Asteron Life Limited

Employee Insurance

Life, TPD and Trauma Covers
Policy Document

(08/19)

1.0 Introduction

1.1 How to understand this policy document

Your Asteron Life Employee Insurance policy consists of this Policy Document, your Policy Schedule and your current Member Schedule. If there is a variation in terms outlined in this Policy Document and either of your schedules, the latest Policy Schedule terms will prevail.

The following information aims to help the employer named in the Policy Schedule understand this policy document:

- when we refer to 'we', 'our', 'us' and 'Asteron' we are referring to Asteron Life Limited;
- when we refer to 'you' and 'your' we are referring to the employer named in the Policy Schedule;
- when we refer to '*member'* we are referring to a person covered under this policy;
- words or expressions used that have a particular meaning are shown in *italic* type and are explained in either the section in which they appear, section 8 or in the Policy Schedule;
- headings are intended to help identify sections of the policy document but are not to be used to interpret the provisions of the policy;
- words indicating the singular can also be taken to mean the plural and vice versa;
- all references to dollar amounts in this policy are references to New Zealand currency;
- all payments to and from us must be in New Zealand dollars;
- this policy is referable to Asteron Life Limited's Statutory Fund Number 1. The assets of this fund will alone be responsible for the payment of benefits under the policy. All premiums in respect of this policy will be credited to that fund and the payment of all insurance claims under this policy will be paid from that fund;
- this policy is to be interpreted in line with the law as it applies in New Zealand;
- this policy is not participating in profit sharing; and
- this policy has no cash value.

1.2 How to contact us

Administration queries
If you have any questions about your policy, or when and how changes can be made to your policy, please contact your broker or write to us at:

Employee Insurance
Asteron Life Limited
PO Box 894
WELLINGTON

Ph: 0800 808 101

Email: employeeinsurance@asteronlife.co.nz

Claims queries
If you have any queries about how to claim or an on-going claim, please write to us at:

Claims
Asteron Life Limited
PO Box 894
WELLINGTON

Ph: 0800 808 101

If there are any complaints concerning the policy
Write to us at
The Complaints Officer
Asteron Life Limited
PO Box 894
WELLINGTON 6140

At the time this policy is issued, Asteron Life is part of the Insurance & Financial Service Ombudsman Scheme (IFSO Scheme). The IFSO Scheme means that policy owners are provided with a free complaints resolution service. If you are not satisfied that we've resolved the complaint, you may refer it to the Insurance & Financial Services Ombudsman. They will respond if the policy and issue is within their jurisdiction. Their contact details are:

Insurance & Financial Services Ombudsman
PO Box 10-845
Wellington 6143
Freephone: 0800 888 202
Facsimile: 04 399 7614
www.ifso.nz

2.0 General conditions

2.1 Commencement date of the policy

This policy commences on the c*ommencement date* in the Policy Schedule.

There may be an initial period between the *commencement date* and the initial *annual renewal date* so as to align the *annual renewal date* to your convenience.

After this initial term, your policy is renewed and reviewed yearly on the *annual renewal date.*

2.2 Rate guarantee period

Subject to section 2.10 the premium rates referred to in the Premium Rate Schedule are guaranteed by us until the end of the *rate guarantee period* as specified in the Policy Schedule.

At the end of each *rate guarantee period*, we may alter this policy on terms that are agreeable to you and us. If we cannot agree on new terms, then the policy will not be renewed.

We may vary the standard premium rates referred to in the Premium Rate Schedule at any time if there is a change in the amount of the total aggregate benefits for all *member*s of 30% or more in any one policy year.

We may vary the standard premium rates referred to in the Premium Rate Schedule at any time in the event of war (whether declared or undeclared) in which New Zealand is involved, or the armed invasion of New Zealand.

This document was prepared on the basis of the legislation and taxation regime and their interpretation applicable at the date of execution of this policy. We reserve the right to adjust the premium rates, at any time (including within the *rate guarantee period*), in response to changes in the legislative or taxation environment, or in response to changes in generally accepted interpretation of the law. One month's written notice will be given to you of any such change.

2.3 When the policy may be cancelled

During each *rate guarantee period,* we may cancel this policy by 90 days' notice in writing to you:

- if the number of *members* is fewer than 10 for a period of longer than three months;
- in the event of your insolvency.

At the end of each *rate guarantee period,* we may cancel this policy by 90 days' notice in writing to you for any reason**.**

At any time, including during each *rate guarantee period*, we may cancel this policy by 30 days' notice if premiums are not received in accordance with the terms of this policy.

You can cancel this policy at any time by giving us 90 days' notice.

No benefit will be payable under this policy on or after the date of cancellation except where the event on which the claim is payable occurred before the policy ended.

At the date of cancellation we will prepare a statement of premium detailing all premiums payable from or refundable to you. Cancellation of this policy for any reason does not prevent us recovering from you any premium relating to any period of cover under this policy prior to the date of cancellation that has not been paid.

2.4 Eligibility of employees

The policy is compulsory for your employees who meet the *eligibility terms* set out in the Policy Schedule and have not attained the *cover cease age* specified in the Policy Schedule.

Contractors and consultants who work directly for your business may be included as *members* of this scheme if stated in the Policy Schedule.

Your employees who meet the criteria will join the plan immediately and will be covered for their *sum insured* as set out in the Policy Schedule up to a maximum of the *automatic acceptance level* referred to in section 2.11. You are responsible for providing new employee details to us prior to the next *annual renewal date*.

For the *automatic acceptance level* to apply, a *member* must be either working for you, or both physically and mentally capable of working for you, in their usual employment capacity without any restriction, on the date they join the policy.

Applications to join the policy will be considered for *members* who are not working or not capable of working without restriction on the date of joining, however the *automatic acceptance level* may not apply. To assist our assessment of the application we may request medical or other evidence satisfactory to us and any resulting cover may be offered on non-standard terms, including such premium loadings, restrictions, exclusions or other conditions that, in our opinion, are appropriate.

Members will only be covered for amounts in excess of the *automatic acceptance level* or in cases where the *automatic acceptance level* does not apply, after we have been provided with medical or other evidence satisfactory to us, and we have provided written acceptance of the cover and the terms on which that cover is accepted. These terms may include such premium loadings, restrictions, exclusions or other conditions that, in our opinion, are appropriate.

Once accepted into the policy, your employee will be a *member* of the policy.

You are responsible for providing details of new employees to us. Details of all new employees must be provided to us with all other employees' details as requested by us for the annual policy premium review.

