Life & Living Insurance

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Cover Wording

Welcome to your Life & Living Insurance

Thank you for choosing Life & Living Insurance.

Find out what your insurance does and doesn't cover

This document explains how the insurance works, your responsibilities, and how to make a claim. Please read it carefully, as it's really important you understand it. While there's a lot of information, if you take time to read it now, you'll know what the insurance covers. Just as important – you'll also know what it doesn't cover.

In this document you'll find sections covering:

- ‘We’, ‘us’, ‘our’ means nib nz insurance limited.
- ‘You’, ‘your’ means the person named in the Policy Schedule as the insurance owner or policy owner. You may also be named as the person insured.
- ‘Beneficiary’ means the person named in the Policy Schedule as the beneficiary. The beneficiary receives any Life cover or Funeral Expenses cover payment if the person insured has died. The beneficiary must be alive at the date of payment or the payment will be made to your estate.
- ‘Person insured’ means the person named in the Policy Schedule as the person who is covered and will be assessed to decide a claim. This person can be different from the owner of the insurance.

Life & Living Insurance is provided by nib nz insurance limited. nib nz insurance is the only organisation responsible for claims under the cover.

nib nz insurance pays Kiwibank Limited for referring customers and also pays nib nz limited for the services it provides. nib nz limited provides financial advice on its own behalf, and not on behalf of nib nz insurance or Kiwibank Limited. You can find more about how nib nz limited provides financial advice at **www.nib.co.nz/about-nib/financial-advice/**.

Life & Living Insurance at a glance

In summary, here's how Life & Living Insurance works:

If you choose **Life Insurance – Life cover** pays a lump sum of money if the person insured dies, or is diagnosed as terminally ill and expected to die within the next 12 months.

If you choose **Living Insurance** – you can choose some or all of these three covers:

- **Serious Illness Trauma cover** – pays a lump sum of money if the person insured is diagnosed with a defined medical condition, such as severe cancer or a severe heart attack.
- **Income Protection Illness cover** – pays a monthly amount if the person insured becomes unable to work because of illness, where they were previously working at least 25 hours per week for a single employer. If they have other income, the monthly payment may be reduced. You can select whether payments are made for up to two or five years. This will be the maximum period we'll make payments for any one illness and any related or similar illness.
- **Redundancy cover** (only available if you also have Income Protection Illness cover) – pays a monthly amount for up to six months if the person insured doesn't work because they've been made redundant.

Funeral Expenses cover – this is complimentary to help with funeral expenses. Whichever cover you've chosen, you'll get a lump sum payment of $15,000 if the person insured dies, or is diagnosed as terminally ill and expected to die within the next 12 months.

You can choose...

Life Insurance

Life cover

AND/OR

Living Insurance

Serious Illness Trauma cover

AND/ OR

Income Protection Illness cover

AND

Redundancy cover
only available if you also have Income Protection Illness cover

⊕ **Complimentary Funeral Expenses cover**

This ‘Life & Living Insurance at a glance’ section is only an overview, and does not form part of your insurance agreement with us. You need to read all the documents that make up your insurance agreement to understand the full terms and conditions.

Read and keep your insurance agreement

These documents set out your insurance agreement with us

- This Life & Living Insurance Cover wording, plus
- Your Policy Schedule
- = your insurance agreement.

This is also sometimes called an 'insurance policy'.

It's important to be truthful and accurate

All information you, and the person insured if that's not you, give us at any time must be correct and complete.

This includes:

- when applying for cover
- the period after applying but before your cover starts
- if you ask us to change your cover or the insurance agreement, and
- if you ask us to re-start your cover after it has ended.

This is very important for us. We rely on this information when deciding whether we can provide or increase your cover, and the pricing and terms of your cover. Unless the law says otherwise, we may cancel or avoid the insurance agreement, and/or decline any claim, if you (or the person insured if that's not you):

- give us information that is incorrect or incomplete, or
- know about but don't provide us information that could have been relevant to our decision.

- To 'avoid' means treating the insurance agreement as invalid, as if it had never been taken out. That means we would not be required to pay any claim, and may require you to refund any claims already paid.

Our decision to cancel or avoid the insurance agreement and/or decline a claim is entirely up to us. If we do cancel the insurance agreement, we don't have to refund any premiums.

Where the insurance agreement gives us rights to cancel or avoid the insurance agreement, or decline claims, this doesn't take away from any other rights that we may also have under law.

This Life & Living Insurance Cover wording sets out the main terms and conditions of the insurance agreement

This Life & Living Insurance Cover wording sets out the main terms and conditions of the insurance agreement, including how the insurance works.

Your most recent Policy Schedule sets out who is insured and for how much

The Policy Schedule shows important details of the insurance agreement. It includes:

- who the person insured is (as it may be someone different to you)
- who the policy owner is
- who the beneficiary is (if one is named)
- what type of cover you have
- any special terms of the cover, for example if there are additional exclusions specific to the person insured, or if any additional premiums apply to the cover
- when the cover starts
- the maximum amount insured under the cover, and
- the premium payments you have to make.

If your application and your Policy Schedule are different, the Policy Schedule overrides anything that is inconsistent in the application.

We'll only replace or change the Policy Schedule to reflect changes that we agree with you or other changes that the Life & Living Insurance Cover wording allows us to make.

If we replace or change the Policy Schedule, the most recent Policy Schedule we send you becomes part of the insurance agreement. The most recent Policy Schedule overrides any earlier versions, except where this Life & Living Insurance Cover wording specifically states otherwise.

Read these documents, file them safely, and let someone know where they are

Please read carefully through all the documents making up your insurance agreement. Check that your Policy Schedule is correct. If you find any mistakes please contact us immediately.

We'll also send you a record showing the cover you've applied for and the information you provided us when doing so. The record and your application don't form part of the insurance agreement. However, to ensure your cover is correct and you haven't forgotten to tell us anything please check the record carefully and let us know if any of the details are incorrect. If the actual details you gave us are different, they will override the record we send you.

We recommend you keep these documents in a safe place. You may need to refer to them to make a claim.

You may like to tell your lawyer, your family, or the executor of your will where you keep these documents.

This insurance agreement is made in New Zealand

The law of New Zealand applies to the insurance agreement. You and we both accept the authority of the New Zealand courts in relation to any disputes relating to the insurance agreement.

Phone us to make a claim

If you wish to make a claim, please phone us on 0800 555 642 as soon as possible.

We need you to give us information so we can assess your claim

We may ask you to provide us with information we reasonably need to assess your claim. This may include medical information. You must pay the cost of providing this initial information. We'll pay any extra cost if we require further medical evidence in order to assess your claim.

We'll need authority from you, and from the person insured if that's not you, to ask others for some personal information. This information will only be what we reasonably require to assess or manage the claim.

We'll also need authority from you, and from the person insured if that's not you, to disclose any information in connection with your claim to other parties, if we reasonably think that's necessary or appropriate to deal with your claim. Other parties include any reinsurer, employer, doctor or hospital.

Assessment of your claim may be delayed if you and the person insured don't provide the information and authorities we need as outlined above. Unless the law says otherwise, we can decline your claim if this delay adds up to six months or more.

