Premium Life Direct
SECURE COVER
PERSONAL SERVICE
LOW PREMIUMS

Product Disclosure Statement issued by:
NobleOak Life Limited
ABN 85 087 648 708  AFSL No. 247302
Issue Date: 05 April 2021
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Welcome to Premium Life Direct

This Product Disclosure Statement (PDS) contains important information you should know about Premium Life Direct to help you decide if it is right for you.

Inside you will find:
- Explanations of Premium Life Direct’s features and benefits, helping you compare it to other insurance products.
- Details of the conditions, limitations and exclusions that apply, so you’ll know when we will pay a claim and when we won’t.
- Details on how to change your cover when you need to, and
- What to do if you need to make a claim.

If you buy Premium Life Direct from NobleOak, your contract with us will be made up of this PDS, your application for insurance, any special acceptance terms applying to your cover, your Certificate of Membership and the most recent Benefit Information notice we’ve sent you. Once your cover is in place, please keep these documents in a safe place for future reference. NobleOak’s Risk Fund No.1 Benefit Fund Rules also form part of the contract (see page 6 for more information; the Rules may be viewed on request.)

Any advice given in this PDS is general only and does not take into account your individual circumstances. You should consider whether this product is right for you with regards to your objectives, financial situation and needs. The benefits described in this PDS are for the Members joining from the Issue Date of this PDS. If you have any questions, please call us on 1300 551 044.

“I believe that the basic attribute of mankind is to look after each other.”
Fred Hollows
What is Premium Life Direct?

Premium Life Direct provides flexibility for you to select the life insurance products you want, within a range of cover levels. It lets you choose the types and amounts of cover you’d like, and you only pay for what you are covered for.

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>Pg.</th>
<th>What you are covered for</th>
<th>Min. Age at Entry</th>
<th>Max. Age at Entry</th>
<th>Cover Expiry Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>8</td>
<td>Choose up to $15m cover in case you die or become terminally ill, helping to clear your debts and support your family.</td>
<td>16</td>
<td>69</td>
<td>99</td>
</tr>
<tr>
<td>+ Add Total and Permanent Disability (TPD) Insurance</td>
<td>10</td>
<td>Choose up to $5m cover that will be advanced from your Life Insurance if you're never able to work again because of sickness or injury, helping you modify your home, replace lost income and clear debts.</td>
<td>16</td>
<td>59</td>
<td>75</td>
</tr>
<tr>
<td>(Optional with Life Insurance)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Add Trauma Insurance (Optional with Life Insurance)</td>
<td>10</td>
<td>Choose up to $2m cover that will be advanced from your Life Insurance if you suffer a serious listed medical condition, helping you pay your treatment expenses and adjust your lifestyle.</td>
<td>18</td>
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<td>70</td>
</tr>
<tr>
<td>Trauma Insurance (Stand Alone)</td>
<td>12</td>
<td>Choose up to $2m cover in case you suffer a serious listed medical condition, helping you pay any excess treatment expenses and adjust your lifestyle. A Survival Period applies to stand-alone Trauma Insurance.</td>
<td>18</td>
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<td>70</td>
</tr>
<tr>
<td>Income Protection Insurance</td>
<td>16</td>
<td>Choose cover of up to 75% of your income (max $25,000 per month) in case you can't work due to sickness or injury, helping you to support your family and cover essential living expenses.</td>
<td>18</td>
<td>59</td>
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<tr>
<td>Business Expenses Insurance</td>
<td>20</td>
<td>If you are self-employed you can choose cover of up to $25,000 per month in case you can't work due to sickness or injury, helping you cover the fixed operating costs of your business.</td>
<td>21</td>
<td>59</td>
<td>65</td>
</tr>
</tbody>
</table>

If you are the trustee of a Self-Managed Super Fund or of an Approved Superannuation Fund, you can choose Life Insurance, TPD Insurance (the 'Any' occupation definition applies, where TPD Insurance is taken under superannuation) and/or Income Protection Insurance for members of your Fund.
1. Consider your eligibility and what cover you need

You need to be an Australian resident between the minimum and maximum ages shown in the previous table to be eligible to be insured under Premium Life Direct.

