ANZ LIFE & LIVING INSURANCE

POLICY DOCUMENT

CHUBB®

ANZ

WELCOME TO YOUR ANZ LIFE & LIVING INSURANCE POLICY DOCUMENT

Thank you for choosing ANZ Life & Living Insurance, which is provided by our trusted partner, Chubb Life Insurance New Zealand Limited. We're pleased to be helping you and your family continue to look forward to a bright future.

UNDERSTANDING THIS POLICY DOCUMENT

This document lists the terms of your policy. It is one of seven documents outlined on page 6 that make up your insurance contract with us. By reading them carefully, you'll know what you're covered for and how to make a claim.

In this document, 'we,' 'us,' 'our' and 'Chubb Life' refer to Chubb Life Insurance New Zealand Limited (Chubb Life), and 'you' or 'your' refer to the policy owner, as stated in the definitions section. 'Person insured' means the person who is insured under this policy, named in the Policy Schedule. If you see a word or term that you don't understand, see the definitions section on pages 19-20.

The information on pages 1-4 and the other flowcharts and diagrams in this Policy Document are provided for information purposes only as a guide to your insurance. They do not form part of the terms of your insurance cover or your contract of insurance. To understand the full terms of your insurance cover, including conditions and exclusions that apply, read the other parts of this Policy Document in full and all the other documents that form your insurance contract.

YOUR POLICY IS UNDERWRITTEN BY CHUBB LIFE INSURANCE NEW ZEALAND LIMITED (CHUBB LIFE)

ANZ Life & Living Insurance is underwritten by Chubb Life. This means Chubb Life provides the insurance cover under this policy and is responsible for the management of your policy and payment of any claims.

Chubb Life and the products issued by it are not guaranteed by any member of ANZ Bank New Zealand Limited and its related companies, or any other person. ANZ Bank New Zealand Limited may receive a commission on any policy it arranges.

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PROTECTING WHAT'S IMPORTANT TO YOU

Life is uncertain, and your lifestyle and financial security are two of the most valuable things you can insure. If you can't look after your family or pay your bills because of critical illness, disability, death or redundancy, ANZ Life & Living Insurance can step in to help do it for you.

It's important to consider a combination of life and living insurances to help protect against many of life's challenges that come your way. Ask yourself the following questions to see how protected you currently are:

Ask yourself	Cover options to help
If I was to die, would my family have enough money to support themselves for a period of time?	We can help you with **Life Cover** that provides a lump-sum payment if you die or are diagnosed with a terminal illness.
If I was diagnosed with a serious illness, would I have enough money to support my family while I receive treatment and recover?	We have **Critical Illness** cover that provides a lump-sum payment if you're diagnosed with one of 12 major illnesses.
If an accident or illness meant I couldn't work for a period of time, would my family be able to survive without my income?	We can talk about **Living Expenses Cover** that provides a monthly payment for up to 24 months to help repay debt or help with living expenses if you can't work due to an accident or illness.
If you were made redundant from your job, would you have enough money to support your family while you find work again?	We have **Redundancy** cover that provides a monthly payment for up to 180 days to help repay debt or help with living expenses if you're made redundant and looking for full-time employment.

ROSS'S STORY

A REAL LIFE EXAMPLE

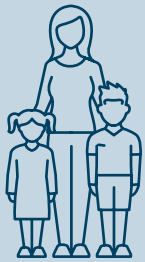
This is Ross's* story which highlights just how much difference having the right insurance can make to protecting your family's future.

With a wife, two great kids, and a job he loved, Ross was looking forward to an even brighter future. But then, in a heartbeat, everything changed. Ross was young, fit and healthy. So when he started to experience stomach upsets, indigestion, coughing and general tiredness, he thought it would soon go away. But it didn't.

Over the next two months, things got steadily worse. Ross went to see his GP, who ordered some tests. The test results were a complete shock. They showed that Ross had stomach cancer and only weeks or months to live.

For both Ross and his family, it was a heart-breaking situation. And on top of everything, his family had to deal with the almost impossible challenge of making the time Ross had left as comfortable and dignified as possible – while preparing for a future without him. Ross's ANZ Life & Living Insurance helped make an incredibly difficult situation easier. As he had a terminal illness, we paid out the full Life Cover benefit amount early. This allowed the mortgage to be repaid, so Ross knew his family would always have the family home to live in, and a secure future.

And while Ross couldn't work because of the care he was receiving, his policy's Living Expenses Cover benefit provided a regular monthly payment. That took away any financial pressures, allowing Ross and his family to concentrate on celebrating his life – and enjoying together the precious time they had left. Around three months later, Ross passed away.



Nothing can make up for the loss of a loved husband and father. But Ross at least had the peace of mind of knowing that his wife and children would have the bright future he wanted for them – and when you have a family, that's priceless.

* Name has been changed to protect our customer's privacy

HOW MUCH COVER DO I NEED?

The amount of protection that you need will depend on your individual circumstances. You may want to balance what you need to protect with what you can afford. Answering a few simple questions in the quote tool can help you determine what types and levels of cover may be suitable for you. You can find the quote tool at anz.co.nz/lifequote.

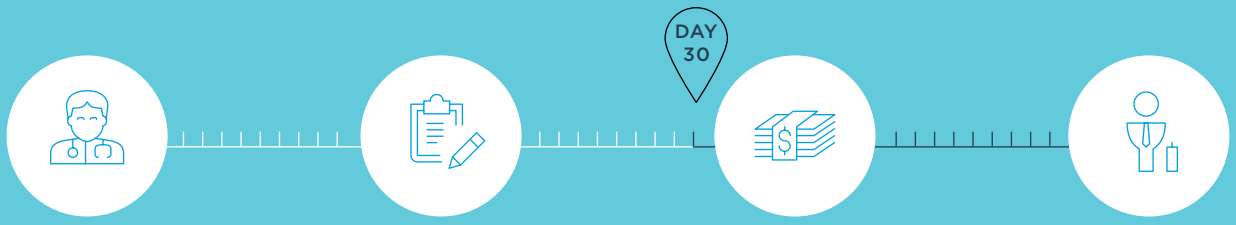
Thinking about the following statements can help you consider the level of protection that's right for you:

Let's think about...			
Life Cover	**Critical Illness cover**	**Living Expenses Cover**	**Redundancy cover**
I want my family to be able to grieve without worrying about how they will pay for my funeral I don't want my family to worry about paying the mortgage or other debt when I die I want to leave some money to help raise my children until they can support themselves	I want to be able to cover the cost of any medical procedure I need I need to be able to keep paying the mortgage and other bills while I'm recovering I would like to be able to take my family on holiday	I need to be able to keep paying the mortgage and other bills while I'm recovering I want to be able to cover any medical costs to help me get better	I need to be able to keep paying the mortgage and other bills while I'm looking for employment

WHAT CLAIM WAIT PERIOD SHOULD I CHOOSE?

