Platinum Plus.
Trauma multi cover.

Your cover in detail.

1. Introduction.

This Trauma multi cover provides **you** with a lump sum payment if an **insured person** suffers from a **trauma condition**, for up to a maximum of five full payments for each **insured person** for each unrelated **trauma condition**.

The **policy schedule** will show which **insured person** this Trauma multi cover applies to and any Additional options that may apply.

2. Built-in benefits.

2.1 Trauma conditions.

Trauma condition means any one of the conditions listed in the below sections and meeting the respective definition in section 8.

2.1.1 The conditions covered for a full benefit payment.

The conditions **we** will pay the **full benefit** for are as follows:

Accidentally acquired HIV

Alzheimer's disease

Angioplasty – triple vessel

Aorta surgery

Aplastic anaemia

Benign brain tumour or benign spinal tumour

Cancer

Carcinoma in situ – major treatment

Cardiomyopathy

Chronic kidney failure (renal failure)

Chronic liver failure

Chronic lung disease

Cognitive impairment

Coma

Coronary artery bypass surgery

Creutzfeldt-Jakob disease (CJD)

Dementia

Encephalitis

Heart attack

Heart valve surgery

Intensive care

Loss of independent existence

Loss of use of hand or foot and sight in one eye

Loss of use of hands and/or feet

Loss of sight in both eyes

Loss of speech

Major head trauma

Major organ transplant

Meningitis and/or meningococcal disease

Motor neurone disease

Multiple sclerosis

Muscular dystrophy

Occupationally acquired HIV

Open heart surgery

Out of hospital cardiac arrest

Paralysis

Parkinson's disease

Peripheral neuropathy

Pneumonectomy

Primary pulmonary hypertension

Profound deafness in both ears

Severe burns

Severe diabetes

Severe inflammatory bowel disease

Stroke

Systemic sclerosis

Terminal illness

2.1.2 The conditions covered for a partial benefit payment.

The conditions **we** will pay a **partial benefit** for are as follows:

Adult onset type 1 insulin dependent diabetes mellitus

Alzheimer's disease diagnosis

Aneurysm

Angioplasty – two vessels or less

Carcinoma in situ without major treatment

Chronic lymphocytic leukaemia

Colostomy and/or ileostomy

Dementia diagnosis

Early stage prostate cancer

Hydrocephalus

Loss of use of one hand or foot

Loss of sight in one eye

Major burns

Malignant melanoma diagnosis

Multiple sclerosis diagnosis

Parkinson's disease diagnosis

Profound deafness in one ear

Severe osteoporosis

Severe rheumatoid arthritis

Systemic lupus erythematosus

2.2 How much do we pay?

2.2.1 First claim for a trauma condition.

When the **insured person** suffers a **trauma condition** for the first time after the **start date** and after the **stand-down period** (where applicable), **we** will pay **you** either:

- the **full benefit**, one fifth (20%) of the **sum insured**, or
- a **partial benefit**, one tenth (10%) of the **sum insured** up to $25,000.

2.2.2 Subsequent claims.

a. **Same trauma condition.**

- **After a partial benefit claim.**

  We will pay a claim for a **full benefit** if a **partial benefit** claim has been paid and the **insured person** subsequently meets the **full benefit** definition for that **trauma condition**.

  The **full benefit** payment will be reduced by the amount of the **partial benefit** paid so that no more than 20% of the **sum insured** is paid for that **trauma condition**.

- **Other payments.**

  We will pay more than one claim for a **trauma condition** if it meets the following:

  - at least six consecutive months have passed since the last diagnosis of the **trauma condition**, and
  - it isn't a recurrence of the original **trauma condition**, and
  - it isn't directly or indirectly caused by or related to the original **trauma condition**, or the symptoms or conditions which caused the **trauma condition** to occur.

b. **Different trauma condition.**

We will pay a claim for a different **trauma condition** if it meets the following:

- it isn't directly or indirectly caused by or related to any previous **trauma condition**, or the symptoms or conditions which caused any previous **trauma condition** to occur, or
- it's a **loss of independent existence** claim (see section 2.2.3 or if the **policy schedule** shows the Loss of independent existence option see section 3.2).

Only one claim can be made per **trauma condition** where the definition requires **permanent incapacity**.

2.2.3 Loss of independent existence.

If the **policy schedule** shows Trauma multi cover – accelerated applies to an **insured person**, **we** will pay more than one payment of the **full benefit** for **loss of independent existence** if:

- the **insured person** continues to meet the **loss of independent existence** definition, and
- there has been at least 12 consecutive months since the last payment for **loss of independent existence**, and
- the cover hasn't ended (see section 6).

If **they** meet the definition of one **trauma condition** and at the same time meets the definition of **loss of independent existence**, then **we** will make one **full benefit** payment.

2.2.4 Maximum amount of cover.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), **we** will reduce the **sum insured** and our payment so that when added to any amount paid or payable under the existing policy, the total for that **insured person** does not exceed $2,000,000.

2.2.5 Trauma multi cover – accelerated.

If the **policy schedule** shows Trauma multi cover – accelerated applies to an **insured person**, payment of the **sum insured** is an advance payment of the Life cover this Trauma multi cover – accelerated is attached to. **We** will reduce that Life cover by the amount **we** pay for the **trauma condition** and adjust the premium accordingly.

Their Trauma multi cover – accelerated **sum insured** can't exceed **their** Life cover **sum insured** unless a claim has been paid for that **insured person**.

2.2.6 Trauma multi cover – standalone.

If the **policy schedule** shows Trauma multi cover – standalone applies to an **insured person, we** will only pay a claim for the Trauma multi cover – standalone if **they** survive for at least 14 days after the diagnosis of the **trauma condition**.

2.3 Stand-down period.

If a **trauma condition** stated below, occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the **insured person**, or would have become apparent to a reasonable person in **their** position, within three months:

- from the date **we** receive the **application** for this cover, then no benefit will ever be payable for that **trauma condition** under this cover, or
- of the date of reinstatement, then no benefit will ever be payable for that **trauma condition** under this cover, or

- of the date of any increase in the **sum insured** (excluding increases due to the CPI option), then no benefit will ever be payable for that **trauma condition** for that increase in **sum insured**.

The stand down applies to the following conditions:

a. **Cancer condition**, **heart attack**, **out of hospital cardiac arrest** or **stroke**.

b. **Angioplasty – two vessels or less** or a**ngioplasty – triple vessel** if there was narrowing or blockage of one or more arteries.

c. **Coronary artery bypass surgery** if there existed disease of the arteries.

d. **Aorta surgery** if there was narrowing, dissection or aneurysm of the abdominal or thoracic aorta.

e. **Heart valve surgery** if there was heart valve defects or abnormalities.

f. **Terminal illness.**

The **stand-down period** won't apply if an **insured person** had similar cover with **us** or another insurance company and this cover replaced that cover, up to the lesser of:

- 20% of the **sum insured** under the replaced cover, or
- the **sum insured** on the previous policy,

provided the previous policy had been in force for at least three months.