When choosing your level of cover, you will need to:

a) Choose your Life Insurance cover amount, and
   - If you would like optional Total and Permanent Disability Insurance, choose your cover amount and either the ‘Own’ occupation and/or ‘Any’ occupation definition (please note that if your occupation when you apply is home duties, then the ‘Domestic Duties’ definition will apply to your cover as issued. See section A of the table on page 10, for the meaning of the ‘Own’ occupation definition, the ‘Any’ occupation definition, and the Domestic Duties definition).

and/or

b) If you would like stand-alone Trauma Insurance, choose your cover amount.

c) Choose your Income Protection Insurance cover amount per month, together with a Waiting Period and Benefit Period.

2. Arrange your quote

To arrange your quote, visit [www.nobleoak.com.au](http://www.nobleoak.com.au) or call NobleOak on 1300 041 494. We can provide general information about the product features and answer any questions you may have.

Your quote can even be sent by email while you’re still on the phone. Once you’re happy with the quote, you can apply for Premium Life Direct or take some time to compare other insurers.

3. Apply

Allow 15 to 30 minutes when applying for Premium Life Direct.

Once we have your full application and payment details, we’ll provide you with free Interim Accidental Cover (see full terms and conditions towards the end of this PDS) while we complete our assessment.

If your application is approved, we will activate your cover and provide you with a welcome pack that outlines the details of your cover.
The people behind
your cover

About NobleOak (the product insurer)

NobleOak Life Limited (NobleOak) is an Australian life company that was established in 1877 and has been protecting Australians for over 140 years. NobleOak is a friendly society regulated by the Australian Prudential Regulation Authority (APRA), and holds an Australian Financial Services Licence issued by the Australian Securities and Investments Commission (ASIC).

Cover provided under Premium Life Direct is reinsured by one of the leading global reinsurers, Hannover Life Re of Australasia Ltd.

When you’re with NobleOak, you can feel secure knowing you’re with a leading friendly society that has become synonymous with trust and integrity. We pride ourselves on personalised, friendly service and our experienced claims specialists are based here in Australia.

We are also a member of the Financial Services Council of Australia and a signatory to the FSC Code of Practice for Life Insurers. The Code sets out the minimum standards for dealing with, communicating with and servicing our clients. It is built around the principles of Clarity and Transparency, Fairness and Respect, Honesty, Timeliness and Communication. At NobleOak we pride ourselves on doing more than meeting the minimum standards. We have been helping Australians for over 140 years to protect their loved ones and lifestyle. Our core philosophy is to put our clients' needs first at all times. We always offer genuine value, provide quality cover and work to make Life insurance more accessible and affordable.

Our Client Guides set out the standards you can expect from the team at NobleOak when taking out and managing your cover and are available at https://www.nobleoak.com.au/about-us/code-of-practice/

NobleOak provides insurance cover under its Risk Fund No.1 Benefit Fund Rules which are approved by NobleOak’s Board and APRA. Upon acceptance for cover under Premium Life Direct you become insured under the master insurance policy that is issued to NobleOak Services Limited ABN 66 112 981 718 AFSL Number 286798 as the Trustee of the My Protection Plan trust. Your cover is governed by the Risk Fund No.1 Benefit Fund Rules. You will receive a welcome pack with a Benefit Schedule setting out your cover, your premiums and any special terms agreed with you. Members may request to view the Risk Fund No.1 Benefit Rules at any time.

We use 'you' and 'Life Insured' to mean the applicant, and/or the person covered or to be covered as the context implies.

Where you apply for cover for yourself and are accepted for cover, you as the cover holder become a member of NobleOak’s Benefit Fund known as Risk Fund No.1, as well as a Life Insured. If you, as the cover holder, apply for someone else to be covered and they are accepted for cover, then they are a Life Insured (but not a member of the Benefit Fund; you as the cover holder become a member).
Peace of mind starts when you apply

Premium Life Direct is a fully-underwritten life insurance contract. That means we ask you about your health and lifestyle at the start, so we can adjust your cover and your premium according to the answers given.