If the Policy Schedule states that Transfer Terms apply, employees who participate in any other employee insurance life, TPD and/or Trauma policy operated by you that is in force on the *commencement date* will be automatically accepted into this policy subject to the following conditions:

- the employee ceases to be covered by the previous employee insurance life, TPD and/or Trauma policy;
- the employee works more than 15 hours per week for you (for TPD and Trauma policies);
- the employee is either working for you, or is both physically and mentally capable of working for you, in their usual employment capacity without any restriction, on the *commencement date*; and

- the cover levels do not exceed this policy's *automatic acceptance levels* stated in the Policy Schedule, unless previously underwritten.

If you have employees who do not meet any of the above requirements and you wish them to be eligible for cover under the policy, you must apply in writing to us on or before a date set as 31 days after the *commencement date*. We will provide you with the information that we require from your employee to assess their acceptance into the policy.

2.5 Cover while being assessed

Where our written acceptance of cover is required, you must provide medical or other evidence as we require, in order for our underwriters to make a proper assessment of the terms (if any) on which such cover may be accepted. During this underwriting process, a *member* who is eligible for the Death Benefit will be covered for *accidental death* for the amount of their proposed insured cover (up to a maximum of $500,000). This cover for *accidental death* will start on the day we receive the application for cover and will end when the first of the following occurs:

- we accept (on any terms) or reject the application for cover; or
- the application for cover is withdrawn; or
- a period of 90 days passes from the day we receive the application for cover.

2.6 When does a member leave the policy?

Cover for a *member* will cease on the first to occur of:

- the date the *member* ceases employment with you;
- the date the *member* ceases to be eligible for the scheme as stated in section 2.4, except as a result of temporary absence (see section 2.7);
- the *member* commences service in the armed forces of any country or organisation (other than the New Zealand Armed Forces Reserve);
- a payment from us under the Total and Permanent Disablement Benefit (if any) as detailed in the Policy Schedule;
- the *member*'s death or *terminal illness*;
- the *member* reaching the *cover cease age* specified in the Policy Schedule;
- you cease to pay the premium in relation to the *member*'s cover; and
- cancellation of this policy by us or you.

If a *member* leaves the policy and the Policy Schedule states that a Continuation Benefit applies and the *member* has not reached the *cover cease* age, we will offer the former *member* a period of *extended cover*. The *extended cover* will cease on the first occurrence of:

(a) a Continuation Benefit being exercised (if available),
(b) the former *member* reaching the *cover cease age*, or
(c) 60 days after cover under the policy ceases.

During the cover extension the former *member* will continue to have cover under all benefits they had immediately prior to leaving the policy and no premiums will be charged during the cover extension.

2.7 Temporary absence

If a *member* is on maternity, long service or sabbatical leave for up to 12 months and prior to the *member* going on leave you have agreed that the *member* will recommence employment with you at the end of the leave period, the *member* will continue to have cover until the end

of the leave period or the expiry of 12 months from the start of the leave period, whichever occurs first. You must continue to pay the premium in relation to that *member*'s cover.

If a *member* who is on maternity, long service or sabbatical leave, does not return to employment with you and meet the necessary conditions to be eligible for the scheme as stated in section 2.4 by the end of the leave period or within 12 months from the start of the leave period, whichever occurs first, the cover of the *member* ceases.

Maternity, long service or sabbatical leave is defined as any employer-approved absence from work, which is longer than 10 weeks with a formally agreed return to work date documented at the outset of the absence.

2.8 Benefit payments under this policy

All payments made by us under sections 3 to 6 will be paid to you or to such person, bank or institution as you may direct.

2.9 Paying for this policy

You are responsible for paying the policy premium, including any premium for *voluntary cover* in section 2.13, in accordance with the following requirements:

- *member* information which we request (e.g. age, salary) is supplied in a format and at a time satisfactory to us;
- payments must be made in accordance with the *premium payment terms* specified in the Policy Schedule;
- payments must be made in a form that is satisfactory to you and us as agreed from time to time; and
- payments will include Government taxes and charges which we incur in relation to this policy and which are not included in the premium rates.

The policy premium covering the initial period between the *commencement date* and initial *annual renewal date* of the policy must be paid before the *commencement date*. The first premium instalment for the period immediately following the initial *annual renewal date* must be paid before the initial *annual renewal date.*

All other premium instalments must be paid within 30 days of the date of our invoice.

We will calculate any refund of premium or any additional premium to be paid by you, for the 12 month period immediately preceding the *annual renewal date*, based on the *premium adjustment* formula specified in the Policy Schedule.

The calculation will be based on the following *member* movements in and out of or affecting cover under the policy in that year:

- when new *member*s join the policy or existing *member*s leave the policy during the year preceding an *annual renewal date* (refer to sections 2.4 and 2.6); or
- where there are changes to benefits within *automatic acceptance levels* (refer to section 2.11) for existing *members* during the policy year.

Any premium refunds or additional premium payments must be made within 31 days of the relevant *annual renewal date*.

2.10 Variation in premiums

We will recalculate the policy premium on each *annual renewal date* based on:

- any premium refunds or additional premium payments arising from section 2.9;
- our then current premium rates for Life, Trauma and TPD;
- the age, sex, occupation and any agreed premium loading factors where appropriate for the *member*s of the policy at the *annual renewal date*; and
- the annual income details of each *member* at that time.

If an increase in annual income would give rise to an increase in cover above the scheme's *automatic acceptance level* as referred to in section 2.11, the *member* will not be covered for the additional amount until we have been provided with medical evidence satisfactory to us, and we have provided written acceptance of the additional cover.

Periodically we review our premium rates for Life, Trauma and TPD. Following any review we will not change the premium rates until the next *annual renewal date*.

If the Policy Schedule indicates that the *rate guarantee period* applies then we will not apply any change in underlying premium rates until the expiry of the *rate guarantee period* except as provided for under section 2.2. During the *rate guarantee period* there will still be changes in the total premium in line with age increases, changes to cover levels and movements of employees in and out of the policy.

We reserve the right to pass onto you any Government taxes and charges that we incur in relation to this policy and which are not included in the premium rates.

2.11 Automatic acceptance level

The *automatic acceptance level* is the maximum cover that we will provide you in relation to a specific *member* without requiring medical or financial underwriting.

We will offer an *automatic acceptance level* provided the scheme meets the following conditions:

- the insurance benefits are fully defined so that neither the *member*, the trustees nor you has the right to vary the level of cover for a *member*;
- the eligibility conditions for employees in section 2.4 are followed, and
- there are at least 10 *members* in the scheme at each *annual renewal date.*

In the event that the above conditions are not met, we may vary or remove at our discretion the *automatic acceptance level*, on each *annual renewal date* of your policy.