2.4 Inbuilt child's trauma benefit.

The Inbuilt child's trauma benefit will be payable if:

- a **child** aged between 3 months and 20 years (inclusive) suffers a **trauma condition** defined in section 8 (apart from **adult onset type 1 insulin dependent diabetes mellitus)**, and
- the **trauma condition** occurs for the first time after the **start date** and after the **stand-down period** (where applicable), and
- the **child** survives for 14 days after suffering the **trauma condition**.

Where the **trauma condition** directly results from **known congenital conditions** or any **child pre-existing conditions**:

- At the **start date** or reinstatement date, no benefit will ever be payable for that **trauma condition** for that **child**.
- At the **start date** the **parent's sum insured** is increased, no benefit will ever be payable for the Inbuilt child's trauma benefit for the amount that relates to that increase in **sum insured**.

We will pay **you** per **child** the lesser of:

- 20% of the **parent's sum insured** up to $50,000, or
- If the **trauma condition** is a **partial benefit**, 10% of the **parent's sum insured** up to $25,000.

A maximum of one Inbuilt child's trauma benefit or Inbuilt newborn child's benefit will be paid irrespective of the number of **trauma conditions** or **newborn conditions** that **child** suffers or the number of covers with **us** insuring either or both **parent(s)** that include the Inbuilt child's trauma benefit or Inbuilt newborn child's benefit or equivalent type child's trauma benefit or newborn child's benefit(s).

Payment of the Inbuilt child's trauma benefit doesn't reduce the **parent's sum insured**.

The Inbuilt child's trauma benefit ends for a **child** on the earliest of the date:

a. the **child's parent(s)** no longer have any cover with **us** that provides this Inbuilt child's trauma benefit, or

b. of that **child's** 21st birthday, or

c. **we** pay an Inbuilt child's trauma benefit or Inbuilt newborn child's benefit, or equivalent type child's trauma or newborn child's benefit claim for that **child**.

2.4.1 Conversion of Inbuilt child's trauma benefit.

A **child** covered under the Inbuilt child's trauma benefit can apply for a Policy with **our** Life cover and Trauma multi cover – accelerated available at that time without having to provide additional health information, within the 30 days before and after reaching the **child's** 21st birthday.

The maximum amount of Life cover and Trauma multi cover – accelerated that can be applied for is 20% of one of the **parent's sum insured** on the day immediately before that **child's** 21st birthday up to $50,000.

We will calculate the premium for the Life cover and Trauma multi cover – accelerated at age 21, based on the **sum insured**, gender and smoking status of that **child**.

The Life cover and Trauma multi cover – accelerated will exclude any claim if the **trauma condition** directly results from any:

- **known congenital conditions**, or
- **child pre-existing conditions**.

The conversion of Inbuilt child's trauma benefit isn't available if the **child** had either had a claim paid or is entitled to make a claim under the Inbuilt child's trauma benefit or under the Inbuilt newborn child's benefit.

This conversion of Inbuilt child's trauma benefit ends for a **child** on the earliest of:

a. the **child's parent(s)** no longer have any cover with **us** that provides the Inbuilt child's trauma benefit, or

b. 30 days after that **child's** 21st birthday.

2.5 Inbuilt newborn child's benefit.

The Inbuilt newborn child's benefit is payable if a biological child of an **insured person** is born with one of the **newborn conditions** and survives for thirty days after birth.

We will pay **you** per child the lesser:

a. of 20% of the **parent's sum insured**, or
b. $50,000.

A maximum of one Inbuilt newborn child's benefit or Inbuilt child's trauma benefit will be paid per child**,** irrespective of the number of **newborn conditions** or **trauma conditions** that child suffers or the number of covers with **us** insuring either or both **parent(s)** that include the Inbuilt newborn child's benefit, or the Inbuilt child's trauma benefit, or equivalent types of newborn child's or child's trauma benefits.

Payment of the Inbuilt newborn child's benefit doesn't reduce the **sum insured** related to the **insured person** who is the biological **parent** of the child.

The Inbuilt newborn child's benefit ends for a child on the earliest of the date:

a. The **insured person**, who is the biological **parent** of the child, no longer has any cover with **us** that provides this Inbuilt newborn child's benefit, or

b. **We** pay an Inbuilt newborn child's benefit, Inbuilt child's trauma benefit, or equivalent type newborn child's or child's trauma benefit claim for that child.

In order for **us** to pay a claim under this Inbuilt newborn child's benefit **we** will require medical information from a **specialist medical practitioner** acceptable to **us** that conclusively evidences the condition. In circumstances where a conclusive diagnosis cannot be made at birth, **we** will defer assessment of the claim until sufficient evidence can be supplied. For example, this might apply in the case of **Loss of sight in both eyes** or **Profound deafness in both ears**, where a conclusive diagnosis may not be possible until later in the child's life. In these cases, the claims assessment will be based on the child's sight or hearing impairment at the date that conclusive diagnosis is first possible.

A claim is only payable under the Inbuilt newborn child's benefit if cover remains in effect for the **insured person** (who is the biological **parent** of the child) up to the date that the conclusive diagnosis for the child occurs.

The Inbuilt newborn child's benefit is only payable where:

a. the birth of the child with one of the **newborn conditions** occurs at least 9 months after the cover **start date**, the **start date** of any increase in cover for the **insured person** who is the biological **parent** of the child (in relation to that increase in **sum insured** only) or the date of any reinstatement, and
b. the **newborn condition** is suffered by a newly born biological child of an **insured person** (**parent**) who is that child's legal guardian, or who that child is and will be permanently living with, and on whom that child is financially dependent.
   Financially dependent means the **insured person** is fully responsible for all the newborn child's daily living expenses.

2.6 Grief counselling benefit.

If **we** pay a lump sum benefit to a **policy owner** under this cover, **we** will reimburse **you**, up to a maximum of $2,500 towards the actual cost of grief counselling, for the **insured person**, **their** spouse, de facto partner or Civil Union partner or **child**, from an accredited counsellor, psychologist or psychiatrist approved by **us**.

The following conditions apply:

- The consultation and/or counselling must be invoiced within 12 months following the payment of the lump sum benefit by **us**.
- **We** must be provided with a receipt for the consultation and/or counselling being claimed.

This benefit is payable for one event only, once per **insured person** regardless of the number of policies and covers that may provide similar benefits for **them**. This is in addition to the **sum insured**.

Where there is more than one **policy owner** the Grief counselling benefit will be divided equally between those **policy owners** who each receive a lump sum benefit.

