Guardian Life Insurance

Product Disclosure Statement
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Guardian INSURANCE ®
There's more to life, with Guardian

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Welcome to Guardian Insurance

Guardian Life Insurance is issued by Hannover Life Re of Australasia Ltd (**Hannover**) ABN 37 062 395 484 of Tower 1, Level 33, 100 Barangaroo Avenue, Sydney NSW 2000. Hannover holds an Australian Financial Services License 530811 to settle and handle claims.

Guardian Insurance products are distributed and promoted by Greenstone Financial Services Pty Ltd (**GFS**) ABN 53 128 692 884, Australian Financial Services Licence 343079 of 50 Norwest Boulevard, Norwest NSW 2153.

Guardian Insurance is a trading name of GFS.

From time to time, Guardian Life Insurance may be updated. Updates which are not materially adverse to you may be found on the Guardian Insurance website **guardianinsurance.com.au** If you request a paper copy, this will be provided to you free of charge.

At Guardian Insurance we are focused on providing a wide range of insurance products with substantial benefits that represent true value for Australian families at all stages of their lives.

When you choose Guardian Insurance you'll find all our communications are straightforward, and our insurance consultants are professionals who are here to work with you in a way that suits your needs.

Guardian Insurance is a trading name of Greenstone Financial Services Pty Ltd (**GFS**). GFS distributes and promotes Guardian Insurance and has partnered with Hannover Life Re of Australasia Ltd (**Hannover**).

Hannover is the insurer of this Guardian Insurance product. Hannover is a wholly-owned subsidiary of Hannover Re and is part of the Hannover Re Group worldwide. The life insurance business of Hannover has been operating in the Australian market since 1994, has a Standard and Poor's Insurer Financial Strength of AA- (Very Strong) and as at 31 December 2023 had a total annual in force premium of AU$1.927 billion. Hannover is regulated by the Australian Prudential Regulation Authority (**APRA**).

Our Promise to You

Hannover has adopted the Life Insurance Code of Practice

To ensure that you receive the highest standard of service when you take out life insurance, Hannover complies with the Life Insurance Code of Practice (**the Code**). We also ensure our partners, including GFS, comply with the Code in all their dealings with you.

The Code 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 covers many aspects of your relationship with GFS and Hannover, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support. This includes setting clear timeframes for handling claims, complaints, information requests and fair assessments of claims.

You can find out about the Code and how to get a copy on the Guardian Insurance website at **guardianinsurance.com.au/code-of-practice**

Product Disclosure Statement (PDS)

Explaining this PDS

This Product Disclosure Statement (**PDS**) is designed to help you decide if Guardian Life Insurance is right for you. It tells you the terms and conditions applying to a Guardian Life Insurance Policy and it also provides important information about keeping premium payments up to date, what to do if you want to make a change and how to go about making a claim.

Any advice given in this PDS is general only and does not take into account your individual objectives or financial situation. You should consider whether this product is right for you, in regard to your objectives, financial situation and needs. You should carefully read this and any other documentation we send you.

Guardian Insurance and GFS do not guarantee Guardian Life Insurance and they are not liable to pay benefits under a Guardian Life Insurance Policy. The assessment and payment of claims for benefits is the responsibility of the insurer, Hannover.

Both Guardian Insurance and GFS have consented to being named in this PDS in the form and context in which it appears and has not withdrawn this consent before the date of this PDS. Hannover has sole responsibility for this PDS.

In this PDS, some words or expressions have special meaning. They normally begin with capital letters and their meaning is explained in the **"Definitions"** on page 32 of this PDS.

Also, in this PDS, references to "you", "your" and "yours" means the person who is the Policyowner or Key Life Insured as the context requires. "We", "our" and "us" mean Hannover Life Re of Australasia Ltd.

Introducing Guardian Life Insurance

Guardian Life Insurance offers a range of insurance combinations to suit your needs.

There's Life insurance – providing lump sum cover in the event of death or Terminal Illness – which you can apply for on its own.

Plus there are also optional benefits that you can apply for with your Life Insurance:

- **Children's Insurance** – lump sum Benefit Amount is paid in the event of a death, diagnosed with a Terminal Illness or suffers a defined serious injury or illness of the Child Insured;
- **Serious Illness Insurance** – lump sum Benefit Amount is paid in the event the Life Insured suffers a defined serious illness;
- **Total & Permanent Disability Insurance** – lump sum Benefit Amount is paid in the event of Total & Permanent Disability.

Whatever combination you choose, with Guardian Life Insurance, the Life Insured is protected 24 hours a day, 7 days a week, worldwide while your Policy is in force.

A full explanation of these benefits, and the terms and conditions applying are set out in the following sections of this PDS.

Your Insurance Policy

If your application is accepted by us, we will issue you a Policy Schedule. Your Insurance Policy consists of the Policy Schedule and:

- this PDS (which includes the terms and conditions applying under your Policy);
- the application/s; and
- any special conditions, amendments or endorsements we issue to you.

Please keep these documents in a safe place for future reference. Any benefits, rights or obligations under this Policy cannot be assigned without obtaining Hannover's written permission beforehand. The Insurance provided under this Policy is written out of the Hannover Australian statutory fund.

Life Insurance

What is Life Insurance?

Life Insurance provides a Benefit Amount in the event that a Life Insured under the Policy suffers an Accidental Death or dies of natural causes, or is diagnosed with a Terminal Illness while covered under this Policy.

Who can take out Life Insurance?

You can apply for a single plan on your own life (Key Life Insured) or you can apply for a joint plan to also include your spouse, partner, or de facto (Partner Life Insured if applying).

You (and your Partner Life Insured, if applying) must be Australian Resident/s aged between 18 and 64 years of age.

Complimentary interim Accidental Death Insurance

If you apply for Insurance by phone, and we require further information to assess your application, you will automatically be provided with interim Insurance for up to 30 days against Accidental Death while we assess your application except in the circumstances explained under the heading **"What is not covered under your interim Accidental Death Insurance?"** on page 9. The amount of interim Accidental Death Insurance cover is the Life Insurance Benefit Amount you apply for subject to the maximum cover amount indicated in **"The amount of Life Insurance you can apply for"** on this page. This cover is provided at no additional cost to you and is subject to the terms explained in this PDS.

Your interim Accidental Death Insurance will cease after 30 days, or on the date we either accept or reject your application, whichever occurs first.

The amount of Life Insurance you can apply for

The minimum Benefit Amount is $100,000. The maximum Benefit Amount for a Life Insured under the Policy at the Commencement Date is:

Maximum Benefit Amount (at Commencement Date)	
Current age	Benefit Amount
18 – 44	$ 1,500,000
45 – 54	$ 800,000
55 – 59	$ 500,000
60 – 64	$ 300,000

If you are a Homemaker aged 18 to 44 (at Commencement Date) a maximum Benefit Amount of $1,000,000 applies.

When you apply with a Partner Life Insured, you both apply for individual Benefit Amounts based on the limits above.

When we will pay the Life Insurance benefit

We will pay the Benefit Amounts explained below if the Life Insured suffers an insured event, namely death or Terminal Illness, while covered under the Policy except in the circumstances explained in **"What is not covered under your Life Insurance?"** on page 9.

Life Insurance

We will pay the Life Insurance Benefit Amount as a lump sum on the death of a Life Insured. While assessing your claim, for deaths that are not the result of a self-inflicted injury, we may advance $15,000 of the Life Insurance Benefit Amount to assist with the costs associated with funeral or other similar expenses without waiting for full claim proofs, but we must have satisfactory evidence of the Life Insured's age and death. This advance payment is not payable if there is reasonable doubt about whether you have complied with your duty to take reasonable care (see page 31 for further details on your duty to take reasonable care).

Terminal Illness

We will pay the Life Insurance Benefit Amount as a lump sum if a Life Insured is diagnosed with a Terminal Illness while covered under the Policy.

