Flexible Lifetime® - Protection

If you want a benefit paid under the Life Protection Plan to form part of your superannuation and you choose AMP Superannuation Limited to be the owner of the plan, you must become a member of the AMP Superannuation Savings Trust.

Please read the following:

Flexible Lifetime - Protection Product Disclosure Statement - Part 2, Superannuation Fund Information

Issued: 3 June 2011

The Product Disclosure Statement for Flexible Lifetime - Protection is in two parts:

Part 1: the document entitled "Flexible Lifetime - Protection" issued 22 May 2010

Part 2: this document, Superannuation Fund Information

Part 1 includes information about obtaining insurance through super.

If you want a benefit paid under the Life Protection Plan to form part of your superannuation and you choose AMP Superannuation Limited to be the owner of the plan, you must become a member of the **AMP Superannuation Savings Trust**, not the AMP Personal Super Fund as currently referred to in Part 1. The AMP Personal Super Fund is no longer available.

All references in Part 1 to the AMP Personal Superannuation Fund are replaced with the AMP Superannuation Savings Trust.

All other information in Part 1 remains the same.

Flexible Lifetime - Protection Supplementary Product Disclosure Statement

Issued: 7 November 2011

This Supplementary Product Disclosure Statement (SPDS) is issued by AMP Life Limited ABN 84 079 300 379, AFS Licence No. 233671 (AMP Life). The superannuation product referred to in this document is issued by AMP Superannuation Limited ABN 31 008 414 104, AFS Licence No. 233060.

This SPDS contains important information and supplements the Flexible Lifetime - Protection Product Disclosure Statement issued on 22 May 2010 and the Superannuation Fund Information issued 3 June 2011 (PDS). You should read this SPDS together with all parts of the PDS.

Updates to Part 1 of the PDS

PDS page reference: Inside front cover
Instructions: The following is added:

The PDS for Flexible Lifetime - Protection is in two parts:

Part 1: this document, Flexible Lifetime - Protection

Part 2: the Superannuation Fund Information

PDS page reference: 7
PDS title reference: How much cover can you apply for?
Instructions: The following change applies to the content in the table, under the heading "TPD cover":

"$3 million*" is replaced with "$5 million*".

The following is added after the existing content:

Trauma cover

The minimum insured amount that you can currently apply for is $10,000. There is no minimum insured amount for Death cover or TPD cover.

PDS page reference: 9
PDS title reference: Additional benefits
Instructions: The following is added:

The Accommodation benefit is an in-built benefit and may be paid in addition to the above benefits. It is not available if the plan owner is the trustee of a self-managed or small APRA superannuation fund.

Accommodation benefit ✘ Super

PDS page reference: 12
PDS title reference: Additional benefits
Instructions: The following is added:

The Accommodation benefit is an in-built benefit and may be paid in addition to the above benefits. It is not available if the plan owner is the trustee of a self-managed or small APRA superannuation fund.

The Death benefit feature is an in-built feature.

Death benefit feature

Accommodation benefit ✘ Super

PDS page reference: 13
PDS title reference: Amount we pay
Instructions: The text in the lower right-hand box is replaced with the following:

The TPD benefit we pay is a lump sum equal to the TPD cover insured amount that applies on the date the insured person satisfies part 4, 5, 6 or 7 of the definition of "totally and permanently disabled" (as applicable).

PDS page reference: 14
PDS title reference: Totally and permanently disabled
Instructions: Part 3 is replaced with the following:

PART 3 HOME DUTIES

The insured person is totally and permanently disabled if:
- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in their home duties for at least 3 months in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in their home duties; or any occupation for which they are reasonably fitted by education, training or experience. (Home duties is defined on page 74).

The insured person must also survive 3 months. Upon admittance of your claim, we will refund any premiums falling due during the survival period, that have been paid for the insured person.

Add Part 7 to the table:

PART 7 DAY 1 TPD

If you meet the definition in Part 1a, 1b, 2 or 3 as a result of one of the defined listed medical conditions, we will waive the 3 month qualifying period and the 3 month survival period, however the insured person must survive for 14 days.

The listed medical conditions are:
- Alzheimer's disease and other dementias,
- blindness,
- cardiomyopathy,
- paralysis - diplegia,
- paralysis - hemiplegia,
- paralysis - paraplegia,
- paralysis - quadriplegia,
- paralysis - tetraplegia,
- loss of hearing,
- loss of speech,
- lung failure,
- major head trauma,
- motor neurone disease,
- multiple sclerosis,
- muscular dystrophy,
- Parkinson's disease (advanced),
- primary pulmonary hypertension,
- severe rheumatoid arthritis.

Each of the listed medical conditions are defined in the Trauma definitions section from page 67.

PDS page reference: 17
PDS title reference: Additional benefits
Instructions: The following is added:

The Accommodation benefit is an in-built benefit and may be paid in addition to the above benefits. It is not available if the plan owner is the trustee of a self-managed or small APRA superannuation fund.

The Death benefit feature is an in-built feature.

Death benefit feature

Accommodation benefit

PDS page reference: 18
PDS title reference: Conditions covered
Instructions: The first bullet point is deleted and replaced with the following:

- Trauma cover Optimum covers 50 trauma conditions and medical procedures (see page 19), and

PDS page reference: 19
PDS title reference: Trauma cover Optimum
Instructions: The following is added to the list of trauma conditions and medical procedures in the left column of the table:

- Diabetes.

The following is added to the list of trauma conditions and medical procedures in the right column of the table:

- Bacterial meningitis and meningococcal disease.

PDS page reference: 21
PDS title reference: Partials package option
Instructions: The paragraph before the table is replaced with the following:

Cover for Partial blindness and Loss of use of one limb commences immediately. However, cover for the other trauma conditions and medical procedures is delayed for 3 months (see page 20).

Instructions: The following are added to the list of trauma conditions and medical procedures in the table:

- Carcinoma in situ of penis
- Carcinoma in situ of perineum
- Type 1 Diabetes
- Loss of use of one limb

Instructions: The paragraph under the table of trauma conditions and medical procedures is replaced with the following:

We may pay more than once under the Partials package option, although:
- we only pay more than once for Coronary Artery Angioplasty where the procedure is at least 6 months after the previous Coronary Artery Angioplasty procedure, and
- otherwise, we will not pay more than once for a specific trauma condition or medical procedure.

The maximum amount we pay for Coronary artery angioplasty is 25% of the Trauma cover insured amount (up to a maximum of $50,000) per procedure.

PDS page reference: 24
PDS title reference: Guaranteed future insurability feature
Instructions: The following are inserted in the first set of bullet points:

- the insured person increases their financial interest in a business for which they are a working partner or a working director, and the Life Protection Plan forms part of a buy/sell, share protection or business succession agreement

– where the insured person is a key person in a business, the business owns the plan, which was written for the purpose of key person protection, and their value as a key person to that business increases
– the insured person takes out or increases a loan secured over the business for which the insured person is the primary guarantor and the Life Protection Plan was written for loan protection.

Instructions: The paragraph above the second set of bullet points is replaced with:

You may increase the insured amount by 25% (up to a maximum of $250,000). Premiums will be based on our premium rates, and the insured person's age, applicable at the time of exercising this feature.

PDS page reference: 24
PDS title reference: Guaranteed future insurability feature - when you can not take out this feature
Instructions: The second bullet point is deleted and replaced with the following:

– the insured person's cover has more than one exclusion or a premium loading of more than 50% or any other special terms,

PDS page reference: 25
Instructions: The following is added:

Accommodation benefit

(Accommodation benefit does not apply if cover is provided through the AMP Superannuation Savings Trust).

We pay the Accommodation benefit to reimburse the reasonable accommodation expenses, once receipts are provided, of an immediate family member of the insured person who accompanies the insured person if the insured person:
– is eligible to claim a benefit under the Terminal Illness benefit, TPD benefit, TPD Partial benefit, Trauma benefit or Children's Trauma benefit option; and
– is bedridden; and
  – became totally disabled, and remains, over 100km away from their usual residence, or
  – the insured person needs to travel more than 100km from home for medical treatment, and
– requires an immediate family member to be with them.

We pay up to $250 per day for a maximum of 14 days.

This benefit is only payable once for each insured person under the Life Protection Plan and must be claimed within 6 weeks of the Terminal Illness, TPD or Trauma claim being paid.

PDS page reference: 25
Instructions: The following is added:

Death benefit feature

This is an in-built feature of the Life Protection Plan with TPD or Trauma cover. This feature is only available if the insured person is not being provided with Death cover under this plan or any other plan where AMP Life is the insurer.

We pay under this Death benefit feature if the insured person dies while this plan is in force. We will pay $10,000 (or the TPD cover or Trauma cover sum insured if it is lower than $10,000) to you or the nominated beneficiary.

We will only pay once on the death of an insured person across all plans with AMP for that insured person. This feature must be claimed within 12 months of death.

This benefit is not payable if the insured person dies by their own hand within 13 months of the commencement or reinstatement of the Life Protection plan, or if the insured person has made a claim under the Terminal Illness benefit, TPD cover or Trauma cover.

PDS page reference: 26 and 27
PDS title reference: Children's Trauma cover option
Instructions: The content is deleted in its entirety and is replaced with the following:

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person.

When we pay

We pay you a benefit under the Children's Trauma cover option if the insured person:
– suffers a listed trauma condition or undergoes a listed medical procedure, and
– survives for 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure.

We also pay a benefit under the Children's Trauma cover option if the insured person dies or is terminally ill.

Terminally Ill means:
– the insured person's doctor tells us in writing that they believe that the insured person has less than 12 months to live, and
– the doctor's prognosis is based on clinical findings and reports, and
– we agree with the doctor's prognosis.

We may also require you to give us information from medical advisers we choose.

The trauma conditions and medical procedures covered under Children's Trauma cover are set out in the table on page 5.

Cover for the trauma conditions in the right-hand column of the table is available to all insured persons and is delayed for 3 months (as set out on page 20 of the PDS under the heading "Delayed cover for some trauma conditions and medical procedures").

Amount we pay

The amount we pay under the Children's Trauma cover option is:

- $100,000 (plus any increases under the Indexation Feature) if the insured person suffers a listed trauma condition or undergoes a listed medical procedure and survives 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure, or
- $25,000 if the insured person dies or is terminally Ill.

CHILDREN'S TRAUMA COVER OPTION COVERS THE FOLLOWING TRAUMA CONDITIONS AND MEDICAL PROCEDURES	
COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN START IMMEDIATELY	COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN IS DELAYED FOR 3 MONTHS (AS SET OUT ON PAGE 20 OF THE PDS)
Benign tumour of the brain or spinal cord Blindness Coma Intensive care Kidney failure Loss of hearing Loss of speech Loss of use of limbs and/ or sight Major head trauma Major organ transplant Paralysis that is one of: Diplegia Hemiplegia Paraplegia Quadriplegia Tetraplegia Peripheral blood stem cell or bone marrow transplant Severe burns	Aplastic anaemia Bacterial meningitis and meningococcal disease Cancer Cardiomyopathy Leukaemia Stroke Subacute sclerosing panencephalitis Viral encephalitis

When we won't pay

We will not pay for a trauma condition or medical procedure for an insured person if:

- the insured person's trauma condition is caused directly or indirectly by, or the medical procedure is required directly or indirectly because of, any congenital condition, or
- the insured person's trauma condition or death is caused directly or indirectly by, or the medical procedure is required directly or indirectly because of:
  - alcohol or drugs, or
  - anybody who is connected to the insured person, or to either of their parents, or to a de facto spouse of either parent.

When Children's Trauma cover option ends

Cover for an insured person under the Children's Trauma cover option ends when one of the following happens:

- the first plan anniversary after the insured person's 16th birthday (see "Conversion to Death cover" below)
- the insured person dies
- we receive your written request to cancel the Children's Trauma cover option for the insured person
- a benefit under the Children's Trauma cover option becomes payable for the insured person
- all cover for the last insured person under the Life Protection Plan (other than an insured person under this option) ends, or
- your Life Protection Plan ends (see page 28).

Conversion to Death cover

If cover for an insured person under the Children's Trauma cover option has not ended earlier, on the first plan anniversary after the insured person's 16th birthday, cover under the Children's Trauma cover option ends and automatically converts to Death cover. The Death cover insured amount at that time will be $100,000 (plus any increases under the Indexation feature).

PDS page reference: 32
PDS title reference: Contribution limits
Instructions: The second row in the table is replaced with the following:

2009-2010, 2010- 2011 and 2011-2012 financial years	$25,000 This amount will be indexed annually from 2012-2013 onwards to average weekly ordinary time earnings (AWOTE) and rounded down to the nearest multiple of $5,000.	$50,000	$150,000

PDS page reference: 32
PDS title reference: Tax on death claims
Instructions: The second paragraph is deleted and replaced with the following:

Where Death benefit lump sums are paid to a person who is not a tax dependant they are generally taxed at a rate of up to 15% (30% in certain circumstances) plus a Flood levy of up to 1%, plus the Medicare levy.

PDS page reference: 41
PDS title reference: Total Disability benefit - When we pay
Instructions: The following replaces the 2 bullet points in this section:

We pay the Total Disability benefit if the insured person is totally disabled and has satisfied these conditions.

ADVANCED PLAN (WHITE COLLAR OCCUPATION)	ADVANCED PLAN (OTHER THAN WHITE COLLAR OCCUPATIONS), STANDARD PLAN AND BASIC PLAN
– The insured person is totally or partially disabled for the whole waiting period, and – unless the insured person has suffered a relapse (see page 48), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.	– The insured person is totally disabled for at least 7 consecutive days during the waiting period (and totally disabled or partially disabled for the remainder of the waiting period), and – unless the insured person has suffered a relapse (see page 48), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Total Disability benefit monthly in arrears.

PDS page reference: 42
PDS title reference: Amount we pay
Instructions: The final paragraph is deleted.

PDS page reference: 43
PDS title reference: Trauma feature
Instructions: The following are added to the list of trauma conditions and medical procedures covered under the Trauma feature:

– Cardiomyopathy
– Coronary artery angioplasty - triple vessel
– Hepatitis B or C - occupationally acquired
– HIV/AIDS - medically acquired
– HIV/AIDS - occupationally acquired
– Pneumonectomy
– Primary pulmonary hypertension

PDS page reference: 44
PDS title reference: Major Fracture or Loss feature
Instructions: The following are added to the list of fractures covered under this feature:

WE COVER FRACTURE OF:	PAYMENT PERIOD (MONTHS)
The skull (not bones of the nose or face)	2
The jaw	1

PDS page reference: 47
PDS title reference: Guaranteed future insurability feature
Instructions: The second paragraph is replaced with the following:

You may increase the maximum monthly benefit by up to 10% (to a maximum of $1,500 each year across all AMP Income Protection Plans). This increase is in addition to any increase to the maximum monthly benefit under the Indexation feature. Premiums will be based on the premium rates applicable at the time of exercising this feature.

PDS page reference: 48
PDS title reference: Change of employer feature
Instructions: The information under this heading is deleted and replaced with the following:

You can shorten the waiting period if the insured person changes employer:
– If the waiting period is 13 weeks or less, you can move to the next shortest waiting period, without providing evidence of the insured person's health, pastimes or occupation.
– If you have a 104 week waiting period, and the insured person's superannuation plan with a 2 year benefit period was cancelled, you can shorten your waiting period to 13, 26 or 52 weeks within 60 days of that superannuation cover ending.

You can only apply to shorten your waiting period once in any 12 month period.

You can't shorten the waiting period while we are paying a benefit under the Income Protection Plan (or during the waiting period). If you shorten the waiting period, the premium will increase.

When you ask us to shorten the waiting period, you need to provide us proof that the insured person has changed employer and that their superannuation cover has ended (if applicable). Usually, all we need is a letter from the insured person's new employer and a superannuation exit statement.

PDS page reference: 59
PDS title reference: What is the premium?
Instructions: The table is deleted and replaced with the following:

2011 PLAN FEES		
Life Protection Plan	$83.35 pa for the first insured person	$16.65 pa for any subsequent insured person(s)
Income Protection Plan	$83.35 pa	$16.65 pa for any other Income Protection Plan or Business Overheads Insurance Plan taken out at the same time to cover the same insured person
Business Overheads Insurance Plan	$83.35 pa	

PDS page reference: 67
PDS title reference: Bacterial meningitis
Instructions: The title is changed to "Bacterial meningitis and meningococcal disease". The definition is deleted and replaced with the following:

The insured person suffers bacterial meningitis or meningococcal septicaemia. The meningitis or septicaemia must produce neurological deficit causing permanent and significant functional impairment or the inability to perform any one of the activities of daily living without assistance from someone else.

PDS page reference: 67
PDS title reference: Benign tumour of the brain or spinal cord
Instructions: The definition is deleted and replaced with the following:

The insured person has a non-cancerous tumour in the brain or spinal cord which is histologically described and which produces neurological deficit:
- causing permanent and significant functional impairment, or
- resulting in the inability to perform any one of the activities of daily living without assistance from someone else, or
- requiring surgery for its removal.

We don't cover any of the following:
- cysts, granulomas and cerebral abscesses, or
- malformations in, or of, the arteries or veins of the brain, or
- haematomas, or
- tumours in the pituitary gland.

PDS page reference: 67
PDS title reference: Cancer
Instructions: The definition is deleted and replaced with the following:

WE WILL PAY	PAYMENT CONDITIONS	WE WON'T PAY

If an insured person suffers from a malignant tumour. This includes:
– a malignant sarcoma,
– Hodgkin's lymphoma,
– non-Hodgkin's lymphoma,
– a malignant bone marrow disorder,
– leukaemia, including:
  – acute leukaemia,
  – chronic myelocytic leukaemia,
  – chronic lymphocytic leukaemia where classified as Binet Stage B and C or Rai Stage I, II or III,
– thrombocythemia,
– polycythemia vera,
– Melanoma where the thickness is 1.5mm or more or the Clark level of invasion is Level 3, or where the melanoma is showing signs of ulceration
– a prostate tumour that is histologically described as having:
  – a TNM Classification of T2, or
  – a TNM Classification of T1 (or any equivalent classification) with a Gleason score of 6 or more, or
  – a TNM Classification of T1 where removal of the entire prostate or radiotherapy is recommended, specifically to arrest the spread of malignancy, and the procedure is the appropriate and necessary treatment,
– tumours which are histologically described as pre-malignant or showing malignant changes of "carcinoma in situ" requiring treatment similar in extent to that which would be undertaken for invasive carcinoma.#
	The cancer must be: Confirmed by pathology tests, and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.	For skin cancers other than melanoma.

Treatment in this instance is defined as surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy).

PDS page reference: 68
Instructions: The following is added:

Carcinoma in situ of penis

The insured person suffers carcinoma in situ of the penis, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of perineum

The insured person suffers carcinoma in situ of the perineum, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Diabetes

The insured person is diagnosed with diabetes by an appropriate consultant medical specialist resulting in at least two of the following:

- severe diabetic retinopathy resulting in visual acuity (corrected or uncorrected) of 6/36 or worse in both eyes,
- severe diabetic neuropathy causing motor and/or autonomic impairment,
- diabetic gangrene leading to surgical intervention,
- severe diabetic nephropathy causing chronic irreversible kidney impairment and requiring regular dialysis or kidney treatment.

PDS page reference: 68
PDS title reference: Cardiomyopathy
Instructions: The definition is deleted and replaced with the following:

The insured person's heart muscle fails to function properly resulting in permanent physical impairment to at least Class 3 of the New York Heart Association Classification of Cardiac Impairment.

PDS page reference: 68
PDS title reference: Coma
Instructions: The definition is deleted and replaced with the following:

The insured person is in a state of unconsciousness and doesn't react to external stimuli. The state of unconsciousness must be continuous for at least 72 hours.

PDS page reference: 70
PDS title reference: Liver failure
Instructions: The definition is deleted and replaced with the following:

The insured person suffers irreversible failure of the liver resulting in permanent jaundice, ascites and/or encephalopathy.

PDS page reference: 70
Instructions: The following is added:

Loss of use of one limb

The insured person, because of irreversible functional impairment on either a neurological or musculoskeletal basis, totally and permanently loses the use of one foot or one hand.

PDS page reference: 70
PDS title reference: Major head trauma
Instructions: The definition is deleted and replaced with the following:

The insured person suffers an accidental head injury which produces neurological deficit:

- causing the inability to perform any one of the activities of daily living without assistance from someone else, or
- causing significant functional impairment,

which in the opinion of an appropriate consultant medical specialist, is likely to be permanent.

PDS page reference: 71
PDS title reference: Multiple sclerosis
Instructions: The definition is deleted and replaced with the following:

The insured person receives an unequivocal diagnosis of multiple sclerosis with more than one episode of well defined neurological deficit with persisting neurological abnormalities by an appropriate consultant medical specialist.

PDS page reference: 72
PDS title reference: Prostate cancer
Instructions: The definition is deleted and replaced with the following:

The insured person is diagnosed as having a prostate tumour equivalent to TNM classification T1 and a Gleason score of 5 or less. The tumour must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.

PDS page reference: 72
PDS title reference: Severe burns
Instructions: The definition is deleted and replaced with the following:

The insured person suffers burns classified as deep dermal thickness or full thickness, to 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart. The burns can be caused by thermal, electrical or chemical agents. The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and legs (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area. We will also pay if the insured person suffers full thickness burns to 50% of both hands or 50% of the face where grafting is required.

PDS page reference: 72
PDS title reference: Severe rheumatoid arthritis
Instructions: The definition is deleted and replaced with the following:

The insured person is diagnosed as having severe rheumatoid arthritis, by an appropriate consultant medical specialist who has confirmed all of the following complications occurred as a direct result of the rheumatoid arthritis:

- at least a 6 week history of severe rheumatoid arthritis which involves 3 or more of the following joint areas:
  - proximal interphalangeal joints in the hands,
  - metacarpophalangeal joints in the hands,
  - metatarsophalangeal joints in the foot, wrist, elbow, knee or ankle,
- simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone)
- typical rheumatoid joint deformity, and
- at least 2 of the following criteria:
  - morning stiffness,
  - rheumatoid nodules,
  - erosions seen on x-ray imaging,
  - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis.

We won't pay for any other form of arthritis.

PDS page reference: 73
Instructions: The following is added:

Type 1 Diabetes

The insured person is diagnosed with Type 1 insulin dependent diabetes mellitus (IDDM) for the first time after the age of 30 by an appropriate consultant medical specialist.

PDS page reference: Interim Accident cover - Certificate
Instructions: The Certificate is replaced in its entirety by the following:

Interim cover - Certificate

About Interim cover

While your application is being considered, we will provide you with Interim cover at no extra cost.

This cover is different to the insurance being applied for and is subject to the terms and conditions set out below.

Interim cover is not available if either you or the insured person:

- have withdrawn an application, or
- have applied for a similar type of plan, and had the application declined or deferred, or
- are currently applying for similar cover outside of AMP, or
- are applying for this cover to replace an existing plan.

Any special terms that we would apply under our underwriting rules to the cover you apply for, will also apply to this Interim cover.

The term "accident" as used in this certificate, means bodily injury caused directly and solely by violent, external and visible means and independent of all other causes.

When cover starts

This cover will start when we receive your completed application and personal statement and either the first premium payment or valid direct debit details at an AMP registered office.

Cover is subject to the premium payment not being dishonoured.

This certificate is for you to keep. It explains the terms and conditions of Interim cover.

When we will pay

If you applied for Death cover

We will pay if you have applied for Death cover for an insured person, and they die during the Interim cover period.

If you applied for TPD cover

We will pay if you have applied for TPD cover for an insured person, and solely as a result of an accident during the Interim cover period, they suffer from the total and irrecoverable loss of:

- the use of 2 limbs, or
- the sight of both eyes, or
- the use of one limb and the sight of one eye,

where a limb means the whole hand below the wrist or the whole foot below the ankle.

The loss must be unable to be remedied and the insured person must survive at least 14 days after the loss.

If you applied for Trauma cover

We will pay if you have applied for Trauma cover for an insured person, and they suffer one of the following trauma conditions or undergoes one of the following medical procedures during the Interim cover period, solely as a result of an accident:

- blindness*
- coma*
- diplegia
- hemiplegia
- intensive care*
- loss of independent living*
- major head trauma*
- paraplegia
- quadriplegia
- severe burns*
- tetraplegia.

* If you applied for Trauma cover Standard these conditions are not covered under that plan and not covered under Interim cover.

The definitions of the above trauma conditions and medical procedures are set out on pages 67 to 73.

If you applied for an Income Protection Plan

We will pay if you have applied for an Income Protection Plan for an insured person, and they become totally disabled during the Interim cover period. The total disability must be caused by an injury which occurs after Interim cover starts, or by an illness which is contracted and/or commences more than 30 days after the Interim cover starts.

This benefit is paid monthly while the insured person is totally disabled, starting from the end of the waiting period selected, for a maximum of 12 months.

If you applied for a Business Overheads Insurance plan

We will pay if you have applied for Business Overheads Insurance Plan for an insured person and they become totally disabled solely as a result of an accident occurring during the Interim cover period.

This benefit is paid monthly while the insured person is totally disabled, starting from the end of the waiting period selected, for a maximum of 6 months.

How much we pay

We will only pay once for Interim cover for Life Protection Plans with Death cover, TPD cover or Trauma cover.

For Death cover under a Life Protection Plan

We will pay you a lump sum under Death cover under a Life Protection Plan.

We will pay the lesser of:

- $1,000,000, or
- the insured amount applied for.

For TPD cover and/or Trauma cover under a Life Protection Plan

We will pay you a lump sum under TPD cover and/or Trauma cover under a Life Protection Plan.

We will pay the lesser of:

- $600,000, or
- the insured amount applied for.

For Income Protection Plan

We will pay you monthly benefits for a maximum of 12 months for Interim cover under Income Protection Plans.

We will pay the lesser of:

- $10,000 per month, or
- the maximum monthly benefit applied for.

The amount we pay may be reduced by Benefit Offsets (see page 49).

For Business Overheads Insurance Plans

We will pay you monthly benefits for a maximum of 6 months for Interim cover under Business Overheads Insurance Plans.

We will pay the lowest of:

- $5,000 per month, or
- the maximum monthly benefit applied for, or
- the insured person's share of the allowable business expenses actually incurred during the period for which they are totally disabled.

The amount we pay may be reduced by Benefit Offsets (see page 58).

When cover stops

Interim cover ceases when one of the following happens:

- 90 days from the date this Interim cover starts, or
- the date your application is approved, declined, deferred or withdrawn, or
- the date we advise that your Interim cover is cancelled.

When we won't pay

We will not pay for intentional or self-inflicted injury or death.

We will not pay where, under our underwriting rules, we would have declined or deferred the insurance applied for.

We will not pay where eligibility for the Interim cover claim is caused by:

- any pre-existing medical condition you or the insured person were aware of at the time of applying for this cover, or
- engaging in any sport, pastime or occupation which would not normally be covered under our standard underwriting rules.

Contact your adviser or financial planner

Need more information?

Everyone has different financial needs. To find the best solution, you may need professional financial advice. Talk to your financial planner or phone AMP on **133 888**.

AMP Life Limited
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NS7407 10/11

Insurance that secures your tomorrow by protecting what you have today

PRODUCT DISCLOSURE STATEMENT
ISSUED 22 MAY 2010

About AMP

AMP first started offering life insurance in 1849. We started selling policies door-to-door, crossing Australia and New Zealand by horse, bicycle and even camel.

Over 160 years later, we have grown to become one of Australia's leading insurance and wealth management groups, with more than 3.4 million customers and 3,900 employees in Australia and New Zealand.

AMP continues to change and evolve with time. It has transformed to meet the needs of the people it touches and to be "a sure friend in uncertain times".

Today one in six Australians trust AMP to manage their financial wellbeing, so they can enjoy the future they want. When you think about it, this is at least one person at every Sunday barbecue.

We understand that insurance is all about peace of mind and are committed to being a financially responsible insurer. We want to make sure our customers are looked after should the unthinkable happen to them.

AMP strives to provide insurance that secures your tomorrow by protecting what you have today.

The issuers

The insurance products referred to in this document are issued by AMP Life Limited ABN 84 079 300 379, AFS Licence No. 233671 (AMP Life). The superannuation product referred to in this document (see page 7) is issued by AMP Superannuation Limited ABN 31 008 414 104, AFS Licence No. 233060 (Trustee).

AMP Life and the Trustee are the joint issuers of this Product Disclosure Statement. Each issuer takes full responsibility for the whole of this document. However, an issuer is not responsible for the products issued by the other issuer.

No other company in the AMP Group guarantees the performance of AMP Life's or the Trustee's obligations to customers or assumes any liability to customers in connection with the products.

The meaning of words used in this document

Throughout this document:

- *AMP Life, we, us* and *our* means AMP Life Limited, and
- *you, your* and *yourself* means the plan owner (or, where cover is taken out through the AMP Personal Superannuation Fund, the insured person, except that any benefit payment will be made by AMP Life to the Trustee).

We use other terms that have specific meanings. These words and their meanings are set out in the dictionary on page 67 to 75.

Contents

Changes to the information in this document

As the information in this document may change from time to time, you can obtain updated information simply by visiting www.amp.com.au/pdsupdates or by calling us on 133 888 to request a free paper copy of the updated information. If the change to the information is materially adverse, we will issue a Supplementary Product Disclosure Statement.

About Flexible Lifetime - Protection

Flexible Lifetime - Protection offers a range of plans that can be tailored to meet your personal insurance needs. This summary will help you understand the types of insurance cover offered and what solution they offer if you need to make a claim.

Life Protection Plan see page 7

There are 3 types of cover available under the Life Protection Plan: Death cover, Total and Permanent Disablement (TPD) cover and Trauma cover.

You can apply for one or more of the covers under one plan. You can apply for the Children's Trauma cover option (see page 26). Death cover and TPD cover are also available through the AMP Personal Super Fund.

TYPE OF COVER	WHY DO I NEED IT?	KEY BENEFITS PAYABLE
Death cover	You may want take out Death cover to ensure that, if you die your mortgage and other debts are paid off and your spouse and children are provided with the income they need to continue their lifestyle.	A lump sum is payable if the insured person dies. We will advance the Death cover insured amount if the insured person is diagnosed as being terminally ill.
Total and Permanent Disablement (TPD) cover	Money is the last thing you would want to think about when faced with a life long disability. An emotional strain can be placed on a family to provide support to someone who may need full-time care together with never being able to work again.	A lump sum is payable if the insured person becomes totally and permanently disabled.
Trauma cover	Nobody likes to think about the possibility of suffering a serious illness or injury in the future. You can't foresee this happening, but you can make plans to help support yourself should the unexpected happen. Trauma cover can help you make the adjustments to your lifestyle that you may either want, or need, to make after suffering a serious illness or injury.	A lump sum is payable if the insured person suffers a specified trauma condition, or undergoes a specified medical procedure, and survives 14 days.

Income Protection Plan see page 35

TYPE OF COVER	WHY DO I NEED IT?	KEY BENEFITS PAYABLE
Income Protection	Income protection can help you continue paying your day-to-day living expenses while you are too ill or injured to go to work.	Monthly benefit payable while the insured person is totally or partially disabled due to an illness or injury.

Business Overheads Insurance Plan see page 51

TYPE OF COVER	WHY DO I NEED IT?	KEY BENEFITS PAYABLE
Business Overheads Insurance	Business Overheads Insurance can help keep your business going while you are too ill or injured to go to work.	Reimbursement of eligible business expenses while the insured person is totally or partially disabled due to an illness or injury.

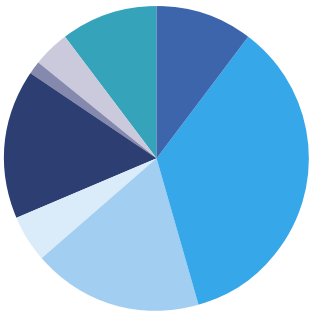
The above gives you a general idea about what each cover is designed to do. However, it is important that you read on so that you understand all of the terms and conditions of the cover.

As Flexible Lifetime - Protection is not a savings product, if you end a plan at any time after the 28 day money back guarantee period (see page 5), you won't receive any money back (except in the limited circumstances set out on page 61 - Refund of premiums). Your plan does not entitle you to share in any profits of AMP Life.

Types of claims paid by AMP in 2009

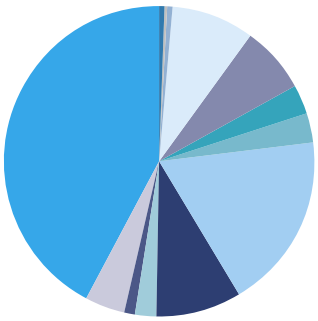
Death claims

- Accidents 10.31%
- Cancer 35.43%
- Cardiovascular 18.01%
- Cerebral Vascular 5.09%
- Natural causes 15.76%
- Neurological 1.3%
- Respiratory conditions 3.91%
- Suicide 10.19%



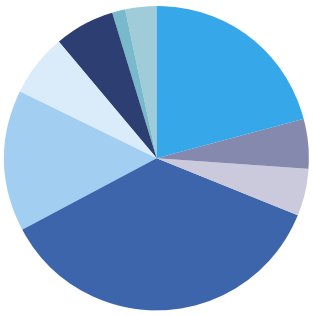
Total and Permanent Disablement claims

- Breast Cancer 0.71%
- Bowel Cancer 0.24%
- Prostate Cancer 0.47%
- Other Cancers 8.71%
- Central Nervous System 7.06%
- Heart Attack 3.06%
- Stroke 3.05%
- Heart Disease 18.35%
- Mental Illness 8.71%
- Musculoskeletal System 2.35%
- Respiratory Conditions 0.94%
- Motor Vehicle Accidents 4.24%
- Other 42.11%



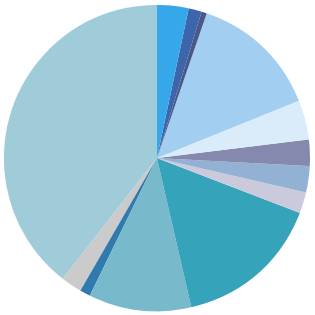
Trauma claims

- Breast Cancers 20.92%
- Bowel Cancer 5.23%
- Prostate Cancer 5.23%
- Other Cancers 35.95%
- Heart Attack 15.03%
- Stroke 6.54%
- Heart disease 6.54%
- Parkinson's Disease 1.31%
- Other 3.25%



Income Protection and Business Overheads Insurance claims

- Breast Cancer 3.59%
- Bowel Cancer 1.15%
- Prostate Cancer 0.63%
- Other Cancers 13.62%
- Central Nervous System 4.14%
- Heart Attack 2.88%
- Stroke 2.79%
- Heart Disease 2.29%
- Mental Illness 15.44%
- Musculoskeletal System 10.86%
- Respiratory Conditions 1.07%
- Motor Vehicle Accidents 2.28%
- Other 39.26%



The 5 steps in applying for Flexible Lifetime - Protection

<table>
<tr><td>Step 1
Making an informed decision</td><td colspan="3">This document sets out important information that you should know about Flexible Lifetime - Protection, including the benefits, features and options available under each plan. You should consider this document before applying for a plan.

The information in this document doesn't take into account your personal objectives, financial situation and needs. We encourage you to speak with your financial planner to help you decide which plan, and which insurance options within a plan, are suited to your circumstances and needs.

If you are applying for cover as the trustee of a Self-Managed Superannuation Fund, you should be aware of some important information which is set out on page 34.</td></tr>
<tr><td>Step 2
Finding out how much your insurance will cost</td><td colspan="3">You can obtain an individual premium quote from your financial planner or by calling AMP on 1300 360 838.</td></tr>
<tr><td rowspan="2">Step 3
Completing your application for insurance</td><td colspan="3">To apply for insurance we require you to complete an application. We also require a personal statement for each insured person. Before you apply for cover, it is important that you understand your duty of disclosure (see page 66).

We provide the following flexible options for you to complete the application and personal statement:</td></tr>
<tr><td>Paper

An application form and a personal statement are included at the back of this document. You can complete them in writing and send them to us.</td><td>Telephone

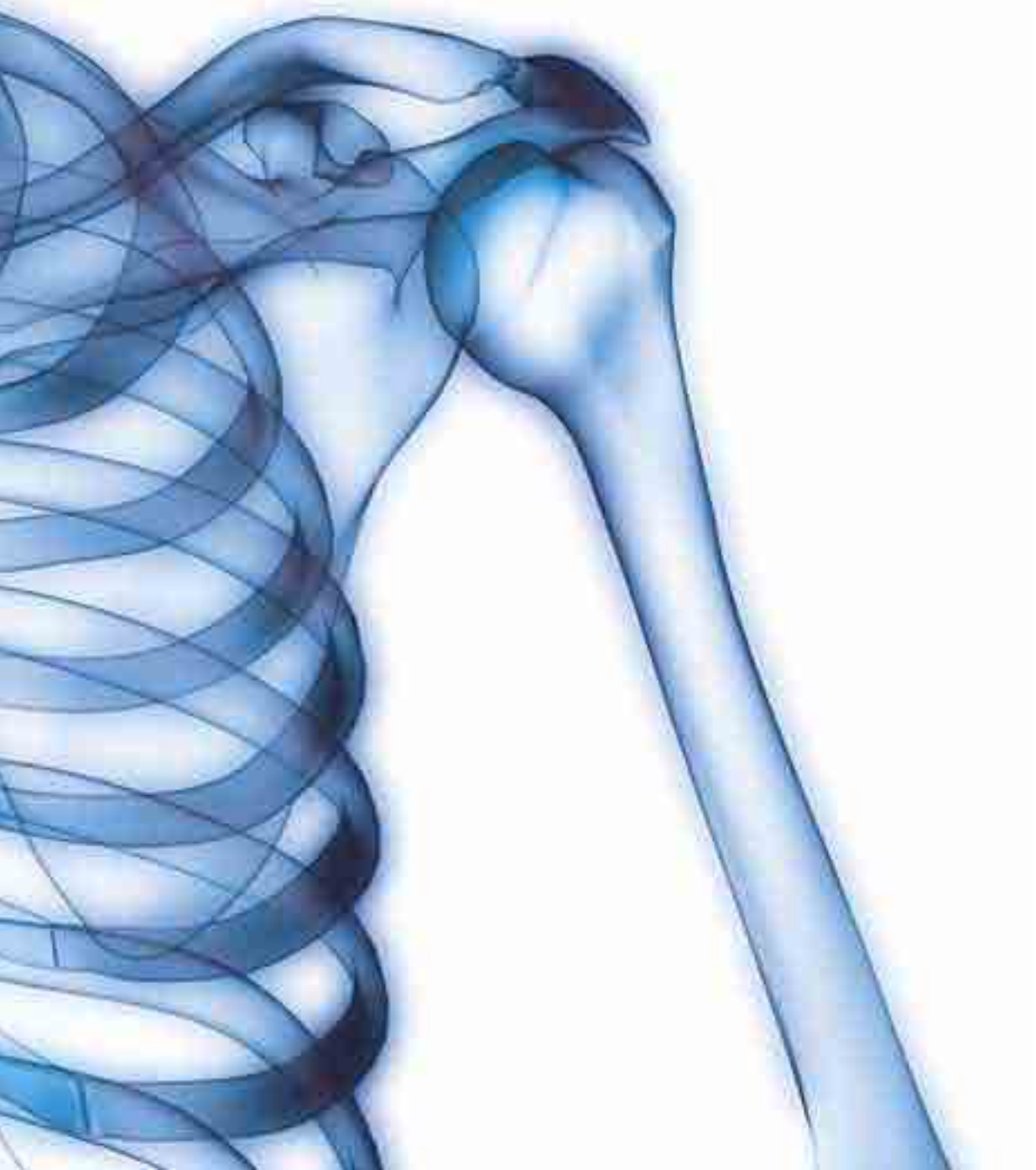
Your financial planner can lodge your application and arrange for AMP to call so that you can complete your personal statement over the phone at a time convenient to you.</td><td>Electronic

You can complete and lodge your application and personal statement electronically with your financial planner.</td></tr>
<tr><td>Step 4
The underwriting process</td><td colspan="3">The process of underwriting takes place after you have submitted your application. Underwriting ensures that everyone insured with AMP pays an appropriate premium. To properly assess your application AMP may obtain information from a range of sources such as your doctor or may require you to have a medical examination or blood tests. In some cases we may offer insurance that is different to what you applied for.