2.7 Financial planning and legal advice benefit.

If **we** pay a lump sum benefit to a **policy owner** under this cover, **we** will reimburse **you**, up to a maximum of $2,500 towards the actual cost of:

- a fully documented financial plan prepared by a financial advice provider providing a financial planning service for the **policy owner**, or
- legal advice the **policy owner** receives from a lawyer.

Where there is more than one **policy owner**, the Financial planning and legal advice benefit will be divided equally between those **policy owners** who each receive a lump sum benefit.

The reimbursement must be claimed within 12 months of receiving the lump sum benefit and will be payable only once in respect of all policies with **us** covering the same **insured person**.

If the reimbursement request is in relation to financial advice, **we** will require evidence to show that the financial plan has been provided, the qualifications of the financial adviser and the costs charged by the financial advice provider.

If the reimbursement request is in relation to legal advice, **we** will require evidence of the fees charged by the lawyer.

The financial plan or legal advice received must be in relation to a lump sum benefit paid by **us** under this cover.

2.8 Special events.

You can increase an **insured person's sum insured** once in any 12-month period before **their** 55th birthday without providing additional health information if one of the circumstances shown below occurs.

a. **You** can increase **their sum insured** by up to the lesser of $250,000 or 50% of **their sum insured** at the **start date** of the cover if any of the following events apply to **them**:
   - marriage, civil union, divorce or being subject to a separation agreement or order, or
   - either, pregnancy at 28 weeks gestation or birth of a **child**, or
   - adoption of a **child**, or

- dependent **child** starting secondary school, or
- financially supporting a dependent **child** through a first course of full-time tertiary education, or
- reaching ages 25, 30, 35, 40 or 45, or
- either, death or terminal illness (diagnosed by an appropriately qualified **medical practitioner**, confirming a prognosis of less than 12 months to live) of a spouse, de facto partner, **child** or civil union partner, or
- **they** permanently stop work to provide full time physical care for the first time for a dependent **relative**.

b. If **they** increase a mortgage on **their** own home or take out a mortgage for **their** own home, investment property, vacation home, or residential block of land, **you** can increase **their sum insured** by up to the lesser of:

- 50% of the **sum insured** at the **start date**, or
- the increase in the value of the existing mortgage or the amount of a new mortgage, or
- $250,000.

c. If **they** co-sign on a new mortgage for a **child**, **you** can increase **their sum insured** by up to the lesser of:

- 50% of the **sum insured** at the **start date**, or
- the amount of the mortgage of the **child**, or
- $250,000.

d. If **they** have a **salary** increase of at least $5,000 or a **salary** increase of at least 10% of **their salary**, **you** can increase **their sum insured** by up the lesser of:

- 25% of the **sum insured** at the **start date**, or
- five times the increase in **their salary**, or
- $250,000.

Conditions.

a. **You** must exercise a Special events increase in writing with supporting evidence within the later of either:

- six months following the event, or
- 30 days of the following **policy anniversary**.

b. An increase under Special events isn't available for:

- both the pregnancy and birth of the same **child**.
- both the terminal illness (diagnosed by an appropriately qualified **medical practitioner**, confirming a prognosis of less than 12 months to live) and death of the same person.

c. An increase under Special events isn't available if:

- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.
- The cover resulted from a Special events increase.

d. Any special terms and loadings that applied to the **sum insured** at the **start date** will also apply to the increase on that **cover**.

e. **Your** premiums will increase in line with the increased **sum insured**. **We** will calculate the premium for the increase using the **insured person's** age at the date **you** exercise a Special events increase. The increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional premium.

f. The maximum increase for an **insured person** for all events is the lesser of:

- $1,000,000, or
- the **sum insured** at the **start date**.

g. If **they** have Trauma multi cover – accelerated **their** Trauma multi cover **sum insured** can't exceed the Life cover **sum insured**.

h. The total cover when added to all other trauma type covers with any insurer after an increase can't exceed $2,000,000.

2.9 Business events.

You can increase an **insured person's sum insured** by up to the lesser of $250,000 or 25% of **their sum insured** at the cover **start date** once in any 12-month period before **their** 55th birthday without providing additional health information if one of the circumstances shown below occurs:

a. Where **they** are a key person in the business, **you** can increase **their sum insured** by the same proportion as the increase in **their** value to the business averaged over the previous three years.

b. Where **they** are a partner in a firm or a shareholder in a company, **you** can increase **their sum insured** by the same proportion as the increase in the value of **their** financial interest averaged over the previous three years.

c. Where **you** have taken out cover for **them** for loan guarantees, **you** can increase **their sum insured** by the same proportion as the increase in the loan relating to the funding of the business.

Conditions.

a. **You** must exercise a Business events increase in writing with supporting evidence within six months following the event.

b. **You** can increase **their sum insured** subject to the need for cover being established by financial underwriting of **them** based on such financial evidence as **we** request.

c. The method chosen to value the business or the **insured person's** value to the business, will be in accordance with industry established valuation methods or the method of valuation used at application time. The method of valuation and valuer must be satisfactory to **us**. The valuer can't be a family member, business partner, employee or employer of **you** or **them**.

d. The business means the entity on which the underwriting was based on at the time of the original application.

e. An increase under Business events isn't available if:

- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.
- The cover is as a result of a Business events increase.
- **We** aren't satisfied that there's financial justification for the additional cover. This is based on the financial evidence **you** provide to **us**.

f. Any special terms and loadings that applied to the **sum insured** at the **start date** will also apply to the increase on that cover.

g. **Your** premiums will increase in line with the increased **sum insured**. **We** will calculate **your** premium for the increase using the age of the **insured person** at the date **you** exercise a Business events increase. The increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional premium.

h. The maximum increase for an **insured person** for all events is the lesser of:

- $1,000,000, or
- the **sum insured** at the **start date**.

i. If **they** have Trauma multi cover – accelerated **their** Trauma multi cover **sum insured** can't exceed the Life cover **sum insured**.

j. The total cover when added to all other trauma type covers with any insurer after an increase cannot exceed $2,000,000.

2.10 Conversion option for the Trauma multi cover – standalone.

If a Trauma multi cover – standalone is shown in the **policy schedule** for an **insured person**, then before **their** 65th birthday **you** may convert that Trauma multi cover – standalone to a Trauma multi cover – accelerated for up to the **sum insured** with an equal amount of Life Cover without providing additional health information.

Conditions.

a. The conversion isn't available if

- The **sum insured** at the **start date** includes a premium loading or an exclusion.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The premiums aren't up to date or are being waived for any reason.
- The **insured person** has suffered from or is suffering from an illness where, considering the current or future treatment the **insured person** would be reasonably expected to receive, death is likely to occur within 12 months at the **conversion date**.
- The **insured person** is under the age of 16.

b. **We** will calculate the premiums for the Life cover and the converted Trauma multi cover – accelerated for **them** based on **their** age at the **conversion date**.

c. If **they** die within three months of the **conversion date**, other than by **accident**, the converted Life cover with the Trauma multi cover – accelerated will not apply. Where this happens, **we** will assess the claim under the Trauma multi cover – standalone terms and conditions.