You'll be asked to choose a 30-day or 90-day claim wait period when you apply for the Living Expenses Cover and Redundancy benefits.

30-DAY CLAIM WAIT PERIOD



DAY 0

You have an accident and break your arm.

DAY 5

The doctor tells you that you can't work for the next month, so you submit a claim.

DAY 31

Because you still can't work, your claim payments will start. You'll also get paid for the 30 days you've already been off work.

DAY 36

Your arm is better and you return to work. You've been paid for a total of 36 days, and your claim payments now stop.

COMPLETING YOUR APPLICATION

If you've decided to apply for ANZ Life & Living Insurance, you'll be asked some questions about your health and lifestyle. Please give as much detail as possible when answering each question. If you're not sure whether something is relevant, tell us anyway. If you've already provided information in a previous application for life insurance, you need to tell us again.

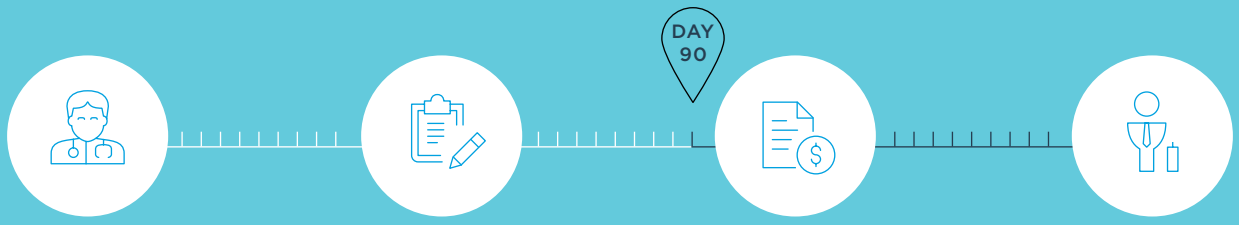
It's important that you answer the questions accurately and completely – if you don't, your policy could be cancelled, avoided or the terms of your policy amended and future claims could be declined.

Once you've completed your application, we'll either offer you cover straight away or your application will be referred to an underwriter.

Applications with cover offered straight away	Applications referred to an underwriter
If we tell you that we can offer you cover straight away, no further underwriting assessment is required. Sometimes a loading (increased premium) and/or exclusions might be applied to your policy. Once we've confirmed we have everything we need from you, your policy will be issued and we'll send out your welcome pack.	Sometimes applications are more complicated and will need to be referred to a trained underwriter. The underwriter will assess your health and lifestyle to make sure we're able to offer you the cover you've applied for, and that you're charged the correct premium. The underwriter may need more information based on the answers you gave us about your health and lifestyle. They may ask you or your doctor for this information.

The claim wait period is the number of days you'll have to wait before a claim will be paid. The premiums will be lower if you choose the 90-day claim wait period.

90-DAY CLAIM WAIT PERIOD



DAY 0

You have a heart attack.

DAY 21

The doctor tells you that you can't work for the next 5 months, so you submit a claim.

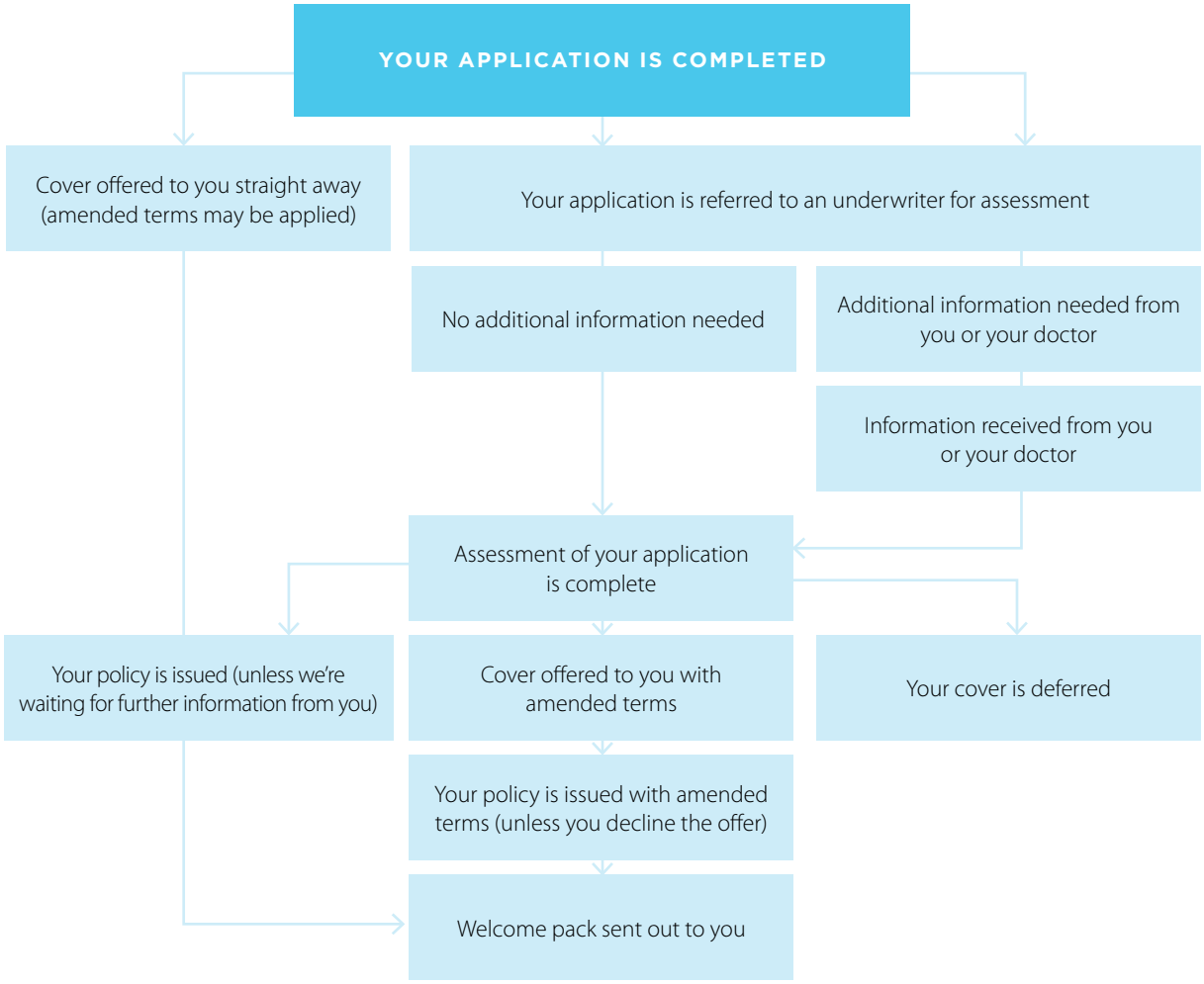
DAY 91

Because you still can't work, your claim payments will start. You'll **not** be paid for the 90 days you've already been off work.

