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1 Please read this first

1.1 Your right to a 14 day free look

Your policy has a 14-day "free-look" period. The free-look period begins on the third business day after this Policy Document is posted to you. This means that you can cancel your Policy within 14 days and we will refund any payment you have made.

To cancel your Policy, return this Policy Document to AMP with a written instruction to cancel the Policy.

You can cancel any alteration within 14 days of receiving a replacement Policy Document or Replacement Schedule and We will refund in full any money you have paid to Us for this alteration.

To cancel your alteration, return this Policy Document to AMP with a written instruction to cancel the alteration.

1.2 Documents making up your contract of insurance

- This Policy Document,
- the attached Schedule which confirms your individual Policy details,
- your Proposal Form for this Policy,
- any other documents provided as part of your application for this Policy, such as a Personal Statement,
- future documents you receive in respect of this Policy.

1.3 Non Disclosure and Mis-statement

1.3.1 Duty of Disclosure

You and the Person Insured are under a duty to disclose all material facts to Us.

A 'material fact' is one that may influence a prudent insurer in deciding whether or not to insure the Person Insured, and if so, on what terms and conditions and at what cost. If the Person Insured's circumstances change materially after You apply for insurance and before We notify you in writing that We will insure the person to be insured, or if We do not have all the material facts, it's important that you tell Us as soon as possible.

1.3.2 AMP's Remedies for Non Disclosure, Misstatement and Fraudulent/False Claims

If You or the Person Insured:

- failed to disclose all material facts to Us; or
- made a statement (other than a statement as to the age of the Person Insured) in the Proposal, Personal Statement or any other document, on the basis of which insurance under this Policy was granted or reinstated, which was:
  - substantially incorrect; and
  - material; and
  - in relation to Life Cover, Life2go Cover, and Home Loan Life Cover, made either:
    1. fraudulently; or
    2. within three years before the earlier of the date on which AMP seeks to decline a claim or cancel or avoid the relevant cover or the Policy (as applicable) for misstatement or the date of the death of the Person Insured (whichever is the earlier); or
- make a claim under the Policy that is false or fraudulent in any respect,

We may, at our complete discretion, take one or more of the following actions:

- avoid from inception any individual cover provided for by the Policy or the entire Policy (this means the individual cover or the entire Policy (as applicable) will be deemed to have never existed and no claims will be paid by Us);
- cancel an individual cover or this Policy from the date that We notify you of the cancellation;

- decline and not pay a claim;
- alter the terms upon which cover is provided under this Policy. If we choose to alter the terms of the Policy We may choose to do so from the Starting Date;
- recover from the Policy Owner any claims that have been paid;
- recover from the Policy Owner all costs and expenses incurred by Us in connection with the Policy and/or the claim; and/or
- immediately remove the Person Insured from being covered under the Policy Document.

We may amend this Policy (subject to statute) as We consider fair, if any incorrect statement about the age of the Person Insured has been made to Us in the Proposal Form, Personal Statement, or other document.

1.4 When your cover starts

The Starting Date for cover under this Policy is shown in the Schedule, or as otherwise shown in any Replacement Schedule you receive later.

1.5 Where to find definitions of terms used in this Policy Document

Words and phrases beginning with capitals (e.g. Person Insured) , other than the names of cover (e.g. Life Cover) are defined in Clause 10 of this Policy Document.

1.6 Is there anyone to whom I can complain if I have problems with this insurance?

Call AMP Customer Services on 0800 808 267, 8am-6pm, Monday to Friday for any enquiries, or write to,

Manager - Customer Services
AMP Services (NZ) Limited
PO Box 55
Auckland

If the matter remains unresolved, a complaint can be made to the Insurance and Savings Ombudsman, by writing to the Insurance and Savings Ombudsman, BDO House, 99-105 Customhouse Quay, PO Box 10 845, Wellington, or by telephoning (04) 499 7612.

2 Indexation Option

By choosing an indexation option, you authorise AMP to increase some or all of your specified covers annually by this percentage.

2.1 Inflation Indexation Options

2.1.1 For all specified covers (except Life Cover with level premium, Home Loan and Future Covers) you can choose to have your specified covers increased annually, either:

- at a rate that is broadly in line with inflation, as measured by the Consumer Price Index (CPI Option); or
- at the greater of 5% or the Consumer Price Index (CPI 5 option), for Life Cover, Disability Cover, Independence Cover, Trauma Cover, Vital Plus Crisis Cover and Vital Crisis Cover.

Your premiums will also increase correspondingly.

The selected option will be shown in the Schedule or most recent Replacement Schedule for the Person Insured.

2.1.2 For Life Cover with level premium you can choose to have your cover increase at a fixed annual rate of 2.5% and Your premiums for Life Cover with level premium will remain level.

The selected option will be shown in the Schedule or most recent Replacement Schedule for the Person Insured.

2.2 How Indexation applies to your Policy

On each Policy Anniversary some or all of your specified covers may be increased. The increase is based on your selected Indexation option in Clause 2.1. For the CPI Option, the increase is applied on each Policy Anniversary based on the Consumer Price Index percentage increase for the year from 1 October to 30 September preceding the Policy Anniversary. For the CPI 5 Option, the increase is applied on each Policy Anniversary and is the greater of 5% and the Consumer Price Index percentage increase for the year from 1 October to 30 September preceding the Policy Anniversary.

By paying the increased Premium (if any), due as a result of Indexation, you indicate that you accept the increased cover.

The increased cover replaces the previous cover and is not additional to it.

Indexation may apply to the total amount of the cover specified, or to a portion of it, as shown in the Schedule or otherwise shown on any most recent Replacement Schedule, subject to the cover amount not exceeding the maximum indexation sum insured for that cover.

2.3 Choosing not to accept an increase

You may choose not to accept an annual Indexation increase. To do this you must send a written notice to AMP before your Policy Anniversary. We will then inform you of the new Premium payable.

If you do not want annual Indexation increases to be applied for all subsequent years for any of your specified covers, you must send written notice to AMP and We will cancel Indexation permanently for that cover.

2.4 When Indexation will not apply

Indexation will not apply if it would result in a decrease in any amount of cover because of a negative inflation rate.

2.5 When Indexation ends

Unless otherwise previously ended, Indexation will end on the Policy Anniversary for the Person Insured preceding:

- age 70, for Life Cover (and therefore Terminal Illness Cover), Independence Cover, Trauma Cover, Vital Plus Crisis Cover, Vital Crisis Cover and Business Survival Cover,
- age 65 for Income Cover, New Job Income Cover and Business Cover,
- age 60 for Disability Cover,
- age 20 for Children's Crisis Cover,
- age 36 for Children's Future Life Cover

or when the maximum sum insured for each Cover is reached.

3 Making a claim

3.1 General conditions for all claims

Before We will accept liability for a claim and make any payment, AMP must receive at the Register the following:

a) this Policy Document, and
b) proper proof, satisfactory to AMP, of

- the age and identity of the Person Insured, and
- the event or continuation of the circumstances which give rise to the claim, and
- your identity.

4 How a claim is paid

4.1 Currency of payments

All monetary amounts referred to in this Policy Document are in New Zealand dollars.

4.2 Payment of claims

Claims under this Policy are payable:

- at the Register, AMP Services (NZ) Limited
- in New Zealand dollars.

4.3 Deducting taxes from payments

AMP will deduct from payments under this Policy the amount of any taxes, duties or other charges which We are required by law to deduct. We are not currently required by law to deduct income tax from regular income covers.

4.4 GST position for non-residents

If a Person Insured is a non-resident of New Zealand or after this Policy is in-force becomes a non-resident of New Zealand, AMP will consider applying a GST rate of 0% on the Policy Premium. To enable AMP to apply the correct rate of GST, written notification of non-residency by the Person Insured is required prior to each Premium Due Date.

Subject to receiving written notification and ongoing proof of non-residency that is satisfactory to AMP, We may, at our sole discretion, adjust or waive the rate of GST that applies to the Policy Premium (as applicable) from the date that the written notification is received from the Person Insured.

4.5 Deducting premiums from payments

We may at our discretion, deduct from payments any Premium that is overdue on the Policy.

4.6 Payment of Death Duties

AMP may use all or part of any payment under this Policy to pay death duties in the circumstances below:

- where the Person Insured is also the Policy Owner at the date of his or her death, and
- where his or her executor or administrator requests AMP in writing to pay any duty payable in respect of the Person Insured's estate to the proper authority.

The amount payable by AMP is reduced accordingly.

4.7 Recover overpaid claim amounts

If AMP makes a payment under this Policy and subsequent verification or determination reveals that we have overpaid (whether because of mistake, through misstatement or non-disclosure by the Policy Owner or otherwise) We may recover any overpaid amount from the Person Insured or Policy Owner. In

cases where the overpayment was caused or contributed to by the Person Insured or Policy Owner, We may also charge the Person Insured or the Policy Owner interest on the overpaid amount at a rate determined by AMP and any costs and expenses incurred in collecting the overpaid amount.

4.8 Partial Payments and Linked Covers

If a Person Insured has Linked Covers and can claim more than one benefit for the same condition including:

a) Partial Payment Disability Benefit, under Linked Disability Cover, a partial payment;
b) partial benefit under the heading "The effect on this Policy of partial benefit payments" of Linked Vital Plus Crisis Cover; or
c) partial benefit under the heading "Partial benefit payment under Trauma Plus Option" of the Trauma Plus Option attached to Linked Trauma Cover,

then which ever partial benefit type listed above, which is financially larger, or of equal value will be paid to You, and all Linked Covers will be reduced by the amount paid accordingly. Only one partial benefit will be paid for the same condition.

5 Premiums: what you pay for this Policy

5.1 Individual Premium for each Person Insured under this Policy

AMP will calculate an Individual Premium for each Person Insured under this Policy, to take effect from each Policy Anniversary. The Individual Premium will take into account the risk factors (e.g. age, health) involved in covering the Person Insured.

5.2 The total Premium for this Policy

The Premium you pay for this Policy will be the sum of the Individual Premiums for each Person Insured under this Policy. A discount will apply if you choose to pay other than monthly, four-weekly or fortnightly.

5.2.1 Premium review

The following Premium review options may be available for this Policy. The Premium review you have chosen for each cover is shown in the Schedule. If no review option is stated in the Schedule, covers are deemed to be annually reviewed. The following Premium review options may not be available for all covers.

a) Yearly stepped Premium
   If you choose to pay a yearly stepped Premium, the Premium you pay during the first year of this Policy is shown in the Schedule. After that, the Premium will automatically change each year. You will be advised of the new rate before each Policy Anniversary. The Premium will also change with any change in cover and may vary if AMP varies Premiums for all similar Policies (see Clause 5.3).
b) Level Premium
   Level Premium is available for Life Cover. If You choose Life Cover with level Premium the cost of protection for the Life Cover with level Premium is as shown in the Schedule or most recent Replacement Schedule and remains the same until the Cover End Date as shown in the Schedule or most recent Replacement Schedule unless We vary Premiums for all similar Policies (see Clause 5.3).

5.2.2 Zero Premium

If you choose Life Cover with level Premium you may also specify a future Zero Premium Date. The policy will continue to be yearly renewable. At the Zero Premium Date the cover will continue to the Cover End Date shown on the Schedule or most recent Replacement Schedule with no further payments being required for that Life Cover with level Premium.

5.3 Variation in rates

Your Premium rates including level Premium rates are not guaranteed. We may vary our Premium rates in any way from time to time. Any variation will be applied to all policies of the same type and with the same risk factors, issued in the same country, and will be effective from the next Policy Anniversary except for variations that change the Premium payable by reason of a legislative change to the tax payable on such Premiums (including, but not limited to, goods and services tax). Variations resulting from such legislative change shall be effective immediately from the effective date of the legislative change.

5.4 What happens if Premiums are not paid

a) If any Premium or Premium instalment is not paid by the Premium Due Date, and all or part of it remains unpaid for 60 days or more, We will cancel this Policy by writing to you at your Last Known Address. Any Premium or Premium instalment paid on the Policy will be first applied to satisfy the oldest outstanding Premium or Premium Instalment amount, then any subsequent outstanding Premium or Premium instalment amounts thereafter.
b) Cancellation is effective whether or not You receive notification, from the Premium Due Date immediately following your last Premium payment. Any Premiums which have already been paid on the Policy will be retained by AMP.

c) We may, at our discretion, automatically deduct any overdue Premiums if we make a claim payment before We cancel the Policy.
d) AMP may agree to reinstate the Policy, provided that application is made within twelve months of the date the unpaid Premium was due. Agreement will be subject to our assessment of any evidence of insurability that We may require.

6 Making changes to your Policy

6.1 How you can change your Policy

Provided all AMP's conditions are met, you can:

- add or remove a Person Insured to or from this Policy,
- add or remove any cover for a Person Insured under this Policy,
- increase or reduce the sum insured for any cover for a Person Insured under this Policy.

For any of the above changes:

- the Policy Owner must request the change in writing
- AMP must approve the request
- any Premium adjustments are made from the effective date of the change.

Any change in cover may result in a change in Premium.

6.2 Making increases to the Policy

You may apply to make increases to cover under this Policy, but any such increases will be subject to AMP's normal terms and conditions applying at that time.

6.3 How We can change your Policy

If We change an existing type of cover or substitute a new type of cover, and in our opinion the changed or new cover is at least as good as your existing cover in all respects, We can, at our discretion, convert your cover to the changed or new cover.

6.4 Upgrade of Benefits

If We make future improvements to a Lifetrack cover that you hold with Us, and these improvements would not result in an increase in premium rates, we'll pass these changes on to You without You having to provide Us with any medical evidence or evidence regarding the Person Insured's occupation, pastimes or place of residence.

Upgrades provide improvements to Your cover including additional benefits and improved definitions. Any improvements and/or changes to your plan definitions will be reviewed at claim time to ensure the Person Insured is assessed using the definition that benefits them the most. This means that should a definition or benefit from the original policy be more beneficial, you'll still be eligible to claim under your original policy definitions.

If the Person Insured is suffering a pre-existing condition at the time the improvement is provided, the improvement will not apply when assessing any claim affected by that pre-existing condition.

Your existing terms, conditions, exclusions, loadings and endorsements which were applied to the Policy prior to an upgrade will continue

7 Special Events Increase Feature

The Special Events Increase Feature option is only available for Life Cover, Trauma Cover, Vital Crisis Cover, Vital Plus Crisis Cover and Disability Cover.

7.1 Special Events Increase Feature

You may apply to increase the sum insured for Life Cover, Trauma Cover, Vital Crisis Cover, Vital Plus Crisis Cover and/or Disability Cover (if applicable) without needing to provide any further evidence of health, on the occurrence of any of the Special Events.

7.2 Evidence required to exercise a Special Event increase

You must apply for a Special Events increase within 12 months of the relevant Special Event. You must provide Us with satisfactory evidence of the Special Event (such as certification of the Special Event or a statutory declaration, together with any other evidence that We may request).

7.3 How the Special Events Feature applies

You can only make one Special Events increase in any 12-month period and You cannot make more than four requests under this Special Events Increase Feature for each Person Insured.

The maximum increase for each Cover in respect of each Special Event is the lesser of:

- 25% of the original sum insured as determined by AMP;
- $250,000;
- the mortgage amount or increase in mortgage amount (in the event of the increase being for a mortgage or increase to any mortgage over Your primary residence); and
- 5 times the increase in the Person Insured's annual income (in the event of an annual income increase).

The minimum increase in respect of each Special Event is:

- $25,000 for each of Life Cover and Disability Cover; and
- $5,000 for Trauma Cover and Crisis Cover.

The total amount of all increases to Life Cover made under this Special Events Increase Feature must not exceed the lesser of:

- the original sum insured as determined by AMP; and
- $1,000,000.

The total amount of all increases to each of Trauma Cover, Crisis Cover and Disability Cover made under this Special Events Increase Feature must not exceed the lesser of:

- the original sum insured as determined by AMP; and
- $250,000.

7.4 When Special Events Increase Feature will not apply:

An increase under the Special Events Increase Feature will not be available if:

- the Person Insured is older than 55 years of age for increases to standalone Disability Cover; or
- the Person Insured is older than 60 years of age, for increases to Life Cover, Trauma Cover, Vital Crisis Cover, Vital Plus Crisis Cover, and Linked Disability Cover; or
- the Person Insured's cover is subject to any premium loadings; or
- You have reinstated the Person Insured's Life Cover under the Life Cover Buyback Option pursuant to Clause 20.10.1 or Clause 21.11; or
- You have reinstated the Person Insured's Crisis Cover under the Crisis Cover Buyback Option pursuant to Clause 20.11.1; or
- You have reinstated the Person Insured's Trauma Cover under the Trauma Cover Buyback Option pursuant to Clause 21.12; or
- premiums for the Person Insured are being waived under the Premium Cover Option; or

- We have paid a benefit under a Terminal Illness, Disability, Trauma Cover or Crisis Cover, or You are entitled to make, or have made a claim under any of these Covers; or
- the maximum sum insured for each Cover is reached.

7.5 When additional Cover is taken out

Any exclusions and/or special conditions that apply to the existing Life Cover, Trauma Cover, Vital Crisis Cover, Vital Plus Crisis Cover and/or Disability Cover will also apply to the increase. The Premium payable will be calculated at the Premium rate current for such Cover, taking into account the sex, current age and occupation of the Person Insured.

7.6 Premium Cover

If this Policy for the Person Insured includes Premium Cover, any exclusions and/or special conditions that apply to the existing Premium Cover will also apply to the increase. The Premium payable will be calculated at the Premium rate current for such cover, taking into account the sex, current age and occupation of the Person Insured.

8 General Conditions

8.1 Basis of the Contract

Your completed Proposal and any other document made in connection with this Policy are the basis on which this Policy is granted and form part of this Policy.

8.2 Governing Law

This Policy is governed by the laws of New Zealand. AMP will abide by the decision of the High Court of New Zealand.

8.3 Limited Liability

The assets of AMP's Statutory Fund No 1 (or other statutory fund of which this Policy forms part when a claim is made) shall alone be liable for the payment of any claims under this Policy.

8.4 Non Participating Policy

This Policy is non-participating, meaning that you are not entitled to benefit from AMP's profits.

9 Ending your Policy

9.1 You may cancel this Policy at any time

a) If you cancel your Policy within 14 days of when you received this Policy Document in accordance with Clause 1.1, then all Premiums you have paid will be refunded in full.
b) If you cancel your Policy at any other time, you are not entitled to receive any Premiums back and there is no cash surrender value payable to you unless you have chosen Life Cover with level premium with a Zero Premium Date. However, AMP will refund any Premiums you have pre-paid for any period ahead of the date of cancellation.

9.2 Events causing the Policy to end

The Policy will end on the first to occur of:
a) the death of the last remaining Person Insured
b) the birthday of the last remaining Person Insured which coincides with the expiry of their last remaining cover
c) cancellation of this Policy by the Policy Owner
d) AMP exercising our right to cancel or avoid this Policy for mis-statement or non-disclosure in accordance with Clause 1.3
e) if a Premium is not paid within sixty days of the due date under Clause 5.4.

9.3 Effect of ending this Policy

If the Policy ends under Clause 9.2(a) to (c) above or if the Policy ends under Clause 9.2(d) as a result of AMP exercising its right to cancel the Policy for mis-statement or non-disclosure in accordance with Clause 1.3, all remaining cover ends on that date, and all Premiums which have been paid may be retained by AMP.

If the Policy ends under Clause 9.2(d) by AMP exercising its right to avoid the Policy for mis-statement or non-disclosure in accordance with Clause 1.3, the Policy will be deemed to have never existed, no claims will be paid.

10 Definitions of Terms used in this Policy

In this Policy …

Activities of Daily Living	1. Washing: the Person Insured can't wash themselves by any means. 2. Dressing: the Person Insured can't both put clothing on and take clothing off. 3. Feeding: the Person Insured can't get food from a plate into their mouth. 4. Continence: the Person Insured can't control both their bowel and their bladder function. 5. Mobility: the Person Insured can't do any one or more of: a) get in and out of a bed b) get on or off a chair/toilet c) move from place to place without using a wheelchair.
AMP	means AMP Life Limited, the issuer and underwriter of this Policy.
Average Monthly Earned Income	means the average monthly income earned by the Person Insured in their occupation. We base our calculation of this amount on their highest income earned (less any expenses incurred in the production of that income, but before taxation) in any period of 12 consecutive months, in the 3 years immediately preceding the commencement of total disability. We divide that amount by 12 to get their monthly income.
Agreed Monthly Income	means the monthly income earned by the Person Insured in their occupation as agreed at the start of the cover (or at the time of any subsequent increase or decrease).
Basic Sum Insured	means the amount shown in the Schedule or most recent Replacement Schedule.
Benefit End Date	means the date on which any benefit payment under this Policy ends, as stated in the Schedule or most recent Replacement Schedule.
Business	means your business or occupation in New Zealand or any business or occupation in New Zealand in which you are a partner and for the purposes of Business Survival Cover means your business in New Zealand at the time the policy is issued or any business in which you are a partner at the time the policy is issued.
Carer	means the primary caregiver, who provides assistance with communication, mobility, or self-care to a disabled or aged person for more than 6 months.
Child of the Person Insured	means a Child of the Person Insured either by birth, legal adoption or legal guardianship as established to AMP.
Consumer Price Index (CPI)	means the All Groups Consumer Price Index number of the New Zealand Consumers' Price Index as certified by the Government Statistician or, if that index is discontinued or varied substantially, any other index selected by AMP.
Cover End Date	means the date on which any cover under this Policy ends, as stated in the Schedule or most recent Replacement Schedule.
Date of Crisis or Trauma	means the date on which We determine that the Person Insured first met the requirements of one of the specified medical conditions.
Eligible Business Expenses	means those expenses incurred by you or considered by Us to be incurred by you in the conduct of the Business, and where you are a partner in the Business, your proportion of those expenses. The expenses must be such that they continue irrespective of whether or not you are disabled.
Full-Time	means to work all morning and all afternoon (or at least 7.5 hours a day) for five days per week, or the equivalent amount of time in the case of shift workers – less than this being regarded as "part-time".
Individual Premium	means the Premium calculated in accordance with Clause 5.1 for each Person Insured.
Indexation	means increases to your specified cover in accordance with the CPI Option or the CPI 5 Option as defined in Clause 2.1.1 or at a fixed annual rate of 2.5% as provided in clause 2.1.2 (if applicable to your Policy).
Last Known Address	means the billing address for the Policy as last notified to AMP.
Linked Cover(s)	means cover linked to another cover for premium and claim purposes. Premiums for linked cover are reduced and any claim paid on one linked cover reduces the sum insured for all linked covers for that Person Insured.

Major Trauma	means the happening to the Person Insured or Child of the Person Insured after the commencement date of this Cover of any of the "Conditions We cover" listed under "Special Definitions of Medical Terms".
Maximum Monthly Benefit	means the monthly amount for which the Person Insured is insured as shown in the Schedule or most recent Replacement Schedule.
Medical Doctor	means a validly qualified medical practitioner registered to practise in Australia, New Zealand, the United Kingdom, the United States of America, or Canada and approved by Us. That person must not be: • you, your business partner, or a member of your immediate family; or • the Person Insured, the Person Insured's business partner, or a member of the Person Insured's immediate family.
Permanent Impairment of Whole Person Function	means the criteria for the assessment and rating of permanent impairment as defined in the "Guides to the Evaluation of Permanent Impairment – 5th Edition" (or subsequent editions) produced by the American Medical Association.
Permanent Occupation	means being employed in regular work for pay or profit of at least $20,000 per annum (adjusted from time to time by Us to reflect changes in the CPI).
Person Insured	means a person or persons, whose life or lives are insured under this Policy.
Personal Statement	means a document which containing information about the Person Insured, used to decide on what terms and conditions and for what Premium We may offer cover.
Policy	means your contract of insurance with AMP, the general terms and conditions of which are detailed in this Policy Document.
Policy Anniversary	means the anniversary of the Starting Date of this Policy.
Policy Document	means this document including any attached Schedule and Replacement Schedule as issued by AMP from time to time.
Policy Owner	means the person or people who own this Policy.
Premium	means what you pay for this Policy.
Premium Due Date	means the regular date the annual Premium or any Premium instalment falls due based on the payment frequency of the Policy.
Proposal or Proposal Form	means the form completed to apply for this Policy.
Qualifying Period	means that period after the cover starts stated in the Policy Document during which no benefit will ever be payable if the condition and or event covered occurs during this period.
Register	means the policy register maintained by AMP, c/- AMP Services (NZ) Limited at its registered address.
Replacement Schedule	means any document issued from time to time in accordance with this Policy to record changes in the Policy.
Schedule	means the Schedule page showing your individual Policy details which is inserted at the beginning of this Policy Document when the Policy is issued.
Special Event	means any of the following events: • the Person Insured marries or enters into a civil union; or • the Person Insured divorces or dissolves their civil union; or • the Person Insured's child is born or they legally adopt a child; or • the Person Insured takes out or increases a mortgage over their primary residence; or • the Person Insured becomes a Carer for the first time; or • the Person Insured has an annual income (excluding bonuses) increase of $10,000 or more. • the Death or Terminal Illness of a spouse or de facto partner or civil union partner of the Person Insured; or • the attainment of ages 25, 30, 35, 40 and 45
Starting Date	is as specified in the Schedule or any Replacement Schedule.
Waiting Period	means that period after the cover starts stated in the Schedule, after the commencement of Total Disability (if applicable), Redundancy or Bankruptcy (if applicable), or Total and Permanent Disablement (if applicable) during which no benefits are payable.
We or Us	means AMP.
Work	means engaging in any profession, business or occupation. "to work" and "Working" have corresponding meaning.
You or Your	means the Policy Owner.

Zero Premium Date	means the Zero Premium Date shown in the Schedule or most recent Replacement Schedule.

11 Transfer of Ownership of this Policy

A Transfer of Ownership of Policy form is used to change the ownership of this Policy. There should be no existing mortgages. If in doubt, please check with AMP before completing the transfer.

Please note:
1. Do not remove this section from the Policy Document.
2. A transfer is not valid unless registered by AMP.
3. Under the Life Insurance Act of 1908, Trusts may not be the registered owners of life insurance policies unless they are registered as a Trustee Company. Trustees may own policies, but do so as individuals.

11.1 Transfer of Ownership of Policy form

Date of Transfer

Current owners / Transferor(s):
(names in full)

If there is more than one Policy Owner, all must sign

Address:

Signature(s) of transferor(s):

Full name, address and signature of witness:

New owners / Transferee(s):
(names in full)

If the transfer is being made to more than one person, then all names, dates of birth and signatures must be shown.

Address:
(to which acknowledgement of transfer and notices are to be sent)

Occupation:

Date(s) of Birth:

Signature(s):

The new Owner(s) are required to provide AMP evidence to verify their identity before the transfer is processed. Transfers to companies will only be processed once we have received verification of identity for that company. Please contact AMP on 0800 808 267 to find out how to do this.

Full name, address and signature of witness:

Registration of Transfer (AMP use only)

Date Registered by AMP

Signature of Secretary:

11.2 Policy Ownership

The Policy is owned in accordance with this clause:

- If there is one Policy Owner, that person owns this Policy, and ownership of this Policy will pass to that Person's estate on their death;
- If there is more than one Policy Owner, they own this Policy as joint tenants, and on the death of one or more of them, ownership of this Policy will pass to the survivors of those joint tenants. On the death of the last Policy Owner, ownership of this Policy will pass to that person's estate
- If there is any conflict between this clause and the provisions of the Simultaneous Deaths Act 1958, this clause will take precendence

If you notified Us of a Policy ownership structure different than the provisions of this clause prior to 26 August 2019, then the Policy is owned in accordance with that structure.

12 Life Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

12.1 Life Cover

If a Person Insured with this Cover dies then AMP will pay the amount of their Life Cover.

12.1.1 How much We will pay

The amount we will pay is the Life Cover for the Person Insured as at the date of their death. This is the amount of Life Cover shown in the Schedule or most recent Replacement Schedule, but

- increased in accordance with Indexation (see Clause 2) if this applies, and
- reduced by the amount of any prior payment for Terminal Illness or other Linked Covers.

If You choose Life Cover with level premium and:

- on the Cover End Date as shown in the Schedule or most recent Replacement Schedule the Person Insured is aged 100, and
- the Person Insured is alive on their 100th birthday

We will refund You the total amount of level premium that We have received for that Life Cover with level premium.

If you choose Life Cover with level premium with a Zero Premium Date, on each Policy Anniversary after the Zero Premium Date has been reached you may choose to:

- continue your cover until the Cover End Date as shown in the Schedule or most recent Replacement Schedule or
- receive a refund of 25% of the total amount of level premium that We have received for that Life Cover with level premium.

12.1.2 The effect on the Policy when Life Cover is paid

Once a claim under this cover has been accepted by AMP, all other covers of the Person Insured are cancelled.

12.1.3 When Life Cover ends

Life Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 101st birthday of the Person Insured or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Life Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Life Cover is reduced to nil due to payments of Terminal Illness Cover, and other Linked Covers
f) when any refund for Life Cover with level premium is paid under Clause 12.1.

12.2 Terminal Illness Cover

If a Person Insured with Life Cover is diagnosed as having a terminal illness while the Life Cover is current then AMP will pay the amount of their Terminal Illness Cover.

12.2.1 What We mean by “terminal illness”

“Terminal illness” means any illness or injury which, in the opinion of AMP after consideration of unequivocal medical evidence provided to us by the Person Insured’s own Medical Doctor and such other evidence as we may require, will result in the death of the Person Insured within twelve months of the date of diagnosis as terminal, regardless of any treatment that might by undertaken.

12.2.2 How much We will pay

The amount payable is an advance lump sum payment of up to 100 percent of the Life Cover of the terminally ill Person Insured calculated as at the date AMP agrees to pay the claim.

12.2.3 The effect on the Policy when Terminal Illness Cover is paid

Once a claim under this cover has been accepted by AMP:

- all other Life Covers and Linked Covers of the Person Insured will reduce by the amount of Terminal Illness Cover paid
- if the Person Insured also has Premium Cover, AMP will waive the premiums for any remaining cover for the Person Insured which are due from that time forward.

12.2.4 When Terminal Illness Cover ends

Terminal Illness Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 101st birthday or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Life Cover for the Person Insured is cancelled by the Policy Owner
e) when there is less than 12 months cover remaining on Life Cover, where the term of the Life Cover has been limited by underwriting.
f) when the value of Life Cover is reduced to nil due to payments of other Linked Covers
g) when any refund for Life Cover with level premium is paid under Clause 12.1.

12.3 Funeral Cover

We may advance the Policy Owner an amount (determined under Clause 12.3.1) from the Person Insured's Life Cover, which can be used for funeral expenses and other immediate costs of the estate, while We are assessing the Life Cover claim for the Person Insured.

12.3.1 How much We Will Pay

We will pay the Policy Owner a lump sum payment of $15,000 (or the amount of the Life Cover for the Person Insured, whichever is the lesser), upon written notification (acceptable to Us) of the Person Insured's death.

12.3.1 The effect on the Policy when Funeral Cover is paid

Any payment made under the Funeral Cover will be treated as an early payment of the Life Cover. The Life Cover for the Person Insured will reduce by the amount of the Funeral Cover paid. Only one Funeral Cover payment will be made for each Person Insured. Payment of the Funeral Cover does not indicate our acceptance of the claim on the Life Cover. If We make a payment under this Funeral Cover and We do not subsequently accept the Life Cover claim, We can recover the Funeral Cover payment from the Policy Owner.

12.4 What is not covered

AMP will not pay any Life Cover, or Terminal Illness Cover if the Policy Owner (not being the Person Insured) causes the Person Insured to die or become terminally ill, or if the Person Insured causes their own death or terminal illness within one year and thirty days after the Life Cover starts or within one year and thirty days of any increase or reinstatement of the Life Cover that the Policy Owner applies for. It doesn't matter if the Person Insured was sane or insane when they became terminally ill or died.

However, payment will be made where any person or corporation, (other than the Person Insured, the Policy Owner at the Starting Date, or AMP), has acquired a financial interest in this Policy, before the death of the Person Insured, by way of either:

- security (for a loan, for example), or
- under a genuine transfer registered by AMP.

In this case, We will pay to the person or corporation the amount of their financial interest. The amount payable will not be more than the amount of the Person Insured's Life Cover as at the date of death.

12.5 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim for Terminal Illness Cover must include:

- satisfactory medical evidence of terminal illness, provided at your expense.

In addition, We may require at our expense:

- medical verification of the terminal illness by a Medical Doctor or specialist nominated by Us.

12.6 Financial Planning Benefit

If we pay 100 per cent of the Life Cover or Terminal Illness Cover and You (or beneficiaries of the estate) obtain a financial plan from a qualified financial adviser (or an adviser approved by us) within 6 months of us paying You 100% of the Life Cover or Terminal Illness Cover we will reimburse you the lesser of:

- $1,500, or
- the actual cost incurred in obtaining the financial plan.

We will only pay the Financial Planning Benefit once under all AMP policies on the life of the Person Insured held by Us.

12.7 Converting to another Policy

You may apply to replace with another policy or cover, Life Cover for any Person Insured with this cover who is under age 60, without further assessment.

At the time of conversion, the replacement policy or cover will be subject to the normal terms and conditions for new policies of that type applying at that time, and

- it will be at the premium then current, and take into account the age of the Person Insured
- the new cover will not exceed the relevant cover under this Policy for the Person Insured as at the date of application
- it will be available from such range of policies and for such categories of risk as AMP has approved for conversions at that time
- it will not unless agreed by AMP or stated in this Policy contain any special provision or additional cover for which AMP then usually charges an increased or additional premium
- it will not contain Disability Cover, Trauma Cover, Vital Plus Crisis Cover, Terminal Illness Cover, or any other cover unless expressly agreed by AMP at that time
- it may include Premium Cover, subject to any evidence required of the person's insurability being satisfactory, and subject to payment of premiums then required.

13 Future Life Cover

Cover under this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

13.1 Future Life Cover

The Policy Owner will have the option of taking out, on their written application Life Cover (subject to Clause 13.3) on the Person Insured's life following the events listed below:

- in the thirty days before the 1st, 2nd , 3rd and 4th anniversaries of the Policy after the inclusion of Future Life Cover.

13.1.1 Evidence required to convert Future Life Cover to Life Cover

Applications for converting Future Life Cover to Life Cover are to be supported at a minimum by:

- production of Business financial accounts which demonstrate the value of the business; or
- in the case of cover effected for loss of profits/keyperson insurance, evidence of increased profitability or replacements costs; or
- in the case of cover effected for loan guarantees, evidence of increased indebtedness relating to funding the Business.

Before converting Future Life Cover to Life Cover both the Person Insured and the Policy Owner must certify that:

- they have no knowledge and have received no medical advice to suggest that a claim can be submitted for the Person Insured on any AMP insurance.

The Person Insured will also have to certify as to their smoking habits.

13.1.2 Circumstances in which We may refuse a Life Cover application

If the Person Insured and the Policy Owner cannot certify as above that a claim cannot be submitted, or if AMP is not satisfied that there is a financial need for the additional cover, AMP can decline the application for Life Cover.

13.2 When Future Life Cover ends

Future Life Cover for a Person Insured ends on the earliest of:

a) the fourth anniversary of the Policy after the inclusion of Future Life Cover, subject to Clause 13.4
b) the death of the Person Insured
c) their 60th birthday
d) when this Policy ends as in Clause 9.2
e) when the Future Life Cover for the Person Insured is cancelled by the Policy Owner
f) when the value of Life Cover for the Person Insured is cancelled or reduced to nil
g) when the value of Future Life Cover for the Person Insured is cancelled or reduced to nil.

13.3 How much Future Life Cover can be converted to Life Cover

Life Cover (or the equivalent kind of cover offered by AMP at the time) taken out may be for a Basic Sum Insured up to the amount of Future Life Cover as shown in the Schedule or most recent Replacement Schedule.

No claim or amount is payable on Future Life Cover.

13.4 Extending your Future Life Cover

To extend the Future Life Cover for another 4 years (up to a maximum of 12 years in total) the Policy Owner will have to provide updated financial information. AMP can decide not to extend the option.

To extend the Future Life Cover beyond 12 years, the Policy Owner and the Person Insured will have to provide financial, health, occupational and pastimes information. AMP can decide not to extend the cover.

13.5 If you don't take up this option

If the Policy Owner does not take up this option during the times allowed, then they forfeit their right to do so.

13.6 When additional Life Cover is taken out

Any additional Life Cover taken out will be subject to the normal terms and conditions for new covers of that type applying at that time, and:

- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the sex, current age and occupation of the Person Insured
- will not, unless otherwise agreed by AMP or stated in this Policy, contain any special provision or additional cover, for which AMP then usually charges an increased or additional Premium.

13.7 Premium Cover

If this Policy for the Person Insured includes Premium Cover, any additional cover taken out can also include a similar cover if the Policy Owner so wishes. Any such cover:

- will be subject to the usual terms and conditions of Premium Cover applying at that time
- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the current age of the Person Insured.

14 Life2go Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

14.1 Life cover

If a Person Insured with this cover dies then AMP will pay the amount of their Life2go Cover.

14.1.1 How much We will pay

The amount We will pay is the Life2go Cover for the Person Insured as at the date of their death. This is the amount of Life2go Cover shown in the Schedule or most recent Replacement Schedule, but

- increased in accordance with Indexation (see Clause 2) if this applies, and
- reduced by the amount of any prior payment for Terminal Illness.

14.1.2 The effect on the Policy when Life2go Cover is paid

Once a claim under this cover has been accepted by AMP, all other covers of the Person Insured are cancelled.

14.1.3 When Life2go Cover ends

Life2go Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 85th birthday of the Person Insured or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Life2go Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Life2go Cover is reduced to nil due to payments of Terminal Illness Cover.

14.2 Terminal Illness Cover

If a Person Insured with Life2go Cover is diagnosed as having a terminal illness while the Life2go Cover is current then AMP will pay the amount of their Terminal Illness Cover.

14.2.1 What We mean by "terminal illness"

"Terminal Illness" means any illness or injury, which in the opinion of AMP after consideration of unequivocal medical evidence provided to us by the Person Insured's own Medical Doctor and such other evidence as we may require, will result in the death of the Person Insured within twelve months of the date of diagnosis as terminal, regardless of any treatment that might be undertaken.

14.2.2 How much We will pay

The amount payable is an advance lump sum payment of up to 100 percent of the Life2go Cover of the terminally ill Person Insured, calculated as at the date AMP agrees to pay the claim.

14.2.3 The effect on the Policy when Terminal Illness Cover is paid

Once a claim under this cover has been accepted by AMP:

- Life2go Cover of the Person Insured reduces by the amount of Terminal Illness Cover paid.

14.2.4 When Terminal Illness Cover ends

Terminal Illness Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 85th birthday of the Person Insured or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Life2go Cover for the Person Insured is cancelled by the Policy Owner
e) when there is less than 12 months cover remaining on Life2go Cover, where the term of the Life2go Cover has been limited by underwriting.

14.3 What is not covered

AMP will not pay any Life2go Cover or Terminal Illness Cover if the Policy Owner (not being the Person Insured) causes the Person Insured to die or become terminally ill, or if the Person Insured causes their own death or terminal illness within one year and thirty days after the Life2go Cover starts or within one year and thirty days of any increase or reinstatement of the Life2go Cover that the Policy Owner applies for. It doesn't matter if the Person Insured was sane or insane when they became terminally ill or died.

However, payment will be made where any person or corporation, (other than the Person Insured, the Policy Owner at the Starting Date, or AMP), has acquired a financial interest in this Policy, before the death of the Person Insured, by way of either:

- security (for a loan, for example), or
- under a genuine transfer registered by AMP.