2.11 Relocation benefit.

If an **insured person**:

a. has been residing outside New Zealand for more than three consecutive months, and

b. **they** then suffer from a **trauma condition** while residing outside of New Zealand, and

c. **we** have accepted a claim for a **full benefit**,

we will reimburse **you** the lesser of:

- $10,000, or
- the actual cost of a single standard economy airfare from **their** location to New Zealand for **them** and one support person (where medically necessary), by the most direct route available plus any additional transport costs to an approved medical facility in New Zealand.

We will pay this Relocation benefit once only for each **insured person** regardless of other covers which may include this Relocation benefit. The Relocation benefit is paid in addition to the **sum insured**. **You** will need to provide **us** with the original invoice and receipt for payment before **we** pay a claim.

This Relocation benefit isn't payable:

- for a **child** under the Inbuilt child's trauma benefit or Inbuilt newborn child's benefit, or
- as a result of any **partial benefit** payment.

3. Additional options.

3.1 CPI option.

If this option is included in this cover, the **policy schedule** will show which **insured person's** cover this applies to.

How **we** apply the CPI option is set out in section 7 of the Policy terms and conditions.

The last increase under this CPI option for an **insured person** will be applied on the earliest of:

- the **policy anniversary** before **their** 65th birthday, or
- the total **sum insured** for all trauma type cover/s for **them** with **us** and any other insurer, reaches $2,000,000.

3.2 Loss of independent existence option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

We will pay **you** a **full benefit** for **loss of independent existence** where at least 12 consecutive months have passed since the last **full benefit** was paid for **them** and the **loss of independent existence** definition is satisfied before the cover ends (see section 6).

Each claim paid for **them** under this Loss of independent existence option will count as one claim towards the maximum of five claims for **them**.

3.3 Buy back option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

12 months after payment of the **full benefit** under the Trauma multi cover – accelerated **you** may buy back the Life cover without providing additional health information.

The maximum amount of Life cover that **you** can buy back is the Trauma multi cover – accelerated **full benefit** amount **we** paid. **We** will contact **you** to let **you** know that the option is able to be exercised.

If **we** pay the **full benefit** amount for a **trauma condition** listed below, **you** may buy back the Life cover six months after **we** pay the **full benefit** amount:

Paralysis, Alzheimer's disease, dementia, loss of use of hand or foot and sight in one eye, loss of use of hands and/or feet, loss of sight in both eyes, multiple sclerosis or Parkinson's disease.

You may exercise this Buy back option once only within 90 days after the end of either the six or 12-month period and before the **insured person's** 70th birthday.

Once the Life cover has been bought back, the portion of the Life cover which has been bought back can't be bought back again at any time.

We will calculate the premium based on the rates applicable for **their** age and the Life cover **sum insured** bought back at the time **you** exercise the Buy back option.

Any Life cover bought back under the Buy back option will be subject to the same terms and conditions that applied to the Life cover when issued.

3.4 Total and permanent disability option.

If this option is included in this cover, the **policy schedule** will show which **insured person** this applies to.

Full benefit.

3.4.1 Total and permanent disability before age 65.

Total and permanent disability means that **we** are satisfied that one of the following events occurs before the **insured person's** 65th birthday:

a. **Own occupation.**

If own occupation is shown in the **policy schedule** for an **insured person,** then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months, and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever be able to work in any capacity in **their own occupation**, or

b. **Any occupation.**

If any occupation is shown in the **policy schedule** for an **insured person**, then **they** have been absent from employment through sickness or injury for an uninterrupted period of three months and in **our** reasonable opinion after considering all the medical evidence and other relevant evidence, has become so disabled that **they** will unlikely ever be able to perform **their own occupation** or **any occupation**, or

c. **Home duties.**

If the **insured person** wasn't **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, regardless of whether own occupation or any occupation is shown in the **policy schedule**, **total and permanent disability** shall mean that **they** for an uninterrupted period of at least three months:

- has been under medical supervision with the complete inability to perform all normal **home duties**, and
- has been unable to leave the home without assistance, and
- in **our** reasonable opinion based on medical and other relevant evidence, is unlikely to ever again be able to perform all normal **home duties**.

3.4.2 Total and permanent disability from age 65 to age 70.

If **we** are satisfied that after the **insured person's** 65th birthday **they** were continuing to perform **their** usual occupational duties without limitation or restriction due to sickness or injury for at least

25 hours per week, then **we** will assess any claim for **total and permanent disability** made before **their** 70th birthday under the definition that applied before **their** 65th birthday.

If **they** were performing **their** occupational duties with limitations or restrictions due to sickness or injury, **we** will assess the claim under the definition applying under section 3.4.4.

3.4.3 Home duties from age 65.

If the **insured person** wasn't **gainfully employed** immediately before the event causing disability due to undertaking full-time **home duties**, and the event causing the **total and permanent disability** happens after **their** 65th birthday, **we** will assess the claim under the definition applying under section 3.4.4.

3.4.4 Total and permanent disability from age 70.

Where the event causing the **total and permanent disability** happens after the **insured person's** 70th birthday, or where sections 3.4.2 or 3.4.3 apply, the following definition applies:

Total and permanent disability means that **we** are satisfied that **they** are totally and permanently unable to perform at least two **activities of daily living** as a result of sickness or injury without the assistance of an adult.

3.4.5 Total and permanent disability partial benefit.

We will pay a **partial benefit** if the **insured person** suffers the total and permanent loss of use of one hand, one foot or the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of 6/60 or less in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

3.4.6 How much do we pay?

When the **insured person** suffers a **total and permanent disability**, **we** will pay **you** either:

- the **full benefit**, less any **partial benefit** payments **we** have paid **you** in respect of that **total and permanent disability**, or
- if the **total and permanent disability** is a **partial benefit,** 10% of the **sum insured** up to $75,000.

Where a **trauma condition** and **total and permanent disability** result from the same sickness or injury, **we** will pay either a claim for a **trauma condition** or a **total and permanent disability** not both.

Where the event giving rise to the payment of the **sum insured** was already covered at the **start date** by a policy issued by **us** or another insurer (existing policy), then **we** will reduce the **sum insured** and **our** payment so that when added to any amount paid or payable under the existing policy, the total for that **insured person** doesn't exceed $5,000,000.

If the **policy schedule** shows Trauma multi cover – accelerated applies to an **insured person**, payment of the Total and permanent disability option is an advance payment of the Life cover this Trauma multi cover – accelerated is attached to. **We** will reduce that Life cover by the amount **we** pay for the **total and permanent disability** and adjust the premium accordingly.

