



Family Life Cover

Product Disclosure Statement

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What's included in this document

Welcome to Real Insurance	5	Life Insurance	8
Our Promise to You	5	What is Life Insurance?	8
Product Disclosure Statement (PDS)	6	Who can take out Life Insurance?	8
Explaining this PDS	6	Complimentary interim Accidental Death Insurance	8
Introducing Family Life Cover	7	The amount of Life Insurance you can apply for	8
Your Insurance Policy	7	When we will pay the Life Insurance benefit	9

The cost of your Life Insurance	9	When we will pay the Total & Permanent Disability Insurance benefit	17
What is not covered under your Life Insurance?	10	The cost of your Total & Permanent Disability Insurance	18
What is not covered under your interim Accidental Death Insurance?	10	What is not covered under your Total & Permanent Disability Insurance?	18
When your Life Insurance starts and ends	11	When your Total & Permanent Disability Insurance starts and ends	19
Children's Insurance Option	12	General Information	20
What is Children's Insurance?	12	Your 30 day money back guarantee	20
Who can take out Children's Insurance?	12	Automatic sum insured increases	20
The amount of Children's Insurance you can apply for	12	Further Insurance options	21
When we will pay the Children's Insurance benefit	12	Premiums	21
The cost of your Children's Insurance	13	How you can pay for your Insurance and when your premium is deducted	21
What is not covered under your Children's Insurance?	14	Changing your Insurance	21
When your Children's Insurance starts and ends	14	When we can cancel your Policy	21
Serious Illness Insurance Option	15	Insurance risks	22
What is Serious Illness Insurance?	15	Benefit payments	22
Who can take out Serious Illness Insurance?	15	Making a claim	23
The amount of Serious Illness Insurance you can apply for	15	Tax	23
When we will pay the Serious Illness Insurance benefit	15	Questions or complaints	23
The cost of your Serious Illness Insurance	16	Privacy	24
What is not covered under your Serious Illness Insurance?	16	Your duty of disclosure	25
When your Serious Illness Insurance starts and ends	16	Glossary	26
Total & Permanent Disability Insurance Option	17	Nomination of Beneficiaries Form	33
What is Total & Permanent Disability Insurance?	17	Direct Debit Service Agreement	35
Who can take out Total & Permanent Disability Insurance?	17		
The amount of Total & Permanent Disability Insurance you can apply for	17		



Family Life Cover is issued by Hannover Life Re of Australasia Ltd ABN 37 062 395 484 of Tower 1, Level 33, 100 Barangaroo Avenue, Sydney NSW 2000.

Family Life Cover is distributed and promoted by Real Insurance. Real Insurance is a trading name of Greenstone Financial Services Pty Ltd ABN 53 128 692 884, Australian Financial Services Licence 343079 of 58 Norwest Blvd, Norwest NSW 2153.

From time to time, Family Life Cover may be updated. Updates which are not materially adverse to you may be found on the Real Insurance website at realinsurance.com.au. If you request a paper copy, this will be provided to you free of charge.

Welcome to Real Insurance

Real Insurance is a trading name of Greenstone Financial Services (**GFS**). GFS has partnered with Hannover Life Re of Australasia Ltd (**Hannover**) which is the insurer of this Real Insurance product.

Hannover is a wholly-owned subsidiary of Hannover Re and is part of the Hannover Re Group worldwide. The life insurance business of Hannover has been operating in the Australian market since 1994, has a Standard and Poor's Insurer Financial Strength of AA- (Very Strong) and as at 31 December 2017 had total annual in force premium of AU\$1 billion.

Hannover is regulated by the Australian Prudential Regulation Authority (APRA).

Our Promise to You

To ensure that you receive the highest standard of service when you take out life insurance, we comply with the Life Insurance Code of Practice (the Code). We also ensure our partners, including GFS, comply with the Code in all their dealings with you.

What does the Life Insurance Code of Practice cover?

The Code sets out the life insurance industry's key commitments and obligations. It covers many aspects of your relationship with GFS and Hannover, from buying insurance to making a claim, to providing options if you experience financial hardship or require additional support.

Key Code Promises

- ✔ we will be honest, fair, respectful, timely and transparent (using plain language) in our communications with you.
- ✔ we will monitor sales to ensure they are completed appropriately.
- ✔ if an inappropriate sale occurs, we will discuss with you how this can be remedied.
- ✔ additional support is available if you have difficulty with buying insurance or making a claim.
- ✔ when you make a claim, we will explain the process to you and keep you informed on the progress of your claim.
- ✔ a decision on your claim will be made within the Code timeframes, and if in exceptional circumstances we cannot meet these timeframes, you will have access to our complaints process.
- ✔ if we deny your claim, we will explain the reasons in writing and let you know the next steps if you disagree with our decision.
- ✔ we will restrict the use of investigators and surveillance, to ensure your legitimate right to privacy.
- ✔ the independent Life Code Compliance Committee will monitor our compliance with the Code.
- ✔ if we do not correct the Code breaches, sanctions can be imposed on us.

Getting a copy

You can get a copy of the Code and a full list of insurance companies that are covered by the Code, on the Financial Services Council website at **fsc.org.au**



Product Disclosure Statement

Explaining this PDS

This Product Disclosure Statement (PDS) is designed to help you decide if Family Life Cover is right for you. It tells you the terms and conditions applying to a Family Life Cover Policy and it also provides important information about keeping premium payments up to date, what to do if you want to make a change and how to go about making a claim.

Any advice given in this PDS is general only and does not take into account your individual objectives or financial situation. You should consider whether this product is right for you, in regard to your objectives, financial situation and needs. You should carefully read this and any other documentation we send you.

Family Life Cover is issued by the insurer, Hannover Life Re of Australasia Ltd (**Hannover**). Hannover has sole responsibility for the PDS, the Policy and the assessment and payment of claims.

GFS has consented to being named in this PDS in the form and context in which it appears and has not withdrawn this consent before the date of this PDS.

In this PDS, some words or expressions have special meaning. They normally begin with capital letters and their meaning is explained in the '**Glossary**' on page 26 of this PDS.

In this PDS, references to “we”, “us” and “our” mean Hannover Life Re of Australasia Ltd.



Introducing Family Life Cover

Family Life Cover offers a range of insurance combinations to suit your needs.

There's Life Insurance – providing lump sum cover in the event of death or Terminal Illness – which you can apply for on its own.

Plus there is a range of optional benefits that you can apply for with your Life Insurance:

- ✓ Children's Insurance – lump sum benefit is paid in the event of a death, Terminal Illness, Blindness, Deafness, Total and Permanent Loss of Use of One Limb, Encephalitis, Major Head Trauma, Meningitis, Paralysis, Benign Tumour of the Brain or of the Spinal Cord, Cancer, Severe Burns, Chronic Kidney Failure or Major Organ Transplant of the Child Insured;
- ✓ Serious Illness Insurance – lump sum benefit is paid in the event the Life Insured suffers a covered serious illness; and
- ✓ Total & Permanent Disability Insurance – lump sum benefit is paid in the event the Life Insured suffers a Total & Permanent Disability.

Whatever combination you choose, with Family Life Cover, the Life Insured is protected 24 hours a day, 7 days a week, worldwide while your Policy is in force.

A full explanation of these benefits, and the terms and conditions of Family Life Cover is contained in this PDS.

Your Insurance Policy

If your application is accepted by us, we will issue you a Policy Schedule. Your Insurance Policy consists of the Policy Schedule and:

- ✓ this PDS (which includes the terms and conditions applying under your Policy);
- ✓ the application/s; and
- ✓ any special conditions, amendments or endorsements we issue to you.

