AAMI
LIFE INSURANCE

Combined Product Disclosure Statement and Financial Services Guide

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AAMI

This product and Product Disclosure Statement (PDS) is issued by TAL Life Limited ABN 70 050 109 450 AFSL 237848 (TAL Life). TAL Life is not part of the Suncorp Group. TAL Life uses the AAMI brand (a brand of the Suncorp network) under licence.

About this document

The Suncorp and TAL group of companies have entered into an agreement for TAL Life Limited ABN 70 050 109 450 AFSL 237848 (TAL Life) to issue Life Insurance under the AAMI brand, a brand of the Suncorp Group (AAMI Life Insurance).

This document is designed to help you decide whether to buy AAMI Life Insurance. This document comprises the Product Disclosure Statement and Policy Document (together referred to as the PDS) and Financial Services Guide (FSG). The PDS contains information about the product's key features, premiums, policy benefits and limits, risks, the complaints handling procedure, and sets out the terms of the policy. The FSG outlines the financial services offered, including the fees and commissions, and is designed to assist you in deciding whether to use any of the financial services we offer. We are required to give you an FSG if we provide certain financial services to you.

The information in this document is general information only, which means it doesn't consider your individual objectives, financial situation or needs. Therefore, before acting on this information you should consider how appropriate this product is for you having regard to those factors and carefully read this PDS before deciding whether to buy or continue to hold this product. You may wish to consider seeking advice from a financial adviser or compare the product with products offered by other insurers.

If you take out a policy, please keep a copy of this document with your policy schedule in a safe place as, together with your application, they form the contract between TAL Life and the policy owner. The PDS sets out all the terms and conditions for the policy and the policy schedule sets out your policy details and any additional terms and conditions applicable to you. Please read the PDS and the policy schedule carefully to understand how your policy operates and to ensure all your details in the policy schedule are correct. If there is any inconsistency between this PDS and the policy schedule, the full terms and conditions contained in the policy schedule will prevail to the extent of the inconsistency.

These documents will be required in the event of a claim. If the policy or sum insured is altered at any time, including increases due to inflation protection, you will receive a new policy schedule confirming the changes.

All correspondence and notices about your policy will be sent to the email address you give to us unless you ask to receive this information in the post. You can nominate at any time to receive your policy correspondence by post instead of email. You should save or print a copy of any information or documents that we email to you and keep these in a safe place so that you can always refer to them. Some documents, such as your policy schedule, may be required in the event of a claim.

If you ever lose or misplace these documents and need another copy, just give us a call or send an email to customerservice@aamilifeinsurance.com.au so a replacement can be organised.

Your AAMI Life Insurance policy does not have a cash value. Like car and home insurance, it's not a savings plan. No premiums or refunds will be payable to you in the event of policy cancellation, except within the 30-day cooling-off period or as outlined within this document.

There are risks involved with taking out insurance and you should be aware of these. Please refer to page 47 for more information.

When you apply for AAMI Life Insurance you will be asked a series of income, health and lifestyle questions. This underwriting process allows us to consider any pre-existing medical conditions, higher risk occupations and/or activities and the level of cover we can offer so that we can tell you exactly what we can cover you for before you purchase the insurance.

Up to date information

All the information in this PDS is current at the time of issue. From time to time we may change or update information about our products. If the change is not materially adverse to you, we may notify you by way of a website update at aami.com.au/policy-documents. If you'd like a free printed copy of this information, please call us on 13 22 44. If the change is a material or significant one, we will notify you within 3 months of the change occurring. We may also make improvements to your policy without any increase to your premium.

About the distributor of this product and issuer of the FSG

TAL Direct Pty Limited ABN 39 084 666 017 AFSL 243260 (TAL Direct) distributes this product and is responsible for the FSG. TAL Direct and TAL Life are part of the TAL Dai-ichi Life Australia Pty Limited ABN 97 150 070 483 group of companies (TAL).

Understanding what we mean

In this document, references to 'you' and 'your' mean the life insured and/or the policy owner as the context requires. References to 'we', 'us' and 'our' mean TAL Life. When reading this PDS, please refer to the Glossary.

Some words and expressions have a special meaning which are explained in the Glossary.

The singular includes the plural and vice versa. Words of one gender include the other gender. Headings are only for convenience. Apart from the Glossary, headings don't affect the interpretation of the words of the policy.

You should be aware that some limitations and exclusions will apply under this insurance product. This means that in some cases we will not pay a claim or will pay a claim only in limited circumstances. Before you buy this insurance, please read this PDS carefully, including sections titled 'When is a benefit not payable?'.

Contents

Why Life Insurance?

No one likes to contemplate that they will ever need it, but life insurance safeguards your family's future and the life you've worked hard to build if you're no longer around. It allows you to create a safety-net with a lump sum payment to your family that provides them with financial choices at a time of death or terminal illness. The payout can help with things like covering the mortgage or other debts, compensating for loss of earnings or contributing to keeping the household running.

With AAMI Life Insurance, you can also choose from a range of Optional Severity Based Illness Covers to help protect yourself and your family from temporary setbacks. These covers provide a lump sum payment that draws down on your main Life Insurance benefit (refer to diagrams on pages 17 to 18 for further detail), to assist with medical and out-of-pocket expenses while you're recovering from certain illnesses. The remaining Comprehensive Life Cover benefit is then payable in the event of your passing, to your family or beneficiaries while you continue to hold the policy. It can help you in life, and your family in death. See examples on pages 17 and 18.

AAMI Life Insurance at a glance

Comprehensive Life Cover
Benefit payable for death or terminal illness cover up to $1,500,000

One or more Optional Severity Based Illness Covers can be added with a combined sum insured up to the lesser of:

- $250,000; or
- the Comprehensive Life Cover benefit amount.

Optional Severity Based Illness Cover
You must meet the specified severity criteria for the insured condition, as defined in this PDS, to qualify for a benefit payment.
See pages 20 to 29 for the list of insured conditions.

Major Illness Cover
Protection in the event of a specified critical illness or injury.

and /or

Cancer Cover
Protection in the event of life-threatening Cancer (of a specified criteria).

These are the benefits you can expect. For complete details of each benefit please find further detail throughout this document.

Convenient	No complicated application process or medical exams required for Australian residents aged 18 to 65. AAMI Life Insurance is designed to provide you with a quick decision on the outcome of your application, based on the information provided by you in a short application and you are not required to undergo any medical tests or exams to apply for this product.
Comprehensive	You can choose to cover yourself and one additional adult for up to $1,500,000 for death or terminal illness and up to $250,000 for Optional Severity Based Illness Covers.
Flexible	Insurance that you can tailor and adjust to your requirements. Under Comprehensive Life Cover, you can increase your life cover benefit amount without any evidence of your health or pastimes following a significant life changing event, such as having a baby or taking out a new mortgage. You can apply to increase or decrease your cover at any time, however, increases outside of a significant life changing event will be subject to you satisfying income, health and lifestyle criteria.

Advanced payout	When a Comprehensive Life Cover claim is approved by us, we can provide an advance payout of up to $10,000, with the balance of the benefit amount payable once we have received all of the claims requirements and documentation. The advance payout can help your family with any immediate costs, such as the expense of legal fees involved with settling the estate.
Premiums	Your premiums are based on your age and will generally increase each year as you get older. For more information see 'About your premiums' on pages 31 to 37.
Existing AAMI customer discount	If you hold other AAMI-branded insurance policies such as home or car insurance, we will apply a 5% discount on your AAMI Life Insurance premium for the life of the policy.
Family discount	Add another adult to your policy and the youngest life insured will receive a 5% discount. This discount doesn't apply to any Optional Severity Based Illness Covers.
Optional benefits available (for customers aged 18 to 55)	
Major Illness Cover	Helps protect you from temporary setbacks due to defined critical illness of specified severity such as Cancer (of a specified criteria), Stroke (resulting in new neurological deficit), Heart Attack (of specified evidence) - partial payment or Heart Attack (with specified evidence of severe heart muscle damage) - full payment.
Cancer Cover	Designed to help protect you from temporary setbacks due to life-threatening Cancer (of a specified criteria) as specified and defined in this document.
Exclusions and Qualifying Period	Exclusions apply to Major Illness Cover and Cancer Cover - see pages 16 to 18 for further details. No benefit will be payable for Cancer (of a specified criteria), Heart Attack (of specified evidence) - partial payment, Heart Attack (with specified evidence of severe heart muscle damage) - full payment, Stroke (resulting in new neurological deficit) and Coronary Artery Bypass Surgery if the condition occurred or was diagnosed, or the circumstances leading to diagnosis became apparent, within 90 days after the cover commencement date including any increases in cover.

1. Taking out cover

Your duty to take reasonable care not to make a misrepresentation

About the application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and for what premium.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

If your application is accepted, the Policy will be a consumer insurance contract.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false statement or answer, a statement or answer that is only partially true, or a statement or answer which does not fairly reflect the truth.

When determining whether you have taken reasonable care not to make a misrepresentation, we may have regard to a range of matters. This will include your particular characteristics or circumstances of which we were aware or ought to have been reasonably aware of.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

What can happen if the duty is not met?

If the duty is not met, this can have serious impacts on your Policy. Your Policy could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put us in the position we would have been in if the duty had been met.

For example we may:

- avoid the Policy (treat it as if it never existed);
- vary the Benefit Amount; or
- vary the terms of the Policy.