It's important to be truthful and accurate

If you make a fraudulent or dishonest claim, we may decline the claim and/or cancel or avoid the insurance agreement. The decision to do so is entirely up to us. If we pay a fraudulent or dishonest claim, at any time afterwards we can require you to refund us whatever we paid.

- To 'avoid' means treating the insurance agreement as invalid, as if it had never been taken out. That means we would not be required to pay any claim, and may require you to refund any claims already paid.

We rely on the information you give us in assessing a claim. We may require you to refund any claim payments if we discover information we should've been given, that means we wouldn't have paid the claim. This is additional to our rights above, but only applies if you (or the person insured if that's not you):

- gave us information that is incorrect or incomplete, or
- knew about but didn't provide us with information that would have been relevant to our assessment of the claim.

Our rights above don't take away from any other rights we may have under law. If we do cancel the insurance agreement, we don't have to refund any premiums.

You must notify us as soon as possible and no later than six months if you have a claim

You must notify us of any claim as soon as possible and within six months of when you first became entitled to make that claim under the insurance agreement. If your late notification of a claim means that information we reasonably require to assess the claim is no longer available, then we may decline the claim unless the law says otherwise.

We pay claims in New Zealand dollars

All amounts we pay for a claim will be in New Zealand dollars.

What you'll pay for the insurance cover

The cost of insurance is called a premium. We provide the insurance cover in return for payment of the premium. Whatever cover you choose, your premium includes an annual policy administration fee. You can find out how often you have to pay, and how much, in your Policy Schedule.

Your premium will usually increase each year

Your premium is not fixed. Even if you keep the same amount of cover, your premiums will usually increase as the person insured grows older. You can ask us to give you an indication of how your premiums may change as the person insured gets older. We can also change the premiums, as set out in the section 'Making changes to the insurance agreement'.

Your cover will generally increase each year

To help keep the value of your insurance cover, we'll automatically increase the amount insured for each type of cover you have on the anniversary of the Life & Living Insurance start date. We'll be guided by the Consumer Price Index, which is an indicator of changes in prices, but the increase in cover will be at least 1% and no more than 7%.

We don't automatically increase the complimentary Funeral Expenses cover. That cover will remain at a single payment of $15,000.

- The 'Life & Living Insurance start date' is the date when your insurance agreement first started. This start date is shown in your Policy Schedule.
- The 'amount insured' for each type of Life & Living Insurance cover is shown in your Policy Schedule.

The automatic increase in the amount insured will also mean an increase in the premium.

When we automatically increase the amount insured, you don't have to answer any health questions or give us any information. The maximum your amount insured can be automatically increased to is:

- Life cover – $1 million
- Serious Illness Trauma cover – $1 million
- Income Protection Illness cover – $6,000 per month
- Redundancy cover – $6,000 per month.

We stop automatically increasing the amount insured under some circumstances

We'll stop automatically increasing the amount insured at certain ages:

- for Life cover, once the person insured has reached 65
- for Serious Illness Trauma cover, Income Protection Illness cover, and Redundancy cover, once the person insured has reached 60.

We'll stop automatically increasing the amount insured for each type of cover you have if that type of cover is at the maximum stated above.

We'll also stop automatically increasing the amount insured for all types of cover you have if:

- you ask us to stop the automatic increases, or
- you've contacted us three years in a row and not taken up the increases, or
- you've had a claim under any type of cover.

We'll send you an updated Policy Schedule

We'll send you an updated Policy Schedule each year before the anniversary of the Life & Living Insurance start date. You must contact us within 30 days of the date we send you the new Policy Schedule showing the increase, if you don't want the amount insured to be automatically increased.

- The 'Life & Living Insurance start date' is the date when your insurance agreement first started. This start date is shown in your Policy Schedule.
- The 'amount insured' for each type of Life & Living Insurance cover is shown in your Policy Schedule.

If your premium remains unpaid, we can cancel the insurance agreement

If you don't pay the premium in full when it's due, and you remain behind on your premiums for two or more payment dates in a row, we can cancel the insurance agreement. Your cover will end from the date stated in the notice we'll give you.

Life cover

How Life cover works

This cover is provided only if you've chosen it and it's shown in your Policy Schedule.

If the person insured dies while covered or is diagnosed as terminally ill while covered, we'll pay the Life cover amount insured. The amount insured will be as shown in the Policy Schedule that was current when the person insured died or was diagnosed as terminally ill.

We won't pay more than once under the Life cover.

- 'Terminal illness' or 'terminally ill' means the person insured is diagnosed with an illness or injury that's expected to lead to death within 12 months. This means 12 months even with the best medical or surgical treatment available in New Zealand. Two appropriate medical specialists must confirm this prognosis. The 12 months is measured from the time of that confirmation.
- 'Medical specialist' means a qualified medical practitioner who is vocationally registered in a relevant specialty and approved by us. The medical specialist cannot be you or the person insured, or an immediate family member or business partner of you or the person insured.

Who we'll pay

Where we pay a claim, we'll pay you, the policy owner, or your estate. However, where there's a beneficiary named in the Policy Schedule, we'll pay them instead if at the time of payment the beneficiary is alive and the person insured has passed away.

When Life cover ends

Cover will end on the date of whichever of the following is first:

- we pay a Life cover claim for terminal illness, or
- the person insured dies, or
- you cancel this cover or the insurance agreement, or
- we cancel the insurance agreement, or
- the anniversary of the Life & Living Insurance start date after the person insured turns 100 years old.

This will not affect a claim or right to claim that arose before the cover ended.

You're not covered in some circumstances

You're not covered if the person insured's death or terminal illness is directly or indirectly as a result of intentional self-inflicted harm within 13 months of:

- the Life cover start date, or
- the start date of an increase to the Life cover requested by you, but this only affects cover for the increase, or
- the Life cover re-start date.

- The ‘start date’ of Life cover is set out in your Policy Schedule.
- Where we increase your cover at your request, the ‘start date’ of the increase is the date we accept the increase. We’ll send you a notice advising of the increase.
- Where we agree to re-start the cover after it has ended, the ‘re start’ date is the date we accept the re-start. We’ll send you a notice advising of the re-start.

You’re not covered if the Policy Schedule has a special term that excludes the event or condition leading to the person insured’s death or terminal illness.

Serious Illness Trauma cover

How Serious Illness Trauma cover works

This cover is provided only if you’ve chosen it and it’s shown in your Policy Schedule.

If the person insured is diagnosed with one of the defined medical conditions below while covered, we’ll pay a defined lump sum amount, which varies depending on the condition.

Who we’ll pay

Where we pay a claim, we’ll pay you, the policy owner.

Payment is based on the severity of defined medical conditions

Depending on the severity of the defined medical condition (see below), we’ll pay all or part of the amount insured, as outlined in more detail below.

- The ‘amount insured’ is normally the amount shown in your Policy Schedule for Serious Illness Trauma cover as at the time the relevant condition is diagnosed. However, the ‘amount insured’ may reduce automatically in certain circumstances, as outlined below.

How the amount insured can automatically reduce

Whenever a defined medical condition is diagnosed that gives you a right to claim under this cover, the amount insured available for later claims is automatically reduced by the amount we’re required to pay for the current claim. This reduction takes effect immediately, even before we’ve paid, but it’s only after we’ve paid a claim that the reduced ‘amount insured’ will be shown on the Policy Schedule.

