complimentary. This cooling off period gives you time to check details and make sure My Protection Plan meets your needs.

If you decide to cancel during the first 30 days, just contact us and let us know. We'll cancel your insurance and you won't have to pay any premiums.

If two people are covered, cover may be cancelled for one or both of you.

COMPLIMENTARY ACCIDENTAL INJURY BENEFIT COVER

The Accidental Injury Benefit is provided to you by ALI Group at no additional cost. You don't pay any additional premium for this component of your My Protection Plan.

INFORMATION PROVIDED BY YOU

We base our decision to insure you on the information provided to us by you or on your behalf. We also base our decision to reinstate or increase benefits or make any other changes to your cover on the information provided at that time. It is important that you answer all questions honestly and accurately as failure to do so may lead to a claim not being paid.

HOW MUCH DOES MY PROTECTION PLAN COST?

Your initial premium amount will be listed in your **policy schedule**. We recalculate your premium on each annual anniversary of your **start date** and it generally increases with age. We take into consideration:

- your level of cover.
- your age and gender.
- whether you smoke or vape tobacco, nicotine or any other substance (or whether you have in the last 12 months).
- any loadings or discount that we have applied to your insurance.
- any government charges we have asked you to pay.

We may deduct any duty, tax, excise or other government charge from a benefit payment. Where GST applies to any part of the premium, we will include this in the premium you must pay.

Your premium includes a monthly policy fee which is included in your premium listed in your **policy schedule**. This fee covers the cost of administering your policy. Only one fee is charged per policy no matter whether your policy covers one or two people.

If you'd like to see a table of premium rates and information on how we calculate them, let us know.

We can change your premiums or policy fee at any time but only if we change them for all **policy owners** who have a My Protection Plan obtained under this version of the **PDS**. We'll tell you one month in advance if we need to change your premium or policy fees.

You don't have to pay any government duties or charges. If this changes, we'll also let you know.

If you give up smoking and vaping for 12 months, call us or complete a notification form (available from us) and we can then reduce your future premiums to the non-smoker premium rates to help you save money.

INSURING TWO PEOPLE

We can set up policies for two people as long as you both meet the requirements listed under 'Are you eligible for cover?' on page 10. Each of you will have separate insurance, even though you're covered by the same policy.

If there are more than two parties to your loan, mulitiple My Protection Plan policies may be established.

YOUR POLICY DOCUMENTS

Together, your **policy schedule** and this **PDS** form your contract of insurance. Please keep them in a safe place as you will need them if you make a claim.

PAYMENT OPTIONS

Premiums are payable monthly in advance (remember your first month is complimentary) with the first due date one month after your policy **start date**. You can pay your premium through automatic deductions from your bank, building society or credit union account or through your MasterCard or Visa.

When you set up your My Protection Plan you'll be authorising Hannover to deduct payments in line with the terms of the 'Direct Debit Service Agreement' on page 25.

You have the right to stop payments. See the 'Direct Debit Service Agreement' on page 25 for more information.

Premiums must be paid by the due date for your cover to continue. If a premium is not paid by its due date, we may cancel your policy. If you have joint cover, this will mean that cover for both **insured persons** will be cancelled because the premium is paid together.

CHANGES TO YOUR COVER

Automatic increases to your benefits

To help protect against inflation, on each annual anniversary of the **start date** we'll increase your benefits in line with the **CPI**.

If the **CPI** is less than 3%, we apply a 3% increase. If the **CPI** is more than 10%, we limit our increase to no more than 10%.

Your premiums will increase to reflect this increase in your benefits.

If you don't want a year's automatic increase let us know within 30 days of the anniversary of the **start date**. If you do this two years in a row, we'll stop automatically increasing your benefits for future years too.

Keep in mind that this automatic increase cannot be applied to only one benefit type.

If you want to restart your automatic increase, you can write to us to request this. We may or may not agree to this. We may ask for extra information to help us decide whether to restart your automatic increase and we may place other conditions on it along with those already outlined in this document.