Whether we can exercise one of these remedies depends on a number of factors, including:

- what we would have done if the duty had been met – for example, whether we would have offered you a Policy, and if so, on what terms
- whether the misrepresentation was fraudulent; and
- in some cases, the type of cover and how long it has been since the cover commencement date.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

Who can apply?

If you're an Australian resident aged 18 to 65, you can request more information and take out AAMI Life Insurance over the phone or online. Just call 13 22 44 or go to aami.com.au/life-insurance for more information. All Australian residents aged 18 to 55 are also eligible to apply for Optional Severity Based Illness Covers.

2. Choosing the right policy

Life insurance can be a simple, cost-effective way to help your family manage the financial impacts of your passing. For the cost of the premiums each year, they'll have access to a lump sum cash payout to financially help keep their lives on track when you're no longer around. There are no hidden fees and charges with AAMI Life Insurance. You'll know exactly what you're paying for. You can get discounts for higher levels of cover and a family discount when adding a partner to your policy (maximum two people per policy).

Upon approval of a death claim, an advance payment of up to $10,000 can be made available to assist with the immediate legal and other expenses that are likely to arise, with the balance of the benefit amount payable once the claim is accepted by us.

Step 1: Choose the amount of life cover

You can select an amount of life cover that suits your circumstances. Choose up to $1,500,000 for each person insured on the policy.

When choosing the amount of cover, work out how much money your family will need if you aren't able to provide for them.

It's important that you have the right level of cover, so be sure to consider things like all living expenses and any debts such as the mortgage, as well as future costs like education. If you're a single parent or a sole-income family, you might need to factor in extra child-care, transport and housekeeping

And don't worry about changes in your circumstances – we know these happen. Alterations to your AAMI Life Insurance policy may be able to be made, subject to you satisfying income, health and lifestyle criteria, or under a significant life changing event. Any changes to your cover are subject to our sole discretion and agreement. Please contact us to understand the possible alterations that may be made to your policy.

Step 2: Choose to add Optional Severity Based Illness Covers

There are two different types of optional covers you can add to your policy for additional peace of mind – Major Illness Cover and/or Cancer Cover. All Australian residents aged 18 to 55 are eligible to apply for these Optional Severity Based Illness Covers. For more detail about these covers and how they work, please see Section 4 – 'Optional Severity Based Illness Covers'. There are additional premiums charged for Optional Illness Covers. If you choose to purchase Optional Severity Based Illness Covers these will be shown on your policy schedule. No cover exists for Cancer (of a specified criteria), Heart Attack (with specified evidence of severe heart muscle damage) - full payment, Heart Attack (of a specified evidence) - partial payment, Stroke (resulting in new neurological deficit) or Coronary Artery Bypass Surgery, if the condition occurred or was diagnosed, or the circumstances leading to diagnosis became apparent, during the 90 days following cover commencement date. For full details, see pages 16 to 29.

Step 3: Choose to add additional lives

You can add an additional life insured to your policy. If you add an additional life insured, the youngest life insured will get a 5% discount on the life cover premium. This discount doesn't apply to any Optional Severity Based Illness Covers.

3. Benefit terms and conditions – Comprehensive Life Cover

The Benefit Amount is payable in the event of the death of a life insured, or their diagnosis with a terminal illness. All Australian residents aged 18 to 65 are eligible to apply. A benefit amount of up to $1,500,000 is available per life insured, subject to meeting underwriting criteria. The maximum benefit amount that can result after inflation protection is $2,500,000.

Maximum benefit payable per life insured

If a life insured is covered under more than one policy issued by TAL, or any of its related companies, including a:

1. TAL Life life insurance policy; and/or
2. life insurance policy under a Suncorp Group brand (Suncorp, AAMI, GIO);

the maximum total benefit that can be paid under all term life policies issued by TAL and any of its related companies is $1,700,000 plus any increases due to inflation protection.

Cover expiry age

Your AAMI Comprehensive Life Cover expires on the policy anniversary following the life insured's 99th birthday unless cover ends earlier due to one of the reasons listed in Section 5 – 'When does cover start and end?'.

When is a benefit not payable?

An AAMI Comprehensive Life Cover benefit is not payable in the event of intentional self-injury or suicide within 13 months of:

- the cover commencement date;
- the date of any benefit amount increase applied by you including under the Life Events feature, but only in respect that increase.

Overseas travel

No payments will be made under AAMI Comprehensive Life Cover if the event giving rise to the claim is caused by you being in a country for which the Australian Department of Foreign Affairs and Trade (DFAT) or any successor government department or agency issued a 'Do Not Travel' warning advice prior to your travel to that country, and which continues to be in force during the time of your stay in that country.

Special terms

We will also not pay an AAMI Comprehensive Life Cover benefit where we have agreed with you a special term in respect of your cover that specifically excludes the event or condition causing or contributing to the claim. Any such special term will be agreed with you before your policy is issued and will appear on your policy schedule.

Life Events feature

With this feature you can increase your AAMI Comprehensive Life Cover benefit amount without any evidence of your health or pastimes following a significant life changing event, such as having a baby or taking out a new mortgage (see page 57 for full list of events). This feature can be exercised once every 12 months and the amount of each increase is up to the lesser of $100,000 or 20% of the AAMI Comprehensive Life Cover benefit amount when you apply for an increase under this feature. Total increases under the Life Events feature cannot exceed 100% of your original benefit amount. Applications must be made within 90 days of a significant life changing event occurring and before the life insured's 60th birthday.

The Life Events feature is not available:

- if you have a policy with a special term (for example a loading or an exclusion due to your health); or
- if you have made a claim or are eligible to make a claim on this policy or any other policy issued by us.

Who receives the benefit payment?

On a single life policy, where the policy owner is also the insured person, they can nominate to whom a benefit will be paid – these people are called the beneficiaries. Any nomination of a beneficiary or beneficiaries is binding on us once we receive it and send written confirmation of the nomination back to you. You can ask us to change or revoke a nomination at any time except after a claimable event has occurred. If a nomination is made, details of each beneficiary will be shown in the policy schedule. If a change or revocation is made in relation to a nomination, a new policy schedule will be issued as confirmation of the change or revocation.

You cannot nominate a beneficiary on a joint life policy; the payment will be made to the surviving policy owner of the policy. If there is no surviving policy owner, the payment will be made to the estate of the policy owner.

In the event a beneficiary dies before the life insured, the allocated portion for that beneficiary may be paid to the policy owner's estate. If there are other surviving beneficiaries, their benefits will be paid as allocated. If there are no surviving beneficiaries, then the benefit will be paid to you, or if you have died, to your legal personal representative or a person we are permitted to pay under the *Life Insurance Act 1995*.

4. Optional Severity Based Illness Covers

Once you have provided a safeguard for your family with AAMI Comprehensive Life Cover, protect them further by adding an Optional Severity Based Illness Cover. The total value of the Optional Illness Cover/s can be an amount up to $250,000, or the Comprehensive Life Cover benefit amount if higher, for each life insured.

The Optional Severity Based Illness Cover/s benefit will be paid as a lump sum from the total life benefit amount, upon the diagnosis of an insured condition covered by the policy or on the life insured undergoing one of the medical procedures covered by the policy. For more information on how Optional Severity Based Illness Covers are paid see pages 20 to 29. Where your Major Illness Cover Benefit amount is $10,000 or more, the benefit payable for Heart Attack (of a specified evidence) - partial payment, is the greater of $10,000 or 10% of your Major Illness Cover Benefit Amount. Where your Major Illness Cover Benefit Amount is less than $10,000, the benefit payable is your total Major Illness Cover Benefit Amount.

The definition of the insured condition must be met for an Optional Severity Based Illness Cover benefit to be payable. Evidence of the insured condition must be provided by a medical practitioner. See pages 20 to 29 for the insured conditions and procedures covered by each of the cover options, their definitions and any exclusions that apply.

There are two Optional Severity Based Illness Cover options. All Australian residents aged 18 to 55 are eligible to apply for either or both Optional Severity Based Illness Covers. There are additional premiums charged for the Optional Severity Based Illness Covers and, if you choose to purchase the Optional Severity Based Illness Covers these will be shown on your policy schedule.

Major Illness Cover

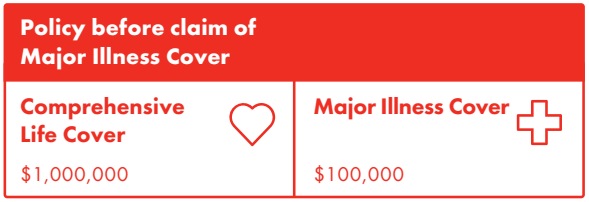
Major Illness Cover is designed to help protect you and your family from a major setback due to defined critical illnesses such as certain life-threatening Cancer (of a specified criteria), Stroke (resulting in new neurological deficit) or Heart Attack (with specified evidence of severe heart muscle damage) - full payment. You must meet the specified severity criteria for the insured condition, as defined in this policy, to qualify for a benefit payment.

Cancer Cover

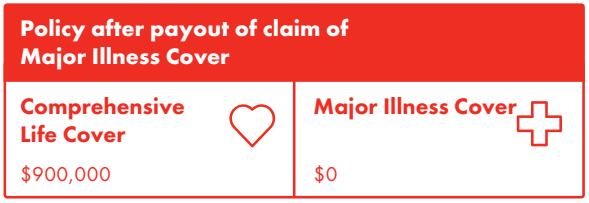
Cancer Cover is designed to help protect you and your family from a major setback due to certain life-threatening Cancer (of a specified criteria). You must meet the specified severity criteria for Cancer, as defined in this policy on pages 20 to 21, to qualify for a benefit payment.