Please keep these documents in a safe place for future reference. Any benefits, rights or obligations under this Policy cannot be assigned without obtaining Hannover's written permission beforehand. The Insurance provided under this Policy is written out of the Hannover Australian statutory fund.



Life Insurance

What is Life Insurance?

Life Insurance provides a benefit in the event that a Life Insured under the Policy suffers an Accidental Death or dies of natural causes, or is diagnosed with a Terminal Illness.

Who can take out Life Insurance?

You can apply for a single plan on your own life (Key Life Insured) or you can apply for a joint plan to also include your spouse, partner, or de facto (Partner Life Insured, if applying).

You (and your Partner Life Insured, if applying) must be Australian Resident/s and between 18 and 64 years of age.

Complimentary interim Accidental Death Insurance

If you apply for Insurance by phone, and we require further information to assess your application, you will automatically be provided with interim Insurance for up to 30 days against Accidental Death while we assess your application except in the circumstances explained under the heading **'What is not covered under your interim Accidental Death Insurance?'** on page 10. The amount of interim

Accidental Death Insurance cover is the Life Insurance Benefit Amount you apply for subject to the maximum cover amount indicated in **'The amount of Life Insurance you can apply for'** on this page. This cover is provided at no additional cost to you and is subject to the terms explained in this PDS.

Your interim Accidental Death Insurance cover will cease after 30 days, or on the Acceptance Date, whichever occurs first.

The amount of Life Insurance you can apply for

The minimum Benefit Amount is \$100,000. The maximum Benefit Amount for a Life Insured under the Policy at the Commencement Date is:

Maximum Benefit Amount (at Commencement Date)	
Current age	Benefit Amount
18 – 44	\$1,000,000
45 – 54	\$ 750,000
55 – 59	\$ 500,000
60 – 64	\$ 300,000

When you apply with a Partner Life Insured, you both apply for individual sums insured based on the limits above.

When we will pay the Life Insurance benefit

We will pay the benefits explained below if the Life Insured suffers an insured event, namely death or Terminal Illness, while covered under the Policy except in the circumstances explained in 'What is not covered under your Life Insurance' on page 10.

Life Insurance

We will pay the Life Insurance Benefit Amount as a lump sum on the death of a Life Insured. While assessing your claim, for deaths that are not the result of self inflicted injury, we may advance \$10,000 of the Life Insurance Benefit Amount to assist with the costs associated with funeral or other similar expenses without waiting for full claim proofs, but we must have satisfactory evidence of the Life Insured's age and death. This advance payment is not payable if there is reasonable doubt about whether you have complied with your duty of disclosure (see page 25 for further details on your duty of disclosure).

Terminal Illness

We will pay the Life Insurance Benefit Amount as a lump sum if a Life Insured is diagnosed with a Terminal Illness while covered under the Policy.

Limit on benefits

The total benefits payable for a Life Insured under the Policy cannot exceed:

- ✓ the maximum Benefit Amount for Life Insurance for your age at the Commencement Date, plus
- ✓ any automatic sum insured increases under the Policy.

If the Life Insured is covered under more than one Family Life Cover Policy, we will apply this limit to the total of the benefits payable for the Life Insured under all Family Life Cover policies. Any reduction in the Benefit Amount will be applied to the Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Benefit Amount is reduced.

Only one Life Insurance Benefit Amount is payable per Life Insured.

The Life Insurance Benefit Amount will be reduced by the amount of:

- ✓ any Total & Permanent Disability benefit paid for a Life Insured; and
- ✓ any Serious Illness Insurance benefit paid for a Life Insured; and
- ✓ any advance payment of the Life Insurance Benefit Amount.

If we reduce the Life Insurance Benefit Amount, we will reduce the premiums accordingly.

The cost of your Life Insurance

Premiums are the cost of your Insurance. The premium you are required to pay when the Policy starts is shown in the Policy Schedule.

Your premium is a stepped premium, which means that it will increase each year as you age. Your premium is calculated at each Policy Anniversary and is based on:

- ✓ the age of each Life Insured at that time; and
- ✓ the Benefit Amount provided for each Life Insured; and
- ✓ the Insurance Plan chosen by you (joint plan or single plan); and
- ✓ various factors which may affect the premium rating for each Life Insured such as gender, smoking status, state of health, family history, occupation and participation in hazardous activities.

When a Life Insured on the Policy attains age 99, the premium will stay the same for the remaining term of the Policy in respect of that Life Insured.

For a premium quote, or to understand more about the cost of your Insurance, please contact Real Insurance on **1300 367 325** (Monday to Friday between 8am and 8pm AEST), or visit realinsurance.com.au

What is not covered under your Life Insurance?

We will not pay a Life Insurance benefit in respect of a Life Insured, if the Life Insured dies, or has a Terminal Illness, directly or indirectly as a result of a self-inflicted injury, within 13 months of:

- ✔ the Acceptance Date of the Policy; or
- ✔ the date that any increase in cover starts (but only in respect of the increase); or
- ✔ where we have agreed to reinstate the Policy after it was cancelled, the date on which we reinstate the Policy (reinstatement date).

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

What is not covered under your interim Accidental Death Insurance?

We will not pay an interim Accidental Death Insurance Benefit Amount in respect of a Life Insured if the Life Insured suffers Accidental Death directly or indirectly as a result of:

- ✔ intentional self-inflicted bodily injury; or
- ✔ engaging in any criminal activities or illegal acts; or
- ✔ suicide or attempted suicide; or
- ✔ the consumption of drugs (unless it was under the direction of a Medical Practitioner and not in connection with treatment for substance abuse, drug addiction or dependence); or
- ✔ the consumption of intoxicating liquor, including having a blood alcohol content over the prescribed legal limit whilst driving; or
- ✔ engaging in any professional sport (meaning the Life Insured's livelihood is substantially dependent on income received as a result of playing sport); or
- ✔ engaging in any motor sports as a rider, driver and/or passenger; or
- ✔ war (whether declared or not) or war-like activity, or taking part in a riot or civil commotion; or
- ✔ being a pilot or crew member of any aircraft, or engaging in any aerial activity except as a passenger in a properly licensed aircraft.

When your Life Insurance starts and ends

If your application for Life Insurance is accepted by us, cover starts for a Life Insured on the Acceptance Date set out in the Policy Schedule. Your first premium is deducted from the Commencement Date, which is also set out in the Policy Schedule.

We guarantee to renew your Life Insurance (provided you pay your premiums when due) for life.

Life Insurance ends for a Life Insured when the first of the following occurs:

- ✓ the date of payment of a death claim for that Life Insured; or
- ✓ the date of payment of a Terminal Illness claim for that Life Insured; or
- ✓ the date of payment of a Total & Permanent Disability claim for the Life Insured where the Total & Permanent Disability Benefit Amount is the same as Life Insurance Benefit Amount; or
- ✓ the date you cancel the Policy; or
- ✓ the date we cancel the Policy.

Children's Insurance Option

This option is only available with Life Insurance. You only have this cover if we accepted your application and it is shown in your Policy Schedule.

What is Children's Insurance?

Children's Insurance provides a benefit in the event the Child Insured suffers a death from any cause, Terminal Illness, Blindness, Deafness, Total and Permanent Loss of Use of One Limb, Encephalitis, Major Head Trauma, Meningitis, Paralysis, Benign Tumour of the Brain or of the Spinal Cord, Cancer, Severe Burns, Chronic Kidney Failure or Major Organ Transplant at least three months after the day cover starts, while covered under the Policy. These medical conditions are defined in the 'Glossary' on page 26.

Who can take out Children's Insurance?

If you (and/or Partner Life Insured) are a parent or legal guardian of a child, you can apply for this Insurance cover for the child, if the child is aged between 2 and 17 years of age, and the child is an Australian Resident.