As long as you disclose everything we need when you apply, you can rest assured that any future claim will be fully paid in accordance with this PDS, being a full disclosure of the underlying terms and conditions in the Risk Benefit Fund Rules. There may also be other special acceptance terms agreed with you following your application.

Our Promise to you

We value you as a person
As a friendly society, our core philosophy is about looking after our clients – ensuring you always receive excellent value, comprehensive products and great service.

We pay claims
We assign a personal claim specialist to help clients and their families when they need it most. They work alongside our clients to provide support at each step of the way. All eligible claims are paid promptly under the condition that all questions are answered truthfully and completely during the application process and at claim time.

We strive to keep premiums low
Unlike larger insurers and banks, we don’t invest heavily in advertising and sponsorships, and we don’t pay high upfront commissions to advisers or brokers. That means we can pass on savings directly to you by offering low premiums.

We guarantee your renewals
As long as premiums are paid, NobleOak guarantees to renew your insurance cover each year up until the expiry age that applies for the cover. Your insurance cover will not be cancelled, nor will your premiums be increased due to any future change in your state of health, lifestyle, occupation or pastimes.

We cover you wherever you are
Once issued, insurance cover is provided worldwide and 24-hours a day, subject to any special terms and conditions NobleOak may apply to your cover.
Life Insurance

Choose an amount of cover in case you die or become terminally ill, helping to clear your debts and support your family.

Death Benefit
If you die while covered for Life Insurance, NobleOak will pay the agreed cover amount as a lump sum to your nominated beneficiaries or estate. You can apply for cover up to $15 million, although higher amounts will be considered where it can be justified.

Funeral Advance Benefit
NobleOak will quickly advance $15,000 of your cover amount to assist with funeral expenses, upon evidence of age and receipt of the death certificate (or other evidence satisfactory to us, acting reasonably, of the insured person’s death). The payment of this benefit will reduce the Death Benefit by the amount paid.

Terminal Illness Benefit
If you become terminally ill, NobleOak will advance the Death Benefit cover amount instead of paying the Death Benefit when you die.

To be eligible for this payment:
• You must be diagnosed as being terminally ill by two Medical Practitioners, one of which is a specialist practising in an area related to the illness or injury suffered by you; and
• Their joint or separate diagnoses certify that you are suffering from an illness, or have incurred an injury, that is likely to result in death within 24 months of their certification.

Financial Advice Benefit
We understand that you or your estate may need some professional advice to ensure that the proceeds of a death or terminal illness claim payment are managed appropriately. That is why we will reimburse the cost of engaging a qualified financial adviser, up to $2,000, to prepare a financial plan if we pay a benefit in excess of $200,000 for death or terminal illness. See page 29 for more details.

Grief Counselling Benefit
We understand that your death or diagnosis with a terminal illness can be a very emotional time. That is why we will reimburse the cost of grief counselling services for you, your spouse or your partner, up to $1,000, if we pay a benefit for death or terminal illness. See page 30 for more details.

Premium Freeze Benefit
You can fix the cost of your cover at any time by contacting us with a request to freeze the premium amount. This means that:
• Your future premiums will be fixed at the amount you were paying on the date of notification, and
• Each year your cover amount will be adjusted to the amount of cover that can be purchased for the frozen premium.

You can contact us at any time to end the Premium Freeze Benefit and the premium freeze will end on the next anniversary of your cover.

Future Increases Benefit
You can increase your cover amount by the lesser of $100,000 or 20% of the original cover amount without the need to provide further medical evidence if one of the following allowable events occurs:
• You take out or increase a mortgage on your primary place of residence
• You marry, register a partnership, or commence a de facto relationship recognised at law
• You or your partner gives birth to or adopts a child
• Your child starts secondary school
• Your spouse dies
• You get divorced
The insurance under the replaced cover was in place for a minimum of 13 consecutive months immediately prior to the commencement of this cover,

- The replaced cover was cancelled immediately after the issue of this cover,
- Any suicide exclusion period has expired under the replaced cover (including exclusions which were applied to the cover after its commencement due to, for example, reinstatements or increases),
- The cover amount being issued by us is the same or less than that under the replaced policy, and
- No claim is payable or pending or entitled to be made under the replaced cover.