How Optional Severity Based Illness Covers work

The Optional Severity Based Illness Covers are attached to your AAMI Comprehensive Life Cover, and any payment under the Optional Severity Based Illness Covers will reduce your AAMI Comprehensive Life Cover benefit by the amount of the payment. Your premiums will reduce accordingly. The diagrams below show examples of how a claim for Optional Severity Based Illness Covers impacts the AAMI Comprehensive Life Cover once the benefit is paid. Each example is distinct from and unrelated to the other.



In the event you suffered an insured condition and we pay you $100,000 under your Major Illness Cover, your Comprehensive Life Cover benefit amount would reduce by $100,000 to $900,000 and your Major Illness Cover would end.



Policy before claim of Cancer Cover	
Comprehensive Life Cover	**Cancer Cover**
$250,000	$250,000

In the event you suffered Cancer (of a specified criteria) as defined in the PDS and we pay you $250,000 under your Cancer Cover, your Comprehensive Life Cover benefit amount and Cancer Cover would reduce to $0 and cover for the life insured under the policy would end.

Policy after payout of claim of Cancer Cover	
Comprehensive Life Cover	**Cancer Cover**
$0	$0

Cover expiry age

Your Optional Severity Based Illness Covers expire on the policy anniversary following the life insured's 65th birthday unless cover ends earlier due to one of the reasons listed in Section 5 – 'When does cover start and end?'.

When is a benefit not payable?

The Optional Severity Based Illness Covers benefit is not payable if the Insured Condition was directly or indirectly caused by:

- any intentionally self-inflicted act (including attempted suicide); or
- the life insured's participation in any criminal or unlawful activity.

See pages 20-29 for other exclusions to specific insured conditions under "What's not covered".

Qualifying Period

No benefit will be payable for Cancer (of a specified criteria), Heart Attack (with specified evidence of severe heart muscle damage) - full payment, Heart Attack (of a specified evidence) - partial payment, Stroke (resulting in new neurological deficit) and Coronary Artery Bypass Surgery if the condition occurred or was diagnosed, or the circumstances leading to diagnosis became apparent, within 90 days after:

- the Optional Severity Based Illness Covers' commencement date;
- the date of an applied for increase but only in respect of the increase;
- the date a life insured was added to the policy, in respect of that life insured; or
- the most recent date that we have agreed to reinstate the policy.

Overseas travel

No payments will be made under AAMI Life Insurance if the event giving rise to the claim is caused by you being in a country for which the Australian Department of Foreign Affairs and Trade (DFAT) or any successor government or agency issued a 'Do Not Travel' warning advice prior to your travel to that country, and which continues to be in force during the time of your stay in that country.

Special terms

We will not pay any benefits where we have agreed with you a special term in respect of your cover that specifically excludes the event or condition leading to the claim. Any such special term will be agreed with you before your policy is issued and will appear in your policy schedule.

Optional Severity Based Illness Covers – Insured conditions

In order for a benefit to be paid, the insured condition must meet the full criteria and severity requirements for that condition.

For many insured conditions, this means the condition will be required to progress beyond a diagnosis.

Diagnosis means the process of a medical practitioner or specialist medical practitioner determining which illness or injury explains an individual's symptoms.

Severity means the seriousness of an insured condition in order for a benefit to be paid.

Details of insured conditions and exclusions under Optional Severity Based Illness Covers:

The Life Insurance Code of Practice (The Code) sets out how insurers will assess your claim if your policy has a medical definition which specifies an obsolete method of diagnosis or treatment that is no longer used in mainstream medical practice in Australia. Information about The Code can be found in the 'Important information' (section 8) of this PDS.

Insured condition	What's covered	What's not covered
Cancer (of a specified criteria) Applicable to Major Illness Cover and Cancer Cover	**Cancer (of a specified criteria)** means any malignant tumour diagnosed with histological or cytological confirmation and characterised by: a) the uncontrolled growth of malignant cells; and b) invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders. **Carcinoma in situ of the breast** which requires: • the removal of the entire breast due to any malignant tumour diagnosed with histological or cytological confirmation; or • breast conserving surgery with either radiotherapy or chemotherapy. **Carcinoma in situ of the testicle** that requires the removal of the entire testicle and malignant tumour requires histological and cytological confirmation. **Skin melanoma** that: a) has evidence of metastasis; b) is at least Clark level 3; c) is showing signs of ulceration; or d) is greater than 1.0mm maximum thickness using the Breslow method. **Non-melanoma skin cancers** that have spread to the bone, lymph node or other distant organs. **Chronic lymphocytic leukaemia** that has progressed to Rai stage 1 or more. **Prostate cancer** that: a) has a Gleason score of 6 or more; or b) requires major interventional therapy including radiotherapy, chemotherapy, biological response modifiers or any other major treatment to arrest the spread of malignancy. If a surgical procedure is performed for any condition above, it must be considered appropriate and necessary to arrest the spread of malignancy.	Any cancer that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of the cover commencement date, an increase in the benefit amount applied for by you (for the increased portion only), or the date of any reinstatement of cover. In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • All tumours which are histologically described as any of the following: a) pre-malignant; b) non-invasive (including tumours that are classified as Tis, Cis or pTa unless stated otherwise); c) high-grade dysplasia; or d) borderline or low malignant potential. • All carcinoma in situ except the examples provided in the 'What's covered' column. • All skin melanomas except the examples provided in the 'What's covered' column. • All non-melanoma skin cancers except the examples provided in the 'What's covered' column. • Chronic lymphocytic leukaemia that has not progressed to Rai stage 1 or more. All prostatic cancers except the examples provided in the 'What's covered' column. • All skin melanomas except the examples provided in the 'What's covered' column.

Insured condition	What's covered	What's not covered
Coronary Artery Bypass Surgery Applicable to Major Illness Cover only	**Coronary Artery Bypass Surgery** means bypass grafting surgery performed to correct or treat coronary artery disease.	Refer to 'When is a benefit not payable?' on pages 18 to 19 including Coronary Artery Bypass Surgery which takes place or the circumstances leading to the procedure become apparent within the first 90 days of the cover commencement date, an increase in the benefit amount applied for by you (for the increased portion only), or the date of any reinstatement of cover.
Heart Attack (with specified evidence of severe heart muscle damage) - full payment Applicable to Major Illness Cover only	**Heart Attack (with specified evidence of severe heart muscle damage) - full payment** means the death of a portion of the heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least three of the following: a) Symptoms of ischaemia. b) New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB). c) Development of new pathological Q waves in the ECG. d) Imaging evidence of new regional wall motion abnormality present at least six weeks after the event. If the tests specified above are inconclusive, other appropriate and medically recognised tests will be considered or the definition will be met if at least three months after the event the insured's left ventricular ejection fraction is less than 50 per cent.	Any heart attack that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of the Cover commencement date, an increase in the benefit amount applied for by you (for the increased portion only), or the date of any reinstatement of cover. In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • Any heart attack which is caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a medical practitioner. If alcohol and/or drugs have contributed to the heart attack, it must be confirmed by an appropriate specialist medical practitioner. • A rise in biological markers because of an elective percutaneous procedure for coronary artery disease. • Other acute coronary syndromes including but not limited to angina pectoris.

Insured condition	What's covered	What's not covered
Heart Attack (of specified evidence) – partial payment Applicable to Major Illness Cover only	**Heart Attack** means the death of a portion of heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following: • Symptoms of ischaemia; • New significant ST-segment -T wave (ST -T) ECG changes or new left bundle branch block (LBBB). • Development of new pathological Q waves in the ECG. • Imaging evidence of new regional wall motion abnormality present at least six weeks after the event If the tests specified above are inconclusive, other appropriate and medically recognised tests will be considered. The benefit payable for 'Heart Attack (of specified evidence) - partial payment' is: • Where your Major Illness Cover Benefit Amount is $10,000 or more, the benefit payable is the greater of $10,000 and 10% of your Major Illness Cover Benefit Amount. • Where your Major Illness Cover Benefit Amount is less than $10,000, the benefit payable is your total Major Illness Cover Benefit Amount. The benefit for Heart Attack (of specified evidence) - partial payment will only be paid once across all Optional Severity Based Illness Cover.	Any heart attack that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of the cover commencement date, an increase in the benefit amount applied for by you (for the increased portion only), or the date of any reinstatement of cover. In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • Any heart attack which is caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a Medical Practitioner. If alcohol and/or drugs have contributed to the heart attack, it must be confirmed by an appropriate specialist Medical Practitioner. • A rise in biomarkers because of an elective percutaneous procedure for coronary artery disease. • Other acute coronary syndromes including but not limited to angina pectoris.
Stroke (resulting in new neurological deficit) Applicable to Major Illness Cover only	**Stroke (resulting in new neurological deficit)** means a cerebrovascular event producing a new neurological deficit confirmed through clinical examination. This requires clear evidence on a CT, MRI or similar, appropriate scan or investigation that a Stroke (resulting in new neurological deficit) has occurred and of infarction of brain tissue, intracranial and/or subarachnoid haemorrhage.	Any stroke that occurs, is diagnosed, or the circumstances leading to the diagnosis become apparent within the first 90 days of the cover commencement date, an increase in the benefit amount applied for by you (for the increased portion only), or the date of any reinstatement of cover. In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • Transient ischaemic attacks. • Non-stroke related reversible neurological deficit. • Cerebral symptoms due to migraine. • Cerebral injury resulting from trauma or hypoxia. • Vascular disease affecting the eye or optic nerve. • Ischaemic disorders of the vestibular system. • Migraine. • Hypoxic events.

