LifeCare

General Terms and Conditions

1 APRIL 2019

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Welcome to LifeCare

By having a LifeCare policy in place you have made an important decision to provide financial protection for you and your family.

These LifeCare General Terms and Conditions explain the benefits and exclusions under your policy, in detail.

This document contains important information that you should take the time to read and keep in a safe place for future reference.

- Where you see a word or phrase in italics, it means it has a special meaning. That meaning is described in the Definitions section.
- Where our terms require us to make a decision, or hold an opinion, we will act in a way that would be expected from a reasonable and prudent licensed insurer in New Zealand.

If you have any questions, wish to discuss any aspect of your cover, a claim, or make changes to keep your cover up to date, simply give us a call on 0800 808 648. We will be happy to help.

Contents

Death & Terminal Illness Benefit

- Refer to *your* latest *Policy Document* for up-to-date details of total *Cover* held.
- *Cover* is valid worldwide.
- *Cover* does not expire due to age of the *Insured*.

What *you* are covered for

We will pay the Death and Terminal Illness Benefit if the *Insured* dies or is diagnosed as suffering from a Terminal Illness(definition follows) while this *Cover* is in force, and all the claim requirements are met.

The amount paid will be the amount shown in the latest *Policy Document*:

- Plus any inflation adjustment applied to the *Cover* since the *Policy Document* was issued – see 'Inflation proof cover' in the 'Additional features included with *your Cover*' section for details, and
- Less any claims already accepted for the Critical Condition Benefit or the Permanent Disability Benefit if held under this *Policy*.

An advance payment of the Death and Terminal Illness Benefit of up to $5,000 may be available as Bereavement Support when a claim is made – see the 'What to expect if *you* claim on this *Cover*' section for details.

TO MAKE A CLAIM:

Call *BNZ Life* 0800 808 648 or +64 4 474 9702 if calling from overseas

Have a read through the *Benefit* details and refer to the 'What to expect if *you* claim on this *Cover*' section for more information about claiming on this *Cover*.

Terminal Illness Means the *Insured* has been diagnosed by an appropriate *Specialist Medical Practitioner* (including consultant medical or surgical specialists) with an advanced or rapidly progressing, incurable, disabling condition, and based on that diagnosis and medical evidence *we* are satisfied that the *Insured* is not expected to live for more than 12 months.

When *you* are not covered by the Death and Terminal Illness Benefit

When the circumstances do not match the description of 'What *you* are covered for' above

If the *Insured*'s circumstances do not match the description of 'What *you* are covered for' above then a claim will not be payable under the Death and Terminal Illness Benefit.

Exclusions (circumstances when *you* are not covered) that apply to everyone

No Death and Terminal Illness Benefit will be paid, if the *Insured* dies or develops a Terminal Illness as a direct or indirect result of:

- An injury or an illness arising from an intentionally self-inflicted act (whether the *Insured* was sane or insane at the time) within 13 calendar months from the later of the *Commencement Date* or the *Reinstatement Date*; or
- The *Insured*'s involvement in an unlawful act whether or not the *Insured* is charged or convicted of an offence in respect of that act.

In these circumstances *we* will retain any premiums paid. Any premiums received after the date of death or diagnosis with a Terminal Illness will be refunded.

Additional exclusion(s) relating specifically to the *Insured* may have been added to this *Benefit*

- Any additional exclusions added to this *Benefit* will be detailed on the latest *Policy Document* for the *Policy*. No Death and Terminal Illness Benefit will be paid in the circumstances described in those additional exclusions.

When *we* were not told key information about the *Insured*

We will not be required to pay or may reduce or vary the Death and Terminal Illness Benefit if:

› The *Insured* or the *Policy Owner* fail to disclose information that is material to *us*.

› Any of the information or statements provided by or on behalf of the *Insured* or the *Policy Owner* is substantially or materially incorrect and this *Policy* was issued or reinstated, or a claim considered, based on that information.

Refer to the 'Times when *we* are not required to pay a claim, or *we* may reduce or cancel *your Cover*' section on Page 26 of this document for further details.

When the *Policy* has been cancelled

You are not covered by the Death and Terminal Illness Benefit if the *Policy* has been cancelled, unless the event occurred before cancellation. The cancellation could have been at the *Policy Owner*'s request, or by *us* for non-payment of premium – see '*We* will cancel *your Policy* if the premiums are not paid' in the 'Paying *your* premiums' section for details.

What to expect if *you* claim on this *Cover*

Some examples of what *we* may ask *you* to provide that will help *us* assess and pay *your* claim

If the *Insured* has been diagnosed with a Terminal Illness:

› Terminal Illness claim form completed by the *Insured* and their *Specialist Medical Practitioner*.

› Copy of all historical and current specialist reports and test results that relate to the *Insured*'s condition.

If the *Insured* has died:

› Certified copy of the death certificate.

› Certified copy of probate or letters of administration (if applicable).

› Certified copy of the coroner's report (if applicable).

The above examples are not everything *we* may ask for as *we* could also ask for other information depending on the circumstances of the claim. *We* will not assess any claim until all the information requested has been provided to *us*.

Bereavement Support Benefit

There are times when the information to support a Death and Terminal Illness Benefit claim can take time to become available. To help with urgent expenses a once only advance payment of the lesser of $5,000 or the Death and Terminal Illness Benefit can be paid as soon as *we* have confirmation of the death of the *Insured* by way of a death certificate.

› Where a death certificate is not available in a timely manner *we* may agree to accept an obituary notice, newspaper report, police report, or written confirmation from the *Policy Owner* or the spouse of the *Insured*, as evidence of the death of the *Insured*.

If a Bereavement Support Benefit claim is made the Death and Terminal Illness Benefit will then be reduced by the amount of the Bereavement Support Benefit payment.

The Bereavement Support Benefit will be paid to the *Policy Owner* (or their personal representatives or the executors or administrators of their estate). If a Bereavement Support Benefit is paid and *we* subsequently decline the claim for a Death and Terminal Illness Benefit, *we* will be entitled to full repayment of the amount paid under the Bereavement Support Benefit within 90 days of the claim being declined.

What happens when a Death and Terminal Illness Benefit claim is approved

› *We* will ask the *Policy Owner* to complete and return a discharge form to *us*. The claim will then be paid to the *Policy Owner*, unless otherwise agreed by the *Policy Owner* and *us*. In the event of the death of the *Policy Owner*, the appropriate person representing the *Policy Owner*'s estate will be asked to complete the discharge form and the payment will be made to the *Policy Owner*'s estate.

› Once a Death or Terminal Illness claim is paid the *Policy* will end.

› Any premiums *we* receive for the period of the *Policy* after the date of death or Terminal Illness will be refunded to the *Policy Owner* or, if the *Policy Owner* has died, the *Policy Owner*'s estate.

Critical Condition Benefit

- Refer to *your* latest *Policy Document* for up-to-date details of total *Cover* held.
- *Cover* must be in place for at least 3 months before the *Insured* first suffers symptoms or is diagnosed as suffering from one of the Critical Conditions Covered to be able to claim on this *Benefit*.
- The Critical Condition Benefit pays a once only portion of the Death and Terminal Illness Benefit in advance so any claims accepted will reduce the Death and Terminal Illness Benefit and any Permanent Disability Benefit on this *Policy*. Refer to the 'What to expect if *you* claim on this *Cover*' section for more details.
- *Cover* is valid worldwide.
- *Cover* expires on the *Anniversary Date* following the *Insured*'s 65th birthday

What *you* are covered for

If the *Insured* is diagnosed as suffering for the first time ever from one of the Critical Conditions Covered, provided that the critical condition is diagnosed while this *Cover* is in force and all the claim requirements are met, *we* will pay once only the Critical Condition Benefit amount shown in the latest *Policy Document* to the *Policy Owner*:

- Plus any inflation adjustment applied to the *Cover* since the *Policy Document* was issued – see 'Inflation proof cover' in the 'Additional features included with *your Cover*' section for details, and
- Less any claims already accepted for any Permanent Disability Benefit if held under this *Policy*.

TO MAKE A CLAIM:

Call *BNZ Life* 0800 808 648 or +64 4 474 9702 if calling from overseas

Have a read through the *Benefit* details and refer to the 'What to expect if *you* claim on this *Cover*' section for more information about claiming on this *Cover*.

Critical Conditions Covered

Advanced Cancer

Advanced Cancer means the presence of one or more malignant tumours positively diagnosed by a *Specialist Medical Practitioner* with histological confirmation and characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue.

The following types of cancers are covered when they meet the required level of advancement specified (unless excluded as stated below):

- **Prostate cancer** of at least TNM classification T2N0M0 or Gleason score of at least 6, or with existence of spread to other organs or lymph nodes.
- **Papillary and follicular carcinoma of thyroid** of at least TNM classification T2N0M0 or with existence of spread to other organs or lymph nodes.
- **Melanoma** diagnosed as malignant and invasive to at least 1.5 mm Breslow thickness or greater or with histological evidence of ulceration. All other skin cancers are excluded unless there is existence of spread to other organs or lymph nodes.
- **Hodgkin's/Non-Hodgkin's Lymphoma** of at least stage two or above.
- Other cancers not listed above including **Breast cancer, Bowel cancer, Lung cancer, Leukaemia** and **Cervical cancer** when they are diagnosed as having progressed to at least TNM classification T1N0M0 (stage 1) or greater.
- Cancers requiring surgery to remove an entire diseased organ to arrest the spread of malignancy, or surgery to remove the cancer which is followed up with either radiotherapy or chemotherapy. The treatment must be considered to be the most appropriate and medically necessary treatment by a *Specialist Medical Practitioner*. Preventative surgery to remove an organ prior to the occurrence of cancer where there is family history or proven genetic predisposition to a specific cancer is excluded.

In all cases the following conditions are excluded from this definition:

- Any cancer which falls below the criteria set out above.
- All Carcinoma in Situ and precancerous lesions including CIN 1, CIN 2 and CIN 3.
- Tumours that are a reoccurrence or metastases of a tumour that first occurred within the 3 month period following the *Commencement Date* or *Reinstatement Date*.