In this case, We will pay to the person or corporation the amount of their financial interest. The amount payable will not be more than the amount of the Person Insured's Life cover as at the date of death.

14.4 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim for Terminal Illness Cover must include:

- satisfactory medical evidence of a terminal illness, provided at your expense.

In addition, We may require at our expense:

- medical verification of the terminal illness by a Medical Doctor or specialist nominated by Us.

15 Disability Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

15.1 Disability Cover

If a Person Insured with this cover becomes Totally and Permanently Disabled then We will pay the amount of their Disability Cover.

"Totally and Permanently Disabled" means disability, which has the result described in any of Parts A, B, C or D and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured.

"Total and Permanent Disability" has a corresponding meaning.

15.1.1 Part A – The duties we cover

Disability, which results in both:

i) the Person Insured:

a. for an uninterrupted period of at least three months (the Waiting Period), being wholly prevented from undertaking the category of duty they are claiming under, being one of the following:

- Regular Remunerative Work; or
- Home Duties; or
- Own Occupation; and

b. after the Waiting Period:

- where they are claiming under the Regular Remunerative Work category, being prevented from undertaking Regular Remunerative Work that would pay remuneration at a rate greater than 25% of the earnings that the Person Insured earned over the last 12 month period in paid employment prior to the illness, accident or injury that led to their disability; or
- where they are claiming under the Home Duties category, being wholly prevented from undertaking Home Duties; or
- where they are claiming under the Own Occupation category, being wholly prevented from undertaking their Own Occupation,

in each case while remaining under the regular care of an attending Medical Doctor; and

ii) Us agreeing that, as a result of their disability, the Person Insured is unlikely:

- where they are claiming under the Regular Remunerative Work category, ever to be able to engage in Regular Remunerative Work that would pay remuneration at a rate greater than 25% of the earnings that the Person Insured earned over the last 12 month period in paid employment prior to the illness, accident or injury that led to their disability; or
- where they are claiming under the Home Duties category, ever to be able to engage in any Home Duties; or
- where they are claiming under the Own Occupation category, ever to be able to engage in their Own Occupation.

i)

"Regular Remunerative Work" means:

- the employment, business or occupation that the Person Insured was engaged in immediately before the illness, accident or injury that led to their disability; or if the Person Insured was not in paid employment or was on Unpaid Leave immediately before the illness, accident or injury that led to their disability, the employment, business or occupation that the Person Insured was engaged in immediately before becoming unemployed or taking Unpaid Leave; and

- any other occupation to which the Person Insured is reasonably fitted by education, training or experience.

For the purposes of this definition, "Unpaid Leave" means unpaid leave from the Person Insured's employment immediately before the illness, accident or injury that led to their disability, duly authorised by the Person Insured's employer.

"Home Duties" means all of the duties associated with running the family home that the Person Insured was performing on a full time basis immediately before the illness, accident or injury that led to their disability, including at least 4 of the following duties:

- Cleaning the family home
- Shopping for food and household items
- Meal preparation
- Laundry services and/or
- Caring for a child aged 16 or under, or aged over 16 and in full time secondary education, or dependant immediate family member (if applicable)

"Own Occupation" means the most recent gainful employment, occupation or business that the Person Insured was engaged in immediately prior to the illness, accident or injury that led to their disability, if and as specified in the Schedule or most recent Replacement Schedule for the Person Insured.

The Person Insured's inability to to undertake or engage in the relevant category of duty must be based on evidence from an appropriate consultant medical specialist who is acceptable to AMP.

For the purpose of this definition, the principal duties of any relevant employment, business or occupation of the Person Insured will be assessed by reference to the typical duties of that employment, business or occupation, as determined by Us, rather than the duties particular to the Person Insured.

15.1.2 Part B - Activities of Daily Living We cover

Disability, which results in both:

- the Person Insured being wholly prevented from undertaking Activities of Daily Living, for an uninterrupted period of at least three months (the Waiting Period), and continuing to be so prevented after that three months, while remaining under the regular care of an attending Medical Doctor; and
- AMP agreeing that the Person Insured will be wholly prevented by that disablement from ever being able to do at least 2 of the 5 Activities of Daily Living without assistance from someone else.

15.1.3 Part C - Accidental injury We cover

The Person Insured is Totally and Permanently Disabled if, as a result of an accident, they suffer the loss of:

- the use of two limbs (where a limb means an entire hand or an entire foot); or
- the sight of both eyes; or
- the use of one limb and the sight of one eye (where a limb means an entire hand or an entire foot);

and they must live for at least three months (the Waiting Period) after the loss without artificial life support.

The loss must:

- in the opinion of an appropriate consultant medical specialist We choose, be such that it is unlikely to ever be remedied; and
- have resulted from an accident which was direct and independent of all other causes and the loss must have been caused directly and solely by violent, external and visible means.

Part D – Cognitive Impairment

Cognitive impairment of the Person Insured that is, in our opinion after considering medical evidence as acceptable by AMP, a permanent cognitive impairment of the brain requiring the Person Insured to be under continuous supervision by another adult person for at least six consecutive months and at the end of that six month period the Person Insured is likely to require ongoing continuous care and supervision by another adult person.

15.2 Partial Payment Disability Benefit

If the Person Insured suffers the total and permanent loss of the use of:

- One hand, or,
- One foot, or
- The entire sight in one eye.

We will pay you the lower of:

- 25% of the Disability Cover benefit determined under clause 15.4 for the Person Insured, or
- $100,000.

We will only pay this benefit once for each Person Insured. After a Partial Payment Disability Benefit has been paid, the amount of the Basic Sum Insured for the relevant Person Insured and the benefit determined under Clause 15.4 will be reduced by the amount paid.

15.3 Waiver of Waiting Period

If the Person Insured is Totally and Permanently Disabled based on the requirements of either Part A or Part D above, the three month waiting period is waived if the Total and Permanent Disability is due to :

- Alzheimer's and other dementias
- Cardiomyopathy
- Diplegia
- Hemiplegia
- Lung Disease
- Major Head Injury
- Motor Neurone Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Paraplegia
- Parkinson's Disease
- Permanent Blindness
- Permanent Deafness
- Permanent Loss of Speech
- Primary Pulmonary Hypertension
- Quadriplegia
- Tetraplegia

15.4 How much We will pay

The amount of Disability Cover payable is calculated as at the earlier of:

- the date on which We agree to accept a claim under this cover, or

- the end of the continuous three month Waiting Period referred to in Clause 15.1

The amount payable is shown in the Schedule or most recent Replacement Schedule for the Person Insured, but is increased with Indexation if this applies and reduced by the amount of any Partial Payment Disability Benefit paid by Us.

Although a Person Insured may be Totally and Permanently Disabled as defined in more than one of Parts A, B, C and D of Clause 15.1, We will pay only one amount of Disability Cover.

15.5 The Effect on the Policy when Disability cover is paid

Once a claim under this Cover has been accepted by AMP:

- if Cover is Linked, any other Linked Covers for the Person Insured will be reduced as from the date the claim for Disability Cover is calculated to be payable in terms of Clause 15.4 above. Cover will be reduced by the amount of Disability Cover paid.
- Premium Cover for a Person Insured will apply after a payment under Disability Cover for any remaining cover if Premium Cover is shown in the Schedule.

15.6 When Disability Cover ends

Disability Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured;
b) the 65th birthday of the Person Insured or an earlier Cover End Date as stated in the Schedule. Provided that, if the Disability Cover is Linked Cover and the Cover End Date is not earlier than the 65th birthday of the Person Insured, then the Cover will continue in respect of "Part B - Activities of Daily Living We Cover" only, until the 70th birthday of the Person Insured and subject to the rest of this Clause 15.6;
c) when this Policy ends as in Clause 9.2 of this Policy;
d) when Disability Cover for the Person Insured is cancelled by the Policy Owner; or
e) when the value of Disability Cover is reduced to nil due to payments of Disability Cover or other Linked Covers.

15.7 What is not covered

AMP will not pay any Disability Cover if:

- the Policy Owner or the Person Insured directly or indirectly causes the Person Insured to:
  - be totally disabled or;
  - be Totally and Permanently Disabled; or
  - be permanently disabled; or
- the Person Insured is Totally and Permanently Disabled as a result of the Person Insured engaging in a criminal act, for which the Person Insured is convicted.

15.8 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Disability Cover must include:

- written notice of the claim, to be received by AMP at the Register, within 12 months of the date on which the Person Insured first became disabled as defined in Clause **Error! Reference source not found.**; and
- any medical or other evidence required by Us. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

15.8.1 Claims received after the Waiting Period

If written notice of a claim is received by Us after:

- the Waiting Period, and
- an increase to your cover through Indexation has been processed by Us with an effective date also later than the Waiting Period; then,

if AMP accepts liability for the claim, cover will be adjusted to exclude the relevant Indexation increase. In this case, We would refund any premium paid corresponding to that Indexation increase.

15.9 Life Cover Buyback Option

This Option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if the Life Cover Buyback Option is current.

15.9.1 Life Cover Buyback Option

You have an option to reinstate the Life Cover that was reduced as a result of a claim payment under Linked Disability Cover on the 12-month anniversary of that payment, without needing to provide further evidence of health. The application to reinstate Life Cover must be received by Us within 60 days after the 12-month anniversary of Our payment under the Linked Disability Cover.

The maximum amount that can be reinstated each time this Life Cover Buyback Option is exercised is the amount paid by Us under "How much We will pay" (including any partial benefits paid under "Partial Payment Disability Benefit") in respect of the Person Insured.

The Premium for the reinstated Life Cover will be based on the premium rates applying at the time of reinstatement and will be subject to any loadings, exclusions or special conditions that applied to the Life Cover that was reduced by the Disability Cover claim payment.

This Option will expire on the earliest occurrence of any of the following:

a) the Person Insured attaining the age of 65;
b) the Policy ending as in Clause 9.2; or
c) this Option being cancelled by the Policy Owner.

15.10 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

16 Future Disability Cover

Cover under this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

16.1 Future Disability Cover

The Policy Owner will have the option of taking out, on their written application, Disability Cover (subject to Clause 16.3) on the Person Insured's life following the events listed below:

- in the thirty days before the 1st, 2nd , 3rd and 4th anniversaries of the Policy after the inclusion of Future Disability Cover.

16.1.1 Evidence required for a Disability Cover application

When converting from Future Disability Cover to Disability Cover, applications to be supported at a minimum by:

- production of business financial accounts which demonstrate the value of the business; or
- in the case of loss of profits Keyperson Insurance, evidence of increased profitability or replacements costs; or
- in the case of loan guarantees, evidence of increased indebtedness relating to funding the business.

Before converting Future Disability Cover to Disability Cover both the Person Insured and the Policy Owner must certify that they have no knowledge and have received no medical advice to suggest that a claim can be submitted for the Person Insured on any AMP insurance.

The Person Insured will also have to certify as to their smoking habits.

16.1.2 Circumstances in which We may refuse a Disability Cover application

If the Person Insured and the Policy Owner cannot certify as above that a claim cannot be submitted, or if AMP is not satisfied that there is a financial need for the additional cover, AMP can decline the application for Disability Cover.

16.2 When Future Disability Cover ends

Future Disability Cover for a Person Insured ends on the earliest of:

a) the fourth anniversary of the Policy after the inclusion of Future Disability Cover, subject to Clause 16.4
b) the death of the Person Insured
c) their 60th birthday
d) when this Policy ends as in Clause 9.2
e) when the Future Disability Cover for the Person Insured is cancelled by the Policy Owner
f) when the value of Disability Cover for the Person Insured is cancelled or reduced to nil.

16.3 How much Future Disability Cover can be converted to Disability Cover

Disability Cover (or the equivalent kind of cover offered by AMP at the time) taken out may be for a Basic Sum Insured up to the amount of Future Disability Cover as shown in the Schedule or most recent Replacement Schedule.

No claim or amount is payable on Future Disability Cover.

16.4 Extending your Future Disability Cover

To extend the Future Disability Cover for up to another 4 years (up to a maximum of 12 years in total) the Policy Owner will have to provide updated financial information. AMP can decide not to extend the Cover.

To extend the Future Disability Cover beyond 12 years, the Policy Owner and the Person Insured will have to provide financial, health, occupational and pastimes information. AMP can decide not to extend the cover.

16.5 If you don't take up this option

If the Policy Owner does not take up this option during the times allowed, then they forfeit their right to do so.

16.6 When additional Disability Cover is taken out

Any additional Disability Cover taken out will be subject to the normal terms and conditions for new covers of that type applying at that time, and:

- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the sex, current age and occupation of the Person Insured
- will not, unless otherwise agreed by AMP or stated in this Policy, contain any special provision or additional cover, for which AMP then usually charges an increased or additional Premium.

16.7 Premium Cover

If this Policy for the Person Insured includes Premium Cover, any additional policy taken out can also include a similar cover if the Policy Owner so wishes. Any such cover:

- will be subject to the usual terms and conditions of Premium Cover applying at that time
- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the current age of the Person Insured.

16.8 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on Premiums. This is included in your Premiums.

17 Independence Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

17.1 Independence Cover

If a Person Insured with this cover loses their independence AMP will pay the amount of their Independence Cover.

17.1 .1 What We mean by loss of independence

"Loss of independence" means disability which has the result described in Parts A, B or C, and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts six months before this cover ends.

17.1.1.1 Part A - The inability to perform activities We cover

Disability which results in both:

1. the Person Insured being wholly prevented from undertaking Activities of Daily Living, for an uninterrupted period of at least six months (the Waiting Period), and continuing to be so prevented after that six months, while remaining under the regular care of an attending Medical Doctor; and
2. AMP agreeing that the Person Insured will be wholly prevented by that disablement from ever being able to do at least 2 of the 5 Activities of Daily Living without assistance from someone else.

17.1.1.2 Part B - The inability to think, learn, or remember

Severe impairment such that:

- The Person Insured has lost the ability to think, learn and remember to such an extent that they cannot score at least 16 out of 30 in a Mini Mental State Examination conducted by an appropriate consultant medical specialist AMP chooses; and
- AMP decides they are unlikely to ever regain their faculties; and
- they require continuous supervision by someone else to either:
  - protect themselves; or
  - protect other people from their actions.

17.1.1.3 Part C – The accidental injuries We cover

If, as a result of an accident, the Person Insured suffers the loss of:

- the use of two limbs (where a limb means an entire hand or an entire foot); or
- the sight of both eyes; or
- the use of one limb and the sight of one eye (where a limb means an entire hand or an entire foot);

and they must live for at least 6 months (the Waiting Period) after the loss without artificial life support.

The loss must:

- in the opinion of an appropriate consultant medical specialist We choose, be such that it is unlikely to ever be remedied; and
- have resulted from an accident which was direct and independent of all other causes and the loss must have been caused directly and solely by violent, external and visible means.

Total and permanent disability has a corresponding meaning.

17.2 How much We will pay

The amount of Independence Cover payable is calculated as at the earlier of:

- the date on which AMP agrees to accept a claim under this cover, or
- the end of the continuous six month Waiting Period (see Clause 17.1.1.1).

The amount payable is shown in the Schedule or most recent Replacement Schedule for the Person Insured, but is increased with Indexation if this applies.

Although a Person Insured may be totally and permanently disabled as defined in more than one of Parts A, B and C of Clause 17.1, We will pay only one amount of Independence Cover.

17.3 The Effect on the Policy when Independence Cover is paid

Once a claim under this cover has been accepted by AMP:

- Premium Cover for a Person Insured will apply after a payment under Independence Cover if Premium Cover is shown in the Schedule.

17.4 When Independence Cover ends

Independence Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 85th birthday of the Person Insured or an earlier date as stated in the Schedule
c) when this policy ends as in Clause 9.2
d) when Independence Cover is cancelled for the Person Insured by the Policy Owner
e) when the value of the Independence Cover is reduced to nil due to payments of Independence Cover.

17.5 What is not covered

AMP will not pay any Independence Cover if:

- the Policy Owner or the Person Insured directly or indirectly causes the Person Insured to:
  - be totally disabled or;
  - be totally and permanently disabled; or
  - be permanently disabled; or
- the Person Insured suffers a Loss of Independence as a result of the Person Insured engaging in a criminal act, for which the Person Insured is convicted.

AMP will not pay if the illness or injury of the Person Insured is caused (directly or indirectly) by their use of alcohol or related to their use of drugs that are not prescribed by a doctor.

17.6 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Independence Cover must include:

- written notice of the claim, to be received by AMP at the Register, within 12 months of the date on which the Person Insured first became disabled as defined in Clause 17.1, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

17.6 1 Claims received after the Waiting Period

If written notice of a claim is received by AMP after:

- the Waiting Period, and
- an increase to your cover through Indexation has been processed by AMP with an effective date also later than the Waiting Period; then,

if AMP accepts liability for the claim, cover will be adjusted to exclude the relevant Indexation increase. In this case, AMP would refund any premium paid corresponding to that Indexation increase.

17.7 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

18 Future Independence Cover

Cover under this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

18.1 Future Independence Cover

The Policy Owner will have the option of taking out, on their written application, Independence Cover (subject to Clause 18.3) on the Person Insured's life following the events listed below:

- in the thirty days before the 1st, 2nd , 3rd and 4th anniversaries of the Policy after the inclusion of Future Independence Cover.

18.1.1 Evidence required for an Independence Cover application

Applications for converting Future Independence Cover to Independence Cover, are to be supported at a minimum by:

- production of Business financial accounts which demonstrate the value of the business; or
- in the case of cover effected for loss of profits/keyperson insurance, evidence of increased profitability or replacement costs; or
- in the case of cover effected for loan guarantees, evidence of increased indebtedness relating to funding the Business.

Before converting Future Independence Cover to Independence Cover both the Person Insured and the Policy Owner must certify that they have no knowledge and have received no medical advice to suggest that a claim can be submitted for the Person Insured on any AMP insurance.

The Person Insured will also have to certify as to their smoking habits.

18.1.2 Circumstances in which We may refuse an Independence Cover application

If the Person Insured and the Policy Owner cannot certify as above that a claim cannot be submitted, or if AMP is not satisfied that there is a financial need for the additional cover, AMP can decline the application for Independence Cover.

18.2 When Future Independence Cover ends

Future Independence Cover for a Person Insured ends on the earliest of:

a) the fourth anniversary of the Policy after the inclusion of Future Independence Cover, subject to Clause 18.4
b) the death of the Person Insured
c) their 60th birthday
d) when this Policy ends as in Clause 9.2
e) when the Future Independence Cover for the Person Insured is cancelled by the Policy Owner
f) when the value of Independence Cover for the Person Insured is cancelled or reduced to nil.

18.3 How much Future Independence Cover can be converted to Independence Cover

Independence Cover (or the equivalent kind of cover offered by AMP at the time) taken out may be for a Basic Sum Insured up to the amount of Future Independence Cover as shown in the Schedule or most recent Replacement Schedule.

No claim or amount is payable on Future Independence Cover.

18.4 Extending your Future Independence Cover

To extend the Future Independence Cover for up to another 4 years (up to a maximum of 12 years in total) the Policy Owner will have to provide updated financial information. AMP can decide not to extend the Cover.

To extend the Future Independence Cover beyond 12 years, the Policy Owner and the Person Insured will have to provide financial, health, occupational and pastimes information. AMP can decide not to extend the Cover.

18.5 If you don't take up this option

If the Policy Owner does not take up this option during the times allowed, then they forfeit their right to do so.

18.6 When additional Independence Cover is taken out

Any additional Independence Cover taken out will be subject to the normal terms and conditions for new covers of that type applying at that time, and:

- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the sex, current age and occupation of the Person Insured
- will not, unless otherwise agreed by AMP or stated in this Policy, contain any special provision or additional cover, for which AMP then usually charges an increased or additional Premium.

18.7 Premium Cover

If this Policy for the Person Insured includes Premium Cover, any additional policy taken out can also include a similar cover if the Policy Owner so wishes. Any such cover:

- will be subject to the usual terms and conditions of Premium Cover applying at that time
- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the current age of the Person Insured.

18.8 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on Premiums. This is included in your Premiums.

19 Vital Crisis Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

19.1 Vital Crisis Cover

If a Person Insured with this cover suffers for the first time any one of the crises set out below and survives for the survival period described in Clause 19.8, then AMP will pay a benefit equal to the amount of the Vital Crisis Cover.

19.2 What We mean by "Crisis"

The specified medical conditions which are included in this cover and which are defined as a "Crisis" are:

- Cancer of the breast, prostate, skin or bowel
- Other cancers
- Coronary Artery Surgery
- Heart Attack - Myocardial Infarction
- Heart Attack - Out of hospital cardiac arrest
- Kidney Failure
- Major Organ Transplant
- Stroke

19.3 How much We will pay

The claim will only be paid if, in our opinion, the full definition given in Clause 19.10 for the relevant condition is met.

The amount We will pay is the Vital Crisis Cover for the Person Insured as at the Date of Crisis. This is the amount of Vital Crisis Cover shown in the Schedule or most recent Replacement Schedule, but

- is increased in accordance with Indexation (see Clause 2) if this applies, and
- varied as permitted by this Policy.

There may be a Qualifying Period (see Clause 19.5)

19.4 The effect on this Policy when a benefit is paid under Vital Crisis Cover

Each Person Insured may claim only once under this cover and once a claim under Vital Crisis Cover has been accepted by AMP the cover will:

- end for the Person Insured under this Policy
- continue for any other Person Insured.

All other Crisis Covers for that Person Insured under this Policy will end.

19.5 What is not covered

- We will not pay if the Person Insured or the Policy Owner causes the Person Insured to suffer a Crisis condition.

In addition, the following medical conditions (see Clause 19.10) have a Qualifying Period:

Condition	Qualifying Period
Cancer of the breast, prostate, skin or bowel	6 months
Coronary Artery Surgery	3 months
Heart Attack – Myocardial Infarction	3 months
Heart Attack – out of hospital cardiac arrest	3 months
Stroke	3 months

If any of these conditions is suffered by the Person Insured within the Qualifying Period then no benefit under Vital Crisis Cover will be payable on that or any future occurrence of that medical condition.

The Qualifying Period applies from:
- the Starting Date of the Cover or the date of last reinstatement of the Cover, or
- the date of an increase to the Vital Crisis Cover (the claim will only be paid on the amount prior to the increase).

19.6 When Vital Crisis Cover ends

Vital Crisis Cover ends for a Person Insured on the earliest of:
a) the death of the Person Insured
b) the 70th birthday of the Person Insured or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Vital Crisis Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Vital Crisis Cover is reduced to nil due to payments of other Linked Covers.
f) when a payment is made under Vital Crisis Cover for the Person Insured.

19.7 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Vital Crisis Cover must include:
- written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured suffers for the first time one of the crises defined in Clause 19.10, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

Medical diagnoses and investigation methods used in many of the Crisis conditions that We cover are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular Crisis condition.

Should the method(s) used to diagnose a Crisis condition not be specified within the relevant definition given in Clause 19.10, We may take a new diagnostic method(s) into consideration in assessing whether the Person Insured has suffered one of the Crisis conditions.

19.8 Survival Period

If the Person Insured suffers a Crisis condition they must survive for 14 days.

However, for some Crisis conditions an additional Survival Period is required under Clause 19.10 (e.g. Coma).

19.9 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

19.10 Special Definitions of Medical Terms

Cancer	*Description* We will pay if a Person Insured suffers a malignant tumour which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We will also cover sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorders and leukaemia. We will not pay under this particular crisis condition for any of the following: • Primary cancer of the breast, prostate, skin or bowel (these are covered in a separate definition); or • AIDS related cancers; or • Tumours which are histologically described as pre-malignant or showing malignant changes of 'carcinoma in situ.' However, if the tumour either produces permanent

significant functional impairment or requires major surgery for its removal, then we would consider a claim application.

Glossary of terms
Bone marrow disorders - life shortening and chronic disorder of bone marrow elements.

Carcinoma in situ - cancer confined to its site of origin and readily curable.

Hodgkin's lymphoma and non-Hodgkin's lymphoma - sometimes treatable malignant diseases causing enlargement of the lymph nodes and spleen.

Leukaemia - a malignant disease of the bone marrow, causing abnormalities in the blood, spleen, and lymph nodes.

Sarcoma - a malignant tumour usually occurring in the bone.

Cancer of the breast, prostate, skin or bowel

Description
We will pay if a Person Insured suffers a malignant tumour of the breast, prostate, skin or bowel which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue.

We will not pay under this particular crisis condition for any of the following:

- Skin cancers other than malignant melanoma at least 1.5mm thick or at least Clark Level 3 depth of invasion; or
- Prostatic tumours which are confirmed as equivalent to or less than TNM ClassificationT1 (including T1a and T1b) unless they have a Gleason score of 6 or more; or
- AIDS related cancers; or
- Tumours which are histologically described as pre-malignant or showing malignant changes of 'carcinoma in situ.' However, if the tumour either produces permanent significant functional impairment or requires major surgery for its removal, then we would consider a claim application.

Glossary of terms
Carcinoma in situ - cancer confined to its site of origin and readily curable.

Clark Level - a classification system describing the depth of invasion of a melanoma past the top layers of the skin. The classifications are from 1 to 5.

Melanoma - a malignant tumour of the skin, usually developing from a mole.

TNM classification - a classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Coronary Artery Surgery

Description
We will pay if a Person Insured has coronary artery disease and as a result undergoes surgery involving bypass grafts to one or more coronary arteries.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We do not pay under this particular crisis condition for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.

Glossary of terms
Angioplasty - the treatment of an internal abnormality of a blood vessel by the inflation of a balloon catheter inserted through a superficial blood vessel and not involving an open surgical operation.
Coronary artery - vessel conveying blood to the heart muscle.

Coronary artery disease - significant narrowing or blockage of the coronary arteries.

Laser and intra-arterial techniques - other procedures sometimes used for coronary artery disease not involving an open surgical operation.

Heart Attack – Myocardial Infarction

Description
We will pay if a part of the Person Insured's heart muscle dies as a result of inadequate blood supply to the relevant area. An appropriate consultant medical specialist must certify that a heart attack had occurred and this must be confirmed by the presence of 2 of the following criteria:

- new electrocardiographic changes characteristic of a Myocardial Infarction
- a diagnostic elevation of cardiac biomarkers associated with Myocardial Infarction (for Troponin I this is defined as a level of over 2 ug/L and for Troponin T a level of over 0.6 ug/L).
- permanent physical impairment to at least Class 3 (marked limitation of activity due to symptoms) of the New York Heart Association Classification of Cardiac Impairment.
- left ventricular ejection fraction of less than 50% measured 3 months or more after the event.

We will not pay for other causes of severe non-cardiac chest pain, heart failure or angina.

Glossary of terms
Angina - severe constricting pain in the chest due to coronary disease.

Cardiac biomarkers - damage to heart muscle can raise the level of these biomarkers. This is shown in a blood test.

Class 3 New York Heart Association Classification of Cardiac Impairment - a functional classification to assess cardio vascular disability.

Electrocardiographic changes - a graph of electrical activity of the heart showing variation from the normal which is consistent with a heart attack.

Troponin – a blood test to determine the level of Troponin which is a specific indicator of myocardial (heart muscle) damage.

Myocardial infarction - death of the heart muscle.

Heart Attack – Out of Hospital Cardiac Arrest

Description
We will pay if a Person Insured suffers a cardiac arrest which:

- is not associated with any medical procedure; and
- is documented by an electrocardiogram; and
- occurs outside a hospital; and
- is due to either cardiac asystole or ventricular fibrillation.

Glossary of terms
Cardiac arrest - sudden, and often unexpected, stoppage of effective heart action.

Cardiac asystole - complete failure of contraction of the heart causing cardiac arrest.

Electrocardiogram - a graph of electrical activity of the heart.

Ventricular fibrillation - heart abnormality with ineffective twitching of the heart chambers.

Kidney (Renal) Failure

Description
We will pay if a Person Insured suffers irreversible failure of both kidneys which requires either:

- continuing renal dialysis; or
- transplantation of a human kidney.

In the opinion of an appropriate consultant medical specialist, the dialysis or transplant must be required on medical grounds and must be the most appropriate treatment.

We will not pay in the event of temporary renal dialysis for acute and reversible kidney failure.

Glossary of terms
Kidney transplant - transplantation of a donor kidney into another person's body.

Renal dialysis - the use of defined filtering techniques to remove waste products normally excreted by the kidney.

Major Organ Transplant

Description
We will pay if a Person Insured receives a transplant from a human donor of bone marrow or one of the following whole organs:

- Kidney
- Heart
- Lung
- Liver (live liver transplants, where the Person Insured's whole liver is removed and a piece of liver from a living person is transplanted into the Person Insured, are covered)
- Small Bowel
- Pancreas

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

We will not pay if the Person Insured donates an organ or tissue for transplant.

Stroke

Description
We will pay if a Person Insured suffers a cerebrovascular episode producing neurological damage which lasts for more than 24 hours. The damage must be evidenced clinically by:

- a cerebral CT scan; or
- an angiogram: or
- a MRI or PET: or
- other reliable imaging technique approved by AMP.

We will not pay for transient ischaemic attacks, reversible ischaemic neurological deficit, major head injuries or symptoms due to migraine or headache.

Glossary of terms
Cerebral - relating to the brain.

Cerebrovascular episode - a disorder of the blood vessels of the brain resulting in impaired blood supply to part of the brain.

CT scan, angiogram, MRI or PET - tests used to demonstrate abnormalities in an organ.

Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.

Transient ischaemic attacks - abnormality of sudden onset and brief duration to certain arteries which may cause symptoms similar to a stroke.

Reversible ischaemic neurological deficit – insufficient blood supply to any part of the body.

20 Vital Plus Crisis Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

20.1 Crisis Cover

If a Person Insured with this cover suffers for the first time one of the crises set out below and survives for the survival period described in Clause 20.8, then AMP will pay a benefit equal to the amount of the Vital Plus Crisis Cover.

20.2 What We mean by "Crisis"

The specified medical conditions which are included in this cover and which are defined as a "Crisis" are:

Crisis Condition	Crisis Condition Expiry Age
Accidental Loss of Use of Hands or Feet or Loss of Sight	85
Alzheimer's Disease and other Dementias	70
Aortic Surgery	70
Aplastic Anaemia	70
Benign Tumour of the Brain or Spinal Cord	70
Blindness	70
Cancer of the breast, prostate, skin or bowel	70
Other Cancers	70
Cardiomyopathy	70
Chronic Liver Disease	70
Chronic Lung Disease	70
Coma	70
Coronary Artery Angioplasty	70
Coronary Artery Angioplasty – Triple Vessel	70
Coronary Artery Surgery	70
Deafness	70
Creutzfeldt–Jakob Disease	70
Early Stage Cancer – Diagnosis Benefit	70
Early Stage Cancer – Major Surgery	70
Encephalitis	70
Heart Attack - Myocardial Infarction	70
Heart Attack - Out of hospital cardiac arrest	70
HIV/AIDS – medically acquired	70
HIV/AIDS – occupationally acquired	70
Kidney Failure	70
Loss of Independent Living	85
Loss of Speech	70
Major Head Trauma	70
Major Organ Transplant	70
Meningitis	70
Motor Neurone Disease	70
Multiple Sclerosis	70
Muscular Dystrophy	85
Open Heart Surgery	70
Paralysis – Diplegia, Hemiplegia, Paraplegia, Quadriplegia, Tetraplegia	85
Parkinson's Disease	70
Primary Pulmonary Hypertension	70
Severe Burns	85
Stroke	70

For all specified Crisis conditions with an expiry age of 70, cover under that condition will cease on the Policy Anniversary immediately following the Person Insured's 70th birthday.

20.3 How much We will pay

The claim will only be paid if, in our opinion, the full definition given in Clause 20.12 for the relevant condition is met.

The benefit payable under the Vital Plus Crisis Cover is the amount shown in the Schedule or most recent Replacement Schedule but:

- increased in accordance with Indexation if this applies
- varied as permitted by this Policy
- subject to Clause 20.4 in relation to diagnosis benefits for the specified conditions (Clause 20.4.1), Early Stage Cancer – Diagnosis Benefit (Clause 20.4.2), Coronary Artery Angioplasty – Partial Benefit (Clause 20.4.3), Accidental Loss of Use of Hands or Feet or Loss of Sight - Partial Benefit (Clause 20.4.4) and Deafness/Loss of Hearing – Partial Benefit (Clause 20.4.5).

The benefit will be the amount current at the Date of Crisis. However, there may be a Qualifying Period (see Clause 20.5).

20.4 The effect on this Policy of partial benefit payments

20.4.1Diagnosis Benefits

In the case of first time diagnosis by a Medical Doctor of Alzheimer's Disease and Other Dementias, Multiple Sclerosis or Parkinson's Disease We will pay the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000.

20.4.2 Early Stage Cancer – Diagnosis Benefit

In the case of first time diagnosis by a Medical Doctor of Early Stage Cancer – Diagnosis Benefit, We will pay the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000.

20.4.3 Coronary Artery Angioplasty – Partial Benefit

In the case of a Coronary Artery Angioplasty – Partial Benefit claim, we will pay the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000.

20.4.4 Accidental Loss of Use of Hands or Feet or Loss of Sight – Partial Benefit

In the case of an Accidental Loss of Use of Hands or Feet or Loss of Sight - Partial Benefit claim, We will pay a partial benefit of up to 10% of the benefit determined under Clause 20.3, up to a maximum of $25,000.

20.4.5 Deafness/Loss of Hearing – Partial Benefit

In the case of a Deafness/Loss of Hearing - Partial Benefit claim, We will pay a partial benefit of up to 25% of the benefit determined under Clause 20.3, up to a maximum of $50,000.

20.4.6 Effect of payment of Partial Benefits

If a partial payment is paid under the Diagnosis Benefits (Clause 20.4.1), Early Stage Cancer – Diagnosis Benefit (Clause 20.4.2), Coronary Artery Angioplasty - Partial Benefit (Clause 20.4.3), Accidental Loss of Use of Hands or Feet or Loss of Sight – Partial Benefit (Clause 20.4.4) or Deafness / Loss of Hearing – Partial Benenfit (Clause 20.4.5) cover for other Crisis conditions will continue for that Person Insured (subject to Clause 20.4.7) but the amount of the Basic Sum Insured for the relevant Person Insured and the benefit determined under Clause 20.3 will be reduced by the amount paid.

20.4.7 Limit on Partial Benefit claims

A maximum of one claim can be paid to the Policy Owner in respect of each Person Insured under each of the Clauses 20.4.1 20.4.4 and 20.4.5. Cover for all partial payments under the relevant Clause will then cease in respect of the relevant Person Insured. If the Person Insured subsequently meets the full definition criteria for that or any other condition specified under Clause 20.12, then the remaining balance will be paid.

A maximum of one claim can be paid for each carcinoma-in-situ condition specified under the Early Stage Cancer - Diagnosis Benefit for each Person Insured. Each Person Insured will only be paid up to a maximum of $50,000 for each claim for Early Stage Cancer – Diagnosis Benefit under all AMP Vital Plus Crisis policies.

We will pay a claim on more than one occasion under Coronary Artery Angioplasty provided the procedures occur at least six months apart.

No other partial benefit claims will be payable other than those provided for in this Clause 20.4.

20.5 What is not covered

We will not pay if the Person Insured or the Policy Owner directly or indirectly causes the Person Insured to suffer a Crisis condition; or if the Person Insured suffers a Crisis condition as a result of engaging in a criminal act for which the Person Insured is convicted.

In addition, the following medical conditions have a Qualifying Period:

Condition	Qualifying Period
Benign Tumour of the Brain or Spinal Cord	3 months
Cancer of the breast, prostate, skin or bowel	6 months
Coronary Artery Angioplasty	3 months
Coronary Artery Angioplasty – Triple Vessel	3 months
Coronary Artery Surgery	3 months
Early Stage Cancer – Diagnosis Benefit	6 months
Early Stage Cancer – Major Surgery	6 months
Heart Attack – Myocardial Infarction	3 months
Heart Attack – out of hospital cardiac arrest	3 months
Stroke	3 months

If the Person Insured seeks advice or treatment from a Medical Doctor on symptoms relating to any of these conditions within the Qualifying Period then no benefit under Vital Plus Crisis Cover will be payable on that or any future occurrence of that medical condition.

The Qualifying Period applies from:

- the Starting Date of the Cover or the date of last reinstatement of the Cover, or
- the date of an increase to the Vital Plus Crisis Cover (the claim will only be paid on the amount prior to the increase).

20.6 When Vital Plus Crisis Cover ends

Vital Plus Crisis Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 85th birthday of the Person Insured (subject to Clause 20.2) or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Vital Plus Crisis Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Vital Plus Crisis Cover is reduced to nil due to payments of other Linked Covers

f) when payment of the Basic Sum Insured is made under Vital Plus Crisis Cover for the Person Insured, unless the Crisis Cover Buyback Option (see Clause 20.11) has been exercised in which case, Vital Plus Crisis Cover ends when payment of the Basic Sum Insured (including any amount repurchased) is made under Vital Plus Crisis Cover for the Person Insured.

20.7 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Vital Plus Crisis Cover must include:

- written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured suffers for the first time one of the crises defined in Clause 20.12 and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

Medical diagnoses and investigation methods used in many of the Crisis conditions that We cover are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular Crisis condition.

Should the method(s) used to diagnose a Crisis condition not be specified within the relevant definition given in Clause 20.12, We may take the new diagnostic method(s) into consideration when assessing whether the Person Insured has suffered one of the Crisis conditions.

20.7.1 Linked Covers

If the cover is Linked, any other Linked Covers for the Person Insured will be reduced as from the date the benefit is determined under Clauses 20.3 or 20.4. Cover will be reduced by the amount of Vital Plus Crisis Cover paid.

20.8 Survival Period

If the Person Insured suffers a Crisis condition they must survive for 14 days.

However, for some Crisis conditions an additional Survival Period is required under Clause 20.12 (e.g. Coma).

20.9 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

20.10 Life Cover Buyback Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if the Life Cover Buyback Option is current.

20.10.1 Life Cover Buyback Option

You have an option to reinstate the Life Cover that was reduced as a result of a claim payment under Linked Vital Plus Crisis Cover on the 12-month anniversary of that payment, without needing to provide further evidence of health, provided the application to reinstate Life Cover is received by Us within 30 days after the 12 month anniversary of our payment of the Linked Vital Plus Crisis Cover.

However, if a claim payment under Linked Vital Plus Crisis Cover relates to a condition listed under Clause 20.10.3, You have an option to reinstate the Life Cover that was reduced as a result of a claim payment under Linked Vital Plus Crisis Cover on the 6-month anniversary of that payment, without needing to provide further evidence of health, provided the application to reinstate Life Cover is received by Us within 30 days after the 6 month anniversary of our payment of the Linked Vital Plus Crisis Cover.

The maximum amount that can be reinstated is the amount paid by Us under section 20.3 (including partial benefits or diagnosis benefits paid in accordance with Clause 20.4) in respect of the Person Insured.

The premium for the reinstated cover will be based on the premium rates applying at the time of reinstatement and will be subject to any loadings, exclusions or special conditions that applied to the Life Cover that was reduced by the Vital Plus Crisis Cover claim.

20.10.2 Partial Payment Feature

Where part of your Linked Vital Plus Crisis Cover has been paid to you, you may reinstate this amount of your Life Cover under the terms and conditions of Clause 20.10.

If the remainder of your Linked Vital Plus Crisis Cover is subsequently paid to you, you may then reinstate that amount of Life Cover under the terms and conditions of Clause 20.10.

This option must be exercised within 30 days after the 12 month anniversary of each payment.