Requesting changes to your benefit amounts

You can ask us to increase or decrease your Death Benefit, Terminal Illness Benefit and Trauma Benefit amounts (within the minimum and maximum amounts of cover) any time after your policy **start date**.

You can't request changes to your Accidental Injury Benefit but any requested increase or decrease in your Death Benefit may result in an increase or decrease in your Accidental Injury Benefit (to 1% of your Death Benefit to a maximum of $2,500 per month).

We may ask for more information to help us decide whether to grant an increase, and we may place conditions on increases, decreases, and making further changes later on. The cooling-off period doesn't apply to increases.

We may in limited circumstances specifically agree to provide a benefit in excess of the limit, and if so, this will be confirmed by us in writing.

If we grant you an increase in benefits, your premiums will also increase. The one month premium-free period doesn't apply to increases, so you'll need to start paying a higher premium as soon as your increase is granted.

If your policy covers two people, you don't need to have the same benefit amounts for each person.

Reinstating your cover

You can ask us to reinstate your cover after it has ended. We may or may not agree to this. We may ask for extra information to help us decide whether to reinstate your cover and we may place other conditions on it along with those already outlined in this document.

Transferring ownership

You can transfer ownership of your insurance by:

- returning a completed Memorandum of Transfer form (we can send this to you on request).
- meeting any other requirements that we tell you including the payment of any costs involved.

The transfer will only be complete when you have done this and we have registered the transfer. If there is more than one owner of the insurance, all owners must agree to the transfer.

Nominating beneficiaries

If you are the sole owner of a My Protection Plan policy covering a single life you may nominate 1 to 5 persons as beneficiaries. A beneficiary or beneficiaries nomination may be made any time after the policy **start date**.

For details on how benefits will be paid, see "How are your benefits paid?" on page 17.

Unfortunately the nomination of beneficiaries is not available for My Protection Plan policies with more than one owner.

Transferring insurers

We may transfer your insurance to another registered life insurer in the future. This would be either a member of the Australian Life Insurance group of companies or another selected insurer.

We would observe all legal requirements applying to transfers, such as the requirements of the Life Insurance Act 1995 (Cth), to safeguard your interests.

RISKS IN TAKING OUT COVER

There may be some risks involved in holding a My Protection Plan policy, such as:

- if you fail to provide an effective authorisation for the deduction of your premiums within 30 days from the **start date** of your cover, we may cancel your policy. This will leave you without cover and unable to make a claim.
- if you don't pay your premiums when they fall due, we may cancel your policy. This will leave you without cover and unable to make a claim.
- you may not have enough cover or the right kind of cover for your circumstances.
- if you fail to comply with your duty of disclosure, we may avoid or vary your policy in accordance with the law.
- your claim may be declined if it falls under the 'Exclusions for pre-existing conditions' (page 11).
- your claim may be declined if it is excluded (see pages 11 – 13).

MAKING A CLAIM

If you need to make a claim, contact us as soon as possible by phone, email or mail. You (or your legal representative) must contact us within six months of the event you're claiming for. If you delay telling us about a claim, we may reduce the amount of the benefit we pay.

We will send you a claim form to complete and return to us. You will also need to send us any evidence we require within six months of the date of your claim.

The type of evidence we need depends on the type of claim. We'll tell you our standard requirements when you contact us, and we may ask for more information later, such as medical evidence from a **Medical Practitioner** that we've chosen.

You'll need to pay for the evidence you send us, but if we ask for an examination by a **Medical Practitioner** we choose, we'll pay for that examination.

We'll always need proof of age before we pay a claim. If your age has been understated in your My Protection Plan application, we will reduce the amount we pay to the extent that the law permits. This reduction will be in proportion to the difference in the premiums which would have been paid and the premiums which have been paid since the cover started. If your age was overstated, we will refund the amount of the overpaid premium plus interest at the rate required by law.