Benign Brain Tumour

Benign Brain Tumour means a non-cancerous tumour in the brain, cranial nerves or meninges which is histologically described and either:

› Producing neurological damage and functional impairment which a *Specialist Medical Practitioner* considers to be permanent, or

› Requiring surgery for its removal.

A tumour in the pituitary gland will only be covered under this definition provided it produces neurological damage and functional impairment which a *Specialist Medical Practitioner* considers to be permanent, or requires a craniotomy for its removal.

Neurological damage and functional impairment includes but is not 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 neuro-imaging investigation (for example a CT or MRI scan) and appropriate clinical findings by a *Specialist Medical Practitioner*.

The following conditions are excluded from this definition:

› Cysts, granulomas and cerebral abscesses

› Malformations in or of the arteries or veins of the brain

› Haematomas

Kidney Failure

Kidney Failure means end stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which the *Insured* is undergoing regular dialysis.

Loss of Limbs and Sight

Loss of Limbs and Sight means the total and permanent loss of the use of:

› Two or more limbs, or

› The sight in both eyes, or

› One limb and the sight of one eye.

For the purpose of this definition a limb means at least an entire hand or an entire foot and loss of sight, either aided or unaided, to the extent of 6/60 or less, or the field of vision is restricted to 20 degrees or less.

Major Head Trauma

Major Head Trauma means an injury to the head which has caused permanent neurological impairment confirmed by a *Specialist Medical Practitioner* at least three months after the injury resulting in either:

› At least 25% permanent impairment of whole person function as defined by the "American Medical Association's Guides to the Evaluation of Permanent Impairment", or

› The total and irreversible inability to perform at least one of the Activities of Daily Living (definition follows) without the assistance of another person.

Major Organ Transplant

Major Organ Transplant means the actual undergoing or placement on an official waiting list in New Zealand or Australia of an organ transplant to the *Insured* of one or more of the following organs:

- Complete heart
- One or both lungs
- Liver (including live donor liver transplants)
- Complete pancreas
- Complete kidney
- Bone marrow.

The transplant must be considered by a *Specialist Medical Practitioner* to be the most appropriate and medically necessary treatment due to the condition being untreatable by any means other than by an organ transplant.

Open Heart Surgery

Open Heart Surgery means the actual undergoing of open heart surgery to either:

- Treat coronary artery disease, or
- Repair or replace a heart valve as a result of heart defect or abnormality, or
- Correct any narrowing, dissection or aneurysm of the abdominal or thoracic aorta.

The procedure must be considered medically necessary by a *Specialist Medical Practitioner*.

The following conditions are excluded from this definition:

- Procedures such as angioplasty, catheter based techniques, stenting or laser relief of an obstruction,
- Any other inter-arterial or keyhole procedure.

Out of Hospital Cardiac Arrest

Out of Hospital Cardiac Arrest means a cardiac arrest which occurs outside of a hospital and is not associated with any medical procedure. The arrest must be due to cardiac asystole or ventricular fibrillation (with or without ventricular tachycardia) and be documented by an electrocardiogram (ECG).

Paralysis

Paralysis means the total and permanent paralysis of two or more limbs with a 'limb' meaning at least an entire hand or an entire foot. Included under this definition are paraplegia, hemiplegia, tetraplegia, quadriplegia and diplegia.

Severe Heart Attack

Severe Heart Attack means an acute myocardial infarction, being the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be confirmed by a *Specialist Medical Practitioner* and evidenced by a 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:

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

If the diagnosis is unable to be supported by at least three of the above criteria, then the definition will be considered to be met based on evidence showing the *Insured*'s left ventricular ejection fraction to be 50% or less (as measured three months after the event).

The following conditions are excluded from this definition:

- A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease
- Other acute coronary syndromes including but not limited to angina pectoris
- A rise and/or fall in cardiac biomarkers in the absence of overt ischaemic disease (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity).

Severe Stroke

Severe Stroke means death of brain tissue caused by an acute cerebrovascular event due to inadequate blood supply or haemorrhage within the skull resulting in symptoms causing neurological deficit as defined below, confirmed by neuro-imaging investigation (for example a CT or MRI scan) and appropriate clinical findings by a *Specialist Medical Practitioner*.

Permanent neurological impairment should be confirmed at least three months after the stroke, and must provide clear evidence of either:

› At least 25% permanent impairment of whole person function as defined by the "American Medical Association's Guides to the Evaluation of Permanent Impairment", or

› The total and irreversible inability to perform at least one of the Activities of Daily Living (definition follows) without the assistance of another person.

The following conditions are excluded from this definition:

› Transient ischaemic attacks and reversible ischaemic neurological deficit

› Cerebral injury resulting from trauma or arterial hypoxia

› Vascular disease affecting solely the eye or optic nerve

› Migraine and vestibular disorders

› Incidental neuro-imaging findings without clearly related symptoms.

Provision for Enhanced Medical Procedures

From time to time medical procedures used for diagnosis of a Critical Condition Covered are updated or replaced by more advanced medical diagnostic testing procedures.

If this circumstance arises upon claim, then *we* may apply an alternative medical test or medical diagnostic testing procedure acceptable to *us* in order to obtain a result similar to the medical diagnostic testing procedure outlined in the list of Critical Conditions Covered.

Activities of Daily Living

For Major Head Trauma and Severe Stroke, *we* refer to the *Insured*'s inability to perform Activities of Daily Living. Activities of Daily Living means the following activities of the *Insured*:

1. Bathing and showering.
2. Dressing and undressing.
3. Eating and drinking.
4. Using the toilet.
5. Getting in and out of bed, chair or wheelchair, or moving from place to place (with or without a wheelchair or other prosthetic device).

When *you* are not covered by the Critical Condition Benefit

When the circumstances do not match the description of 'What *you* are covered for' above

If the *Insured*'s circumstances do not match the description of 'What *you* are covered for' above then a claim will not be payable under the Critical Condition Benefit.

Exclusions (circumstances when *you* are not covered) that apply to everyone

No Critical Condition Benefit will be paid if an event (described in Critical Conditions Covered) results directly or indirectly from:

› An injury or illness where symptoms are first suffered or it is diagnosed within 3 months of the *Commencement Date* or the *Reinstatement Date*;

› An injury or an illness arising from an intentionally self-inflicted act (whether the *Insured* was sane or insane at the time).

› Alcohol or drug abuse by the *Insured*.

› The *Insured*'s involvement in an unlawful act whether or not the *Insured* is charged or convicted of an offence in respect of that act.

› Any specific exclusions detailed under each of the Critical Conditions Covered.

Additional exclusion(s) relating specifically to the *Insured* may have been added to this *Benefit*

› Any additional exclusions added to this *Benefit* will be detailed on the latest *Policy Document* for the *Policy*. No Critical Condition Benefit will be paid in the circumstances described in those additional exclusions.

When *we* were not told key information about the *Insured*

We are not required to pay or may reduce or vary the Critical Condition Benefit if:

› The *Insured* or the *Policy Owner* fail to disclose information that is material to *us*.

› Any of the information or statements provided by or on behalf of the *Insured* or the *Policy Owner* substantially or is materially incorrect and this *Policy* was issued or reinstated, or a claim considered, based on that information.

Refer to the 'Times when *we* are not required to pay a claim, or *we* may reduce or cancel *your Cover*' section on Page 26 of this document for further details.

When the Critical Condition Benefit is reduced to $0

You are not covered by the Critical Condition Benefit when the *Cover* amount has reduced to $0. This can happen when:

› A previous Critical Condition Benefit claim has been accepted or a Permanent Disability Benefit Claim has been accepted that reduces the Critical Condition Benefit amount to zero

› The *Policy Owner* requested the reduction

› The Critical Condition Benefit has expired due to the *Insured's* age (this does not affect *your* ability to claim if the critical condition was diagnosed prior to the expiry).

When the *Policy* has been cancelled

You are not covered by the Critical Condition Benefit if the *Policy* has been cancelled , unless the event occurred before cancellation. The cancellation could have been at the *Policy Owner's* request, or by *us* for non-payment of premium - *see 'We* will cancel *your Policy* if the premiums are not paid' in the 'Paying *your* premiums' section for details.

What to expect if *you* claim on this *Cover*

Some examples of what *we* may ask *you* to provide that will help *us* assess and pay *your* claim

› Critical Condition claim form completed by the *Insured* and their *Specialist Medical Practitioner*. Claim forms are completed at *your* expense.

› Copy of all historical and current specialist reports and test results that relate to the *Insured's* condition.

› The *Insured* may be asked to undergo further examination by a *Specialist Medical Practitioner.*

The above examples are not everything *we* may ask for as *we* could also ask for other information depending on the circumstances of the claim. *We* will not assess any claim until all the information requested has been provided to *us*.

What happens when a Critical Condition Benefit claim is approved

› *We* will ask the *Policy Owner* to complete and return a discharge form to *us*. The claim will then be paid to the *Policy Owner*, unless otherwise agreed by the *Policy Owner* and *us*.

› Critical Condition Benefit claims are paid only once, and when a claim is paid the Critical Condition Benefit will end.

› The Permanent Disability Benefit *Cover* amount (if held) will be reduced by the amount of the Critical Condition Benefit claim paid.

› The Death & Terminal Illness Benefit *Cover* amount will be reduced by the amount of the Critical Condition Benefit claim paid.

› Following payment of a Critical Condition Benefit claim, if there is a Death & Terminal Illness Benefit remaining, any other remaining *Benefits* on the *Policy* will continue and the premium will be adjusted to reflect the reduced *Cover*. If the Death & Terminal illness Benefit *Cover* has reduced to $0 the *Policy* and any other remaining *Benefits* will end.

Permanent Disability Benefit

- Refer to *your* latest *Policy Document* for up-to-date details of total *Cover* held.
- The Permanent Disability Benefit pays a once only portion of the Death and Terminal Illness Benefit in advance so any claims accepted will reduce the Death and Terminal Illness Benefit and any Critical Condition Benefit on this *Policy*. Refer to the 'What to expect if *you* claim on this *Cover*' section for more details.
- Accepted Permanent Disability Benefit claims are paid six months after the *Insured* becomes Permanently Disabled, or after any Temporary Disability Benefit claim has ended if that *Benefit* is also held.
- *Cover* is valid while the *Insured* is living in New Zealand, Australia, European Union Member States, United Kingdom, United States of America or Canada.
- *Cover* expires on the *Anniversary Date* following the *Insured*'s 65th birthday

What *you* are covered for

We will pay the Permanent Disability Benefit once only if the *Insured* becomes Permanently Disabled (definition follows) and all the claim requirements are met.

