

AHI

Sports Group Personal Accident

AHI
Product Disclosure Statement (PDS)
and Policy Wording

SP19012024

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ahiinsurance.com.au

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Important Information

This document contains two parts:

- Product Disclosure Statement - contains general information the Insured needs to be aware of before applying for the product and about the Policy; and

- The Policy Wording - contains the terms and conditions of this insurance Policy.

Product Disclosure Statement (PDS)

What is a Product Disclosure Statement (PDS)
This Product Disclosure Statement (PDS) contains important information about this product and includes the Policy Wording. You should read this PDS carefully before making a decision to purchase this product. This PDS will assist you in making an informed decision whether this product will meet your needs. In this PDS:

1. 'We', 'Our', 'Us' means Tokio Marine & Nichido Fire Insurance Co., Ltd, ABN 80 000 438 291, AFS Licence No. 246548 (TMNF).
2. 'Insured' means the person or company who is named in the Policy Schedule as the Insured. The Insured is the contracting party for this Policy.
3. 'Insured Person' means any person shown by name, classification or meeting the criteria specified for an Insured Person in the Policy Schedule for the insurance cover selected by the Insured and with respect to who the premium has been paid. The Insured Person and the type of cover chosen will be set out in the Policy Schedule.

Accident & Health International (AHI)
Accident & Health International Underwriting Pty Limited, ABN 26 053 335 952, AFS Licence No. 238261 (AHI) is an underwriting agency specifically created to provide Personal Accident, Medical and Travel insurance. AHI acts on behalf of Tokio Marine & Nichido Fire Insurance Co., Ltd, ABN 80 000 438 291, AFS Licence No. 246548 (TMNF), with full authority to quote and issue contracts of insurance, collect premiums and pay Claims.

For any queries about this Policy, please contact the appointed insurance advisor. Their details are shown in the Policy Schedule. In the event there is no appointed advisor, please contact AHI. Their details are in this document.

The Insurers
Tokio Marine & Nichido Fire Insurance Co., Ltd, ABN 80 000 438 291, AFS Licence No. 246548 (TMNF).

What is 'the Policy'
A policy is a contract of insurance between the Insured and the Insurer, and contains all the details of the cover that We provide.

The Policy consists of:

1. the Policy Wording document which sets out details of the Insured's cover, applicable terms, conditions, limitations and exclusions; and
2. the current Policy Schedule, issued by Us to You, which is a separate document setting out the specific terms of insurance applicable to You. The specific terms include exclusions, conditions, limits and other terms and conditions specifically applicable to your cover, and may amend the Policy Wording in this PDS. This is referred to as the Policy Schedule in this Policy document; and
3. any other document issued by Us in writing, which modifies any of the above, such as an endorsement or supplementary PDS.

The Policy should be carefully read and retained by the Insured. These documents should be read together as they jointly form the contract of insurance between Us and the Insured. Any new or replacement Policy Schedule detailing changes to the Policy or the Period of Insurance We may send to the Insured will become the current Policy Schedule, which should be carefully read and retained by the Insured.

The Purpose of the Cover
This insurance is entered into with the Insured and provides cover in relation to the Insured and Insured Persons. In some cases, the Insured may also be an Insured Person.

Insured Persons who are not the Insured are not parties to the contract between Us and the Insured. This means an Insured Person cannot cancel or vary the Policy in any way (only the Insured can do this).

Insured Persons who are not the Insured have a right to recover their loss in accordance with Section 48 of the Insurance Contracts Act. Section 48 states that Insured Persons have the same obligations in relation to a Claim made by them that the Insured would have to Us (for example, complying with Claims conditions such as subrogation) and may discharge the Insured's obligations in relation to a loss. We have the same defences to an action by an Insured Person as We would in an action by the Insured.

Where the Policy covers Insured Persons (other than the Insured), the Insured:

1. is not Our agent;
2. acts independently from Us in entering into this insurance to provide cover to Insured Persons; and
3. is not authorised by Us to provide any recommendations or options about the insurance or other financial services to an Insured Person.

Any notices of expiry, variation, avoidance or cancellation will be sent by Us to the Insured. We will not provide any notices in relation to this insurance to the Insured Persons. The Insured is required to notify Insured Persons when this occurs.

An Insured Person's access to cover:

1. starts at the time the relevant person becomes an Insured Person; and
2. ends at the earliest of the following:
    a. the relevant person no longer meets the terms specified in the Policy Schedule which apply to an Insured Person;
    b. the date and time You request that such Insured Person ceases to have access to the Benefits under the Policy; or

c. the date and time the Policy ends in accordance with the Policy terms, either because the period of insurance has ceased and the Policy has not been renewed with Us or the Policy has been cancelled in accordance with the Policy terms.

Our Agreement with the Insured
If We accept the application for cover, the Insured and Insured Persons will be insured under this Policy for:

1. loss or damage caused by one or more of the Insured Events set out in this Policy; and
2. the other Benefits, as set out in this Policy.

This cover will be given on the basis:

1. that the Insured has paid or agreed to pay Us the premium for the cover the Insured selected when cover was requested and which the current Policy Schedule indicates is in force; and
2. of the verbal and/or written information provided by the Insured to Us prior to inception of the Policy.

Duty of Disclosure (for Non-Consumer Contracts) & Duty to take reasonable care not to make a misrepresentation (for Consumer Contracts)
Before the Insured enters into a contract of insurance, the Insured has a duty under the Insurance Contracts Act 1984 (Cth), as amended from time to time (ICA), as set out below. Please contact Us if any assistance is required in relation to this section.

For the purposes of this section:

- "Consumer Contract" means a contract of insurance defined under section 11AB of ICA, to which Division 1A, Part IV of ICA applies;
- "Non-Consumer Contract" means a contract of insurance that is not a Consumer Contract, to which Division 1, Part IV of ICA applies.

Duty applicable to a Non-Consumer Contract
If the Policy is a Non-Consumer Contract, the Insured has a duty to disclose anything that the Insured knows, or could reasonably be expected to know, to be a matter relevant to Our decision to enter into a Non-Consumer Contract with the Insured and if so, on what terms.

The Insured does not need to tell Us anything that:

- reduces the risk We insure the Insured for;
- is common knowledge;
- We know, or should know, as an insurer; or
- We waive the Insured's compliance with this duty.

The Insured must comply with this duty up until the time We agree to insure the Insured under a new Policy and when the Policy is renewed, varied, extended, reinstated or replaced.

Duty applicable to a Consumer Contract
If the Policy is a Consumer Contract, before the Insured enters into an insurance contract with Us, the ICA requires the Insured to take reasonable care not to make a misrepresentation.

What this means is that the Insured must take care to ensure the accuracy of any information that is provided to Us, as Our decision whether to enter into a Consumer Contract with the Insured, and if so on what terms, will be based on the information the Insured provides. The Insured's duty includes:

- Giving honest, accurate and complete answers to any questions We ask;
- Making reasonable enquiries to determine the accuracy of any information given to Us; and
- Taking care to ensure that any representation made to Us is accurate.

The Insured must comply with this duty before the commencement of the Policy and when the Policy is renewed, varied, extended, reinstated or replaced.

Non-compliance with duty
If the Insured does not comply with the duty set out above (as applicable), We may cancel the Policy or reduce the amount We pay for a Claim, or both. If the Insured does not comply with this duty fraudulently, We may avoid the Policy altogether and treat it as if it never existed.

Choosing the most suitable Cover
Cover is provided for the Insured (including where the Insured is also an Insured Person) and the Insured Persons as set out in the Policy Schedule.

It is important that the Insured makes sure that the Sum Insured they have selected for each Benefit provides sufficient protection for their needs.

The Insured can select cover from any of the following Benefits included in the Policy:

Benefits
Some or all of the following Benefits may be included in this Policy. The Sum Insured for each is shown in the Policy Schedule. If the Sum Insured shown in the Policy Schedule is $0.00 for a Benefit, no cover is provided under this Policy for that Benefit. The circumstances under which a Claim is payable for each of these covers is detailed under "Benefits" in the Policy Wording.

Death and Capital Benefits
Weekly Injury Benefit
Broken / Fractured Bones Benefits
Accidental HIV Infection Lump Sum Benefit
Bed Care Benefit
Domestic Help Benefit
Family Accommodation and Transport Expenses Benefit
Funeral Expenses Benefit
Home and Vehicle Modification Benefit
Non-Medicare Medical Expenses
Out of Pocket Expenses Benefit

Retraining and Rehabilitation Expenses Benefit
Student Tutorial Benefit
Unexpired Membership Benefit

Benefit Limits
Benefits may be subject to Benefit Limits. Benefit Limits may affect the amount payable in the event of a Claim. If a Benefit Limit is applicable to a Benefit, it will be shown in the Policy Schedule below the Benefit it applies to, indented from the left margin of the Schedule of Benefits.

Age Limitation
Age limits apply to this policy. No cover is provided for Insured Persons who have not attained the minimum age or who have attained the maximum age limits of the Policy at the time of an Event.

1. The maximum age limit is shown in the Policy Schedule against "Maximum Age Limit (sub limits may apply)". If "Maximum Age Limit (sub limits may apply)" is not shown in the Policy Schedule, no maximum age limit applies to the Policy.
2. The minimum age limit is shown in the Policy Schedule against "Minimum Age Limit (sub limits may apply)". If "Minimum Age Limit (sub limits may apply)" is not shown in the Policy Schedule, no minimum age limit applies to the Policy.

Specific age limits may also apply to each Benefit included on this Policy. Please refer to each Benefit for full details.

The most We will Pay
The Policy may include an Aggregate Limit of Liability which is the most We will pay for all Benefits in any one Period of Insurance under this Policy. If applicable, it is shown in the Policy Schedule against "Aggregate Limit of Liability". We may also include an Aggregate Limit of Liability for specific Benefits or Events. If We include a specific Aggregate Limit of Liability for a Benefit or an Event, such limit will be shown in the Policy Schedule. In the event this limit is reached, the amount may be reinstated with Our agreement and payment of the appropriate additional premium (plus any charges).