DAY 241

You've recovered from your heart attack and you return to work. You've been paid for a total of 151 days, and your claim payments now stop.

HOW WE GET YOUR COVER IN PLACE AS QUICKLY AS POSSIBLE



What are 'amended terms'?	What does 'cover is deferred' mean?
Sometimes we can't offer you the cover you applied for because of your health and lifestyle. In these instances, we would look to offer you 'amended terms'. This could mean not offering you a benefit you applied for, charging an additional premium or excluding a medical condition, pastime, activity or part of the body.	Occasionally we're unable to offer you cover due to the uncertainty surrounding a medical condition you have and/or your occupation. In this case, we defer cover and invite you to re-apply if your medical condition improves or you have changed your occupation.

WHAT HAPPENS NEXT?

Once your policy is in place, we'll send you a welcome pack. The welcome pack includes: a welcome letter, policy schedule, any amended terms applied to your policy, the answers you provided to the health and lifestyle questions and the policy document. Please read all the documents in the welcome pack. If any information is missing or incorrect please let us know as soon as possible. It's a good idea to keep these documents in a safe place as you may need to refer to them to make a claim.

ANZ LIFE & LIVING INSURANCE OVERVIEW

LIFE COVER (including Terminal Illness)	CRITICAL ILLNESS	LIVING EXPENSES COVER	REDUNDANCY (can only be taken with Living Expenses Cover)
Pays amount selected up to $1,000,000 when the person insured dies or is diagnosed with a Terminal Illness	Pays a lump sum of up to $200,000 if the person insured is diagnosed with one of these 12 major illnesses: • Cancer • Chronic liver disease • Chronic lung disease • Coronary artery angioplasty (triple vessel only) • Coronary artery bypass graft • Heart valve surgery • Kidney failure • Major heart attack • Major organ transplant • Multiple sclerosis • Paralysis • Stroke	Pays amount selected up to $4,000 per month for a maximum of 24 months for any one condition or event	Pays amount selected up to $4,000 per month for a maximum of 180 consecutive days
Terminal Illness generally means diagnosis of an advanced or rapidly progressive incurable illness where the insured's life expectancy is no greater than 12 months from the date of diagnosis	No claim will be paid if the person insured dies within 14 days of being diagnosed	Covers accidental bodily injury or illness that completely stops the person insured from engaging in their usual full-time employment or self-employment or, if not in full-time employment or self-employment, they are confined to hospital or bed at home	The person insured must be in full-time employment for at least 180 consecutive days with the same employer before the date of redundancy
Includes a Funeral benefit which provides an advance payment of $10,000 of the Life Cover benefit	No claim will be paid if the diagnosis is made before, or within 90 days of, the policy start date	Full-time employment is defined as 20 hours per week or more in permanent employment or fixed-term employment with a single employer	Claim wait period starts upon registration with an appropriate employment agency or the first day unemployed, whichever is the later
Cover starts on the policy start date shown in the Policy Schedule	A period of 90 days applies to establish permanence of impairment for: • Multiple sclerosis • Paralysis • Stroke	Self-employment is defined as 20 hours per week or more of paid employment either: • by a company controlled directly or indirectly by the person insured (or members of the person insured's immediate family), or • as a self-employed contractor, sole trader, partner in a partnership or in a similar arrangement	No cover when the person insured receives notice of redundancy or potential redundancy before or within 180 days of the policy start date
Cover ceases at age 99	Can only be paid once during the term of the policy, and the benefit ceases on payment of a claim	Cover ceases at age 65	Not eligible if the person insured takes voluntary redundancy
	Cover ceases at age 65		Amount selected cannot exceed the sum insured under Living Expenses Cover
			Cover ceases at age 65

At the date of a claim, the person insured must be legally entitled to live in New Zealand, or to work in New Zealand in full-time employment or self-employment.

WHAT YOU NEED TO KNOW AT THE START

THIS POLICY DOCUMENT IS PART OF YOUR INSURANCE CONTRACT

This Policy Document forms part of the insurance contract between us, you, and the person insured.

The other parts of the contract are:

- the Welcome Letter
- the Policy Schedule
- the completed Health and Lifestyle Questions
- the Offer of Cover, Acknowledgement of Application or Application Form, as applicable
- any spoken or written statements made to ANZ Bank New Zealand Limited or us (by the person insured or in their name) while the person insured was applying for or reinstating this policy
- any Amended Terms offered or applied to this policy.

YOUR INSURANCE COVER STARTS ON THE POLICY START DATE

Insurance cover starts on the policy start date shown in the Policy Schedule.

WHAT YOU MUST PAY IS STATED IN THE POLICY SCHEDULE

The Policy Schedule shows the amount you must pay for the first year of this insurance cover. The amount to pay is called a premium.

INFORMATION YOU AND THE PERSON INSURED GIVE US NEEDS TO BE CORRECT AND COMPLETE

Read all parts of the insurance contract to make sure they are correct

Please read this Policy Document, the Policy Schedule, the completed Health and Lifestyle Questions and any Amended Terms. Make sure the information is correct. If you find any mistakes or if you have any questions, please phone us on 0800 658 585.

Incorrect or incomplete information may mean you are not covered

The information in the insurance contract needs to be correct and complete. For the information to be complete, you and the person insured must tell us everything that may influence:

- our decision to insure the person insured for the benefits applied for
- the terms on which we decide to insure the person insured
- our decision to reinstate the policy.

If we later find that any information is incorrect, or incomplete, we may not pay your claim, we may change your insurance by applying Amended Terms, or we may cancel or avoid your policy. ('Avoiding' a policy is a technical term, which means cancelling the insurance policy as if it had never been taken out.) Any Amended Terms we apply will be based on what we would have insured you for if you had given us correct and complete information. If anything you or the person insured told us changed after the person insured applied for insurance and before the policy start date, you or the person insured need to tell us about it.

YOU HAVE A 30-DAY FREE-LOOK PERIOD AND CAN CANCEL THE POLICY AT ANY TIME

If you are not completely satisfied with this policy, you can cancel it at any time. If you cancel this policy within 30 days of the policy start date, we will refund any premiums you have paid. You can cancel the policy by calling us on 0800 658 585.

KEEP YOUR INSURANCE CONTRACT DOCUMENTS IN A SAFE PLACE

We recommend that you keep this Policy Document, the Policy Schedule, your copy of the completed Health and Lifestyle Questions (if applicable), any Amended Terms and the Offer of Cover or Acknowledgement of Application (if applicable) in a safe place. You may need to refer to them to make a claim.

Tell your lawyer, your family, or the executor of your will where you keep these documents so they can make a claim when they need to.