If your age has been understated and the claimable event happened after your policy has ceased for age reasons, your claim will not be accepted.

We won't pay any benefits until all documents and evidence are sent to us.

How are your benefits paid?

Terminal Illness Benefits, Trauma Benefits and Accidental Injury Benefits are paid directly to you (or if you have a jointly owned policy, to both of you) – not to your lender. This means you can make your own decisions about where your money is spent.

In the case of the Death Benefit, the payment goes to:

- your nominated beneficiary or beneficiaries if you have made a valid nomination, or if not, to your estate – if you were the sole **policy owner**.
- the surviving **policy owner** – if you were a joint **policy owner**.

Where a nominated beneficiary is under the age of 18, the benefit payment will be made to a nominated trustee or legal guardian for the benefit of the beneficiary until they reach 18. If necessary, the court may appoint a guardian or trustee, and any costs will be met from the benefit funds.

TAXATION

Generally Death, Terminal Illness and Trauma Benefits are not assessable as income and the premium is not tax deductible. Accidental Injury Benefits may be assessable as income.

This information is based on our interpretation of the current tax laws. Your situation may differ and we recommend that you seek independent professional tax advice.

PROTECTING YOUR PRIVACY

For the purposes of this notice, "we", "our" and "us" means Hannover and anyone collecting information on our behalf.

We are committed to protecting the privacy of the personal information we collect. All personal information is handled in line with the Australian Privacy Principles and the Privacy Act 1988 (Cth).

The information we collect may include personal and sensitive information about you, such as health information.

We collect, hold and use your information so we can:

- provide premium quotes.
- assess your application for insurance.
- issue and administer your insurance.
- assess claims.
- improve our insurance products.
- provide information about our products to our customers.

In most cases, we'll collect your personal information when you apply for a loan or loan increase or complete a personal statement. We may collect it face-to-face, over the phone or online. We may also collect it from a third party, such as your mortgage broker, financial adviser, health professional, accountant or another organisation we have an arrangement with.

Disclosing your personal information

We won't disclose your personal information without your consent to anyone outside ALI Group and the insurer other than:

- anyone we outsource tasks to, including our authorised representatives, the administrators and their representatives.
- medical practitioners, reinsurers, legal advisers and claims investigators.
- other insurers we transfer your policy to.
- where the law requires (or allows) disclosure.

These third parties may be located outside Australia. A list of the countries of their location is available on our websites. Anyone we outsource tasks to must meet our privacy requirements when they use your information. This includes only using your information for the tasks we outsource to them.

If you want a copy of your personal information, or want to update it, or if you have a complaint, you can read more about our privacy policies available on our websites or contact:

- ALI Group's Privacy Officer, ALI Group, GPO Box 4737, Sydney NSW 2001 or email: service@aligroup.com.au
- Hannover's Privacy Officer, Hannover Life Re of Australasia, Tower 1, Level 33, 100 Barangaroo Avenue, Sydney NSW 2000 or email: privacyofficer@hlra.com.au

COMPENSATION ARRANGEMENTS

Hannover has compensation arrangements in place in line with the Corporations Act 2001.

Let's keep in touch

If we have your email address, we'll send updates about your cover to your inbox.

If we don't have your email address or if you've let us know that you prefer contact by mail, we'll send our correspondence to you at the postal address you last gave us.

We may also send some correspondence, such as overdue premium reminders, to your mobile via SMS unless you advise us otherwise.

To make sure you have the latest information about your My Protection Plan policy, it's important to let us know if your contact details change by calling or writing to us.

If you have any questions about your My Protection Plan policy or our service, please contact ALI Group.

IF YOU HAVE A COMPLAINT

This policy is underwritten by Hannover and is distributed by ALI Group. We're committed to providing you with quality products and delivering the highest quality service.

Please contact ALI Group if you have a complaint about our service, your insurance or the way we've handled your personal information.