3.4.7 Total and permanent disability early payment benefit.

If the cause of the **insured person's total and permanent disability** is due to one of the below conditions, **we** will waive the requirement for **them** to be absent from employment or unable to undertake full-time **home duties** for an uninterrupted period of three months. The conditions are:

- Alzheimer's disease
- Cardiomyopathy
- Chronic lung disease
- Dementia
- Major head trauma
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease
- Systemic sclerosis
- Terminal illness

4. Claims.

4.1. Notice.

You or the **insured person** must notify **us** in writing immediately or as soon as practically possible if **you** or **they** become aware of any claim or potential claim under this Trauma multi cover.

We will advise **you** of the requirements **we** need to assess **your** claim.

We won't pay any claim until **we** receive all the requirements **we** need to assess the claim and confirm that **they** meet the definition of a **trauma condition**.

4.2 Obligations.

You and the **insured person** (if possible) must:

- Complete **our** claim form in full and send it to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of **their** or **your** personal information in connection with the claim held by any other party.
- Authorise the disclosure of **their** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require. This may include financial and occupational evidence.

The **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the occurrence of the **trauma condition**.

- Undergo one or more medical examinations if **we** reasonably request **them** at our expense. This may include blood tests and medical testing.

- **We** may also request other additional claim proofs necessary to complete our assessment of the claim including an independent opinion from an appropriate **medical practitioner** or **specialist medical practitioner** approved by us.

You must pay any expenses incurred in proving **your** claim.

5. Exclusion.

You can't claim under this cover in connection with an intentional self-inflicted act or injury.

6. When this cover ends.

This Trauma multi cover ends for an **insured person** on the earliest of the date:

a. **you** cancel **their** Trauma multi cover, or

b. this Policy ends for any reason, or

c. **we** have paid an amount equal to the **sum insured**, or

d. **they** die, or

e. if **they** have Trauma multi cover - standalone, on **their** 70th birthday.

7. General definitions.

The definitions shown below apply to all derivatives of the words defined. Where applicable, an **insured person** will include a **child**.

Accident.

Bodily injury caused solely and directly by violent, accidental, external or visible means. The injury must be unintended and unexpected.

Any occupation.

An occupation for which the **insured person** is suited to by education, training or experience, which would remunerate at a rate greater than 25% of **their** earnings over the last 12-month period of employment.

Application.

A completed application form for this cover, accompanied by either the first premium payment or the receipt of a valid payment instruction by **us**.

Cancer condition.

Cancer, carcinoma in situ – major treatment, carcinoma in situ – without major treatment, chronic lymphocytic leukaemia, malignant melanoma diagnosis and **early stage prostate cancer.**

Child pre-existing condition.

Any illness, sickness, disease, injury or medical condition existing that:

- the **parent** or **child** was aware of, or
- the **child** had signs or symptoms of, or
- the **child** had investigations or sought medical advice for, or

- a reasonable person or **parent** in the circumstances would seek diagnosis, care or treatment for,

on or before the date the Inbuilt child's trauma benefit starts for a **child**.

Conversion date.

The later of the:

- date the conversion of the Trauma multi cover – standalone to Trauma multi cover – accelerated becomes effective, or
- actual date **we** receive the first premium for the Life cover and the Trauma multi cover – accelerated.

The conversion date can't be backdated.

Full benefit.

Payment of one fifth (20%) of the **sum insured**.

Gainfully employed.

Working in an occupation or job as an employee for reward, salary, commission or any other income. For an **insured person** who's self-employed, working in any business or professional practice which could produce income for that business or professional practice.

Home duties.

The duties normally associated with a person who is engaged in full time unpaid home duties within the family home, and isn't employed in any occupation or working outside the **insured person's** home for salary, reward or profit and includes:

a. Cleaning the family home, such as using a vacuum cleaner, sweeping with a broom, using a mop and cleaning dishes (automatic or manual).

b. Cooking the family meals, such as preparing fresh and frozen food and using an oven, stove or microwave oven.

c. Doing the family's laundry, such as loading and unloading a washing machine, hanging out clothes or using a dryer, folding clothes and ironing.

d. Shopping, such as attending shops or using the phone or internet to purchase food for the family.

e. Taking care of **their** dependent children (where applicable) such as supervising, lifting, transporting, feeding and bathing.

We won't consider an **insured person** who's actively seeking employment or is performing less than full time unpaid **home duties** to be performing **home duties**.

Known congenital condition.

A health anomaly, medical condition or defect which is:

- present at birth, and
- known by the **parent** or **child** at the date the Inbuilt child's trauma benefit starts for a **child**.

Newborn condition.

Any of the eight conditions defined in section 9.

New York Heart Association Classification of Cardiac Impairment.

Class 1 – no limitation of physical activity, no symptoms with ordinary physical activity.

Class 2 – slight limitation of physical activity, symptoms occur with ordinary physical activity.

Class 3 – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity.

Class 4 – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.

Own occupation.

The field of work in which the **insured person** has trained in, specialises in and was engaged in

immediately before becoming **totally and permanently disabled**.

Partial benefit.

A part payment for the **sum insured** as set out in section 2.2 for a **trauma condition** and if applicable sections 3.4.5 and 3.4.6 for **total and permanent disability**.

Permanent incapacity.

The **insured person** is suffering permanent incapacity if **they** have neurological damage and functional impairment causing permanent and irreversible:

- inability to perform at least one of the **activities of daily living** without assistance of an adult, or
- at least 25% permanent impairment of **whole person function**.

Stand-down period.

The period set out in section 2.3 where no benefit will ever be payable under this cover**.**

Total and permanent disability.

A sickness or injury resulting in the **insured person** meeting the definition as outlined in section 3.4.

Trauma condition.

A condition as defined in section 8.

Whole person function.

The evaluation of whole person function derived from the most recent edition of the American Medical Association's book Guides to the Evaluation of Permanent Impairment (Guides) as assessed by an appropriately qualified **medical practitioner**.

8. Trauma definitions.

Trauma conditions covered for a full benefit payment.

Accidentally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV), acquired via blood transfusion or accidental means, with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to **us** within thirty days of the incident. The report must be supported by a negative HIV antibody test within seven days of the incident.

Transmission via any form of sexual activity or deliberate injection of a drug not prescribed by a **medical practitioner** is excluded.

Alzheimer's disease.

The confirmed diagnosis by a **specialist medical practitioner** of Alzheimer's disease with the permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Angioplasty – triple vessel.

Undergoing a coronary artery angioplasty to correct narrowing or blockage of three or more

coronary arteries within one or more procedures within a two-month period.

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Aorta surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to correct any narrowing, dissection or aneurysm of the abdominal or thoracic aorta by repair or its replacement.

Aplastic anaemia.

Bone marrow failure that results in anaemia, neutropenia and thrombocytopenia and requires treatment with at least one of the following:

- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplant
- Peripheral blood stem cell transplant
- Blood product transfusions.

Benign brain tumour or benign spinal tumour.