TIP

You can call us to make changes or if you have an enquiry

You can contact us if you have questions, concerns or would like to make changes to the policy.


0800 658 585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WHAT YOU NEED TO KNOW ABOUT PAYING FOR YOUR INSURANCE COVER

To keep the insurance cover, you need to keep paying your premiums.

YOU CAN RENEW YOUR POLICY AT THE END OF EACH TERM

The term of this policy (that is, the period you have insurance cover for) depends on how often you pay premiums. For example, if you have chosen to make premium payments each month, the term of the policy is one month.

At the end of each term, you have the right to renew your policy for a further term. You renew the policy by making a further premium payment. For example, if you pay monthly, you can renew your policy for the next month by paying the premium due for that month.

YOUR PREMIUMS MAY CHANGE EACH YEAR

If you keep the same level of cover, your premiums may increase as the person insured grows older. We recalculate premiums every year on the anniversary of the policy start date. We will advise you of the new premium in writing.

Your cover will increase in line with inflation unless you decline the increase

Each year, we will offer to increase the amount of the Life Cover benefit and the Critical Illness benefit without asking you to complete the Health and Lifestyle Questions again. The increase will be in line with the annual percentage change of the Consumer Price Index (CPI), to a maximum of 5 per cent and a minimum of 0 per cent. This percentage change will be taken from the most recent September CPI change published at the time of the offer. If the CPI is changed or stopped, we will choose another appropriate indicator of changes in consumer prices.

We will write to tell you how much cover we are offering, and what the premium will be.

If you want the increase, do nothing. The offer will take effect at the anniversary of the policy start date.

If you accept the increase in cover and pay the increased premium, we will pay the increased cover amount if you need to make a claim.

If you do not want the increase, either return the decline slip provided with the offer or call us on 0800 658 585 within 30 days of the anniversary of the policy start date.

When we will not offer an inflation-related increase

We will not offer you the inflation-related increase on your Life Cover benefit if any of the following apply.

- You decline the inflation-related increase three years in a row.
- We have paid you the Critical Illness benefit.
- Your Life Cover benefit is more than $1,000,000.
- Your Policy Schedule does not state that you have the Life Cover benefit.

We will not offer you the inflation-related increase on your Critical Illness benefit if any of the following apply.

- You decline the inflation-related increase three years in a row.
- Your Critical Illness benefit is more than $200,000.
- Your Policy Schedule does not state that you have the Critical Illness benefit.

We can change the premium rate

We do not guarantee the premium amount. As well as increases where the person insured grows older, we may change your premiums in either of the following circumstances.

- We make a general adjustment of premiums or applicable discounts.
- Changes in legislation lead to a change in any tax or charge to this type of insurance.

WHAT YOU NEED TO KNOW ABOUT THE END OF THE POLICY

The policy will end on the earliest of:

- the death of the person insured
- the date you cancel the policy
- the date the policy lapses because you did not keep paying premiums
- the 99th birthday of the person insured
- the 65th birthday of the person insured if your Policy Schedule does not state that you have the Life Cover benefit.

We will not refund any premiums you have paid if you cancel your policy more than 30 days after the policy start date.

WHEN THE BENEFITS END

Life Cover benefit

If your Policy Schedule states you have the Life Cover benefit, the benefit will end on the earliest of:

- the death of the person insured
- the payment of a Terminal Illness claim for the person insured
- the date you cancel the benefit
- the 99th birthday of the person insured.

In no circumstances will we pay both a Life Cover and a Terminal Illness claim for the same person insured.

Critical Illness benefit

If your Policy Schedule states you have the Critical Illness benefit, the benefit will end on the earliest of:

- the payment of a Critical Illness claim for the person insured
- the payment of a Terminal Illness claim for the person insured
- the date you cancel the benefit
- the 65th birthday of the person insured.

Living Expenses Cover benefit

If your Policy Schedule states you have the Living Expenses Cover benefit, the benefit will end on the earliest of:

- the date you cancel the benefit
- the 65th birthday of the person insured.

Redundancy benefit

If your Policy Schedule states you have the Redundancy benefit, the benefit will end on the earliest of:

- the date your Living Expenses Cover benefit ends
- the date you cancel the benefit
- the 65th birthday of the person insured.

COVER WILL END IF YOU MISS A PREMIUM

If you do not pay a premium, the policy will remain in force for 30 days past the date on which the premium was due, and will then lapse. All cover will end as soon as the policy lapses.

You can reinstate your policy after it lapses within a limited time period

We may choose to reinstate a lapsed policy if one of the following happens.

- We hear from you within 30 days of the date the policy lapsed, with:
  - your written or spoken request to reinstate the policy, and
  - full payment of any unpaid premium.
- We hear from you within 30 to 60 days of the date the policy lapsed, with:
  - your written request to reinstate the policy
  - the newly completed Health and Lifestyle Questions
  - a signed declaration form, and
  - full payment of any unpaid premium.

If more than 60 days have passed since the date the policy lapsed, you cannot reinstate the lapsed policy. The person insured must make a new application for a new policy.

WHAT YOU NEED TO KNOW ABOUT MAKING A CLAIM

HOW TO MAKE A CLAIM

If you need to make a claim, please phone us on 0800 658 585.

So that we can deal with your claim as quickly as possible, please notify us as soon as you can for a Life Cover benefit or Terminal Illness claim.

You must notify us within 180 days of the event leading to a Living Expenses Cover, Critical Illness, or Redundancy benefit claim. If you don't notify us within this time limit, we may choose not to accept your claim. We are able to choose not to accept your claim if late notification means we can't assess your claim properly (for example, because evidence we need to assess your claim has been lost or is unavailable).

If you are not up to date with your premium payments at the time of making a claim, we might deduct this amount from any claim payments we make to you.

You and the person insured must complete all required claim forms and pay any cost associated with completing them.

THE INFORMATION YOU GIVE US FOR A CLAIM MUST BE CORRECT AND COMPLETE

We depend on information from you and others when you make a claim, and while we are paying a benefit under your policy. This information must be correct and complete. 'Complete' means those who provide information must tell us anything they know that might affect our decision to accept your claim or continue paying a claim. The test for whether someone 'knows' information is whether a reasonable person, in those circumstances, would be expected to know that information.

What happens if information is incorrect or incomplete

If information is incorrect or incomplete, we may do either or both of the following:

- decline to accept your claim
- cancel the policy.

If we have already paid the claim, we are entitled to recover any payments we have made.

WHEN WE WILL NOT PAY ANY BENEFIT UNDER THE POLICY

This policy has certain exclusions. An exclusion is a set of circumstances where the insurance policy does not apply and does not provide cover. Below, we list the standard exclusions that apply to all benefits available under ANZ Life & Living Insurance. In the separate sections for each benefit, we list the additional exclusions for particular benefits. If we have sent you or the person insured Amended Terms, any exclusions contained in the Amended Terms will also apply to your insurance policy.