20.10.3 Life Cover Buyback After Six Months Feature

If the Linked Vital Plus Crisis Cover claim payment was for any of the following conditions, the option to reinstate the Life Cover is available six months after that payment:

- Accidental Loss of Use of Hands or Feet or Loss of Sight
- Alzheimer's Disease and Other Dementias
- Blindness
- Deafness/Loss of Hearing
- HIV/AIDS – occupationally acquired
- Multiple Sclerosis
- Paralysis - Diplegia
- Paralysis - Hemiplegia
- Paralysis - Paraplegia
- Paralysis - Quadriplegia
- Paralysis - Tetraplegia
- Parkinson's Disease
- Severe Burns

This option must be exercised within 30 days after the six month anniversary of the Linked Vital Plus Crisis Cover claim payment.

20.10.4 When this option expires.

Each of these options will expire on the earlier occurrence of any one of the following,

- the Person Insured attaining age 70;
- the policy ending as in Clause 9.2;
- this cover being cancelled by the Policy Owner;
- exercising of the option (or final option where more than one Linked Vital Plus Crisis Cover payment has been made);
- the death of the Person Insured;
- the application to reinstate the Life Cover is not received within 30 days after the 12 month anniversary of the payment (or final payment if there is more than one); or
- if the claim was for one of the conditions specified in Clause 20.10.3, within 30 days after the six month anniversary of the Linked Vital Plus Crisis Cover benefit.

20.11 Crisis Cover Buyback Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if the Crisis Cover Buyback Option is current.

20.11.1 Crisis Cover Buyback Option

You have an option to repurchase the Vital Plus Crisis Cover that was paid to You as a result of a claim under linked or stand-alone Vital Plus Crisis Cover on the 12-month anniversary of that payment, without needing to provide further evidence of health, provided the application to repurchase Vital Plus Crisis Cover is received by Us within 30 days of the 12 month anniversary of our payment of the initial Vital Plus Crisis Cover claim.

The maximum amount that can be repurchased is the amount paid by Us under section 20.3 (excluding any partial payment made under the following Crisis conditions set out in Clause 20.4: Accidental Loss of Use of Hands or Feet or Loss of Sight, Coronary Artery Angioplasty – Partial Benefit, Alzheimer's Disease and Other Dementias, Deafness/Loss of Hearing, Multiple Sclerosis, Parkinson's Disease and Early Stage Cancer – Diagnosis Benefit) in respect of the Person Insured.

If the original Vital Plus Crisis Cover was linked, the maximum amount that can be repurchased will be limited to the lesser of the original benefit paid by Us and the remaining Life Cover sum insured. Where the Person Insured has the Life Cover Buyback option, the Vital Plus Crisis Cover amount that can be repurchased will be limited to the lesser of the original benefit paid by Us and the Life Cover sum insured after the client has exercised this option.

The premium for the repurchased cover will be based on the premium rates applying at the time of repurchase and will be subject to any loadings, exclusions or special conditions that applied to the original Vital Plus Crisis Cover that was paid to You.

If the Person Insured is subsequently diagnosed with a Crisis condition covered by this Vital Plus Crisis Cover, we will only pay the repurchased benefit if:

- the condition occurred or was diagnosed, or
- the symptoms became apparent,

After the Vital Plus Crisis Cover was repurchased.

The repurchased cover will not include the additional optional benefits of Crisis Cover Buyback and Life Cover Buyback.

20.11.2 We will not pay the repurchased benefit if the subsequent Crisis condition:

- Is the same as the original Crisis condition, or
- Is directly or indirectly caused by or related to the original Crisis condition, or symptoms or conditions that caused the occurrence of the original Crisis condition, or
- Is a Loss of Independent Existence, or
- Is a 'Heart Condition' (see below) and the original Crisis condition was also a 'Heart Condition', or
- Is a *Stroke* or *Paralysis* (directly or indirectly resulting from a Stroke) and the original Crisis condition was a 'Heart Condition', or
- Is a *Cancer* or *Cancer of the breast, prostate, skin or bowel* and the original Crisis condition was also either *Cancer*, *Cancer of the breast, prostate, skin or bowel, Early Stage Cancer – Death Benefit or Early Stage Cancer – Major Surgery*.

A 'Heart Condition' means any of the following definitions (as per section 20.12):
Aortic Surgery, Cardiomyopathy, Coronary Artery Surgery, Coronary Artery Angioplasty – Triple Vessel, Heart Attack - Myocardial infarction, Heart Attack - Out of Hospital Cardiac Arrest, Open Heart Surgery and Primary Pulmonary Hypertension

20.11.3 When this option expires.

This option will expire on the earlier occurrence of any one of the following,

- the Person Insured attaining age 65,
- the policy ending as in Clause 9.2,
- this cover being cancelled by the Policy Owner,
- exercising of the option,
- the death of the Person Insured, or
- the application to repurchase the Vital Plus Crisis Cover not being received by Us within 30 days after the 12 month anniversary of the payment of the Vital Plus Crisis Cover benefit.

20.12 Special Definitions of Medical Terms

Accidental Loss of Use of Hands or Feet or Loss of Sight	*Description* We will pay if a Person Insured totally and permanently loses: • the use of two limbs (where a limb means an entire hand or an entire foot); or • the sight of both eyes (to the extent of 6/60 or less); or • the use of one limb (where a limb means an entire hand or an entire foot) and the sight of one eye (to the extent of 6/60 or less). And they must live for at least 6 months after the loss without artificial life support. We will pay a partial benefit of up to 10% of the sum insured subject to a maximum of $25,000 if a Person Insured totally and permanently loses: • the use of either a single limb (where a limb means an entire hand or an entire foot) or • the sight of one eye (to the extent of 6/60 or less). And they must live for at least 6 months after the loss without artificial life support. • The loss must be in the opinion of an appropriate consultant medical specialist We choose, such that it is unlikely to ever be remedied; and • have resulted from an accident which was direct and independent of all other causes; and • the loss must have been caused directly and solely by violent, external and visible means.
Alzheimer's Disease and Other Dementias	*Description* If the Person Insured is diagnosed for the first time by an appropriate medical specialist to have Alzheimer's Disease or any Other Irreversible Dementia (as per the definitions below) We will pay a diagnosis benefit of the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000. If as a result of this illness the medical specialist considers that the Person Insured is permanently unable to perform any one of the five Activities of Daily Living without assistance from someone else, We will pay the full benefit. We do not cover dementia directly aggravated by alcohol, or related to drug use that is not prescribed by a doctor. *Glossary of terms* Dementia - A progressive mental deterioration due to organic disease of the brain. Alzheimer's Disease - as defined in the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised 2000" (or subsequent editions) produced by the American Psychiatric Association. Other Irreversible Dementia – severe permanent cognitive impairment as determined by a Folstein Mini-Mental score of 23 or less out of 30.

Aortic Surgery	*Description* We will pay if a Person Insured has surgery performed to correct a structural abnormality of the thoracic or abdominal aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We will not pay for surgery performed using catheter techniques. *Glossary of terms* Aorta - the main artery arising from the heart with branches to every part of the body. Catheter techniques – the treatment of internal abnormalities by means of a catheter inserted through a superficial blood vessel to apply certain techniques, and not involving an open surgical operation. Catheter – a hollow tube.
Aplastic Anaemia	*Description* We will pay if a Person Insured has aplasia of the bone marrow which requires: • bone marrow transplantation; or • immunosuppressive therapy. *Glossary of terms* Aplasia - failure of the bone marrow to produce blood cells. Aplastic anaemia - a severe form of anaemia caused by aplasia of the bone marrow. Immunosuppressive therapy - therapy which suppresses the immune system.
Benign Tumour of the Brain or Spinal Cord	*Description* We will pay if a Person Insured has a non-cancerous tumour in the brain or spinal cord which is histologically described and which: • produces neurological damage and functional impairment which an appropriate consultant medical specialist considers is likely to be permanent; or • requires surgery for its removal. We do not cover any of the following: 1. cysts, granulomas and cerebral abscesses; 2. malformations in, or of, the arteries or veins of the brain; 3. haematomas; or 4. tumours in the pituitary gland unless it is sufficiently large that: a) it requires open craniotomy to remove it; and/or b) in the opinion of an appropriate consultant medical specialist, there is significant and permanent neurological damage such as visual field defects. *Glossary of terms* Benign tumour - an enlargement or swelling due to overgrowth of tissue which pushes aside normal tissue but does not invade it. Craniotomy - surgical procedure which opens the skull. Cerebral abscess - a localised collection of pus occurring in the brain. Cyst - a sac or capsule containing liquid or semi-solid substance. Granuloma - a mass of tissue occurring in reaction to the presence of, for example, a foreign body or bacterial infection.

Haematoma - a mass produced by a coagulation of blood in a tissue or cavity.

Histologically described - a conclusion reached after a microscopic examination of cells.

Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Pituitary gland - the master gland of the endocrine system which controls hormone production of other endocrine glands.

Blindness

Description
We will pay if a Person Insured totally loses the sight in both eyes as confirmed by an appropriate consultant medical specialist. That loss must be irreversible and unable to be corrected by glasses or any other means.

The definition of total loss of sight is:
1. visual acuity less than 6/60 in both eyes after correction; or
2. a field of vision constricted to 10 degrees or less of arc; or
3. a combination of visual defects resulting in the same degree of visual impairment as that occurring in (1) or (2).

Glossary of terms
Visual acuity – clarity of vision

6/60 – what a person who has 6/60 vision sees at 6 metres compared to what a person with full clarity of vision sees at 60 metres.

Cancer

Description
We will pay if a Person Insured suffers a malignant tumour which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We will also cover sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorders and leukaemia.

We will not pay under this particular crisis condition for any of the following:
- Primary cancer of the breast, prostate, skin or bowel (these are covered in a separate definition); or
- AIDS related cancers; or
- Tumours which are histologically described as pre-malignant or showing malignant changes of carcinoma in situ.

However, if the tumour requires major surgery for its removal, then we would consider a claim application under Early Stage Cancer – Major Surgery.

Glossary of terms
Bone marrow disorders - life shortening and chronic disorder of bone marrow elements.

Carcinoma in situ - cancer which has not yet resulted in infiltration or active destruction beyond the basement membrane.

Hodgkin's lymphoma and non-Hodgkin's lymphoma - sometimes treatable malignant diseases causing enlargement of the lymph nodes and spleen.

Leukaemia - a malignant disease of the bone marrow, causing abnormalities in the blood, spleen, and lymph nodes.

Sarcoma - a malignant tumour usually occurring in the bone.

Cancer of the breast, prostate, skin or bowel

Description
We will pay if a Person Insured suffers a malignant tumour of the breast, prostate, skin or bowel which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue.

We will not pay under this particular crisis condition for any of the following:

- Skin cancers other than malignant melanoma at least 1.5mm thick or at least Clark Level 3 depth of invasion; or
- Prostatic tumours which are confirmed as equivalent to or less than TNM ClassificationT1 (all categories) unless they have a Gleason score of 6 or more; or
- AIDS related cancers; or
- Tumours which are histologically described as pre-malignant or showing malignant changes of carcinoma in situ.

Glossary of terms
Carcinoma in situ - cancer which has not yet resulted in infiltration or active destruction beyond the basement membrane.
Clark Level - a classification system describing the depth of invasion of a melanoma past the top layers of the skin. The classifications are from 1 to 5.

Melanoma - a malignant tumour of the skin, usually developing from a mole.

TNM classification - a classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Cardiomyopathy

Description
We will pay if a Person Insured's heart muscle fails to function properly resulting in permanent physical impairment to at least Class 3 (marked limitation of activity due to symptoms) of the New York Heart Association Classification of Cardiac Impairment.

Glossary of Terms
Class 3 New York Heart Association Classification of Cardiac Impairment - a functional classification to assess cardio vascular disability.

Chronic Liver Disease

Description
We will pay if a Person Insured is diagnosed by an appropriate consultant medical specialist to have end stage liver failure. There must be permanent jaundice, ascites or encephalopathy.

We will not pay for Chronic Liver Disease that is directly caused by alcohol, or relates to drug misuse.

Glossary of Terms
Ascites – an accumulation of fluid in the abdomen.

Encephalopathy – conditions where there are signs of cerebral irritation without any local lesion to account for them.

Jaundice – a yellow discolouration of the skin.

Chronic Lung Disease

Description
We will pay if the Person Insured has end stage lung disease requiring permanent supplementary oxygen, with:

- FEV 1 test results of consistently less than 1 litre, or
- an appropriate medical consultant considers that as a result the Person Insured is permanently unable to perform any one of the 5 Activities of Daily Living without assistance from someone else.

Glossary of Terms
FEV 1 – (Forced Expiratory Volume in 1 Second). A test to measure the volume of air breathed out in the first second of a forced expiration following a full inspiration.

The normal FEV1 for a person alters with height, age and sex. The following table gives the normal FEV1 ranges for various heights:

Height	Sex	18-40	41-60	61+
1.65m (5'5")	Female	2.57-2.68	2.24-2.49	1.78-2.16
1.75m (5'9")	Female	3.11-3.20	2.81-2.97	2.13-2.58
1.75m (5'9")	Male	3.37-3.55	2.97-3.29	2.36-2.83
1.85m (6'1")	Male	3.99-4.19	3.50-3.89	2.79-3.39

Coma

Description
We will pay if a Person Insured is in a state of unconsciousness characterised by them being totally unrousable and unresponsive to all external stimuli, persisting continuously with the use of a life support system for a period of at least 72 hours.

We will not pay for Coma that is caused by the Person Insured's alcohol or drug use that is not prescribed by a Medical Doctor.

Coronary Artery Angioplasty

Description
We will pay the greater of 25% of the benefit determined under clause 20.3 (up to a maximum of $50,000) or $10,000 if a Person Insured undergoes Angioplasty of one or two of the coronary arteries within the same surgical procedure (with or without the insertion of a stent, laser therapy or atherectomy).

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We will pay a partial benefit for Angioplasty on more than one occasion provided the procedures occur at least six months apart.

Coronary Artery Angioplasty – Triple Vessel

Description
We will pay if an insured person undergoes Angioplasty to 3 or more coronary arteries within the same surgical procedure (with or without the insertion of a stent, laser therapy or atherectomy).

Angiographic evidence, indicating obstruction of 3 or more coronary arteries, is required to confirm the need for this procedure.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Glossary of terms
Angioplasty - the treatment of an internal abnormality of a blood vessel by the inflation of a balloon catheter inserted through a superficial blood vessel and not involving an open surgical operation.

Coronary Artery Surgery

Description
We will pay if a Person Insured has coronary artery disease and as a result undergoes surgery involving bypass grafts to one or more coronary arteries.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We do not pay under this particular crisis condition for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.

Glossary of terms
Angioplasty - the treatment of an internal abnormality of a blood vessel by the inflation of a balloon catheter inserted through a superficial blood vessel and not involving an open surgical operation.

Coronary artery - vessel conveying blood to the heart muscle.

Coronary artery disease – significant narrowing or blockage of the coronary arteries.

Laser and intra-arterial techniques - other procedures sometimes used for coronary artery disease not involving an open surgical operation.

Creutzfeldt-Jakob Disease

Description
We will pay if the Person Insured receives the certain diagnosis of Creutzfeldt-Jakob Disease where such a diagnosis has been documented by the occurrence of cerebellar dysfunction with associated progressive dementia, uncontrolled muscle spasms, tremors and athetosis, requiring continual and permanent medical supervision.

Deafness/Loss of Hearing

Description
We will pay if a Person Insured totally loses hearing in both ears through injury or disease, and that loss cannot be repaired. We won't pay if a hearing device, aid or implant improves the hearing.

We will pay a partial benefit of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) if the Person Insured totally loses all hearing in one ear (as confirmed by an appropriate consultant medical specialist) through injury or disease, and that loss cannot be repaired. We won't pay if a hearing device, aid or implant improves, or is likely to improve, the hearing.

Early Stage Cancer – Diagnosis Benefit

Description
We will pay a diagnosis benefit of the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000 if the Person Insured is, for the first time diagnosed with carcinoma-in-situ of any of the following sites (as confirmed by an appropriate consultant medical specialist):

- Carcinoma-in-situ of the breast
- Carcinoma-in-situ of the vagina
- Carcinoma-in-situ of the cervix-uteri
- Carcinoma-in-situ of the ovary
- Carcinoma-in-situ of the vulva
- Carcinoma-in-situ of the fallopian tube

This benefit also covers a malignant tumour of the prostate histologically described as TNM classification T1 (all categories) through biopsy or with a Gleason score of 1-5.

Cervical Intraepithelial Neoplasia classifications (CIN) CIN-1, CIN-2 and CIN-3 are excluded, unless they meet the definition of Early Stage Cancer - Major Surgery.

A maximum of one claim can be paid for each carcinoma-in-situ condition specified under the Early Stage Cancer - Diagnosis Benefit for each Person Insured. Each Person Insured will only be paid up to a maximum of $50,000 for each claim for Early Stage Cancer – Diagnosis Benefit under all AMP Vital Plus Crisis policies.

Glossary of terms
Carcinoma-in-situ – a focal, autonomous new growth of carcinomatous cells which have not yet resulted in the invasion of normal tissue beyond the basement membrane. The carcinoma-in-situ must be positively diagnosed by biopsy and be classified as TisNOMO according to the TNM staging method or FIGO Stage 0.

TNM classification - a classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Early Stage Cancer – Major Surgery

If the carcinoma-in-situ or prostatic tumour requires major surgery for its removal, which is considered to be medically necessary by a consultant medical specialist, AMP will pay the full benefit determined under Clause 20.3. The surgery must be the most appropriate and necessary treatment solely to arrest the spread of malignancy and includes (but is not limited to) a mastectomy, prostatectomy, hysterectomy but excludes a lumpectomy and/or prophylactic surgery.

Glossary of terms

Carcinoma-in-situ – a focal, autonomous new growth of carcinomatous cells which have not yet resulted in the invasion of normal tissue beyond the basement membrane. The carcinoma-in-situ must be positively diagnosed by biopsy and be classified as TisNOMO according to the TNM staging method or FIGO Stage 0.

Hysterectomy – a surgical procedure to remove the entire uterus

Lumpectomy – surgery of the breast to remove a tumour, including part of the breast tissue.

Mastectomy – a surgical procedure to remove the entire breast

Prophylactic surgery – elective surgery to remove the breast to prevent the occurrence of cancer where there is family history or proven genetic predisposition to breast cancer

Prostatectomy – a surgical procedure to remove the entire prostate gland due to the presence of a prostatic tumour.

TNM classification - a classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Encephalitis

Description
We will pay if a Person Insured is diagnosed as having encephalitis by an appropriate consultant medical specialist resulting in either:

- at least 25% permanent impairment of the whole person function; or
- the permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else.

Glossary of Terms
Encephalitis – inflammation or infection of the brain.

Permanent Impairment of the Whole Person Function – criteria for the assessment and rating of permanent impairment as defined in the "Guides to the Evaluation of Permanent Impairment – 5th Edition" (or subsequent editions) produced by the American Medical association.

Heart Attack – Myocardial Infarction

Description
We will pay if a part of the Person Insured's heart muscle dies as a result of inadequate blood supply to the relevant area. An appropriate consultant medical specialist must certify that a heart attack had occurred and this must be confirmed by the presence of 2 of the following criteria:

- new electrocardiographic changes characteristic of a Myocardial Infarction
- a diagnostic elevation of cardiac biomarkers associated with Myocardial Infarction (for Troponin I this is defined as a level of over 2 ug/L and for Troponin T a level of over 0.6 ug/L).
- permanent physical impairment to at least Class 3 (marked limitation of activity due to symptoms) of the New York Heart Association Classification of Cardiac Impairment.
- left ventricular ejection fraction of less than 50% measured 3 months or more after the event.

We will not pay for other causes of severe non-cardiac chest pain, heart failure or angina.

Glossary of terms
Angina - severe constricting pain in the chest due to coronary disease.

Cardiac biomarkers - damage to heart muscle can raise the level of these biomarkers. This is shown in a blood test.

Class 3 New York Heart Association Classification of Cardiac Impairment - a functional classification to assess cardio vascular disability.

Electrocardiographic changes - a graph of electrical activity of the heart showing variation from the normal which is consistent with a heart attack.

Troponin – a blood test to determine the level of Troponin which is a specific indicator of myocardial (heart muscle) damage.

Myocardial infarction - death of the heart muscle.

Heart Attack – Out of Hospital Cardiac Arrest

Description
We will pay if a Person Insured suffers a cardiac arrest which:

- is not associated with any medical procedure; and
- is documented by an electrocardiogram; and
- occurs outside a hospital; and
- is due to either cardiac asystole or ventricular fibrillation.

Glossary of terms
Cardiac arrest - sudden, and often unexpected, stoppage of effective heart action.

Cardiac asystole - complete failure of contraction of the heart causing cardiac arrest.

Electrocardiogram - a graph of electrical activity of the heart.

Ventricular fibrillation - heart abnormality with ineffective twitching of the heart chambers.

HIV/AIDS – Medically Acquired

Description
We will pay if a Person Insured acquires the Human Immunodeficiency Virus (HIV) through accidental infection as a result of a medical procedure. We will only pay if We believe, on the balance of probabilities, the infection arose because of one of the following medical events. The event must have been medically necessary and performed by or under the supervision of a Medical Doctor, and:

1. it must have occurred to the Person Insured as a result of any one of the following procedures:
   a) a blood transfusion,
   b) the transfusion with blood products,
   c) an organ transplant to the Person Insured,
   d) assisted reproductive techniques, and
2. Sero conversion to the HIV infection is documented to have occurred within 6 months of the accident.

If the infection occurred outside of New Zealand, the Person Insured must notify Us within 30 days of the medical procedure and must provide Us with evidence of a negative HIV antibody test taken within 7 days of the medical procedure.

Before We pay, We will require proof of the incident to AMP's satisfaction via appropriate medical evidence from the relevant hospital and / or surgeon that the infection was medically acquired.

We will not pay if:

- the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection;
- sero conversion does not occur within 6 months of the accident; or
- the infection occurred outside of New Zealand and the Person Insured has not notified Us within 30 days of the medical procedure and provided Us with evidence of a negative HIV antibody test taken within 7 days of the medical procedure.

Glossary of terms
HIV – HIV stands for Human Immunodeficiency Virus. Over time infection with HIV causes the immune system to become deficient, which can lead to the development of illnesses such as cancers and a form of pneumonia.

Sero conversion - the documented change from the absence to the presence in the blood of antibodies to the Human Immunodeficiency Virus (HIV). These antibodies usually appear in the blood for the first time within 8 to 12 weeks of infection occurring but can appear later.

HIV/AIDS – Occupationally Acquired

Description
We will pay if a Person Insured becomes infected with the Human Immunodeficiency Virus (HIV):

- as a result of an accident occurring during the course of the Person Insured's normal occupation; and
- while the Person Insured was carrying out their normal occupational duties; and
- Sero conversion to the HIV infection is documented to have occurred within 6 months of that accident.

Any accident giving rise to a potential claim must be reported within 14 days of the occurrence:

- To the relevant authority or employer; and
- To Us; and
- Be supported by a negative HIV antibody test taken after the accident.

We will only pay if We are able to:

- independently test all blood samples used;
- take further samples and test these;
- obtain a copy of the report made to the relevant institution or employer; and
- obtain all evidence relating to the alleged source of infection.

We will not pay if:

- The HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection;
- Sero conversion does not occur within 6 months of the accident.

Glossary of terms
HIV - stands for Human Immunodeficiency Virus. Over time infection with HIV causes the immune system to become deficient, which can lead to the development of illnesses such as cancers and a form of pneumonia.

Sero conversion - the documented change from the absence to the presence in the blood of antibodies to the Human Immunodeficiency Virus (HIV). These antibodies usually appear in the blood for the first time within 8 to 12 weeks of infection occurring but can appear later.

Kidney (Renal) Failure

Description
We will pay if a Person Insured suffers irreversible failure of both kidneys which requires either:

- Continuing renal dialysis; or
- Transplantation of a human kidney.

In the opinion of an appropriate consultant medical specialist, the dialysis or transplant must be required on medical grounds and must be the most appropriate treatment.

We will not pay in the event of temporary renal dialysis for acute and reversible kidney failure.

Glossary of terms
Kidney transplant - transplantation of a donor kidney into another person's body.

Renal dialysis - the use of defined filtering techniques to remove waste products normally excreted by the kidney.

Loss of Independent Living

Description
We will pay if a Person Insured suffers total and permanent inability to perform at least two of the 5 Activities of Daily Living without assistance from someone else.

Loss of Speech

Description
We will pay if a Person Insured totally loses the ability to speak due to organic brain disease or injury. In the opinion of an appropriate consultant medical specialist, the loss must be irreversible.

Glossary of terms
Organic brain disease - a disease of the brain in which there is structural or functional impairment as opposed to psychiatric disorders.

Functional impairment - abnormalities of the nervous system producing certain symptoms and resulting in some disorder of function.

Major Head Trauma

Description
We will pay if a Person Insured suffers an accidental head injury which results in either:

- at least 25% permanent impairment of the whole person function; or
- the permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else.

Glossary of terms
Permanent Impairment of the Whole Person Function – criteria for the assessment and rating of permanent impairment as defined in the "Guides to the Evaluation of Permanent Impairment – 5th Edition" (or subsequent editions) produced by the American Medical association.

Major Organ Transplant

Description
We will pay if a Person Insured receives a transplant from a human donor of bone marrow or one of the following whole organs:

- Kidney
- Heart
- Lung
- Liver (live liver transplants, where the Person Insured's whole liver is removed and a piece of liver from a living person is transplanted into the Person Insured, are covered)
- Small Bowel
- Pancreas

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

We will not pay if the Person Insured donates an organ or tissue for transplant.

Meningitis

Description

We will pay if a Person Insured is diagnosed as having meningitis by an appropriate consultant medical specialist resulting in either:

- at least 25% permanent impairment of the whole person function; or
- the permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else.

Glossary of terms
Permanent Impairment of the Whole Person Function – criteria for the assessment and rating of permanent impairment as defined in the "Guides to the Evaluation of Permanent Impairment – 5th Edition" (or subsequent editions) produced by the American Medical association.

Motor Neurone Disease

Description
We will pay if a Person Insured is diagnosed to have motor neurone disease by an appropriate consultant medical specialist.

Glossary of terms
Motor neurone disease - disorders with progressive muscle weakness and wasting due to progressive destruction of nerves.

Multiple Sclerosis

Description
If the Person Insured is diagnosed for the first time by an appropriate medical specialist to have Multiple Sclerosis (as per the definition below), We will pay a diagnosis benefit of the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000.

If as a result of this illness the Person Insured suffers neurological damage which causes:

- at least 25% Permanent Impairment of the Whole Person Function (as per the definition below); or
- permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else; or
- an inability to take more than a few steps, restricted to wheelchair, as measured by an EDSS level of 7.5 or above.

We will pay the full benefit.

Glossary of terms
EDSS – Expanded Disability Status Scale. A scoring system that may be used by a professional neurologist to follow the progression of Multiple Sclerosis disability.

Multiple sclerosis - disease with abnormal nervous tissue in the brain and spinal cord, which interferes with the normal function of the nerves, as defined in "The 2005 Revisions to the McDonald Diagnostic Criteria for MS" (or subsequent revisions).

Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.

Permanent Impairment of the Whole Person Function – criteria for the assessment and rating of permanent impairment as defined in the "Guides to the Evaluation of Permanent Impairment – 5th Edition" (or subsequent editions) produced by the American Medical Association.

Muscular Dystrophy

Description
We will pay if the Person Insured receives an unequivocal diagnosis of Muscular Dystrophy certified by an appropriate consultant neurologist.

Glossary of Terms
Muscular Dystrophy - an inherited disease which results in the muscles failing to function.

Open Heart Surgery	*Description* We will pay if the Person Insured has cardiac surgery requiring diversion of the blood through a heart-lung machine, to correct any heart defect. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We will not pay for angioplasty or for minimally invasive repair of cardiac valves. *Glossary of terms* Angioplasty – the treatment of an internal abnormality of a blood vessel by the inflation of a balloon catheter inserted through a superficial blood vessel and not including an open surgical operation.
Paralysis - Diplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both arms or both legs. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Paralysis – Hemiplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both the arm and the leg on the same side of the body. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Paralysis – Paraplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both legs. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Paralysis – Quadriplegia/ Tetraplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both arms and both legs. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Parkinson's Disease	*Description* If the Person Insured is diagnosed for the first time by an appropriate medical specialist to have Parkinson's Disease (as per the definition below), We will pay a diagnosis benefit of

the greater of 25% of the benefit determined under Clause 20.3 (up to a maximum of $50,000) or $10,000.

If as a result of this illness the Person Insured suffers neurological damage which causes:

- at least 25% Permanent Impairment of the Whole Person Function (as per the definition below); or
- permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else.

We will pay the full benefit.

Glossary of terms
Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Parkinson's disease - a progressive disease of the brain with muscle stiffness and tremor, as defined in the "United Kingdom Parkinson's Disease Society brain bank diagnostic criteria for Parkinson's Disease."

Permanent Impairment of the Whole Person Function – criteria for the assessment and rating of permanent impairment as defined in the "Guides to the Evaluation of Permanent Impairment – 5th Edition" (or subsequent editions) produced by the American Medical Association.

Primary Pulmonary Hypertension

Description
We will pay if a Person Insured suffers primary pulmonary hypertension associated with the right ventricle being substantially enlarged and this is established by cardiac catheterisation and/or echocardiography.

We do not pay for any other causes of pulmonary hypertension.

Glossary of Terms
Cardiac catheterisation - a tube inserted into the heart or coronary arteries.

Echocardiography - the use of ultrasound to investigate the heart.
Primary pulmonary hypertension - a condition, cause unknown, associated with increased pressure in the heart-lung circulation, and manifested by an enlarged right ventricle of the heart, as confirmed by chest X-ray, ECG, echocardiogram and cardiac catheter studies.

Right ventricle - one of the major lower chambers of the heart.

Severe Burns

Description
We will pay if a Person Insured suffers full thickness burns to:

- 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart; or
- 25% of their face requiring surgical debridement and/or grafting; or
- 50% of both hands requiring surgical debridement and/or grafting.

The burns can be caused by thermal, electrical or chemical agents.

Glossary of terms:
Lund Browder Body Surface Chart: The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and each leg (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area.

Stroke

Description
We will pay if a Person Insured suffers a cerebrovascular episode producing neurological sequelae which lasts for more than 24 hours, as confirmed by a Neurologist and supported by the results of any of the following scans:

- a cerebral CT scan; or
- an angiogram; or
- a MRI or PET; or
- other reliable imaging technique approved by AMP.

We will not pay for transient ischaemic attacks, major head injuries or symptoms due to migraine or headache.

Glossary of terms
Cerebral - relating to the brain.

Cerebrovascular episode - a disorder of the blood vessels of the brain resulting in impaired blood supply to part of the brain.

CT scan, angiogram, MRI or PET - tests used to demonstrate abnormalities in an organ.

Neurological sequelae - abnormalities of the nervous system producing certain symptoms and resulting in functional impairment.

Transient ischaemic attacks – abnormality of sudden onset and brief duration to certain arteries which may cause symptoms similar to a stroke.

21 Trauma Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

21.1 Trauma Cover

If a Person Insured with this cover suffers for the first time one of the Major Trauma conditions set out below and survives for the survival period described in Clause 21.8, then AMP will pay a benefit equal to the Basic Sum Insured.

21.2 Conditions We cover

Major Trauma Condition	Expiry Age	Major Trauma Condition	Expiry Age
Advanced Diabetes	70	Heart Valve Surgery	70
Alzheimer's Disease	70	HIV/AIDS – Medically Acquired	70
Aortic Surgery	70	HIV/AIDS – Occupationally Acquired	70
Aplastic Anaemia	70	Kidney (Renal) Failure	70
Benign Tumour of the Brain or Spinal Cord	70	Loss of Independent Living	85
Blindness	70	Loss of Speech	70
Cancer	70	Loss of Use of Hands or Feet or Loss of Sight	85
Cancer of the breast, prostate, skin or bowel	70	Major Head Trauma	70
Cardiomyopathy	70	Major Organ Transplant	70
Child's Trauma	18	Meningitis	70
Chronic Liver Disease	70	Motor Neurone Disease	70
Chronic Lung Disease	70	Multiple Sclerosis	70
Coma	70	Muscular Dystrophy	85
Coronary Artery Angioplasty – Triple Vessel	70	Paralysis – Diplegia	85
Coronary Artery Surgery	70	Paralysis – Hemiplegia	85
Deafness/Loss of Hearing	70	Paralysis – Paraplegia	85
Dementia	70	Paralysis – Quadriplegia/Tetraplegia	85
Creutzfeldt–Jakob Disease	70	Parkinson's Disease	70
Early Stage Cancer – Major Surgery	70	Pneumonectomy	70
Encephalitis	70	Primary Pulmonary Hypertension	70
Heart Attack - Myocardial Infarction	70	Severe Burns	85
Heart Attack - Out of hospital cardiac arrest	70	Stroke	70

Cover for all Major Trauma conditions will cease on the Policy Anniversary immediately following the Person Insured's 70th or 85th birthdays, as listed above according to the "Conditions We Cover".

21.3 How much We will pay

The claim will only be paid if, in our opinion, the full definition for the Major Trauma condition is met.

The benefit payable under this cover is the Basic Sum Insured but:

- increased in accordance with Indexation if this applies; and
- varied as permitted by this Policy.

The benefit will be the amount current at the Date of Trauma. However, there may be a Qualifying Period (see Clause 21.5).

21.4 The effect on this Policy when a benefit is paid under Trauma Plus Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if the Trauma Plus Option is current.

Effect of payment under Trauma Plus Option

If a payment is paid under the Trauma Plus Option, cover for other Major Trauma conditions will continue for that Person Insured but the amount of the Basic Sum Insured for the relevant Person Insured will be reduced by the amount paid.

21.5 What is not covered

We will not pay if the:

- Person Insured, or Child of the Person Insured, or the Policy Owner directly or indirectly causes the Person Insured or a Child of the Person Insured, to suffer a Major Trauma; or
- If the Person Insured, or Child of the Person Insured, suffers a Major Trauma as a result of engaging in a criminal act for which the Person Insured, or Child of the Person Insured, is convicted.

In addition, the following Major Trauma Conditions have a three month Qualifying Period:

- Advanced Diabetes
- Cancer
- Cancer of the breast, prostate, skin or bowel
- Child's Trauma
- Coronary Artery Angioplasty – Triple Vessel
- Coronary Artery Bypass Surgery
- Early Stage Cancer – Major Surgery
- Heart Attack – Myocardial Infarction
- Stroke

If the Person Insured or Child of the Person Insured seeks advice or treatment from a Medical Doctor on symptoms relating to any of these Major Trauma conditions within the Qualifying Period then no benefit under Trauma Cover will be payable on that or any future occurrence of that Major Trauma.

The Qualifying Period applies from:

- the Starting Date of the Cover or the date of last reinstatement of the Cover, or
- the date of an increase to the Basic Sum Insured (the claim will only be paid on the amount prior to the increase).

21.6 Child's Trauma

A Child of the Person Insured, who is aged between 3 and 18 years, is covered for the first occurrence of one of the Major Trauma conditions covered under Trauma Cover. A Qualifying Period (see Clause 21.5) applies.

How much We will pay

The payment for a Child's Trauma is 20% of the Basic Sum Insured up to a maximum of $50,000.

The effect on the Policy when Child's Trauma is paid

A payment made under Child's Trauma will not reduce the Basic Sum Insured. We will only make one payment under Child's Trauma for each Child of the Person Insured. If the child is also covered by Child's Trauma on another AMP Trauma Cover, only one payment will be made in respect of that Child of the Person Insured. The payment made in cases of multiple cover will be based on the greater Basic Sum Insured up to a maximum of $50,000.

What is not covered

We will not pay a Child's Trauma where the Child's Trauma directly or indirectly arises from:

- an injury intentionally caused by the Person Insured or a parent (or guardian) of the child or a person who lives in the same household as the child;
- any pre-existing conditions; or
- any congenital defects.

When Child's Trauma ends

Child's Trauma ends at the earliest of:

a) when the Child of the Person Insured turns age 18; or
b) one of the events occurring under "When Trauma Cover Ends".

21.7 When Trauma Cover ends

Trauma Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 85th birthday of the Person Insured (subject to "Conditions We cover") or the Expiry Date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Trauma Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Trauma Cover is reduced to nil due to payments of other Linked Covers including Trauma Plus Option
f) when payment of the Basic Sum Insured is made under Trauma Cover or Trauma Plus Option (if applicable) for the Person Insured, unless the "Trauma Cover Buyback Option" has been exercised in which case, Trauma Cover ends when payment of the Basic Sum Insured (including any amount reinstated) is made under Trauma Cover, or Trauma Plus Option, for the Person Insured.

21.8 Survival Period

If the Person Insured (or a Child of the Person Insured) suffers a Major Trauma they must survive for 14 days, however for some Major Trauma conditions an additional Survival Period is required under Clause 21.13

21.9 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Trauma Cover must include:

- written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured suffers for the first time one of the Major Trauma conditions, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

Medical diagnoses and investigation methods used in many of the Major Trauma conditions are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular condition.

Should the method(s) used to diagnose a Major Trauma condition not be specified within the relevant definition, We may take the new diagnostic method(s) into consideration when assessing whether the Person Insured has suffered a Major Trauma.

Linked Covers

If the cover is Linked, any other Linked Covers for the Person Insured will be reduced as from the Date of Trauma. Linked Covers will be reduced by the amount of Trauma Cover paid.

Trauma Plus Option

If this Option is shown in the Schedule or most recent Replacement Schedule for the Person Insured, and is current, the amount payable under this Option will be reduced as from the Date of Trauma. Cover will be reduced by the amount of Trauma Cover paid.

21.10 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

21.11 Life Cover Buyback Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if the Life Cover Buyback Option is current.

Life Cover Buyback Option

You have an option to reinstate the Life Cover that was reduced as a result of a claim payment under Linked Trauma Cover or Trauma Plus Option (if applicable) on the 12-month anniversary of that payment, without needing to provide further evidence of health. The application to reinstate Life Cover must be received by Us within 30 days after the 12 month anniversary of our payment of the Linked Trauma Cover or Trauma Plus Option.

However, if a claim payment under Linked Trauma Cover relates to a Major Trauma condition listed under "Life Cover Buyback After Six Months Feature", You have an option to reinstate the Life Cover that was reduced as a result of a claim payment under Linked Trauma Cover on the 6-month anniversary of that payment, without needing to provide further evidence of health. The application to reinstate Life Cover must be received by Us within 30 days after the 6 month anniversary of our payment of the Linked Trauma Cover.

The maximum amount that can be reinstated is the amount paid by Us under "How much We will pay" (including any partial benefits made under Trauma Plus Option) in respect of the Person Insured.

The premium for the reinstated cover will be based on the premium rates applying at the time of reinstatement and will be subject to any loadings, exclusions or special conditions that applied to the Life Cover that was reduced by the Trauma Cover claim.

Partial Payment Feature

Where a partial payment under Trauma Plus Option has been paid to you, you may reinstate this amount of your Life Cover under the terms and conditions of this option.

If the remainder of your Linked Trauma Cover or Trauma Plus Option is subsequently paid to you, you may then reinstate that amount of Life Cover under the terms and conditions of this option.

This option must be exercised within 30 days after the 12 month anniversary of each payment.

Life Cover Buyback After Six Months Feature

If the Linked Trauma Cover claim payment was for any of the following Major Trauma conditions, the option to reinstate the Life Cover is available six months after that payment:

- Alzheimer's Disease
- Blindness
- Deafness/Loss of Hearing
- Dementia
- HIV/AIDS – occupationally acquired
- Loss of Use of Hands or Feet or Loss of Sight
- Multiple Sclerosis
- Paralysis - Diplegia
- Paralysis - Hemiplegia
- Paralysis - Paraplegia
- Paralysis – Quadriplegia/ Tetraplegia
- Parkinson's Disease
- Severe Burns

This option must be exercised within 30 days after the six month anniversary of the Linked Trauma Cover claim payment.

