LIFEPROTECT TRAUMA COVER

This cover wording should be read together with the **policy schedule** and the LifeProtect Policy Terms and Conditions.

Please read these documents carefully and keep them in a safe place.

Effective from 30 April 2025

Powered by fidelity life

YOUR COVER IN DETAIL

Words that are bold in this document are defined terms – you can find the definitions in section 7 or 8 of this cover wording, or in section 11 of the LifeProtect Policy Terms and Conditions.

1. Introduction

This Trauma Cover provides **you** with a lump sum payment if the **insured person** suffers from a **trauma condition**.

The **policy schedule** names the **insured person** this Trauma Cover applies to and shows any optional Trauma Reinstatement Benefit that may apply.

2. Built-in benefits

2.1 Trauma conditions.

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

2.1.1 The conditions covered for a full benefit payment.

The conditions **we** will pay the **sum insured** for are as follows:

- Alzheimer's disease
- Angioplasty – triple vessel
- Aorta surgery
- Aplastic anaemia
- Benign brain tumour or benign spinal tumour
- Cancer
- Carcinoma in situ – major treatment
- Cardiomyopathy
- Chronic kidney failure (renal failure)
- Chronic liver failure
- Chronic lung disease
- Cognitive impairment
- Coma
- Coronary artery bypass surgery
- Creutzfeldt-Jakob disease (CJD)
- Dementia
- Encephalitis
- Heart attack
- Heart valve surgery
- Intensive care
- Loss of independent existence
- Loss of limb and eye
- Loss of limbs
- Loss of sight in both eyes
- Loss of speech
- Major head trauma
- Major organ transplant
- Medically acquired HIV
- Meningitis and/or meningococcal disease
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Occupationally acquired HIV
- Open heart surgery
- Out of hospital cardiac arrest
- Paralysis
- Parkinson's disease
- Peripheral neuropathy
- Pneumonectomy
- Primary pulmonary hypertension
- Severe burns
- Severe diabetes
- Severe inflammatory bowel disease
- Stroke
- Systemic sclerosis
- Total deafness in both ears

2.1.2 The conditions covered for a partial benefit payment.

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

- Adult onset type 1 insulin dependent diabetes mellitus
- Alzheimer's disease diagnosis
- Aneurysm
- Angioplasty – two vessels or less
- Carcinoma in situ without major treatment
- Chronic lymphocytic leukaemia
- Colostomy and/or ileostomy
- Dementia diagnosis
- Early stage prostate cancer
- Hydrocephalus
- Loss of one limb

- Loss of sight in one eye
- Major burns
- Malignant melanoma diagnosis
- Multiple sclerosis diagnosis
- Parkinson's disease diagnosis
- Severe osteoporosis
- Severe rheumatoid arthritis
- Systemic lupus erythematosus
- Total deafness in one ear

2.2 How much do we pay?

When the **insured person** suffers a **trauma condition** for the first time after the **start date** and after the **stand-down period** (as defined in section 2.4 where applicable), **we** will pay **you** either:

- the **sum insured** (as at the date the **trauma condition** was suffered), or
- the amount specified for a **partial benefit** payment (as at the date the trauma condition was suffered).

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

The Trauma Cover **sum insured** will reduce by any partial payment of the **sum insured** payable under this cover for an **insured person**, except when **we** pay a Child's Trauma Benefit. **We** will adjust the **premium** accordingly.

2.3 Survival period.

We will only pay a claim for the Trauma Cover if **the insured person** survives for at least 14 days after suffering the **trauma condition**.

2.4 Stand-down period.

If a **trauma condition** stated below occurred or was diagnosed, or the signs or symptoms leading to diagnosis became apparent to the **insured person**, or would have become apparent to a reasonable person in **their** position, within 90 days of:

- the date **we** receive the complete application and valid payment instruction, or the date of reinstatement, then no benefit will ever be payable for that **trauma condition** under this cover, or
- the date of any increase in the **sum insured** (excluding increases due to **CPI** Increases), then no benefit will ever be payable for that **trauma condition** for that increase in **sum insured**.

The stand-down period applies to the following conditions:

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

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

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

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

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

The **stand-down period** won't apply if the **insured person** had similar cover with **us** or another insurance company and this cover replaced that cover, up to the **sum insured** under the replaced cover, provided the previous cover had been in force for at least three months.