For example, imagine you start with an amount insured of $100,000. Let’s say you’re then diagnosed with a low severity medical condition that means you can claim for $25,000. This would automatically reduce the ‘amount insured’ by $25,000 for any later claims. So immediately after the diagnosis, the ‘amount insured’ available for later claims would be $75,000. Subject to meeting all other requirements, once we paid the $25,000, we’d send you a new Policy Schedule showing the reduced ‘amount insured’ of $75,000.

How you're paid for low severity events

You'll be paid once for the first low severity cancer event, and once for the first low severity cardio-vascular event. You're not covered for any additional low severity events. The payment for a low severity event will be 25% of the amount insured, up to a maximum of $50,000 per payment.

How you're paid for high severity events

You'll be paid for only one high severity event. The single payment will be 100% of the amount insured. Serious Illness Trauma cover will end as soon as the first claim is paid for a high severity event, meaning no further claims can be made.

What low and high severity events are covered

The table below lists the medical conditions covered. The specific definition of each medical condition is included in the wording further below.

Condition	Low severity - we pay 25% of the amount insured, up to a maximum of $50,000 per payment	High severity - we pay 100% of the amount insured
Cancer	Carcinoma in situ of the breast Carcinoma in situ of the female organs Carcinoma in situ of the male organs Early stage melanoma Early stage prostatic cancer	Malignant cancer
Cardio-vascular	Moderate heart attack Coronary artery angioplasty – single or double vessel	Severe heart attack Coronary artery angioplasty – triple vessel Coronary artery bypass surgery Stroke
Other Conditions		Advanced Alzheimer's, Advanced Dementia, Advanced Motor Neuron disease, Advanced Multiple Sclerosis, Advanced Muscular Dystrophy, Advanced Parkinson's disease, Aplastic Anaemia, Blindness, Chronic liver disease, Chronic lung disease, Chronic renal failure, Coma, Encephalitis, Loss of speech, Major organ transplants, Paralysis, Pneumonectomies, Severe burns, Medical condition resulting in the permanent inability to perform two or more 'activities of daily living' without requiring assistance from another person

When Serious Illness Trauma cover ends

Cover will end on the date of whichever of the following is first:

- we pay a high severity payment, or
- the person insured dies, or
- we pay the Funeral Expenses cover benefit, or
- you cancel this cover or the insurance agreement, or
- we cancel the insurance agreement, or
- the anniversary of the Life & Living Insurance start date after the person insured turns 65 years old.

This will not affect a claim or right to claim that arose before the cover ended.

You're not covered in the first 90 days for cancer medical conditions

You're not covered for any of the cancer medical conditions listed above in the first 90 days after the Serious Illness Trauma cover start date or re-start date. We call this the stand-down period. This means you're not covered for a defined cancer medical condition or its symptoms if the first sign or symptom or diagnosis occurs before the end of the stand-down period.

The same applies for the first 90 days after the start date of an agreed increase to your cover that you requested, but this only affects cover for the increase.

- The 'start date' for your Serious Illness Trauma cover is as shown in your Policy Schedule.
- Where we agree to increase your cover at your request, the 'start date' of the increase is the date we accept the increase. We'll send you a notice advising you of the increase.
- If we agree to re-start the Serious Illness Trauma cover after it has ended, the 're-start' date is the date we accept the re-start. We'll send you a notice advising of the re-start.

For the purposes of the stand-down period, a 'sign' or 'symptom' means any sign or symptom of the relevant medical condition that would lead a reasonable person to seek medical advice.

You're not covered in some circumstances

You're not covered if:

- the person insured dies within 14 days of the diagnosis of the defined medical condition, or
- a criminal act by you, or by the person insured if that's not you, has caused or contributed to the medical condition, or
- the Policy Schedule has a special term that excludes an event or condition from Serious Illness Trauma cover.

- 'Criminal act' or 'criminal activity' means conduct that is an offence, where the maximum punishment allowed by law for that type of offence is a prison sentence or a sentence of home detention. This includes any conduct that meets the legal requirements for such an offence, even if the conduct does not result in any charges or convictions. It is not necessary for the requirements to be proved beyond a reasonable doubt.

Definitions of medical conditions

In this section we define the medical conditions eligible for Serious Illness Trauma cover. If a condition is not listed below, it's not covered. For cover to apply all the requirements of the relevant defined medical condition must be met.

We use medical terms in this section because they are necessary to describe the precise diagnosis.

We may change these definitions in the future, as detailed under the heading 'We can change the Serious Illness Trauma cover details' below.

- Some of the medical definitions below refer to the person insured requiring permanent assistance from another person with 'activities of daily living'. If the person insured can perform the activity on their own by using special equipment, we will not treat them as requiring assistance from another person to perform that activity.
- Each of items 1-5 below counts as one 'activity of daily living':
  1. bathing and showering
  2. dressing and undressing
  3. eating and drinking
  4. maintaining continence with a reasonable level of personal hygiene
  5. getting in and out of bed, a chair or wheelchair or moving from place to place by walking, wheelchair or walking aid.
- Some of the medical definitions below refer to a 'medical specialist'. This means a qualified medical practitioner who is vocationally registered in a relevant specialty and approved by us. The medical specialist cannot be you or the person insured, or an immediate family member or business partner of you or the person insured.

Advanced Alzheimer's

Means the unequivocal diagnosis of Alzheimer's disease of a specific severity, which must confirm permanent irreversible failure of brain function for which no other recognisable drug, alcohol or chemical abuse has been identified as contributing to the condition. A Mini-Mental State Examination score of 23 or less is required, or an equivalent test. The diagnosis is confirmed by an appropriate specialist in psychogeriatrics, psychiatry, neurology or geriatrics.

Advanced Dementia

Means unequivocal diagnosis of permanent and irreversible failure of brain function with significant cognitive impairment confirmed by a consultant neurologist. A Mini-Mental State Examination score of 23 or less is required, or an equivalent test. The diagnosis is confirmed by an appropriate medical specialist in psychogeriatrics, psychiatry, neurology or geriatrics.

Advanced Motor Neurone disease

Means unequivocal diagnosis of Motor Neurone disease diagnosed by a consultant neurologist. The person insured must have also sustained a neurological deficit causing at least 25% permanent impairment of whole person functioning* or requiring permanent assistance from another person to perform one or more of the activities of daily living. The whole person functioning* must be assessed by a neurologist.

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

Advanced Multiple Sclerosis

Means the unequivocal diagnosis by a consultant neurologist of Multiple Sclerosis causing permanent neurological damage. The person insured must have at least 25% permanent impairment of whole person functioning* that is permanent for a continuous period of at least 90 days. The whole person functioning must be assessed by a neurologist. Diagnosis must be supported by confirmatory neurological investigations, for example, lumbar puncture, evoked visual responses, evoked auditory responses, and MRI evidence of lesions in the central nervous system.

Advanced Muscular Dystrophy

Means unequivocal diagnosis of muscular dystrophy diagnosed by a consultant neurologist leading to at least 25% permanent impairment of whole person functioning.* The whole person functioning must be assessed by a neurologist.

Advanced Parkinson's disease

Means the unequivocal diagnosis of Idiopathic Parkinson's disease by a specialist neurologist. The person insured must have also sustained a neurological deficit causing at least 25% permanent impairment of whole person functioning* or requiring permanent assistance from another person to perform one or more of the activities of daily living. The whole person functioning must be assessed by a neurologist.

