Supplementary Product Disclosure Statement

Avant Life Insurance

23 January 2025

Avant
By doctors *for* doctors

Supplementary Product Disclosure Statement

Changes to the Avant Life Insurance Product Disclosure Statement

This Supplementary Product Disclosure Statement (SPDS) supplements and should be read together with the Avant Life Insurance Product Disclosure Statement (dated 5 April 2021) (Insurance PDS). Both the Insurance PDS and this SPDS are issued jointly by NobleOak Life Limited ABN 85 087 648 708 (AFS Licence No. 247302) (NobleOak) and Avant Insurance Limited ABN 82 003 707 471 (AFSL No. 238765) (Avant). The purpose of this SPDS is to advise you of some changes to the PDS. Page references in this SPDS are references to pages of the Insurance PDS.

The terms of the Insurance PDS continue to apply, except as updated by the changes in this SPDS.

On page 3 the section entitled 'The Life Insurance Code of Practice' is replaced with the following:

The Life Insurance Code of Practice

The Life Insurance Code of Practice outlines the standards that we're committed to in providing life insurance services to you. The code can be found at cali.org.au/life-code

On page 9 – the sections on Eligibility, Your Application , Your indicative quote, Complimentary interim cover are deleted and replaced with the following.

Existing members may apply to vary their benefits and cover levels

Avant Life Insurance is closed to new members. However existing members may apply to vary their benefits and cover levels by contacting Avant. On page 10 the Cooling-off period no longer applies for existing members. On pages 64 and 65, the Complimentary Interim Cover no longer applies for existing members.

Updates to Medical definitions

On pages 75-82 of the Insurance PDS where the Medical Definition in the left hand column in the table below appears, replace the Medical definition in the Insurance PDS as is set out in the right hand column in the table below. These reflect changes in medical practices and the periodical review we undertake for specific trauma events in line with the Life Insurance Code of Practice

Medical definition	Changes to the Insurance PDS
Angioplasty - through specific procedures	The undergoing of coronary artery angioplasty on one or more coronary arteries to correct a narrowing or blockage that is considered the appropriate and necessary treatment on the basis of angiographic evidence. This must be confirmed by a *specialist medical practitioner* in the field. You may claim multiple times for angioplasty with no waiting period between treatments. 'Coronary artery angioplasty' means the actual undergoing of either: • balloon angioplasty; • insertion of a stent; • atherectomy; or • laser angioplasty to correct a narrowing or blockage of coronary arteries within the same procedure.
Benign brain tumour (diagnosed) – resulting in neurological deficit	Diagnosis of a non-malignant tumour of the brain or pituitary gland giving rise to neurological deficit. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI The following are excluded: • cysts; • granulomas; • cholesteatomas; • malformations in, or of, the arteries or veins of the brain; and • haematomas.
Benign brain tumour – resulting in significant impairment	The presence of a benign tumour in the brain or pituitary gland which either: • requires the tumour to be therapeutically managed by invasive neurosurgical techniques such as radiotherapy (e.g. gamma knife stereotactic radiosurgery), laser therapy and ultrasonic aspiration, or surgically removed on the advice of a specialist medical practitioner in the field; or • produces neurological deficit causing: - permanent and total inability to perform without assistance of another person at least one of the *activities of daily living*; or - significant permanent impairment, as confirmed by a *specialist medical practitioner* in the field. The following are excluded: cysts; granulomas; cholesteatomas; malformations in, or of, the arteries or veins of the brain; haematomas; acoustic neuroma and other cranial nerve tumours.

Benign spinal cord tumour (diagnosed) - resulting in neurological deficit	Diagnosis of a non-malignant tumour of the spinal cord giving rise to neurological deficit. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI. The following are excluded: • cysts; • granulomas; • cholesteatomas; and • haematomas
Benign spinal cord tumour - resulting in significant impairment	The presence of a benign tumour in the spinal cord which either: • requires the tumour to be therapeutically managed by invasive neurosurgical techniques such as radiotherapy (e.g. gamma knife stereotactic radiosurgery), laser therapy, ultrasonic aspiration, or surgically removed on the advice of a *specialist medical practitioner* in the field; or • produces neurological deficit causing: - permanent and total inability to perform without assistance of another person, at least one of the activities of daily living; or - significant permanent impairment, as confirmed by a *specialist medical practitioner* in the field. The following are excluded: cysts; granulomas; cholesteatomas; haematomas.
Carcinoma in situ	Carcinoma in situ (non-invasive cancer cells), characterised by a focal autonomous new growth of carcinomatous cells which has not yet resulted in the invasion of normal tissues, classified as such in relevant staging criteria such as Tis (TNM staging) or an equivalent staging system. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. Only the following sites are covered: • cervix uteri (classified as High-grade Squamous Intraepithelial Lesion (HSIL) or Cervical Intraepithelial Neoplasia grade 3 (CIN3). Excludes CIN-1 or CIN-2); • corpus uteri; • fallopian tube – must be limited to the tubal mucosa; • ovary; • vagina; • vulva (classified as High-grade Squamous Intraepithelial Lesion (HSIL) or Vulval Intraepithelial Neoplasia grade 3 (VIN3)); • breast; • penis; • perineum; or • testicle.
Crohn's disease (severe) - requiring permanent medication	The diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, and requires permanent maintenance treatment with immunosuppressant or biologic medication.
Dementia (major neurocognitive disorder) - permanent and of specified severity	The unequivocal diagnosis of dementia confirmed by an appropriate medical specialist. The diagnosis must confirm the existence of Major Neurocognitive Disorder of the brain that has caused a permanent decline in cognitive ability severe enough to interfere with independence and daily life for which no other recognisable cause has been identified. Major Neurocognitive Disorder (major NCD) is defined under the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by American Psychiatric Association. It requires evidence of significant cognitive decline in one or more of the cognitive domains below. The cognitive deficits must be sufficient to interfere with independence in activities of daily living. The cognitive deficits must not be attributable to another mental disorder. The criterion of maintenance or loss of independent functioning represents the key distinction between mild and major NCD. The DSM-5 details six cognitive domains which may be affected in both mild and major NCD • Complex attention, which includes sustained attention, divided attention, selective attention and information processing speed; • Executive function, which includes planning, decision making, working memory, responding to feedback, inhibition and mental flexibility; • Learning and memory, which includes free recall, cued recall, recognition memory, semantic and autobiographical long term memory, and implicit learning; • Language, which includes object naming, word finding, fluency, grammar and syntax, and receptive language; • Perceptual-motor function, which includes visual perception, visuoconstructional reasoning and perceptual-motor coordination; and • Social cognition, which includes recognition of emotions, theory of mind and insight

Loss of hearing in one ear – total and irrecoverable	Irreversible loss of hearing (except by Cochlear implant) in one ear, after which the affected ear has an auditory threshold of greater than 81 decibels from the frequencies of 500 hertz to 3,000 hertz, as certified by a *specialist medical practitioner* in the field.
Loss of hearing – total and irrecoverable (except by Cochlear implant) in both ears	Irreversible loss of hearing (except by Cochlear implant) in both ears, after which the better ear has an auditory threshold of greater than 81 decibels from the frequencies of 500 hertz to 3,000 hertz, as certified by a *specialist medical practitioner* in the field.
Motor neurone disease	The unequivocal diagnosis of motor neurone disease confirmed by a *specialist medical practitioner* in the field.
Open heart surgery – through a specified procedure	The undergoing of surgery that involves cutting through the sternum to expose the heart for treatment of cardiac defect(s), cardiac aneurysm or benign cardiac tumour(s). Angioplasty, valvuloplasty, endovascular procedures, minimally invasive procedures and other non-surgical techniques are excluded.
Other cancers – excluding early stage cancers	The presence of a malignant tumour other than classified as breast, prostate or skin cancer, where malignant tumour is confirmed with histological examination and characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes leukaemia, sarcoma and lymphoma, and inaccessible brain tumours described as malignant on neuroimaging. Specifically excluded are tumours histologically: • described as pre-malignant; or borderline or low malignant potential; or non-invasive; or • show the malignant changes of carcinoma in situ, other than carcinoma in situ of the testicle if treatment requires the removal of the entire testicle. Please see the definitions of *Breast cancer – excluding early stage breast cancers, Prostate cancer – excluding early stage prostate cancers and Skin cancer – excluding early stage skin cancers* for details on what is covered for malignant tumour in those regions.
Prostate cancer – early stage	A tumour located within the prostate gland and histologically described as TNM classification T1 according to the TNM staging method.
Prostate cancer – excluding early stage prostate cancers	The presence of a malignant prostate tumour, which is confirmed by histological examination, where it is: • a TNM clinical classification of at least T2N0M0; or • a Gleason score of at least 6; or • any stage of prostate cancer where you undergo major interventional therapy specifically designed to kill or destroy cancer cells. Major interventional therapy includes, but is not limited to, prostatectomy, radiotherapy, brachytherapy, chemotherapy, biologic response modifiers or any other major treatment
Skin cancer – excluding early stage skin cancers	The presence of a malignant skin tumour, which is confirmed by histological examination, where the malignant tumour: • is a non-melanoma skin cancer or a melanoma skin cancer that has spread to the bone, lymph node, or other distant organs; or • is a melanoma having progressed to at least TNM classification T2aN0M0; or with at least 1mm Breslow thickness; or where the melanoma is showing signs of ulceration. Basal cell and squamous cell carcinomas of the skin are excluded unless it has metastasised to or invaded other organs.
Stroke - resulting in neurological deficit	A cerebrovascular event producing neurological deficit. The stroke must be confirmed by a *specialist medical practitioner* in the field and requires clear evidence by neuro-imaging (e.g. CT, MRI or similar scanning technique) that a stroke has occurred demonstrating infarction of brain tissue, intracranial haemorrhage and/or subarachnoid haemorrhage. The following are specifically excluded: • transient ischemic attack; • non-stroke related reversible neurological deficit; • cerebral symptoms due to migraine; • cerebral injury resulting from head trauma or hypoxia; and • disturbances of vision or balance due to disease of the eye, optic nerve or the vestibular function.
Ulcerative colitis (severe) – requiring permanent medication	The diagnosis of ulcerative colitis that has failed to be controlled by standard therapy, including cortisone treatment, and requires permanent maintenance treatment with immunosuppressant or biologic medication.

Avant *Life Insurance* Product Disclosure Statement

Product Disclosure Statement
and Litigation Support Benefit

Issue number: 1.0
5 April 2021

Avant
By doctors *for* doctors

About this Product Disclosure Statement

The purpose of this Product Disclosure Statement (PDS) is to provide you with information about Avant Life Insurance so you can make the best choices for you and your family. Should you want more information about Avant Life Insurance products, please call us on **1800 128 268** or visit **avant.org.au/life**

Understanding what we mean

While our aim is to provide straightforward explanations, some of the terms and words used have specific meanings, including some non-technical words commonly used. These words have been italicised and are explained in either the 'Definitions' or 'Medical Definitions' sections at the end of this document.

You'll also note that we refer to the different covers in this PDS as plans rather than policies. After all, aren't they a part of your plan for protecting yourself and your family's future?

Who we are

Avant Mutual Group Limited (Avant Mutual) has chosen to work with NobleOak Life Limited (NobleOak) to provide this insurance cover to you. NobleOak is a friendly society and similar to Avant Mutual, NobleOak has been protecting its members for over 100 years. NobleOak and Avant Mutual have a shared philosophy of making tailored insurance solutions and personal service available to members with the suite of Avant Life Insurance products.

This PDS is issued jointly by NobleOak Life Limited ABN 85 087 648 708 (AFSL No. 247302) (NobleOak) and Avant Insurance Limited ABN 82 003 707 471 (AFSL No. 238765) (Avant). Avant is the insurer for the Litigation Support Benefit (a general insurance benefit) which is available together with the Income Protection benefit; and NobleOak is the insurer for all other benefits (which are life insurance benefits). NobleOak and Avant each take full responsibility for the entirety of the PDS.

Avant Life Insurance is a registered business name of Doctors Financial Services Pty Limited ABN 56 610 510 328 (DFS). DFS provides administration services in respect of your insurance cover on behalf of NobleOak (and on behalf of Avant in connection with the Litigation Support Benefit within Income Protection Cover).

When reading this PDS, 'we'/'us'/'our' refers to NobleOak (and for the Litigation Support Benefit within Income Protection Cover, it refers to Avant). 'You'/'your' refers to the insured person or plan owner, as the context requires.

This Product Disclosure Statement is not advice

It is important to note that information provided in this PDS is general in nature and does not take into account your individual financial situation, needs or objectives. You should consider how appropriate the cover discussed in this PDS is for your needs before making any decisions and seek professional advice where appropriate.

Up-to-date information

All the information contained in this PDS is current at the time of issue but it can change from time to time. If the change is not materially adverse, the updated information will be available on our website, avant.org.au/life. Alternatively, if the change is materially adverse, we will notify you as required by law.

Your contract

If you purchase an Avant Life Insurance plan/s , your contract with us will be made up of this PDS, your application for insurance, your *plan schedule*, and the Avant Benefit Fund Rules (including the relevant appendices to those Rules). You may request a copy of the Avant Benefit Fund Rules at any time.

This PDS is subject to and governed by the laws of New South Wales, Australia. Premiums and any benefits are payable in Australia, in Australian dollars.

Our plans allow you to select one or more insurance covers (on a standalone or linked basis), each with a number of built-in or optional benefits.

The Standalone Covers available under an Avant Life Insurance plan are:

- Life – Standalone Cover
- TPD – Standalone Cover
- Trauma – Standalone Cover
- Income Protection – Standalone Cover
- Practice Expenses – Standalone Cover

Children's Cover is also available but can only be purchased by you if you own another Avant Life Insurance plan.

The Linked Covers available under an Avant Life Insurance plan are:

- Linked TPD Cover
- Linked Trauma Cover

Linked Cover is described in further detail on page 30 of this PDS.

Further information

You may request further information about your Avant Life Cover, TPD Cover, Trauma Cover, Children's Cover, Income Protection Cover, or Practice Expense Cover plan(s) , including a copy of the Avant Benefit Fund Rules by contacting us (see the back cover of this PDS for details).

The Life Insurance Code of Practice

The Life Insurance Code of Practice outlines the standards that we're committed to in providing life insurance services to you. The code can be found at fsc.org.au

Table of contents

Tailored protection for you and your family

As a doctor, you understand better than most that life and death are unpredictable. That is why ensuring your personal life is protected, is just as important as protecting your professional life. Avant Mutual understands a doctor's insurance needs are unique.

That's why we have developed a comprehensive suite of life insurance products especially for doctors. With an Avant Life Insurance plan, you can have peace of mind knowing you have protected your and your family's future by choosing from a range of Life Insurance products specifically tailored for medical practitioners.

What to consider when deciding on your protection

There are many things to consider when deciding on the type and level of cover that is right for you. While this is not advice, generally speaking depending on your personal circumstances and what life and career stage you are at, you are likely to have different priorities. Some of the things you might wish to consider can be found below.

Your home

Mortgage repayments

Rent

Home modifications if required due to a disability

Your income

Salary including overtime

Super contributions

Income from your practice

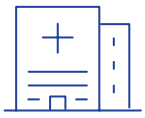
Your family and lifestyle

Everyday expenses

Medical bills

Children's education

Final expenses



Your practice

Practice income

Practice expenses

Key people

Business succession planning

Types of cover	What the proceeds can be used to help protect			
	Your home	Your income	Your family and lifestyle	Your practice
Life Cover Provides a lump sum payment if you die or become *terminally ill*.	✓	✓	✓	✓
Total and Permanent Disablement (TPD) Cover Provides a lump sum payment if as a result of an illness or injury you are unlikely to ever again be able to work in your own speciality, if you suffer from one of the listed *occupationally disabling conditions*, or if you contract HIV, Hepatitis B or Hepatitis C due to a workplace incident.	✓	✓	✓	✓
Trauma Cover Provides a lump sum payment if you suffer one of the listed trauma events.	✓	✓	✓	✓
Children's Cover Provides a lump sum payment if a child listed on your plan suffers one of the listed child trauma events, and a Children's Support Benefit if you or your partner need to cease work to care for the child or pay for a full time carer.			✓	
Income Protection Cover Provides a *monthly benefit* if you are unable to work in the specialty that you were working in prior to the illness or injury, or are able to work but only in a reduced capacity, due to an illness or injury.	✓	✓	✓	
Practice Expense Cover Provides a *monthly reimbursement* of eligible fixed ongoing practice expenses (such as rent and electricity) up to specified limits, if you are unable to work at full capacity due to an illness or injury.				✓

Applying for cover

Eligibility

Avant Life Insurance has been developed exclusively for doctors.
If you're a registered medical practitioner and an Australian resident, you are eligible to apply. Additional eligibility requirements (such as age) apply to certain cover types – you should refer to the eligibility requirements for each cover type in this PDS as applicable.

In some cases, we may approve your cover subject to special conditions and/or a modified initial premium. You will be notified of these special conditions and/ or premium modifications changes and you will need to agree to them before cover can be issued.

Your application

We understand the realities of a career in medicine and how time poor medical professionals often are. This is why the application process has been designed to be as simple and straightforward as possible.

There are a number of ways in which you can obtain an indicative quote and complete your application for an Avant Life Insurance product:

- Online – visit avant.org.au/life
- Phone – contact us on **1800 128 268** and one of our insurance product specialists will assist
- Avant Financial Adviser – an Avant Financial Adviser can review your personal circumstances and provide recommendations on cover that would be suitable for you.

Once you have decided on the cover you require, you must accurately complete and submit an application form, which will include questions about your health, financial situation, lifestyle and pastimes. If you are using an Avant Financial Adviser, they will assist you with your application.

Your indicative quote

You will be provided with an indicative quote that shows the cost of cover (with applicable stamp duty applied) and options selected. This quote is valid for 30 days. Please note that this is a provisional quote based on the basic information supplied by you and our standard premium rates for your age, smoking status and gender. The actual premium applicable to you may be adjusted higher or lower after we take into account the information provided in your application.

It is also subject to change if the information supplied by you is not correct. A new quote may be required after the previously mentioned 30 day period.

You may also request a table of premium rates showing all rates and factors that apply to your cover. Further information on how premiums are calculated can be obtained by contacting us (see the back cover of this PDS for details).

Complimentary interim cover

When applying for insurance, you have a duty to disclose any information that may impact our decision to provide cover or the terms that apply. The information you provide allows us to properly review the risks and price it accordingly; therefore, keeping premiums affordable for all doctors.

While we are assessing your application, we will provide you with complimentary interim cover, as applicable to the cover(s) you apply for. For more information see Complimentary Interim Cover on page 64.

Your duty of disclosure

Before we agree to issue your Avant Life Insurance plan, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to provide your cover and on what terms.

You do not need to tell us anything that:

- reduces the risk to be undertaken by us
- is common knowledge
- we know or should know in the ordinary course of our business as an insurer
- we waive the duty for you to tell us.

Your duty to disclose relevant matters continues until we accept your cover. This same duty applies before your plan is subsequently extended, varied or reinstated, or if you apply for new cover within your plan.

Non-disclosure

If you have taken the important step to protect yourself and your family, you want to know that your cover will be there when you need it. However, if you fail to disclose all information of relevance, or if the information you provide is fraudulent, we may reduce or cancel your cover or refuse to pay a claim.

If you fail to comply with your duty of disclosure and we would not have entered into the insurance contract if you had told us, we may cancel your insurance cover (and your plan) within three years of entering into it.

If we choose not to cancel your insurance cover and your plan, we may elect to vary your insurance cover and plan at any time by:

- reducing your *sum insured* and/or *monthly sum insured*. This would be worked out using a formula that takes into account the premium that would have been paid if you had told us everything as required (Life Cover contains a Death Benefit, so we may only reduce your Life Cover *sum insured* within three years of the commencement date of your Life Cover),
- varying the terms of your insurance cover (and your plan) in a way that places us in the same position we would have been in if you had told us everything as required.

If your non-disclosure is fraudulent, we may refuse to pay a claim and cancel your insurance cover (and your plan) or any part of it, irrespective of the type of cover, at any time.

You should be aware that a failure by the insured person to tell us a matter of the kind referred to above will be treated as a failure by the plan owner to comply with his/her duty of disclosure.

When your cover commences

Your cover will officially commence when we have approved your application for the cover and received your payment. Upon approval, we will provide you with a *plan schedule* that lists key information about your cover, its commencement date and the options you have chosen.

Subject to any special conditions noted on your *plan schedule*, cover commences from the date shown on your *plan schedule*.

If we accept your application, we will issue a *plan schedule* detailing:

- the plan owner
- the insured person
- details of the insured person (such as gender, date of birth, occupation details and smoker status)
- the type of insurance provided
- whether the plan is connected to another plan such as through the Super Splitting Option
- the sum insured or monthly sum insured (as applicable)
- the cover commencement date
- the cover expiry date (which applies subject to the other ways cover can end which are outlined within this PDS).
- whether your premium is calculated on a stepped or level basis
- any premium adjustments which apply
- any special conditions which apply to you in addition to the terms and conditions outlined within this PDS
- the premium payable for the following year and when it is payable.

Cooling-off period

If you're not completely satisfied with your Avant Life Insurance plan, you may cancel it within 30 days of the commencement date and receive a full refund of any premium paid provided you have not made a claim.

Commission

Our employees (and, if you purchase Avant insurance cover through an insurance adviser, the adviser) work for a salary and do not receive a commission payment if you purchase insurance cover from us. However, if you purchase through an adviser we may pay a level commission to the Australian Financial Services Licence (AFSL) holder for each year you hold your plan. If you receive personal advice, your insurance adviser will provide details of the commission payments in the Statement of Advice that they will give you. If commissions are paid, we pay these amounts out of your premium payments – they are not additional amounts you have to pay.

Risks to consider when purchasing cover

When choosing to apply for any form of insurance, it is important to understand the potential risks before making your decision. This includes the risk that the cover type may not be appropriate for your needs, your ability to continue to pay premiums and other factors, such as exclusions that may apply and changes to superannuation legislation.

There are a number of risks that you must be aware of before deciding to purchase cover. These include:

- The cover type or amount may not be appropriate or may be inadequate for your needs (you should consider the options you select carefully).
- If you become unable to pay your premium we may cancel your plan.
- If you do not disclose to us every matter that you know or could reasonably be expected to know, that would be relevant to our decision about whether or not to accept your application and on what terms, we may cancel your plan or reduce the benefit amount payable.
- Should an exclusion apply to your plan, a benefit may not be paid to you.
- Premium rates are not guaranteed and may increase or decrease in the future, regardless of which premium type you select.
- Superannuation legislation may change and if some of your cover is held within superannuation, you may be unable to access the benefit amount if you do not meet a condition of release under superannuation law.

We suggest that you speak with an insurance adviser before making a decision about your insurance arrangements.

Premiums

Premium structure

To help you better manage your cash flow, you have the choice of two premium structures – stepped or level.

As a general rule, if affordability today is your primary concern, such as when you're an intern or Doctor in Training, stepped premiums will allow you to purchase what you need today for less money. However, if you intend to retain your cover for the long term, level premiums may save you money and your premiums may become increasingly affordable over time.

Stepped premiums

If you select stepped premiums, the amount you pay will generally increase at each plan *anniversary date* based on your age at the time of increase. Of course, other factors may result in an increase in premium, such as any increase in the *sum insured* due to Cover Indexation (see Cover Indexation section on page 23).

Level premiums

If you select level premiums, the amount you pay will be based on your age at your plan commencement date. Your premiums will generally remain the same for the level of cover, until the plan *anniversary date* following your 65th birthday when they will convert to stepped premiums.

Sometimes we may need to make changes to our rates as part of a review of our pricing. This may result in a change to your level premium rates. Further detail on when level premiums may change can be found below in the 'Changes to underlying premium rates' section.

If there is an increase to your *sum insured* – for example, due to Cover Indexation (see page 23) – then your premium will increase accordingly. The increase in premium will be calculated based on your age at the time the cover is increased.