Choosing a Sum Insured
It is important that the Insured makes sure that the Sum Insured they have selected for each Benefit provides sufficient protection for its needs or the Insured Persons' needs.

Policy Cost and Payment
The cost of the Policy will be shown on the quotation We provide, once We have received all required information to complete the quotation. The cost of the Policy is calculated according to various risk indicators such as:

- Age of Insured Persons
- Activities undertaken during the Scope of Cover
- Previous claims experience for this type of risk
- Risk location
- The Benefit Sum Insured

The cost of the Policy is made up of premium, administration fees and government taxes (such as Goods & Services Tax (GST) and Stamp Duty), where applicable.

Renewal Procedure
Before this Policy expires We will normally offer renewal by sending a renewal invitation advising the amount payable to renew this Policy. It is important that the Insured checks the information shown before renewing each year to be satisfied that the details are correct.

Taxation Implications
This Policy may be subject to a Goods & Services Tax in relation to premium.

Depending on the location of the risk being insured, this Policy may be subject to Stamp Duty in relation to premium and GST.

Depending upon the Insured or Insured Person's entitlement to claim Input Tax Credits under this Policy, We may reduce the payment of any Claim by the amount of any Input Tax Credit.

Any Claim paid in respect of the Weekly Injury Benefit is subject to personal income tax. Where We are required to do so, We will withhold personal income tax amounts from Claim payments We make and forward these amounts to the Australian Taxation Office on behalf of the Insured or Insured Person. Where required, We will provide the Insured a summary of the amounts withheld at the end of each financial year.

The Insured and /or Insured Persons should consult an authorised tax advisor if there are any questions that relate to their particular circumstances.

Making a Claim and what is an Excess, Deferral Period and Co-payments
If the Insured or Insured Person needs to make a Claim, please send a written notice of the Claim to AHI within thirty (30) consecutive days of the date of the incident occurring or as soon as reasonably possible. AHI will provide a copy of the claim form which will need to be completed to Our reasonable satisfaction and provided to Us as soon as reasonably practicable. Any costs involved in the collection of information for the form are the responsibility of the Insured or Insured Person.

At any time after a Claim has been lodged We may conduct enquiries into the circumstances of the Claim. We may ask for medical examinations or, in the event of death, We may request an autopsy. This will be done at Our expense.

Any payments will be made in Australian (AUD) dollars unless otherwise shown in the Policy Schedule.

Once a payment is made under this Policy, We may attempt to recover the amount We have paid to the Insured or Insured Person if We find someone else is responsible for the loss or

damage. We will do this in the name of the Insured or Insured Person as applicable. We may also need to defend the Insured or the Insured Person against allegations of loss or damage, in which case We require their full co-operation with Us at all times.

Depending on the circumstances of the Claim, an Excess or Deferral Period may apply, or the Insured or Insured Person may be required to contribute to the cost of the Claim as follows:

1. Excess - an Excess is the amount paid by the Insured or Insured Person when a Claim is made.
2. Deferral Period – a Deferral Period is the continuous period of time shown in the Policy Schedule during which no Benefits are payable.
3. Co-payments – a co-payment is an arrangement where We will reimburse a portion of an expense that has been incurred leaving the remainder to be paid by the Insured Person.

To see some example Claim scenarios please visit: www.ahiinsurance.com.au/claims-examples

Cooling-Off
The Insured has a cooling-off period of twenty-one (21) consecutive days from the date on which the Policy was issued to cancel the Policy. If the request is made to Us in writing to cancel the Policy within the twenty-one (21) consecutive days, We will cancel the Policy and provide a full refund of premium less charges or taxes which we are unable to recover, provided neither the Insured nor any Insured Person has exercised a right or power under the terms of the Policy in that period (e.g. Insured Person has started their Journey, the Policy has already expired or if any Claim has been made under the Policy).

Complaints and Dispute Resolution
The Insured is entitled to make a complaint to Us about any aspect of the Insured's relationship with Us.

We are committed to resolving any complaint or dispute fairly and as quickly as possible. If the Insured is dissatisfied with Our service in any way, please contact Us and We will acknowledge receipt as soon as practicable, and resolve the Insured's concerns within thirty (30) days. If We are unable to or if the Insured is still not satisfied, as part of Our internal dispute resolution process, We will review the Insured's complaint and provide the Insured with a response.

When the Insured makes a complaint, please provide Us with as much information as possible. If the Insured needs any other assistance to make a complaint, please let Our staff know and they will do their best to help the Insured. This might include giving the Insured extra time to explain the Insured's complaint or asking Us to contact another person on behalf of the Insured to get more information about the Insured's complaint.

If the Insured is not satisfied with Our response to the Insured's complaint, or We have taken more than thirty (30) days to respond to the Insured from the date the Insured first made the Insured's complaint, the Insured's may be eligible to escalate the matter to the Australian Financial Complaints Authority (AFCA) if the Insured's matter is within the jurisdiction as set out in their Rules. AFCA is an independent external disputes resolution scheme who can assess the Insured's matter free of charge to the Insured, and can issue a binding outcome on Us. The Insured does not have to accept any decisions that We or AFCA makes. If the Insured's matter falls outside the AFCA jurisdiction as set out in their Rules, the Insured can access any other external dispute resolution options.

How to make a complaint
The Insured can contact Us to make a complaint, or if the Insured requires assistance to lodge a complaint, using the contact details provided below:

Post: GPO Box 4213, SYDNEY NSW 2001
Email: complaints@ahiinsurance.com.au
Phone: (02) 9251 8700

When the Insured makes a complaint, We will:

- acknowledge the Insured's complaint as soon as practicable;
- keep a record of the Insured's complaint and give the Insured a reference number and contact details so that the Insured can follow up at any time;
- make sure we understand and investigate the cause of the Insured's complaint;
- respond to the Insured as quickly as possible;
- keep the Insured informed of Our progress at least every ten (10) business days if We can't resolve the Insured's complaint straight away; and
- provide an outcome within a maximum of thirty (30) calendar days.

If We're unable to provide the Insured with an outcome within thirty (30) days, We will:

- inform the Insured of the reason for the delay;
- if the Policy is a Consumer Contract, advise the Insured of the Insured's right to complain to AFCA; and
- provide the Insured with AFCA's contact details.

Privacy

AHI – Privacy
As part of AHI's dealings with the Insured and Insured Persons, AHI may need to collect personal information (which may include sensitive information) when the Insured is applying for, changing or renewing a Policy with Us or when We are processing a Claim in order to help Us properly administrate the Insured's insurance proposal, policy or Claim. AHI will collect this information directly from the Insured or Insured Person where possible, but there may be occasions when AHI collects this information from a third party such as an insurance advisor.

AHI will only use information for the purposes for which it was collected, other related purposes and as permitted or required by law. The level of quality and/or quantity of information

provided may affect AHI's ability to provide insurance cover as needed.

AHI may share this information with other companies within its group and third parties who provide services to AHI or on Our behalf, some of which may be located outside of Australia.

For more details on how AHI collects, stores, uses and discloses personal information, please read AHI's privacy policy located at www.ahiinsurance.com.au. Alternatively, contact AHI at privacy@tokiomarine.com.au or call (02) 9251 8700 to request a copy be sent.

It is recommended to obtain a copy of this privacy policy and read it carefully. By applying for, using or renewing any of AHI's products or services, or providing AHI with collected personal information, agreement is granted to AHI to this information being collected, stored, used and disclosed as set out in this policy.

AHI's privacy policy also contains information about how to access and seek correction of collected personal information, complain about a breach of the privacy law, and how AHI will deal with a complaint.

TMNF – Privacy
Privacy is important to Us. TMNF is dedicated to upholding the Insured and Insured Person's privacy and protecting their personal information. We are bound in Australia by the Privacy Act 1988 (Cth) and its associated Australian Privacy Principles, along with any other applicable privacy laws and codes, when collecting, using, disclosing, holding, handling and transferring any personal information. TMNF has ongoing practices, procedures and systems in place to ensure that We manage personal information in an open and transparent way.

We may use the Insured or Insured Persons personal information (such as name, date of birth, contact details, and in certain cases explained in Our Privacy Policy, sensitive information) for the following purposes:

- to determine whether and on what terms We might issue the Insured or Insured Persons with an insurance policy;
- to open and administer any products and services the Insured or Insured Persons may sign up for;
- to help improve Our products and services;
- to undertake market research, customer data analysis and direct marketing activities;
- to manage and resolve complaints made;
- to report information required by law or regulations;
- to perform any other appropriately related functions.

If the Insured or Insured Persons don't provide all the information requested, the main consequence is that We may not be able to issue the Insured or Insured Persons with a policy or pay a Claim.

Unless it is unreasonable or impracticable under the circumstances, We will collect the Insured or Insured Persons personal information directly from the Insured or Insured Persons advisor or someone authorised by the Insured or Insured Persons, for example, the Insured or Insured Persons insurance broker, financial planner, legal services provider, agent or carer. In issuing and/or managing the Insured or Insured Persons policy or Claim We may need to disclose the Insured or Insured Persons personal information to third parties such as another insurer, Our reinsurers, an insurance broker, Our legal providers, Our accountants, loss investigators or adjusters, anyone acting as the Insured or Insured Persons agent or regulatory bodies as well as Our various third party service providers described in Our Privacy Policy. We may also disclose the insured or insured person's information as required by law.

In providing the Insured or Insured Persons with Our services it may be necessary to disclose the Insured or Insured Persons information overseas where We have a presence or engage such parties, including but not limited to Japan, USA, Canada, Bermuda, New Zealand, Thailand, Hong Kong, Europe (including the United Kingdom), Singapore and India.