The amount of Children's Insurance you can apply for

You can apply for an Insurance Benefit Amount from \$20,000 up to a maximum of \$50,000 for each Child Insured under the Policy (in increments of \$10,000).

When we will pay the Children's Insurance benefit

We will pay the benefits explained below if the Child Insured of a Life Insured suffers an insured event; namely death from any cause, Terminal Illness, Blindness, Deafness, Total and Permanent Loss of Use of One Limb, Encephalitis, Major Head Trauma, Meningitis, Paralysis, Benign Tumour of the Brain or of the Spinal Cord, Cancer, Severe Burns, Chronic Kidney Failure or Major Organ Transplant while covered under the Policy except in the circumstances explained in '**What is not covered under your Children's Insurance?**' on page 14.

Only one Benefit Amount is payable per Child Insured. Once a Benefit Amount has been paid for a Child Insured, the Children's Insurance will cease and no further claims can be made.

Death from any cause

We will pay the Children's Insurance Benefit Amount as a lump sum in the case the Child Insured dies from any cause, or is diagnosed with a Terminal Illness, at least three months after the day cover starts providing we have paid no Children's Insurance Benefit Amount in relation to a serious injury or illness for that Child Insured.

Accidental Death

We will pay the Children's Insurance Benefit Amount as a lump sum in the case of Accidental Death of the Child Insured providing we have paid no Children's Insurance Benefit Amount in relation to a serious injury or illness for that Child Insured.

Serious injury or Illness

We will pay the Children's Insurance Benefit Amount as a lump sum in the event the Child Insured suffers Blindness, Deafness, Total and Permanent Loss of Use of One Limb, Encephalitis, Major Head Trauma, Meningitis, Paralysis, Benign Tumour of the Brain or of the Spinal Cord, Cancer, Severe Burns, Chronic Kidney Failure or Major Organ Transplant as a result of injury or illness while covered under the Policy except in the circumstances explained in **'What is not covered under your Children's Insurance?'** on page 14.

Where we have paid a Children's Insurance Benefit Amount in relation to serious injury or illness, there are no further benefits payable under this Children's Insurance option for that Child Insured.

The serious injury or illness condition must be diagnosed by a Medical Practitioner and confirmed by our medical advisers.

Limit on benefits

Only one Benefit Amount is payable per Child Insured. The total benefit payable cannot exceed \$50,000 for each Child Insured, plus any automatic sum insured increases.

If the Child Insured is covered for Children's Insurance under more than one Family Life Cover Policy, we will apply this limit to the total of the Children's Insurance Benefit Amounts payable for the Child Insured under all such policies. Any reduction in the Children's Insurance Benefit Amount will be applied to the Children's Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Children's Insurance Benefit Amount is reduced.

The cost of your Children's Insurance

The premium you are required to pay for this option when the Policy starts is shown in your Policy Schedule.

The Children's Insurance premium is a stepped premium, which means that it will increase each year as the Child Insured ages. The premium is calculated at each Policy Anniversary and is based on the Benefit Amount provided for each Child Insured.

For a premium quote, or to understand more about the cost of your Insurance, please contact Real Insurance on **1300 367 325** (Monday to Friday between 8am and 8pm AEST), or visit **realinsurance.com.au**

What is not covered under your Children's Insurance?

We will not pay a Children's Insurance Benefit Amount if the Child Insured suffers Blindness, Deafness, Total and Permanent Loss of Use of One Limb, Encephalitis, Major Head Trauma, Meningitis, Paralysis, Benign Tumour of the Brain or of the Spinal Cord, Cancer, Severe Burns, Chronic Kidney Failure or Major Organ Transplant directly or indirectly as a result of:

- ✔ a Congenital Condition; or
- ✔ the intentional act of the Policyowner or person who will otherwise be entitled to all or part of the Benefit Amount; or
- ✔ an injury which occurs or an illness which becomes apparent, before the Children's Insurance for the Child Insured starts, or during the first three months after the Children's Insurance starts or, if reinstated, the reinstatement date. We will pay for any new and unrelated occurrence of Blindness, Deafness, Total and Permanent Loss of Use of One Limb, Encephalitis, Major Head Trauma, Meningitis, Paralysis, Benign Tumour of the Brain or of the Spinal Cord, Cancer, Severe Burns, Chronic Kidney Failure or Major Organ Transplant suffered by a Child Insured after this three month period, while covered under the Policy.

We will not pay for a Children's Insurance Benefit Amount if the Child Insured dies or is diagnosed with a Terminal Illness which becomes apparent before or during the first three months after the Children's Insurance starts or, if reinstated, the reinstatement date.

When your Children's Insurance starts and ends

If your application for Children's Insurance is accepted by us at the Commencement Date then the Children's Insurance starts on the Acceptance Date. If we agree to add Children's Insurance to your Policy after the Commencement Date, we will advise you of the date the Children's Insurance starts.

The Children's Insurance ends for a Child Insured when the first of the following occurs:

- ✔ the date of death of the Child Insured; or
- ✔ the date of death of the Key Life Insured; or
- ✔ the date of payment of a Children's Insurance Benefit Amount for the Child Insured; or
- ✔ the date you cancel the Policy; or
- ✔ the date we cancel the Policy; or
- ✔ the date you cancel this cover; or
- ✔ the Policy Anniversary following Child Insured's 21st birthday.

Serious Illness Insurance Option

This option is only available with Life Insurance. You only have this cover if we accepted your application and it is shown in your Policy Schedule.

What is Serious Illness Insurance?

Serious Illness Insurance provides a benefit in the event that a Life Insured under the Policy suffers a Heart Attack, Cancer, Stroke or has Coronary Artery Bypass Surgery. These medical conditions, including certain exclusions, are defined in the 'Glossary' on page 26.

Who can take out Serious Illness Insurance?

You can apply for this Insurance cover if you (and your Partner Life Insured, if applying) are Australian Resident/s and between 18 and 59 years of age.

The amount of Serious Illness Insurance you can apply for

You (and/or your Partner Life Insured) can apply for a Serious Illness Insurance Benefit Amount from \$50,000 up to the lesser of \$500,000 or 50% of the Life Insurance Benefit Amount for that Life Insured provided under your Policy.

When we will pay the Serious Illness Insurance benefit

We will pay the Serious Illness Insurance Benefit Amount as a lump sum if the Life Insured suffers an insured event; namely Heart Attack, Cancer, Stroke or has Coronary Artery Bypass Surgery, while covered under the Policy providing the Life Insured survives for 14 days after the

day that the serious illness is contracted, except in the circumstances explained in 'What is not covered under your Serious Illness Insurance?' on page 16.

The Heart Attack, Cancer, Stroke or Coronary Artery Bypass Surgery must be diagnosed by a Medical Practitioner and confirmed by our medical advisers.

Limit on benefits

Only one Benefit Amount is payable per Life Insured under this Serious Illness Insurance as a result of that Life Insured experiencing a Heart Attack, Cancer, Stroke or Coronary Artery Bypass Surgery.

The total Serious Illness Insurance Benefit Amount payable for a Life Insured cannot exceed the lesser of \$500,000 or 50% of the total Life Insurance Benefit Amount for that Life Insured under this Policy.

If the Life Insured is covered for Serious Illness Insurance under more than one Family Life Cover Policy, we will apply this limit to the total of the Serious Illness benefits payable for the Life Insured under all Family Life Cover policies. Any reduction in the Serious Illness Benefit Amount will be applied to the Serious Illness Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Serious Illness Benefit Amount is reduced.