If you have requested to increase your *sum insured*, the premium applicable to the increased portion of cover will be calculated based on your age at the time of the increase.

Your existing level premium may also be recalculated based on your current age if you make a variation to your plan.

Please note that only a level premium structure is available for Children's Cover.

Changes to underlying premium rates

The underlying premium rates are not guaranteed for both stepped and level premiums. However, once your plan has commenced, you will never be singled out for an underlying premium rate increase. Any increase will be applied to all plan holders to whom the same premium rate applies, after 30 days' written notice.

How premiums are calculated

Your premium is the cost of the cover(s) within your Avant Life Insurance plan. It is based on your individual circumstances at the time of application such as your age, gender, health and lifestyle, as well as the level of cover and options you have selected. If your risk factors change for the better after your plan has started, you can request a review and your premium may decrease.

Your premium will depend on:

- the level of cover you require (the higher the *sum insured*, the higher the premium);
- whether you select stepped or level premiums (stepped premiums are generally lower than level premiums at the commencement of a plan but increase each year as you get older);
- for Income Protection Cover and Practice Expense Cover, the *waiting period* you select (the longer the *waiting period*, the lower the premium);
- for Income Protection Cover, the *benefit period* you select (the longer the *benefit period*, the higher the premium);
- if you have TPD Cover, whether it is purchased as standalone cover or is linked to Life Cover (premiums for linked cover are generally lower than standalone cover);
- if you have Trauma Cover, whether it is linked to Life Cover or to Life and TPD Cover (the more plans your Trauma Cover is linked to, the lower your premium will be);
- the frequency of your premium payments (quarterly or monthly premium payments will attract a 2.5% increased premium);
- your current age;
- your gender;
- whether or not you are a smoker (premiums are higher for smokers and those who have recently stopped smoking than for non-smokers);
- your state of health; and
- any pastimes you participate in (premiums are generally higher for those who engage in hazardous activities).

Your premium will include any stamp duty charged by the government of the state you reside in. No Goods and Services Tax (GST) or other taxes levied by state or the Federal Government, currently apply.

Payment options

Premiums can be paid by the following payment options: If you select to pay your premiums via credit card, we accept Visa and MasterCard only.

	First payment	Monthly	Quarterly	Yearly
Credit card	✓	✓	✓	✓
Direct debit	✓	✓	✓	✓
BPAY				✓

Premium suspension

If you are experiencing financial hardship you may elect to suspend your premiums and cover for a period of up to 6 consecutive months.

During this period, you will not have to pay premiums. However, your insurance cover is suspended during the period which means that you will not be eligible to claim for or in respect of any illness, injury, medical condition, trauma event, death or any event that happens during this period. An illness, injury, medical condition or trauma event is taken to have happened the earlier of where:

- a doctor first gave the insured person advice, care or treatment or recommended that the insured person seek advice, care or treatment for the illness (including infection), injury, medical condition or trauma event; and
- the insured person first had any sign or symptom of the illness, injury, medical condition or trauma event for which a reasonable person in the same circumstances would have sought advice, care or treatment from a doctor.

Application for this benefit is subject to you submitting an application for Premium Suspension along with accurate and satisfactory evidence that during the relevant period the insured person is experiencing financial hardship due to:

- being unemployed;
- being on sabbatical, maternity, paternity or long term leave from work; or
- the insured person's household income for the last 3 consecutive months reducing by 30% or more (as compared to the household income over the preceding three month period).

Where you seek for the Premium Suspension to be removed prior to the end of the 6 month period, a declaration of good health must be completed by you and will be subject to an underwriting assessment and our acceptance.

Reinstatement of cover following lapse for non-payment of premiums

If any one or more of your covers lapse as a result of missed premium payments, you may apply to us to have your cover reinstated.

You may apply to have your cover reinstated within one year of its lapse.

Reinstatement is subject to our approval process and you may need to provide updated medical evidence or information about your pastimes and occupation. As a result of this process, we may apply new exclusions or loadings to your cover. Any exclusion or loading previously placed on your cover and the periods for which they applied, may also be reinstated.

Upon approval, all outstanding premiums between the date of lapse and the date of reinstatement will need to be paid. Your reinstated cover will commence on the reinstatement date.

You will not be eligible to claim for an illness, injury or medical event, death or any other event that occurs following the lapse date and prior to the reinstatement date.

Taxation information

The below information is based on an interpretation of current laws and is a general statement only. We recommend you seek professional tax advice.

Life Cover and TPD Cover

Outside of superannuation – The premiums for Life Cover, TPD Cover and TPD Cover Super Linked, are generally not tax deductible to you. However, there are some circumstances where the premium, or part of the premium, may be claimed as a tax deduction. For example, this may be relevant in situations where an employer owns a plan or pays the premiums.

Owned by your SMSF – The premiums for Life Cover Super and TPD Cover Super are usually tax deductible and benefits tax assessable to your SMSF.

Trauma and Children's Cover

Premiums are generally not tax deductible to you. However, there are some circumstances where the premium, or part of the premium, may be claimed as a tax deduction. For example, this may be relevant in situations where an employer owns a plan or pays the premiums.

Income Protection

Outside of superannuation – For income earners, Income Protection and Income Protection Super Linked premiums are usually tax deductible and benefits are assessable as taxable income.

Owned by your SMSF – Income Protection Super premiums are usually tax deductible to the superannuation fund paying the premium. When a benefit is paid to the superannuation fund, these benefits will be passed onto you and will be assessable as taxable income.

Practice Expense Cover

For income earners, Practice Expense Cover is usually tax deductible and benefits tax assessable.

Plan ownership

Plan ownership

Legislation and taxation are often changing and there may be tax and/or cash flow reasons that make it beneficial for you to fund your cover individually, through a company or trust, or (where superannuation laws permit) within your SMSF. The choice is yours.

Unless otherwise agreed by us, for those *Australian residents* who are *medical practitioners*, the 3 ownership options generally available for Avant Life Insurance are:

1. **individual ownership** – this can be the insured person or an individual aged 18 or over who is an *Australian resident* and has an insurable interest in the life of the insured person
2. **ownership by a registered Australian corporation/ partnership/family trust** which has an insurable interest in the life of the insured person
3. **ownership by the trustee of a Self-Managed Super Fund (SMSF)** of which you are a member (Life Cover, Income Protection Cover, and TPD Cover only) – for Income Protection and TPD Cover, your cover will be split into two plans with the cover allowable under the *Superannuation Industry (Supervision) Act 1993 (Cth)* (SIS Act) being owned by the trustee of the SMSF and an amount of cover owned by you (see 'Super Splitting Option' below for further details)

For Children's Cover, the plan can only be owned by any parent, grandparent or legal guardian of the insured child if they also own another Avant Life Insurance plan.

Ownership can also be transferred from one entity to another throughout the life of your plan/s with the authority of the current owner. This includes moving ownership from within superannuation to outside of superannuation, or the other way around, where ownership within superannuation is permissible.

Please note that some benefits are not available within superannuation due to superannuation law restrictions.

The ownership options available to the different cover types are summarised below:

Cover type	Individual	Corporation, Partnership or Family Trust	SMSF
Life Cover	✓	✓	✓
TPD Cover	✓	✓	✓*
Trauma Cover	✓	✓	
Children's Cover	✓		
Income Protection	✓	✓	✓*
Practice Expense Cover	✓	✓	

*Super Splitting Option will apply

Beneficiaries – Life Cover

The choice to have Life Cover is driven by the desire to protect those we love. To ensure your loved ones are getting the money they need, you can nominate who you would like to receive the Death Benefit or Advanced Payment Benefit. For example, you can nominate your spouse, children or estate and the proportion of the benefit you would like each party to receive.

If Life Cover is on your own life and you have purchased it as an individual, you can nominate who you would like to receive the Death Benefit or Advanced Payment Benefit and what their share will be.

Any such nomination or any revocation or amendment, must be made using our Beneficiary Nomination form. Beneficiary nominations will not be valid until we have confirmed them to you in writing.

If Life Cover is taken on a life other than the plan owner's, any Death Benefit or Advanced Payment Benefit will be paid to the plan owner.

If you wish to amend or revoke your nomination/s, you will need to complete and submit a new Beneficiary Nomination form, which will completely replace all previous nominations.

See also 'Paying your benefit' section on page 20 of this PDS.

Super Splitting Option (Life, TPD and Income Protection)

Many of the benefits and features of Avant's TPD Cover and Avant's Income Protection Cover cannot be offered within superannuation due to legislative restrictions. To ensure you still have access to the full range of benefits, we have created the Super Splitting Option which allows you to purchase the same fully featured cover. It does this by splitting these covers into two plans – one within superannuation ('TPD Cover Super' & 'Income Protection Super', respectively) and one outside of superannuation ('TPD Cover Super Linked' and 'Income Protection Super Linked', respectively).

Life Cover Super (i.e. Life Cover taken within superannuation), TPD Cover Super (i.e. TPD Cover taken within superannuation) and Income Protection Super (i.e. Income Protection Cover taken within superannuation) plans can be purchased by your complying SMSF. This means that once your application has been accepted, the trustee of your SMSF will become the plan owner of your plan/s.

Life Cover Super, TPD Cover Super and Income Protection Super do not contain an investment component.

While there may be advantages of paying premiums within superannuation, there may be tax implications upon benefit payment. Before you seek to exercise this option, we recommend you seek professional tax advice to understand these tax implications.

Life Cover

Life Cover can either be purchased within superannuation or outside of superannuation.

TPD Cover

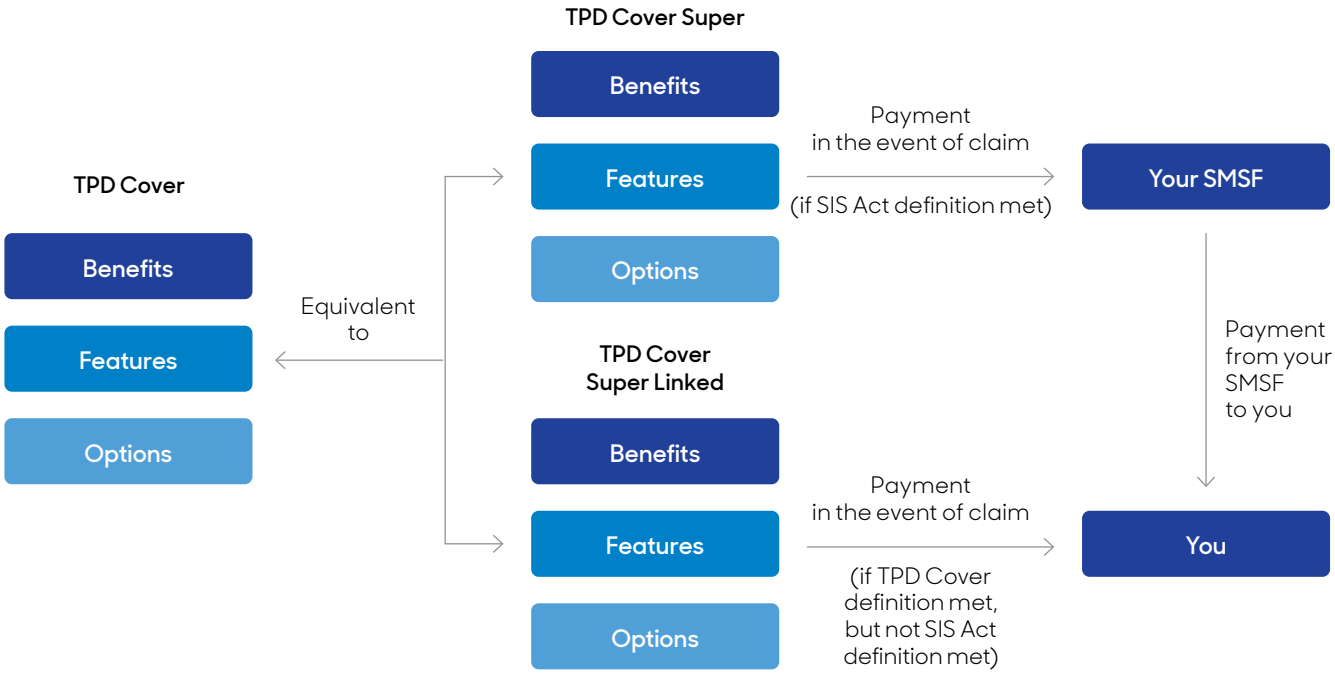
When purchased within superannuation, TPD Cover is split into two plans (TPD Cover Super and TPD Cover Super Linked) which, when combined, provide the same benefits, features and options as TPD Cover purchased outside of superannuation.

All TPD Cover benefits that meet the required superannuation legislation (e.g. SIS Act definition of Permanent Incapacity) can be released by your superannuation fund under your TPD Cover Super plan.

Those benefits that cannot be paid under your TPD Cover Super plan will be payable under your TPD Cover Super Linked plan.

This means that in the event of a claim you may receive benefits from your plan within superannuation, your superannuation linked plan or from both. Irrespective of where the benefits are paid from, the total benefit paid will be the same as if you had purchased TPD Cover entirely outside of superannuation.

Premiums will be split between your TPD Cover Super plan and your TPD Cover Super Linked plan. However, the total premium paid for your TPD Cover Super plan and your TPD Cover Super Linked plan, will be the same as the premium that would have been paid had you chosen not to purchase your cover within super.



Income Protection Cover

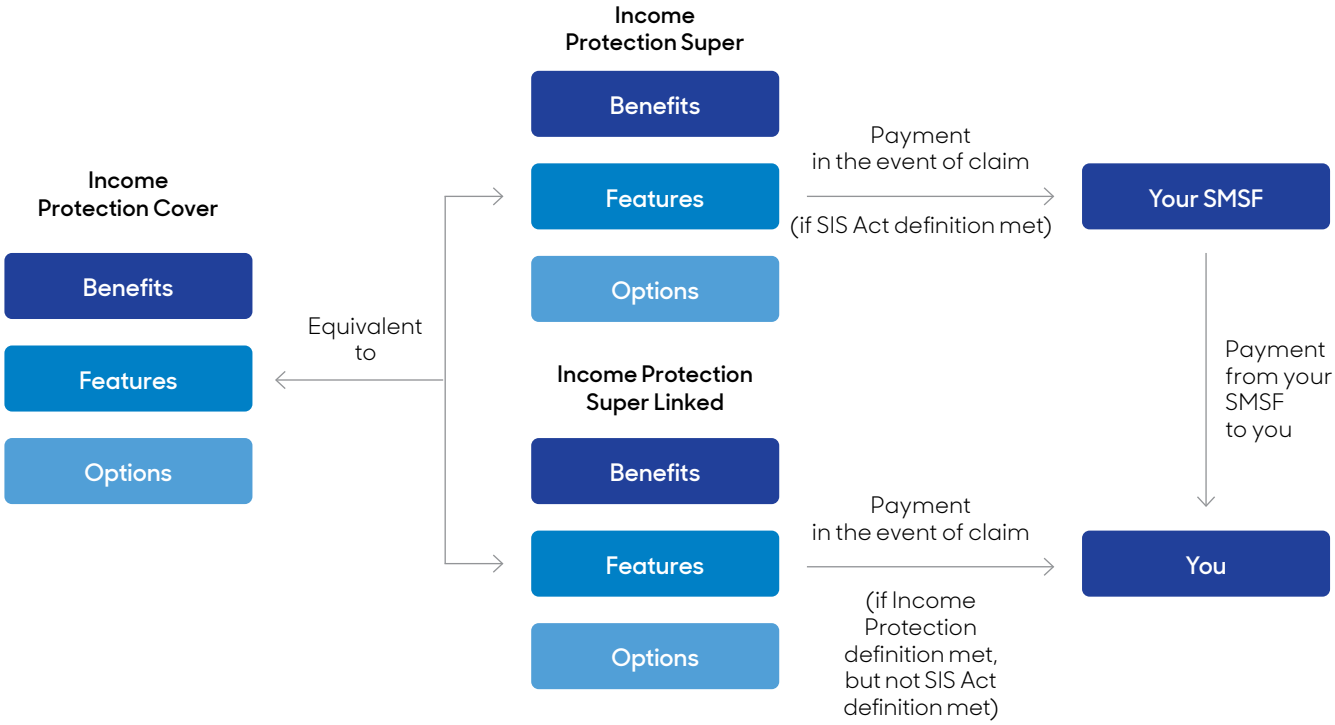
When purchased within superannuation, Income Protection Cover is split into two plans (Income Protection Super and Income Protection) which, when combined, provide the same benefits, features and options as Income Protection purchased outside of superannuation.

All Income Protection Cover benefits that meet the required superannuation legislation (e.g. SIS Act definition of Temporary Incapacity and any relevant cashing or payment restrictions) can be released by your superannuation fund under your Income Protection Super plan.

Those benefits that cannot be paid under your Income Protection Super plan, will be payable under your Income Protection Super Linked plan.

This means that in the event of a claim, you may receive benefits from your Income Protection Super plan, your Income Protection Super Linked plan or from both. Irrespective of where the benefits are paid from, the total benefit paid will be the same as if you purchased Income Protection entirely outside of superannuation.

Premiums will be split between your Income Protection Super plan and your Income Protection Super Linked plan. However, the total premium paid for your Income Protection Super plan and your Income Protection Super Linked plan, will be the same as the premium that would have been paid had you chosen not to purchase your cover within super.



Making a claim

How to make a claim

If you think you are eligible to make a claim or are unsure and would like some assistance, it is important that you contact us as soon as possible. We will send you a claim form and explain in detail our requirements and what the next steps are.

You, (or, for Life Cover where death has occurred your estate or beneficiary) should notify us as soon as reasonably possible if an event, illness or injury occurs and you expect it will result in a claim. This can be done in the following ways:

- calling us on **1800 128 268**
- emailing us at claims@avant.org.au
- contacting your insurance adviser.

Claim forms will then be issued and need to be completed, signed and returned to us for assessment.

Claim requirements

As well as your claim form, we may require additional information depending on the cover you are claiming under. This may include (but is not limited to) the following items which must be
accurately provided in a form satisfactory to us before we can make an assessment:

- your *plan schedule*;
- evidence confirming the claimable event or condition and when it occurred;
- supporting evidence from an appropriate specialist *independent medical practitioner* registered in Australia or New Zealand (or other country approved by us) if the claim is for illness or injury;
- confirmatory investigations including, but not limited to, clinical, radiological, histological and laboratory evidence where relevant for illness or injury claims;
- evidence of your *regular occupation* and duties (not needed for claims under Life Cover);
- proof of your age;
- in addition, for Income Protection Cover:
  - evidence of your income;
  - evidence confirming study leave, an overseas placement or age of children requiring care;
  - evidence of superannuation contributions paid by you;
  - documentation from the relevant professional body confirming you can no longer perform exposure prone procedures;
  - proof of incurred costs where the benefit payment is based on reimbursement;
- in addition, for Practice Expense Cover, evidence of your income and proof of eligible practice expenses (including incurred expenses)

The documentation and evidence we require you to provide in relation to your claim is to be provided at your own cost.

Assessing your claim

When it comes to assessing your claim, we rely on information you submit to us with your claim and information you disclosed as part of your application. We then use this information to make a decision on your claim and the benefit amount payable. We may also request a medical examination by a practitioner chosen by us and/or further information about your financial situation.

In order to determine whether your claim is valid and what benefit is payable, we will assess the information submitted with your claim and any information you disclosed to us as part of your application. Where information was not verified at the time of application, we reserve the right to verify it at the time of claim.

We must be satisfied that there has been an occurrence of the illness or injury. We therefore reserve the right to require you to undergo an examination and any reasonable tests, to enable your diagnosis to be confirmed by a specialist medical practitioner appointed by us. If we request a medical examination by a medical practitioner we select, we will pay for it.

If you are situated overseas at the time of claim, then we (acting reasonably) may require you to submit at our expense to any additional medical examination conducted by a health care practitioner appointed by us in the relevant jurisdiction, if we (acting reasonably) require you to do so.

In circumstances where it is not possible for us to appoint a health care practitioner in an overseas jurisdiction including where a suitably qualified health care practitioner is not available, we may require you to return to Australia for the examination at your own expense.

Additionally, when you make a claim under Income Protection Cover and/or Practice Expense Cover and it is necessary to enable us to calculate your *monthly benefit* and/or *monthly reimbursement* amount, you must allow us to examine your business and personal financial circumstances including requesting copies of personal and business tax returns, assessment notices and/or other financial evidence in order to substantiate your income and/or practice expenses.

You should notify us as soon as reasonably practicable of a claim. Where you do not notify us of a claim in a timely manner and our interests are prejudiced as a result, we may reduce our liability by an amount that fairly represents the extent to which our interests were prejudiced as a result of the delay.

Paying your benefit

Who the benefit is paid to

All benefits will be paid to the plan owner, unless we are legally required to pay a benefit to someone else (in which case the benefit will be paid in accordance with that requirement).

If you have a valid beneficiary nomination/s at the time of your death, the benefits available under your Life Cover (taken outside of superannuation) will be paid to your beneficiary/ies in accordance with your nomination, provided it is lawful for us to do so. If your nomination/s is subject to an external dispute resolution process, we will pay any benefits as directed by a court or by the relevant dispute resolution authority.

Where there is no valid beneficiary nomination/s at the time of your death, we will pay any benefit to:

- the plan owner if they are not the insured person; or
- the plan owner's estate if they were the insured person.

Cover purchased within superannuation

If you have purchased your cover through your SMSF, any benefit will initially be paid to the trustee of that fund.

Cover purchased within your SMSF

If you have a Life Cover Super, TPD Cover Super or Income Protection Super plan, any amount payable from these benefits will be paid to the trustee of the applicable SMSF. The trustee will distribute the benefits in accordance with the governing rules of the superannuation fund and superannuation law.

While there may be advantages of paying life insurance premiums within superannuation, there may be tax implications upon benefit payment. Benefits are typically tax assessable to your SMSF (but circumstances can vary). The amounts ultimately received by the benefit recipients may have special tax treatment which does not depend on the nature of the original insurance claim payment.

We recommend you seek professional tax advice.

Premium Waiver while on claim (Income Protection and Practice Expenses Cover)

Injury, illness or litigation can be stressful enough without having to worry about premium payments. Should you be entitled to receive a *monthly benefit* under your Income Protection plan or Practice Expense Cover, your premiums will be waived for the period you receive that benefit, and for the *waiting period*. We will also refund any premiums you have paid which cover the same period.

You don't have to pay premiums for your Income Protection Cover while we are paying you an Income Replacement Benefit, Limited Capacity to Work Benefit, or Litigation Support Benefit; or for your Practice Expense Cover while we are paying you a Practice Expense Reimbursement Benefit, Partial Reimbursement Benefit, Payment Extension Benefit, or Lease Extension Benefit. This also applies where you have a benefit entitlement under your plan, but it is reduced to nil due to payments received from other sources (see 'When a benefit is reduced' on pages 56 and 62).

We will refund any premiums you've already paid which apply to the *waiting period* and any subsequent period where we are paying you an Income Replacement Benefit, Limited Capacity to Work Benefit or Litigation Support Benefit under Income Protection Cover; or a Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit, Payment Extension Benefit or Lease Extension Benefit under Practice Expense Cover. For example, if you have paid an annual premium, we will refund the portion of the annual premium that relates to the *waiting period* and the period where you received a benefit payment.

Yearly increases to your Income Protection benefit, whilst benefits are being paid

To ensure your benefit payments are as valuable to you as they were when payment commenced, after each year of receiving the Income Replacement Benefit or Limited Capacity to Work Benefit, your *monthly benefit* and Superannuation Reimbursement Benefit limit will increase in line with the CPI. Any increase will be applied on the yearly anniversary of the date you were eligible to receive benefits.

Once the payment of the *monthly benefit* ends, the *sum insured* will revert to the amount that applied at the commencement of the *waiting period*.

When multiple benefits are payable

Income Protection Cover

If you are eligible to receive more than one of the below benefits for the same period of time, only the one which provides you the highest *monthly benefit* will be paid:

- Income Replacement Benefit
- Limited Capacity to Work Benefit
- Litigation Support Benefit

The exceptions to this are the:

- Superannuation Reimbursement Benefit
- Daily Hospital Benefit
- Rehabilitation Benefit

These benefits will be paid in addition to any other benefit.