Where your cover has replaced another cover issued by us or another insurer and the sum insured under your cover is greater than the sum insured under the replaced cover, then the suicide exclusion will apply to the difference in the sums insured, from the commencement of your cover.

**Benefit Reductions**

The Death Benefit (including where it is paid as the Terminal Illness Benefit) is reduced by any amounts we pay under the optional Total and Permanent Disablement insurance cover and/or the optional Trauma Insurance cover.

**Compliance with SIS regulations**

Under SIS regulations, life insurance under superannuation doesn’t permit certain benefits to be paid. As such, if the cover is held by an SMSF (as a Trustee Member) or within an Approved Superannuation Fund we will not be able to pay the Funeral Advance Benefit, Financial Advice Benefit or Grief Counselling Benefit. In this PDS, references to SIS mean the Superannuation Industry (Supervision) Act 1993.

**Exclusions**

The Death Benefit and the Funeral Advance Benefit will not be payable if death is a result of:

- Suicide occurring within 13 months following the commencement, reinstatement or increase of the insurance cover (but only to the extent of that increase), or
- Any special terms, which are specific to you and noted in any special acceptance terms agreed with you in connection with your cover.

Assisted dying, as provided for in Australian State, Territory or Commonwealth legislation will not be considered suicide where it is permitted by and conducted in compliance with applicable legislation.

The 13 month suicide exclusion will not apply to your cover if it replaced existing life cover issued by us or another insurer, as long as:

**Premium Pause**

If you become unemployed or need to take extended leave from employment other than for travel, for a maximum of 12 months, because of full time study, maternity/paternity leave or compassionate leave, then you can contact us and ask us to pause your premiums for up to twelve months.

The premium pause is available once your cover has been in place for more than 2 years. We will not pay any claim arising from an event which occurs during the premium pause or within 90 days of restarting your premium payments.

Utilising the premium pause will not be treated as a reinstatement or increase of cover. If you pause your Life Insurance any attached optional benefits or covers (TPD or Trauma Insurance) will also be paused.

**Indexation**

To guard against inflation, your cover amount will automatically be increased at each anniversary using the Consumer Price Index, or 3%, whichever is the greater. Your premium will be adjusted accordingly. See page 30 for details.

“We make a living by what we get, but we make a life by what we give.”

Winston Churchill
Total and Permanent Disablement Insurance

(Optional with your Life Insurance cover)

Choose up to $5m cover in case you’re never able to work again because of Sickness or Injury, helping you modify your home, replace lost income and clear debts.

Total and Permanent Disablement (TPD) Benefit

If you become totally and permanently disabled due to Sickness or Injury, NobleOak will pay you the agreed cover amount as a lump sum. You can apply for an amount up to your Life Insurance sum insured, to a maximum of $5 million.

Note: if your occupation is home duties, the Domestic Duties definition for TPD will apply.

Total and Permanent Disablement means solely as a result of your Sickness or Injury (whether physical or mental):

A
You have been absent from work (or have not performed Domestic Duties) for a continuous period of at least 3 months, and at the end of those 3 months, we are reasonably satisfied that your Sickness or Injury (whether physical or mental) makes it unlikely that you will:

- If the ‘Own’ occupation definition applies: ever again engage in your own Occupation.
- If the ‘Any’ occupation definition applies: ever again engage in any gainful employment for which you are reasonably qualified by education, training or experience.
- If the ‘Domestic Duties’ definition applies: ever again be able to perform your usual unpaid Domestic Duties, or

B
You have suffered Loss of Limbs and/or Sight - total and permanent, or

C
You have suffered Loss of Independence - total and permanent.