Limit on benefits

The total benefits payable for a Life Insured under the Policy cannot exceed:

- the maximum Benefit Amount for Life Insurance for the Life Insured's age at the Commencement Date; plus
- any automatic Benefit Amount increases under the Policy.

If the Life Insured is covered under more than one Guardian Life Insurance Policy, we will apply this limit to the total of the Benefit Amounts payable for the Life Insured under all Guardian Life Insurance Policies. Any reduction in the Benefit Amount will be applied to the Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Benefit Amount is reduced.

We will make reasonable attempts to contact you prior to making any reduction. If we are unable to reach you, we will:

- proceed with the reduction and provide a refund of premium if required as described above; and
- send you an updated Policy Schedule reflecting the adjustments to the Policy.

If the Life Insurance Benefit Amount once adjusted still does not comply with the maximum or minimum limit available on the Policy, we reserve the right to cancel the Policy from inception and treat it as though it never existed. We will notify you of the cancellation in writing.

Only one Life Insurance Benefit Amount is payable per Life Insured.

The Life Insurance Benefit Amount will be reduced by the amount of:

- any Total & Permanent Disability benefit paid for a Life Insured; and
- any Serious Illness Insurance benefit paid for a Life Insured; and
- any advance payment of the Life Insurance Benefit Amount.

If we reduce the Life Insurance Benefit Amount, we will reduce the premiums accordingly.

The cost of your Life Insurance

Premiums are the cost of your Insurance. The premium you are required to pay when the Policy starts is shown in the Policy Schedule.

Your premium is a stepped premium, which means that it will increase each year as you age. Your premium will be calculated at each Policy Anniversary and is based on:

- the age of each Life Insured at that time; and
- the Benefit Amount provided for each Life Insured; and
- the Insurance Plan chosen by you (joint plan or single plan); and
- various factors which may affect the premium rating for each Life Insured such as gender, smoking status, state of health, family history, occupation and participation in hazardous activities.

When a Life Insured on the Policy attains age 99, the premium will stay the same for the remaining term of the Policy in respect of that Life Insured.

For a premium quote, or to understand more about the cost of your Insurance, please contact a **Guardian Insurance Consultant** on **1300 709 431** or visit **guardianinsurance.com.au**

What is not covered under your Life Insurance?

We will not pay a Life Insurance Benefit Amount in respect of a Life Insured, if the Life Insured dies, or has a Terminal Illness, as a result of a self-inflicted injury, within 13 months of:

- the Acceptance Date of the Policy; or
- the date that any increase in cover starts (but only in respect of the increase); or
- where we have agreed to reinstate the Policy after it was cancelled, the date on which we reinstate the Policy (reinstatement date).

We will not pay any Benefit Amounts where we have agreed a special term with you 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 on your Policy Schedule.

What is not covered under your interim Accidental Death Insurance?

We will not pay an interim Accidental Death Insurance Benefit Amount in respect of a Life Insured if the Life Insured suffers Accidental Death as a result of:

- intentional self-inflicted bodily injury; or
- engaging in any criminal activities or illegal acts; or
- suicide or attempted suicide; or
- the consumption of drugs (unless it was under the direction of a Medical Practitioner and not in connection with treatment for substance abuse, drug addiction or dependence); or

- the consumption of intoxicating liquor, including having a blood alcohol content over the prescribed legal limit whilst driving; or
- engaging in any motor sports as a rider, driver and/or passenger; or
- war (whether declared or not) or war-like activity, or taking part in a riot or civil commotion; or
- being a pilot or crew member of any aircraft, or engaging in any aerial activity except as a passenger in a properly licensed aircraft.

When your Life Insurance starts and ends

If your application for Life Insurance is accepted by us, cover starts for a Life Insured and/or Partner Life Insured (if applicable) on the Acceptance Date set out in the Policy Schedule. Your first premium is deducted from the Commencement Date, which is also set out in the Policy Schedule.

We guarantee to renew your Life Insurance (provided you pay your premiums when due) for life.

Life Insurance ends for a Life Insured when the first of the following occurs:

- the date of death of the Life Insured; or
- the date of payment of a Terminal Illness claim for that Life Insured; or
- the date of payment of a Total & Permanent Disability claim for the Life Insured where the Total & Permanent Disability Benefit Amount exhausts the Life Insurance Benefit Amount for the Life Insured (see page 21); or
- the date you cancel the Policy; or
- the date we cancel the Policy.

Where the Policy ends solely as a result of the Key Life Insured's cover ending, if there is a Partner Life Insured who wishes to retain cover, the Benefit Amount for the Partner Life Insured, and any Child Insured under this Policy, can continue under a new policy. We will issue a new Policy to the surviving Partner Life Insured in his or her name as the Policyowner. The new Policy will be issued on the same terms as this Policy and takes effect subject to payment of the first premium.

Children's Insurance Option

This option is only available with Life Insurance. You only have this cover if we accepted your application and it is shown in your Policy Schedule.

What is Children's Insurance?

Children's Insurance provides a Benefit Amount in the event the Child Insured suffers a death by any cause, is diagnosed with a Terminal Illness or suffers a defined serious injury or illness; namely:

- Bacterial Meningitis (and/or invasive meningococcal disease); or
- Benign (non-cancerous) tumour of the Brain or Spinal Cord - with permanent neurological impairment, or requiring specified treatment; or
- Cancer (Children's Insurance Option); or
- Encephalitis – with permanent neurological impairment; or
- End Stage Chronic Kidney Failure – requiring specified treatment; or
- Hearing Loss (permanent and of specified severity, or requiring cochlear implant); or
- Major Brain Injury – requiring admission of more than 4 consecutive days in an Intensive Care Unit (ICU); or
- Major Burns to the Skin – of specified severity; or
- Major Organ Transplant – specified organs or being on a transplant waiting list; or
- Paralysis (total and permanent) – specified; or
- Total and Permanent Loss of Use of One Specified Limb; or
- Vision Loss (permanent and of specified severity, despite best treatment)

at least three months after the day cover starts, while covered under the Policy. These medical conditions are defined in the **"Definitions"** on page 32.

Who can take out Children's Insurance?

If you (and/or Partner Life Insured) are a parent or legal guardian of a child, you can apply for this Insurance cover for the child, if the child is aged between 2 and 17 years of age, and the child is an Australian Resident. If you have Children's Insurance, each Child Insured is shown in the Policy Schedule.

You can apply for an Insurance Benefit Amount from $20,000 up to a maximum of $50,000 for each Child Insured under the Policy.

The amount of Children's Insurance you can apply for

You can apply for an Insurance Benefit Amount from $20,000 up to a maximum of $50,000 for each Child Insured under the Policy (in increments of $10,000).

When we will pay the Children's Insurance benefit

We will pay the Benefit Amount explained below if the Child Insured of a Life Insured suffers a death by any cause, is diagnosed with a Terminal Illness or suffers a defined serious injury or illness while covered under the Policy except in the circumstances explained in **"What is not covered under your Children's Insurance?"** on page 14.

Only one Benefit Amount is payable per Child Insured. Once a Benefit Amount has been paid for a Child Insured, the Children's Insurance will cease and no further claims can be made.

Death from any cause

We will pay the Children's Insurance Benefit Amount as a lump sum in the case the Child Insured dies from any cause, or is diagnosed with a Terminal Illness, at least three months after the day cover starts, providing we have paid no Children's Insurance Benefit Amount in relation to a serious injury or illness for that Child Insured.

Accidental Death

We will pay the Children's Insurance Benefit Amount as a lump sum in the case of Accidental Death of the Child Insured providing we have paid no Children's Insurance Benefit Amount in relation to a serious injury or illness or a Terminal Illness for that Child Insured.