Interim Accident cover while we assess your application. In most cases, we provide you with Interim Accident cover at no extra cost, while your application is being assessed (see page 77).</td></tr>
<tr><td>Step 5
Your certificate of insurance</td><td colspan="3">If we agree to issue a plan, we will issue a certificate of insurance. The certificate of insurance is the contract of insurance between you and us. This document will set out the insured persons, the type of cover for each insured person, the insured amounts, the options selected and other important information about the plan.</td></tr>
</table>

Our commitment to you

Know exactly what you're getting	We have included the plan rules in this document so that you know the exact terms of the insurance before you apply.
28 day money back guarantee	If we accept your application for insurance cover, we will send you a certificate of insurance. You have 28 days to check that the insurance meets your needs. If it doesn't, simply write to us requesting that your plan be cancelled and return the certificate of insurance. Your premium will be refunded in full. You cannot return your plan if you have exercised any rights or powers available under it. If insurance cover is acquired through the AMP Personal Super Fund, the refund must be paid to another complying superannuation fund (see page 61 for more information).
Keeping you informed	Each year, we will send you an Annual Statement advising you about your insurance, fees and premiums for the next year. If you have changed occupation, ceased smoking or have experienced an improvement in health this may be an opportunity to be re-assessed and obtain a premium reduction. You can also get up-to-date information about your plan online. To register, visit **www.amp.com.au** and select "My Portfolio" from the online services menu.
Automatic plan enhancements	Our products are reviewed on a regular basis to ensure you receive competitive cover. If we enhance your plan without changing premium rates, we will automatically provide you the enhancements for which you are eligible at no extra charge. We will write and advise you of the changes on your plan anniversary.
Feel secure - anywhere in the world	An insured person is covered worldwide, 24 hours a day, 7 days a week. For Income Protection and Business Overheads Insurance, benefit payments may stop after 3 months unless the insured person returns to Australia or New Zealand - see pages 40 and 53.
Guaranteed renewable	As long as you pay premiums when they are due, we guarantee to continue cover until the cover ends. Different rules apply to Income Protection Basic plans (see page 49).
Supportive claims service	We are committed to paying all genuine claims in a professional empathetic manner and providing a supportive claims service. If you need to make a claim we have specially trained claims staff who will be ready to assist you. Either you or an authorised representative can call your financial planner or call us, to begin this process. See Claiming a benefit on page 63.
Customer satisfaction	If you have a question, please contact us. Our details are on the back cover. We aim to provide products and services that exceed your expectations. If we don't meet your expectations, please tell us. We hope that we can resolve the issue when you contact us. If we can't, we'll aim to give you a response within 10 working days. We will keep you advised at regular intervals of the status of your complaint. If we can't resolve your complaint to your satisfaction within 45 days, then you may have the right to lodge a complaint with the: Financial Ombudsman Service: GPO Box 3, Melbourne Victoria 3001. Phone: 1300 78 08 08 Fax: 03 9613 6399 Email: info@fos.org.au Website: www.fos.org.au If you have a plan through the AMP Personal Super Fund, please see page 33 for information about the Trustee's complaints process.
Respecting your privacy	Your privacy is important to us. See page 65 for information about how we handle your personal information.



About the Life Protection Plan

The Life Protection Plan offers flexible solutions to provide insurance that secures tomorrow by protecting what you have today. You can structure your plan to meet your needs and provide you with peace of mind.

Flexibility to tailor a plan that meets your needs

The Life Protection Plan gives you choices - so you have the flexibility to tailor a plan that suits your needs. This section sets out the choices available to you. Cover is subject to our acceptance.

Who can own the plan?

The Life Protection Plan can be owned by:

An individual	Two individuals (as joint tenants)	A company

If you want a benefit paid under the Life Protection Plan to form part of your superannuation, you can select a superannuation trustee to own the plan. The trustee can be:

AMP Superannuation Limited, the trustee of the AMP Personal Super Fund	A trustee of a self-managed superannuation fund or a small APRA superannuation fund

If you choose AMP Superannuation Limited to be the owner of the Life Protection Plan, you must first become a member of the AMP Personal Super Fund (see page 29).

If you choose the trustee of a self-managed superannuation fund or a small APRA superannuation fund to be the owner of the Life Protection Plan, please read the important information on page 34.

Who can be an insured person?

The "insured person" is the person whose life is covered under the Life Protection Plan. There can be more than one insured person under the Life Protection Plan (up to a maximum of 19).

If the Life Protection Plan is taken out through the AMP Personal Super Fund, there can only be one insured person.

The insured person must be within the ages set out in the table on page 8 when you apply for cover.

What cover suits your needs?

There are 3 types of cover available under the Life Protection Plan. You can include one or more of the following types of cover under the one Life Protection Plan:

Death cover	**Total and Permanent Disablement (TPD) cover**	**Trauma cover**	
		Optimum	**Standard**
(see page 9)	(see page 12)	(see page 17)	(see page 17)

If the Life Protection Plan is taken out through the AMP Personal Super Fund, the plan must include Death cover, and may also include TPD cover. Trauma cover is not available through the AMP Personal Super Fund.

How do you want to structure your plan?

If you select more than one type of cover for the same insured person under the Life Protection Plan, you can choose to make the covers either Stand Alone or Linked. Stand alone cover has a higher premium than Linked cover.

STAND ALONE	LINKED
If we pay a benefit under one type of cover (for example Trauma cover), it does not reduce the insured amount of any other cover (for example Death cover) for the insured person under the Life Protection Plan.	If we pay under one type of cover (for example Trauma cover), the insured amount of each remaining type of cover (for example Death cover) is reduced by the amount we pay.

How much cover can you apply for?

The maximum insured amount that you can currently apply for is:

DEATH COVER	TPD COVER	TRAUMA COVER
No maximum	$3 million*	$2 million*

* These amounts are inclusive of all cover you may have with any insurer at the time you apply for cover or an increase in cover. The insured amounts may increase above these maximums during the term of your plan under the Indexation feature (see page 24).

What type of premium works for you?

You can choose either a stepped premium or level premium (see page 61).

If you choose a level premium, the premium will automatically change to stepped from the plan anniversary after the insured person turns 64.

Do any optional benefits and features suit your needs?

The optional benefits and features available under each type of cover are set out on:

- Death cover - page 9
- TPD cover - page 12
- Trauma cover - page 17.

Life Protection Plan - Facts

Entry ages and cover expiry age

COVER TYPE	ENTRY AGE OF THE INSURED PERSON		EXPIRES ON THE PLAN ANNIVERSARY AFTER THE INSURED PERSON TURNS
	STEPPED PREMIUMS	LEVEL PREMIUMS	
Death cover	10 to 74	10 to 59	99
Death cover through the AMP Personal Super Fund	10 to 64	10 to 59	74
TPD cover	15 to 59	15 to 59	99
TPD cover through the AMP Personal Super Fund	15 to 59	15 to 59	74
Trauma cover Optimum	13 to 59	13 to 59	99
Trauma cover Standard	13 to 59	13 to 59	74

OPTION	ENTRY AGE OF THE INSURED PERSON	EXPIRES ON THE PLAN ANNIVERSARY AFTER THE INSURED PERSON TURNS
Children's Trauma cover option	1 to 12	16
Business Safeguard option* (with Death cover)	15 to 59	65
Business Safeguard option* (with TPD cover)	15 to 54	65
Waiver of Premium option	10 to 54	59**
Waiver of Premium option through the AMP Personal Super Fund	15 to 54	59**
TPD Plus option	15 to 59	64
Partials package (with Trauma Optimum)	13 to 59	69
Partials package (with Trauma Standard)	13 to 59	64
Optimum Buy Back option	13 to 59	64
Optimum Trauma Reinstatement Option	13 to 59	64

The entry ages also apply to increases in cover and additions to existing plans.

* The Business Safeguard option is only available if the insured person's Death cover and/or TPD cover insured amount is $500,000 or more. The option is not available for an insured person with a premium loading or exclusion for health reasons.

** If we are waiving premiums for an insured person at the plan anniversary after their 59th birthday, we will continue to waive premiums until the plan anniversary after their 70th birthday, as long as they remain totally disabled (see page 25).

Taxation information

ARE PREMIUM PAYMENTS DEDUCTIBLE?	ARE BENEFIT PAYMENTS ASSESSABLE FOR INCOME TAX?
Generally, Life Protection Plan premiums are not tax deductible. However, where a business arranges the Life Protection Plan to cover loss of revenue (profits) should an employee be covered under the plan, premiums may be tax deductible.	Generally, payment of the Death Cover, TPD Cover or Trauma Cover insured amount will not attract income tax or capital gains tax (CGT). However: – when we pay the Death Cover amount, CGT may apply if the plan owner is not the same person or entity as the plan owner when the Life Protection Plan began, – CGT applies to TPD Cover and Trauma Cover amounts we pay if the plan owner is not the insured person, or a relative (as defined for taxation purposes) of the insured person, – where a business arranges the Life Protection Plan to cover loss of revenue (profits) should an employee be covered under the plan, the amounts we pay will attract income tax.

Please see page 31 for information about the tax laws that apply to cover acquired through the AMP Personal Super Fund.

We recommend that you speak to your accountant or tax adviser about your personal tax circumstances.

Plan Rules - Death cover

Benefits and features at a glance

The benefits and features of Death cover are listed below.

In-built benefits and features are shown below like this:

→ [ ]

Additional premium options can be added to Death cover. These options will only apply if they are shown in your Certificate of Insurance, and are shown below like this:

→ [ ]

Some benefits and features do not apply if Death cover is taken out through the AMP Personal Super Fund. These benefits and features are shown below like this:

→ ✘ Super

The benefits and features of Death cover are explained in detail on the pages listed below.

Some words and expressions used in the Plan Rules have a specific meaning.

These words and expressions are defined in the dictionary (see pages 67 to 75).

Key benefit

Death benefit
(see page 10)

Advanced payment benefits

We may advance payment of the Death cover insured amount under these benefits:

Terminal Illness benefit
(see page 10)

Funeral benefit
(see page 10) ✘ Super

Additional benefits

The Financial Planning Benefit is an in-built benefit and may be paid in addition to the above benefits. It is not available if the plan owner is the trustee of a self-managed or small APRA superannuation fund. The Children's Trauma benefit is an additional premium option which can be added to Death cover, TPD cover or Trauma cover under a Life Protection Plan.

Financial Planning benefit ✘ Super
(see page 24)

Children's Trauma benefit option ✘ Super
(see page 26)

Features

Increasing cover features

These features allow the Death cover insured amount to be increased without providing evidence of the insured person's health or pastimes.

Indexation feature
(see page 24)

Guaranteed Future Insurability feature
(see page 24)

Business Safeguard option ✘ Super
(see page 25)

Other features

Nomination of beneficiaries
(see page 10)

Waiver of premium option
(see page 25)

24 hour, worldwide cover

Each insured person with Death cover is covered worldwide, 24 hours a day, 7 days a week.

Guaranteed renewable

As long as you pay premiums when they are due, we guarantee to continue Death cover until the cover ends (see page 11).

Benefits and features explained

When we pay

We only pay a benefit under Death cover if the insured event happens after cover starts and before cover ends (see page 11).

We won't pay a benefit under Death cover in some circumstances (see "When we won't pay" on page 11). Also, you must satisfy our claim requirements before we pay a benefit (see page 63).

Other than that, we will pay a benefit under Death cover in the circumstances set out in this section and page 24.

Death benefit

We pay the Death cover insured amount if the insured person dies.

Terminal Illness benefit

We advance payment of the Death cover insured amount if the insured person is terminally ill.

Terminally ill means:

- the insured person's doctor tells us in writing that they believe that the insured person has less than 12 months to live
- the doctor's prognosis is based on clinical findings and reports, and
- we agree with the doctor's prognosis.

We may also require you to give us information from medical advisers we choose.

The amount we pay under the Terminal Illness benefit is the Death cover insured amount on the date we agree with the doctor's prognosis.

On payment of the Terminal Illness benefit, Death cover for the insured person under the Life Protection Plan will end. If you have linked TPD cover and/or Trauma cover for the insured person, their TPD cover and/or Trauma cover insured amount/s will be reduced by the amount of the Terminal Illness benefit payable. You don't have to pay premiums for an insured person under the Life Protection Plan if we have paid the Terminal Illness benefit for that insured person.

Funeral benefit

(Funeral Benefit does not apply if cover is provided through the AMP Personal Super Fund).

We pay $20,000 (or the Death cover insured amount, if less) if:

- the Funeral benefit is claimed, and
- we receive a certified copy of the insured person's death certificate.

The Death cover insured amount reduces by the amount we pay under the Funeral benefit. We pay the balance of the Death cover insured amount (if any) if we accept the claim for the Death benefit.

We pay the Funeral benefit to:

- you, or
- if you have died, a person we are permitted to pay under the *Life Insurance Act* (which currently includes a spouse, defacto, child, parent or sibling of the insured person, or a person who satisfies us that they are entitled to obtain probate of the insured person's Will).

Nomination of beneficiaries

If you are both the sole plan owner and sole insured person of the Life Protection Plan, you can nominate one or more beneficiaries to receive the Death benefit under the Life Protection Plan.

Your nomination will automatically be revoked if:

- you cease to be the sole plan owner or the sole insured person of the Life Protection Plan, or
- a nominated beneficiary dies before you (even if there are other surviving beneficiaries).

You can cancel your nomination at any time by writing to us.

If Death cover is acquired through the AMP Personal Super Fund, we pay the Death Benefit to the Trustee. However, you can make a binding nomination or non-binding nomination through the AMP Personal Super Fund. See page 30 for further information about who the Trustee will pay your Death benefit to.

Who we pay

PLAN OWNER	WHO WE PAY
Sole plan owner with no nominated beneficiary	If you are alive, we pay the Terminal Illness benefit or Death benefit to you. If you have died, we pay the Death benefit to your estate.
Sole plan owner with a nominated beneficiary(ies).	We pay the Terminal Illness benefit to you. We pay the Death benefit to your nominated beneficiary(ies).
Two individuals as joint tenants	If both plan owners are alive, we pay the Terminal Illness benefit or Death benefit to the joint plan owners. If an owner has died, we pay the Terminal Illness benefit or Death benefit to the surviving owner.
Trustee	The Trustee.

When we won't pay

Unless Death cover is Replacement cover (see below), we won't pay a benefit under Death cover for an insured person if the insured person dies, or becomes terminally ill, by their own hand within 13 months of the date the Death cover starts or the date the Death cover was last reinstated. This applies regardless of whether the insured person was sane or insane when they died or became terminally ill.

Also, if we increased the Death cover insured amount for the insured person because you asked us to, we won't pay the increased portion of the Death cover insured amount if the insured person dies, or becomes terminally ill, by their own hand within 13 months of the date of the increase. This does not apply to increases under the Indexation feature.

Replacement cover

If Death cover replaces Death cover issued by us, or another insurer, the 13 month period will not apply (but only up to the insured amount under the previous cover) if:

- you would have been entitled to claim under the previous cover had it not been replaced
- the previous cover was in force at the time we issued the Death cover, and
- the previous cover was in place for a continuous period of at least 13 months.

We will require satisfactory evidence of the above points at the time of any claim for this exception to apply.

When Death cover ends

The Death cover under your Life Protection Plan for an insured person ends when one of the following happens:

- the insured person dies
- we receive your written request to cancel the Death cover for that insured person
- the insured person's Death cover reduces to nil because another benefit (for example, the Terminal Illness benefit or other linked benefits) becomes payable
- the end date for the insured person's Death cover shown on the certificate of insurance
- the plan anniversary after the insured person's 99th birthday, or if cover is acquired through the AMP Personal Super Fund, the plan anniversary after the insured person's 74th birthday, or
- your Life Protection Plan ends (see page 28).

Plan Rules - Total and Permanent Disablement (TPD) cover

Benefits and features at a glance

The benefits and features of TPD cover are listed below.

In-built benefits and features are shown below like this: →

Additional premium options can be added to TPD cover. These options will only apply if they are shown in your certificate of insurance, and are shown below like this: →

Some benefits and features do not apply if TPD cover is taken out through the AMP Personal Super Fund. These benefits and features are shown below like this: → ✘ Super

The benefits and features of TPD cover are explained in detail on the pages listed below.

Some words and expressions used in the Plan Rules have a specific meaning.

These words and expressions are defined in the dictionary (see pages 67 to 75).

Key benefits

TPD benefit
(see page 13)

TPD Partial benefit ✘ Super
(see page 15)

Additional benefits

The Financial Planning benefit is an in-built benefit and may be paid in addition to the above benefits. It is not available if the plan owner is the trustee of a self managed or small APRA superannuation fund. The Children's Trauma benefit is an additional premium option which can be added to Death cover, TPD cover or Trauma cover under a Life Protection Plan.

Financial Planning benefit ✘ Super
(see page 24)

Children's Trauma benefit option ✘ Super
(see page 26)

Features

Increasing cover features

These features allow the TPD cover insured amount to be increased without providing evidence of the insured person's health or pastimes.

Indexation feature
(see page 24)

Guaranteed Future Insurability feature
(see page 24)

Business Safeguard option ✘ Super
(see page 25)

Other features

TPD Plus option
(see page 15)

Own occupation option
(see page 15)

Waiver of premium option
(see page 25)

24 hour, worldwide cover

Each insured person with TPD cover is covered worldwide, 24 hours a day, 7 days a week.

Guaranteed renewable

As long as you pay premiums when they are due, we guarantee to continue TPD cover until the cover ends (see page 16).

Benefits and features explained

When we pay

We only pay a benefit under TPD cover if the insured event happens after cover starts and before cover ends (see page 16).

We won't pay a benefit under TPD cover in some circumstances (see "When we won't pay" on page 16). Also, you must satisfy our claim requirements before we pay a benefit (see page 63).

Other than that, we will pay a benefit under TPD cover in the circumstances set out in this section and page 24.

TPD benefit

When we pay

We pay you the TPD benefit if the insured person becomes totally and permanently disabled.

What does "totally and permanently disabled" mean?

An insured person is totally and permanently disabled if they satisfy one of the parts of the definition of totally and permanently disabled in the table on page 14. However:

- part 1a of the definition of totally and permanently disabled does not apply to TPD cover taken out through the AMP Personal Super Fund, and
- part 2 of the definition of totally and permanently disabled only applies if own occupation option is shown in the certificate of insurance for the insured person, and
- on and from the plan anniversary after the insured person's 64th birthday, the insured person is only totally and permanently disabled if they satisfy part 4, 5 or 6 of the definition of totally and permanently disabled.

Amount we pay

IF WE ACCEPT THE CLAIM BECAUSE THE INSURED PERSON HAS SATISFIED PART 1A, 1B, 2, OR 3 OF THE DEFINITION OF "TOTALLY AND PERMANENTLY DISABLED":	IF WE ACCEPT THE CLAIM BECAUSE THE INSURED PERSON HAS SATISFIED PART 4, 5 OR 6 OF THE DEFINITION OF "TOTALLY AND PERMANENTLY DISABLED":
The TPD benefit we pay is a lump sum equal to the TPD cover insured amount that applies on the date 3 months after the insured person stopped performing (or would have stopped performing) home duties, regular remunerative work or their own occupation (as applicable).	The TPD benefit we pay is a lump sum equal to the TPD cover insured amount that applies on the date the insured person satisfies part 4, 5 or 6 of the definition of "totally and permanently disabled" (as applicable).

We only pay the TPD cover insured amount once in respect of an insured person, even if the insured person satisfies two or more parts of the definition of totally and permanently disabled at the same time.

If you have linked Death and/or Trauma cover for the insured person, their Death and/or Trauma cover insured amount(s) will be reduced by the amount of the TPD benefit payable and your premium will be reduced having regard to the reduced insured amount(s).

If you have any combination of linked Death, TPD and Trauma cover for the insured person and you are eligible for a benefit under two or all three types of cover at the same time for the same condition, we only pay a benefit under one type of cover. If the insured amounts are not equal, we pay a benefit under the cover which has the highest insured amount.

Totally and permanently disabled

Part 1a Unable to work (other than cover through the AMP Personal Super Fund)

The insured person is totally and permanently disabled if:

- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in regular remunerative work for at least 3 months in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in regular remunerative work:
  - for which they are reasonably fitted by education, training or experience, and
  - which allows them to earn greater than 25% of their pre-disability income.

(Regular remunerative work is defined on page 75).

The insured person must also survive 3 months. Upon admittance of your claim, we will refund any premiums falling due during this 3 month period that have been paid for the insured person.

Part 1b Unable to work

The insured person is totally and permanently disabled if:

- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in regular remunerative work for at least 3 months in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in regular remunerative work for which they are reasonably fitted by education, training or experience. (Regular remunerative work is defined on page 75).

The insured person must also survive 3 months. Upon admittance of your claim, we will refund any premiums falling due during this 3 month period that have been paid for the insured person.

Part 2 Unable to work - Own occupation

Part 2 only applies if Own Occupation option is shown in the Certificate of Insurance for the insured person

The insured person is totally and permanently disabled if:

- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in their own occupation for at least 3 months in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in their own occupation. (Own occupation is defined on page 75).

The insured person must also survive 3 months. Upon admittance of your claim, we will refund any premiums falling due during this 3 month period, that have been paid for the insured person.

Part 3 Home Duties

The insured person is totally and permanently disabled if:

- they suffer an illness or injury, and
- the illness or injury wholly prevents them from engaging in their home duties for at least 3 months in a row, and
- since they became ill or injured, they have been under the ongoing care and attention of a doctor for that illness or injury, and
- in our opinion, the illness or injury means that they are unlikely to ever work in their home duties. (Home duties is defined on page 74).

The insured person must also survive 3 months. Upon admittance of your claim, we will refund any premiums falling due during this 3 month period, that have been paid for the insured person.

Part 4 Loss of use of limbs and/or sight

The insured person is totally and permanently disabled if they suffer from the total and irrecoverable loss of:

- the use of 2 limbs, or
- the sight of both eyes, or
- the use of one limb and the sight of one eye,

where a limb means the whole hand below the wrist or the whole foot below the ankle.

The loss must be unable to be remedied and the insured person must survive for 14 days after the loss.

Part 5 Loss of independent living

The insured person is totally and permanently disabled if they become totally and permanently unable to perform at least 2 of the activities of daily living without assistance from someone else. ("Activities of daily living" is defined on page 73).

We will not pay for loss of independent living caused directly by alcohol or drug abuse.

The insured person must survive for 14 days after the loss.

Part 6 Loss of cognitive functioning

The insured person is totally and permanently disabled if they:

- suffer significant and permanent cognitive impairment with a loss of intellectual capacity, and
- are required to be under the continuous care and supervision of someone else.

The insured person must survive for 14 days after the loss.

TPD Partial benefit

(TPD Partial benefit does not apply if cover is provided through the AMP Personal Super Fund).

When we pay

We pay you the TPD Partial benefit for an insured person if they suffer total and irrecoverable loss of:

- the use of one limb (where a limb means the whole hand below the wrist or the whole foot below the ankle), or
- the sight of one eye, where visual acuity has reduced to 6/60 or less and the loss is unable to be corrected by glasses or any other means.

The loss must be unable to be remedied and the insured person must survive for 14 days after the loss.

We only pay the TPD Partial benefit once for each insured person. If the insured person's loss satisfies the conditions of both the TPD benefit and the TPD Partial benefit, we only pay you the TPD benefit.

Amount we pay

The TPD Partial benefit we pay is a lump sum equal to 25% of the TPD cover insured amount (up to a maximum of $500,000).

If the TPD Partial benefit is payable:

- the TPD cover insured amount for the insured person, and
- the insured amount(s) under any linked Death cover and/or Trauma cover,

will be reduced by the TPD Partial benefit payable, and your premium will be reduced having regard to the reduced insured amount(s).

TPD Plus option

This is an additional premium option which is available if the insured person's TPD cover is linked to Death cover. It only applies if it is shown in your certificate of insurance for the insured person.

Under this option, we will automatically restore the Death cover insured amount for an insured person to the amount that it was before it was reduced by payment of the TPD benefit. This option does not restore an insured amount because of a payment of the TPD Partial Benefit.

You will not pay a premium for the restored amount for the remaining term of your Life Protection Plan, from the date we make the TPD benefit payment. However, you must still pay the premium for any amount of Death cover that exceeds the TPD amount.

We do not restore the Death cover insured amount if:

- the insured person dies within 14 days after we pay the TPD benefit, or
- we have paid a Terminal Illness benefit for the insured person.

The option ceases to apply on the plan anniversary after the insured person's 64th birthday.

Own Occupation option

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person.

This option is only available to certain occupations which include professional, white collar workers and light blue collar (trade and light manual) workers.

Under this option, you can claim the TPD cover insured amount if the insured person meets part 2 of the definition of "total and permanent disablement" (see page 14).

When we won't pay

We will not pay a claim if the insured person's:

- total and permanent disablement (for a TPD benefit), or
- total and irrecoverable loss of the use of a limb or the sight of an eye (for a TPD Partial benefit),

was caused directly or indirectly by an intentional or deliberate act by you or the insured person.

When TPD cover ends

The TPD cover under your Life Protection Plan for an insured person ends when one of the following happens:

- the insured person dies
- the TPD benefit for the insured person becomes payable
- we receive your written request to cancel the TPD cover for the insured person
- the insured person's TPD cover reduces to nil because another linked benefit becomes payable
- the end date for that insured person's TPD cover shown on the certificate of insurance
- the plan anniversary after the insured person's 99th birthday, or if cover is acquired through the AMP Personal Super Fund, the insured person's 74th birthday
- if you have acquired the TPD cover through the AMP Personal Super Fund, the date your Death cover ends, or
- your Life Protection Plan ends (see page 28).

Plan Rules - Trauma cover

(Not available through the AMP Personal Super Fund)

Benefits and features at a glance

The benefits and features of Trauma cover are listed below.

In-built benefits and features are shown below like this: →

Additional premium options can be added to Trauma cover. These options will only apply if they are shown in your certificate of insurance, and are shown below like this: →

The benefits and features of Trauma cover are explained in detail on the pages listed below.

Some words and expressions used in the Plan Rules have a specific meaning.

These words and expressions are defined in the dictionary (see page 67 to 75).

Key benefits

Trauma benefit
(see page 18)

Partials Package option
(see page 21)

Additional benefits

The Financial Planning Benefit is an in-built benefit and may be paid in addition to the above benefits. It is not available if the plan owner is the trustee of a self managed or small APRA superannuation fund. The Children's Trauma benefit is an additional premium option which can be added to Death cover, TPD cover or Trauma cover under a Life Protection Plan.

Financial Planning benefit
(see page 24)

Children's Trauma benefit option
(see page 26)

Features

Increasing cover features

These features allow the Trauma cover insured amount to be increased without providing evidence of the insured person's health, occupation or pastimes.

Indexation feature
(see page 24)

Guaranteed Future Insurability feature
(see page 24)

Other features

Optimum Trauma Reinstatement option
(Trauma Optimum cover only)
(see page 22)

Optimum Buyback option
(Trauma Optimum cover only)
(see page 22)

Waiver of premium option
(see page 25)

24 hour, worldwide cover

Each insured person with Trauma cover is covered worldwide, 24 hours a day, 7 days a week.

Guaranteed renewable

As long as you pay premiums when they are due, we guarantee to continue Trauma cover until the cover ends (see page 23).

Benefits and features explained

When we pay

We only pay a benefit under Trauma cover if the insured event happens after cover starts and before cover ends (see page 23).

We won't pay a benefit under Trauma cover in some circumstances (see "When we won't pay" on page 23). Also, you must satisfy our claim requirements before we pay a benefit (see page 63).

Other than that, we will pay a benefit under Trauma cover in the circumstances set out in this section and page 24.

Trauma Benefit

When we pay

We pay you the Trauma benefit if the insured person:

- suffers a listed trauma condition or undergoes a listed medical procedure, and
- survives for 14 days from that date of the diagnosis of the trauma condition or the date of the medical procedure.

If the relevant trauma condition is coma, the insured person must survive for the additional period included within the definition of this condition (see page 68).

The trauma conditions and medical procedures covered differ depending on whether you have Trauma cover Optimum or Trauma cover Standard for the insured person.

The trauma conditions and medical procedures are defined on pages 67 to 73.

Amount we pay

The Trauma benefit we pay is a lump sum equal to the Trauma cover insured amount that applies on the date that the definition of the trauma condition or medical procedure is met.

We only pay the Trauma cover insured amount once in respect of an insured person, even if the insured person satisfies the definition of two or more trauma conditions at the same time (unless the Optimum Trauma Reinstatement option is exercised and the Trauma benefit again becomes payable - see page 22).

If you have any combination of linked Death, TPD and Trauma cover for the insured person and you are eligible for a benefit under two or all three types of cover at the same time for the same condition, we only pay a benefit under one type of cover. If the insured amounts are not equal, we pay a benefit under the cover which has the highest insured amount (although, for the purposes of the Optimum Trauma Reinstatement option and the Optimum Buy Back option, if applicable, we will treat you as having been paid the Trauma benefit).

If you have linked Death and/or TPD cover for the insured person, their Death and/or TPD cover insured amount(s) will be reduced by the amount of the Trauma benefit payable and your premium will be reduced having regard to the reduced insured amount(s).

Conditions covered

The trauma conditions and medical procedures covered depends on the type of Trauma cover that applies to the insured person.

- Trauma cover Optimum covers 48 trauma conditions and medical procedures (see page 19), and
- Trauma cover Standard covers 15 trauma conditions and medical procedures (see page 20).

Trauma cover Optimum

TRAUMA COVER OPTIMUM COVERS THE FOLLOWING TRAUMA CONDITIONS AND MEDICAL PROCEDURES:	
COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN STARTS IMMEDIATELY	COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN IS DELAYED FOR 3 MONTHS (AS SET OUT ON PAGE 20)
Alzheimer's disease and other dementias Aplastic anaemia Blindness Cardiomyopathy Coma Encephalitis Hepatitis B or C - occupationally acquired HIV/AIDS - medically acquired HIV/AIDS - occupationally acquired Intensive care Kidney failure Liver failure Loss of hearing Loss of independent living Loss of speech Loss of use of limbs and/or sight Lung failure Major head trauma Major organ transplant Motor neurone disease Multiple sclerosis Muscular dystrophy Myelodysplasia Myelofibrosis Paralysis that is one of: – Diplegia – Hemiplegia – Paraplegia – Quadriplegia – Tetraplegia Parkinson's disease (advanced) Peripheral blood stem cell or bone marrow transplant Peripheral neuropathy Primary pulmonary hypertension Severe burns Systemic sclerosis	Aortic surgery Benign tumour of the brain or spinal cord Cancer Coronary artery angioplasty - triple vessel Coronary artery surgery Heart attack - myocardial infarction Heart attack - out of hospital cardiac arrest Heart valve surgery Open heart surgery Pneumonectomy Severe rheumatoid arthritis Stroke Systemic lupus erythematosus
Under Trauma cover Optimum, on and from the plan anniversary following the insured person's 69th birthday, the only trauma conditions covered are: – loss of independent living, and – loss of use of limbs and/or sight.	

Trauma cover Standard

TRAUMA COVER STANDARD COVERS THE FOLLOWING TRAUMA CONDITIONS AND MEDICAL PROCEDURES:	
COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN STARTS IMMEDIATELY	COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN IS DELAYED FOR 3 MONTHS (AS SET OUT BELOW)
Kidney failure Major organ transplant Paralysis that is one of: – Diplegia – Hemiplegia – Paraplegia – Quadriplegia – Tetraplegia Peripheral blood stem cell or bone marrow transplant	Aortic surgery Cancer Coronary artery surgery Heart attack - myocardial infarction Heart attack - out of hospital cardiac arrest Heart valve surgery Stroke
Under Trauma cover Standard, on and from the plan anniversary following the insured person's 64th birthday, the trauma conditions and medical procedures above will cease to be covered and will be replaced by: – loss of independent living, and – loss of use of limbs and/or sight.	

Delayed cover for some trauma conditions and medical procedures

Unless Trauma cover is Replacement Cover (see below), cover does not start for those trauma conditions and medical procedures which are expressed to be "delayed for 3 months" until 3 months after:

- the Trauma cover start date
- an increase to the Trauma cover insured amount (other than an increase under the Indexation feature) in respect of the increased portion only
- the most recent reinstatement of Trauma cover.

This means that for those trauma conditions and medical procedures which are expressed to be "delayed for 3 months":

- the trauma condition, or
- the medical condition which the medical procedure is intended to address,

must be diagnosed at least 3 months after the Trauma cover start date. If the diagnosis occurs before this time, we will never pay for that trauma condition or medical procedure under the Life Protection Plan, even if the insured person suffers the same trauma condition again or undergoes the same medical procedure again.

Replacement Cover

If Trauma cover replaces trauma cover issued by us, or another insurer, the 3 month delayed start date will not apply (but only up to the insured amount under the previous cover) if:

- you would have been entitled to claim under the previous cover for the same trauma condition or medical procedure had it not been replaced
- the previous cover was in force at the time we issued the Trauma cover, and
- the previous cover was in place for a continuous period of at least 3 months.

We will require satisfactory evidence of the above points at the time of any claim for this exception to apply.

Partials package option

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person and the insured person's Trauma cover insured amount is at least $40,000.

This option provides you with additional cover for 18 partial trauma conditions and medical procedures set out in the table below.

We pay under the Partials package if the insured person:

- suffers a listed partial trauma condition or undergoes a listed medical procedure, and
- survives for 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure.

Cover for partial blindness commences immediately. However, cover for the other trauma conditions and medical procedures is delayed for 3 months (see page 20).

THE PARTIALS PACKAGE COVERS THE FOLLOWING TRAUMA CONDITIONS AND MEDICAL PROCEDURES:

Aortic surgery by minimal invasive techniques
Carcinoma in situ of breast
Carcinoma in situ of cervix uteri
Carcinoma in situ of fallopian tubes
Carcinoma in situ of ovary
Carcinoma in situ of testes
Carcinoma in situ of vagina
Carcinoma in situ of vulva
Complications of pregnancy
Coronary artery angioplasty
Heart valve surgery by minimal invasive techniques
Melanoma
Parkinson's disease
Partial blindness
Prostate cancer
Severe inflammatory bowel disease
Severe osteoporosis
Temporal arteritis

We may pay more than once under the Partials package, although we will not pay more than once for a specific trauma condition or medical procedure.

Amount we pay

Subject to the maximums below, the amount we pay under the Partials package for a trauma condition or a medical procedure is 25% of the Trauma cover insured amount.

The maximum amount we pay under the Partials package for a trauma condition or a medical procedure is:

For the following conditions: – Carcinoma in situ of fallopian tubes – Carcinoma in situ of vagina – Carcinoma in situ of vulva	25% of the Trauma cover insured amount
For Coronary artery angioplasty:	$50,000
For all other trauma conditions and medical procedures under the Partials package:	$25,000

If a benefit is payable under the Partials Package:

- the Trauma cover insured amount for the insured person, and
- the insured amount(s) under any linked Death cover and/or TPD cover,

will be reduced by the benefit payable, and your premium will be reduced having regard to the reduced insured amount(s).

When cover under this option ends

Cover for an insured person under the Partials package ends when one of the following happens:

- the plan anniversary after the insured person reaches age:
  - 64, if you have Trauma cover Standard, or
  - 69, if you have Trauma cover Optimum
- the Trauma cover insured amount reduces to less than $40,000.

Optimum Trauma Reinstatement option (Trauma cover Optimum Only)

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person.

This option allows you to restore Trauma cover after we have paid the Trauma Benefit, without providing evidence of the insured person's health, occupation or pastimes. This option does not allow you to restore a benefit amount paid under the Partials package.

This option becomes exercisable one year after we pay the Trauma benefit. You must exercise the option within 30 days of the claim anniversary, by completing the relevant application form.

The premium for the restored Trauma cover will be based on our Trauma cover premium rates, and the insured person's age, applicable at the time of exercising this option, taking into account any special conditions or premium loadings applying to the original Trauma cover.