Suicide within 13 months

We will not pay any benefit under the policy if the person insured commits suicide, or attempts to commit suicide, in the 13 months after either of the following:

- the policy start date
- the date on which a policy is reinstated.

Not entitled to live or work in New Zealand

We will not pay any benefit under the policy if the person insured, at the date of the claim, is not legally entitled to live in New Zealand, or to work in New Zealand in full-time employment or self-employment.

WHAT YOU NEED TO KNOW ABOUT CLAIMING ON THE LIFE COVER BENEFIT

This section of the Policy Document tells you the conditions for Life Cover benefit claims and payments, including payment of the Funeral benefit.

When we will pay you

If your Policy Schedule states you have the Life Cover benefit, we will pay it when the person insured dies or is diagnosed with a Terminal Illness while the policy is in force, provided that all the conditions outlined in this Policy Document are met. We will only pay either a Terminal Illness or a Life Cover claim, not both.

Funeral benefit

If at least 180 days have passed since the policy start date, we will make an advance payment of $10,000 of the Life Cover benefit. We call this the Funeral benefit. You do not need to apply for the Funeral benefit. We will automatically pay this benefit as soon as we receive formal notification of the death of the person insured and a completed Funeral benefit claim form.

How much we will pay you

The amount of the Life Cover benefit is either:

- stated in the Policy Schedule, or
- stated in the latest letter sent to you, offering to increase your cover in line with inflation (if you accepted the offer).

We will pay this sum, less any amount already paid in advance for the Funeral benefit.

When we won't pay you

We will not accept a claim under the circumstances discussed in 'When we will not pay any benefit under the policy' on page 9.

LIFE COVER (including Terminal Illness)
Pays amount selected up to $1,000,000 when the person insured dies or is diagnosed with a Terminal Illness
Terminal Illness generally means diagnosis of an advanced or rapidly progressive incurable illness where the insured's life expectancy is no greater than 12 months from the date of diagnosis
Includes a Funeral benefit which provides an advance payment of $10,000 of the Life Cover benefit
Cover starts on the policy start date shown in the Policy Schedule
Cover ceases at age 99

WHAT YOU NEED TO KNOW ABOUT CLAIMING ON THE CRITICAL ILLNESS BENEFIT

This section of the Policy Document tells you the conditions for Critical Illness benefit claims and payments.

When we will pay you

If your Policy Schedule states you have the Critical Illness benefit, we will pay when the person insured is diagnosed for the first time with one of the included medical conditions, provided that:

- the policy is in force
- the diagnosis is made 90 days or more after the policy start date; and
- the person insured survives for at least 14 days after being diagnosed.

See 'Included medical conditions' on pages 12-13.

When we pay a Critical Illness benefit we will no longer cover the person insured for the Critical Illness benefit.

How much we will pay you

The amount of cover for the Critical Illness benefit is either:

- stated in the Policy Schedule, or
- stated in the latest letter sent to you, offering to increase your cover in line with inflation (if you accepted the offer).

You must provide medical evidence for the diagnosis

You must provide satisfactory medical evidence that the person insured has been diagnosed for the first time with one of the included medical conditions. We can require the person insured to obtain a diagnosis from a medical specialist appointed by us.

The cost of providing medical evidence is to be met by the person insured. However, we will pay the cost of the medical specialist appointed by us.

We reserve the right to request any additional information relating to any Critical Illness claim from you, the person insured or any other person.

When we won't pay you

We will not accept a claim under the circumstances discussed in 'When we will not pay any benefit under the policy' on page 9. In addition, we will not pay the Critical Illness benefit if the medical condition occurs as a direct result of the person insured participating in a criminal act.

CRITICAL ILLNESS
Pays a lump sum of up to $200,000 if the person insured is diagnosed with one of these 12 major illnesses: • Cancer • Chronic liver disease • Chronic lung disease • Coronary artery angioplasty (triple vessel only) • Coronary artery bypass graft • Heart valve surgery • Kidney failure • Major heart attack • Major organ transplant • Multiple sclerosis • Paralysis • Stroke
No claim will be paid if the person insured dies within 14 days of being diagnosed
No claim will be paid if the diagnosis is made before, or within 90 days of, the policy start date
A period of 90 days applies to establish permanence of impairment for: • Multiple sclerosis • Paralysis • Stroke
Can only be paid once during the term of the policy, and the benefit ceases on payment of a claim
Cover ceases at age 65

INCLUDED MEDICAL CONDITIONS

This section lists the medical conditions covered by the Critical Illness benefit. We use medical terms in this section, because they are necessary to describe the precise diagnosis. Any conditions not listed below are not covered by the Critical Illness benefit.

Cancer

We will pay on first diagnosis of one or more malignant tumours. The diagnosis must be confirmed by histopathological examination.

Malignant tumours are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. Malignant tumours include leukaemia, lymphoma, Hodgkin's disease and other malignant bone marrow disorders.

Malignant melanomas are covered provided there is:

- evidence of ulceration as determined by histological examination; or
- at least Clark Level 3 depth of invasion; or
- thickness measuring at least 1.5mm using the Breslow method as determined by histological examination.

The following tumours are excluded from the Critical Illness benefit:

- chronic lymphocytic leukaemia, Binet Stages A & B or Rai stages 0, 1 and 2
- carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or tumours that are histologically described as pre-malignant or non-invasive, or that are classified as FIGO stage 0, or that have a TNM classification of Tis
- all other types of skin cancer, unless there is evidence of metastases
- Kaposi's sarcoma and other tumours associated with HIV infection, AIDS or AIDS-related complex
- prostatic cancers that histological tests show have a TNM Classification of T1 or Gleason score of less than 6 (or are of another equivalent or lesser histological classification)
- tumours treated by endoscopic procedures alone
- tumours that first occurred within 90 days of the policy start date, or tumours that are a recurrence or metastases of a tumour that first occurred within 90 days of the policy start date.

Chronic liver disease

We will pay on first diagnosis of end-stage liver failure with permanent jaundice, ascites and encephalopathy. Liver disease directly or indirectly related to alcohol use or drug abuse is excluded from the Critical Illness benefit.

Chronic lung disease

We will pay on first diagnosis of severe, permanent and irreversible lung disease (including emphysema) where there is dyspnoea at rest with markedly abnormal pulmonary function tests.

The diagnosis must be supported by all of the following medical evidence:

- the need for permanent and continuous daily oxygen therapy
- vital capacity being less than 50% of normal
- FEV1 (Forced Expiratory Volume at one second) test results must consistently be less than 1 litre.

Coronary artery angioplasty (triple vessel only)

We will pay on first instance of angioplasty (with or without an insertion of a stent or laser therapy) on three or more coronary arteries in the same procedure, carried out on the advice of a cardiologist acceptable to us, to correct the narrowing or blockage of the arteries. We require angiographic evidence to confirm the need for the procedure.