When this option expires.

Each of these options will expire on the earlier occurrence of any one of the following,

a) the Person Insured attaining age 70;
b) the policy ending as in Clause 9.2;

c) this cover being cancelled by the Policy Owner;
d) exercising of the option (or final option where more than one Linked Trauma Cover or Trauma Plus Option payment has been made);
e) the death of the Person Insured;
f) the application to reinstate the Life Cover is not received within 30 days after the 12 month anniversary of the payment (or final payment if there is more than one); or
g) if the claim was for one of the Major Trauma conditions specified under "Life Cover Buyback After Six Months Feature", within 30 days after the six month anniversary of the Linked Trauma Cover benefit.

21.12 Trauma Cover Buyback Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if the Trauma Cover Buyback Option is current.

Trauma Cover Buyback Option

You have an option to reinstate the Trauma Cover and Trauma Plus Option (if applicable) that was paid to You as a result of a claim under stand-alone or Linked Trauma Cover or Trauma Plus Option on the 12-month anniversary of that payment, without needing to provide further evidence of health. The application to reinstate Trauma Cover and Trauma Plus Option must be received by Us within 30 days of the 12 month anniversary of our payment of the Trauma Cover or Trauma Plus Option claim.

The maximum amount that can be reinstated is the amount paid by Us under "How much We will pay" (excluding any partial payments made under Trauma Plus Option) in respect of the Person Insured.

If the original Trauma Cover was Linked, the maximum amount that can be reinstated will be limited to the lesser of the original benefit paid by Us and the remaining Life Cover sum insured. Where the Person Insured has the Life Cover Buyback option, the Trauma Cover amount that can be reinstated will be limited to the lesser of the original benefit paid by Us and the Life Cover sum insured after the client has exercised this option.

The premium for the reinstated cover will be based on the premium rates applying at the time of reinstatement and will be subject to any loadings, exclusions or special conditions that applied to the original Trauma Cover and Trauma Plus Option that was paid to You.

A Premium discount may apply to reinstated Trauma Cover and Trauma Plus option after a claim has been paid for a Cancer Condition or Heart Condition.

The reinstated cover will not include the additional optional benefits of Trauma Cover Buyback and Life Cover Buyback.

If the Person Insured is subsequently diagnosed with a Major Trauma condition, we will only pay the reinstated benefit if:

- the condition occurred or was diagnosed, or
- the symptoms became apparent,

after the Trauma Cover and Trauma Plus Option was reinstated.

We will not pay the reinstated benefit if the subsequent Major Trauma condition:

- Is the same as the original Major Trauma condition, or
- Is directly or indirectly caused by or related to the original Major Trauma condition, or symptoms or conditions that caused the occurrence of the original Major Trauma condition, or
- Is a Loss of Independent Living, or
- Is a 'Heart Condition' (see below) and the original Major Trauma condition was also a 'Heart Condition', or

- Is a *Stroke* or *Paralysis* (directly or indirectly resulting from a Stroke) and the original Major Trauma condition was a 'Heart Condition', or
- Is a 'Cancer Condition' (see below) and the original Major Trauma condition was a 'Cancer Condition'.

A 'Heart Condition' means any of the following Trauma Cover Major Trauma conditions:

Aortic Surgery	Heart Attack - Myocardial infarction
Cardiomyopathy	Heart Attack - Out of Hospital Cardiac Arrest
Coronary Artery Angioplasty – Triple Vessel	Heart Valve Surgery
Coronary Artery Surgery	Primary Pulmonary Hypertension

If applicable, a 'Heart Condition' also means any of the following Trauma Plus Option Major Trauma conditions:

Coronary Artery Angioplasty	Minimally Invasive Aortic Surgery
Heart Attack	Minimally Invasive Heart Valve Surgery

A 'Cancer Condition' means any of the following Trauma Cover Major Trauma conditions:

Cancer	Early Stage Cancer – Major Surgery
Cancer of the Breast, Prostate, Skin or Bowel	

If applicable, a 'Cancer Condition' also means any of the following Trauma Plus Option Major Trauma conditions:

Chronic Lymphocytic Leukaemia	Early Stage Cancer – Diagnosis Benefit

When this option expires.

This option will expire on the earlier occurrence of any one of the following,

- the Person Insured attaining age 70,
- the Policy ending as in Clause 9.2,
- this cover being cancelled by the Policy Owner,
- exercising of the option,
- the death of the Person Insured, or
- the application to reinstate the Trauma Cover and Trauma Plus Option not being received by Us within 30 days after the 12 month anniversary of the payment of the Trauma Cover or Trauma Plus Option benefit.

21.13 Special Definitions of Medical Terms

Advanced Diabetes	We will pay if the Person Insured suffers severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist and resulting in at least two of the following: ▪ Severe diabetic retinopathy resulting in visual acuity uncorrected and corrected of 6/36 or worse in both eyes; or ▪ Severe diabetic neuropathy causing motor and/or autonomic impairment; or ▪ Diabetic gangrene leading to surgical intervention; or ▪ Severe diabetic nephropathy causing chronic irreversible renal impairment (as measured by a corrected creatinine clearance below the laboratory's measured normal range).
Alzheimer's Disease	We will pay if the Person Insured receives the unequivocal diagnosis of Alzheimer's Disease as certified by a medical practitioner specialising in neurology, psycho-geriatrics, psychiatry or geriatrics. Alzheimer's Disease means permanent and irreversible loss of brain function which has resulted in significant cognitive impairment for which no recognisable cause other than Alzheimer's disease has been identified, to the extent that

	the Person Insured has been medically certified as requiring ongoing continuous care and supervision by another adult person to protect the Person Insured and ensure their safety.
Aortic Surgery	We will pay if the Person Insured has surgery performed to correct a structural abnormality of the thoracic or abdominal aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. Angioplasty, intra-aterial procedures or other non-surgical techniques are excluded.
Aplastic Anaemia	We will pay if the Person Insured has aplasia of the bone marrow which requires: • bone marrow transplantation; or • immunosuppressive therapy.
Benign Tumour of the Brain or Spinal Cord	We will pay if the Person Insured has a non-cancerous tumour in the brain or spinal cord which is histologically described and which: • produces neurological damage and functional impairment which an appropriate consultant medical specialist considers is likely to be permanent; or • requires surgery for its removal. We do not cover any of the following: 1. cysts, granulomas and cerebral abscesses; 2. malformations in, or of, the arteries or veins of the brain; 3. haematomas; or 4. tumours in the pituitary gland unless it is sufficiently large that: a) it requires open craniotomy to remove it; and/or b) in the opinion of an appropriate consultant medical specialist, there is significant and permanent neurological damage such as visual field defects.
Blindness	We will pay if the Person Insured totally loses the sight in both eyes as confirmed by an appropriate consultant medical specialist. That loss must be irreversible and unable to be corrected by glasses or any other means. The definition of total loss of sight is: 1. visual acuity less than 6/60 in both eyes after correction; or 2. a field of vision constricted to 10 degrees or less of arc; or 3. a combination of visual defects resulting in the same degree of visual impairment as that occurring in (1) or (2).
Cancer	We will pay if the Person Insured suffers a malignant tumour which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We will also cover sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorders and leukaemia. We will not pay under this particular Major Trauma condition for any of the following: • Primary cancer of the breast, prostate, skin or bowel (these are covered in a separate definition); or • Tumours which are histologically described as pre-malignant or showing malignant changes of carcinoma-in-situ. • Lymphocytic leukaemia less than Rai Stage 1. However, if the tumour requires major surgery for its removal, then we would consider a claim application under Early Stage Cancer – Major Surgery.
Cancer of the breast, prostate, skin or bowel	We will pay if the Person Insured suffers a malignant tumour of the breast, prostate, skin or bowel which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We will not pay under this particular Major Trauma condition for any of the following: • Skin cancers other than: – malignant melanoma at least 1.5mm Breslow thickness or at least Clark Level 3 depth of invasion or where the melanoma is showing histological evidence of ulceration; or – Squamous cell carcinoma of the skin where there is evidence of metastases; or

	• Prostatic tumours which are confirmed as equivalent to or less than TNM ClassificationT1 (all categories) unless they have a Gleason score of 6 or more; or • Tumours which are histologically described as pre-malignant or showing malignant changes of carcinoma-in-situ.
Cardiomyopathy	We will pay if the Person Insured's heart muscle fails to function properly resulting in permanent physical impairment to at least Class 3 (marked limitation of activity due to symptoms) of the New York Heart Association Classification of Cardiac Impairment.
Chronic Liver Disease	We will pay if the Person Insured is diagnosed by an appropriate consultant medical specialist to have end stage liver failure. There must be permanent jaundice, ascites or encephalopathy.
Chronic Lung Disease	We will pay if the Person Insured has end stage lung disease requiring permanent supplementary oxygen, with: • Forced Expiratory Volume in 1 Second ("FEV 1") test results of consistently less than 1 litre, or • an appropriate medical consultant considers that as a result the Person Insured is permanently unable to perform any one of the five Activities of Daily Living without assistance from someone else.
Coma	We will pay if the Person Insured is in a state of unconsciousness characterised by them being totally unrousable and unresponsive to all external stimuli, persisting continuously with the use of a life support system for a period of at least 72 hours. We will not pay for Coma that is caused by the Person Insured's alcohol or drug use that is not prescribed by a Medical Doctor.
Coronary Artery Angioplasty – Triple Vessel	We will pay if a Person Insured undergoes Angioplasty to 3 or more coronary arteries within the same surgical procedure (with or without the insertion of a stent, laser therapy or atherectomy). Angiographic evidence, indicating obstruction of 3 or more coronary arteries, is required to confirm the need for this procedure. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.
Coronary Artery Surgery	We will pay if the Person Insured has coronary artery disease and as a result undergoes surgery involving bypass grafts to one or more coronary arteries. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We will not pay for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.
Creutzfeldt-Jakob Disease	We will pay if the Person Insured receives the certain diagnosis of Creutzfeldt-Jakob Disease where such a diagnosis has been documented by the occurrence of cerebrellar dysfunction with associated progressive dementia, uncontrolled muscle spasms, tremors and athetosis, requiring continual and permanent medical supervision.
Deafness/Loss of Hearing	We will pay if the Person Insured totally loses hearing in both ears through injury or disease, and that loss cannot be repaired. We won't pay if a hearing device, aid or implant improves the hearing.
Dementia	We will pay if the Person Insured receives the unequivocal diagnosis of Dementia (other than Alzheimer's Disease), as certified by a medical practitioner specialising in neurology, psycho-geriatrics, psychiatry or geriatrics. Dementia means permanent and irreversible loss of brain function which results in significant cognitive impairment for which no other recognisable cause has been identified, to the extent that the Person Insured has been medically certified as requiring ongoing continuous care and supervision by another adult person to protect the Person Insured and ensure their safety.
Early Stage Cancer – Major Surgery	We will pay if the Person Insured suffers the occurrence of a carcinoma-in-situ or prostatic tumour that requires major surgery for its removal, which is considered to be medically necessary by a consultant medical specialist. The surgery must be the most appropriate and necessary treatment solely to arrest the spread of malignancy and includes (but is not

	limited to) a mastectomy, prostatectomy, hysterectomy but excludes a lumpectomy and/or prophylactic surgery. Carcinoma-in-situ means a focal, autonomous new growth of carcinomatous cells which have not yet resulted in the invasion of normal tissue beyond the basement membrane. The carcinoma-in-situ must be positively diagnosed by biopsy and be classified as TisNOMO according to the TNM staging method or FIGO Stage 0. Hysterectomy means a surgical procedure to remove the entire uterus. Lumpectomy means surgery of the breast to remove a tumour, including part of the breast tissue. Mastectomy means a surgical procedure to remove the entire breast. Prophylactic surgery means elective surgery to remove the breast to prevent the occurrence of cancer where there is family history or proven genetic predisposition to breast cancer. Prostatectomy means a surgical procedure to remove the entire prostate gland due to the presence of a prostatic tumour.
Encephalitis	We will pay if the Person Insured is diagnosed as having encephalitis by an appropriate consultant medical specialist resulting in either: • at least 25% Permanent Impairment of Whole Person Function; or • the permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else.
Heart Attack – Myocardial Infarction	We will pay if a part of the Person Insured's heart muscle dies as a result of inadequate blood supply to the relevant area. An appropriate consultant medical specialist must certify that a heart attack had occurred and this must be confirmed by the presence of 2 of the following criteria: • new electrocardiographic changes characteristic of a Myocardial Infarction • a diagnostic elevation of cardiac biomarkers associated with Myocardial Infarction (for Troponin I this is defined as a level of over 2,000 ng/L and for Troponin T a level of over 600 ng/L). • left ventricular ejection fraction of less than 50% measured 3 months or more after the event. • New pathological Q waves. If the above tests are inconclusive, other appropriate and medically recognised tests will be considered. We will not pay for other causes of severe non-cardiac chest pain, heart failure or angina.
Heart Attack – Out of Hospital Cardiac Arrest	We will pay if the Person Insured suffers a cardiac arrest which: • is not associated with any medical procedure; and • is documented by an electrocardiogram; and • occurs outside a hospital; and • is due to either cardiac asystole or ventricular fibrillation.
Heart Valve Surgery	We will pay if the Person Insured has cardiac surgery to repair or replace a heart valve as a consequence of a heart valve defect. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. Angioplasty, intra-arterial procedures and other non-surgical techniques are excluded.
HIV/AIDS – Medically Acquired	We will pay if the Person Insured acquires the Human Immunodeficiency Virus (HIV) through accidental infection as a result of a medical procedure. We will only pay if We believe, on the balance of probabilities, the infection arose because of one of the following

medical events. The event must have been medically necessary and performed by or under the supervision of a Medical Doctor, and:

1. it must have occurred to the Person Insured as a result of any one of the following procedures:
   a) a blood transfusion,
   b) the transfusion with blood products,
   c) an organ transplant to the Person Insured,
   d) assisted reproductive techniques, and
2. Sero conversion, as determined by an appropriate consultant medical specialist, to the HIV infection is documented to have occurred within 6 months of the accident.

If the infection occurred outside of New Zealand, the Person Insured must notify Us within 30 days of the medical procedure and must provide Us with evidence of a negative HIV antibody test taken within 7 days of the medical procedure.

Before We pay, We will require proof of the incident to AMP's satisfaction via appropriate medical evidence from the relevant hospital and / or surgeon that the infection was medically acquired.

We will not pay if:

- the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection;
- sero conversion does not occur within 6 months of the accident; or
- the infection occurred outside of New Zealand and the Person Insured has not notified Us within 30 days of the medical procedure and provided Us with evidence of a negative HIV antibody test taken within 7 days of the medical procedure.

HIV/AIDS – Occupationally Acquired

We will pay if the Person Insured becomes infected with the Human Immunodeficiency Virus (HIV):

- as a result of an accident occurring during the course of the Person Insured's normal occupation; and
- while the Person Insured was carrying out their normal occupational duties; and
- Sero conversion, as determined by an appropriate consultant medical specialist, to the HIV infection is documented to have occurred within 6 months of that accident.

Any accident giving rise to a potential claim must be reported within 14 days of the occurrence:

- To the relevant authority or employer; and
- To Us; and
- Be supported by a negative HIV antibody test taken after the accident.

We will only pay if We are able to:

- independently test all blood samples used;
- take further samples and test these;
- obtain a copy of the report made to the relevant institution or employer; and
- obtain all evidence relating to the alleged source of infection.

We will not pay if:

- The HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection;
- Sero conversion does not occur within 6 months of the accident.

Kidney (Renal) Failure

We will pay if the Person Insured suffers irreversible failure of both kidneys which requires either:

- Continuing renal dialysis; or
- Transplantation of a human kidney.

In the opinion of an appropriate consultant medical specialist, the dialysis or transplant must be required on medical grounds and must be the most appropriate treatment.

	We will not pay in the event of temporary renal dialysis for acute and reversible kidney failure.
Loss of Independent Living	We will pay if the Person Insured suffers total and permanent inability to perform at least two of the five Activities of Daily Living without assistance from someone else.
Loss of Speech	We will pay if the Person Insured totally loses the ability to speak due to organic brain disease or injury. In the opinion of an appropriate consultant medical specialist, the loss must be irreversible. Organic brain disease means a disease of the brain in which there is structural or functional impairment as opposed to psychiatric disorders. Functional impairment means abnormalities of the nervous system producing certain symptoms and resulting in some disorder of function.
Loss of Use of Hands or Feet or Loss of Sight	We will pay if the Person Insured totally and permanently loses: • the use of two limbs (where a limb means an entire hand or an entire foot); or • the sight of both eyes (to the extent of 6/60 or less); or • the use of one limb (where a limb means an entire hand or an entire foot) and the sight of one eye (to the extent of 6/60 or less). The loss must be in the opinion of an appropriate consultant medical specialist We choose, such that it is unlikely to ever be remedied.
Major Head Trauma	We will pay if the Person Insured suffers an accidental head injury which results in either: • at least 25% Permanent Impairment of Whole Person Function; or • the permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else.
Major Organ Transplant	We will pay if the Person Insured receives a transplant from a human donor of bone marrow or one of the following whole organs: • Kidney • Heart • Lung • Liver (live liver transplants, where the Person Insured's whole liver is removed and a piece of liver from a living person is transplanted into the Person Insured, are covered) • Small Bowel • Pancreas In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment. We will not pay if the Person Insured donates an organ or tissue for transplant.
Meningitis	We will pay if the Person Insured is diagnosed as having meningitis by an appropriate consultant medical specialist resulting in either: • at least 25% Permanent Impairment of Whole Person Function; or • the permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else.
Motor Neurone Disease	We will pay if the Person Insured is diagnosed to have Motor Neurone Disease by an appropriate consultant medical specialist.

Multiple Sclerosis	We will pay if the Person Insured is diagnosed by an appropriate medical specialist to have Multiple Sclerosis and as a result of this illness the Person Insured suffers neurological damage which causes: • at least 25% Permanent Impairment of Whole Person Function; or • permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else; or • an inability to take more than a few steps, restricted to wheelchair, as measured by an Expanded Disability Status Scale ("EDSS") level of 7.5 or above, as determined by a consultant neurologist.
Muscular Dystrophy	We will pay if the Person Insured receives an unequivocal diagnosis of Muscular Dystrophy as certified by an appropriate consultant neurologist.
Paralysis - Diplegia	We will pay if the Person Insured suffers total and permanent paralysis of both arms or both legs resulting in complete loss of ability to move those parts of the body. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.
Paralysis – Hemiplegia	We will pay if the Person Insured suffers total and permanent paralysis of both the arm and the leg on the same side of the body resulting in complete loss of ability to move those parts of the body. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.
Paralysis – Paraplegia	We will pay if the Person Insured suffers total and permanent paralysis of both legs resulting in complete loss of ability to move those parts of the body. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.
Paralysis – Quadriplegia/ Tetraplegia	We will pay if the Person Insured suffers total and permanent paralysis of both arms and both legs resulting in complete loss of ability to move those parts of the body. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.
Parkinson's Disease	We will pay if the Person Insured is diagnosed by an appropriate medical specialist to have Parkinson's Disease, and as a result of this illness the Person Insured suffers neurological damage which causes: • at least 25% Permanent Impairment of Whole Person Function; or • the permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else.
Pneumonectomy	We will pay if the Person Insured requires the excision of an entire lung when deemed medically necessary by an appropriate specialist and whose opinion is supported by our medical advisers.
Primary Pulmonary Hypertension	We will pay if the Person Insured suffers primary pulmonary hypertension associated with the right ventricle being substantially enlarged and this is established by cardiac catheterisation and/or echocardiography. We do not pay for any other causes of pulmonary hypertension.
Severe Burns	We will pay if the Person Insured suffers full thickness burns to: • 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart; or • 25% of their face requiring surgical debridement and/or grafting; or • 50% of **both** hands requiring surgical debridement and/or grafting. The burns can be caused by thermal, electrical or chemical agents.
Stroke	We will pay if the Person Insured suffers a cerebrovascular episode producing neurological sequelae, which lasts for more than 24 hours, as confirmed by a Neurologist and supported by the results of any of the following scans: • a cerebral CT scan; or

- an angiogram; or
- a MRI or PET; or
- other reliable imaging technique approved by AMP.

Cerebrovascular episode means a disorder of the blood vessels of the brain resulting in impaired blood supply to part of the brain.

Neurological sequelae means abnormalities of the nervous system producing certain symptoms and resulting in functional impairment.

We will not pay for transient ischaemic attacks, major head injuries or symptoms due to migraine or headache.

22 Trauma Plus Option

Cover against any of the risks in this Clause will only apply if Trauma Plus Option and Trauma Cover are shown in the Schedule or most recent Replacement Schedule for the Person Insured, and both are current.

22.1 Trauma Plus Option

If a Person Insured with this cover suffers for the first time one of the Major Trauma conditions set out below and survives for the survival period described in Clause 22.7, then AMP will pay a benefit equal to the Trauma Cover Basic Sum Insured, or a partial benefit for those conditions listed under "Partial payment of benefit".

22.2 Conditions We cover

Adult Insulin Dependent Diabetes
Alzheimer's Disease Diagnosis
Breast Tumour – Diagnosis Benefit
Coronary Artery Angioplasty
Chronic Lymphocytic Leukaemia
Colostomy and/or Ileostomy
Deafness/Loss of Hearing in One Ear
Deafness/Loss of Hearing – Cochlear Implant
Dementia Diagnosis
Early Stage Cancer – Diagnosis Benefit
Heart Attack
Hydrocephalus
Intensive Care
Loss of Sight in One Eye
Loss of Use of One Limb
Major Burns
Major Organ Transplant Waiting List
Malignant Melanoma – Diagnosis Benefit
Minimally Invasive Aortic Surgery
Minimally Invasive Heart Valve Surgery
Multiple Sclerosis Diagnosis
Parkinson's Disease Diagnosis
Prostate Tumour – Diagnosis Benefit
Severe Inflammatory Bowel Disease
Severe Osteoporosis
Severe Rheumatoid Arthritis
Systemic Lupus Erythematosus
Systemic Sclerosis

22.3 How much We will pay

The claim will only be paid if, in our opinion, the full definition for the Major Trauma condition is met.

The benefit payable under this option is the Trauma Cover Basic Sum Insured but:

- increased in accordance with Indexation if this applies
- varied as permitted by this Policy
- subject to the section "Partial payment of benefit" in relation to partial benefits for the specified conditions.

The benefit will be the amount current at the Date of Trauma. However, there may be a Qualifying Period (see Clause 22.5).

22.4 Partial benefit payment under Trauma Plus Option

A partial benefit becomes payable if the Person Insured suffers one of the following Major Trauma conditions:

Adult Insulin Dependent Diabetes
Breast Tumour – Diagnosis Benefit
Coronary Artery Angioplasty
Chronic Lymphocytic Leukaemia
Colostomy and/or ileostomy
Deafness / Loss of Hearing – Cochlear implant
Deafness/ Loss of Hearing in One Ear
Dementia Diagnosis
Early Stage Cancer – Diagnosis Benefit
Intensive Care
Loss of Sight in One Eye
Loss of Use of One Limb
Major Burns
Malignant Melanoma – Diagnosis Benefit
Minimally Invasive Aortic Surgery
Minimally Invasive Heart Valve Surgery
Multiple Sclerosis Diagnosis
Parkinson's Disease Diagnosis
Prostate Tumor – Diagnosis Benefit

Hydrocephalus	Severe Inflammatory Bowel Disease Severe Osteoporosis

Effect of payment of partial benefits

If a payment is paid under the partial benefits listed above, cover for other Major Trauma conditions will continue for that Person Insured but the amount of the Trauma Cover Basic Sum Insured for the relevant Person Insured, and the benefit determined at the Date of Trauma, will be reduced by the amount paid.

Limit on partial benefit claims

A maximum of one claim can be paid to the Policy Owner in respect of each Person Insured under each of the partial benefits for any of the partial benefit payments under Trauma Plus Option listed above except for Coronary Artery Angioplasty and Early Stage Cancer – Diagnosis Benefit, as described below. We will pay a claim on more than one occasion under Early Stage Cancer - Diagnosis Benefit for each Person Insured provided the diagnosis relates to a different Early Stage Cancer condition as listed in the definition. Each claim will be up to a maximum of $50,000 for all AMP Trauma Plus Options and Vital Plus Crisis Cover policies.

We will pay a claim on more than one occasion under Coronary Artery Angioplasty provided the procedures occur at least six months apart.

No other partial benefit claims will be payable other than those provided for in this Clause.

22.5 What is not covered

We will not pay if the:

- Person Insured or the Policy Owner directly or indirectly causes the Person Insured to suffer a Major Trauma; or
- If the Person Insured suffers a Major Trauma as a result of engaging in a criminal act for which the Person Insured is convicted.

In addition, the following conditions have a three month Qualifying Period:

- Adult Insulin Dependent Diabetes
- Breast Tumour – Diagnosis Benefit
- Coronary Artery Angioplasty
- Chronic Lymphocytic Leukaemia
- Early Stage Cancer – Diagnosis Benefit
- Heart Attack
- Malignant Melanoma – Diagnosis Benefit
- Minimally Invasive Aortic Surgery
- Minimally Invasive Heart Valve Surgery
- Prostate Tumour – Diagnosis Benefit
- Severe Inflammatory Bowel Disease
- SevereOsteoporosis
- Severe Rheumatoid Arthritis
- Systemic Lupus Erythematosus

If the Person Insured seeks advice or treatment from a Medical Doctor on symptoms relating to any of these Major Trauma conditions within the Qualifying Period then no benefit under the Trauma Plus Option will be payable on that, or any future occurrence of that Major Trauma.

The Qualifying Period applies from:

- the Starting Date of the Cover or the date of last reinstatement of the Cover, or
- the date of an increase to the Trauma Cover Basic Sum Insured (the claim will only be paid on the amount prior to the increase).

22.6 When Trauma Plus Option ends

Trauma Plus Option ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 70th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Trauma Plus Option and/or Trauma Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Trauma Plus Option and/or Trauma Cover is reduced to nil due to payments of other Linked Covers
f) when payment of the Basic Sum Insured is made under Trauma Plus Option or Trauma Cover for the Person Insured, unless the "Trauma Cover Buyback Option" has been exercised in which case, Trauma Plus Option ends when payment of the Basic Sum Insured (including any amount reinstated) is made under the Trauma Plus Option or Trauma Cover for the Person Insured.

22.7 Survival Period

If the Person Insured suffers a Major Trauma they must survive for 14 days, however for some Major Trauma conditions an additional Survival Period is required under Clause 22.10.

22.8 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Trauma Plus Option must include:

- written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured suffers for the first time one of the Major Trauma conditions, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

Medical diagnoses and investigation methods used in many of the Major Trauma conditions that We cover are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular condition.

Should the method(s) used to diagnose a Major Trauma condition not be specified within the relevant definition, We may take the new diagnostic method(s) into consideration when assessing whether the Person Insured has suffered a Major Trauma.

Trauma Cover

Trauma Cover for the Person Insured will be reduced as from the Date of Trauma, by the amount of Trauma Plus Option paid.

Linked Covers

If the Trauma Cover is Linked, any other Linked Covers for the Person Insured will be reduced as from the Date of Trauma, by the amount of Trauma Plus Option paid.

22.9 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

22.10 Special Definitions of Medical Terms

Adult Insulin Dependent Diabetes	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured receives the unequivoval diagnosis of type 1 insulin dependent diabetes mellitus. Adult Insulin Dependent Diabetes means the onset and first diagnosis, after the age of 30, of type 1 insulin dependent diabetes mellitus (IDDM) by an appropriate consultant specialist.

Alzheimer's Disease Diagnosis	We will pay if the Person Insured receives the unequivocal diagnosis of Alzheimer's Disease, as certified by a consultant neurologist, which has resulted in a significant cognitive impairment for which no other recognisable cause has been identified. Significant cognitive impairment is defined as a deterioration or loss of intellectual capacity as measured by clinical evidence and standardised testing and has resulted in the Person Insured scoring 24 or less in a Mini-Mental State Examination.
Breast Tumour – Diagnosis Benefit	We will pay a one off partial benefit of the greater of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000 if the Person Insured is diagnosed for the first time (as confirmed by an appropriate consultant medical specialist) with carcinoma-in-situ of the breast where the tumour is classified as TNM state Tis. There is no requirement for the breast to be removed. Carcinoma-in-situ means focal new growth of malignant cells that have not yet invaded normal tissues and have been diagnosed by biopsy.
Chronic Lymphocytic Leukaemia	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured is diagnosed with Chronic Lymphocytic Leukaemia which is histologically described as Rai Stage 0.
Colostomy and/or Ileostomy	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured requires a colostomy and/or ileostomy which means the creation of a permanent, non-reversible opening, linking the colon and/or ileum to the external surface of the body.
Coronary Artery Angioplasty	We will pay the greater of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000 if the Person Insured undergoes Angioplasty of one or two of the coronary arteries within the same surgical procedure (with or without the insertion of a stent, laser therapy or atherectomy). In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We will pay a partial benefit for Angioplasty on more than one occasion provided the procedures occur at least six months apart.
Deafness/Loss of Hearing – Cochlear Implant	We will pay a one off partial benefit of 25% of the Trauma Cover Basic Sum Insured, up to a maximum of $50,000, if the Person Insured is approved for cochlear implant surgery. The cochlear implant must be deemed necessary by an appropriate consultant medical specialist. This must be certified at least 3 months after the ability to hear was first lost.
Deafness/Loss of Hearing – Loss of Hearing in One Ear	We will pay a one off partial benefit of 25% of the Trauma Cover Basic Sum Insured, up to a maximum of $50,000, if the Person Insured totally loses all hearing in one ear (as confirmed by an appropriate consultant medical specialist) through injury or disease, and that loss cannot be repaired. We will not pay if a hearing device, aid or implant improves, or is likely to improve, the hearing.
Dementia Diagnosis	We will pay a one off partial benefit of the greater of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000 if the Person Insured receives the unequivocal diagnosis of Dementia (other than Alzheimer's Disease) as certified by a consultant neurologist, which has resulted in significant cognitive impairment for which no other recognisable cause has been identified. Significant cognitive impairment is defined as a deterioration or loss of intellectual capacity as measured by clinical evidence and standardised testing and has resulted in the Person Insured scoring 24 or less in a Mini-Mental State Examination.
Early Stage Cancer – Diagnosis Benefit	We will pay a partial benefit of the greater of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000 if the Person Insured is diagnosed for the first time (as confirmed by an appropriate consultant medical specialist) with one of the following cancer conditions (each bullet point representing a different condition):

	• Carcinoma-in-situ of the vulva, vagina, ovary, cervix-uteri or fallopian tube where by the tumour is classified as TNM stage Tis or FIGO stage 0 (under the old FIGO classification). • Carcinoma-in-situ of the cervix that is at TNM stage Tis or CIN 3 grading. • Carcinoma-in-situ of the penis - where the tumour is classified as TNM stage Tis requiring surgical excision. The cancer cells do not penetrate the basement membrane nor invade the surrounding tissues. • Carcinoma-in-situ of the testicle - where the tumour is classified as TNM stage Tis in one or both testes. The cancer cells do not penetrate the basement membrane nor invade the surrounding tissues. Carcinoma-in-situ means focal new growth of malignant cells that have not yet invaded normal tissues and have been diagnosed by biopsy. Following a partial payment, unless we have already made a payment for the particular Early Stage Cancer condition a claim is submitted for, we will make subsequent payments for other Early Stage Cancer conditions listed above.
Heart Attack	We will pay if the Person Insured suffers a heart attack which means the death of heart muscle as a result of inadequate blood supply to the relevant area, confirmed by a cardiologist and evidenced by: ▪ Typical rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference range, PLUS one of the following: ▪ Signs and symptoms of ischaemia which are consistent with myocardial infarction; or ▪ New serial ECG changes with the development of any one of the following: • ST elevation or depression; or • T wave inversion; or • left bundle branch block (LBBB); or • pathological Q waves or ▪ Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality. If the above tests are inconclusive, we will consider other appropriate and medically recognised tests. Other acute coronary syndromes including but not limited to angina pectoris are excluded. A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease is also excluded.
Hydrochepalus	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured suffers from hydrocephalus, which means an excessive accumulation of cerebrospinal fluid within the cranium requiring the insertion of a shunt, as determined by an appropriate consultant medical specialist.
Intensive Care	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured has an accident or sickness which causes the need for: ▪ continuous mechanical ventilation via a tracheal intubation 24 hours per day for 3 consecutive days; or ▪ being confined to an authorised intensive care unit of a registered medical hospital for 24 hours per day for at least 5 consecutive days at the recommendation of an appropriate consultant medical specialist. The benefit is not payable where the accident or illness is a result of, or directly related to, alcohol or drug use.
Loss of Sight in One Eye	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured totally and permanently loses the sight of one eye (to the extent of 6/60 or less).
Loss of Use of One Limb	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured totally and permanently loses the use of a single limb (where a limb means an entire hand or an entire foot).

Major Burns	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured suffers full thickness burns to at least 10% of the body surface area, but less than 20%.
Major Organ Transplant Waiting List	We will pay if the Person Insured is placed on a recognised New Zealand or Australian major organ transplant waiting list to receive a transplant from a human donor of bone marrow or one of the following whole organs: • Kidney • Heart • Lung • Liver • Small Bowel • Pancreas In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment. We will not pay if the Person Insured donates an organ or tissue for transplant.
Malignant Melanoma – Diagnosis Benefit	We will pay a one off partial benefit of the greater of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000 if the Person Insured is diagnosed for the first time (as confirmed by an appropriate consultant medical specialist) with a malignant melanoma that is less than 1.5mm depth of invasion using the Breslow method and less than Clark Level 3.
Minimally Invasive Aortic Surgery	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured has minimally invasive surgery of the aorta through an intra-arterial procedure or other non surgical technique. In the opinion of an appropriate consultant medical specialist, the treatment must be deemed the most appropriate and required on medical grounds.
Minimally Invasive Heart Valve Surgery	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured has minimally invasive heart valve surgery through an intra-arterial procedure or other non-surgical technique. In the opinion of an appropriate consultant medical specialist, the treatment must be deemed the most appropriate and required on medical grounds.
Multiple Sclerosis Diagnosis	We will pay a one off partial benefit of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000, if the Person Insured receives the unequivocal diagnosis of Multiple Sclerosis as certified by a consultant neurologist.
Parkinson's Disease Diagnosis	We will pay a one off partial benefit of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000, if the Person Insured receives the unequivocal diagnosis of Parkinson's Disease, as certified by a consultant neurologist.
Prostate Tumour – Diagnosis Benefit	We will pay a one off partial benefit of the greater of 25% of the Trauma Cover Basic Sum Insured (up to a maximum of $50,000) or $10,000 if the Person Insured is diagnosed for the first time (as confirmed by an appropriate consultant medical specialist) with a prostate tumour classified as T1 (all categories) under the TNM classification system or with a Gleason Score less than 6 or an equivalent classification where major interventionist therapy is not required.
Severe Inflammatory Bowel Disease	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured suffers severe inflammatory bowel disease. Severe inflammatory bowel disease means a diagnosis of Crohn's disease and/or ulcerative colitis that has failed surgical and conventional medical intervention and requires immunosuppressive therapy such as cortisone and other immunomodulation therapy for at least 12 months.

Severe Osteoporosis	We will pay a one off partial benefit of 10% of the Trauma Cover Basic Sum Insured, up to a maximum of $25,000, if the Person Insured suffers severe osteoporosis. Severe osteoporosis means the Person Insured, before the age of 50, suffers at least 2 vertebral body fractures or a fracture of the neck or femur, due to osteoporosis and has bone mineral density reading with a T-score of less than -2.5 (i.e. 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least 2 sites by dual energy x-ray absorptiometry (DEXA).
Severe Rheumatoid Arthritis	We will pay if the Person Insured is diagnosed as having severe rheumatoid arthritis, by a rheumatologist who has confirmed all of the following complications occurred as a direct result of the rheumatoid arthritis: ▪ at least a 6 week history of severe rheumatoid arthritis, which involves 3 or more of the following joint areas: - proximal interphalangeal joints in the hands, - metacarpophalangeal joints in the hands, - metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle, ▪ simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone) ▪ typical rheumatoid joint deformity, and ▪ at least 2 of the following criteria: - morning stiffness, - rheumatoid nodules, - erosions seen on x-ray imaging, - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis. We won't pay for any other form of arthritis.
Systemic Lupus Erythematosus	We will pay if the Person Insured receives the unequivocal diagnosis of Systemic Lupus Erythematosus as certified by an appropriate consultant medical specialist. The condition must have progressed to the point that the Person Insured has the permanent inability to perform independently at least one of the five Activities of Daily Living.
Systemic Sclerosis	We will pay if the Person Insured receives the unequivocal diagnosis of Systemic Sclerosis as certified by an appropriate consultant medical specialist. The condition must have progressed to the point the Person Insured has the permanent inability to perform independently at least one of the five Activities of Daily Living.

23 Children's Crisis Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

23.1 Children's Crisis Cover

If a Person Insured with this cover suffers for the first time one of the crises set out below and survives for the survival period described in Clause 23.9, AMP will pay a benefit equal to the amount of their Children's Crisis Cover.

23.2 What We mean by "Crisis"

The specified medical conditions which are included in this cover and which are defined as a "Crisis" are:

- Aplastic Anaemia
- Bacterial Meningitis
- Cancer of the breast, prostate, skin or bowel
- Other Cancers
- Leukaemia
- Major Head Trauma
- Major Organ Transplant
- Paralysis – Diplegia
- Paralysis – Hemiplegia
- Paralysis – Paraplegia
- Paralysis- Quadriplegia
- Paralysis- Tetraplegia
- Severe Burns
- Subacute Sclerosing Panencephalitis
- Viral Encephalitis

23.3 How much We will pay

The claim will only be paid if, in our opinion, the full definition given in Clause 23.11 for the relevant condition is met.

The claim payable under the Children's Crisis Cover is the amount shown in the Schedule or most recent Replacement Schedule but:

- increased in accordance with Indexation if this applies, and
- varied as permitted by this Policy.

The benefit will be the amount current at the Date of Crisis.

23.4 The effect on this Policy when a benefit is paid under Children's Crisis Cover

Each Person Insured may claim only once under this Cover and once a claim under Children's Crisis Cover has been accepted by AMP the Cover will:

- end for the Person Insured under this Policy
- continue for any other Person Insured.

All other Crisis Covers for that Person Insured under this Policy will end.

23.5 What is not covered

AMP will not pay any Children's Crisis Cover if the Person Insured's Crisis condition is caused:

- by their use of alcohol or related to their use of drugs that are not prescribed by a doctor; or
- by anybody who is connected to the Person Insured, or to either of their parents, or to their parents' partners, or to the Policy Owner; or
- by any congenital condition (a condition that existed when the Person Insured was born)

- by engaging in a criminal act for which the Person Insured is convicted.

23.6 When Children's Crisis Cover ends

Children's Crisis Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 20th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2
d) when Children's Crisis Cover for the Person Insured is cancelled by the Policy Owner
e) when a payment is made under Children's Crisis Cover for the Person Insured.