Insured condition	What's covered	What's not covered
Paralysis Applicable to Major Illness Cover only	**Paralysis** means the total and permanent loss of function of two or more limbs through illness or injury causing permanent damage to the nervous system. This includes, but is not limited to, quadriplegia, paraplegia, diplegia and hemiplegia.	In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: ● Conditions which are caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a medical practitioner.
Major Organ Transplant (of specified organs) Applicable to Major Illness Cover only	**Major Organ Transplant (of specified organs)** means either the undergoing of a Major Organ Transplant (of specified organs) or upon the advice of an appropriate specialist medical practitioner, the placement on a waiting list of a Transplantation Society of Australia and New Zealand recognised transplant unit for the human to human transplant from a donor (who is not the life insured) to the life insured of: ● bone marrow; or one of the following organs: ● kidney; ● heart; ● lung; ● liver; ● pancreas; or ● small bowel.	In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: ● Any transplant of the liver which is caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a medical practitioner. The transplant of any other organ, part or parts of an organ or any other tissue transplant which is not listed on page 26.
Major Organ Failure (of specified organs) Applicable to Major Illness Cover only	**Major Organ Failure (of specified organs)** means any of the following: Chronic lung failure (on permanent oxygen therapy) means end-stage lung disease with a consistent pulmonary function test result of: - FEV1 less than 40% predicted; or - a DLCO less than 40% predicted; and - on permanent oxygen therapy. ● Chronic liver failure (resulting in permanent symptoms) means end-stage liver failure resulting in permanent jaundice, ascites and/or encephalopathy; or ● Chronic kidney failure – (undergoing permanent dialysis) means undergoing permanent dialysis treatment prescribed by a renal physician due to impairment of total kidney function to a severity constituting end stage kidney failure.	In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: ● Conditions which are caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a medical practitioner.

Insured condition	What's covered	What's not covered
Permanent Major Physical Impairment Applicable to Major Illness Cover only	**Permanent Major Physical Impairment** means any of the following: • the total and permanent loss of the use of two or more limbs due to an accidental injury; • the total and irrecoverable loss of sight in both eyes (whether aided or unaided) as a result of illness or injury to the extent that: (a) visual acuity in both eyes, on a Snellen Scale after correction by suitable lens is less than 6/60, or (b) the visual field is reduced to 20 degrees or less of arc; or • the irrecoverable profound loss of all hearing in both ears, resulting in an auditory threshold of 91 decibels or greater, averaged at frequencies 500, 1000 and 3000 hertz, both natural and assisted, as a result of illness or injury. The condition must be diagnosed by an appropriate specialist medical practitioner.	In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • Conditions which are caused or contributed to by alcohol abuse or the use of drugs other than as prescribed by a medical practitioner.
Severe Burns Applicable to Major Illness Cover only	**Severe Burns** means tissue injury caused by thermal, electrical or chemical agents resulting in full thickness burns. Must be a result of an accidental injury. This requires: • 20% of the body surface area as measured by the Lund and Browder Body Surface Chart; • 50% of both hands requiring surgical debridement and/or grafting; or • 50% of the face requiring surgical debridement and/or grafting.	In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • Any burns resulting from the Life Insured being under the influence of alcohol (over the prescribed legal limit according to relevant state or territory limit), or any drug not prescribed by a medical practitioner, or any drug prescribed by a medical practitioner and not taken in the correct dosage.
Major Head Trauma Applicable to Major Illness Cover only	**Major Head Trauma (resulting in neurological deficit)** means head injury due to an accident resulting in permanent neurological deficit. This requires at least a permanent 25% of Whole Person Impairment as defined in the latest edition of the 'Guides to the evaluation of Permanent Impairment, American Medical Association'.	In addition to 'When is a benefit not payable?' on pages 18 to 19 the following are also not covered: • Major Head Trauma resulting from the Life Insured being under the influence of alcohol (over the prescribed legal limit according to relevant state or territory limit), or any drug not prescribed by a medical practitioner, or any drug prescribed by a medical practitioner and not taken in the correct dosage.

5. When does cover start and end?

If we accept your application and you have paid the first premium, we will issue you a policy schedule. Your policy starts at the cover commencement date set out in your policy schedule.

Your cover in respect of a life insured ends when the earliest of the following events occurs:

- for Comprehensive Life Cover, the policy anniversary immediately following the life insured's 99th birthday;
- for Optional Illness Covers, the policy anniversary immediately following the life insured's 65th birthday;
- the death of the life insured;
- the payment of the terminal illness benefit;
- the benefit amount is reduced to zero;
- your policy is cancelled due to:
  - non-payments of premiums (where we have given you notice required by law); or
  - you making a fraudulent claim; or
- the date we cancel your policy following a request from the policy owners.

If you have not complied with your duty to take reasonable care not to make a misrepresentation and we avoid the cover, this will mean that we cancel the cover from the start and treat it as if it never existed.

6. About your premiums

What are the costs?

The cost of your policy depends on a range of factors, including but not limited to the type of cover, your age and gender, whether or not you smoke, the length of time you have had your policy and how often you choose to pay your premiums. We may also take your occupation, health, income, personal pastimes, lifestyle and other factors into account in determining insurance premium amounts.

We ask for this information so that the premiums we charge take into account the different levels of risk presented by different customer groups. Your premium is calculated based on your age at each Policy anniversary and the length of time you have had your Policy. Premiums will generally increase as you age and with the length of time you hold your cover. The increases will generally be more significant as you get older.

Sometimes discounts may apply to certain policies; however, these may not apply for the full term of your policy.

Once we know a little bit about you and the cover you require, we can provide you with an indicative quote for your premium. The quoted premium may change once we have all the information we require to complete our assessment of an application for cover.

All premiums are payable in advance, by the due date shown in your policy schedule. We will inform you of the premium payable in subsequent years before each policy anniversary.

Inflation protection

Our Inflation protection feature helps your Cover keep up with rises in the costs of living. Benefit amounts increase each year up to the policy anniversary after age 70 in line by the indexation factor or by 5%, whichever is greater.

The maximum benefit amount that can result after inflation protection is $2,500,000.

If you don't wish to receive the increase you will need to let us know.

When do you or don't you have to pay?

The premium is due on the date and at the frequency shown in the policy schedule. All premiums are payable by the due date shown in your policy schedule (unless otherwise advised). You can change the frequency of premium payments at any time.

If you are paying by direct debit, the premium will be deducted from the account that you have authorised us to debit, on the agreed date and frequency. If the agreed date falls on a weekend or public holiday, the deduction will be made on the next business day.

Changes in premiums

Premium rates are not guaranteed. Your premium will change when any of the following events occur:

- your premium will increase each year in accordance with your age and any increase to your benefits, such as Inflation Protection increases in cover amounts;
- if you make any changes to your policy;
- if your benefit amount is increased or decreased;
- if you add or remove a cover or option;
- any discount that applies changes or ceases, including because you make changes to your policy;
- if there are changes in government duty or taxes and we choose to pass on these additional costs. If this happens, we will give you 30 days' written notice; or
- we choose to increase the underlying premium rates on our AAMI Life Insurance portfolio. Please see next section.

We can change our premium rates

The cost of your cover is not guaranteed to remain the same each year. We can change the premium rates we use to determine your premium.

Decisions to change premium rates do not occur because of changes to an individual customer's own circumstances, but rather are determined in relation to the group of customers that we insure.

We will act reasonably when making decisions to change our premium rates and will only make changes to the extent reasonably necessary to protect our legitimate business interests.

Our premiums are determined so that the total premium for our group of insured customers is sufficient to cover our expected future claims costs, meeting our associated costs of doing business and margins in providing cover to you.

We review associated factors on an ongoing basis which may include, but are by no means limited to, our assessment of regulatory or legislative requirements, our operating costs or the commercial environment. These are only some examples of factors that we may consider, and others may apply. The outcome of any premium review performed by us may result in a change to the premium rates we charge you. If we change the premium rates, you will be advised of the change to your premiums at least 30 days before the change takes effect.

If your premiums increase, you will always have the option to reduce the premium by reducing your cover, subject to any minimum premiums or sum insured applicable to your policy.

You will also always have the right to cancel your cover, at any time and for any reason, including a premium increase. There may be other options available to help you manage the cost of your cover. Please call us for assistance. There are no cancellation fees or penalties for cancelling your policy.

Your policy cannot be singled out for a change in how a premium is charged because of an adverse change in the health or circumstances of the life insured after the policy commencement date.

Payment frequency

You can pay your premium fortnightly, monthly or annually via a direct debit from your nominated account or credit card. If you pay annually, you get 12 months of cover for the price of 11.

The total first year premium, or the first instalment of the premium you must pay is shown in your policy schedule.

We also provide you with a payment schedule, which lists the regular payment dates for the coming year. This schedule is included with your policy schedule.

You can change the frequency of premium payments at any time. An updated payment schedule will be sent for your records.

Payment method

Premiums may be paid by:

- direct debit; or
- credit card.

The premium will be deducted from the account that you have authorised us to debit, on the agreed date and frequency. Depending on weekends and public holidays, the deduction will be made on the next business day. If we are unable to debit on the agreed date due to insufficient funds we will, subject to the relevant debit authority, attempt to debit again.

Unpaid premium and premium dishonours

To ensure your cover continues you must pay your premiums when due.