We will otherwise collect, hold, use and disclose the Insured or Insured Persons personal information in accordance with Our Privacy Policies, which set out how the Insured or Insured Persons may access and correct the personal information that We hold about the Insured or Insured Persons and how to lodge a complaint.

To learn more about collection and use of the Insured or Insured Persons personal information, see Our Privacy Policy, which can be viewed at Our website www.tokiomarine.com.au or contact Us on (02) 9225 7500.

Updating the PDS
Information in the PDS may need to be updated from time to time if certain changes occur and where this is required and permitted by law. We will issue the Insured with a new PDS or a Supplementary PDS to update information in the PDS.

If the update is to correct a statement or an omission, that is not materially adverse from the point of view of a reasonable person deciding whether to acquire this Policy, we may issue the Insured with notice of this information in other forms.

A paper copy of any updated information can be obtained without charge by calling Us on the contact details provided in this document.

Intermediary Remuneration
Tokio Marine & Nichido Fire Insurance Co., Ltd pays remuneration to insurance intermediaries when We issue, renew or vary a Policy the intermediary has arranged or referred to Us. The type and amount of remuneration varies and may include commission and other payments.
Information about the remuneration We may pay intermediaries can be obtained by requesting it from the intermediary or insurance advisor.

Financial Claims Scheme
The Insured or Insured Person may be entitled to payment under the financial claims scheme in the event Tokio Marine & Nichido Fire Insurance Co., Ltd becomes insolvent. Access to the Scheme is subject to eligibility criteria. Information about the scheme can be obtained from www.fcs.gov.au.

General Insurance Code of Practice
We proudly support and are a signatory to the General Insurance Code of Practice ('the Code').

The purpose of the Code is to raise the standards of practice and service in the general insurance industry. The objectives of the Code are:

- to commit Us to high standards of service;
- to promote better, more informed relations between Us and Our valued customers;
- to maintain and promote trust and confidence in the general insurance industry;
- to provide fair and effective mechanisms for the resolution of complaints and disputes between Us and the Insured; and
- to promote continuous improvement of the general insurance industry through education and training.

This is Our commitment to all Our valued customers. We have adopted and support the Code and are committed to complying with it.

Further information about the Code and the customer's rights under it is available at www.codeofpractice.com.au or contact Us.

Contact Details

Accident & Health International Underwriting Pty Limited
ABN 26 053 335 952
AFS Licence No. 238261
Level 17, 60 Margaret Street
SYDNEY NSW 2000

Telephone: (02) 9251 8700
Fax: (02) 9251 8755
Website: www.ahiinsurance.com.au
Email: enquiries@ahiinsurance.com.au

The Insurer
Tokio Marine & Nichido Fire Insurance Co., Ltd
ABN 80 000 438 291
AFS Licence No.246548 (TMNF)
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SYDNEY NSW 2000

Telephone: +61 2 9225 7500
Website: www.tokiomarine.com.au

This Product Disclosure Statement was prepared on 19/01/2024. AHI is authorised to distribute this Product Disclosure Statement.

Policy Wording

Important Notice

Accident & Health International Underwriting Pty Ltd (hereinafter called AHI) gives notice that this contract has been effected under an Authority given to AHI by the Insurer(s). AHI has entered into the contract as an agent of the Insurer(s) and not an agent of the Insured. A commission is payable by Us to AHI for arranging this insurance.

All cover under this Policy is subject to:

1. the payment of premium; and
2. the terms and conditions contained in this Policy document and in the Policy Schedule; and
3. the limits of liability referred to in the Policy and in the Policy Schedule.

This Policy consists of several Benefits. An Insured Person is covered for insurance under only those Benefits selected by the Insured as shown in the Policy Schedule.

We hereby agree to insure such Insured Persons as nominated by the Insured from time to time on the terms, conditions, limitations and exclusions set out in this Policy.

There is a maximum amount payable under each Benefit of the Policy with respect to each Insured Person, and with respect to all Claims payable under this Policy during each Period of Insurance. The limit of Our liability is the Sum Insured against each Benefit as shown in the Policy Schedule and is subject to the overall maximum amount in any one Period of Insurance as also shown in the Policy Schedule against “Aggregate Limit of Liability”.

Within this Policy certain capitalised words have specific meanings as defined in the ‘AHI Standard Definitions’ section. It is important that you are aware of them. Words that are capitalised but are not defined in the ‘AHI Standard Definitions’ section refer to corresponding section headings within this policy.

Benefits

The Policy consists of a number of Benefits that provide the level of cover to the Insured and/or Insured Persons. Please refer to the relevant Benefits of the Policy and the Policy Schedule for full Benefits details. The General Conditions and Limitations and General Exclusions of this Policy apply to all Benefits of the Policy in addition to the specific Conditions and Exclusions of the Benefit. If the Sum Insured stated in the Policy Schedule is $0.00 for a Benefit, no cover is provided under this Policy for that Benefit.

Each Benefit is explained under four (4) applicable headings:

1. Extent of Cover – details the Events that are covered under each Benefit.
2. Compensation – details the way We will pay the Compensation under each Benefit.
3. Conditions – explains the conditions which are required to be met for an Insured or Insured Person to make a Claim against that Benefit and are in addition to the General Conditions and Limitations that apply to all Benefits under this Policy.
4. Exclusions – details when We will not pay a Claim under each Benefit and are in addition to the General Exclusions that apply to all Benefits under this Policy.

This Policy contains a number of provisions in the Benefit sections, General Conditions and Limitations, and General Exclusions that an Insured Person (and in some circumstances the Insured) is required to comply with.

If an Insured or an Insured Person does not comply with the terms of the Policy, such as a provision that is set out in a Benefit section, in the Policy Schedule, or in the General Conditions and Limitations, or General Exclusions, then the Insurer may be entitled under Section 54 of the Insurance Contracts Act to:

1. refuse to pay a Claim in whole or in part that fairly represents the extent to which its interests are prejudiced as a result of the non-compliance; or
2. refuse to pay a Claim in whole or in part where the non-compliance has caused or contributed to all or some of the loss that is the subject of the Claim.

Benefit Limits
Benefits may be subject to Benefit Limits. Benefit Limits may affect the amount payable in the event of a Claim. If a Benefit Limit is applicable to a Benefit, it will be shown in the Policy Schedule below the Benefit it applies to, indented from the left margin of the Schedule of Benefits.

All definitions for terms used in each Benefit or Benefit Limit can be found under the AHI Standard Definitions heading of this Policy.

Death and Capital Benefits

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in any of the following Insured Events which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Insured Events	Percentage of Benefit Payable
Death	100%
Permanent Total Disablement	100%
Paraplegia/Quadriplegia	100%
Permanent and incurable paralysis of all limbs	100%
Permanent and incurable insanity	100%
Permanent total loss of sight in: (a) Both eyes (b) One (1) eye	 100% 100%
Permanent total Loss of Use of: (a) Two (2) limbs (b) One (1) limb	 100% 100%
Permanent total Loss of Use of: (a) The lens in both eyes (b) Hearing in both ears	 100% 100%
Permanent total Loss of Use four fingers and thumb of either hand	80%
Permanent total Loss of Use of four fingers of either hand	50%
Permanent total Loss of Use of: (a) The lens in one (1) eye (b) Hearing in one (1) ear	 60% 20%
Burns (a) Third degree burns and/or resultant disfigurement which covers more than 40% of the entire external body (b) Second degree burns and/or resultant disfigurement which covers more than 40% of the entire external body	 50% 25%
Permanent total Loss of Use of one thumb of either hand (a) both joints (b) one (1) joint	 30% 15%
Permanent total Loss of Use of fingers of either hand: (a) three (3) joints (b) two (2) joints (c) one (1) joint	 10% 8% 5%

Death and Capital Benefits (continued)

Insured Events	Percentage of Benefit Payable
Permanent total Loss of Use of toes of either foot:	
(a) all - one (1) foot	15%
(b) great - both joints	5%
(c) great - one (1) joint	3%
(d) other than great, each toe	1%
Fractured leg or patella with established non-union	10%
Shortening of leg by at least 5cm	7.5%

Unspecified Permanent Disablement
For permanent disablement occurring as outlined in the Extent of Cover not otherwise provided for under the above mentioned Insured Events, We will pay a percentage of the Death and Capital Benefit calculated in proportion to the reduction in the Insured Person's whole body function expressed in percentage, as certified by both the Insured Person's treating Medical Practitioner and a Medical Practitioner appointed by Us.

If the Medical Practitioner appointed by Us has a contrary assessment to that of the Insured Person's Medical Practitioner, We will seek the opinion of a third Medical Practitioner, appointed by mutual agreement and at Our expense.

If there is disagreement between all three Medical Practitioners, then the percentage reduction in whole body function shall be taken as the average of the three opinions.

The maximum Compensation payable shall be 75% of the Sum Insured shown in the Policy Schedule against Death and Capital Benefits

Disappearance
If an Insured Person has been missing for a period of three hundred and sixty five (365) consecutive days following the sinking, wrecking or disappearance of an aircraft, vehicle or vessel in which the Insured Person was travelling (the 365 Day Period), and the Insured Person's body has not been found during the 365 Day Period, then the Insured Person will be deemed to have suffered the Insured Event "Death".

We will only pay the Insured Event "Death" as a result of Disappearance after the Insured or the legal representative of the Insured Person's estate has given us a signed undertaking that the benefit will be repaid to Us if, after Our payment, it is later determined that the Insured Person did not die as a result of the Insured Event.

Exposure
If an Insured Person is exposed to the elements as a result of sustaining an Injury and suffers from any of the Insured Events within three hundred and sixty five (365) consecutive days as a direct result of that exposure, We will treat that Insured Event as if it were caused by an Injury for the purposes of this Policy.