23.7 Conversion of Children's Crisis Cover

The Children's Crisis Cover sum insured can be converted to Lifetrack Trauma Cover on written application, without assessment of the person insured's health or occupation. The conditions that apply to the Conversion of Children's Crisis Cover are as follows:

- Once converted the cover under Children's Crisis Cover will cease
- Conversion is available from age 16 and ends 30 days after the expiration of Children's Crisis Cover at age 20
- The new Lifetrack Trauma Cover will not include the optional Trauma Plus Option, or any Buyback options
- No benefit will be payable under the Trauma Cover for any congenital condition (a condition that existed when the Person Insured was born)

23.8 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Children's Crisis Cover must include:

- written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured suffers for the first time one of the crises defined in Clause 23.11, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

Medical diagnoses and investigation methods used in many of the Crisis conditions that We cover are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular Crisis condition.

Should the method(s) used to diagnose a Crisis condition not be specified within the relevant definition given in Clause 23.11, We may take the new diagnostic method(s) into consideration in assessing whether the Person Insured has been diagnosed with a Crisis condition.

23.9 Survival Period

If the Person Insured suffers a Crisis condition they must survive for 14 days.

However, for some Crisis conditions an additional Survival Period is required under Clause 23.11 (e.g. Coma).

23.10 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

23.11 Special Definitions of Medical Terms

Aplastic Anaemia	*Description* We will pay if a Person Insured has aplasia of the bone marrow which requires: • bone marrow transplantation; or

- immunosuppressive therapy.

Glossary of terms
Aplasia - failure of the bone marrow to produce blood cells.

Aplastic Anaemia - a severe form of anaemia caused by aplasia of the bone marrow.

Immunosuppressive therapy - therapy which suppresses the immune system.

Bacterial Meningitis

Description
We will pay if a Person Insured is diagnosed as having bacterial meningitis (including listeria monocytogenes meningitis and meningococcal disease), by lumbar puncture documenting the presence of bacteria in the cerebro spinal fluid. A Medical Doctor or appropriate consultant medical specialist must certify that the Person Insured has:

- severe inflammation of the meninges of the brain; and
- at least 25% Permanent Impairment of the Whole Person Function; or
- if the Person Insured is aged seven years or over, permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else.

Glossary of terms

Cerebro spinal fluid - fluid which surrounds the brain and fills the inner spaces within it.

Meningitis - inflammation of the covering of the brain and spinal cord.

Listeria monocytogenes meningitis – a bacterial infection of the brain membrane or meninges.

Meningococcal disease – a bacterial infection common in children, caused by inflammation of the coverings (meninges) of the brain.

Permanent Impairment of the Whole Person Function – criteria for the assessment and rating of permanent impairment as defined in the “Guides to the Evaluation of Permanent Impairment – 5th Edition” (or subsequent editions) produced by the American Medical Association.

Cancer

Description
We will pay if a Person Insured suffers a malignant tumour which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We also cover sarcoma, Hodgkin’s lymphoma, non-Hodgkin’s lymphoma and malignant bone marrow disorders including leukaemia.

We will not pay under this particular crisis condition for any of the following:

- Primary cancer of the breast, prostate, skin or bowel (these are covered in a separate definition); or
- Tumours which are confirmed as pre-malignant or showing malignant changes of ‘carcinoma in situ’ and not requiring major surgery; or
- AIDS related cancers.

Glossary of terms
Bone marrow disorders - life shortening and chronic disorder of bone marrow elements.

Carcinoma in situ - cancer confined to its site of origin and readily curable.

Hodgkin’s lymphoma and non-Hodgkin’s lymphoma - sometimes treatable malignant diseases causing enlargement of the lymph nodes and spleen.

Leukaemia - a malignant disease of the bone marrow, causing abnormalities in the blood, spleen, and lymph nodes.

Sarcoma - a malignant tumour usually occurring in the bone.

Cancer of the breast, prostate, skin or bowel	*Description* We will pay if a Person Insured suffers a malignant tumour of the breast, prostate, skin or bowel which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We will not pay under this particular crisis condition for any of the following: • skin cancers other than melanoma at least 1.5mm thick or at least Clark Level 3 depth of invasion; or • prostatic tumours which are confirmed as equivalent to or less than TNM Classification T1 (including T1a and T1b) unless they have a Gleason score of 6 or more; or • tumours which are histologically described as pre-malignant or showing malignant changes of 'carcinoma in situ' and not requiring major surgery; or • AIDS related cancers. *Glossary of terms* Carcinoma in situ - cancer confined to its site of origin and readily curable. Clark Level - a classification system describing the depth of invasion of a melanoma past the top layers of the skin. The classifications are from 1 to 5. Melanoma - a malignant tumour of the skin, usually developing from a mole. TNM classification - a classification system describing the extent of local infiltration and spread to glands or other parts of the body.
Leukaemia	*Description* We will pay if a Person Insured is diagnosed with leukaemia, including acute lymphoblastic leukaemia, acute myeloid leukaemia, chronic lymphocytic leukaemia and chronic myeloid leukaemia. *Glossary of terms* Acute lymphoblastic leukaemia (ALL) – a type of leukaemia that is caused by abnormal division of bone marrow stem cells. Acute myeloid leukaemia (AML) – a type of leukaemia that is caused by rapid development of myeloid cells, reducing the number of mature cells. Chronic lymphocytic leukaemia (CLL) - a type of leukaemia that is caused by defective lymphocytes (white blood cells). Chronic myeloid leukaemia (CML) – a type of leukaemia that affects granulocytes blood cells. Leukaemia - a malignant disease of the bone marrow, causing abnormalities in the blood, spleen, and lymph nodes.
Major Head Trauma	*Description* We will pay if a Person Insured suffers an accidental head injury which results in significant neurological damage which, in the opinion of an appropriate consultant medical specialist, is likely to be permanent. *Glossary of terms* Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.
Major Organ Transplant	*Description* We will pay if a Person Insured receives a transplant from a human donor of bone marrow, or one of the following whole organs:

- Kidney
- Heart
- Lung
- Liver
- Small bowel
- Pancreas.

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

We will not pay if the Person Insured donates an organ or tissue for transplant.

Paralysis - Diplegia

Description
We will pay if the Person Insured suffers total and permanent paralysis of both arms or both legs.

We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.

Glossary of terms
Paralysis – complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – Hemiplegia

Description
We will pay if a Person Insured suffers total and permanent paralysis of both the arm and the leg on the same side of the body.

We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.

Glossary of terms
Paralysis – complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – Paraplegia

Description
We will pay if a Person Insured suffers total and permanent paralysis of both legs.

We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.

Glossary of terms
Paralysis – complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Paralysis – Quadriplegia/ Tetraplegia

Description
We will pay if a Person Insured suffers total and permanent paralysis of both arms and both legs.

We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause.

Glossary of terms
Paralysis – complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.

Severe Burns

Description
We will pay if a Person Insured suffers full thickness burns to:
- 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart, or

- 25% of their face requiring surgical debridement and/or grafting, or
- 50% of **both** hands requiring surgical debridement and/or grafting.

The burns can be caused by thermal, electrical or chemical agents.

Glossary of terms
Lund Browder Body Surface Chart: The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and each leg (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area.

Subacute Sclerosing Panencephalitis

Description
We will pay if a Person Insured is diagnosed to have subacute sclerosing panencephalitis by an appropriate consultant medical specialist.

Glossary of terms
Subacute sclerosing panencephalitis - a progressive and fatal disease of the brain suspected to be of viral origin.

Viral Encephalitis

Description
We will pay if a Person Insured is diagnosed as having encephalitis by an appropriate consultant medical specialist. The Person Insured must have impaired brain function. The impairment must:

- continue for at least 6 weeks, and
- be certified by an appropriate consultant medical specialist to exist and to be likely to be permanent.

Glossary of terms
Encephalitis - infection of the brain causing inflammation.

24 Children's Future Life Cover

Cover under this Clause will only apply if shown in the Schedule or most recent Replacement Schedule, for the Person Insured, and if current.

24.1 Children's Future Life Cover

For thirty days before and after the policy anniversary occurring after the 18th, 21st, 25th, 30th and 35th birthdays of the Person Insured, the Policy Owner will have the option of taking out, on their written application, Life Cover on the Person Insured's life, irrespective of the Person Insured's state of health or occupation at that time.

The Policy Owner will also have the option of taking out, on their written application, Life Cover on the Person Insured's life following the events listed below, irrespective of the Person Insured's state of health or occupation at that time:

- in the thirty days before or after the birth of a child of the Person Insured, or adoption of a child by the Person Insured; and
- in the thirty days after completion of a university education, to cover the related debt; and
- in the thirty days before or after the Person Insured purchases their principal residence for the first time, or before or after subsequent increase in indebtedness specifically related to the improvement of their principal residence, but only to the extent of the original or increased indebtedness. The indebtedness must have occurred because of a transaction with a recognised mortgage provider.

24.2 When Children's Future Life Cover ends

Children's Future Life Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) their 36th birthday
c) when this Policy ends as in Clause 9.2
d) when the Children's Future Life Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Children's Future Life Cover for the Person Insured is cancelled or reduced to nil.

24.3 How much Children's Future Life Cover can be converted to Life Cover

Life Cover taken out may be for a Basic Sum Insured up to the amount of Children's Future Life Cover as shown in the Schedule or most recent Replacement Schedule.

No claim or amount is payable on Children's Future Life Cover.

24.4 If you don't take up this option

If the Policy Owner does not take up this option during the times allowed, then they forfeit their right to do so.

24.5 When additional Cover is taken out

Any additional cover taken out will be subject to the normal terms and conditions for new covers of that type applying at that time, and:

- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the current age of the Person Insured
- will not, unless otherwise agreed by AMP or stated in this Policy, contain any special provision or additional cover, for which AMP then usually charges an increased or additional Premium.

24.6 Premium Cover

If this Policy includes Premium Cover, any additional policy taken out can also include a similar cover if the Policy Owner so wishes. Any such cover:

- will be subject to the usual terms and conditions of Premium Cover applying at that time
- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the current age of the Person Insured.

25 Income Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

25.1 Total Disablement Feature

If a Person Insured with this cover becomes Totally Disabled AMP will pay a monthly benefit under the Total Disablement Feature.

25.1.1 What We mean by Totally Disabled

"Totally Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Totally Disabled. The Person Insured is Totally Disabled if:

- they are so ill or injured that they can't do their usual occupation for more than 10 hours per week; and
- they are under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- they do not do any remunerative work (apart from up to 10 hours per week in their usual occupation).

However, for some occupations after the Person Insured has been Totally Disabled for 2 or 5 years, the definition of being Totally Disabled changes. If this definition applies to the Person Insured it will be specified in the Schedule. It becomes:

- they are so ill or injured that they can't do any remunerative work for which they are reasonably suited by their education, training, or experience; and
- they are under the ongoing care of a Medical Doctor for that illness or injury; and
- they do not do any remunerative work.

"Total Disablement" has a corresponding meaning.

25.1.2 How much We will pay

For Indemnity Value cover the benefit payable under the Total Disablement Feature is the lower of:

- the Maximum Monthly Benefit described in Clause 25.1.4, and
- 75% of your Average Monthly Earned Income (see Clause 10) less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 25.1.6.

For Agreed Value cover the benefit payable under the Total Disablement feature is the Maximum Monthly Benefit described in Clause 25.1.4 less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 25.1.6.

The benefit is paid monthly in arrears for the duration of the Person Insured's entitlement. Benefits payable for periods of less than one month are calculated on a daily basis.

25.1.3 When a benefit is payable under the Total Disablement Feature

Payment of benefits under the Total Disablement Feature will start on the first day of Total Disablement after the Waiting Period specified in the Schedule.

To qualify for a benefit under the Total Disablement Feature

- if your Waiting Period is two weeks, the Person Insured must be unable to work at all for a continuous period exceeding the Waiting Period, or
- if your Waiting Period is longer than two weeks, the Person Insured must be unable to work at all for an initial period of at least two weeks. During the remainder of the Waiting Period the Person Insured

must be unable to return to their usual occupation on a Full-Time basis other than for up to a total of 10 hours per week.

25.1.4 Maximum Monthly Benefit

The Maximum Monthly Benefit which is payable during the first year of this cover is as shown in the Schedule or most recent Replacement Schedule for the Person Insured.

Indexation on Maximum Monthly Benefit
If indexation is selected, the Maximum Monthly Benefit will increase for subsequent years on each Policy Anniversary, in line with the percentage increase in the CPI for the preceding year ending 30 September. If the percentage change in the CPI is nil or negative for the year, the Maximum Monthly Benefit will not change.

If Claims Escalation is selected, and if benefits are being paid under this cover at the time of any Policy Anniversary, the benefit will be increased in line with the Consumer Price Index.
The Maximum Monthly Benefit for any year may not exceed our limit for new covers at the Policy Anniversary.

You may choose not to accept an annual Maximum Monthly Benefit increase. To do this you must send a written application to AMP. We will then inform you of the new Premium payable. By paying the increased Premium in respect of an increased Maximum Monthly Benefit, you indicate that you accept the increase.

25.1.5 When benefit payment under the Total Disablement Feature ends

Payments of benefits under the Total Disablement Feature for a Person Insured end on the earliest of:
a) the expiry of the Benefit Period as shown in the Schedule or most recent Replacement Schedule, or
b) the Person Insured ceasing to be Totally Disabled, or
c) the death of the Person Insured, or
d) the 65th birthday of the Person Insured, or
e) the Policy ending as in Clause 9.2, or
f) this cover being cancelled for the Person Insured by the Policy Owner.

25.1.6 Periodic income replacement payments

The benefits payable under the Total Disablement Feature (under Clause 25.1.2) will be determined on the basis of payments received by the Person Insured, or to which they are entitled, relating to the period for which Total Disablement benefits are payable. These payments include those:

- from their employer, former employer, employment business or partnerships or like sources (including any income earned during the period not exceeding 10 hours per week referred to in Clause 25.1.1),
- from Accident Compensation or other welfare benefits because the Person Insured is disabled (unless the Policy Owner can prove, and We agree, that the payments are a permanent disability benefit being paid as income),
- from other regular income insurance policies or superannuation, because the Person Insured is disabled.

These payments will not include:

- investment income including, without limitation, income from rent and royalties; or
- regular amounts paid as compensation because of the Person Insured's pain and suffering; or
- sick leave where it is not used; or
- lump sum payments received or due to be received because the Person Insured is disabled, unless they were previously paid as a regular income, and where they were converted to a lump sum at the Person Insured's or Policy Owner's discretion. Where an income is taken as a lump sum, We will offset from what We pay every month, one 100th of the lump sum amount received.

If such payments are not made monthly, AMP will calculate a monthly rate for the purposes of Clause 25.1.2.

If at any time during or after a period of Total Disablement, We learn that such payment has been made to (or is payable to or claimable by) the Person Insured in respect of that month which We were not aware of, the benefit for that month may be reduced. Any difference between the benefit paid for that month and the reduced amount must be repaid.

25.2 Recovery Feature

If a Person Insured with this cover becomes Totally Disabled, as defined and is then able to return to work for more than 10 hours per week on other than a Full-Time basis in their usual occupation, then AMP will pay a benefit under the Recovery Feature as calculated below.

25.2.1 How much We will pay

The benefit payable under the Recovery Feature is equal to: $\frac{(A-B)\times C}{A}$

Where:

- A is the Person Insured's Average Monthly Earned Income for Indemnity Value cover, or the Person Insured's Agreed Monthly Income for Agreed Value cover (see Clause 10)
- B is the Person Insured's current monthly earned income from their occupation or work
- C is the Total Disablement benefit for that month (see Clause 25.1.2)

For example		
Average Monthly Earned Income / Agreed Monthly Income		$2,000
Current monthly earnings		$900
Total Disablement benefit for the month		$1,500
Recovery Feature benefit (this month)	$\frac{(2{,}000-900)\times 1{,}500}{2{,}000}$ = $\frac{(1{,}100\times 1{,}500)}{2{,}000}$	
Total		$825

For the month you will receive:	
Recovery Feature benefit	$825
Current Earnings	$900
Total	$1,725

This compares with the benefit payable under the Total Disablement Feature of $1,500 for the month. It is, therefore, in the interests of the Person Insured to take up work.

This benefit is paid monthly in arrears for the duration of the Person Insured's entitlement (see Clause 25.2.3). Benefits for periods of less than one month are calculated on a daily basis.

25.2.2 When Recovery Feature starts

Recovery Feature starts on the Starting Date of this cover, but benefit payment will start one month after the end of the Waiting Period, as stated in the Schedule.

To qualify for a benefit under Recovery Feature:

- if your Waiting Period is two weeks, the Person Insured must be Totally Disabled (as defined under clause 25.1.1) continuously for the Waiting Period;
- if your Waiting Period is longer than two weeks, the Person Insured must be Totally Disabled (as defined under clause 25.1.1) continously for at least the first two weeks of the Waiting Period. During the remainder of the Waiting Period, the Person Insured must be able to return to work for more than 10 hours per week but as a direct result of the accident, injury or illness, is unable to return to work

Full-Time and is earning less than their Average Monthly Earned Income for Indemnity Value Cover or the Agreed Monthly Income for Agreed Value Cover (see clause 10); and

- the Person Insured is under the ongoing care of a Medical Doctor for the illness or injury and is complying with the advice and treatment recommended by that Medical Doctor.

25.2.3 When benefit payment under Recovery Feature ends

Payments of benefits under Recovery Feature end for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) the Policy ending as in Clause 9.2
d) this cover being cancelled for the Person Insured by the Policy Owner
e) the expiry of the Benefit Period stated in the Schedule or most recent Replacement Schedule
f) when any of the conditions for payment set out in Clause 25.2.2 are not met
g) the Benefit End Date as shown in the Schedule or most recent Replacement Schedule
h) the Person Insured returns to work on a Full-Time basis.
i) the Recovery Feature benefit calculated under clause 25.2.1 being nil or negative .

25.3 Relapse Feature

If the Person Insured is able to work for more than 10 hours per week during the Waiting Period after a period during which they were Totally Disabled, and they suffer a relapse and are again Totally Disabled, then:

- if they are able to work for 5 days in a row (or less), and they suffer a relapse of the same or a related illness or injury, then the Waiting Period continues. It does not start again. We only start to pay when the Person Insured is Totally Disabled for the total number of days that make up the normal Waiting Period.
- if they are able to work for more than 5 days in a row, and they suffer a relapse of the same or a related illness or injury, then the Waiting Period starts all over again. We don't count the days that the Person Insured was Totally Disabled before the relapse.

If the Person Insured suffers a relapse, which in our opinion arises from the same or a related cause for which they were previously entitled to a benefit, then:

- if the Person Insured has been able to work for 12 months or more after We stopped paying, then We treat the claim as a new claim, and the Waiting Period and the Benefit Payment Period start all over again.
- if the Person Insured has been able to work for less than 12 months after We stopped paying, then We treat the claim as a continuation of the same claim. That is, the Waiting Period and the Benefit Payment Period do not start again.

25.4 Rehabilitation and Vocational Costs Feature

The Rehabilitation and Vocational Costs benefit is payable at AMP's discretion, for reimbursement of money spent with AMP's prior approval, on equipment, home alterations, training, counselling and other capital expenses which are certified by the Person Insured's attending Medical Doctor to be necessary in the course of rehabilitation or that AMP agrees will assist the Person Insured to return to Full-Time work. This benefit is not payable for expenses that are reimbursable from other sources. The Person Insured must notify AMP and must receive prior written approval of AMP before the costs are incurred (see Clause 25.15.2).

25.4 1 How much We will pay

AMP may pay multiple payments but the total benefit payable over the term of the claim is 12 times the monthly amount We would pay if the Person Insured was Totally Disabled. It is not contingent upon the Person Insured receiving a monthly benefit under Income Cover. It may be paid before the end of the Waiting Period.

25.5 Bedcare Feature

Provided that the Person Insured is bedridden (as defined) during the Waiting Period, AMP will pay an amount based on the monthly amount that it would normally pay if the Person Insured was Totally Disabled. We calculate what We pay on a daily basis, and We pay for every day that the Person Insured is bedridden during the Waiting Period.

25.5.1 What We mean by "Bedridden"

The definition of "bedridden" is:

a) the Person Insured is unable to work at all; and
b) the Person Insured is confined to bed for more than 3 days in a row; and
c) a Medical Doctor requires them to be (and they are) under the full-time care of a registered nurse. The nurse cannot be the Person Insured or the Policy Owner, or a member of the immediate family of either.

If the Person Insured is bedridden more than once during one Waiting Period, they don't have to be bedridden on the second or subsequent occasion for a further 3 days in a row – We treat all of the days they were bedridden as one claim.

25.5.2 When Bedcare Feature ends

We stop paying on the earlier of:

a) the expiry of the Waiting Period; or
b) 91 days payment under the Bedcare Feature; or
c) the Person Insured no longer being bedridden; or
d) the Income Cover ends (see Clause 25.13).

25.6 Unpaid Leave Feature

If the Person Insured undertakes a period of leave without pay from their occupation, then the Policy Owner may choose one of the options below (see Clause 25.6.2).

25.6.1 What We mean by "leave without pay"

"Leave without pay" here means:

a) compassionate leave, or
b) maternity leave, or
c) paternity leave, or
d) sabbatical leave, or
e) study leave for study at a registered educational centre.

25.6.2 The Policy Owner's options

In the event of the Person Insured taking unpaid leave, you have two options in respect of Income Cover:

- to continue cover and the payment of Premiums during the period of leave without pay (see Clause 25.6.3)
- to cancel cover and the payment of Premiums, with a guaranteed right to recommence cover after the period of leave without pay (see Clause 25.6.4) but within 12 months of cancelling the cover.

25.6.3 Option to continue cover

If you choose to continue the payment of Premiums, cover will continue during the period of leave without pay.

If the Person Insured suffers a sickness or accident during the period of leave without pay, and becomes Totally Disabled as defined, benefit payment will start from the later of the end of the Waiting Period or the end of the period of leave.

25.6.4 Option to cancel cover

If you choose not to continue the payment of Premiums, cover will stop immediately. No benefits will be payable during the period of leave without pay, nor during the first month after the Person Insured returns to work, for sickness or accident occurring during the period of leave without pay.

Cover will recommence only if the following conditions have been met:

- the Person Insured has returned to their usual occupation, and
- the Person Insured has worked for at least 25 hours per week for at least one month after their return to work, and
- the period of employment since returning to work is continuous, and
- the return to work occurs within 12 months of stopping work, and
- payment of Premiums has recommenced.

Where payment of Premiums has not recommenced but the Person Insured has returned to work for a continuous period of at least one month and you have notified Us in writing of your intention to recommence cover, cover can recommence. Should disability occur, the Waiting Period will start from the date that the payment of Premiums recommences.

25.6.5 Limit to Period

Unpaid Leave Feature is limited to a maximum continuous period of 12 months. If the period of leave without pay exceeds or is expected to exceed 12 months, Income Cover will be cancelled.

25.6.6 Notification of leave

Written notice of the Person Insured's absence from their occupation on leave without pay must be received by AMP not later than one month after the beginning of the period of leave. You must also provide details of:

- the date of stopping work
- the reason for the leave
- the expected duration of the period of leave
- your choice to continue or cancel Premium payments and cover.

25.6.7 Return to work

No additional health evidence will be required on return to work. The Maximum Monthly Benefit and the terms of this cover will remain unchanged upon return to work after a period of unpaid leave.

For Indemnity Value cover the Average Monthly Earned Income (See Clause 10) for claims arising within the first six months after the Person Insured returns to work will be based on the average monthly earnings in the 12 months prior to the period of leave without pay. If the Person Insured has not returned to Full-Time work, then the Average Monthly Earned Income will be based on a pro rata percentage of the average monthly earnings in the 12 months prior to the period of leave without pay. For claims arising after the first six months, the Average Monthly Earned Income will be based on the average monthly earnings after the return to work.

For Agreed Value cover the Agreed Monthly Income (see clause 10) will be the Agreed Monthly Income prior to the period of leave without pay. If the Person Insured has not returned to Full-Time work, then the Agreed Monthly Income will be based on a pro rata percentage of the Agreed Monthly Income prior to the period of leave without pay.

25.6.8 Frequency of Unpaid Leave Option

There must be a continuous period of at least 12 months of employment between each period during which an Unpaid Leave Feature option applies.

25.7 Long Waiting Period Conversion Option

A Person Insured with a 104 week Waiting Period can elect to reduce to a 13 week Waiting Period upon resignation from a job, provided they:

- had an at arms length relationship with the employer (in AMP's opinion); and
- apply within 30 days of resignation; and
- certify they did not resign because of ill health or incapacity; and
- can answer some basic income and occupation questions to AMP's satisfaction; and
- can show firm plans (e.g. a letter of offer) to recommence paid re-employment within the next 12 months in a job We would normally insure.

25.8 Claims Escalation Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

This option allows the monthly benefit paid to the Person Insured upon claim under this cover to increase each year at the Policy Anniversary. The percentage increase that is applied will be the percentage increase in the CPI for the preceding year ending 30 September. The increase will be applied on the Policy Anniversary. If the percentage change in the CPI is nil or negative for the year, the monthly benefit paid on claim will not change.

25.9 Chronic Condition Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

25.9.1 Chronic Condition Option

We pay if the Person Insured has a chronic condition (as defined in Clause 25.9.2). We only pay under this option during the Waiting Period.

25.9.2 What We mean by "Chronic Condition"

"Chronic Condition" means that as a result of physical illness or injury, the ability of the Person Insured to do their usual occupation has been, and continues to be, significantly reduced. This is evidenced by:

- Clinically significant test results showing their illness or injury is expected to be constantly present for life and there is no known cure; and
- Their weekly hours of work have been reduced on a Medical Doctor's advice to less than 75% of the average normal hours that they worked in the 3 years before they lodged their claim, and this reduction continues for at least 3 consecutive months and also while We are paying under the cover; and
- The Person Insured's weekly income has been reduced to less than 75% of their highest in the 3 years before they claim.

As Chronic Condition Option only covers chronic conditions that result from physical illness or injury, We do not cover conditions that are psychosomatic or psychiatric in nature.

25.9.3 How much We will pay

If the Person Insured suffers a Chronic Condition, AMP will pay a benefit for the duration of the Waiting Period, equal to the difference between what We would pay under the Total Disablement Feature and the amount the Person Insured is earning (or could earn) from work.

25.9.4 When benefit payment under Chronic Condition Option ends

Payment of benefit under Chronic Condition Option ends for a Person Insured on the earliest of:

a) the end of the Waiting Period
b) the Person Insured's 65th birthday
c) the Policy ending as in Clause 9.2
d) this cover being cancelled for the Person Insured by the Policy Owner

e) the death of the Person Insured
f) when any of the conditions set out in Clause 25.9.2 cease to be met.

25.10 Death benefit

If the Person Insured dies while receiving a benefit under either the Total Disablement Feature or the Recovery Feature, We will pay a lump sum equal to 3 times the amount described in Clause 25.1.2 up to a maximum of $10,000 to the Policy Owner.

No death benefit will be paid if the Person Insured's death occurs:

- As a direct or indirect result of an intentional self-inflicted act (whether sane or insane); or
- During the Waiting Period.

Only one death benefit is payable for each Person Insured across all AMP Income Cover policies issued by AMP.

25.11 Payments while located overseas

Coverage is provided 24 hours, world-wide. We pay the normal amount we would pay for up to 3 months if the Person Insured is resident outside Australia or New Zealand and while they are Totally Disabled as defined in Clause 25.1.1. We may continue to pay beyond 3 months, and We reserve the right for claim assessments to be conducted in a country nominated by Us. If We discontinue payments, then when the Person Insured returns to Australia or New Zealand, We will start paying again provided they are still Totally Disabled.

25.12 Airfare Assistance if Totally Disabled while overseas

Airfare assistance is available if the Person Insured has been resident outside of Australia or New Zealand for more than 30 days, and they have been unable to work at all for at least 14 days because they are Totally Disabled while they were overseas. We will reimburse up to the cost of one single economy airfare for the Person Insured to return home, by the most direct route available, less any amounts that are reimbursed from other sources.

25.13 When Income Cover ends

Income Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2
d) the Person Insured ceasing to be actively engaged in their usual occupation for more than 12 months for reasons other than their total disablement, unless We have been notified in writing and our written consent has been given. In giving consent We may vary the terms and conditions of this Policy, including an increase in the Premium
e) AMP exercising our right to cancel in the event that a period of leave without pay exceeds, or is expected to exceed, 12 months (see Clause 25.6.5)
f) when Income Cover for the Person Insured is cancelled by the Policy Owner
g) when the Person Insured ceases to comply with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP.

25.14 What is not covered

No benefits will be paid under this Cover if the Person Insured is unable to work due to injury, accident or illness wholly or partly, directly or indirectly caused:

- on purpose – we won't pay if the Policy Owner, the Person Insured or a relative of the Person Insured causes the Person Insured to be unable to work.
- (if the optional AIDS exclusion is contained in the Schedule) by the presence in the Person Insured's body of:
  i. Any Human Immunodeficiency Virus (HIV)
  ii. Acquired Immunodeficiency Syndrome (AIDS)

iii. Any AIDS related condition or infection.

- (if the optional Injury and Accident Exclusion is contained in the Schedule) by an accident
- by the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted

As normal and uncomplicated pregnancy and childbirth are not illnesses for the purposes of the definition of Total Disablement, they are not covered under this Cover.

25.15 Making a claim

25.15.1 Notifying AMP of a claim

As well as meeting the general conditions in Clause 3.1 and Clause 25.15.3, any claim for a benefit payment under Total Disablement, the Bedcare Feature or the Chronic Condition Option must be given to Us within one month after:

- the occurrence of Total Disablement, or
- the onset of the Chronic Condition, or
- the Person Insured becoming bedridden.

No claim will be payable for periods more than one month before AMP's receipt of notice of a claim.

25.15.2 We must be notified of a claim under the Rehabilitation and Vocational Costs Feature (and give prior written approval) before any costs are incurred.

25.15.3 Evidence for claims

As well as meeting the general conditions in Clause 3.1, before We can assess your eligibility for a claim under Income Cover, we require:

- evidence of hours worked and income earned
- evidence of the Average Monthly Earned Income of the Person Insured (for Indemnity Value cover only)
- evidence that the Person Insured is declaring the benefit for tax purposes e.g. Tax Return (for Agreed Value cover only)
- proof, to the satisfaction of AMP, that the Person Insured continues to receive medical treatment from, and follow the advice of, a Medical Doctor or appropriate consultant medical specialist who is acceptable to AMP.

For the purposes of ongoing claim assessment, AMP may request at our expense the Person Insured :

- undergo one or more examinations by a Medical Doctor nominated by AMP
- undergo medical tests which may include the taking of blood samples for pathological examination by medical personnel nominated by AMP
- provide any other information that AMP requires to assess entitlements under this Policy, for example, Inland Revenue assessments and business accounts.

All evidence must be provided within two months of the claim period to which it relates. No claim will be payable in respect of any period more than two months prior to AMP's receipt of proper evidence supporting a claim.

25.15.4 Payment of claims

All benefits under Income Cover will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits under Income Cover will be paid to the employer.

25.16 Premium Cover

If Premium Cover is selected for Income Cover, the premium will be waived from the earlier of the end of the Income Cover Waiting Period or the Premium Cover Waiting Period. Upon the Person Insured

becoming Totally Disabled and receiving a monthly benefit under the Total Disablement Feature (clause 25.1) or the Recovery Feature (clause 25.2), any premiums paid from the first day of Total Disablement will be refunded to the Policy Owner. Premiums will continue to be waived until the Person Insured ceases to be Totally Disabled, the Person Insured dies or the Cover End Date specified in the Schedule (whichever is earlier).

25.17 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

26 Income Cover Essentials

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

26.1 Total Disablement Feature

If a Person Insured with this cover becomes Totally Disabled AMP will pay a monthly benefit under the Total Disablement Feature.

26.1.1 What We mean by Totally Disabled

"Totally Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Totally Disabled. The Person Insured is Totally Disabled if:

- they are so ill or injured that they can't do their usual occupation for more than 10 hours per week; and
- they are under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- they do not do any remunerative Work (apart from up to 10 hours per week in their usual occupation).

However, for some occupations, after the Person Insured has been Totally Disabled for 2 or 5 years, the definition of being Totally Disabled changes. If this definition applies to the Person Insured it will be specified in the Schedule. It becomes:

- they are so ill or injured that they can't do any remunerative work for which they are reasonably suited by their education, training, or experience; and
- they are under the ongoing care of a Medical Doctor for that illness or injury; and
- they do not do any remunerative Work.

"Total Disablement" has a corresponding meaning.

26.1.2 How much We will pay

For Indemnity Value cover the benefit payable under the Total Disablement Feature is the lower of:

- the Maximum Monthly Benefit described in Clause 25.1.4, and
- 75% of your Average Monthly Earned Income (see Clause 10) less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 25.1.6.

For Agreed Value cover the benefit payable under the Total Disablement feature is the Maximum Monthly Benefit described in Clause 25.1.4 less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 26.1.6.

The benefit is paid monthly in arrears for the duration of the Person Insured's entitlement. Benefits payable for periods of less than one month are calculated on a daily basis.

26.1.3 When a benefit is payable under the Total Disablement Feature

Payment of benefits under the Total Disablement Feature will start on the first day of Total Disablement after the Waiting Period specified in the Schedule.

To qualify for a benefit under the Total Disablement Feature

- if your Waiting Period is two weeks, the Person Insured must be unable to Work at all for a continuous period exceeding the Waiting Period, or

- if your Waiting Period is longer than two weeks, the Person Insured must be unable to Work at all for an initial period of at least two weeks. During the remainder of the Waiting Period the Person Insured must be unable to return to their usual occupation on a Full-Time basis other than for up to a total of 10 hours per week.

26.1.4 Maximum Monthly Benefit

The Maximum Monthly Benefit which is payable during the first year of this cover is as shown in the Schedule or most recent Replacement Schedule for the Person Insured.

Indexation on Maximum Monthly Benefit

If Indexation is selected, the Maximum Monthly Benefit will increase for subsequent years on each Policy Anniversary, in line with the percentage increase in the CPI for the preceding year ending 30 September. If the percentage change in the CPI is nil or negative for the year, the Maximum Monthly Benefit will not change.

If Claims Escalation is selected, and if benefits are being paid under this cover at the time of any Policy Anniversary, the benefit will be increased in line with the Consumer Price Index.

The Maximum Monthly Benefit for any year may not exceed our limit for new covers at the Policy Anniversary.

You may choose not to accept an annual Maximum Monthly Benefit increase. To do this you must send a written application to AMP. We will then inform you of the new Premium payable. By paying the increased Premium in respect of an increased Maximum Monthly Benefit, you indicate that you accept the increase.

26.1.5 When benefit payment under the Total Disablement Feature ends

Payments of benefits under the Total Disablement Feature for a Person Insured end on the earliest of:

a) the expiry of the Benefit Period as shown in the Schedule or most recent Replacement Schedule, or
b) the Person Insured ceasing to be Totally Disabled, or
c) the Person Insured not complying with reasonable or consistent treatment and/or rehabilitation which in our opinion could be reasonably expected to assist their return to Work, or
d) the death of the Person Insured, or
e) the 65th birthday of the Person Insured, or
f) the Policy ending as in Clause 9.2, or
g) this cover being cancelled for the Person Insured by the Policy Owner.

26.1.6 Periodic income replacement payments

The benefits payable under the Total Disablement Feature (under Clause 25.1.2) and the Recovery Feature (under Clause 26.2.2) will be determined on the basis of payments received by the Person Insured, or to which they are entitled, relating to the period for which Total Disablement or Partial Disablement benefits are payable. These payments include those:

- from their employer, former employer, employment business or business partnerships, family trust or company (including any income earned during the period not exceeding 10 hours per week referred to in Clause 25.1.1),
- that you have the capacity to earn but have not necessarily received, such as any payment (determinded by hours and, or amount) that in our opinion, based on the advice of Medical Doctor(s) or appropriate consultant Medical Specialist(s) acceptable to AMP, the Person Insured could be reasonably expected to receive for Work,
- from any government funded source (such as Accident Compensation Corporation), and
- from other regular income, received or entitled to be received from, any disability, sickness or accident insurance policies or superannuation.

These payments will not include:

- investment income including, without limitation, income from rent and royalties; or

- regular amounts paid as compensation because of the Person Insured's pain and suffering; or
- sick leave where it is not used; or
- lump sum payments received or due to be received because the Person Insured is disabled, unless they were previously paid as a regular income, and where they were converted to a lump sum at the Person Insured's or Policy Owner's discretion. Where an income is taken as a lump sum, We will offset from what We pay every month, one 100th of the lump sum amount received.

If such payments are not made monthly, AMP will calculate a monthly rate for the purposes of Clause 25.1.2.

If at any time during or after a period of Total Disablement or Partial Disablement, We learn that such payment has been made to (or is payable to or claimable by) the Person Insured in respect of that month which We were not aware of, the benefit for that month and any future months (or the month in which We learnt of the payment) may be reduced. Any difference between the benefit paid for that month and the reduced amount must be repaid or will be reduced in the month We learn of the payment.

26.2 Recovery Feature

If a Person Insured with this cover becomes Partially Disabled, as defined, then AMP will pay a benefit under the Recovery Feature as calculated below.

26.2.1 What We mean by Partially Disabled

"Partially Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Partially Disabled. The Person Insured is Partially Disabled if:

- under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- able to do any occupation for more than 10 hours per week but due to the illness, accident or injury is unable to earn 75% or greater of their Average Monthly Earned Income; or
- able to do any occupation for more than 10 hours per week but due to the illness, accident or injury is unable to Work more than 75% or greater of their average weekly hours according to their Average Monthy Earned Income.

26.2.2 How much We will pay

The benefit payable under the Recovery Feature is equal to: $\frac{(A-B)\times C}{A}$

Where:

- A is the Person Insured's Average Monthly Earned Income for Indemnity Value cover, or the Person Insured's Agreed Monthly Income for Agreed Value cover (see Clause 10)
- B is the Person Insured's current monthly earned income from their occupation or work and any amounts paid or payable as "periodic income replacement payments" described in Clause 26.1.6
- C is the Total Disablement benefit for that month (see Clause 25.1.2)

This benefit is paid monthly in arrears for the duration of the Person Insured's entitlement (see Clause 25.2.4). Benefits for periods of less than one month are calculated on a daily basis.

26.2.3 When Recovery Feature starts

Recovery Feature starts on the Starting Date of this cover, but benefit payment will start one month after the end of the Waiting Period, as stated in the Schedule.

To qualify for a benefit under Recovery Feature:

- if the Waiting Period is two weeks, the Person Insured must be Totally Disabled (as defined under clause 26.1.1) continuously for the Waiting Period; or

if the Waiting Period is longer than two weeks, the Person Insured must be Totally Disabled (as defined under clause 26.1.1) continuously for at least the first two weeks of the Waiting Period. During the remainder of the Waiting Period, the Person Insured must be Partially Disabled (as defined under clause 26.2.1)

26.2.4 When benefit payment under Recovery Feature ends

Payments of benefits under Recovery Feature end for a Person Insured on the earliest of:

a) the Person Insured ceasing to be Partially Disabled
b) the death of the Person Insured
c) the 65th birthday of the Person Insured
d) the Policy ending as in Clause 9.2
e) this cover being cancelled for the Person Insured by the Policy Owner
f) the expiry of the Benefit Period stated in the Schedule or most recent Replacement Schedule
g) when any of the conditions for payment set out in Clause 26.2.3 are not met
h) the Benefit End Sate as shown in the Schedule or most recent Replacement Schedule
i) The Person Insured not undertaking reasonable or consisten treatment and/or rehabilitation which in our opinion could be expected to assist their return to Full-Time Work
j) the Recovery Feature benefit calculated under clause 26.2.2 being nil or negative.