- If the Temporary Disability Benefit is included on the *Policy*, *we* will pay any accepted claim for the Permanent Disability Benefit once any Temporary Disability Benefit claim being paid has ended. *We* may decide to pay the Permanent Disability Benefit claim earlier than this, which would end the Temporary Disability Benefit claim.
- If the Temporary Disability Benefit is not included on the *Policy*, *we* will pay any accepted claim for the Permanent Disability Benefit on the expiry of six months from the *Insured* becoming Permanently Disabled.

The amount paid will be the amount shown in the latest *Policy Document* less any claims already accepted for the Critical Condition Benefit if held under this *Policy*.

TO MAKE A CLAIM:

Call *BNZ Life* 0800 808 648 or +64 4 474 9702 if calling from overseas

Have a read through the *Benefit* details and refer to the 'What to expect if *you* claim on this *Cover*' section for more information about claiming on this *Cover*.

How *we* will determine whether the *Insured* is Permanently Disabled

To enable *us* to determine whether the *Insured* is Permanently Disabled *we* may require the *Insured* to undergo an assessment by a *Specialist Medical Practitioner*.

We will determine whether the *Insured* is Permanently Disabled if they meet any one of the three definitions in the table below.

If at the time of illness or injury the *Insured*:	Permanent Disability and Permanently Disabled mean
Was engaged in an occupation for financial reward for 20 hours or more per week.	The *Insured* is as a direct consequence of the injury or illness wholly prevented by disability from ever again being able to engage in any employment, for which the *Insured* is reasonably fitted by knowledge, training, education or past work experience.
Was not engaged in an occupation for financial reward for 20 hours or more per week.	The *Insured* is, as a direct consequence of the injury or illness, prevented by the disability from ever again being able to perform at least three Activities of Daily Living (definition follows) without the assistance of another person.
Has suffered total and permanent loss of function.	As a direct consequence of the injury or illness the *Insured* has suffered the total and permanent loss of use of either: › Two or more limbs, or › The sight of both eyes, or › One limb and the sight of one eye. For the purpose of this definition a limb means at least an entire hand or an entire foot and loss of sight, either aided or unaided, to the extent of 6/60 or less, or the field of vision is restricted to 20 degrees or less.

Activities of Daily Living

Where the *Insured* was not engaged in an occupation for financial reward for 20 hours or more per week at the time of the illness or injury *we* refer to the inability to perform Activities of Daily Living. Activities of Daily Living means the following activities of the *Insured*:

1. Bathing and showering.
2. Dressing and undressing.
3. Eating and drinking.
4. Using the toilet.
5. Getting in and out of bed, chair or wheelchair, or moving from place to place (with or without a wheelchair or other prosthetic device).

When *you* are not covered by the Permanent Disability Benefit

When the circumstances do not match the description of 'What *you* are covered for' above

If the *Insured's* circumstances do not match the description of 'What *you* are covered for' above then a claim will not be payable under the Permanent Disability Benefit.

Exclusions (circumstances when *you* are not covered) that apply to everyone

No Permanent Disability Benefit will be paid if:

› The *Insured* is living outside New Zealand, Australia, European Union Member States, United Kingdom, United States of America or Canada. A claim will be considered by *us* if the *Insured* returns to one of these countries while the claim is submitted and assessed.

› The Permanent Disability results directly or indirectly from:

- An injury or an illness arising from an intentionally self-inflicted act (whether the *Insured* was sane or insane at the time)
- Alcohol or drug abuse by the *Insured*
- The *Insured's* involvement in an unlawful act whether or not the *Insured* is charged or convicted of an offence in respect of that act.

Additional exclusion(s) relating specifically to the *Insured* may have been added to this *Benefit*

› Any additional exclusions added to this *Benefit* will be detailed on the latest *Policy Document* for the *Policy*. No Permanent Disability Benefit will be paid in the circumstances described in those additional exclusions.

When *we* were not told key information about the *Insured*

We will not be required to pay or may reduce or vary the Permanent Disability Benefit if:

› The *Insured* or the *Policy Owner* fail to disclose information that is material to *us*.

› Any of the information or statements provided by or on behalf of the *Insured* or the *Policy Owner* is substantially or materially incorrect and this *Policy* was issued or reinstated, or a claim considered, based on that information.

Refer to the 'Times when *we* are not required to pay a claim, or *we* may reduce or cancel *your Cover*' section on Page 26 of this document for further details.

When the Permanent Disability Benefit is reduced to $0

You are not covered by the Permanent Disability Benefit when the *Cover* amount has reduced to $0. This can happen when:

› A previous claim has been accepted

› The *Policy Owner* requested the reduction

› If the Permanent Disability Benefit has expired due to the *Insured's* age.

When the *Policy* has been cancelled

You are not covered by the Permanent Disability Benefit if the *Policy* has been cancelled, unless the event occurred before cancellation. The cancellation could have been at the *Policy Owner's* request or by *us* for non-payment of premium – see '*We* will cancel your *Policy* if the premiums are not paid' in the 'Paying *your* premiums' section for details.

What to expect if *you* claim on this *Cover*

Some examples of what *we* may ask *you* to provide that will help *us* assess and pay *your* claim

› Permanent Disability claim form completed by the *Insured* and their *Specialist Medical Practitioner*. Claim forms are completed at *your* expense.

› Copy of all historical and current specialist reports and test results that relate to the *Insured's* condition.

› The *Insured* may be required to undergo further examinations by a *Specialist Medical Practitioner*.

› The *Insured* may also be required to complete vocational and functional assessments.

The above examples are not everything *we* may ask for as *we* could also ask for other information depending on the circumstances of the claim. *We* will not assess any claim until all the information requested has been provided to *us*.

What happens if the *Insured* can't do their usual job, but could do other jobs based on their skills and experience

The Permanent Disability Benefit covers a person when they are unable to ever again, engage in any employment for which they are reasonably fitted by knowledge, training, education or past work experience. This means that *you* cannot claim *your* Permanent Disability Benefit unless the *Insured* is unable to ever again return to any job they could reasonably be expected to be able to do based on their skills and experience.

For example, if the *Insured* was working as a builder and suffered an illness that mean they could never work as a builder again:

› A claim would not be paid if the *Insured* could reasonably be expected do other building related work, such as building site supervision, completing building reports, or providing building consents.

› A claim would not be paid if the *Insured* had previously trained and worked as a chef and the nature of the disability meant they could reasonably be expected to perform this role again.

› A claim would be paid if the *Insured* could not perform their role as a builder or any other role that they had skills and experience for.

This example has been simplified to help explain how Permanent Disability Benefit claims work. Every *Insured* has different skills and experience, and every disability suffered will have different impacts on the *Insured's* ability to return to employment. To help *us* assess a claim and determine if the *Insured* meets the requirements for a Permanent Disability Benefit claim to be paid, *we* may seek independent specialist input or require other assessments to be completed as noted above.

What happens when a Permanent Disability Benefit claim is approved

› If a Temporary Disability Benefit is also included on the *Policy*, *we* will pay any accepted claim for the Permanent Disability Benefit once any Temporary Disability Benefit claim being paid has ended. *We* may decide to pay the Permanent Disability Benefit claim earlier than this, which would end the Temporary Disability Benefit claim.

› If the Temporary Disability Benefit is not included on the *Policy*, *we* will pay any accepted claim for the Permanent Disability Benefit on the expiry of six months from the *Insured* becoming Permanently Disabled.

› *We* will ask the *Policy Owner* to complete and return a discharge form to *us*. The claim will then be paid to the *Policy Owner*, unless otherwise agreed by the *Policy Owner* and *us*.

› Permanent Disability Benefit claims are only paid once. When a claim is paid the Permanent Disability Benefit will end, any Temporary Disability Benefit or Redundancy Benefit included on the *Policy* will also end.

› The Critical Condition Benefit *Cover* amount (if held) will be reduced by the amount of the Permanent Disability Benefit claim paid.

› The Death & Terminal Illness Benefit *Cover* amount will be reduced by the amount of the Permanent Disability Benefit claim paid.

› Following payment of a Permanent Disability Benefit, if there is a Death & Terminal Illness Benefit remaining, any other remaining *Benefits* on the *Policy* will continue and the premium will be adjusted to reflect the reduced *Cover*. If the Death & Terminal illness Benefit *Cover* has reduced to $0 the *Policy* and any other remaining *Benefits* will end completely.

Temporary Disability Benefit

- Refer to *your* latest *Policy Document* for up-to-date details of:
  - Total *Cover* held.
  - *Stand Down Period*
  - *Benefit Term*
- *Cover* is valid worldwide, however if the *Insured* is living outside New Zealand *we* will pay a claim for a maximum of 90 days.
- *Cover* expires on the *Anniversary Date* following the *Insured's* 65th birthday

What *you* are covered for

We will pay the Temporary Disability Benefit to the *Policy Owner* if the *Insured* is continuously unable to work in any capacity due to illness or injury for at least 30 days and continues to be Totally Disabled or Partially Disabled (definition follows) beyond the end of the *Stand Down Period*.

The *Stand Down Period* commences on the later of:

- The date the *Insured* ceased work as a result of the disability
- The date of the event that caused the disability
- The date the *Insured* consulted with an appropriate *Registered Medical Practitioner* in relation to the illness or injury that caused the disability.

If payable, the Temporary Disability Benefit amount paid will be the amount shown in the latest *Policy Document* adjusted as described in the 'How claims are calculated while the *Insured* is Totally Disabled' or 'How claims are calculated while the *Insured* is Partially Disabled' sections. The amount paid will be calculated each month a claim continues and will depend on whether the *Insured* is Totally Disabled or Partially Disabled in that month.

TO MAKE A CLAIM:

Call *BNZ Life* 0800 808 648 or +64 4 474 9702 if calling from overseas

Have a read through the *Benefit* details and refer to the 'What to expect if *you* claim on this *Cover*' section for more information about claiming on this *Cover*.