We will not pay a claim under the restored Trauma cover if:

- the insured person suffers a trauma condition or undergoes a medical procedure for which we have already paid a Trauma benefit, or
- the insured person was diagnosed with, or suffered symptoms leading to diagnosis of:
  - the new trauma condition, or
  - the medical condition that the new medical procedure is intended to address,

  that became apparent between the date that we paid the Trauma benefit and the date Trauma cover is restored under the Optimum Trauma Reinstatement option, or
- the new trauma condition, or the medical condition that the new medical procedure is intended to address, is the same as the original trauma condition or medical condition, or is directly or indirectly caused by or related to the original trauma condition, medical condition or medical procedure, for which the previous Trauma Benefit was paid, or
- the new trauma condition, or the new medical procedure, is directly or indirectly related to:
  - the treatment used for the previous trauma condition, or
  - the previous medical procedure, or
- the new trauma condition is for kidney failure or a heart condition and the previous Trauma cover payment was for systemic lupus erythematosus, or
- the new trauma condition is:
  - a heart condition
  - a stroke, or
  - paralysis (directly or indirectly resulting from a stroke),

and the previous Trauma cover payment was for a heart condition.

Please refer to page 74 for the definition of heart condition and page 75 for the definition of paralysis.

We will only pay a benefit under the reinstated Trauma cover for a trauma condition or medical procedure if acceptable evidence is provided that the new trauma condition or medical procedure is:

- independent of, and totally unrelated to, the previously paid trauma condition or medical procedure, and
- totally unrelated to the treatment used for the original trauma condition, or the original medical procedure, for which we paid.

When this feature ends

The Optimum Trauma Reinstatement option will end on the earlier of:

- the plan anniversary after the insured person turns 64, and
- the Optimum Trauma Reinstatement option end date shown in the certificate of insurance.

Optimum Buy Back option (Trauma cover Optimum Only)

This is an additional premium option which is available if the insured person's Trauma cover is linked to Death cover. It only applies if it is shown in your certificate of insurance for the insured person.

This option allows you to restore Death cover for an insured person by the amount it was reduced after payment of the Trauma Benefit, without providing evidence of the insured person's health, occupation or pastimes. This option does not allow you to restore an insured amount because of a payment under the Partials Package.

This option becomes exercisable one year after we pay the Trauma benefit. You must exercise the option within 30 days of the claim anniversary by completing the relevant application form.

The premium for the restored Death cover will be based on our Death cover premium rates, and the insured person's age, applicable at the time of exercising this option, taking into account any special conditions or premium loadings applying to the original Death cover.

When this feature ends

The Optimum Buy Back option will end when one of the following happens:

- the plan anniversary after the insured person turns 64, and
- the Optimum Buy Back option end date shown in the certificate of insurance.

When we won't pay

We will not pay if the trauma condition, or if the purpose for the medical procedure, was caused directly or indirectly by an intentional or deliberate act by you or the insured person.

When Trauma cover ends

The Trauma cover under your Life Protection Plan for an insured person ends when one of the following happens:

- the insured person dies
- a Trauma benefit for the insured person becomes payable
- we receive your written request to cancel the Trauma cover for the insured person
- the insured person's Trauma cover reduces to nil because another linked benefit becomes payable
- the end date for that insured person's Trauma cover shown on the certificate of insurance
- the plan anniversary after the insured person's 74th birthday for Trauma cover Standard or the insured person's 99th birthday for Trauma cover Optimum, or
- your Life Protection Plan ends (see page 28).

Plan Rules - Additional benefits, features and options under the Life Protection Plan

Financial Planning benefit

(Financial Planning benefit does not apply if cover is provided through the AMP Personal Super Fund or the Life Protection Plan is owned by a self-managed or small APRA superannuation fund).

We will reimburse the recipient of a benefit under the Life Protection Plan for the cost of financial planning advice up to $2,000 (in addition to the amount of the benefit we paid). The recipient must produce evidence of this expense in a form we accept and the financial advice must come from a suitable and qualified person we accept.

If there is more than one recipient of a benefit, we divide the Financial Planning benefit equally between the recipients.

This benefit is payable only once for each insured person under the Life Protection Plan and must be claimed within 12 months of the claim being paid.

Guaranteed Future Insurability feature

You can increase the Death cover and/or TPD cover and/or Trauma cover insured amount for an insured person without providing evidence of the insured person's health, occupation or pastimes when one of the following happens:

- the insured person marries
- the insured person divorces
- the insured person's child is born or they legally adopt a child
- the insured person's child starts school
- the insured person is granted a housing loan by a financial institution to buy their first home
- the insured person completes their first undergraduate degree at a recognised Australian university
- the insured person has an annual income increase of $10,000 or more, or
- the insured person becomes a carer for the first time.

You must apply for the increase within 12 months of the date the event occurs. You must provide appropriate proof of the event that we accept (such as certification of the event or a statutory declaration).

You can only increase the insured amount once under this feature in any 12 month period for each type of cover under the Life Protection Plan.

You may increase the insured amount by 25% of the original insured amount (up to a maximum of $250,000). Premiums will be based on our premium rates, and the insured person's age, applicable at the time of exercising this feature.

This feature does not apply to:

- the Children's Trauma cover option
- the Death cover insured amount restored after exercising the TPD Plus option
- the Death cover insured amount restored after exercising the Optimum Buy Back option, or
- the Trauma cover insured amount restored after exercising the Optimum Trauma Reinstatement option.

Maximum increases

The maximum amount by which you can increase an insured person's Death cover insured amount under this feature over the term of the Life Protection Plan is the original Death cover insured amount (to a maximum of $1,000,000).

The maximum amount by which you can increase an insured person's TPD cover insured amount under this feature over the term of the Life Protection Plan is the original TPD cover insured amount (to a maximum of $250,000). The maximum amount you can increase TPD cover to through this feature is $2.5million.

The maximum amount by which you can increase an insured person's Trauma cover insured amount under this feature over the term of the Life Protection Plan is the original Trauma cover insured amount (to a maximum of $250,000). The maximum amount you can increase Trauma cover to through this feature is $2 million.

When you can not take out this feature

You cannot take out this feature for an insured person if at the time of your request:

- the insured person is age 55 or more
- the insured person's cover has a premium loading or special terms,
- the insured person's premiums are being waived under the Waiver of Premium option, or
- a person is eligible to make, or has made, a terminal illness, TPD or trauma claim under any AMP plan in relation to the insured person.

Indexation feature

Each year, unless otherwise agreed, on the plan anniversary we will increase the insured amounts for all insured persons under the Life Protection Plan by the higher of:

- the percentage increase in the CPI (see page 74) since the last plan anniversary (or since the plan start date if this is the first plan anniversary under the Life Protection Plan), and
- 5%.

We will notify you of the increase in the annual statement we send you each year. You must tell us if you do not want this increase, in full or in part.

The Indexation feature ceases to apply to an insured person on the plan anniversary after age 74 for Death cover, TPD cover and Trauma cover.

The Indexation feature does not apply to:

- the $25,000 Death cover insured amount under Children's Trauma cover option (see page 26)
- the Trauma cover insured amount restored as a result of exercising the Optimum Trauma Reinstatement option (see page 22)
- the Death cover insured amount restored as a result of exercising the TPD Plus option (see page 15), or
- the Death cover insured amount restored as a result of exercising the Optimum Buy Back option (see page 22).

Business Safeguard option

(Business Safeguard option does not apply if cover is provided through the AMP Personal Super Fund or to Trauma cover).

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person.

This option is designed to be used for business purposes such as:

- business succession planning (buy/sell agreement)
- loan guarantor insurance, and
- key person insurance.

The option allows you to apply to increase the Death cover insured amount and/or TPD cover insured amount for an insured person, without providing evidence of the insured person's health or pastimes. You can apply to increase the insured amount for an insured person under this option by:

- if the insured person is a key person to the business - the actual increase in the value of the insured person to the business since the latter of the last time the option was exercised and the commencement of the option, or
- if the Life Protection Plan forms part of a written buy/sell, share purchase or business continuation agreement - the actual increase in the value of the insured person's interest in the business since the latter of last time the option was exercised and the commencement of the option.

Before we increase the level of cover for an insured person under this option, we may require financial evidence of the increase in the value of the business from an appropriate person (eg an independent qualified accountant or business valuer) we approve.

If we increase the insured amount for an insured person under this option, your premium will increase in line with the higher level of cover.

When does the option end?

The Business Safeguard option for Death cover or TPD cover (as applicable) ends when one of the following happens:

- you do not exercise this option under Death cover or TPD cover (as applicable) for 5 years
- the 10th anniversary of the commencement of this option under Death cover or TPD cover (as applicable)
- the insured person turns 65
- for Death cover, the Death cover insured amount reaches 5 times the original insured amount (up to a maximum of $15,000,000)
- For TPD cover, the TPD cover insured amount reaches 5 times the original insured amount (up to a maximum of $2,500,000)
- a person has made, or is eligible to make, a terminal illness, trauma or TPD claim in respect of the insured person under any plan with us.

Waiver of Premium option

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person.

You can choose one of the following 2 types of Waiver of Premium option:

- **Individual Life** - you do not have to pay the Life Protection Plan premium (including the Plan Fee) for a particular insured person if they become totally disabled before the plan anniversary after their 59th birthday and while they continue to remain totally disabled, or
- **Nominated Life** - you do not have to pay the Life Protection Plan premium (including the plan fee) for all insured persons if the nominated insured person is totally disabled before the plan anniversary after their 59th birthday and while they continue to remain totally disabled.

The option will cease to apply to your Life Protection Plan on the plan anniversary after the insured person's 59th birthday. However, if we are waiving premiums at that plan anniversary, we will continue to waive your premiums until the plan anniversary after the insured person's 70th birthday (providing they remain totally disabled).

What does "totally disabled" mean?

An insured person is totally disabled if the insured person is unable, due to injury or illness, to engage in any regular remunerative work for which they are reasonably fitted by their education, training or experience for a continuous period of more than 6 months.

Please see page 75 for the meaning of "regular remunerative work".

Individual Life option

Under this option, the cover for the insured person continues, even though we waive the premiums for that insured person. Further, the premium you paid during the 6 months while we determined if the insured person was totally disabled will be refunded to you. However, if cover is provided through the AMP Personal Super Fund, the Trustee will pay this refund into a complying superannuation fund nominated by the member or an account in the AMP Eligible Rollover Fund established on behalf of the member.

You must restart paying the premium for the insured person when one of the following happens:

- as soon as the insured person stops being totally disabled
- the date Death cover ends for the insured person, or
- the plan anniversary after the insured person's 70th birthday.

Nominated Life option

Under this option, the cover for all the insured persons continues, even though we waive the premiums for all insured persons if the nominated insured person is totally disabled. Further, the premium you paid during the 6 months while we determined if the nominated insured person was totally disabled will be refunded to you.

You must restart paying your premium when one of the following happens:

- the nominated insured person is no longer totally disabled
- the date Death cover ends for the nominated insured person
- the plan anniversary after the nominated insured person's 70th birthday, or
- if the nominated insured person dies.

Plan Rules - Children's Trauma cover option

This is an additional premium option. It only applies if it is shown in your certificate of insurance for the insured person.

When we pay

We pay you a benefit under the Children's Trauma cover option if the insured person:

- suffers a listed trauma condition or undergoes a listed medical procedure, and
- survives for 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure.

We also pay a benefit under the Children's Trauma cover option if the insured person dies.

The trauma conditions and medical procedures covered under Children's Trauma cover are set out in the table below.

The insured person does not have cover for the trauma conditions and medical procedures set out in the left hand column of the table until the insured person reaches age 10. If the insured person is over 10 years of age when Children's Trauma cover starts, cover for these conditions and procedures starts immediately.

Cover for the trauma conditions in the right hand column of the table is available to all insured persons and is delayed for 3 months (as set out on page 20 under the heading "Delayed cover for some trauma conditions and medical procedures").

Amount we pay

The amount we pay under the Children's Trauma cover option is:

- $100,000 (plus any increases under the Indexation Feature) if the insured person suffers a listed trauma condition or undergoes a listed medical procedure and survives 14 days from the date of the diagnosis of the trauma condition or the date of the medical procedure, or
- $25,000 if the insured person dies.

CHILDREN'S TRAUMA COVER OPTION COVERS THE FOLLOWING TRAUMA CONDITIONS AND MEDICAL PROCEDURES	
FOR CHILDREN 10 YEARS AND OLDER COVER FOR THE TRAUMA CONDITIONS AND MEDICAL PROCEDURES IN THIS COLUMN STARTS IMMEDIATELY	COVER FOR THE TRAUMA CONDITIONS IN THIS COLUMN IS AVAILABLE TO ALL INSURED PERSONS COVERED UNDER THE CHILDREN'S TRAUMA COVER OPTION AND IS DELAYED FOR 3 MONTHS (AS SET OUT ON PAGE 20)
Blindness	Aplastic anaemia
Coma	Bacterial meningitis
Kidney failure	Cancer
Loss of hearing	Leukaemia
Loss of use of limbs and/or sight	Subacute sclerosing panencephalitis
Major head trauma	Viral encephalitis
Major organ transplant	
Paralysis that is one of: – Diplegia – Hemiplegia – Paraplegia – Quadriplegia – Tetraplegia	
Peripheral blood stem cell or bone marrow transplant	
Severe burns	

When we won't pay

We will not pay for a trauma condition or medical procedure for an insured person if:

- the insured person's trauma condition is caused directly or indirectly by, or the medical procedure is required directly or indirectly because of, any congenital condition, or
- the insured person's trauma condition or death is caused directly or indirectly by, or the medical procedure is required directly or indirectly because of:
  - alcohol or drugs, or
  - anybody who is connected to the insured person, or to either of their parents, or to a de facto spouse of either parent.

If the insured person suffers a trauma condition or medical procedure listed in the left hand column of the table on page 26 before the insured person turns age 10, we will never pay for that trauma condition or medical procedure, even if the insured person suffers the same trauma condition or undergoes the same medical procedure again later.

When Children's Trauma cover option ends

Cover for an insured person under the Children's Trauma cover option ends when one of the following happens:

- the first plan anniversary after the insured person's 16th birthday (see "Conversion to Death cover" below)
- the insured person dies
- we receive your written request to cancel the Children's Trauma cover option for the insured person
- a benefit under the Children's Trauma cover option becomes payable for the insured person
- all cover for the last insured person under the Life Protection Plan (other than an insured person under this option) ends, or
- your Life Protection Plan ends (see page 28).

Conversion to Death cover

If cover for an insured person under the Children's Trauma cover option has not ended earlier, on the first plan anniversary after the insured person's 16th birthday, cover under the Children's Trauma cover option ends and automatically converts to Death cover. The Death cover insured amount at that time will be $100,000 (plus any increases under the Indexation feature). This Death cover only includes the Death benefit, Terminal Illness benefit, Funeral benefit, Financial Planning benefit, Indexation feature and the Guaranteed Future Insurability feature.

General rules

Premiums and fees

See page 59.

When your plan and cover starts

Your Life Protection Plan starts on the date specified in your certificate of insurance. Your cover and any increase in the insured amount of your existing cover, starts on the date we notify you in writing.

When your plan ends

Your Life Protection Plan ends when one of the following happens:

- We receive your written request to cancel the Life Protection Plan.
- We cancel your Life Protection Plan because you have not paid your premium or any other amount payable under the plan.
- All cover for the last insured person end.
- If you have a Life Protection Plan through the AMP Personal Super Fund - you are no longer eligible to make superannuation contributions to the AMP Personal Super Fund. (When this happens you can apply for a Life Protection Plan, as described under "Replacement Option" on page 29).

We may also cancel your plan or cover for any reason the law permits. For example, if you do not comply with your duty of disclosure, we may cancel your plan or cover from the plan or cover start date and treat it as never having existed.

Reinstating the Plan

You may apply to have your plan reinstated if we cancel the plan because you have not paid your premium. You must apply within 12 months after the due date of the premium you did not pay.

We may reinstate your plan on any terms we determine at the time.

When you don't have to pay premiums

You don't have to pay premiums for an insured person under a Life Protection Plan if:

a) we have paid the Terminal Illness benefit for that insured person, or

b) your premiums are being waived under the Waiver of Premium option (see page 25).

You do not need to pay the premiums for Death cover for an insured person if their Death cover was reinstated as a result of exercising the TPD Plus option (see page 15).

Once we have accepted your claim for a benefit payment under the Life Protection Plan, we will refund any premiums for that cover that fell due since the date of the insured person's death or injury or illness commenced.

Transfer of Ownership

You can transfer a Life Protection Plan that is not provided through the AMP Personal Super Fund. To transfer ownership you must complete the transfer form on the last page of your certificate of insurance and send it to us, together with the certificate of insurance.

Ownership will transfer when we register the transfer. We will register the transfer if we have received all required information. After the transfer, we will only communicate with the new plan owner.

You can't transfer a Life Protection Plan provided through the AMP Personal Super Fund.

Life Protection Plan through the AMP Personal Super Fund

General

The Life Protection Plan can be acquired through the AMP Personal Super Fund. To do this, you must become a member of the AMP Personal Super Fund. AMP Superannuation Limited (Trustee), the trustee of the AMP Personal Super Fund, will acquire the Life Protection Plan on your behalf and will be the owner of the plan. The Trustee is a wholly owned subsidiary of AMP Life Limited.

This section sets out:

- the types of contributions that can be made to pay the premium for your insurance cover
- when the Trustee will pay a benefit under the Life Protection Plan to you or a beneficiary
- information about nominating a beneficiary to receive a death benefit
- tax information
- what to do if you have a complaint, and
- general information about the Trustee.

What cover is available through the AMP Personal Super Fund?

You can apply for Death cover only or Death and TPD cover through the AMP Personal Super Fund under a Life Protection Plan. To have TPD cover, the Life Protection Plan must also have Death cover.

Contributions

What contributions are accepted?

Having insurance in superannuation means that you have to satisfy superannuation contribution rules. The contributions that you make are used to pay the premium for your insurance cover. The following types of contributions can be made to the Fund:

CONTRIBUTION TYPE	CONTRIBUTION DESCRIPTION
Member contributions	Contributions you as a member either pay from your after-tax income or which you personally claim as a tax deduction.
Spouse contributions	Contributions your spouse pays into your plan. (Your spouse must not be entitled to a tax deduction for the contributions and must not live separately from you on a permanent basis).
Superannuation Guarantee (SG) and award/Industrial Agreement Employer contributions[1]	Contributions an employer must pay under legislation, including contributions paid to comply with an award or industrial agreement.
Salary sacrifice and additional employer contributions	You may be able to arrange for your employer to make contributions to pay the premium for your insurance cover instead of paying you an equivalent amount of pre-tax salary. These "salary sacrifice" contributions are treated as employer contributions. Your employer can also make employer contributions to your plan in addition to SG, Award/Industrial Agreement and Salary Sacrifice contributions.

1. The Life Protection Plan isn't designed to solely meet an employer's total SG obligations. Your employer may need to contribute to other superannuation products to meet their total SG obligations.

We do not accept directed termination payments, transfers or rollovers from other superannuation funds as contributions.

Your contributions will be credited as premium payments to a life insurance policy with AMP Life to secure your benefits.

When contributions can be made

All types of contributions can be made into your plan if you are under age 65. From age 65, the contributions that can be made are set out in the table. If you don't satisfy these requirements the Trustee won't be able to accept your contributions. If the Trustee can't accept your contributions your cover will lapse, unless it is transferred to another AMP product.

TYPE OF CONTRIBUTION^	YOU ARE UNDER AGE 65	YOU ARE AGE 65 TO UNDER 70	YOU ARE AGE 70 TO UNDER 75
Member contributions	At any time	Only if you are working at least on a part-time basis*	Only if you are working at least on a part-time basis*
Spouse contributions	At any time	Only if you are working at least on a part-time basis*	No spouse contributions accepted
Superannuation Guarantee (SG) and Award/Industrial Agreement Employer contributions	At any time	At any time	Award/ Industrial Agreement Employer contributions at any time (SG contributions end at age 70)
Salary Sacrifice and additional employer contributions	At any time	Only if you are working at least on a part-time basis*	Only if you are working at least on a part-time basis*

* You are considered to be working on a part-time basis if you have already worked at least 40 hours in a period of 30 consecutive days during the same financial year that the contribution is made.

^ Different rules apply when claiming tax deductions for contributions (see page 31).

Replacement option

You can continue your Death cover and/or TPD cover when you no longer can make contributions, by applying for a current Life Protection Plan or an equivalent plan without providing any evidence of health, occupation and pastimes. The new Life Protection Plan will be dependent on the terms and conditions applicable at the time.

Benefit payment rules

Who does the Trustee pay the Death benefit to?

You can nominate one or more beneficiary(ies) to receive their lump sum death benefit. Generally, all beneficiaries must be your dependants. A dependant includes:

- a spouse (including a de facto spouse)
- a child (including an adopted child, a stepchild or ex-nuptial child)
- any person who is financially dependent on you, and
- any person with whom you have an interdependency relationship under law.

You can also nominate your estate (referred to as "legal personal representative").

How can your death benefit be paid?

You can choose how you would want the Death benefit paid.

There is a choice of:

- Option 1 - Binding nomination.
- Option 2 - Non-binding (or preferred) nomination, or
- Option 3 - No nomination.

Before making a nomination, there are a number of factors that should be kept in mind, for example, the type of beneficiary nominated can have tax implications for dependant(s) when they receive the Death benefit.

For this reason, we strongly recommend that you discuss the nomination with a financial planner prior to filling in the application forms and personal statement.

Option 1 - Binding nomination

If the Trustee is provided with a binding nomination that satisfies all legal requirements, then the Trustee must pay the Death benefit to the beneficiaries nominated and in the proportions specified. However, the Trustee is not required to pay the Death benefit in accordance with the binding nomination if it's aware either:

- that doing so would breach a court order, or
- that the giving of, or failure to change, a nomination was a breach of a court order.

One of the legal requirements for a binding nomination is that it must be signed and dated in the presence of 2 witnesses over 18 who are not nominated beneficiaries. The Trustee will automatically treat the nomination as though it was non-binding if:

- the binding nomination does not satisfy this or other legal requirements, or
- it is not signed or correctly completed.

When the Trustee receives the nomination it will not check if the nominated beneficiaries on the nomination form are dependants or a legal personal representative.

The binding nomination will normally become invalid when one of the following happens:

- 3 years have lapsed from the date the *Binding Nomination* form was signed (a new *Binding Nomination* form will need to be completed for there to be a binding nomination).
- Any nominated beneficiary dies before you die.
- Any nominated beneficiary (other than the legal personal representative) is not a dependant at the time of death.
- You marry or enter into a de facto relationship after signing the Binding Nomination Form.
- You get divorced or your de facto relationship ends after signing the Binding Nomination Form.
- A non-binding nomination is made (as described in Option 2 - Non-binding nomination).

If the binding nomination is no longer valid, then the Trustee will automatically treat the binding nomination as a non-binding nomination (see Option 2 - Non-binding nomination).

It is important that the binding nomination is regularly reviewed and updated:

- when your personal circumstances change, or
- if 3 years pass from the date of your last binding nomination.

The binding nomination can be cancelled or changed at any time. If the binding nomination is cancelled without making another nomination, then the Trustee must pay the Death benefit in accordance with Option 3 - No nomination.

Option 2- Non-binding (or preferred) nomination

If a non-binding (or preferred) nomination is made or a binding nomination becomes a non-binding nomination (as described under Option 1 - Binding nomination), then the Trustee will decide which beneficiary will receive the Death benefit.

The Trustee will take into consideration your wishes that the death benefit be paid to the nominated beneficiary(ies), but depending on the circumstances at the time of death, the Trustee may decide to pay the Death benefit differently.

When the Trustee receives the nomination it will not check if:

- the nominated beneficiary(ies) on the nomination form are dependants or a legal personal representative, or
- the nomination form has been signed or correctly completed.

A non-binding nomination will continue to apply until it is cancelled or a new one is made. Therefore, it is important that a non-binding nomination is kept up-to-date in line with your personal circumstances. A non-binding nomination can be cancelled at any time or a new one can be made at any time.

If the non-binding nomination is cancelled without making another nomination, then the Trustee must pay the Death benefit in accordance with Option 3 - No nomination.

Option 3 - No nomination

If a nomination is not made, or your existing nomination is cancelled, and a new nomination is not made, then the Trustee must pay the Death benefit to your estate.

However, if the estate is insolvent or if a legal personal representative has not been appointed to manage the estate within a reasonable period of time, then the Trustee will decide:

- if there are dependants, which dependants will receive the Death benefit (and in what proportions), or
- if there are no dependants, which other persons will receive the Death benefit (and in what proportions).

This means that if there is neither a binding nor non-binding nomination, you should consider making a Will or altering your Will to cover the Death benefit.

Payment rules for terminal illness and TPD benefits

The Trustee can only pay the Terminal Illness benefit and TPD benefit in accordance with superannuation rules.

As the superannuation payment rules are different from the definition of "terminal illness" and "total and permanent disablement" under the plan, there may be some instances where the Trustee will not be able to pay a Terminal Illness benefit or TPD benefit directly to you.

For example, under superannuation law:

"Permanent incapacity", in relation to a member, means ill-health (whether physical or mental), where the trustee is reasonably satisfied that the member is unlikely, because of the ill-health, to engage in gainful employment for which the member is reasonably qualified by education, training or experience. The definition of "permanent incapacity" under superannuation law differs from the definition of "totally and permanently disabled" on page 14. For example, AMP Life may pay the TPD benefit to the Trustee because you are a paraplegic, but the Trustee may not be able to release the benefit from the AMP Personal Super Fund if you are still able to work.	A terminal medical condition exists in relation to a person at a particular time if the following circumstances exist: – Two registered medical practitioners have certified, jointly or separately, that the person suffers from an illness, or has incurred an injury, that is likely to result in the death of the person within a period (the certification period) that ends not more than 12 months after the date of the certification. – At least one of the registered medical practitioners is a specialist practising in an area related to the illness or injury suffered by the person. – For each of the certificates, the certification period has not ended. The definition of "terminal medical condition" under superannuation law differs from the definition of "terminally ill" on page 10.

It is recommended you discuss the differences in definitions with your financial planner.

If the Trustee is not be able to pay a Terminal Illness benefit or TPD benefit directly to you, the Trustee will transfer the benefit to an account in the AMP Eligible Rollover Fund set up on your behalf, or to a similar complying superannuation fund nominated by you. Any such transferred benefits can only be subsequently released if you satisfy the superannuation payment rules (eg reaching age 65 or retiring after you have reached your preservation age).

Additional identification requirements

Before paying any benefit, the Trustee may need to verify the identity of:

- you
- any person(s), including the estate, selected to receive payments in the event of your death, and
- anyone acting on your behalf.

Verification generally involves checking the name and date of birth or address against a reliable independent document such as a passport or driver's licence, and may involve taking and retaining a copy of that document.

The Trustee may decide to delay or refuse any request or transaction, including benefit payments, if it is concerned that the request or transaction may breach any obligation of, or cause us to commit or participate in an offence under the Anti-Money Laundering and Counter Terrorism Financing Act 2006 (Cth). The Trustee is not liable for any loss or damage arising from any such delay.

Taxation

Outlined below is our general understanding of current legislation and rules as at the date of preparation of this document. Taxation laws and their interpretation may change from time to time. The Trustee will inform you of any changes that will affect your plan. We recommend that you consult your tax adviser.

Tax deductions for employers or self-employed individuals

There are tax deductions for contributions made by employers to fund insurance cover premiums for the benefit of their employees.

Self-employed individuals may be able to claim a tax deduction for their personal contributions.

Contribution limits

There are limits that apply to contributions made to superannuation funds. Contributions above those limits (caps) are subject to "excess contributions tax" of between 31.5% and 46.5%.

The cap amount and how much extra tax you pay once you exceed it depend upon whether the contributions are:

- concessional - which are generally made to a super fund for or by you in a financial year and are included in the assessable income of the super fund (for example, super guarantee, salary sacrificed amounts and any amount you are allowed as a personal super deduction in your income tax return), and
- non-concessional - which are generally made to a super fund by or for you in a financial year and are not included in the super fund's assessable income (for example, personal contributions you make from your after-tax income).

This is a summary of the contributions caps:

	CONCESSIONAL CAP	TRANSITIONAL CONCESSIONAL CAP (The transitional concessional cap is for those who are 50 years old or older on 30 June in a financial year and is available until 30 June 2012 and is not indexed.)	NON-CONCESSIONAL CAP (The non-concessional cap is 6 times the concessional contribution cap.)
2009–2010 financial year and 2010-2011 financial year	$25,000 This amount will be indexed annually from 2011–2012 onwards to average weekly ordinary time earnings (AWOTE) and rounded down to the nearest multiple of $5,000.	$50,000	$150,000
Tax on amounts over the cap	31.5% (in addition to the 15% paid by the super fund)	31.5% (in addition to the 15% paid by the super fund)	46.5%
Other information	Any concessional contributions in excess of the cap will also count towards your non-concessional contributions cap.	Any concessional contributions in excess of the cap will also count towards your non-concessional contributions cap.	If you are under 65 years old at any time during the financial year, you may be able to bring forward the next 2 years of contributions, but certain conditions apply. This effectively allows you to contribute up to 3 times the cap at once, or at any time during the 3 financial years.

Other tax concessions

Contributions by employees on lower incomes and contributions made by a spouse may attract tax concessions. Your financial planner or tax adviser can provide more details about these concessions.

Tax on death claims

Death benefit lump sums paid to dependants, as defined for tax purposes (eg spouse, de facto spouse, your child under age 18, or people financially dependent on a person at the time of death or in an interdependent relationship) are generally tax free.

Where Death benefit lump sums are paid to a person who is not a tax dependant they are generally taxed at a rate of up to 15% (30% in certain circumstances) plus the Medicare levy.

Tax on Total and Permanent Disablement claims

Tax concessions apply if the total and permanent disablement results in you being unable to ever be gainfully employed.

Tax on Terminal Illness

Terminal Illness benefits are totally tax free if you meet the "terminal medical condition" release set by superannuation rules.

Collection of Tax File Numbers

The Trustee is required to disclose the following details before you provide your Tax File Number (TFN).

The Trustee can collect your TFN under the Superannuation Industry (Supervision) Act 1993 (Cth).

You are under no obligation to disclose your TFN to the Trustee and it is not an offence to not quote your TFN.

However, if you do not disclose your TFN to the Trustee, the Life Protection Plan cannot be acquired through the AMP Personal Super Fund.

If the TFN is disclosed to the Trustee, the Trustee will treat it as confidential and use it only for lawful purposes, including:

- To find superannuation benefits, where other information is insufficient.
- To ensure you can continue to contribute to your account.
- To calculate tax on any superannuation benefits you may be entitled to.
- If the Trustee is paying unclaimed money, it must give the TFN to the Commissioner of Taxation.
- The Trustee may also give the TFN to the Commissioner of Taxation if you receive a benefit, or for the purposes of the Lost Members' Register, and
- If you wish to transfer your benefits to another superannuation fund or retirement savings account, the Trustee would provide the TFN to the trustee of that other fund or retirement savings account provider. However, if you do not want the Trustee to do this, you can notify the Trustee in writing at the time not to do so.

These purposes may change in the future as a result of further legislative changes. More information about the use of Tax File Numbers and superannuation changes can be obtained from the Australian Taxation Office Superannuation Hotline 13 10 20.

Complaints

The Trustee has established procedures to deal with any complaint. If you make a complaint, the Trustee will:

- acknowledge its receipt and ensure an appropriate person properly considers the complaint, and
- respond to you as soon as possible.

If your complaint cannot be resolved at first contact then the Trustee will keep you informed of the progress and aim to give you a response to your complaint within 10 working days. If the complaint is not resolved by that time, then the Trustee will keep you advised at regular intervals of the status of your complaint.

If the Trustee can't resolve your complaint to your satisfaction within 90 days, then you may have the right to lodge a complaint with the Superannuation Complaints Tribunal (SCT).

The SCT reviews the decisions of superannuation trustees as they affect an individual member. It is independent from the Trustee. Please try to resolve the complaint directly with the Trustee before contacting the SCT.

Superannuation Complaints Tribunal

Phone: 1300 780 808

Fax: 03 8635 5588

Email: info@sct.gov.au

or write to: Locked Bag 3060, GPO MELBOURNE VIC 3001

Time limits on making complaints to the SCT

If you contact the SCT more than 12 months after the Trustee's decision or response, then the SCT may decide not to deal with your complaint. However, this general rule does not apply to a complaint about the denial of a TPD claim.

If the Trustee denies your TPD benefit claim, then you may be unable to make a complaint to the SCT if:

- you lodge a TPD benefit claim with the Trustee more than 2 years after you permanently stop working, or
- you complain to the SCT more than 2 years after the Trustee's first (original) decision to deny your TPD benefit claim.

Your beneficiaries have 28 days to lodge a complaint with the SCT in relation to a decision to pay the death benefit.

You should contact the SCT first to ensure that it can deal with your complaint.

The Trustee

The Trustee:

- is responsible for all aspects of the operation of the your Life Protection Plan
- is responsible for ensuring that the AMP Personal Super Fund is properly administered in accordance with the trust deed and policy documents, and
- ensures that the AMP Personal Super Fund complies with relevant legislation, that all members' benefits are calculated correctly, and that members are kept informed of the operations of the AMP Personal Super Fund.

The Trustee has indemnity insurance.

The trust deed

The trust deed for the AMP Personal Super Fund establishes the AMP Personal Super Fund. It also contains:

- the member's rights and obligations relating to the AMP Personal Super Fund, and
- the Trustee's rights and obligations as the trustee (for example, the right to charge fees, the right to be indemnified, the right to terminate the trust and the limits on our liability).

The rights and obligations of a trustee are also governed by laws affecting superannuation and general trust law.

You can ring the Trustee to get a copy of the trust deed (contact details are on the back cover).

Annual report

The Trustee will prepare an annual report of the AMP Personal Super Fund each year. A copy can be obtained by contacting AMP (our contact information is included on the back cover).

Complying Superannuation Fund Notice

This Complying Superannuation Fund Notice confirms that the AMP Personal Super Fund:

- is a resident regulated superannuation fund within the meaning of the Superannuation Industry (Supervision) Act (SIS), and
- is not subject to a direction under section 63 of SIS.

Pursuant to section 25 of the Superannuation Guarantee (Administration) Act, a contribution made by an employer for the benefit of an employee to the AMP Personal Super Fund is conclusively presumed to be a contribution to a complying superannuation fund if the employer receives a copy of this Complying Superannuation Fund Notice at or before the time that the contribution is made, except in the limited circumstances set out in that section.

Self managed or small APRA superannuation fund trustee ownership

Self Managed or small APRA Superannuation Fund trustee owners must read the following information.

The trustee of a self managed or small APRA Superannuation Fund is solely responsible for ensuring that they have received independent financial, legal and taxation advice about their ability to purchase one of these AMP products.

AMP will make all payments to the trustee of the superannuation fund. The distribution of benefits to a member of the self managed or small APRA superannuation fund is the responsibility of the trustee of that fund and they will be responsible to determine whether benefits can be distributed to members of the fund in conformity to the trust deed governing the fund and superannuation law, and for assessing the taxation implications of doing so.

All taxation information in this document is in respect of individuals and employers only. We strongly recommend that the trustee specifically requests advice in relation to the tax deductibility of premiums, the impact of the sole purpose test requirements of the superannuation Industry (Supervision) Act 1993 (SIS), the release of any insurance payments received by the trustee under these products in light of the cashing restrictions under SIS, and the tax obligations in respect of the payments to the member by the trustee. Some benefits paid under the policy may need to be preserved by the trustee until there is a nil cashing restriction under SIS.

About the Income Protection Plan

(Not available through the AMP Personal Super Fund)

Flexibility to tailor a plan that meets your needs

The Income Protection Plan gives you choices - so that you have the flexibility to tailor a plan that suits your needs. This section sets out the choices available to you. Cover is subject to our acceptance.

Who can own the plan?

The Income Protection Plan can be owned by:

An individual	**A trustee of a self managed superannuation fund or small APRA superannuation fund**

We pay a benefit under the Income Protection Plan to the plan owner.

If you choose the trustee of a self managed superannuation fund or a small APRA superannuation fund to be the owner of the Income Protection Plan, please read the important information on page 34.

What plan type is right for you?

There are 3 plan types available under the Income Protection Plan:

Advanced plan	**Standard plan**	**Basic plan**

The benefits, features and options available under each plan are set out on pages 37 to 39.

Who can be an insured person?

The "insured person" is the person whose life is covered under the Income Protection Plan. There can only be one insured person under an Income Protection Plan.

Unless the plan is owned by a trustee of a self managed superannuation fund or small APRA superannuation fund, the plan owner and the insured person must be the same person.

We only insure certain types of occupations. The insured person must be between the ages set out in the table on page 36 when you apply for this cover.

What benefit type suits your needs?

You may choose an agreed value or indemnity plan. A lower premium is charged for indemnity plans and the amount we pay at the time of claim may be lower.

AGREED VALUE	INDEMNITY
The benefit we pay is based on the maximum monthly benefit, even if the insured person's income subsequently falls (see page 40).	The benefit we pay will not be more than 75% of the insured person's income in the 12 months immediately before they became totally disabled or partially disabled. This may be less than the maximum monthly benefit (see page 40).

How much cover do you need?

You can insure a percentage of the insured person's income (defined on page 74). The percentages are set out in the table below. If you apply for the Superannuation Contribution option (see page 46), your maximum monthly benefit will be increased by an additional 12%.

INCOME	MAXIMUM % INSURED
The first $320,000	75% (or 84% if the Superannuation Contribution option applies)
The next $240,000	50% (or 56% if the Superannuation Contribution option applies)
Amounts over $560,000*	15% (or 16.8% if the Superannuation Contribution option applies)

* Limitations may apply for benefits in excess of $30,000 per month.

Currently, the minimum amount of cover is $1,250 per month ($250 per month for increases to existing plans excluding increases under the Guaranteed future insurability feature).

What length of benefit period and waiting period suits your needs?

The benefit period is the maximum period of time that we will pay some benefits. The premium is cheaper if you choose a shorter benefit period.

The waiting period is the period you must wait before you can become eligible for a Total Disability benefit or a Partial Disability benefit. The premium is cheaper if you choose a longer waiting period.