If more than one separate and distinct illness or injury results in your inability to work at full capacity, payments will be based on the illness or injury that provides the highest benefit.

Practice Expense Cover

If you are eligible to receive both the Practice Expense Reimbursement Benefit and Partial Reimbursement Benefit, only the benefit which provides you the highest *monthly reimbursement* will be paid.

If more than one separate and distinct illness or injury resulted in your inability to work at full capacity, payments will be based on the illness or injury that provides the highest benefit.

General features and benefits

World Wide Cover

No matter where your medical career or personal life takes you, World Wide Cover means that you can rest assured knowing that you're protected 24 hours a day, regardless of where or when your death, illness or injury occurs.

Guaranteed Renewable

Our Guaranteed Renewable feature ensures you have the peace of mind knowing that your cover will remain in place so long as you continue to pay your premiums when due. This applies regardless of changes in your health.

Once your cover has been accepted, we cannot adversely alter its terms if your health, or the health of your child where you have Children's Cover, declines while the cover is in place. You should note that we may still vary your premium in the circumstances set out under the heading 'Changes to underlying premium rates' on page 12 of this PDS.

The Litigation Support Benefit is a general insurance benefit and the terms upon which it is offered may be varied at each plan *anniversary date* or withdrawn entirely. Any changes to this benefit after your plan's commencement will be provided to you at least 30 days before your annual renewal date.

Upgrade guarantee

You shouldn't miss out on future enhancements to Avant cover simply because you chose to protect yourself and your family sooner rather than later. All enhancements will therefore be passed on to you provided they do not result in a change in your premium.

From time to time, we may improve the benefits and features of Avant's cover as described in this PDS. If we do, these enhancements will be made available to you if you hold the relevant cover, provided that they are approved by the Australian Prudential Regulation Authority (APRA) and do not result in a change to your standard premium rates.

Where future enhancements have been made available to you, then, in the event of a claim:

- you may accept the enhancements and your claim will be assessed against the terms of the plan as at the date you lodge your claim; or
- if you feel the enhancements are less favourable, your claim will be assessed against the terms of the plan which applied to you before the upgrade occurred.

Enhancements will not apply to current claims or to any claims resulting from an event, illness or injury that occurred before the enhancement came into effect.

Medical Advancements

You know just how fast medical advancements occur. To ensure your Trauma Cover and Children's Cover remain relevant and up-to-date with these enhancements, we will consider these when assessing any claim so long as your condition is diagnosed to the same severity as described below.

For Trauma Cover and Children's Cover , if due to medical advancements, the medical diagnostic techniques and investigations used in our medical definitions have been superseded, are inconclusive or impractical to apply, we will consider other medically recognised methods or tests that conclusively diagnose the condition to at least the same severity.

The following requirements must be met for a claim to be considered under new or alternative diagnostic techniques and/or investigations:

- they are not experimental and are medically necessary and medically equivalent or superior to the diagnostic technique or investigation referenced in the medical definition, and
- they must be deemed medically acceptable based on medical standards and medically recognised in Australia by specialist medical practitioners.

Cover Indexation

To ensure your cover remains as valuable to you tomorrow as it does today, it will automatically increase each year in line with the *Consumer Price Index (CPI)*. You have the option of declining this increase each year before it occurs.

Your *sum insured* and/or *monthly sum insured* (as applicable) will be automatically increased each year in line with the *CPI*. This feature helps to protect your cover against the effects of inflation.

Each year, you will be given the opportunity to decline the increase. If you do not want the automatic indexation increase to apply for the 12 month period of your cover, you must tell us no later than 1 month after the plan anniversary.

If you do not decline the increase by informing us within the required timeframe, your *sum insured* and/or *monthly sum insured* will increase and your premium will increase accordingly.

If you hold TPD Cover Super and TPD Cover Super Linked, or you hold Income Protection Super and Income Protection Super Linked, in each case your choice to accept or decline indexation will apply to both plans (see 'Super Splitting Option' on page 15 for further details).

Any premium loadings, exclusions or special terms applicable to your cover will also apply to increases made under this feature.

The Cover Indexation feature will not apply if you have purchased the Future Needs Guarantee (Business) Option which is available with Avant's Life Cover and with Avant's TPD Cover.

Future Needs Guarantee

You cover has been designed to grow with you as your personal life, medical career and financial position changes. With Avant's Life, TPD, and Trauma covers if, for example, you become a parent, take out a mortgage, or start a private practice you may have a need for additional cover. Similarly, with Income Protection Cover, if your income grows; or with Practice Expense Cover, if your share of eligible practice expenses increases. To make applying for increases as straightforward and easy as possible, we will allow you to increase your *sum insured* by up to a certain amount each year without the need to provide updated medical information for assessment.

Life Cover, TPD Cover, and Trauma Cover

The Future Needs Guarantee allows you to increase your *sum insured* for Life Cover, TPD Cover and/or Trauma Cover, after certain personal or professional events occur, without the need to provide updated medical information or details about your pastimes or occupation.

This feature is available once per year until your plan *anniversary date* after you turn 55. You will need to make your request in writing no later than 30 days after the next plan *anniversary date* following the personal or professional event having occurred.

You may increase your cover by the lesser of $500,000 and the maximum yearly increase amount, after one of the following events:

Personal events	**Maximum yearly increase** (up to $500,000)
You are married, register a de facto relationship or enter into a de facto agreement	25% of the *sum insured* at the date you were last fully underwritten.
You or your *partner* give birth or legally adopt a child.	
Your first dependent child starts high school.	
You take out or increase your mortgage for your primary place of residence (excludes refinancing or redrawing)	The lesser of: · 25% of the *sum insured* at the date you were last fully underwritten · The amount of the new mortgage or increase to your mortgage (as applicable).

Professional events	**Maximum yearly increase** (up to $500,000)
You are admitted into a specialty training program	25% of the *sum insured* at the date the you were last fully underwritten.
You qualify as a Fellow of your specialty.	
You become a *partner* or associate of your medical practice.	
You start a private practice.	The lesser of: · 25% of the *sum insured* at the date you were last fully underwritten · the value of your ownership, or increased ownership, in the practice (as applicable).
You increase your ownership in a practice in which you work.	

The increase amount will be in addition to any increase that is the result of Cover Indexation (see page 23) and will be subject to the exclusions listed under 'When a benefit is not payable' for each cover type (as applicable).

The total increase amount available over the life of your plan will be restricted as follows:

- you cannot increase your *sum insured* by an amount that is greater than your *sum insured* at the date you were last fully underwritten;
- increases to TPD which is linked to Life Cover and to linked Trauma Cover which is linked to Life Cover are capped so that the *sum insured* following the increase does not exceed the *sum insured* of the Life Cover plan to which it is linked (and in the case of TPD Cover, the *sum insured* must not exceed $5,000,000); and
- following an increase, your total TPD Cover *sum insured* cannot exceed $5,000,000 less your current *sum insured* and your total Trauma Cover *sum insured* cannot exceed $2,000,000 less your current *sum insured*.

As well, the total increase amount available over the life of your Trauma Cover plan cannot exceed the lesser of:

- the current *sum insured* on a linked Life Cover plan less your current *sum insured* on your Trauma Cover plan; and
- $2,000,000 less your current *sum insured*.

Satisfactory evidence documenting the change to your personal situation or the professional event which gave rise to your increase request will need to be provided to us.

Any premium adjustments, exclusions or special conditions that apply to your Life Cover, TPD Cover or Trauma Cover plan will also apply to any increases made under this feature.

The Future Needs Guarantee is not available:

- with your Life Cover or your TPD Cover if have purchased the Future Needs Guarantee (Business) Option for that cover;

- with cover where you have a premium loading higher than 50%;
- with cover where you have more than one medical exclusion; or
- if you have been paid, are eligible, or about to be eligible, for a claim under your Life Cover, TPD Cover or Trauma Cover (as applicable).

Income Protection Cover and Practice Expense Cover

If your *income* or *share* of eligible practice expenses increases, you can increase your Income Protection or Practice Expense Cover (respectively, as applicable) each year without having to provide further medical information. Changes take effect at the applicable plan *anniversary date*.

You may increase your cover within 30 days after your plan *anniversary date* up until the *anniversary date* immediately after you turn 55. The increase must be justified and supported by satisfactory evidence of your current work, and of your regular income (for Income Protection Cover) or your *share* of eligible business expenses (for Practice Expense Cover) which might include for example your personal tax return (and if relevant, business tax returns) for the prior year.

For **Income Protection Cover**, if you are 20 to 35 years old at the time of applying to exercise the Future Needs Guarantee, the Future Needs Increase available is the lower of:

- 30% of your *monthly sum insured*; and
- the actual increase in your monthly earnings.

If you are 36 to 55 years old, at the time of applying to exercise the Future Needs Guarantee, the Future Needs Increase available is the lower of:

- 15% of your *monthly sum insured*; and
- the actual increase in your monthly earnings.

Monthly sum insured approved at time of application	Maximum yearly increase if you are aged 20 to 35	Maximum yearly increase if you are aged 36 to 55
$15,000 or less	You can increase your *monthly sum insured* each and every year by up to 30% until it reaches $30,000 without the need for any further medical information.	You can increase your *monthly sum insured* each and every year by up to 15% until it reaches $30,000 without the need for any further medical information.
$15,001 to $30,000	You can increase your *monthly sum insured* each and every year by up to 30% until it reaches double your original *monthly sum insured* without the need for any further medical information. E.g. If you started with a *monthly sum insured* of $20,000 you can increase it each year until it reaches $40,000.	You can increase your *monthly sum insured* each and every year by up to 15% until it reaches double your original *monthly sum insured* without the need for any further medical information. E.g. If you started with a *monthly sum insured* of $20,000 you can increase it each year until it reaches $40,000.
$30,001 or more	You can increase your *monthly sum insured* each and every year by up to 30% until it reaches $60,000 without the need for any further medical information.	You can increase your *monthly sum insured* each and every year by up to 15% until it reaches $60,000 without the need for any further medical information.

For **Practice Expense Cover**, the yearly Future Needs Increase available is the lower of 15% of the previous year's *monthly sum insured* and the actual increase in your monthly eligible practice expenses. The cumulative total of all increases under this Future Needs Guarantee must not exceed the higher of:

- the *monthly sum insured* at the date you were last fully underwritten for Practice Expense Cover; and
- $30,000 per month.

This increase in Income Protection Cover or Practice Expense Cover is in addition to any previous increase in cover as a result of Cover Indexation (see 'Cover Indexation' on page 23 for further details).

This feature is not available with Income Protection Cover or Practice Expense Cover if:

- you have a premium loading higher than 50% or you have more than one medical exclusion shown on your *plan schedule*;
- you are eligible, or about to be eligible, for a claim under your Income Protection or Practice Expense Cover; or
- you are no longer *gainfully employed*.

For each of Income Protection Cover and Practice Expense Cover respectively, if you have not applied for an increase under this feature in the previous three years, the maximum increase you can apply for under the Future Needs Guarantee is $2,000. You may need to provide us with appropriate financial evidence to support your nominated increase.

Other increases or decreases – Life, TPD, Trauma and Income Protection covers

It is possible to apply for a higher increase to your cover or a decrease, at any time. However, if you choose to increase your cover, we may request that you provide updated medical information. Increases to your cover are limited so the new increased *sum insured* or *monthly sum insured* does not exceed the maximum *sum insured* or *monthly sum insured* allowed for each cover type.

Future Needs Guarantee (Business) Option – available with Life and TPD covers

Many doctors are either self-employed or partners in a practice and choose to help protect their business with Life Cover and/or TPD Cover. Purchasing the Future Needs Guarantee (Business) Option allows you to increase your sum insured each year upon the occurrence of certain business events without having to provide medical evidence or information about pastimes and occupation for assessment.

The Future Needs Guarantee (Business) option allows you to increase your *sum insured* for Life Cover and/or TPD Cover, after a business- related event occurs, without the need to provide updated medical information or details about pastimes or occupation.

This feature is provided as an additional option with Life Cover and/or TPD Cover and if chosen, an additional charge will apply.

Under this feature, you may request an increase to your cover once per year until the cover *anniversary date* after you turn 70 for your Life Cover or 55 for your TPD Cover, provided an event listed in the below table has occurred and that event is consistent with your original reason for applying. For example, if your purpose for purchasing Life Cover was to provide a buy-sell arrangement should your business *partner* die, then the reason or business event for increasing your *sum insured* could be an increase in the value of your business. Increase requests will need to be made in writing no later than 30 days after the next plan *anniversary date* following the business event having occurred.

Your Life Cover and/or TPD Cover *sum insured* can be increased up to the maximum yearly increase amount according to the specific business event that occurred:

Business events	Maximum benefit increase
The value of your practice increases, and the original intent of your plan/s was to support a business purpose such as a buy-sell arrangement, a share purchase agreement or a business succession agreement.	The increase relating to this approved business event/ purpose using the same methodology as was used to determine your original *sum insured*.
The value of a *key person* to your practice increases and the *key person* is the insured person under your plan/s.	
A business loan is increased and the person fully or partially responsible for its repayment is the insured person under your plan/s.	
Any other business event approved by us.	

The increase amount will be subject to the exclusions listed under 'When a benefit is not payable' (see pages 57 and 62). Any premium adjustments, exclusions or special conditions that apply to your Life Cover and/or TPD Cover will also apply to any increases made under this option.

For Life Cover, the total increase amount available over the life of your plan is three times your *sum insured* on the date you were last fully underwritten.

If you also hold TPD – Linked to Life Cover, you cannot increase your TPD – Linked to Life Cover *sum insured* to an amount higher than your Life Cover *sum insured* or to an amount greater than $5,000,000 (whichever is less).

If you also hold TPD – Standalone Cover, you cannot increase your TPD – Standalone Cover *sum insured* to an amount greater than $5,000,000.

The combined *sum insured* of your TPD – Standalone Cover and TPD – Linked to Life Cover cannot exceed $5,000,000.

Satisfactory evidence documenting the business event that gave rise to your increase request will need to be provided to us.

The Future Needs Guarantee (Business) Option is not available if:

- it isn't listed on your *plan schedule*;
- you have a premium loading higher than 50%;
- you have more than one medical exclusion; or
- you have been paid, are eligible, or about to be eligible, for a claim under your Life Cover, TPD Cover or Trauma Cover.

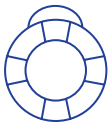
Overview of Lump Sum Products

Life Cover

TPD Cover

Trauma Cover

Children's Cover



Life Cover

Whether you have chosen Life Cover to protect your family, or to protect against the death of a partner or *key person* in your practice, you can have peace of mind knowing that a lump sum payment will be available should the worst happen.

Death Benefit

Provides a lump sum payment equal to the Life Cover *sum insured* if the insured person dies. These funds can be used for a variety of purposes such as paying down debt, covering lost income, or allowing the purchase of a deceased business partner's share of your medical practice.

Advanced Payment Benefit

Provides a payout of up to $25,000 as soon as possible, while the full claim is being processed. It's designed to assist with the immediate expenses that are incurred upon the insured person's death such as burial costs, legal fees and family travel expenses.

Terminal Illness Benefit

Provides an advanced payment of the Life Cover *sum insured* if the insured person is diagnosed with a *terminal illness*. These funds will help ensure you can continue providing for yourself and your family and that the insured person continues to receive the care they need.

See fuller details of Avant's Life Cover on pages 31 to 33 of this PDS.

TPD Cover

You've studied for many years to enable you to practise in your specialty so it's important to know that if an illness or injury impacts your ability to work, your cover will be there to support you.

As Avant's TPD Cover has been specifically designed for doctors, we offer definitions that mean if you are no longer able to work in your *own occupation*, including your chosen that you're working in at the time of the illness or injury, and you meet the terms of TPD Cover, the TPD Benefit will be paid, regardless of whether you can continue working as a medical professional in some other limited capacity.

Total and Permanent Disablement Benefit (TPD Benefit)

The TPD benefit will provide a lump sum payment equal to the TPD Cover *sum insured* if, as a result of illness or injury, you, a *key person* in your practice or practice partner (whoever is the insured person) are unable to work again or suffer from an *occupationally disabling condition*.

Partial and Permanent Disablement Benefit (PPD Benefit)

While the loss of a limb or eye may not automatically qualify for payment of a TPD Benefit, we recognise the impact such an event can have. For these scenarios, the PPD Benefit may provide a lump sum payment of up to $500,000, made as an advance payment of a portion of your full TPD Benefit.

Occupational HIV or Hepatitis Benefit

The Occupational HIV or Hepatitis Benefit provides a lump sum payment equal to the TPD Cover *sum insured* in the event of a workplace *accident* during the course of the insured person's *regular occupation* that results in them contracting HIV, hepatitis B or hepatitis C.

See fuller details of Avant's TPD Cover on pages 34 to 36 of this PDS.

Trauma Cover

When you suffer a major health trauma such as *Stroke – resulting in neurological deficit* or *Heart attack– of specified severity*, more than your health is impacted. Apart from taking time off work to recover, you may need to make home modifications or lifestyle adjustments.

Furthermore, as a doctor, you know that some medical treatments are not covered by Medicare, health insurance or are not currently available in Australia and therefore can result in significant out-of-pocket expenses. In the event of the unexpected, Trauma Cover provides you and your family with a measure of financial security, so you can focus on getting better.

Trauma Benefit

Trauma Cover will provide you a lump sum payment equal to your full Trauma Cover *sum insured* to help cover the unexpected costs that arise when you suffer from one of the listed trauma events covered.

Partial Trauma Benefit

Not all serious illnesses or injuries are the same. However, we recognise that as a result of illness or injury there may still be a need to take time off work, make lifestyle adjustments and pay for unplanned medical treatment costs. The Partial Trauma Benefit provides you with a benefit payment of up to 25% of your Trauma Cover *sum insured* for the trauma events listed as 'partial benefit' in the Trauma Events table on pages 38 and 39. This Partial Trauma Benefit is made as an advance payment of a portion of your Trauma Benefit.

See fuller details of Avant's Trauma Cover on pages 37 to 40 of this PDS.

Children's Cover

If your child suffers a serious illness, injury or major health trauma listed on pages 42 and 43, Avant's Children's Cover will provide you with the financial resources to help ensure you, or a family member, can be there to care for your child whilst still providing financial support for your family.

Children's Support Benefit

When your child is sick, you want to know that you or another family member can be there to care for them while still financially supporting your family. This is why Children's Cover can provide a payment of $5,000 per month if your child is confined to a bed at home or in hospital and an immediate family member stops paid work to care for an insured child (or a non-family adult is paid to care for them).

Children's Trauma Benefit

Similar to the benefits available under Trauma Cover, we will make a lump sum payment to you equal to the Children's Cover *sum insured* should your child be diagnosed with or suffer from a listed major health trauma.

Children's Partial Trauma Benefit

To help cover the costs of your child's illness or injury, we will pay 25% of your Children's Cover *sum insured* if they suffer a one of the less severe partial trauma events. This Children's Partial Trauma Benefit is made as an advance payment of a portion of the Children's Trauma Benefit.

Children's Death and Terminal Illness Benefit

Should your insured child die or be diagnosed with a *terminal illness*, we will provide a lump sum payment of $25,000 to assist with funeral costs, time off work and other expenses (and the Children's Cover will come to an end).

See fuller details of Avant's Children's Cover on pages 41 to 44 of this PDS.

This page contains important information on some of the key features of Life, TPD and/or Trauma Cover and should be read in conjunction with the Life Cover, TPD Cover and Trauma Cover information on the following pages.

Eligibility and Available Sums Insured

To be eligible for Life, TPD, or Trauma Cover the insured person must be a *registered medical practitioner* and an *Australian resident*.

Entry ages of insured persons

Cover type	Minimum entry age	Maximum entry age
Life Cover	20	70 (stepped premium) 60 (level premium*)
TPD Cover	20	60
Trauma Cover	20	60
Children's Cover	2	16

*Please note that level premiums will change to a stepped premium structure from age 65.

Sum insured

Cover type	Minimum sum insured	Maximum sum insured
Life Cover	$50,000	Unlimited
TPD Cover	$50,000	$5,000,000
Trauma Cover	$50,000	$2,000,000
Children's Cover (per child)	$50,000	$200,000

Standalone vs Linked Cover

You can structure your TPD Cover and Trauma Cover in two different ways – Standalone or Linked Cover. The structure you select will affect the premium you pay and what happens to your cover (including the relevant *sum insured*) in the event of a claim. The more plans your cover is linked to, the lower your premiums will be.

Standalone Cover

If you purchase Standalone Cover, any claim that becomes payable under the cover will not impact any other cover types held under this PDS. The Standalone Covers available under an Avant Life Insurance plan are:

- Life – Standalone Cover
- TPD – Standalone Cover
- Trauma – Standalone Cover

Linked Cover

If you purchase Linked Cover, any claim that becomes payable under these covers will reduce the *sum insured* of any Avant Life Insurance plans that are linked to that cover. If we reduce your sum insured, your premiums will also be reduced. If your *sum insured* has been reduced to nil, then no premiums will be payable.

If Linked Covers are split within and outside superannuation, where there is a reduction in your *sum insured*, the reduction will reduce both covers by an equivalent amount.

The Linked Covers available under an Avant Life Insurance plan are:

TPD – Linked to Life Cover only

If your TPD Cover plan is linked to Life Cover, any claim that becomes payable under your TPD Cover will reduce the *sum insured* on your Life Cover by the amount of the claim payment.

Any claim that becomes payable under the Terminal Illness Benefit will also reduce the TPD Cover *sum insured* by the amount of the claim.

Trauma – Linked to Life Cover only

If your Trauma Cover plan is linked to Life Cover, any claim that becomes payable under your Trauma Cover will reduce the *sum insured* on your Life Cover by the amount of the claim payment.

Any claim that becomes payable under the Terminal Illness Benefit will reduce the Trauma Cover *sum insured* by the amount of the claim.

Trauma – Linked to Life Cover and TPD Cover

If your Trauma Cover plan is linked to Life Cover and TPD Cover, any claim that becomes payable under your Trauma Cover will reduce the *sum insured* on both your Life Cover and TPD Cover plans by the amount of the benefit payment.

Any claim that becomes payable on the linked TPD Cover will also result in a reduction to the linked Trauma Cover *sum insured* and Life Cover *sum insured* by the amount of the claim payment.

Any claim that becomes payable under the Terminal Illness Benefit will reduce both the linked Trauma Cover *sum insured* and TPD Cover *sum insured* by the amount of the payment.

Life Cover

Death Benefit

If the insured person dies while cover is in force under this plan, we will make a lump sum payment to the plan owner, nominated beneficiary/ies or the insured person's estate. The payment or Death Benefit will be equal to the amount you have chosen to insure under this plan together with any adjustments described in the PDS such as Cover Indexation (your Life Cover *sum insured*).

In the instance where multiple beneficiaries are named, the Death Benefit amount will be split according to the percentage allocation you have specified.

Advanced Payment Benefit

To help cover the immediate costs of death, this benefit will provide a portion of the Death Benefit as an advance payment to the plan owner, nominated beneficiary/ies or the insured person's estate. The amount payable will be the lesser of your Life Cover *sum insured* as at the date of death and $25,000. The Death Benefit will be reduced by the amount paid under this benefit.

This benefit will be paid upon receipt of a certified copy of the death certificate or satisfactory evidence of death, except where there is reasonable doubt over whether an exclusion applies or whether the Death Benefit will be payable.

In the instance where multiple beneficiaries are named, the Advanced Payment Benefit amount will be split according to the percentage allocation you have specified.

Advanced Payment Benefit claims will not be available if there is reasonable doubt about whether a Death Benefit will be payable.

If the full Death Benefit claim is denied, the Advanced Payment Benefit amount must be repaid to us.

Terminal Illness Benefit

If the insured person becomes *terminally ill* while Life Cover is in place we will make an advance payment of the full Death Benefit to you as plan owner. The amount payable will be your Life Cover *sum insured* as at the date of certification.