26.3 Relapse Feature

If the Person Insured is able to Work for more than 10 hours per week during the Waiting Period after a period during which they were Totally Disabled, and they suffer a relapse and are again Totally or Partially Disabled, then:

- if they are able to Work for 5 days in a row (or less), and they suffer a relapse of the same or a related illness or injury, then the Waiting Period continues. It does not start again. We only start to pay when the Person Insured is Totally Disabled or Partially Disabled for the total number of days that make up the normal Waiting Period.
- if they are able to Work for more than 5 days in a row, and they suffer a relapse of the same or a related illness or injury, then the Waiting Period starts all over again. We don't count the days that the Person Insured was Totally Disabled or Partially Disabled before the relapse.

If the Person Insured suffers a relapse, which in our opinion arises from the same or a related cause for which they were previously entitled to a benefit, then:

- if the Person Insured has been able to Work for 12 months or more after We stopped paying, then We treat the claim as a new claim, and the Waiting Period and the Benefit Payment Period start all over again.
- if the Person Insured has been able to Work for less than 12 months after We stopped paying, then We treat the claim as a continuation of the same claim. That is, the Waiting Period and the Benefit Payment Period do not start again.

26.4 Unpaid Leave Feature

If the Person Insured undertakes a period of leave without pay from their occupation, then the Policy Owner may choose one of the options below (see Clause 25.64.2).

26.4.1 What We mean by "leave without pay"

"Leave without pay" here means:

a) compassionate leave, or
b) maternity leave, or
c) paternity leave, or
d) sabbatical leave, or
e) study leave for study at a registered educational centre.

26.4.2 The Policy Owner's options

In the event of the Person Insured taking unpaid leave, you have two options in respect of Income Cover:

- to continue cover and the payment of Premiums during the period of Leave without pay (see Clause 26.4.3)
- to cancel cover and the payment of Premiums, with a guaranteed right to recommence cover after the period of Leave without pay (see Clause 25.6.4.4) but within 12 months of cancelling the cover.

26.4.3 Option to continue cover

If you choose to continue the payment of Premiums, cover will continue during the period of Leave without pay.

If the Person Insured suffers a sickness or accident during the period of Leave without pay, and becomes Totally Disabled as defined, benefit payment will start from the later of the end of the Waiting Period or the end of the period of leave.

26.4.4 Option to cancel cover

If you choose not to continue the payment of Premiums, cover will stop immediately. No benefits will be payable during the period of Leave without pay, nor during the first month after the Person Insured returns to Work, for sickness or accident occurring during the period of Leave without pay.

Cover will recommence only if the following conditions have been met:

- the Person Insured has returned to their usual occupation, and
- the Person Insured has worked for at least 25 hours per week for at least one month after their return to Work, and
- the period of employment since returning to Work is continuous, and
- the return to Work occurs within 12 months of stopping Work, and
- payment of Premiums has recommenced.

Where payment of Premiums has not recommenced but the Person Insured has returned to Work for a continuous period of at least one month and you have notified Us in writing of your intention to recommence cover, cover can recommence. Should disability occur, the Waiting Period will start from the date that the payment of Premiums recommences.

26.4.5 Limit to Period

Unpaid Leave Feature is limited to a maximum continuous period of 12 months. If the period of Leave without pay exceeds or is expected to exceed 12 months, Income Cover Essentials will be cancelled.

26.4.6 Notification of leave

Written notice of the Person Insured's absence from their occupation on Leave without pay must be received by AMP no later than one month after the beginning of the period of leave. You must also provide details of:

- the date of stopping Work;
- the reason for the leave;
- the expected duration of the period of leave; and
- your choice to continue or cancel Premium payments and cover.

26.4.7 Return to work

No additional health evidence will be required on return to Work. The Maximum Monthly Benefit and the terms of this cover will remain unchanged upon return to Work after a period of unpaid leave.

For Indemnity Value cover the Average Monthly Earned Income (See Clause 10) for claims arising within the first six months after the Person Insured returns to Work will be based on the average monthly earnings prior to the period of Leave without pay. If the Person Insured has not returned to Full-Time

Work, then the Average Monthly Earned Income will be based on a pro rata percentage of the average monthly earnings prior to the period of Leave without pay. For claims arising after the first six months, the Average Monthly Earned Income will be based on the average monthly earnings after the return to Work.

For Agreed Value cover the Agreed Monthly Income (see clause 10) will be the Agreed Monthly Income prior to the period of Leave without pay. If the Person Insured has not returned to Full-Time Work, then the Agreed Monthly Income will be based on a pro rata percentage of the Agreed Monthly Income prior to the period of Leave without pay.

26.4.8 Frequency of Unpaid Leave Feature

There must be a continuous period of at least 12 months of employment between each period during which an Unpaid Leave Feature option applies.

26.5 Long Waiting Period Conversion Option

A Person Insured with a 104 week Waiting Period can elect to reduce to a 13 week Waiting Period upon resignation from a job, provided they:

- had an at arms length relationship with the employer (in AMP's opinion); and
- apply within 30 days of resignation; and
- certify they did not resign because of ill health or incapacity; and
- can answer some basic income and occupation questions to AMP's satisfaction; and
- can show firm plans (e.g. a letter of offer) to recommence paid re-employment within the next 12 months in a job We would normally insure.

26.6 Claims Escalation Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

This option allows the monthly benefit paid to the Person Insured upon claim under this cover to increase each year at the Policy Anniversary. The percentage increase that is applied will be the percentage increase in the CPI for the preceding year ending 30 September. The increase will be applied on the Policy Anniversary. If the percentage change in the CPI is nil or negative for the year, the monthly benefit paid on claim will not change.

26.7 Chronic Condition Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

26.7.1 Chronic Condition Option

We pay if the Person Insured has a Chronic Condition (as defined in Clause 25.9). We only pay under this option during the Waiting Period.

26.7.2 What We mean by "Chronic Condition"

"Chronic Condition" means that as a result of physical illness or injury, the ability of the Person Insured to do their usual occupation has been, and continues to be, significantly reduced. This is evidenced by:

- Clinically significant test results showing their illness or injury is expected to be constantly present for life and there is no known cure; and
- Their weekly hours of work have been reduced on a Medical Doctor's advice to less than 75% of the average normal hours that they worked in the 3 years before they lodged their claim, and this reduction continues for at least 3 consecutive months and also while We are paying under the cover; and
- The Person Insured's weekly income has been reduced to less than 75% of their highest in the 3 years before they claim.

As Chronic Condition Option only covers chronic conditions that result from physical illness or injury, We do not cover conditions that are psychosomatic or psychiatric in nature.

26.7.3 How much We will pay

If the Person Insured suffers a Chronic Condition, AMP will pay a benefit for the duration of the Waiting Period, equal to the difference between what We would pay under the Total Disablement Feature and the amount the Person Insured is earning (or could earn) from work.

26.7.4 When benefit payment under Chronic Condition Option ends

Payment of benefit under Chronic Condition Option ends for a Person Insured on the earliest of:

a) the end of the Waiting Period
b) the Person Insured's 65th birthday
c) the Policy ending as in Clause 9.2
d) this cover being cancelled for the Person Insured by the Policy Owner
e) the death of the Person Insured
f) when any of the conditions set out in Clause 25.97.2 cease to be met
g) when Income Cover Essentials ends as in Clause 26.9

26.8 Payments while located overseas

Coverage is provided 24 hours, world-wide. We pay the normal amount we would pay for up to 3 months if the Person Insured is resident outside Australia or New Zealand and while they are Totally Disabled as defined in Clause 25.1.1. We may continue to pay beyond 3 months, and We reserve the right for claim assessments to be conducted in a country nominated by Us. If We discontinue payments, then when the Person Insured returns to Australia or New Zealand, We will start paying again provided they are still Totally Disabled.

26.9 When Income Cover Essentials ends

Income Cover Essentials ends for a Person Insured on the earliest of:

a) the death of the Person Insured.
b) the 65th birthday of the Person Insured.
c) when this Policy ends as in Clause 9.2.
d) the Person Insured ceasing to be actively engaged in their usual occupation for more than 12 months for reasons other than their total disablement, unless We have been notified in writing and our written consent has been given. In giving consent We may vary the terms and conditions of this Policy, including an increase in the Premium.
e) AMP exercising our right to cancel in the event that a period of Leave without pay exceeds, or is expected to exceed, 12 months (see Clause 25.6).
f) when Income Cover Essentials for the Person Insured is cancelled by the Policy Owner.
g) when the Person Insured ceases to comply with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP.
h) When the Person Insured ceases to comply with reasonable or consistant treatment and/or rehabilitation which in our opinion could be expected to assist their return to Full-Time Work.

26.10 What is not covered

No benefits will be paid under this Cover if the Person Insured is unable to Work due to injury, accident or illness wholly or partly, directly or indirectly caused:

- on purpose – we won't pay if the Policy Owner, the Person Insured or a relative of the Person Insured causes the Person Insured to be unable to Work.
- (if the optional Injury and Accident Exclusion is contained in the Schedule) by an accident.
- by the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted

As normal and uncomplicated pregnancy and childbirth are not illnesses for the purposes of the definition of Total Disablement, they are not covered under this Cover.

26.11 Making a claim

26.11.1 Notifying AMP of a claim

As well as meeting the general conditions in Clause 3.1 and Clause 25.15, any claim for a benefit payment under Total Disablement or the Chronic Condition Option must be given to Us within one month after:

- the occurrence of Total Disablement, or
- the onset of the Chronic Condition.

No claim will be payable for periods more than one month before AMP's receipt of notice of a claim.

26.11.2 Evidence for claims

As well as meeting the general conditions in Clause 3.1, before We can assess your eligibility for a claim under Income Cover Essentials, we require:

- evidence of hours worked and income earned;
- evidence of the Average Monthly Earned Income of the Person Insured (for Indemnity Value cover only); and
- proof, to the satisfaction of AMP, that the Person Insured continues to receive medical treatment from, and follow the advice of, including recommended treatment and/or rehabilitation, a Medical Doctor or appropriate consultant medical specialist who is acceptable to AMP or as agreed to by the Person Insured with AMP in writing.

For the purposes of ongoing claim assessment, AMP may request at its expense the Person Insured :

- undergo one or more examinations by a Medical Doctor nominated by AMP;
- undergo medical tests which may include the taking of blood samples for pathological examination by medical personnel nominated by AMP; and
- provide any other information that AMP requires to assess entitlements under this Policy, for example, Inland Revenue assessments and business accounts.

All evidence must be provided within two months of the claim period to which it relates. No claim will be payable in respect of any period more than two months prior to AMP's receipt of proper evidence supporting a claim.

26.11.3 Payment of claims

All benefits under Income Cover Essentials will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits under Income Cover will be paid to the employer.

26.12 Premium Cover

If Premium Cover is selected for Income Cover Essentials, the premium will be waived from the earlier of the end of the Income Cover Essentials Waiting Period or the Premium Cover Waiting Period.

Upon the Person Insured becoming Totally Disabled and receiving a monthly benefit under the Total Disablement Feature (clause 26.1) or the Recovery Feature (clause 26.2), any premiums paid from the first day of Total Disablement will be refunded to the Policy Owner. Premiums will continue to be waived until the Person Insured ceases to be Totally Disabled, the Person Insured dies or the Cover End Date specified in the Schedule (whichever is earlier).

26.13 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on Premiums. This is included in your Premiums.

26.14 Taxation of Agreed Value

AMP understands for Agreed Value cover the benefits payable under this policy are not taxable and the premiums payable are not tax deductible.

If tax legislations changes and the tax treatment of this cover changes We will inform you in writing of any changes necessary to the policy and the date those changes occur.

27 Income Cover Total

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

27.1 Total Disablement Feature

If a Person Insured with this cover becomes Totally Disabled AMP will pay a monthly benefit under the Total Disablement Feature.

27.1.1 What We mean by Totally Disabled

"Totally Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Totally Disabled. The Person Insured is Totally Disabled if:

- they are so ill or injured that they can't do their usual occupation for more than 10 hours per week; and
- they are under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- they do not do any remunerative Work (apart from up to 10 hours per week in their usual occupation).

However, for some occupations after the Person Insured has been Totally Disabled for 2 or 5 years, the definition of being Totally Disabled changes. If this definition applies to the Person Insured it will be specified in the Schedule. It becomes:

- they are so ill or injured that they can't do any remunerative Work for which they are reasonably suited by their education, training, or experience; and
- they are under the ongoing care of a Medical Doctor for that illness or injury; and
- they do not do any remunerative Work.

"Total Disablement" has a corresponding meaning.

27.1.2 How much We will pay

For Indemnity Value cover the benefit payable under the Total Disablement Feature is the lower of:

- the Maximum Monthly Benefit described in Clause 25.1.4, and
- 75% of your Average Monthly Earned Income (see Clause 10) less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 25.1.6.

For Agreed Value cover the benefit payable under the Total Disablement feature is the Maximum Monthly Benefit described in Clause 25.1.4 less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 27.1.6.

The benefit is paid monthly in arrears for the duration of the Person Insured's entitlement. Benefits payable for periods of less than one month are calculated on a daily basis.

27.1.3 When a benefit is payable under the Total Disablement Feature

Payment of benefits under the Total Disablement Feature will start on the first day of Total Disablement after the Waiting Period specified in the Schedule. The Waiting Period only ends when the total number of consecutive days the Person Insured has been Totally Disabled or Partially Disabled (as applicable), when added together, equal the Waiting Period.

We treat days of Total Disability or Partial Disability as being consecutive even if those days are interrupted by a period of attempted return to Work under the Relapse Feature.

To qualify for a benefit under the Total Disablement Feature

- the Person Insured must be either Totally Disabled or Partially Disabled for whole Waiting Period, and
- at the end of the Waiting Period is Totally Disabled.

27.1.4 Maximum Monthly Benefit

The Maximum Monthly Benefit which is payable during the first year of this cover is as shown in the Schedule or most recent Replacement Schedule for the Person Insured.

Indexation on Maximum Monthly Benefit

If Indexation is selected, the Maximum Monthly Benefit will increase for subsequent years on each Policy Anniversary, in line with the percentage increase in the CPI for the preceding year ending 30 September. If the percentage change in the CPI is nil or negative for the year, the Maximum Monthly Benefit will not change.

If Claims Escalation is selected, and if benefits are being paid under this cover at the time of any Policy Anniversary, the benefit will be increased in line with the Consumer Price Index.

The Maximum Monthly Benefit for any year may not exceed our limit for new covers at the Policy Anniversary.

You may choose not to accept an annual Maximum Monthly Benefit increase. To do this you must send a written application to AMP. We will then inform you of the new Premium payable. By paying the increased Premium in respect of an increased Maximum Monthly Benefit, you indicate that you accept the increase.

27.1.5 When benefit payment under the Total Disablement Feature ends

Payments of benefits under the Total Disablement Feature for a Person Insured end on the earliest of:

a) the expiry of the Benefit Period as shown in the Schedule or most recent Replacement Schedule, or
b) the Person Insured ceasing to be Totally Disabled, or
c) the Person Insured not complying with reasonable or consistent treatment and/or rehabilitation which in our opinion could be expected to assist their return to Work, or
d) the death of the Person Insured, or
e) the 65th birthday of the Person Insured, or
f) the Policy ending as in Clause 9.2, or
g) this cover being cancelled for the Person Insured by the Policy Owner.

27.1.6 Periodic income replacement payments

The benefits payable under the Total Disablement Feature (under Clause 27.1.2) and Recovery Feature (under Clause 27.3.2) will be determined on the basis of payments received by the Person Insured, or to which they are entitled, relating to the period for which Total Disablement or Partial Disablement benefits are payable. These payments include those:

- as a result of personal exertion from their employer, former employer, employment business or business partnerships, family trust or company (including any income earned during the period not exceeding 10 hours per week referred to in Clause 27.1.1).
- that you have the capacity to earn but have not necessarily received, such as any payment determined by hours and, or amount) that in our opinion, based on the advice of Medical Doctor(s) or appropriate consultant Medical Specialist(s) acceptable to AMP, the Person Insured could be reasonably expected to receive for Work.
- from any government funded source (such as Accident Compensation Corporation).
- from other regular income, received or entitled to be received, from any disability, sickness or accident insurance policies or superannuation.

These payments will not include:

- investment income including, without limitation, income from rent and royalties; or
- regular amounts paid as compensation because of the Person Insured's pain and suffering; or
- sick leave; or
- lump sum payments received or due to be received because the Person Insured is disabled, unless they were previously paid as a regular income, and where they were converted to a lump sum at the Person Insured's or Policy Owner's discretion. Where an income is taken as a lump sum, We will offset from what We pay every month, one 100th of the lump sum amount received.

If such payments are not made monthly, AMP will calculate a monthly rate for the purposes of Clause 25.1.2.

If at any time during or after a period of Total Disablement or Partial Disablement, We learn that such payment has been made to (or is payable to or claimable by) the Person Insured in respect of that month which We were not aware of, the benefit for that month and any future months (or the month in which We learnt of the payment) may be reduced. Any difference between the benefit paid for that month and the reduced amount must be repaid or will be reduced in the month We learn of the payment.

27.2 Total Disablement Booster Benefit

If a Person Insured qualifies for a benefit under the Totally Disablement Feature, then AMP will pay a booster benefit of up to an additional one third (1/3) of the monthly Total Disability Benefit (as calculated under Clause 27.1.2) for the first three months from the end of the Waiting Period.

The Total Disablement Booster Benefit will be paid until the earlier of:

a) Three (3) months of Total Disablement Booster Benefit has been made;
b) The Person Insured ceases to be Totally Disabled; or
c) The Income Cover Total ends (see Clause 27.17).

27.3 Recovery Feature

If a Person Insured with this cover becomes Partially Disabled, then AMP will pay a benefit under the Recovery Feature as calculated below.

27.3.1 What do We mean by Partially Disabled

"Partially Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury;
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before the cover ends.

We will pay if the Person Insured is Partially Disabled. The Person Insured is Partially Disabled if:

- under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- able to do any occupation for more than 10 hours per week but due to the illness, accident or injury they are unable to earn an income which is equal to or greater than 75% of their Average Monthly Income; or
- able to do any occupation for more than 10 hours per week but due to the illness, accident or injury they are unable to Work more than 75% or greater of their average weekly hours according to their Average Monthy Earned Income..

"Partial Disablement" has a corresponding meaning.

27.3.2 How much We will pay

The benefit payable under the Recovery Feature is equal to: $\frac{(A-B)\times C}{A}$

Where:
- A is the Person Insured's Average Monthly Earned Income for Indemnity Value cover, or the Person Insured's Agreed Monthly Income for Agreed Value cover (see Clause 10)
- B is the Person Insured's current monthly earned income from their occupation or Work and any amounts paid or payable as "periodic income replacement payments" under Clause 27.1.6.
- C is the Total Disablement benefit for that month (see Clause 25.1.2)

This benefit is paid monthly in arrears for the duration of the Person Insured's entitlement (see Clause 25.23.4). Benefits for periods of less than one month are calculated on a daily basis.

27.3.3 When a benefit is payable under the Recovery Feature

Payment of benefits under the Recovery Feature will start on the first day of Partial Disability after the Waiting Period specified in the Schedule. The Waiting Period only ends when the total number of consecutive days the Person Insured has been Totally Disabled or Partially Disabled (as applicable), when added together, equal the Waiting Period.

We treat days of Totally Disabled or Partially Disabled as being consecutive even if those days are interrupted for a period of attempted return to Work under the Relapse Feature.

To qualify for a benefit under the Recovery Feature:
- the Person Insured must be either Totally Disabled or Partially Disabled for the whole Waiting Period, and
- at the end of the Waiting Period is Partially Disabled.

27.3.4 When benefit payment under Recovery Feature ends

Payments of benefits under Recovery Feature end for a Person Insured on the earliest of:
a) the Person Insured is no longer Partially Disabled
b) the death of the Person Insured
c) the 65th birthday of the Person Insured
d) the Policy ending as in Clause 9.2
e) this cover being cancelled for the Person Insured by the Policy Owner
f) the expiry of the Benefit Period stated in the Schedule or most recent Replacement Schedule
g) when any of the conditions for payment set out in Clause 27.3.3 are not met
h) the Benefit End Date as shown in the Schedule or most recent Replacement Schedule
i) The Person Insured not undertaking reasonable or consistant treatment and/or rehabilitation which in our opinion could be expected to assist their return to Full-Time Work
j) the Recovery Feature benefit calculated under clause 27.3.2 being nil or negative.

27.4 Recovery Feature Booster Benefit

If a Person Insured qualifies for a benefit under Recovery Feature, then AMP will pay a booster benefit of up to an additional one third (1/3) of the Recovery Feature benefit as calculated under Clause 27.3.2 for the first three months of the claimable period.

The amount payable under this booster benefit may be limited so that the total of the Recovery Feature Booster Benefit, the Recovery Feature and all other income earned through the Person Insured's personal exertion does not exceed 100% of the Person Insured's Average Monthly Earned Income or Maximum Monthly Benefit (whichever is lesser).

The benefit will be paid until the earlier of:
a) The Person Insured is no longer entitled to a benefit under the Recovery Feature;
b) Three (3) months of Recovery Feature Booster Benefit have been paid; or
c) The total of the Recovery Feature and all other income earned through the Person Insured's personal exertion exceeds 100% of the Person Insured's Average Monthly Earned Income or Maximum Monthly Benefit (whichever is lesser).

27.5 Relapse Feature

If the Person Insured returns to work during the Waiting Period after a period during which they were Totally Disabled or Partially Disabled, and they suffer a relapse and are again Totally Disabled or Partially Disabled, then:

- if they are able to work for 5 days in a row (or less), and they suffer a relapse of the same or a related illness or injury, then the Waiting Period continues. It does not start again. We only start to pay when the Person Insured is Totally Disabled or Partially Disabled for the total number of days that make up the normal Waiting Period.
- if they are able to work for more than 5 days in a row, and they suffer a relapse of the same or a related illness or injury, then the Waiting Period starts all over again. We don't count the days that the Person Insured was Totally Disabled or Partially Disabled before the relapse.

If the Person Insured suffers a relapse, which in our opinion arises from the same or a related cause for which they were previously entitled to a benefit, then:

- if the Person Insured has been able to work for 12 months or more after We stopped paying, then We treat the claim as a new claim, and the Waiting Period and the Benefit Payment Period start all over again.
- if the Person Insured has been able to work for less than 12 months after We stopped paying, then We treat the claim as a continuation of the same claim. That is, the Waiting Period and the Benefit Payment Period do not start again.

27.6 Rehabilitation Costs Feature

The Rehabilitation Costs benefit is payable at AMP's discretion, for reimbursement of money spent with AMP's prior written approval, on equipment, home alterations and other capital expenses which are certified by the Person Insured's appropriate consultant Medical Specialist to be necessary in the course of rehabilitation or that AMP agrees will assist the Person Insured to return to Full-Time Work. This benefit is not payable for expenses that are reimbursable from other sources. The Person Insured must notify AMP and must receive prior written approval of AMP before the costs are incurred (see Clause 25.15.2).

27.6.1 How much We will pay

AMP may pay multiple payments but the total benefit payable over the term of the claim is 12 times the monthly amount We would pay if the Person Insured was Totally Disabled. It is not contingent upon the Person Insured receiving a monthly benefit under Income Cover Total. It may be paid before the end of the Waiting Period.

27.7 Vocational Costs Feature

The Vocational Costs benefit is payable at AMP's discretion, for reimbursement of money spent with AMP's prior approval on vocational training which is certified by the Person Insured's attending Medical Doctor or appropriate Medical Specialist to be necessary in the course of rehabilitation or that AMP agrees will assist the Person Insured to return to Full-Time Work. This benefit is not payable for expenses that are reimbursable from other sources. The Person Insured must notify AMP and must receive prior written approval of AMP before the costs are incurred (see Clause 27.19.2).

27.7.1 How much We will pay

AMP may pay multiple payments but the total benefit payable over the term of the claim is 12 times the monthly amount We would pay if the Person Insured was Totally Disabled. It is not contingent upon the Person Insured receiving a monthly benefit under Income Cover Total. It may be paid before the end of the Waiting Period.

27.8 Bedcare Feature

Provided that the Person Insured is Bedridden (as defined below) during the Waiting Period, AMP will pay an amount based on the monthly amount that it would normally pay if the Person Insured was

Totally Disabled. We calculate what We pay on a daily basis, and We pay for every day that the Person Insured is Bedridden during the Waiting Period.

27.8.1 What We mean by "Bedridden"

The definition of "Bedridden" is:
a) the Person Insured is unable to Work at all; and
b) the Person Insured is confined to bed for more than 3 days in a row; and
c) a Medical Doctor requires them to be (and they are) under the full-time care of a registered nurse. The nurse cannot be the Person Insured or the Policy Owner, or a member of the immediate family of either.

If the Person Insured is Bedridden more than once during one Waiting Period, they don't have to be Bedridden on the second or subsequent occasion for a further 3 days in a row – We treat all of the days they were Bedridden as one claim.

27.8.2 When Bedcare Feature ends

We stop paying on the earlier of:
a) the expiry of the Waiting Period;
b) 91 days payment under the Bedcare Feature;
c) the Person Insured no longer being Bedridden; or
d) when Income Cover Total ends (See Clause 27.17)

27.9 Unpaid Leave Feature

If the Person Insured undertakes a period of Leave without pay from their occupation, then the Policy Owner may choose one of the options set out in the Unpaid Leave Feature under Income Cover Total.

27.9.1 What We mean by "Leave without pay"

"Leave without pay" here means:
a) compassionate leave, or
b) maternity leave, or
c) paternity leave, or
d) sabbatical leave, or
e) study leave for study at a registered educational centre.

27.9.2 The Policy Owner's options

In the event of the Person Insured taking Leave without pay, you have two options in respect of Income Cover Total:
- to continue cover and the payment of Premiums during the period of Leave without pay (see Clause 25.69.3)
- to cancel cover and the payment of Premiums, with a guaranteed right to recommence cover after the period of Leave without pay (see Clause 25.6.9.4) but within 12 months of cancelling the cover.

27.9.3 Option to continue cover

If you choose to continue the payment of Premiums, cover will continue during the period of Leave without pay.

If the Person Insured during the period of Leave without pay becomes Totally Disabled or Partially Disabled as defined, benefit payment will start from the later of the end of the Waiting Period or the end of the period of leave.

27.9.4 Option to cancel cover

If you choose not to continue the payment of Premiums, cover will stop immediately. No benefits will be payable during the period of Leave without pay, or during the first month after the Person Insured returns to Work, for Total Disablement or Partial Disablement occurring during the period of Leave without pay.

Cover will recommence only if the following conditions have been met:

- the Person Insured has returned to their usual occupation, and
- the Person Insured has worked for at least 25 hours per week for at least one month after their return to Work, and
- the period of employment since returning to Work is continuous, and
- the return to Work occurs within 12 months of stopping Work, and
- payment of Premiums has recommenced.

Where payment of Premiums has not recommenced but the Person Insured has returned to Work for a continuous period of at least one month and you have notified Us in writing of your intention to recommence cover, cover can recommence. Should Total Disablement or Partial Disablement occur, the Waiting Period will start from the date that the payment of Premiums recommences.

27.9.5 Limit to Period

Unpaid Leave Feature is limited to a maximum continuous period of 12 months. If the period of Leave without pay exceeds or is expected to exceed 12 months, Income Cover Total will be cancelled.

27.9.6 Notification of leave

Written notice of the Person Insured's absence from their occupation on Leave without pay must be received by AMP no later than one month after the beginning of the period of leave. You must also provide details of:

- the date of stopping Work;
- the reason for the leave;
- the expected duration of the period of leave; and
- your choice to continue cover or cancel Premium payments and cover.

27.9.7 Return to work

No additional health evidence will be required on return to Work. The Income Cover Total cover will remain unchanged upon return to Work after the period of Leave without pay.

For Indemnity Value cover the Average Monthly Earned Income (See Clause 10) for claims arising within the first six months after the Person Insured returns to work will be based on the average monthly earnings prior to the period of Leave without pay. If the Person Insured has not returned to Full-Time Work, then the Average Monthly Earned Income will be based on a pro rata percentage of the average monthly earnings prior to the period of Leave without pay. For claims arising after the first six months, the Average Monthly Earned Income will be based on the average monthly earnings after the return to Work.

For Agreed Value cover the Agreed Monthly Income (see clause 10) will be the Agreed Monthly Income prior to the period of leave without pay. If the Person Insured has not returned to Full-Time work, then the Agreed Monthly Income will be based on a pro rata percentage of the Agreed Monthly Income prior to the period of leave without pay.

27.10 Long Waiting Period Conversion Option

A Person Insured with a 104 week Waiting Period can elect to reduce to a 13 week Waiting Period upon resignation from a job, provided they:

- had an at arms length relationship with the employer (in AMP's opinion);
- apply in writing to AMP within 30 days of resignation;
- certify they did not resign because of ill health or incapacity;
- can answer income and occupation questions to AMP's satisfaction; and
- can show firm plans (e.g. a letter of offer) to recommence paid re-employment within the next 12 months in a job We would normally insure.

27.11 Claims Escalation Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

This option allows the monthly benefit paid to the Person Insured upon claim under this cover to increase each year at the Policy Anniversary. The percentage increase that is applied will be based on the percentage increase in the CPI for the preceding year ending 30 September. The increase will be applied on the Policy Anniversary. If the percentage change in the CPI is nil or negative for the year, the monthly benefit paid on claim will not change.

27.12 Chronic Condition Option

This option will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

27.12.1 Chronic Condition Option

We pay if the Person Insured has a Chronic Condition (as defined in Clause 27.12.2). We only pay under this option during the Waiting Period.

27.12.2 What We mean by "Chronic Condition"

"Chronic Condition" means that as a result of physical illness or injury, the ability of the Person Insured to do their usual occupation has been, and continues to be, significantly reduced. This is evidenced by:

- Clinically significant test results showing their illness or injury is expected to be constantly present for life and there is no known cure; and
- Their weekly hours of work have been reduced on a Medical Doctor or an appropriate consultant medical specialist acceptable to AMP's advice to less than 75% of the average normal hours that they worked in the 3 years before they lodged their claim, and this reduction continues for at least 3 consecutive months and also while We are paying under the cover; and
- The Person Insured's weekly income has been reduced to less than 75% of their highest in the 3 years before they claim.

As Chronic Condition Option only covers Chronic Conditions that result from physical illness or injury, We do not cover conditions that are psychosomatic or psychiatric in nature.

27.12.3 How much We will pay

If the Person Insured suffers a Chronic Condition, AMP will pay a benefit for the duration of the Waiting Period, equal to the difference between what We would pay under the Total Disablement Feature and the amount the Person Insured is earning (or could earn) from Work.

27.12.4 When benefit payment under Chronic Condition Option ends

Payment of a benefit under Chronic Condition Option ends for a Person Insured on the earliest of:

a) the end of the Waiting Period;
b) the Person Insured's 65th birthday;
c) the Policy ending as in Clause 9.2;
d) this cover being cancelled for the Person Insured by the Policy Owner;
e) the death of the Person Insured;
f) when any of the conditions set out in Clause 27.12.2 cease to be met: or
g) when Income Cover Total ends as in Clause 27.17.

27.13 Death benefit

If the Person Insured with this cover dies, and the cover is current, We will pay a lump sum equal to 3 times the amount described in Clause 27.1.2 to the Policy Owner.

No death benefit will be paid if the Person Insured's death occurs as a direct or indirect result of an intentional self-inflicted act (whether sane or insane).

Only one death benefit is payable for each Person Insured across all AMP Income Cover policies issued by AMP.

27.14 Payments while located overseas

Coverage is provided 24 hours, world-wide. If the Person Insured is Totally Disabled or Partaily Disabled while overseas, and they are entitled to receive payments from AMP, We will pay the claim as long as all AMP claim requirements are met (see Clause 27.19).

If the Person Insured becomes disabled while in New Zealand or Australia and subsequently travels or resides overseas, claim payments will only be made if, in travelling or residing overseas ,they are following the advice of the treating Medical Doctor and AMP have agreed in writing to such residence or travel prior to their depature.

AMP Claims should be advised in writing at least 3 months in advance of any start date of travel and/or residence overseas.

27.15 Airfare Assistance if Totally Disabled while overseas

Airfare assistance is available if the Person Insured has been resident outside of Australia or New Zealand for more than 30 days, and they have been unable to Work at all for at least 14 days because they are Totally Disabled while they were overseas. We will reimburse up to the cost of one single economy airfare for the Person Insured to return home, by the most direct route available, less any amounts that are reimbursed from other sources.

27.16 Specified Sickness Benefit

If the Person Insured suffers a sickness as listed below, we will deem him or her to be Totally Disabled for the purposes of this clause.

Payment of the Total Disability Benefit will commence from the end of the Waiting Period and will be paid for a period of 6 months less the Waiting Period, but will cease immediately if one criteria under the section When Income Cover Total ends (See clause 27.17) is met.

At the end of the 6 month period, if the Person Insured still meets the definition of Totally Disabled or Partially Disabled then a claim may be payable under clause 27.1.2 or 27.3.2.

We will pay a claim for each Specified Sickness under this clause provided that the Specified Sickness occurs at least six months apart. If one or more Specified Sickness claims are payable simultaneously, or where the Person Insured is receiving a Total Disability Benefit or a benefit under the Recovery Feature, We will only pay one amount of benefit under Income Cover Total.

The Specified Sicknesses are:

Cancer	Mulitiple Sclerosis
Coronary Artery Surgery	Paraplegia
Heart Attack – Myocardial Infarction	Quadriplegia
Heart Valve Surgery	Severe Burns
Kidney (Renal) Failure	Stroke
Major Organ Transplant	

For the purpose of this clause:

Cancer	*Description* Is a malignant tumour which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. Included are sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorders and leukaemia.

The following are excluded:

- Tumours which are histologically described as pre-malignant or showing malignant changes of carcinoma-in-situ.
- Lymphocytic leukaemia less than Rai Stage 1.

Coronary Artery Surgery

Description

Surgery involving bypass grafts to one or more coronary arteries.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures are not included.

Heart Attack – Myocardial Infarction

Description

Heart muscle dies as a result of inadequate blood supply to the relevant area. An appropriate consultant medical specialist must certify that a heart attack had occurred and this must be confirmed by the presence of 2 of the following criteria:

- new electrocardiographic changes characteristic of a Myocardial Infarction
- a diagnostic elevation of cardiac biomarkers associated with Myocardial Infarction (for Troponin I this is defined as a level of over 2,000 ng/L and for Troponin T a level of over 600 ng/L).
- left ventricular ejection fraction of less than 50% measured 3 months or more after the event.
- New pathological Q waves.

If the above tests are inconclusive, other appropriate and medically recognised tests will be considered. Other causes of severe non-cardiac chest pain, heart failure or angina are excluded.

Heart Valve Surgery

Description

Cardiac surgery to repair or replace a heart valve as a consequence of a heart valve defect.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

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

Kidney(Renal) Failure

Description

Irreversible failure of both kidneys which requires either:

- Continuing renal dialysis; or
- Transplantation of a human kidney.

In the opinion of an appropriate consultant medical specialist, the dialysis or transplant must be required on medical grounds and must be the most appropriate treatment.

Major Organ Transplant

Description

Transplant from a human donor of bone marrow or one of the following whole organs:

- Kidney
- Heart
- Lung
- Liver (live liver transplants, where the Person Insured's whole liver is removed and a piece of liver from a living person is transplanted into the Person Insured, are covered)
- Small Bowel
- Pancreas

In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment. Organ or tissue donation for transplant by the Person Insured is excluded.

Multiple Sclerosis	*Description* Diagnosis of Multiple Sclerosis and as a result of this illness the Person Insured suffers neurological damage which causes: • at least 25% Permanent Impairment of Whole Person Function; or • permanent inability to perform any one of the five Activities of Daily Living without assistance from someone else; or • an inability to take more than a few steps, restricted to wheelchair, as measured by an Expanded Disability Status Scale ("EDSS") level of 7.5 or above, as determined by a consultant neurologist.
Paraplegia	*Description* Total and permanent paralysis of both legs resulting in complete loss of ability to move those parts of the body. Paralysis of the Person Insured due to psychological or psychiatric causes is excluded.
Quadriplegia	*Description* Total and permanent paralysis of both arms and both legs resulting in complete loss of ability to move those parts of the body. Paralysis of the Person Insured due to psychological or psychiatric causes is excluded.
Severe Burns	*Description* Full thickness burns to: • 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart; or • 25% of their face requiring surgical debridement and/or grafting; or • 50% of both hands requiring surgical debridement and/or grafting. The burns can be caused by thermal, electrical or chemical agents.
Stroke	*Description* Cerebrovascular episode producing neurological sequelae, which lasts for more than 24 hours, as confirmed by a Neurologist and supported by the results of any of the following scans: • a cerebral CT scan; or • an angiogram; or • a MRI or PET; or • other reliable imaging technique approved by AMP. Cerebrovascular episode means a disorder of the blood vessels of the brain resulting in impaired blood supply to part of the brain. Neurological sequelae means abnormalities of the nervous system producing certain symptoms and resulting in functional impairment. Transient ischaemic attacks, major head injuries or symptoms due to migraine or headache are excluded.

27.17 When Income Cover Total ends

Income Cover Total ends for a Person Insured on the earliest of:

a) the death of the Person Insured;
b) the 65th birthday of the Person Insured;
c) when this Policy ends as in Clause 9.2*;*
d) the Person Insured ceasing to be actively engaged in their usual occupation for more than 12 months for reasons other than their Total Disablement, unless We have been notified in writing and our written consent has been given. In giving consent We may vary the terms and conditions of this Policy, including an increase in the Premium;

e) AMP exercising our right to cancel where a period of Leave without pay exceeds, or is expected to exceed, 12 months (see Clause 27.9.5) or the conditions of return to work are not fulfilled;
f) when Income Cover Total for the Person Insured is cancelled by the Policy Owner;
g) when the Person Insured ceases to comply with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; or
h) when the Person Insured ceases to undertake reasonable or consistent treatment and, or rehabilitation which in our opinion could be expected to assist their return to Full-Time Work.

27.18 What is not covered

No benefits will be paid under this cover if the Person Insured is unable to Work due to injury, accident or illness wholly or partly, directly or indirectly caused:

- on purpose – we won't pay if the Policy Owner, the Person Insured or a relative of the Person Insured causes the Person Insured to be unable to work.
- (if the optional Injury and Accident Exclusion is contained in the Schedule) by an accident.
- by the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted.

As normal and uncomplicated pregnancy and childbirth are not illnesses for the purposes of the definition of Total Disablement or Partial Disablement, they are not covered under this cover.

27.19 Making a claim

27.19.1 Notifying AMP of a claim

As well as meeting the general conditions in Clause 3.1 and Clause 9.3, any claim for a benefit payment under Total Disablement, Recovery Feature, the Bedcare Feature or the Chronic Condition Option must be given to Us within one month after:

- the occurrence of Total Disablement, or
- the occurence of Partial Disability under the Recovery Feature, or
- the onset of the Chronic Condition, or
- the Person Insured becoming Bedridden.

No claim will be payable for periods more than one month before AMP's receipt of notice of a claim.

27.19.2 We must be notified of a claim under the Rehabilitation Costs Feature and Vocational Costs Feature (and give prior written approval) before any costs are incurred.

27.19.3 Evidence for claims

As well as meeting the general conditions in Clause 3.1, before We can assess your eligibility for a claim under Income Cover Total, we require:

- evidence of hours worked and income earned;
- evidence of the Average Monthly Earned Income of the Person Insured (for Indemnity Value cover only); and
- proof, to the satisfaction of AMP, that the Person Insured continues to receive medical treatment from, and follow the advice , including recommended treatment and/or rehabilitation, of, a Medical Doctor or appropriate consultant medical specialist who is acceptable to AMP or as agreed to by the Person Insured with AMP in writing.