Compensation
We will pay the Percentage of Benefit Payable shown for the Insured Event of the amount shown in the Policy Schedule against "Death and Capital Benefits".

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Any Compensation payable for Death and Capital Benefits shall be reduced by any sum already paid for under Weekly Injury Benefit in respect of the same Injury.

Conditions

1. We must receive evidence to Our reasonable satisfaction of the Insured Event, which could include:

    a. a death certificate from the relevant jurisdiction's Registry of Births, Deaths and Marriages or equivalent; or
    b. a report confirming that the Insured Person is missing and presumed dead issued by:

        i. the police or coroner in Australia; or
        ii. the embassy or equivalent representative of the relevant country where the Insured Event has occurred outside of Australia.

2. Compensation shall not be payable for more than one of the Insured Events in respect of the same Injury or Accident. If two (2) or more Insured Events have occurred, the Insured Event with the highest Compensation will be payable. For the avoidance of doubt, if two (2) or more Insured Events in respect of the same Injury have the same Compensation then only one Insured Event will be payable.
3. Compensation shall not be payable unless the Insured Person shall as soon as reasonably practicable after the happening of any Injury that the Insured Person is (or should have been) reasonably aware may or is reasonably likely to give rise to a Claim under this Policy, procure and follow proper medical advice from a Medical Practitioner.
4. The maximum amount payable for this Benefit in any one Period of Insurance for any one Insured Person is the amount shown in the Policy Schedule against "Death and Capital Benefits".

Exclusions

1. No cover is provided for any Injury which is wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).
2. No cover is provided for Insured Event "Permanent Total Disablement" for Insured Persons who have attained:

    a. the age of seventy (70) or over; or
    b. the age shown in the Policy Schedule against "Maximum Age Limit (sub limits may apply)",

    whichever is the lesser, at the time of an Event.

Weekly Injury Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in one of the following Insured Events:

- Temporary Total Disablement; or
- Temporary Partial Disablement,

and as a result suffers a loss of Income which is not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will pay the lesser of:

1. 1/7th of the amount shown in the Policy Schedule against "Weekly Injury Benefit"; or
2. 1/7th of the Insured Person's Income,

for each completed twenty-four (24) hours of continued disablement.

After a period of three hundred and sixty-five (365) consecutive days of disablement, We will increase this Benefit amount by five (5%) percent for the remainder of the Benefit Period.

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. The Insured Event must occur within three hundred and sixty-five (365) consecutive days of the date of the Injury.
2. If an Injury requires surgical treatment which cannot be performed within three hundred and sixty-five (365) consecutive days from the date of the Accident, and

    a. the Insured Person can demonstrate that such treatment was known as necessary during the three hundred and sixty-five (365) day period from the date of Accident; and
    b. a Medical Practitioner certifies this,

    We will treat this as a continuation of the first Injury provided surgery does not occur in a period in excess of seven hundred and thirty (730) consecutive days from the date of the Accident.
3. The Insured Person must as soon as reasonably practicable after the happening of any Injury that the Insured Person is reasonably aware may (or should have been aware) or is likely to give rise to a Claim under this Policy, procure and follow proper medical advice from a Medical Practitioner.
4. Payments under this Benefit shall be reduced by the amount of any Workers' Compensation, Transport Accident Compensation, statutory compensation (or any ordinance or any other legislation having similar effect) entitlement for incapacity for work or any other payment which the Insured Person is entitled to receive for disability from any Other Insurance policy, except where this condition would be voided by Section 45 of the Insurance Contracts Act.
5. Notwithstanding Condition 2, if an Insured Person suffers a recurrence of Temporary Total Disablement or Temporary Partial Disablement from the same or related Injury within one hundred and eighty-two (182) consecutive days, the subsequent period of disablement will be deemed a continuation of the prior disablement. A new Deferral Period will not apply and the total Benefit Period shall not exceed the maximum Benefit Period, as specified in the Policy Schedule, inclusive of the Benefit already received.
6. If the Insured Person suffers a recurrence of Temporary Total Disablement or Temporary Partial Disablement from the same or related Injury after working on a full-time unrestricted basis for at least one hundred and eighty-two (182) consecutive days, the subsequent period of disablement shall be deemed to have resulted from a new Injury. A new Deferral Period and a new maximum Benefit Period as specified in the Policy Schedule shall apply.
7. Where the Insured Person is an employee and their employment with the Insured or their pre-disability employer is terminated or they are made redundant, and the Insured Person receives a lump sum termination or redundancy payment, We will reduce and/or off-set the payment of any entitlements under this Benefit by the equivalent periodical payments (or proportional weekly equivalent of any lump sum payment) the Insured Person received.
8. If the Insured Person redeems or commutes or settles their entitlement to Income from any other source, Our payments for Weekly Injury Benefit will immediately cease.
9. At time of Claim, the Insured or Insured Person must give Us written notification if the Insured or Insured Person hold any Other Insurance with any insurer providing for weekly compensations of a similar kind which, together with this insurance, will exceed the Insured Person's Income.
10. All Compensation shall be paid monthly in arrears.
11. In respect of Temporary Partial Disablement, the maximum We will pay is forty (40%) percent of the Compensation payable for Temporary Total Disablement.
12. In respect of Temporary Partial Disablement, if an Insured Person is able to return to work in a limited capacity but elects not to do so, the maximum We will pay is twenty-five (25%) percent of the Compensation payable for Temporary Total Disablement.
13. If the Insured Persons post-disability weekly Income exceeds the applicable Temporary Partial Disablement Benefit that would have been paid under this Benefit then no Weekly Injury Benefit is payable.

Exclusions

1. No cover is provided for any Injury that is wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).
2. No cover is provided for any period where the Insured Person is receiving or is entitled to receive sick leave payments.

Broken / Fractured Bones Benefits

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in any of the following Insured Events which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Insured Events	Percentage of Benefit Payable
Neck or spine (Full-Break)	100%
Neck or spine (not being a Full-Break)	50%
Pelvis girdle (Hip bone)	25%
Skull, shoulder blade	10%
Collar bone, upper leg	10%
Upper arm, kneecap, forearm, elbow	7.5%
Lower leg, jaw, wrist, cheek, ankle, hand, foot	5%
Ribs	5%
Finger, thumb, toe	2.5%

Compensation
We will pay the Percentage of Benefit Payable stated for the Insured Event of the amount shown in the Policy Schedule against “Broken / Fractured Bones Benefits”.

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. The maximum Compensation payable for any one Injury is the amount shown in the Policy Schedule against “Broken / Fractured Bones Benefits”.

Exclusions

1. No cover is provided for any Injury wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).

Accidental HIV Infection Lump Sum Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person contracts the Human Immunodeficiency Virus (HIV) as a result of:

1. Injury caused by a violent physical bodily assault by another person; or
2. Medical treatment of an Injury,

which is not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Any general exclusions which apply to HIV infection do not apply to this benefit.

Compensation
We will pay the amount shown in the Policy Schedule against “Accidental HIV Infection Lump Sum Benefit”.

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. There must be a positive diagnosis of HIV infection within one hundred and eighty-two (182) consecutive days of the Event occurring.
2. The Event leading to the HIV infection must be reported to Us, and medical tests must be carried out by a Medical Practitioner, no more than forty- eight (48) consecutive hours from the date and time of the Event giving rise to the HIV infection.
3. A recognised laboratory must carry out the testing and prove that the Insured Person was not HIV positive at the time of the Event giving rise to the HIV infection.
4. Medical treatment must be provided by a Medical Practitioner or legally qualified and registered nurse.

Exclusions

1. No cover is provided if it is proven the Insured Person already had HIV prior to the Event giving rise to the HIV infection.
2. No cover is provided for any Injury wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).

Bed Care Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury and as a result is unable to perform the 'activities of daily living' such as washing, cooking, bathing, dressing and movement around the Insured Person's principal residence (Activities of Daily Living) and the Insured Person is confined to bed (other than in a Hospital or other medical facility), which is not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will pay the amount shown in the Policy Schedule against "Daily Benefit" for each completed twenty-four (24) hours of continued bed confinement.

The maximum We will pay is the amount shown in the Policy Schedule against "Bed Care Benefit".

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. A Medical Practitioner must certify that the Insured Person is unable to perform the 'Activities of Daily Living' and is confined to bed for the period claimed.

Exclusions
1. No cover is provided for bed confinement which lasts less than a period of forty-eight (48) consecutive hours

Domestic Help Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person, sustains an Injury which results in Temporary Total Disablement and as a result incurs expenses for domestic help, covering at home childcare, routine household cleaning and garden maintenance activities which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will pay for or reimburse the reasonable expenses as described in the Extent of Cover. The maximum amount We will pay is 1/7th of the amount shown in the Policy Schedule against "Domestic Help Benefit" per day of continued Temporary Total Disablement.

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. The Temporary Total Disablement must occur within three hundred and sixty-five (365) consecutive days of the date of the Injury.
2. The Insured person must as soon as reasonably practicable after the happening of any Injury giving rise to a Claim, procedure and follow proper medical advice from a Medical Practitioner.
3. All Compensation shall be paid in arrears.
4. The domestic help provided must be certified as necessary by a Medical Practitioner to assist in the rehabilitation the Insured Person.

Exclusions

1. No cover is provided for expenses that would have been incurred irrespective of the Injury.
2. No cover is provided for any Injury that is wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).
3. No cover is provided for domestic help provided by a Relative of the Insured Person or a Relative of the Insured Person's Partner.

Family Accommodation and Transport Expenses Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in them being admitted as an in-patient to a Hospital and the Insured Person's Family incurs expenses to travel to and remain with the Insured Person for the duration of their stay as an in-patient, which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will pay for or reimburse the reasonable expenses as described in the Extent of Cover. The maximum amount We will pay is shown in the Policy Schedule against "Family Accommodation and Transport Expenses Benefit".