If the *Terminal Illness* Benefit is paid, your Life Cover and any linked cover will end and no further benefits will be paid.

Automatic Life Cover Reinstatement feature

Under the Automatic Life Cover Reinstatement feature, we will automatically reinstate any of the Life Cover *sum insured* linked to your:

- TPD Cover that was subsequently reduced as a result of a TPD Benefit or Occupational HIV or Hepatitis Benefit claim payment; and/or
- Trauma Cover that was subsequently reduced as a result of a Trauma Benefit claim payment,

six months after your valid claim form was received or the date your claim was paid, whichever is later. No medical evidence or information on your pastimes or occupation will need to be provided. The Life Cover *sum insured* will be reinstated to the sum insured immediately prior to the claim payment.

Premiums for your reinstated Life Cover will also resume from the reinstatement date. If your original premium was stepped, then your premium for the reinstated cover will be based on your age at reinstatement. Alternatively, if your original premium was level, the same premium will apply (see 'Premium structure' on page 12).

Any exclusions or medical, occupation or pastime loadings that applied to your original Life Cover will also apply to the reinstated cover.

After your Life Cover is reinstated, the Future Needs Guarantee feature, the Future Needs Guarantee (Business) Option, and the Cover Indexation feature will no longer be available for the reinstated portion of your *sum insured*.

If you wish, you may decline to have your cover reinstated; however, you must do so within 30 days of the reinstatement date if any premiums paid are to be refunded.

Cover Reinstatement will not be available if:

- a Partial Trauma Benefit under your linked Trauma Cover has been paid;
- a Partial and Permanent Disablement Benefit under your linked TPD Cover plan has been paid;
- you're about to submit, have submitted or have been paid a *Terminal Illness* Benefit;
- you have previously reinstated in aggregate 100% of your Life Cover *sum insured* under this feature; or
- you die before the reinstatement date.

When a benefit is not payable

Exclusions apply to your Life Cover plan as described in this PDS.

No benefit payment for Life Cover will be made:

- if the event giving rise to the claim is caused by or related to an intentional, self-inflicted act within 13 months of the commencement date, the date of reinstatement, or the date of an increase to your *sum insured* (though only for the amount of the increase);
- if the event giving rise to the claim occurred before the commencement date, reinstatement date, or voluntary increase date (in respect of the amount of the increase only), unless clearly disclosed to and accepted by us; or
- for any specific exclusion outlined on your *plan schedule*.

Claims may not be paid in other circumstances described in this PDS – for example, Advanced Payment Benefit claims will not be paid whilst there is a reasonable doubt about whether the full Death Benefit will be payable (see page 32).

When cover ends

Your Life Cover will end on the earliest of:

- your death;
- your Life Cover *sum insured* is reduced to nil as a result of a benefit payment under a linked plan (and the Automatic Life Cover Reinstatement feature is not available, including where it has previously been activated and is no longer available);
- your signed request to cancel your cover is received by us;
- we cancel your cover due to:
  - non-payment of premiums
  - your failure to comply with the duty of disclosure (as described on page 9), or
  - a fraudulent claim;
- not meeting the eligibility requirements of your cover; and
- any other date applied under a special condition as shown on your *plan schedule*.

TPD Cover

Total and Permanent Disablement Benefit (TPD Benefit)

If the insured person suffers an illness or injury which prevents them from working again in their *own occupation*, they may qualify for a TPD Benefit. The benefit amount will be paid in a lump sum and will be equal to your TPD Cover *sum insured* as at the date the insured person qualifies for the TPD Benefit.

To qualify for a TPD Benefit, we must be satisfied based on all available information, that the insured person is totally and permanently disabled. This means that solely because of illness or injury, the insured person:

1. has been absent from work and unable to work in their *own occupation* for three months and is unlikely to ever work in their *own occupation* again; or
2. has an *occupationally disabling condition*.

Under the first definition, after the initial three-month period, we will assess the insured person's likely ability to ever be able to work again. We will take into account their *own occupation* including their chosen medical specialty. This means you may be eligible for the TPD Benefit if the insured person can't work in their *own occupation*, even if they can work in another medical or unrelated occupation.

Research, study or lecturing in addition to practising medicine (and if ceasing to practice)

If the insured person is undertaking part-time research or university lecturing in addition to continuing to practise medicine, this does not change their eligibility for any of the benefits under their Avant TPD Cover, and in the event of injury or illness they would be assessed based on their ability to perform the duties of their *own occupation* (not perform research or lecture).

Should the insured person cease practising medicine to conduct research for a finite period of time, not exceeding 36 months, in the event of injury or illness they would be assessed based on their ability to perform the duties of their *own occupation* (not perform research) provided they remained qualified to practise their medical specialty.

Should the insured person cease practising medicine to undertake a full-time research or university lecturing role (without a specified end date or for more than 36 months) then in the event of injury or illness they would be assessed based on their ability to perform the duties of the research or university lecturing role.

This certainty of cover based on your *own occupation* would work the same way in the event of other temporary changes such as returning to full-time study for up to 36 months.

Occupationally disabling condition

Under the second definition, an *occupationally disabling condition* will result in an immediate payment without assessment against the definition of *own occupation*. An *occupationally disabling condition* occurs when the insured person suffers:

- *significant permanent impairment;*
- *loss of two limbs – total and irrecoverable;*
- *loss of sight in both eyes – total and irrecoverable;*
- *HIV, Hepatitis B or C – occupationally acquired;*
- *loss of independence - total and irreversible; or*
- *severe cognitive impairment - permanent.*

Partial and Permanent Disablement Benefit (PPD Benefit)

If the insured person suffers:

- *loss of sight in one eye – total and irrecoverable; or*
- *loss of a single limb – total and irrecoverable*

you will be eligible for an advance payment of a portion of your full TPD Benefit.

Benefit amount

Your PPD Benefit will be a lump sum payment which is the lesser of:

- 25% of your TPD Cover sum insured; or
- $500,000.

Following the payment of your PPD Benefit, any TPD Benefit payable under your TPD Cover plan will be reduced by the same amount.

Only one PPD Benefit payment is available during the life of your plan.

Occupational HIV or Hepatitis Benefit

If the insured person is infected with the human immunodeficiency virus (HIV), hepatitis B or C as a result of an *accident* or malicious act during the course of their *regular occupation*, we will make a lump sum payment of your full TPD Cover *sum insured* as long as the following criteria are met:

To be eligible, the virus must have been acquired as a result of:

- an *accident* arising out of the insured person's *regular occupation*; or
- a malicious act of another person, or persons, arising out of the insured person's *regular occupation*.

Proof of a new HIV or hepatitis B or C infection must be registered within six months of the *accident* or malicious act.

Any incident giving rise to a potential claim must:

- be reported to the relevant authority or employer within seven days of the incident;
- be supported by a negative HIV or hepatitis B or C test (as applicable) taken within seven days of the incident; and
- the sero-conversion of the infection must occur within six months of the incident.

Automatic TPD Cover Reinstatement feature

Under the Automatic TPD Cover Reinstatement feature, we will automatically reinstate the TPD Cover *sum insured* linked to your Trauma Cover that was subsequently reduced as a result of a Trauma Benefit claim payment made under Trauma Cover which is linked to your TPD Cover, six months after your valid claim form was received or the date your claim was paid, whichever is later. No medical evidence or information on your pastimes or occupation will need to be provided. The TPD Cover *sum insured* will be reinstated to the *sum insured* immediately prior to the claim payment.

Premiums for your reinstated TPD Cover will also resume from the reinstatement date. If your original premium was stepped, then your premium for the reinstated cover will be based on your age at reinstatement. Alternatively, if your original premium was level, the same premium will apply (see 'Premium structure' on page 12).

Any exclusions or medical, occupation or pastime loadings that applied to your original TPD Cover will also apply to the reinstated cover.

Additionally, you will be unable to claim again under your TPD Cover for the trauma event or any *medically related events* that resulted in your Trauma Cover claim being paid.

After your TPD Cover is reinstated, the Future Needs Guarantee feature, the Future Needs Guarantee (Business) Option, and the Cover Indexation feature will no longer be available for the reinstated portions of your *sum insured*.

If you wish, you may decline to have your cover reinstated; however, you must do so within 30 days of the reinstatement date if any premiums paid are to be refunded.

Cover Reinstatement will not be available if:

- a Partial Trauma Benefit under your linked Trauma Cover has been paid;
- you're about to submit, have submitted or have been paid a Terminal Illness Benefit under a linked Life Cover plan;
- your Trauma Benefit claim was for *loss of independence – total and irreversible* under a linked Trauma Cover plan;
- you have previously reinstated in aggregate 100% of your TPD Cover *sum insured* under this Automatic TPD Cover Reinstatement feature; or
- you die before the reinstatement date.

When a benefit is not payable

Exclusions apply to your TPD Cover plan as described in this PDS.

No benefit payment for TPD Cover will be made:

- if the event giving rise to the claim is caused by or related to an intentional, self-inflicted act;
- if the event giving rise to the claim occurred before the commencement date, reinstatement date, or voluntary increase date (in respect of the increase amount only), unless clearly disclosed to and accepted by us;
- if the event giving rise to a TPD Cover claim is a *medically related event* to that which resulted in a claim under linked Trauma Cover and subsequent reduction and reinstatement of TPD Cover under the Automatic Cover Reinstatement feature; or
- for any specific exclusion outlined on your *plan schedule*.

No benefit will be payable for the Occupational HIV or Hepatitis Benefit in relation to:

- infection arising from any means other than an *accident* or malicious act of another person arising out of the insured person's regular occupation, such as a deliberately, self-inflicted or induced cause, or from sexual activity, or from recreational intravenous drug use; or
- the insured person not undertaking ongoing effective treatment(s) where they exist for HIV, hepatitis B or C which would make these viruses inactive and non-infectious. If the treatment was unable to be continued on medical grounds or the medical treatment was unsuccessful, then this exclusion would not apply.

When cover ends

Your TPD Cover will end on the earliest of:

- the plan *anniversary date* following your 70th birthday;
- your death;
- a full TPD Benefit, or Occupational HIV or Hepatitis Benefit is paid;
- your TPD Cover *sum insured* is reduced to nil as a result of a benefit payment under a linked plan (and the Automatic TPD Cover reinstatement feature is not available, including where it has been previously been activated and is no longer avialable);
- your signed request to cancel your cover is received by us;
- we cancel your cover due to:
  - non-payment of premiums,
  - your failure to comply with the duty of disclosure (as described on page 9), or
  - a fraudulent claim;
- not meeting the eligibility requirements of your cover; and
- any other date applied under a special condition as shown on your *plan schedule*.

Trauma Cover

Trauma Benefit

If you're diagnosed with or suffer one of the trauma events listed as full benefits in the 'Trauma events' table and you survive 14 days from the date of that event, we will pay a lump sum payment to you.

Your Trauma Benefit amount will be equal to your Trauma Cover *sum insured* that applied when the trauma event first occurred.

If you suffer multiple trauma events at the same time, only one Trauma Benefit payment will be made.

Partial Trauma Benefit

If you're diagnosed with or suffer one of the trauma events listed as a partial benefit in the 'Trauma Events' table and you survive 14 days from the date of that event, the Partial Trauma Benefit will be paid as an advance payment of a portion of your Trauma Benefit.

The Partial Trauma Benefit amount is 25% of your Trauma Cover *sum insured* that applied when the trauma event first occurred, up to a maximum of $200,000.

Your Trauma Cover *sum insured*, which is the amount payable in the event of a full Trauma Benefit payment, will be reduced by the Partial Trauma Benefit amount. If you receive payment for multiple Partial Trauma Benefits over the life of your Trauma Cover plan and as a result, your Trauma Cover *sum insured* is reduced below $10,000, we will pay that amount to you in the event of a claim.

If you suffer multiple partial trauma events at the same time, only one Partial Trauma Benefit will be paid. If you also qualify for a Trauma Benefit only the Trauma Benefit will be paid.

The Partial Trauma Benefit is only payable once per listed event. However, there are exceptions. You may claim multiple times for *Angioplasty – through specific procedures* provided these events occurred at least six months apart; and more than one payment is also available for *Carcinoma in situ*, provided it occurs on a different part of the body from the previous claim.

Trauma Events

Cardiac conditions

Full benefit

- *Aortic surgery – excluding less invasive surgeries*
- *Cardiomyopathy/heart failure – resulting in significant permanent impairment*
- *Coronary artery bypass surgery – excluding less invasive procedures**
- *Heart attack – of specified severity**
- *Heart valve surgery – excluding specified procedures*
- *Open heart surgery – through a specified procedure*
- *Pulmonary arterial hypertension (idiopathic and familial) – resulting in significant permanent impairment*

Partial benefit

- *Angioplasty – through specific procedures**
- *Cardiac arrest – out of hospital, excluding medical procedures*

Cancer and tumours

Full benefit

- *Benign brain tumour – resulting in significant impairment*
- *Benign spinal cord tumour – resulting in significant impairment*
- *Blood cancer – excluding specified early stage cancers**
- *Breast cancer – excluding early stage breast cancers**
- *Prostate cancer – excluding early stage prostate cancers**
- *Skin cancer – excluding early stage skin cancers**
- *Other cancers – excluding early stage cancers**

Partial benefit

- *Benign brain tumour (diagnosed) – resulting in neurological deficit*
- *Benign spinal cord tumour (diagnosed) – resulting in neurological deficit*
- *Carcinoma in situ**
- *Lymphocytic leukaemia – early stage**
- *Melanoma – early stage**
- *Prostate cancer – early stage**

Permanent conditions

Full benefit

- *Loss of hearing – total and irrecoverable (except by Cochlear implant) in both ears*
- *Loss of independence – total and irrecoverable*
- *Loss of sight – total and irrecoverable in both eyes*
- *Loss of a single limb – total and irrecoverable*
- *Loss of speech – total and irrecoverable*

Partial benefit

- *Crohn's disease (severe) – requiring permanent medication*
- *Loss of hearing in one ear – total and irrecoverable*
- *Loss of sight in one eye – total and irrecoverable*
- *Ulcerative colitis (severe) – requiring permanent medication*

Organ conditions
Full benefit
• *Chronic lung disease – requiring long-term oxygen therapy* • *Kidney failure – requiring renal dialysis or renal transplantation* • *Liver failure – chronic with specified severity* • *Organ transplant (major) – from another donor* • *Pneumonectomy – removal of entire lung*
Blood conditions
Full benefit
• *Aplastic anaemia – requiring specified treatment* • *Hepatitis B or C – occupationally-acquired* • *HIV – contracted from a medical procedure* • *HIV – occupationally-acquired*
Neurological conditions
Full benefit
• *Alzheimer's disease – permanent and of specified severity* • *Severe cognitive impairment - permanent* • *Dementia (major neurocognitive disorder) – permanent and of specified severity* • *Encephalitis – resulting in significant impairment* • *Major head trauma – resulting in significant permanent impairment* • *Meningitis – resulting in significant impairment* • *Meningococcal disease – resulting in significant impairment* • *Motor neurone disease* • *Multiple sclerosis – with at least two episodes of neurological deficit* • *Muscular dystrophy* • *Paralysis – total and permanent* • *Parkinson's disease* • *Stroke – resulting in neurological deficit**
Partial benefit
• *Brain surgery – requiring craniotomy* • *Coma (impaired consciousness) – of specified severity*
Other events
Full benefit
• *Burns (severe) – covering specified surface area* • *Diabetes (severe) – of specified severity* • *Intensive care – requiring continuous mechanical ventilation for 10 days* • *Rheumatoid arthritis (severe) – of specified severity*
Partial benefit
• *Diabetes (type 1 insulin dependent)**

Notes on Trauma Events table

Please see the 'Medical definitions' section on page 74 for definitions of each of the above conditions.

The conditions marked with an asterisk (*) have a 90-day qualifying period. This means no Trauma Benefit or Partial Trauma Benefit will be paid for these conditions if they occur within the first 90 days of applying for cover, cover reinstatement or increases to your *sum insured* (but only for the increase amount).

If the Trauma Cover is replacing existing trauma cover provided by us or another insurer, the qualifying period will not apply if:

- the existing trauma cover being replaced has been in force for at least 90 days, and all existing qualifying periods on that existing trauma cover have expired;
- the replacement Trauma Cover *sum insured* is for the same as (or a lower *sum insured* than) the existing trauma cover; or if higher, then the 90-day qualifying period remains applicable in respect of the excess *sum insured* over the existing trauma cover;
- the replacement Trauma Cover covers the same (or a subset of the) trauma events as the existing trauma cover;
- the existing trauma cover is cancelled within 7 days of the issue of the replacement Trauma Cover; and
- no claim is payable or pending under the existing trauma cover, and there is no eligibility to make a claim under the existing trauma cover.

When a benefit is not payable

Exclusions apply to your Trauma Cover plan as described in this PDS.

No Trauma Benefit or Partial Trauma Benefit payment will be made under Trauma Cover if:

- the event was subject to a qualifying period and the *trauma date* occurred within that period;
- you have previously received a benefit payment for that trauma event (excluding the exceptions outlined under 'Partial Trauma Benefit' on page 38);
- you have previously received a benefit payment for a trauma event and Trauma Cover has subsequently been reinstated (under the Automatic Trauma Cover Reinstatement feature) and the new trauma event is a *medically related event* to the original trauma event;
- the event giving rise to the claim is caused by or related to an intentional, self-inflicted act;
- the event giving rise to the claim occurred before the commencement date, reinstatement date or voluntary increase date (in respect of the increase amount only), unless clearly disclosed to and accepted by us; or
- the event giving rise to the claim was the result of or related to any specific exclusion outlined on your *plan schedule*.

Automatic Trauma Cover Reinstatement feature

Under the Automatic Trauma Cover Reinstatement feature, we will automatically reinstate:

- the Trauma Cover *sum insured* linked to TPD Cover that was subsequently reduced as a result of a TPD Benefit claim payment; and/or
- the Trauma Cover *sum insured* that was subsequently reduced as a result of a Trauma Benefit claim payment,

six consecutive months after your valid claim form was received, or the date your claim was paid, whichever is later. No medical evidence or information on your pastimes or occupation will need to be provided. The Trauma Cover *sum insured* will be reinstated to the *sum insured* immediately prior to the claim payment.

Premiums for your reinstated Trauma Cover will also resume from the reinstatement date. If your original premium was stepped, then your premium for the reinstated plan will be based on your age at reinstatement. Alternatively, if your original premium was level, the same premium which applied at the time of your claim will apply subject to any changes which may be applicable (see 'Premium structure' on page 12 which describes how level premiums may change).

Any exclusions or medical, occupation or pastime loadings that applied to your original Trauma Cover will also apply to the reinstated cover.

Additionally, you will be unable to claim again under your Trauma Cover for the trauma event or any *medically related event* that resulted in your Trauma Cover claim being paid.

After your Trauma Cover is reinstated, the Future Needs Guarantee feature, the Future Needs Guarantee (Business) Option, and the Cover Indexation feature will no longer be available for the reinstated portions of your *sum insured*.

If you wish, you may decline to have your cover reinstated; however, you must do so within 30 days of the reinstatement date if any premiums paid are to be refunded.

Cover Reinstatement will not be available if:

- a Partial Trauma Benefit has been paid;
- a Partial and Permanent Disablement Benefit under your linked TPD Cover plan has been paid;
- you're about to submit, have submitted or have been paid a Terminal Illness Benefit under a linked Life Cover plan;
- your Trauma Benefit claim was for *loss of independence – total and irreversible*;
- you have previously reinstated in aggregate 100% of your Trauma Cover *sum insured* under this Automatic Trauma Cover Reinstatement feature; or
- you die before the reinstatement date.

When cover ends

Your Trauma Cover plan will end on the earliest of:

- the plan *anniversary date* following your 70th birthday;
- your death;
- your Trauma Cover *sum insured* is reduced to nil as a result of a benefit payment under a linked plan (and the Cover Reinstatement feature is not available, including where it has previously been activated and is no longer available);
- your request to cancel your plan is received by us (Note: if your Trauma Cover is linked to Life Cover, choosing to cancel your Life Cover will also cancel your Trauma Cover);
- we cancel your plan due to:
  - non-payment of premiums,
  - your failure to comply with the duty of disclosure (as described on page 9),
  - a fraudulent claim, or
  - not meeting the eligibility requirements of your cover, and;
- any other date applied under a special condition as shown on your *plan schedule*.

Children's Cover

Children's Support Benefit

If an insured child is confined to bed at home or in hospital for a period of at least seven consecutive days and care is required and:

- either an immediate adult family member stops paid work to care for the insured child; or
- a non-family adult is paid to care for the insured child;

we will pay $5,000 for each month, or part thereof, to help financially support the adult upon whom the insured child relies.

The Children's Support Benefit will accrue from the first day the insured child is confined to bed and will continue until the earlier of:

- six consecutive months; or
- the insured child is no longer confined to a bed.

This benefit is paid in addition to any other benefit paid under Children's Cover.

Children's Trauma Benefit

If an insured child is diagnosed with or suffers, one of the events listed as full benefits in the table 'Children's Cover Trauma Events' and they survive 14 days after the date of that event, we will pay the Children's Trauma Benefit to you as a lump sum payment.

The Children's Trauma Benefit amount will be equal to the Children's Cover *sum insured* that applied when the event first occurred.

If your child suffers multiple trauma events at the same time, only one Children's Trauma Benefit payment will be made.

Children's Partial Trauma Benefit

If your child is diagnosed with or suffers one of the 13 trauma events listed as partial benefits in the table 'Children's Cover Trauma Events' and they survive 14 days after the date of that event, the Children's Partial Trauma Benefit will be paid as an advance payment of a portion of your Children's Trauma Benefit. The Children's Partial Trauma Benefit is 25% of your Children's Cover *sum insured* subject to a minimum of $10,000.

Your Children's Cover *sum insured* will be reduced by the amount of any Children's Partial Trauma Benefit paid. If you receive payment for multiple Children's Partial Trauma Benefits over the life of your Children's Cover plan and as a result, your *sum insured* is reduced below $10,000, we will pay that amount to you in the event of a claim.

If your child suffers multiple partial trauma events at the same time, only one Children's Partial Trauma Benefit will be paid. If your child also qualifies for a Children's Trauma Benefit only the Children's Trauma Benefit will be paid.

The Children's Partial Trauma Benefit is only payable once per listed event. However, there are exceptions. You may claim multiple times for *Angioplasty – through specific procedures* provided these events occurred at least six months apart. More than one payment is also available for *Carcinoma in situ*, provided it occurs on a different part of the body from the previous claim.