Aplastic Anaemia

Means bone marrow failure over a period of at least two months, which results in anaemia, neutropenia and thrombocytopenia confirmed by a medical specialist requiring treatment of one of blood product transfusion; marrow-stimulating agents; immunosuppressive agents; or bone marrow transplantation. Aplastic anaemia must be confirmed by a medical specialist.

Blindness

Means the total and permanent irreversible loss of sight in both eyes, whether aided or unaided. This must be evidenced by a visual acuity less than 6/60 in both eyes after correction, and be provided by an ophthalmologist.

Carcinoma in situ of the breast

Means a focal autonomous new growth of carcinomatous cells within the breast 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. Medically necessary complete removal of the breast (mastectomy) will be assessed under the malignant cancer definition.

Carcinoma in situ of the female organs

Means a focal autonomous new growth of carcinomatous cells within the:

- cervix-uteri
- corpus-uteri
- fallopian tubes (the tumour must be limited to the tubal mucosa)
- ovary
- vagina, or
- vulva

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.

Carcinoma in situ of the male organs

Means a focal autonomous new growth of carcinomatous cells within the:

- penis
- testes, or
- perineum

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.

Chronic liver disease

Means end-stage liver failure resulting in permanent jaundice, ascites, and/or encephalopathy confirmed by a medical specialist. Liver disease arising from drug and alcohol abuse is specifically excluded.

Chronic lung disease

Means end-stage respiratory failure as diagnosed by an appropriate specialist in respiratory disease. The result of the respiratory failure requires continuous oxygen therapy and the person insured has a FEV 1 test result of less than 1 litre.

Chronic renal failure

Means the kidneys have reached the end-stage of renal disease resulting in chronic irreversible failure of the kidneys to function, as a result of which regular renal dialysis is instituted or transplantation performed. This must be confirmed by a medical specialist.

Coma

Means a state of unconsciousness, unarousable and unresponsive to external stimuli, persisting continuously for at least 72 hours, requiring the use of life-support systems. Medical induced coma and coma arising from drug and alcohol abuse are specifically excluded.

Coronary artery angioplasty – single or double vessel

Means undergoing of angioplasty to one or two coronary arteries, to treat coronary artery disease. Angiographic evidence is required to confirm the need to undergo this procedure.

Coronary artery angioplasty – triple vessel

Means the undergoing of angioplasty on three or more coronary arteries (namely the left anterior descending, left circumflex, right coronary artery) in the same procedure to correct a narrowing or blockage.

Coronary artery bypass surgery

Means the undergoing of coronary artery bypass surgery for the treatment of coronary artery disease that a medical specialist considers is the appropriate and necessary treatment.

Early stage melanoma

Means the presence of one or more malignant melanomas. The melanoma is less than Clark Level 3 and less than 1.5mm Breslow thickness, and showing no signs of ulceration as determined by histological examination. The malignancy must be characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. Tumours which are histologically described as pre-malignant (including Lentigo Maligna) are excluded.

Early stage prostatic cancer

Means a prostate tumour that is histologically described as having:

- a TNM classification T1 (or any equivalent or lesser classification), or
- a Gleason score of 5 or less

The removal of the entire prostate will be assessed under the malignant cancer definition.

Encephalitis

Means the unequivocal diagnosis of severe inflammatory disease of the brain diagnosed by an appropriate specialist. The person insured must have also sustained a neurological deficit causing at least 25% permanent impairment of whole person functioning* or requiring permanent assistance from another person to perform one or more activities of daily living. Encephalitis arising from drug and alcohol abuse is specifically excluded.

Loss of speech

Means the inability to produce intelligible speech, due to sickness or injury. This loss must be total and permanent (irreversible) as assessed three months after the event by an appropriate medical specialist. Loss of speech related to any psychological cause is excluded.

Major organ transplants

Means the placement on the major organ transplant waiting list in New Zealand or Australia, for a transplant from a human donor of one or more of the following organs: bone marrow, heart, intestine, kidney, liver, lung, pancreas, or small bowel. The transplant of all other organs, parts of organs or any other tissue transplant is excluded.

Malignant cancer

Means positively and unequivocally diagnosed with histological or cytological evidence of the presence of one or more malignant tumours, including lymphoma (including Hodgkin's disease and non Hodgkin's lymphoma disease), leukaemia, multiple myeloma and malignant bone marrow disorders, that are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue.

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

The following cancers are excluded:

- Tumours which are histologically described as pre-malignant or show the malignant changes of carcinoma in situ, including all categories of cervical dysplasia and/or cervical intraepithelial neoplasia,
- Carcinoma in situ of the breast unless the person insured has a medically required mastectomy to remove the entire breast,
- Melanomas which are both less than 1.5mm Breslow thickness and less than Clark Level 3 depth of invasion,
- All hyperkeratosis and basal cell carcinomas, and squamous cell carcinomas of skin unless it has metastasised distally to other solid organs,
- Chronic lymphocytic leukaemia less than Rai stage 1,
- Papillary carcinoma of the thyroid unless having progressed to at least clinical classification T2N0M0, and
- Prostatic cancer which is TNM classification T1 or less and which has a Gleason score of 5 or less, unless it results in the medically required removal of the entire prostate.

Moderate heart attack

Means death of a portion of heart muscle arising from inadequate blood supply to the relevant area. The basis for diagnosis must be supported by evidence of the following clinical features being present and consistent with myocardial infarction (and not due to elective medical intervention):

- new electrocardiographic (ECG) changes, or
- rise and/or fall of Troponin I or Troponin T, with at least one value of Troponin I between 500ng/L and 2000.0ng/L or Troponin T between 25ng/L and 600ng/L.

If the above tests are inconclusive, we may, at our reasonable discretion, consider any other appropriate medical evidence in support of a diagnosis.

Myocardial infarctions arising from elective percutaneous procedures are excluded.

Paralysis

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

Pneumonectomies

Means the undergoing of surgery to remove an entire lung.

Severe burns

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

Severe heart attack

Means death of a portion of heart muscle arising from inadequate blood supply to the relevant area. The basis for diagnosis must be supported by evidence of the following clinical features being present and consistent with myocardial infarction and not due to medical intervention:

- new electrocardiographic (ECG) changes, and either a:
  i. diagnostic elevation of cardiac enzymes CK-MB, or
  ii. rise and/or fall of Troponin I or Troponin T, with at least one value of Troponin I greater than 2000.0ng/L or Troponin T greater than 600ng/L.

If these are inconclusive, we will consider a claim based on conclusive evidence that the person insured has been diagnosed as having suffered a myocardial infarction, resulting in any one of the following:

- new pathological Q waves, or
- heart attack triggering ventricular fibrillation, or
- a permanent left ventricular ejection fraction of 40% or less, measured three or more months after the event.