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. The Hospital must be located in Australia.
2. The Hospital must be located outside a Radius of 100km from the Insured Person's normal place of residence.

Exclusions

1. No cover is provided for any Injury wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).

Funeral Expenses Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover an Insured Person suffers an Injury resulting in the Insured Persons Death and subsequently the deceased Insured Person's Family or estate incurs reasonable Funeral Expenses, being;

1. all reasonable funeral, burial or cremation and associated expenses; and/or
2. all reasonable expenses incurred in transporting the Insured Person's body, moral remains or ashes to a place nominated by the deceased Insured Persons estate,

which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will pay for or reimburse the reasonable expenses as described in the Extent of Cover. The maximum amount We will pay is shown in the Policy Schedule against "Funeral Expenses Benefit".

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions
No specific conditions apply to this Benefit, only the General Conditions and Limitations.

Exclusions
No specific exclusions apply to this Benefit, only the General Exclusions.

Home and Vehicle Modification Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in a Claim which We accept against this Policy for one of the following Insured Events under Death and Capital Benefits:

- Permanent Total Disablement; or
- Paraplegia/Quadriplegia ; or
- Permanent and incurable paralysis of all limbs; or
- Permanent and incurable insanity; or
- Permanent total loss of sight in:

    a. Both eyes; or
    b. One (1) eye; or

- Permanent total Loss of Use of:

    a. Two (2) limbs; or
    b. One (1) limb; or

- Permanent total Loss of Use of:

    a. The lens in both eyes; or
    b. Hearing in both ears,

and as a direct result of such Injury is unable to perform the activities of daily living requiring modification to the Insured Person's:

1. principal residence (including but not limited to the installation of ramps for external or internal wheelchair access, internal guide rails, emergency alert system and similar disability aids); or
2. private vehicle (used for non-commercial purposes) including but not limited to the installation of steering wheel modifications and pedal adjustments,

and incurs expenses for those modifications which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will pay for or reimburse the reasonable expenses as described in the Extent of Cover. The maximum amount We will pay is shown in the Policy Schedule against "Home and Vehicle Modification Benefit".

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. Modifications must be required in order to perform the activities of daily living such as driving, washing, cooking, bathing, dressing and movement around the Insured Person's residence.
2. Our prior written agreement and the agreement of the Insured Person's attending Medical Practitioner to certify that these modifications are necessary in order for the Insured Person to perform the activities of daily living must be obtained prior to modifications being undertaken.
3. Cover is applicable in respect of the Insured Person's principal residence only and/or one private non-commercial vehicle (as applicable) only.
4. Modifications must be in accordance with any law or by-laws.

Exclusions

1. No cover is provided where the payment of the Benefit would constitute the carrying on of a "Health Insurance Business" as defined under the Private Health Insurance Act 2007 (Cth) or any succeeding legislation to that Act or would result in a breach of the provisions of the Health Insurance Act 1973 (Cth) or any similar legislation.

Non-Medicare Medical Expenses

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury, which directly results in the Insured Person or the Insured incurring Non-Medicare Medical Expenses which are covered under this Policy, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will reimburse the Non-Medicare Medical Expenses as described in the Extent of Cover, after deducting:

1. any expense not covered under this Policy;
2. any benefit not payable under this Policy;

The maximum amount We will pay is shown in the Policy Schedule against "Non-Medicare Medical Expenses".

Conditions

1. To claim an expense, the expense must be incurred within three hundred and sixty-five (365) days of sustaining the Injury.
2. Non-Medicare Medical Expenses are only payable to the extent they are not recoverable, or recovered, from a Recognised Insurance Provider or applicable statutory scheme. In order to claim any difference (up to a maximum of the Benefit Limit) between the incurred expense and the benefit received from the Recognised Insurance Provider or applicable statutory scheme the Insured Person must provide evidence to Us of the claim made against the Recognised Insurance Provider or applicable statutory scheme and the benefit received

Exclusions

1. No cover is provided for any dental fee unless it is:
   a. incurred sound and natural teeth due to the relevant Injury, other than dental fee incurred for first teeth, dentures, implants, crowns, prosthetic teeth and dental fillings which are not covered under the Policy; and
   b. certified by a Medical Practitioner as necessary solely for the purposes of treatment for recovery of the relevant Injury.
2. No cover is provided for any expense incurred after three hundred and sixty-five (365) consecutive days from the date of the Injury.
3. No cover is provided if any portion of the Non-Medicare Medical Expense which is paid or payable by Medicare.
4. No cover is provided for costs that are not incurred as a direct result of the Injury or are not certified as necessary by a Medical Practitioner or Dental Practitioner in aiding the recovery from the Injury;
5. No cover is provided for any expense, which in the opinion of a Medial Practitioner, relate to the prevention of future Injury(ies).

Out of Pocket Expenses Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury and as a direct result incurs otherwise unforeseeable, reasonable expenses for:

1. Medical Mobility Equipment; and/or
2. local transportation (other than in an ambulance) for the purpose of seeking medical treatment; and/or
3. replacement of items damaged as a result of the Injury,

which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will reimburse the reasonable expenses as described in the Extent of Cover. The maximum amount We will pay is shown in the Policy Schedule against "Out of Pocket Expenses".

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. We will only make a payment under this Benefit if:
   a. the expenses are not covered under another Benefit under this Policy (to the extent permitted by law); and
   b. the payment of the Benefit does not constitute the carrying on of a "Health Insurance Business" as defined under the Private Health Insurance Act 2007 (Cth) or any succeeding legislation to that Act or would result in a breach of the provisions of the Health Insurance Act 1973 (Cth) or any succeeding legislation to that Act; and
   c. a Medical Practitioner certifies that the Medical Mobility Equipment is required by the Insured Person as a direct result of the Injury.

Exclusions
No specific exclusions apply to this Benefit, only the General Exclusions.

Retraining and Rehabilitation Expenses Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in a Claim which We accept against this Policy for one of the following Insured Events under Weekly Injury Benefit:

- Temporary Total Disablement; or
- Temporary Partial Disablement,

and subsequently the Insured Person incurs expenses for vocational training, tuition or guidance which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will reimburse the reasonable expenses as described in the Extent of Cover. The maximum amount We will pay is shown in the Policy Schedule against "Retraining and Rehabilitation Expenses Benefit".
The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. Medical evidence must be supplied by the Insured Person's treating Medical Practitioner that the vocational training, tuition or guidance is necessary to rehabilitate the Insured Person as a result of the Injury.
2. Our written agreement must be obtained prior to the commencement of the vocational training, tuition or guidance.

Exclusions
No specific exclusions apply to this Benefit, only the General Exclusions.

Student Tutorial Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person who is a registered full-time student at an educational institution sustains an Injury which results in the Insured Person:

1. being temporarily unable to attend their scheduled classes; and
2. incurring additional home tutorial expenses,

which are not otherwise excluded in this Benefit, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation
We will reimburse the reasonable expenses as described in the Extent of Cover. The maximum We will pay is 1/7th of the amount shown in the Policy Schedule against "Student Tutorial Benefit" per day of continued Temporary Total Disablement.

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. The incurred expenses must occur within three hundred and sixty-five (365) consecutive days of the date of the Injury.
2. The Insured Person must as soon as reasonably practicable after the happening of any Injury giving rise to a Claim, procure and follow proper medical advice from a Medical Practitioner.
3. All Compensation shall be paid in arrears.
4. The Insured Person's inability to attend classes must be certified by a Medical Practitioner.
5. The home tutorial services must be performed by someone who is suitably qualified or experienced to provide such tutoring and is not a Relative of the Insured Person or persons living with the Insured Person.

Exclusions

1. No cover is provided for expenses that would have been incurred irrespective of the Injury.
2. No cover is provided for any Injury that is wholly or partly attributable to childbirth or pregnancy or the complications of these (except for unexpected medical complications or emergencies arising from an Injury).
3. No cover is provided for home tutorial services provided by a Relative of the Insured Person or a Relative of the Insured Person's Partner.

Unexpired Membership Benefit

Extent of Cover
If, during the Period of Insurance and occurring within the Scope of Cover, an Insured Person sustains an Injury which results in a Claim which We accept against this Policy for one of the following Insured Events under Death and Capital Benefits:

- Permanent Total Disablement; or
- Paraplegia/Quadriplegia ; or

- Permanent and incurable paralysis of all limbs; or
- Permanent and incurable insanity; or
- Permanent total loss of sight in:

    a. Both eyes; or
    b. One (1) eye; or

- Permanent total Loss of Use of:

    a. Two (2) limbs; or
    b. One (1) limb; or

- Permanent total Loss of Use of:

    a. The lens in both eyes; or
    b. Hearing in both ears,

or one of the following Insured Events under Weekly Injury Benefit:

- Temporary Total Disablement; or
- Temporary Partial Disablement,

which is not otherwise excluded in this Benefit and as a result of such Injury is unable to participate in any sport or gym activity for which the Insured Person has pre-paid a membership fee, association fee or registration fee, We will pay the Compensation in accordance with the terms set out in this Benefit.

Compensation

We will reimburse the described fees which have been paid for the current season, on a pro-rata basis. The maximum amount We will pay is shown in the Policy Schedule against “Unexpired Membership Benefit”.

The Compensation is subject to any Benefit Limits applicable to this Benefit.

Conditions

1. A Medical Practitioner must certify in writing that the Temporary Total Disablement and/or Temporary Partial Disablement will continue for a minimum period of one hundred and eighty two (182) consecutive days.
2. A Medical Practitioner must certify in writing that the Injury is preventing the Insured Person from continuing their participation in any sport or gym activity for which they have pre-paid the relevant membership, association or registration fee.