2.5 Child's Trauma Benefit.

The Child's Trauma Benefit will be payable if:

- a **child** aged between 2 and 20 (inclusive) suffers a **trauma condition** defined in section 8 (apart from **adult onset type 1 insulin dependent diabetes mellitus**), and
- the **trauma condition** occurs for the first time after the **start date** and after the **stand-down period** (as defined in section 2.4 where applicable), and
- the **child** survives for 14 days after suffering the **trauma condition**.
- the requirements of the Claims sections 4.1 and 4.2 in this cover wording and sections 8.1 to 8.4 in the LifeProtect Policy Terms and Conditions are met.

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

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

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

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

A maximum of one Child's Trauma Benefit will be paid irrespective of the number of **trauma conditions** that **child** suffers or the number of covers the **parent(s)** have with **us** with the Child's Trauma Benefit or equivalent type child's trauma benefit.

Payment of the Child's Trauma Benefit doesn't reduce the **parent's sum insured**.

The Child's Trauma Benefit ends for a **child** on the earliest of the date:

a. the **child's parent(s)** no longer have any cover with **us** that provides this Child's Trauma Benefit, or

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

c. **we** pay a Child's Trauma Benefit or equivalent type child's trauma benefit claim for that **child**.

2.5.1 Conversion of Child's Trauma Benefit.

A **child** covered under the Child's Trauma Benefit can apply for a policy with **our** Trauma Cover available at that time, without having to provide additional health information within the 30 days before and after reaching the **child's** 21st birthday.

The maximum amount of Trauma Cover that can be applied for is 20% of one of the **parent's sums insured**, on the day immediately before that **child's** 21st birthday, up to a maximum of $50,000.

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

The Trauma Cover will exclude any claim if the **trauma condition** directly results from any:

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

The conversion of Child's Trauma Benefit isn't available if the **child** has either had a claim paid or is entitled to make a claim under the Child's Trauma Benefit.

This conversion of Child's Trauma Benefit ends for a **child** on the earliest of:

a. the **child's parent(s)** no longer have any cover with **us** that provides the Child's Trauma Benefit, or

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

2.6 Financial Planning and Legal Advice Benefit.

When **we** pay a lump sum benefit of at least $100,000 under this cover, **we** will reimburse **you**, up to a maximum of $2,500 (including GST), towards the cost of:

- a fully documented financial plan prepared by a financial advice provider providing a financial planning service for **you**, or
- legal advice **you** receive from a lawyer.

Where there is more than one **policy owner** the Financial Planning and Legal Advice Benefit will be divided equally between those **policy owners**.

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

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

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

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

2.7 Special Events Increase.

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

a. **You** can increase **the sum insured** by up to the lesser of $250,000 or 50% of **the sum insured** as at the **start date** of the cover, if any of the following events apply to **them**:

   - marriage or civil union; or one of divorce or being subject to a separation agreement or order, or
   - either, pregnancy at 28 weeks gestation or birth of a **child**, or
   - adoption of a **child**, or
   - dependent **child** starting secondary school, or
   - financially supporting a dependent **child** through a first course of full-time tertiary education, or
   - reaching ages 25, 30, 35, 40, or 45, or
   - either, death or terminal illness (diagnosed by an appropriately qualified **medical practitioner**, confirming a prognosis of less than 12 months to live) of a spouse, de facto partner, **child** or civil union partner, or
   - **they** permanently stop work to provide full-time physical care for the first time for a dependent **relative**.

You cannot apply for more than one increase:

- if the **insured person** enters into a marriage or civil union relationship, or separates and/or divorces from a marriage or civil union relationship, with the same person more than once,

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

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

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

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

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

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

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

Conditions.

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

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

b. An increase under Special Events Increase isn't available if:

- The cover's been issued as a result of an optional Trauma Reinstatement Benefit being exercised.
- The **insured person** has either had a claim paid or is entitled to be paid a claim under any policy with **us** or any other insurance company.
- The **premiums** aren't up to date or are being waived for any reason.
- The portion of cover is itself a result of a Special Events Increase.

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

d. **Your premiums** will increase in line with the increased **sum insured**. **We** will calculate the **premium** for the increase using the **insured person's** age and premium rates at the **start date** of that increase. **The** increased **sum insured** applies from the date **we** confirm the new **sum insured** to **you**, subject to payment of the additional **premium**.

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

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

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

2.8 Relocation Benefit.

If the **insured person**:

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

b. **they** then suffer from a **trauma condition** listed under section 2.1.1 while residing outside of New Zealand, and

c. **we** have accepted a claim for the **sum insured**, **we** will reimburse **you** the lesser of:

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

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

We will pay this Relocation Benefit once only for the **insured person** over the duration of this Policy. This Relocation Benefit isn't payable:

- for a **child** under the Child's Trauma Benefit, or
- as a result of any **partial benefit** payment.