Children's Cover Trauma Events

Cardiac conditions

Full benefit

- *Aortic surgery – excluding less invasive surgeries*
- *Cardiomyopathy/heart failure – resulting in significant permanent impairment*
- *Coronary artery bypass surgery – excluding less invasive procedures**
- *Heart attack – of specified severity**
- *Heart valve surgery – excluding specified procedures*
- *Pulmonary arterial hypertension (idiopathic and familial) – resulting in significant permanent impairment*
- *Open heart surgery*

Partial benefit

- *Angioplasty – through specific procedures**
- *Cardiac arrest – out of hospital, excluding medical procedures*

Cancer and tumours

Full benefit

- *Benign brain tumour – resulting in significant impairment*
- *Benign spinal cord tumour – resulting in significant impairment*
- *Blood cancer – excluding specified early stage cancers**
- *Breast cancer – excluding early stage breast cancers**
- *Skin cancer – excluding early stage skin cancers**
- *Other cancers – excluding early stage cancers**

Partial benefit

- *Benign brain tumour (diagnosed) – resulting in neurological deficit*
- *Benign spinal cord tumour (diagnosed) – resulting in neurological deficit*
- *Carcinoma in situ**
- *Lymphocytic leukaemia – early stage**
- *Melanoma – early stage**

Permanent conditions

Full benefit

- *Loss of hearing – total and irrecoverable (except by Cochlear implant) in both ears*
- *Loss of sight – total and irrecoverable in both eyes*
- *Loss of a single limb – total and irrecoverable*
- *Loss of speech – total and irrecoverable*

Partial benefit

- *Crohn's disease (severe) – requiring permanent medication*
- *Loss of hearing in one ear – total and irrecoverable*
- *Loss of sight in one eye – total and irrecoverable*
- *Ulcerative colitis (severe) – requiring permanent medication*

Organ conditions

Full benefit

- *Chronic lung disease – requiring long-term oxygen therapy*
- *Kidney failure – requiring permanent dialysis or transplantation*
- *Liver failure – chronic with specified severity*
- *Organ transplant (major) – from another donor*
- *Pneumonectomy – removal of entire lung*

Blood conditions
Full benefit • *Aplastic anaemia – requiring specified treatment* • *HIV – contracted from a medical procedure*
Neurological conditions
Full benefit • *Severe cognitive impairment - permanent* • *Encephalitis – resulting in significant impairment* • *Major head trauma – resulting in significant permanent impairment* • *Meningitis – resulting in significant impairment* • *Meningococcal disease – resulting in significant impairment* • *Multiple sclerosis – with at least two episodes of neurological deficit* • *Muscular dystrophy* • *Paralysis – total and permanent* • *Stroke – resulting in neurological deficit**
Partial benefit • *Brain surgery – requiring craniotomy* • *Coma (impaired consciousness) – of specified severity*
Neurological conditions
Full benefit • *Burns (severe) – cover specified surface area* • *Diabetes (severe) – of specified severity* • *Intensive care – requiring continuous mechanical ventilation for 10 days*

Notes on Children's Cover Trauma Events table

Please see the 'Medical definitions' section on page 74 for definitions of each of the above conditions.

The conditions marked with an asterisk (*) have a 90-day qualifying period. This means no Children's Trauma Benefit or Children's Partial Trauma Benefit will be paid for these conditions if they occur within the first 90 days of applying for cover, cover reinstatement or increases to your *sum insured* (but only for the increase amount).

If the Children's Cover is replacing existing children's trauma cover provided by us or another insurer, the qualifying period will not apply if:

- the existing children's trauma cover being replaced has been in force for at least 90 days, and all existing qualifying periods on that existing cover have expired;
- the replacement Children's Cover is for the same as (or a lower *sum insured* than) the existing children's trauma cover; or if higher, then the 90 day qualifying period remains applicable in respect of the excess *sum insured* over the existing children's trauma cover;
- the replacement Children's Cover covers the same (or a subset of the) trauma events as the existing children's trauma cover;
- the existing children's trauma cover is cancelled within 7 days of the issue of the replacement Children's Cover; and
- no claim is payable or pending under the existing children's trauma cover, and there is no eligibility to make a claim under the existing children's trauma cover.

Children's Death and Terminal Illness Benefit

If an insured child dies or is diagnosed with a *terminal illness* while your Children's Cover is in place, we will pay a lump sum benefit of $25,000 to you.

If the benefit is paid upon the diagnosis of a *terminal illness* or in the event of death, your Children's Cover plan will end and no further benefit will be available.

Children's Cover Conversion feature

Within 30 days of the plan *anniversary date* following the insured child's 21st birthday, the insured child may apply in writing for Life Cover with Trauma Cover linked or just Trauma – Standalone Cover, for the same *sum insured* as their Children's Cover plan.

We will issue the new plan subject to standard plan issue requirements including an assessment of smoker status. However, we will not reassess any other aspects of their health.

The premiums for their new plan will be based on the rates that apply to the type of plan at that time (which may depend on factors including smoker status). Any exclusions or loadings that applied to the original Children's Cover may also apply to their new plan.

Conversion is only available if we have not paid a benefit under the Children's Cover for the insured child.

When a benefit is not payable

Exclusions apply to your Children's Cover plan as described in this PDS.

No Children's Trauma or Children's Partial Trauma payment will be made under Children's Cover if:

- the event was subject to a qualifying period and the *trauma date* occurred within that period;
- the event giving rise to the claim is caused by a congenital condition that was present at or before the birth of the insured child;
- a benefit payment for the same trauma event has already been paid (excluding the exceptions outlined under 'Children's Partial Trauma Benefit' on page 42);
- the event giving rise to the claim occurred before the commencement date, reinstatement date or voluntary increase date (in respect of the increase amount only), unless clearly disclosed to and accepted by us;
- the event giving rise to the claim is caused by or related to an intentional, self-inflicted act;
- the event giving rise to the claim is an inflicted act or omission by the plan owner, parent, or guardian of the insured child; or
- the event giving rise to the claim was the result of or related to any specific exclusion outlined on the *plan schedule*.

No Children's Death or Terminal Illness Benefit payment will be made under Children's Cover if:

- the event giving rise to the claim is caused by or related to a congenital condition that was present at or before the birth of the insured child
- the event giving rise to the claim is caused by or related to an intentional, self-inflicted act within 13 consecutive months of the commencement date, the date of any reinstatement or the date of any accepted increase in *sum insured*, though only for the increase amount;
- the event giving rise to the claim occurred before the commencement date, reinstatement date or voluntary increase date (in respect of the increase amount only), unless clearly disclosed to and accepted by us;
- the event giving rise to the claim is an inflicted act or omission by the plan owner, parent, or guardian of the insured child; or
- the event giving rise to the claim was the result of or related to any specific exclusion outlined on the *plan schedule*.

When cover ends

Your Children's Cover plan will end on the earliest of:

- the cancellation of the Avant Life Insurance plan which your Children's Cover plan is attached to;
- the death of the insured child;
- the plan *anniversary date* following the 21st birthday of the insured child;
- the death of the plan owner;
- the *sum insured* is reduced to nil as a result of a benefit payment;
- your request to cancel your plan is received by us;
- we cancel your plan due to:
  - non-payment of premiums,
  - your failure to comply with the duty of disclosure (as described on page 9), or
  - a fraudulent claim; or
  - not meeting the eligibility requirements of your cover; and
- any other date applied under a special condition as shown on your *plan schedule*.

Overview of Income Products

Income Protection Cover

Practice Expense Cover

Income Protection Cover

In the event of illness or injury, Avant Income Protection Cover ensures you have a financial safety net of up to 75% of your *regular income*, plus up to a further 10% to reimburse you for superannuation contributions you make while on claim.

Income Replacement Benefit

A *monthly benefit* that replaces up to 75% of your lost income if you are unable to work due to an illness or injury so that you can continue to meet ongoing expenses and support you and your family while you recover.

Limited Capacity to Work Benefit

A *monthly benefit* that tops up your income if you are unable to work at full capacity due to an illness or injury so that you can continue to meet ongoing expenses and support you and your family while you recover.

Superannuation Reimbursement Benefit

Reimburses you for monthly contributions you make into a superannuation fund while you are receiving a *monthly benefit* to minimise the impact that your illness or injury has on your retirement nest egg.

For each of the Income Replacement Benefit, Limited Capacity to Work Benefit and Superannuation Reimbursement Benefit, after the end of the *waiting period*, payments continue whilst you are unable to work at full capacity, up until the end of your *benefit period*.

Daily Hospital Benefit

Pays $1,000 per day for up to 90 days while you are unable to work and confined to a hospital bed for 3 or more consecutive days. It assists with the loss of income and the additional costs associated with a hospital stay such as day care arrangements for your children, additional travel costs, or even the cost of boarding a pet.

Rehabilitation Benefit

Reimburses you, up to 100% of your *monthly sum insured* for a period of up to 12 months, for any workplace modifications, rehabilitation programs and/or other approved expenses which are not covered by Medicare or private health insurance to assist you to return to full time work as soon as possible.

Death Benefit

A lump sum payment equal to three times your *monthly sum insured* (up to a maximum lump sum of $40,000), on your death to assist your family with those immediate costs that continue even after death such as utilities, mortgage and other bills.

Litigation Support Benefit (Avant members only)

A monthly payment of up to 50% of your income if it is impacted by a medico-legal claim for which Avant is providing you representation, to lessen possible financial strain during this difficult period.

Practice Expense Cover

Avant Practice Expense Cover provides reimbursement of eligible fixed ongoing expenses to assist with your practice continuing to meet its obligations if you are prevented from working due to illness or injury, and means that you can have a practice to return to once you recover. For practice owners, it can be an important accompaniment to Income Protection which only covers net income (i.e. gross billings less expenses).

Practice Expense Reimbursement Benefit

A *monthly reimbursement* of eligible expenses or your *share* of those expenses, if you are unable to work due to an illness or injury so that you can continue to meet your practice's fixed financial commitments such as rent, electricity, and staff salaries, while you recover.

Partial Reimbursement Benefit

A *monthly reimbursement* of a portion of eligible expenses or your *share* of those expenses, if you are unable to work a full capacity due to an illness or injury so that you can continue to meet your practice's fixed financial commitments such as rent, electricity, and staff salaries, while you recover to full income producing capacity.

Lease Extension Benefit

Keeping your place of business, and the local client base you have built, can be integral to your medical practice's future success. To help you achieve this, we will reimburse your lease costs if you cannot work to your full capacity after all other benefits under Practice Expense Cover have been paid for up to another 18 months.

These pages 48 to 51 contain important information on some of the key features of Income Protection Cover and/or Practice Expense Cover (as described on these pages). Please read them in conjunction with the Income Protection Cover and Practice Expense Cover information on the following pages.

Eligibility

Entry ages

Cover type	Minimum entry age	Maximum entry age
Income Protection Cover	20	55 (for a to age 60 *benefit period*) 60 (for all other *benefit periods*)
Practice Expense Cover	20	60

Sum insured

Cover type	Minimum monthly sum insured	Maximum monthly sum insured
Income Protection Cover	Nil	75% of your monthly income up to $60,000 (cover in excess of $30,000 is subject to a 2 year *benefit period*)
Practice Expense Cover	$2,500	$60,000

Occupation requirements

Cover type	Requirement
Income Protection Cover	*Gainfully employed* for at least 20 hours per week as a *registered medical practitioner.*
Practice Expense Cover	*Gainfully employed* for at least 20 hours per week as a *registered medical practitioner,* and either: self employed, or a medical practice owner or part-owner of a medical practice.

Monthly sum insured

Your *monthly sum insured* is used to determine the *monthly benefit* for your Income Protection Cover Income Replacement Benefit and the *monthly reimbursement* for your Practice Expense Cover Practice Expense Reimbursement Benefit if illness or injury prevents you from working in your chosen medical specialty. You can choose a *monthly sum insured* that best fits your needs or that you can afford, within specified limits.

Income Protection Cover

Your annual income	Maximum monthly sum insured
Up to $320,000	75% of your monthly income
Between $320,000 and $560,000	$20,000 per month + 50% of your monthly income above $320,000p.a.
Between $560,000 and up to $2,200,000	$30,000 per month + 20% of your monthly income above $560,000p.a.
Above $2,200,000	$60,000 per month

You can select any *monthly sum insured* up to the limits in the following table:
For the purposes of calculating your *monthly sum insured*, you cannot insure income that is not derived from your personal exertion or activities, such as interest, dividend payments or rental income.

The maximum *monthly sum insured* available including the Superannuation Reimbursement Benefit is $60,000.

For sole practitioners, partners and contractors

For the purposes of calculating your annual income, you can include all income derived from your personal exertion less your share of eligible business expenses necessarily incurred in generating that income. When assessing your income there are some expenses we do not need to include. These expenses can be added back to increase the amount that you can insure. While some practices may have complex structures in place, the following is provided as a guide to assist you to calculate your insurable annual income.

Net income before tax
Gross Billings
Less expenses

+

Your "add backs"
Salary/wage paid to yourself
Directors fees paid to yourself
Superannuation paid to yourself
Motor vehicle expenses (portion related to personal use only)
Depreciation

If your spouse is employed in your business primarily for income splitting or taxation purposes, you may select a *monthly sum insured* based on the income you actually generated including the benefits paid to your spouse.

For employees

For the purposes of calculating your annual income, this is your total remuneration package and includes salary, regular overtime, superannuation contributions and any other fringe benefits or compensation.

Protection for your retirement

You can increase your *monthly sum insured* by up to an additional 10% of your *regular income*, to a maximum benefit of $2,667 per month, to reimburse you for superannuation contributions made by you while on claim for the Income Replacement Benefit or Limited Capacity to Work Benefit.

Benefit type

Avant Income Protection provides an indemnity type of benefit. This means your *monthly sum insured* will be assessed when you make a claim to ensure it does not provide a benefit more than your *pre-disability income*. This may result in you being paid less than your *monthly sum insured* if your *regular income* has dropped since your plan commenced and you have not requested we alter the *monthly sum insured* accordingly.

Practice Expense Cover

You can select a *monthly sum insured* to cover your portion of your servicing and/or practising company's eligible practice expenses. Eligible practice expenses include:

- all lease, loan and rent expenses
- the salaries and associated costs of all non-income producing employees including *relatives* (provided your *relatives* have been employed for more than six consecutive months)
- business loan principal repayments
- all other regular expenses.

You can also choose to cover the net costs of a locum (a person sourced externally to your practice who is a direct replacement for you). The 'net cost of a locum' arises when the gross sales, income or billings generated by the locum, are less than the total fees incurred with hiring that locum.

A more detailed list of eligible practice expenses can be found on page 61 under 'Eligible practice expenses'.

The maximum *monthly sum insured* you can choose from is the lower of $60,000 and your *share* of eligible practice expenses.

Waiting period

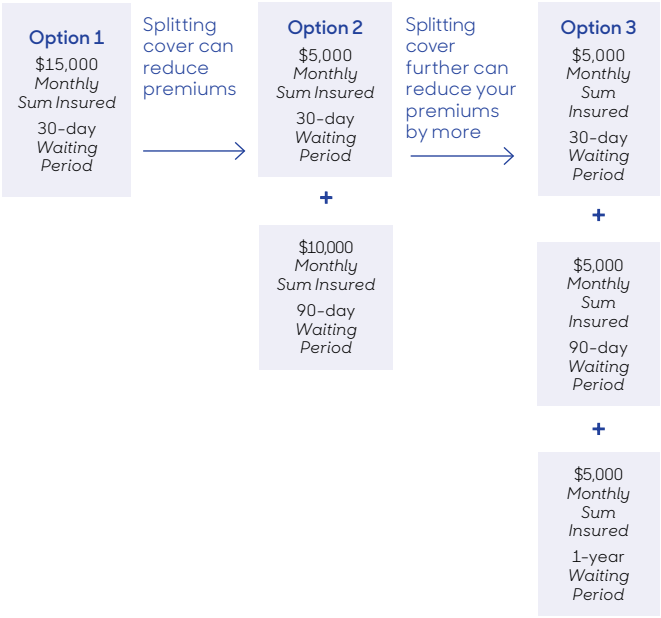
Your *waiting period* is the time between when you are first unable to work at full capacity and when your benefit payments will commence.

For Income Protection Cover you have the following options:

- 30, 60, 90 or 180 days
- 1 or 2 years

For Practice Expense Cover you may select 30 days or 90 days.

With Income Protection Cover, if your need for a replacement income is different in the event of a short-term illness or injury compared to a one that is long term, you may also want to consider splitting your *monthly sum insured* across two or more *waiting periods*. By doing this, you can reduce your premium when compared to having your full *monthly sum insured* at a shorter *waiting period* as outlined by the following Income Protection example. By selecting *waiting periods* that align with your short, medium and long term needs you can reduce your Income Protection Cover premium.



Recurring illness or injury

If you return to work after receiving an Income Replacement Benefit or Limited Capacity to Work Benefit (under Income Protection Cover), or a Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit (under Practice Expense Cover) and you suffer a relapse of the same or a related illness or injury within 12 consecutive months of your claim ending, we will waive the *waiting period* and treat the relapse as a continuation of your original claim and *benefit period*.

In this instance, under Income Protection Cover we will apply the higher of the *pre-disability income* used for your original claim or your *pre-disability income* at the relapse date, when determining your *monthly benefit*.

If the relapse occurs more than 12 months after the date we last paid an Income Replacement Benefit or Limited Capacity to Work Benefit (under Income Protection Cover) or a Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit (under Practice Expense Cover), we will treat it as a new claim and the *waiting period* will start again.

Change of waiting period

If you select a two-year *waiting period* on your Income Protection to complement an existing group income protection or salary continuance policy which has a two-year benefit period, you may later reduce your *waiting period* without the need to supply updated medical information.

You may request this change to your *waiting period* when your existing group income protection or salary continuance policy ceases or is about to cease involuntarily, for a reason other than a claim, and you are not able to continue your cover under a continuation option.

You will need to request the reduction to your *waiting period* in writing within 30 days of your group cover ceasing and to provide evidence of your continued *gainful employment*.

Your premium will be adjusted to reflect the premium rates that apply for the reduced *waiting period*.

Benefit period

Your *benefit period* is the maximum time that your Income Replacement Benefit will be paid following the completion of your *waiting period*.

For Income Protection Cover you may choose 2 years, to age 60, to age 65, or to age 70.

For Practice Expense Cover the *benefit period* is 1 year (although in some cases a benefit may be paid beyond this period – see Payment Extension terms on page 61).

Multiple illnesses or injuries

Even if you've already received an Income Replacement Benefit or Limited Capacity to Work Benefit under your Income Protection Cover, or a Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit under your Practice Expense Cover, you will still be entitled to the same benefits if a new and unrelated illness or injury results in loss of income.

A new *waiting period* and *benefit period* will apply to any unrelated illness or injury that prevents you from working after receiving an Income Replacement Benefit, Limited Capacity to Work Benefit, Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit.

If a new illness or injury occurs for Income Protection Cover:

- within 12 consecutive months of your original *benefit period* ending, your *monthly benefit* and Superannuation Reimbursement Benefit will be determined by applying the higher of the *pre-disability income* used for your original claim and your *pre-disability income* at the relapse date.
- after 12 consecutive months of your original *benefit period* ending, your *monthly benefit* and Superannuation Reimbursement Benefit will be determined by applying your *pre-disability income* at the date of your new illness or injury.

If a new illness or injury occurs for Practice Expense Cover:

- within 12 consecutive months of your original *benefit period*, your *monthly reimbursement* will be determined by applying the higher of the *pre-disability practice income* used for your original claim and your *pre-disability practice income* at the relapse date.
- after 12 consecutive months of your original *benefit period* ending, your *monthly reimbursement* will be determined in accordance with the benefit amount information on page 61.

Cover for Infectious Conditions

Contracting an infectious condition may impact a doctor's ability to work and earn an income even though they may otherwise be fit and healthy. It's important for doctors to have certainty of cover for these conditions and from all forms of contraction; not just needlestick injuries or workplace accidents. Doctors are exposed to infectious conditions involving viruses, bacteria, fungi, and other micro-organisms more often than the public due to the nature of their employment. Many of these conditions are transmitted in rare, isolated events, but they can still have an impact on a doctor's ability to practice if they become infected.

We will consider you injured if you contract an *infection* and you are restricted by AHPRA, the Medical Board of Australia, your hospital credentialing committee or any other medical governing body from performing important and essential duties of your *regular occupation*. You may therefore be eligible under Income Protection Cover for either the Income Replacement Benefit or the Limited Capacity to Work Benefit, or either the Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit under Practice Expense Cover, should you have a reduction in income as a result of the restriction, even if you are physically capable of performing the important and essential duties of your *regular occupation*.

To claim under this feature, at the time of the *infection*, you must have been *gainfully employed* as a medical professional with Income Protection Cover or Practice Expense Cover in force under your plan. However, you do not need to have contracted the *infection* as a result of duties you were performing as part of your occupation.

Also, at the time of *infection*, exposure prone procedures, as defined by AHPRA, the Medical Board of Australia, your hospital credentialing committee or any other medical professional governing body, are at least one of the important and essential duties of your *regular occupation* necessary to produce *regular income*; and due to the *infection*, you are unable to perform exposure prone procedures in accordance with the instructions AHPRA, the Medical Board of Australia, your hospital credentialing committee or any other medical professional governing body.

If we request, we are to be provided with the following in support of a claim:

- evidence of your regular occupation and duties;
- the relevant test results;
- access to test all the blood samples used for any test results; and
- the instruction, notice or other documentation from AHPRA, the Medical Board of Australia, your hospital credentialing committee or any other medical professional governing body that confirms that you cannot continue exposure prone procedures.

Benefits will not be paid with respect to this feature if the *infection* is a result of or related to:

- an event, which in our reasonable opinion, occurred before Income Protection Cover or Practice Expense Cover (as applicable) started;
- an *infection* occurring or a current claim continuing after a cure date in respect of that condition, where cure date means a treatment has been developed and approved on a certain date, which when applied thereafter renders the *infection* inactive, non-infectious and therefore cured, whether or not the insured person has agreed or declined to take that treatment; or
- not taking an approved vaccine prior to the *infection* that was recommended by the relevant authority for use by the insured person in performing their occupation, so as to prevent such an *infection*.

Cover for Elective Surgery

Elective surgery is often necessary to maintain your quality of life, and to enable your continued practise in medicine in your chosen specialty to allow you to earn an income. If you require elective surgery and it leads to a reduction in income, you can rest assured that you will have cover after an initial qualifying period (or from day one, if the elective surgery is required as a result of an *accident*).

If as a result of elective surgery performed:

- on the advice of an *independent medical practitioner*;
- to improve your appearance as a result of an illness or injury; or
- to donate a body organ or bone marrow to someone else,

you will be eligible for either an Income Replacement Benefit or Limited Capacity to Work Benefit under Income Protection Cover, or a Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit under Practice Expense Cover, where the applicable benefit would otherwise have been payable except that your inability to work was due to the surgery, rather than an illness or injury.

Benefits will not be paid for elective surgery if it occurs within a 3 month period of applying for your Income Protection or Practice Expense plan, reinstatement or an increase to your *monthly sum insured* (in this case, you may still be entitled to a *monthly benefit* in the case of Income Protection Cover, or *monthly reimbursement* in the case of Practice Expense Cover; however, it will be calculated using your *monthly sum insured* prior to the increase). Where elective surgery is the result of an *accident* that occurred after your plan commenced or reinstated, these restrictions will not apply.

Income Protection Cover

Income Replacement Benefit

Eligibility

If you suffer an illness or injury while in *usual employment* you may qualify for an Income Replacement Benefit under one of the following three definitions.

1. **Duties-based definition** – solely because of illness or injury, you are:
   - not capable of doing one or more duties that are important and essential to producing income in your *regular occupation*;
   - not working in any *gainful employment*; and
   - under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.
2. **Percentage-based definition** – solely because of illness or injury, you:
   - have suffered a reduction of 80% or more in your ability to generate monthly earnings from your *regular occupation*;
   - are not working in any other *gainful employment*; and
   - are under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.
3. **Hours-based definition** – solely because of illness or injury, you are:
   - unable to work for more than 10 hours per week in your *regular occupation*;
   - not capable of generating more than 20% of your *pre-disability income*;
   - not working in any other *gainful employment*; and
   - under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.

If you suffer an illness or injury while not in *usual employment*, you may qualify for an Income Replacement Benefit under the following definition:

4. **Home duties-based definition** – solely because of illness or injury, you are:
   - unable to perform all *home duties*; and
   - under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.

If you have not been in *usual employment* and have not received an income for 3 consecutive years, your *pre-disability income* will be nil in which case a *monthly benefit* will not be payable.

Benefit amount

Provided you meet one of the above definitions, your *monthly benefit* will be the lower of:

- the *monthly sum insured* shown on your *plan schedule*; and
- a portion of your *regular income* as follows:
  - 75% of your *pre-disability income* up to $26,667 ($320,000 per annum); plus
  - 50% of any *pre-disability income* between $26,667 and $46,667 ($320,000 to $560,000 per annum); plus
  - 20% of any *pre-disability income* greater than $46,667 ($560,000 per annum),

reduced by any payments from other sources (see page 51).

The Income Replacement Benefit will begin to accrue after your selected *waiting period*. We will aim to make your first payment two weeks after the end of the *waiting period*. All other payments will be paid monthly in arrears.

Any part-month Income Replacement Benefit payments will be pro-rated for partial months using 30ths (i.e. on the basis of a deemed 30 days in a month).