How *we* will determine whether the *Insured* is disabled

When determining whether the *Insured* is Totally Disabled, Partially Disabled or not disabled, *we* may require the *Insured* to undergo an assessment by a *Specialist Medical Practitioner*. *We* will also consider:

- Available medical evidence received from an appropriate *Registered Medical Practitioner*
- Any other relevant considerations directly related to the *Insured's* medical condition.

Each month *we* will assess a claim and will determine whether the *Insured* is Totally Disabled or Partially Disabled based on the following:

If at the time of illness or injury the *Insured* was/is:	Total Disability and Totally Disabled mean	Partial Disability and Partially Disabled mean
Engaged in an occupation for financial reward for 20 hours or more per week.	The inability of the *Insured* solely due to illness or injury to carry out the important duties of his or her occupation on an ongoing basis for 7 hours or more per week	The *Insured*: › Has returned, or is capable of returning, to paid employment for 7 hours or more per week, and › Is unable to generate more than 80% of their Pre-Disability Income (definition follows) solely due to illness or injury.

Continued...

If at the time of illness or injury the *Insured* was/is:	Total Disability and Totally Disabled mean	Partial Disability and Partially Disabled mean
Not engaged in an occupation for financial reward for 20 hours or more per week.	The *Insured* is as a direct consequence of illness or injury prevented from being able to perform three or more Activities of Daily Living (definition follows) without the assistance of another person on a continuous monthly basis	There is no cover for Partial Disability
Noted as a 'Homemaker' in the *Policy Document* (regardless of how many hours they were/are working).	The *Insured* is as a direct consequence of illness or injury prevented from being able to perform three or more Activities of Daily Living (definition follows) without the assistance of another person on a continuous monthly basis	There is no cover for Partial Disability

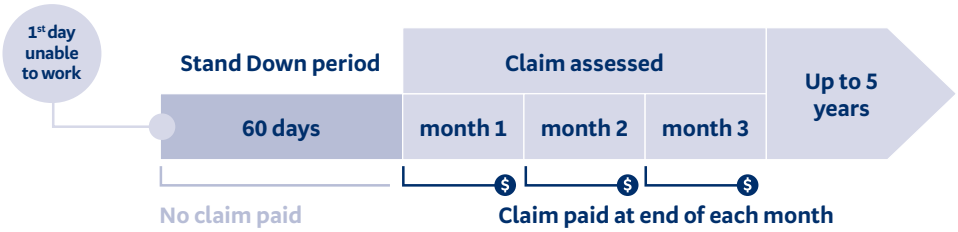
Activities of Daily Living

Where the *Insured* is noted as a 'Homemaker' or was not engaged in an occupation for financial reward for 20 hours or more per week at the time of the illness or injury *we* refer to the inability to perform Activities of Daily Living. Activities of Daily Living means the following activities of the *Insured:*

1. Bathing and showering.
2. Dressing and undressing.
3. Eating and drinking.
4. Using the toilet.
5. Getting in and out of bed, chair or wheelchair, or moving from place to place (with or without a wheelchair or other prosthetic device).

Claims are paid after the completion of the *Stand Down Period* and are paid at the end of each month

The following is an example of how this may work for a Temporary Disability Benefit with a 60 day *Stand Down Period* and 5 year *Benefit Term*.



How *we* work out the maximum length of time a claim will be paid for

The maximum length of time (in total) the Temporary Disability Benefit will be paid for any one condition or related condition is the *Benefit Term*.

We may restrict the maximum *Benefit Term* under the following circumstances:

- Claim payments arising from mental illness diagnosed by an appropriate *Registered Medical Practitioner* will be limited to a maximum 24 months in total across all occurrences. Mental illness can include but is not limited to depression, anxiety, phobias or stress related disorders.
- The Temporary Disability Benefit will be paid for a maximum of 90 days whilst the *Insured* is living outside New Zealand, unless otherwise agreed by *us*. A claim may be paid for longer if the *Insured* returns to living in New Zealand.
- Claim payments will cease on the *Insured's* 67th birthday regardless of the *Benefit Term* noted.

Where the condition is a relapse of a previous condition that a claim was paid for

A claim payment will not be subject to the *Stand Down Period* if the claim is within 6 months of the last payment of a Temporary Disability Benefit claim, and the new claim is for the same or a related condition.

When *you* are not covered by the Temporary Disability Benefit

When the circumstances do not match the description of 'What *you* are covered for' above

If the *Insured's* circumstances do not match the description of 'What *you* are covered for' above then a claim will not be payable under the Temporary Disability Benefit.

Exclusions (circumstances when *you* are not covered) that apply to everyone

No Temporary Disability Benefit will be paid if the Total Disability or the Partial Disability results directly or indirectly from:

- The normal effects of pregnancy, childbirth or miscarriage unless the pregnancy results in complications which lead to the Total Disability or Partial Disability lasting more than 90 days after the end of the pregnancy, in which case the *Stand Down Period* will start from the 91st day
- An injury or an illness arising from an intentionally self-inflicted act (whether the *Insured* was sane or insane at the time)
- Alcohol or drug abuse by the *Insured*
- The *Insured's* involvement in an unlawful act whether or not the *Insured* is charged or convicted of an offence in respect of that act
- Mental illness where the *Insured* is self-employed, on contract or running their own business, if the diagnosis is less than 2 years after the *Commencement Date* or *Reinstatement Date*. Mental illness includes but is not limited to depression, anxiety, stress related disorders or phobias.

Additional exclusion(s) relating specifically to the *Insured* may have been added to this *Benefit*

- Any additional exclusions added to this *Benefit* will be detailed on the latest *Policy Document* for the *Policy*. No Temporary Disability Benefit will be paid in the circumstances described in those additional exclusions.

Not following treatment recommendations may impact a claim

We may decline to pay a claim or may cease payment of the Temporary Disability Benefit if the *Insured* refuses, or does not comply with, any medical or surgical treatment recommended by an appropriate *Registered Medical Practitioner*.

When *we* were not told key information about the *Insured*

We are not required to pay or may reduce or vary the Temporary Disability Benefit if:

- The *Insured* or the *Policy Owner* fail to disclose information that is material to *us*.
- Any of the information or statements provided by or on behalf of the *Insured* or the *Policy Owner* is substantially or materially incorrect and this *Policy* was issued or reinstated or a claim considered, based on that information.

Refer to the 'Times when *we* are not required to pay a claim, or *we* may reduce or cancel *your Cover*' section on Page 26 of this document for further details.

When the Temporary Disability Benefit is reduced to $0

You are not covered by the Temporary Disability Benefit when the *Cover* amount has reduced to $0. This can happen when:

- A Permanent Disability Benefit claim has been paid
- The *Policy Owner* requested the reduction
- The Temporary Disability Benefit has expired due to the *Insured's* age (this does not affect *your* ability to claim for a temporary disability if the *Insured's* circumstances match the description of 'What *you* are covered for' above prior to the expiry).

When the *Policy* has been cancelled

You are not covered by the Temporary Disability Benefit if the *Policy* has been cancelled, unless the event occurred before cancellation. The cancellation could have been at *your* request, or by *us* for non-payment of premium – see '*We* will cancel *your Policy* if the premiums are not paid' in the 'Paying *your* premiums' section for details.

How claims are calculated while the *Insured* is Totally Disabled

The amount of the Temporary Disability Benefit will be the *Cover* shown in the latest *Policy Document*, adjusted as follows:

› Reduced by any after tax income (including, but not limited to, sick leave payments) or after tax benefit from any other insurer, persons or organisations being received or entitled to be received by the *Insured* because of illness or injury to the *Insured* (including, but not limited to, Accident Compensation Corporation 'ACC' payments), and

› Restricted to the lesser of $2,500 per month or the *Cover* shown for Temporary Disability in the *Policy Document*, where the *Insured* is:

- Not working due to being unemployed, on extended leave without pay or parental leave at the time of claim, and the period where they have not been working exceeds 9 months, or
- Self-employed or running their own business for less than 2 years.

Example 1:

› The *Insured* is unable to work due to illness.
› The temporary disability cover is $4,000 per month.
› The *Insured* is not entitled to receive a sickness benefit, ACC or any other income related to the illness.

The claim for the month would be $4,000.

Temporary disability cover	$4,000
Less other income	$0
Amount of claim	**$4,000**

Example 2:

› The *Insured* is unable to work due to illness.
› The temporary disability cover is $4,500 per month.
› The *Insured* has another policy that pays $1,500 during the month because of the illness.

The claim for the month would be reduced to $3,000.

Temporary disability cover	$4,500
Less other income	$1,500
Amount of claim	**$3,000**

Example 3:

› The *Insured* is unable to work due to injury.
› The temporary disability cover is $4,500 per month.
› ACC pays the *Insured* income of $4,700 during the month.

The claim for the month would be $0.

Temporary disability cover	$4,500
Less income from ACC	$4,700
Amount of claim	**$0**

How claims are calculated while the *Insured* is Partially Disabled

The amount of the Temporary Disability Benefit will be the *Cover* shown in the latest *Policy Document*, adjusted as follows:

› Reduced by the proportion of Pre-Disability Income (definition follows) earned, or capable of being earned, in the month being assessed, using the following formula:

$$\textbf{Temporary Disability Cover} \times \frac{\textbf{(Pre-Disability Income – Income While Disabled)}}{\textbf{Pre-Disability Income}}$$

› Reduced by any after tax benefit from any other insurer, persons or organisations (including ACC), being received or entitled to be received by the *Insured* because of illness or injury to the *Insured*.

If *we* determine the *Insured* is not working to their capability, Income While Disabled (definition follows) will be calculated based on what the *Insured* could be expected to earn if the *Insured* were working to the extent of their capability as determined by an appropriate *Registered Medical Practitioner.*

Example 1:

› Prior to being injured the *Insured* was earning $9,000 per month.
› The temporary disability cover is
› $4,500 per month.
› After a few months, the *Insured* can only return to work part time and earns $1,000 during the month.

The *Insured* receives $1,500 in the month from ACC.