Where a Benefit Amount is paid under this Serious Illness Insurance, we will reduce the Life and any Total & Permanent Disability Insurance Benefit Amount by that Serious Illness Insurance Benefit Amount in respect of that Life Insured. If we reduce the Life Insurance Benefit Amount and/or the Total & Permanent Disability Benefit Amount, we will reduce your premium accordingly.

The cost of your Serious Illness Insurance

The premium you are required to pay for this option is shown in your Policy Schedule.

The Serious Illness Insurance premium is a stepped premium, which means that it will increase each year as you age. Your premium is calculated at each Policy Anniversary and is based on:

- ✓ the age of each Life Insured at that time; and
- ✓ the Benefit Amount provided for each Life Insured; and
- ✓ the Insurance Plan chosen by you (joint plan or single plan); and
- ✓ various factors which may affect the premium rating for each Life Insured such as gender, smoking status, state of health, family history, occupation and participation in hazardous activities.

For a premium quote, or to understand more about the cost of your Insurance, please contact Real Insurance on **1300 367 325** (Monday to Friday between 8am and 8pm AEST), or visit realinsurance.com.au

What is not covered under your Serious Illness Insurance?

We will not pay a Serious Illness Insurance Benefit Amount if the Life Insured suffers a Heart Attack, Cancer, Stroke or has Coronary Artery Bypass Surgery directly or indirectly as a result of an intentional self-inflicted bodily injury or attempted suicide.

There are a number of cancers excluded from the definition of Cancer. It is important that you check these in the 'Glossary' on page 26.

No Benefit Amount will be payable if the condition resulting in a claim first becomes apparent before the Serious Illness Insurance for the Life Insured starts or during the first three months after:

- ✓ the Serious Illness Insurance for the Life Insured starts; or
- ✓ the date that any increase in cover starts (but only in respect of that increase); or
- ✓ where we have agreed to reinstate the Policy after it was cancelled, the date on which we reinstate the Policy (reinstatement date).

We will pay for any new and unrelated occurrence of a Heart Attack, Cancer, Stroke or Coronary Artery Bypass Surgery after this three month period.

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

When your Serious Illness Insurance starts and ends

If your application for Serious Illness Insurance is accepted by us at the Commencement Date then the Serious Illness Insurance starts on the Acceptance Date. If we agree to add Serious Illness Insurance to your Policy after the Commencement Date, we will advise you of the date the Serious Illness Insurance starts.

The Serious Illness Insurance ends for a Life Insured when the first of the following occurs:

- ✓ the date of death of the Life Insured; or
- ✓ the date of payment of a Benefit Amount for the Life Insured; or
- ✓ the date you cancel the Policy; or
- ✓ the date we cancel the Policy; or
- ✓ the date you cancel this cover; or
- ✓ the Policy Anniversary following the Life Insured's 65th birthday.

Total & Permanent Disability Insurance Option

This option is only available with Life Insurance. You only have this cover if we accepted your application and it is shown in your Policy Schedule.

What is Total & Permanent Disability Insurance?

Total & Permanent Disability Insurance provides a benefit in the event that a Life Insured under the Policy suffers Total & Permanent Disability.

Who can take out Total & Permanent Disability Insurance?

You can apply for this Insurance if you (and/or your Partner Life Insured) are aged between 18 and 59 years of age, are working at least 20 hours per week, and are Australian Resident/s.

The amount of Total & Permanent Disability Insurance you can apply for

The minimum Total & Permanent Disability Insurance Benefit Amount is \$50,000.

The maximum Total & Permanent Disability Insurance Benefit Amount for a Life Insured under the Policy at the Commencement Date is the lesser of the maximum Benefit Amount shown below or the Life Insurance Benefit Amount for that Life Insured provided under your Policy.

Maximum Benefit Amount (at Commencement Date)	
Current age	Benefit Amount
18 – 44	\$1,000,000
45 – 54	\$ 750,000
55 – 59	\$ 500,000
60 – 64	Not applicable

When we will pay the Total & Permanent Disability Insurance benefit

We will pay the Total & Permanent Disability Insurance Benefit Amount as a lump sum if the Life Insured suffers Total & Permanent Disability (insured event) while covered under the Policy, except in the circumstances explained in **‘What is not covered under your Total & Permanent Disability Insurance?’** on page 18.

The Total & Permanent Disability must be certified by a Medical Practitioner and confirmed by our medical advisers.

Limit on benefits

Only one Benefit Amount is payable per Life Insured under this Total & Permanent Disability Insurance.

The Total & Permanent Disability Insurance Benefit Amount payable for a Life Insured cannot exceed the Life Insurance Benefit Amount for each Life Insured under this Policy.

If the Life Insured is covered for Total & Permanent Disability Insurance under more than one Family Life Cover Policy, we will apply this limit to the total of the Total & Permanent Disability benefits payable for the Life Insured under all Family Life Cover policies. Any reduction in the Total & Permanent Disability Benefit Amount will be applied to the Total & Permanent Disability Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Total & Permanent Disability Benefit Amount is reduced.

Where a Benefit Amount is paid under this Total & Permanent Disability Insurance, we will reduce the Life Insurance and any Serious Illness Insurance Benefit Amount by the Total & Permanent Disability Insurance Benefit Amount in respect of that Life Insured. If we reduce the Life Insurance Benefit Amount and/or the Serious Illness Insurance Benefit Amount, we will reduce your premium accordingly.

The cost of your Total & Permanent Disability Insurance

The premium you are required to pay for this option when the Policy starts is shown in your Policy Schedule.

The Total & Permanent Disability Insurance premium is a stepped premium, which means that it will increase each year as you age. Your premium is calculated at each Policy Anniversary and is based on:

- ✔ your age (and/or the age of the Partner Life Insured, if any) at that time; and
- ✔ the Benefit Amount provided for each Life Insured; and

- ✔ the Insurance Plan chosen by you (joint plan or single plan); and
- ✔ various other factors which affect your premium rating (applicable to you or your Partner Life Insured as appropriate) such as gender, smoking status, state of health, family history, occupation and participation in hazardous activities.

For a premium quote, or to understand more about the cost of your Insurance, please contact Real Insurance on **1300 367 325** (Monday to Friday between 8am and 8pm AEST), or visit realinsurance.com.au

What is not covered under your Total & Permanent Disability Insurance?

We will not pay a Total & Permanent Disability Insurance Benefit Amount if the Life Insured suffers a Total & Permanent Disability directly or indirectly as a result of:

- ✔ an injury caused or accelerated by an intentional act performed by the Life Insured, Policyowner or person who will otherwise be entitled to all or part of the Benefit Amount; or
- ✔ an injury caused as a result of engaging in any motor sport as a rider, driver and/or passenger.

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

When your Total & Permanent Disability Insurance starts and ends

If your application for Total & Permanent Disability Insurance is accepted by us at the Commencement Date then the Total & Permanent Disability Insurance starts on the Acceptance Date. If we agree to add Total & Permanent Disability Insurance to your Policy after the Commencement Date, we will advise you of the date the Total & Permanent Disability Insurance starts.

The Total & Permanent Disability Insurance ends for a Life Insured when the first of the following occurs:

- ✔ the date of death of the Life Insured; or
- ✔ the date of payment of a Total & Permanent Disability Insurance Benefit Amount for the Life Insured; or
- ✔ the date you cancel the Policy; or
- ✔ the date we cancel the Policy; or
- ✔ the date you cancel this cover; or
- ✔ the Policy Anniversary following the Life Insured's 65th birthday.



General Information

Your 30 day money back guarantee

You have 30 days from the Commencement Date or the date any optional benefit starts to make sure you are happy with it, and decide whether you want to keep the Policy or optional benefit. This is known as the “cooling-off” period. If you want to cancel your Policy, or the optional benefit within this 30 day period you may do so provided you have not made a claim under the Policy.