We may vary the *automatic acceptance level* stated in the Policy Schedule at any time if there is a change since the last *annual renewal date* of 30% or more in either:

- the total number of *members*; or
- the aggregate *sum insured* for all *members.*

2.12 Forward underwriting limits

If we underwrite an employee and offer them cover, we may offer the *member* a Forward Underwriting Limit (FUL). This means that if the *member*'s cover is based on the *member*'s salary and if that increases, we will automatically increase the *member*'s cover level until their level reaches the FUL without requesting further medical underwriting.

We will notify the *member* directly if a Forward Underwriting Limit applies.

2.13 Voluntary cover levels

In addition to the *members*' *compulsory cover levels*; *members* may be entitled to apply for additional Death Benefits (section 3.0), Total and Permanent Disablement Benefits (section 4.0) and Trauma Benefits (section 5.0). Details of *voluntary cover*, if available, are in the Policy Schedule.

Any *voluntary cover* will be underwritten by us.

The amount of *voluntary cover* for the Death Benefit, Total and Permanent Disablement Benefit or Trauma Benefit will be agreed between us and the *member*. The agreed *voluntary cover* amount will be shown in the current Member Schedule.

Members can alter their *voluntary cover* levels within 30 days prior to the *annual renewal date*.

2.14 Cover while overseas

We will cover *members* who are working overseas provided:

- at any one time those *members* are fewer than 15% of the total *members*;
- those *members* are New Zealand Citizens or Permanent Residents;
- those *members* are working overseas for a maximum of three years;
- those *members* are working for a branch or subsidiary of the New Zealand employer.

If any of the provisions above are not met, you must apply to us to continue cover for those *members*. We may impose conditions.

Members who are working overseas for less than 30 days or on holiday travel overseas will remain covered, subject to meeting all other requirements of this policy.

We won't cover any *member* working in or travelling to or from destinations which are deemed to be 'extreme' or 'high' risk by us. Destinations deemed to be 'extreme' or 'high' risk can be determined by visiting the New Zealand Government website at www.safetravel.govt.nz. Destinations labelled as 'some risk' are acceptable for insurance cover.

If the New Zealand Government no longer publishes these ratings, we will use the last rating list published by the New Zealand Government or choose an alternative list that we will inform you of on or before the next *annual renewal date*.

2.15 Member's privacy

We confirm we may need to collect medical and financial information in relation to any *member* to assist us in processing applications for Life, Trauma and/or TPD Cover, changes to the policy and in assessing claims. This information may be disclosed in strictest confidence to our staff, consultants, reinsurance companies, doctors or other qualified medical personnel. Your *members* do not have to agree to these disclosures; however, failure to do so may mean benefits payable to you under this policy are avoided or reduced.

3.0 Life Cover

3.1 Death Benefit

If a *member* dies while covered under this policy, we will pay the *sum insured* for the Death Benefit as defined in the Policy Schedule,

plus the *member*'s Death Benefit *voluntary cover* level (if any) as indicated on the current Member Schedule, and

less any payment made for the Terminal Illness Benefit;
less any payment made for the Accelerated Trauma Benefit; and
less any payment made for the Funeral Advancement Benefit if applicable.

3.2 Terminal Illness Benefit

If a *member* becomes *terminally ill* while covered under this policy, we will pay the *sum insured* for the Death Benefit as defined in the Policy Schedule,

plus the *member*'s Death Benefit *voluntary cover* level (if any) as indicated on the current Member Schedule, and

less any payment made for the Accelerated Trauma Benefit if applicable.

A *member* is considered to be *terminally ill* for the purposes of this policy if:

- in the opinion of a *specialist medical practitioner*;
- if we require, in the opinion of one of our approved *specialist medical practitioners*; and
- in our assessment, having considered medical or other evidence we may require,

the *member*'s life expectancy is, due to *sickness* and even with available medical treatment, not greater than 12 months.

3.3 Funeral Advancement Benefit

If a *member* dies while covered under this policy, we will make an advanced payment of $15,000 for the *member*'s funeral.

The Funeral Advancement Benefit will reduce the Death Benefit *sum insured* for that *member* by the same amount. We will need acceptable written evidence of the *member*'s death before paying this benefit. We will only pay one Funeral Advancement Benefit for each *member*.

If the Death Benefit *sum insured* is less than $15,000, we will pay the full *sum insured* of the Death Benefit only.

3.4 Optional Additional Benefit

This section tells you about the benefits you can choose to add to your Life Cover. See your Policy Schedule to confirm which optional benefit you have selected.

3.4.1 Personal Accident & Major Burns Benefit

If the Policy Schedule states that a Personal Accident & Major Burns Benefit applies, we will pay a benefit if a *member* suffers

- *major burns,* or
- an *injury* which directly results in a *loss of physical function* of a hand, foot, finger or sight.

For the purposes of this benefit:
major burns means full thickness burns to at least 20% of the body surface area; and
loss of a defined physical function means:

- for a hand or foot the total and permanent loss of use and control from the wrist or ankle joint;
- for an eye the irrecoverable loss of the entire sight;
- for a thumb and index finger the complete severance through or above the metacarpophalangeal joints.

The maximum payment for each *accident* per *member* is the lesser of:

- The *member*'s Death Benefit *sum insured* that applied at the time of the *accident or injury*,
- The greatest 'maximum benefit payable' (as shown in the table below) of all physical functions which the *member* qualifies for, and
- $50,000 for *major burns.*

Defined physical functions	Maximum benefit payable
Both hands Both feet Entire sight of both eyes One hand and one foot One foot and entire sight of one eye	$50,000
One hand One foot	$25,000
Entire sight of one eye	$16,250
Thumb and index finger of either hand	$12,500

The Personal Accident and Major Burns Benefit is not payable if:

- The Policy Schedule does not state that the Personal Accident and Major Burns Benefit applies for the *member*
- A Death Benefit, TPD Benefit, Trauma Benefit or Terminal Illness Benefit is payable in respect of the *member* as a result of the same *accident* or *injury*
- The *accident* or *injury* was a direct or indirect result of a deliberate act of self harm by the *member*
- The *accident* or *injury* was a direct or indirect result of the *member* participating in any criminal act
- The *loss of physical function* does not occur within 180 days of the date of the *injury*
- The *accident*, *injury, major burns* or *loss of physical function* occurred before the *member*'s insurance commenced under this policy.