The claim for the month would be calculated as follows:

$4,500 X ($9,000 - $1,000) / $9,000	$4,000
Less income from ACC	$1,500
Amount of claim	**$2,500**

Example 2:

› Prior to being injured the *Insured* was earning $9,000 per month.
› The temporary disability cover is $4,500 per month.
› After a few months, the Insured can only return to work part time and earns $1,000 during the month.
› The *Insured* receives $3,000 in the month from ACC.

The claim for the month would be calculated as follows:

$4,500 X ($9,000 - $1,000) / $9,000	$4,000
Less income from ACC	$3,000
Amount of claim	**$1,000**

Example 3:

› Prior to a serious illness the *Insured* was earning $8,000 per month.
› The temporary disability cover is $4,000 per month.
› After a few months, the *Insured* can only return to work part time and earns $2,000 in the month.
› The *Insured* is not entitled to receive a sickness benefit, ACC or any other illness related income during the month.

The claim for the month would be calculated as follows:

$4,000 X ($8,000 - $2,000) / $8,000	$3,000
Amount of claim	**$3,000**

Income While Disabled means

When the *Insured* is employed

The total remuneration package received or entitled to be received by the *Insured* while they are disabled.

› Total remuneration package includes salary, wages, commissions, bonuses, overtime payments, pre-tax Kiwisaver contributions, motor vehicle allowances and fringe benefits (as that term is defined in section CX2 of the Income Tax Act 2007).

Income While Disabled does not include other unearned income which is not from the *Insured*'s occupation such as dividends, interest, investment income, rental income, earned or received by the *Insured*.

When the *Insured* is self-employed, on contract or a business owner

The *Insured*'s salary and wages (calculated as per 'When the *Insured* is employed' above), and share of net profit generated from their occupation within the entity/entities or businesses the *Insured* is associated with which they receive, or are entitled to receive, while they are disabled.

Net profit (before the deduction of income tax) is calculated by:

› Adding the gross earnings across the entities or businesses the *Insured* is associated with,

› Less any expenses incurred in producing the gross earnings, referred to in the point above, across the entities or businesses the *Insured* is associated with.

Income While Disabled does not include other unearned income which is not from the *Insured*'s occupation such as dividends, interest, investment income, rental income, earned or received by the *Insured*.

Pre-Disability Income means

When the *Insured* is employed

The total remuneration package earned by the *Insured* for the 12 consecutive months immediately prior to the *Insured* becoming disabled.

› Total remuneration package includes salary, wages, regular commissions, regular bonuses, regular overtime payments, pre-tax Kiwisaver contributions, motor vehicle allowances and fringe benefits (as that term is defined in section CX2 of the Income Tax Act 2007).

› Regular refers to an average over the 36 consecutive months immediately prior to the *Insured* becoming disabled.

Pre-Disability Income does not include other unearned income which is not from the *Insured*'s occupation such as dividends, interest, investment income, rental income, earned or received by the *Insured*.

When the *Insured* is self-employed, on contract or a business owner

The *Insured*'s salary and wages (calculated as per 'When the *Insured* is employed' above), and share of net profit generated from their occupation within the entity/entities or businesses the *Insured* is associated with, over the 12 consecutive months immediately prior to the *Insured* becoming disabled.

Net profit (before the deduction of income tax) is calculated by:

› Adding the gross earnings across the entities or businesses the *Insured* is associated with,

› Less any expenses incurred in producing the gross earnings, referred to in the point above, across the entities or businesses the *Insured* is associated with.

Pre-Disability Income does not include other unearned income which is not from the *Insured*'s usual occupation, such as dividends, interest, investment income, rental income, earned or received by the *Insured*.

What to expect if *you* claim on this *Cover*

Make sure *you* get in touch early

You must notify *us* of any Temporary Disability Benefit claim no later than 30 days after the *Stand Down Period*. *We* may accept claims notified later than this date at *our* absolute discretion, in which case any claim paid may be reduced.

Some examples of what *we* may ask *you* to provide that will help *us* assess and pay *your* claim

- Temporary Disability claim forms completed by the *Insured* and a *Registered Medical Practitioner* or a *Specialist Medical Practitioner*. Claim forms are completed at *your* expense.
- Copy of all historical and current medical reports and test results that relate to the *Insured*'s incapacity to work.
- The *Insured* may be required to complete an examination by a *Specialist Medical Practitioner*.
- The *Insured* may also be required to complete vocational and functional assessments.
- Evidence of the *Insured*'s Pre-Disability Income e.g. payslips, summary of earnings or financial statements (which will help *us* assess claims if the *Insured* is able to return to work in the future on a part-time basis).

Provided the *Insured* continues to be Temporarily or Partially Disabled beyond the end of the *Stand Down Period*, for each month *you* claim *we* will ask for:

- Progress Reports completed by the *Insured* and a *Registered Medical Practitioner* or *Specialist Medical Practitioner* confirming ongoing Total Disability or Partial Disability.
- Evidence of any Income While Disabled received e.g. payslips or financial statements.

The above examples are not everything *we* may ask for as *we* could also ask for other information depending on the circumstances of the claim. *We* will not assess any claim, or make a monthly claim payment, until all the information requested has been provided to *us*.

What happens when a Temporary Disability Benefit claim is approved

- The ongoing payment of the claim is subject to *us* continuing to receive satisfactory evidence of the eligibility to claim.
- *We* will then assess whether the *Insured* is still totally disabled or partially disabled, and calculate the amount of the claim to pay (these calculations are described earlier in this section).
- Claims are paid at the end of the monthly period being assessed.
- Claims are paid to the *Policy Owner*, unless otherwise agreed by the *Policy Owner* and *us*.
- The monthly assessment and payment will continue until the *Insured* no longer meets the Total Disability or Partial Disability definitions; or until the end of the *Benefit Term*, whichever is sooner.
- The premiums for the Temporary Disability Benefit and any Permanent Disability Benefit will be waived during the period of payment of the Temporary Disability Benefit claim and will be payable again when the claim has ended. The *Policy Owner* must continue to pay all other applicable premiums under the *Policy* throughout the period of the claim.

The *Insured* can work part time if they are able once a Temporary Disability Benefit claim has been accepted

To be able to make a Temporary Disability claim the *Insured* must be completely unable to work for 30 consecutive days and continue to be Totally Disabled or Partially Disabled beyond the end of the *Stand Down Period*. After this period the *Insured* may be able to have a gradual return to work without affecting your ability to claim. However, once the *Insured* is earning, or capable of earning up to 80% of their Pre-Disability Income (calculated on a pro rata per month basis) a claim will no longer be paid.

Assistance with vocational retraining and rehabilitation may be available

To assist the *Insured* to return to paid work while claiming the Temporary Disability Benefit, *we* will reimburse the *Insured* for any retraining or rehabilitation expenses, if:

- *We* agree to their retraining or rehabilitation expenses before they are incurred; and
- Expenses are not reimbursed from other sources such as the ACC.

The maximum payment will be the lesser of:

- The actual costs of the rehabilitation retraining measure or programme agreed by *us*; or
- 3 times the monthly Temporary Disability *Cover*; or
- $10,000.

Once a claim has finished

You may need to claim on the Temporary Disability Benefit more than once, so the cover can continue after *you* have made a claim. When a claim ends, the premiums for any Temporary Disability Benefit and any Permanent Disability Benefit will be payable again allowing the cover to continue.

We recommend *you* seek tax advice specific to *your* situation

We recommend *you* seek tax advice specific to *your* situation and the tax deductibility of any premiums including whether *you* need to pay tax on any potential claims received under this *Benefit*.

Our understanding of the tax position of this Temporary Disability Benefit

Our understanding of the current tax position of this Temporary Disability Benefit is that:

› Premiums are not deductible for tax purposes; and

› Claim proceeds are not tax assessable.

What *we* will do if this position ever changes

If the tax position is ever changed by the Inland Revenue Department so that premiums become deductible and claim proceeds become taxable then *we* will confirm that *we* will allow the Temporary Disability Benefit to be increased as follows:

› An amount required to ensure that the Temporary Disability Benefit after the deduction of tax is the equivalent of the Temporary Disability Benefit that would have been paid immediately prior to any such change in tax position

› *We* will accept the increase on the same terms as the original *Cover* without any further medical or financial evidence

› *We* will notify the *Policy Owner* in writing as soon as reasonably practicable when *we* become aware of any such change in tax position

› The *Policy Owner* must then make a request to *us* to increase the amount of *Cover* accordingly

› *We* must receive any such increase request within 60 days of our notification of the change in tax position, otherwise the offer to increase without underwriting will expire

› The increase will only take place if the *Insured* is not claiming under the Temporary Disability Benefit, otherwise the increase will occur when the claim has ended.

At the time of any such increase the premium payable for the Temporary Disability Benefit will also increase proportionally.

Redundancy Benefit

- Refer to *your* latest *Policy Document* for up-to-date details of total *Cover* held.
- *Stand Down Period* 30 days
- *Benefit Term* 6 months
- *Cover* must be in place for at least 6 months before the *Insured* is first advised of the potential to be made Redundant to be able to claim on this *Benefit*.
- *Cover* is valid while the *Insured* is working in New Zealand, or working overseas on secondment while working for a New Zealand employer.
- *Cover* expires on the *Anniversary Date* following the *Insured's* 65th birthday

What *you* are covered for

We will pay the Redundancy Benefit to the *Policy Owner* if the *Insured*:

- Is made Redundant (definition follows) and continues to be unemployed beyond the end of the *Stand Down Period*, and
- Was engaged in permanent employment working 30 hours or more per week for at least 6 consecutive months immediately prior to being given notice of Redundancy, and
- Continues to take all reasonable steps to obtain alternative permanent employment, and provides *us* with written evidence of this.

TO MAKE A CLAIM:

Call *BNZ Life* 0800 808 648 or +64 4 474 9702 if calling from overseas

Have a read through the *Benefit* details and refer to the 'What to expect if *you* claim on this *Cover*' section for more information about claiming on this *Cover*.

How *we* will determine whether the *Insured* has been made Redundant

We will assess whether the *Insured* has been made Redundant based on the following:

Redundancy and Redundant

Redundancy and Redundant mean the involuntary loss of permanent employment of the *Insured* in New Zealand (other than by dismissal or resignation), because their position or role is no longer needed by their employer.