Coronary artery bypass graft

We will pay on first instance of open heart surgery, using bypass grafts, carried out on the advice of a relevant specialist, to correct narrowing or blockage of one or more coronary arteries. The surgery must have been proven necessary by coronary angiography or other suitable means. Balloon angioplasty, laser surgery, non-surgical techniques or any other similarly intra-arterial procedures are specifically excluded from the Critical Illness benefit.

Heart valve surgery

We will pay on first instance of open heart surgery, deemed medically necessary by a consultant cardiologist, to repair or replace a heart valve as a consequence of a heart valve defect. Balloon and other catheter techniques are specifically excluded from the Critical Illness benefit.

Kidney failure

We will pay on first diagnosis of end-stage kidney (renal) failure presenting as chronic, irreversible failure of both kidneys to function, as a result of which either regular renal dialysis is instituted or renal transplant is performed.

Major heart attack
We will pay on first diagnosis of the death of a part of the heart muscle due to lack of blood supply to the heart muscle.

The diagnosis must be:

- confirmed by a cardiologist, and
- evidenced by a rise or fall of cardiac biomarkers, such as Troponins, with at least one value above the upper reference range of laboratory normal (99th percentile).

One of the following must also apply:

- new cardiac symptoms and signs consistent with myocardial infarction, or
- electrocardiogram (ECG) tests that show new changes associated with a myocardial infarction, or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality consistent with a myocardial infarction.

If the above tests are inconclusive, not undertaken, or the tests are outdated due to technical advances, we will consider other appropriate and medically recognised tests that diagnose a heart attack of the same degree of severity as outlined above.

The following are not covered under this definition:

- other acute coronary syndromes
- elevations of Troponins in the absence of overt ischaemic disease.

Major organ transplant
We will pay when the person insured first receives a human-to-human transplant of a heart, liver, lung, kidney, pancreas, small bowel, or bone marrow. Alternatively, we will pay when a specialist approved by us confirms that the person insured has been accepted onto the official New Zealand or Australian waiting list for one of the above transplants. The transplant of all other organs, parts of organs, or any other tissue or cell is excluded from the Critical Illness benefit.

Multiple sclerosis
We will pay on unequivocal diagnosis by a consultant neurologist of multiple sclerosis causing permanent neurological damage. The person insured must have a whole person impairment of at least 25% that is permanent for a continuous period of at least 90 days. 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.

Paralysis
We will pay on complete and permanent loss of the use of two or more limbs due to spinal cord or brain injury, or disease. 'Limb' is defined as the complete arm or complete leg. To establish permanence, the paralysis must have persisted for a continuous period of at least 90 days.

Stroke
We will pay on a cerebrovascular incident resulting in permanent neurological damage. The person insured must have a whole person impairment of at least 25% that is permanent for a continuous period of at least 90 days. A CT, MRI or similar appropriate scan must provide clear evidence that a stroke has occurred, with infarction of brain tissue and either of the following:

- intracranial or subarachnoid haemorrhage
- embolisation from an extra-cranial source.

Specifically excluded are cerebral symptoms due to:

- transient ischaemic attacks
- reversible neurological deficit
- migraine
- cerebral injury resulting from trauma or hypoxia
- vascular disease affecting the eye, optic nerve or vestibular functions.

ADVANCING MEDICAL TESTING PROCEDURES

Occasionally medical procedures used for diagnosis of a Critical Illness condition are updated or replaced by more advanced medical testing procedures. If this happens, we may consider using another appropriate and medically recognised test or procedure to help assess a Critical Illness claim.

WHAT YOU NEED TO KNOW ABOUT CLAIMING ON THE LIVING EXPENSES COVER BENEFIT

This section of the Policy Document tells you the conditions for Living Expenses Cover claims and payments.

To claim the Living Expenses Cover benefit, the person insured needs to suffer a disability as defined below in 'How we define disability'.

How we define disability

Disability means total and continuous disablement caused by either:

- illness, or
- bodily injury caused solely and directly by accidental, external and visible means.

One of the following must also apply.

- If the person insured was in full-time employment or self-employment at the time the illness or bodily injury happened, the person insured has been diagnosed by a registered medical practitioner as being unable to work any hours in their usual full-time employment or self-employment.
- If the person insured was not in full-time employment or self-employment at the time the illness or bodily injury happened, a registered medical practitioner has certified that the person insured needs to be confined to hospital or bed at home.

In either case, the person insured must also require regular treatment from a registered medical practitioner for the disability.

For the purposes of this policy, it does not include disability related to any of the following:

- intentional self-harm, including any attempted suicide, intentionally self-inflicted injuries or illness, or intentionally contracted bacteria or virus
- the person insured participating in a criminal act
- the normal effects of pregnancy, childbirth or miscarriage
- medical or surgical treatment, except where such treatment is needed because of an event for which we have accepted a claim.

LIVING EXPENSES COVER

Pays amount selected up to $4,000 per month for a maximum of 24 months for any one condition or event

Covers accidental bodily injury or illness that completely stops the person insured from engaging in their usual full-time employment or self-employment or, if not in full-time employment or self-employment, they are confined to hospital or bed at home

Full-time employment is defined as 20 hours per week or more in permanent employment or fixed-term employment with a single employer

Self-employment is defined as 20 hours per week or more of paid employment either:

- by a company controlled directly or indirectly by the person insured (or members of the person insured's immediate family), or
- as a self-employed contractor, sole trader, partner in a partnership or in a similar arrangement

Cover ceases at age 65

When we will start paying you

If your Policy Schedule states you have the Living Expenses Cover benefit, we will start paying if the person insured suffers from a disability while the policy is in force, provided that both of the following apply:

- all the conditions outlined in this Policy Document are met
- the person insured is totally and continuously disabled for a longer period than the claim wait period selected.

Your claim wait period (30 or 90 days) for the Living Expenses Cover benefit is stated in your Policy Schedule and starts from the date of the disability.

- If you have a 30-day claim wait period, payment will be made after the claim wait period ends, but the 30 days will be included when calculating how much benefit will be paid. This means that after your 30-day claim wait period ends, we will pay both:
  - a single payment equal to the stated amount of the Living Expenses Cover benefit, to cover the claim wait period, and
  - 1/30th of the stated amount of the Living Expenses Cover benefit for each day after the end of the claim wait period.
- If you have a 90-day claim wait period, we will start paying 1/30th of the stated amount of the Living Expenses Cover benefit for each day after the end of the claim wait period.

We will treat a subsequent claim as the same claim if we were previously paying the Living Expenses Cover benefit, and both the following apply:

- the person insured had returned to full-time employment or self-employment, or (if they had no full-time employment or self-employment) was no longer confined to hospital or bed at home, and
- within 90 days, they suffered disability again from the same, a similar, or a related condition or event.