Serious injury or illness

We will pay the Children's Insurance Benefit Amount as a lump sum in the event the Child Insured suffers:

- Bacterial Meningitis (and/or invasive meningococcal disease); or
- Benign (non-cancerous) tumour of the Brain or Spinal Cord - with permanent neurological impairment, or requiring specified treatment; or
- Cancer (Children's Insurance Option); or
- Encephalitis – with permanent neurological impairment; or
- End Stage Chronic Kidney Failure – requiring specified treatment; or
- Hearing Loss (permanent and of specified severity, or requiring cochlear implant); or
- Major Brain Injury – requiring admission of more than 4 consecutive days in an Intensive Care Unit (ICU); or
- Major Burns to the Skin – of specified severity; or
- Major Organ Transplant – specified organs or being on a transplant waiting list; or
- Paralysis (total and permanent) – specified; or
- Total and Permanent Loss of Use of One Specified Limb; or
- Vision Loss (permanent and of specified severity, despite best treatment)

while covered under the Policy, except in the circumstances explained in **"What is not covered under your Children's Insurance?"** on this page.

Where we have paid a Children's Insurance Benefit Amount in relation to serious injury or illness or Terminal Illness, there are no further benefits payable under this Children's Insurance option for that Child Insured.

The serious injury or illness condition must be diagnosed by a Medical Practitioner or a Specialist Medical Practitioner (as indicated in the **"Definitions"** on page 32), the diagnosis may require confirmation by our medical advisers. If confirmation is required, our medical advisers will review the medical evidence submitted in support of your claim, nothing will be required from you for this review to occur.

Limit on benefits

Only one Benefit Amount is payable per Child Insured. The total benefit payable cannot exceed $50,000 for each Child Insured, plus any automatic sum insured increases.

If the Child Insured is covered for Children's Insurance under more than one Guardian Life Insurance Policy, we will apply this limit to the total of the Children's Insurance Benefit Amounts payable for the Child Insured under all Guardian Life Insurance policies. Any reduction in the Children's Insurance Benefit Amount will be applied to the Children's Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Children's Insurance Benefit Amount is reduced.

The cost of your Children's Insurance

The premium you are required to pay for this option when the Policy starts is shown in your Policy Schedule.

The Children's Insurance premium is a stepped premium, which means that it will increase each year as the Child Insured ages. The premium is calculated at each Policy Anniversary and is based on the Benefit Amount provided for each Child Insured.

For a premium quote, or to understand more about the cost of your Insurance, you should contact a **Guardian Insurance Consultant** on **1300 709 431**, or visit **guardianinsurance.com.au**

What is not covered under your Children's Insurance?

We will not pay a Benefit Amount if the Child Insured suffers a defined serious injury or illness as a result of:

- a Congenital Condition; or
- the intentional act of the Policyowner or person who will otherwise be entitled to all or part of the Benefit Amount; or
- an injury which occurs or an illness which becomes apparent, before the Children's Insurance for the Child Insured starts, or during the first three months after the date that the Children's Insurance starts or, if reinstated, the reinstatement date.

We will pay for any new and unrelated occurrence of:

- Bacterial Meningitis (and/or invasive meningococcal disease); or

- Benign (non-cancerous) tumour of the Brain or Spinal Cord - with permanent neurological impairment, or requiring specified treatment; or
- Cancer (Children's Insurance Option); or
- Encephalitis – with permanent neurological impairment; or
- End Stage Chronic Kidney Failure – requiring specified treatment; or
- Hearing Loss (permanent and of specified severity, or requiring cochlear implant); or
- Major Brain Injury – requiring admission of more than 4 consecutive days in an Intensive Care Unit (ICU); or
- Major Burns to the Skin – of specified severity; or
- Major Organ Transplant – specified organs or being on a transplant waiting list; or
- Paralysis (total and permanent) – specified; or
- Total and Permanent Loss of Use of One Specified Limb; or
- Vision Loss (permanent and of specified severity, despite best treatment)

suffered by a Child Insured after this three month period, while covered under the Policy.

We will not pay a Children's Insurance Benefit Amount in respect of a Child Insured if the Child Insured dies (other than from an Accidental Death where the Accident occurs after the Acceptance Date) or is diagnosed with a Terminal Illness which becomes apparent before or during the first three months after the Children's Insurance starts or, if reinstated, the first three months after the Children's Insurance for the Child Insured is reinstated, the reinstatement date.

When your Children's Insurance starts and ends

If your application for Children's Insurance is accepted by us, then Children's Insurance starts on the Acceptance Date. If we agree to add Children's Insurance to your Policy after the Acceptance Date, we will advise you of the date the Children's Insurance starts.

The Children's Insurance ends for the Child Insured when the first of the following occurs:

- the date of death of the Child Insured; or
- the date of death of the Key Life Insured; or
- the date of payment of a Children's Insurance Benefit Amount for the Child Insured; or
- the date you cancel the Policy; or
- the date we cancel the Policy; or
- the date you cancel this cover for the Child Insured; or
- the Policy Anniversary following the Child Insured's 21st birthday.

Where the Policy ends solely as a result of the Key Life Insured's cover ending, if there is a Partner Life Insured who wishes to retain cover, the Benefit Amount for the Partner Life Insured, and any Child Insured under this Policy, can continue under a new policy. We will issue a new Policy to the surviving Partner Life Insured in his or her name as the Policyowner. The new Policy will be issued on the same terms as this Policy and takes effect subject to payment of the first premium.

Serious Illness Insurance Option

This option is only available with Life Insurance. You only have this cover if we accepted your application and it is shown in your Policy Schedule.

What is Serious Illness Insurance?

Serious Illness Insurance provides a benefit in the event that a Life Insured under the Policy suffers:

- Cancer – excluding specified early stage cancers; or
- Heart Attack – with evidence of severe permanent heart muscle damage; or
- Heart Bypass Surgery (Coronary Artery Bypass Graft Surgery); or
- Stroke – resulting in specified permanent impairment

while covered under the Policy. These medical conditions, including certain exclusions, are defined in the **"Definitions"** on page 32.

Who can take out Serious Illness Insurance?

You (and your Partner Life Insured, if applying) must be Australian Resident/s and aged between 18 and 59 years of age.

The amount of Serious Illness Insurance you can apply for

You (and/or your Partner Life Insured) can apply for a Serious Illness Insurance Benefit Amount from $50,000 up to the lesser of $500,000 or 50% of the Life Insurance Benefit Amount for that Life Insured provided under your Policy.

When we will pay the Serious Illness Insurance benefit

We will pay the Serious Illness Insurance Benefit Amount as a lump sum if the Life Insured suffers an insured serious illness event while covered under the Policy providing the Life Insured survives for fourteen (14) days after the day that the serious illness is contracted, except in the circumstances explained in **"What is not covered under your Serious Illness Insurance?"** on page 19.

The serious illness must be diagnosed by a Medical Practitioner or a Specialist Medical Practitioner (as indicated in the **"Definitions"** on page 32), the diagnosis may require confirmation by our medical advisers. If confirmation is required, our medical advisers will review the medical evidence submitted in support of your claim, nothing will be required from the claimant for this review to occur.

Limit on benefits

Only one Benefit Amount is payable per Life Insured under this Serious Illness Insurance as a result of that Life Insured experiencing:

- Cancer – excluding specified early stage cancers; or
- Heart Attack – with evidence of severe permanent heart muscle damage; or
- Heart Bypass Surgery (Coronary Artery Bypass Graft Surgery); or
- Stroke – resulting in specified permanent impairment.

The total Serious Illness Insurance Benefit Amount payable for a Life Insured cannot exceed the lesser of $500,000 or 50% of the total Life Insurance Benefit Amount for that Life Insured under this Policy.

If the Life Insured is covered for Serious Illness Insurance under more than one Guardian Life Insurance Policy, we will apply this limit to the total of the serious illness benefits payable for the Life Insured under all Guardian Life Insurance policies. Any reduction in the serious illness Benefit Amount will be applied to the Serious Illness Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the serious illness Benefit Amount is reduced.

Where a Benefit Amount is paid under this Serious Illness Insurance, we will reduce the Life and any Total & Permanent Disability Insurance Benefit Amount by that Serious Illness Insurance Benefit Amount in respect of that Life Insured. If we reduce the Life Insurance Benefit Amount and/or the Total & Permanent Disability Insurance Benefit Amount, we will reduce your premium accordingly.