Date of Redundancy

Date of Redundancy means the later of:

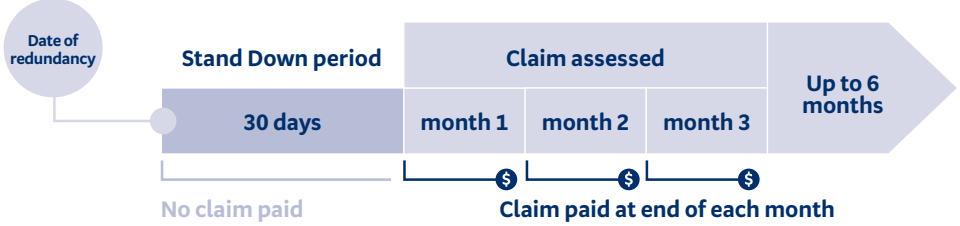
- The date that the *Insured* ceases work, or
- The end of the *Insured's* paid notice period (even if the *Insured* does not work the full notice period)

Claims are paid after the completion of the *Stand Down Period* and are paid at the end of each month

The *Stand Down Period* commences on the *Date of Redundancy*. Following the *Stand Down Period* claim payments will be made at the end of each month until the earlier of:

- The date the *Insured* is first re-employed (including self-employed) for 30 hours or more per week
- 6 months following the end of the *Stand Down Period*.

The following is an example of how this will work for a Redundancy Benefit with a 30 day *Stand Down Period*.



Claims are assessed differently when Redundancy occurs before, during or just after a planned period of Parental Leave. This is to reflect the period the *Insured* is not actively looking for work and is outlined under 'How claims are calculated if the *Insured* is on Parental Leave'.

How *we* work out the maximum length of time a claim will be paid for

The maximum length of time the Redundancy Benefit will be paid (for any single Redundancy event) is 6 months (the *Benefit Term)*.

We may restrict the maximum *Benefit Term* under the following circumstances:

- The *Insured* is re-employed, working 30 hours or more per week.
- The *Insured* is not providing satisfactory evidence of the steps they are taking to obtain alternative permanent employment. This evidence is required each month before a claim payment can be paid.

When *you* are not covered by the Redundancy Benefit

When the circumstances do not match the description of 'What *you* are covered for' above

If the *Insured's* circumstances do not match the description of 'What *you* are covered for' above then a claim will not be payable under the Redundancy Benefit.

When the *Insured* does not take all reasonable steps to find alternative permanent employment

We are not required to pay a claim and may cease payment of the Redundancy Benefit if the *Insured* does not take all reasonable steps to find alternative permanent employment.

Exclusions (circumstances when *you* are not covered) that apply to everyone

No Redundancy Benefit will be paid if the *Insured*:

- Is made Redundant or is advised of the potential for Redundancy at any time before, and anytime during the first 6 months after the *Commencement Date* or *Reinstatement Date*
- Is made Redundant from casual or seasonal employment, or a fixed term contract
- Has taken voluntary Redundancy, voluntarily resigned, or is dismissed from employment
- Is self-employed or a working director or manager where the *Insured* or the *Policy Owner* had, at the *Date of Redundancy*, effective control over the *Insured's* continued employment
- Knew or should have known of Redundancy, or the potential for Redundancy, before the *Commencement Date* or *Date of Reinstatement*
- Is living or working outside New Zealand at the *Date of Redundancy* unless it is part of a secondment while working for a New Zealand employer.

When *we* were not told key information about the *Insured*

We will not be required to pay or may reduce or vary the Redundancy Benefit if:

- The *Insured* or the *Policy Owner* fail to disclose information that is material to *us*.
- Any of the information or statements provided by or on behalf of the *Insured* or the *Policy Owner* is substantially or materially incorrect and this *Policy* was issued or reinstated, or a claim considered, based on that information.

Refer to the 'Times when *we* are not required to pay a claim, or *we* may reduce or cancel *your Cover*' section on Page 26 of this document for further details.

If the Redundancy Benefit is reduced to $0

You are not covered by the Redundancy Benefit when the *Cover* amount has reduced to $0. This can happen when:

› A Permanent Disability claim has been accepted

› The *Policy Owner* requested the reduction

› The Redundancy Benefit has expired due to the *Insured's* age (this does not affect *your* ability to claim for a redundancy that happened prior to the expiry).

When the *Policy* has been cancelled

You are not covered by the Redundancy Benefit if the *Policy* has been cancelled, unless the event occurred before cancellation. The cancellation could have been at the *Policy Owner's* request, or by *us* for non-payment of premium – see '*We* will cancel *your Policy* if the premiums are not paid' in the 'Paying *your* premiums' section for details.

How claims are calculated

The amount of the Redundancy Benefit will be the *Cover* shown in the latest *Policy Document*, adjusted as follows:

› Reduced by any other regular after tax income from wages or salary, and

› Reduced by any after tax unemployment related benefit.

These payments include any payments that the *insured* receives or is entitled to receive from any source including:

› Another insurer, person or organisation,

› Government funded sources (such as Inland Revenue Department or Work and Income New Zealand).

Any Redundancy settlement or lump sum Redundancy payment received from the *Insured's* previous employer will not impact the amount or payment of the Redundancy Benefit.

How claims are calculated if the *Insured* is on Parental Leave

Claims are assessed differently when Redundancy occurs before, during or just after a planned period of Parental Leave. This is to reflect the period the *insured* is not actively looking for work.

Parental Leave	Parental Leave means the *Insured* has taken approved government and/or employer Parental Leave to care for their new born baby (or babies) or a child (or children) who are now in their care.

If the *Insured* is made Redundant before they commence Parental Leave

Before commencing Parental Leave, claims will be assessed in accordance with the section 'What *you* are covered for'. If the *Insured* is still on claim on the birth of the child, or the date the child comes into the *Insured's* care, the Redundancy claim assessments will go on hold until the *Insured* actively commences looking for alternative permanent employment. If the *Insured* has not commenced actively looking for permanent employment within 12 months of the birth of the child (or the date the child came into the *Insured's* care) the *Benefit Term* for the Redundancy claim will end.

The *Policy Owner* must continue to pay all applicable premiums under the *Policy* throughout the period the claim is on hold.

If the *Insured* is made Redundant while they are on Parental Leave

If the *Insured* is made Redundant while on Parental Leave the Date of Redundancy will be the date the *Insured* actively commences looking for alternative permanent employment. If the *Insured* has not commenced actively looking for permanent employment within 12 months of the birth of the child (or the date the child came into the *Insured's* care) the *Benefit Term* for that Redundancy claim will end.

The *Policy Owner* must continue to pay all applicable premiums under the *Policy* throughout the period the claim is on hold.

If the *Insured* is made Redundant within 6 months of returning to work from Parental Leave

If the *Insured* is made Redundant within 6 months of returning to work (after a period of Parental Leave) the requirement for the *Insured* to have been continuously working 30 or more hours per week for 6 months will be calculated by *us* by combining:

› The time in permanent employment immediately prior to the Parental Leave, and

› The time in permanent employment following the Parental Leave

The claim will then be assessed in accordance with the section 'What *you* are covered for'.

In all cases the exclusions noted in the section 'When *you* are not covered by the Redundancy Benefit' will still apply.

What to expect if *you* claim on this *Cover*

Make sure *you* get in touch early

You must notify *us* of any Redundancy Benefit claim no later than 30 days after the *Stand Down Period*. *We* may accept claims notified later than this date at *our* absolute discretion, in which case any claim paid may be reduced.

Some examples of what *we* may ask *you* to provide that will help *us* assess and pay *your* claim

› Redundancy claim form completed by the *Insured* and their employer. Claim forms are completed at *your* expense.

› Proof of both employment and redundancy.

› Proof of the *Insured*'s registration with WINZ or another recruitment agency, including online agencies.

For each month *you* claim *we* will ask *you* for:

› A Progress Report completed by the *Insured*

› Evidence of any income from salary of wages or unemployment related benefit received by the *Insured*.

› Satisfactory evidence of the *Insured* seeking employment.

The above examples are not everything *we* may ask for as *we* could also ask for other information depending on the circumstances of the claim. *We* will not assess any claim, or make a monthly claim payment, until all the information requested has been provided to *us*.

What happens when a Redundancy Benefit claim is approved

› The ongoing payment of the claim is subject to *us* continuing to receive satisfactory evidence of the eligibility to claim.

› *We* will then calculate the amount of the claim to pay (these calculations are described earlier).

› Claims are paid at the end of the monthly period being assessed.

› Claims are paid to the *Policy Owner*, unless otherwise agreed by the *Policy Owner* and *us*.

› The monthly assessment and payment will continue until the *Insured* finds new employment for 30 hours or more per week or until the end of the *Benefit Term*, whichever is sooner.

› The premiums for the Redundancy Benefit will be waived for the period during which the Redundancy Benefit is being paid and will be payable again when the claim has ended. *The Policy Owner* must continue to pay all other applicable premiums under the *Policy* throughout the period of the claim.

Once a claim has finished

› Provided the Redundancy Benefit hasn't expired, the Redundancy Benefit will remain in place after *you* have made a claim.

› After the claim ends, the premiums for the Redundancy Benefit will restart.

› Before you can claim again on the Redundancy Benefit the *Insured* will need to have been engaged in permanent employment working 30 hours or more per week for at least 6 consecutive months.

We recommend *you* seek tax advice specific to *your* situation

We recommend *you* seek tax advice specific to *your* situation and the tax deductibility of any premiums including whether *you* need to pay tax on any potential claims received under this *Benefit*.

Our understanding of the tax position of this Redundancy Benefit

Our understanding of the current tax position of this Redundancy Benefit is that:

› Premiums are not deductible for tax purposes

› Claim benefits are not tax assessable.