The following table shows the available benefit periods and waiting periods for each plan type:

PLAN TYPE	BENEFIT PERIODS AVAILABLE				
	1 YEAR	2 YEARS	5 YEARS	TO AGE 60	TO AGE 65
	WAITING PERIODS AVAILABLE (WEEKS)				
Advanced	4	2, 4	2, 4, 8	2, 4, 8, 13, 26, 52, 104	2, 4, 8, 13, 26, 52, 104
Standard	4	2, 4	2, 4, 8	2, 4, 8, 13, 26, 52, 104	2, 4, 8, 13, 26, 52, 104
Basic	2, 4	2, 4	2, 4, 8	N/A	N/A

What type of premium works for you?

For Advanced and Standard plans, you can choose either a Stepped premium or Level premium (see page 61). Only stepped premiums are available under the Basic plan.

Do any optional benefits and features suit your needs?

The optional benefits and features available under the Income Protection Plan are set out on pages 37 to 39.

Income Protection Plan facts

Cover entry ages and expiry ages

ENTRY AGES			
BENEFIT PERIOD	ADVANCED PLAN AND STANDARD PLAN		BASIC PLAN
	STEPPED PREMIUM	LEVEL PREMIUM	
To age 65	19 to 59	19 to 59	N/A
To age 60	19 to 54	19 to 54	N/A
1, 2 or 5 years	19 to 49	19 to 54	19 to 49

The entry ages also apply to increases in cover and additions to existing plans.

	PLANS WITH BENEFIT PERIOD OF 1 YEAR, 2 YEARS, 5 YEARS OR "TO AGE 60"	PLANS WITH BENEFIT PERIOD "TO AGE 65"
Expiry age	60	65

The insured person's occupation

Based on the duties of the insured person's occupation, we allocate an occupation category. We use the following codes to describe occupation categories: 4A, 3A, 2A, A, 4B, 3B, 2B, 1B or E.

The insured person's occupation category will affect the premium you pay and the type of plan you can apply for. Your financial planner can tell you which category the insured person's occupation belongs to. The following table provides a guide. The insured person's occupation category will be shown in your premium quote.

CATEGORY	DESCRIPTION
4A	Selected professional occupations (other than medical practitioners and dentists) eg accountant, solicitor.
3A	Medical professional, eg medical practitioner, dentists.
2A	White collar occupation - office environment only, sedentary, eg bank clerk, management consultant.
A	White collar occupation - travel or work outside the office environment or are not primarily sedentary in nature within the office environment, eg sales representative.
4B	Light/minimal manual work - supervision of manual work with up to 10% manual work being performed, eg building foreman, owner of café.
3B	Trade qualified - skilled craftspeople or tradespeople in non-hazardous industries. The occupation must require technical or trade qualifications and relevant licence (if required), eg mechanic, builder.
2B	Owner of businesses that involves manual work, however, trade qualifications are generally not required to perform the occupation. Also includes light manual occupations with limited skill required, eg greengrocer, blind and awning installers.
1B	Heavy manual - blue collar occupations involved in either heavy manual work, or do not require any level of trade qualification. A degree of skill is still required, eg bricklayer, local truck driver.
E	Selected hazardous or heavy manual occupations. Generally unskilled or unqualified. Should have a minimum of 3 years experience, eg bulldozer operator, open coal miner, roof plumber.

Taxation information

ARE PREMIUM PAYMENTS DEDUCTIBLE?	ARE BENEFIT PAYMENTS ASSESSABLE FOR INCOME TAX?
Premium payments are generally tax deductible	Benefit payments are generally assessable for income tax and should be included in your tax return.

We recommend that you speak to your accountant or tax adviser about your personal tax circumstances.

Plan Rules - Income Protection

Benefits and features at a glance

The benefits and features of the Income Protection Plan are listed below.

In-built benefits and features that apply to the **Advanced Plan, Standard Plan** and **Basic Plan*** are shown in this section like this:

* The Death feature does not apply to the Basic Plan.

In-built benefits and features that only apply to the **Advanced Plan** are shown in this section like this:

Additional premium options** can be added to your Income Protection Plan. These options will only apply if they are shown in your Certificate of Insurance, and are shown in this section like this:

** The AIDS Exclusion option is a discounted premium option.

The benefits and features of the Income Protection Plan are explained in detail on pages 41 to 48.

Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see pages 67 to 75).

Income benefits

We will pay you one of the following income benefits at any one time - as long as you satisfy the conditions for payment:

Total Disability benefit (see page 41)

Partial Disability benefit (see page 42)

A waiting period applies before you become eligible for a payment under these benefits (unless the insured person has suffered a relapse).

However, you may be eligible for a payment under one of these benefits during the waiting period.

Bedcare benefit (see page 45)

Day 1 Accident option (Advanced plans and Standard plans only) (see page 45)

Major Fracture or Loss feature (see page 44)

Trauma feature (see page 43)

A waiting period does not apply to these benefits.
These benefits are payable for a specified period, even if the insured person can work.

Death feature (Advanced plans and Standard plans only) (see page 45)

We may pay 6 extra payments equal to the total disability benefit (to a maximum of $60,000) if the insured person dies while they are totally disabled or partially disabled and we are paying you one of the above income benefits (although we don't pay under the death feature if the insured person dies during the waiting period).

Additional benefits

These additional benefits may be paid in addition to one of the income benefits referred to on the previous page:

Superannuation Contribution option (see page 46)

Superannuation - With this additional premium option, contributions to the insured person's superannuation may continue to be made while you are receiving an income benefit.

Rehabilitation Costs feature (see page 46)

Rehabilitation bonus (see page 46)

Rehabilitation - Either or both of these rehabilitation benefits may be paid while the insured person is totally disabled, both during the waiting period and while we are paying an income benefit under the Income Protection Plan (and the Rehabilitation bonus may be paid up to 3 months after the insured person returns to continuous full-time work).

Accommodation benefit (see page 47)

Domestic Transport benefit (see page 46)

Overseas Transport benefit (see page 46)

Disability away from home - One of these benefits may be paid (which may be in addition to an income benefit) if the insured person becomes totally disabled more than 100 kilometres away from home.

Family Support benefit (see page 47)

Family Support - We may pay this benefit (in addition to an income benefit) if the insured person is totally disabled and an immediate family member stops working to look after the insured person.

Features

The Income Protection Plan has the following features:

Indexation feature (see page 47)

Guaranteed Future Insurability feature (see page 47)

Claims Escalation option (Standard plans and Basic plans only) (see page 47)

On Hold feature (see page 48)

Change of Employer feature (see page 48)

Attempted return to work feature (see page 48)

Relapse feature (see page 48)

Premium Waiver (see page 48)

Aids Exclusion option (see page 47)

Increasing cover features - These features allow your maximum monthly benefit to be increased without providing evidence of the insured person's health, occupation or pastimes.

Claims Escalation option is not available for Advanced plans because, under the Advanced plan, a similar feature is already included in the Indexation Feature.

Employment event features - These features give you choices if the insured person's employment circumstances change.

Disability features

The AIDS Exclusion option is a discounted premium option

24 hour, worldwide cover

The insured person is covered worldwide, 24 hours a day, 7 days a week (although benefit payments may stop after 3 months unless the insured person returns to Australia or New Zealand - see page 40).

Guaranteed renewable

For Advanced plans and Standard plans, as long as you pay premiums when they are due, we guarantee to continue the Income Protection plan until the plan ends (see page 50). Different rules apply to Basic plans (see page 49).

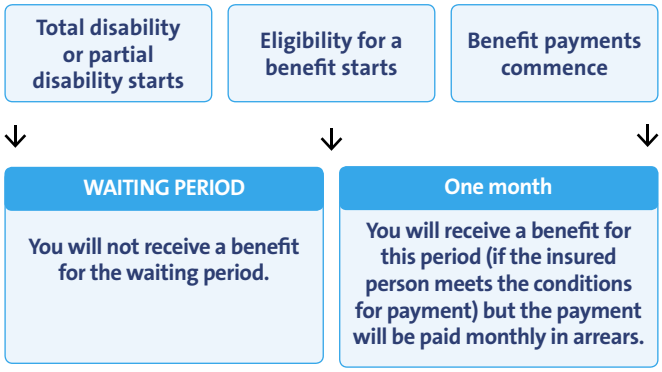
Understanding the waiting period, the benefit period and the monthly benefit

Waiting period

The waiting period is the period of time that you must wait before you become eligible for a Total Disability Benefit or a Partial Disability Benefit. The length of the waiting period you choose is shown in the certificate of insurance.

The waiting period starts on the date the insured person becomes totally disabled or partially disabled (as applicable). The waiting period only ends when the total number of consecutive days the insured person has been totally disabled or partially disabled (as applicable), when added together, equal the waiting period.

The following diagram illustrates how the waiting period and the timing of payments work.



We treat days of total disability or partial disability as being consecutive even if those days are interrupted by a period of attempted return to work under the Attempted return to work feature (see page 48).

Benefit period - how long we pay

The benefit period is the maximum period of time that we will pay the Total Disability benefit, and for Advanced plans and Standard plans, the Partial Disability benefit. The benefit period you choose is shown in your certificate of insurance. For Basic plans, the maximum period of time we will pay the Partial Disability benefit under one claim is 2 years, even if the benefit period is longer.

For the purposes of determining when the benefit period ends, you will be treated as being paid a benefit during any period that your benefit is reduced to nil under benefit offsets (see page 49).

When the insured person is outside Australia or New Zealand

We pay for an illness or injury that happens anywhere in the world at any time. However, we may not pay for more than 3 months while the insured person is outside Australia or New Zealand (maximum overseas payment period).

We may agree to keep paying for more than 3 months while the insured person is outside Australia or New Zealand if you ask us to and you, and the insured person, agree to any conditions we set.

If we don't pay after the maximum overseas payment period, then, when the insured person returns to Australia or New Zealand, we will start paying again if you are still entitled to be paid under the Income Protection Plan. We will not pay you for any period before the insured returns to Australia or New Zealand (other than the maximum overseas payment period).

If the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, then we may assist you with their return travel expenses (see Overseas Transport benefit on page 46).

Monthly benefit

The amount we pay under most benefits under the Income Protection Plan is the Monthly Benefit or is calculated by reference to the Monthly Benefit. The meaning of Monthly Benefit differs depending on whether you have an Agreed Value Plan or an Indemnity Plan, which is shown in your Certificate of Insurance.

Agreed Value	Monthly benefit means the maximum monthly benefit, less any applicable Benefit Offsets (see page 49).
Indemnity	Monthly benefit means the lesser of: – the maximum monthly benefit, and – 75% of the insured person's income in the 12 months immediately before the start of the waiting period (or the date you become eligible for the Major Fracture and Loss feature or the Trauma feature) divided by 12, less any applicable Benefit Offsets (see page 49).

Maximum monthly benefit means the amount you apply for and we accept (as shown in your Certificate of Insurance), as varied in accordance with the terms of the Plan (for example, under the Indexation Feature) or by agreement.

Benefits and features explained

When we pay

We only pay a benefit under the Income Protection Plan if the insured event happens after cover starts and before cover ends (see page 50).

We won't pay a benefit under the Income Protection Plan in some circumstances (see "When we won't pay" on page 50). Also, for some plans, we may reduce the amount we pay under a benefit if you receive payments from other sources (see "Benefit Offsets" on page 49). You must satisfy our claim requirements before we pay a benefit (see page 63).

Other than that, we will pay a benefit under the Income Protection Plan in the circumstances set out in this section.

Total Disability benefit

When we pay

We pay the Total Disability benefit if the insured person is totally disabled and has satisfied these conditions:

- the insured person has been totally disabled for the whole waiting period, and
- unless the insured person has suffered a relapse (see page 48), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Total Disability benefit monthly in arrears.

What does "totally disabled" mean?

The meaning of "totally disabled" will depend on whether you have an Advanced plan, Standard plan or Basic plan.

If you have an Advanced plan, the insured person will be considered totally disabled if they satisfy either the "duties based" or "hours based" definition of totally disabled below.

If you have a Standard plan or Basic plan, the insured person will be considered totally disabled if they satisfy the "duties based" definition of totally disabled below.

DEFINITION OF TOTALLY DISABLED	
Duties based	The insured person is totally disabled if: – they are so ill or injured that they are unable to carry out any one duty, or combination of duties, which are critical to the proper performance of their usual occupation, and – they are under the ongoing care of a doctor for that illness or injury, and – they do not do any remunerative work (see page 75 for the meaning of "remunerative work"). If the insured person suffers an illness or injury more than 12 consecutive months after temporarily leaving remunerative work (other than for maternity or paternity leave), the first bullet point in the definition of "totally disabled" becomes: – they are so ill or injured that they are unable to carry out any remunerative work for which they are reasonably suited by their education, training or experience.

DEFINITION OF TOTALLY DISABLED CONTINUED		
Hours based	If the insured person is working more than 20 hours a week in the 12 months immediately preceding disability, the insured person is totally disabled if: – they are so ill or injured that they are unable to carry out the important income producing duties of their usual occupation for more than 10 hours a week, and – they are under the ongoing care of a doctor for that illness or injury, and – they are not working for more than 10 hours a week.	If the insured person is working 20 hours or less a week in the 12 months immediately preceding disability, the insured person is totally disabled if: – they are so ill or injured that they are unable to carry out the important income producing duties of their usual occupation for more than 5 hours a week, and – they are under the ongoing care of a doctor for that illness or injury, and – they are not working for more than 5 hours a week.
	If the insured person suffers an illness or injury more than 12 consecutive months after temporarily leaving remunerative work (other than for maternity or paternity leave), we treat the insured person's usual occupation as being any occupation for which they are reasonably suited by education, training or experience.	

Amount we pay

The monthly amount we pay under the Total Disability benefit is the monthly benefit.

If, in any month, the insured person is totally disabled for less than the full month, the daily amount we pay is the monthly amount divided by the number of days in that month, for each day that the insured person is totally disabled.

When we stop paying

We stop paying the Total Disability benefit when one of the following happens:

- the insured person is no longer totally disabled
- if you have a 1, 2 or 5 year benefit period, all periods that we have paid a benefit in relation to the one claim add up to the benefit period
- the Income Protection Plan ends (see page 50).

If we stop paying because the insured person is no longer totally disabled, you may be eligible to claim the Partial Disability benefit. If we accept your Partial Disability benefit claim, benefit payments will continue without a new waiting period applying.

Partial Disability benefit

When we pay

We pay the Partial Disability benefit if the insured person is partially disabled and has satisfied these conditions:

ADVANCED PLAN (WHITE COLLAR OCCUPATION)	ADVANCED PLAN (OTHER THAN WHITE COLLAR OCCUPATIONS), STANDARD PLAN AND BASIC PLAN
– The insured person has been either totally disabled or partially disabled for the whole waiting period, and – unless the insured person suffers a relapse (see page 48), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.	– The insured person has been totally disabled for at least 7 consecutive days during the waiting period, and – the insured person has been totally disabled or partially disabled for the remainder of the waiting period, and – unless the insured person suffers a relapse (see page 48), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Partial Disability benefit monthly in arrears.

What does "partially disabled" mean?

The insured person is "partially disabled" if:

- they perform remunerative work but because they are so ill or injured they earn less than they did immediately before that illness or injury, and
- they are under the ongoing care of a doctor for that illness or injury.

Amount we pay

The monthly amount we pay under the Partial Disability benefit is calculated using the following formula:

$$\frac{(A - B)}{A} \times C$$

Where:

A = Monthly pre-disability income.

B = The insured person's monthly income earned while partially disabled (if this amount is less than zero, we will treat it as zero).

C = Monthly benefit (see page 40).

If, in any month, the insured person is partially disabled for less than the full month, the daily amount we pay is the monthly amount divided by the number of days in that month, for each day that the insured person is partially disabled.

Other than for the Advanced plan (white collar occupations), the amount we pay under the Partial Disability benefit may be reduced - see benefit offsets on page 49.

What does pre-disability income mean?

– Agreed value plans

If you have an agreed value plan, monthly "pre-disability income" is 1/12 of the insured person's highest average income for any 12 consecutive months between 2 years before the Income Protection Plan started and the start of the waiting period.

– Indemnity plans

If you have an indemnity plan, monthly "pre-disability income" is 1/12 of the insured person's income in the 12 months immediately before the start of the waiting period.

If you have an Advanced plan and we have accepted your claim for a Partial Disability benefit, on each anniversary of the claim (ie the date you became eligible for a benefit under the Income Protection Plan), we will increase "pre-disability income" by the percentage increase in the CPI since the date we commenced paying the benefit. If you have a Standard plan or Basic plan, we will only do this if the Claims Escalation option applies to your Income Protection Plan (see page 47).

When we stop paying

We stop paying the Partial Disability benefit when one of the following happens:

- The insured person is no longer partially disabled.
- If you have a Basic plan, the sum of all the periods for which we have paid the Partial Disability benefit under one claim is equal to 2 years - even if the benefit period is longer than 2 years.
- If you have a 1, 2 or 5 year benefit period, the sum of all the periods we have paid a benefit under the one claim is equal to the benefit period.
- The Income Protection Plan ends (see page 50).

Trauma feature (Advanced plans only)

When we pay

We pay under the Trauma feature if the insured person suffers any of the following trauma conditions or undergoes any of the following medical procedures:

- Aortic surgery
- Cancer
- Coma
- Coronary artery surgery
- Heart attack - myocardial infarction
- Heart attack - out of hospital cardiac arrest
- Heart valve surgery
- Intensive care
- Kidney failure
- Major head trauma
- Major organ transplant
- Open heart surgery
- Peripheral blood stem cell or bone marrow transplant
- Severe burns
- Stroke

Please refer to pages 67 to 73 for the definitions of these trauma conditions and medical procedures.

We pay under the Trauma feature monthly in arrears. We pay even if the insured person does not stop working.

We only pay once for each trauma condition and medical procedure. You can make more than one claim under the Trauma feature as long as each claim is for a different trauma condition or medical procedure.

If the Trauma feature and Major Fracture or Loss feature are payable at the same time, the higher benefit, but not both, will be paid.

Amount we pay

The amount we pay under the Trauma feature is the monthly benefit each month for 6 months. If we paid you under another income benefit for the same claim before we accepted your claim under the Trauma feature, we can take this into account in determining when the 6 month period ends.

We do not take account of any income the insured person receives from remunerative work or any payments set out in Benefits Offsets on page 49.

When does cover start?

Cover does not start under the Trauma feature until 3 months after:

- the Income Protection Plan start date
- an increase to the maximum monthly benefit (other than an increase under the Indexation feature) in respect of the increased portion only
- the most recent reinstatement of the Income Protection Plan.

This means that:

- the trauma condition, or
- the medical condition which the medical procedure is intended to address,

must be diagnosed at least 3 months after the Trauma feature start date. If the diagnosis occurs before this time, we will never pay for that trauma condition or medical procedure under the Trauma feature, even if the insured person suffers the same trauma condition again or undergoes the same medical procedure again.

When we stop paying

We stop paying under the Trauma feature when one of the following happens:

- we have paid under the Trauma feature for 6 months, or
- the Income Protection Plan ends (see page 50).

At the end of the 6 month period, you may be eligible for another benefit (for example, the Total Disability benefit or the Partial Disability benefit). The waiting period for the Total Disability benefit or the Partial Disability benefit can be satisfied while you are receiving a benefit under the Trauma feature.

Major Fracture or Loss feature (Advanced plans only)

When we pay

We pay under the Major Fracture or Loss feature each time the insured person suffers one of the major fractures or losses in the following tables. If the insured person suffers more than one fracture or loss in the same incident, we pay for the one with the longest payment period. We pay under the Major Fracture or Loss feature monthly in arrears. We pay even if the insured person does not stop working.

If the Major Fracture or Loss feature and the Trauma feature are payable at the same time, the higher benefit, but not both, will be paid.

Amount we pay

The amount we pay under the Major Fracture or Loss feature is the monthly benefit each month of the payment period. However, if your benefit period is shorter than the payment period, we only pay for the benefit period.

If we paid you under another income benefit for the same claim before we accepted your claim under the Major Fracture or Loss feature, we can take this into account in determining when the payment period ends. We do not take account of any income the insured person receives from remunerative work or any payments set out in benefit offsets on page 49.

Fractures covered

"Fracture" means the disruption in continuity of bone, with or without displacement. The fracture must be shown by radiographic or scanning techniques

WE COVER FRACTURE OF:	PAYMENT PERIOD (MONTHS)
The spine causing paraplegia or quadriplegia	60
A thigh	3
A pelvis	3
A leg between the knee and foot	2
A kneecap	2
An upper arm	2
A shoulder blade	2
An ankle	2
A hand (requiring a plaster cast or surgery)	1
A forearm above the wrist	1
A collar bone	1
A wrist	1

Losses covered

WE COVER PERMANENT AND IRRECOVERABLE LOSS OF USE OF:	PAYMENT PERIOD (MONTHS)
Both feet*, or both hands*	24
The entire sight of both eyes	24
Any 2 of, a foot*, a hand*, and the entire sight of one eye	24
One leg at or above the knee	18
One arm at or above the elbow	18
One foot*, or one hand*, or the entire sight of one eye	12
The entire thumb, and index finger, of the same hand at or above the first joint	6

*A foot means the whole foot below the ankle and a hand means the whole hand below the wrist.

When we stop paying

We stop paying under the Major Fracture or Loss feature when one of the following happens:

- We have paid for the payment period.
- If you have a 1, 2 or 5 year benefit period, the sum of all the periods that we have paid a benefit under the one claim is equal to the benefit period, or
- The Income Protection Plan ends (see page 50).

At the end of the payment period, you may be eligible for another benefit (for example, the Total Disability benefit or the Partial Disability benefit). The waiting period for the Total Disability benefit or the Partial Disability benefit can be satisfied while you are receiving a benefit under the Major Fracture or Loss feature.

Bedcare benefit (Advanced plans only)

When we pay

We pay the Bedcare benefit if the insured person is bedridden for at least 3 days in a row during the waiting period.

We will not pay the Bedcare benefit for any period that you are entitled to a payment under the Day 1 Accident option, the Trauma feature or the Major Fracture or Loss feature.

The insured person is "bedridden" if they are:

- totally disabled, and
- their doctor requires them to be, and they are, under the full-time care of a registered nurse. The nurse can't be you, or a member of your immediate family or of the insured person.

Amount we pay

The amount of the Bedcare benefit we pay is 1/30th of the monthly benefit for each day the insured person is bedridden during the waiting period.

When we stop paying

We stop paying the Bedcare benefit when one of the following happens:

- the insured person is no longer bedridden
- the waiting period ends
- we have paid the Bedcare benefit for 180 days, or
- the Income Protection Plan ends (see page 50).

If the insured person is bedridden more than once during one waiting period, we treat all of the days they were bedridden as one claim.

Day 1 Accident option (Advanced plans and Standard plans only)

This is an additional premium option. It only applies if it is shown in your certificate of insurance.

When we pay

We pay under the Day 1 Accident option if the insured person is totally disabled for at least 3 days in a row during the waiting period due to an accident.

Accident means bodily injury caused directly and solely by violent, external and visible means and independent of all other causes.

We pay under the Day 1 Accident option monthly in arrears. We will not pay under the Day 1 Accident option for any period that you are entitled to a payment under the Trauma feature or the Major Fracture or Loss feature.

Amount we pay

The amount we pay under the Day 1 Accident option is 1/30th of the monthly benefit for each day that the insured person is totally disabled during the waiting period due to an accident. This amount may be reduced (see benefit offsets on page 49).

When we stop paying

We stop paying under the Day 1 Accident option when one of the following happens:

- the insured person is no longer totally disabled
- the waiting period ends
- we have paid you under the Day 1 Accident option for 30 days, or
- the Income Protection Plan ends (see page 50).

Death feature (Advanced plans and Standard plans only)

We pay under the Death feature if the insured person dies while they are totally disabled or partially disabled and you are receiving an income benefit under this Income Protection Plan (although we don't pay under the death feature if the insured person dies during the waiting period).

We pay 6 extra payments, with each payment equal to the amount we would have paid each month if the insured person was totally disabled.

The maximum we will pay under this benefit under all AMP income protection plans is $60,000.

Superannuation Contribution option

This is an additional premium option. It only applies if it is shown in your certificate of insurance.

When we pay

We will pay under the Superannuation Contribution option if we are paying you under one of the following income benefits:

- Total Disability benefit
- Partial Disability benefit
- Major Fracture or Loss feature
- Trauma feature
- Bedcare benefit, or
- Day 1 Accident option.

Amount we pay

The Superannuation Contribution option is an additional 12% of the maximum monthly benefit you can insure. The maximum monthly benefit in the certificate of insurance includes the additional 12% if the Superannuation Contribution option applies to your Income Protection Plan.

Who we pay

If you are a trustee of a superannuation fund, we will pay the benefit to you. Otherwise, you can choose to:

- receive the benefit directly, or
- nominate a complying superannuation fund or retirement savings account, to which the benefit will be paid on your behalf.

The amount paid under either direction is assessable income and needs to be included in the insured person's tax return in the financial year it is received. The income tax payable on the amount paid will need to be paid from another source as the amount paid to the complying superannuation fund or retirement savings account can't be used to pay income tax because it is required to be preserved in accordance with legislation.

When we stop paying

We stop paying under the Superannuation Contribution option when one of the following happens:

- we stop paying under the income benefits listed above, or
- the Income Protection Plan ends (see page 50).

Rehabilitation Costs feature

When we pay

We will pay the Rehabilitation Costs feature for the reimbursement of the costs of any equipment, vocational rehabilitation programs or works which we agree the insured person needs for rehabilitation when the insured person is totally disabled. We will not reimburse you for medical costs, treatment costs (such as physiotherapy) or any other costs which can only be reimbursed by a registered health insurer.

We do this while the insured person is totally disabled, both during the waiting period and while we are paying a benefit under the Income Protection Plan.

For us to reimburse any costs:

- we need the insured person's doctor to tell us in writing that the equipment, vocational rehabilitation programs or works are necessary for their rehabilitation
- we need a written estimate of the costs, and
- we must agree in writing to pay the costs before you incur them.

Amount we pay

We pay under the Rehabilitation Costs feature up to 12 times the monthly benefit.

When we won't pay

We won't pay:

- if we disagree with the doctor
- any part of the costs which you or the insured person can recover from anywhere else, or
- any costs incurred after the Income Protection Plan ends.

Rehabilitation bonus

We pay the Rehabilitation bonus for up to 12 months while the insured person participates in a rehabilitation program approved by us.

Before the insured person commences the program, we must have approved it in writing.

We pay while the insured person is totally disabled, both during the waiting period and while we are paying a benefit under the Income Protection Plan (and for up to 3 months after the insured person returns to continuous full-time remunerative work).

The amount we pay under the Rehabilitation bonus is an additional one-third of the monthly benefit.

Overseas Transport benefit

We pay the Overseas Transport benefit if the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, to assist with their return travel expenses to Australia.

We reimburse up to the cost of one single economy airfare for the insured person, by the most direct route available, less any amounts anyone else pays you or the insured person for this expense.

Domestic Transport benefit (Advanced plans only)

We pay the Domestic Transport benefit if the insured person is in Australia but more than 100km from their usual residence when they become totally disabled, and requires emergency transportation within Australia. This benefit reimburses costs directly arising from their transportation, other than:

- ambulance services, and
- costs reimbursed from other sources.

This benefit is payable only once in any 12 month period.

We pay up to 3 times the monthly benefit.

Accommodation benefit (Advanced plans only)

We pay the Accommodation benefit to reimburse the reasonable accommodation expenses, once receipts are provided, of an immediate family member of the insured person who accompanies the insured person if:

- you are eligible for a benefit under the Bedcare benefit, and
- the insured person became totally disabled, and remains, over 100km away from their usual residence.

We pay each time a new claim is made if the above requirements are met. This benefit is only payable once in any 12 month period.

We pay up to $250 per day for a maximum period of 60 days.

Family Support benefit (Advanced plans only)

When we pay

We pay the Family Support benefit while the insured person is totally disabled if:

- we have been paying a benefit under the Income Protection Plan for more than one month, and
- the insured person requires the full-time assistance of an immediate family member who was in full-time paid employment when the insured person became totally disabled but who stops all paid employment to look after the insured person.

We pay each time a new claim is made if the above requirements are met.

Amount we pay

We pay 1/30th of the monthly benefit for each day that the conditions of payment are met (to a maximum of $150 per day).

When we stop paying

We stop paying the Family Support benefit when one of the following happens:

- you no longer satisfy the conditions for payment
- we have paid the Family Support benefit for 6 months, or
- the Income Protection Plan ends (see page 50).

AIDS Exclusion option

This is a discounted premium option. It only applies if it is shown in your certificate of insurance.

If the AIDS Exclusion option applies to your Income Protection Plan, we will not pay a benefit for disability arising from the presence of HIV in the insured person's body, or AIDS or any AIDS-related illness.

Indexation feature

On each plan anniversary, we will increase the maximum monthly benefit, unless you tell us not to.

If you have a Basic plan or Standard plan, we will not increase your maximum monthly benefit if we are paying you a benefit (although the maximum monthly benefit may be increased while on claim if the Claims Escalation option applies to your Income Protection Plan - see below).

The amount we will increase the maximum monthly benefit by will be the percentage increase in CPI since the last plan anniversary (or since the plan start date if this is the first plan anniversary under the Income Protection Plan). We won't reduce the maximum monthly benefit if the CPI is negative.

This increase will be clearly identified in the annual statement we send you each year. If you do not want this increase, in full or in part, then you need to tell us.

Guaranteed Future Insurability feature

You can increase the maximum monthly benefit without providing evidence of the insured person's health, occupation or pastimes when the insured person's income increases.

You may increase the maximum monthly benefit by 10% (to a maximum of $1,000 across all AMP Income Protection Plans). This increase is in addition to any increase to the maximum monthly benefit under the Indexation feature. Premiums will be based on the premium rates applicable at the time of exercising this feature.

You may only request an increase once in any 12 month period. You must provide us with appropriate proof of the insured person's increase in income.

When you cannot take out this feature

You can't request an increase the maximum monthly benefit under this feature if at the time of your request:

- the insured person is age 55 or more
- you are unable to provide proof of income to support the requested increase to your maximum monthly benefit
- your Income Protection Plan has a premium loading or special terms, or
- a person is eligible to make a claim, or is claiming a benefit, under any income protection plan with us.

Claim Escalation option

This is an additional premium option on Standard and Basic plans, and only applies if it is shown in your certificate of insurance.

If the Claims Escalation option applies to your Income Protection Plan, we will increase benefit payments made to you under a claim by the percentage increase in the CPI 12 months after the end of the waiting period and every 12 months after that.

If the insured person suffers a relapse (see page 48), we add up all the periods we have paid when calculating the 12 month period.

When you have the Claims Escalation option and we stop paying a claim, the maximum monthly benefit is reduced to the amount it was when we started paying a benefit.

On Hold feature

You can put your Income Protection Plan "on hold" within the first 12 months after the insured person temporarily leaves remunerative work. You must tell us in writing if you want to put your cover "on hold".

While the Income Protection Plan is "on hold" a reduced premium is payable and there is no cover. This means, we won't pay for any illness or injury which happens while the Income Protection Plan is "on hold". You can leave your plan on hold indefinitely until the plan ends.

We guarantee to take the Income Protection Plan "off hold" when the insured person starts remunerative work again and you tell us in writing that you wish to take the cover "off hold". We will take the Income Protection Plan "off hold" in these circumstances without you having to provide evidence of the insured person's health, pastimes or occupation.

Your premium once your Income Protection Plan ceases to be "on hold" is no longer reduced. The premium when the insured person starts remunerative work again will be based on our premium rates at that time.

Change of Employer feature

You can shorten the waiting period if the insured person changes employer and the waiting period at the time is 13 weeks or less.

You can shorten the waiting period to the next shortest waiting period we have available at that time, without providing evidence of the insured person's health, pastimes or occupation. However, you can do that only once in any 12 month period.

You can't shorten the waiting period while we are paying a benefit under the Income Protection Plan (or during the waiting period). If you shorten the waiting period, the premium will increase.

When you ask us to shorten the waiting period, you need to provide us proof that the insured person has changed employer. Usually, all we need is a letter from the insured person's new employer.

Attempted return to work feature

If the insured person returns to work during the waiting period (and is not totally disabled or partially disabled) for 5 days (or less) in a row, the waiting period does not start again. That is so, even if the insured person returns to work more than once during the waiting period. The days of attempted return to work are added to the waiting period for the purposes of determining when the waiting period ends.

Relapse feature

Benefit periods "To age 60 or 65"

If the insured person suffered an illness or injury, and then they again suffer the same illness or injury or one that arises from the same cause or a related cause **within 12 months** after we stopped paying the Total Disability benefit or the Partial Disability benefit, we treat the insured person as having suffered a relapse. We will recommence payment of the Total Disability benefit or Partial Disability benefit, as applicable, without applying a new waiting period.

If the insured person suffered an illness or injury, and then they again suffer the same illness or injury or one that arises from the same cause or a related cause **at least 12 months after** we stopped paying the Total Disability benefit or the Partial Disability benefit, we will not treat the insured person as having suffered a relapse. We treat it as a new claim and the waiting period starts again.

Benefit periods of 1, 2 and 5 years

If the insured person suffered an illness or injury, and then they again suffer the same illness or injury or one that arises from the same cause or a related cause, what happens depends on why we stopped paying.

If we stopped paying because we had paid for the full benefit period, we will only pay if the insured person has worked in their usual occupation for at least their usual income for at least 6 months in a row since we stopped paying. In that case, we treat the claim as a new claim and both the waiting period and benefit period start again.

Otherwise:

- If the insured person suffers the same illness or injury or one that arises from the same cause or a related cause **within 6 months** of when we stopped paying, then we treat the insured person as having suffered a relapse. We will treat the claim as a continuation of the previous claim and recommence payment of the Total Disability benefit or Partial Disability benefit (as applicable) without applying a new waiting period.
- If the insured person suffers the same illness or injury or one that arises from the same cause or a related cause **at least 6 months after** we stopped paying, then we will not treat it as a relapse. We treat it as a new claim and the waiting period and benefit period start again.

Premium waiver - when you don't have to pay premiums

You don't have to pay premiums if we are paying a benefit under the Income Protection Plan. This is so even if the benefit payable under the Income Protection Plan is reduced to nil due to benefit offsets (see page 49).

Once we have accepted your claim for a Total Disability benefit or Partial Disability benefit under the Income Protection Plan, we will refund any premiums that fell due during the waiting period.

If we have paid until the benefit period ended and the insured person is still totally disabled or partially disabled, your Income Protection Plan still continues until the Income Protection Plan ends. You do not have to pay the premium while the insured person is totally disabled. However, for the purposes of determining whether this premium waiver will apply, we apply the duties based definition of "totally disabled" on page 41 and the first bullet point of that definition becomes:

- they are so ill or injured that they are unable to do any remunerative work for which they are reasonably suited by their education, training or experience.

Specific rules for Basic plans

If you have a Basic plan, when we have finished paying a claim we have the choice of:

- Keeping the cover going on the same terms as it had before the claim.
- At any time after the first plan anniversary, we can change the terms of the Income Protection Plan (for example we can charge extra premiums or add a specific rule to your Income Protection Plan), or
- At any time after the second plan anniversary, we can cancel the cover.

What we will do will depend on the circumstances of the claim.

If we don't cancel the Income Protection Plan after a claim, we will keep the Income Protection Plan going each year on the terms we set out when the claim was finished.

We will do this as long as you pay the premium on time - until we finish paying any other claim under the Income Protection Plan. When we finish paying any other claim, we can again change the terms of the cover or cancel it.

Benefit offsets

When we will reduce the amount we pay

ADVANCED PLAN (WHITE COLLAR OCCUPATIONS)

We will not reduce a benefit by payments you or the insured person receives from any other source.

This does not apply to reductions permitted under the Rehabilitation Costs feature, the Overseas Transport benefit and the Domestic Transport benefit.

ADVANCED PLAN (OTHER THAN WHITE COLLAR OCCUPATIONS), STANDARD PLAN AND BASIC PLAN

We will reduce the amount we pay under the Total Disability benefit, the Partial Disability benefit and the Day 1 Accident option, if you or the insured person receives any of the following payments:

- Regular payments from any workers compensation, accident compensation or public liability scheme payable because the insured person is ill or injured.
- Regular payments from any insurance policy covering the insured person after you applied for the Income Protection Plan if either:
  - the insurer did not consider this Income Protection Plan in assessing your eligibility, or
  - the insured person's total income from all insurance policies exceeds 75% of their pre-disability income.

If any of these payments are not paid monthly, we will convert them to monthly payments for our calculation. If the payment is a lump sum, we will only take into consideration that part of the payment that relates to compensation for loss of wages or earning capacity.

We ignore any other income or regular payments (including investment income and amounts paid as compensation because of the insured person's pain and suffering).

We reduce the amount we pay so that you do not receive more than:

- 75% of the insured person's pre-disability income while the insured person is totally disabled, or
- 100% of the insured person's pre-disability income if they are partially disabled.

We can recalculate how much we pay, or have paid, if we did not include amounts listed above. You must return any amount we have overpaid. We can choose either to:

- reduce any amounts we pay in the future to cover those overpayments, or
- recover from you any amounts you owe us.

If we have underpaid, we will pay you the amount we owe.

Deducting taxes or charges

We can deduct from amounts we pay, any taxes or government charges that:

- the law requires us to deduct, or
- have to be paid and which we decide to deduct.

Premiums and fees

See page 59.

When we won't pay

We won't pay if the insured person's injury or illness was caused directly or indirectly by:

- war - whether war was declared or not, or
- your, or the insured person's, intentional or deliberate act.

We don't pay for normal and uncomplicated pregnancy or childbirth. However, we pay if the insured person is totally disabled or partially disabled because they suffer complications during pregnancy or while giving birth.

When cover starts

Your Income Protection Plan starts on the date specified in your certificate of insurance. Any alteration to your cover, or increase in the maximum monthly benefit, starts on the date we notify you in writing.

When the Income Protection plan ends

Your Income Protection Plan ends when one of the following happens:

- the insured person turns 60 (if the benefit period is 1 year, 2 years, 5 years or "to age 60")
- the insured person turns 65 (if the benefit period is "to age 65")
- the insured person dies
- the date we receive your written request to cancel the Income Protection Plan
- we cancel your Income Protection Plan because you have not paid your premium or any other amount payable under the plan
- the insured person leaves remunerative work and intends never to return to remunerative work, or
- if you have a Basic plan, we cancel the plan in the circumstances set out in the Specific rules for Basic plans on page 49.