2.9 CPI Increases.

If **CPI** Increases are included in this cover, the **policy schedule** will state it.

How **we** apply **CPI** Increases is set out in section 7.1 of the LifeProtect Policy Terms and Conditions.

The last increase under **CPI** Increases for the **insured person** under Trauma Cover will be applied on the earliest of:

- the **policy anniversary** after **their** 65th birthday, or
- the total sum insured for all trauma type covers for the **insured person** with **us** and any other insurer, reaching $2,000,000. **You** must notify **us** if the total trauma type covers on the **insured person** will exceed this amount.

3. Optional Trauma Reinstatement Benefit

3.1 Trauma Reinstatement Benefit.

If this option is included in this cover, the **policy schedule** will state it.

12 months from the payment of the full **sum insured** under Trauma Cover, other than for **loss of independent existence**, **you** may buy back the Trauma Cover without providing additional health information.

This option is subject to the following conditions:

a. **You** may exercise this Trauma Reinstatement Benefit once only within 90 days after the end of the 12-month period, and before **the insured person's** 65th birthday.

b. The maximum amount that **you** can repurchase is the lesser of the benefit paid and $2,000,000.

c. **We** will calculate the premium based on the rates applicable for both the age of the **insured person** and the Trauma Cover **sum insured** bought back at the time **you** exercise the Trauma Reinstatement Benefit.

d. The Trauma Cover bought back under the Trauma Reinstatement Benefit will be subject to the same terms and conditions that applied to the **sum insured** at the **start date**, subject to (e) below.

e. The bought back cover won't include any options or built-in benefits except payment of the **trauma conditions** listed in section 2.1.

f. If the **insured person** is subsequently diagnosed with a **trauma condition**, **we** will pay the bought back amount only if the **trauma condition** occurred, was diagnosed, or the symptoms leading to a diagnosis became apparent after the Trauma Cover **sum insured** was bought back.

g. **We** won't pay the bought back Trauma Cover **sum insured** if the **trauma condition** is:

   - the same as the original **trauma condition**, or
   - directly or indirectly caused by or related to the original **trauma condition**, or symptoms or conditions which caused the original **trauma condition** to occur, or
   - a **loss of independent existence**, or
   - a **heart condition** and the original **trauma condition** was also a **heart condition**, or
   - a **stroke** or **paralysis** (directly or indirectly resulting from a **stroke**) and the original **trauma condition** was a **stroke**.

h. The Trauma Reinstatement Benefit isn't available where **we** have paid a claim for any **partial benefit**.

i. If the original **trauma condition** claimed for was for a **cancer condition** or a **heart condition**, a discount will apply to the premium on the bought back cover. **We** will determine the discount that will apply by the original **trauma condition** that was claimed for.

4. Claims

4.1 Notice.

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

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

We won't pay any claim until **we** receive all the requirements **we** need to assess the claim and confirm that the **trauma condition** experienced by the **insured person** meets the definition set out in this document.

4.2 Obligations.

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

- Complete **our** claim form(s) in full and send it/them to **us** as soon as reasonably possible.
- Supply **us** with all relevant medical evidence **we** reasonably require in connection with the claim.
- Authorise the disclosure to **us** of the **insured person's** or **your** personal information in connection with the claim held by any other party.

- Authorise the disclosure of the **insured person's** or **your** personal information held by **us** to another party to evaluate the claim.
- Provide **us** with any other relevant information **we** reasonably require. **You** must pay any expenses incurred in providing this information to prove **your** claim.

The **insured person** must:

- Provide a signed report from an appropriate **specialist medical practitioner** confirming the occurrence of the **trauma condition**.
- Undergo one or more medical examination(s) if **we** reasonably request of the **insured person** at **our** expense. This may include blood tests and medical testing.

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

5. Exclusion

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

6. When this cover ends

This Trauma Cover ends for the **insured person** on the earliest of the date:

a. **you** cancel **the** Trauma Cover, or

b. this Policy ends for any reason, or

c. **we** pay the **sum insured** for **them**, or

d. of the **policy anniversary** after **their** 70th birthday, or

e. **they** die.

7. General definitions

The definitions shown below apply to all derivatives of the words defined. Where applicable, an **insured person** will include a **child**. Where defined words are not shown below, they may be found in the LifeProtect Policy Terms and Conditions.