We will not apply a new claim wait period to such a reoccurrence.

We will pay no more than $4,000 a month per person insured, regardless of the number of policies we have issued that cover the person insured.

When we will stop paying you

If the person insured was employed at the time the illness or bodily injury happened, we will stop paying the Living Expenses Cover benefit when the person insured returns to their previous full-time employment or self-employment for at least 20 hours per week.

We will also stop paying the Living Expenses Cover benefit if either of the following occurs:

- The person insured begins self-employment or any employment for salary or wages for at least 20 hours per week.
- A registered medical practitioner declares that the person insured is medically fit to resume self-employment or employment for salary or wages for at least 20 hours per week whether or not self-employment or employment is available. The self-employment or employment needs to be work for which the person insured is reasonably suited by education, training, or previous work experience.

We will always stop paying the Living Expenses Cover benefit on the person insured's 65th birthday.

If the person insured had no full-time employment or self-employment at the time the illness or bodily injury happened, we will stop paying the Living Expenses Cover benefit when a registered medical practitioner certifies that the person insured no longer needs to be confined to hospital or bed at home.

We will pay the Living Expenses Cover benefit for a maximum combined period of 24 months for claims that arise out of the same, similar or related illness, injury or event.

When we won't pay you

We will not accept a claim, or will stop making payment on a claim, under the circumstances discussed in 'When we will not pay any benefit under the policy' on page 9. In addition:

- We will not accept a claim for a Living Expenses Cover benefit if either of the following are true:
  - The person insured lived away from New Zealand at the time the illness or bodily injury happened.
  - The person insured was working outside of New Zealand at the time the illness or bodily injury happened.
- We can, at our sole discretion, refuse to pay or stop paying the Living Expenses Cover benefit if the person insured refuses to follow the recommendations of a registered medical practitioner, or appropriate specialist for:
  - any medical or surgical treatment
  - a rehabilitation programme.

WHAT YOU NEED TO KNOW ABOUT CLAIMING ON THE REDUNDANCY BENEFIT

This section of the Policy Document tells you the conditions for Redundancy benefit claims and payments.

You cannot have the Redundancy benefit unless you also have the Living Expenses Cover benefit.

When we will start paying you

If your Policy Schedule states you have the Redundancy benefit, we will start paying when the person insured is made redundant while the policy is in force, provided that:

- all the conditions outlined in this Policy Document are met
- the person insured does not, within the claim wait period, begin or get self-employment, or employment for salary or wages for at least 20 hours per week
- at least 180 days have passed since the policy start date before the person insured receives written or spoken notice of redundancy or potential redundancy.

The start date of redundancy is the later of:

- the day the person insured registered with an appropriate employment agency to look for work
- the day they ceased work due to redundancy.

Your claim wait period (30 or 90 days) for the Redundancy benefit is stated in your Policy Schedule and begins on the start date for Redundancy.

- If you have a 30-day claim wait period, payment will be made after the claim wait period ends, but the 30 days will be included when calculating how much benefit will be paid. This means that after your 30-day claim wait period ends, we will pay both:
  - a single payment equal to the stated amount of the Redundancy benefit, to cover the claim wait period, and
  - 1/30th of the stated amount of the Redundancy benefit for each day after the end of the claim wait period.
- If you have a 90-day claim wait period, we will start paying 1/30th of the stated amount of the Redundancy benefit for each day after the end of the claim wait period.

We will pay no more than $4,000 a month per person insured, regardless of the number of policies we have issued that cover the person insured.

REDUNDANCY (can only be taken with Living Expenses Cover)
Pays amount selected up to $4,000 per month for a maximum of 180 consecutive days
The person insured must be in full-time employment for at least 180 consecutive days with the same employer before the date of redundancy
Claim wait period starts upon registration with an appropriate employment agency or the first day unemployed, whichever is the later
No cover when the person insured receives notice of redundancy or potential redundancy before or within 180 days of the policy start date
Not eligible if the person insured takes voluntary redundancy
Amount selected cannot exceed the sum insured under Living Expenses Cover
Cover ceases at age 65

What needs to happen before we will pay you

Before we pay you, you and the person insured must send us any required claim forms and all of the following:

- proof of redundancy
- proof that the person insured has registered with an appropriate employment agency to look for work
- copies of job applications made by the person insured, and responses.

When we will stop paying you

We will stop paying a redundancy claim on the earlier of:

- the date the person insured begins or gets self-employment, or employment for salary or wages for at least 20 hours per week
- the date on which we have paid the Redundancy benefit for 180 consecutive days (for each period of redundancy).

We will always stop paying the Redundancy benefit on the person insured's 65th birthday.

When we won't pay you

We will not accept a claim, or will stop making payment on a claim, under the circumstances discussed in 'When we will not pay any benefit under the policy' on page 9. In addition:

- We will not accept a redundancy claim if any of the following are true:
  - The person insured was living outside of New Zealand at the date of the redundancy
  - The person insured was working outside of New Zealand at the date of the redundancy
  - The person insured was not legally entitled to work in full-time employment in New Zealand at the date of the redundancy.
- We will not accept a claim under this policy if the person insured's redundancy is:
  - caused by, or resulting from, a strike or labour dispute involving the person insured or the person insured's employer
  - from temporary, seasonal, part-time, casual, or relief work or caused by the expiry or non-renewal of a fixed-term employment contract
  - caused by voluntary redundancy, resignation or retirement
  - from an employer that the person insured is a director, shareholder or owner of, or which the person insured controls
  - from an employer which is controlled by a relative of the person insured, or of which a relative of the person insured is a director, shareholder or owner.
- We will only accept a redundancy claim if the person insured has been in full-time employment with the same employer for at least 180 consecutive days immediately before the date of redundancy.
- We will not accept or continue paying a redundancy claim if the person insured is not making every endeavour to find full-time employment, self-employment or fixed-term employment, including during the claim wait period.

WHAT YOU NEED TO KNOW ABOUT HOW WE WORK

CHUBB LIFE IS THE UNDERWRITER FOR ANZ LIFE & LIVING INSURANCE

Being the underwriter means that Chubb Life issues your policy and provides the insurance cover under it. Chubb Life is a licensed insurer.

WE WORK UNDER NEW ZEALAND LAW AND IN NEW ZEALAND CURRENCY

This policy is governed and interpreted according to the laws of New Zealand. All money referred to in this policy is expressed and payable in New Zealand dollars.

STATUTORY FUND

We are required under the Insurance (Prudential Supervision) Act 2010 to establish a statutory fund. The statutory fund relevant to your policy is Chubb Life's Statutory Fund Number One.

Your premiums will be placed in, and any benefits paid from, this statutory fund.