We may also cancel your Income Protection Plan for any reason the law permits. For example, if you do not comply with your duty of disclosure, we may cancel your plan from the plan start date and treat it as never having existed.

Reinstating the Plan

You may apply to have your Income Protection Plan reinstated if we cancel the plan because you have not paid your premium. You must apply within 3 months after the due date of the premium you did not pay.

We may reinstate your plan on any terms we determine at the time.

Transferring ownership

You can't transfer the ownership of the Income Protection Plan to anyone else. Also, you can't use the plan as security for any loan and the only person we will pay under the plan is you. That is so even if we receive notice of a trust, assignment, lien or charge related to an attempt to transfer any rights under the plan to anyone.

About the Business Overheads Insurance plan

(Not available through the AMP Personal Super Fund)

Under a Business Overheads Insurance plan you can be reimbursed for eligible business overheads while the insured person is totally disabled or partially disabled due to illness or injury.

Is this plan right for you?

This cover is particularly appropriate for:

- Small businesses, partnerships with 5 or less partners and sole traders. Generally, it does not matter how the business is structured or who owns it.
- Businesses where the cashflow is earned as a result of services rendered (eg professionals or consultants).

Generally, this cover will not be suitable for businesses where cashflow is earned from the sale of goods (eg retail shopkeepers).

To be eligible for this cover, you need to show us that:

- the insured person's efforts are largely responsible for generating the business cash flow (or their share of its cash flow)
- if the insured person were unable to work, that cash flow would significantly decline, or even cease, and
- the insured person is responsible for the payment (or their share) of business expenses.

Flexibility to tailor a plan that meets your needs

The Business Overheads Insurance plan gives you choices - so that you have the flexibility to tailor a plan that suits your needs. This section sets out the choices available to you.

Who can own the plan?

The Business Overheads Insurance plan can be owned by:

An individual	A company

A Business Overheads Insurance plan can be owned by the individual or company that incurs the overhead costs of the business.

We pay a benefit under the Business Overheads Insurance plan to the plan owner.

Who can be an insured person?

The "insured person" is the person whose life is covered under the Business Overheads Insurance plan. There can only be one insured person under a Business Overheads Insurance plan.

We only insure certain types of occupations. The person must be between the ages of 19 to 59 when you apply for cover. These entry age requirements apply to new business, as well as to increases and additions to existing plans.

How much cover do you need?

You can choose a maximum monthly benefit up to 100% of your monthly business expenses. The minimum maximum monthly benefit is currently $1,250.

How long is the benefit period and what waiting period suits your needs?

The benefit period is one year. This is the maximum period of time that we will pay most benefits. It can be extended by up to 6 months in some circumstances (see page 56).

The waiting period is the period you must wait before you can become eligible for a Total Disability benefit or a Partial Disability benefit.

You can have either a 2 week or 4 week waiting period.
The premium is cheaper if you choose a longer waiting period.

Business Overheads Insurance Plan facts

Cover expiry age

Cover expires at age 65.

Taxation information

ARE PREMIUM PAYMENTS DEDUCTIBLE?	ARE BENEFIT PAYMENTS ASSESSABLE FOR INCOME TAX?
Premium payments are generally tax deductible if incurred by a business.	Benefit payments are generally assessable for income tax and should be included in your business's tax return.

We recommend that you speak to your accountant or tax adviser about your personal tax circumstances.

Plan rules - Business Overheads Insurance

Benefits and features at a glance

The benefits and features of the Business Overheads Insurance Plan are listed below.

In-built benefits and features are shown below like this: →

A discounted premium option can be added to your Business Overheads Insurance Plan. This option will only apply if it is shown in your Certificate of Insurance, and is shown below like this: →

The benefits and features of the Business Overheads Insurance Plan are explained in detail on pages 54 to 57. Some words and expressions used in the Plan Rules have a specific meaning. These words and expressions are defined in the dictionary (see pages 67 to 75).

Key benefits

We will pay you one of the following business income benefits at any one time - as long as you satisfy the conditions for payment:

Total Disability benefit
(see page 54)

Partial Disability benefit
(see page 55)

Additional benefits

These additional benefits may be paid in addition to one of the business income benefits referred to above:

Cash Flow bonus
(see page 56)

Locum bonus
(see page 56)

Overseas transport benefit
(see page 56)

Features

The Business Overheads Insurance Plan has the following features:

Indexation feature
(see page 57)

Attempted return to work feature
(see page 57)

Relapse feature
(see page 57)

On Hold feature
(see page 57)

Aids Exclusion option
(see page 57)

Premium Waiver
(see page 57)

24 hour, worldwide cover

The insured person is covered worldwide, 24 hours a day, 7 days a week (although benefit payments may stop after 3 months unless the insured person returns to Australia or New Zealand - see page 53).

Guaranteed renewable

As long as you pay premiums when they are due, we guarantee to continue the Business Overheads Insurance plan until the plan ends (see page 58).

Understanding the Waiting Period, Benefit Period and the Maximum Monthly Benefit

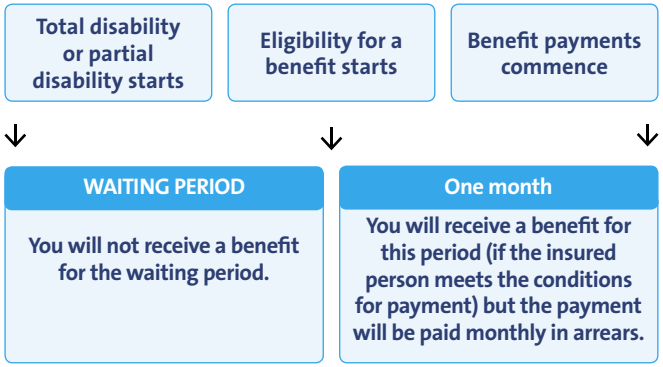
Waiting period

The waiting period is the period of time you must wait before you become eligible for a Total Disability benefit or Partial Disability benefit. The length of the waiting period you choose is shown in the Certificate of Insurance.

The waiting period starts on the date the insured person becomes totally disabled.

The waiting period only ends when the total number of days the insured person has been totally disabled or partially disabled (as applicable) when added together, equal the waiting period.

The following diagram illustrates how the waiting period and the timing of payments work.



Benefit period

The benefit period is 12 months. It is the maximum period of time that we will pay the Total Disability benefit and the Partial Disability benefit for one claim. We may extend the benefit period in some circumstances (see page 56).

When the insured person is outside Australia or New Zealand

We will pay for an illness or injury that happens anywhere in the world at any time. However, we may not pay for more than 3 months while the insured person is outside Australia or New Zealand (maximum overseas payment period).

We may agree to keep paying for more than 3 months while the insured person is outside Australia or New Zealand if you ask us to and you, and the insured person, agree to any conditions we set.

If we don't pay after the maximum overseas payment period, then, when the insured person returns to Australia or New Zealand, we will start paying again if you are still entitled to be paid under the Business Overheads Insurance plan. We will not pay you for any period before the insured person returns to Australia or New Zealand (other than the maximum overseas payment period).

If the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, then we may assist you with their return travel expenses (see Overseas Transport benefit on page 56).

Maximum monthly benefit

The maximum monthly benefit is the amount you apply for, and we accept, as varied in accordance with the terms of the Business Overheads Insurance plan (for example, under the Indexation feature) or by agreement.

Benefits and features explained

When we pay

We only pay a benefit under the Business Overheads Insurance Plan if the insured event happens after cover starts and before cover ends (see page 58).

We won't pay a benefit under the Business Overheads Insurance Plan in some circumstances (see "When we won't pay" on page 58). Also, we may reduce the amount we pay under a benefit if you receive payments from other sources (see "Benefit Offsets" on page 58). You must satisfy our claim requirements before we pay a benefit (see page 63).

Other than that, we will pay a benefit under the Business Overheads Insurance Plan in the circumstances set out in this section.

Total Disability benefit

When we pay

We pay the Total Disability benefit if the insured person is totally disabled and has satisfied these conditions:

- the insured person has been totally disabled for the whole waiting period, and
- unless the insured person has suffered a relapse (see page 57) the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Total Disability benefit monthly in arrears.

What does "totally disabled" mean?

The insured person is "totally disabled" if:

- they are so ill or injured that they are unable to carry out any one duty, or combination of duties, which are critical to the proper performance of their usual occupation, and
- they are under the ongoing care of a doctor for that illness or injury, and
- they do not do any remunerative work (see page 75 for the meaning of "remunerative work").

Amount we pay

We will reimburse the eligible business overheads (as defined on this page) incurred in a month, up to the maximum monthly benefit.

If, in any month, the insured person is totally disabled for less than a full month, we will pay a daily amount for each day that the insured person is totally disabled in that month. We calculate the daily amount by dividing the monthly amount by the number of days for that month.

We may reduce the amount of Total Disability benefit we pay by:

- benefit offsets (see page 58), and
- any amount which the person who replaces the insured person has generated (since the end of the waiting period) in excess of the amount they cost.

What are eligible business overheads?

Eligible business overheads include ongoing fixed costs which will continue to be payable while the insured person is disabled, such as:

- Salaries of non-income producing staff - including family members who have been employed for more than 3 months in the business at the date the insured person became totally disabled. For example, we will pay salaries for secretaries, bookkeeping staff etc. We also pay costs directly relating to those salaries. For example, we pay workers compensation and superannuation costs.
- Rent and mortgage interest payments for the business premises - unless they are also the insured person's residence.
- Property rates and property taxes.
- Leasing costs for office equipment and motor vehicles.
- Electricity, water, heating and telephone bills.
- Cleaning and laundry bills.
- General insurance premiums.
- Subscriptions to professional associations.
- Advertising costs.
- Accountant's and auditor's fees, and
- Any other business overheads we agree to cover.

Note: When the business employs someone to replace the insured person, if all the reasonable costs of employing that replacement person (eg salary, travel, accommodation, superannuation, etc) exceed the business income the replacement generates, then we treat that excess as an eligible business overhead.

What are not eligible business overheads?

The following costs are not eligible business overheads:

- Any form of remuneration paid to:
  - The insured person.
  - Someone who is not a genuine employee adding value to the business.
  - The person who replaces the insured person - for example a locum.
  - People who earn income for the business, and
  - Any member of the insured person's family who has been employed for less than 3 months in the business at the date the insured person became totally disabled.
- The cost of stock, equipment, or other assets of the business.
- Payments of the principal of any mortgage or debt.
- Any rent or mortgage payments on the insured person's residential premises - even if the insured person uses those premises for their business.
- Any tax the business has to pay.
- Any depreciation.
- Expenses which the business does not incur regularly, and
- Expenses which are not normal and necessary for the business.

When we stop paying

We stop paying the Total Disability benefit when one of the following happens:

- the insured person is no longer totally disabled
- all the periods we have paid because of one claim add up to 12 months, unless the benefit period is extended (see page 56), or
- the Business Overheads Insurance plan ends (see page 58).

If we stop paying because the insured person is no longer totally disabled, you may be eligible for the Partial Disability benefit. If we accept your Partial Disability benefit claim, benefit payments will continue without a new waiting period applying.

Partial Disability benefit

When we pay

We pay the Partial Disability benefit if the insured person is partially disabled and satisfies these conditions:

- The insured person has been totally disabled for at least 7 consecutive days during the waiting period.
- The insured person has been totally disabled or partially disabled for the remainder of the waiting period, and
- Unless the insured person has suffered a relapse (see page 57), the insured person has been continuously totally disabled or partially disabled since the end of the waiting period.

We pay the Partial Disability benefit monthly in arrears.

What does "partially disabled" mean?

An insured person is "partially disabled" if:

- they perform remunerative work but the illness or injury which made them totally disabled causes them to earn less than they did before they became totally disabled, and
- they are under the ongoing care of a doctor for that illness or injury.

Amount we pay

The monthly amount of the Partial Disability benefit we pay is calculated using the following formula:

$$\frac{(A - B)}{A} \times C$$

Where:

A = Pre-disability business income. This is 1/12th of the insured person's business income during the 12 months before the insured person became totally disabled.

B = The insured person's monthly business income while partially disabled. If this amount is less than zero, we will treat it as zero.

C = The amount we would have paid if the insured person was totally disabled.

We pay a daily amount if the insured person is partially disabled for less than a full month. The daily amount we pay is the monthly amount divided by the number of days in that month, for each day that the insured person is partially disabled.

We may reduce the amount of the Partial Disability benefit we pay by the benefit offsets (see page 58).

When we stop paying

We stop paying the Partial Disability benefit when one of the following happens:

- the insured person is no longer partially disabled
- all the periods we have paid because of one claim add up to 12 months, unless the benefit period is extended (see page 56), or
- the Business Overheads Insurance plan ends (see page 58).

When we extend the benefit period

We will extend the period we pay you if:

- we have been paying you for a period of 12 months, and
- the insured person continues to be totally disabled or partially disabled, and
- the total amount we have paid is less than 12 times the maximum monthly benefit.

We will continue to pay you until one of the following happens:

- the expiration of a further 6 months
- the total amount we have paid you equals 12 times the maximum monthly benefit
- the insured person ceases to be totally disabled or partially disabled, or
- The Business Overheads Insurance plan ends.

Locum bonus

Where we are paying a claim and you have employed a locum to the insured person's position, we pay a lump sum amount of $1,000 to help you meet the cost of this appointment. This amount does not increase with the Indexation feature.

This amount will only be paid once during the term of the plan.

Cash Flow bonus

We pay a Cash Flow bonus, in addition to the Total Disability benefit, to help you cope with the peaks and troughs in your eligible business overheads from month to month. The Cash Flow bonus is paid out of the "benefits pool" or the "expenses pool", as explained below:

WHAT IS THE "BENEFITS POOL"?	WHAT IS THE "EXPENSES POOL"?
If, in any month, we pay a Total Disability benefit which is less than the monthly benefit, we will allocate the difference to the benefits pool.	If, in any month, we pay a Total Disability benefit which equals the monthly benefit (but that amount is less than the eligible business overheads incurred) we will allocate unpaid eligible business overheads to the expenses pool.
The monthly benefit is the maximum monthly benefit less benefit offsets (see page 58).	

Amount we pay

The amount of Cash Flow bonus we pay is:

NEGATIVE CASH FLOW SITUATION	POSITIVE CASH FLOW SITUATION
The amount by which your eligible business overheads (less benefit offsets) in a particular month exceeds your maximum monthly benefit (up to a maximum of the benefits pool).	The amount by which your eligible business overheads (less benefit offsets) in a particular month are less than your maximum monthly benefit (up to a maximum of the expenses pool).

Example

Maria is a surveyor in sole practice. She is injured in a car accident and can't work. She has a Business Overheads Insurance plan, so we start paying her eligible overheads. Her maximum monthly benefit is $2,000.

While she is totally disabled, she doesn't receive any reimbursement of overheads from anyone else and she doesn't appoint a locum.

In January, Maria's eligible business costs are $1,800. We pay her that amount, and we allocate the left over $200 to the benefits pool.

In February, Maria's business has an expensive month - her insurance, rates, and electricity bills arrive. Maria's eligible business costs are $2,350 and she is in a negative cash flow situation. We pay Maria the maximum monthly benefit, $2,000 plus the $200 from the benefits pool. We allocate the $150 of unpaid overheads ($2,350 - $2,200 paid to her) to the expenses pool.

In March, Maria is in a positive cash flow situation. Her eligible business costs are $750. We add the $150 from the expenses pool to the $750 for March, and pay Maria $900.

Overseas Transport benefit

We pay the Overseas Transport benefit if the insured person has been outside Australia for more than 30 days, and they have been totally disabled for at least 14 days while they were overseas, to assist with their return travel expenses to Australia.

We reimburse up to the cost of one single economy airfare for the insured person, by the most direct route available, less any amounts anyone else pays you or the insured person for this expense.

AIDS Exclusion option

This is a discounted premium option. It only applies if it is shown in your certificate of insurance.

If the AIDS Exclusion option applies, we will not pay a benefit for disability arising from the presence of HIV in the insured person's body, or AIDS or any AIDS-related illness.

Indexation feature

On each plan anniversary, we will increase the maximum monthly benefit by the percentage increase in the CPI since the last plan anniversary (or since the plan start date if this is the first plan anniversary under the Business Overheads Insurance plan). However, we will not do this if:

- you tell us not to, or
- we are paying you a benefit.

We will not reduce the maximum monthly benefit if the CPI is negative.

This increase will be clearly identified in the annual statement we send you each year.

If you do not want this increase, in full or in part, then you need to tell us.

Attempted return to work feature

If the insured person returns to work during the waiting period (and is not totally disabled or partially disabled) for 5 days (or less) in a row, the waiting period does not start again. That is so, even if the insured person returns to work more than once during the waiting period. The days of attempted return to work are added to the waiting period for the purposes of determining when the waiting period ends.

Relapse feature

If the insured person suffered an illness or injury, and then they again suffer the same illness or injury or one that arises from the same or a related cause, what happens depends on why we stopped paying.

If we stopped paying because we had paid 12 times the monthly benefit, we will only pay if the insured person has worked in their usual occupation for at least their usual income for at least 6 months in a row since we stopped paying. In that case, we treat the claim as a new claim and both the waiting period and benefit period start again.

Otherwise:

- If the insured person suffers the same illness or injury or one that arises from the same cause or a related cause **at least 6 months after** we stopped paying, then we will not treat it as a relapse. We treat it as a new claim and both the waiting period and the benefit period start again.
- If the insured person suffers the same illness or injury or one that arises from the same cause or a related cause **within 6 months after** we stop paying, then we treat the insured person as having suffered a relapse. We will treat the claim as a continuation of the previous claim. The waiting period and the benefit period do not start again. Instead, we add up all the periods we pay you for that claim and treat them as one benefit period.

On Hold feature

You can put the Business Overheads Insurance plan "on hold" within the first 12 months after the insured person temporarily leaves remunerative work. You must tell us in writing if you want to put your cover "on hold".

While the Business Overheads Insurance plan is "on hold" a reduced premium is payable and there is no cover. That means, we won't pay for any illness or injury which happens while the plan is "on hold".

We guarantee to take the Business Overheads Insurance plan "off hold" when the insured person starts remunerative work again and you tell us in writing that you wish to take the Business Overheads Insurance plan "off hold". We will take the Business Overheads Insurance plan "off hold" in these circumstances without you having to provide evidence of the insured person's health, pastimes or occupation.

Your premium once your Business Overheads Insurance plan ceases to be "on hold" is no longer reduced. The premium when the insured person starts remunerative work again will be based on our premium rates at that time.

Premium Waiver - when you don't have to pay premiums

You do not need to pay premiums under the Business Overheads Insurance plan if we are paying a benefit under the Business Overheads Insurance plan. This is so even if the benefit payable under the Business Overheads Insurance plan is reduced to nil due to benefit offsets (see page 58).

Once we have accepted your claim for a Total Disability benefit or Partial Disability benefit under the Business Overheads Insurance plan, we will refund any premiums that fell due during the waiting period.

If we have paid until the benefit period ended and the insured person is still totally disabled or partially disabled, your cover still continues until the Business Overheads Insurance plan ends. You do not have to pay the premium while the insured person is totally disabled. However, for the purpose of this premium waiver, the first bullet point in the definition of "totally disabled" on page 54 becomes:

- they are so ill or injured that they are unable to carry out any remunerative work for which they are reasonably suited by their education, training or experience.

Continue cover

We can continue cover up to 12 months after the insured person temporarily stops working for reasons other than illness or injury.

Benefit offsets

When we will reduce the amount we pay

We will reduce the amount of the Total Disability benefit and Partial Disability benefit we pay if you, or the insured person, receives a business expense benefit from other insurance policies.

We deduct taxes and charges

We can deduct from amounts we pay, any taxes or government charges that:

- the law requires us to deduct, or
- have to be paid and which we decide to deduct.

Premiums and fees

See page 59.

When we won't pay

We will not pay if the insured person's injury or illness was caused directly or indirectly by:

- war - whether war was declared or not, or
- your, or the insured person's, intentional or deliberate act.

We do not pay for normal and uncomplicated pregnancy or childbirth. However, we will pay if the insured person is totally disabled or partially disabled because they suffer complications during pregnancy or while giving birth.

When does your cover start?

Your Business Overheads Insurance Plan starts on the date specified in your certificate of insurance. Any alteration to your cover, or increase in the maximum monthly benefit, starts on the date we notify you in writing.

When the plan ends

Your Business Overheads Insurance plan ends when one of the following happens:

- The insured person turns 65.
- The insured person dies.
- We receive your written request to cancel the Business Overheads Insurance plan.
- We cancel your Business Overheads Insurance plan because you have not paid your premium or any other amount payable under the plan.
- The insured person leaves remunerative work and intends never to return to remunerative work, or
- The insured person leaves remunerative work for more than 12 months but you did not put the Business Overheads Insurance plan "on hold" under the On Hold feature.

We may also cancel your Business Overheads Insurance plan for any reason the law permits. For example, if you do not comply with your duty of disclosure, we may cancel your plan from the plan start date and treat it as never having existed.

Reinstating the Plan

You may apply to have your plan reinstated if we cancel the plan because you have not paid your premium. You must apply within 3 months after the due date of the premium you did not pay.

We may reinstate your plan on any terms we determine at the time.

Transferring ownership

You can't transfer the ownership of the Business Overheads Insurance plan to anyone else. Also, you can't use the plan as security for any loan and the only person we will pay under the plan is you. That is so even if we receive notice of a trust, assignment, lien or charge related to an attempt to transfer any rights under the plan to anyone.

Premiums and fees - facts

What is the premium?

The amount you pay for your plan is called a premium. Your premium includes a plan fee (which can increase each year by the CPI) and will usually change each year.

Before you apply for cover, you can obtain an individual premium quote from your financial planner or by calling AMP on 1300 360 838. Each year, AMP will send you an Annual Statement advising you about your premiums for the next year.

2010 PLAN FEES		
Life Protection plan	$81.10 pa for the first insured person	$16.20 pa for any subsequent insured person(s)
Income Protection plan	$81.10 pa	$16.20 pa for any other Income Protection plan or Business Overheads Insurance plan taken out at the same time to cover the same insured person
Business Overheads Insurance plan	$81.10 pa	

Note: Only one person can be insured under an Income Protection plan or Business Overheads Insurance plan.

The minimum premium (including the plan fee) for a plan is $250 pa for the first insured person and $200 pa each for any other insured person(s).

Flexible payment options

You can pay premiums yearly, half-yearly or monthly by direct debit from your:

- bank account, building society account, or credit union account, or
- MasterCard, or
- VISA, or
- American Express card.

You can also pay yearly or half-yearly by cheque, BPAY or Post Billpay.

These payment options are subject to change.

Factors that affect your premium

The following table describes the various premium factors we consider and how they may affect your premium.

PREMIUM FACTOR	HOW IT AFFECTS YOUR COVER
Type of insurance	We apply different base premium rates to different benefits and options.
Age	Generally, as you become older the cost of insurance increases.
Gender	As illness and life expectancy varies between men and women, we may charge different premium rates. Death cover and Trauma cover premiums are generally cheaper for females. TPD cover premiums are generally similar for males and females. Income Protection and Business Overheads Insurance premiums are generally cheaper for males.
Smoking status	We charge more for smokers.
Premium type	We apply different base premium rates depending on your choice of stepped or level premiums. If the premium type is stepped, premiums generally increase each year in line with the insured person's age. Stepped premiums are cheaper than level premiums in the early years of cover. If the premium type is level, premiums do not increase each year because of the insured person's age (but your premium can increase for other reasons). Level premiums are more expensive than stepped premiums in the early years of cover but will become cheaper than stepped premiums in the longer term.
State of health	We charge different rates depending on your state of health and family medical history.
Sports/ recreational activities	We charge more for anyone engaged in activities we consider "high risk", eg scuba diving.
Optional extras	Adding options (eg Own Occupation option) will increase the premium payable.
Stamp duty	Stamp duty is a Government levy payable on insurance (see Government duties on page 60).
Payment frequency	If you pay more often than yearly, we may include an additional premium frequency loading in the premium.
ADDITIONAL FACTOR FOR TPD COVER, INCOME PROTECTION PLAN AND BUSINESS OVERHEADS INSURANCE PLAN	
Occupation	Generally, occupations with hazardous duties or higher risks are charged more.
ADDITIONAL FACTORS FOR INCOME PROTECTION PLAN AND BUSINESS OVERHEADS INSURANCE PLAN	
Waiting period	The premium is cheaper if you choose a longer waiting period.
Benefit period	The premium is cheaper if you choose a shorter benefit period.
ADDITIONAL FACTOR FOR INCOME PROTECTION PLAN	
Agreed value or indemnity	We charge more for Agreed value plans.

Government duties

Your premium may also include government stamp duty or a similar tax.

Stamp duty is either incorporated into the base premium rate or is an additional charge. If it is an additional charge it will be shown on your annual statement. We may change the way we recover stamp duty, from incorporating it into base premium rates to making it an additional charge.

Currently, additional stamp duty charges vary between 1.5% and 11% of the cost of the base premium, depending on the plan, cover and/or options selected, and the State or Territory we record as the address of the first insured person on your plan.

As stamp duty differs between States and Territories it is important that you inform us of any changes to the address of the first insured person on your plan.

Discount and loadings

We apply discounts or loadings to the premiums for Life Protection Plans and Income Protection Plans, based on the size of the sum insured. These discounts and loadings are not guaranteed. The premium adjustment is effective on the full amount of the sum insured for each insured person. Each benefit is calculated separately. Due to the operation of the discount tables there will be instances where the premium for the same insured person may be less for a larger sum insured. The premium quote you receive will already take these discounts/loadings into account.

If you pay more often than yearly, we may include an additional premium frequency loading in the premium. This fee is a percentage of the yearly premium payable.

For monthly payments the loading is currently 7.52% and for half-yearly payments it is 3%.

Direct Debit Service Agreement

The following terms will apply to any direct debit that you, your spouse or your employer set up to make payments. These terms equally apply to members of the AMP Personal Super Fund if the insurance is acquired through the AMP Personal Super Fund. Here a reference to "you" will also include a reference to a "member".

Before you request a direct debit arrangement you must check that the account you want to nominate can have direct debit (eg some passbook savings accounts cannot have direct debit). To find out if we can debit from your account, contact your financial institution.

Please double-check any account details you provide by comparing them with a recent statement from your financial institution.

This agreement allows AMP Life Customer Service Division to deduct from your nominated account the amount and at the frequency shown on the certificate of insurance, or the amount as modified annually due to increases under the Indexation feature.

If we want to change this agreement, we will notify you 14 days in advance unless the change is specifically in relation to Government stamp duty. If you disagree with this change, please notify us within these 14 days.

AMP will keep your financial institution account details confidential. However, we will disclose these details:

- if you give permission
- if a court order applies
- to settle a claim, or
- if our financial institution needs information.

If the due date is on a weekend or public holiday, we will process your payment on the next business day.

You should make sure that sufficient cleared funds are available in your account on the due date for payment.

If there are not sufficient funds and your financial institution dishonours the payment, any charges incurred by:

- your financial institution may be debited from your account, and
- AMP may be debited from your Plan.

If you want to change or cancel this agreement or dispute a debit, contact our Customer Service area. In particular, if you want to:

- Change this agreement (eg the amount you pay, how often you pay, account number, deferring payment due to unforeseen circumstances) - you need to contact us at least 3 days before the due date.
- Cancel this agreement or an individual payment - you need to contact us at least 5 days before the due date.
- Dispute a debit that has been made from your account - AMP will respond to your initial dispute within 5 business days.

Cancellations and claims may also be made through your financial institution.

If you believe that a debit has not been correctly processed, you should contact us immediately on 131 267.

You indemnify us against all losses, costs, damages and liabilities that we suffer as a result of you breaching this agreement, or providing us with an invalid or non-binding direct debit request addressed to us.

Ad-hoc direct debit

You, your spouse or your employer can request us to transfer ad-hoc amounts from your, your spouse's or your employer's bank account. Ad-hoc direct debits are not an automatic periodical deduction of a fixed amount. Debits from your, your spouse's or your employer's bank account will only occur each time you, your spouse or your employer instruct us by phone or in writing.

Plan Rules - Premiums and fees

Both the initial premium you are required to pay and when it is due are stated in your Certificate of Insurance. Your initial premium consists of:

- the basic premium
- the plan fee, and
- government charges (eg Stamp Duty).

Premium types - stepped or level premiums

Stepped method

Under the stepped method, we will recalculate the basic premium for an insured person's cover on each plan anniversary, based on the insured person's age on that date. The premium will usually increase.

Level method

Under the level method, the premium for:

- an insured person's initial insured amount (for a Life Protection Plan) or maximum monthly benefit (for an Income Protection Plan), is based on the insured person's age at the plan start date, and
- any increase in the insured amount (for a Life Protection Plan) or the maximum monthly benefit (for an Income Protection Plan), is based on the insured person's age at the date of the increase.

If you choose a level premium for Death cover, TPD cover or Trauma cover the premium will automatically change to stepped from the plan anniversary after the insured person turns 64.

Changes to premium rates

Regardless of whether your premium type is Stepped or Level, the premium rates are not guaranteed. We may vary premium rates at any time. Any increase in your premium will apply at your next plan anniversary.

We can't single you out for an individual premium rate variation. If we increase premium rates we will apply the increase to all plans that we consider to be similar to your plan.

If we reduce our premium rates (or increase any discounts) for the Life Protection Plan we may keep your premium the same by increasing the insured amount under your plan. We will tell you in writing before we do this.

Keeping the premium the same

If you do not want your premium to increase on a plan anniversary, you need to write to us before the plan anniversary to let us know.

As we will reduce the insured amount (for a Life Protection Plan) or the maximum monthly benefit (for Income Protection Plans or Business Overheads Insurance Plans) to keep the premium the same, you must also tell us at the time the plan or cover that you want to reduce or cancel.

Premium frequency loading

If you pay more often than yearly, we may include an additional premium frequency loading in the premium. This loading is a percentage of the yearly premium payable. We can change the percentage at any plan anniversary and we will inform you of any changes before it applies.

If you stop paying premiums

If you don't pay each premium as it becomes due, we can end your plan. If you don't pay on time, we will write and remind you and you will have 30 days to pay before we take steps to end your plan.

Refund of premiums

If you end your plan during a period that you have already paid the premium, we will refund the premium (or proportion of that premium) less the plan fee, stamp duty and Government charges, for any unused complete months.

We don't refund premiums if the plan ends for any other reason.

If cover under a Life Protection Plan is acquired through the AMP Personal Super Fund, the Trustee will pay this refund into a similar complying superannuation fund nominated by the member, or to an account in the AMP Eligible Rollover Fund on behalf of the member.

This right is in addition to any "cooling off" rights you have under a plan.

Statutory fund

Premiums are paid to, and benefit payments are made from (and are limited to), the assets of our No. 1 Statutory Fund.

Payments to your financial planner

Standard commission

AMP Life will normally pay a standard commission to the financial planner for your plan. We pay this out of the insurance premiums - you do not pay this additional amount.

If you do not have a financial planner, then the premium remains the same.

Depending on the commission structure selected, the standard commission (including GST) is:

- 112.75% of the first year's premiums and 11% of premiums for that year and each subsequent year, or
- 55% of the first year's premiums and 22% of premiums for that year and each subsequent year, or
- 30.25% pa of premiums.

Regardless of the commission structure selected, the premium remains the same.

If the personal statement is completed using AMP's *easywrite* automated underwriting for insurance cover, depending on the commission structure selected, the commission (including GST) is:

- 130% of the first year's premiums and 11% of premiums for that year and each subsequent year, or
- 70% of the first year's premiums and 22% of premiums for that year and each subsequent year, or
- 30.25% pa of premiums.

The premium will be the same whether or not *easywrite* automated underwriting is used by the financial planner to complete the personal statement.

The financial planner will notify us at the time of application of the required commission structure.

All of the rates quoted above include 10% GST which the financial planner is required to pay to the Australian Taxation Office. These commission rates apply as at the date of this document. You or the member can contact their financial planner or us for any changes to commission rates.

Alternative commission

You and your financial planner can agree to an alternative to the standard commission. If lower commission is agreed between you and your financial planner, the cost of your insurance will be reduced.

Alternative forms of remuneration

AMP Life is required to comply with an industry code on alternative forms of remuneration. The code is the Investment and Financial Services Association and Financial Planning Association Industry Code of Practice on Alternative Forms of Remuneration (the Code) in the wealth management industry.

The Code requires AMP Life to maintain a register that records any material forms of alternative remuneration, which it pays or receives. Registers are required to be maintained by investment managers, platform providers, representatives and licensees.

The register is publicly available for inspection by you and a copy of the register can be requested by contacting AMP on 131 267.

Plan Rules - Claiming a benefit

How to claim

We aim to be proactive in our claims management. Our claim requirements vary depending on the type of, and reason for, the claim you are making. We pride ourselves on providing a supportive claims service and are committed to paying genuine claims. This includes the provision of a Claims Concierge Service and a specially trained and empathetic claims team.

The 4 steps of the claims process:

Step 1 - Notifying AMP of your intention to claim.

Step 2 - You complete and return the claim paperwork.

Step 3 - AMP assesses your claim.

Step 4 - We assist you with your claim payment.

To notify us of your intention to claim a benefit, you or an authorised representative acting on your behalf can contact our Claims team on the following numbers:

Death claims **1300 373 654**

Disability claims **1300 366 214**

Disability claims includes claims under the Terminal Illness benefit, Total and Permanent Disablement cover, Trauma cover, Income Protection and Business Overheads Insurance.

Upon this notification we will send claim forms for you to complete and return to us. These forms will be specific to the plan and benefit type under which you are claiming. Our initial claims requirements will be outlined in our letter to you which may include, but are not limited to:

- Initial Claim Form.
- Certified copy of the death certificate (if applicable).
- Initial Medical Report, completed by the insured person's treating doctor.
- Medical evidence, including proof of diagnosis of the medical condition or occurrence of the medical procedure for which the claim is being made.
- Copies of any medical reports from relevant specialists, scans or test results (eg clinical, histological and radiological evidence) which will assist in the assessment of your claim.
- Any other evidence and history of the insured person's health
- Employer's statement (if applicable).
- Certified copy of yours and the insured person's proof of identity.

In addition, we will advise you of the direct contact details of our claims representative for your future reference.

You must also provide us with any other documents and information we reasonably require to consider your claim. For example, you must provide us any information which we reasonably require about:

- The insured person's income and expenses. For example, we will usually ask for the insured person's income tax returns, income tax assessment notices and any relevant books of account. We may ask you what the insured person's income and expenses:
  - were when the plan started, or you last changed it, and
  - were just before you became eligible for a benefit, and
  - are while we are paying, and
- any other information we believe is relevant in assessing your claim.

We may also require the insured person to attend, and cooperate at, any assessments. Some of those assessments may be by medical advisers we choose. The insured person may also need to have medical tests.

We will pay the costs of obtaining information from medical advisers we choose. In all other cases, you must pay the costs of providing information in support of your claim.

Time limit

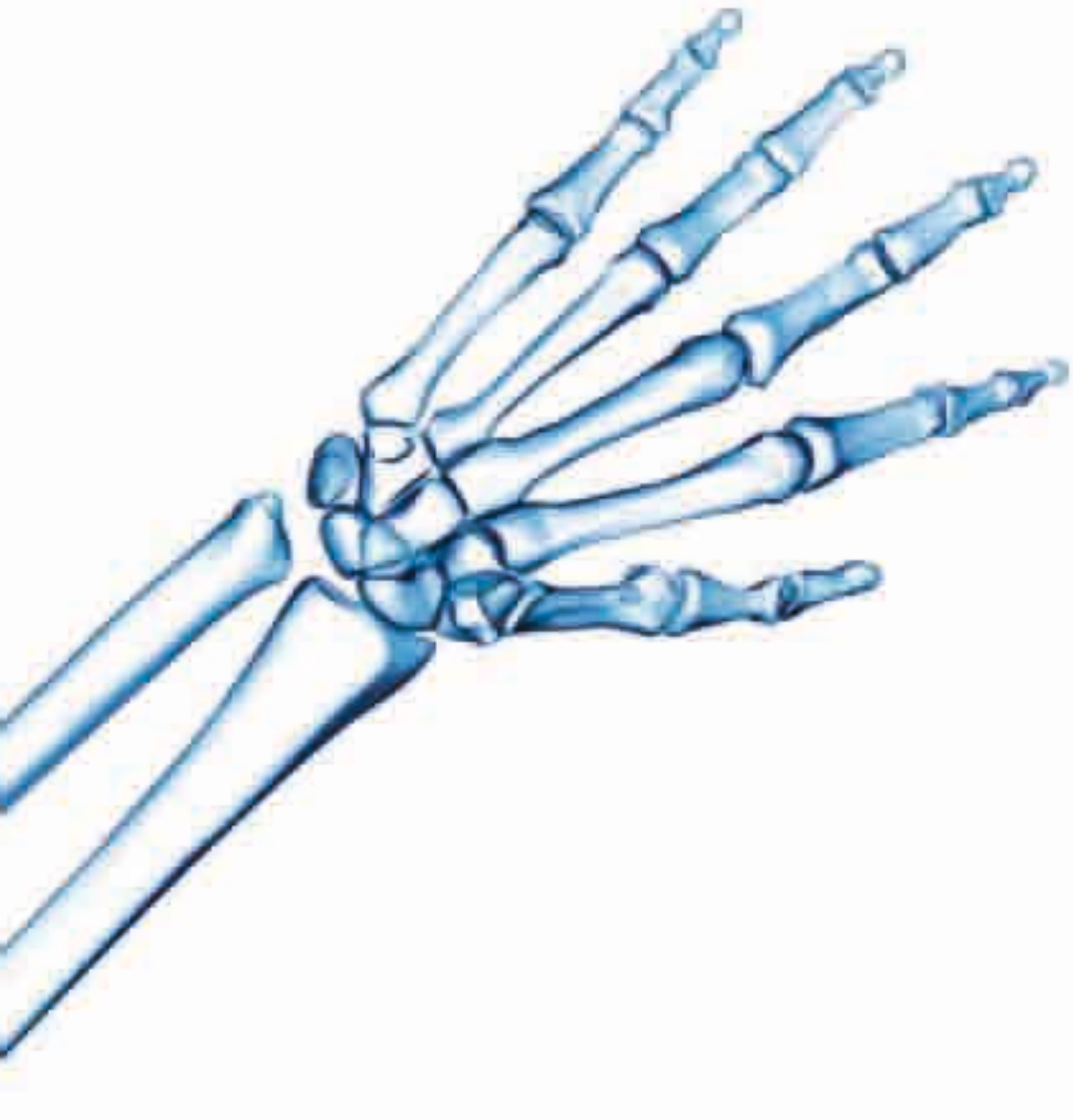
You must tell us you are going to claim a benefit as soon as practicable.