Serious Illness Insurance provides a benefit from $50,000, for a range of covered conditions.

The cost of your Serious Illness Insurance

The premium you are required to pay for this option is shown in your Policy Schedule. The Serious Illness Insurance premium is a stepped premium, which means that it will increase each year as you age.

Your premium is calculated at each Policy Anniversary and is based on:

- the age of each Life Insured at that time; and
- the Benefit Amount provided for each Life Insured; and
- the Insurance Plan chosen by you (joint plan or single plan); and
- various factors which affect the premium rating for each Life Insured such as gender, smoking status, state of health, family history, occupation and participation in hazardous activities.

For a premium quote, or to understand more about the cost of your Insurance, please contact a **Guardian Insurance Consultant** on **1300 709 431**, or visit **guardianinsurance.com.au**

What is not covered under your Serious Illness Insurance?

We will not pay a Serious Illness Insurance Benefit Amount if the Life Insured suffers:

- Cancer – excluding specified early stage cancers; or
- Heart Attack – with evidence of severe permanent heart muscle damage; or
- Heart Bypass Surgery (Coronary Artery Bypass Graft Surgery); or
- Stroke – resulting in specified permanent impairment

as a result of an intentional self-inflicted bodily injury or attempted suicide.

There are a number of cancers excluded from the definition of Cancer - excluding specified early stage cancers. It is important that you check these in the **"Definitions"** on page 32.

No Benefit Amount will be payable if the condition resulting in a claim first becomes apparent before the Serious Illness Insurance for the Life Insured starts or during the first three months after:

- the Serious Illness Insurance for the Life Insured starts; or
- the date that any increase in cover starts (but only in respect of that increase); or
- where we have agreed to reinstate the Policy after it was cancelled, the date on which we reinstate the Policy (reinstatement date).

We will pay for any new and unrelated occurrence of a defined serious illness after this three-month period.

We will not pay any Benefit Amounts where we have agreed a special term with you 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 on your Policy Schedule.

When your Serious Illness Insurance starts and ends

If your application for Serious Illness Insurance is accepted by us, then Serious Illness Insurance starts on the Acceptance Date. If we agree to add Serious Illness Insurance to your Policy after the Acceptance Date, we will advise you of the date the Serious Illness Insurance starts.

The Serious Illness Insurance ends for a Life Insured when the first of the following occurs:

- the date of death of the Life Insured; or
- the date of payment of a serious illness Benefit Amount for the Life Insured; or
- the date of payment of a Total & Permanent Disability Insurance claim for the Life Insured where the Total & Permanent Disability Insurance Benefit Amount is the same, or higher, as the Serious Illness Insurance Benefit Amount; or
- the date you cancel the Policy; or
- the date we cancel the Policy; or
- the date you cancel this cover; or
- the Policy Anniversary following the Life Insured's 65th birthday.

Total & Permanent Disability Insurance Option

This option is only available with Life Insurance. You only have this cover if we accepted your application and it is shown in your Policy Schedule.

What is Total & Permanent Disability Insurance?

Total & Permanent Disability Insurance provides a benefit in the event that a Life Insured under the Policy suffers Total & Permanent Disability while covered under the Policy.

Who can take out Total & Permanent Disability Insurance?

You (and/or your Partner Life Insured) must be Australian Resident/s aged between 18 and 59 years of age and working at least 20 hours per week.

The amount of Total & Permanent Disability Insurance you can apply for

The minimum Total & Permanent Disability Insurance Benefit Amount is $50,000.

The maximum Total & Permanent Disability Insurance Benefit Amount for a Life Insured under the Policy at the Commencement Date is the lesser of the maximum Benefit Amount shown in the table below or the Life Insurance Benefit Amount for that Life Insured provided under your Policy.

Maximum Benefit Amount (at Commencement Date)	
Current age	Benefit Amount
18 – 44	$ 1,000,000
45 – 54	$ 800,000
55 – 59	$ 500,000
60 – 64	Not eligible

When we will pay the Total & Permanent Disability Insurance benefit

We will pay the Total & Permanent Disability Insurance Benefit Amount as a lump sum if the Life Insured suffers Total & Permanent Disability (insured event) while covered under the Policy, except in the circumstances explained in **"What is not covered under your Total & Permanent Disability Insurance?"** on page 23.

The Total & Permanent Disability must be certified by a Medical Practitioner or a Specialist Medical Practitioner (as indicated in the **"Definitions"** on page 32), the diagnosis may require confirmation by our medical advisers. If confirmation is required, our medical advisers will review the medical evidence submitted in support of your claim, nothing will be required from the claimant for this review to occur.

We will pay the Total & Permanent Disability Insurance Benefit as a lump sum if the Insured suffers a Total & Permanent Disability while covered under the Policy.

Limit on benefits

Only one Benefit Amount is payable per Life Insured under this Total & Permanent Disability Insurance.

The Total & Permanent Disability Insurance Benefit Amount payable for a Life Insured cannot exceed the Life Insurance Benefit Amount for that Life Insured under this Policy.

If the Life Insured is covered for Total & Permanent Disability Insurance under more than one Guardian Life Insurance Policy, we will apply this limit to the total of the Total & Permanent Disability benefits payable for the Life Insured under all Guardian Life Insurance policies. Any reduction in the Total & Permanent Disability Benefit Amount will be applied to the Total & Permanent Disability Insurance most recently commenced and we will refund the premiums paid referable to the amount by which the Total & Permanent Disability Benefit Amount is reduced.

Where a Benefit Amount is paid under this Total & Permanent Disability Insurance, we will reduce the Life and any Serious Illness Insurance Benefit Amount by the Total & Permanent Disability Insurance Benefit Amount in respect of that Life Insured. If we reduce the Life Insurance Benefit Amount and/or the Serious Illness Insurance Benefit Amount, we will reduce your premium accordingly.

The cost of your Total & Permanent Disability Insurance

The premium you are required to pay for this option when the Policy starts is shown in your Policy Schedule.

The Total & Permanent Disability Insurance premium is a stepped premium which means that it will increase each year as you age. Your premium is calculated at each Policy Anniversary and is based on:

- the age of each Life Insured at that time; and
- the Benefit Amount provided for each Life Insured; and
- the Insurance Plan chosen by you (joint plan or single plan); and
- various factors which affect the premium rating for each Life Insured such as gender, smoking status, state of health, family history, occupation and participation in hazardous activities.

For a premium quote or to understand more about the cost of your Insurance, please contact a **Guardian Insurance Consultant** on **1300 709 431**, or visit **guardianinsurance.com.au**

What is not covered under your Total & Permanent Disability Insurance?

We will not pay a Total & Permanent Disability Insurance Benefit Amount if the Life Insured suffers a Total & Permanent Disability as a result of:

- an injury caused or accelerated by an intentional act performed by the Life Insured, Policyowner or person who will otherwise be entitled to all or part of the Benefit Amount; or
- an injury caused as a result of engaging in any motor sport as a rider, driver and/or passenger.

We will not pay any Benefit Amount where we have agreed a special term with you 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 on your Policy Schedule.

When your Total & Permanent Disability Insurance starts and ends

If your application for Total & Permanent Disability Insurance is accepted by us, then Total & Permanent Disability Insurance starts on the Acceptance Date. If we agree to add Total & Permanent Disability Insurance to your Policy after the Acceptance Date, we will advise you of the date the Total & Permanent Disability Insurance starts.

The Total & Permanent Disability Insurance ends for a Life Insured when the first of the following occurs:

- the date of death of the Life Insured; or
- the date of payment of a Total & Permanent Disability Insurance Benefit Amount for the Life Insured; or
- the date of payment of a Serious Illness Insurance claim for the Life Insured where the Serious Illness Insurance Benefit Amount is the same, or higher, as the Total & Permanent Disability Benefit Amount; or
- the date you cancel the Policy; or
- the date we cancel the Policy; or
- the date you cancel this cover; or
- the Policy Anniversary following the Life Insured's 65th birthday.