Should an illness or injury result in payment of the Income Replacement Benefit, or Limited Capacity to Work Benefit, for more than two years, future *monthly benefit* payments and Superannuation Reimbursements combined for that illness or injury will be capped at $30,000 per month plus any increases as a result of Cover Indexation.

When benefit payments cease

The payment of an Income Replacement Benefit will continue until the earliest of:

- you ceasing to be eligible to receive an Income Replacement Benefit;
- you becoming eligible to receive a Limited Capacity to Work Benefit;
- the expiry of the *benefit period*;
- the plan *anniversary date* following your 60th, 65th or 70th birthday depending on the *benefit period* you choose;
- the termination or end of your Income Protection Plan; and
- your death.

Limited Capacity to Work Benefit

Eligibility

If you suffer an illness or injury while in *usual employment* you may qualify for a Limited Capacity to Work Benefit if, solely because of the illness or injury, you:

- are working in your *regular occupation* in a reduced capacity, or in any other occupation;
- are under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury; and
- have suffered a reduction of 20% or more in the ability to:
  - generate a *regular income*;
  - perform the *regular income*-producing duties; or
  - maintain the same number of hours worked,

  in your *regular occupation*.

Benefit amount

Provided you meet the above definition, your *monthly benefit* will be:

$$\frac{\text{Pre-disability income minus post-disability income}}{\text{Pre-disability income}} \times \text{the monthly amount we would pay if you were claiming an Income Replacement Benefit}$$

The Limited Capacity to Work Benefit will begin to accrue after your selected *waiting period*. We will aim to make your first payment two weeks after the end of the *waiting period*. All other payments will be paid monthly in arrears.

Any part-month Limited Capacity to Work Benefit payments will be pro-rated for partial months using 30ths (ie. on the basis of a deemed 30 days in a month).

If you eligible for a Limited Capacity to Work Benefit and you are not working to your full capacity as a result of causes other than your illness or injury, your *monthly benefit* will be calculated based on what you could reasonably be expected to earn if you were working to the extent of your full capacity.

Should you be on a claim for longer than two years (for the same or related illness or injury), then your *monthly benefit* and Superannuation Reimbursement Benefit combined will be capped at $30,000 a month plus any increases as a result of Cover Indexation.

When benefit payments cease

The payment of a Limited Capacity to Work Benefit will continue until the earliest of:

- you ceasing to be eligible to receive a Limited Capacity to Work Benefit;
- you becoming eligible to receive an Income Replacement Benefit;
- the expiry of the *benefit period*;
- the plan *anniversary date* following your 60th, 65th or 70th birthday depending on the *benefit period* you choose;
- the termination or end of your Income Protection Plan; and
- your death.

Superannuation Reimbursement Benefit

Eligibility

If you are receiving an Income Replacement Benefit or a Limited Capacity to Work Benefit then you may also qualify for a Superannuation Reimbursement Benefit during the same period provided:

- your *monthly benefit* as calculated for an Income Replacement Benefit is lower than your *monthly sum insured* shown on your *plan schedule*; and
- you are contributing to your superannuation while you are eligible to receive an Income Replacement Benefit or Limited Capacity to Work Benefit.

Benefit amount

Provided you meet the above eligibility requirements, your monthly Superannuation Reimbursement Benefit will be the lower of:

- 10% of your *pre-disability income*;
- the monthly superannuation contributions paid by you while you are eligible to receive an Income Replacement Benefit or Limited Capacity to Work Benefit;
- your *monthly sum insured* as shown on your *plan schedule* less the *monthly benefit* we would pay if you were claiming an Income Replacement Benefit;
- your *monthly sum insured* as shown on your *plan schedule* less the *monthly benefit* we would pay if you were claiming a Limited Capacity to Work Benefit; and
- $ 2,667.

If no superannuation contributions are satisfactorily evidenced or made for some or all of the claim duration, then the Superannuation Reimbursement will not apply for that period.

Should an illness or injury result in payment of the Income Replacement Benefit or Limited Capacity to Work Benefit for more than two years, future *monthly benefit* payments and Superannuation Reimbursements combined for that illness or injury will be capped at $30,000 per month plus any increases as a result of Cover Indexation.

Daily Hospital Benefit

Eligibility

If you're unable to work and require bed rest within a hospital for at least three consecutive days, you may qualify for the Daily Hospital Benefit.

Benefit amount

The Daily Hospital Benefit payment is $1,000 per day, for each day you require bed rest within a hospital, for a period up to 90 days.
It is paid monthly in arrears and will be accrued from the first day of bed rest.

This benefit is paid in addition to any other benefit you receive under your Income Protection plan.

Rehabilitation Benefit

Eligibility

If we are paying you an Income Replacement Benefit or Limited Capacity to Work Benefit and you participate in a rehabilitation program, make workplace modifications or incur rehabilitation costs so you can return to work in your full capacity, we may reimburse these costs to you.

We must agree in writing before you commence a rehabilitation program, purchase any equipment or incur other costs associated with your rehabilitation. Only expenses that will not be reimbursed by another source, such as Medicare or private health, will be approved.

We will act reasonably in providing approval and will provide approval within 5 business days, as long as we are provided with such evidence we reasonably require to verify the claimed expenses.

We will not pay for any expense to the extent that such payment is prohibited by health insurance laws. Generally, this includes expenses which are typically covered by Medicare or by health insurance. We are unable to meet expenses which are regulated under the *Private Health Insurance Act 2007 (Cth)* or the *National Health Act 1953 (Cth)*.

Any rehabilitation costs you seek reimbursement for should be recommended by an independent tertiary qualified vocational or rehabilitation specialist.

Benefit amount

The Rehabilitation Benefit provides a payment of up to 100% of your *monthly sum insured* for approved rehabilitation and/or retraining programs. Payment is made monthly in arrears, for up to a maximum of 12 months over the life of your Income Protection plan.

In addition, the Rehabilitation Benefit can be used to cover the cost of any approved additional out-of-pocket expenses related to your rehabilitation (for example, travel costs and workplace or home modifications).

This benefit is paid in addition to any other benefit you receive under your Income Protection plan.

Death Benefit

Eligibility

If you die while this plan is in place, we will make a lump sum payment to the plan owner or your estate.

Benefit amount

The Death Benefit payment will be equal to three times your *monthly sum insured* up to a maximum of $40,000.

Litigation Support Benefit (benefit for Avant members only)

The Litigation Support Benefit is only available to *medical practitioners* who are voting members of Avant Mutual and insured by Avant under a **Practitioner Indemnity Insurance Policy** (PIIP) or Intern Indemnity Insurance Policy (IIIP).

Avant Insurance Limited ABN 82 003 707 471 (AFSL No. 238765) is the insurer of the Litigation Support Benefit.

The Litigation Support Benefit is a general insurance benefit and these are the policy terms upon which it is offered. Additional references in this document to the Litigation Support Benefit form part of these terms.

Eligibility

The Litigation Support Benefit will provide you with a benefit if:

- you are voting member of Avant Mutual at the time of making a claim under this benefit
- Avant has indemnified you, and is providing you with legal representation, under your PIIP or IIIP for a:
  - disciplinary, criminal or coronial matter;
  - civil liability matter; or
  - any other agreed matter; and
- your income drops below 50% of your *pre-litigation income*.

The Litigation Support Benefit does not provide a benefit if:

- the PIIP or IIIP claim or request for indemnity relates to an *incident* which occurred prior to applying for your Income Protection plan unless you were reasonably unaware the *incident* would lead to a claim or request for indemnity under your PIIP or IIIP.
- you are pursuing another party, irrespective of whether the claim or matter is accepted under your PIIP or IIIP.

If you become a voting member of Avant Mutual and Avant provides you with insurance under a PIIP or IIIP after your plan's commencement date, you may apply to have the Litigation Support Benefit added to your Income Protection plan.

Benefit amount

Provided you meet the eligibility requirements, your benefit will be the lower of:

- the *monthly sum insured* stated on your *plan schedule*; or
- 50% of your *pre-litigation income* less any *post-litigation income*.

If you are eligible for a Litigation Support Benefit and you are not working to your full capacity as a result of causes other than a case or trial, your benefit will be calculated on what you could reasonably be expected to earn if you were working to the extent of your full capacity.

The *waiting period* for the Litigation Support Benefit will begin on the date that a claim or matter under a PIIP or IIIP has been accepted and Avant is providing you with legal representation as a result of a:

- disciplinary, criminal or coronial matter;
- civil liability matter; or
- any other agreed matter.

During the *waiting period* no benefit is payable. The *waiting period* that applies to the Litigation Support Benefit will be the *waiting period* indicated on your *plan schedule* unless this period is more than 90 days. In which case, the *waiting period* will be 90 days.

The Litigation Support Benefit begins to accrue after your selected *waiting period*. We will aim to make your first payment two weeks after the end of this period. All other payments will be paid monthly in arrears.

If you're found guilty of a criminal offence, either during a criminal investigation or trial, or part of the final determination, you must repay Avant any benefit you have received under the Litigation Support Benefit in relation to that claim.

Benefits will cease on the earlier of the following:

- final determination of the investigation;
- final determination or settlement of a civil claim;
- withdrawal, for any reason, of Avant's support for you under your PIIP or IIIP;
- payment of benefits for 12 months for any one event; and
- payment of $500,000 in benefits over any rolling three-year period or in relation to any one event.

When a benefit is reduced

Payments from other sources

Should other sources provide you with a replacement income as a result of the same illness or injury for which you receive an Income Replacement Benefit and that replacement income is greater than 10% of your *pre-disability income*, your *monthly benefit* and/or Superannuation Reimbursement Benefit will be reduced.

Your *monthly benefit* and/or Superannuation Reimbursement will be reduced so the total payments you receive (your combined *monthly benefit*, Superannuation Reimbursement Benefit and replacement income from other sources) is not greater than the maximum *monthly benefit* and Superannuation Reimbursement Benefit applicable to your income, according to the table below.

Your pre-disability income	Maximum monthly benefit	Maximum Superannuation Reimbursement Benefit
Up to $320,000p.a	75% of your monthly income	10% of your monthly income
Between $320,000 and $560,000p.a	$20,000 per month + 50% of your monthly income above $320,000p.a	$2,667 per month
Between $560,000 and $2,200,000p.a	$30,000 per month + 20% of your monthly income above $560,000p.a	$2,667 per month
Above $2,200,000p.a	$60,000 per month	

Alternatively, if you are receiving a Limited Capacity to Work Benefit and that payment is greater than 10% of your *pre-disability income*, your *monthly benefit* and/or Superannuation Reimbursement Benefit will be reduced so the total payments you receive (your combined *post-disability income*, *monthly benefit*, Superannuation Reimbursement Benefit and replacement income from other sources) does not exceed 100% of your *pre-disability income*. Replacement income from other sources includes:

- any insurance payments with respect to illness or injury, replacing income;
- any disability income insurance payments, such as those paid or payable by other life insurance companies;
- lump sum insurance payments. In this case, we will convert it to a monthly amount by dividing it by 60.

Replacement Income from other sources does not include:

- lump sum payments for pain and suffering;
- lump sum payments for the loss of use of a part of your body;
- a lump sum trauma or total and permanent disablement benefit;
- interest and dividends;
- sick, long service or annual leave;
- benefits available under common law; or
- superannuation payment (except payments of disability income benefits).

Living outside of Australia

Benefits are only paid for a period of up to two years while you are outside Australia. In some circumstances, benefits may continue to be paid beyond two years if you return to Australia or attend a regional medical facility approved by us.

Refusal to undergo medical treatment or vaccination

The payment of an Income Replacement Benefit or Limited Capacity to Work Benefit will end if you unreasonably refuse to undergo medical treatment, including rehabilitation, to treat your condition as recommended by your *independent medical practitioner*.

When a benefit is not payable

Exclusions apply to your Income Protection plan as described in this PDS.

No payment will be made:

- if the event giving rise to your claim is caused directly or indirectly by an intentional, self-inflicted act;
- for uncomplicated pregnancy, termination, miscarriage or childbirth (Note: if illness or injury continues for longer than 90 days after the pregnancy ends, cover will be provided and the illness or injury will be considered to have started on the date the pregnancy ended);
- if you are entitled to receive a reimbursement of expenses under law, health insurance or other insurance;
- for any exclusion listed on your *plan schedule*;
- if the event giving rise to the claim occurred before your plan commencement date, reinstatement date or voluntary increase date (in respect to the increase amount only), unless clearly disclosed to and accepted by us.

In the event of contracting an infectious condition, you will not be eligible for a benefit if you did not take the vaccine recommended by the relevant authority to prevent the infection.

We will not pay for any period while you are in jail.

When cover ends

Your Income Protection plan will end on the earliest of:

- the plan *anniversary date* following your 60th, 65th or 70th birthday depending on the *benefit period* you choose;
- your death;
- your request to cancel your plan is received by us;
- we cancel your plan due to:
  - non-payment of premiums,
  - your failure to comply with the duty of disclosure (as described on page 9), or
  - a fraudulent claim;
- not meeting the eligibility requirements of your cover; and
- any other date applied under a special condition as shown on your *plan schedule*.

Supporting you throughout your medical career

Because your career as a doctor can be so varied we have included a range of features that support you throughout various stages your life.

Medical Training or Study Cover

In order to advance your career, there will be periods when you engage in further medical training or study. Should you suffer an illness or injury while completing training or study and you're eligible for a benefit under Avant Income Protection, the benefit you receive will be based on your income prior to starting training or study, even if your income is now reduced.

If you change or cease employment, reduce your hours of *gainful employment* or take a salary reduction for a period of time up to 3 consecutive years for any of the following reasons, cover will continue as if your *regular occupation* continued without a change in *regular income* or duties:

- completion of Fellowship;
- medical study or research; or
- any other reason as prior approved by us.

This feature will cease to apply once you've resumed your *regular occupation* or 3 consecutive years has elapsed (whichever is the earlier).

Overseas Cover

We recognise the overseas career opportunities and goals of doctors today. To support you while you're realising these opportunities, this feature ensures any benefit paid as a result of illness or injury will be based on your income prior to taking the overseas position. This applies even if your overseas position resulted in a reduction of income.

If you take an overseas placement for a period of time up to 3 consecutive years to work for any of the following organisations or placements, cover will continue as if your *regular occupation* continued without a change in *regular income* or duties:

- Doctors Without Borders;
- an Australian Defence Forces posting outside of Australia;
- a special medical placement overseas; or
- any other similar organisation or placement prior approved by us.

This feature will cease to apply once you've been away from your regular occupation for more than three consecutive years.

Family Support Break

Becoming the primary carer of a child generally means a reduced income. We understand this is likely to be a temporary situation while your children are young and that it should not affect your cover if a serious illness or injury occurs. Should you choose to maintain your current cover, we will base any benefit you are entitled to on your income and occupation prior to the family support break, even if you have not been working or your income is now reduced.

Alternatively, you may choose to reduce your premiums by reducing your cover. However, to ensure you have the protection you need when you return to work, Family Support Break allows you to reinstate your original cover without the need to provide updated medical information.

If you choose to take a career break while in *gainful employment*, or reduce the hours you work, so as to be the primary carer of a child who is no older than six years of age, you may choose to maintain your Income Protection Cover at its current level or reduce your *monthly sum insured*.

This feature will cease to apply once you stop being a primary care giver or your youngest child turns seven.

Maintain your monthly sum insured

If you maintain your current *monthly sum insured*, your cover will continue as if your *regular occupation* had continued without change in *regular income* or duties, provided you continue to be a registered medical practitioner. Should you be eligible for an Income Replacement Benefit or Limited Capacity to Work Benefit, we will take into account the *regular income* you earned before your family support break, regardless of whether your income is now reduced.

This applies even where:

- you have been a primary carer for a period greater than three consecutive years; and
- you return to work on a part-time basis after commencing a family support break.

Reduce your monthly sum insured

Should you choose to reduce your *monthly sum insured*, you can reinstate the original amount at any time prior to the end of your family support break, without the need to provide updated medical information.

Each time a reduction or reinstatement of the original *monthly sum insured* is requested, the reason for the family support break must be provided to us. Your premium will be adjusted to reflect the revised level of cover. No minimum *monthly sum insured* or premium will apply.

Any cover you reinstate after a family support break will be subject to a 90-day qualification period. This means that the benefit paid will be based on your *monthly sum insured* prior to reinstatement for the first 90 days after reinstating your cover.

Assessment of your claim

In the event of injury or illness while you are performing the role of the primary care giver and working part time, you will be assessed against the duties of your *regular occupation*.

In the event of injury or illness while you are performing the role of the primary care giver and not working, if, due to the injury or illness, you cannot perform your duties as the primary care giver, you will be assessed against the duties of your *regular occupation*. At the end of your scheduled maternity or paternity leave period (or after 12 consecutive months if you do not have a scheduled return-to-work date) if you have not fully recovered, you will be assessed against your ability to perform the duties of your *regular occupation*.

Unemployment Cover

The aim of Income Protection Cover is to be there for you through thick and thin. If you're unemployed, either with or without a current registration to practise medicine, there are still circumstances under which you may qualify for the benefits provided by Avant's Income Protection plan.

The Unemployment Cover feature applies if you're:

- unemployed and a *registered medical practitioner* – provided you've been unemployed for less than three years and you're not retired; or
- unemployed but no longer a *registered medical practitioner* – provided you've been unemployed for less than 12 consecutive months or less and you're not retired.

If you meet one of the above requirements, your cover will continue as if your *regular occupation* had continued without a change in your *regular income* or duties.

Should you be eligible for an Income Replacement Benefit or Limited Capacity to Work Benefit, we will take the *regular income* you earned before unemployment into account.

Practice Expense Cover

Practice Expense Reimbursement Benefit

Eligibility

If you suffer an illness or injury while *gainfully employed* and it prevents you from working, you may qualify for the Practice Expense Reimbursement Benefit under one of the following three definitions:

1. **Duties-based definition** – solely because of illness or injury, you are:
   - not capable of doing one or more duties that are important and essential to producing your *share* of *practice income*;
   - not working in any *gainful employment*; and
   - under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.
2. **Percentage-based definition** – solely because of illness or injury, you:
   - have suffered a reduction of 80% or more in your ability to generate your *share* of *practice income* from your *regular occupation*;
   - are not working in any other *gainful employment*; and
   - are under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.
3. **Hours based definition** – solely because of illness or injury, you are:
   - unable to work for more than 10 hours per week
   - not capable of generating more than 20% of your *share* of *practice income*;
   - not working in any other *gainful employment*; and
   - under the regular care and following the advice of an *independent medical practitioner* in relation to that illness or injury.

Benefit amount

Provided cover is in force and you meet one of the above listed definitions, we will reimburse your eligible practice expenses (see 'Eligible practice expenses' on page 61 for a detailed list) each month to the lesser of:

- the *monthly sum insured* stated on your *plan schedule*; and
- your monthly *share* of eligible practice expenses;

as reduced by payments from other sources.

Monthly payments for the Practice Expense Reimbursement Benefit will commence after your selected *waiting period* (see page 49). Your first payment will be made two weeks after the end of this period and then monthly in arrears.

Any part-month Practice Expense Reimbursement Benefit payments will be pro-rated for partial months using 30ths (ie. on the basis of a deemed 30 days in a month).

Payment Extension

If you continue to be eligible for either the Practice Expense Reimbursement Benefit or the Partial Reimbursement Benefit after 12 months due to the same illness or injury, we will continue to reimburse your eligible practice expenses for up to 12 more months until 12 times your *monthly sum insured* has been paid. The amount we will reimburse each month is the amount you were receiving under the Practice Expense Reimbursement Benefit or the Partial Reimbursement Benefit.

When benefit payments cease

The payment of a Practice Expense Reimbursement Benefit will continue until the earliest of:

- you ceasing to be eligible to receive a Practice Expense Reimbursement Benefit;
- you becoming eligible to receive a Partial Reimbursement Benefit;
- the later of the expiry of either the *benefit period* or payment extension period described above;
- the plan *anniversary date* following your 70th birthday;
- the termination or end of your Practice Expense Cover plan; and
- your death.

Partial Reimbursement Benefit

Eligibility

If you're *gainfully employed* and working in your *regular occupation* in a reduced capacity or another occupation in a reduced capacity, you may qualify for a Partial Reimbursement Benefit, if solely because of illness or injury, you:

- have suffered a reduction of 20% or more, in your ability to:
  - generate your *share* of *practice income*;
  - perform your *share* of the regular practice income-producing duties; or
  - maintain the same number of hours worked, in your *regular occupation*; and
- are not eligible for a Practice Expense Reimbursement Benefit; and
- are under the regular care of and following the advice of an *independent medical practitioner* in relation to that illness or injury.

Benefit amount

Provided you meet the above criteria, we will reimburse your eligible practice expenses proportional to the *practice income* you lose as a result of working in a reduced capacity. The *monthly reimbursement* amount will be calculated as follows:

$$\frac{\text{Your } \textit{share} \text{ of } \textit{pre-disability practice income} \text{ minus your } \textit{share} \text{ of } \textit{post-disability practice income}}{\text{Your } \textit{share} \text{ of } \textit{pre-disability practice income}} \times \text{the monthly amount we would pay if you were claiming a Practice Expense Reimbursement Benefit}$$

Monthly payments for the Partial Reimbursement Benefit will commence after your selected *waiting period* (see page 49). Your first payment will be made two weeks after the end of this period and then monthly in arrears.

Any part-month Partial Reimbursement Benefit payments will be pro-rated for partial months using 30ths (ie. on the basis of a deemed 30 days in a month).

Payment Extension

If you continue to be eligible for either the Practice Expense Reimbursement Benefit or the Partial Reimbursement Benefit after 12 months due to the same illness or injury, we will continue to reimburse your eligible practice expenses for up to 12 more months until 12 times your *monthly sum insured* has been paid. The amount we will reimburse each month is the amount you were receiving under the Practice Expense Reimbursement Benefit or the Partial Reimbursement Benefit.

When benefit payments cease

The payment of a Partial Reimbursement Benefit will continue until the earliest of:

- you ceasing to be eligible to receive a Partial Reimbursement Benefit;
- you becoming eligible to receive a Practice Expense Reimbursement Benefit;
- the later of the expiry of either the *benefit period* or payment extension period described above;
- the plan *anniversary date* following your 70th birthday;
- the termination or end of your Practice Expense Cover Plan; and
- your death.

Lease Extension Benefit

Eligibility

If you continue to be eligible for either the Practice Expense Reimbursement Benefit or the Partial Reimbursement Benefit due to illness or injury after all *monthly reimbursements* have ceased, including any additional payment under the Payment Extension Benefit, then a Lease Extension Benefit becomes payable for up to another 18 months.

Benefit amount

This Lease Extension Benefit is the lower of:

- your *share* of the actual lease costs, month by month; or
- 25% of your *monthly sum insured*.

Lease costs mean the sum of monthly lease payments for equipment, motor vehicle and medical premises.

When benefit payments cease

The payment of a Lease Extension Benefit will continue until the earliest of:

- you ceasing to be eligible to receive a Practice Expense Benefit or Partial Reimbursement Benefit;
- the end of the 18 month period; and
- cover ending under your plan, or the end or termination of your plan.

Eligible Practice Expenses

Eligible practice expenses means the regular or continuing fixed expenses incurred by your business, which are not a payment of capital or of a capital, private or domestic nature, and could not reasonably be considered to give a private benefit to you or members of your family or a company, trust or other entity from which you or your family derives a benefit.

These expenses include the following items of expenditure provided they are incurred in the normal conduct and operation of your business:

Regular expenses

- Accountants' and auditors' fees
- Subscriptions to the AMA and other professional bodies
- Subscriptions to medical industry and business-related publications
- Technology costs – including medical software and IT support
- Personal and practice professional indemnity insurance premiums
- Other business insurance premiums
- Cleaning, electricity, gas, heating, laundry, telephone (including mobile phone) and water
- Advertising costs.