Stroke

Means any cerebro-vascular accident or incident producing acute neurological sequelae. This includes infarction of brain tissue, intracranial or subarachnoid haemorrhage, or embolisation from an extracranial source. The basis for diagnosis shall be supported by evidence on a Computerised Tomography (CT), Magnetic Resonance Imaging (MRI) or similar scan that a stroke has occurred and has resulted in permanent neurological deficit causing at least 10% permanent impairment of whole person function.*The whole person functioning must be assessed by a neurologist. Transient ischaemic attacks, cerebral events due to reversible neurological deficits, migraine, hypoxia or trauma and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Medical condition resulting in the permanent inability to perform two or more 'activities of daily living' without requiring assistance from another person

Means due to a medical condition, the person insured is permanently unable to perform two or more 'activities of daily living' without the physical assistance of someone else..If the person insured can perform the activity on their own by using special equipment, we will not treat them as requiring assistance from another person to perform that activity.

Each of the items 1-5 below counts as one 'activity of daily living':

1. bathing and showering
2. dressing and undressing
3. eating and drinking
4. maintaining continence with a reasonable level of personal hygiene
5. getting in and out of bed, a chair or wheelchair or moving from place to place by walking, wheelchair or walking aid.

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

We can change the Serious Illness Trauma cover details

We can change the Serious Illness Trauma cover definitions and add or remove medical conditions covered. We can also change whether medical conditions are high severity or low severity.

We will only do this where we reasonably consider it necessary to protect our legitimate business interests. For example, we may do this where changes in medical practice significantly reduce the impact of a medical condition on people who have it. Another example could be if it becomes more difficult or expensive for us to provide the cover

Reasons for this might include, among other things:

- medical research
- health or population trends
- changes in medical practice
- medical advances mean detection of some conditions occur earlier in their development, or
- changes in the causes or prevalence of particular medical conditions.

If we make this type of change, it will apply to all customers who have Serious Illness Trauma cover. We'll give you at least 60 days' notice of any changes, and the date they'll apply from. If there are any special terms mentioned in your Policy Schedule, these will continue to apply, unless we tell you they don't apply.

If you're not happy with any changes, you can cancel your Serious Illness Trauma cover. If you do this before the changes take effect, you can ask for a proportionate refund of any premiums that you've paid ahead of time for that cover, for any period that falls after the date the changes take effect.

Any change will not affect a claim or right to claim that arose before the date of the change.

Income Protection Illness cover

How Income Protection Illness cover works

This cover is provided only if you've chosen it and it's shown in your Policy Schedule.

If the person insured is in a 25 hr+ role and is unable to work because of an illness, we'll make monthly payments as detailed below.

- '25 hr+ role' means a paid role for at least 25 hours per week with a single employer.

There are exceptions that apply if the person insured was not working in a 25 hr+ role when they first became unable to work. These are detailed below under the heading 'Exceptions if not in a 25 hr+ role'.

You may also be eligible for a further lump sum payment. You can apply only once we've paid the monthly payments for a particular illness for the maximum cover period shown in your Policy Schedule. The lump sum will be paid only if the person insured is likely to be permanently unable to work because of that same illness. Also, the person insured must be likely to need permanent assistance from another person with two or more activities of daily living, as detailed below.

Who we'll pay

Where we pay a claim for Income Protection Illness cover, we'll pay you, the policy owner.

You're paid monthly payments

You'll get monthly payments if the person insured suffers an illness that results in at least 30 consecutive days of them being unable to work. This 30 day period is a wait period. You won't be paid for this 30 day period.

- The person insured is 'unable to work' if, in our reasonable opinion, they're entirely prevented solely as a result of the illness from working in any occupation for which they're reasonably suited. In assessing whether they're reasonably suited to an occupation, we'll look solely at their education, training and experience. The person insured must also be under the continuous care and following the advice of a medical specialist, solely as a result of the same illness.
- 'Medical specialist' means a qualified medical practitioner who is vocationally registered in a relevant specialty and approved by us. This cannot be you or the person insured, or an immediate family member or business partner of you or the person insured.

You'll be paid the monthly amount for this cover as shown in your Policy Schedule that was current when the person insured first became unable to work. This monthly amount will be reduced by other income available to the person insured as detailed below.

The monthly payment is paid in arrears. As shown in the diagram below, this means we'll make the first payment one month after the end of the wait period, and monthly after that. Payments will stop after we've paid the monthly payments for the maximum cover period shown in your Policy Schedule. We'll also stop payments in other circumstances, which are listed further below under the heading 'When we'll stop monthly payments'.

30 day wait period

12 April	12 May	12 June	12 July
Date unable to work due to illness		First payment made in arrears for the period 12 May to 11 June	Second payment made in arrears for the period 12 June to 11 July

A part payment, based on a daily rate, will be made for periods that are less than one full month. The daily rate is calculated by multiplying the monthly payment by 12 and then dividing by 365.

While you're receiving the monthly payments, we won't charge you the premiums under the insurance agreement.

Exceptions if not in a 25 hr+ role

If the person insured was not working in a 25 hr+ role when they first became unable to work, then no claim will be paid unless one of the exceptions below applies. If one of the exceptions applies, the claim will be paid if it meets all the other requirements of the Income Protection Illness cover.

- **Exception 1:**
  When the person insured first became unable to work, they were on approved unpaid leave from a 25 hr+ role, and the unpaid leave started no more than 12 months earlier.
- **Exception 2:**
  When the person insured first became unable to work, they were on approved unpaid leave from a 25 hr+ role which started longer than 12 months earlier. The person insured is now unable however to continue the activities for which the unpaid leave was approved, solely as a result of the illness that has also made them unable to work. In these circumstances, the monthly amount under this cover will be a maximum of $1,200 per month, or the specified monthly amount, whichever is lower.

- '25 hr+ role' means a paid role for at least 25 hours per week with a single employer.
- 'Specified monthly amount' means the Income Protection Illness cover amount insured specified in the Policy Schedule that was current when the person insured first became unable to work

If there's no ACC cover, we may pay

If the person insured suffers an injury of a kind that is not eligible for ACC, we'll treat that injury as if it was an 'illness' under the Income Protection Illness cover. If the person insured is unable to work as a result of that injury, they'll be paid as long as they meet all the other requirements of the Income Protection Illness cover.

There is no cover for an injury if the person insured is entitled to ACC but hasn't applied. There is also no cover for an injury if the person insured is self-employed and has chosen to opt out of ACC.

There is no cover for an injury if an ACC benefit for that injury has been stopped.

Your monthly payments will be reduced by other income

The amount you'll receive will be reduced by any income the person insured continues to receive or is entitled to receive from other sources.

This includes:

- the person insured's salary or wages, including sick leave entitlement
- if the person insured is self-employed, any work-related income from their own work activity, and
- any other insurance-related payments, including payments from other insurance providers or any government payments, for example a sickness or ACC benefit.

We'll reduce your payments if the person insured is entitled to receive a benefit from a Government agency or ACC, whether or not they are receiving that benefit. This includes where the person insured would be entitled to receive a benefit but they haven't applied, or the benefit has been stopped. We'll reduce payments by the amount of the benefit entitlement.

Your payment won't be reduced by payments made under a nib nz limited Home Loan Insurance policy.

If the same illness strikes again within six months, you won't have another 30 day wait period

After we've paid a claim and the person insured returns to work, if they suffer again from the same illness, we'll treat this as a continuation of the earlier claim. This applies only if the illness recurs, and makes them unable to work, within six months of the last payment for the earlier claim.