3.5 Life Cover Continuation

If the Policy Schedule states that a Life Cover Continuation Benefit applies, former *members* who cease to have cover under the policy (see section 2.6) and do not qualify for or have not lodged or been paid a benefit other than a Trauma Benefit, are eligible to continue their life cover subject to the following:

- the former *member* has not attained the *cover cease* age as defined in the Policy Schedule;
- the former *member* must apply for cover continuation within the period of *extended cover*;
- the level of life insurance cover will be no greater than the cover that was provided to the former *member* under the policy at the time the cover ceased (see section 2.6);
- the former *member* satisfies our underwriting requirements in respect of their new occupation;
- the former *member* satisfies our underwriting requirements in respect of any hazardous pursuits;
- the former *member* satisfies our underwriting requirements in respect of residence and travel;
- regardless of whether the former *member* is a New Zealand Citizen or Permanent Resident, the former *member* must reside in New Zealand;
- the premium for the new cover will be based on our premium rates available at the time. This premium will be based on the former *member*'s age, *sum insured*, gender, new occupation, hazardous pursuits and smoking status at the time the application for continuation option is received by us, increased by any loading factors which applied in respect of the former *member* at the time the *member* ceased to have cover under the policy (see section 2.6); and
- the product that will be made available by us to the former *member* will be a product made available by us to the general public that we consider provides the most similar benefits (including at our sole discretion the exclusion of any benefits or the variation of any other terms and conditions of that product) to the benefits available under this policy.

4.0 Total and Permanent Disablement (TPD) Cover

4.1 TPD Benefit

If the Policy Schedule states that a Total and Permanent Disablement Cover applies and a *member* becomes *totally and permanently disabled* while covered under this policy, we will pay the *sum insured* for the Total and Permanent Disablement Benefit as stated in the Policy Schedule,

plus the *member*'s Total and Permanent Disablement Benefit *voluntary cover* level (if any) as indicated on the current Member Schedule; and

less any payment made for the Accelerated Trauma Benefit if applicable.

Upon payment of a Total and Permanent Disablement Benefit the *member* for whom the benefit has been paid will cease to be a *member* of the policy and no further benefits will be payable.

4.1.1 If the Policy Schedule states that "own occupation" applies

A *member* is *totally and permanently disabled* under the "own occupation" definition:

- the *member* has suffered a *sickness* or *injury*;
- the *member* has been absent from and unable to work in the *member*'s *usual occupation* solely because of the *sickness* or *injury* for a continuous period of at least three months; and
- we believe, after consideration of medical and any other evidence requested by us, that the *member* is, solely because of the *sickness* or *injury*, incapacitated to such an extent that the *member* is unlikely ever to be able to work again in the *member*'s *usual occupation*.

A *member* with "own occupation" cover will also be considered *totally and permanently disabled* if they meet the "modified defintion" in section 4.1.3.

4.1.2 If the Policy Schedule states that "any occupation" applies

A *member* is *totally and permanently disabled* under the "any occupation" definition if:

- the *member* has suffered a *sickness* or *injury*;
- the *member* has been absent from and unable to work solely because of the *sickness* or *injury* for a continuous period of at least three months; and
- we believe, after consideration of medical and any other evidence requested by us, that the *member* is, solely because of the *sickness* or *injury*, incapacitated to such an extent that the *member* is unlikely ever to be able to work again in any occupation for which the *member* is reasonably suited by education, training or experience which would pay remuneration at a rate greater than 25% of the *member*'s earnings during their last 12 months of work.

A *member* with "any occupation" cover will also be considered *totally and permanently disabled* if they meet the "modified defintion" in section 4.1.3.

4.1.3 If the Policy Schedule states that “modified definition” applies

A *member* is *totally and permanently disabled* under the “modified definition” if:

- a *member* suffers *loss of limbs or sight*; or
- a *member* is constantly and permanently *unable to perform* at least two of the numbered *activities of daily living*; or
- a *member* suffers *significant cognitive impairment*.

4.2 TPD Fast-Track Benefit

TPD Fast Track-Benefit applies if:

- the Policy Schedule states that "any occupation" or "own occupation" applies for the *member*; and
- the *member* has a firm diagnosis from a *specialist medical practitioner* for any of the eligible medical conditions (as defined in the commonly used words section 8.0) while covered under this policy, listed below.

If the TPD Fast Track Benefit applies, we will waive the requirement for the *member* to be unable to work for a continuous period of at least three months before they are eligible for a TPD Benefit.

Medical Conditions eligible for the TPD Fast-Track Benefit:

- *Alzheimer’s disease*
- *blindness*
- *cardiomyopathy*
- *chronic lung failure*
- *deafness*
- *dementia*
- *major head trauma*
- *multiple sclerosis*
- *muscular dystrophy*
- *Parkinson's disease*
- *pulmonary hypertension*
- *severe rheumatoid arthritis*
- *systemic lupus erythematosus (SLE) with nephritis.*

For a *member* to qualify for a TPD Benefit under a fast-track medical condition, the remaining criteria applicable to the TPD Benefit shown in the Policy Schedule (section 4.1) still apply.

4.3 TPD Cover Continuation

If the Policy Schedule states that a TPD Cover Continuation Benefit applies, former *members* who cease to have cover under the policy (see section 2.6) and do not qualify for or have not lodged or been paid a benefit other than a Trauma Benefit, are eligible to continue their Total and Permanent Disablement cover subject to the following:

- the former *member* has not attained the *cover cease* age as defined in the Policy Schedule;
- the former *member* must apply for cover continuation within the period of *extended cover*;
- the former *member* satisfies our underwriting requirements in respect of their intended new employment including but not limited to occupation, hours worked, experience/training, timing of commencement, employment status and income;
- the former *member* satisfies our underwriting requirements in respect of any hazardous pursuits;
- the former *member* satisfies our underwriting requirements in respect of residence and travel;
- regardless of whether the former *member* is a New Zealand Citizen or Permanent Resident, the former *member* must reside in New Zealand;
- the associated Death Benefit must be continued where the level of life cover will be no greater than the cover that was provided to the former *member* under the policy at the time the cover ceased (see section 2.6);
- the level of Total and Permanent Disablement Benefit cover will be no greater than the cover that was provided to the former *member* under the policy at the time the cover ceased (see section 2.6);
- the premium for the new cover will be based on our premium rates available at the time. This premium will be based on the former *member*'s age, *sum insured*, gender, new occupation, hazardous pursuits and smoking status at the time the application for continuation option is received by us, increased by any loading factors which applied in respect of the former *member* at the time the *member* ceased to have cover under the policy (see section 2.6); and
- the product that will be made available by us to the former *member* will be a product made available by us to the general public that we consider provides the most similar benefits (including at our sole discretion the exclusion of any benefits or the variation of any other terms and conditions of that product) to the benefits available under this policy.