If you don't pay the premium when due or the premium deduction from your account can't be made, then:

- if the unpaid premium is the first premium, the policy will be cancelled and treated as if it had not existed at all.
- if the unpaid premium is a premium other than the first premium, we will allow 30 days from the due date to make this payment. If we have not received payment by this time, we will send you a notice telling you that we will cancel your policy if the premium then due is not paid by the date shown in the notice. This date will be at least 28 days from the date of the giving of this notice. If you do not pay the premium by that date, we will cancel the policy.

If any benefit under the policy becomes payable, any unpaid premium due to us will be deducted from the benefit paid to you. No benefit will be paid for insured events occurring after this policy is cancelled.

What happens if I stop paying?

Your cover is only valid while premiums are paid when due, so if you stop paying, your cover will end in accordance with the process outlined above in the 'Unpaid premium and premium dishonours' section. AAMI Life Insurance is an insurance policy, and like other insurance policies such as car insurance, it is not a savings plan. If you stop paying or cancel outside of the first 30 days, there will be no refund of any of the money you've paid in premiums except where outlined otherwise within this document.

If you are having trouble meeting your premium payments, we may be able to offer you options to assist. Please call us to discuss the options that might be available to you.

If your policy is cancelled due to non-payment of premiums (following notice from us as required by law), you may contact us if you wish us to consider issuing you with a new policy. Any new policy will be subject to the terms and conditions then applying. Your application for a new policy will be subject to acceptance by us.

Taxation

If you are considering the tax implications of purchasing and receiving benefits under AAMI Life Insurance, it is important you seek independent, professional taxation advice. The complexity of taxation laws and rulings is such that this advice should be specific to your circumstances. For comprehensive advice regarding the taxation implications of paying premiums or receiving any of the benefits under the policy that takes into account your personal circumstances, please contact a registered tax agent, tax (financial) adviser or the Australian Taxation Office.

The following general information only applies to Australian resident individuals who are both the policy owner and the life insured and the recipient of any benefits and who are not taking out the insurance for business purposes. It is based on the Australian tax law as at the date this PDS was prepared. The tax law and its interpretation are subject to change. Where the law requires an amount to be withheld or deducted from a benefit payment, we will withhold or deduct the required amount from the payment and forward it to the relevant authority.

Generally, the premiums you pay will not be tax deductible. Benefits payable under the policy may be assessed under the capital gains tax provisions, if you are not the original policy owner and you acquired the interest in the policy for consideration.

This taxation information is based on the continuation of present laws and their current interpretation and is a general statement only. For advice regarding taxation please contact your registered accountant or the Australian Taxation Office.

AAMI Life Insurance is treated as input taxed under the Australian Goods and Services Tax (GST) law and premiums are not subject to GST. The premium rates are inclusive of any GST costs incurred in relation to the policy. An input tax credit will not be available to the policy owner.

Government duties

We reserve the right to pass on to you any government duties, taxes or other charges that are or become payable by us or you in respect of this policy.

Premium and commission

TAL Life may pay commissions and other benefits to companies within the Suncorp Group of companies and/or TAL Direct. Any amounts paid are factored into the cost of your policy. AAMI Life Insurance and/or TAL Direct will provide details of the benefits they will receive in the FSG given to you.

7. Making a claim

How do I make a claim if I ever need to?

AAMI Life Insurance helps take the financial difficulty out of what can be a very stressful time. That's why we've kept the process as straightforward as possible. To claim a benefit, we require claim documentation in support of benefit entitlement. We may ask for additional information to ensure that the terms and conditions of the policy as set out in this PDS are satisfied.

Step 1

If you or your legal representative need to make a claim, please contact us on 1300 450 322 as soon as you can. We strongly encourage you to contact us at the earliest possible opportunity. A delay in notifying us may mean it could take longer for us to process your claim, as it may be difficult for us to access the information we need to finalise our decision. You or your legal representative will need to provide us with claim details and our claims staff will provide you with a list of all requirements needed to assess your claim. We will help you understand the claims process, what to expect for the assessment of your claim and to make the claim as easy as possible for you.

AAMI Life Insurance Claims

Telephone:	1300 450 322
Email:	claims@aamilifeinsurance.com.au
In writing:	AAMI Life Insurance Claims Department Reply Paid 5380 Sydney NSW 2001

Step 2

You or your legal representative will need to collate all the relevant information and return it to us. Depending on the claim, we'll let you know if any additional requirements (including relevant health records) are needed once the initial information is reviewed.

Duty to take reasonable care not to make a misrepresentation

Claims may be declined in full or in part and the policy may be avoided in full or varied if the policy owner and/or the life insured fails to comply with the duty to take reasonable care not to make a misrepresentation as stated on pages 9 to 11 or makes a misrepresentation while applying for cover or any alteration in cover.

We will require relevant information from you or your legal representative to assess your claim and to be satisfied of our liability under your policy. Where relevant to assessing any claim you make, we have the right to request you or your legal representative to provide access to medical, and other relevant records. We also have the right to request you to provide your consent or grant us authority to obtain access to such records.

If you or your legal representative do not provide the above relevant records or you do not provide consent or authority for us to access relevant records to assess your claim, we may not be able to assess any claim you make (in which case we may not pay a claim which we have not been able to assess).

Fraudulent claims

We may refer any suspected fraudulent claims or illegal activity to the relevant law enforcement authorities and will, to the extent permissible by law, seek to recover any monies paid, expenses or damages incurred in obtaining such evidence as may be required to protect our rights. If you make a fraudulent claim under your policy or another policy you have with us, then to the extent permitted by law we may cancel your policy and may refuse payment of your claim.

Information we will need

You or your legal representative must provide us, at your own expense, with any completed claim forms, information or certified copies of documentation supporting the claim that we reasonably require. We will contact you or your legal representative within a reasonable time from the date you submit your claim and inform you of any additional information and/or documentation that we require in order to assess your claim. We require the following for all claims:

- certified copy of proof of age of the life insured;
- certified copy of identification document of the policy owner; and
- completed initial claim form.

Authority to obtain information

To obtain all relevant evidence and records to assess your claim and our liability under your Policy, we will request that you or your legal representative provide us with relevant medical, financial, employment and other records about you. We may also request that you or your legal representative provide consent or grant us authority to obtain access to such records.

This includes both information and records which are relevant to determining whether you complied with your duty to take reasonable care not to make a misrepresentation when you applied for, reinstated or modified your Policy, and information and records that we reasonably require to assess your claim.

For example, we may require information and records from medical practitioners who have treated you in relation to a condition giving rise or contributing to your claim, and historical medical records which are relevant to determining whether you complied with your duty to take reasonable care not to make a misrepresentation when you applied for, reinstated or modified your Policy.

If you do not provide the relevant records or you do not provide consent or authority for us to obtain the relevant records, it may impact our ability to provide you with a Policy or assess our liability under your Policy (in which case we may not pay a claim).

For Optional Severity Based Illness Covers claims, we will require proof of the insured event for which a claim is being made, supported by (but not limited to):

- evidence of the date and location of where the event leading to the insured event occurred (if applicable); and
- appropriate evidence from a medical practitioner, including confirmatory investigations such as clinical, radiological, histological and laboratory evidence.

Claim requirements at our expense

We reserve the right to obtain any additional information that we deem necessary. Should we request any further information in excess of the initial and progress claim requirements in order to assess your entitlement to a benefit, these requirements will be met at our expense.

Depending on the type of claim, you may be required to provide or participate in some or all the following:

- additional medical examination(s) which may involve imaging studies and clinical, histological and laboratory evidence to confirm the occurrence of the condition;

- confirmatory assessment and diagnosis of current functional and vocational capacity by a qualified medical practitioner or an appropriately qualified person selected by us, acting reasonably;
- access to details of the life insured's previous medical consultations; and
- interviews with various parties including you, in relation to your claim by a member of our staff or someone appointed by us, as often as is required.

Payment of claims

We will pay your claim once we have received all the claim requirements and established proof which we reasonably consider is acceptable to us, of your entitlement to be paid a benefit under this policy.

Misstatement of age

If the age of the life insured has been understated on the application for this policy, then the benefit payable in respect of a life insured will be recalculated based on the benefit that the premium would have purchased if the correct age had been provided. If the age of the life insured has been overstated, we will refund any excess premium paid. Where the terms and conditions of a benefit vary by the age of the life insured, the correct age of the life insured, if applicable, will be used to determine whether a benefit is payable.

We may also vary the end date of the policy to what it would have been had the correct date of birth been provided by the life insured.

When we will not pay a claim

We are not liable to pay a claim or may reduce a benefit arising from or in any way connected with anything we have specifically excluded or adjusted in the policy schedule.

For the avoidance of doubt, we will also not pay a claim:

- where your claim does not meet the relevant policy terms and conditions for a benefit to be paid;
- where the life insured did not take reasonable care not to make a misrepresentation when they applied for, reinstated or varied the policy, and we apply a remedy available under the *Insurance Contracts Act 1984* (Cth);
- where we do not receive all information we reasonably require to assess your claim or compliance with your duty to take reasonable care not to make a misrepresentation; or
- where there is insufficient evidence to support your claim.

Your policy is subject to the applicable laws of Australia including the *Insurance Contracts Act 1984* (Cth). For example, under section 54 of the *Insurance Contracts Act 1984* (Cth), if the effect of your policy is that we may refuse to pay your claim or reduce your benefit due to some act or omission by you or someone else that occurs after your policy commences, we may:

- refuse to pay your claim, but only to the extent that such act or omission could reasonably be regarded as having caused or contributed to the loss which gives rise to your claim; or
- reduce the amount of your benefit, but only by an amount that fairly represents the extent to which our interests are prejudiced by the act or omission.