General Information

30-day money back guarantee

You have 30 days from the Commencement Date or the date any optional benefit starts to make sure you are happy with the Policy, and decide whether you want to keep the Policy or optional benefit. This is known as the "cooling off" period. If you wish to cancel your Policy, and/or optional benefits within this 30-day period you may do so provided you have not made a claim under the Policy.

If you wish to cancel your Policy and/or optional benefits within the cooling off period, please either send a written request providing your instruction to cancel along with your full name and Policy number to:

Guardian Insurance
Reply Paid 6728
Baulkham Hills NSW 2153

Or email:
enquiries@guardianinsurance.com.au

Or alternatively you can call us on **1300 709 431**.

If your request is received within 30 days of your Commencement Date, we will refund any premiums you have paid within 15 business days. If you wish to discuss the matter or make alterations to your cover, you can contact us on **1300 709 431**.

Automatic sum insured increases

To help your level of Insurance keep up with the cost of living, your Insurance and all optional benefits (if applicable) are automatically increased on each Policy Anniversary by 5%.

Automatic increases will continue even where the maximum Benefit Amount is met or exceeded.

We will send you an updated Policy Schedule each year your Policy remains in force 30 days prior to your Policy Anniversary setting out your updated Benefit Amount and premium. You can decline the automatic increase by calling us on **1300 709 431**, or by writing to **Guardian Customer Support**, Reply Paid 6728, Baulkham Hills NSW 2153 or email Guardian Insurance at **enquiries@guardianinsurance.com.au**
If you decline the automatic increase, the updated Policy Schedule we sent you will not be valid and we will send you a replacement Policy Schedule.

If you decline the automatic sum insured increase in any given year, we will continue to offer you automatic sum insured increases on each subsequent Policy Anniversary until you are no longer eligible for them.

The automatic increases will end on the Policy Anniversary after the Life Insured's 75th birthday.

Further Insurance options

We may offer you the option of incorporating further Insurance benefits under your Policy. If you accept such offers, we will issue you with a new Policy Schedule setting out the terms and conditions about the Insurance option.

Premiums

We may change the premium rates applying to your Policy, but only if we change the premium rate applying to all (or the same group of) Guardian Life Insurance Policyowners. We will send written notice of any change to you (to your last address notified to us) at least 90 days before the effective date of the change.

How you can pay for your Insurance and when your premium is deducted

Your premium will be debited on the date of your choice, either fortnightly, monthly or annually. The date you select for your first premium deduction will become your Policy Commencement Date. You can pay either by automatic debit from your bank, credit union or building society account or by charge to your credit card.

You may apply at any time to change the method of payment of premiums by calling **1300 709 431**.

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

Changing your Insurance

You can call us on **1300 709 431** to discuss changing your insurance cover if you wish to make changes to:

- decrease your Insurance;
- increase your Insurance;
- change from a single plan to a joint plan (or from a joint plan to a single plan); or
- change a Life Insured's status from a smoker to a non-smoker, for the purpose of determining your Insurance premium rating. You will need to provide a declaration.

Any change to the terms and conditions relating to the change are subject to approval and written confirmation by us.

When we can cancel your Policy

If your premium remains unpaid for more than one month from when it is due, your Policy will be cancelled. Prior to cancelling your Policy we will provide a written notice (to your last address notified to us) setting out the premium payments that are overdue and the timeframe you have to rectify any overdue payments. Within six months of the date that the Policy is cancelled by us, you can apply to reinstate cover, however your application will be subject to underwriting and may require new terms and conditions or your application to reinstate cover could be declined.

The Policy will be cancelled if the Policyowner is on a temporary work visa and ceases to reside in Australia. You are required to tell us if the Life Insured is on a temporary work visa and ceases to reside in Australia.

If the Life Insurance Benefit Amount does not comply with the maximum or minimum benefit limits available on the Policy, we reserve the right to cancel the Policy from inception, refund any premiums paid and treat it as if it never existed, as outlined in **'Limits on benefits'** section on page 8.

If you wish to cancel your Policy and/or optional benefits, please send a written request providing your instruction to cancel along with your full name and Policy number to **Guardian Customer Support**, Reply Paid 6728, Baulkham Hills NSW 2153. If you wish to discuss the matter or make alterations to your cover, you can contact us on **1300 709 431**.

Insurance risks

There are a number of insurance risks you should be aware of, including:

- you need to select the Insurance product and apply for the appropriate level of cover for your needs. If you do not have enough cover it might cause you or your family to suffer financial hardship even after receiving the payment of the Benefit Amount;
- if you are replacing a contract or policy with another contract or policy, you should consider all the terms and conditions of each policy before making a decision to change. Your new cover may not provide the same level or scope of cover and you may need to re-serve waiting periods and your new cover may not provide the required protection if you make errors or omissions in your new application;
- your health circumstances may change which may mean that new cover is not available;
- before cancelling any existing policy, you should check that you have been issued with a new policy, otherwise you risk being uninsured;
- this Policy is an insurance policy designed purely for protection and is not a savings plan, which means that if you cancel your Policy (after the 30-day cooling off period) or we cancel your Policy, you will not receive anything back unless you have paid more than 30 days in advance;
- over time your circumstances may change and you may find that you are less able to afford to pay the premium; and
- we may not pay a benefit in some circumstances (refer to the relevant sections in the PDS about what is not covered under your policy) because an exclusion applies under your Policy.

Benefit payments

Unless a valid beneficiary nomination (explained below) applies:

- we make all benefit payments to you, the Policyowner; or
- if the Policyowner dies, the Insurance benefit will be paid to the Policyowner's legal personal representative, or other person that we are permitted to pay under the Life Insurance Act 1995.

If the Benefit Amount exceeds $100,000 and a beneficiary has not been nominated, we may be required to obtain documentation under the Act at an additional cost to your legal personal representative before we can pay the Benefit Amount.

All Benefit Amount payments in connection with this Policy will be made in Australian dollars.

The payment of the Benefit Amount in accordance with the above and or to a nominated beneficiary is full and final discharge of our liability under the Policy.

Benefit Nominations

As the Policyowner, we recommend that you nominate a beneficiary or beneficiaries to receive the Benefit Amount payable under your Policy on your death.

To nominate a beneficiary you can download a Nomination of Beneficiaries Form from **guardianinsurance.com.au** which can be signed manually or using an electronic signature, or contact Guardian Insurance at:

Phone:	**1300 709 431**
Email:	enquiries@guardianinsurance.com.au
Writing:	Guardian Customer Support Reply Paid 6728 Baulkham Hills NSW 2153

Making a Claim

If you (or your legal personal representative on your death) wish to claim under this Policy, please call **1300 308 578**, or write to **Guardian Customer Support**, Reply Paid 6728, Baulkham Hills NSW 2153. We will send you a form to be completed, signed and returned.

We may also require your treating doctor or specialist to complete a form at your (or your estate's) expense. The Policy and the Insurance for the benefit must be in force when the insured event occurs.

Claims should be made as soon as possible after the event giving rise to the claim. We encourage you to lodge your claim within 120 days of the insured event, this will assist in reducing any delays within the claim assessment.

Before a claim can be fully assessed we must receive proof, provided at your (or your estate's) expense and to our reasonable satisfaction, that the insured event has occurred. In addition:

- proof must be supported by one or more appropriate Medical Practitioners or Specialist Medical Practitioners (as indicated in the **"Definitions"** on page 32); and
- all relevant information, including any test, examination, or laboratory results, must be provided to us.

We reserve the right to require the Life Insured to undergo, at our expense, examinations or other reasonable tests (including, where necessary, a post-mortem examination) to confirm the occurrence of an insured event. In addition, we may conduct investigations to assess the validity of the claim. This could involve the use of investigation agents and surveillance, legal advisers and the collection of personal data.