5.0 Trauma Cover

5.1 Trauma Benefit

If the Policy Schedule states that a Trauma Cover applies and a *member* qualifies under this section for a Trauma Benefit while covered under this policy, we will pay the *sum insured* for the Trauma Benefit as stated in the Policy Schedule,

plus the *member*'s Trauma Benefit *voluntary cover* level (if any) as indicated on the current Member Schedule.

If the Policy Schedule states that an "accelerated payout" applies, i.e. Accelerated Trauma Benefit, the *sum insured* for the Death Benefit (see section 3) and the *sum insured* for the Total and Permanent Disablement Benefit (see section 4) will be reduced by the amount paid under the Trauma Benefit.

Upon payment of a Trauma Benefit the *member* for whom the benefit has been paid will cease to be covered for Trauma under this policy and no further Trauma Benefits will be payable. We will only pay the Trauma Benefit *sum insured* once for each *member.*

A Trauma Benefit will be payable if the *member* has one of the serious medical conditions (as defined in the commonly used words section 8.0) while covered under this policy, listed under (a) below, or they undergo one of the major surgeries listed under (b) below.

(a) Serious medical conditions:

The *member* diagnosed by a *specialised medical practitioner* as having one of the following serious medical conditions (as defined in the Commonly used words section 8.0) while covered for that condition under this policy, and survives at least 14 days from the date of diagnosis:

- *Alzheimer's disease*
- *aplastic anaemia*
- *benign tumour of the brain or spinal cord*
- *blindness*
- *burns*
- *cancer**
- *cardiomyopathy*
- *chronic kidney (renal) failure**
- *chronic liver failure*
- *chronic lung failure*
- *coma*
- *Creutzfeldt-Jakob disease*
- *deafness*
- *dementia*
- *encephalitis*
- *heart attack**
- *HIV - medically acquired*
- *HIV – occupationally acquired*
- *intensive care*
- *loss of independent existence*
- *loss of limbs*
- *loss of sight (one eye) and limb*
- *loss of speech*
- *major head trauma*
- *major organ transplant (placement on waiting list)**
- *meningitis*
- *motor neurone disease*

- *multiple sclerosis*
- *muscular dystrophy*
- *out of hospital cardiac arrest*
- *paralysis*
- *Parkinson's disease*
- *peripheral neuropathy*
- *pulmonary hypertension*
- *severe peripheral vascular disease*
- *significant cognitive impairment*
- *stroke**
- *systemic sclerosis*

(b) Major surgical procedures:

The *member* undergoes any of the following major surgery (as defined in the Commonly used words section 8.0) while covered under this policy, and survives at least 14 days from the date of surgery:

- *coronary artery angioplasty - triple vessel**
- *coronary artery bypass surgery**
- *heart surgery (open)**
- *major organ transplant (undergoing the transplant)**
- *pneumonectomy**
- *repair or replacement of aorta**
- *repair or replacement of valves**

Unless this policy is a replacement policy, cover does not start for conditions or procedures that are marked (*) until 3 months after the commencement of membership to this policy.

5.2 Trauma Cover Continuation

If the Policy Schedule states that the Trauma Cover Continuation Benefit applies, former *members* who cease to have cover under the policy (see section 2.6) and do not qualify for or have not lodged or been paid a Trauma Benefit, are eligible to continue their Trauma cover subject to the following:

- the former *member* has not attained the *cover cease* age as defined in the Policy Schedule;
- the former *member* must apply for cover continuation within the period of *extended cover*;
- the former *member* satisfies our underwriting requirements in respect of their new occupation;
- the former *member* satisfies our underwriting requirements in respect of any hazardous pursuits;
- the former *member* satisfies our underwriting requirements in respect of their residence and travel;
- regardless of whether the former *member* is a New Zealand Citizen or Permanent Resident, the former *member* must reside in New Zealand;
- the associated Death Benefit must be continued where the level of life cover will be no greater than the cover that was provided to the former *member* under the policy at the time the cover ceased (see section 2.6);
- the level of trauma cover will be no greater than the cover that was provided to the former *member* under the policy at the time the cover ceased (see section 2.6);
- the premium for the new cover will be based on our premium rates available at the time. This premium will be based on the former *member*'s age, *sum insured*, gender, new occupation, hazardous pursuits and smoking status at the time the application for continuation option is received by us, increased by any loading factors which applied in respect of the former *member* at the time of the *member* ceased to have cover under the policy (see section 2.6); and

- the product that will be made available by us to the former *member* will be a product made available by us to the general public that we consider provides the most similar benefits (including at our sole discretion the exclusion of any benefits or the variation of any other terms and conditions of that product) to the benefits available under this policy.

6.0 Limitations on cover

6.1 Limitations on the Life Cover

We will not pay the Death Benefit *voluntary cover* if the *member*'s death is caused directly or indirectly by an intentional self-inflicted act, whether sane or insane, within 13 months of the *member* joining the policy.

This exclusion will not apply to a *member* if the Death Benefit *voluntary cover* provided under this policy replaces the Death Benefit *voluntary cover* on the *member*'s life under another policy owned by you that has been continuously in place for longer than 13 months prior to the *member* joining the policy (but only up to the amount insured under the policy being replaced).

6.2 Limitations on Total and Permanent Disablement Cover

We will not pay the Total and Permanent Disablement (TPD) Cover (if this cover has been chosen) if becoming *totally and permanently disabled* was caused, directly or indirectly by;

- the *member*'s participation in any *criminal activity*; or
- service in the armed forces of any country or organisation (other than the New Zealand Armed Forces Reserve).

We will not pay the Total and Permanent Disablement Cover *voluntary cover* if the *member*'s total and permanent disablement is caused directly or indirectly by an intentional self-inflicted act, whether sane or insane, within 13 months of the *member* joining the policy.

This exclusion will not apply to a *member* if the Total and Permanent Disablement Cover *voluntary cover* provided under this policy replaces the Total and Permanent Disablement Cover *voluntary cover* on the *member*'s disablement cover under another policy owned by you that has been continuously in place for longer than 13 months prior to the *member* joining the policy (but only up to the amount insured under the policy being replaced).

6.3 Limitations on Trauma Cover

We will not pay the Trauma Cover (if this cover has been chosen) if the event giving rise to the claim was caused, directly or indirectly by;

- a self-inflicted act, whether sane or insane;
- the *member*'s participation in any *criminal activity*; or
- service in the armed forces of any country or organisation (other than the New Zealand Armed Forces Reserve).