Accident.

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

Activities of daily living.

a. Bathing or showering - the ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash satisfactorily by other means.

b. Dressing and undressing - the ability to put on, take off, secure and unfasten all necessary garments and as appropriate any braces, artificial limbs or other surgical appliances.

c. Eating and drinking – the ability to feed oneself once food and drink have been prepared.

d. Using a toilet – the ability to use the toilet with or without aids or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.

e. Moving from place to place by walking, wheelchair or with the assistance of a walking aid including mechanical or motorised devices.

The **insured person** will be considered to be able to perform the activity if it can be performed by using equipment or adaptive devices.

Cancer condition.

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

Child pre-existing condition.

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

- the **parent** or **child** was aware of, or
- the **child** had signs or symptoms of, or
- the **child** had investigations or sought medical advice for, or
- a reasonable person or **parent** in the circumstances would seek diagnosis, care or treatment for,

on or before the date the Child's Trauma Benefit starts for a **child**.

Heart condition.

Angioplasty – triple vessel, angioplasty – two vessels or less, aorta surgery, cardiomyopathy, coronary artery bypass surgery, heart attack, heart valve surgery, open heart surgery, out of hospital cardiac arrest or **primary pulmonary hypertension.**

Known congenital condition.

A health anomaly, medical condition or defect which is:

- present at birth, and
- known by the **parent** or **child** at the date the Child's Trauma Benefit starts for a **child**.

Medically necessary.

Health care services that a **medical practitioner** or **specialist medical practitioner**, exercising prudent clinical judgement, would provide to the **insured person** for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury,
- not primarily for the convenience of **them**,
- the most appropriate level or type of service or supply that can be safely provided to **them**, and
- being provided in the context of the condition covered and not because of treatment for another condition not covered or excluded under the cover.

Partial benefit.

A part payment of the **sum insured**. The definitions and the amount paid for each **trauma condition** partial benefit is detailed in section 8.2.

Radical surgery.

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

Trauma condition.

A condition as defined in section 8.

Whole person function.

The evaluation of whole person function derived from the most recent edition of the American Medical Association's book Guides to the Evaluation of Permanent Impairment, or an equivalent guide to impairment approved by **us**, as assessed by an appropriately qualified **medical practitioner**.

8. Trauma definitions

8.1 Trauma conditions covered for a full benefit payment.

Alzheimer's disease.

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

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

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

Angioplasty – triple vessel.

Undergoing a coronary artery angioplasty to correct narrowing or blockage of three or more coronary arteries within one or more procedures within a two-month period.

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

Aorta surgery.

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

Aplastic anaemia.

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

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

Benign brain tumour or benign spinal tumour.

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

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

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

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

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

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

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

Cancer.

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

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

- Hodgkin's and Non-Hodgkins lymphoma (all stages)
- Chronic lymphocytic leukaemia of Rai stage 1 or higher
- Malignant melanomas meeting any of the following criteria:
  - at least Clark level 3 depth of invasion, or
  - 1mm Breslow thickness or greater, or
  - showing evidence of ulceration.
- Prostatic cancers meeting any of the following:
  - at least TNM classification T2, or
  - a Gleason score greater than or equal to 6, or
  - the entire prostate has been removed through a prostatectomy, or
  - **medically necessary** treatment by radiotherapy or chemotherapy has been performed.
- Papillary and follicular carcinoma of thyroid of at least TNM classification T2
- Squamous cell carcinomas of the skin where the carcinomas have spread to other organs, bones or lymph nodes
- Other cancers not listed above of at least TNM classification T1.

This definition doesn't include the following:

- Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia, CIN1, CIN2 and CIN3).
- Tumours histologically classified as pre-malignant or having low-malignant potential.
- All hyperkeratosis or basal cell carcinomas of the skin.

Carcinoma in situ – major treatment.

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

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

Cardiomyopathy.

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

Chronic kidney failure (renal failure).

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

Chronic liver failure.

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

Chronic lung disease.

End stage lung disease requiring permanent oxygen therapy and with:

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

Cognitive impairment.

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

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

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

Coma.

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

Trauma Cover for coma will only be paid where the **insured person** survives for at least a further fourteen days without the use of a life support system.

Coma related to alcohol or drug abuse is excluded.

Coronary artery bypass surgery.

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

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

Creutzfeldt-Jakob disease (CJD).

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

Dementia.

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

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

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

Encephalitis.