Phone: 1800 006 776 (toll free)

Email: service@aligroup.com.au

Post: GPO Box 4737, Sydney NSW 2001

We'll help you with any complaint, managing it or redirecting it if we need to.

We'll try to resolve your complaint as soon as possible, usually within 45 days. If you're not happy with the way we resolve it or we take more than 45 days to respond, you can raise your complaint directly with the Australian Financial Complaints Authority (AFCA).

AFCA is an independent complaints resolution scheme approved by the financial services regulator, the Australian Securities and Investments Commission. It was established to provide free advice and assistance to consumers to help them resolve disputes with financial services providers.

AFCA may attempt to settle your complaint through conciliation but it can also arrange a formal hearing.

You must try to resolve the complaint with us before you can ask AFCA to help. AFCA's contact details are:

Australian Financial Complaints Authority Limited
GPO Box 3
Melbourne VIC 3001

Phone: 1800 931 678 (toll free)
Email: info@afca.org.au

Contact us for further details about our resolution procedures.

Appendix A: Glossary

Alzheimer's Disease (dementia)

Progressive cognitive impairment of at least six months duration caused by irreversible organic brain disease such as Alzheimer's Disease with one of the following:

- a Mini Mental State Examination (MMSE) score of 20 or less.
- inability to perform at least two of the activities of daily living (as outlined under Loss of independent existence definition).

The diagnosis must be confirmed by a **Medical Practitioner**.

Cancer

Cancer means the confirmed diagnosis of the presence of one or more malignant tumours histologically characterised by the uncontrolled growth and spread of malignant cells, and the invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour also includes leukaemia, sarcoma and lymphoma.

The following are specifically excluded:

- Tumours which are histologically classified as 'pre-malignant', 'non-invasive', 'high-grade dysplasia', 'borderline' or 'having low malignant potential'
- All carcinoma in situ except for carcinoma in situ of the breast where total mastectomy was performed specifically to arrest the spread of malignancy and where it was considered the appropriate and necessary treatment
- All prostatic cancers, unless having progressed to T2 on the TNM Clinical Staging System; or histologically classified as having a Gleason Score of 7 or higher; or having resulted in the surgical removal of the prostate (where it was considered by treating doctors to be the appropriate and necessary treatment)
- All melanomas less than 1mm thickness as determined by histological examination and which is also less than Clark Level 3 depth of invasion
- All Hyperkeratosis or Basal Cell Carcinoma (BCC) of skin and Squamous Cell Carcinoma (SCC) of skin unless having spread to the bone, lymph node, or another distant organ
- Chronic lymphocytic leukaemia Rai Stage 0
- All cancers of the thyroid unless:
  a) having progressed to at least TNM classification T2N0M0 (Stage II); or
  b) where total thyroidectomy is undertaken
- All cancers of the bladder unless having progressed to at least TNM classification T1N0M0 (Stage I)
- Cutaneous lymphoma confined to the skin.

The diagnosis must be confirmed by a **Medical Practitioner**.

Cardiomyopathy

Cardiomyopathy means a permanent and irreversible condition of impaired ventricular function of variable aetiology (often not determined) resulting in:

- significant physical impairment i.e. Class III of the New York Heart Association classification of cardiac impairment; or
- a left ventricular ejection fraction of less than 40%.

Cardiomyopathy directly related to alcohol abuse is excluded.

The diagnosis must be confirmed by a **Medical Practitioner**.

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Chronic

A condition is chronic if it is recurrent, has lasted more than one month or required ongoing prescribed medication or treatment.

Controlled

A condition is controlled if regulated by medication or treatment and the condition does not restrict your lifestyle.

Coronary artery bypass surgery

Coronary artery bypass surgery means the actual undergoing of by-pass graft surgery, either through an open heart operation procedure or through a 'key-hole' surgical technique, to two or more blocked coronary arteries causing inadequate myocardial blood supply.