7.0 Claiming under this policy

7.1 General

The claim conditions specified in this policy document must be satisfied and liability admitted by us before any payments under the policy can be made.

Payment of benefits under the policy will only be considered upon:
- our claim requirements being met by you and the *member*; and
- relevant legislative and common law requirements being adhered to.

7.2 Advice of a claim

We must be advised of a claim as soon as possible after the event giving rise to the claim.

We may reduce the amount we pay or may refuse to pay the claim if:
- we are not told of the event giving rise to the claim within 30 days of the event occurring; and
- we are disadvantaged because of the delay.

For example, we may need the *member* to be examined by a doctor of our choice to assist with our assessment of the claim. If there is a delay in telling us about the event on which the claim is based, we may be unable to schedule a timely medical examination which may disadvantage us in assessing the claim. If that occurs, we may be entitled to not pay the claim or take other action which we are legally entitled to take.

7.3 Completing our claim forms

Our Claim Notification Form is required to be completed in the first instance and further information may be required depending on the type of claim.

7.4 Claim requirements

Payments under this policy will be made once:

(a) we have received the following (in a manner that is satisfactory to us both in form and content):
- properly completed claim form(s);
- proof of the event or condition for which the claim is being made;
- proof of age (unless previously provided);
- copies of all investigations performed which may include, but is not limited to, clinical, radiological, histological and laboratory evidence; and

(b) our additional claim requirements (section 7.4.1) have been met; and

(c) we have confirmed the *member* is eligible for a payment.

7.4.1 Additional claim requirements

We can ask *member*s to provide us with additional information relating to:

- the *member*'s business or personal income and expenses;
- the *member*'s activities; and
- other insurance policies and claims of the *member*.

Any costs associated with these additional claim requirements must be met by you.

At claim time, we may also:

- require the *member* to be examined by a *registered doctor* or other health professional of our choice;
- require the *member* who has become disabled overseas to return to New Zealand for assessment;
- require an accountant of our choice to verify the *member*'s income and/or expenses prior to and during the *member*'s disablement;
- arrange to meet with the *member* and discuss the circumstances surrounding the claim;
- require information surrounding the *member*'s employment circumstances; and
- require a signed authority to enable us to seek and obtain information relevant to the *member's* claim from Government departments, other medical practitioners or other organisations.

We will meet any costs associated with these further claim requirements, other than the cost of the *member* returning to New Zealand for assessment.

If a *member* does not provide us with the information we request, we may stop paying or decline to pay a benefit to you.

7.5 Incorrect or incomplete information

All statements made by you or the *member* or on your or the *member*'s behalf in support of any claim must be complete and correct. If any claim under this policy is supported by incomplete or incorrect information, then the claim in question and any related claim may not be payable in whole or in part.

We may also cancel the *member*'s cover under the policy.

8.0 Commonly used words

The words and phrases used in this document that appear in *italics* are defined in this section.

Included in the definitions are serious medical conditions and major surgical procedures used to help decide if the *member* is eligible for a claim to be paid under your policy.

To be eligible for a claim all medical events require an unequivocal diagnsosis confirmed by an appropriate *specialist medical practitioner*. You and the *member* must also meet all claim criteria under the applicable benefit and section 7.4 in this policy.

accident or ***accidental*** means a single, sudden, unintended, visible, external event that causes bodily *injury*.

accidental death means death from a bodily *injury* that is caused solely and directly by external, violent and accidental means and is independent of any other cause.

activities of daily living are:
- bathing and showering
- dressing and undressing
- eating and drinking
- maintaining continence with a reasonable level of personal hygiene
- getting in and out of bed, a chair or wheelchair or moving from place to place by walking, wheelchair or walking aid.

Alzheimer's disease means dementia resulting in permanent failure of brain function with significant cognitive impairment due to no recognisable cause, confirmed by a neurologist. Significant cognitive impairment which is directly or indirectly caused by alcohol or drug abuse is excluded.

aplastic anaemia means bone marrow failure that results in anaemia, neutropenia and thrombocytopenia requiring treatment.

automatic acceptance level is the maximum cover that we will provide you in relation to a specific *member* without requiring medical or financial underwriting.

benign tumour of the brain or spinal cord means a non-cancerous tumour in the brain or spinal cord which:
- produces neurological damage and functional impairment which we consider is likely to be permanent; or
- requires surgery for its removal.

Neurological damage and functional impairment include but are not limited to: memory loss, impaired speech, weakness of limbs and visual field defects.

The following are excluded:
- cysts, granulomas and cerebral abscesses;
- malformations in, or of the arteries or veins of the brain;
- haematomas; or
- tumours in the pituitary gland unless it is sufficiently large that it requires open craniotomy to remove it, or in the opinion of a *specialist medical practitioner*, there is significant and permanent neurological damage such as visual field defects.

blindness means the total and permanent loss of sight in both eyes, whether aided or unaided, as a result of *sickness* or *injury.* This must be evidenced by:

(a) visual acuity less than 6/60 in both eyes after correction;

(b) a field of vision constricted to 20 degrees or less of arc; or
(c) a combination of visual defects resulting in the same degree of visual impairment as that occurring in a) or b)

burns means full thickness burns to at least:
- 20% of the body surface area;
- 25% of the face, requiring surgical debridement and/or grafting; or
- 50% of both hands, requiring surgical debridement and/or grafting.

cancer means the presence of one or more invasive malignant tumours, including melanomas, leukaemia, malignant bone marrow disorders, Hodgkin's lymphoma and malignant lymphomas, characterised by:

(a) the uncontrolled growth and spread of malignant cells; and
(b) the invasion and destruction of normal tissue, and must also:
    - require treatment (whether undertaken or not) that includes surgery, radiotherapy, chemotherapy, biological response modifiers or any other major treatment to arrest the spread of the malignancy and the treatment is the appropriate and necessary treatment; or
    - be totally incurable.

Prostate cancer is only covered if it:
- has a TNM classification of at least T2;
- has a Gleason score of 6 or more; or
- requires treatment, as stated above, to arrest the spread of malignancy; and this treatment has been undertaken.

The following cancers are excluded:
- Chronic Lymphocytic Leukaemia which is histologically described as Rai Stage 0;
- melanomas which are less than 1.5mm depth of invasion using the Breslow method, and less than Clark Level 3 and have no evidence of ulceration as determined by histological examination;
- all other types of skin cancers unless there is evidence of metastases;
- tumours which are histologically described as pre-malignant or show the malignant changes of 'carcinoma in situ' or Cervical Intraepithelial Neoplasia (CIN), unless resulting in radical surgery which involves the removal of the entire affected organ (which includes breast, cervix, uterus, vagina, prostate, colon/rectum, bladder).