Tax

In most cases your premium will not be tax deductible and tax will not be payable on any Benefit Amount paid under your Policy.

This information is based on continuance of present tax laws and our interpretation of those laws. Your individual situation may differ and you should seek qualified professional advice in relation to your particular circumstances.

Questions or Complaints

We hope that you never have a reason to complain, but if you do, we will do our best to work with you to resolve it. To lodge a complaint or if you require assistance to lodge a complaint, please contact us using one of the following means:

Phone: **1300 709 431**

Writing: Customer Support Complaints
Guardian Insurance
Reply Paid 6728
Baulkham Hills NSW 2153

Email: enquiries@guardianinsurance.com.au

Our complaint resolution process has three steps.

1. Initial response

Usually when you have a complaint, we can resolve it immediately on the phone. If we cannot immediately resolve your complaint to your satisfaction, we will refer your complaint to our centralised complaints team who will acknowledge receipt of your complaint within 24 hours (or one business day) where reasonable. If we are still unable to resolve your complaint within five days or your complaint is in relation to hardship or the value or decline of a claim, we will escalate your complaint for review by our Internal Dispute Resolution team.

2. Internal Dispute Resolution

All matters escalated to our Internal Dispute Resolution team will be responded to in writing. After full consideration of the matter, a written final response will be provided within 30 days that will outline the decision reached and the reasons for the decision.

3. External Dispute Resolution

In the unlikely event that your complaint is not resolved to your satisfaction, or a final response has not been provided within 30 days, you may be eligible to refer your matter to the Australian Financial Complaints Authority (AFCA) provided your matter is within the scope of AFCA's Complaint Resolution Scheme Rules. AFCA is a free, fair and independent dispute resolution scheme.

You may contact AFCA at:

Australian Financial Complaints Authority

Mail: GPO Box 3, Melbourne VIC 3001

Phone: 1800 931 678

Website: afca.org.au

Email: info@afca.org.au

Privacy

In this section, "we", "our" and "us" means Hannover Life Re of Australasia Ltd and anyone collecting information on our behalf.

We collect the personal information requested in the application for insurance directly from you and we assume that, where you disclose information about others, you have obtained their permission to do so.

Your personal information is collected for the purpose of processing your application, administering your Policy (if issued) and assessing and paying any claims under the Policy. Your information may also be used to consider any other application you may make in the future, or to perform our administrative operations. If you do not consent to us collecting and using your personal information in this manner, or do not provide the requested information in full, we will be unable to provide the requested insurance. Guardian Insurance may use your personal information (but not sensitive information) to assist them in developing and identifying products and services that may interest you and (unless you ask them not to by calling them on **1300 709 431**) telling you about Guardian Insurance products and services offered by Guardian Insurance.

Your personal information may be disclosed to third parties who assist in the provision of insurance services (i.e. reinsurers, related companies, our advisers, persons involved in claims, medical service providers, external claims data collectors and verifiers, your employer, your agents and other persons where required by law). We may disclose your personal information to parties located in other countries as listed in Hannover's Privacy Policy.

By applying for cover, you consent to sensitive information (including health information) about you being collected and it being used to consider your application for insurance, assess a claim, using it or giving it to related companies for research and analysis, to design or underwrite new insurance products, and disclosing it to any of the third parties listed above for these purposes. Your sensitive information will not be disclosed for any other purpose. Third parties are prohibited from using your personal information for purposes other than those for which it is supplied.

You can read more about how we collect, use and disclose your personal information including how to access your information or complain about a breach of your privacy by accessing Guardian Insurance's Privacy Policy at **guardianinsurance.com.au/privacy-policy** or Hannover's Privacy Policy at **hannover-re.com/privacyau** or you can request a copy. If you wish to gain access to your information (including correcting or updating it), have a complaint about a breach of your privacy, or have any other query relating to privacy please call **1300 709 431**.

Your 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 an answer that is false, an answer that is only partially true, or an answer which does not fairly reflect the truth.

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

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your Insurance. Your cover could be voided (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.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond;
- answer every question;
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it; and
- review your application carefully, whether you or someone else helped you complete your application (for example, your interpreter or authorised third party), and any other documentation we provide you that was used in the assessment of your application.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

If you need help

It is important that you understand this information and the questions we ask. Ask us for help if you have difficulty understanding the process of buying Insurance or answering our questions.

If you are having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. If you want, you can have a support person you trust with you while speaking with us.

Definitions

In this Policy, some words begin with a capital letter, for example, Policy Anniversary. These words have the special meanings as explained below.

Acceptance Date	means the date your application is accepted by us and cover starts as set out in the Policy Schedule.
Accident	means an event resulting in bodily injury occurring while this Policy is in force, where the injury is directly and solely caused by accidental, violent, external and visible means without any other contributing causes and where the injury is not self-inflicted.
Accidental Death	means death occurring as a direct result of an Accident and where death occurs within 90 days of the Accident.
Australian Resident	means a person who resides in Australia at the time of application and either holds Australian or New Zealand citizenship; or holds an Australian permanent residency visa; or has been in Australia continuously for six months or more on a temporary work visa and resides in Australia.
Bacterial Meningitis (and/or invasive meningococcal disease)	means the confirmed diagnosis of one of the following in the Child Insured: • a bacterial infection of the meninges (thin membranes that cover the brain and the spinal cord); or • meningococcal septicaemia (meningococcal bacterial infection in the blood stream). The diagnosis must be confirmed by an appropriate Specialist Medical Practitioner in that field.
Benefit Amount	means the amount payable on the applicable insured event covered under this Policy in respect of a Life Insured and Child Insured (as applicable). The Benefit Amount for each benefit for each Life Insured and Child Insured is shown in the Policy Schedule.
Benign (non-cancerous) tumour of the Brain or Spinal Cord - with permanent neurological impairment, or requiring specified treatment	means a non-cancerous tumour in the brain or spinal cord in the Child Insured, confirmed by imaging studies such as Computerised Tomography (CT) scan or Magnetic Resonance Imaging (MRI), that has resulted in either permanent neurological impairment or has required radiotherapy, chemotherapy, targeted therapies or surgical removal of the tumour. The following do not constitute "permanent neurological impairment": • an abnormality seen on brain or spinal cord scans/imaging without definite related clinical symptoms; • neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms; • symptoms of psychological or psychiatric origin.

Cancer (Children's Insurance Option)	means the confirmed diagnosis, in the Child Insured, of the presence of one or more malignant tumours histologically characterised by the uncontrolled growth and spread of malignant cells, and the invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes carcinoma, leukaemia, sarcoma, lymphoma, multiple myeloma and inaccessible brain tumours described as malignant on neuroimaging. The diagnosis must be confirmed by a Specialist Medical Practitioner.
Cancer - excluding specified early stage cancers	means the confirmed diagnosis in the Life Insured of the presence of one or more malignant tumours characterised by the uncontrolled growth and spread of malignant cells, and the invasion and destruction of normal tissue beyond the basement membrane as confirmed histologically by a pathologist. The term malignant tumour includes carcinoma, leukaemia, sarcoma, lymphoma, multiple myeloma and inaccessible brain tumours described as malignant on neuroimaging. The following early stage cancers are specifically excluded: • tumours which are histologically classified as 'pre-malignant', 'non-invasive', 'high-grade dysplasia', 'borderline' or 'having low malignant potential'; • all carcinoma in situ except for carcinoma in situ of the breast where total mastectomy was performed specifically to arrest the spread of malignancy and where it was considered the appropriate and necessary treatment; • all prostatic cancers, unless having progressed to T2 on the TNM Clinical Staging System; or histologically classified as having a Gleason Score of 7 or higher; or having resulted in the surgical removal of the prostate (where it was considered by treating doctors to be the appropriate and necessary treatment); • all melanomas less than 1mm thickness as determined by histological examination and which is also less than Clark Level 3 depth of invasion; • all non-melanoma skin cancers unless having spread to the bone, lymph node, or another distant organ; • chronic lymphocytic leukemia Rai Stage 0; • all cancers of the thyroid unless: – having progressed to at least TNM classification T2N0M0; or – surgical removal of the whole thyroid gland is undertaken • all cancers of the bladder unless having progressed to at least TNM classification T1N0M0 (Stage I); • indolent cutaneous lymphoma confined to the skin; and