A non-cancerous tumour in the brain or spinal cord that gives rise to characteristic symptoms of intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment and results in:

- permanent neurological damage and functional impairment diagnosed by an appropriate **specialist medical practitioner**, or
- surgical treatment for its removal where this is considered the appropriate and medically necessary treatment.

A tumour in the pituitary gland will be covered if results in:

- permanent neurological damage and functional impairment diagnosed by an appropriate **specialist medical practitioner**, or
- requires a craniotomy to remove it.

Neurological damage and functional impairment include but aren't limited to: memory loss, impaired speech, vision loss and paralysis on one side of the body.

The presence of the underlying tumour must be confirmed by imaging studies such as a CT or MRI scan.

Cysts, granulomas, malformations in or of the arteries or veins of the brain and haematomas are excluded.

Cancer.

The confirmed presence of one or more invasive malignant tumours diagnosed by a **specialist medical practitioner** with supporting histological evidence of uncontrolled growth of malignant cells and invasion of normal tissue beyond the basement membrane. The term malignant tumour also includes leukaemia, sarcoma, malignant bone marrow disorders, and malignant lymphomas.

In addition to the above, only cancers meeting the following specified level of advancement for that cancer are covered:

- Hodgkin's and Non-Hodgkins lymphoma (all stages)
- Chronic lymphocytic leukaemia of Rai stage 1 or higher
- Malignant melanomas meeting any of the following criteria:
  - at least Clark Level 3 depth of invasion, or
  - 1mm Breslow thickness or greater, or
  - showing evidence of ulceration.
- Prostatic cancers meeting any of the following:
  - at least TNM classification T2, or

- a Gleason score greater than or equal to 6, or
- the entire prostate has been removed through a prostatectomy, or
- **medically necessary** treatment by radiotherapy or chemotherapy has been performed.

- Papillary and follicular carcinoma of thyroid of at least TNM classification T2
- Squamous cell carcinomas of the skin where the carcinomas have spread to other organs, bones or lymph nodes
- Other cancers not listed above of at least TNM classification T1

This definition doesn't include the following:

- Tumours showing the malignant changes of carcinoma-in-situ (including cervical dysplasia CIN1, CIN2 and CIN3)
- Tumours histologically classified as pre-malignant or having low-malignant potential
- All hyperkeratosis or basal cell carcinomas of the skin
- Pituitary Neuroendocrine Tumours (PitNETs) unless invasion of surrounding structures or metastasis is unequivocally proven histologically.

Carcinoma in situ – major treatment.

The actual undergoing of treatment for pre-invasive carcinoma in situ. The tumour must be positively diagnosed by a **specialist medical practitioner** as Tis according to the TNM classification or FIGO stage 0, with supporting histological evidence and resulting in one of the following being performed:

- **radical surgery**, or
- **medically necessary** treatment by radiotherapy or systemic chemotherapy.

Radical surgery means the actual undergoing of **medically necessary** surgery to remove an entire affected organ or breast. Where surgery involves the colon, radical surgery means partial or full colectomy.

Cardiomyopathy.

Impaired ventricular function of variable aetiology, resulting in physical impairments to the degree of at least class 3 of the **New York Heart Association Classification of Cardiac Impairment**.

Chronic kidney failure (renal failure).

End stage renal failure diagnosed by an appropriate **specialist medical practitioner** and presenting as chronic irreversible failure of both kidneys to function and resulting in regular renal dialysis being started.

Chronic liver failure.

End stage liver failure diagnosed by an appropriate **specialist medical practitioner** based on any of the following symptoms: permanent jaundice, ascites and encephalopathy.

Chronic lung disease.

End stage lung disease requiring permanent oxygen therapy and with:

- FEV1 test results of consistently less than one litre, or
- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Cognitive impairment.

Injury or illness of the brain resulting in permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Coma.

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continually with the use of a life support system for at least 72 hours.

The Trauma multi cover – standalone benefit for **coma** will only be paid where the **insured person** survives for at least a further fourteen days without the use of a life support system.

Coma related to alcohol or drug abuse is excluded.

Coronary artery bypass surgery.

Medically necessary coronary artery bypass graft surgery to correct coronary artery disease that is causing inadequate myocardial blood supply.

Angioplasty, intra-arterial procedures and other non-surgical techniques are excluded.

Creutzfeldt-Jakob disease (CJD).

The unequivocal diagnosis of CJD by a **specialist medical practitioner** with signs and symptoms of cerebellar dysfunction, severe progressive dementia, uncontrolled muscle spasm, tremor and athetosis resulting in the **insured person** requiring permanent and continual supervision for **their** safety.

Dementia.

The confirmed diagnosis by a **specialist medical practitioner** of dementia with the permanent and irreversible loss of cognitive function. Loss of cognitive function is deterioration or loss of intellectual capacity which requires the need for daily supervision of another adult to ensure the **insured person**'s safety**.** Daily supervision means situations such as preparing food, taking medicines, leaving the home or activities of similar severity.

The loss needs to be measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- Short or long term memory
- Orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year)
- Deductive or abstract reasoning

Encephalitis.

Severe inflammation of the brain diagnosed by a **specialist medical practitioner** as resulting in:

- significant and permanent neurological sequelae, or
- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Heart attack.

The diagnosis of the death of a portion of heart muscle as a result of inadequate blood supply to the heart muscle consistent with a heart attack. The diagnosis must be based on a combination of tests, medical evidence and opinion of a **specialist medical practitioner** appropriate to **us,** which would generally be recognised by a **specialist medical practitioner** as being appropriate for the purpose of determining whether death of part of the heart muscle has occurred.

The following are excluded:

- other acute coronary and other non-coronary syndromes, including but not limited to angina pectoris, and

- a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease.

Heart valve surgery.

Surgery, including minimally invasive surgery or percutaneous procedures, to replace or repair a cardiac valve or valves as a consequence of heart valve defects or abnormalities.

Intensive care.

An **accident** or sickness, which at the recommendation of an appropriate **specialist medical practitioner**, has resulted in the **insured person**:

- requiring continuous mechanical ventilation by means of tracheal intubation for at least five consecutive days (24 hours per day), or
- being admitted to the intensive care ward of an appropriately certified hospital for at least five consecutive days (24 hours per day).

Intensive care as a direct or indirect result of drug or alcohol abuse is excluded.

Loss of independent existence.

As a result of disease, sickness or injury, the **insured person** is totally and permanently unable to perform at least two of the **activities of daily living** without the assistance of an adult.

Loss of use of hand or foot and sight in one eye.

The **insured person** suffers the total and permanent loss of the use of:

- one foot or one hand, and
- the sight in one eye.

The loss of the sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of 6/60 or less in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Loss of use of hands and/or feet.

The **insured person** suffers the total and permanent loss of the use of either both feet, both hands or one foot and one hand.

Loss of sight in both eyes.