For the purposes of ongoing claim assessment, AMP may request at our expense the Person Insured :

- undergo one or more examinations by a Medical Doctor nominated by AMP;
- undergo medical tests which may include the taking of blood samples for pathological examination by medical personnel nominated by AMP; and, or
- provide any other information that AMP requires to assess entitlements under this Policy, for example, Inland Revenue assessments and business accounts.

All evidence must be provided within two months of the claim period to which it relates. No claim will be payable in respect of any period more than two months prior to AMP's receipt of proper evidence supporting a claim.

27.19.4 Payment of claims

All benefits under Income Cover Total will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits under Income Cover Total will be paid to the employer.

27.20 Premium Cover

If Premium Cover is selected for Income Cover Total, the premium will be waived from the end of the Income Cover Total Waiting Period, or Premium Cover Waiting Period.

Upon the Person Insured receiving a monthly benefit under the Total Disablement Feature (Clause 27.1) or the Recovery Feature (Clause 27.2), any Premiums paid from the first day of either Total Disablement or Partial Disablement will be refunded to the Policy Owner.

Premiums will continue to be waived until, the Person Insured ceases to be Totally or Partially Disabled, the Person Insured dies or the Cover End Date specified in the Schedule or Replacement Schedule (whichever is earlier).

27.21 Goods and Services Tax (GST)

Goods and Services Tax (GST) is included in your Premiums and is therefore payable.

27.22 Taxation of Agreed Value

AMP understands for Agreed Value cover the benefits payable under this policy are not taxable and the premiums payable are not tax deductible.

If tax legislation changes and the tax treatment of this cover changes We will inform you in writing of any changes necessary to the policy and the date those changes occur.

28 Accident Lump Sum

Cover under this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

28.1 Accident Lump Sum

Subject to the terms of the Policy, the Accident Lump Sum is payable when an Event specified in "When the Accident Lump Sum is payable" occurs on or after the Starting Date for this benefit and prior to the Benefit End Date for this benefit.

28.2 How much We will pay

The maximum Amount of Benefit (Accident Lump Sum) is the lower of:

- twenty-three (23) times the Maximum Monthly Benefit in respect of the Person Insured as determined under the Clause headed "Maximum Monthly Benefit" in Income Cover Essentials or Income Cover Total (as relevant) ; or
- $250,000.

The amount of Benefit payable is determined by reference to the maximum Amount of Benefit (Accident Lump Sum) as follows:

a) For Event No.1 – 100% of the maximum Amount of Benefit;
b) For Event No.2 – 100% of the maximum Amount of Benefit; or
c) For Event No.3 – 50% of the maximum Amount of Benefit.

28.3 When the Accident Lump Sum is payable

We will pay you the Amount of Benefit (Accident Lump Sum) if the Person Insured suffers an accidental injury which results, within 12 calendar months of the accidental injury, directly and independently of all other causes, in one of the following Events:

Event No 1 – The death of the Person Insured
Event No 2 – The total and irrecoverable loss of:

a) The use of both hands;
b) The use of both feet;
c) The sight in both eyes;
d) The use of one hand and one foot;
e) The use of one hand and the sight of one eye; or
f) The use of one foot and the sight of one eye.

Event No 3 – The total and irrecoverable loss of:

a) The use of one hand;
b) The use of one foot; or
c) The sight of one eye.

We will pay for one Event only. We will only make one payment under an Accidental Lump Sum benefit in respect of any Person Insured. If the Person Insured is also covered by another accidental lump sum benefit on another income protection insurance policy issued by us or by another member of the AMP group of companies, only one payment will be made in respect of that Person Insured.

28.3.1 What We mean by "accidental injury"
"Accidental injury" means injury which occurs solely, directly and independently of any other cause from an injury resulting from an Accident. An "Accident" means a violent, unexpected, external and visible event causing bodily injury.

28.4 What is not covered

We will not pay the Accident Lump Sum for any injury which is directly or indirectly attributable to or contributed to by:

a) Any illness, disease, naturally occurring condition or degenerative condition;
b) Any intentional self-injury, suicide or attempted suicide;
c) War or warlike activities;
d) Flying, or attempting to fly, in an aircraft other than as a farepaying passenger travelling in an aircraft engaged in a scheduled commercial flight or charter service;
e) Being under the influence of intoxicating liquor or of a drug, other than a drug taken or administered in accordance with the advice of a Medical Doctor; or
f) The Person Insured participating in a criminal or illegal act.

28.5 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim for Accident Lump Sum must include:

- Written notice of the claim, to be received by AMP, within twelve months of the date on which the Event occurred to the Person Insured.
- Any medical or other evidence required by AMP. This must be provided at Your expense. This must be received within six months of Us receiving written notice of the claim.

28.6 When Accident Lump Sum ends

This cover ends for a Person Insured on the earliest of:

- The death of the Person Insured; or
- The 65th birthday of the Person Insured; or
- When this Policy ends as in Clause 9.2; or
- When the cover is cancelled for the Person Insured by the Policy Owner; or
- When a Benefit has been paid under this Clause.

29 Future Growth Income Cover

Cover under this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

29.1 Future Growth Income Cover

The Policy Owner will have the option of taking out, on their written application, Income Cover, Income Cover Essentials or Income Cover Total on the Person Insured's life following the event listed below:

- In the thirty days before or after the anniversary of the Policy following an increase in the Person Insured's income.

29.1.1 Evidence required for an Income Cover application

Applications for converting Future Growth Income Cover to Income Cover, Income Cover Essentials or Income Cover Total, are to be supported at a minimum by proof of the Person Insured's current occupation, regularity of hours of work and income.

Before taking out Income Cover, Income Cover Essentials or Income Cover Total both the Person Insured and the Policy Owner must certify that they have no knowledge and have received no medical advice to suggest that a claim can be submitted for the Person Insured on any AMP insurance.

The Person Insured will also have to certify as to their smoking habits.

29.1.2 Circumstances in which We may refuse an Income Cover application

If the Person Insured and the Policy Owner cannot certify as above that a claim cannot be submitted, or if AMP is not satisfied as to the matters set out in Clause 29.1.1 or that there is a financial need for the additional cover, AMP can decline the application for Income Cover, Income Cover Essentials or Income Cover Total.

29.2 When Future Growth Income Cover ends

Future Growth Income Cover for a Person Insured ends on the earliest of:

a) The fourth anniversary of the Policy following the inclusion of Future Growth Income Cover, subject to Clause 29.4
b) The death of the Person Insured
c) Their 60th birthday
d) When this Policy ends as in Clause 9.2
e) When the Future Growth Income Cover for the Person Insured is cancelled by the Policy Owner
f) When the value of Income Cover, Income Cover Essentials or Income Cover Total for the Person Insured is cancelled or reduced to nil.

29.3 How much Future Growth Income Cover can be converted to Income Cover, Income Cover Essentials or Income Cover Total

Income Cover, Income Cover Essentials or Income Cover Total taken out may be for a basic monthly benefit up to the amount of Future Growth Income Cover as shown in the Schedule or most recent Replacement Schedule.

No claim or amount is payable on Future Growth Income Cover.

29.4 Extending your Future Growth Income Cover

To extend the Future Growth Income Cover for another 4 years (up to a maximum of 8 years in total) the Policy Owner will need to provide updated financial information. AMP can decide not to extend the Cover.

29.5 If you don't take up this option

If the Policy Owner does not take up this option during the time allowed, then they forfeit their right to do so.

29.6 When additional Income Cover, Income Cover Essentials or Income Cover Total is taken out

Any additional Income Cover, Income Cover Essentials or Income Cover Total taken out will be subject to the normal terms and conditions for new covers of that type applying at that time, and:

- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the sex, current age, smoking status and occupation of the Person Insured
- will not, unless otherwise agreed by AMP or stated in this Policy, contain any special provision or additional cover, for which AMP then usually charges an increased or additional Premium.

29.7 Premium Cover

If this Policy for the Person Insured includes Premium Cover, any additional policy taken out can also include a similar cover if the Policy Owner so wishes. Any such cover:

- will be subject to the usual terms and conditions of Premium Cover applying at that time
- will require the Premium payable to be calculated at the premium rate then current for such policies, taking into account the current age of the Person Insured.

29.8 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on Premiums. This is included in your Premiums.

30 New Job Income Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule, and if current.

30.1 Total Disablement Feature

If a Person Insured with this cover becomes Totally Disabled then AMP will pay a monthly benefit under the Total Disablement Feature.

30.1.1 What We mean by Totally Disabled

"Totally Disabled" means disablement which as the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Totally Disabled. The Person Insured is Totally Disabled if:

- they are so ill or injured that they can't do their usual occupation for more than 10 hours per week; and
- they are under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- they do not do any remunerative work (apart from up to 10 hours per week in their usual occupation).

"Total Disablement" has a corresponding meaning.

30.1.2 How much We will pay

The benefit payable under the Total Disablement Feature is the lower of:

- The Maximum Monthly Benefit described in Clause 30.1.4, and
- 75% of your Average Monthly Earned Income (see Clause 10) less any amounts paid, or payable, as "periodic income replacement payments" described in Clause 30.1.6.

30.1.3 When a benefit is payable under the Total Disablement Feature

Payment of benefits under the Total Disablement Feature will start on the first day of Total Disablement after the Waiting Period specified in the Schedule.

This benefit is paid monthly in arrears for the duration of the Person Insured's entitlement. Benefits payable for periods of less than one month are calculated on a daily basis.

30.1.4 Maximum Monthly Benefit

The Maximum Monthly Benefit which is payable during the first year of this cover is as shown in the Schedule or most recent Replacement Schedule for the Person Insured.

Indexation on Maximum Monthly Benefit

If indexation is selected, the Maximum Monthly Benefit will increase for subsequent years on each Policy Anniversary, in line with the percentage increase in the CPI for the preceding year ending 30 September. If the percentage change in the CPI is nil or negative for the year, the Maximum Monthly Benefit will not change.

The Maximum Monthly Benefit for any year may not exceed our limit for new covers at the Policy Anniversary.

You may choose not to accept an annual Maximum Monthly Benefit increase. To do this you must send a written application to AMP. We will then inform you of the new Premium payable. By paying the increased Premium in respect of an increased Maximum Monthly Benefit, you indicate that you accept the increase.

30.1.5 When benefit payment under the Total Disablement Feature ends

Payments of benefits under the Total Disablement Feature for a Person Insured end on the earliest of:

a) the expiry of the 12 month Benefit Period, or
b) the Person Insured ceasing to be Totally Disabled, or
c) the death of the Person Insured, or
d) the 65th birthday of the Person Insured, or
e) the Policy ending as in Clause 9.2, or
f) this cover being cancelled for the Person Insured by the Policy Owner.

30.1.6 Periodic income replacement payments

The benefits payable under the Total Disablement Feature (under Clause 30.1.2) will be determined on the basis of payments received by the Person Insured, or to which they are entitled, relating to the period for which Total Disablement benefits are payable. These payments include those:

- from their employer, former employer, employment business or partnerships or like sources (including any income earned during the period not exceeding 10 hours per week referred to in Clause 30.1.1),
- from Accident Compensation or other welfare benefits because the Person Insured is disabled (unless the Policy Owner can prove, and We agree, that the payments are a permanent disability benefit being paid as income),
- from other regular income insurance policies or superannuation, because the Person Insured is disabled.

These payments will not include:

- investment income including, without limitation, income from rent and royalties; or
- regular amounts paid as compensation because of the Person Insured's pain and suffering; or
- sick leave where it is not used; or
- lump sum payments received or due to be received because the Person Insured is disabled, unless they were previously paid as a regular income, and where they were converted to a lump sum at the Person Insured's or Policy Owner's discretion. Where an income is taken as a lump sum, We will offset from what We pay every month, one 100th of the lump sum amount received.

If such payments are not made monthly, AMP will calculate a monthly rate for the purposes of Clause 30.1.2.

If at any time during or after a period of Total Disablement, We learn that such payment has been made to (or is payable to or claimable by) the Person Insured in respect of that month which We were not aware of, the benefit for that month may be reduced. Any difference between the benefit paid for that month and the reduced amount must be repaid.

30.2 Recovery Feature

If a Person Insured with this cover becomes Totally Disabled, as defined and is then able to return to work for more than 10 hours per week on other than a Full-Time basis, then AMP will pay a benefit under the Recovery Feature as calculated below.

30.2.1 How much We will pay

The benefit payable under the Recovery Feature is equal to: $\frac{(A-B)\times C}{A}$

Where:

- A is the Person Insured's Average Monthly Earned Income (see Clause 10)
- B is the Person Insured's current monthly earned income from their occupation or work
- C is the Total Disablement benefit for that month (see Clause 30.1.2

For example		
Average Monthly Earned Income		$2,000
Current monthly earnings		$900
Total Disablement benefit for the month		$1,500
Recovery Feature benefit (this month)	$\frac{(2{,}000-900)\times 1{,}500}{2{,}000}$ = $\frac{(1{,}100\times 1{,}500)}{2{,}000}$	
Total		$825
For the month you will receive:		
Recovery Feature benefit		$825
Current Earnings		$900
Total		$1,725

This compares with the benefit payable under the Total Disablement Feature of $1,500 for the month. It is, therefore, in the interests of the Person Insured to take up work. .

This benefit is paid monthly in arrears for the duration of the Person Insured's entitlement (see Clause 30.2.3). Benefits for periods of less than one month are calculated on a daily basis.

30.2.2 When Recovery Feature starts

Recovery Feature starts on the Starting Date of this cover, but any benefit payment will start one month after the end of the Waiting Period, as stated in the Schedule.

To qualify for a benefit under Recovery Feature:

- if your Waiting Period is two weeks, the Person Insured must be Totally Disabled (as defined under clause 30.1.1) continuously for the Waiting Period; or
- if your Waiting Period is longer than two weeks, the Person Insured must be Totally Disabled (as defined under clause 30.1.1) continuously for at least the first two weeks of the Waiting Period. During the remainder of the Waiting Period the Person Insured must be able to return to work for more than 10 hours per week but as a direct result of the accident, injury or illness is unable to return to work Full-Time and is earning less than their Average Monthly Earned Income (see clause 10); and
- the Person Insured is under the ongoing care of a Medical Doctor for the illness or injury and is complying with the advice and treatment recommended by a Medical Doctor.

30.2.3 When benefit payment under Recovery Feature ends

Payments of benefits under Recovery Feature end for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) the Policy ending as in Clause 9.2
d) this cover being cancelled for the Person Insured by the Policy Owner
e) the expiry of the Benefit Period stated in the Schedule or most recent Replacement Schedule
f) when any of the conditions for payment set out in Clause 30.2.2 are not met
g) the Benefit End Date as shown in the Schedule or most recent Replacement Schedule
h) the Person Insured returns to work on a Full-Time basis.
i) the Recovery Feature benefit calculated under clause 30.2.1 being nil or negative (Clause 10).

30.3 Relapse Feature

If the Person Insured is able to work for more than 10 hours per week during the Waiting Period after a period during which they were Totally Disabled, and they suffer a relapse and are again unable to work at all, then:

- if they are able to work for 5 days in a row (or less), and they suffer a relapse of the same or a related illness or injury, then the Waiting Period continues. It does not start again. We only start to

pay when the Person Insured is Totally Disabled for the total number of days that make up the normal Waiting Period.

- if they are able to work for more than 5 days in a row, and they suffer a relapse of the same or a related illness or injury, then the Waiting Period starts all over again. We don't count the days that the Person Insured was Totally Disabled at all before the relapse.

If the Person Insured suffers a relapse, which in our opinion arises from the same, or a related, cause for which they were previously entitled to a benefit, then:

- if the Person Insured has been able to work for 12 months or more after We stopped paying, then We treat the claim as a new claim, and the Waiting Period and the Benefit Payment Period start all over again.
- if the Person Insured has been able to work for less than 12 months after We stopped paying, then We treat the claim as a continuation of the same claim. That is, the Waiting Period and the Benefit Payment Period do not start again.

30.4 Rehabilitation and Vocational Costs Feature

The Rehabilitation and Vocational Costs benefit is payable at AMP's discretion, for reimbursement of money spent with AMP's prior approval, on equipment, home alterations, training, counselling and other capital expenses which are certified by the Person Insured's attending Medical Doctor to be necessary in the course of rehabilitation or that AMP agrees will assist the Person Insured to return to Full-Time work. This benefit is not payable for expenses that are reimbursable from other sources. The Person Insured must notify AMP and must receive prior written approval of AMP before the costs are incurred (see Clause 25.151).

30.4.1 How much We will pay

AMP may pay multiple payments but the total benefit payable over the term of the claim is 12 times the monthly amount We would pay if the Person Insured was Totally Disabled. It is not contingent upon the Person Insured receiving a Monthly Benefit under Income Cover. It may be paid before the end of the Waiting Period.

30.5 New Job Income Cover Conversion Option

A conversion option to Income Cover Total or Income Cover Essentials is available within 60 days following the 1st Policy Anniversary with occupational and income evidence satisfactory to AMP but without medical underwriting.

The Maximum Monthly Benefit available upon conversion is subject to AMP's review and acceptance of the Person Insured's current income and will not exceed the Maximum Monthly Benefit shown in the Schedule or most recent Replacement Schedule. The Person Insured cannot be receiving (or be entitled to receive) a monthly benefit from New Job Income Cover at the time of conversion.

This Option must be used within 60 days following the first anniversary of the New Job Income Cover. If the Option is not used, the Option lapses permanently and New Job Income Cover will continue with a one year Benefit Payment Period.

30.6 Payments while located overseas

Coverage is provided 24 hours, world-wide. We pay the normal amount we would pay for up to 3 months if the Person Insured is resident outside Australia or New Zealand and while they are Totally Disabled as defined in Clause 30.1.1. We may continue to pay beyond 3 months, and We reserve the right for claim assessments to be conducted in a country nominated by Us. If We discontinue payments, then when the Person Insured returns to Australia or New Zealand, We will start paying again provided they are still Totally Disabled.

30.7 When New Job Income Cover ends

New Job Income Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2
d) the Person Insured ceasing to be actively engaged in their usual occupation for more than 12 months for reasons other than their total disablement.
e) when New Job Income Cover for the Person Insured is cancelled by the Policy Owner
f) if New Job Income Cover is converted to Income Cover Total or Income Cover Essentials under Clause 30.5.

30.8 What is not covered

No benefits will be paid under this Cover if the Person Insured is unable to work due to injury or illness wholly or partly, directly or indirectly caused:

- on purpose – we won't pay if the Policy Owner or the Person Insured causes the Person Insured to be unable to work.
- (if the optional AIDS exclusion is contained in the Schedule) by the presence in the Person Insured's body
  of:
  i. Any Human Immunodeficiency Virus (HIV)
  ii. Acquired Immunodeficiency Syndrome (AIDS)
  iii. Any AIDS related condition or infection.
- by the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted.

As normal and uncomplicated pregnancy and childbirth are not illnesses for the purposes of the definition of Total Disablement, they are not covered by this cover.

30.9 Making a claim

30.9.1 Notifying AMP of a Claim

As well as meeting the general conditions in Clause 3.1 and Clause 30.9.3, any claim for a benefit payment under Total Disablement must be given to Us within one month after the occurrence of Total Disablement.

No claim will be payable for periods more than one month before AMP's receipt of the notice of a claim.

30.9.2 We must be notified of a claim under the Rehabilitation and Vocational Costs Feature before the costs are incurred.

30.9.3 Evidence for claims

As well as meeting the general conditions in Clause 3.1, before We can assess your eligibility for a claim under New Job Income Cover, we require:

- evidence of hours worked and income earned.
- evidence of the Average Monthly Earned Income of the Person Insured.
- proof, to the satisfaction of AMP, that the Person Insured continues to receive medical treatment from, and follow the advice of, a Medical Doctor or appropriate consultant medical specialist who is acceptable to AMP.

For the purpose of ongoing claim assessment, AMP may request at our expense the Person Insured :

- undergo one or more examinations by a Medical Doctor nominated by AMP
- undergo medical tests which may include the taking of blood samples for pathological examination by medical personnel nominated by AMP.

- provide any other information AMP requires to assess entitlements under this Policy, for example, Inland Revenue assessments and business accounts.

30.9.4 All evidence must be provided within two months of the claim period to which it relates. No claim will be payable in respect of any period more than two months prior to AMP's receipt of proper evidence supporting a claim.

30.9.5 Payment of claims

All benefits under New Job Income Cover will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits under New Job Income Cover will be paid to the employer.

30.10 Premium Cover

If Premium Cover is selected for New Job Income Cover, the premium will be waived from the earlier of the end of the New Job Income Cover Waiting Period or the Premium Cover Waiting Period.

30.11 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

31 Business Survival Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

31.1 Total Disablement Feature

If a Person Insured with this cover becomes Totally Disabled AMP will pay a monthly benefit under the Total Disablement Feature.

31.1.1 What We mean by Totally Disabled

"Totally Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Totally Disabled. The Person Insured is Totally Disabled if:

- they are so ill or injured that they can't do their usual occupation for more than 10 hours per week; and
- they are under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- they do not do any remunerative work (apart from up to 10 hours per week in their usual occupation).

"Total Disablement" has a corresponding meaning.

31.2 How much We will pay

The benefit payable under the Total Disablement feature is the Maximum Monthly Benefit described in Clause 31.4.

This benefit is paid monthly in advance for the duration of the Person Insured's entitlement (see Clause 31.5), less the Waiting Period. Benefits payable for periods of less than one month are calculated on a daily basis.

31.3 When a benefit is payable under the Total Disablement Feature

Payment of benefits under the Total Disablement Feature will start on the first day of Total Disablement after the Waiting Period specified in the Schedule.

31.4 Maximum Monthly Benefit

If the Policy Type specified in the Schedule is Employer the Maximum Monthly Benefit that is payable for the Person Insured is as shown in the Schedule or most recent Replacement Schedule.

If the Policy Type specified in the Schedule is Employee the Maximum Monthly Benefit that is payable is calculated as:

a. 100% of the Maximum Monthly Benefit as shown in the Schedule or most recent Replacement Schedule for the Person Insured for the first six months of the Benefit Period
b. 50% of the Maximum Monthly Benefit as shown in the Schedule or most recent Replacement Schedule for the Person Insured for the remainder of the Benefit Period.

Indexation on Maximum Monthly Benefit

If Indexation is selected, the Maximum Monthly Benefit will increase for subsequent years on each Policy Anniversary, in line with the indexation percentage increase in the CPI for the preceding year ending 30 September. If the percentage change in the CPI is nil or negative for the year, the Maximum Monthly Benefit will not change.

The Maximum Monthly Benefit for any year may not exceed our limit for new covers at the Policy Anniversary.

You may choose not to accept an annual Maximum Monthly Benefit increase. To do this you must send a written application to AMP. We will then inform you of the new Premium payable. By paying the increased Premium in respect of an increased Maximum Monthly Benefit, you indicate that you accept the increase.

31.5 When benefit payments under the Total Disablement Feature end

Payment of benefits under the Total Disablement Feature ends for a Person Insured on the earliest of:

a) the expiry of the Benefit Period as shown in the Schedule or most recent Replacement Schedule
b) the death of the Person Insured
c) the 70th birthday of the Person Insured
d) the Policy ending as in Clause 9.2
e) the Business Survival Cover being cancelled for the Person Insured by the Policy Owner
f) the Person Insured ceasing to be Totally Disabled
g) the Person Insured doing any remunerative work apart from up to 10 hours per week in their usual occupation
h) the Policy Owner ceasing to have an ownership interest in the Business
i) the Person Insured ceasing to be actively engaged in the Business for reasons other than their total disablement.

31.6 Relapse Feature

If the Person Insured is able to work for more than 10 hours per week during the Waiting Period after a period during which they were Totally Disabled, and they suffer a relapse and are again Totally Disabled, then:

- if they are able to work for 5 days in a row (or less), and they suffer a relapse of the same or a related illness or injury, then the Waiting Period continues. It does not start again. We only start to pay when the Person Insured is Totally Disabled for the total number of days that make up the normal Waiting Period.
- if they are able to work for more than 5 days in a row, and they suffer a relapse of the same or a related illness or injury, then the Waiting Period starts all over again. We don't count the days that the Person Insured was Totally Disabled before the relapse.

If the Person Insured suffers a relapse, which in our opinion arises from the same or a related cause for which they were previously entitled to a benefit:

- if the Person Insured has been able to work for 12 months or more after We stopped paying, then We treat the claim as a new claim, and the Waiting Period and the Benefit Payment Period start all over again.
- if the Person Insured has been able to work for less than 12 months after We stopped paying, then We treat the claim as a continuation of the same claim. That is, the Waiting Period and the Benefit Payment Period do not start again.

31.7 Payments while located overseas

Coverage is provided 24 hours, world-wide. We pay the normal amount we would pay for up to 3 months if the Person Insured is resident outside Australia or New Zealand and while they are Totally Disabled as defined in Clause 31.1.1. We may continue to pay beyond 3 months, and We reserve the

right for claim assessments to be conducted in a country nominated by Us. If We discontinue payments, then when the Person Insured returns to Australia or New Zealand, AMP will start paying again provided they are still Totally Disabled.

31.8 When Business Survival Cover ends

Business Survival Cover ends for a Person Insured on the earliest of:

a. the death of the Person Insured
b. the 70th birthday of the Person Insured
c. when this Policy ends as in Clause 9.2
d. if the Person Insured ceases to be actively engaged in the Business for more than 60 days for reasons other than Total Disablement, unless We have been notified in writing and our written consent has been given. In giving consent We may vary the terms and conditions of this Policy, including an increase in Premium.
e. if the Policy Type is Employer and the Person Insured ceases to have an ownership interest in the Business, unless We have been notified in writing and our written consent has been given. In giving consent We may require financial evidence to our satisfaction and We may vary the terms and conditions of this Policy, including an increase in Premium. Consent will not be given if the Person Insured is Totally Disabled.
f. when Business Survival Cover for the Person Insured is cancelled by the Policy Owner.

31.9 What is not covered

No benefits will be paid under this Cover if the Person Insured is unable to work due to injury, accident or illness wholly or partly, directly or indirectly caused:

- on purpose – we won't pay if the Policy Owner or the Person Insured causes the Person Insured to be unable to work.
- (if the optional AIDS exclusion is contained in the Schedule) by the presence in the Person Insured's body of:
  i. Any Human Immunodeficiency Virus (HIV)
  ii. Acquired Immunodeficiency Syndrome (AIDS)
  iii. Any AIDS related condition or infection.
- by the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted.

As normal and uncomplicated pregnancy and childbirth are not illnesses for the purposes of the definition of Total Disablement, they are not covered by this cover.

31.10 Making a claim

31.10.1 Notifying AMP of a Claim

As well as meeting the general conditions in Clause 3.1 and Clause 31.10.2, any claim for a benefit payment under Business Survival Cover must:

- be given to Us within one month after the occurrence of Total Disablement.
- include proof, to the satisfaction of AMP, that the Person Insured continues to receive medical treatment from, and follow the advice of, a Medical Doctor or appropriate consultant medical specialist who is acceptable to AMP.

No claim will be payable for periods more than one month before AMP's receipt of the notice of a claim.

31.10.2 Evidence for Claims

For the purposes of ongoing claim assessment, AMP may request at our expense the Person Insured undergo:

- one or more examinations by a Medical Doctor nominated by AMP
- medical tests which may include the taking of blood samples for pathological examination by medical personnel nominated by AMP.

All evidence must be provided within two months of the claim period to which it relates. No claim will be payable in respect of any period more than two months prior to AMP's receipt of proper evidence supporting a claim.

31.10.3 Payment of Claims

All benefits under Business Survival Cover will be paid to the Policy Owner.

31.11 Premium Cover

If Premium Cover is selected for Business Survival Cover, the premium will be waived from the earlier of the end of Business Survival Cover Waiting Period or the Premium Cover Waiting Period.

31.12 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

32 Business Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

32.1 Total Disablement Feature

If a Person Insured with this cover becomes Totally Disabled AMP will pay a monthly benefit under the Total Disablement Feature.

32.1.1 What We mean by Totally Disabled

"Totally Disabled" means disablement which has the result described below and which:

a) results from an illness, accident or injury, and
b) starts on or after the date on which this cover started for the Person Insured, and
c) starts before this cover ends.

We will pay if the Person Insured is Totally Disabled. The Person Insured is Totally Disabled if:

- they are so ill or injured that they can't do their usual occupation; and
- they are under the ongoing care of a Medical Doctor for that illness or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
- they do not do any remunerative work.

"Total Disablement" has a corresponding meaning.

32.2 How much We will pay

The benefit payable under the Total Disablement Feature is the lower of:

- the Maximum Monthly Benefit described in Clause 32.4, and
- Eligible Business Expenses which are incurred during the month for which a benefit is payable (see Clause 32.6), less the amount by which the income generated by the Person Insured's replacement exceeds the expenses involved in employing that person for the month.

If the benefit payable by AMP, together with any other benefit which We consider to be business expense insurance, exceeds in any month the Eligible Business Expenses incurred during the month, then the benefit payable by AMP will be reduced by the excess.

This benefit is paid monthly in arrears for the duration of the Person Insured's entitlement (see Clause 32.5), less the Waiting Period. Benefits payable for periods of less than one month are calculated on a daily basis.

32.3 When a benefit is payable under the Total Disablement Feature

Payment of benefits under the Total Disablement Feature will start on the first day of Total Disablement after the Waiting Period specified in the Schedule.

32.4 Maximum Monthly Benefit

The total amount of Maximum Monthly Benefit payable in respect of any particular claim is the equivalent of twelve Maximum Monthly Benefit payments, but these may be paid over a period of up to 18 months.

The Maximum Monthly Benefit which is payable during the first year of this cover is as shown in the Schedule or most recent Replacement Schedule for the Person Insured.

Indexation on Maximum Monthly Benefit

If indexation is selected, the Maximum Monthly Benefit will increase for subsequent years on each Policy Anniversary, in line with the percentage increase in the CPI for the preceding year ending 30 September. If the percentage change in the CPI is nil or negative for the year, the Maximum Monthly Benefit will not change.

The Maximum Monthly Benefit for any year may not exceed our limit for new covers at the Policy Anniversary.

You may choose not to accept an annual Maximum Monthly Benefit increase. To do this you must send a written application to AMP. We will then inform you of the new Premium payable. By paying the increased Premium in respect of an increased Maximum Monthly Benefit, you indicate that you accept the increase.

32.5 When benefit payments under the Total Disablement Feature end

Payment of benefits under the Total Disablement Feature ends for a Person Insured on the earliest of:

a) the expiry of the Benefit Period as shown in the Schedule or most recent Replacement Schedule
b) the death of the Person Insured
c) the 65th birthday of the Person Insured
d) the Policy ending as in Clause 9.2
e) the Business Cover being cancelled for the Person Insured by the Policy Owner
f) the Person Insured ceasing to be Totally Disabled
g) the Person Insured does any remunerative work
h) the payment of the Person Insured's total entitlement in respect of the particular claim.

32.6 Eligible Business Expenses

Eligible Business Expenses consist of expenses that are normal and necessary to the Business. They must be expenses that will continue irrespective of whether or not the Person Insured is disabled and include expenses:

- in respect of Business premises (other than a residential address): rent and mortgage interest
- in respect of operating the Business: electricity, gas, water, heating, laundry, telephone, cleaning, property rates and property taxes
- salaries of employees who do not generate income for the Business and costs directly relating to salaries e.g. superannuation and fringe benefits tax.
- general expenses including accountants' and auditors' fees, business and general insurance premiums, advertising costs, leasing costs on equipment or motor vehicles and subscriptions to professional associations.
- in respect of employing a replacement person, to the extent that all reasonable costs of employing that replacement person (e.g. salary, travel, accommodation, superannuation etc) exceed the business income the replacement generates; this excess is an eligible expense.

32.6.1 Expenses Excluded

Eligible Business Expenses do not include the following expenses:

- Any form of remuneration paid to: the Person Insured, someone who is not a genuine employee adding value to the Business, the person who replaces the Person Insured (other than allowed for as an eligible expense), people who earn income for the Business, any member of the Person Insured's family who has been employed for less than 3 months in the Business at the date the Person Insured became unable to work.
- the cost of goods, wares and merchandise of any nature used in the Business
- payments of principal on mortgage or other debts
- rent and mortgage interest on the Person Insured's residence even if used as business premises
- income tax or company tax
- purchase of equipment used in the Business or acquisition of any other assets
- depreciation, including real estate depreciation
- expenses for which the Business is not regularly liable
- expenses other than genuine expenses considered to be normal and necessary in the conduct of the Business.

32.7 Relapse

If the Person Insured is able to work during the Waiting Period after a period during which they were unable to work at all, and they suffer a relapse and are again unable to work at all, then:

- if they are able to work for 5 days in a row (or less), and they suffer a relapse of the same or a related illness or injury, then the Waiting Period continues. It does not start again. We only start to pay when the Person Insured is unable to work at all for the total number of days that make up the normal Waiting Period.
- if they are able to work for more than 5 days in a row, and they suffer a relapse of the same or a related illness or injury, then the Waiting Period starts all over again. We don't count the days that the Person Insured was unable to work at all before the relapse.

If the Person Insured suffers a relapse, which in our opinion arises from the same or a related cause for which they were previously entitled to a benefit:

- if the Person Insured has been able to work for 12 months or more after We stopped paying, then We treat the claim as a new claim, and the Waiting Period and the Benefit Payment Period start all over again.
- if the Person Insured has been able to work for less than 12 months after We stopped paying, then We treat the claim as a continuation of the same claim. That is, the Waiting Period and the Benefit Payment Period do not start again.

32.8 Rehabilitation Costs Feature

The Rehabilitation Costs benefit is payable at AMP's discretion, for reimbursement of money spent with AMP's prior approval, on training or on equipment and other capital expenses which are certified by the Person Insured's attending Medical Doctor to be necessary in the course of rehabilitation. This benefit is not payable for expenses that are reimbursable from other sources.

32.8.1 How much We will pay

The total benefit payable is 12 times the monthly amount We would pay if the Person Insured was unable to work at all. It is not contingent upon the Person Insured receiving a monthly benefit under Business Cover. It may be paid before the end of the Waiting Period.

32.9 Payments while located overseas

Coverage is provided 24 hours, world-wide. We pay the normal amount we would pay for up to 3 months if the Person Insured is resident outside Australia or New Zealand and while they are Totally Disabled as defined in Clause 32.1.1. We may continue to pay beyond 3 months, and We reserve the right for claim assessments to be conducted in a country nominated by Us. If We discontinue payments, then when the Person Insured returns to Australia or New Zealand, We will start paying again provided they are still Totally Disabled.

32.10 Airfare Assistance if Totally Disabled while overseas

Airfare assistance is available if the Person Insured has been resident outside of Australia or New Zealand for more than 30 days, and they have been unable to work at all for at least 14 days because they are Totally Disabled while overseas. We will reimburse up to the cost of one single economy airfare for the Person Insured to return home, by the most direct route available, less any amounts that are reimbursed from other sources.

32.11 When Business Cover ends

Business Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2
d) the Person Insured ceasing to be actively engaged in their Business for more than 12 months for reasons other than their Total Disablement, unless We have been notified in writing and our written

consent has been given. In giving consent We may vary the terms and conditions of this Policy, including an increase in the Premium.

e) when Business Cover for the Person Insured is cancelled by the Policy Owner.

32.12 What is not covered

No benefits will be paid under this Cover if the Person Insured is unable to work due to injury, accident or illness wholly or partly, directly or indirectly caused:

- on purpose – we won't pay if the Policy Owner or the Person Insured causes the Person Insured to be unable to work.
- (if the optional AIDS exclusion is contained in the Schedule) by the presence in the Person Insured's body of:
  I. Any Human Immunodeficiency Virus (HIV)
  II. Acquired Immunodeficiency Syndrome (AIDS)
  III. Any AIDS related condition or infection
- by the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted.

As normal and uncomplicated pregnancy and childbirth are not illnesses for the purposes of the definition of Total Disablement, they are not covered by this cover.

32.13 Making a claim

32.13.1 Notifying AMP of a Claim

As well as meeting the general conditions in Clause 3.1 and Clause 32.13.3, any claim for a benefit payment under Business Cover must:

- be given to Us within one month after the occurrence of Total Disablement.
- include proof, to the satisfaction of AMP, that the Person Insured continues to receive medical treatment from, and follow the advice of, a Medical Doctor or appropriate consultant medical specialist who is acceptable to AMP.

No claim will be payable for periods more than one month before AMP's receipt of the notice of a claim.

32.13.2 We must be notified of a claim under the Rehabilitation Costs Feature before the costs are incurred.

32.13.3 Evidence for Claims

As well as meeting the general conditions in Clause 3.1, any claim for Business Cover must include:

- evidence of all Eligible Business Expenses and other financial details as We may require.

For the purposes of ongoing claim assessment, AMP may request at our expense the Person Insured:

- undergo one or more examinations by a Medical Doctor nominated by AMP
- undergo medical tests which may include the taking of blood samples for pathological examination by medical personnel nominated by AMP
- provide any other information that AMP requires to assess entitlements under this Policy, for example business accounts.

All evidence must be provided within two months of the claim period to which it relates. No claim will be payable in respect of any period more than two months prior to AMP's receipt of proper evidence supporting a claim.

32.13.4 Payment of Claims

All benefits under Business Cover will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits under Business Cover will be paid to the employer.

32.14 Premium Cover

If Premium Cover is selected for Business Cover, the premium will be waived from the earlier of the end of Business Cover Waiting Period or the Premium Cover Waiting Period.

32.15 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

33 Premium Cover

Cover against any of the risks in this Clause will only appear if shown in the Schedule or most recent Replacement Schedule, and if current.

33.1 Premium Cover

If a Person Insured with this cover becomes Totally Disabled, We will waive the Person Insured's Premium for the Covers which the Policy Owner has chosen to cover with Premium Cover under this Policy for as long as that disability persists continuously.

33.2 What We mean by "Totally Disabled"

"Totally Disabled" means disability which has the result described below and which:

a) results from an illness, accident or injury; and
b) starts on or after the date on which this cover came into effect for the Person Insured; and
c) starts before this cover ends.

"Total Disablement" has a corresponding meaning.

The Person Insured is Totally Disabled if:

a) they are so ill or injured that they can't do their usual occupation for more than 10 hours per week; and
b) they are under the ongoing care of a Medical Doctor for that illness, accident or injury and are complying with the advice and treatment recommended by a Medical Doctor or appropriate consultant Medical Specialist who is acceptable to AMP; and
c) they do not do any remunerative work (apart from up to 10 hours per week in their usual occupation).

Home maker or not employed

If:

a) the Person Insured's occupation shown in their Schedule or most recent replacement Schedule is 'home maker' or 'home duties'; or
b) the Person Insured is not in paid employment or has been on Unpaid Leave for more than 12 months before the date on which they became Totally Disabled, then

the Person Insured is Totally Disabled if, due to their illness, accident or injury, We determine that they are unable to perform at least 2 of the 5 Activities of Daily Living without assistance from someone else.

We will pay if;

a) the Person Insured is Totally Disabled; and
b) the disability of the Person Insured has continued for at least 3 consecutive months (the Waiting Period); and
c) the disability of the Person Insured is supported by evidence from an appropriate consultant medical specialist who is acceptable to AMP; and
d) the Person Insured has been under the regular care and attention of a Medical Doctor since they became disabled.

"Unpaid Leave" means the Person Insured is employed immediately before the illness, accident or injury that led to their Total Disablement, but has been on authorised leave from their employer.

33.3 How much We will pay

The share of the Premium which will be waived is the Individual Premium for the Person Insured plus any Premium payable on any Children's Crisis Cover or Children's Future Life Cover included in the Policy as at the end of the continuous three-month Waiting Period referred to in Clause 33.2.