	• Pituitary Neuroendocrine Tumours (PitNETs) unless invasion of surrounding structures or metastasis is unequivocally proven histologically and/or radiologically by Magnetic Resonance Imaging (MRI). The diagnosis must be confirmed by a Medical Practitioner in the field.
Child Insured	in respect of the optional Children's Insurance means the Life Insured named in the Policy Schedule in respect of Children's Insurance.
Commencement Date	means the date on which your first premium payment is deducted. The date you select for the first Premium deduction is set out in the Policy Schedule.
Congenital Condition	means an illness, disability or defect existing at or from a Child Insured's birth.
Diplegia - (total and permanent)	means total and permanent loss of use of symmetrical parts of the body (such as both arms or both sides of the face) caused by permanent damage to the nervous system, in the Child Insured. The diagnosis must be confirmed by a Medical Practitioner.
Encephalitis - with permanent neurological impairment	means the diagnosis of acute inflammatory disease of the brain tissue (infectious, autoimmune or unknown cause) in the Child Insured resulting in permanent neurological impairment with persistent symptoms. The diagnosis must be confirmed by an appropriate Specialist Medical Practitioner in that field.
End Stage Chronic Kidney Failure - requiring specified treatment	means chronic irreversible failure of both kidneys, in the Child Insured, that requires regular renal dialysis or kidney transplant.
Hearing Loss (permanent and of specified severity, or requiring cochlear implant)	means a confirmed diagnosis in the Child Insured of permanent and disabling hearing loss due to Injury or Illness, with any one of the following: • partial loss of hearing in both ears - best corrected hearing threshold level for the better ear of 31 decibels averaged at frequencies from 500 to 3,000 hertz; or • profound loss of hearing in one ear - best corrected hearing threshold of 80 decibels in one ear, averaged at frequencies from 500 to 3,000 hertz. Loss of hearing requiring a cochlear implant is included. The diagnosis must be made by an appropriate Specialist Medical Practitioner in that field.

Heart Attack - with evidence of severe permanent heart muscle damage	means the unequivocal diagnosis of a heart attack (acute myocardial infarction), as confirmed by a cardiologist based on the criteria specified in the 4th Universal Definition of Myocardial Infarction AND resulting in any one of the following: • development of new pathological Q waves in the ECG; • imaging evidence of new regional wall motion abnormality in a pattern consistent with an ischaemic cause and persisting for at least six weeks; or • imaging evidence of left ventricular ejection fraction less than 50 per cent at least six weeks after the event. The following are not covered: • a rise in biological markers as a result of an elective percutaneous procedure (such as a coronary stent) for coronary artery disease; other acute coronary syndromes including, but not limited to, angina pectoris; • other causes of increased troponin levels in non-obstructive coronary arteries including myocarditis or coronary spasm where there is no evidence of acute myocardial infarction; or • any cardiomyopathy including Takotsubo cardiomyopathy (Takotsubo Syndrome). If the tests specified above are inconclusive or unable to be met, we will consider other appropriate and medically recognised tests that demonstrate the equivalent degree of severity defined by this definition. The diagnosis must be confirmed by a Medical Practitioner.
Heart Bypass Surgery (Coronary Artery Bypass Graft Surgery)	means the actual undergoing of bypass graft surgery for the treatment of coronary artery disease, either through: • an open-heart operation (sternotomy); • minimally invasive direct surgery (mini-thoracotomy); • minimally invasive keyhole surgery; or • hybrid coronary revascularisation (combination of minimally invasive surgery and coronary stent). The procedure must be confirmed as medically necessary by a Specialist Medical Practitioner in that field.
Hemiplegia (total and permanent)	means the total and permanent loss of use of one side of the body (such as one arm and one leg on the same side) caused by permanent damage to the nervous system, in the Child Insured. The diagnosis must be confirmed by a Medical Practitioner.

Homemaker	means the Life Insured who is the main provider of domestic duties within the family home and if also in paid employment, working for less than 10 hours per week. Domestic duties are the tasks performed by a Life Insured whose main occupation is to maintain their family home. Domestic duties specifically include: • cooking and preparing meals – meaning the ability to prepare meals using kitchen appliances; • cleaning the home – meaning the ability to carry out the basic internal household chores using domestic equipment such as a vacuum and mop; • washing clothes – meaning the ability to do the household's laundry to a basic standard; • shopping for groceries – meaning the ability to purchase general household grocery items; • caring for Children – meaning the ability to care for and supervise Children (where applicable). You will not be considered to be unable to carry out all normal domestic duties if you are able to perform any one of these duties.
Insurance	means, in respect of a Life Insured, the Insurance benefits that have been applied for by the Policyowner and accepted by us as indicated on the Policy Schedule.
Insurance Plan	means the Insurance Plan nominated by the Policyowner in the application, subject to acceptance by us. The Insurance Plans available under the Policy are: • single plan – this Insurance Plan applies if the Key Life Insured is the only person nominated in the application; or • joint plan – this Insurance Plan applies if there is a Key Life Insured and a Partner Life Insured nominated in the application.
Key Life Insured	means a person named in the Policy Schedule as the Key Life Insured.
Life Insured	means, as the context requires, the Key Life Insured and, if applicable, the Partner Life Insured and a Child Insured.
Major Brain Injury – requiring admission of more than 4 consecutive days in an Intensive Care Unit (ICU)	means an accidental head or brain injury in the Child Insured resulting in the admission to ICU for more than 4 consecutive days (96 hours). The diagnosis must be confirmed by a Medical Practitioner.

Major Burns to the Skin – of specified severity	means thermal, electrical or chemical injury in the Child Insured, resulting in any one of the following: • burns to ≥ 10% of the total body surface area (TBSA) as measured by the Lund and Browder Body Surface Chart; • inhalation burns; • full thickness burns to ≥ 5% of TBSA; • circumferential burns of the chest or a limb; • deep dermal or full thickness burns to 50% of either the total combined area of both hands or both feet; • deep dermal or full thickness burns to any part of the face, genitalia or perineum. The diagnosis must be confirmed by an appropriate Specialist Medical Practitioner in that field.
Major Organ Transplant - specified organs or being on a transplant waiting list	means the Child Insured either having been the recipient, or upon specialist medical advice is placed on an officially recognised Australian transplant waiting list (such as OrganMatch), to undergo a transplant from another human donor of one or more of the following organs or tissues: • bone marrow or haematopoietic (stem) cells; • intestine; • heart; • kidney; • partial liver; • lung; or • pancreas. Other than specified, the transplantation of all other organs or parts of any organ or any other tissue or graft is excluded.
Medical Practitioner	means a Medical Practitioner registered with the Australian Health Practitioner Regulation Agency (AHPRA), who must not be the Policyowner or a Life Insured under this Policy, their spouse, relative or business associate.
Monoplegia (total and permanent)	means the total and permanent loss of use of one limb (such as one arm or one leg) caused by permanent damage to the nervous system, in the Child Insured. The diagnosis must be confirmed by a Medical Practitioner.
Paralysis (total and permanent) - specified	means total and permanent loss of use of one or more limbs caused by permanent damage to the nervous system as a result of injury or illness, in the Child Insured. This includes, but is not limited to, Monoplegia, Hemiplegia, Diplegia, Paraplegia, and Quadriplegia/ Tetraplegia. The diagnosis must be confirmed by a Medical Practitioner.