The **insured person** suffers the permanent and irreversible loss of sight in both eyes.

The permanent and irreversible loss of sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of 6/60 or less in both eyes after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Loss of speech.

The total and permanent loss of the ability to produce intelligible speech as a result of permanent damage to the larynx or its nerve supply or to the speech centres of the brain, whether caused by injury, tumour or sickness.

Loss of speech due to psychological reasons is excluded.

Major head trauma.

Permanent neurological deficit caused by an external accidental injury to the head which is confirmed by a **specialist medical practitioner** as resulting in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult

Major organ transplant.

The actual transplant, or placement on an official waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit, of one or more of the following organs or tissues:

- Kidney
- Heart
- Lung
- Liver (including live donor liver transplants)
- Pancreas
- Small bowel
- Bone marrow
- Blood-forming stem cell transplant.

The transplant must be confirmed by an appropriate **specialist medical practitioner** as being **medically necessary** and treatable only by a transplant. The transplant of all other organs, parts of organs (except for liver transplant) or any other tissue transplant is excluded.

Meningitis and/or meningococcal disease.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of meningitis and/or meningococcal disease including meningococcal septicaemia that results in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Motor neurone disease.

The unequivocal diagnosis of motor neurone disease by an appropriate **specialist medical practitioner**.

Multiple sclerosis.

The unequivocal diagnosis by an appropriate **specialist medical practitioner** of multiple sclerosis confirming more than one episode of well-defined neurological abnormalities and:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability to perform at least one of the **activities of daily living** without the assistance of an adult, or
- Expanded Disability Status Scale (EDSS) level of 7.5 or higher.

The diagnosis must be based on confirmatory neurological investigations e.g. lumbar puncture, evoked visual responses, evoked auditory responses and NMR (Nuclear Magnetic Resonance) evidence of lesions of the central nervous system.

Muscular dystrophy.

The unequivocal diagnosis of muscular dystrophy by an appropriate **specialist medical practitioner**.

Occupationally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV), acquired via blood transfusion or accidental means during the course of carrying out the **insured person's** normal occupation, with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to **us** within thirty days of the incident. The report must be supported by a negative HIV antibody test within seven days of the incident.

Transmission via any form of sexual activity or deliberate injection of a drug not prescribed by a **medical practitioner** is excluded.

Open heart surgery.

Undergoing open heart surgery to treat a cardiac defect, cardiac aneurysm or benign cardiac tumour.

Repair via catheter surgery, minimally invasive 'keyhole' or similar techniques are excluded.

Out of hospital cardiac arrest.

A sudden unexpected stoppage of effective heart action which:

- isn't associated with any medical procedure, and
- is documented by an electrocardiogram, and
- occurs outside a hospital, and
- is due to either cardiac asystole (complete failure of the heart causing cardiac arrest) or ventricular fibrillation (heart abnormality with ineffective twitching of the heart chambers) with or without ventricular tachycardia.

If an electrocardiogram is not available, **we** will consider other evidence acceptable to **us** that unequivocally confirms an out of hospital cardiac arrest has occurred. Such evidence may include Automated External Defibrillator (AED) data, ambulance medical reports, and documented administration of cardiopulmonary resuscitation (CPR) by an attending ambulance officer.

Paralysis.

The total and permanent loss of use of one or more limbs resulting from injury or disease.

Limb means an entire arm or leg and included in this definition is monoplegia, diplegia, hemiplegia, paraplegia, quadriplegia and tetraplegia. The diagnosis must be confirmed by a **specialist medical practitioner**.

Parkinson's disease.

The unequivocal diagnosis of Idiopathic **Parkinson's disease** by a **specialist medical practitioner** resulting in:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Peripheral neuropathy.

Irreversible loss of function of peripheral nerves, diagnosed by a **specialist medical practitioner** and resulting in either:

- at least 25% permanent impairment of **whole person function**, or
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Peripheral neuropathy related to alcohol or drug use is excluded.

Pneumonectomy.

The removal of an entire lung. This must be considered the **medically necessary** treatment by an appropriate **specialist medical practitioner**.

Primary pulmonary hypertension.

Irreversible raised pressure in the pulmonary arteries with right ventricular enlargement established by investigations including cardiac catheterisation.

Profound deafness in both ears.

An unequivocal diagnosis of profound and permanent loss of hearing in both ears, both natural and assisted (excluding cochlear implant), by an appropriate **specialist medical practitioner**. Profound loss of hearing is having an average hearing threshold of 91dB or greater, measured at frequencies of 500, 1000, and 1500 Hz.

Severe burns.

Tissue injury caused by thermal, electrical or chemical agents that results in full thickness burns or third degree burns to at least:

- 20% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or
- 50% of both hands requiring surgical debridement and/or grafting, or

- 25% of the face requiring surgical debridement and/or grafting.

Severe diabetes.

The confirmation by an appropriate **specialist medical practitioner** that the **insured person** has experienced at least two of the following complications as a direct result of diabetes:

- retinopathy that results in corrected visual acuity of 6/36 or worse in both eyes, or
- neuropathy causing:
    - irreversible autonomic neuropathy that results in postural hypotension and/or motility problems in the gut with intractable diarrhoea, or
    - polyneuropathy leading to severe mobility problems due to sensory and/or motor deficits, or
- chronic infection or gangrene that results in amputation of a whole hand or foot, or
- nephropathy causing chronic, irreversible kidney impairment for at least three months where the glomerular filtration rate has reduced to less than 28ml/min (chronic kidney disease stage 4, International Chronic Kidney Disease classification).

Severe inflammatory bowel disease.

The confirmed diagnosis by an appropriate **specialist medical practitioner** of either:

- Crohn's disease, or
- ulcerative colitis,

that has failed surgical treatment, is resistant to conventional medical intervention, and requires either:

- permanent immunosuppressive therapy, or
- surgical removal of the entire large bowel (colon and rectum).

Stroke.

A cerebrovascular incident, producing a sudden onset of neurological symptoms, including infarction of brain tissue, intracerebral or subarachnoid haemorrhage, or embolisation, and evidenced by CT, MRI or similar scan.

Transient ischaemic attacks, cerebral symptoms due to migraine, cerebral injury from trauma or hypoxia and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Systemic sclerosis.

The unequivocal diagnosis of systemic sclerosis, as confirmed by an appropriate **specialist medical practitioner**, causing:

- skin thickening accompanied by various degrees of tissue fibrosis, and
- chronic inflammatory infiltration in visceral organs, and
- the permanent inability of the **insured person** to perform at least one of the **activities of daily living** without the assistance of an adult.

Terminal illness.

An illness where, after considering the current or future treatment the **insured person** would be reasonably expected to receive, **they** are likely to die within 12 months. The **specialist medical practitioner** treating **their** condition must certify the diagnosis and prognosis of the **terminal illness**. Another **specialist medical practitioner** nominated by **us** must confirm the diagnosis and prognosis.