The 'carcinoma in situ' or Cervical Intraepithelial Neoplasia (CIN) must be positively diagnosed by biopsy and be classified as Tis according to the TNM staging method or FIGO Stage 0.

cardiomyopathy means impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

chronic kidney (renal) failure means end stage renal failure presenting as chronic irreversible failure of the function of both kidneys, as a result of which regular renal dialysis is instituted or transplantation performed.

chronic liver failure means end stage liver failure with the following symptoms: permanent jaundice, ascites and encephalopathy.

chronic lung failure means end stage lung disease requiring permanent supplementary oxygen, with:
- FEV 1 test results of consistently less than 1 litre; or

- A *specialist medical practitioner* considers that as a result the *member* is permanently *unable to perform* any one of the five *activities of daily living*.

coma means a state of unconsciousness causing the *member* to be incapable of sensing or responding to external stimuli or internal need, resulting in a documented Glasgow Coma Scale of 6 or less, for a continuous period of at least 72 hours (3 consecutive days). Coma as a result of alcohol or drug abuse is excluded.

compulsory cover level means the cover level of a *member* as defined in the Policy Schedule.

coronary artery angioplasty – triple vessel means undergoing angioplasty (with or without insertion of a stent) to three or more coronary arteries within the same procedure to treat coronary artery disease.

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

coronary artery bypass surgery means bypass grafting performed to correct or treat coronary artery disease.

Creutzfeldt-Jakob disease (CJD) means the unequivocal diagnosis of CJD confirmed by a neurologist as permanent failure of brain function and resulting in significant cognitive impairment.

criminal activity means any crime for which a *member* is convicted and receives a jail sentence or a sentence of home detention.

deafness means the total and permanent loss of natural hearing in both ears.

dementia means permanent failure of brain function with significant cognitive impairment confirmed by a neurologist. Dementia directly related to alcohol or drug abuse is excluded.

disabled, disability or ***disablement*** means *totally disabled* or *partially disabled*.

encephalitis means the severe inflammatory disease of the brain (cerebral hemisphere, brainstem or cerebellum), resulting in neurological deficit causing either:
- the *member* to suffer at least 25% impairment of whole person function* that is permanent; or
- the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*.

* as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

extended cover means the cover available to former *members* on the terms set out at section 2.6.

heart attack means the death of heart muscle as a result of inadequate blood supply to the relevant area, confirmed by a cardiologist and evidenced by:
- typical rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference range,

PLUS one of the following:

(a) signs and symptoms of ischaemia which are consistent with myocardial infarction; or
(b) new serial ECG changes with the development of any one of the following:

- ST elevation or depression;
- T wave inversion;
- new left bundle branch block (LBBB);
- pathological Q waves; or

(c) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive, we will consider other appropriate and medically recognised tests.

Other acute coronary syndromes including but not limited to angina pectoris are excluded. A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease is also excluded unless the baseline value is normal and the elevation is greater than 10 times the 99th percentile of the upper reference.

heart surgery (open) means the undergoing of open heart surgery for treatment of a cardiac defect, cardiac aneurysm or benign cardiac tumour. Repair via catheter surgery, minimally invasive, 'keyhole' or similar techniques are specifically excluded.

HIV – medically acquired means *accidental* infection with the Human Immunodeficiency Virus (HIV) which we believe, on the balance of probabilities, arose from one of the following medically necessary events which must have occurred to the *member* as a result of medical treatment performed by a recognised and registered health professional:

- a blood transfusion;
- transfusion with blood products;
- organ transplant to the *member*;
- assisted reproductive techniques; or
- a medical procedure or operation performed by a doctor.

Notification and proof of the incident will be required via a statement from a district health board or equivalent statutory body that the infection was medically acquired. HIV infection transmitted, other than occupationally acquired as defined below, by any other means including sexual activity or recreational intravenous drug use is excluded.

HIV – occupationally acquired means infection with the Human Immunodeficiency Virus (HIV) where the HIV was acquired as a result of:

- an *accident* arising out of the *member*'s normal occupation; or
- a malicious act of another person or persons arising out of the *member*'s normal occupation; and
- sero-conversion to HIV occurs within six months of the *accident* or malicious act.

Any incident giving rise to a potential claim must:

- be reported to the relevant authority or employer within 30 days of the incident;
- be reported to us with proof of the incident within 30 days of the incident; and
- be supported by a negative HIV antibody test taken within seven days of the incident.

HIV infection transmitted, other than medically acquired, by any other means including sexual activity or recreational intravenous drug use is excluded.

injury means physical injury caused solely and directly by an *accident* while cover for the applicable benefit was in force under this policy.

intensive care means that a *sickness* or *injury* has resulted in the *member* requiring continuous mechanical ventilation by means of tracheal intubation for seven consecutive days (24 hours per day), in an authorised intensive care unit of a hospital at the recommendation of a *specialist medical practitioner*. *Sickness* or *injury* which is directly or indirectly caused by alcohol or drug intake, or self-inflicted means, is excluded.

loss of independent existence means a condition where the *member* is constantly and permanently *unable to perform* two or more of the *activities of daily living*, as a result of *sickness* or *injury*.

loss of limbs means the total and permanent loss of use of:

- both feet; or
- both hands;

as diagnosed by an occupational physician or neurologist.

loss of sight (one eye) and limb means the total and permanent loss of use of:

- one foot; or
- one hand; and
- sight in one eye whether aided or unaided (evidenced by visual acuity less than 6/60 in the eye after correction)

as diagnosed by an occupational physician, neurologist or ophthalmologist (as appropriate).

loss of speech means the total loss of speech both natural and assisted as a result of *sickness* or *injury* for a continuous period of at least three months and the subsequent diagnosis that loss of speech both natural and assisted will be total and permanent. Loss of speech related to any psychological cause is excluded.

major head trauma means that an *injury* to the head has caused either:

- the *member* to suffer at least 25% impairment of whole person function* that is permanent; or
- the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*.

* as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

major organ transplant means the placement on a recognised New Zealand or Australian Waiting List for, or the undergoing of, an organ transplant from a human donor of one or more of the following: kidney, heart, liver, lung, pancreas, small bowel and bone marrow. The transplantation of all other organs or parts of any organ or of any other tissue is excluded.

member means a person covered under this policy.

meningitis means the unequivocal diagnosis of meningitis where the condition is characterised by severe inflammation of the meninges of the brain, causing either:

- the *member* to suffer at least 25% impairment of whole person function* that is permanent; or
- the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*.