Lease, loan and rent

- Leasing costs of equipment, vehicles and property
- Interest payments on medical practice related loans
- Loan principal repayments for practice-related medical equipment
- Property rates and taxes
- Rent.

Locum

- Any net costs associated with employing a locum should you be unable to work, to perform the work you normally perform (in this case, net costs are treated as the total expenses incurred with hiring the locum less the revenue generated by the locum)

Salaries

- Salaries of non-income producing employees (including related costs such as payroll tax and superannuation)
- Salaries of any of your *relatives* (including related costs such as payroll tax and superannuation), provided that they have been employees or contractors for at least six months

Other

- Other fixed expenses normally incurred in the conduct of your business

Eligible practice expenses do not include:

- the cost of books, equipment, fittings, goods, implements, merchandise, wares or products used in your practice;
- fittings and fixtures;
- depreciation of equipment and vehicles;
- your salary and salary-related costs;
- salaries and related costs of employee doctors or any other part owners;
- any share of the practice expenses which are not normally attributable to you; or
- expenses of a private or domestic nature.

When a benefit is reduced

Payment from other sources

Should other sources provide you a payment as a result of the same illness or injury for which you receive a Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit and that payment is greater than 10% of your *share* of eligible practice expenses, your *monthly reimbursement* payment will be reduced. It will be reduced so the total payment you receive (your *monthly reimbursement* payment plus payment from other sources) is not greater than your *share* of eligible practice expenses.

Payments from other sources include any non-Avant practice or business expense cover insurance payments. Payments from other sources do not include:

- regular income you earn while working
- lump sum payments for pain and suffering
- lump sum payments for the loss of use of part of your body
- a lump sum trauma benefit or total and permanent disablement benefit
- income protection benefits
- interest and dividends
- sick, long service or annual leave
- benefits available under common law

Refusal to undergo medical treatment or vaccination

Any *monthly reimbursement* payment will end if you unreasonably refuse to undergo medical treatment, including rehabilitation, to treat your condition as recommended by your *independent medical practitioner*.

Alternatively, in the event of contracting an infectious condition, you will not be eligible for a benefit if you did not take the vaccine recommended by the relevant authority to prevent the *infection*.

When a benefit is not payable

Exclusions apply to your Practice Expense Cover plan as described in this PDS.

No payment will be made:

- if the event giving rise to your claim is caused by or related to an intentional, self-inflicted act;
- for uncomplicated pregnancy, termination, miscarriage or childbirth (Note: if illness or injury continues for longer than 90 days after the pregnancy ends, cover will be provided and the illness or injury will be considered to have started on the date the pregnancy ended);
- if you are entitled to receive a reimbursement of expenses under law or other insurance;
- for any exclusion listed on your *plan schedule*;
- if the event giving rise to the claim occurred before your plan commencement date, reinstatement date or voluntary increase date (in respect to the increase amount only), unless clearly disclosed to and accepted by us.

We will not pay for any period while you are in jail.

When cover ends

Your Practice Expense Cover plan will end on the earliest of:

- the plan *anniversary date* following your 70th birthday
- your death
- your request to cancel your plan is received by us
- we cancel your plan due to:
  - non-payment of premiums
  - your failure to comply with the duty of disclosure (as described on page 9)
  - a fraudulent claim
  - not meeting the eligibility requirements of your cover
- any other date applied under a special condition as shown on your *plan schedule*.

Other terms and conditions

Complimentary Interim Cover

Interim cover benefits, features, options and conditions

As soon as we have received your completed application, and payment authority, you may be eligible for complimentary interim cover. All benefits, features and options of the cover(s) you have applied for, are provided to you under your complimentary interim cover, subject to and in accordance with, the other provisions of those covers.

Interim cover commencement date

Interim cover is effective from the date your completed application and payment authority are received by us.

Interim cover end date

Your interim cover ends on the earliest of:

- 4pm on the 90th day after the commencement date of interim cover;
- the time and date we have accepted, declined or deferred your application;
- the time and date the applicable cover under your plan commences; and
- the time and date your application is withdrawn.

Interim cover eligibility

You are not eligible for interim cover if, on the date which would otherwise be the commencement date of interim cover, you have:

- current insurance with us or another insurer, which provides the same or similar cover (whether individually or as part of a package) and you have indicated in your application that it will be replaced with the corresponding Avant cover; or
- interim cover with us or another insurer for insurance which provides the same or similar cover (whether individually or as part of a package).

Interim cover benefit amount

The interim benefit amount determined in accordance with the terms set out in this PDS is calculated with reference to the lesser of:

- the sum insured or monthly sum insured (as applicable to the type of cover) of the cover you applied for; or
- the sum insured or monthly sum insured (as applicable to the type of cover) of the cover you applied for which we would have approved based on your application.

If we would have declined your application, no benefit will be payable.

For Income Protection Cover and Practice Expenses Cover, we will pay an interim benefit where you suffer disability for at least the waiting period that was applied for, after the waiting period is satisfied, to a maximum of the benefit period applied for.

Additionally, a benefit will not be paid when the event leading to your claim is caused by:

- an intentional self-inflicted injury or act; or
- any cause that we would have applied as an exclusion or would not have accepted at all, under our usual underwriting and assessment guidelines; or
- in relation to Children's Cover;
  - a congenital condition that was present at or before birth of the insured child; or
  - any inflicted act or omission by the applicant, parent or guardian of the insured child.

If an interim cover benefit is paid and your cover is or will be linked to other cover, the amount of that benefit will reduce any benefit available under the linked cover.

Any notice of a claim or payment made under interim cover will affect your application and as a result, your application may be declined.

Important information

No cash value

Your Avant Life Insurance plan does not have a surrender value or a cash-in value at any point.

Complaints and Dispute Resolution

Your satisfaction is very important to us. Should you be dissatisfied with your plan or our service, please contact us following the steps outlined below.

If you have a complaint about the service provided or your privacy, you should direct your complaint according to the type of plan you hold.

Complaints about your cover not issued through your SMSF

If you wish to make a complaint in relation to a plan that is not issued through your SMSF, including a TPD Cover Super Linked plan, you can write to:

Avant Life Insurance
PO Box 746
Queen Victoria Building, NSW, 1230.

We will attempt to resolve your complaint within 45 days of the date it is received by us. If we are unable to resolve your complaint within that period, we will inform you of the reasons for the delay and ask for your consent to resolve the complaint within 90 days of the date it was received.

If your complaint has not been resolved to your satisfaction within 45 days of lodging your initial complaint (or, if you have agreed, within 90 days), you may contact the Australian Financial Complaints Authority (AFCA).

AFCA is an independent body designed to help you resolve complaints relating to financial products, as well as complaints relating to financial advice and sales of financial and investment products. There are some circumstances where AFCA cannot deal with your complaint, however they can advise you of these circumstances.

Complaints with AFCA may be resolved by a conciliation process or arbitration. The complaints procedure is free of charge and decisions made by AFCA are binding on us. Before you ask AFCA to help you, please try to resolve the issue with us first.

AFCA can be contacted as follows:

- **1800 931 678**
- info@afca.org.au
- Australian Financial Complaints Authority
  GPO Box 3 Melbourne, VIC, 3001.

Their website is afca.org.au

Complaints about cover issued through your SMSF

If your cover has been issued through your SMSF you should address your complaint to the trustee of that superannuation fund. That trustee will provide you with the details of its complaint- handling arrangements, where applicable.

Privacy

Within this section, 'we' and 'us' refer to NobleOak and Avant.

We collect, use and retain personal information in accordance with the Australian Privacy Principles and the *Privacy Act 1988 (Cth)* (Privacy Act). Our detailed privacy policies are available on our respective websites at:

- avant.org.au/privacy-policy
- nobleoak.com.au/terms-of-use-privacy-policy
- or by calling us on **1800 128 268**.

We collect your personal information (which may include sensitive information such as health information) when you are applying for or changing an insurance plan with us, or when we are processing a claim, in order to help us properly administer your insurance application, plan or claim.

The primary purpose for our collection and use of your personal information is to enable us to provide insurance services to you. Sometimes, we may use your personal information for our marketing campaigns, in relation to new products, services or information that may be of interest to you.

We may also disclose your personal information to third parties, including service providers engaged by us to carry out certain business activities on our behalf, other companies within our group of companies, other insurers, our reinsurers, medical and health practitioners, government agencies and regulators (where we are required to by law), law enforcement bodies and agents and/or representatives of persons covered under our plans. Some of these third parties may be located outside Australia. Lists of countries in which recipients of your information are likely to be located are available in the privacy policies on our respective websites.

In all instances where personal information may be disclosed to third parties who may be located overseas, in addition to any local data privacy laws to which those entities are subject, we have measures in place to ensure that those parties hold and use such information in accordance with the consent provided by you and in accordance with our obligations under the Privacy Act. In dealing with us, you agree to us using and disclosing your personal information as set out in this section and in our respective privacy policies. This consent remains valid unless you alter or revoke it by giving written notice to our respective privacy officers. However, should you choose to withdraw your consent, it is important for you to understand that this may mean we may not be able to provide you with this insurance or respond to any claim.

Direct Debit Service Agreement

If you choose to pay your premiums via a direct debit from your bank account or credit card, you will be entering into the below direct debit service agreement with us. We are the entity who collects your premium payment.

This agreement sets out the terms and conditions on which the account holder has authorised us to debit money from their account and our obligations and those of the account holder under this agreement.

The account holder understands and agrees that:

- direct debiting may not be available on all accounts. The account holder is responsible for ensuring the specified account can accept direct debits and there are sufficient cleared funds available in the nominated account to permit payments under the direct debit request on the due date for payments
- we accept no responsibility for issues arising where incorrect details have been provided. The account holder should check the account details provided to us are correct. If uncertain, check with your financial institution before completing the direct debit request
- we will debit the account for the sum of the amounts due at the debit date for all specified plans
- changes to bank account details must be provided in writing to us or by telephoning us (or by such other means as we approve)
- we will give the account holder at least 14 days' notice in writing if there are any changes to the terms of this service agreement.

We agree that:

- when the due date for payment is not a business day, the debit will be processed on the next business day
- the account holder can cancel, change, defer or suspend the direct debit request on a plan by providing notice to us in writing or by telephone (or by such other means as we approve), or directly with the account holder's financial institution (which is required to act promptly on the instructions). Notification must be received by us at least 14 days before the next drawing date in order to process your instructions
- the account holder's financial institution can change the direct debit request only to the extent of advising us of new account details
- upon request, we will forward a copy of the current terms and conditions for direct debits to the account holder by email, post, facsimile or other agreed method
- we will provide details of this direct debit, on request.

Disputes

The account holder should give notice of any disputed debit to us. We will respond within seven working days of receiving your letter. Alternatively, the account holder can take it up directly with the account holder's financial institution.

Dishonoured debits

If a debit is unsuccessful, we will cancel the payment in respect of the dishonoured debit. In some instances, such as where your account has insufficient funds, we may notify you and attempt

a second deduction from your account within 14 days. You should ensure that your account has sufficient funds before any second deduction. If we receive new information from you after a dishonour, we will process a one-off debit to pay the plan up to date. If two consecutive dishonours occur, we may cancel the authority. We may charge a dishonour fee to the relevant plan.

Currently the fee is nil. The financial institution may also charge fees relating to the dishonour to the account, which is the account holder's responsibility.

Confidential information

We may disclose information about your account to your banker (in connection with a claim made against it relating to an alleged incorrect or wrongful debit made from the account), your financial institution or your insurance advisor. We will not disclose information about you or the account to any other person, except where you have given consent or where the disclosure is required by law.

Notices to us

The account holder may give notice to us in writing or by contacting us on **1800 128 268** (see the back cover of this PDS for details).

Definitions

Accident means a random and unforeseen event that results in loss, damage or harm, independent of all other causes.

Anniversary date means the yearly date when the processing of your plan, including the application of indexation and stepped premium increases, takes place. Your first *anniversary date* will be 12 months after the commencement date on your *plan schedule* and will occur on that same date each year unless we decide to change it.

Australian resident means a person who is an Australian or New Zealand citizen, an Australian permanent resident or holder of a temporary 457 working visa or equivalent (as approved by the Department of Immigration and Citizenship), who is residing in Australia at the time of application.

Benefit period means the maximum period of time that a *monthly benefit* or *monthly reimbursement* will be paid in respect of the insured person so long as they continue to meet the requirements of the Income Replacement Benefit, Limited Capacity to Work Benefit, Practice Expense Reimbursement Benefit or Partial Reimbursement Benefit, as applicable. The *benefit period* starts at the end of the *waiting period*.

The *benefit period* that applies to an insured person in respect to the *monthly benefit* or *monthly reimbursement* is shown on the *plan schedule*.

For Income Protection Cover, the *benefit period* will be either:

- 2 years; or
- to the *anniversary date* after the insured person turns 60, 65 or 70 (as indicated on the *plan schedule*).

For Practice Expenses Cover, the *benefit period* will be 1 year.

Consumer Price Index (CPI) means the *consumer price index* as defined and published by the Australian Bureau of Statistics (or any body which succeeds it). It is a weighted average of the eight Australian capital cities combined, for successive 12-month periods, finishing on 30 September each year and on and from 1 February the following year, applied at the relevant *anniversary date* in respect of each plan owner.

Gainful employment (and gainfully employed) means to be employed or self-employed for gain or reward in any business, trade, profession, vocation, calling or occupation.

Home duties means the following five activities:

1. cooking and preparing meals (i.e. the ability to prepare meals using basic ingredients and normal kitchen appliances)
2. cleaning the house (i.e. the ability to carry out basic internal household chores using various tools such as a mop or vacuum cleaner)
3. washing and drying clothes (i.e. the ability to maintain the household's laundry by using the washing machine and being able to hang clothes on a washing line or clothes airer)
4. shopping for groceries (i.e. the ability to physically purchase general household grocery items with either the use of a shopping basket or trolley)
5. if you normally look after a child or children up to the age of 12 as part of your everyday activities, looking after that child or children (i.e. the ability to care for and supervise a child or children up to the age of 12, including preparation of meals, bathing, dressing and getting the children to and from school by the usual mode of transport).

Incident means any act, error, omission or circumstance in relation to the provision of healthcare or unpaid healthcare that may give rise to a claim or request for indemnity under your Avant **Practitioner Indemnity Insurance Policy** or Intern Indemnity Insurance Policy.

Independent medical practitioner means a *medical practitioner* who:

- is independent of you; and
- is not you, your spouse, your *partner*, your family member, your *relative*, your business *partner*, your employee or your employer.

Infection (for the purpose of Cover for Infectious Conditions under Income Protection Cover and Practice Expenses Cover only) means the bodily invasion of one (or more) of:

- HIV;
- Hepatitis B virus;
- Hepatitis C virus;
- Tropical and rural based infections such as dengue fever, Ross River virus and Q fever; or
- any other infectious condition which is listed at the time by the relevant professional governing body, which would prevent the insured person from performing exposure prone procedures.

Key person means an employed person who is essential to the economic prosperity of the business in which he or she is employed.

Medically related event(s) means any illnesses or injuries that are related to a medical event or sequence of medical events, which caused an insurance benefit to be paid under any cover in this PDS.

Medical practitioner means a *medical practitioner* registered to practice in Australia; or a *medical practitioner* registered to practice in another country if specifically approved by us acting reasonably.

Monthly benefit means the actual amount payable to you each month (or part month) during a claim in accordance with this PDS and the Avant Benefit Fund Rules.

The *monthly benefit* does not include any Superannuation Reimbursement Benefit payable.

Monthly reimbursement means the actual amount payable to you each month (or part month) during a claim in accordance with this PDS and the Avant Benefit Fund Rules.

Monthly sum insured means the monthly dollar amount of your insurance cover as set out in your *plan schedule*.

Occupationally disabling condition means:

- *significant permanent impairment;*
- *loss of two limbs – total and irrecoverable;*
- *HIV, Hepatitis B or C – occupationally acquired*
- *loss of sight in both eyes – total and irrecoverable;*
- *loss of independence– total and irreversible;* or
- *severe cognitive impairment–permanent.*

Own occupation means the most recent specialty the insured person was engaged in for reward and qualified to perform. If the insured person was solely engaged in permanent employment other than their specialty or they are no longer qualified to perform their specialty, then 'own occupation' means the most recent occupation the insured person was engaged in for reward and qualified to perform, prior to the injury or illness.

Partner means a legally married partner or de facto partner (where de facto partner means someone who has been in a relationship with and living with that person for a period of at least 12 consecutive months).

Plan schedule means the information that is provided to you confirming the details of your insurance cover. It will be updated each time your insurance cover changes.

Post-disability income means *regular income* (expressed monthly):

- you earned during the month of illness or injury on which your *monthly benefit* is based when *gainfully employed*; or
- assessed by us (acting reasonably) upon medical and other information we receive, as being able to be earned by you during the month of illness or injury on which your *monthly benefit* is based when you're not *gainfully employed*.

For the avoidance of doubt, this includes any income received from a business in which you are an owner or part owner, including any income received while unable to work at full capacity due to illness or injury.

Post-disability practice income means the *practice income* (expressed monthly):

- you earned in the month of illness or injury on which your *monthly reimbursement* payment is based when *gainfully employed*; or
- assessed by us (acting reasonably) upon medical and other information we receive, as being able to be earned by you during the month of illness or injury on which your *monthly reimbursement* payment is based when you're not *gainfully employed*.

Post-litigation income means the *regular income* (expressed monthly):

- you earned during the month of litigation on which your *monthly benefit* is based when *gainfully employed*; or
- assessed by us upon medical and other information we receive, as being able to be earned by you during the month of litigation on which your *monthly benefit* is based when you're not *gainfully employed*.

Practice income means the gross monthly income generated by your business before expenses and tax, subject to a minimum of $0.

Pre-disability income, unless otherwise stated, means:

a) when you are aged between 20 and 65 (inclusive), the higher of:

- the highest average *regular income* (expressed monthly) earned by you for any consecutive 12-month period in the three years prior to the date of the illness or injury; and
- if applicable, the highest average *regular income* (expressed monthly) earned by you for any consecutive 12-month period in the three years prior to the start of any period of:
  - study leave – if you are taking study leave in accordance with the 'Medical Training or Study Cover' feature (described on page 57) at the time of the illness or injury and the commencement date of the study leave was not more than three years prior to the date of the illness or injury,
  - overseas placement – if you are on overseas placement in accordance with the 'Overseas Cover' feature (described on page 57) at the time of the illness or injury and the commencement date of the overseas placement was not more than three years prior to the date of the illness or injury,
  - family support break – if you are taking a family support break in accordance with the 'Family Support Break' feature (described on page 58) at the time of illness or injury your youngest child is not more than six years old prior to the date of the illness or injury.

b) when you are aged between 66 and 70 (inclusive), the *regular income* (expressed monthly) earned by you in the 12-month period prior to the date the *waiting period* commenced.

Once on claim, the *pre-disability income* will be notionally increased by the rate of CPI at each claim anniversary.

Pre-disability practice income means your highest *practice income* (expressed monthly) for any consecutive 12 month period in the three years prior to the date of your illness or injury.

Pre-litigation income mean your highest average *regular income* (expressed monthly) for any consecutive 12-month period in the three years immediately preceding the date of your claim or trial.

Registered medical practitioner means a doctor (including an intern) who is practising or entitled to practise in accordance with the laws of Australia or any of its states or territories.

Regular income means:

- if you directly or indirectly own all or part of the business in which you perform your work, your share of the gross monthly income generated by the business as a result of your physical exertion, less your share of the eligible business expenses necessarily incurred in generating that income. If the eligible business expenses includes salary, wages, director fees or superannuation paid to you, motor vehicle expenses relating to your personal use or depreciation costs, then these expenses can be added back in order to determine your *regular income*; or
- if you do not directly or indirectly own all or part of the business in which you perform your work, the gross monthly income earned from your personal exertion by way of total remuneration package including salary, regular overtime, superannuation contributions, commissions, bonus payments and any other fringe benefits or compensation.

In either case, *regular income* does not include income which is not derived from your personal exertion or activities, such as interest or dividend payments.

Regular occupation means the most recent *gainful employment* you were engaged in and qualified to perform; and for Income Protection Cover, subject to the following:

- if you are undertaking training, study or research (in accordance with 'Medical Training or Study Cover' on page 57), or not working and taking a family support break (in accordance with 'Family Support Cover' on page 57) *regular occupation* means the most recent *gainful employment* you were engaged in and qualified to perform prior to these events;
- if you are undertaking an overseas placement (in accordance with 'Overseas Cover' on page 58) then upon your return to Australia, *regular occupation* means the most recent *gainful employment* you were engaged in and qualified to perform while in Australia;
- if you are no longer a *registered medical practitioner*, the most recent occupation other than as a *registered medical practitioner* that you were engaged in and qualified to perform; or
- if you are no longer a *registered medical practitioner* and have not been *gainfully employed* for more than 12 consecutive months, you will be considered to be unemployed.

Relative means your spouse, sibling, parent, father-in-law, mother-in-law, son or daughter, or any other person in a bona-fide living arrangement with you who is financially interdependent.

Share means either:

- if you are self-employed, then 100%;
- if you are the sole owner of a small business, then 100%;
- if you are a part-owner of a small business, then it means the percentage share which is apportioned to you in line with the usual manner profits and/or losses of your business are divided.

Sum insured means the amount of insurance cover provided for each benefit as shown in your *plan schedule*.

Terminal illness (and terminally ill) means:

For non-superannuation business:

- an *independent medical practitioner* has certified that you suffer from an illness, or have incurred an injury, that is likely to result in your death within 12 months of the date of certification.

For superannuation business:

- two *independent medical practitioners* have certified, jointly or separately, that you suffer from an illness or have incurred an injury, that is likely to result in your death within 24 months of the date of certification;
- at least one of the *independent medical practitioners* is a specialist practising in an area related to the illness or injury; and
- for each of the certificates, the certification period has not ended.

Specialist medical practitioner means a *medical practitioner* who practices in a specialty field and is listed on the Australian Health Practitioner Regulation Agency (AHPRA) Specialist Register, who cannot be the insured person, or a member of the insured person's family, or their business *partner*, employee or employer.

Trauma date means in respect of a trauma event, the earliest of:

- the date the trauma event was diagnosed by an *independent medical practitioner*;
- the date the trauma event first became apparent to the insured person; and
- the date the symptoms of the trauma event were first observed by an *independent medical practitioner* or by the insured person.

Usual employment means:

- *gainfully employed*;
- undertaking study leave in accordance with the Medical Training or Study Cover feature;
- undertaking an overseas placement in accordance with the Overseas Cover feature;
- taking a family support break in accordance with the Family Support Break feature; or
- unemployed, but meets the requirements of the Unemployment Cover feature.

Waiting period means the continuous period of time that you must meet the applicable benefit eligibility criteria (described on pages 53, 54 and 60) before a *monthly benefit* or *monthly reimbursement* (as applicable) is payable. The *waiting period* that applies is shown on your *plan schedule*.

For the Income Replacement Benefit, Limited Capacity to Work Benefit, Practice Expense Reimbursement Benefit and Partial Reimbursement Benefit:

For the Income Replacement Benefit, the Limited Capacity to Work Benefit, Practice Expense Reimbursement Benefit and Partial Reimbursement Benefit, your waiting period will start
on the earlier of:

- the date you become unable to work at full capacity solely as a result of an illness or injury as certified by an *independent medical practitioner*;
- the date you first stopped working (as long as you consulted an *independent medical practitioner* within seven days of ceasing work). Your *independent medical practitioner* will need to certify that your illness or injury is likely to have prevented you from working at full capacity from the date you first stopped working; or
- if you did not consult an *independent medical practitioner* within seven days of ceasing work, the date an *independent medical practitioner* first certifies that you are unable to work at full capacity solely as a result of illness or injury;

To be eligible to receive a benefit, you must meet the eligibility criteria for either benefit for the duration of your *waiting period*. If you return to work at full capacity during your *waiting period*, the days you work will be added to the end of your *waiting period*.