Exclusions

1. No cover is provided for any fees for which a refund is available or where fees have not been paid.

General Exclusions

The following exclusions apply to all Benefits under this Policy. We will not pay for a Claim under the Policy if the Claim arises directly or indirectly out of or in relation to any of the following:

1. an Insured Person who has attained the age shown in the Policy Schedule against "Maximum Age Limit (sub limits may apply)" at the time of an Event.
2. any Benefit payment that that would result in Us breaching any of the following:

    a. the Private Health Insurance Act 2007 (Cth) and the Private Health Insurance (Health Insurance Business) Rules; or
    b. the National Health Act 1953 (Cth); or
    c. the Health Insurance Act 1973 (Cth),

    as amended from time to time;
3. any Claims arising from the Insured Person being under the influence of intoxicating liquor or any other drug unless it was prescribed by a Medical Practitioner and taken in accordance with the Medical Practitioner's advice.
4. an Insured Person engaging in or taking part in naval, military or air force service or operations.
5. racing and/or time trials of any form, other than on foot.
6. Claims arising from the use, existence or escape of nuclear weapons material or ionising radiation from or contamination by radioactivity from any nuclear fuel or nuclear waste from the combustion of nuclear fuel.
7. any deliberate self-inflicted harm or Injury, caused or committed by the Insured Person, including suicide or attempted suicide, reckless misconduct or any criminal or illegal act.
8. War, Civil War, rebellion, revolution, insurrection or military or usurped power in or confiscation or nationalisation or requisition or destruction of or damage to property by or under the order of any government or public or local authority in the Insured's Country of Domicile or Country of Expatriation, or the Insured Person taking part in a riot or civil commotion.
9. an Insured Person engaging in or taking part in or training for Professional Sports of any kind.
10. an Insured Person engaging in air travel except as a passenger in any registered and licensed aircraft that carries passengers.
11. Events attributable wholly or partly to childbirth or pregnancy or the complications of these.
12. any Claim in relation to or in connection with a Pre-Existing Condition, unless the Pre-Existing Condition had been declared to and accepted by Us in writing.
13. losses arising from Nuclear, Biological or Chemical Terrorism.

No cover is provided or deemed to be provided and We shall not be liable to pay any Claim or provide any benefit hereunder to the extent that:

14. the provision of such cover, payment of such Claim or provision of such benefit would expose Us to any sanction, prohibition or restriction under United Nations Security Council (UNSC) resolutions or the trade or economic sanctions, laws or regulations of Australia, European Union, United Kingdom and/or the United States of America.

General Conditions and Limitations

The following conditions and limitations apply to this Policy.

Additions and Deletions
The Insured must declare to Us in writing of any Insured Persons who are required to be covered under the Policy during the Period of Insurance within thirty (30) consecutive days from their Effective Date of Cover. Cover will be subject to a pro-rata premium for time on risk, which can be paid on a quarterly or annual basis. The Insured must also declare to Us any Insured Persons who no longer require cover under the Policy within thirty (30) consecutive days from their date of cessation.

The maximum pro-rata refund premium applicable for Insured Persons that no longer require cover under the Policy will be limited to one hundred and twenty (120) consecutive days. Furthermore, We reserve the right not to refund any premium, or only a refund portion of the premium, if We have paid a Claim or intend to pay a Claim under the Policy during the Period of Insurance.

Age Limitation
Age limits apply to this policy. No cover is provided for Insured Persons who have not attained the minimum age or who have attained the maximum age limits of the Policy at the time of an Event.

1. The maximum age limit is shown in the Policy Schedule against “Maximum Age Limit (sub limits may apply)”. If “Maximum Age Limit (sub limits may apply)” is not shown in the Policy Schedule, no maximum age limit applies to the Policy.
2. The minimum age limit is shown in the Policy Schedule against “Minimum Age Limit (sub limits may apply)”. If “Minimum Age Limit (sub limits may apply)” is not shown in the Policy Schedule, no minimum age limit applies to the Policy.

Specific age limits may also apply to each Benefit included on this Policy. Please refer to each Benefit for full details.

Cancellation

1. The Insured may cancel the Policy at any time by telling Us in writing:

    a. If the Insured cancels the Policy, (subject to the cooling-off rights) We shall retain and be entitled to the proportional premium for the period during which the Policy has been in force plus Our cancellation charge;
    b. Cancellation by the Insured will be effective when We receive the request; and
    c. Where there is more than one Insured under the Policy, We will only cancel the Policy when a written agreement to cancel it is received from all of the Insureds.

2. We may only cancel the Policy by giving the Insured written notice and where permitted by law, including where it is in accordance with the provisions contained in Part VII ‘expiration, renewal and cancellation’ of the Insurance Contracts Act, including where the Insured has:

    a. made a misrepresentation to Us before the Policy was entered into in breach of the duty to take reasonable care not to make a misrepresentation; or
    b. failed to comply with a provision of the Policy including failure to pay the premium; or
    c. made a fraudulent Claim under the Policy or any other policy during the time the Policy has been in effect; or
    d. failed to notify Us of a specific act or omission as required by the Policy.

3. If We cancel the Policy, We will advise the Insured in writing and cancellation will take effect at whatever is the earlier of the following times:

    a. when another contract of insurance is taken out by the Insured to replace the Policy; or
    b. at 4.00p.m. local standard time of the third business day after the day on which notice was given to the Insured or such later time as We may specify in the notice.

    After cancellation and subject to the cooling-off rights (See ‘Important Information’), We will keep the premium for the period that the Policy was in force and We will return to the Insured the unexpired portion of the premium for the period from the date the Policy was cancelled to the due date of the Policy. We will not refund any premium if a Claim has been made under any Benefit of this Policy.

4. Where the Policy is cancelled, We do not notify any Insured Persons who are not the Insured.

Change in Activities
The Insured must inform Us as soon as reasonably practicable of any change or alteration in the Insured’s activities that the Insured knows, or ought reasonably to know, will cause an increase in the likelihood of the Insured or an Insured Person making a Claim under the Policy. This includes but is not limited to:

- Change in duties covered; or
- Change in sporting or business activities; or
- Change in age groups or level of contact sport.

If We agree to accept this change, We will do so in writing, and You must pay Us any additional premium that We may reasonably require. We reserve the right to amend cover or decline to cover any change in activities according to the terms of the Policy or where permitted by law. We also reserve the right to charge additional premium where We agree to cover the change in activities.

Furthermore, where We are permitted by law to cancel the Policy as a result of a failure by the Insured to notify Us, as required, We reserve the right not to refund any premium, or only a refund portion of the premium, if We have paid a Claim or intend to pay a Claim under the Policy during the Period of Insurance.

Claim Forms
We will, upon receipt of notice of a Claim, provide Claim forms and other documentation as required by Us for completion by the Insured Person and/or Insured as the case may be. We shall not be liable to make any payment under this Policy unless the Claim form is completed to Our reasonable satisfaction and provided to Us as soon as reasonably practicable. All information reasonably required by Us must be furnished at the expense of the Insured unless otherwise agreed by Us.

From time to time We may request a progressive Claim form be completed by the Insured Person's attending Medical Practitioner.

Claims Off-Set and Other Deductions
In respect of any Benefit which is intended to reimburse incurred expenses or financial losses, there is no cover under the Policy for any loss, damage, liability, Insured Event, Injury or sickness which is covered under any Other Insurance policy, health or medical scheme or any government legislation or is payable by any other source. We will however pay the difference between what is payable under the Other Insurance policy, health or medical scheme or any government legislation or such other source and what the Insured or the Insured Person would be otherwise entitled to recover under the Policy, where permissible by law. We will take into account any Excess or co-payment.

Consent to Notification
Acceptance of this Policy means that the Insured consents that We may provide information, including but not limited to notices, in an email or in any other form of electronic communication.

Currency
All amounts shown in the Policy are in Australian dollars (AUD), unless otherwise shown in the Policy Schedule against "Policy Currency". Any Claim or Benefit paid under this Policy will be paid in Australian dollars (AUD) or the currency shown in the Policy Schedule against "Policy Currency". International bank transaction fees are covered to a maximum of fifty ($50) dollars per Claim.

If expenses are incurred in a currency different to Australian dollars (AUD) dollars or the currency shown in the Policy Schedule against "Policy Currency", then the rate of currency exchange used to calculate the amount payable will be the rate at the time of incurring the expense or suffering a loss sourced from the OANDA website www.oanda.com. Note, that exchange rate differences may occur resulting in variation between original value and final payment amount, this can be minimised by requesting all payment be made in Australian dollars (AUD) into an Australian bank account.

Documentation
The Insured must provide all Insured Persons:

1. with a copy of the PDS at the commencement of the Period of Insurance;
2. with information that any Claim they make is subject to the terms, conditions and exclusions of the Policy;
3. with information that is relevant to the Policy cover contained in the Policy Schedule, including but not limited to the definition of Insured Persons, the Period of Insurance, the Scope of Cover and the nature and effect of any endorsement to the Policy; and
4. if the Policy is lapsed or cancelled, a note to this effect.

As We are not in direct contact with, and We do not know who the fluctuating body of Insured Persons are, We must rely on the Insured to ensure that the Insured Persons receive the required Policy information.

Due Diligence
The Insured and all Insured Person(s) will exercise due diligence in doing all things to avoid or reduce any loss under the Policy.

Duplicate Benefit Cover
If an Insured Person is entitled to a benefit payable under more than one policy issued by Us held by the same Insured and for the same Event, We will only pay a benefit under one policy, whichever provides the highest benefit limit.