If you wish to cancel your Policy and/or optional benefits within the cooling-off period, please send a written request providing your instruction to cancel along with your full name and policy number to **Real Insurance**, PO Box 6728, Baulkham Hills NSW 2153. If your request is received within 30 days of your Commencement Date we will refund any premiums you have paid. If you wish to discuss the matter or make alterations to your cover you can contact us on **1300 367 325** (Monday to Friday between 8am and 8pm AEST).

Automatic sum insured increases

To help your level of Insurance keep up with the cost of living, your Insurance and all optional benefits (if applicable) are automatically increased on each Policy Anniversary by 5%.

Automatic increases will continue even where the maximum Benefit Amount is met or exceeded.

We will send you an updated Policy Schedule each year your Policy remains in force 30 days prior to your Policy Anniversary setting out your updated Benefit Amount and premium. You can decline the automatic increase by phoning us on **1300 367 325** (Monday to Friday between 8am and 8pm AEST), or by writing to **Real Insurance**, PO Box 6728, Baulkham Hills NSW 2153. If you decline the automatic increase, the updated Policy Schedule we sent you will not be valid and we will send you a replacement Policy Schedule.

If you decline the automatic sum insured increase in any given year, we will continue to offer you automatic sum insured increases on each subsequent Policy Anniversary until you are no longer eligible for them.

The automatic increases will end on the Policy Anniversary following the Life Insured's 75th birthday.

Further Insurance options

We may offer you the option of incorporating further Insurance benefits under your Policy. If you accept such offers, we will issue you with a new Policy Schedule setting out the terms and conditions of the Insurance option.

Premiums

We may change the premium rates applying to your Policy, but only if we change the premium rate applying to all (or the same group of) Family Life Cover Policyowners. We will send written notice of any change to you (to your last address notified to us) at least 90 days before the effective date of the change.

How you can pay for your Insurance and when your premium is deducted

Your premium will be debited on the date of your choice, either fortnightly, monthly or annually. The date on which your first premium is deducted will become your Policy Commencement Date. You can pay either by automatic debit from your bank, credit union or building society account or by credit card.

You may apply at any time in writing or by phone to change the method of payment of premiums. Payment frequency changes can only be made on the Policy Anniversary following the request.

All payments made in connection with this Policy must be made in Australian currency.

Changing your Insurance

You can phone us on **1300 367 325** (Monday to Friday between 8am and 8pm AEST) to discuss changing your insurance cover. You may need to confirm changes in writing if you wish to:

- ✔ decrease your Insurance; and
- ✔ increase your Insurance; and
- ✔ change from a single plan to a joint plan (or from a joint plan to a single plan); and
- ✔ change a Life Insured's status from a smoker to a non-smoker, for the purpose of determining your Insurance premium rating. You must provide a completed declaration form.

Any change and the terms and conditions relating to the change are subject to approval and written confirmation by us.

When we can cancel your Policy

If you don't pay your premium when it is due and it remains unpaid for more than one month your Policy could be cancelled. It may be reinstated within six months of the date that the Policy was cancelled, but only if we agree and subject to any terms and conditions we might require.

The Policy will be cancelled if the Policyowner is on a temporary work visa and ceases to reside in Australia.

If you wish to cancel your Policy and/or optional benefits, please send a written request providing your instruction to cancel along with your full name and policy number to **Real Insurance**, PO Box 6728, Baulkham Hills NSW 2153. If you wish to discuss the matter or make alterations to your cover you can contact us on **1300 367 325** (Monday to Friday between 8am and 8pm AEST).

Insurance risks

There are a number of insurance risks you should be aware of, including:

- ✔ you need to select the Insurance product and apply for the appropriate level of cover for your needs. If you do not have enough cover it might cause you or your family to suffer financial hardship even after receiving the benefit payment;
- ✔ if you are replacing a contract or policy with another contract or policy, you should consider all the terms and conditions of each policy before making a decision to change; and
- ✔ this Policy is designed purely for protection, unlike some other types of life insurance that have savings and investments components, which means that if you cancel your Policy (after the 30 day cooling-off period) you will not receive anything back unless you have paid more than 30 days in advance.

Benefit payments

Unless a valid Nomination (explained below) applies:

- ✔ we make all benefit payments to you, the Policyowner; or
- ✔ if the Policyowner dies, the Insurance benefit will be paid to the Policyowner's legal personal representative, or other person that we are permitted to pay under the Life Insurance Act 1995.

All benefits paid in connection with this Policy will be made in Australian currency.

Nominations

As Policyowner, you can nominate a beneficiary or beneficiaries to receive the benefits payable under your Policy on your death.

To make a nomination, you need to complete a Nomination of Beneficiaries Form (available on page 33 of this PDS or download from realinsurance.com.au) and return it to Real Insurance.

Conditions of Nominations

The following conditions apply:

- ✔ there must not be more than five nominees; and
- ✔ nominations must be of a natural person; and
- ✔ nominations must be in writing on a Nomination of Beneficiaries Form; and
- ✔ you may vary the nomination at any time by properly completing and signing a new Nomination of Beneficiaries Form and forwarding it to Real Insurance. The variation takes effect when it is received at Real Insurance; and
- ✔ payment of benefits will be made on the basis of the latest valid nomination received at Real Insurance; and
- ✔ if a nominee is a minor when payment is made, the payment will be made to the minor's legal guardian on trust for the benefit of the minor; and
- ✔ if a nominee pre-deceases the Policyowner, that nominee's share is payable to the Policyowner's legal personal representative, or other person that we are permitted to pay under the Life Insurance Act 1995.

The payment of the benefit in accordance with the above in respect of a Life Insured is full and final discharge of our liability under the Policy for that benefit.

If the Policyowner dies leaving a surviving Partner Life Insured, from the time of the Policyowner's death, the Benefit Amount for all surviving Lives Insured under this Policy will continue (subject to payment of the first premium) under a new Policy we will issue to the surviving Partner Life Insured in his or her name as the Policyowner. The new Policy will be issued on the same terms as this Policy and takes effect subject to payment of the first premium.

Making a claim

If you (or your legal personal representative on your death) wish to claim under this Policy, please phone **1300 307 297** (Monday to Friday between 8am and 8pm AEST), or write to Real Insurance, PO Box 6728, Baulkham Hills NSW 2153. We will send you a form to be completed, signed and returned. We may also require your treating doctor or specialist to complete a form at your (or your estate's) expense.

The Policy and the Insurance for the benefit must be in force when the insured event occurs.

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

Before a claim can be fully assessed we must receive proof, provided at your (or your estate's) expense and to our satisfaction, that the insured event has occurred. In addition:

- ✔ proof must be supported by one or more appropriate Medical Practitioners; and
- ✔ all relevant information, including any test, examination, or laboratory results, must be provided to us.

We may be entitled to refuse to pay the benefit under this Policy if a claim is made more than 120 days after the insured event giving rise to the claim without good cause or if we do not have evidence to our satisfaction of the Life Insured's death, the cause of the Life Insured's death, or of the applicable insured event.

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

Tax

In most cases your premium will not be tax deductible and tax will not be payable on any benefit paid under your Policy.

This information is based on continuance of present tax laws and our interpretation of those laws. Your individual situation may differ and you should seek qualified professional advice in relation to your particular circumstances.

Questions or complaints

We hope that you never have reason to complain, but if you do we will do our best to work with you to resolve it. Our complaints resolution process has three steps.