What *we* will do if this position ever changes

If the tax position is ever changed by the Inland Revenue Department so that premiums become deductible and claim benefits become taxable then *we* will confirm that it will allow the Redundancy Benefit to be increased as follows:

› An amount required to ensure that the Redundancy Benefit after the deduction of tax is the equivalent of the Redundancy Benefit that would have been paid immediately prior to any such change in tax position

› *We* will accept the increase on the same terms as the original *Cover* without any further financial evidence

› *We* will notify the *Policy Owner* in writing as soon as reasonably practicable when *we* become aware of any such change in tax position

› The *Policy Owner* must then make a request to us to increase the amount of *Cover* accordingly

› *We* must receive any such increase request within 60 days of *our* notification of the change in tax position, otherwise the offer to increase without underwriting will expire

› The increase will only take place if the *Insured* is not claiming under the Redundancy Benefit, otherwise the increase will occur when the claim has ended.

At the time of any such increase the premium payable for the Redundancy Benefit will also increase proportionally.

Claiming on *your Cover*

To claim just call *us* on 0800 808 648 – *we're* here to help

Insurance is something *you* hope *you* never need to use, because when *you* do it usually means something unforeseen has happened. No doubt it will be a stressful time. *We're* here to help so even if *you're* not sure about whether *you're* able to claim for what's happened, please get in touch and *we* can go through *your* situation with *you*.

If *you* need to claim *you* can simply:

› call *us* on 0800 808 648 (+64 4 474 9702) Monday – Friday 8am – 6pm, or

› write to *us* at BNZ Life, P.O. Box 1299, Wellington.

Let *us* know as soon as something happen

Telling *us* as soon as something happens can make a big difference to the process of getting *your* claim paid.

› It means *we* can help *you* through the claims assessment process as quickly and smoothly as possible.

› *We'll* be able to let *you* know if there's anything *you* need to be doing to meet the claim requirements.

› If *you're* claiming for a monthly benefit, any delay in submitting the claim could reduce the number of payments *you'll* receive.

What will happen when *you* call *us*?

When *you* contact *us* to claim *we* will ask *you* a few questions to understand what's happened and check whether *you're* likely to have *Cover* for that situation.

If needed *we'll* send *you* a claim form to complete, and let *you* know what other information *we'll* need to be able to assess and pay *your* claim. Each *Cover* option works a little differently, and every claim is unique, so *we'll* try to let *you* know exactly what *we* need when *you* call *us* but *we* may need to ask for further information during the assessment.

Once *we* have all the information needed *we'll* do a detailed assessment of whether *your* claim is covered by comparing *your* situation with the 'What *you* are covered for' and 'When *you* are not covered by' sections of the *Benefit you* are claiming on.

We'll then let *you* know whether *we* can pay *your* claim or not. *Our* aim is to be able to assess and pay *your* claim as quickly as possible.

Making a claim does not increase *your* premium

We will not increase *your* premiums just because *you* have enquired about a potential claim or made a claim. In fact, *your* premiums may decrease if some of the *Benefits* on the *Policy* end or are reduced because *you* received a claim payment.

A claim may be reduced when there are outstanding premiums on the *Policy*

If a claim is accepted while any premiums are due and outstanding *we* may deduct the unpaid premium from the claim payable.

Additional features included with *your Cover*

Child death cover

If a child of the *Insured* (either by birth or legal adoption or is under the guardianship of the *Insured*) while aged between 3 and 10 years old suffers an accident (bodily injury caused directly and solely by violent, accidental, external and visible means and independent of any other cause) and, as a direct result of that accident, dies within 90 days of the accident's occurrence, and the claim requirements are met, *we* will pay the Child death cover of $2,000 to the *Insured*.

The Child death cover will be paid upon proof satisfactory to *us* of the validity of the claim, this can include the child's birth certificate (or other proof of age), proof of the death of the child, proof of the adoption or guardianship of the child. *We* may ask for other information depending on the circumstances of the claim.

No Child death cover will be paid if the child's death occurs as a result of an unlawful act by either the *Policy Owner* or *Insured*.

The *Policy Owner* irrevocably instructs *us* to pay any Child death cover claim to the *Insured*. Payment of a Child death cover claim does not reduce the Death and Terminal Illness Benefit.

If the *Insured* is also covered under other LifeCare policies, only one Child death cover claim will be paid in respect of each child.

Inflation proof cover

Your Cover will usually increase each year

To help protect the value of *your Cover*, *we* will automatically increase the amount of *Cover* under the Death and Terminal Illness Benefit and Critical Condition Benefit at each *Anniversary Date*.

We will be guided by the Consumer Price Index (CPI), which is an indicator of changes in prices.

We will calculate the amount of any increase and any offer will be made to the *Policy Owner* prior to the *Anniversary Date*.

Unless the offer is declined before the *Anniversary Date*, the *Cover* amounts will be increased in accordance with the offer and the premium will be adjusted to reflect the new *Cover* amounts.

When an increase to *your Cover* will not be offered

An increase will not be offered if:

› A claim has been accepted under the Critical Condition Benefit or the Permanent Disability Benefit

› The *Policy Owner* has declined the increase in two successive years.

If the *Insured* dies or is diagnosed as suffering from a Terminal Illness or Critical Condition prior to the *Anniversary Date* the claimable amount will be the amount before the CPI increase.

Times when *we* are not required to pay a claim, or *we* may reduce or cancel *your Cover*

This *Cover* is provided on the basis that the information given by the *Insured* and the *Policy Owner* is true and correct and all material facts have been disclosed. When this is not the case it may impact your *Cover*, or mean that *we* are not required to pay a claim.

Please phone *us* on 0800 808 648 or +64 4 474 9072 (if calling from overseas) if *you*:

› Are concerned there may be an incorrect statement made or material fact not disclosed during the application for *Cover*,

› Find a mistake in the *Cover* or information we have sent to *you*, or

› Have any questions relating to information *you* need to disclose.

What can happen if there are incorrect statements or a failure to disclose material facts

If either:

› The *Insured* or the *Policy Owner* fails to disclose information that is material to *us*, or

› Any of the information or statements provided by or on behalf of the *Insured* or the *Policy Owner* is substantially or materially incorrect and this *Policy* was issued or reinstated, or a claim considered based on that information

We:

› Are not required to pay a claim, and if *we* have already paid a claim *we* may recover any payments made.

› May alter the terms of *Cover* provided, reduce the *Cover*, or cancel the *Cover* of any *Benefit* under your *Policy*.

› May cancel all *Benefits* and *Cover* under your *Policy*.

Where *we* choose to alter the terms, reduce cover, or cancel any *Benefit* or the entire *Policy*, *we* will be entitled to retain all premiums paid in relation to the *Policy* up to that date. *We* may choose to make the changes effective from the *Commencement Date* or *Reinstatement Date*.

Incorrect statements / failure to disclose material facts may include:

› Information relating to any illness or injury (such as *Registered Medical Practitioner's* visit and/or recommended treatment) that the *Insured* was aware of prior to the *Commencement Date* or *Reinstatement Date* and was not disclosed to *us*

› A failure to disclose symptoms that existed prior to the *Commencement Date* or *Reinstatement Date* that would cause a reasonable person to seek diagnosis, care or treatment

› Any statement made in support of a claim that is untrue. This includes being untrue by any omission of information.

What happens when there is a misstatement of the age of the *Insured*

If an application contains a misstatement of the age of the *Insured*, *we* may vary the *Benefits* provided under this *Policy* and/or the premium. Any variation may be made only to the extent permitted by section 7 of the Insurance Law Reform Act 1977.

Make sure the money from a claim goes where *you* need it to

When a claim is paid, it is paid to the *Policy Owner* (except for Child Death Cover which is paid to the *Insured*). This means that for claims paid while the *Policy Owner* is still alive, they can decide how to put the money from the claim to good use. Alternatively, if the *Policy Owner* has died, any claims paid will become part of their estate, along with their other assets.

A Will can help carry out the *Policy Owner*'s wishes

A Will can help ensure that the money from any claim (and other assets) is passed on the way the *Policy Owner* wishes. In the absence of a Will, the law may determine how the estate is divided. Regardless of who owns this *Policy* having an up-to-date Will in place is a good idea for everyone.

For more information about creating or updating a Will please talk to *your* legal adviser.

The difference between a *Policy Owner* and an *Insured*

It's important to understand the difference between:

› The *Insured* (the person whose life is covered), and

› The *Policy Owner* (the person who the contract of insurance is with and who stands to receive the money from any claims paid).

They can be the same person, or they can be different people with different roles and rights.

Roles and Rights of the *Policy Owner* vs *Insured*			
If the *Insured* and the *Policy Owner* are the same person	**Role and right**	**If they are different**	
		Policy Owner	***Insured***
✓	Receives all claim payments^	✓	X
✓	Change or cancel the *Policy*	✓	X
✓	Receive communications about the *Policy*	✓	✓*
✓	Transfer the *Policy* ownership to someone else	✓	X
✓	Responsible for paying the premiums	✓	X

^Child death cover is payable to the *Insured*.
*Only receive a copy of the *Insured*'s health and lifestyle answers and summary of *cover* when a *Policy* is issued.

Communications about the *Policy* will be posted, delivered or sent by email to the *Policy Owner* at the *Policy Owner*'s last known address or email address advised to *us* by the *Policy Owner*. The method of communication will be at *our* discretion.

You can change who the *Policy Owner* is

To transfer the ownership of this *Policy* to someone else call *us* on 0800 808 648 or visit www.bnz.co.nz to get a Memorandum of Transfer form.

The current *Policy Owner* and new *Policy Owner* must complete the form and post it to: BNZ Insurances, PO Box 1299, Freepost Authority Number 138014, Wellington 6140.

A change of ownership is not effective until *we* register the completed Memorandum of Transfer.

This is in accordance with the Life Insurance Act 1908.

Changing *your Cover*

You can change *your* amount and type of *Cover*

The *Policy Owner* may apply to *us* to have the *Cover* updated. This includes:

› Adding or removing *Benefits* covered under the *Policy*, or

› Increasing or reducing the amount of *Cover* for a *Benefit(s)*.

A new *Policy Document* will be sent each time a change is made. The changes will be effective from the date specified in the new *Policy Document* and the premium will be adjusted to reflect the changes made.

If *Cover* is increased or added after the *Commencement Date*, the relevant *Benefit* wait periods and *Stand Down Periods* apply to the increase or addition from the date of the change.

Each time *you* add *Cover* to *your Policy*, that *Cover* will have its own LifeCare General Terms and Conditions which will be sent to *you* when the new *Cover* is issued. They may be different to previous ones *you* have received.