Duty to Co-Operate

1. The Benefits of this Policy depend on the Insured or any person covered by this Policy giving Us or AHI any reasonable information and help We or AHI require. This includes giving Us or AHI written statements and/or documents We or AHI consider relevant. We or AHI may also require the Insured or any person covered by this Policy to attend court to give evidence. The Insured and any person covered by this Policy must help Us or AHI even when We have paid a Claim.
2. If the Insured or any person covered by this Policy are in receipt of weekly Benefit payments for Temporary Total Disablement or Temporary Partial Disablement, We may appoint a return to work coordinator or vocational rehabilitation provider. Such persons will work with the Insured, the Insured Person's Employer and the Insured's nominated treating Medical Practitioner to explore and facilitate possible return to work strategies within the functional parameters of the medical condition. The Insured must give Us reasonable cooperation in participating in such injury management.
3. If the Insured or any person covered by this Policy do not cooperate with the above the Insured or any person covered by this Policy will be in breach of this Policy and payments may be either suspended, or be reduced to the

extent that the Insured's non-cooperation prejudices Our liability to make ongoing Benefit payments as permitted by Section 54 of the Insurance Contracts Act

Governing Law and Jurisdiction
This Policy shall be governed and construed in accordance with the laws of Australia. Any dispute under this Policy shall be resolved in accordance with the laws of Australia.

Headings
Headings have been included for ease of reference and it is understood and agreed that the terms, conditions and exclusions of the Policy are not to be construed or interpreted by reference to such headings.

Instalment Premium Payments
Where We agree that the Insured can pay the premium by seven (7) or more premium instalments and an instalment is unpaid for more than one (1) month, We may be entitled to cancel your policy in accordance with Section 62 of the Insurance Contracts Act.

Limit of Liability
The most We will pay in any one Period of Insurance under this Policy is shown in the Policy Schedule against "Aggregate Limit of Liability". We may also include an Aggregate Limit of Liability for specific Benefits or Events. If We include a specific Aggregate Limit of Liability for a Benefit or an Event, such limit will be shown in the Policy Schedule. In the event the Aggregate Limit of Liability is reached, the amount can be reinstated with Our agreement and payment of the appropriate additional premium (plus any charges).

Notice of Claim
Written notice of Claim must be given to AHI as soon as reasonably practicable after the occurrence of any circumstances giving rise to a Claim.

Other Insurance
In the event of a Claim, the Insured Person must advise Us as soon as reasonably practicable of any Other Insurance they are entitled to Claim under or have access to that covers the same risk or loss.

Payments
Unless otherwise stated, all Compensation shall be paid to the Insured Person, or in the case of the Insured Person's death, to the Insured Person's legal personal representative.

Physical Examination and Autopsy
In relation to a Claim under this Policy where We do not agree with the opinion given by the Medical Practitioner, We have the right (at Our own expense) to conduct any medical examination or examinations of the Insured Person or in the event of death, arrange for an autopsy to be carried out. We may also at any time during a Claim ask for further information or appoint a person to conduct further enquiries into the nature and circumstances of the Claim.

If the Medical Practitioner (authorised by Us) forms an opinion that is contrary to the opinion of the initial Medical Practitioner, We will obtain an independent Medical Practitioner's opinion which will be the opinion used for the purposes of determining a Claim.

Premium Adjustments
This Policy may be subject to a premium adjustment if there are any changes to the underwriting information provided by the Insured. We may ask for updated underwriting information at the end of the Period of Insurance.

Any premium adjustment is subject to the Insured's Claims experience and the application of Our minimum premium (which is available on request).

Singular / Plural
If it is consistent with the context of any clause in this Policy, the singular includes the plural and vice versa.

Subrogation

1. If We make any payments under the Policy to an Insured or an Insured Person, then, to the extent the Insured or Insured Person may have a cause of action for loss or damage against any third party in respect of the facts, matters and circumstances which gave rise to the payments being made under the Policy, then We have a right of subrogation and repayment including any Claim for interest by way of an action which may be brought in the name of the Insured and/or Insured Person against such third party. Both the Insured and Insured Person must provide reasonable cooperation to Us in pursuing any such right.
2. If the Insured Person brings a Claim for loss or damage in their own name against a third party in respect of the facts, matters and circumstances which gave rise to the payments being made under this Policy, then the Insured Person must include in their Claim any payments which may be recoverable from the third party including a Claim for interest (recoverable payments) and should the Insured Person recover damages against the third party either by way of settlement or judgment then the Insured Person must repay to Us out of any such damages the recoverable payments which the Insured Person received under this Policy. We will provide reasonable cooperation to the Insured Person and their legal advisers in bringing any such action.
3. If the Insured Person has at any time entered into or enters into a contract or agreement with another party that prevents the Insured Person's entitlement, and hence Our entitlement, to recover under Our right of subrogation then We may be entitled to rely on Section 54 of the Insurance Contracts Act to refuse to pay a Claim in whole or in part.

Written Approval
If the Insured Person seeks to return to the Country of Expatriation from their Country of Domicile, it must be on the written approval of Our Medical Practitioner in consultation with the Insured Person's attending Medical Practitioner.

AHI Standard Definitions

The meaning of the words as defined in this section apply to this Policy, when such words are capitalised.

ACCIDENT means a sudden, external, unforeseeable and unexpected specific Event which occurs at a definable time and place.

AGGREGATE LIMIT OF LIABILITY means the most We will pay.

AHI means Accident & Health International Underwriting Pty Ltd, ABN 26 053 335 952, AFS Licence No. 238261, of Level 17, 60 Margaret Street, Sydney, New South Wales, 2000, Australia.

ALLIED HEALTH CARE PROVIDER means a legally licensed, registered and qualified health professional that performs diagnostic procedures, provides therapeutic service and patient care in a Hospital, private practice, in-home or community health facility who is not:

1. a Medical Practitioner and who is not the Insured Person and/or the Insured, or
2. a Relative of the Insured and/or Insured Person.

Allied Health Care Provider includes but is not limited to audiologists, chiropractors, dental hygienists, dietitians, exercise physiologists, medical technologists, occupational therapists, orthoptists, orthotists and prosthetists, osteopaths, pharmacists, podiatrists, psychologists, physical therapists, radiographers, respiratory therapists, speech / language pathologists, sonographers, and social workers.

BENEFIT means Compensation which We will pay to the Insured or Insured Person, or as otherwise specified in the Policy, when a specific set of circumstances are satisfied as detailed in this Policy. Benefits are located under the Benefits heading in the Policy Wording.

BENEFIT LIMIT means a condition applicable to a Benefit.

BENEFIT PERIOD means the maximum period of time for which We will continue to pay a Benefit irrespective of whether Claims are made under this Policy or another policy held by the Insured or Insured Person with Us, unless We have agreed to provide that cover over and above this Policy. If a Deferral Period applies to the Benefit, the Benefit Period for that Benefit begins at the end of the Deferral Period.

CHARTER FLIGHT means an aircraft that is chartered for a specific trip(s) by the Insured or Insured Person to fly to and/or from declared take-off and landing facilities and where the flight is not part of an airline's regular scheduled flights for the general public.

CIVIL WAR (whether declared or not) means any of the following: armed opposition, insurrection, revolution, armed rebellion or sedition between two or more parties belonging to the same country where the opposing parties are of different ethnic, religious or idealistic groups.

CLAIM means an application for Compensation under a Benefit of this Policy.

COUNTRY OF DOMICILE means the country in which the Insured Person is deemed a citizen or permanent resident (e.g. holder of a multiple entry visa or permit which gives an Insured Person resident rights in such country).

COUNTRY OF EXPATRIATION means a country other than the Insured Person's Country of Domicile, that is:

1. where the Insured Person will spend most of their time whilst outside of their Country of Domicile; or
2. where the Insured Person is residing whilst on an overseas expatriate assignment; or
3. as declared to Us; or
4. as named in the Policy Schedule.

DAILY BENEFIT means the maximum amount We will pay for each elapsed period of twenty four (24) consecutive hours.

DEFERRAL PERIOD means the continuous period of time shown in the Policy Schedule during which no Compensation is payable for a Benefit. The Deferral Period begins at the point in time that the Benefit would have been payable if there was no Deferral Period.

DENTAL PRACTITIONER means a person legally qualified in dentistry who is registered or licensed to practice dentistry under the laws of the country in which they practice dentistry as a dentist, dental hygienist, dental prosthetist, dental therapist, oral surgeon, orthodontist, oral health therapist or specialist who is not the Insured Person and/or the Insured or a Relative of the Insured and/or Insured Person.

DEPENDENT CHILD or DEPENDENT CHILDREN means an Insured Person's or their Partner's dependent child or children, including step or legally adopted child or children, as long as they are under eighteen (18) years of age, or under twenty-five (25) years of age while they are full-time students attending a legally accredited registered training organisation or institution of higher learning, and are primarily dependent upon the Insured Person for maintenance and support. Dependent Child or Dependent Children also includes any child or children of any age who are living permanently with the Insured Person who through a disability are totally incapable of self-support.

EFFECTIVE DATE OF COVER means the date the:

1. Insured Person first becomes an Insured Person under this Policy and is shown in the Policy Schedule or subsequent endorsement as an Insured Person; and
2. Premium is paid or agreed to be paid by the Insured for the Insured Person.

EXCESS means the amount an Insured or Insured Person must contribute towards the cost of a Claim under this Policy. Where an Excess applies it will be shown in the Policy Schedule and Compensation will be paid less the Excess amount.

EXPENSE LIMITATION means the maximum percentage of an expense which We will reimburse in the event of a Claim.

EVENT means a situation or series of situations that give rise to a Claim.

FAMILY means the Insured Person, their Partner and/or Dependent Children or if the Insured Person is a Dependent Child, their parent, guardian or siblings.

FRANCHISE means a minimum amount of loss that must be exceeded before a Claim can be considered.

FULL-BREAK means the bone is completely broken through with no connections.