Medical definitions

Activities of daily living means the following five activities:

1. Bathing – the ability to shower or bathe.
2. Dressing – the ability to put on and take off clothing.
3. Toileting – the ability to use the toilet, including getting on or off.
4. Feeding – the ability to get food from a plate into the mouth.
5. Mobility – the ability to move from place to place by walking, wheelchair or with the assistance of a walking aid and getting in and out of bed, a chair or a wheelchair.

Alzheimer's disease – permanent and of specified severity

The unequivocal diagnosis of Alzheimer's dementia confirmed by a *specialist medical practitioner* in the field. The diagnosis must confirm permanent failure of the brain function with cognitive impairment for which no other recognisable cause has been identified.

Aortic surgery – excluding less invasive surgeries

Surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta, but not its branches.

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

Angioplasty – through specific procedures

The undergoing of coronary artery angioplasty on one or more coronary arteries to correct a narrowing or blockage that is considered the appropriate and necessary treatment on the basis of angiographic evidence. This must be confirmed by a *specialist medical practitioner* in the field.

You may claim multiple times for angioplasty with no waiting period between treatments.

'Coronary artery angioplasty' means the actual undergoing of either:

- balloon angioplasty;
- insertion of a stent;
- atherectomy; or
- laser therapy

to correct a narrowing or blockage of coronary arteries within the same procedure.

Aplastic anaemia – requiring specified treatment

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

- blood product transfusions; or
- marrow stimulating agents; or
- immunosuppressive agents; or
- bone marrow transplantation (including stem cell transplantation).

Benign brain tumour (diagnosed) – resulting in neurological deficit

Diagnosis of a non-malignant tumour of the brain or pituitary gland giving rise to symptoms of neurological deficit. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.

The following are excluded:

- cysts;
- granulomas;
- cholesteatomas;
- malformations in, or of, the arteries or veins of the brain; and
- haematomas.

Benign brain tumour – resulting in significant impairment

The presence of a non-cancerous tumour in the brain or pituitary gland which either:

- requires the tumour to be therapeutically managed by invasive neurosurgical techniques such as radiotherapy (e.g. gamma knife stereotactic radiosurgery), laser therapy and ultrasonic aspiration, or surgically removed on the advice of a *specialist medical practitioner* in the field; or
- produces neurological deficit causing:
  - permanent and total inability to perform without assistance of another person at least one of the *activities of daily living*; or
  - *significant permanent impairment*, as confirmed by a *specialist medical practitioner* in the field.

The following are excluded: cysts; granulomas; cholesteatomas; malformations in, or of, the arteries or veins of the brain; haematomas; acoustic neuroma and other cranial nerve tumours.

Benign spinal cord tumour (diagnosed) – resulting in neurological deficit

Diagnosis of a non-malignant tumour of the spinal cord giving rise to symptoms of neurological deficit. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.

The following are excluded:

- cysts;
- granulomas;
- cholesteatomas; and
- haematomas.

Benign spinal cord tumour – resulting in significant impairment

The presence of a non-cancerous tumour in the spinal cord which either:

- requires the tumour to be therapeutically managed by invasive neurosurgical techniques such as radiotherapy (e.g. gamma knife stereotactic radiosurgery), laser therapy, ultrasonic aspiration, or surgically removed on the advice of a *specialist medical practitioner* in the field; or
- produces neurological deficit causing:
  - permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*; or
  - *significant permanent impairment*, as confirmed by a *specialist medical practitioner* in the field.

The following are excluded: cysts; granulomas; cholesteatomas; haematomas.

Blood cancer – excluding specified early stage cancers

The presence of a leukaemia, lymphoma, Hodgkin's disease and other haemopoietic malignancies.

Chronic lymphocytic leukaemia less than RAI Stage 1 is excluded.

Brain surgery – requiring craniotomy

Any medical condition that requires intervention through a craniotomy.

Breast cancer – excluding early stage breast cancers

The presence of a malignant tumour in the breast, which is confirmed by histological examination.

Carcinoma in situ of the breast is only covered if:

- it requires the removal of the entire breast; or
- other surgery and adjuvant therapy (such as radiotherapy; and/or chemotherapy) is performed specifically to arrest the spread of malignancy and this procedure is the appropriate and necessary treatment.

Burns (severe) – covering specified surface area

Tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness or deep partial thickness) burns to at least:

- 20% of the body surface area as measured by the Rule of Nines or the Lund & Browder Body Surface chart, requiring surgical debridement and/or grafting; or
- 50% of each hand, requiring surgical debridement and/or grafting; or
- 50% of the face , requiring surgical debridement and/or grafting.

Carcinoma in situ

A carcinoma in situ characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues.

'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method.

Only carcinoma in situ of the following sites are covered:

- cervix uteri (tumour must be classified as Tis according to the TNM staging method or have cervical intraepithelial neoplasia (CIN) classifications CIN-3. Excluded are tumours classified CIN-1 or CIN-2);
- corpus uteri;
- fallopian tube – the tumour must be limited to the tubal mucosa;
- ovary, vagina, vulva or breast; or
- penis, perineum, or testicle.

Cardiac arrest – out of hospital, excluding medical procedures

Cardiac arrest that is not associated with any medical procedure, is documented by an electrocardiogram, occurs out of hospital and is:

- cardiac asystole; or
- ventricular fibrillation with or without ventricular tachycardia.

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

Cardiomyopathy/heart failure – resulting in significant permanent impairment

Impaired ventricular function of variable aetiology, or a myocardial disorder in which the heart muscle is structurally and functionally abnormal, resulting in

- a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*; or
- *significant permanent physical impairment*, as confirmed by a *specialist medical practitioner* in the field.

Chronic lung disease – requiring long-term oxygen therapy

End-stage respiratory failure requiring permanent and continuous oxygen therapy. The diagnosis must be confirmed by a *specialist medical practitioner* in the field.

Coma (impaired consciousness) – of specified severity

A state of unconsciousness with no reaction to external stimuli resulting in a documented Glasgow Coma Scale of 6 or less, for a continuous period of at least 72 hours.

Coronary artery bypass surgery – excluding less invasive procedures

The actual undergoing of coronary artery bypass surgery, which
is considered medically necessary to correct or treat coronary artery disease.

Angioplasty, and other intra-arterial or laser procedures are excluded.

Crohn's disease (severe) – requiring permanent medication

The diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, and requires permanent immunosuppressive medication.

Dementia (major neurocognitive disorder) – permanent and of specified severity

The unequivocal diagnosis of dementia confirmed by a *specialist medical practitioner* in the field. The diagnosis must confirm the existence of Major Neurocognitive Disorder of the brain that has caused a permanent decline in cognitive ability severe enough to interfere with independence and daily life for which no other recognisable cause has been identified.

Major Neurocognitive Disorder (major NCD) is defined under the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by American Psychiatric Association. It requires evidence of significant cognitive decline in one or more of the cognitive domains below. The cognitive deficits must be sufficient to interfere with independence in activities of daily living. The cognitive deficits must not be attributable to another mental disorder. The criterion of maintenance or loss of independent functioning represents the key distinction between mild and major NCD.

The DSM-5 details six cognitive domains which may be affected in both mild and major NCD:

- Complex attention, which includes sustained attention, divided attention, selective attention and information processing speed;
- Executive function, which includes planning, decision making, working memory, responding to feedback, inhibition and mental flexibility;
- Learning and memory, which includes free recall, cued recall, recognition memory, semantic and autobiographical long term memory, and implicit learning;
- Language, which includes object naming, word finding, fluency, grammar and syntax, and receptive language;
- Perceptual-motor function, which includes visual perception, visuoconstructional reasoning and perceptual-motor coordination; and
- Social cognition, which includes recognition of emotions, theory of mind and insight.

Diabetes (severe) – of specified severity

Severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a *specialist medical practitioner* in the field and resulting in at least two of the following criteria:

- severe diabetic retinopathy resulting in visual acuity uncorrected and corrected of 6/36 or less in both eyes;
- severe diabetic neuropathy causing motor and/or autonomic impairment;
- diabetic gangrene leading to surgical intervention;
- severe diabetic nephropathy causing chronic irreversible renal impairment as measured by estimated Glomerular Filtration Rate (eGFR) less than 30 mL/min/1.73m2 (CKD stage 4, International Chronic Kidney Disease classification).

Diabetes (type 1 insulin dependent)

The unequivocal new diagnosis of Type 1 insulin dependent diabetes mellitus (IDDM) in adulthood.

Encephalitis – resulting in significant impairment

An inflammatory disease of the brain resulting in neurological deficit causing:

- a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*; or
- *significant permanent impairment*, as confirmed by a *specialist medical practitioner* in the field.

Heart attack – of specified severity

The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following:

- signs and symptoms of ischaemia (inadequate blood supply to the heart muscle) consistent with a heart attack; or
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]); or
- development of pathological Q waves in the ECG; or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive or our noted diagnostic techniques are impractical to apply or have been superseded, we will consider other medically recognised tests.

A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease is excluded. Also excluded are other acute coronary syndromes including but not limited, to angina pectoris.

Heart valve surgery – excluding specified procedures

The undergoing of surgery considered medically necessary to repair or replace cardiac valves as a consequence of heart valve defects or abnormalities that cannot be corrected by non-surgical techniques.

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

Hepatitis B or C – occupationally-acquired

Infection with hepatitis B or hepatitis C where the virus was acquired as a result of an:

- an *accident* arising out of the insured person's normal occupation; or
- a malicious act of another person, or persons, arising out of the insured person's normal occupation.

Proof of a new hepatitis B or C infection must be registered within six months of the *accident* or malicious act.

Any incident giving rise to a potential claim must:

- be reported to the relevant authority or employer within seven days of the incident;
- be supported by a negative hepatitis B or C test taken within seven days of the incident; and
- the sero-conversion from hepatitis B surface antigen negative to hepatitis B surface antigen positive or hepatitis C antibody negative to hepatitis C antibody positive must occur within six months of the incident.

Exclusions and limitations

- No benefit will be payable in relation to infection arising from any other means such as a deliberately, self-inflicted or induced cause, or from sexual activity, or from recreational intravenous drug use;
- where effective treatment(s) exist for hepatitis B or hepatitis C which would make the viruses inactive and non-infectious, payment will be subject to the insured person undergoing treatment(s). If the treatment(s) were unable to be continued on medical grounds or the treatment(s) were unsuccessful, then the insured person will be eligible for payment subject to the terms and conditions of the plan.

HIV – contracted from a medical procedure

Infection with the human immunodeficiency virus (HIV) which we reasonably believe to have arose from one of the following medically necessary events which must have occurred to the insured person in Australia by a recognised and registered health professional:

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

Any incident giving rise to a potential claim must:

- be reported to the relevant health authority (and the authority must confirm that the infection was medically acquired); and
- the sero-conversion of the HIV infection must occur within six months of the incident.

We encourage you to report any incident giving rise to a potential claim within 30 days.

Exclusions and limitations

- No benefit will be payable unless the relevant authority confirms that the HIV infection was medically acquired;
- No benefit will be payable in relation to infection arising from any other means such as a deliberately, self-inflicted or induced cause, or from sexual activity, or from recreational intravenous drug use; and
- where effective treatment(s) exist for HIV which would make the virus inactive and non-infectious, payment will be subject to the insured person undergoing treatment(s). If the treatment(s) were unable to be continued on medical grounds or the treatment(s) were unsuccessful, then the insured person will be eligible for payment subject to the terms and conditions of the plan.

HIV – occupationally-acquired

Infection with the human immunodeficiency virus (HIV) where the virus was acquired as a result of:

- an accident arising out of your normal occupation; or
- a malicious act of another person, or persons, arising out of your normal occupation.

Proof of a new HIV infection must be registered within six months of the accident or malicious act.

Any incident giving rise to a potential claim must be reported to the relevant health authority or employer at the time of the event.

Sero-conversion evidence of the HIV infection must occur within 6 months of the incident.

We encourage you to report any accident or act giving rise to a potential claim to us within 30 days. Your accidental infection will need to be supported by a negative HIV antibody test taken within 7 days after the incident.

Exclusions and limitations

- No benefit will be payable in relation to infection arising from any other means such as a deliberately, self-inflicted or induced cause, or from sexual activity, or from recreational intravenous drug use;
- where effective treatment(s) exist for HIV which would make the virus inactive and non-infectious, payment will be subject to the insured person undergoing treatment(s). If the treatment(s) were unable to be continued on medical grounds or the treatment(s) were unsuccessful, then the insured person will be eligible for payment subject to the terms and conditions of the plan.

Intensive care – requiring continuous mechanical ventilation for 10 days

An illness or injury that has resulted in:

- the insured person requiring continuous mechanical ventilation by means of tracheal intubation for at least 10 consecutive days (and 24 hours every day) in an authorised intensive care unit of an acute care hospital; and
- a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*.

Kidney failure – requiring renal dialysis or renal transplantation

End stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which a permanent requirement for regular renal dialysis is instituted or renal transplant undertaken.

The definition will be met if, despite the need for regular dialysis or a kidney transplant as confirmed by a *specialist medical practitioner* in the field, the insured person chooses renal supportive care.

Liver failure – chronic with specified severity

The unequivocal diagnosis of end stage liver failure together with permanent jaundice (yellow discolouration of the skin or eyes) and either ascites (abnormal build-up of fluid in the abdomen) or hepatic encephalopathy (a decline in the brain function that occurs as a result of severe liver disease). The diagnosis must be confirmed by a *specialist medical practitioner* in the field.

Loss of hearing in one ear – total and irrecoverable

Profound and irreversible loss of hearing (except by Cochlear implant) in one ear, after which the affected ear has an auditory threshold of greater than 81 decibels from the frequencies of 500 hertz to 3,000 hertz, as certified by a *specialist medical practitioner* in the field.

Loss of hearing – total and irrecoverable (except by Cochlear implant) in both ears

Profound and irreversible loss of hearing (except by Cochlear implant) in both ears, after which the better ear has an auditory threshold of greater than 81 decibels from the frequencies of 500 hertz to 3,000 hertz, as certified by a *specialist medical practitioner* in the field.

Loss of independence – total and irreversible

The total and irreversible inability to perform at least two of the activities of daily living without the assistance of another person.

Loss of sight in one eye – total and irrecoverable

The total and irrecoverable loss of sight in one eye, as certified by a *specialist medical practitioner* in the field. The extent of the visual loss must be such that the best corrected visual acuity is reduced to at least 6/60, or the visual field reduced to at least 20 degrees of arc.

For clarity:

- Any loss of sight that is recoverable through treatment or visual aids, including (but not limited to) cataracts, is excluded as it would not be considered irrecoverable.
- Best corrected visual acuity is reduced to at least 6/60 means that even with the use of visual aids, the insured person needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.
- 'visual field is reduced to at least 20 degrees of arc' means that the insured person's field of vision is less than 20 degrees in diameter.

Loss of sight – total and irrecoverable in both eyes

The total and irrecoverable loss of sight of both eyes, as certified by a *specialist medical practitioner* in the field. The extent of the visual loss must be such that the best corrected visual accuity is reduced to at least 6/60, or the visual field reduced to at least 20 degrees of the arc.

For clarity:

- Any loss of sight that is recoverable through treatment or visual aids, including (but not limited to) cataracts, is excluded as it would not be considered irrecoverable.
- Best corrected visual acuity is reduced to at least 6/60 means that even with the use of visual aids, the insured person needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.
- 'visual field is reduced to at least 20 degrees of arc' means that the insured person's field of vision is less than 20 degrees in diameter.

Loss of a single limb – total and irrecoverable

The total and irrecoverable loss of use of an entire hand or foot.

Loss of speech – total and irrecoverable

The total and irrecoverable loss of speech as a result of illness or injury which must be established, and the diagnosis reaffirmed after a continuous period of three months of such loss, by a *specialist medical practitioner* in the field.

Loss of speech related to any psychological cause is excluded.

Loss of two limbs – total and irrecoverable

The total and irrecoverable loss of use of two entire hands, or two entire feet, or an entire hand and an entire foot.

Lymphocytic leukaemia – early stage

The presence of chronic lymphocytic leukaemia diagnosed as Rai stage 0, which is defined to be in the blood and bone marrow only.

Major head trauma – resulting in significant permanent impairment

Accidental cerebral injury resulting in permanent neurological deficit causing:

- a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*; or
- *significant permanent impairment*, as confirmed by a *specialist medical practitioner* in the field.

Melanoma – early stage

The presence of a malignant skin tumour, which is confirmed by histological examination, where the tumour is a malignant melanoma without ulceration and measuring less than TNM classification T2aN0M0, or less than 1mm Breslow thickness.

All tumours that are histologically described as melanoma in situ are excluded.

Meningitis – resulting in significant impairment

All potential manifestations of bacterial meningitis causing:

- a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*; or
- *significant permanent impairment,* as confirmed by a *specialist medical practitioner* in the field.

Meningococcal disease – resulting in significant impairment

All potential manifestations of meningococcal septicaemia causing:

- a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*; or
- *significant permanent impairment*, as confirmed by a *specialist medical practitioner* in the field.

Motor neurone disease

The unequivocal diagnosis of motor neurone disease.

Multiple sclerosis – with at least two episodes of neurological deficit

Multiple Sclerosis means an immune-mediated inflammatory disease causing neurological impairment due to an immune system attack on myelinated nerves in the brain, spinal cord
and/or optic nerves.

The diagnosis must be confirmed by a *specialist medical practitioner* in the field and supported by relevant clinical/ neurological findings, lesions on Magnetic Resonance Imaging (MRI) and the presence of oligo-clonal bands within cerebrospinal fluid (CSF) in accordance with the 2017 McDonald Criteria. There must be more than one episode of confirmed neurological deficit.

Muscular dystrophy

The unequivocal diagnosis of muscular dystrophy. The diagnosis must be made by a specialist medical practitioner in the field.

Open heart surgery – through a specified procedure

The undergoing of a thoracotomy for treatment of cardiac defect(s), cardiac aneurysm or benign cardiac tumour(s).

Organ transplant (major) – from another donor

The insured person medically requires and undergoes the transplant from a human donor or, upon specialist medical advice, is placed on an official Australian acute care hospital 'waiting list' to undergo organ transplant from a human donor for one or more of the following:

- kidney,
- heart,
- liver,
- lung,
- pancreas,
- small bowel, and
- bone marrow.

The transplantation of all other organs or parts of any organ or of any other tissue is excluded.

'Waiting list' means the waiting list of a Transplantation Society of Australia and New Zealand recognised transplant list.

Other cancers – excluding early stage cancers

The presence of a malignant tumour other than classified as breast, prostate or skin cancer, where malignant tumour is confirmed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes leukaemia, sarcoma and lymphoma, and inaccessible brain tumours described as malignant on neuroimaging.

Specifically excluded are tumours histologically:

- described as pre-malignant; or borderline or low malignant potential; or non-invasive; or
- show the malignant changes of carcinoma in situ, other than carcinoma in situ of the testicle if treatment requires the removal of the entire testicle.

Please see the definitions of *Breast cancer – excluding early stage breast cancers*, *Prostate cancer – excluding early stage prostate cancers* and *Skin cancer – excluding early stage skin cancers for details on what is covered for malignant tumour in those regions.*

Pneumonectomy – removal of entire lung

The removal of an entire lung when considered necessary and appropriate treatment.

Paralysis – total and permanent

The permanent and total loss of use of one or more limbs resulting from disease, illness or injury of the brain or spinal cord, where limb includes arms and legs.

This includes, but is not limited to, quadriplegia, paraplegia, diplegia (such as both arms or both sides of the face) and hemiplegia (such as one arm and one leg of the same side of the body).

Parkinson's disease

The unequivocal diagnosis of idiopathic Parkinson's disease confirmed by a *specialist medical practitioner* in the field. All other types of Parkinsonism are excluded (e.g. secondary to medication).

Prostate cancer – early stage

A tumour located within the prostate gland and histologically described as TNM classification T1 according to the TNM staging method with a Gleason Score of 5 or less.

Prostate cancer – excluding early stage prostate cancers

The presence of a malignant prostate tumour, which is confirmed by histological examination, where it is:

- a TNM clinical classification of at least T2N0M0; or
- a Gleason score of at least 6; or
- any stage of prostate cancer where you undergo major interventionist therapy specifically designed to kill or destroy cancer cells. Major interventionist therapy includes, but is not limited to, prostatectomy, radiotherapy, brachytherapy, chemotherapy, biologic response modifiers or any other major treatment.

Pulmonary arterial hypertension (idiopathic and familial) – resulting in significant permanent impairment

The confirmed diagnosis of idiopathic or familial (meaning of a spontaneous or unknown cause, or inherited) pulmonary arterial hypertension (increased blood pressure in the blood vessels of the lungs) with right ventricular enlargement (enlarged right side of the heart muscle) established by investigations including cardiac catheterisation, resulting in permanent physical impairment to the degree of at least Class III* of the World Health Organisation Functional Classification of Pulmonary Hypertension.

The diagnosis must be confirmed by a *specialist medical practitioner* in the field.

*Class III of the World Health Organisation Functional Assessment of Pulmonary Hypertension means:

Patients with pulmonary hypertension resulting in a slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity causes undue dyspnoea or fatigue, chest pain or near syncope.

Rheumatoid arthritis (severe) – of specified severity

The unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. The diagnosis must be supported and evidenced by all of the following four criteria:

- diagnosis of Rheumatoid Arthritis as specified by the American College of Rheumatology and European League Against Rheumatism: 2010 Rheumatoid Arthritis Classification Criteria;
- symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or 4 large joints (ankles, knees, hips, elbows, shoulders);
- the insured person has failed at least 6 months of intensive treatment with two conventional disease modifying anti rheumatic drugs (DMARDs). This excludes corticosteroids and non-steroidal anti-inflammatories; and
- the disease must be progressive and non-responsive to all conventional therapy. Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for Rheumatoid Arthritis.

Degenerative osteoarthritis and all other arthridities are excluded.

Significant permanent impairment means permanent impairment of at least 25 per cent whole person function as defined in the most current edition of the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'.

Significant permanent physical impairment means permanent impairment to the degree of at least Class 3 of the New York Heart Association (or equivalent) classification of cardiac impairment.

Severe cognitive impairment – permanent

A total and permanent deterioration or loss in intellectual capacity due to sickness or injury resulting in the insured person requiring another person's assistance or verbal cueing to protect them, as measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

- short or long-term memory;
- orientation as to person (such as personal identity), place (such as location), and time (such as day, date and year); and
- deductive or abstract reasoning.

The diagnosis must be confirmed by a *specialist medical practitioner* in the field.

Skin cancer – excluding early stage skin cancers

The presence of a malignant skin tumour, which is confirmed by histological examination, where the malignant tumour:

- is a non-melanoma skin cancer or a melanoma skin cancer that has spread to the bone, lymph node, or other distant organs; or
- is a melanoma having progressed to at least TNM classification T2aN0M0; or with at least 1mm Breslow thickness; or where the melanoma is showing signs of ulceration.

Basal cell and squamous cell carcinomas of the skin are excluded unless it has metastasised to other organs.

Stroke – resulting in neurological deficit

A cerebrovascular event producing neurological deficit. The stroke must be confirmed by a *specialist medical practitioner* in the field and requires clear evidenced by neuro-imaging (e.g. CT, MRI or similar scanning technique) that a stroke has occurred demonstrating infarction of brain tissue, intracranial haemorrhage and/or subarachnoid haemorrhage.

The following are specifically excluded:

- transient ischemic attack;
- non-stroke related reversible neurological deficit;
- cerebral symptoms due to migraine;
- cerebral injury resulting from head trauma or hypoxia; and
- disturbances of vision or balance due to disease of the eye, optic nerve or the vestibular function.

Ulcerative colitis (severe) – requiring permanent medication

The diagnosis of ulcerative colitis that has failed to be controlled by standard therapy, including cortisone treatment, and requires permanent immunosuppressive medication.

Contact us

For general enquiries in relation to this PDS, a referral to an insurance adviser or the administration of your plan, please contact:

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A subsidiary of Avant Mutual Group Limited ABN 58 123 154 898

Version 1.0
5 April 2021

MJN-401 04/22 (DT-2423)

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