CPI

The Consumer Price Index (CPI) is the weighted average of the eight capital cities combined published by the Australian Bureau of Statistics or its successor. If the CPI is not published, or is considered by us to be inappropriate, the increase will be calculated by reference to other retail price index our Appointed Actuary decides most nearly replaces it.

Disabling injury

An injury that:

- happens after your cover starts;
- is directly and solely caused by accidental, physical, violent, external and visible means;
- isn't connected to a pre-existing condition; and
- results in your disability.

A disabling injury must be diagnosed by a **Medical Practitioner** and confirmed by the medical specialists we choose to assess you.

Disabled / disability

You are disabled if:

- you were working 20 or more hours a week at the time of the **disabling injury** and you now can't attend or engage in your usual occupation; or
- you were working less than 20 hours a week at the time of the **disabling injury** and you're now totally and temporarily unable to perform at least two activities of daily living (bathing, dressing, toileting, mobility, continence, feeding) without physical assistance and special equipment.

Excessive alcohol consumption

The **insured person** had a blood alcohol concentration higher than the legal driving percentage as evidenced by toxicology reports or any other tests results that were available.

Heart attack

Heart attack means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area, measured by the tests specified below, where the diagnosis is supported by a 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 three of the following:

a) symptoms of ischaemia consistent with myocardial infarction

b) ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block)

c) development of new pathological Q waves on the ECG

d) new regional wall motion abnormality persisting for at least six weeks and confirmed on cardiac imaging including echocardiogram, cardiac CT, cardiac MRI or cardiac radio nuclear scan.

If the tests specified are inconclusive or unable to be met, then the definition will be met if three months after the event the insured's left ventricular ejection fraction is less than 50 per cent.

The following are not covered:

- A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease
- Other acute coronary syndromes including but not limited to angina pectoris.

The diagnosis must be confirmed by a **Medical Practitioner**.

Insured person

The person(s) who is/are insured under the policy is/are noted as the insured person on the **policy schedule**. This is the person(s) whose death, **terminal illness**, injury or illness causes us to pay a benefit. There may be up to two insured persons and in that case, the cover provided in respect of each insured person will exist as a separate insurance, despite being provided under the same policy. This means that:

- policy conditions are applied to each insured person separately and reference to an insured person in respect of a benefit or a claim is a reference to the insured person covered for that benefit or who is subject of that claim;
- benefits are payable in relation to each insured person;
- payment of a benefit in relation to one insured person does not affect the right for the other to obtain a benefit; and
- termination of one insured person's cover does not affect the other's cover so long as premiums continue to be paid.

Kidney failure

End stage renal disease presented as **chronic** irreversible failure of both kidneys to function, as a result of which either regular renal dialysis is instituted or renal transplantation is carried out.

The diagnosis must be confirmed by a **Medical Practitioner**.

Loss of independent existence

This means that the **insured person** is totally and permanently unable to perform independently two or more of the following activities of daily living:

- Bathing – the ability to shower or bathe
- Dressing – the ability to put on or take off clothing
- Toileting – the ability to use the toilet, including getting on or off
- Mobility – the ability to get in and out of bed and a chair
- Continence – the ability to control bladder and bowel function
- Feeding – the ability to get food from a plate into the mouth.

Medical Practitioner

Medical Practitioner is a qualified, practicing medical specialist, licensed to practice his or her medical specialty within Australia or New Zealand, and whose specialty qualifies him or her to make a diagnosis or prognosis of **terminal illness** or as the context requires, to diagnose a medical condition, illness, disability or injury covered under the policy, of an **insured person**. The Medical Practitioner must not be the **policy owner** or an **insured person** under the policy, their spouse, relative or business associate.