You can cancel this *Cover* at any time

The *Policy Owner* may cancel the *Cover* by:

› Calling 0800 808 648 or +64 4 474 9072 (if calling from overseas)

› Sending *us* a request to cancel within BNZ Internet Banking

› Contacting *us* in writing

You can cancel during *your* 'free look' period

You have a 30-day free look period to cancel the *Cover* and get *your* premiums back. This period begins on the *Commencement Date*. If *you* ask *us* to cancel within this time, *we* will cancel the *Cover* on the date *we* receive *your* request and refund any premiums *you've* paid.

The free look period also applies when *you* add new *Cover* or *you* choose to increase *your* existing *Cover*, but only to the added or increased *Cover* and any premiums relating to the increase.

You can cancel at any other time, but premiums won't be refunded

You may cancel *your Policy* at any time by contacting *us*.

If *your* premium is paid in fortnightly or monthly instalments, when *we* receive *your* request, *we* will cancel the *Policy* from the next date a premium payment is due, or if *you're* behind in *your* premium payments *we* will cancel the *Cover* immediately. *You* won't receive a refund of any premiums paid.

If *your* premium is paid annually, *we* will cancel the *Policy* and if premiums have been paid in advance, the premium will be refunded on a pro rata basis for the period after the date of cancellation.

No surrender value

There is no surrender value (accumulation of cash value over time) on this *Policy*.

Paying *your* premiums

How is *your* premium worked out?

We will calculate the premium on each *Anniversary Date*

The initial premium is shown in the letter sent with *your Policy Document*. *We* will calculate and let *you* know the premium when *your Cover* starts and on each *Anniversary Date*.

Your premium is based on:

- The total amount of *Cover* for each *Benefit*
- The initial level premium term selected for the Death and Terminal Illness and the Critical Condition Benefits
- The *Insured*'s age, gender and smoking status (premiums will generally increase with age)
- Any premium loading applied when the *Cover* was issued
- Any applicable premium discounts
- *Our* table of premiums and policy fees.

We may at *our* absolute discretion recalculate the premium at any time (including any time which is not an *Anniversary Date*) if *our* table of premiums and *Policy* fees are revised in respect of all those *Insured*.

Additional fees

An administration fee for LifeCare policies may be determined by *us* and applied to the premium if it is paid in fortnightly or monthly instalments.

We will give the *Policy Owner* at least 60 days' notice of any change in premium or administration fee which will come into effect at any time other than an *Anniversary Date*, or *we* will communicate any increase prior to the *Anniversary Date* where changes will come into effect on an *Anniversary Date*.

Who is responsible for making sure the premiums are paid?

The *Policy Owner* must ensure the premium is paid to *us* on or before the due date(s) for payment using one of the payment options *we* provide.

We will cancel *your Policy* if the premiums are not paid

This *Policy* will lapse and cease automatically if any instalment of premium remains unpaid for more than 30 days after the due date. *We* will give written notice of unpaid premium prior to lapsing a *Policy*, and when a *Policy* has lapsed, to the *Policy Owner*.

A *Policy* that has been cancelled for unpaid premiums could be reinstated (started again)

As long as the *Policy Owner* applies for reinstatement of a *Policy* within 60 days of it being cancelled for unpaid premiums the *Policy* may be reinstated at *our* discretion, and on such terms and conditions as *we* may determine.

- The *Cover* may be on different terms and conditions to those that applied to the original *Cover*.
- Any limitations to *Cover* linked to the *Commencement Date* of *your Cover* will apply again from the *Date of Reinstatement*.

To assess if *we* can offer a reinstatement *we* may require confirmation that there are no changes in respect to the *Insured*'s health and lifestyle.

The *Policy* cannot be reinstated without *our* written consent. *Our* acceptance of premiums shall not be construed as reinstatement of the *Policy* unless *we* confirm in writing to the *Policy Owner* that the *Policy* has been reinstated.

Important information about the risks of replacing any existing cover you have

As life changes, the things that are important to you, the people that depend on you, your financial commitments, and therefore the protection you need may change as well. It's a good idea to review your life insurance on a regular basis to make sure it continues to provide the protection you need.

Your needs might have changed, you might want to have all your banking and insurance in the same place, maybe someone has suggested reviewing your cover, or you just want to check you're getting the best cover or price. Whatever your reason, changing cover you already have needs careful consideration as there may be risks that result in a situation where your new cover won't pay out on a claim that your previous cover would have.

What are the risks of replacing existing cover

- Any health issues you have suffered since taking out your current cover don't impact that cover, but it's important to fully disclose your entire health history when applying for replacement cover or you may not be able to claim under the new policy.
- If there has been a change in your health, pastimes or occupation since your existing policy started your new policy may:
  - Contain restrictions or limitations that your current policy may not have.
  - Cost more to get the same or similar benefits.
- You may temporarily lose some cover when you switch to a new policy if the new policy has initial stand-down periods before claims can be made.
- The new policy may cover fewer things than your current policy. Every policy is different:
  - Cover can have a similar sounding name, but significantly different cover (particularly policies that cover disablement or serious illness).
  - Even subtle differences in the definitions used between policies can impact the cover provided (e.g. medical conditions, employment, occupation, income, etc).
- There may be differences in customer experience, service or claims processes.
- There may be differences in financial strength ratings between the old and new insurers.
  - Insurers must let you know what their financial strength rating is, and the rating scale used, so you can compare ratings.

If you don't check the details before you make changes to your cover, what you thought was going to give you better protection or be a better deal, might turn out not to.

- *Be happy that any new policy is better for you than your current cover before you apply.*
- *Check any new cover issued to make sure you got what you wanted, and whether the cover or price has changed.*
- *Do not cancel any existing cover unless your new cover has been confirmed, you're happy with it, and the cover is issued.*
- *You must contact the old insurer directly to cancel your existing policy/benefit.*

Some things to check when comparing the cover provided by two policies

Check the details of the cover provided	› Do the policies provide the same type of cover or is one more restricted? For example, an Accident Only policy won't pay a claim if you die because of illness. › Even cover that sounds similar can have significantly different cover, subtle differences in the definitions used in policies impact the cover they provide. Look out for differences in medical conditions, employment, occupation, income, etc. › Has an exclusion (a limitation in cover provided) been applied to the current or new policy? It may mean there could be times where you can't claim on that policy.
Are pre-existing conditions you may have covered?	Some policies exclude pre-existing conditions for a period of time (or permanently).
How long can cover continue?	Different covers may expire at different times or some can be kept as long as you like.
Is there an initial no cover period?	When you already have cover, this may mean you temporarily lose some of your cover if you switch to a new policy.

Some things to check when comparing the cost of cover

Check the reasons why one policy is cheaper	› Is it because it covers you for less things? › Are/were you a smoker? Smokers generally pay more for cover, but if you stop smoking you can often ask your insurer to review your premiums to get a saving. › Is there a discount on the premium? Check how long it lasts or if it stops after a while.
Different benefit options cost different amounts	This could be due to the amount of cover selected or the type of cover the benefit offers.
Will the premium change every year as you age?	Most do, and others let you fix the premium for a number of years. This can affect whether cover seems cheaper or more expensive.
Do you have any health issues, a risky occupation or dangerous hobbies	Be aware that any initial quote you're given for a new policy might change once your application has been fully assessed.

Definition of terms used throughout this document

Anniversary Date means an anniversary of the *Policy Start Date*.

Benefit / Benefits means any one or more of the Death and Terminal Illness Benefit, Critical Condition Benefit, Permanent Disability Benefit, Temporary Disability Benefit, or Redundancy Benefit where included under this *Policy*.

Benefit Term means the selected Benefit Term as shown in the latest *Policy Document* in relation to either the Temporary Disability Benefit or the Redundancy Benefit. This is the maximum length of time that a claim will be paid for any one condition/event or related conditions.

BNZ Life means BNZ Life Insurance Limited, also referred to as *we / us / our* throughout this document.

Commencement Date means the date specified in the *Policy Document* on which *Cover* commences (and, where the amount of a *Benefit* is increased or a new *Benefit* is added, means (in relation to the increase or a new *Benefit*) the date specified as the Commencement Date for that increase or that new *Benefit*).

Cover means the amounts and *Benefits* that *we* agree to insure on the *Insured* as detailed in the *Policy Document* and described in the LifeCare General Terms and Conditions relevant to the *Commencement Date(s)* of the *Cover*.

Date of Reinstatement means the date on which the *Policy* is reinstated as described under the 'Paying *your* premiums section'.

Insured means the person named on the *Policy Document* who the *Cover* relates to.

Policy means all the cover that *BNZ Life* has agreed to insure on the *Insured* as detailed in your *Policy Document* regardless of the *Commencement Date*.

Policy Document means the latest copy of the *Policy Document* sent to the *Policy Owner*, that details the *Benefits* taken to cover the *Insured*.

Policy Owner means the owner(s) of this *Policy*, the person who will receive the claim payments and who the *Policy* is formally with and is named on the *Policy Document*, also referred to as *you / your* throughout this document.

Policy Start Date means the first date *Cover* was issued under this *Policy*.

Registered Medical Practitioner means a doctor acceptable to us who is legally qualified and properly registered, with a current annual practicing certificate issued by the New Zealand Medical Council or the Medical Board of Australia / Australian Health Practitioner Regulation Agency. The doctor cannot be the *Insured*, *Policy Owner*, an immediate family member, a business partner or person who is otherwise related to the *Insured* or *Policy Owner*. *We* reserve the right to accept the advice of a registered medical practitioner practising outside New Zealand or Australia. The practitioner must have qualifications equivalent to New Zealand or Australian standards.

Specialist Medical Practitioner means a *Registered Medical Practitioner* who is a Member or Fellow of an appropriately recognised Specialist College, and who has Medical Council of New Zealand vocational registration (or the Australian equivalent) in the specialty that directly relates to the medical condition experienced by the *Insured*.

Stand Down Period means the length of time that must elapse before a claim for the Temporary Disability Benefit or the Redundancy Benefit will be considered and is shown in the *Policy Document*.

We / us / our means *BNZ Life* as defined above.

You / your means the *Policy Owner* as defined above.

Notes:

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