Paraplegia (total and permanent)	means the total and permanent loss of use of both legs caused by permanent damage to the nervous system, in the Child Insured. The diagnosis must be confirmed by a Medical Practitioner.
Partner Life Insured	means a person named in the Policy Schedule as the Partner Life Insured. A Partner may be a legal spouse or de facto of the Key Life Insured and may be of the same gender as the Key Life Insured.
PDS	is an abbreviation of Product Disclosure Statement.
Policy	means the legal contract between the Policyowner and us. This PDS, your application, any future application accepted by us, the current Schedule, and any special conditions, amendments, or endorsements make up the Policy.
Policy Anniversary	means the anniversary of the Commencement Date of your Policy.
Policyowner, you, your, yours	means the Key Life Insured. This Policy may not be transferred or assigned to another person.
Quadriplegia (total and permanent) / Tetraplegia (total and permanent)	means the total and permanent loss of use of both arms and both legs caused by permanent damage to the nervous system, in the Child Insured. The diagnosis must be confirmed by a Medical Practitioner.
Schedule	means the Schedule issued with this Policy that confirms the details of your Policy, including any special terms or conditions, amendments, or endorsements, and updated from time to time. A new Schedule will be issued at any time we agree with you to change the details in respect of a Life Insured under this Policy. A new Schedule will replace previous Schedules.
Specialist Medical Practitioner	means a Medical Practitioner who practices in a specialty field and is listed on Australian Health Practitioner Regulation Agency's (AHPRA) Specialist Register. The Specialist Medical Practitioner must not be the Policyowner or a Life Insured under this Policy, their spouse, relative or business associate.
Stroke – resulting in specified permanent impairment	means acute focal injury of the central nervous system (brain, spinal cord, or retina) by one of the following causes: • thrombus or clot causing infarction (death of tissue due to insufficient blood supply) • intracerebral bleed (a focal collection of blood within the brain tissue or ventricular system that is not caused by trauma) • non-traumatic subarachnoid haemorrhage There must be both: • evidence on neuroimaging (CT or MRI scan) of focal ischaemic injury in a defined vascular distribution; and • clinical evidence of focal ischaemic injury based on persistent neurological deficit at least 6 weeks after the stroke and all other causes ruled out.

	The following are excluded: • transient ischaemic attacks ("TIAs") • subdural and epidural haematoma • silent strokes (silent infarcts) • neurological symptoms caused by migraines • disorders of the vestibular system • autoimmune conditions affecting the optic nerve • brain damage due to an Accident, injury or widespread cerebral hypoxia. The diagnosis must be confirmed by a Medical Practitioner.
Terminal Illness	means the diagnosis, by a Medical Practitioner or Specialist Medical Practitioner, of a Terminal Illness where life expectancy, after taking into account all reasonably available treatment, is 12 months or less.
Total & Permanent Disability	is where as a result of sickness or injury, the Life Insured: • suffers the loss of limbs or sight; or • is unable to work; or • suffers loss of independent existence; defined as follows: **a. loss of limbs or sight** Means the total & permanent loss of use of: – both hands; or – both feet; or – one hand and one foot; or – the sight of one eye; or – the use of either one hand or one foot; or – the sight of both eyes. **b. unable to work** If the Life Insured is not a Homemaker, a state of physical or mental incapacity which: – results in the Life Insured being disabled and unable to work in any employed capacity for at least six consecutive months; and – in our reasonable opinion, after considering medical evidence and/or other evidence, results in the Life Insured being unable ever to follow any occupation for which he or she is reasonably qualified by education, training or experience.

If the Life Insured is a Homemaker, a state of physical or mental incapacity which:

- results in the Life Insured being unable to engage in normal domestic duties for at least six consecutive months; and

If the Life Insured is a Homemaker, a state of physical or mental incapacity which:

- results in the Life Insured being unable to engage in normal domestic duties for at least six consecutive months; and
- in our reasonable opinion, after considering medical evidence and/or other evidence, results in the Life Insured being unable ever to perform normal domestic duties or engage in any other occupation for which he or she is reasonably qualified by education, training or experience.

c. loss of independent existence

- There is a permanent and irreversible inability of the Life Insured to perform any two of the following "activities of daily living" without the physical assistance of someone else. If the Life Insured can perform the activity on their own by using special equipment, we will not treat them as unable to perform the activity.

Activity	Description
Washing	Bathing and showering
Dressing	Dressing and undressing
Eating	Eating and drinking
Continence	Maintaining continence with a reasonable level of personal hygiene
Mobility	Getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or walking aid

or

- The Life Insured suffers cognitive impairment that results in the Life Insured requiring permanent and constant supervision for a continuous period of at least 6 months. The Life Insured's impairment must be established by a Medical Practitioner.

Total and Permanent Loss of Use of One Specified Limb	means complete and irrecoverable loss of use of one limb. Limb in this context means an arm, leg, hand or foot. The diagnosis must be confirmed by a Medical Practitioner. For the purpose of this definition 'loss of use' means the inability to use the affected limb in a meaningful or practical way, such as holding, grasping, typing, carrying, standing or walking.
Vision Loss (permanent and of specified severity, despite best treatment)	means a confirmed diagnosis in the Child Insured of a permanent and disabling vision loss due to Injury or Illness with any of the following: • moderate loss of vision in both eyes - best corrected visual acuity is 6/18 or less in the better eye; or • severe loss of vision in one eye - best corrected visual acuity is at least 6/60 or less in at least one eye, or the visual field is reduced to at least 20 degrees or less of arc; or • any degree of cortical vision impairment. The diagnosis must be made by an appropriate Specialist Medical Practitioner in that field. Visual acuity of 6/18 or less means that even with visual aids the Child Insured needs to be at 6 metres or less to see what someone with normal vision can see at 18 metres. Visual acuity of 6/60 or less means that even with visual aids the Child Insured needs to be at 6 metres or less to see what someone with normal vision can see at 60 metres.

Direct Debit Service Agreement

1. Hannover Life Re of Australasia Ltd ABN 37 062 395 484 ("Debit User") will initiate direct premium debit payments in the manner referred to in the Schedule (contained in the Direct Debit Request).
2. Debit payments will be made when due. The Debit User will not issue individual confirmation of payments made.
3. The Debit User will give the customer at least 14 days' written notice if the Debit User proposes to vary details of this arrangement, including the amount and frequency of debit payments.
4. If the customer wishes to defer any payment or alter any of the details referred to in the Policy Schedule, they must either contact the Debit User on **1300 709 431**, or write to the Debit User at Reply Paid 6728, Baulkham Hills NSW 2153.
5. Customer queries concerning disputed debit payments must be directed to the Debit User in the first instance. Details of the dispute resolution process that applies to the Debit User are described in this PDS on page 29. Queries about claims in regards to disputed debit payments should also be directed to the Debit User and may also be directed to the customer's financial institution nominated in the Schedule.
6. Direct payment debiting is not available on the full range of accounts at all financial institutions. If in doubt, the customer should check with their financial institution before completing the Direct Debit Request.
7. The customer should ensure that their account details given in the Policy Schedule are correct by checking against a recent statement from their financial institution at which their account is held.
8. It is the customer's responsibility to have sufficient cleared funds available, by the premium due date, in the account to be debited to enable debit payments to be made in accordance with the Direct Debit Request.
9. By authorising the Direct Debit Request, the customer warrants and represents that he/ she/ they is/are duly authorised to request and instruct the debiting of premium payments from the account described in the Policy Schedule.
10. If a debit payment falls due on any day which is not a business day, the payment will be made on the next business day. If you are uncertain as to when a debit payment will be processed to your account, you should make enquiries directly with the financial institution nominated in the Policy Schedule.
11. If a debit payment is returned unpaid, the customer may be charged a fee by the financial institution nominated in the Policy Schedule for each returned item.
12. Customers wishing to cancel the Direct Debit Request or to stop individual payments must give at least 7 days' written notice to the Debit User at the address referred above.
13. Except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required by law, the Debit User and its service providers will keep details of the customer's account and debit payments confidential.

For more information call 1300 709 431
Or visit guardianinsurance.com.au

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