If we continue the earlier claim, you won't have to wait 30 consecutive days; the payments will begin again as soon as we accept your renewed claim. You, or the person insured if that's not you, must provide supporting evidence reasonably satisfactory to us. The evidence must include an opinion from a medical specialist that the illness is a recurrence of the earlier condition.

- 'Medical specialist' means a qualified medical practitioner who is vocationally registered in a relevant specialty and approved by us. The medical specialist cannot be you or the person insured, or an immediate family member or business partner of you or the person insured.

When we'll stop monthly payments

We'll stop paying the monthly amount if:

- the person insured is no longer unable to work, or
- we've paid monthly amounts for the maximum cover period shown in the Policy Schedule, taking into account all payments we've made for the same, similar or related illness, including any recurring illness, or
- the person insured refuses to follow the recommendations of a medical specialist for any medical or surgical treatment, or suitable rehabilitation programme, or
- the cover ends, as set out below under 'When Income Protection Illness cover ends', or
- the person insured travels or resides overseas for more than six months without prior written approval from us.

- The person insured is 'unable to work' if, in our reasonable opinion, they're entirely prevented solely as a result of the illness from working in any occupation for which they're reasonably suited. In assessing whether they're reasonably suited to an occupation, we'll look solely at their education, training and experience. The person insured must also be under the continuous care and following the advice of a medical specialist, solely as a result of the same illness.
- 'Medical specialist' means a qualified medical practitioner who is vocationally registered in a relevant specialty and approved by us. This cannot be you or the person insured, or an immediate family member or business partner of you or the person insured.

We may also pay a lump sum

You may also be eligible for a further lump sum payment. We'll only consider your eligibility for this payment after you've received the Income Protection Illness cover monthly payments for the maximum cover period shown in your Policy Schedule. The illness for which you claim the lump sum must be the same one for which you received those monthly payments.

The lump sum is 60 times the specified monthly amount. However, if 'Exception 2' above applied to your claim for the monthly payments, the lump sum is $72,000, or 60 times the specified monthly amount, whichever is lower.

- 'Specified monthly amount' means the Income Protection Illness cover amount insured specified in the Policy Schedule that was current when the person insured first became unable to work.

We'll make the lump sum payment if, in our reasonable opinion, the person insured is likely to be permanently unable to work solely because of that illness. Also, the person insured must be likely to need permanent assistance from another person with two or more activities of daily living.

- Each of items 1-5 below counts as one 'activity of daily living':
  1. bathing and showering
  2. dressing and undressing
  3. eating and drinking
  4. maintaining continence with a reasonable level of personal hygiene
  5. getting in and out of bed, a chair or wheelchair or moving from place to place by walking, wheelchair or walking aid.
- If the person insured can perform the activity on their own by using special equipment, we will not treat them as requiring assistance from another person to perform that activity. We'll assess their ability to perform activities of daily living through the claims process.

If you're not eligible when the monthly payments finish, you may become eligible later, but only if you keep your Income Protection Illness cover in place in the meantime. If you've received monthly payments for the maximum cover period and want to keep the cover in place, you'll need to resume paying the premiums under the insurance agreement.

When Income Protection Illness cover ends

Cover will end on the date of whichever of the following is first:

- we pay the lump sum referred to above, or
- the person insured dies, or
- we pay the Funeral Expenses cover benefit, or
- you cancel this cover or the insurance agreement, or
- we cancel the insurance agreement, or
- the anniversary of the Life & Living Insurance start date after the person insured turns 65 years old.

If we're making any monthly payments, they'll stop when the cover ends. This will not affect any right you may have to claim amounts that should have been paid to you before the cover ended.

You're not covered in the first 30 days

You're not covered in the first 30 days from the Income Protection Illness cover start date or re-start date. We call this the stand-down period. This means you're not covered for an illness or its symptoms if the first sign, symptom or diagnosis occurs before the end of the stand-down period. The same applies for the first 30 days after the start date from an increase to your cover that you've requested, but this only affects cover for the increase.

- For the purposes of the stand-down period, a 'sign' or 'symptom' means any sign or symptom of the relevant illness that would lead a reasonable person to seek medical advice.
- The 'start date' for your Income Protection Illness cover is as shown in your Policy Schedule.
- Where we increase your cover at your request, the 'start date' of the increase is the date we accept the increase. We'll send you a notice advising you of the increase.
- Where we agree to re-start the cover after it has ended, the 're start' date is the date we accept the re-start. We'll send you a notice advising of the re-start.

You're not covered in some circumstances

You're not covered if, as at the start date or re-start date, the person insured was not engaged in any paid work for at least 25 hours per week with a single employer.

You're not covered if the person insured is unable to work due to an injury of a kind that is eligible for ACC. You're not covered if the injury is of a kind that is sometimes covered by ACC but the person insured is self-employed and has chosen to opt out of ACC. You're not covered if ACC has declined the claim on the basis that the person insured's injury does not prevent them from working.

You're not covered if the Policy Schedule has a special term that excludes the illness or the event or condition leading to the illness.

You're not covered if:

- the illness arises directly or indirectly as a result of intentional self-inflicted harm by the person insured, or
- the illness is connected to the person insured using or being addicted to an intoxicating substance or drugs, other than drugs obtained solely on prescription, or
- the event giving rise to the claim is caused directly or indirectly by the person insured's participation in criminal activity, or
- the illness arises directly or indirectly from an act of war or an act of terrorism.

- 'War' includes warlike activities such as use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, or religious ends. War means war whether declared or not.
- 'Terrorism' means the use or threatened use of violence, in order to achieve a political, religious, or ideological aim.
- 'Criminal act' or 'criminal activity' means conduct that is an offence, where the maximum punishment is a prison sentence or a sentence of home detention. This includes any conduct that meets the legal requirements for such an offence, even if the conduct does not result in any charges or convictions. It is not necessary for the requirements to be proved beyond a reasonable doubt.

Redundancy cover

How Redundancy cover works

This cover is provided only if you've chosen it and it's shown in your Policy Schedule.

If the person insured isn't working because they've been made redundant while covered, we'll make monthly payments as detailed below for up to 6 months.

- 'Redundancy' or 'redundant' means that, on or after the Redundancy cover start date, the person insured loses paid employment because their role is made redundant by their employer. The redundancy occurs on the date their employment ends.
  It's not a redundancy if the person insured loses employment due to incapability, or resigns or is dismissed.
  To qualify as redundant, immediately before their employment ended the person insured must have been:
  - in continuous paid employment for the previous six months, or
  - on unpaid leave from paid employment for less than 12 months.
- 'Paid employment' means the person insured is working for at least 25 hours a week in New Zealand for a single employer. The employer must not be the person insured, the policy owner, or any of their immediate family. The employer also must not be a company or limited partnership that is directly or indirectly controlled by the person insured or policy owner, or by any of their immediate family.
- The 'start date' for your Redundancy cover is as shown in your Policy Schedule.

If you're claiming under Redundancy cover, the person insured has a responsibility to continue to look for employment. This includes being registered with at least one employment agency and actively seeking paid employment during the period we are making claim payments. We may ask for evidence that they are doing so.

Who we'll pay

Where we pay a claim for Redundancy cover, we'll pay you, the policy owner.

You're paid monthly payments

You'll get monthly payments if the person insured is redundant and this results in at least 30 consecutive days of them being out of work. This 30 day period is a wait period. You won't be paid for this 30 day period.