1 – Immediate Response

Usually when you have a concern, we can resolve it immediately on the phone. If we can't immediately resolve your concern we will treat it as a complaint and take steps to resolve your matter as soon as possible. Please contact us using one of the following means:

Phone: 1300 367 325
(Monday to Friday between
8am and 8pm AEST)

Writing: Customer Support Complaints
Real Insurance
PO Box 6728
Baulkham Hills NSW 2153

Email: service@reallifecover.com.au

Please supply your Policy number to enable the enquiry to be dealt with promptly. Your complaint or enquiry will be dealt with by someone with appropriate authority.

2 – Internal Dispute Resolution

If we haven't resolved your matter to your satisfaction, at your request, we will escalate your complaint for review by our Internal Dispute Resolution team. All escalated matters will be acknowledged within two business days of being escalated. After full consideration of the matter a written final response will be provided that will outline the decision reached and the reasons for the decision.

3 – External Dispute Resolution

In the unlikely event that your complaint is not resolved to your satisfaction, or a final response has not been provided within 45 days, you may be eligible to refer your matter to the Australian Financial Complaints Authority (AFCA), providing your matter is within the scope of AFCA Terms of Reference. AFCA is an independent dispute resolution service provided free of charge.

You may contact AFCA at:

Australian Financial Complaints Authority

Mail: GPO Box 3, Melbourne VIC 3001

Phone: 1800 931 678

Website: www.afca.org.au

Email: info@afca.org.au

Privacy

For the purposes of this Notice "we", "our" and "us" means Hannover Life Re of Australasia Ltd and anyone collecting information on our behalf.

We may collect personal information directly from you through the application process or, where that is not reasonably practical, from other sources. For example, we may obtain information from other insurers or medical practitioners.

Your personal information is collected for the purpose of processing your application, administering your Policy and assessing and paying any claims under the Policy. Your information may also be used to consider any other application you may make in the future, or to perform our administrative operations. If you do not consent to us collecting and using your personal information in this manner, or do not provide the requested information in full, we will be unable to provide the requested insurance services or you may be deemed to not have complied with your duty of disclosure. Real Insurance may use your personal information (but not sensitive information) to assist them in developing and identifying products and services that may interest you and (unless you ask them not to by calling them on **1300 367 325** Monday to Friday between 8am and 8pm AEST) telling you about products and services offered by Real Insurance.

Your personal information may be disclosed to third parties who assist in the provision of insurance services (i.e. reinsurers, related companies, our advisers, persons involved in claims, medical service providers, external claims data collectors and verifiers, your employer, your agents and other persons where required by law). We are unlikely to send your personal information to any foreign jurisdiction and we take steps to ensure our service providers don't either.

By applying for cover, you consent to sensitive information about you being collected and it being used to consider your application for Insurance, assess a claim, using it or giving it to related companies for research and analysis, to design or underwrite new insurance products, and disclosing it to any of the third parties listed above for these purposes. Your sensitive information will not be disclosed for any other purpose. Third parties are prohibited from using your personal information for purposes other than those for which it is supplied.

You can read more about how we collect, use and disclose your personal information in Real Insurance's Privacy Policy, including how to complain about a breach of the Privacy Principles, which is available on the Real Insurance website at realinsurance.com.au or you can request a copy. If you wish to gain access to your information (including correcting or updating it), have a complaint about a breach of your privacy or have any other query relating to privacy please call **1300 367 325** (Monday to Friday between 8am and 8pm AEST).

Your duty of disclosure

Before you enter into a life insurance contract, you have a duty of disclosure to tell us anything you know, or could reasonably be expected to know, which is relevant to our decision to insure you, and other Lives Insured, and on what terms. You have this duty until we agree to insure you. Your duty applies to all lives insured under the Policy, and you have the same duty to disclose those matters before you extend, vary or reinstate this Policy.

You do not need to tell us anything that:

- ✔ reduces the risk we insure you for; or
- ✔ is of common knowledge; or
- ✔ we know, or as an insurer, should know; or
- ✔ we waive your duty to tell us about.

If you do not tell us something

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

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the contract within three years of entering into it. This means we could refuse to pay a benefit.

If we choose not to avoid the contract, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the contract provides cover on death, we may only exercise this right within three years of entering into the contract.

If we choose not to avoid the contract or reduce the amount you have been insured for, we may, at any time vary the contract in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the contract provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.



Glossary

In this Policy, some words begin with a capital letter, for example, Benefit Amount. These words have the special meanings as explained below.

Acceptance Date means the date your application is accepted by us and cover starts as set out in the Policy Schedule.

Accident means an event resulting in bodily injury occurring while this Policy is in force, where the injury is directly and solely caused by accidental, violent, external and visible means without any other contributing causes and where the injury is not self inflicted.

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

Australian Resident means a person who resides in Australia at the time of application and either holds Australian or New Zealand citizenship; or holds an Australian permanent residency visa; or has been in Australia continuously for six months or more on a temporary work visa and resides in Australia.

Benefit Amount means the amount payable on the applicable insured event covered under this Policy in respect of a Life Insured and Child Insured (as applicable). The Benefit Amount at the

Acceptance Date for each benefit for each Life Insured and Child Insured is shown in the Policy Schedule.

Benign Tumour of the Brain or of the Spinal Cord means the presence of a non-cancerous tumour on the brain or spinal cord causing a Permanent neurological deficit with persisting symptoms. The diagnosis must be confirmed by a Medical Practitioner.

“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 spinal cord other scans without definite related clinical symptoms.

Benign Tumour of the Brain or of the Spinal Cord (continued)

- ✓ Neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms.
- ✓ Symptoms of psychological or psychiatric origin.

Blindness means the permanent loss of sight in the Child Insured due to Injury or Illness, such that:

- ✓ visual acuity is 6/60 or less in at least one eye, or
- ✓ the visual field is reduced to 20 degrees or less of arc,

measured, in each case, after taking into account visual aids.

If the above is not met, other evidence confirming an equivalent severity of blindness will be considered. Diagnosis must be confirmed by specialist Medical Practitioner in the field.

Cancer means the confirmed diagnosis by a Medical Practitioner 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 cancers are specifically excluded for Serious Illness Insurance Option claims:

- ✓ tumours which are histologically classified as 'pre-malignant', 'noninvasive', '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); and
- ✓ cutaneous lymphoma where the skin is the only organ affected.

The above exclusions do not apply for Children's Insurance Option.

The diagnosis must be confirmed by specialist Medical Practitioner in the field.

Child Insured in respect of the optional Children's Insurance means the Life Insured named in the Policy Schedule in respect of Children's Insurance.

Chronic Kidney Failure means end stage renal failure presenting as chronic irreversible failure of the function of both kidneys, which requires permanent dialysis.

Commencement Date means the date on which your first premium payment is deducted. The date you select for the first premium deduction is set out in the Policy Schedule.

Congenital Condition means an illness, disability or defect existing at or from a Child Insured's birth.

Coronary Artery Bypass Surgery means the actual undergoing of bypass 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.

Deafness means a confirmed diagnosis in the Child Insured of the total and irreversible loss of hearing, both natural and assisted, in one or both ears. The diagnosis must be confirmed by specialist Medical Practitioner in the field.

Diplegia means total and permanent loss of use of symmetrical parts of the body through injury caused by permanent damage to the nervous system. The diagnosis must be confirmed by a Medical Practitioner.

Encephalitis means the diagnosis of a bacterial infection of the brain tissue in the Child Insured. The diagnosis must be confirmed by Medical Practitioner.

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:

- ✓ symptoms of ischaemia consistent with myocardial infarction;
- ✓ ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block);
- ✓ development of new pathological Q waves on the ECG;
- ✓ 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; or
- ✓ other acute coronary syndromes including but not limited to angina pectoris.