If you delay in making a claim or providing information:

- this may delay the payment of any benefits you receive from us, and
- we may reduce the amount we pay (which may be to nil) to the extent that we have been prejudiced by the delay.

When we pay

We will pay as soon as we have processed a claim that satisfies the rules of the plan.



Providing information to AMP

Your Privacy

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it. We may also use this information for related purposes - for example, providing you with ongoing information about financial services that may be useful for your financial needs. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services, that may be made available by us, other members of the AMP Group, or by your financial planner. We usually disclose information of this kind:

- To other members of the AMP Group.
- To your financial planner or broker (if any).
- To the owner of the plan.
- To external service suppliers who supply administrative, financial or other services to assist the AMP Group in providing AMP Financial Services.
- To the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost superannuation.
- To anyone you have authorised or if required by law.

If health information is collected in relation to this financial product, then additional restrictions apply. AMP Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, AMP Life, to assess your application for new or additional insurance. AMP Life may also use this information for directly related purposes - for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims. AMP Life may disclose this type of health information to:

- The financial planner or broker responsible for the plan.
- The trustee.
- The owner of your personal insurance plan (if applicable).
- AMP Life's reinsurers.
- Medical practitioners.
- Any person AMP Life considers necessary to help either assess claims or resolve complaints.
- Anyone you have authorised or if required by law.

If you are an insured person, aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

Under the National Privacy Principles, you may generally access personal information about you held by the AMP Group. Also, you may let us know if you think any of it is inaccurate, incomplete or out-of-date. The AMP Privacy Policy Statement sets out the AMP Group's policy on management of personal information.

You may obtain a copy by contacting us on 131 267 or visiting our website at **www.amp.com.au**.

Your duty of disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of life insurance.

Your duty however does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of its business, ought to know
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it.

If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Plan Rules - Dictionary of defined terms

The terms defined in this Dictionary are separated into 2 categories:

- Trauma definitions - including AMP's Claims Guiding Statement (pages 67 to 73), and
- Other general definitions of terms used throughout this document (pages 73 to 75).

Trauma definitions

These definitions apply to trauma conditions and medical procedures covered under the Life Protection Plan and Income Protection Plan.

CLAIMS GUIDING STATEMENT

Medical diagnoses and investigation methods used in many of the trauma conditions that we cover are advancing at a rapid rate. Some of these new diagnostic method(s) may prove to better define a particular trauma condition. Should the insured person be diagnosed with one of the trauma conditions, and the method(s) used to diagnose it isn't specified within our trauma definition, we may take that method(s) into consideration. This may assist in the assessment of your claim.

Alzheimer's disease and other dementias

The insured person's brain function fails significantly and permanently. The failure must cause the insured person to:

- be unable to perform any one of the activities of daily living without assistance from someone else, or
- require daily care on an ongoing basis.

We won't pay if the dementia is directly caused by alcohol or drug abuse.

Aortic surgery

The insured person has surgery performed to correct a structural abnormality of the aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We won't pay for surgery performed using intraluminal or laparoscopic techniques.

Aortic surgery by minimal invasive techniques

The insured person has keyhole surgery performed to correct a structural abnormality of the aorta. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Aplastic anaemia

The insured person has severe aplasia of bone marrow as defined by an appropriate consultant medical specialist.

Bacterial meningitis

The insured person suffers bacterial meningitis caused by a proven organism. The meningitis must produce neurological deficit causing permanent and significant functional impairment.

Benign tumour of the brain or spinal cord

The insured person has a non-cancerous tumour in the brain or spinal cord which is histologically described and which produces neurological deficit causing permanent and significant functional impairment or requires radical surgery for its removal.

We don't cover any of the following:

- cysts, granulomas and cerebral abscesses, or
- malformations in, or of, the arteries or veins of the brain, or
- haematomas, or
- tumours in the pituitary gland.

Blindness

The insured person loses the sight of both eyes to the extent that visual acuity is 6/60 or less in both eyes, or to the extent that the visual field is reduced to 10 degrees or less of arc. That loss must be irreversible and unable to be corrected by glasses or any other means.

Cancer

WE WILL PAY	PAYMENT CONDITIONS	WE WON'T PAY

If an insured person suffers from a malignant tumour. This includes:
– a malignant sarcoma,
– Hodgkin's lymphoma,
– non-Hodgkin's lymphoma,
– a malignant bone marrow disorder,
– leukaemia, including:
  – acute leukaemia,
  – chronic myelocytic leukaemia,
  – chronic lymphocytic leukaemia where classified as Binet Stage C or Rai Stage I, II or III,
– Melanoma where the thickness is 1.5mm or more or the Clark level of invasion is Level 3,
– A prostate tumour that is histologically described as having:
  – a TNM Classification of T2, or
  – a TNM Classification of T1 (or any equivalent classification) with a Gleason score of 8 or more, or
  – a TNM Classification of T1 where the entire prostate has been removed, or radiotherapy has been undertaken, specifically to arrest the spread of malignancy, and the procedure is the appropriate and necessary treatment
– tumours which are histologically described as pre-malignant or showing malignant changes of "carcinoma in situ" requiring treatment similar in extent to that which would be undertaken for invasive carcinoma#.
	The cancer must be:
	– confirmed by pathology tests, and
	– characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.
		For:
		– HIV/AIDS related cancers, or
		– skin cancers other than melanoma.

Treatment in this instance is defined as surgery and adjuvant therapy (such as radiotherapy and/or chemo-therapy)

Carcinoma in situ of breast

The insured person suffers carcinoma in situ of the breast, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of cervix uteri

The insured person suffers carcinoma in situ of the cervix-uteri, where the tumour is classified as:

- CIN 3 grading, or
- tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of fallopian tubes

The insured person suffers carcinoma in situ of the fallopian tubes, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of ovary

The insured person suffers carcinoma in situ of the ovary, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of testes

The insured person suffers carcinoma in situ of one or both testes, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of vagina

The insured person suffers carcinoma in situ of the vagina, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Carcinoma in situ of vulva

The insured person suffers carcinoma in situ of the vulva, where the tumour is classified as tumour in situ (Tis) according to the TNM Classification system.

Cardiomyopathy

The insured person's heart muscle fails to function properly resulting in permanent physical impairment to at least Class 3 of the New York Heart Association Classification of Cardiac Impairment. We won't pay for cardiomyopathy that is directly caused by alcohol, or related to drug use that is not prescribed by a doctor.

Coma

The insured person is in a state of unconsciousness and doesn't react to external stimuli. The state of unconsciousness must score 6 or less on the Glasgow Coma Scale.

The state of unconsciousness must either:

- be continuous for at least 4 days, followed by new functional impairment producing neurological signs which last at least a further 14 days. The signs must be demonstrated clinically and by a cerebral CT scan, angiogram, MRI, PET, or any other reliable imaging technique approved by AMP, or
- be continuous for at least 90 days.

In all circumstances, we won't pay for any coma that is:

- caused by the insured person's alcohol or drug abuse, or
- is the result of the insured person suffering another trauma condition for which we pay.

Complications of pregnancy

The insured person experiences one of the following complications of pregnancy:

- Hydatidiform mole - the insured person suffers a molar pregnancy, characterised by the presence of a hydatidiform mole and confirmed by an appropriate consultant medical specialist.
- Neo-natal death - the insured person gives birth to a child of at least 20 weeks gestation that does not survive 30 days.
- Still birth (excluding elective pregnancy termination) - the insured person's child suffers foetal death in utero after at least 20 weeks gestation and confirmed by a death certificate.

Coronary artery angioplasty

The insured person undergoes angioplasty involving less than 3 coronary arteries during the same procedure (with or without the insertion of a stent, laser therapy or atherectomy).

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

Coronary artery angioplasty - triple vessel

The insured person undergoes angioplasty of the coronary arteries (with or without the insertion of a stent, laser therapy or atherectomy) to 3 or more coronary arteries within the same surgical procedure.

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

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

Coronary artery surgery

The insured person has coronary artery disease and as a result has surgery involving bypass grafts to one or more coronary arteries. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We don't pay under this particular trauma condition for procedures such as angioplasty, laser and intra-arterial techniques or other non-surgical procedures.

Encephalitis

The insured person is diagnosed as having encephalitis by an appropriate consultant medical specialist.

The insured person must have impaired brain function which causes permanent inability to perform any one of the activities of daily living without assistance from someone else.

We won't pay for encephalitis caused directly or indirectly by HIV/AIDS.

Heart attack - myocardial infarction

Part of the insured person's heart muscle dies as a result of inadequate blood supply to the relevant area.

An appropriate consultant medical specialist must certify that a heart attack has occurred and provide confirmatory evidence of this by the following test results:

- new electrocardiographic changes consistent with myocardial infarction, and
- abnormal biomarkers such as a cardiac enzyme rise above the upper limit of normal, or
- a rise of Troponin I above 2.0 ng/ml or Troponin T above 0.6 ng/ml.

If on the above criteria, a heart attack is confirmed, but the results are below the limits indicated, then the following will be considered as diagnostic evidence:

- abnormal wall motion as assessed by echocardiography, or
- reduction of left ventricular ejection fraction to 50% or less,

where either of the above is confirmed at least 6 weeks after the cardiac event.

We won't pay for other causes of severe non-cardiac chest pain, heart failure or angina.

Heart attack - out of hospital cardiac arrest

The insured person suffers a cardiac arrest 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 or ventricular fibrillation.

Heart valve surgery

The insured person has surgery to correct, or replace, a cardiac valve. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

We won't pay for surgery performed using intraluminal or laparoscopic procedures.

Heart valve surgery by minimal invasive techniques

The insured person has keyhole surgery performed to repair or replace a cardiac valve. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment.

Hepatitis B or C - occupationally acquired

The insured person becomes infected with Hepatitis B or C, which is:

- acquired as a result of an accident occurring during the course of the insured person's normal occupation, and
- acquired while the insured person was carrying out their normal occupational duties, and
- documented by proof indicating:
  - Hepatitis B surface antigen negative to Hepatitis B surface antigen positive, or
  - Hepatitis C antibody negative to Hepatitis C antibody positive

within 6 months of the presumed causal event.

Any accident giving rise to a potential claim must be:

- reported to the relevant authority or employer, and
- reported to us within 14 days of its occurrence, and
- supported by a negative Hepatitis B or C test taken within 7 days of the accident.

We will only pay if we are able to:

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

We won't pay if the infection is acquired through any other cause including but not limited to sexual activity, recreational intravenous drug use or deliberate self-infection.

HIV/AIDS - medically acquired

The insured person acquires HIV through accidental infection as a result of a medical procedure. We will only pay if we believe on the balance of probabilities that the infection arose because of one of the medical events listed below.

The event must have been medically necessary and it was performed by or under the supervision of a medical doctor or a dentist, and:

- it occurred to the insured person in either Australia or New Zealand, and
- it occurred as a result of any one of the following procedures:
  - a blood transfusion
  - the transfusion with blood products
  - an organ transplant to the insured person
  - assisted reproductive techniques.

Before we will pay, we will require proof of the incident via a statement from a Statutory Health Authority that the infection was medically acquired.

We won't pay if the HIV infection is acquired through any other cause including but not limited to sexual activity, intravenous drug use except as a legitimate medical procedure, or deliberate self-infection.

HIV/AIDS - occupationally acquired

The insured person becomes infected with HIV if:

- the virus is acquired as a result of an accident occurring during the course of the insured person's normal occupation, and
- the virus is acquired while the insured person was carrying out their normal occupational duties, and
- sero conversion to the HIV infection occurs within 6 months of that accident.

Any accident giving rise to a potential claim must be:

- reported to the relevant authority or employer, and
- reported to us within 14 days of its occurrence, and
- supported by a negative HIV antibody test taken after the accident.

We will only pay if we are able to:

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

We won't pay if:

- the HIV infection is acquired through any other cause including but not limited to sexual activity, recreational intravenous drug use or deliberate self-infection, or
- recommended precautionary measures aren't taken before or after the presumed causal event.

Intensive care

The insured person has an accident or illness which requires them to have continuous mechanical ventilation by means of tracheal intubation. The tracheal intubation must need to continue for 10 consecutive days (24 hours per day) in an authorised intensive care unit of an acute care hospital.

We won't pay where the accident or illness is a result of alcohol or drug use that isn't prescribed by a doctor.

Kidney failure

The insured person suffers irreversible failure of both kidneys which requires either:

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

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

We won't pay in the event of temporary renal dialysis for acute and reversible kidney failure.

Leukaemia

The insured person is diagnosed with leukaemia.

Liver failure

The insured person suffers irreversible failure of the liver and as a result the only effective treatment option is to receive a liver transplant. In the opinion of an appropriate consultant medical specialist, the transplant must be required on medical grounds and must be the most appropriate treatment.

We won't pay if the liver failure is directly caused by alcohol or related to use of other drugs not prescribed by a doctor.

Loss of hearing

The insured person suffers a total and permanent loss of hearing, both natural and assisted from both ears. A cochlear implant must be deemed necessary by an appropriate consultant medical specialist. This must be certified at least 3 months after the ability to hear was first lost.

Loss of independent living

The insured person suffers total and permanent inability to perform at least 2 of the activities of daily living without assistance from someone else.

We won't pay for loss of independent living caused directly by alcohol or drug abuse.

Loss of speech

The insured person totally loses the ability to speak due to organic brain disease or accidental injury. The loss must be irreversible. We won't pay for loss of speech which is due to any psychological cause.

Loss of use of limbs and/or sight

The insured person, because of irreversible functional impairment on either a neurological or musculoskeletal basis, totally and permanently loses the:

- use of both feet, or
- use of both hands, or
- use of one foot and one hand, or
- sight in both eyes (to the extent of 6/60 or less), or
- any combination of 2 of: a hand, a foot or sight in an eye (to the extent of 6/60 or less).

Lung failure

The insured person suffers irreversible failure of both lungs and as a result requires continuous oxygen supply and with FEV1 test results of consistently less than one litre.

Major head trauma

The insured person suffers an accidental head injury which produces neurological deficit causing significant functional impairment which, in the opinion of an appropriate consultant medical specialist, is likely to be permanent.

Major organ transplant

The insured person requires a transplant from a donor of one of the following whole organs and is placed on a waiting list at an Australian hospital:

- kidney
- heart
- liver
- lung
- pancreas.

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

We won't pay in the event of a donation by the insured person of an organ for transplant.

Melanoma

The insured person has a malignant melanoma where the thickness is less than 1.5mm and Clark level of invasion is 2. The melanoma must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue. We won't pay for a melanoma where the thickness is less than 1.5mm and the Clark level of invasion is Level 1.

Motor neurone disease

The insured person receives an unequivocal diagnosis of motor neurone disease by an appropriate consultant medical specialist.

Multiple sclerosis

The insured person receives an unequivocal diagnosis of advanced multiple sclerosis by an appropriate consultant medical specialist. There must be significant neurological deficit which causes permanent inability to perform any one of the activities of daily living without the assistance of someone else.

Muscular dystrophy

The insured person receives an unequivocal diagnosis of muscular dystrophy by an appropriate consultant medical specialist.

Myelodysplasia

The insured person is diagnosed to have myelodysplasia by an appropriate consultant medical specialist. The condition must have progressed to the point that it is permanent and the severity is such that the insured person requires a blood transfusion at least monthly and/or admission to hospital due to complications of the disorder at least 4 times per year.

Myelofibrosis

The insured person is diagnosed to have myelofibrosis by an appropriate consultant medical specialist. The condition must have progressed to the point that it is permanent and the severity is such that the insured person requires a blood transfusion at least monthly.

Open heart surgery

The insured person has open heart surgery requiring diversion of the blood through a heart-lung machine, in order to have surgery to correct any heart defect including heart valve surgery. In the opinion of an appropriate consultant medical specialist, the treatment must be required on medical grounds and must be the most appropriate treatment. We won't pay under this particular trauma condition for procedures such as valvotomy or coronary artery angioplasty which don't require open heart surgery.

Paralysis - diplegia

The insured person suffers total and permanent paralysis of both arms or both legs due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

Paralysis - hemiplegia

The insured person suffers total and permanent paralysis of both the arm and the leg on the same side of the body due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

Paralysis - paraplegia

The insured person suffers total and permanent paralysis of both legs due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

Paralysis - quadriplegia

The insured person suffers total and permanent paralysis of both arms and both legs due to organic disease or accidental injury. We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

Paralysis - tetraplegia

The insured person suffers total and permanent paralysis of both arms and both legs, together with loss of head movement, due to organic disease or accidental injury.

We won't pay for partial paralysis, for temporary post-viral paralysis, or for paralysis due to psychological causes.

Parkinson's disease (advanced)

The insured person receives an unequivocal diagnosis of advanced Parkinson's disease. There must be significant neurological deficit which causes permanent inability to perform any one of the activities of daily living without assistance from someone else.

Parkinson's disease

The insured person receives an unequivocal diagnosis of Parkinson's disease as confirmed by an appropriate consultant neurologist.

Parkinson's disease means the unequivocal diagnosis of idiopathic Parkinson's disease due to degeneration in the nigrostriatal area of the mid-brain and characterised clinically, by one or more of the following symptoms; rigidity, tremor, akinesia.

Other forms of Parkinsonism, whether related to medication, toxins or other neurodegenerative conditions are specifically excluded.

Partial blindness

The insured person:

- loses the sight in both eyes with irreversible eye damage to the extent of 6/24, or
- loses the sight in one eye where visual acuity has reduced to 6/60 or less in that one eye,

and the loss is unable to be corrected by glasses or any other means.

Peripheral blood stem cell or bone marrow transplant

The insured person receives a bone marrow transplant, or peripheral blood stem cell transplant for the treatment of a:

- malignant blood disorder, or
- metabolic disorder,

where transplant is required.

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

(No payment will be made where the insured person is a donor of an organ or stem cells for transplantation to another person.)

Peripheral neuropathy

The insured person is diagnosed to have peripheral neuropathy by an appropriate consultant medical specialist. The condition must have progressed to the point that it is permanent and results in the insured person not being able to do any one or more of the below activities without assistance from someone else:

- get in and out of a bed
- get on or off a chair/toilet
- move from place to place without using a wheelchair.

We won't pay if the peripheral neuropathy is directly caused by alcohol or related to use of other drugs not prescribed by a doctor.

We won't pay if this condition is contributed to or caused by HIV/AIDS related conditions.

Pneumonectomy

The insured person undergoes surgical removal of an entire lung. In the opinion of an appropriate consultant medical specialist, the insured person must require the treatment on medical grounds and it must be the most appropriate treatment.

Primary pulmonary hypertension

The insured person suffers primary pulmonary hypertension associated with the right ventricle being enlarged and this:

- is established by cardiac catheterisation and/or echocardiography, and
- results in permanent physical impairment to at least Class 3 of the New York Heart Association Classification of Cardiac Impairment.

We don't pay for any other causes of pulmonary hypertension.

Prostate cancer

The insured person is diagnosed as having a prostate tumour equivalent to TNM Classification T1 and a Gleason score of less than 8. The tumour must be confirmed by pathology tests and characterised by the uncontrolled spread of malignant cells and the invasion of normal tissue.

Severe burns

The insured person suffers burns classified as deep dermal thickness or full thickness, to 20% or more of their body surface area as measured by the Lund Browder Body Surface Chart.

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

The head (including the neck) and each arm (including the hand) are separately considered to be 9% of the total body surface. The front, back and legs (including feet) are each separately considered to be 18% of the total body surface, with the remaining 1% being the perineal area.

We will also pay if the insured person suffers full thickness burns to the whole of both hands or the whole of the face where grafting is required.

Severe inflammatory bowel disease

The insured person suffers severe inflammatory bowel disease. Severe inflammatory bowel disease means a diagnosis of Crohn's disease and/or ulcerative colitis that has failed surgical and conventional medical intervention and requires indefinite second-line therapy.

Severe osteoporosis

The insured person suffers severe osteoporosis. Severe osteoporosis means the insured person, before the age of 50, suffers at least 2 vertebral body fractures or a fracture of the neck or femur, due to osteoporosis and has bone mineral density reading with a T-score of less than -2.5 (ie 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least 2 sites by dual energy x-ray absorptiometry (DEXA).

Severe rheumatoid arthritis

The insured person is diagnosed as having severe rheumatoid arthritis, by an appropriate consultant medical specialist who recommends reconstructive surgery as part of the most appropriate treatment, where response to conventional disease modifying therapy has failed and the condition has progressed to the point that the insured person can't perform any one of the activities of daily living without assistance from someone else.

We won't pay for any other form of arthritis.

Stroke

The insured person suffers a cerebrovascular episode producing neurological damage which lasts for more than 24 hours.

The damage must be evidenced clinically by:

- cerebral CT scan, or
- an angiogram, or
- an MRI or PET, or
- other reliable imaging techniques approved by AMP Life.

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

Subacute sclerosing panencephalitis

The insured person suffers subacute sclerosing panencephalitis.

Systemic lupus erythematosus (SLE)

The insured person suffers systemic lupus erythematosus where irreversible organ damage has occurred requiring intravenous immunosuppressive or cytotoxic therapy.

The organ damage includes lupus nephritis, cerebral lupus, cardiac disease specially related to SLE. An appropriate consultant medical specialist must confirm the diagnosis of SLE with pathological and other supporting evidence.

Systemic sclerosis

The insured person is diagnosed to have systemic sclerosis by an appropriate consultant medical specialist.

The condition must have progressed to the point that the insured person can't perform any one of the activities of daily living without assistance from someone else.

Temporal arteritis

The insured person is diagnosed with arteritis and, as a result, permanently loses sight in one eye.

Viral encephalitis

The insured person suffers encephalitis due to direct viral invasion of the central nervous system. The encephalitis must produce neurological deficit causing permanent and significant functional impairment.

General definitions

Activities of daily living

1. Washing: the insured person can wash themself by some means.
2. Dressing: the insured person can put clothing on or take clothing off.
3. Feeding: the insured person can get food from a plate into their mouth.
4. Continence: the insured person can control both their bowel and bladder function.
5. Mobility: the insured person can:
   a) Get in and out of a bed.
   b) Get on or off a chair/toilet.
   c) Move from place to place without using a wheelchair.

AMP Personal Super Fund

AMP Personal Superannuation Fund (ABN 90 806 277 502).

AMP Life

AMP Life Limited.

Business Income

Gross monthly income earned by the business as a result of the insured person's personal exertion or activities. We do not include investment income.

Benefit period

For Income Protection

See page 40.

For Business Overheads Insurance

See page 53.

Carer

The primary caregiver, who provides assistance with communication, mobility or self-care to a disabled or aged person, for more than 6 months.

Certificate of Insurance

A reference to a Certificate of Insurance in this document means the Certificate of Insurance that we send you when your plan starts, as amended by:

- the Annual Statement we give you each year, and
- any notice we give you which records a change in the terms of your plan as agreed between you and us.

CPI

CPI means Consumer Price Index.

When we make a calculation using the increase in the CPI, we use the percentage annual increase in the Australian National All Groups Consumer Price Index published by the Australian Bureau of Statistics. We use the Index published for the most recent September quarter. However, if that index is abolished or changed, we may use another index which we believe fairly and accurately reflects changes in the cost of living. When calculating the increase, we use the annual percentage increase to the index relative to the September quarter in the previous calendar year.

Doctor

Doctor means a legally qualified medical practitioner registered to practise in Australia, New Zealand, the United Kingdom, the United States of America, or Canada.

That person may not be:

- you, your business partner, or a member of your immediate family, or
- the insured person, the insured person's business partner, or a member of the insured person's immediate family.

Dollar (or $)

All references to dollar amounts in this document are references to Australian currency. All payments to and from us must be in Australian dollars.

Full-time occupation

The insured person is engaged in remunerative work for at least 25 hours per week, 40 weeks per year.

Heart condition

Heart condition means any of the following trauma definitions:

- aortic surgery
- cardiomyopathy
- coronary artery angioplasty - triple vessel
- coronary artery surgery
- heart attack - myocardial infarction
- heart attack - out of hospital cardiac arrest
- heart valve surgery
- major organ transplant (heart only)
- open heart surgery
- primary pulmonary hypertension.

Home duties

The insured person is engaged in home duties if they are doing at least 4 of the following duties related to running the family home:

- cleaning the family home
- shopping for food and household items
- meal preparation
- laundry services
- caring for a child or dependant (if applicable).

Income

For employed persons

The insured person's total package from employment, including commissions, regular bonuses, fringe benefits and any other items relating to their own efforts, less tax deductible expenses related to earning that income. We do not include superannuation contributions by the employer when determining the insured person's total package. Superannuation contributions by the employer may be covered by choosing the Superannuation Contribution Option.

We include superannuation contributions made by an employer that are part of a salary sacrifice arrangement between the employee and employer. We do not include investment income.

For self-employed persons

Where the insured person owns (directly or indirectly) all or part of the business or practice, income means income earned by the business or practice as a result of the insured person's personal exertion or activities less their share of the business expenses incurred in earning that income.

We do not include investment income.

Income benefit

Income benefit means one of the benefits listed on page 37.

Insured amount

Insured amount means the amount you apply for and we accept for a particular type of cover under the Life Protection Plan, as shown in your Certificate of Insurance and varied in accordance with the terms of the Plan (for example, under the Indexation Feature) or by agreement.

If there are multiple insured persons under the one Life Protection Plan, a reference to insured amount in this document means the insured amount referable to a particular insured person, as the context implies.

Insured person

The person(s) named as the "insured person" in the Certificate of Insurance, before the plan ends.

Linked

See page 7.

Month

Calendar month.

Monthly benefit

(see page 40).

Maximum monthly benefit

For Income Protection (see page 40).

For Business Overheads Insurance (see page 53).

Ongoing care

The insured person:

- has sought advice, care and treatment from a doctor in relation to their illness or injury and is continuing to do so at reasonable intervals in the circumstances, and
- is following the advice, care and treatment of the doctor, and
- is taking all other reasonable measures to minimise or avoid further illness or injury.

Own occupation

The primary full-time occupation the insured person has performed immediately prior to becoming disabled.

Paralysis

Paralysis means any of the following definitions:

- diplegia
- hemiplegia
- paraplegia
- quadriplegia
- tetraplegia.

Partially disabled

For Income Protection

See page 42.

For Business Overheads Insurance

See page 55.

Plan anniversary

The date of the Plan anniversary for the Plan appears in the Certificate of Insurance. For most Plans, it will be the same date in each year as the date on which the Plan starts. However, if you want it to be a different date, we may agree to make it a different date.

The Plan anniversary is the date in each year on which we make any increase under the Indexation feature. When we recalculate the premium each year, the new amount applies for one year from the Plan anniversary.

Pre-disability income

For TPD cover

Remuneration received in the last 12 consecutive months of regular remunerative work before the insured person became unable to work due to illness or injury.

For Income Protection

See page 42.

Regular remunerative work

The insured person is engaged in regular remunerative work if they are doing work in any employment, business, or occupation for at least 10 hours per week. They must be doing it for reward, or the hope of reward, of any type.

Remunerative work

The insured person is engaged in remunerative work if they are doing work in any employment, business, or occupation. They must be doing it for reward - or the hope of reward - of any type.

Significant impairment/significant functional impairment

Abnormalities of the nervous system producing certain symptoms and resulting in some disorder of function including cognitive or motor function or speech, vision or hearing impairment or other disability requiring daily assistance with any of the activities of daily living.

Special terms

Any terms which we apply to the insured person or the plan and which does not apply to all Flexible Lifetime - Protection plans.

Stand Alone

See page 7.

Totally disabled

For Waiver of Premium

See page 25.

For Income Protection

See page 41.

For Business Overheads Insurance

See page 54.

Waiting period

For Income Protection (see page 40).

For Business Overheads Insurance (see page 53).

We, us, our

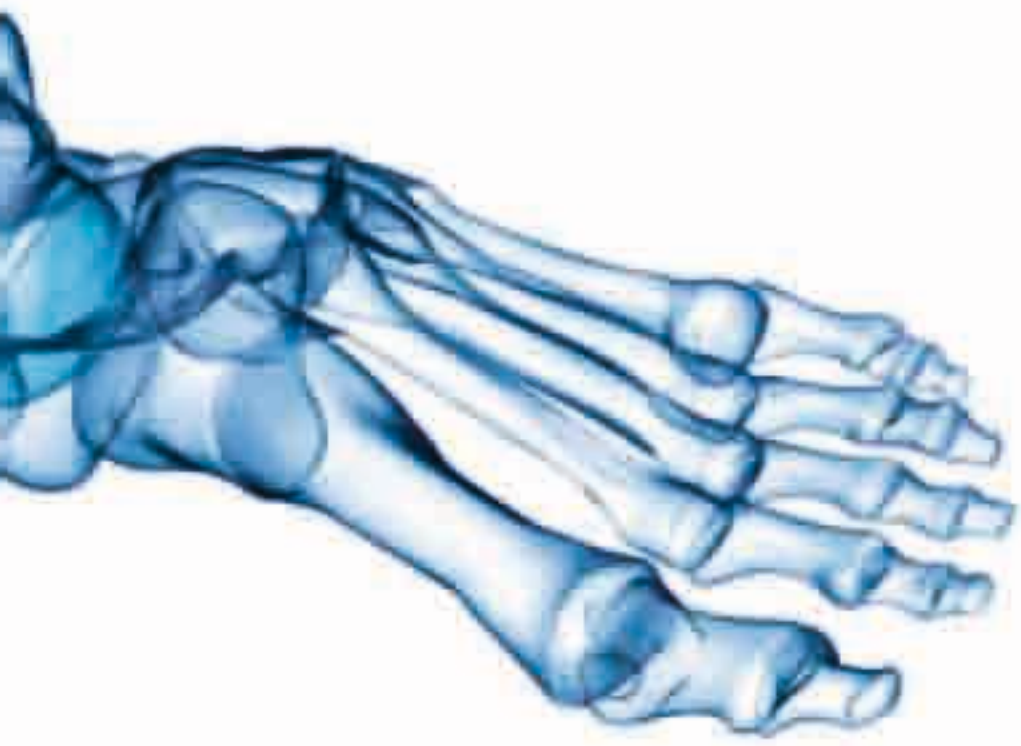
AMP Life Limited.

White collar

The insured person's occupation is "white collar" if the Certificate of Insurance shows their occupation category as "White collar", "4A", "3A", "2A" or "A".

You

The plan owner (or, where cover is taken out through the AMP Personal Super Fund, the insured person, except that AMP Life will pay any benefit to the Trustee).



Interim Accident cover - Certificate

About Interim Accident cover

While your application is being considered, we will provide you with Interim Accident cover at no extra cost.

This cover is different to the insurance being applied for and is subject to the terms and conditions set out below.

Interim Accident cover is not available if either you or the insured person:

- have withdrawn an application, or
- have applied for a similar type of plan, and had the application declined, or
- are currently applying for similar cover outside of AMP, or
- are applying for this cover to replace an existing plan.

The term "accident", as used in this certificate, means bodily injury caused directly and solely by violent, external and visible means and independent of all other causes.

Any special terms that we would apply under our underwriting rules to the cover you apply for, will also apply to this Interim Accident cover.

When cover starts

This cover will start when we receive your completed application and personal statement and either the first premium payment or valid direct debit details at an AMP registered office.

Cover is subject to the premium payment not being dishonoured.

This certificate is for you to keep. It explains the terms and conditions of Interim Accident cover.

When we will pay

If you applied for Death cover

We will pay if you have applied for Death cover for an insured person, and they die solely as a result of an accident during the Interim Accident cover period.

If you applied for TPD cover

We will pay if you have applied for TPD cover for an insured person, and solely as a result of an accident during the Interim Accident cover period, they suffer from the total and irrecoverable loss of:

- the use of 2 limbs, or
- the sight of both eyes, or
- the use of one limb and the sight of one eye,

where a limb means the whole hand below the wrist or the whole foot below the ankle.

The loss must be unable to be remedied and the insured person must survive at least 14 days after the loss.

If you applied for Trauma cover

We will pay if you have applied for Trauma cover for an insured person, and they suffer one of the following trauma conditions or undergoes one of the following medical procedures during the Interim Accident cover period, solely as a result of an accident:

- blindness*
- coma*
- diplegia
- hemiplegia
- intensive care*
- major head trauma*
- paraplegia
- quadriplegia
- severe burns*
- tetraplegia.

*If you applied for Trauma cover Standard these conditions are not covered under that plan and not covered under Interim Accident cover.

The definitions of the above trauma conditions and medical procedures are set out on pages 67 to 73.

If you applied for an Income Protection Plan

We will pay if you have applied for an Income Protection Plan for an insured person, and they become totally disabled solely as a result of an accident occurring during the Interim Accident cover period.

This benefit is paid monthly while the insured person is totally disabled, starting from the end of the waiting period selected, for a maximum of 12 months.

If you applied for a Business Overheads Insurance Plan

We will pay if you have applied for Business Overheads Insurance Plan for an insured person and they become totally disabled solely as a result of an accident occurring during the Interim Accident cover period.

This benefit is paid monthly while the insured person is totally disabled, starting from the end of the waiting period selected, for a maximum of 6 months.

How much we pay

We will only pay once for Interim Accident cover for Life Protection Plans with Death cover, TPD cover or Trauma cover.

For Death cover under a Life Protection Plan

We will pay you a lump sum under Death cover under a Life Protection Plan.

We will pay the lesser of:

- $1,000,000, or
- the insured amount applied for.

For TPD cover and/or Trauma cover under a Life Protection Plan

We will pay you a lump sum under TPD cover and/or Trauma cover under a Life Protection Plan.

We will pay the lesser of:

- $600,000, or
- the insured amount applied for.

For Income Protection Plan

We will pay you monthly benefits for a maximum of 12 months for Interim Accident cover under Income Protection Plans.

We will pay the lesser of:

- $10,000 per month, or
- the maximum monthly benefit applied for.

The amount we pay may be reduced by Benefit Offsets (see page 49).

For Business Overheads Insurance Plans

We will pay you monthly benefits for a maximum of 6 months for Interim Accident cover under Business Overheads Insurance Plans.

We will pay the lowest of:

- $5,000 per month, or
- the maximum monthly benefit applied for, or
- the insured person's share of the allowable business expenses actually incurred during the period for which they are totally disabled.

The amount we pay may be reduced by Benefit Offsets (see page 58).

When cover stops

Interim Accident cover ceases when one of the following happens:

- 90 days from the date this Interim Accident cover starts, or
- the date your application is approved, declined or withdrawn, or
- the date we advise that your Interim Accident cover is cancelled.

When we won't pay

We will not pay for intentional or self-inflicted injury or death.

We will not pay where, under our underwriting rules, we would have declined the insurance applied for.

We will not pay where the accident is caused by:

- any pre-existing medical condition you or the insured person were aware of at the time of applying for this cover, or
- engaging in any sport, pastime or occupation which would not normally be covered under our standard underwriting rules.

Notes

Notes

Please staple all relevant material together

AMP Flexible Lifetime® - Protection Application

Office/Planner use only

Planner number

Multiple applications ☐

Before you sign this application form, be aware that AMP Life or your financial planner is obliged to provide you with a Product Disclosure Statement containing a summary of the important information in relation to these plans. This information will help you to understand the plan and decide whether it is appropriate to your needs.

It is essential to attach a copy of the quote(s) and other relevant materials to this application form.

Mark boxes with (✗) where appropriate, otherwise use block letters. Leave a box between words.

1. PLANS INCLUDED

What plan(s) are you applying for?

Life Protection Plan

All insured persons

☐ Superannuation **OR**

☐ Ordinary (includes self-managed superannuation funds)

Office/Planner use only

Request ID

Plan number

Type of application

☐ New business (including conversion/continuation)

☐ Increase to existing plan

☐ Addition of insured person to existing plan (ordinary only)

☐ Addition of new cover to existing plan.

Income Protection Plan and/or Business Overheads Insurance Plan

Insured person 1

☐ Income Protection

☐ Business Overheads Insurance

Office/Planner use only

Request ID

Plan number

Plan number

Type of application

☐ New business (including conversion/continuation)

☐ Increase to existing plan

☐ Second plan discount

AMP Flexible Super application lodged: ☐ No ☐ Yes

Insured person 2

☐ Income Protection

☐ Business Overheads Insurance

Office/Planner use only

Request ID

Plan number

Plan number

Type of application

☐ New business (including conversion/continuation)

☐ Increase to existing plan

☐ Second plan discount

AMP Flexible Super application lodged: ☐ No ☐ Yes

If more than 2 insured persons are applying, please provide a separate application

2. INSURED PERSON'S DETAILS

Insured person 1

Title | Surname

Given names

Previous surname | Date of birth | Sex ☐ Male ☐ Female

Country of birth

Marital Status ☐ married ☐ single ☐ widowed ☐ divorced ☐ de facto

Have you smoked tobacco or any other substance or used nicotine replacement products within the last 12 months? ☐ No ☐ Yes

Current occupation | Income pre-tax pa $

Your relationship to owner for Life Protection Plan:

☐ self ☐ spouse/partner ☐ business partner ☐ employee ☐ dependant Other:

Residential address ☐ (✗) box if an overseas resident

Unit No.		Street No.		Street name	
Suburb				State	Postcode
Country					

Do you want us to change the address for other AMP plans you have? ☐ No ☐ Yes

Home phone number | Business phone number | Mobile phone number

Email address

Correspondence address (if same as above, leave blank)

Unit No.		Street No.		Street name	
Suburb				State	Postcode
Country					

Personal statement type

☐ *easywrite* tele ☐ *easywrite* office ☐ Paper

TAX FILE NUMBER - FOR SUPERANNUATION ONLY

Information on the collection of Tax File Numbers is included in the Product Disclosure Statement.