You'll be paid the monthly amount insured for this cover as shown in the Policy Schedule that was current when the person insured became redundant.

The monthly payment is paid in arrears. As shown in the diagram below, this means we'll make the first payment one month after the end of the wait period, and monthly after that. Payments will stop after we've paid the monthly payments for six months. We'll also stop payments in other circumstances, which are listed further below under the heading 'When we'll stop monthly payments'.

30 day wait period

12 April	12 May	12 June	12 July
Date employment ends		First payment made in arrears for the period 12 May to 11 June	Second payment made in arrears for the period 12 June to 11 July

If your entitlement to payment ends part way through a month, we'll make a part payment based on a daily rate. The daily rate is calculated by multiplying the monthly payment by 12 and then dividing by 365.

While you're receiving monthly payments, we won't charge you premiums under the insurance agreement.

When we'll stop monthly payments

We'll stop paying the monthly amount if:

- the person insured begins any work that produces income, or
- the person insured engages in any activity that prevents them from working or actively seeking work, or
- the person insured fails to provide evidence that they are registered with an employment agency and actively seeking paid employment, or
- we've paid six consecutive monthly amounts, or
- the cover ends-see below.

When Redundancy cover ends

Cover will end on the date of whichever of the following is first:

- the person insured dies, or
- we pay the Funeral Expenses cover, or
- the Income Protection Illness cover ends, or
- you cancel this cover or the insurance agreement, or
- we cancel the insurance agreement, or
- the anniversary of the Life & Living Insurance start date after the person insured turns 65.

Any monthly claim payments will stop when the cover ends. Otherwise, this will not affect any right you may have to claim amounts that should have been paid to you before the cover ended.

You're not covered in the first six months

You're not covered for a redundancy that occurs before or during the first six months from the Redundancy cover start date or re-start date. We call this the stand-down period.

Also, there is no cover where you or the person insured knew or could reasonably have been expected to know about the redundancy or likelihood of redundancy at any time before or during this period.

The same applies from the start date of an increase to your cover that you've requested, although this will only affect the amount of the increase.

- The 'start date' for your Redundancy cover is as shown in your Policy Schedule.
- Where we increase your cover at your request, the 'start date' of the increase is that date we accept the increase. We'll send you a notice advising of the increase.
- If we agree to re-start the Redundancy cover after it has ended, then the 're-start' date is the date we accept the re-start. We'll send you a notice advising you of the re-start.

You're not covered in some circumstances

You cannot claim under this cover for periods where you are entitled to be paid under the Income Protection Illness cover.

You're not covered if:

- the person insured is made redundant from seasonal work, relief work, or work under a fixed-term employment contract, or
- the person insured has taken voluntary redundancy or voluntarily resigned, or
- the redundancy results from a strike or labour dispute involving the person insured or their employer, or
- the redundancy arises directly or indirectly from an act of war or an act of terrorism.

- 'War' includes warlike activities such as use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, or religious ends. War means war whether declared or not.
- 'Terrorism' means the use or threatened use of violence, in order to achieve a political, religious, or ideological aim.
- 'Criminal act' or 'criminal activity' means conduct that is an offence, where the maximum punishment allowed by law for that type of offence is a prison sentence or a sentence of home detention. This includes any conduct that meets the legal requirements for such an offence, even if the conduct does not result in any charges or convictions. It is not necessary for the requirements to be proved beyond a reasonable doubt.

Funeral Expenses cover

How Funeral Expenses cover works

This cover is provided only while at least one of the other types of cover under the insurance agreement is in place.

If the person insured dies or is diagnosed as terminally ill, the complimentary cover can help with funeral-related expenses. It is a lump sum of $15,000.

- 'Terminal illness' or 'terminally ill' means the person insured is diagnosed with an illness or injury that is expected to lead to death within 12 months. This means 12 months even with the best medical or surgical treatment available in New Zealand. Two appropriate medical specialists must confirm this prognosis. The 12 months is measured from the time of that confirmation.
- 'Medical specialist' means a qualified medical practitioner who is vocationally registered in a relevant specialty and approved by us. This cannot be you or the person insured, or an immediate family member or business partner of you or the person insured.

Who we'll pay

Where we pay a claim, we'll pay you, the policy owner, or your estate. However, where there's a beneficiary named in the Policy Schedule, we'll pay them instead if at the time of payment the beneficiary is alive and the person insured has passed away.

The payment of the Funeral Expenses cover doesn't guarantee acceptance of a Life cover claim, if you have Life cover. You or your estate must repay the payment made within 30 days of us asking if we subsequently decline the Life cover claim or avoid the insurance agreement. We may require a beneficiary to agree to this same repayment condition before we pay them under the Funeral Expenses cover.

To 'avoid' means treating it as invalid, as if it had never been taken out. That means we would not be required to pay any claim, and may require you to refund any claims already paid.

When Funeral Expenses cover ends

Cover will end on the date of whichever of the following is first:

- we pay a death or terminal illness claim, or
- we pay a funeral expenses claim, or
- you cancel the insurance agreement, or
- we cancel the insurance agreement, or
- when all other cover under the insurance agreement has ended.

This will not affect a claim or right to claim that arose before the cover ended.

You're not covered in some circumstances

You're not covered if the person insured's death or terminal illness is directly or indirectly as a result of intentional self-inflicted harm within 13 months of:

- the start date of this cover, or
- the re-start date of this cover.

- The 'start date' of Funeral Expenses cover is as shown in your Policy Schedule.
- If we agree to re-start the insurance agreement after it has ended, then the 're-start' date is the date we accept the re-start. We'll send you a notice advising you of the re-start.

You're not covered if the Policy Schedule has a special term that excludes the event or condition leading to the death or terminal illness.

Making changes to the insurance agreement

The insurance agreement is between you, the policy owner and us, nib nz insurance limited.

You can change the beneficiary

You can name a beneficiary if you're both the policy owner and person insured, i.e. the same name will be in both places in your Policy Schedule. The beneficiary can be any living person.

The beneficiary receives any Life cover or Funeral Expenses cover payment if the person insured has died.

The beneficiary must be living at the time of the payment. Otherwise we'll pay your estate.

The beneficiary can claim this payment directly even though they are not a party to the insurance agreement. The beneficiary's consent isn't required in order to change the beneficiary or the insurance agreement.

You (but not your estate) may change or remove the beneficiary at any time by contacting us. We'll send you a new Policy Schedule with the name of the beneficiary changed. The change only applies once the new beneficiary is named in your Policy Schedule.

You can change the policy owner as allowed under the heading below. If this happens, any beneficiary will automatically be removed, and any claim payments will be made to the policy owner.

You can change the policy owner

You can change the policy owner, meaning you're no longer responsible for and no longer have the benefits of the insurance agreement. You'll need to register the change with us by completing our transfer forms. You'll also need to ensure you're up to date on payment of your premiums. Once that is done, we'll send an updated Policy Schedule to the new policy owner.

Any change of ownership is only effective once we've issued the new Policy Schedule. From that time, the rights of the old policy owner are transferred to the new policy owner, subject to the same rights that we would have had against the old policy owner. To have the benefit of the insurance agreement, the new policy owner will need to agree to pay all premiums and comply with the insurance agreement from the date of the change.