Hemiplegia means the total and permanent loss of use of one side of the body caused by permanent damage to the nervous system. The diagnosis must be confirmed by a Medical Practitioner.

Homemaker means the Life Insured who is the main provider of domestic duties within the family home and if also in paid employment, working for less than 10 hours per week.

Domestic duties are the tasks performed by a Life Insured whose main occupation is to maintain their family home. These tasks are:

- ✓ cooking of meals for their family;
- ✓ cleaning of the home;
- ✓ shopping for their family's food;
- ✓ doing their family's laundry; and
- ✓ taking care of dependant children (if applicable).

Homemaker (continued)

Domestic duties do not include duties performed outside the person's home for salary, reward or profit.

Insurance means, in respect of a Life Insured, the Insurance benefits that have been applied for by the Policyowner and accepted by us as indicated on the Policy Schedule.

Insurance Plan means the Insurance Plan nominated by the Policyowner in the application, subject to acceptance by us. The Insurance Plans available under the Policy are:

- ✓ single plan – this Plan applies if the Key Life Insured is the only person nominated in the application.
- ✓ joint plan – this Plan applies if there is a Key Life Insured and a Partner Life Insured nominated in the application.

Key Life Insured means a person named in the Policy Schedule as the Key Life Insured.

Life Insured means, as the context requires, the Key Life Insured and, if applicable, the Partner Life Insured and a Child Insured.

Major Head Trauma means an accidental head injury in the Child Insured resulting in the admission to ICU for more than four consecutive days (96 hours). The diagnosis must be confirmed by a Medical Practitioner.

Major Organ Transplant means either having undergone an organ transplant, or upon specialist medical advice is placed on an official Australian acute care hospital waiting list to undergo an organ transplant, from another human donor of one or more of the following:

- ✓ kidney
- ✓ heart
- ✓ liver
- ✓ lung

- ✓ pancreas, or
- ✓ bone marrow.

The transplantation of all other organs or parts of any organ or any other tissue is excluded.

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 a prognosis of Terminal Illness or as the context requires, to diagnose a medical condition, illness, disability or injury covered under this Policy, of a Life Insured or Child Insured and, in the case of a Child Insured, must be a paediatrician. The Medical Practitioner must not be the Policyowner or a Life Insured under this Policy, their spouse, relative or business associate.

Meningitis (and / or meningococcal disease) means the diagnosis of a bacterial infection of the meninges of the brain or meningococcal septicaemia in the Child Insured. The diagnosis must be confirmed by a specialist Medical Practitioner in that field.

Monoplegia means the total and permanent loss of use of one limb caused by permanent damage to the nervous system. The diagnosis must be confirmed by a Medical Practitioner.

Paralysis means total and permanent loss of use of one or more limbs through injury or illness caused by permanent damage to the nervous system. This includes, but is not limited to, Monoplegia, Hemiplegia, Diplegia, Paraplegia, and Quadriplegia/ Tetraplegia. The diagnosis must be confirmed by a Medical Practitioner.

Paraplegia means the total and permanent loss of use of both legs caused by permanent damage to the nervous system. The diagnosis must be confirmed by a Medical Practitioner.

Partner Life Insured means a person named in the Policy Schedule as the Partner Life Insured. A Partner may be a legal spouse or de-facto of the Key Life Insured and may be of the same gender as the Key Life Insured.

PDS is an abbreviation of Product Disclosure Statement.

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

Policy Anniversary means the anniversary of the Commencement Date of your Policy.

Policyowner, you, your, yours means the Key Life Insured. This Policy may not be transferred or assigned to another person.

Quadriplegia/Tetraplegia means the total and permanent loss of use of both arms and both legs caused by permanent damage to the nervous system. The diagnosis must be confirmed by a Medical Practitioner.

Schedule means the Schedule issued with this Policy and updated from time to time. A new Schedule will be issued at any time we agree with you to change the details in respect of a Life Insured under this Policy. A new Schedule will replace previous Schedules.

Severe Burns means full thickness (third degree) or deep partial thickness (second degree) burns to at least:

- ✔ 10% of the body surface area as measured by the Lund and Browder Body Surface Chart;
- ✔ 50% of both hands, requiring surgical debridement and / or grafting; or
- ✔ 50% of the face, requiring surgical debridement and / or grafting.

The diagnosis must be confirmed by a specialist Medical Practitioner in that field.

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 six weeks after the stroke; and
- ✔ 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.

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; and
- ✔ 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

Stroke (continued)

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; or
- ✔ symptoms of psychological or psychiatric origin.

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

Total & Permanent Disability is where as a result of sickness or injury, the Life Insured:

- ✔ suffers the loss of limbs or sight; or
- ✔ is unable to work; or
- ✔ suffers loss of independent existence;

defined as follows:

a. *loss of limbs or sight*

Means the total and permanent loss of use of:

- both hands; or
- both feet; or
- one hand and one foot; or
- the sight of one eye and the use of either one hand or one foot; or
- the sight of both eyes.

b. *unable to work*

If the Life Insured is not a Homemaker, a state of physical or mental incapacity which:

- results in the Life Insured being disabled and unable to work in any employed capacity for at least six consecutive months; and
- in our opinion, after considering medical evidence and/or other evidence, results in the Life Insured being unable ever to follow any occupation for which he or she is reasonably qualified by education, training or experience.

If the Life Insured is a Homemaker, a state of physical or mental incapacity which:

- results in the Life Insured being unable to engage in normal domestic duties for at least six consecutive months; and
- in our opinion, after considering medical evidence and/or other evidence, results in the Life Insured being unable ever to perform normal domestic duties or engage in any other occupation for which he or she is reasonably qualified by education, training or experience.

c. *loss of independent existence*

- There is a permanent and irreversible inability of the Life Insured to perform any two of the following "activities of daily living" without the physical assistance of someone else. If the Life Insured can perform the activity on their own by using special equipment, we will not treat them as unable to perform the activity.

Activity	Description
Washing	bathing and showering
Dressing	dressing and undressing
Eating	eating and drinking
Continence	maintaining continence with a reasonable level of personal hygiene
Mobility	getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or walking aid

or

- The Life Insured suffers cognitive impairment that results in the Life Insured requiring permanent and constant supervision for a continuous period of at least 6 months. The Life Insured's impairment must be established by a Medical Practitioner nominated by us.

Total and Permanent Loss of Use of One

Limb means complete and irrecoverable loss of the use of one limb. Limb in this context means an arm, leg, hand or foot. The diagnosis must be confirmed by a Medical Practitioner.

Nomination of Beneficiaries Form

As the Policyowner, you have the option to nominate a beneficiary or beneficiaries to receive benefits payable under your Policy on your death. The option to nominate a beneficiary is subject to the conditions listed below.

Unless a valid nomination applies (explained below):

- ✔ we make all benefit payments to you, the Policyowner; or
- ✔ if the Policyowner dies, for a joint plan, the Insurance benefit will be paid to the surviving Partner Life Insured, or for a single plan, the Insurance benefit will be paid to the Policyowner's legal personal representative, or other person that Hannover Life Re of Australasia Ltd are permitted to pay under the Life Insurance Act 1995.

Nominations

As Policyowner, you can nominate beneficiaries to receive payment of any benefits on your death. To make a nomination, you need to complete this Nomination of Beneficiaries Form and return it to Real Insurance.