NO SURRENDER VALUE

This policy does not have a surrender value and does not participate in the profits or share in the surplus of Chubb Life.

HOW WE USE INFORMATION ABOUT YOU

ANZ Bank New Zealand Limited will pass to Chubb Life the information collected about you so that Chubb Life can assess your application. Chubb Life or its related companies may collect, use or disclose the information about you for the purposes of assessing whether to offer insurance cover and administering your policy.

Examples of the people who may be given your information, or from whom it may be collected include, but are not limited to: Chubb Life's related companies; ANZ Bank; selected reinsurers; any doctor or other health professional; hospitals; government agencies; accountants; employers (past or current); insurance companies; or any other party whom you have consulted or may consult, and other persons insured and policy owners on the policy.

These are examples only; we can give information to, and collect information from, anyone where it is reasonably necessary to do so to administer your policy. You and the person insured can access or correct any personal information we hold by writing to us at **Chubb Life Insurance New Zealand Limited, Private Bag 92131, Victoria Street West, Auckland 1142.** You or the person insured may have to pay a fee to access the information we have.

For further information about our privacy policy and how this applies to your information, see the privacy section of our website at **chubblife.co.nz/privacy**.

Your personal information may also be held and used by ANZ Bank New Zealand Limited and other members of the ANZ Banking Group. For further information about ANZ's privacy policy and how this applies to your information, see the ANZ Privacy Statement available at **anz.co.nz/about-us/privacy.**

HOW TO CONTACT THE INSURANCE & FINANCIAL SERVICES OMBUDSMAN

If you are not satisfied with the way we resolve any enquiry or complaint, you can contact the **Insurance & Financial Services Ombudsman, PO Box 10-845, Wellington 6143 (Freephone 0800 888 202).**

DEFINITION OF TERMS USED IN THIS POLICY

The definitions below explain what we mean by words we frequently use in this Policy Document.

Acknowledgement of Application means the document issued to the person insured after applying for insurance, which summarises the cover applied for and includes the declarations the person insured gave that are relevant to your policy. The person insured will have received an Acknowledgement of Application if he or she was told at the point of sale that the application would need to be assessed.

Amended Terms are any special or additional terms that form part of this policy. They contain changes to the standard cover terms, such as increasing your premium, an exclusion, deferral or reduction of the sum insured. Amended Terms may be contained in a letter, Policy Schedule or other written communication from us.

Application Form means the paper application form that the person insured may have completed when applying for this policy.

Claim wait period means the number of consecutive days before a claim will be paid. Your claim wait period is stated in the Policy Schedule.

Critical Illness means one of the defined conditions under the section entitled 'Included medical conditions' in this Policy Document.

Critical Illness benefit means the Critical Illness benefit amount that is either:

- stated in the Policy Schedule, or
- stated in the latest letter we sent to you, offering to increase your cover in line with inflation (if you accepted the offer).

Disability means total and continuous disablement caused by either:

- illness, or
- bodily injury caused solely and directly by accidental, external and visible means.

'Disabled' has a corresponding meaning.

Fixed-term employment has the same meaning as in the Employment Relations Act 2000. Currently, it means employment where the person insured and the employer agree that the employment will end:

- on a specified date or at the end of a specified period
- when a specified date occurs, or
- when a specified project has been completed.

Full-time employment means permanent employment or fixed-term employment for salary or wages by a single employer for at least 20 hours per week. This does not include self-employment.

Funeral benefit means the advance payment of $10,000 of the Life Cover benefit on the death of the person insured.

Health and Lifestyle Questions means the document that contains the person insured's answers to questions about their health, their lifestyle and their family's medical history.

Lapse means the policy is no longer in force due to missed premium payments. 'Lapsed' has a corresponding meaning.

Life Cover benefit means the Life Cover benefit amount that is either:

- stated in the Policy Schedule, or
- stated in the latest letter sent to you, offering to increase your cover in line with inflation (if you accepted the offer).

Living Expenses Cover benefit means the Living Expenses Cover benefit amount specified in the Policy Schedule.

Offer of Cover means the document issued to the person insured after applying for insurance, which summarises the cover applied for and includes the declarations the person insured gave that are relevant to your policy. The person insured will have received an Offer of Cover if he or she was told at the point of sale that they have been offered cover.

Person insured means the person who is insured under this Policy, named in the Policy Schedule.

Policy means the insurance contract between you, us and the person insured, and any renewal of it. The seven parts of the insurance contract are:

- the Welcome Letter
- the Policy Schedule
- the completed Health and Lifestyle Questions
- the Offer of Cover, Acknowledgement of Application or Application Form, as applicable
- any spoken or written statements made to ANZ Bank New Zealand Limited or us (by the person insured or in their name) while applying for or reinstating this policy
- any Amended Terms offered or applied to this policy
- this Policy Document.

Policy Document means this document together with any supplementary or additional documents we may issue from time to time that we tell you will form part of the Policy Document.

Policy owner means the policy owner named in the Policy Schedule. In general, the policy owner controls the policy. The proceeds of any benefit will be paid to the policy owner. In this document, we use 'you' and 'your' to refer to the policy owner, not to the person insured. If you require a change of policy ownership, use the Memorandum of Transfer form on the back of the Policy Schedule.

Policy Schedule means the schedule forming part of this policy. If we replace or amend the schedule, Policy Schedule means the schedule as replaced or amended.

DEFINITION OF TERMS USED IN THIS POLICY

Policy start date means the original date on which the policy starts, as stated in the Policy Schedule.

Redundancy means the person insured has lost full-time employment (other than by dismissal, resignation or incapacity) because their position or role is no longer needed by the employer.

'Redundant' has a corresponding meaning.

Redundancy benefit means the Redundancy benefit amount specified in the Policy Schedule.

Registered medical practitioner means a person registered as a medical practitioner with the Medical Council of New Zealand. The registered medical practitioner must not be the person insured or the policy owner or any partner or relative of the person insured or policy owner.

Reinstate means putting the policy back in force after it has lapsed.

Self-employment means the person insured is paid for employment of more than 20 hours per week:

- by a company controlled directly or indirectly by the person insured (or members of the person insured's immediate family), or
- as a self-employed contractor, sole trader, partner in a partnership or in a similar arrangement.

Terminal Illness means diagnosis of an advanced or rapidly progressive incurable illness in the person insured where two medical specialists (one appointed by us) agree that the life expectancy of the person insured is no greater than 12 months from the date of diagnosis.

Welcome Letter means the document that confirms your cover is in place. This letter outlines premium payment details along with other important information.

Whole person impairment means the person has been evaluated as having at least 25% impairment of whole person function, as determined by the American Medical Association's book *Guides to the Evaluation of Permanent Impairment*, 6th edition or subsequent editions.

CONTACT US

You can contact us if you have questions, concerns or would like to make changes to the policy.

0800 658 585

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