HOSPITAL means a place registered as a hospital for the care and treatment of sick or injured persons and which has the following characteristics:

1. organised diagnostic and surgical facilities, either on premises or in facilities available to the hospital on a pre-arranged basis;
2. provides twenty-four (24) hours a day nursing services by registered nurses;
3. is under the supervision of a Medical Practitioner; and
4. is not primarily a clinic, a place for custodial care, a place for the treatment of alcoholism or any other substance abuse, a nursing, rest or convalescence home or home for the aged or similar establishment.

INCOME means:

1. If the Insured Person is an employee, the Insured Person's gross weekly rate of pay exclusive of overtime payments, bonuses, commissions and allowances averaged over the period of three hundred and sixty-five (365) consecutive days prior to the date the disablement (with respect to which We have agreed to pay a Claim under the Policy) commenced or over such shorter period that an Insured Person has been continuously employed prior to the date of disablement as certified by the Medical Practitioner; or
2. In the case of a self-employed person, the Insured Person's weekly pre-tax income derived from personal exertion, after deduction of all expensesnecessarily incurred in connection with that income, averaged over the period of three hundred and sixty- five (365) consecutive days or over such shorter period that an Insured Person has been continuously self-employed prior to the date of disablement as certified by the Medical Practitioner.

If the Insured Person does not meet 1 or 2 above, then the Insured Person's Income shall be deemed to be nil.

INCOME LIMITATION means the maximum percentage of the Insured Person's Income which We will pay in the event of a Claim.

INCOME MULTIPLIER means the maximum multiple of the Insured Person's annualised Income which We will pay in the event of a Claim.

INJURY means bodily injury resulting from an Accident that occurs fortuitously to the Insured Person. Injury does not include:

1. any consequences of an Injury which are ordinarily described as being a sickness, illness or disease, including but not limited to any congenital condition, heart condition, stroke or any form of cancer;
2. an aggravation of a pre-existing Injury;
3. any degenerative condition.

INSURANCE CONTRACTS ACT means the Insurance Contracts Act 1984 (Cth) as amended from time to time.

INSURED means the named company, organisation or person listed as the Insured in the Policy Schedule with whom We enter into the Policy. They are the contracting party.

INSURED EVENT means an Event covered under the Policy.

INSURED PERSON means any person stated by name, classification or meeting the criteria specified for an Insured Person in the Policy Schedule for the insurance cover selected by the Insured and with respect to whom a premium has been paid.

INSURER means:

Tokio Marine & Nichido Fire Insurance Co., Ltd,
ABN 80 000 438 291
AFS Licence No.246548 (TMNF)

Level 17, 60 Margaret Street,
SYDNEY NSW 2000

Telephone: +61 2 9225 7500
Website: www.tokiomarine.com.au

LOSS OF USE means loss of, by physical severance, or total and Permanent loss of the effective use of a part of the body.

MEDICAL MOBILITY EQUIPMENT means any out of Hospital mobility and movement equipment to assist in patient transportation and recovery approved by a Medical Practitioner including A-frames, crutches, walker, walking stick, wheelchair (non-motorised), scooter (non-motorised), moon boot, knee brace, neck, arm or leg supports.

MEDICAL PRACTITIONER means a person who:

a. is qualified in medicine, optometry, psychology, psychiatry, or dentistry, and registered with the relevant medical board of Australia or the respective medical board of the country in which they practice medicine, psychology, psychiatry, optometry, or dentistry and
b. is not the Insured Person, the Insured, director or employee of the Insured, or Relative of the Insured.

MEDICARE GAP means the difference between the payment made by Medicare and the Medicare Benefits Schedule fee for the expense.

NON-MEDICARE MEDICAL EXPENSES means any expense, which:

1. is certified by a Medical Practitioner , as necessary for the treatment of the relevant Injury covered by the Policy solely for the purposes of recovery;
2. is incurred by the Insured or the Insured Person within three hundred and sixty-five (365) consecutive days from the date of the relevant Injury covered by the Policy;
3. may include private Hospital fees (including accommodation), Prescription Medicines, certain dental services, ambulance or emergency transport services, orthotists services prescribed by a surgeon, or services provided by an Allied Health Care Provider after referral by the treating Medical Practitioner;

NON-SCHEDULED FLIGHT means a flight(s) in an aircraft that flies over normal air-routes but does not follow set timetables and the take-offs and/or landings are on recognised airfields or airports or similar facilities.

NUCLEAR, BIOLOGICAL OR CHEMICAL TERRORISM means Terrorism involving the use of fusion, fission, radiation, biological or chemical weapons.

OCCURRENCE means an Event which results in bodily Injury or property damage, neither expected nor intended from the Insured Person's standpoint.

OTHER INSURANCE means in the event of a Claim, the Insured or an Insured Person must advise Us as to the existence of any other insurance they are entitled to Claim under or have access to that covers the same Events or loss.

PARAPLEGIA means Permanent, total and entire paralysis of both legs and part or whole of the lower half of the body.

PARTNER means an Insured Person's wife or husband, defacto partner or a partner who has continuously cohabited with the Insured Person for a period of ninety (90) consecutive days or more at the time of the Event, and who is not also an Insured Person.

PERIOD OF INSURANCE means the period of time after the Inception Date and before the Expiry Date shown in the Policy Schedule.

PERMANENT (in relation to disablement) means lasting at least three hundred and sixty-five (365) consecutive days and at the end of that time as certified by a Medical Practitioner as unlikely to improve.

PERMANENT TOTAL DISABLEMENT means where in the opinion of a Medical Practitioner, an Insured Person:

a. who is employed, is unable to entirely and continuously engage in any occupation or employment for which the Insured Person is suited by reason of education, training, experience, or skill; or
b. who is not employed, is unable to engage in any and every occupation for the remainder of the Insured Person's life, and
c. is under the regular care of and acting in accordance with the instructions or advice of a Medical Practitioner..

POLICY means this Product Disclosure Statement (PDS), the policy wording, current Policy Schedule and any other documents We may issue to the Insured that We advise will form part of the Policy. Other documents can consist of endorsements and/or Supplementary Product Disclosure Statements (SPDS's).

POLICY SCHEDULE means any current, subsequent, renewal or variation schedule listing the Benefits and limits that forms part of the Policy issued by Us to the Insured.

PRE-EXISTING CONDITION means injury, sickness, any medical or physical condition, symptom, disorder, disease, disability or illness (including mental illness), of which an Insured Person, in the three hundred and sixty-five (365) consecutive days prior to becoming the Insured Person:

1. was aware of, or a reasonable person in the circumstances could be expected to have been aware of, whether diagnosed or not; or
2. has sought, or received recommendation for, medical advice or treatment, or a reasonable person in the circumstances would have sought medical advice or treatment,

Any medical condition that an Insured Person has suffered from or been treated for, which is under ongoing monitoring or investigation, is considered a Pre-Existing Condition.

PRESCRIPTION MEDICINES means medication prescribed by a Medical Practitioner and are not available without a prescription.

PROFESSIONAL SPORTS means any sport for which an Insured Person receives an allowance, sponsorship, appearance fee or monetary payment as a result of the Insured Persons' participation, which accounts for more than fifteen (15%) percent of the Insured Persons' annual Income from all sources.

PSYCHOLOGY EXPENSES means charges made by a duly qualified psychologist for the provision of mental health services provided that the Insured Person is referred for such treatment by their treating Medical Practitioner.

QUADRIPLEGIA means Permanent, total and entire paralysis of both arms and both legs.

RADIUS means the distance in a straight line from its starting point to its destination.

RECOGNISED INSURANCE PROVIDER means any Australian or international insurer licensed to insure general insurance or health insurance including as a registered health fund.

RELATIVE means the Insured Person's Family, children, parent, parent-in-law, grandparent, step-parent, grandchild, brother, brother-in-law, sister, sister-in-law, daughter-in-law, son-in-law, fiancé, fiancée, half-brother, half-sister, aunty, uncle, niece or nephew.

SCOPE OF COVER means the operative period for which a Benefit is payable, as shown in the Policy Schedule.

SUM INSURED means the maximum amount of Compensation We will pay under a Benefit for any one Insured Person, for any one Event.

TEMPORARY PARTIAL DISABLEMENT means where in the opinion of a Medical Practitioner:

1. if the Insured Person continues to be employed by the Insured, the Insured Person is temporarily unable to engage in a substantial part of their usual occupation or business duties resulting in more than a twenty five (25%) percent loss of Income earned prior to the relevant Injury; or
2. if the Insured Person ceases to be employed by the Insured, the Insured Person is temporarily unable to engage in at least twenty five (25%) percent of any occupation for which they may be suited by way of their education, training or experience,

and is under the regular care of and acting in accordance with the instructions or advice of a Medical Practitioner.

TEMPORARY TOTAL DISABLEMENT means where in the opinion of a Medical Practitioner:

1. if the Insured Person continues to be employed by the Insured, the Insured Person is temporarily unable to entirely and continuously engage in any aspect of their usual occupation or any of their business duties; or
2. if the Insured Person ceases to be employed by the Insured, the Insured Person is temporarily unable to entirely and continuously engage in any occupation for which they may be suited by way of their education, training or experience,

and is under the regular care of and acting in accordance with the instructions or advice of a Medical Practitioner.

TERRORISM means any act, preparation in respect of action or threat of action, designed to:

1. influence a government or any political division within it for any purpose; and/or
2. intimidate or influence the public or any section of the public with the intention of advancing a political, religious, ideological or similar purpose.

WAITING PERIOD means the period of continuous cover that an Insured Person must accumulate before a specific Benefit/any Benefits can be paid.

WAR (whether war is declared or not) means a state of armed conflict between different countries, different groups or factions within a country, Nuclear, Biological or Chemical Terrorism, invasion, acts of foreign enemies, hostilities, or war-like operations or Civil War.

WE/OUR/US/TMNF/AIA/LIU means the Insurer.

Contact Us

To find out how AHI can help you protect what matters most, please get in touch.

Sydney I Melbourne I Brisbane I Perth
1800 618 700