Tax File Number

Existing insurance details

Other than this/these applications, are you applying for, or do you have in force, any personal insurance with AMP or any other insurer? ☐ No ☐ Yes

If **"Yes"**, please provide details of:

- any policies in force with AMP
- any policies in force with other insurers
- any policies that you are applying for with other insurers.

Please do **not** include:

- values of cover from this application.

Name of insurer	Life cover	Total & Permanent Disablement cover	Trauma cover	Monthly disability (income) cover	Disability type	Is this cover to be cancelled?†
AMP Life Limited	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	☐ No ☐ Yes
Amount to Cancel	$	$	$	$		Policy No:
	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	☐ No ☐ Yes
Amount to Cancel	$	$	$	$		Policy No:
	$	$	$	$	☐ TSC* ☐ IP** ☐ BOI***	☐ No ☐ Yes
Amount to Cancel	$	$	$	$		Policy No:

* Temporary salary continuance cover. ** Income protection cover. *** Business overheads insurance cover.

† **Important note:** Your application will be considered on the understanding that if you intend to cancel any existing cover, that you will do so on acceptance of this application. Failure to do so may render invalid a claim on your AMP plan. If this application is to replace a current AMP plan, the plan to be replaced will cease and a new plan will start.

2. INSURED PERSON'S DETAILS (CONTINUED)

Insured person 2

Title | Surname

Given names

Previous surname | Date of birth | Sex ☐ Male ☐ Female

Country of birth

Marital Status ☐ married ☐ single ☐ widowed ☐ divorced ☐ de facto

Have you smoked tobacco or any other substance or used nicotine replacement products within the last 12 months? ☐ No ☐ Yes

Current occupation | Income pre-tax pa $

Your relationship to owner for Life Protection Plan:

☐ self ☐ spouse/partner ☐ business partner ☐ employee ☐ dependant Other:

Residential address ☐ (✘) box if an overseas resident

Unit No.	Street No.	Street name	
Suburb		State	Postcode
Country			

Do you want us to change the address for other AMP plans you have? ☐ No ☐ Yes

Home phone number | Business phone number | Mobile phone number

Email address

Correspondence address (if same as above, leave blank)

Unit No.	Street No.	Street name	
Suburb		State	Postcode
Country			

Personal statement type

☐ *easywrite* tele ☐ *easywrite* office ☐ Paper

TAX FILE NUMBER - FOR SUPERANNUATION ONLY

Information on the collection of Tax File Numbers is included in the Product Disclosure Statement.

Tax File Number

Existing insurance details

Other than this/these applications, are you applying for, or do you have in force, any personal insurance with AMP or any other insurer? ☐ No ☐ Yes

If **"Yes"**, please provide details of:

- any policies in force with AMP
- any policies in force with other insurers
- any policies that you are applying for with other insurers.

Please do **not** include:

- values of cover from this application.

Name of insurer	Life cover	Total & Permanent Disablement cover	Trauma cover	Monthly disability (income) cover	Disability type	Is this cover to be cancelled?†
AMP Life Limited	$	$	$	$	☐ ☐ ☐ TSC* IP** BOI***	☐ No ☐ Yes
Amount to Cancel	$	$	$	$		Policy No:
	$	$	$	$	☐ ☐ ☐ TSC* IP** BOI***	☐ No ☐ Yes
Amount to Cancel	$	$	$	$		Policy No:
	$	$	$	$	☐ ☐ ☐ TSC* IP** BOI***	☐ No ☐ Yes
Amount to Cancel	$	$	$	$		Policy No:

* Temporary salary continuance cover. ** Income protection cover. *** Business overheads insurance cover.

† **Important note:** Your application will be considered on the understanding that if you intend to cancel any existing cover, that you will do so on acceptance of this application. Failure to do so may render invalid a claim on your AMP plan. If this application is to replace a current AMP plan, the plan to be replaced will cease and a new plan will start.

Insured child 1

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

Country of birth

Residential address ☐ (✘) box if an overseas resident

Unit No.	Street No.	Street name	
Suburb		State	Postcode
Country			

Children's Trauma cover details

Children's trauma cover $100,000 (includes $25,000 death cover) ☐

The Indexation feature is automatically included. If not required, please mark the box. ☐ No CPI

Premium type: ☐ Stepped ☐ Level

Personal Statement Type: ☐ *easywrite* tele ☐ *easywrite* office ☐ Paper

Insured child 2

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

Country of birth

Residential address ☐ (✘) box if an overseas resident

Unit No.	Street No.	Street name	
Suburb		State	Postcode
Country			

Children's Trauma cover details

Children's trauma cover $100,000 (includes $25,000 death cover) ☐

The Indexation feature is automatically included. If not required, please mark the box. ☐ No CPI

Premium type: ☐ Stepped ☐ Level

Personal Statement Type: ☐ *easywrite* tele ☐ *easywrite* office ☐ Paper

3. PLAN OWNERS

Type of owner

☐ Self-managed super fund → Complete a) below

☐ Individual → Complete b) below for Life Protection Plan, or Go to Section 10 for Income Protection Plan and/or Business Overheads Insurance Plan

☐ Company (not available for Income Protection Plan) → Complete c) below

Plan owner 1

a) Self-managed superannuation fund owner

Trustee name

Superannuation fund name

b) Individual owner

Title

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

c) Company owner

Company name

Address

Unit No. | Street No. | Street name

Suburb | State | Postcode

Country

Home phone number

Business phone number

Mobile phone number

Email address

Plan owner 2 for Life Protection Plan

Type of owner ☒ Individual

Title

Surname

Given names

Date of birth

Sex ☐ Male ☐ Female

Address

Unit No. | Street No. | Street name

Suburb | State | Postcode

Country

Home phone number

Business phone number

Mobile phone number

Email address

4. ADDRESS FOR CORRESPONDENCE

Addressee

Address: (Indicate either one if same as section 3) ☐ Plan owner 1 ☐ Plan owner 2

Unit No./ PO Box	Street No./ Box No.	Street name	
Suburb		State	Postcode
Country			

5. REASON INSURANCE IS NEEDED

☐ Family protection ☐ Personal loan ☐ Business loan ☐ Buy/sell ☐ Keyperson ☐ Other

6. LIFE PROTECTION PLAN

Insured person 1

a) Cover structure

Type of cover ☐ Linked ☐ Stand alone

Premium type ☐ Stepped ☐ Level

b) Death cover

Cover applied for $

c) Total and Permanent Disablement cover

Cover applied for $

Own occupation option ☐ No ☐ Yes

TPD Plus option ☐ No ☐ Yes

Occupation code ☐ A ☐ B ☐ C

d) Trauma cover

Cover applied for $

Trauma type ☐ Optimum ☐ Standard

Trauma options

Partials Package option ☐ No ☐ Yes

Trauma Optimum options

Buy back option ☐ No ☐ Yes

Trauma Reinstatement option ☐ No ☐ Yes

e) Cover options

Waiver of premium ☐ Individual life ☐ Nominated life

Business Safeguard option ☐ No ☐ Yes

The Indexation feature is automatically included. If not required, please mark the box. ☐ No CPI

Insured person 2

a) Cover structure

Type of cover ☐ Linked ☐ Stand alone

Premium type ☐ Stepped ☐ Level

b) Death cover

Cover applied for $

c) Total and Permanent Disablement cover

Cover applied for $

Own occupation option ☐ No ☐ Yes

TPD Plus option ☐ No ☐ Yes

Occupation code ☐ A ☐ B ☐ C

d) Trauma cover

Cover applied for $

Trauma type ☐ Optimum ☐ Standard

Trauma options

Partials Package option ☐ No ☐ Yes

Trauma Optimum options

Buy back option ☐ No ☐ Yes

Trauma Reinstatement option ☐ No ☐ Yes

e) Cover options

Waiver of premium ☐ Individual life ☐ Nominated life

Business Safeguard option ☐ No ☐ Yes

The Indexation feature is automatically included. If not required, please mark the box. ☐ No CPI

7. NOMINATION OF BENEFICIARIES (OPTIONAL) - DEATH COVER ONLY

You must read this information before completing the beneficiary details below.

For Death cover with individual ownership:

☐ You may (only) nominate beneficiaries if:

- there is only one insured person on this plan
- this person is also the sole owner of this plan (ie not a company or joint owner), and
- this person has applied for death cover.

Death benefit payments to beneficiaries are subject to terms and conditions of the plan and limitations imposed by the law at the time of the claim payment. I understand that this nomination will be void if there is a change in plan ownership, or if insured person(s) are added to the plan.

For Death cover taken out through the AMP Superannuation Savings Trust:

What type of death nomination would you like to make for this plan? (✘ one only)

☐ Non-Binding death nomination
If you make a non-binding death nomination, the trustee will decide who will receive your death benefit in the event of your death. We will generally pay your nominated beneficiary(ies), but may decide to pay your death benefit differently.

☐ Binding death benefit nomination
The trustee may pay your death benefit in the event of your death to the person(s) or your legal personal representative/estate you have nominated, provided your nomination is valid. If this form is not completed correctly, we will treat your death benefit nomination as non-binding. We will advise you if this happens.

You can only nominate your legal personal representative/estate or a person(s) who is dependant to receive your death benefit. A dependant includes:

- your spouse (including de facto spouse), or
- your children (including an adopted child, a stepchild, or ex-nuptual child), or
- anyone who is financially dependant on you at the time of your death, or
- anyone who has an interdependency relationship with you at the time of your death.

A person must be dependant at the date of your death to be considered by the trustee to be a beneficiary of your death benefit.

Beneficiary details

I nominate the following beneficiary(ies) to receive the specified proportion of the death benefit payable in the event of my death:

☐ Legal personal representative/estate — Proportion of total benefit ☐☐☐ %

and/or — Use full percentages only.

Given names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to applicant:
☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency Other: ________

Date of birth (of beneficiary) ☐☐☐☐☐☐☐☐ Sex ☐ Male ☐ Female Proportion of total benefit ☐☐☐ %

Given names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to applicant:
☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency Other: ________

Date of birth (of beneficiary) ☐☐☐☐☐☐☐☐ Sex ☐ Male ☐ Female Proportion of total benefit ☐☐☐ %

Given names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to applicant:
☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency Other: ________

Date of birth (of beneficiary) ☐☐☐☐☐☐☐☐ Sex ☐ Male ☐ Female Proportion of total benefit ☐☐☐ %

Given names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to applicant:
☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency Other: ________

Date of birth (of beneficiary) ☐☐☐☐☐☐☐☐ Sex ☐ Male ☐ Female Proportion of total benefit ☐☐☐ %

Total 1 0 0 %

If further beneficiaries are required, please attach a separate page to this form

WITNESS DECLARATIONS - for binding death nominations only

For a binding death benefit nomination, the following is to be read and signed by the 2 witnesses to your signing and dating this application:

1. I am 18 years of age or over.
2. I am not a nominated beneficiary of this applicant and my name does not appear in Section 7 of this form.
3. This form was signed and dated by the applicant in my presence.

Name of first Witness

Signature of first Witness

Date

Name of second Witness

Signature of second Witness

Date

8. PAYMENT DETAILS - LIFE PROTECTION PLAN

Are the premiums paid by your employer? (Applicable only for plans taken out through the AMP Superannuation Savings Trust) ☐ No ☐ Yes

Total premium $ [ ][ ][ ][ ][ ][ ].[ ][ ] per ☐ year ☐ half-year ☐ month

Initial payment option ☐ credit card ☐ direct debit ☐ cheque

Regular payment option ☐ credit card ☐ direct debit (must be chosen if initial payment is direct debit)
☐ notice (not available for monthly payment)

We will deduct your initial premium within 5 days of our acceptance of your application for insurance.

Credit card debit authority

Type of credit card ☐ VISA ☐ MasterCard ☐ AMEX

Credit card number [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] Expiry date [ ][ ][ ][ ]

Name on credit card [ ]

Direct debit authority

BSB number [ ][ ][ ][ ][ ][ ]

Account number [ ][ ][ ][ ][ ][ ][ ][ ]

Account in the name of

[ ]

Name of financial institution (eg bank, building society, credit union)

[ ]

Branch location

[ ]

Preferred date for ongoing premium deductions (eg 15th).
First premium may be deducted on a different date, dependant on when the plan starts. [ ][ ]

Signature(s) of account/cardholder(s)

I/We request AMP Life (user ID000103), until further notice in writing to debit my/our account/credit card, as outlined above any amounts which they may debit or charge me/us through the direct debit system. I/We have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement. I/We understand that AMP or I/we may terminate this request at any time.

Signature ✗ [ ]

Signature ✗ [ ]

Date [ ][ ][ ][ ][ ][ ][ ][ ]

Date [ ][ ][ ][ ][ ][ ][ ][ ]

9. CONVERSION/CONTINUATION OPTION DETAILS - LIFE PROTECTION PLAN

Please contact your financial planner or AMP to confirm your eligibility for a conversion or continuation option. Complete this section only if you are transferring from an existing AMP plan and AMP has approved the transfer.

I/We, as owner(s) of the plan(s) below (the "old" plan):

Existing plan number(s)

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Continuation option from an AMP Superannuation fund plan number

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

- Request that the old plan be converted effective from the issue date of the new plan being applied for.
- Acknowledge that all cover for the insured person under the old plan will end when the new plan is issued.
- Acknowledge that this new plan is issued on the basis that I/we complied with the Duty of Disclosure at the time of issue of the old plan and on the basis that any statements made by me/us and all insured persons under the old plan were true and complete.
- Acknowledge that any special conditions applying to the old plan will continue under the new plan.
- Understand that the exclusion applicable to death or terminal illness will not apply to my new plan for the same amount of cover, provided the one year and 30 day period under my old plan has finished.

If Income Protection Plan and/or Business Overheads Insurance Plan are not required, continue to section 14.

10. INCOME PROTECTION PLAN

Insured person 1

Type of cover ☐ Advanced ☐ Standard ☐ Basic

Type of plan ☐ Agreed value ☐ Indemnity

Benefit period ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 60 ☐ To age 65

Waiting period ☐ 2 weeks ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐ 26 weeks ☐ 52 weeks ☐ 104 weeks

Total maximum monthly benefit $ ☐☐☐☐☐☐
(Including 12% superannuation contribution option amount)

Superannuation contribution option ☐ No ☐ Yes

AIDS cover ☐ No ☐ Yes

Standard and Basic plans:

Claims Escalation option ☐ No ☐ Yes

Advanced and Standard plans:

Day 1 accident option ☐ No ☐ Yes

Premium type ☐ Stepped ☐ Level

The Indexation feature is automatically included.
If not required, please mark the box ☐ No CPI

Occupation code ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ 4B ☐ 3B ☐ 2B ☐ 1B ☐ E

Insured person 2

Type of cover ☐ Advanced ☐ Standard ☐ Basic

Type of plan ☐ Agreed value ☐ Indemnity

Benefit period ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 60 ☐ To age 65

Waiting period ☐ 2 weeks ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐ 26 weeks ☐ 52 weeks ☐ 104 weeks

Total maximum monthly benefit $ ☐☐☐☐☐☐
(Including 12% superannuation contribution option amount)

Superannuation contribution option ☐ No ☐ Yes

AIDS cover ☐ No ☐ Yes

Standard and Basic plans:

Claims Escalation option ☐ No ☐ Yes

Advanced and Standard plans:

Day 1 accident option ☐ No ☐ Yes

Premium type ☐ Stepped ☐ Level

The Indexation feature is automatically included.
If not required, please mark the box ☐ No CPI

Occupation code ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ 4B ☐ 3B ☐ 2B ☐ 1B ☐ E

For Advanced and Standard plans with one year benefit period and conversion option, please specify details of conversion option

Insured person 1

Will you be using the conversion option? ☐ No ☐ Yes

Maximum monthly benefit
(including 12% Superannuation contribution option amount) $ ☐☐☐☐☐☐

Benefit period ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 60 ☐ To age 65

Waiting period ☐ 2 weeks ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐ 26 weeks ☐ 52 weeks ☐ 104 weeks

AIDS cover ☐ No ☐ Yes

Premium type ☐ Stepped ☐ Level

Occupation code ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ 4B ☐ 3B ☐ 2B ☐ 1B ☐ E

Insured person 2

Will you be using the conversion option? ☐ No ☐ Yes

Maximum monthly benefit
(including 12% Superannuation contribution option amount) $ ☐☐☐☐☐☐

Benefit period ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 60 ☐ To age 65

Waiting period ☐ 2 weeks ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐ 26 weeks ☐ 52 weeks ☐ 104 weeks

AIDS cover ☐ No ☐ Yes

Premium type ☐ Stepped ☐ Level

Occupation code ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ 4B ☐ 3B ☐ 2B ☐ 1B ☐ E

11. BUSINESS OVERHEADS INSURANCE PLAN

Insured person 1

Benefit period ☒ 1 year

Waiting period ☐ 2 weeks ☐ 4 weeks

Maximum monthly benefit $

AIDS cover ☐ No ☐ Yes

Premium type ☒ Stepped

The Indexation feature is automatically included.
If not required, please mark the box ☐ No CPI

Insured person 2

Benefit period ☒ 1 year

Waiting period ☐ 2 weeks ☐ 4 weeks

Maximum monthly benefit $

AIDS cover ☐ No ☐ Yes

Premium type ☒ Stepped

The Indexation feature is automatically included.
If not required, please mark the box ☐ No CPI

12. PAYMENT DETAILS - INCOME PROTECTION PLAN AND/OR BUSINESS OVERHEADS INSURANCE PLAN

Insured person 1

Total premium $. per ☐ year ☐ half-year ☐ month

Initial payment option ☐ credit card ☐ direct debit ☐ cheque

Regular payment option ☐ credit card ☐ direct debit (must be chosen if initial payment is direct debit)
☐ notice (not available for monthly payment)

We will deduct your initial premium within 5 days of our acceptance of your application for insurance.

Credit card debit authority

Type of credit card ☐ VISA ☐ MasterCard ☐ AMEX

Credit card number Expiry date

Name on credit card

Direct debit authority

BSB number

Account number

Account in the name of

Name of financial institution (eg bank, building society, credit union)

Branch location

Preferred date for ongoing premium deductions (eg 15th).
First premium may be deducted on a different date, dependant on when the plan starts.

Signature(s) of account/cardholder(s)

I/We request AMP Life (user ID000103), until further notice in writing to debit my/our account/credit card, as outlined above any amounts which they may debit or charge me/us through the direct debit system. I/We have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement. I/We understand that AMP or I/we may terminate this request at any time.

Signature ✗

Date

Signature ✗

Date

Insured person 2

Total premium $. per ☐ year ☐ half-year ☐ month

Initial payment option ☐ credit card ☐ direct debit ☐ cheque

Regular payment option ☐ credit card ☐ direct debit (must be chosen if initial payment is direct debit)
☐ notice (not available for monthly payment)

We will deduct your initial premium within 5 days of our acceptance of your application for insurance.

Credit card debit authority

Type of credit card	☐ VISA ☐ MasterCard ☐ AMEX
Credit card number	Expiry date
Name on credit card	

Direct debit authority

BSB number

Account number

Account in the name of

Name of financial institution (eg bank, building society, credit union)

Branch location

Preferred date for ongoing premium deductions (eg 15th).
First premium may be deducted on a different date, dependant on when the plan starts.

Signature(s) of account/cardholder(s)

I/We request AMP Life (user ID000103), until further notice in writing to debit my/our account/credit card, as outlined above any amounts which they may debit or charge me/us through the direct debit system. I/We have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement. I/We understand that AMP or I/we may terminate this request at any time.

Signature ✗

Signature ✗

Date

Date

13. CONVERSION DETAILS - INCOME PROTECTION PLAN AND/OR BUSINESS OVERHEADS INSURANCE PLAN

Please contact your financial planner or AMP to confirm your eligibility for a conversion. Complete this section only if you are transferring from an existing AMP plan and AMP has approved the transfer.

Insured person 1

Existing Income Protection plan number(s)

Existing Business Overheads plan number(s)

Insured person 2

Existing Income Protection plan number(s)

Existing Business Overheads plan number(s)

I/We, as owner(s) of the plan above (the "old" plan):

- Request that the old plan be converted effective from the issue date of the new plan being applied for.
- Acknowledge that all cover for the insured person under the old plan will end when the new plan is issued.
- Acknowledge that this new plan is issued on the basis that I/we complied with the Duty of Disclosure at the time of issue of the old plan and on the basis that any statements made by me/us and all insured persons under the old plan were true and complete.
- Acknowledge that any special conditions applying to the old plan will continue under the new plan.

Signature(s) of previous plan owner(s)

Signature

Date

Signature

Date

Signature(s) of previous plan owner(s)

Signature

Date

Signature

Date

14. YOUR DUTY OF DISCLOSURE

The Insurance Contracts Act 1984 outlines an insured's Duty of Disclosure and the consequences of non-disclosure. You must answer all the questions in the Personal Statement completely and accurately. This helps AMP Life to decide whether to provide insurance, how much to charge and whether any special rules should apply. You must also disclose:

- anything else you think may be relevant to AMP Life's decision about insuring you, or
- anything a reasonable person in the circumstances could be expected to know would be relevant to AMP Life's decision.

This may include giving information which is not specifically asked for, eg if you have a medical problem which your doctor cannot explain or diagnose, or if you are involved in any criminal activity, or if you are facing bankruptcy, etc.

The Duty of Disclosure does not require you to disclose things:

- that diminish our risks of insuring you, or
- are common knowledge, or
- AMP Life knows (or ought to know) in the ordinary course of its business as an insurer, or
- when AMP Life has waived the Duty of Disclosure .

This Duty continues until your application for insurance is accepted and will recommence on extension, reinstatement or variation of your insurance.

If you don't comply with your Duty of Disclosure

If you fail to comply with your duty of disclosure we are entitled to void the insurance within 3 years of the commencement of the insurance. Alternatively AMP Life may elect (by written notice) not to void the insurance and, if it chooses, reduce the sum you are insured for, in accordance with a formula that takes into account the premium that would have been payable, if AMP Life had received all relevant information.

Non-disclosure

If you fail to comply with your Duty of Disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Death, Total and Permanent Disablement (Superannuation) cover

Before the Trustee effects insurance cover with the insurer, the Trustee has a Duty of Disclosure. It is a condition of your obtaining insurance cover that you have the same Duty of Disclosure to the Trustee. Any reference to the "insurer" in the section headed "Your Duty of Disclosure" includes a reference to the "Trustee".

15. AGREEMENT AND DECLARATION - FOR ALL PLANS INCLUDED IN THIS APPLICATION

I/We agree that:

1. I/We have received and read the Flexible Lifetime - Protection Product Disclosure Statement dated 22 May 2010 (and any applicable supplements).
2. My/Our financial planner is authorised to use the information provided by me/us in this application and any other form relevant to AMP to complete and submit an electronic application on my/our behalf.
3. I/We have read the Duty of Disclosure on page A13 and understand the consequences of not complying with my Duty of Disclosure.
4. I/We also understand that I/we need to tell AMP of any change to an insured person(s) health, occupation or pastimes, or other things relevant to the insurance application that happen to that person after I/we have completed this Application and the Personal Statement(s) that could alter AMP's decision to insure them, right up to the point that AMP issues the Certificate of Insurance.
5. I/We understand that AMP may obtain information from any doctor or hospital used by the insured person(s).
6. I/We have read the Privacy information in the Product Disclosure Statement and agree to the various uses and exchanges of my/our personal information and acknowledge my/our right to access personal information held about me/us by the AMP group.
7. I/We have read all the information provided in this application and believe it is complete and correct even if the information has been written by someone else.
8. For plans applied for electronically, I/we understand that AMP may cancel my/our insurance contract issued and cover provided if AMP does not receive signed copies of the Application and Personal Statement(s) (if required) within 60 days of the insurance cover being issued.

Signature(s) of insured persons

Insured person 1

Signature

✗

Date

Insured person 2

Signature

✗

Date

I give my consent to my financial planner to provide information to AMP, on my behalf, concerning my health, pastimes, occupation and financial status, for the purpose of expediting the assessment of my application for insurance.

I give my consent to AMP to disclose to my financial planner any personal medical information or finding that results in my application for Insurance being accepted on non-standard or amended terms, or declined. I understand that AMP will not provide copies of medical or other reports regarding my application for insurance to my financial planner without first obtaining my specific consent to do so.

Signature

✗

Date

Signature

✗

Date

For Plan Owners if not an insured person

Plan owner 1

Signature

✗

Date

Plan owner 2

Signature

✗

Date

Notes:

1. **Joint owners:** If a Life Protection Plan has more than one plan owner, ownership is joint tenancy and, on the death of an owner, ownership will pass to the surviving plan owner(s).
2. **Register:** Life Protection Plans will be registered in the State or Territory of the first plan owner's address. Other plans will be registered in the insured person's State or Territory of residence.

Further declarations for life protection plan taken out through the AMP Superannuation Savings Trust

9. I am applying/have applied already to the Trustee of the AMP Superannuation Savings Trust, to be a member of that fund and agree to be bound by the provisions of the Trust Deed.
10. Where I am making an application with the assistance of a financial planner, my financial planner is authorised to use the information provided by me in this application and any other form to complete and submit an electronic application on my behalf.
11. If I have applied for TPD cover and my occupation is currently "home duties", I acknowledge that I have previously been employed or self-employed for gain or reward.
12. If my employer is going to contribute to the AMP Superannuation Savings Trust to pay for my insurance premium:
    a) I confirm that any contributions made under an award or industrial agreement can legally be paid into the AMP Superannuation Savings Trust, and
    b) I will write to advise the Trustee if my employer stops making these contributions.
13. I understand that I cannot receive a terminal illness benefit or a TPD benefit (including benefits paid under the "own occupation" or "home duties" provisions within the TPD definition) in cash unless I am able to access my superannuation benefit.
14. I understand AMP can't refund premiums paid in cash, unless I meet a condition of release, and the refund must be paid to another superannuation fund at my direction or will be paid to the AMP Eligible Rollover Fund.

Where I am making a death benefit nomination, I agree and declare that:

15. I have read and understood the information provided on the death benefit nominations in the Product Disclosure Statement.
16. I request the trustee to accept my death benefit nomination for my plan, as shown in Section 7.
17. Where I am making a binding death benefit nomination, the 2 witnesses who signed this form were present at the time I signed and dated this declaration and that on expiry I wish this binding nomination to become non-binding.

Signature of insured person

✗

Date

FINANCIAL PLANNER AND OFFICE USE ONLY

Financial Planner name	Planner number	Phone number	Email address	Initial income split (total 100%)	Servicing planner (✗ one)
				%	☐
				%	☐
				%	☐

Commission details

Please indicate the insurance commission type and level to apply. The commission amounts shown include GST.

Upfront*

- ☐ 112.8% Initial, 11% Trail
- ☐ 90.2% Initial, 11% Trail
- ☐ 67.7% Initial, 11% Trail
- ☐ 45.1% Initial, 11% Trail
- ☐ 22.6% Initial, 11% Trail
- ☐ 0% Initial, 11% Trail
- ☐ 0% Initial, 0% Trail

Hybrid*

- ☐ 55% Initial, 22% Trail
- ☐ 44% Initial, 22% Trail
- ☐ 33% Initial, 22% Trail
- ☐ 22% Initial, 22% Trail
- ☐ 11% Initial, 22% Trail
- ☐ 0% Initial, 22% Trail

Level

- ☐ 30.3% Level commission
- ☐ 24.2% Level commission
- ☐ 18.2% Level commission
- ☐ 12.1% Level commission
- ☐ 6.1% Level commission

* All applications submitted using *easywrite* will result in a higher initial commission.

AMP will arrange medicals on your behalf. If you prefer to arrange medicals yourself, please tick the box ☐

Notes

Authority for medical report - to be completed and signed by insured person 1

I

(full name of insured person) hereby authorise you to release at any time details of my personal and family medical history, including referrals to or treatment by other Practitioners, to AMP Life Limited ABN 84 079 300 379 and to any other person or entity acting on AMP Life's behalf. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise.

A photocopy of this authorisation shall be as valid as the original. Under Government Privacy legislation, I may access a copy of your report from AMP. Furthermore, I have been advised by AMP of the ways this information may be used and to whom it may be disclosed, and approve those purposes.

Signature of insured person

✗

Date

Authority for medical report - to be completed and signed by insured person 2

I

(full name of insured person) hereby authorise you to release at any time details of my personal and family medical history, including referrals to or treatment by other Practitioners, to AMP Life Limited ABN 84 079 300 379 and to any other person or entity acting on AMP Lifes behalf. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise.

A photocopy of this authorisation shall be as valid as the original. Under Government Privacy legislation, I may access a copy of your report from AMP. Furthermore, I have been advised by AMP of the ways this information may be used and to whom it may be disclosed, and approve those purposes.

Signature of insured person

✗

Date

Financial Authority (Authority to obtain personal information from accountant to be completed by insured person 1)

Only to be completed if you wish your accountant to release information to AMP.

I

(full name of insured person)

hereby authorise my accountant, (insert name and address of accountant)

or any accountant, financial institution, or any other financial service provider that I currently or may in future use to release details of my financial history to AMP Life Limited ABN 84 079 300 379. The purpose is to allow AMP Life Limited to assess my application for insurance.

Signature of insured person

✗

Date

Financial Authority (Authority to obtain personal information from accountant to be completed by insured person 2)

Only to be completed if you wish your accountant to release information to AMP.

I

(full name of insured person)

hereby authorise my accountant, (insert name and address of accountant)

or any accountant, financial institution, or any other financial service provider that I currently or may in future use to release details of my financial history to AMP Life Limited ABN 84 079 300 379. The purpose is to allow AMP Life Limited to assess my application for insurance.

Signature of insured person

✗

Date

Authority for pathology tests

I have recently applied to AMP Life Ltd ABN 84 079 300 379 for Life Insurance/Income Continuation cover and, as part of their standard underwriting requirements, I am to undertake the following blood tests:

- **Multiple Biochemical Analysis (MBA)**
- **HDL/LDL Cholesterol**
- **Hepatitis B and C serology**
- **HIV Antibodies.**

I hereby provide authorisation for the above blood tests to be performed in connection with my insurance application and the results to be forwarded to: **The Chief Medical Officer, AMP Life Limited, PO Box 300, PARRAMATTA NSW 2124.**

I also provide my consent and authorisation for the HIV antibodies test and in the event of a positive result, request that the following doctor be advised of the result, to enable appropriate counselling to be conducted:

Doctor's name

Doctor's address

Unit No.	Street No.	Street name	State	Postcode
Suburb				

Name of insured person

Signature of insured person

✗

Date

Instructions to the insured person when blood tests are required

You must fast for 8 hours (you may drink water) before having blood tests done. An early morning appointment may help make fasting easier for you.

You can choose from the following alternatives to get your blood tests done:

1. Via your own or usual doctor. You will need to take this tear-off form along to your doctor to ensure that the correct blood tests are completed.
2. Via a paramedical facility*. Your financial planner will contact one of these service providers who will then contact you to arrange an appointment at a time and place convenient for yourself for a nurse to visit you to take blood.
3. Via a local pathology collection centre*. As per your own or usual doctor, you will need to take this tear-off form along to the collection centre to ensure that the correct blood tests are completed.

* You will need to confirm your identification at the time of providing the blood sample for 2 or 3 above.

Instructions to the financial planner when blood tests are required

1. If your client chooses to attend their own or usual doctor to have the required blood tests done, you will need to ensure that they take this tear-off form with them.
2. If your client is comfortable using a paramedical facility, you will need to complete a *Health Request* form for the particular provider to be able to follow up with your client. AMP's Paramedical service providers include:

Lifescreen	**Phone: 1800 686 000**	**Fax: 1800 804 758**
Symbion Health	**Phone: 1800 770 001**	**Fax: 1800 770 002**
Pathrec	**Phone: 1800 066 895**	**Fax: 1800 631 582**

   If you do not have one of these forms available, contact Lifescreen and they will immediately fax one to you. When you return this form to them, they will then look after everything for you.
3. If your client chooses to attend a local pathology collection centre, you will need to provide your client with the address and arrange an appointment accordingly.

You will need to ensure that your client takes this tear-off form to their appointment.

This page has been left blank intentionally.

Please staple all relevant material together

AMP

Personal Statement

Office/Planner use only

Financial Planner number

Plan number

If there is more than one insured person, please provide a separate Personal Statement for each insured person.

Mark boxes with (✗) where appropriate, otherwise use block letters. Leave a box between words.

DETAILS

Title

Surname

Given names

Date of birth

Sex

☐ Male ☐ Female

May we phone or email you if we need to clarify any details contained in this statement? ☐ No ☐ Yes

If "Yes", please provide preferred contact details:

Phone number

Preferred contact time

am/pm ☐ Any

Preferred contact day

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Any

Email address

IMPORTANT NOTE

This Personal Statement must be complete and correct because it will be the basis on which AMP Life Limited (ABN 84 079 300 379) may agree to insure you. You must therefore read and understand your DUTY OF DISCLOSURE explained below.

If you are unsure of anything in the statement, please ask your Financial Planner or AMP to explain it.

If you require more room to provide your answers than has been allocated on this form, please provide a separate signed and dated page(s) and attach this page(s) to your application.

YOUR DUTY OF DISCLOSURE

The Insurance Contracts Act 1984 outlines an insured's Duty of Disclosure and the consequences of non-disclosure. You must answer all the questions in the Personal Statement completely and accurately. This helps AMP Life to decide whether to provide insurance, how much to charge and whether any special rules should apply. You must also disclose:

- anything else you think may be relevant to AMP Life's decision about insuring you, or
- anything a reasonable person in the circumstances could be expected to know would be relevant to AMP Life's decision.

This may include giving information which is not specifically asked for eg if you have a medical problem which your doctor cannot explain or diagnose, or if you are involved in any criminal activity, or if you are facing bankruptcy, etc.

The Duty of Disclosure does not require you to disclose things:

- that diminish our risks of insuring you, or
- are common knowledge, or
- AMP Life knows (or ought to know) in the ordinary course of its business as an insurer, or
- when AMP Life has waived the Duty of Disclosure

This Duty continues until your application for insurance is accepted and will recommence on extension, reinstatement or variation of your insurance.

If you don't comply with your Duty of Disclosure

If you fail to comply with your Duty of Disclosure we are entitled to void the insurance within 3 years of the commencement of the insurance. Alternatively AMP Life may elect (by written notice) not to void the insurance and, if it chooses, reduce the sum you are insured for, in accordance with a formula that takes into account the premium that would have been payable, if AMP Life had received all relevant information.

1. RESIDENCE

a) Are you an Australian or New Zealand citizen, or do you have an Australian permanent residency visa? ☐ No ☐ Yes

If "No":

i) What is your country of birth?

ii) How long have you lived in Australia? ☐☐ years ☐☐ months

iii) What type of visa do you hold?

iv) Have you applied for an Australian permanent residency visa? ☐ No ☐ Yes

2. TRAVEL

a) Do you have any definite plans to travel or reside overseas, other than New Zealand in the next 12 months? ☐ No ☐ Yes

If "Yes":

i) What countries will you travel to?

ii) What is the purpose of travel?

iii) When is the planned departure and duration?

3. SPORTS ACTIVITIES

Do you currently participate, or intend to participate, in any hazardous activity, competitive sport, aviation or flying activity other than as a regular fare paying passenger? ☐ No ☐ Yes

If "Yes", please complete one of the supplementary questionnaires on page B14.

4. DOCTOR INFORMATION

a) Name and address of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw)

Name	Address	Phone number

If you have known your doctor for less than 2 years, please provide details of the previous doctor.