These will be waived as from the start of the Waiting Period so that the Policy Owner will be refunded the Premiums paid during that time.

33.4 When Premiums will be waived earlier

The Premium to be waived as in Clause 33.3 will be waived earlier if the Person Insured is receiving a regular monthly benefit under Income Cover, Income Cover Essentials, New Job Income Cover, Business Cover, Business Survival Cover or Home Loan Temporary Disability Cover as a result of Total Disablement. In this case the Premium will be waived once the Person Insured starts to receive this monthly benefit and any premiums paid from the first day of Total Disablement will be refunded to the Policy Owner.

The Premium to be waived as in Clause 33.3 will be waived earlier if the Person Insured is receiving a regular monthly benefit under Income Cover Total as a result of Total or Partial Disablement. In this case the Premium will be waived once the Person Insured starts to receive this monthly benefit and any premiums paid from the first day of Total Disablement or Partial Disablement will be refunded to the Policy Owner.

33.5 When Premium Cover ends

1. This cover ends for a Person Insured on the earliest of:
   a) the death of the Person Insured, or
   b) the 65th birthday of the Person Insured, or
   c) when this Policy ends as in Clause 9.2, or
   d) when this cover is cancelled for the Person Insured by the Policy Owner.
2. Exceptions:
   If the premiums of the Person Insured are being waived under this cover on the 65th birthday of the Person Insured, this cover will cease on the earlier of:
   a) the Person Insured ceasing to be Totally Disabled; or
   b) the expiry of the Cover for which the Premium is being waived.

For the purposes of clause 33.5 (2a), if the Person Insured has retired from their usual occupation, Totally Disabled means that the Person Insured is unable to perform two or more of the five Activities of Daily Living without assistance from someone else.

33.6 What is not covered

Premium Cover does not cover Total Disablement which:

- started prior to the Starting Date for this cover; or
- has been directly or indirectly caused by, or results from, the Policy Owner or Person Insured the Person Insured to be Totally Disabled; or
- results from the Person Insured engaging in conduct which gives rise to any criminal act, for which the Person Insured is convicted.

33.7 Making a claim

a) As well as meeting the general conditions in Clause 3.1, any claim for Premium Cover must include:
   - written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured first became Totally Disabled
   - any medical or other evidence required by AMP. This must be provided at your expense. This must be received at the Register within six months of Us receiving written notice of the claim.

b) AMP may require, at your expense, at any time during the continuance of a claim:
   - that you provide medical or other evidence of the continued disability, and
   - that the Person Insured is medically examined by a Medical Doctor or specialist nominated by AMP,
     within one month of being requested by AMP.
   - that you provide proof, to the satisfaction of AMP, that the Person Insured continues to receive and follow medical advice and treatment from a Medical Doctor or specialist acceptable to AMP.

If the Person Insured works at all while Totally Disabled, We may require copies of records acceptable to Us which accurately and fully detail both the hours that the Person Insured has worked each day and the work undertaken. Examples of the records that AMP may require include (but are not limited to) signed timesheets recording start and end times and wage records.

AMP's liability to pay a claim for Premium Cover will end in respect of that claim if any of the requirements in Clauses 33.7a or 33.7b) are not met within one month of a request from AMP.

33.7.1 Claims received after the Waiting Period

If written notice of a claim is received by AMP after:

- the relevant Waiting Period as specified below, and
- an increase to your cover through Indexation has been processed by AMP with an effective date also later than the relevant Waiting Period; then,

if AMP accepts liability for the claim, cover will be adjusted to exclude the relevant Indexation increase. In this case, AMP would refund any premium paid corresponding to that Indexation increase.

A three month Waiting Period applies to Premium Cover.

33.8 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premium.

34 Home Loan Life Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

34.1 Life cover

If a Person Insured with this cover dies then AMP will pay the amount of their Life Cover.

34.1.1 How much We will pay

The amount We will pay is the Home Loan Life Cover for the Person Insured as at the date of their death. This is the amount of Home Loan Life Cover shown in the Schedule or most recent Replacement Schedule, but reduced by the amount of any prior payment for Terminal Illness or Home Loan Crisis Cover.

34.1.2 The effect on the Policy when Home Loan Life Cover is paid

Once a claim under this cover has been accepted by AMP, all other covers of the Person Insured are cancelled.

34.1.3 When Home Loan Life Cover ends

Home Loan Life Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 70th birthday of the Person Insured or an earlier date as stated in the Schedule
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Life Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Life Cover is reduced to nil due to payments of Terminal Illness Cover and other Linked Covers

34.2 Terminal Illness Cover

If a Person Insured with Home Loan Life Cover is diagnosed as having a terminal illness while the Home Loan Life Cover is current then AMP will pay the amount of their Terminal Illness Cover.

34.2.1 What We mean by "terminal illness"

"Terminal illness" here means any illness or injury, which in the opinion of AMP after consideration of unequivocal medical evidence provided to us by the Person Insured's own Medical Doctor and such other evidence as we may require, will result in the death of the Person Insured within twelve months of the date of diagnosis as terminal, regardless of any treatment that might be undertaken.

34.2.2 How much We will pay

The amount payable is an advance lump sum payment of up to 100 percent of the Home Loan Life Cover of the terminally ill Person Insured,calculated as at the date AMP agrees to pay the claim.

34.2.3 The effect on the Policy when Terminal Illness Cover is paid

Once a claim under this cover has been accepted by AMP:

- all other Home Loan Life Cover and Home Loan Crisis Cover of the Person Insured reduces by the amount of Terminal Illness Cover paid
- if the Person Insured also has the Premium Cover Option, AMP will waive the premiums for the Person Insured which are due from that time forward.

34.2.4 When Terminal Illness Cover ends

Terminal Illness Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 70th birthday of the Person Insured
c) when a Terminal Illness Cover payment or payments for the full sum insured are made for that Person Insured

d) when this Policy ends as in Clause 9.2
e) when Home Loan Life Cover for the Person Insured is cancelled by the Policy Owner
f) when there is less than 12 months cover remaining on Home Loan Life Cover, where the term of the Home Loan Life Cover has been limited by underwriting.
g) when the value of Home Loan Life Cover is reduced to nil due to payments of other Linked Covers.

34.3 What is not covered

AMP will not pay any Home Loan Life Cover if the Policy Owner (not being the Person Insured) causes the Person Insured to die or become terminally ill, or if the Person Insured causes their own death or terminal illness within one year and thirty days after the Home Loan Life Cover starts or within one year and thirty days of any increase or reinstatement of the Home Loan Life Cover that the Policy Owner applies for. It doesn't matter if the Person Insured was sane or insane when they became terminally ill or died.

However, payment will be made where any person or corporation, (other than the Person Insured, the Policy Owner at the Starting Date, or AMP), has acquired a financial interest in this Policy, before the death of the Person Insured, by way of either:

- security (for a loan, for example), or
- under a genuine transfer registered by AMP.

In this case, We will pay to the person or corporation the amount of their financial interest. The amount payable will not be more than the amount of the Person Insured's Life Cover as at the date of death.

34.4 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim for Terminal Illness Cover must include:

- satisfactory medical evidence of a terminal illness, provided at your expense.

In addition, We may require at our expense:

- medical verification of the terminal illness by a Medical Doctor or specialist nominated by Us.

34.5 Restrictions to your cover

It is not possible to have more than one AMP Home Loan Cover applying to the same home loan.

35 Home Loan Crisis Cover

Cover against any of the risks in this Clause will only apply if shown in the Schedule or most recent Replacement Schedule for the Person Insured, and if current.

35.1 Home Loan Crisis Cover

If a Person Insured with this cover suffers for the first time one of the crises set out below and survives for the survival period prescribed in Clause 35.8, then AMP will pay a benefit equal to the amount of the Home Loan Crisis Cover.

35.2 What We mean by "Crisis"

The specified medical conditions which are included in this cover and which are defined as a "Crisis" are:

- Accidental Loss of use of Hands or Feet or Loss of Sight
- Alzheimer's Disease and other Dementias
- Aortic Surgery
- Aplastic Anaemia
- Benign Tumour of the Brain or Spinal Cord
- Blindness
- Cancer of the breast, prostate, skin or bowel
- Other Cancers
- Cardiomyopathy
- Chronic Lung Disease
- Coma
- Coronary Artery Surgery
- Deafness
- Heart Attack - Myocardial Infarction
- Heart Attack - Out of hospital cardiac arrest
- HIV - Medically acquired
- HIV - Occupationally acquired
- Kidney Failure
- Loss of Independent Living
- Loss of Speech
- Major Head Trauma
- Major Organ Transplant
- Motor Neurone Disease
- Multiple Sclerosis
- Open Heart Surgery
- Paralysis – Diplegia, Hemiplegia, Paraplegia, Quadriplegia, Tetraplegia
- Parkinson's disease
- Primary Pulmonary Hypertension
- Severe Burns
- Stroke

35.3 How much We will pay

The claim will only be paid if, in our opinion, the full definition given in Clause 35.10 for the relevant condition is met.

The claim payable under the Home Loan Crisis Cover is the amount shown in the Schedule or most recent Replacement Schedule but varied as permitted by this Policy.

The benefit will be the amount current at the Date of Crisis. However, there may be a Qualifying Period (see Clause 35.5).

35.4 The effect on this Policy when a benefit is paid under Home Loan Crisis Cover

Each Person Insured may claim only once under this cover and once a claim under Home Loan Crisis Cover has been accepted by AMP the cover will:

- end for the Person Insured under this Policy
- continue for any other Person Insured

and all other Crisis Covers for that Person Insured under this Policy will end.

If the cover is Linked, any other Linked Covers for the Person Insured will be reduced as from the date the benefit is determined under Clause 35.3. Cover will be reduced by the amount of Home Loan Crisis Cover paid.

35.5 What is not covered

We will not pay if the Person Insured or the Policy Owner causes the Person Insured to suffer a Crisis condition.

In addition, the following medical conditions have a Qualifying Period:

Condition	Qualifying Period
Benign Tumour of the Brain or Spinal Cord	3 months
Cancer of the breast, prostate, skin or bowel	6 months
Coronary Artery Surgery	3 months
Heart Attack – Myocardial Infarction	3 months
Heart Attack – out of hospital cardiac arrest	3 months
Stroke	3 months

If any of these conditions is suffered by the Person Insured within the Qualifying Period then no benefit under Home Loan Crisis Cover will be payable on that or any future occurrence of that medical condition.

The Qualifying Period applies from:

- the Starting Date of the Cover or the date of last reinstatement of the Cover, or
- the date of an increase to the Home Loan Crisis Cover (the claim will only be paid on the amount prior to the increase).

35.6 When Home Loan Crisis Cover ends

Home Loan Crisis Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2 of this Policy
d) when Home Loan Crisis Cover for the Person Insured is cancelled by the Policy Owner
e) when the value of Home Loan Crisis Cover is reduced to nil due to payments of Home Loan Life Cover Terminal Illness Benefit
f) when a payment is made under Home Loan Crisis Cover for the Person Insured.

35.7 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Home Loan Crisis Cover must include:

- written notice of the claim, to be received by AMP at the Register, within twelve months of the date on which the Person Insured suffers for the first time one of the crises defined in Clause 35.10, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within six months of Us receiving written notice of the claim.

35.8 Survival Period

If the Person Insured suffers a Crisis condition that We cover, they must survive for 14 days without any artificial life support.

However, for some Crisis conditions an additional Survival Period is required under Clause 35.10 (e.g. Coma).

35.9 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

35.10 Special Definitions of Medical Terms

Accidental Loss of use of Hands or Feet or Loss of Sight	*Description* We will pay if a Person Insured, because of physical severance, totally and permanently loses: • the use of two limbs (where a limb means an entire hand or an entire foot); or • the sight of both eyes (to the extent of 6/60 or less); or • the use of one limb (where a limb means an entire hand or an entire foot) and the sight of one eye (to the extent of 6/60 or less). And they must live for at least 6 months after the loss without artificial life support. The loss must be in the opinion of an appropriate consultant medical specialist We choose, such that it is unlikely to ever be remedied; and Have resulted from an accident which was direct and independent of all other causes and the loss must have been caused directly and solely by violent, external and visible means.
Alzheimer's Disease and Other Dementias	*Description* We will pay if a Person Insured is diagnosed to have Alzheimer's Disease, or any other irreversible dementia, and as a result is: • unable to perform any one of the 5 Activities of Daily Living without assistance from someone else; and • an appropriate consultant medical specialist considers that inability is likely to be permanent. We do not cover dementia directly aggravated by alcohol, or related to drug use that is not prescribed by a doctor. *Glossary of terms* Dementia - A progressive mental deterioration due to organic disease of the brain.
Aortic Surgery	*Description* We will pay if a Person Insured has surgery performed through a thoracotomy or laparotomy to correct a structural abnormality of the thoracic or abdominal aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We will not pay for surgery performed using catheter techniques. *Glossary of terms* Aorta - the main artery arising from the heart with branches to every part of the body. Catheter techniques – the treatment of internal abnormalities by means of a catheter inserted through a superficial blood vessel to apply certain techniques, and not involving an open surgical operation. Catheter – a hollow tube. Laparotomy - incision of the abdomen.

Thoracotomy - incision of the chest.

Aplastic Anaemia

Description
We will pay if a Person Insured has severe aplasia of the bone marrow which in the opinion of an appropriate consultant medical specialist requires:

- bone marrow transplantation; or
- immunosuppressive therapy.

Glossary of terms
Aplasia - failure of the bone marrow to produce blood cells.

Aplastic Anaemia - a severe form of anaemia caused by aplasia of the bone marrow.

Immunosuppressive therapy - therapy which suppresses the immune system.

Benign Tumour of the Brain or Spinal Cord

Description
We will pay if a Person Insured has a non-cancerous tumour in the brain or spinal cord which is histologically described and which:

- produces neurological damage and functional impairment which an appropriate consultant medical specialist considers is likely to be permanent; or
- requires surgery for its removal.

We do not cover any of the following:

- Cysts, granulomas and cerebral abscesses;
- Malformations in, or of, the arteries or veins of the brain;
- Haematomas; or
- Tumours in the pituitary gland unless it is sufficiently large that:
  - it requires open craniotomy to remove it; and/or
  - in the opinion of an appropriate consultant medical specialist, there is significant and permanent neurological damage such as visual field defects.

Glossary of terms
Benign tumour - an enlargement or swelling due to overgrowth of tissue which pushes aside normal tissue but does not invade it.

Craniotomy - surgical procedure which opens the skull.

Cerebral abscess - a localised collection of pus occurring in the brain.

Cyst - a sac or capsule containing liquid or semi-solid substance.

Granuloma - a mass of tissue occurring in reaction to the presence of, for example, a foreign body or bacterial infection.

Haematoma - a mass produced by a coagulation of blood in a tissue or cavity.

Histologically described - a conclusion reached after a microscopic examination of cells.

Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in disorders of function.

Pituitary gland – the master gland of the endocrine system which controls hormone production of other endocrine glands.

Blindness

Description
We will pay if a Person Insured totally loses the sight in both eyes as confirmed by an appropriate consultant medical specialist. That loss must be irreversible and unable to be corrected by glasses or any other means.

The definition of total loss of sight is:

1. Visual acuity less than 6/60 in both eyes after correction; or
2. a field of vision constricted to 10 degrees or less of arc; or
3. a combination of visual defects resulting in the same degree of visual impairment as that occurring in (1) or (2).

Glossary of terms
Visual acuity – clarity of vision

6/60 – what a person who has 6/60 vision sees at 6 metres compared to what a person with full clarity of vision sees at 60 metres.

Cancer

Description
We will pay if a Person Insured suffers a malignant tumour which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue. We also cover sarcoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, malignant bone marrow disorders and leukeamia with the exception of chronic lymphocytic leukaemia, Binet stages A and B or Rai stages 0, I and II.

We will not pay under this particular crisis condition for any of the following:
- cancer of the breast, prostate, skin or bowel; or
- tumours which are confirmed as pre-malignant or showing malignant changes of 'carcinoma in situ' and not requiring radical surgery; or
- AIDS related cancers.

Glossary of terms
Binet/Rai stages - classification of chronic lymphocytic leukaemia which describes disease progression.

Bone marrow disorders - life shortening and chronic disorder of bone marrow elements.

Carcinoma in situ - cancer confined to its site of origin and readily curable.

Chronic lymphocytic leukaemia - a form of leukaemia that is usually only life threatening in its advanced stages.

Hodgkin's lymphoma and non-Hodgkin's lymphoma - sometimes treatable malignant diseases causing enlargement of the lymph nodes and spleen.

Leukaemia - a malignant disease of the bone marrow, causing abnormalities in the blood, spleen, and lymph nodes.

Sarcoma - a malignant tumour usually occurring in the bone.

Cancer of the breast, prostate, skin or bowel

Description
We will pay if a Person Insured suffers a malignant tumour of the breast, prostate, skin or bowel which is confirmed by pathology tests and results in the spread of malignant cells and the invasion of normal tissue.

We will not pay under this particular crisis condition for any of the following:
- skin cancers other than melanoma at least 1.5mm thick or at least Clark Level 3 depth of invasion; or
- prostatic tumours which are confirmed as equivalent to or less than TNM Classification T1 (including T1a and T1b); or
- tumours which are histologically described as pre-malignant or showing malignant changes of 'carcinoma in situ' and not requiring radical surgery; or
- AIDS related cancers.

Glossary of terms
Carcinoma in situ - cancer confined to its site of origin and readily curable.

Clark Level - a classification system describing the depth of invasion of a melanoma past the top layers of the skin. The classifications are from 1 to 5.

Melanoma - a malignant tumour of the skin, usually developing from a mole.

TNM classification - a classification system describing the extent of local infiltration and spread to glands or other parts of the body.

Cardiomyopathy

Description
We will pay if a Person Insured's heart muscle fails to function properly resulting in permanent physical impairment to at least Class 3 (marked limitation of activity due to symptoms) of the New York Heart Association Classification of Cardiac Impairment.

We will not pay for Cardiomyopathy that is directly caused by alcohol, or related to drug use that is not prescribed by a doctor.

Glossary of Terms
Class 3 New York Heart Association Classification of Cardiac Impairment - a functional classification to assess cardio vascular disability.

Chronic Lung Disease

Description
We will pay if a Person Insured has end stage lung disease requiring permanent supplementary oxygen, with FEV 1 test results of consistently less than 1 litre.

Glossary of Terms
FEV 1 – (Forced Expiratory Volume in 1 Second). A test to measure the volume of air breathed out in the first second of a forced expiration following a full inspiration.

Coma

Description
We will pay if a Person Insured is in a state of unconsciousness and does not react to external stimuli. The state of unconsciousness must be classified as 6 or less on the Glasgow Coma Scale:

The state of unconsciousness must be either:
- continuous for at least 7 days resulting in new functional impairment producing neurological signs which last at least a further 14 days and the signs must be demonstrated clinically and by a cerebral CT scan, angiogram, MRI, PET, or other reliable imaging technique approved by AMP Life; or
- continuous for at least 90 days.

In all circumstances, We will not pay for any coma that is:
- artificially induced, deepened or sustained by medical intervention; or
- caused by the Person Insured's alcohol or drug use that is not prescribed by a doctor; or
- the result of the Person Insured suffering another crisis condition for which We pay.

Glossary of Terms
Glasgow Coma Scale - a scale which measures the degree of unconsciousness.

CT scan, angiogram, MRI or PET - tests used to demonstrate abnormalities in an organ.

Functional impairment - abnormalities of the nervous system producing certain symptoms and resulting in some disorder of function.

Neurological signs - abnormalities of the nervous system producing objective clinical abnormalities.

Coronary Artery Surgery

Description
We will pay if a Person Insured has coronary artery disease and as a result has open heart surgery involving bypass grafts to one or more coronary arteries.

In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We do not pay under this particular crisis condition for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.

Glossary of terms
Angioplasty - the treatment of an internal abnormality of a blood vessel by the inflation of a balloon catheter inserted through a superficial blood vessel and not involving an open surgical operation.

Coronary artery - vessel conveying blood to the heart muscle.

Coronary artery disease - significant narrowing or blockage of the coronary arteries.

Laser and intra-arterial techniques - other procedures sometimes used for coronary artery disease not involving an open surgical operation.

Deafness/Loss of Hearing

Description
We will pay if a Person Insured totally loses hearing in both ears through injury or disease, and that loss cannot be repaired. We won't pay if a hearing device, aid or implant improves the hearing.

Heart Attack – Myocardial Infarction

Description
We will pay if part of a Person Insured's heart muscle dies as a result of inadequate blood supply to the relevant area. An appropriate consultant medical specialist must certify that a heart attack has occurred and this must be confirmed by the presence of:

- new electrocardiographic changes; and
- a diagnostic elevation of cardiac enzymes above the upper limit of normal.

We will not pay for other causes of severe non-cardiac chest pain, heart failure or angina.

Glossary of terms
Angina – severe constricting pain in the chest due to coronary disease.

Cardiac enzymes - damage to heart muscle can raise the level of these enzymes. This is shown in a blood test.

Electrocardiographic changes - a graph of electrical activity of the heart showing variation from the normal which is consistent with a heart attack.

Myocardial infarction - death of the heart muscle.

Heart Attack – Out of Hospital Cardiac Arrest

Description
We will pay if a Person Insured suffers a cardiac arrest which:

- is not associated with any medical procedure; and
- is documented by an electrocardiogram; and
- occurs outside a hospital; and
- is due to either cardiac asystole or ventricular fibrillation.

Glossary of terms
Cardiac arrest - sudden, and often unexpected, stoppage of effective heart action.

Cardiac asystole - complete failure of contraction of the heart causing cardiac arrest.

Electrocardiogram - a graph of electrical activity of the heart.

Ventricular fibrillation - heart abnormality with ineffective twitching of the heart chambers.

HIV/AIDS – Medically Acquired

Description

We will pay if a Person Insured acquires the Human Immunodeficiency Virus (HIV) through accidental infection as a result of a medical procedure. We will only pay if We believe, on the balance of probabilities, the infection arose because of one of the following medical events. The event must have been medically necessary and performed by or under the supervision of a Medical Doctor or a dentist, and:

1. it must have occurred to the Person Insured in either New Zealand or Australia; and
2. it must have occurred as a result of any one of the following procedures:
   - a blood transfusion,
   - the transfusion with blood products,
   - an organ transplant to the Person Insured,
   - assisted reproductive techniques, and
3. Sero conversion to the HIV infection is documented to have occurred within 6 months of the accident.

Before We pay, We will require proof of the incident to AMP's satisfaction via appropriate medical evidence from the relevant hospital and / or surgeon that the infection was medically acquired. Independent verification may be required.

We will not pay if:

- the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection; or
- sero conversion does not occur within 6 months of the accident.

Glossary of terms

HIV - stands for Human Immunodeficiency Virus. Over time infection with HIV causes the immune system to become deficient, which can lead to the development of illnesses such as cancers and a form of pneumonia.

Sero conversion - the documented change from the absence to the presence in the blood of antibodies to the Human Immunodeficiency Virus (HIV). These antibodies usually appear in the blood for the first time within 8 to 12 weeks of infection occurring but can appear later.

HIV/AIDS – Occupationally Acquired

Description

We will pay if a Person Insured becomes infected with the Human Immunodeficiency Virus (HIV):

- as a result of an accident occurring during the course of the Person Insured's normal occupation; and
- while the Person Insured was carrying out their normal occupational duties; and
- Sero conversion to the HIV infection is documented to have occurred within 6 months of that accident.

Any accident giving rise to a potential claim must be reported within 14 days of its occurrence:

- to the relevant authority or employer; and
- to Us; and
- be supported by a negative HIV antibody test taken after the accident.

We will only pay if We are able to:

- independently test all blood samples used;
- take further samples and test these;
- obtain a copy of the report made to the relevant institution or employer; and
- obtain all evidence relating to the alleged source of infection.

We will not pay if:

- the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection;
- sero conversion does not occur within 6 months of the accident.

Glossary of terms
HIV - stands for Human Immunodeficiency Virus. Over time infection with HIV causes the immune system to become deficient, which can lead to the development of illnesses such as cancers and a form of pneumonia.

Sero conversion - the documented change from the absence to the presence in the blood of antibodies to the Human Immunodeficiency Virus (HIV). These antibodies usually appear in the blood for the first time within 8 to 12 weeks of infection occurring but can appear later.

Kidney (Renal) Failure

Description
We will pay if a Person Insured suffers irreversible failure of both kidneys which requires either:

- continuing renal dialysis; or
- transplantation of a human kidney.

In the opinion of an appropriate consultant medical specialist, the dialysis or transplant must be required on medical grounds and must be the most appropriate treatment.

We will not pay in the event of temporary renal dialysis for acute and reversible kidney failure.

Glossary of terms
Kidney transplant - transplantation of a donor kidney into another person's body.

Renal dialysis - the use of defined filtering techniques to remove waste products normally excreted by the kidney.

Loss of Independent Living

Description
We will pay if a Person Insured suffers total and permanent inability to perform at least two of the 5 Activities of Daily Living without assistance from someone else. The inability to perform the Activities of Daily Living must continue for at least 6 months, although at AMP's discretion claims may be considered earlier.

We will not pay for loss of independent living directly caused by alcohol, or related to drug use that is not prescribed by a doctor.

Loss of Speech

Description
We will pay if a Person Insured totally loses the ability to speak due to organic brain disease or injury. In the opinion of an appropriate consultant medical specialist, the loss must be irreversible.

We will not pay for loss of speech which is directly caused by alcohol, or related to drug use that is not prescribed by a doctor.

Glossary of terms
Organic brain disease - a disease of the brain in which there is structural or functional impairment as opposed to psychiatric disorders.

Functional impairment - abnormalities of the nervous system producing certain symptoms and resulting in some disorder of function.

Major Head Trauma

Description
We will pay if a Person Insured suffers an accidental head injury which results in significant neurological damage which, in the opinion of an appropriate consultant medical specialist, is likely to be permanent.

Glossary of terms
Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.

Major Organ Transplant	*Description* We will pay if a Person Insured receives a transplant from a human donor of bone marrow, or one of the following whole organs: • Kidney • Heart • Lung • Liver • Small bowel • Pancreas. In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment. We will not pay if the Person Insured donates an organ or tissue for transplant.
Motor Neurone Disease	*Description* We will pay if a Person Insured is diagnosed to have motor neurone disease by an appropriate consultant medical specialist. There must be neurological damage which causes permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else. *Glossary of terms* Motor neurone disease - disorders with progressive muscle weakness and wasting due to progressive destruction of nerves. Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.
Multiple Sclerosis	*Description* We will pay if a Person Insured is diagnosed to have Multiple Sclerosis by an appropriate consultant medical specialist. There must be neurological damage which causes permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else. *Glossary of terms* Multiple sclerosis - disease with abnormal nervous tissue in the brain and spinal cord which interferes with the normal function of the nerves. Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.
Open Heart Surgery	*Description* We will pay if a Person Insured has open heart surgery requiring diversion of the blood through a heart-lung machine, to correct any heart defect. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We will not pay for procedures such as valvotomy or angioplasty which do not require open heart surgery. *Glossary of terms* Angioplasty – the treatment of an internal abnormality of a blood vessel by the inflation of a balloon catheter inserted through a superficial blood vessel and not including an open surgical operation. Valvotomy – surgical widening of a narrowed heart valve.
Paralysis - Diplegia	*Description*

	We will pay if a Person Insured suffers total and permanent paralysis of both arms or both legs. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Paralysis – Hemiplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both the arm and the leg on the same side of the body. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Paralysis – Paraplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both legs. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Paralysis – Quadriplegia/ Tetraplegia	*Description* We will pay if a Person Insured suffers total and permanent paralysis of both arms and both legs. We will not pay if the Person Insured's paralysis is due to psychological or psychiatric cause. *Glossary of terms* Paralysis - complete loss of the ability to move parts of the body. It is a symptom of a wide variety of disorders.
Parkinson's disease	*Description* We will pay if a Person Insured is diagnosed to have advanced Parkinson's disease by an appropriate consultant medical specialist. There must be neurological damage which causes permanent inability to perform any one of the 5 Activities of Daily Living without assistance from someone else. *Glossary of terms* Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in disorders of function. Parkinson's disease - a progressive disease of the brain with muscle stiffness and tremor.
Primary Pulmonary Hypertension	*Description* We will pay if a Person Insured suffers primary pulmonary hypertension associated with the right ventricle being enlarged and this: • is established by cardiac catheterisation and/or echocardiography; and,

- results in permanent physical impairment to at least Class 3 (marked limitation of activity due to symptoms) of the New York Heart Association Classification of Cardiac Impairment.

We do not pay for any other causes of pulmonary hypertension.

Glossary of Terms
Cardiac catheterisation - a tube inserted into the heart or coronary arteries.

Echocardiography - the use of ultrasound to investigate the heart.

Class 3 New York Heart Association Classification of Cardiac Impairment - a functional classification to assess cardio vascular disability.

Primary pulmonary hypertension - a condition, cause unknown, associated with increased pressure in the heart-lung circulation, and manifested by an enlarged right ventricle of the heart, as confirmed by chest X-ray, ECG, echocardiogram and cardiac catheter studies.

Right ventricle - one of the major lower chambers of the heart.

Severe Burns

Description
We will pay if a Person Insured suffers third degree burns to 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart described below. The burns can be caused by thermal, electrical or chemical agents.

The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and each leg (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area.

Stroke

Description
We will pay if a Person Insured suffers a cerebrovascular episode producing neurological damage which lasts for more than 24 hours. The damage must be evidenced clinically by:

- a cerebral CT scan; or
- an angiogram; or
- a MRI or PET; or
- other reliable imaging technique approved by AMP.

We will not pay for transient ischaemic attacks, reversible ischaemic neurological deficit, major head injuries or symptoms due to migraine or headache.

Glossary of terms
Cerebral - relating to the brain.

Cerebrovascular episode - a disorder of the blood vessels of the brain resulting in impaired blood supply to part of the brain.

CT scan, angiogram, MRI or PET - tests used to demonstrate abnormalities in an organ.

Neurological damage - abnormalities of the nervous system producing certain symptoms and resulting in functional disorders.

Transient ischaemic attacks - abnormality of sudden onset and brief duration to certain arteries which may cause symptoms similar to a stroke.

Reversible ischaemic neurological deficit - insufficient blood supply to any part of the body.

36 Home Loan Redundancy Cover

Cover against any of the risks in this Clause will only appear if shown in the Schedule or most recent Replacement Schedule, and if current.

36.1 Home Loan Redundancy Cover

If the Person Insured under this cover is made redundant or declared bankrupt AMP will pay the amount of their Home Loan Redundancy Cover, whilst any part of the home loan referred to in the Proposal is owing.

36.2 When your cover starts

The Starting Date for cover is shown in the Schedule for each Person Insured, or as otherwise shown in any Replacement Schedule you receive later.

A Waiting Period applies in respect of the first 30 days from the date of redundancy or bankruptcy under Home Loan Redundancy Cover.

A Qualifying Period of six months from the Starting Date of the Home Loan Redundancy Cover applies for Home Loan Redundancy Cover on existing mortgages.

36.3 What We mean by redundancy and bankruptcy

"Redundancy" means a situation where the Person Insured's employment is terminated by the employer due to the fact that the position held is, or will become, unnecessary to the employer. Redundancy does not include situations involving a seasonal lay-off, the completion of a fixed-term agreement, or where employment is terminated due to the Person Insured not performing to the employer's satisfaction.

"Bankruptcy" means a situation where the Person Insured:

- being self-employed, is judged bankrupt in Australia or New Zealand, or
- is employed in Australia or New Zealand by a company, controlled by the Person Insured, which is placed in liquidation due to an inability to pay its debts.

For Home Loan Redundancy Cover the Person Insured must have been continuously employed in a Permanent Occupation for at least six months immediately prior to the redundancy or bankruptcy and must be under the age of 65 years at the time of redundancy or bankruptcy.

36.4 How much We will pay

The benefit payable under the Home Loan Redundancy Cover will be up to the amount shown in the Schedule or most recent Replacement Schedule.

The benefit is payable monthly in arrears from the end of the Waiting Period (see Clause 36.2). No benefit is payable during the Waiting Period.

The benefit will be payable for six months, or until the Person Insured returns to a Permanent Occupation or Home Loan Redundancy Cover ends under Clause 36.5, whichever occurs first.

36.5 When Home Loan Redundancy Cover ends

Home Loan Redundancy Cover for a Person Insured ends on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2
d) when Home Loan Redundancy Cover for the Person Insured is cancelled by the Policy Owner.

36.6 What is not covered

Home Loan Redundancy Cover does not cover:

- redundancy or bankruptcy if the Person Insured knew or ought to have known at the Starting Date, or at the date of an increase or reinstatement in the cover, that they would become redundant or bankrupt during the term of the cover. In the case of an increase in cover, the Home Loan Redundancy Cover prior to the increase applies instead.
- redundancy or bankruptcy occurring within six months of the date of an increase in the cover, which is the result of something of which the Person Insured was aware at the date of the increase. The Home Loan Redundancy Cover prior to the increase applies instead.
- redundancy where the Person Insured voluntarily chooses redundancy or where the employer is owned or controlled by the Person Insured or the spouse, de facto spouse, parent or parents, child or children or siblings of the Person Insured.
- claims under Home Loan Redundancy Cover if AMP is already paying a claim under this cover on the same loan for a second Person Insured, or if AMP is already paying a claim under Home Loan Temporary Disability Cover for either Person Insured.
- claims where the Person Insured is on leave without pay.

If the original home loan on which cover was taken has been repaid or discharged, the monthly benefit shown in the Schedule or most recent Replacement Schedule will not be payable unless the Person Insured has a current home loan in-place

36.7 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Home Loan Redundancy Cover must include:

- written notice of the claim, to be received by AMP at the Register, within two months of the date on which the Person Insured first became redundant or bankrupt as defined in Clause 36.3, and
- authority for AMP to confirm redundancy with the employer.

All evidence must be received at the Register within two months of Us receiving written notice of the claim.

36.8 Payment of claims

All benefits for Redundancy Cover will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits for Redundancy Cover will be paid to the employer. The Policy Owner, Person Insured and the lender are then responsible for continuing to make and collect the loan repayments respectively.

36.9 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.

37 Home Loan Temporary Disability Cover

Cover against any of the risks in this Clause will only appear if shown in the Schedule or most recent Replacement Schedule, and if current.

37.1 Home Loan Temporary Disability Cover

If a Person Insured under this cover becomes Temporarily Totally Disabled then AMP will pay the amount of their Home Loan Temporary Disability Cover, whilst any part of the home loan referred to in the Proposal is owing.

37.2 When your cover starts

The Starting Date for cover is shown in the Schedule for each Person Insured, or as otherwise shown in any Replacement Schedule you receive later.

A Waiting Period (during which no benefit is payable) applies in respect of the first 30 days of disability under Home Loan Temporary Disability Cover.

37.3 What We mean by Temporary Total Disability

A. For a Person Insured in a Permanent Occupation, "Temporary Total Disability" means disability which meets all of the following conditions:
- continues for a period of at least 30 days
- results from injury or illness
- starts on or after the date on which this cover started for the Person Insured
- starts before this cover ends for the Person Insured
- within the first two years of the claim, makes the Person Insured unable, due to bodily injury or illness, to substantially carry out the duties of their usual occupation or business occupation from which they have received an income
- for any remaining period of claim, makes the Person Insured unable, due to bodily injury or illness, to carry out the duties of any Permanent Occupation for which they are reasonably suited by education, training or experience.

B. For a Person Insured not in a Permanent Occupation at the onset of the disability, "Temporary Total Disability" means disability which meets all of the following conditions:
- continues for a period of at least 30 days
- results from injury or illness
- starts on or after the date on which this cover started for the Person Insured
- starts before this cover ends for the Person Insured
- makes the Person Insured unable, on medical advice acceptable to AMP, to carry out at least 2 of the 5 Activities of Daily Living, as defined, without assistance from someone else.

37.4 How much We will pay

The benefit payable under Home Loan Temporary Disability Cover will be the amount shown in the Schedule or most recent Replacement Schedule. The benefit is payable monthly in arrears from the end of the Waiting Period (see Clause 37.2). No benefit is payable during the Waiting Period.

The benefit will be payable until the Person Insured is no longer Temporarily Totally Disabled in accordance with Clause 37.3, or until Home Loan Temporary Disability Cover ends under Clause 37.7, whichever occurs first.

37.5 Restrictions to cover

Where there are two Persons Insured under this Cover for the same loan, and where the Person Insured earning the lower income per annum is in a Permanent Occupation:

- cover can be up to a maximum of $40,000 per annum for that Person Insured if they earn $40,000 per annum or less
- the maximum cover per annum cannot be greater than the income per annum of that Person Insured if they earn more than $40,000 per annum

Where there are two Persons Insured under this Cover for the same home loan, the maximum benefit payment that the two Persons Insured can receive at any one time cannot be greater than 160% of the monthly home loan repayment for which the Home Loan Total Temporary Disability Cover was taken.

37.6 Recurrent Temporary Total Disability

A recurrent temporary total disability occurs when, after an entitlement to a benefit under Home Loan Temporary Disability Cover ends, the Person Insured suffers a further temporary total disability which, in our opinion, arises from the same, or a related, cause for which they were previously entitled to a benefit under Home Loan Temporary Disability Cover.

A. for recurrent Temporary Total Disability occurring within 90 days of the previous entitlement ending:
   - we will waive the Waiting Period (see Clause 37.2), and
   - we will treat the successive period of temporary total disability as being continuous with the previous period.

B. for recurrent Temporary Total Disability occurring more than 90 days after the previous entitlement ending:
   - the Waiting Period applies (see Clause 37.2), and
   - the successive periods of temporary total disability are not treated as being continuous.

37.7 When Home Loan Temporary Disability Cover ends

Home Loan Temporary Disability Cover ends for a Person Insured on the earliest of:

a) the death of the Person Insured
b) the 65th birthday of the Person Insured
c) when this Policy ends as in Clause 9.2
d) when Home Loan Temporary Disability Cover for the Person Insured is cancelled by the Policy Owner

37.8 What is not covered

Home Loan Temporary Disability Cover does not cover:

- disability occurring within six months of the date of an increase in the cover, which is the result of something of which the Person Insured was aware at the date of increase. The Home Loan Temporary Disability Cover prior to the increase applies instead.
- disability which is the result of intentional, self-inflicted injury, whether the Person Insured is sane or not.
- pregnancy and childbirth
- claims under Home Loan Temporary Disability Cover if AMP is already paying a claim to the Person Insured or joint Person Insured under Home Loan Redundancy Cover.

If the original home loan on which cover was taken has been repaid or discharged, the monthly benefit shown in the Schedule or most recent Replacement Schedule will not be payable unless the Person Insured has a current home loan in-place.

37.9 Making a claim

As well as meeting the general conditions in Clause 3.1, any claim under Home Loan Temporary Disability Cover must include:

- written notice of the claim, to be received by AMP at the Register, within two months of the date on which the Person Insured first became unable to work as defined in Clause 37.2, as a result of disability, and
- any medical or other evidence required by AMP. This must be provided at your expense and must be received at the Register within two months of Us receiving written notice of the claim.

37.10 Payment of claims

All benefits for Home Loan Temporary Disability Cover will be paid to the Person Insured except where the benefit is taken out and is owned by the Person Insured's employer, in which case the benefits for Home Loan Temporary Disability Cover will be paid to the employer. The Policy Owner, Person Insured and the lender are then responsible for continuing to make and collect the loan repayments respectively.

37.11 Goods and Services Tax (GST)

Goods and Services Tax (GST) is payable on premiums. This is included in your Premiums.