Conditions

The following conditions apply:

- ✔ There must not be more than five nominees. Nominations must be of a natural person; and
- ✔ Nominations must be in writing on a Nomination of Beneficiaries Form; and
- ✔ You may vary the nomination at any time by properly completing and signing a new Nomination of Beneficiaries Form and forwarding it to Real Insurance. The variation takes effect when it is received at Real Insurance; and
- ✔ Payment of benefits will be made on the basis of the latest valid nomination received at Real Insurance; and
- ✔ If a nominee is a minor when payment is made, the payment will be made to the minor's legal guardian on trust for the benefit of the minor; and
- ✔ If a nominee pre-deceases the Policyowner, that nominee's share is payable to the Policyowner's legal personal representative, or other person that we are permitted to pay under the Life Insurance Act 1995.

Full Name of Beneficiary	Address	Phone Number	Date of Birth	Relationship to Policyowner	Proportion of Benefit
			/ /		%
			/ /		%
			/ /		%
			/ /		%
			/ /		%
			/ /		%
Your Policy number					
Name of Policyowner					
Signature of Policyowner				Date: / /	

Please return this form to Real Insurance PO Box 6728, Baulkham Hills NSW 2153

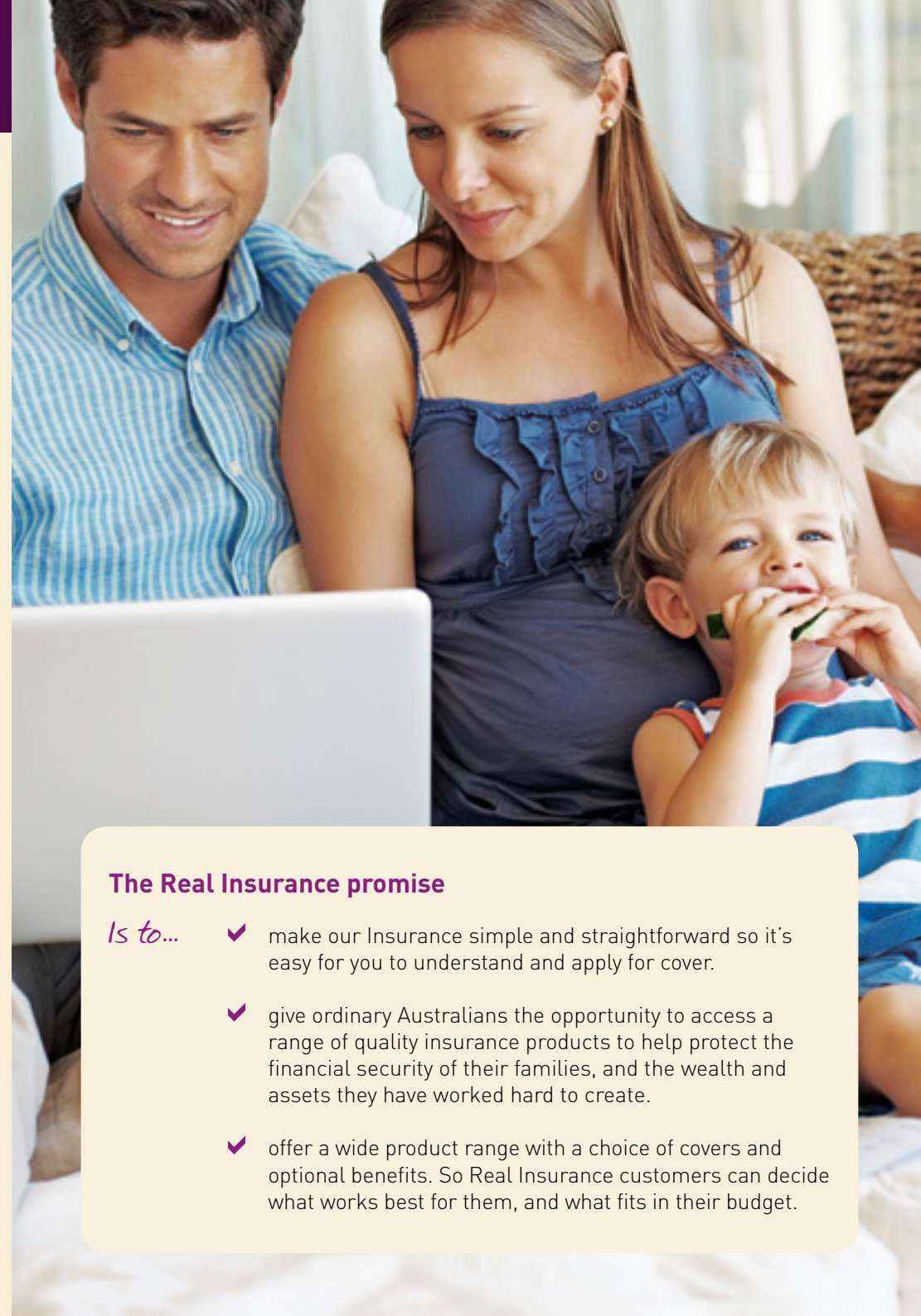
Nomination of Beneficiaries Form

If you wish to nominate a beneficiary or beneficiaries to receive benefits payable under your Policy on your death, please complete the form on the reverse of this page and return it to:

Real Insurance

PO Box 6728

Baulkham Hills NSW 2153



The Real Insurance promise

Is to...

- ✓ make our Insurance simple and straightforward so it's easy for you to understand and apply for cover.
- ✓ give ordinary Australians the opportunity to access a range of quality insurance products to help protect the financial security of their families, and the wealth and assets they have worked hard to create.
- ✓ offer a wide product range with a choice of covers and optional benefits. So Real Insurance customers can decide what works best for them, and what fits in their budget.

Direct Debit Service Agreement

1. Hannover Life Re of Australasia Ltd ABN 37 062 395 484 ("Debit User") will initiate direct premium debit payments in the manner referred to in the Schedule (contained in the Direct Debit Request).
2. Debit payments will be made when due. The Debit User will not issue individual confirmation of payments made.
3. The Debit User will give the customer at least 14 days' written notice if the Debit User proposes to vary details of this arrangement, including the amount and frequency of debit payments.
4. If the customer wishes to defer any payment or alter any of the details referred to in the Policy Schedule, they must either contact the Debit User on **1300 367 325** (Monday to Friday between 8am and 8pm AEST), or write to the Debit User at PO Box 6728, Baulkham Hills NSW 2153.
5. Customer queries concerning disputed debit payments must be directed to the Debit User in the first instance. Details of the dispute resolution process that applies to the Debit User are described in this PDS on page 23. Queries about claims in regards to disputed debit payments should also be directed to the Debit User and may also be directed to the customer's financial institution nominated in the Schedule.
6. Direct payment debiting is not available on the full range of accounts at all financial institutions. If in doubt, the customer should check with their financial institution before completing the Direct Debit Request.
7. The customer should ensure that their account details given in the Policy Schedule are correct by checking against a recent statement from their financial institution at which their account is held.
8. It is the customer's responsibility to have sufficient cleared funds available, by the premium due date, in the account to be debited to enable debit payments to be made in accordance with the Direct Debit Request.
9. By authorising the Direct Debit Request, the customer warrants and represents that he/she/they is/are duly authorised to request and instruct the debiting of premium payments from the account described in the Policy Schedule.
10. If a debit payment falls due on any day which is not a business day, the payment will be made on the next business day. If you are uncertain as to when a debit payment will be processed to your account, you should make enquiries directly with the financial institution nominated in the Policy Schedule.
11. If a debit payment is returned unpaid, the customer may be charged a fee by the financial institution nominated in the Policy Schedule for each returned item.
12. Customers wishing to cancel the Direct Debit Request or to stop individual payments must give at least seven days' written notice to the Debit User at the address referred above.
13. Except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required by law, the Debit User and its service providers will keep details of the customer's account and debit payments confidential.

**For more information about
Family Life Cover**

Call 1300 367 325

Monday to Friday 8am–8pm (AEST)

Visit realinsurance.com.au