There may be circumstances where the act or omission was necessary to protect a person or property, or it was not reasonably possible to avoid the act or omission. In those circumstances we may not refuse to pay the claim, only because of that act or omission.

8. Important things you need to know about your cover

We encourage our customers to make sure they understand all aspects of their AAMI Life Insurance, so here's what you need to know before and after you take out your cover.

How we communicate with you

All correspondence and notices about your policy will be sent to the email address you give to us unless you ask to receive this information in the post. You can nominate at any time to receive your policy correspondence by post instead of email. You should save or print a copy of any information or documents that we email to you and keep these in a safe place so that you can always refer to them. Some documents, such as your policy schedule, may be required in the event of a claim.

If you change your mind (cooling-off period)

We offer a 30-day money-back guarantee, giving you time to review your policy, and make sure it's the right one for you. This is commonly referred to as a cooling-off period. If you cancel your policy within 30 days of the cover commencement date and you haven't made a claim, we'll refund the premium you've paid.

You can cancel your policy at any time after the cooling-off period. Cancellation is effective immediately upon your request, which means you're no longer covered after that. If you've paid an annual premium and cancel your cover during the year, we'll refund the unused portion of the premium you paid.

More than one life insured

You can have two lives insured on the same policy, subject to them meeting entry age and Australian resident requirements and satisfying income, health and lifestyle criteria. Each life insured can have a different amount of Comprehensive Life Cover.

Both lives insured will be shown individually on your policy schedule along with their respective premium.

If more than one life insured is covered under this policy, a reference to a life insured means each respective life insured individually.

You may add a new life insured to your policy after the cover commencement date (if you did not add one at the cover commencement date), subject to the life insured meeting entry age requirements, and satisfying health and lifestyle criteria, where applicable. If a new life insured is added, a new policy schedule will be sent to you listing both the lives insured covered under the policy, effective as of the issue date of the policy schedule. The 30-day cooling-off period only applies when the policy is first issued. No further cooling-off period applies when a life insured is added to an existing policy.

Any alteration to a joint policy will require both policy owners' approval.

Alterations to existing cover

We understand that circumstances change, and you may need to make changes to your cover. You may be able to make the following changes:

- update your contact details;
- add or remove a life insured;
- increase or decrease your benefit amount;
- add or remove optional cover;
- change the premium frequency or the date we debit your bank account or credit card; and
- change how you pay your premiums.

You may increase the Comprehensive Life Cover benefit amount for each life insured up to the maximum amount prior to the life insured reaching 65 years of age, subject to the life insured satisfying health and lifestyle criteria, or under a under the Life Events feature. You may increase the Optional Severity Based Illness Covers benefit amount for each life insured up to the maximum amount prior to the life insured reaching 55 years of age, subject to the life insured satisfying health and lifestyle criteria.

Premiums for the increased portion of cover will be based on the premium rate applying to the life insured's age at the time of increase. Alterations to your policy may have an impact on your premium.

Any changes to your cover are subject to our sole discretion and agreement. Please contact us to understand the possible alterations that may be made to your policy.

No cash value

Your AAMI Life Insurance policy does not have a cash value. Like your car and home insurance, it's not a savings plan. No premiums or refunds will be payable to you in the event of policy cancellation, except within the 30-day cooling-off period or as outlined within this document.

Guaranteed continuation of cover

As long as you continue to pay your premiums when due, we guarantee to continue your policy each year until cover ends. This guarantee of continuation of cover applies regardless of any changes to your health or personal circumstances.

Currency

All payments in connection with this policy must be made in Australian dollars.

Statutory fund

The assets of TAL Life's Statutory Fund Number 1 will alone be liable for the payment of the benefits under this policy. You have no rights to the assets of TAL Life or any other TAL Life statutory fund.

Sanctions Laws

In limited cases, Australian and overseas laws prohibit ("sanction") payments to or from certain persons, and dealings in certain assets (including insurance policies).

Where any law requires us, we will not provide cover under, accept premium for, or make a claim or other payment under the policy, if any policy owner, life insured or nominated beneficiary:

- is listed on the Australian Department of Foreign Affairs and Trade or other applicable Australian or overseas sanctions list, or where dealing with such person or asset is otherwise unlawful;
- live in a sanctioned country; or
- requests payment to an account of a bank listed on any Australian or relevant overseas sanctions list or if such bank is located in a sanctioned country.

We are not liable to provide cover, accept premium, or make a claim or other payment if that would expose us to any prohibited sanction under any applicable law.

Duty of utmost good faith

We and you have a duty of utmost good faith under this contract, which means that both of us must act with honesty and fairness when dealing with each other in relation to your Policy. Under the *Insurance Contracts Act 1984* (Cth), neither of us may rely on a term of your Policy, if such reliance would be to fail to act with utmost good faith.

Variations

This policy can only be changed by TAL Life in writing. No other person or company including an agent of TAL Life has the right to change any part of the policy.

Special conditions and exclusions

It is important that you read the policy schedule to confirm the details are correct and to note any special conditions or exclusions which may apply to this policy.

Risks

There are risks involved with taking out insurance that you should be aware of. These include:

- you may not select the right insurance product and cover level for your needs;
- it is possible to pay more in premiums than the amount you are covered for;
- if you are replacing another insurance contract, you should consider the terms and conditions of each insurance contract before deciding to make the change;
- our policies do not contain a savings or investment component, which means that if you cancel your policy after the 30-day cooling-off period, you may not receive any money back; and
- you should consider if you have the financial capacity to fund the costs of cover, over the period you intend to hold the cover. This includes periods in which your financial capacity may change such as, but not limited to, changing employment circumstances, entering retirement or another change in your financial situation. You should form your own assessment of your capacity to fund premiums.

You should consider if the policy meets your needs both now and in the future. You may need to seek assistance from a financial adviser to assist you to determine if the terms are consistent with your objectives, financial situation and needs.

Complaints process

We offer an internal complaints department to assist with any concerns you may have about your policy, our services or your privacy. If you have a complaint about your policy or our services, please contact us on the details below:

Telephone: 13 22 44

Email: customerservice@aamilifeinsurance.com.au

In writing: AAMI Life Insurance
Reply Paid 5380
Sydney NSW 2001

We will attempt to resolve your complaint within 30 days of the date it is received.

If we are unable to resolve your complaint within that period, we will inform you of the reasons for the delay and let you know when we expect to provide a response to your complaint.

More information about our complaints process can be found in the AAMI Complaints Policy at https://www.aami.com.au/contact/life-complaint-handling-process

If an issue has not been resolved to your satisfaction or we do not respond to your complaint within 30 days, you can lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers.

Website: www.afca.org.au

Email: info@afca.org.au

Telephone: 1800 931 678 (free call)

In writing: Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

Time limits may apply to complaints to AFCA. You may wish to consult the AFCA website or contact AFCA directly to find out if there is a time limit on lodging a complaint with AFCA.

Life Insurance Code of Practice

We have adopted the Life Insurance Code of Practice (the Code) which sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest. It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers as well as how insurers will assess your claim if your policy has a medical definition which specifies an obsolete method of diagnosis or treatment that is no longer used in mainstream medical practice in Australia. The Code covers many aspects of a customer's relationship with their insurer, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support. More information can be found at aami.com.au/contact/code-of-practice

Contacting us

If there's anything we haven't answered for you here, or even if there's anything you're not completely sure about, please don't hesitate to contact us on the details below:

Telephone: 13 22 44

Email: customerservice@aamilifeinsurance.com.au

In writing: AAMI Life Insurance
Reply Paid 5380
Sydney NSW 2001

9. Your privacy

This Privacy Statement is given on behalf of both TAL Life and AAMI. In this section 'TAL Life' means TAL Life Limited ABN 70 050 109 450 and its related companies that assist it to provide its services, 'AAMI' means a member of the Suncorp Group of companies, 'we'/'us'/'our' means TAL Life and AAMI collectively (or singularly/separately where the context requires) and 'you'/'your' means the life insured and/or the policy owner as the context requires.

Personal and sensitive information is collected from you or about you to enable us to provide insurance products or services to you. Further information may be requested from you at a later time, such as if you want to make alterations to your insurance policy or at claim time when financial and health information about you may need to be collected to assess the claim. If you do not supply the information that is required, then it may not be possible to provide the product to you or pay the claim.

Privacy policy

The ways in which your personal information is collected, used, secured and disclosed are set out in the respective privacy policies which are available at tal.com.au/privacy-policy and aami.com.au/privacy, and are free of charge on request.

A privacy policy contains details about the following:

- the kinds of personal information that we collect and hold;
- how we collect and hold personal information (including sensitive information such as health and lifestyle information);
- the purposes for which we collect, hold, use and disclose personal information (including sensitive information);
- how our customers may access personal information about them which is held by us and how they can correct that information; and
- how we deal with any complaints that our customers may have regarding privacy issues.

Contacting us about privacy matters

If you have any questions regarding privacy-related matters, including how we manage your information, or a privacy-related complaint, please contact us on the details below:

Telephone: 13 22 44

Email: customerservice@aamilifeinsurance.com.au

In writing: The Privacy Officer
AAMI Life Insurance
Reply Paid 5380
Sydney NSW 2001

TAL Life and AAMI rely on the accuracy of the information you provide. If you think the information held about you is incorrect, please let us know using the communication methods above.