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

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

Heart attack.

The death of a portion of heart muscle as a result of inadequate blood supply. The basis of diagnosis must be confirmed by an appropriate **specialist medical practitioner** and evidenced by a typical rise and/or fall of cardiac biomarkers (Troponin I, Troponin T or CK-MB) and must also be supported by one of the following changes consistent with a heart attack:

- new cardiac symptoms and signs, or
- electrocardiogram (ECG) tests showing new significant changes, or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, **we** will consider other appropriate and medically recognised tests provided in support of the diagnosis.

The following are excluded:

- other acute coronary and other non-coronary syndromes, including but not limited to angina pectoris, and
- a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease.

Heart valve surgery.

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

Intensive care.

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

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

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

Loss of independent existence.

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

Loss of limb and eye.

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

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

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

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

Loss of limbs.

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

Loss of sight in both eyes.

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

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

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

Loss of speech.

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

Loss of speech due to psychological reasons is excluded.

Major head trauma.

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

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

Major organ transplant.

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

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

The transplant must be confirmed by an appropriate **specialist medical practitioner** as being **medically necessary** and treatable only by a transplant. The transplant of all other organs, parts of organs (except for liver transplant) or any other tissue transplant is excluded. This cover is only applicable to the recipient of an organ or tissue transplant, not the donor.

Medically acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV), acquired via one of the following medical events or procedures, conducted by an appropriate **medical practitioner**:

- a blood transfusion; or
- transfusion with blood products; or
- organ transplant to the **insured person**; or
- assisted reproductive techniques; or
- any other medical procedure or operation.

Notification and proof of the incident will be required from a recognised health authority confirming the infection is medically acquired.

We must be given access to independently test any blood samples used and to take further independent blood tests if required.

We exclude HIV that is medically acquired if a cure for HIV or AIDS was available at the time the procedure that caused the infection is performed.

We exclude HIV transmission by any other means, other than **Occupationally Acquired HIV** as defined below, including sexual activity or deliberate injection of a drug not prescribed by a **specialist medical practitioner**.

Meningitis and/or meningococcal disease.

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

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

Motor neurone disease.

The unequivocal diagnosis of motor neurone disease by two appropriate **specialist medical practitioners**.

Multiple sclerosis.

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

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

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

Muscular dystrophy.

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

Occupationally acquired HIV.

Infection by the Human Immunodeficiency Virus (HIV), acquired via accidental means during the course of

- carrying out the **insured person's** normal occupation, or
- a violent act of another person arising out of **insured person's** normal occupation,

with sero-conversion to HIV infection occurring within six months of the accident.

Any accident which may lead to a claim must be reported to the relevant authority or employer within seven days of the incident.

The report must be supported by a negative HIV antibody test within seven days of the incident.

We must be given access to independently test any blood samples used.

We exclude HIV transmission by any other means, other than **Medically Acquired HIV** as defined above, including but not limited to, sexual activity or deliberate injection of a drug not prescribed by a **specialist medical practitioner**.

Open heart surgery.

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

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

Out of hospital cardiac arrest.

A sudden unexpected stoppage of effective heart action which:

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

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

Paralysis.

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

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

Parkinson's disease.

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

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

Peripheral neuropathy.

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

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

Peripheral neuropathy related to alcohol or drug use is excluded.

Pneumonectomy.

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

Primary pulmonary hypertension.

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

Severe burns.

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

- 20% of the Body Surface Area as measured by the Rule of 9's or the Lund and Browder Body Surface Chart, or
- 50% of both hands requiring surgical debridement and/or grafting, or
- 25% of the face requiring surgical debridement and/or grafting.

Severe diabetes.

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

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

Severe inflammatory bowel disease.

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

- Crohn's disease, or
- ulcerative colitis,

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

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

Stroke.

A cerebrovascular incident including infarction of brain tissue, intracranial or subarachnoid haemorrhage, or embolisation from an intracranial source as evidenced by CT, MRI or similar scan.

Transient ischaemic attacks and cerebral symptoms due to migraine are excluded.

Systemic sclerosis.

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

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

Total deafness in both ears.

The total and irreversible loss of hearing both natural and assisted (excluding via cochlear implant), in both ears as a result of sickness or injury as confirmed by a **specialist medical practitioner**.

8.2 Trauma conditions covered for a partial benefit payment.

Adult onset type 1 insulin dependent diabetes mellitus.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is diagnosed by a **specialist medical practitioner** after **their** 30th birthday with Type 1 diabetes mellitus which requires insulin.