Paralysis

Total and irreversible loss of use of two or more limbs through paralysis due to injury or disease of the spinal cord and includes the following:

- Hemiplegia - means the total and permanent loss of use of one side of the body caused by damage to the spinal cord.
- Diplegia - means the total and permanent loss of use of symmetrical sides of the body caused by damage to the spinal cord.
- Paraplegia - means the total and permanent loss of use of both legs caused by damage to the spinal cord.
- Quadriplegia/Tetraplegia - means the total and permanent use of both arms and both legs caused by damage to the spinal cord.

The diagnosis must be confirmed by a **Medical Practitioner**.

PDS

The Product Disclosure Statement and Policy Document is referred to as the PDS.

Policy owner

The person who owns the policy is noted as the policy owner on the **policy schedule**. If the policy is held in joint names, you will both be joint policy owners. The policy owner is entitled to any benefits which become payable, and is responsible for making premium payments. Upon the death of one joint policy owner, the ownership of the policy will revert to the surviving policy owner.

Policy schedule

The document provided to you at the start of your policy. Your policy schedule shows you:

- the name and address of each **insured person**.
- the **start date** of your cover.
- your annual and monthly premiums.
- your monthly policy fee.
- the date your first premium is due.
- the sums you're insured for in each benefit category.
- whether a pre-existing condition exclusion or agreed exclusion applies to your cover (see pages 11-13 for more on exclusions).

Policy year

The period of twelve months after your policy **start date** and each subsequent twelve month period thereafter that your policy remains current.

Reinstatement date

The date we grant your request to reinstate your cover. The reinstatement date is included in written confirmation we will send to you.

Serious mental condition

A mental condition is serious if it requires hospitalisation or treatment with multiple medications. This includes schizophrenia, bipolar disorder, psychosis, Post Traumatic Stress Disorder, drug or alcohol dependency, suicide attempt or major depressive disorder. It does not include mild stress, depression or anxiety that is adequately controlled by medication and/or counselling only.

Severe burns

Tissue injury caused by thermal, electrical or chemical agents resulting in 3rd degree burns to at least 20% of the body surface as measured by the Lund & Browder body surface chart or any 3rd degree burns to the face.

Start date

Your policy start date is the "Commencement Date" listed on your **policy schedule**.

Stroke

Stroke means death of brain tissue resulting from insufficient blood supply (typically due to a thrombus or clot), bleeding within the skull, or intracerebral embolism, and that has resulted in permanent neurological impairment. This diagnosis must be supported by both of the following:

- Evidence of permanent neurological deficit with persisting clinical symptoms confirmed by a neurologist at least 6 weeks after the stroke
- Findings on Magnetic Resonance Imaging (MRI), Computerised Tomography (CT), or other reliable imaging techniques consistent with the diagnosis of a new stroke and compatible with the neurological deficit.

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The following are excluded:

- Transient ischaemic attacks
- Cerebral events and symptoms due to reversible neurological deficits and migraine
- Vascular disease affecting the eye or optic nerve
- Ischaemic disorders of the vestibular system
- Any stroke related to recreational drug use and/or substance abuse
- Brain damage due to an accident or injury.

"Permanent neurological deficit with persisting symptoms" means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the **insured person's** life. It includes outcomes such as: numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function.

The following do not constitute "permanent neurological deficit with persisting symptoms":

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, such as e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

The diagnosis must be confirmed by a **Medical Practitioner**.

Surgery to the Aorta

Surgery to the aorta means surgical repair to the aorta to correct any narrowing, dissection or aneurysm of the aorta but does not include angioplasty, intra arterial procedures or other non-surgical techniques. For the purposes of this definition, aorta shall mean the thoracic or abdominal aorta, but none of its branches.

Terminally ill / terminal illness

You become terminally ill where in our opinion you:

- are terminally ill or injured; and
- as a result of the terminal illness or injury you are expected to live for less than 12 months.

Total loss of hearing

The total irreversible loss of hearing (aided or unaided) in both ears as a result of sickness or injury of greater than 90 dB across the frequencies of 500Hz, 1000Hz, 2000Hz and 3000Hz in two measurements taken at least 6 months apart

The diagnosis must be confirmed by a **Medical Practitioner**.