You can apply to increase or decrease cover

You may apply at any time to change your Life or Living Insurance cover. Any decision to accept your application is entirely up to us.

To apply to add or increase cover, the person insured must be aged:

- 18-70 for Life cover
- 18-60 for any Living Insurance (Serious Illness Trauma cover, Income Protection Illness cover and Redundancy cover).

Special terms may apply. If cover is increased or added after the Life & Living Insurance start date, the usual wait periods and stand-down periods apply to the increase or addition, from the date of the change.

Decreasing all or part of your cover may mean other changes also need to be made.

- The 'Life & Living Insurance start date' is the date when your insurance agreement first started. This start date is shown in your Policy Schedule.

You can apply to change to non-smoking status

If the person insured is recorded as a smoker in any Policy Schedule, you may apply for the premium to be adjusted to that of a non-smoker. To do this the person insured must have stopped smoking for a period of at least 12 consecutive months.

We can change the cost of insurance/premiums

We may change the premium rates, the criteria for when different premium rates apply, and/or the method of calculating the premiums.

We'll give you at least 60 days' notice of the changes and the date that they'll apply from, except where the law requires a change in less than 60 days. If there are any special terms mentioned in your Policy Schedule, these will continue to apply, unless we say they don't apply.

If you're not happy with any changes, you can cancel some or all of the covers provided under your insurance agreement.

We can change the Serious Illness Trauma cover

We can change certain aspects of the Life & Living Insurance Cover wording for Serious Illness Trauma cover. This is set out under the heading 'We can change the Serious Illness Trauma cover details' in the Serious Illness Trauma section above.

We can change the cover wording terms

We can change this Life & Living Insurance Cover wording:

- to extend or improve the cover, or
- to make changes that don't adversely affect the cover, or
- where we reasonably consider the change is necessary to:
  - comply with law, or
  - deal with the impact of a change in the law, or
  - deal with the impact of a change in interpretation of the law.

If we do this, we'll give you at least 60 days' notice, unless we reasonably consider that a shorter notice period is necessary to comply with law.

If there are any special terms mentioned in your Policy Schedule, these will continue to apply, unless we say they don't apply. Any change will not affect a claim or right to claim that arose before the date of the change.

This does not take away from any of our other rights to make changes as mentioned under the headings above.

Cancelling or ending the insurance agreement

You can cancel during your 'free look' period

You have a 30-day free look period to cancel the insurance agreement and get your premiums back. This period begins on the Life & Living Insurance start date. If you ask us to cancel within this period, we'll do so from the date we receive your request and refund any premiums you've paid.

The free look period also applies when you add new cover to your insurance agreement or you choose to increase your existing cover, but only to the added or increased cover.

You can cancel at any other time, but premiums won't be refunded

You may cancel specific cover or the whole insurance agreement at any time by contacting us. When we receive your request, we'll cancel the specific cover or the insurance agreement from the next date a premium payment is due or if you're behind in your premium payments we'll cancel the cover immediately. You won't receive a refund of any premium, except where the insurance agreement specifically states otherwise. If you have Redundancy cover and cancel Income Protection Illness cover, your Redundancy cover will also be cancelled.

We can cancel if your premiums are unpaid

We can give you notice cancelling the insurance agreement if you're behind on the payment of your premiums for two or more payment dates in a row. No premium will be refunded.

You can apply to re-start within three months

You can apply to re-start the insurance agreement if it has ended because of the premiums not being paid. To do this you must make a request to re-start within three months of the cancellation. Whether we agree to re-start the insurance agreement is entirely up to us.

If we do agree to re-start, you must have paid any unpaid premium in full before the cover starts again. This includes premiums for the period between the cancellation and the re-start.

Also:

- we may require confirmation that there are no changes in respect to your health and lifestyle, and
- the cover may be on different terms and conditions to those that applied to the original insurance agreement, and
- any stand-down periods for your cover will apply again from the date your cover re-starts.

Once the insurance agreement has re-started, it will be applied as if it had been in place continuously since the original Life & Living Insurance start date shown in your Policy Schedule. The only exception is that any stand-down periods and wait periods for your cover will apply again from the date your cover re-starts.

- Where we agree to re-start the cover after it has ended, the 're start' date is the date we accept the re-start. We'll send you a notice advising you of the re-start.

We can cancel the insurance agreement for incomplete or incorrect information

We have certain rights to cancel or avoid the insurance agreement if we've been provided with information that is incorrect or incomplete. These include the rights set out above under the sections 'Phone us to make a claim' and 'Read and keep you insurance agreement', and also other rights given by law.

- To 'avoid' means treating the insurance agreement as invalid, as if it had never been taken out. That means we would not be required to pay any claim, and may require you to refund any claims already paid.

Other rights to cancel

Nothing in this insurance agreement takes away from any other rights we may have under law to decline a claim or cancel or avoid the insurance agreement.

When the insurance agreement ends by itself

The insurance agreement will end when there is no more cover in place, and all valid claims have been paid.

Making a complaint

We hope that you never have reason to complain. If you do, we'll do our best to work with you to resolve things. Our contact details are in the 'How to contact us' section.

If you're not satisfied with the way we resolve any enquiry or complaint, you can contact the Insurance & Financial Services Ombudsman Scheme.

- Post - Insurance & Financial Services Ombudsman Scheme, PO Box 10-845, Wellington 6143.
- Freephone - 0800 888 202
- Email - **info@ifso.nz**

The Insurance & Financial Services Ombudsman Scheme's office is located at Level 2, Solnet House, 70 The Terrace, Wellington 6011.

You can obtain more information about the Insurance & Financial Services Ombudsman Scheme by visiting their website at **https://www.ifso.nz/**

The Insurance & Financial Services Ombudsman Scheme is an independent body. Their services are available to you at no cost.

Your premiums are paid into, and your claims paid from, a statutory fund

This insurance agreement forms part of the nib nz insurance limited Statutory Fund. Under the Insurance (Prudential Supervision) Act 2010, life insurers are required to have a statutory fund for life insurance policies.

This means the amounts you pay us will be paid into this fund, and any claims paid will be paid from this fund.

How to contact us

Contact us if you have questions, concerns, claim enquiries, or would like to make changes to your insurance cover or your contact details.

- Freephone **0800 555 642** between 8:30am and 5:00pm Monday to Friday
- Email **Lifeservice@nib.co.nz**
- nib nz insurance limited, PO Box 91630, Auckland 1142, New Zealand.

How we may contact you

We may contact you:

- by phone
- by letter
- by email, if you have provided us with an email address
- through an online portal, if we have sent you a login for that portal, and/or
- through any other platform on which you agree to receive communications from us.

Where this Life & Living Insurance Cover wording refers to a 'notice', this includes by any one of the communication methods listed above.

Make sure you keep your contact details up to date

Please tell us if any of your contact details change. We'll be contacting you with important information regularly.

If you change contact details and don't tell us, you'll be taken to have received any notices sent to the most recent contact details we have for you. We can contact you by any one of the communication methods listed above, so you'll need to keep your details up to date for all of them.

Need help?

Call us on 0800 555 642
Mon to Fri: 8.30am – 5.00pm
Go to nib.co.nz

nib nz insurance limited
PO Box 91630, Auckland 1142

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