Alzheimer's disease diagnosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with Alzheimer's disease by a **specialist medical practitioner**.

Aneurysm.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** has either:

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

Angioplasty – two vessels or less.

We will pay 25% of the **sum insured** up to a maximum of $25,000 each time the **insured person** undergoes a coronary artery angioplasty to correct narrowing or blockage of one or two coronary arteries. If the **sum insured** is less than $10,000 **we** will pay the **sum insured**.

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

Carcinoma in situ – without major treatment.

We will pay 10% of the **sum insured** to a maximum of $25,000 the first time the **insured person** is diagnosed by a **specialist medical practitioner** with carcinoma in situ of the breast, cervix uteri, vagina, vulva, fallopian tubes, ovary, corpus uteri, anus, perineum, penis or testicle. Tumours must be classified as Tis according to the TNM classification or FIGO stage 0 with supporting histological evidence.

Chronic lymphocytic leukaemia.

We will pay 25% of the **sum insured** up to a maximum of $50,000 the first time the **insured person** is positively diagnosed by a **specialist medical practitioner** with chronic lymphocytic leukaemia of Rai stage 0.

Colostomy and/or ileostomy.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** undergoes the creation of a permanent non-reversible opening, linking the colon or ileum to the external surface of the body.

Dementia diagnosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with dementia by a **specialist medical practitioner**.

Early stage prostate cancer.

We will pay 25% of the **sum insured** up to a maximum of $50,000 the first time the **insured person** is positively diagnosed by a **specialist medical practitioner** with supporting histological evidence of early stage prostate cancer of TNM classification T1 (all categories) or Gleason score less than or equal to 5.

Hydrocephalus.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** requires a shunt to remove an excessive accumulation of cerebrospinal fluid or to relieve increased pressure within the cranium.

Loss of one limb.

We will pay 25% of the **sum insured** up to a maximum of $25,000 if the **insured person** suffers the total and permanent loss of use of one hand or one foot.

Loss of sight in one eye.

We will pay 25% of the **sum insured** up to a maximum of $25,000 if the **insured person** suffers the permanent and irreversible loss of sight in one eye.

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

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

Major burns.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** suffers tissue damage caused by thermal, electrical or chemical agents that results in third degree burns to at least:

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

Malignant melanoma diagnosis.

We will pay 25% of the **sum insured** up to a maximum of $50,000 the first time the **insured person** is positively diagnosed by a **specialist medical practitioner** with supporting histological evidence of malignant melanoma that is Clark Level 1 or 2 depth of invasion, and less than 1mm in thickness as measured using the Breslow method.

Multiple sclerosis diagnosis.

We will pay 25% of the **sum insured** up to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with multiple sclerosis confirming more than one episode of well-defined neurological abnormalities by an appropriate **specialist medical practitioner**.

Parkinson's disease diagnosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with Idiopathic Parkinson's disease by a **specialist medical practitioner**.

Severe osteoporosis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** before **their** 50th birthday:

- suffers at least two vertebral body fractures or a fracture of the neck of the femur, due to osteoporosis, and
- has bone mineral density reading with a T- score of less than -2.5. This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** before **their** 50th birthday is diagnosed with severe rheumatoid arthritis by an appropriate **specialist medical practitioner**. The diagnosis must confirm all the following:

- morning stiffness of the joints, and
- swelling and pain in the joints of at least three joint groups, involving the corresponding joints on both sides of the body. One of the groups must be joints on the fingers or toes, or the knuckles of the hand or wrist, and
- small nodular swelling beneath the skin, and
- a positive rheumatoid factor test, and
- x-ray evidence showing multiple and extensive changes to joints typical of rheumatoid arthritis, and
- diffuse osteoporosis with severe hand and spinal deformity.

Systemic lupus erythematosus.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** is unequivocally diagnosed with systemic lupus erythematosus by a **specialist medical practitioner**. The diagnosis must be made in a clinical setting based on the American College of Rheumatology (ACR) revised criteria and have evidence of lupus nephritis as confirmed by:

- grade 3 to 5 nephritis (WHO classification of lupus nephritis), and
- persisting proteinuria (more than 2+).

Total deafness in one ear.

We will pay 25% of the **sum insured** to a maximum of $25,000 if the **insured person** suffers the total and irreversible loss of hearing, both natural and assisted (excluding via cochlear implant), in one ear as a result of sickness or injury as confirmed by an appropriate **specialist medical practitioner**.