* as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

motor neurone disease means the unequivocal diagnosis of motor neurone disease by a *specialist medical practitioner*.

multiple sclerosis means a disease characterised by demyelination in the brain and spinal cord. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities causing either:

- the *member* to suffer at least 25% impairment of whole person function* that is permanent; or

- the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*; or
- being assigned a 7.5 or higher score on the Expanded Disability Status Scale (EDSS) by a consultant neurologist.

Neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging) evidence of lesions in the central nervous system, evoked visual responses, and evoked auditory responses are required to confirm unequivocal diagnosis.

* as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

muscular dystrophy means the unequivocal diagnosis of muscular dystrophy, where the condition causes either:

- the *member* to suffer at least 25% impairment of whole person function* that is permanent; or
- the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*.

* as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

out of hospital cardiac arrest means cardiac arrest that is due to cardiac asystole, or ventricular fibrillation with or without ventricular tachycardia, and:

- is not associated with any medical procedure; and
- is documented by an electrocardiogram; and
- occurs out of hospital.

paralysis means the total and permanent loss of use of one or more limbs resulting from spinal cord *injury* or disease, or from brain *injury* or disease.
Included in this definition are paraplegia, tetraplegia, quadriplegia, diplegia, and hemiplegia.

Parkinson's disease means the unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of the following: rigidity, tremor, akinesia, resulting in the degeneration of the nigrostriatal system causing either:

- the *member* to suffer at least 25% impairment of whole person function* that is permanent; or
- the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*.

* as defined in the current American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

peripheral neuropathy means irreversible loss of function of peripheral nerves diagnosed by a *specialist medical practitioner* causing the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*. Peripheral neuropathy related to alcohol or drug use is specifically excluded.

pneumonectomy means the undergoing of surgery to remove an entire lung. The treatment must be considered medically necessary by a *specialist medical practitioner*.

pulmonary hypertension means primary pulmonary hypertension associated with right ventricular enlargement established by medical investigations including cardiac catheterisation.

registered doctor is a medical doctor who is legally qualified and properly registered in either New Zealand or Australia. The doctor cannot be:

- the *member* or you; or
- a business partner of either you or the *member*; or
- an immediate family member related to either you or the *member.*

Asteron Life reserves the right to accept the advice of a medical practitioner practising outside New Zealand or Australia. Where reasonable, we may require that the *registered doctor* is a specialist in a field relevant to the *member*'s *sickness* or *injury*.

The medical practitioner must have qualifications equivalent to New Zealand or Australian standards.

repair or replacement of aorta means surgery to correct any narrowing, dissection, or aneurysm of the thoracic or abdominal aorta.

repair or replacement of valves means surgery to replace or repair a cardiac valve or valves as a consequence of heart valve defects or abnormalities. This includes minimally invasive surgery, keyhole and all percutaneous valve replacement or repair procedures.

severe peripheral vascular disease means severe restriction of blood flow through the arteries below the knee resulting in amputation of the leg below the knee or higher.

severe rheumatoid arthritis means the unequivocal diagnosis of severe rheumatoid arthritis by a *specialist medical practitioner*. The diagnosis must be supported by, and evidence, all of the following criteria:

(a) at least a six week history of severe rheumatoid arthritis, which involves three or more of the following joint areas:
   - proximal interphalangeal joints in the hands;
   - metacarpophalangeal joints in the hands; and
   - metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle;

(b) simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone);

(c) typical rheumatoid joint deformity; and

(d) at least two of the following criteria:
   - morning stiffness;
   - rheumatoid nodules;
   - erosions seen on x-ray imaging;
   - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis.

Degenerative osteoarthritis and all other arthridities are excluded.

sickness is an illness or disease the *member* suffers while cover for the applicable benefit was in force under this policy.

significant cognitive impairment means a permanent deterioration or loss of intellectual capacity that requires the *member* to be under continual care and supervision by someone else for at least four hours per day.Significant cognitive impairment which is directly or indirectly caused by alcohol or drug abuse is excluded.

specialist medical practitioner means a *registered doctor* who is a Member of Fellow of an appropriately recognised Specialist College, and who has Medical Council of New Zealand vocational registration in the specialty that directly relates to the medical condition experienced by the *member.*

stroke means the suffering of a stroke as a result of a cerebrovascular event. There must be clear evidence on a CT (Computed Tomography), MRI, or similar appropriate scan that a stroke has occurred and of either:

- Infarction of brain tissue; or
- Intracranial or subarachnoid haemorrhage.

Cerebral symptoms due to transient ischaemic attacks, migraine, and cerebral *injury* resulting from trauma or hypoxia and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

sum insured means the amount of cover stated or amount calculated using the formula stated in the Policy Schedule as the *sum insured*, as adjusted from time to time under this policy or by agreement between you and us.

systemic lupus erythematosus (SLE) with nephritis means the unequivocal diagnosis of SLE by a *specialist medical practitioner*, according to internationally accepted criteria including the American College of Rheumatology revised criteria for the classification of SLE.

The following criteria apply:

- A diagnosis of SLE in the clinical setting requires the presence of any four or more of the 11 criteria listed below. These are Malar rash, Discoid rash, Photosensitivity, Oral ulcers, Arthritis, Serositis, Renal disorder, Neurological disorder, Hematologic disorder, Immunologic disorder, Antinuclear antibody.
- In addition to the diagnosis of SLE, lupus nephritis must be confirmed by renal changes as measured by a renal biopsy, that it is grade 3 to 5 of the WHO classification of lupus nephritis, and be associated with persisting proteinuria (more than 2+).

systemic sclerosis means an unequivocal diagnosis of systemic sclerosis by a *specialist medical practitioner* causing the *member* to be constantly and permanently *unable to perform* one or more of the numbered *activities of daily living*.

TPD means Total and Permanent Disablement.

unable to perform means the *member* is unable to perform one or more of the numbered *activities of daily living* without the physical assistance of someone else. If the *member* can perform the activity on their own by using special equipment, we will not treat them as unable to perform that duty or activity.

usual occupation is the occupation in which the *member* was most recently engaged as their principal source of income from personal exertion in the 12 months immediately before becoming *disabled*.

voluntary cover is additional Death Benefits, Total and Permanent Disablement Benefits and Trauma Benefits that have been applied for in addition to the *members*' *compulsory cover levels. A*ny *voluntary cover* will be underwritten by us.