Trauma conditions covered for a partial benefit.

Adult onset type 1 insulin dependent diabetes mellitus.

The diagnosis by a **specialist medical practitioner** after the **insured person's** 30th birthday with type 1 diabetes mellitus which requires insulin.

Alzheimer's disease diagnosis.

The unequivocal diagnosis of Alzheimer's disease by a **specialist medical practitioner**.

Aneurysm.

The **insured person** has either:

- a cerebral aneurysm of any size that is treated by a **specialist medical practitioner** surgically via clipping or endovascular surgery, or
- an aortic aneurysm that has been definitely identified through MRI or CT scanning and:
  - is larger than 5.5cm in diameter, or
  - is larger than 3.5cm in diameter and growing at a rate faster than 0.5cm in diameter per year, or
  - has ruptured.

Angioplasty – two vessels or less.

The undergoing of a coronary artery angioplasty to correct narrowing or blockage of one or two coronary arteries.

Angiographic evidence indicating obstruction of the treated coronary arteries and confirmation from a **specialist medical practitioner** is required to confirm that the procedure is **medically necessary**.

Carcinoma in situ – without major treatment.

The first time diagnosis by a **specialist medical practitioner** with carcinoma in situ of the breast, cervix uteri, vagina, vulva, fallopian tubes, ovary, corpus uteri, anus, perineum, penis or testicle. Tumours must be classified as Tis according to the TNM classification or FIGO stage 0 with supporting histological evidence.

Chronic lymphocytic leukaemia.

The first time positive diagnosis by a **specialist medical practitioner** with chronic lymphocytic leukaemia of Rai stage 0.

Colostomy and/or ileostomy.

The undergoing of the creation of a permanent non-reversible opening, linking the colon or ileum to the external surface of the body.

Dementia diagnosis.

The unequivocal diagnosis with dementia by a **specialist medical practitioner**.

Early stage prostate cancer.

The first time positive diagnosis by a **specialist medical practitioner** with supporting histological evidence of early stage prostate cancer of TNM classification T1 (all categories) or Gleason score less than or equal to 5.

Hydrocephalus.

The requirement of a shunt to remove an excessive accumulation of cerebrospinal fluid or to relieve increased pressure within the cranium.

Loss of use of one hand or foot.

The total and permanent loss of use of one hand or one foot.

Loss of sight in one eye.

The permanent and irreversible loss of sight in one eye must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of 6/60 or less in the affected eye after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Major burns.

Tissue damage caused by thermal, electrical or chemical agents that results in full thickness burns or third degree burns to at least:

- 9% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or

- 50% of either hand, or combined over both hands, requiring surgical debridement and/or grafting.

Malignant melanoma diagnosis.

The first time positive diagnosis by a **specialist medical practitioner** with supporting histological evidence of malignant melanoma that is Clark Level 1 or 2 depth of invasion, or less than 1mm in thickness as measured using the Breslow method.

Multiple sclerosis diagnosis.

The unequivocal diagnosis with **multiple sclerosis** confirming more than one episode of well-defined neurological abnormalities by an appropriate **specialist medical practitioner**.

Parkinson's disease diagnosis.

The unequivocal diagnosis with Idiopathic **Parkinson's disease** by a **specialist medical practitioner**.

Profound deafness in one ear.

An unequivocal diagnosis of profound and permanent loss of hearing in one ear, both natural and assisted (excluding cochlear implant), by an appropriate **specialist medical practitioner**. Profound loss of hearing is having an average hearing threshold of 91dB or greater, measured at frequencies of 500, 1000, and 1500 Hz.

Severe osteoporosis.

The diagnosis with severe osteoporosis by an appropriate **specialist medical practitioner** before the **insured person's** 50th birthday: The diagnosis must confirm the following:

- suffers at least two vertebral body fractures or a fracture of the neck of the femur, due to osteoporosis, and

- has bone mineral density reading with a T-score of less than -2.5. This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis.

The unequivocal diagnosis of rheumatoid arthritis confirmed by an appropriate **specialist medical practitioner**, that fails to achieve remission or sustain low disease activity for at least 6 months despite treatment with conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDs).

This excludes corticosteroids and non-steroidal anti-inflammatories.

Systemic lupus erythematosus.

The unequivocal diagnosis of systemic lupus erythematosus by a **specialist medical practitioner**. The diagnosis must be made in a clinical setting based on the American College of Rheumatology (ACR) revised criteria and have evidence of lupus nephritis as confirmed by:

- grade 3 to 5 nephritis (WHO classification of lupus nephritis), and

- persisting proteinuria (more than 2+).

9. Newborn conditions covered for a Newborn child's benefit.

Absence of function of one or more limbs.

Means the total and permanent loss of function of at least one limb as diagnosed by an appropriate **specialist medical practitioner**. Limb is defined as the whole hand or whole foot.

Cleft palate.

A fissure of the palate at birth associated with possible separation of the lip extending into the nose. Clefts can occur on one or both sides of the upper lip. The benefit will only be paid for those cases with cleft palate, or cleft lip and palate. No benefit is payable for cleft lip alone.

Down's syndrome.

A genetic disorder caused by trisomy of chromosome 21. Diagnosis must be confirmed through a confirmatory blood test evidencing the disorder.

Loss of sight in both eyes.

The child suffers the permanent and irreversible loss of sight in both eyes. The permanent and irreversible loss of sight must be confirmed by an appropriate **specialist medical practitioner** and measured by one of the following:

- visual acuity of 6/60 or less in both eyes after correction, or
- a field of vision constricted to 20 degrees of arc or less, or
- a combination of visual defects resulting in the same degree of visual impairment as that occurring in either of the above.

Profound deafness in both ears.

An unequivocal diagnosis of profound and permanent loss of hearing in both ears, both natural and assisted (excluding cochlear implant), and confirmed by an appropriate **specialist medical practitioner**. Profound loss of hearing is having an average hearing threshold of 91dB or greater, measured at frequencies of 500, 1000, and 1500 Hz.

Spina bifida.

Congenital defective closure of the bone encasement of the spinal cord through which the cord and meninges may or may not protrude. Only Spina Bifida associated with a meningeal cyst (meningocele) or a cyst containing both meninges and spinal cord (meningomyelocele) or only spinal cord (myelocele) shall be covered. All other forms of spina bifida are excluded.

Tetralogy of Fallot.

A congenital anatomical abnormality of the heart with right ventricular outflow tract obstruction and a ventricular septal defect. The diagnosis must be confirmed by an appropriate **specialist medical practitioner** and supported by an echocardiogram or other diagnostic test and must require surgical repair.

Transposition of Great Arteries.

The complete transposition of the aorta and pulmonary artery. The diagnosis must be confirmed by an appropriate **specialist medical practitioner** and supported by an echocardiogram or other diagnostic test and must require surgical repair.