Name	Address	Phone number

b) Date of last consultation with any doctor ☐☐☐☐☐☐☐☐

c) Name of doctor that you saw (if same as above, write "As above")

d) Please advise reason for your last consultation

e) Please advise results/outcome of your last consultation

f) Were you referred for further tests, investigations or referred to a specialist? ☐ No ☐ Yes

If "Yes", please provide full details

5. INSURANCE DETAILS

Have you ever made a claim or received benefits in regard to any illness, injury, or condition? ☐ No ☐ Yes

If "Yes", please provide full details:

6. HABITS

a) Have you smoked tobacco or any other substance or used nicotine replacement products in the last 12 months? ☐ No ☐ Yes

If "Yes", please advise the type of substance : **quantity per:**

_____ _____ day _____ week _____ month

b) Do you consume alcohol? ☐ No ☐ Yes

If "Yes", please advise number of standard drinks* per:

_____ day _____ week _____ month

c) Have you ever used illegal or illicit drugs? ☐ No ☐ Yes

If "Yes", please advise details including type, frequency and date(s) of usage: _____

d) Have you ever received treatment or been recommended for treatment by a doctor or other medical facility for the use of drugs or alcohol? ☐ No ☐ Yes

If "Yes", please advise details including date(s) of treatment: _____

*A standard drink = 1 nip spirits, 1 wine glass of wine, sherry glass port/sherry, 10oz/285ml glass of beer

7. MEDICAL HISTORY

Height _____ cm or _____ ft _____ ins

Weight _____ kg or _____ st _____ lbs

- **If you answer "Yes" to any of the bold conditions, complete the relevant Medical Questionnaire on pages B8 to B13.**
- **If you answer "Yes" to conditions which are not bold, provide details in the Additional Information table on the following page.**

Have you ever had symptoms of, been told you had, or received advice from any health professionals including but not limited to doctors, specialists, counsellors or chiropractors for any of the following:

a) **High blood pressure, chest pain, high cholesterol, stroke** or any **heart or vascular disorder?** ☐ No ☐ Yes

b) **Asthma, bronchitis or any other lung disorder?** ☐ No ☐ Yes

c) **Epilepsy,** seizure disorder, multiple sclerosis, paralysis, migraine, dizziness, neuritis or any other neurological disorder? ☐ No ☐ Yes

d) **Kidney stones**, nephritis, passing blood in the urine or any other kidney or bladder disorder? ☐ No ☐ Yes

e) Hepatitis, cirrhosis or any liver or gall bladder disorder? ☐ No ☐ Yes

f) **Diabetes**, sugar in urine, thyroid or pancreatic disorder? ☐ No ☐ Yes

g) Indigestion, reflux, **ulcer or hernia?** ☐ No ☐ Yes

h) Colitis, passing blood from the bowel or any other bowel disorder? ☐ No ☐ Yes

i) Anaemia, leukaemia, haemophilia, received a blood transfusion or any other blood disorder? ☐ No ☐ Yes

j) Cancer, tumour, **lump, cyst or skin lesion** of any kind? ☐ No ☐ Yes

k) **Back or neck pain, sciatica, whiplash or any other spinal disorder?** ☐ No ☐ Yes

l) **Repetitive strain injury**, chronic fatigue syndrome, fibromyalgia, or muscle strain? ☐ No ☐ Yes

m) **Arthritis, gout or any disorder of the joints?** ☐ No ☐ Yes

n) **Bipolar, manic or major depressive illness, schizophrenia** or any other **psychotic disorder?** ☐ No ☐ Yes

o) Any other **mental health condition,** including but not limited to **depression, anxiety, stress** or **personality disorder?** ☐ No ☐ Yes

p) **Psoriasis, eczema, dermatitis** or any other **skin condition?** ☐ No ☐ Yes

q) Sleep apnoea or any other sleep disorder? ☐ No ☐ Yes

r) Any impairment of sight not corrected by glasses or contact lenses? ☐ No ☐ Yes

s) Any ear disorder such as hearing loss or tinnitus? ☐ No ☐ Yes

t) Have you ever had an occupational needle stick injury? ☐ No ☐ Yes

u) i) Have you, or do you intend to participate in any activity that increases your chances of contracting the HIV virus? This would include things such as working or engaging in sexual intercourse with a prostitute or intravenous drug user or someone you suspect or know to be HIV positive, or engaging in anal sexual intercourse. If you have answered "Yes" to this question, AMP will contact you for further information. ☐ No ☐ Yes

ii) Are you suffering from AIDS, or infected with HIV, or are you carrying antibodies to the HIV virus? If you have answered "Yes" to this question, AMP will contact you for further information. ☐ No ☐ Yes

v) Have you had any other disorder or impairment, taken any medication or undergone any medical tests, including genetic tests not mentioned above? ☐ No ☐ Yes

w) Do you intend to seek any medical advice, undergo any tests, including genetic tests or investigations in the future? ☐ No ☐ Yes

Males only

x) Any prostate disorder or abnormality? ☐ No ☐ Yes

Females only

y) Have you had an **abnormal pap smear** or any gynaecological condition? ☐ No ☐ Yes

z) i) Have you ever had a breast ultrasound or mammogram? ☐ No ☐ Yes

ii) Have you ever had a breast lump (even if you have not seen a doctor about it?) ☐ No ☐ Yes

iii) Are you currently pregnant? ☐ No ☐ Yes

If "Yes", expected date of delivery? ☐☐☐☐☐☐☐☐

iv) Have you ever had a complication with a past or current pregnancy? ☐ No ☐ Yes

ADDITIONAL INFORMATION (REQUIRED IF "YES" ANSWERED FOR CONDITIONS NOT IN BOLD)

Question letter	Condition/ test/ reason	Date first started	Date of last symptoms	Have you completely recovered?	Full details of treatment	Full name and address of doctor or hospital
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		
		/ /	/ /	Yes/No		

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

8. FAMILY HISTORY

Has any first degree blood related family member (father, mother, brother, sister) had diabetes, stroke, a heart condition, familial polyposis, breast, ovarian, colon or bowel cancer, polycystic kidney disease, Huntington's chorea, motor neurone disease or muscular dystrophy? ☐ No ☐ Yes

If "Yes", please complete the table below:

Family member/ relationship to you	List all conditions and cause of death if applicable (if cancer, please give type and site)	Age at onset

9. OCCUPATION AND INCOME DETAILS (THIS SECTION MUST BE COMPLETED FOR ALL APPLICATIONS)

a) What is your current occupation?

b) How many hours per week do you work in your main occupation? ☐ hours

c) How many weeks per year do you work in your main occupation? ☐ weeks

d) Do you have any other occupation? ☐ No ☐ Yes

If "Yes", please provide details (including type of occupation, duties, number of hours worked per week and the income earned in the last 12 months):

e) Do you have any definite plans to change your occupation? ☐ No ☐ Yes

If "Yes", please provide details:

f) Have you or any business that you have, or have had, ownership of, ever been made bankrupt, been liquidated or been placed under administration? ☐ No ☐ Yes

If "Yes", please provide details including when and date of discharge if applicable:

g) What is your current annual income? (income earned through personal exertion, less any expenses incurred whilst earning that income)?

$ ☐☐☐☐☐☐☐ +

10. ADDITIONAL OCCUPATION AND INCOME DETAILS

To be completed only if applying for Total and Permanent Disablement, Income Protection, Temporary Salary Continuance or Business Overheads Insurance.

a) Name of your business or employer

b) Address of your business or employer

c) Do you hold any professional/trade qualifications? ☐ No ☐ Yes

If "Yes", give details:

Type

Institution

d) What are the main duties of your occupation?

Duties (eg office work, sales, supervision, manual work, explosives handling)	% of time
	%
	%
	%
	%
	100%

Location (eg office, on-site, driving, underground, offshore, underwater, at heights or at home)	% of time
	%
	%
	%
	%
	100%

To be completed if applying for Income Protection, Temporary Salary Continuance or Business overheads Insurance

e) Has your main occupation and/or employment status changed in the last 3 years? ☐ No ☐ Yes

If "Yes", please provide details of your previous occupation, duties and dates of change:

Occupation	Employment status	Date from	Date to
		/ /	/ /
		/ /	/ /
		/ /	/ /

f) Do you have any definite plans to take extended leave (eg parental or study leave) in the near future? ☐ No ☐ Yes

If "Yes", please provide full details including type and length of leave and your intentions on returning to work:

g) Do you have definite plans to change your working arrangements to part-time, casual or self-employed? ☐ No ☐ Yes

If "Yes", please provide full details including current and future employment status:

h) Are you self-employed (including sole trader, in a partnership or employee of your own company or trust)? ☐ No ☐ Yes

If "Yes", please complete the questions for SELF-EMPLOYED (i to m)
If "No", please complete the questions for EMPLOYEE (n to p)

SELF-EMPLOYED - SOLE TRADER, PARTNERSHIP, EMPLOYEE OF OWN COMPANY OR TRUST

i) How long have you been self-employed? ☐ years ☐ months

j) Please select which of the following applies:
☐ sole trader ☐ in a partnership ☐ employee of your own company or trust

k) What is the percentage of the business that you own and how many employees do you have? ☐ % ☐ employees

l) Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If "Yes", please provide for how long, and the source (eg salary, investment income, company profits):

m) Please indicate your share of the business income/expenses, etc for the last 2 financial years for which tax returns, assessment notices and accounts are available.

Tax year ending	Gross income A	Expenses incurred B	Net profit or loss before tax A-B=C	any salary, wages, director's fees, superannuation D	Your total income C+D=E
30/06/	$	$	$	$	$
30/06/	$	$	$	$	$

EMPLOYEE - WITH NO OWNERSHIP INTEREST IN YOUR EMPLOYER'S BUSINESS:

n) What is your base annual salary from your main occupation (including salary packaged items, but excluding compulsory government superannuation contributions)?

Current financial year	Previous financial year 30/06/20☐☐
$	$

o) Do you receive any:
Commission, bonuses or regular overtime ☐ No ☐ Yes

	Current financial year	Previous financial year 30/06/20☐☐
Commission	$	$
Bonuses	$	$
Regular overtime	$	$

p) Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If "Yes", please provide for how long, and the source (eg salary, investment income, company profits):

11. AGREEMENT AND DECLARATION

I, the insured person, agree and declare that:

a) I have read my duty of disclosure. I have kept my duty of disclosure in mind when completing my Personal Statement, and I understand any plan issued by AMP will be based on information I give in my Personal Statement, any additional questionnaire(s), form(s) and statement(s), as well as telephone underwriting (if applicable).

b) I understand I must tell AMP of any change in my health, occupation or pastimes and of any other thing that happens to me which may in any way affect the risk of insuring me, where this change occurs after I have completed this Personal Statement right up to the time that AMP issues the plan.

c) All the information provided in my Personal Statement is complete and correct. If any information has been written by someone else, I have reviewed this information and confirm it is complete and correct. I understand that if I do not comply with my duty to disclose all information completely and accurately, the insurance might be cancelled or the terms may be altered by AMP.

d) I authorise any doctor, hospital or other health service provider that I have or may attend to release details of my personal and family medical history, including referrals to or treatment by other practitioners, to AMP. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. I understand that, under Government Privacy legislation, I may access a copy of these reports from AMP. I have been advised by AMP of the ways this information may be used, and to whom it may be disclosed, and approve those purposes.

e) I have read the Privacy Information on page B16 and agree to the various uses and exchanges of my personal information and acknowledge my right to access personal information held about me by the AMP Group.

f) I have read the HIV Antibodies Test Information on page B16 and I agree that if an HIV test is required to assess my application for insurance, that I consent to such a test being performed and that I will provide advice at the time of blood collection as to whom I wish to be notified in the event of a positive HIV antibody result.

IMPORTANT: This agreement and declaration must be signed after you have read your duty of disclosure and privacy information and completed your Personal Statement. Only sign this agreement and declaration if you agree to make the declaration.

My signature to this declaration confirms my agreement to all of the above

Date

✗

Insured person

Signature of my parent/guardian if I am under age 16

Date

✗

Parent/guardian if applicable

12. FINANCIAL PLANNER INFORMATION (TO BE COMPLETED BY FINANCIAL PLANNER)

If this application has been discussed with an Underwriter prior to submission, provide the following:

Underwriter's name

Date

Discussion details

Pre-arranged medical tests

- ☐ Doctor Medical Exam
- ☐ Paramedical Exam
- ☐ Blood Test
- ☐ Specialist Medical Exam
- ☐ Resting ECG
- ☐ Stress ECG
- ☐ Express check

Other (please specify)

Financial Planner notes

13. HEALTH QUESTIONNAIRES

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

1. High blood pressure (hypertension)

a) When was high blood pressure first diagnosed?

b) What was your blood pressure reading at that time?

c) What was your blood pressure when last tested?

Date	Blood pressure reading	Have treatments changed since this result?

d) Have you taken medication to control your blood pressure? ☐ No ☐ Yes

If "Yes" please provide details of medication, ie type, dose and when taken.

e) Are you currently on the same medication as detailed above? ☐ No ☐ Yes

If "No" please provide details of current treatment.

f) Have you had any medical investigations relating to your high blood pressure? ☐ No ☐ Yes

If "Yes" please provide details.

g) Do you have any complications as a result of your blood pressure? ☐ No ☐ Yes

If "Yes" please provide details.

h) Does your usual doctor have details of your blood pressure and treatment? ☐ No ☐ Yes

If "No" please provide the name and address of the doctor who has records of your investigations and treatment.

Name	Medical provider	Address

2. High cholesterol

a) When were you first diagnosed with high cholesterol?

b) What was your cholesterol level at this time?

c) What was your cholesterol level when last tested?

Date	Cholesterol reading	Have treatments changed since this result?

d) Have you ever taken medication to reduce your cholesterol? ☐ No ☐ Yes

If "Yes" please provide details of medication, ie type, dose and when taken

e) Are you currently on the same medication as detailed above? ☐ No ☐ Yes

If "No" please provide details of current treatment

f) Does your usual doctor have details of your cholesterol results and treatment? ☐ No ☐ Yes

If "No" please provide the name and address of the doctor who has records of your investigations and treatment.

Date	Medical provider	Address
/ /		

3. Mental health condition

a) Please indicate (✓ the appropriate box(es)) the mental health condition(s) you have had, or received treatment for:

- ☐ Anxiety (including generalised anxiety, panic or phobic disorder)
- ☐ Eating disorder (including anorexia nervosa and bulimia)
- ☐ Depression (including major depression and dysthymia)
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post-traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness or chronic tiredness

Other (please describe below)

b) Has the cause of your condition been identified? ☐ No ☐ Yes

If "Yes", please provide the details:

c) How often do/did you have symptoms? ☐☐ years ☐☐ months

Describe your symptoms

d) Date your condition first began ☐☐/☐☐/☐☐☐☐ Date of last symptoms ☐☐/☐☐/☐☐☐☐

e) Have you ever been prescribed any medication? ☐ No ☐ Yes

If "Yes", please provide details including the name of all drugs, dosage and how frequently taken:

Medicine (eg zoloft)	Dose	Frequency

f) Are you still taking medication for your condition? ☐ No ☐ Yes **If "No", date ceased?** ☐☐/☐☐/☐☐☐☐

g) Have you ever been absent from work or had your lifestyle restricted in any way, as a result of this condition(s)? ☐ No ☐ Yes

If "Yes", please provide the details:

h) Have you or are you consulting any psychologist, psychiatrist, counsellor or any other therapist for this condition(s)? ☐ No ☐ Yes

If "Yes", please provide details including dates of your most recent visit:

i) Have you ever been hospitalised for this condition(s)? ☐ No ☐ Yes

If "Yes", please provide details including dates of hospitalisation and treatment:

j) Have you ever attempted suicide? ☐ No ☐ Yes

If "Yes", please provide the details:

k) **Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to this condition:**

Date	Medical Provider	Address
/ /		

4. General medical condition

a) Name of condition

Cause if known

b) Date your condition first began

Date of last symptoms

c) How often do you have symptoms?

Describe your symptoms

d) Have you ever taken medication for this condition? ☐ No ☐ Yes

If "Yes", please provide details (including name, dose and frequency):

e) Are you still taking this medication? ☐ No ☐ Yes

f) Have you ever had any other treatment (eg physiotherapy, surgery, etc) or been in hospital or received emergency Treatment for this condition? ☐ No ☐ Yes

If "Yes", please provide details:

g) Are any tests, surgery or treatment planned or scheduled in relation to this condition? ☐ No ☐ Yes

If "Yes", please provide details:

h) Are there any residual complications or disabilities resulting from this condition? ☐ No ☐ Yes

If "Yes", please provide details:

i) Have you ever been absent from work or incapacitated as a result of this condition? ☐ No ☐ Yes

If "Yes", please provide details:

j) Does your usual doctor have details of this condition? ☐ No ☐ Yes

If "Yes", please provide details:

k) **Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to this condition:**

Date	Medical provider	Address
/ /		

5. Abnormal pap smear

a) **Please indicate (✓ the appropriate box(es)) the condition(s) you have had, or received treatment for:**

☐ Carcinoma
☐ CIN3
☐ CIN2
☐ CIN1
☐ Human Papilloma Virus
☐ Atypia or change (caused by infection or irritation)
☐ Other abnormality

b) When was the condition diagnosed? Date

c) Has the abnormality been surgically removed? ☐ No ☐ Yes

If "Yes", please provide details for each abnormality you have selected, including dates:

d) Have you had a follow up pap smear? ☐ No ☐ Yes

If "Yes", please provide date and result:

e) **Give details of your most recent visit to a doctor or hospital relating to this condition:**

Date	Medical provider	Address
/ /		

6. Respiratory disorders (eg asthma, bronchitis etc)

a) Name of condition

b) How long has it been since you last experienced symptoms (including but not limited to, shortness of breath, coughing, chest tightness or wheezing)?

c) Do you use any inhalers? ☐ No ☐ Yes

If "Yes" how often to you take your medication?

Medicine (eg ventolin)	Dose	Frequency

d) Have you ever required treatment with oral steroids, or been admitted to hospital in the past 12 months as a result of this condition? ☐ No ☐ Yes

If "Yes", how many times have you used oral steroids or been hospitalised for this condition in the past 12 months?

Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to your condition:

Date	Medical Provider	Address
/ /		

7. Cyst/mole/skin lesion

a) **Please indicate (✓ the appropriate box(es)) the condition(s) you have had, or received treatment for:**

☐ Mole or naevi
☐ Hyperkeratosis or solar keratosis
☐ Sebaceous (fatty) cyst
☐ Basal Cell Carcinoma (BCC)
☐ Squamous Cell Carcinoma (SCC)
☐ Melanoma

b) Other lesions (please describe below)

c) Please advise the location(s) of the skin lesion(s):

d) Has the lesion been fully removed? ☐ No ☐ Yes

If "Yes", please advise the method and date(s) of removal (eg frozen "burnt", lasered off or surgically removed):

e) Give details of your most recent visit to a doctor or hospital relating to this condition:

Date	Medical provider	Address
/ /		

8. Back or neck or other musculoskeletal disorder

a) Name of condition

b) What part of your back is affected (eg neck, upper, middle, lower and/or whole spine)?

c) What was the cause of this condition?

d) How long ago did this condition begin?

e) Are you still experiencing symptoms? ☐ No ☐ Yes

If "Yes", how frequently do you suffer symptoms?

If "No", when did you last suffer symptoms?

f) Do, or did your symptoms radiate to other areas (eg legs, arms or groin)? ☐ No ☐ Yes

If "Yes", please provide details:

g) Have you ever had to do or intend to have surgery for this condition? ☐ No ☐ Yes

If "Yes", please provide details:

h) Have you ever had, or are you contemplating having investigations such as CT or MRI scans? ☐ No ☐ Yes

If "Yes", please provide details (doctor, date and result etc):

i) Have you ever been absent from work, incapacitated or had your lifestyle restricted as a result of this condition? ☐ No ☐ Yes

If "Yes", please provide details:

j) Please provide details of all treatment that you have had or may have in the future for this condition, eg physiotherapy, chiropractic treatment, and/or medications, including dates, name and address of doctors, chiropractors or physiotherapists.

If "Yes" please provide details:

9. Diabetes

a) Which of the following best describes your condition:

- ☐ Type 2 Diabetes (Non-Insulin Dependent)
- ☐ Type 1 Diabetes (Insulin Dependent)
- ☐ Gestational Diabetes
- ☐ Not sure
- ☐ Glucose Intolerance
- ☐ Diabetes Insipidus
- ☐ Insulin Resistant

b) How long ago were you diagnosed with this condition?

c) How is this condition treated?

- ☐ Diet
- ☐ Oral medication
- ☐ Insulin
- ☐ Other

Please advise details including name of medication, dosage used per day:

d) Do you have any complications as a result of your diabetes (eg eye, kidney or nerve problems, high blood pressure or vascular disease etc)? ☐ No ☐ Yes

If "Yes", please provide details:

e) Have you ever suffered from a diabetic or insulin coma, or required hospitalisation due to your diabetes or any related condition? ☐ No ☐ Yes

If "Yes", please provide details:

f) When did you last have this condition checked by a medical practitioner?

g) Please provide your doctor's details, including name and address:

Date	Medical provider	Address
/ /		

10. Occupational needle stick injury

a) Have you had any tests performed due to this needle stick injury? ☐ No ☐ Yes

If "Yes", please advise details of test(s) performed and the results if known:

b) Are any tests pending due to your needle stick injury ☐ No ☐ Yes

If "Yes", please advise what test(s) are to be performed and when this is to occur:

14. SPORTING ACTIVITIES QUESTIONNAIRES

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attached to your application.

1. DIVING

a) Which of the following best describes your participation in this activity, please select all that apply:

☐ Scuba ☐ Enriched Air ☐ Mixed Gases

☐ Snorkel ☐ Other Diving Activity

b) Do you have recognised diving qualifications eg PADI, FAUI or NAUI and or relevant qualifications for mixed gases?

If "Yes", please provide details of all diving qualifications you have obtained:

c) How many dives do you perform per annum?

d) What is the maximum depth to which you dive? (In metres)

e) **Do you dive:**

In caves	☐ No	☐ Yes		At night	☐ No	☐ Yes	
In dams or lakes	☐ No	☐ Yes		Potholing	☐ No	☐ Yes	
In ice diving	☐ No	☐ Yes		Internal exploration of wrecks	☐ No	☐ Yes	

If "Yes", please provide details including frequency:

f) Do you ever dive alone or participate in depth record attempts? ☐ No ☐ Yes

If "Yes", please provide details including number of dives and location of the dives:

2. MOTOR SPORT on land or on water

a) Are you a professional or sponsored driver? ☐ No ☐ Yes

Please indicate (✓ the appropriate box(es)) the activity(ies) you take part in:

☐ Bicycles ☐ Jet ski racing ☐ Trucks

☐ Boats ☐ Karts/go karts ☐ Other (specify below)

☐ Car ☐ Motorcycles

b) Provide details of your involvement

Category	
Class	
Vehicle	
Fuel	
Engine capacity	
No. of events last 12 mths	
No. of events next 12 mths	
Maximum speed	
No. of vehicles per event	

c) Competition licence type ☐ Issuing body ☐ Years held

d) Do you have definite plans to compete overseas? ☐ No ☐ Yes

If "Yes", please provide details:

e) Do you participate or intend to participate in record attempts, testing of prototypes or testing of vehicles? ☐ No ☐ Yes

If "Yes", please provide details:

f) Have you ever had a motor sport accident, or has your competition licence ever been suspended? ☐ No ☐ Yes

If "Yes", please provide details:

3. Aviation

a) **Please indicate the activity(ies) you take part in:**

Type of flying*	Fixed wing or helicopter	No. of hours past 12 months	No. of hours next 12 months

*Type of flying as defined by the aviation authorities: eg aerobatics; agricultural (including crop dusting and inspecting); airline operations; air racing; aircraft record attempts; ballooning; charter flying; commuter operations; competition flying; experimental flying; gliding; hang gliding; microlighting/powered hang gliders; paragliding and parascending; private flying or business commuting; record attempts; stunt flying; test flying; training/instructing; other (specify).

b) Type of aircraft that you usually fly?

c) Licence type

Years held

d) Name of your pilot's club or association

e) Air navigation order under which your flying is controlled

f) Do you have any definite plans to upgrade or change your licence? ☐ No ☐ Yes

g) Do you have any definite plans to fly outside of australia, or take off or land from anywhere that is not a registered airfield? ☐ No ☐ Yes

If "Yes", please provide details:

h) Have you ever been involved in flying accidents, been grounded or had your licence revoked? ☐ No ☐ Yes

If "Yes", please provide details:

4. Other activities

a) **Please indicate the activity(ies) you take part in:**

b) Frequency of participation? ☐ per annum Duration of participation? ☐ years

c) Details of any licences or qualifications

d) Name of any club or organisation that you are a member of

e) Location(s) where you undertake or participate in this activity

f) Maximum altitude/depth or speed etc

g) Do you participate in competition? ☐ No ☐ Yes

If "Yes", please provide details:

h) Details of any injury(ies) as a result of participating in this activity

i) Details of any definite plans to change from what you stated above

j) Details of any other relevant features of your involvement in this activity

PRIVACY INFORMATION

Your privacy is important to us and further information about AMP's collection of personal information is provided in our Product Disclosure Statement.

Our primary purpose in collecting information about your health is to assess the application for new or additional insurance from AMP. We may also use this information for directly related purposes such as deciding whether we need more information from you; arranging reinsurance; assessing future applications for new or altered insurance; and assessing and administering claims.

We will generally collect health information from someone else, such as a doctor, with consent. We may use a third party to collect the information on our behalf. We need this information to assess the insurance application and, if you choose not to provide such consent, we may not be able to process the application.

We need this information to assess the insurance application and, if you choose not to provide such consent, we may not be able to proceed with the application.

We may disclose this type of information to:

- If your insurance is part of a superannuation fund, the trustee of that fund.
- The Financial Planner or broker responsible for the plan, (if any).
- AMP's reinsurers.
- Medical practitioners.
- Any person AMP considers necessary to assist in either the assessment of claims under your plan or the resolution of complaints, and
- Anyone you have authorised.

Aspects of your health information may be provided to the owner of the Plan in resolving or explaining terms of acceptance or if the standard Plan Rules are varied. You have the right to access personal information held about you by the AMP group, as explained in your Product Disclosure Statement.

HIV ANTIBODIES TEST INFORMATION

For AMP Life to consider your insurance application, you may need to have a blood test for Human Immunodeficiency Virus (HIV) antibodies. Depending on the type of insurance you have applied for, the blood sample may also be used to determine other matters like your serum cholesterol and kidney and liver functions.

AIDS - Acquired Immune Deficiency Syndrome is the final stage of the illness caused by HIV. HIV destroys some of the defence mechanisms which protect us against infections and cancers. As a result, people infected with HIV may suffer severe infections and cancer as well as organ damage. The most recent evidence suggests that the virus stays in the body indefinitely and causes progressive damage. There is still no cure or vaccine for AIDS but in many cases those infected may survive 10 or more years.

A positive HIV antibody test can have major social, medical, psychological and legal consequences which you should consider before having this test done. These include:

- Possible ill-informed discrimination.
- Possible lawful exclusion from employment if you work in one of a very limited range of occupations where there is a risk of transmitting HIV.
- HIV and AIDS are notifiable to government authorities, but your identity would not be reported.
- As HIV positive people will develop AIDS and long term outlook is uncertain, life and disability insurance is not normally available to people with HIV.
- Some countries restrict the entry of people with HIV.
- It is an offence to knowingly transmit HIV or to put other people at risk of infection.

You may choose to not have the test done. If you decide not to have the test, AMP can't consider your application for insurance. You may choose to arrange your own HIV antibody test and have the results sent to AMP.

If you choose to have AMP arrange the test, the results will be sent under confidential cover to AMP's medical officer/chief underwriter to protect your privacy. In the event of a positive result, this will be communicated to you via the doctor you have specified in your authority for HIV test. Otherwise, acceptance of your insurance application will indicate that your HIV antibody test was negative.

Please staple all relevant material together

FILE NOTE
TO BE KEPT BY ADVISER ON CLIENT FILE

AMP Flexible Lifetime® - Protection Electronic Lodgement Authority Form

This Electronic Lodgement Authority Form is only to be completed if the Flexible Lifetime - Protection Application is being lodged electronically.

Do not use this form if AMP Superannuation Limited is the plan owner. Complete the Application for Membership instead.

1. PLAN OWNER AUTHORITY AND DECLARATION

1. I have received the Flexible Lifetime - Protection Product Disclosure Statement, dated 22 May 2010 (PDS) and understand that the PDS is an important document that I should consider before deciding to apply for cover. I have read the privacy statement in the PDS about the collection and use of my personal information by AMP Life.
2. I have read the Duty of Disclosure notice set out in the PDS and understand the consequences of not complying with my duty of disclosure.
3. I authorise my financial planner/intermediary (**Adviser**) to lodge my application for Flexible Lifetime - Protection electronically.
4. I understand that when providing information to my Adviser in relation to my application for Flexible Lifetime - Protection (and when my Adviser lodges my application), he/she is acting on my behalf (and not on behalf of AMP Life). AMP Life may assume that the information my Adviser provides to AMP Life is an accurate and complete record of the information I provided to my Adviser.
5. I understand that my application for insurance cover is subject to acceptance by AMP Life and that cover does not start until AMP Life notifies me in writing. I understand that my duty of disclosure continues until AMP Life notifies me in writing that my application has been accepted.
6. I understand that if my application is accepted, I will be provided with a Certificate of Insurance. I undertake to check the accuracy and completeness of the information in the Certificate of Insurance and notify AMP Life immediately if any of the information is inaccurate or incomplete.

Direct Debit Authority *(if applicable)*

7. I request AMP Life (user ID000103), until further notice in writing, to debit from my account/credit card (the details of which have been provided to the Adviser in connection with the application for insurance), any amounts which they may debit or charge me through the direct debit system. I have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement. I understand that AMP Life or I may terminate this request at any time.

By signing below, you are confirming the authorities, declarations and acknowledgements in points 1 to 6 above (and point 7 above, if account details have been provided, unless you are not the account holder and section 2 below has been signed).

Plan owner 1

Signature

✗

Date

Print name

Plan owner 2 (if applicable)

Signature

✗

Date

Print name

2. ACCOUNT HOLDER SIGNATURE (only required if the account holder(s) making the above direct debit request are different from the plan owner(s)).

By signing below, you are making the Direct Debit Request in point 7 above.

Signature of account holder

✗

Date

Signature of account holder

✗

Date

3. INSURED PERSON AUTHORITY AND DECLARATION

Declaration and acknowledgement

1. I have read the privacy statement in the Flexible Lifetime - Protection Product Disclosure Statement, dated 22 May 2010 about the collection and use of my personal information by AMP Life.
2. I understand that if the application for insurance is accepted, I will be provided with a paper copy of the Risk Insurance Personal Statement. I undertake to check the accuracy and completeness of the information in the Risk Insurance Personal Statement and notify AMP Life immediately if any of the information is inaccurate or incomplete.
3. I consent to AMP Life disclosing to my financial planner/intermediary (**Adviser**) any personal medical information that is relevant to the assessment of my application for insurance. I understand that AMP Life will not provide copies of medical or other reports regarding my application to my Adviser without first obtaining my consent.

Medical authority

4. I, the insured person noted below, authorise any medical practitioner to release at any time details of my personal and family medical history, including referrals to, or treatment by, other medical practitioners, to AMP Life Limited and to any other person or company acting on AMP Life's behalf. The purpose of this medical authority is to allow AMP Life to assess my application for new/additional/reinstated insurance (as applicable) and any claim that may arise. A photocopy of this authority is valid as the original. I understand that under privacy legislation, I may access a copy of your report from AMP Life. I have been informed by AMP Life of the ways this information may be used and to whom it may be disclosed, and approve of those purposes.

Electronic lodgement authority *(Not applicable if the Risk Insurance Personal Statement is to be completed using Easywrite Tele)*

5. I authorise my Adviser to lodge my Risk Insurance Personal Statement for Flexible Lifetime - Protection electronically.
6. I understand that the answers I provide to my Adviser in relation to the Risk Insurance Personal Statement for Flexible Lifetime - Protection must be accurate and complete and I must tell AMP Life if any of my answers become inaccurate or incomplete before my application for insurance is accepted.
7. I understand that when providing information to my Adviser in relation to my Risk Insurance Personal Statement for Flexible Lifetime - Protection (and when my Adviser lodges my Personal Statement), he/she is acting on my behalf (and not on behalf of AMP Life). AMP Life may assume that the information my Adviser provides to AMP Life is an accurate and complete record of the information provided by me to my Adviser.

Insured person 1

Signature

✗

Date

Print name

Insured person 2 (if applicable)

Signature

✗

Date

Print name

Please note that by signing this form you are, among other things, providing AMP Life with an authority to collect information about your medical history.

4. ADVISER USE ONLY

Checklist

- ☐ Section 1 has been signed and dated by the plan owner(s).
- ☐ If applicable, if the account holder(s) making the Direct Debit Request are different from the plan owner(s), Section 2 has been completed.
- ☐ Section 3 has been signed and dated by each insured person. If there are more than 2 insured persons, the additional insured persons have signed and dated a photocopy of this page, which has been stapled to this form.
- ☐ **Note:** When collecting information from your client and lodging an application for insurance with AMP Life, you are acting on behalf of your client.
- ☐ I will keep this form as a file note on the client file and provide a copy to AMP Life on request.

Adviser name

Plan number (insert when application is lodged)

Please staple all relevant material together

AMP

AMP Flexible Lifetime® - Protection
Application for membership to the AMP Superannuation Savings Trust
(including Electronic Lodgement Authority)

This Application for membership is only to be completed if the Flexible Lifetime - Protection Application is being lodged electronically and AMP Superannuation Limited is the plan owner.

This Application for membership cannot be lodged electronically. It must be sent to AMP Life.

Mark boxes with (✗) where appropriate, otherwise use block letters. Leave a box between words.

1. APPLICANT'S DETAILS

Surname

Given names

Date of birth

Address

Address

2. TAX FILE NUMBER

Please refer to the Product Disclosure Statement for important information that you should consider before providing your Tax File Number.

Tax File Number

3. DEATH BENEFIT NOMINATION (Completion of this section is optional)

☐ **No nomination**	Refer to the Product Disclosure Statement for information about how your death benefit will be paid if you don't make a death benefit nomination.
☐ **Non-binding death benefit nomination**	If you make a non-binding death benefit nomination, the Trustee will consider your nomination but may decide to pay your death benefit differently.
☐ **Binding death benefit nomination**	If you make a valid binding death benefit nomination (which remains valid at the date of your death), the Trustee will pay the death benefit to your nominated beneficiaries.

Please refer to the Product Disclosure Statement for important information about making a non-binding death benefit nomination or a binding death benefit nomination.

☐ Legal personal representative/estate

Proportion of total benefit %

and/or

Given names

Surname

Relationship to applicant:

☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency Other:

Date of birth (of beneficiary)

Sex ☐ Male ☐ Female

Proportion of total benefit %

Given names

Surname

Relationship to applicant:

☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency Other:

Date of birth (of beneficiary)

Sex ☐ Male ☐ Female

Proportion of total benefit %

Note: The total of your beneficiary nominations must equal 100%. Additional beneficiaries can be nominated by attaching the additional details to this form.

4. APPLICANT'S DECLARATION

Declaration to the Trustee

1. I have received the Flexible Lifetime - Protection Product Disclosure Statement, dated 22 May 2010 (PDS) and understand that the PDS is an important document that I should consider before deciding to apply for cover and membership of the Fund. I have read the privacy statement in the PDS about the collection and use of my personal information by the Trustee and AMP Life.
2. I am applying to the Trustee of the Fund to become a member of the Fund and understand that, as a member, I will be bound by the provisions of the trust deed. If my employer is going to contribute to the Fund to pay for my insurance premium, I confirm that any contributions made under an award or industrial agreement can legally be paid into the Fund. I will write to advise the Trustee if my employer stops making these contributions.
3. Where I am making a death benefit nomination (section 3), I declare that I have read and understood the information about death benefit nominations in the PDS. If I am making a binding death benefit nomination on this form, the 2 witnesses who signed this form (section 6) were present at the time I signed and dated this declaration and that on expiry I wish this binding nomination to become non-binding, unless it is replaced by a new binding nomination.

Electronic lodgement authority and declaration to AMP Life

4. I have read the Duty of Disclosure notice set out in the PDS and understand the consequences of not complying with the duty of disclosure.
5. I authorise my financial planner/intermediary **(Adviser)** to lodge my application for insurance and, if applicable, the Risk Insurance Personal Statement (together, **Insurance Application**) electronically.
6. I understand that the answers I provide to my Adviser in relation to my Insurance Application must be accurate and complete and I must tell AMP Life if any of my answers become inaccurate or incomplete before my Insurance Application is accepted.
7. I understand that when providing information to my Adviser in relation to my Insurance Application (and when my Adviser lodges my Insurance Application), he/she is acting on my behalf (and not on behalf of AMP Life). AMP Life may assume that the information my Adviser provides to AMP Life is an accurate and complete record of the information I provided to my Adviser.
8. I understand that my Insurance Application is subject to acceptance by AMP Life and that cover does not start until AMP Life notifies me in writing. I understand that if my Insurance Application is accepted, I will be provided with a Certificate of Insurance and a paper copy of the Risk Insurance Personal Statement. I undertake to check the accuracy and completeness of the information in these documents and notify AMP Life immediately if any of the information is inaccurate or incomplete.
9. I understand that any benefits payable under the plan will be paid by AMP Life to the Trustee and the Trustee will only pay the insurance proceeds to me or a beneficiary, as applicable, in accordance with the rules of the Fund.
10. I consent to AMP Life disclosing to my Adviser any personal medical information that is relevant to the assessment of my Insurance Application. I understand that AMP Life will not provide copies of medical or other reports regarding my application to my Adviser without first obtaining my consent.

Medical authority

11. I, the applicant noted below, authorise any medical practitioner to release at any time details of my personal and family medical history, including referrals to, or treatment by, other medical practitioners, to AMP Life Limited and to any other person or company acting on AMP Life's behalf. The purpose of this medical authority is to allow AMP Life to assess my application for new/additional/reinstated insurance (as applicable) and any claim that may arise. A photocopy of this authority is valid as the original. I understand that under privacy legislation, I may access a copy of your report from AMP Life. I have been informed by AMP Life of the ways this information may be used and to whom it may be disclosed, and approve of those purposes.

Direct Debit Authority (if applicable)

12. I request AMP Life (user ID000103), until further notice in writing, to debit from my account/credit card (the details of which have been provided to the Adviser in connection with the Insurance Application), any amounts which they may debit or charge me through the direct debit system. I have read and agree to the terms of the direct debit service agreement in the Product Disclosure Statement. I understand that AMP Life or I may terminate this request at any time.

By signing below, you are confirming the authorities, declarations and acknowledgements in points 1 to 11 above (and point 12 above, if account details have been provided, unless you are not an account holder and section 5 below has been signed).

Signature of applicant

✗

Date

Print name

Please note that by signing this form you are, among other things, providing AMP Life with an authority to collect information about your medical history.

5. ACCOUNT HOLDER SIGNATURE (only required if the account holder(s) making the above direct debit request are different from the insured person).

By signing below, you are making the Direct Debit Request in point 12 on the previous page.

Signature of account holder

✗

Date

Signature of account holder

✗

Date

6. WITNESS DECLARATION (Only required if the applicant is making a binding death benefit nomination)

1. I am 18 years of age or over.
2. I am not a nominated beneficiary in section 3 of this form.
3. This form was signed and dated by the applicant in my presence.

Signature of witness 1

✗

Signature of witness 2

✗

Date

Date

Print name of witness 1

Print name of witness 2

7. ADVISER USE ONLY

Checklist

- ☐ Section 1 has been completed.
- ☐ The applicant has provided their Tax File Number in section 2.
- ☐ If applicable, the applicant has completed the death benefit nomination in section 3. (**Note:** Section 3 is optional). **Note:** In some cases, a binding death benefit nomination may not be able to be made when the client signs this form (for example, because 2 witnesses may not be available at that time). In those circumstances, a binding death benefit nomination can be made on a separate *AMP Superannuation Savings Trust Binding Death Benefit Nomination* Form, which can be attached to this form.
- ☐ Section 4 has been signed and dated by the applicant.
- ☐ If applicable, if the account holder(s) making the Direct Debit Request are different from the applicant, section 5 has been completed.
- ☐ If a binding death benefit nomination has been made, the applicant's signature has been witnessed by 2 witnesses and section 6 has been signed and dated by 2 witnesses.
- ☐ **Note:** When collecting information from your client and lodging an application for insurance with AMP Life, you are acting on behalf of your client.
- ☐ **SEND THIS FORM TO AMP LIFE.**

Adviser name

Plan number (insert when application is lodged)

This page has been left blank intentionally.

Contact your adviser or financial planner

Need more information?

Everyone has different financial needs. And to find the best solution, you may need professional financial advice. Talk to your financial planner or:

Phone 133 888

Internet www.amp.com.au

AMP Life Limited
33 Alfred Street Sydney NSW 2000

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