Additional information about privacy issues

The website of the Privacy Commissioner which is available at www.oaic.gov.au is a useful source of additional information about both the privacy rights of individuals and the privacy laws imposed on organisations like the providers of this product. This website also contains sensible steps that individuals can take to protect their information when dealing with organisations and when using modern technology. We take no responsibility for the contents of this government run website.

Access to information held about you

Under the current privacy laws and regulations, you are generally entitled to access the personal information held about you. To access that information, simply make a request in writing to TAL. This process enables us to confirm your identity for security reasons and to protect your personal information from being sought by a person other than yourself.

If, for any reason your request to access and/or update your information is declined, you'll be provided with details of the reasons. In some circumstances it may be appropriate to provide copies of complex medical information to a treating medical practitioner rather than directly to the customer so that the medical terminology can be explained.

There are some limited exemptions where you are unable to access the personal information held about you. These are not limited to but include the following circumstances if:

- the access would have an unreasonable impact on the privacy of other people;
- the access request is frivolous or vexatious; and
- giving access would be unlawful.

Disclosure of information

In processing and administering your insurance (including at the time of claim) your personal information may be disclosed to other parties such as organisations to whom the providers of this product outsource mailing and information technology, government regulatory bodies, as well as disclosed to and received from companies within the AAMI and TAL groups (if applicable). Your personal information (including health information) may also be disclosed to other bodies such as reinsurers, health professionals, investigators, lawyers and external complaints resolution bodies.

Generally, customer information will not be used or disclosed for any purpose other than providing the products and services unless:

- you consent to the use or disclosure of the information;
- the use or disclosure is required or authorised under an Australian law or a court/tribunal order;
- the use or disclosure of the information is reasonably necessary for one or more enforcement-related activities conducted by, or on behalf of, an enforcement body, e.g. the police.

Sometimes we need to get personal information from or provide it to parties located overseas for the purposes outlined in this privacy statement. For more information on this including a list of countries where personal information may be disclosed, refer to our respective privacy policies.

Our marketing practices and opt-out

We and our related bodies corporate, affiliate companies and their partners, service providers and agents who operate and/or offer products (including life and general insurance, banking and superannuation) and services under the AAMI brand may use your personal information (including your telephone number and your email or other electronic addresses) to keep you informed about other products (including general insurance, banking and superannuation), services and offers which may be of interest to you. We may do this by phone (where we have your valid consent), mail, email and SMS or other electronic messages. These consents shall remain in effect in accordance with relevant law or unless and until you notify us that you do not want to receive such direct marketing communications from the AAMI brand.

In order to keep you informed about products (including life insurance), services and offers which may be of interest to you as well as improving our products and services that we may provide to you, we collect your personal information from and disclose it to others (including between the AAMI and TAL group of companies) that provide us with specialised data warehousing, matching, trending or analytical services, as well as customer feedback, general marketing and product development services.

We may use online targeted marketing, data and audience matching, and market segmentation to improve advertising relevance to you. We may also collect your personal information for marketing through competitions and by purchasing contact lists.

We, and other people who provide us with services, may combine the personal information collected from you or others, with the information we, or companies in AAMI, or our service providers already hold about you.

If, in relation to the AAMI brand, you do not wish to receive direct marketing communications (including via telephone calls), or do not want your personal information to be used or disclosed for marketing purposes, please call us on 13 22 44 or email customerservice@aamilifeinsurance.com.au. You can update your marketing preferences at any time.

10. Glossary

The Glossary defines expressions used in the PDS and the policy.

Accidental injury or injury means a bodily injury directly and solely caused by violent, external and visible means. The injury must occur after the cover commencement date and/or reinstatement date.

Intentional self-inflicted injuries and injuries which occurred prior to the cover commencement date and/or reinstatement date are not covered.

Australian resident means you are currently residing in Australia, received the PDS/FSG in Australia and you are a/an:

- Australian citizen;
- New Zealand citizen; or
- Australian permanent resident.

If you currently reside in Australia, received the PDS/FSG in Australia, have applied to be an Australian citizen or Australian permanent resident and are awaiting the outcome of your application, we will consider you an eligible Australian Resident but only as a Life Insured under the Policy.

Benefit amount means the benefit amount you apply for and which is accepted by us at the start of the policy (the cover commencement date) together with any requested increase, which we have accepted in writing, or any increases that we have automatically applied to your policy such as inflation protection increases.

Cover means the cover you have applied for and which we have accepted in writing. The cover we have accepted will be shown in your policy schedule.

Cover commencement date means the date you first take out cover (this date will be shown in your policy schedule).

Cover expiry date means the date at which cover ceases. The cover expiry date for each type of cover and your policy will be set out in your policy schedule.

Illness means an illness or disease that first manifests itself or is first suffered by the life insured after the cover commencement date or in the case of an increase to a benefit, after the commencement of the increase, and which is diagnosed by a medical practitioner.

Immediate family member means a spouse, partner (same or opposite sex) de facto partner, child, parent and/or sibling of a life insured or policy owner.

Indexation factor means the percentage change in the Consumer Price Index (CPI) which is the weighted average of the 8 Australian capital cities combined as published by the Australian Bureau of Statistics or any body which succeeds it and in respect of the 12 month period finishing on 30 September. The indexation factor will be applied from 1 January the following year. If the CPI is not published by this date, the indexation factor will be calculated upon a retail price index which we consider most nearly replaces it.

Injury means accidental injury.

Insured condition means the medical condition, injury or medical procedure covered under the Major Illness Cover or Cancer Cover as specified and defined in this PDS.

Life insured means the person whose circumstances we assess and accept as a life insured and who is named as such in the policy schedule. Also described as 'you' or 'your'.

Limb means an arm, hand, leg or foot.

Medical practitioner means a person who is registered as a medical practitioner in Australia, other than:

- you or the life insured;
- a business partner of you or the life insured; or
- an immediate family member of you or the life insured.

If practising other than in Australia, the medical practitioner must be approved by us, acting reasonably and have qualifications equivalent to Australian standards.

Unless registered as a medical practitioner, physiotherapists, nurse practitioners, and/or alternative therapy providers, chiropractors and acupuncturists, for example, are not considered by us to be medical practitioners.

Policy means the legal contract between the policy owner and us. This document, the application (whether in writing, verbally or online), the personal statements, the policy schedule and any special conditions or endorsements make up the policy.

Policy anniversary means the anniversary of the cover commencement date of your policy.

Policy commencement date means the date you first take out the policy (this date will be shown in your policy schedule).

Policy owner means the person who applies and is accepted for this policy and who is so named in the policy schedule (also described as 'you' or 'your'). The policy owner is the only person who may extend, vary, cancel or otherwise exercise any rights under the policy.

Policy schedule means the document we send you titled 'policy schedule' which sets out the details of your particular policy including who is the policy owner, who is the life insured, which benefits you have applied and been accepted for, any special terms we have agreed with you, the premium payable and your cover commencement date and cover expiry date.

Significant life changing event means:

- marriage;
- having a baby or adopting a child;
- taking out a new mortgage;
- the death of an immediate family member; or
- your child starting school.

Terminal illness means an Illness where, after having regard to the current treatment or such treatment as the life insured may reasonably be expected to receive, the life insured will not survive more than 12 months.

Two medical practitioners, at least one of whom is a specialist medical practitioner specialising in the life insured's illness, or an area related to the illness, must certify in writing (either jointly or separately), that despite reasonable medical treatment, the life insured is suffering a terminal illness which will lead to death within 12 months of the date of certification. The terminal illness and certification must occur while cover is in place.

We, us, our, TAL Life, the insurer means TAL Life Limited, ABN 70 050 109 450 AFSL 237848.

You, and **your** mean the policy owner and/or life insured as the context requires.

11. Direct debit request service agreement

This direct debit request service agreement is issued by TAL. It sets out the conditions for using direct debit to pay your insurance premiums. Please keep this agreement in a safe place for future reference.

How direct debit works

On the day your premiums are due, we send a request to your financial institution to debit the payment from your nominated account.

It usually takes between 1 to 3 days for the funds to be deducted — so make sure you keep enough money in your account during this time. If there are insufficient funds in your account to cover your premium payment, your bank may charge you a dishonour fee, and your insurance premiums will become overdue. TAL does not charge a dishonour fee for missed payments, but we may cancel your cover if your premiums remain unpaid.

When we deduct your payments

Usually we'll deduct your payment on the day it is due. Here are the exceptions:

- weekends — we'll deduct your payment the next business day, usually Monday; and
- public holidays — we'll deduct your payment the next business day. For public holidays that do not apply in all states, we'll deduct your payment the day it's due.

Our promise to you

We promise to:

- give you at least 14 business days' written notice of changes to this agreement; and
- keep your nominated account information confidential, except where conducting direct debits with your financial institution, or otherwise as required by law.

Your commitment to us

You agree that:

- you've given us the correct account details (please check a recent account statement to confirm);
- the account you've nominated can accept direct debits through the Bulk Electronic Clearing System (BECS). Please be aware that not all accounts allow direct debits through BECS. If you are unsure please check with your financial institution before completing your direct debit request form;
- all account holders are party to this agreement; and
- sufficient funds will be available on the due dates to cover your direct debit payments.

How to make changes

To make a change to your direct debit arrangement, please contact us on 13 22 44. We can help you with:

- changing your nominated account details;
- delaying, stopping or suspending any debits; and
- cancelling the agreement completely.