Total loss of sight

The total irreversible loss of sight (aided or unaided) in both eyes with a visual acuity of 20/200 or less in the better eye or a visual field of less than 20 degrees in the better eye as a result of sickness or injury and confirmed by an ophthalmologist.

Well managed

Well managed means a **Medical Practitioner** has advised cholesterol is well controlled or that cholesterol readings are within normal limits, no requirement to change medication (dosage or type) for 2 years, no requirement to increase the frequency of having cholesterol levels checked in the last 2 years, and no advice to undergo further investigation for complications of high cholesterol such as heart disease.

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Appendix B: Direct Debit Service Agreement

Authorisation

By providing us with the Direct Debit Request, you have authorised Hannover Life Re of Australasia Ltd to arrange for funds to be debited from your account for the purpose of paying the premiums on the insurance cover provided by your My Protection Plan. The authorisation will be on the terms set out in this agreement and may be provided to us in writing, email or verbally. Any change to the account to which your Direct Debit Request applies, may also be provided to us in writing, email or verbally.

We will draw the premium from your account each month on the premium due date. We will not issue a billing notification prior to initiating a drawing.

The amount of the premium may vary and we will not notify you of this variation unless we are required to do so under this **PDS**.

We will only draw from your account those amounts that you have authorised under the Direct Debit Request and except in the circumstances permitted by this **PDS** we will not change the amount or frequency of drawing arrangements, without your prior approval. Importantly, you will not be able to vary the amount or frequency of the premium that will be debited to your account.

We may change the terms of this agreement without your consent. If we do, we will tell you 14 days prior to the change.

Drawing arrangements

Where the premium due date falls on a non-business day, we will draw the premium on the next business day.

We will not draw an amount from your account other than the full premium due. In the event that the drawing is dishonoured by your financial institution, we may (in our discretion) make further attempts to draw the amount from your account after we receive notice of the dishonour.

We reserve the right to cancel the authorisation if three or more drawings are returned unpaid by your financial institution.

We will keep all information relating to your account confidential and will only use the information for purposes connected with this agreement and the insurance. However, our financial institution may also require this information to be provided in connection with a claim made on it relating to an alleged incorrect or wrongful debit. Our Privacy Policy will apply to this information.

Your rights

By giving written notice to us at least 14 days prior to the premium due date (either directly or through your financial institution):

- you may cancel the authorisation;
- you may change the account details to which the authorisation applies; or
- you may stop a drawing being made from the account.

If you believe that there has been an error in debiting your account you should take the matter up with us or lodge a Direct Debit Claim through your financial institution. If we cannot resolve the matter to your satisfaction you may also contact your financial institution. If we conclude that your account has been incorrectly debited we will arrange for this to be corrected.

Your responsibilities

It is your responsibility to:

- ensure that direct debiting is available on your account and the account details you have given are correct;
- ensure that sufficient funds are available in the account to meet the drawing on each premium due date. If there are insufficient funds and the payment is dishonoured then you will be responsible for any fee charged by the financial institution to your account. You will also be responsible for any fee that is incurred by us and we are authorised to recover this from your account;
- ensure that the person or persons who have given us the authorisation to draw on the account are permitted to do so under the account signing instructions held by your financial institution;
- advise us if the account is transferred or closed;
- arrange for a suitable alternate payment method if you wish to cancel the authorisation;
- check your account statement to verify that the amounts debited are correct; and
- pay any fees or charges made to your account by your financial institution in connection with the drawings made on your account.

"THE MONEY I RECEIVED MEANT THAT I COULD FOCUS ON MY RECOVERY AND NOT WORRY ABOUT SELLING MY HOME^.

- CHERYL, 54, BREAST CANCER

^ Real life ALI Group policyholder testimonial.

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