We'll need at least 2 business days' notice before your next payment for these changes to take effect. If you delay, suspend, stop or cancel your direct debit payment, you'll need to make alternative payment arrangements to ensure your insurance cover can continue.

12. Financial Services Guide

This Financial Services Guide (FSG) is provided by TAL Direct Pty Limited ABN 39 084 666 017 (TAL Direct, the Licensee, we, us and our). TAL Direct holds an Australian Financial Services Licence (AFSL 243260) and is related to the insurer TAL Life Limited ABN 70 050 109 450, AFSL 237848 (TAL Life). TAL Direct and TAL Life are part of the TAL Dai-ichi Life Australia Pty Limited ABN 97 150 070 483 group of companies (TAL).

Purpose of this Financial Services Guide

This FSG is designed to assist you in deciding whether to use any of the services we offer. It contains important information about:

- the services we are authorised to provide under our Australian Financial Services Licence (AFSL);
- the remuneration received by us and any other relevant parties;
- who we act for when providing the financial services;
- how we handle your personal information;
- our internal and external dispute resolution services; and
- our compensation arrangements.

TAL Direct is responsible for the content of this FSG and has authorised its distribution.

Our services

TAL Direct is authorised under its AFSL to:

- provide financial product advice on life risk, and superannuation to retail clients;
- provide general advice only on general insurance products to retail clients;
- deal in life risk, superannuation and general insurance products to retail clients; and
- arrange superannuation products for retail clients.

About our representatives

A number of representatives have been appointed by TAL Direct to provide a financial service over the telephone and via webchat. These people have received specialist training to discuss the products we offer. They are only authorised to provide general advice. TAL Direct is responsible for any financial service provided by a representative over the telephone or via webchat.

General advice warning

It's important that you understand and are happy with your purchase decision. Any advice you receive is general advice only and has been prepared without considering your objectives, financial situation or needs, so you should consider whether it is appropriate for you, having regard to those factors. Before acting on the advice, you should obtain a copy of the relevant Product Disclosure Statement (PDS) and consider it carefully before deciding whether or not to acquire the product.

Who we act for

TAL Direct is acting for itself when it provides a financial service.

When our representatives provide general financial product advice, or arrange for the insurer to issue policies, they act for TAL Direct.

TAL Direct has been authorised under an arrangement called a 'binder':

- by TAL Life, for life cover;

to:

- enter into, vary or cancel insurance cover; and
- until 8 December 2021, manage, administer and settle claims;

on behalf of the insurer as if it was the insurer. This means that TAL Direct is acting for the insurer in these circumstances.

From 9 December 2021, TAL Direct will cease to manage, administer and settle claims on behalf of the insurer.

TAL Direct's authority is subject to the limits of authority agreed to with this insurer.

The insurer's registered address is:

- TAL Life Limited, Level 16, 363 George Street, Sydney NSW 2000

Our associations and relationships

It's important that you are aware of the relationships we have with other service providers so you can decide on the services you wish to use. Given that we are a TAL group company, we are affiliated with TAL Life.

If our representatives provide general advice or recommend a product issued by a TAL group company, the TAL group company may benefit from this by receiving fees (including product, administration, investment or management fees) charged on that product. The amount and calculation of those fees are shown in the relevant PDS. Further, we and our representatives may also benefit if a TAL group company product is issued to you, or a TAL group company product you hold is varied, as a result of the general advice provided to you. You can request details of this remuneration from us before you apply for your TAL group product – see the 'How to contact us' section for details.

Companies in the TAL group may provide services and obtain fees and charges or other benefits from the product issuer or service provider if you obtain a product or service from a company in the TAL group. These relationships will be detailed in the relevant disclosure document. Where we enter into transactions with related parties, we operate in accordance with the related party protocols and TAL policies and procedures which require us to transact on terms that would be reasonable if the parties were dealing at arm's length.

Dispute resolution process

If you have a complaint about your policy, our services or your privacy, please contact us on the details below:

Telephone:	13 22 44
Email:	customerservice@aamilifeinsurance.com.au
In writing:	AAMI Life Insurance Reply Paid 5380 Sydney NSW 2001

We will attempt to resolve your complaint within 30 days of the date it is received. If we are unable to resolve your complaint within that period, we will inform you of the reasons for the delay and let you know when we expect to provide a response to your complaint. More information about our complaints process can be found in the AAMI Complaints Policy at https://www.aami.com.au/contact/life-complaint-handling-process

If an issue has not been resolved to your satisfaction or we do not respond to your complaint within 30 days, you may lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers.

Website:	www.afca.org.au
Email:	info@afca.org.au
Telephone:	1800 931 678 (free call)
In writing:	Australian Financial Complaints Authority GPO Box 3 Melbourne VIC 3001

Time limits may apply to complaints to AFCA. You may wish to consult the AFCA website or contact AFCA directly to find out if there is a time limit on lodging a complaint with AFCA.

AFCA is an independent body and its service to you is free. Different terms of reference are applied by AFCA depending on whether your complaint relates to a life insurance product or a general insurance product. Please refer to the AFCA website for details.

Personal information

Personal and sensitive information (together 'personal information') is collected from you to enable TAL Direct and the insurer to provide their products or services to you. Further information may be requested from you at a later time, such as during the underwriting assessment, if you want to make alterations to your insurance policy, or when you make a claim.

The way in which we collect, use and disclose your information is described in our Privacy policy which is available at tal.com.au, and is free of charge on request. If you have any questions or complaints relating to your privacy, please contact us using the contact details below. Generally, you are entitled to gain access to information we hold about you. If you wish to request access, please let us know.

If you do not supply the requested information to us, we may not be able to provide our products and services to you such as issue a policy or assess a claim. In processing and administering your insurance (including at the time of claim) your personal information may be collected from, or disclosed to, the insurer and AFSL as well as any related bodies corporate including the third parties if it is legally permitted or authorised to do so. For example, we may need to collect information from, or disclose information to, general practitioners or health services providers to verify any health information you provide. Other examples include financial advisers, our related bodies corporate and other companies with which we have a business arrangement such as organisations to whom we outsource our mailing, administration and information technology, investigators, reinsurers, government agencies and law enforcement bodies if required or authorised to do so, or any person acting on your behalf such as a lawyer or accountant.

Information regarding the privacy rights of individuals is available at www.oaic.gov.au which is the website of the Office of the Australian Information Commissioner.

Opt-out

From time to time we and TAL group of companies may use your information to offer, invite you to apply or promote and market (by all communication channels, including telephone) our products (including life insurance) and services to you. Your consent shall remain in effect in accordance with relevant law or until you tell us otherwise. If you do not want to receive telemarketing calls, or any information on other products (including life insurance) or services offered under the relevant brand by us or the insurer, please contact us on 13 22 44.

Remuneration

When life insurance is arranged for you, you will be required to pay a premium and this will be paid to the insurer of the product. The premium includes any commission payable by the insurer for distributing the product, so you do not need to pay any extra.

Where a representative arranges a policy for you over the telephone, that representative may in addition to their salary receive additional variable remuneration from TAL. The amount of this remuneration is dependent on a number of factors including the number of policies issued and the quality of the representative's conduct.

If we provide you with a financial service, you are entitled to request details of this remuneration and may do so by contacting us on the number specified in this FSG. This request may be made after you receive the FSG and before any financial service is provided to you. There may be circumstances where additional commissions, bonuses and non-cash incentives are paid, and these will accrue from time to time. These are not an additional cost to you. TAL may also pay referral fees or commissions to people or organisations that refer new customers to us. The referral fee may be paid in the form of an upfront commission fee and/or periodical trail fees. This will be at no additional cost to you. In addition to paying referral fees, TAL may from time to time give other non-cash benefits to referral partners.

Direct Debit Request summary

This summary describes how the Direct Debit Request system works. The full Direct Debit Request Service Agreement (Agreement) is available to you at aami.com.au/policy-documents. You should read the Agreement carefully as it explains your rights and obligations relating to your ongoing direct debits.

When you complete your bank details and sign the authority, you are authorising the direct debit of the appropriate premiums from your nominated account. Your authority will always be kept confidential. If your premium cannot be paid (for example there's not enough money in your nominated account), your bank may dishonour that payment, in which case your policy may lapse. Insurance cover ceases when the policy has lapsed.

If you have concerns about its operation or you subsequently need to change any aspects of the authority, please contact us. From time to time updates about our services which are subject to change and which are not materially averse to you may be found at aami.com.au/policy-documents and if you request a paper copy of any updated information, this will be provided to you without charge.

Compensation arrangements

TAL Direct is part of TAL and we confirm that TAL retains professional indemnity (PI) insurance to cover the activities of licensees within TAL, including TAL Direct. This PI cover is maintained in accordance with the law, is subject to its terms and conditions and provides indemnity up to the sum insured for the activities of the representatives of TAL and TAL Direct.

How to contact us

Telephone:	13 22 44
Email:	customerservice@aamilifeinsurance.com.au
In writing:	AAMI Life Insurance Reply Paid 5380 Sydney NSW 2001

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We're here to help you

13 22 44

aami.com.au

Issuer of the PDS:
TAL Life Limited
ABN 70 050 109 450, AFSL 237848
Level 16, 363 George Street, Sydney NSW 2000

Issuer of this FSG:
TAL Direct Pty Limited
ABN 39 084 666 017, AFSL 243260
Reply Paid 5380, Sydney NSW 2001

AAMI