Subject to:

- If this cover is held by a trustee of a superannuation fund, the ‘Any’ occupation definition will always need to be met.
- If you are under the age of 65 and permanently retired from the workforce at the time of disablement, the ‘Domestic Duties’ definition will apply.
- If you are age 65 or older, ‘B’ or ‘C’ will apply.
- If you were not gainfully employed for at least 15 hours per week at the commencement of insurance cover, the ‘Domestic Duties’ definition will apply (subject to the following bullet point).
- If the Domestic Duties definition applied to your cover at time of application, and immediately prior to your Sickness or Injury giving rise to a claim you had been working for more than 6 consecutive months and working more than 15 hours per week on average during that time, we will assess you under the ‘Any’ occupation definition.
How a TPD claim is paid

TPD Insurance is available as an optional extra with Life Insurance. Any claim paid under TPD Insurance will reduce the remaining Life Insurance cover amount (and Trauma Insurance if also taken) by the amount of TPD Benefit paid.

The period of total disablement begins on the first day absent from work due to the Sickness or Injury. After turning age 65, the TPD Benefit is reduced at each anniversary by 10% (of the value at age 65), until expiry by age 75, when TPD Insurance will be extinguished. Premiums will be reduced accordingly.

Financial Advice Benefit

We understand that you may need some professional advice to ensure that the proceeds of a Total & Permanent Disability claim payment are managed appropriately. That is why we will reimburse the cost of engaging a qualified and licensed financial adviser, up to $2,000, to prepare a financial plan if we pay a TPD benefit in excess of $200,000. See page 29 for more details.

Premium Freeze Benefit

You can fix the cost of your cover at any time by contacting us with a request to freeze the premium amount. This means that:

- Your future premiums will be fixed at the amount you were paying on the date of notification; and
- Each year your cover amount will be adjusted to the amount of cover that can be purchased for the frozen premium.

You can contact us at any time to end the Premium Freeze Benefit and the premium freeze will end on the next anniversary of your cover.

Future Increases Benefit

You can increase your cover amount by the lesser of $100,000 or 20% of the original cover amount without the need to provide further medical evidence if one of the following allowable events occurs:

- You take out or increase a mortgage on your primary place of residence
- You marry, register a partnership, or commence a de facto relationship recognised at law
- You or your partner gives birth to or adopts a child
- Your child starts secondary school
- Your spouse dies
- You get divorced

Indexation

To help protect you against inflation, your cover amount will automatically be increased at each policy anniversary using the Consumer Price Index, or 3%, whichever is the greater. Your premium will be adjusted accordingly. See page 30 for details.

Premium Pause

If you become unemployed or need to take extended leave from employment other than for travel, for a maximum of 12 months, because of full time study, maternity/paternity leave or compassionate leave, then you can contact us and ask us to pause your premiums for up to twelve months.

The premium pause is available once your cover has been in place for more than 2 years. We will not pay any claim arising from any Sickness or Injury which occurs during the premium pause or within 90 days of restarting your premium payments.

When your cover starts again as a result of the premium pause period ending and the subsequent 90 day period expiring, it will not be treated as a reinstatement of cover.

Exclusions

A benefit will not be payable for TPD Insurance where:

- Total and Permanent Disablement is caused or contributed to by any intentional self-injury or intended suicide irrespective of whether sane or insane within 13 months from commencement, reinstatement or increase of the insurance cover (but only to the extent of that increase), or
- Any exclusion applies, which is specific to you and noted in any special acceptance terms agreed with you in connection with your cover.

Compliance with SIS regulations

Under SIS regulations, insurance provided through a superannuation fund can only be provided where the insurable event is consistent with a SIS Act Condition of Release.

If TPD insurance is held through a SMSF (as a Trustee Member) or an Approved Superannuation Fund, only the 'Any' Occupation definition is consistent with SIS regulations.
Trauma Insurance
(Available as stand-alone cover, or optional with Life Insurance cover)

Choose up to $2m cover in case you suffer a serious listed medical condition, helping you pay your treatment expenses and adjust your lifestyle.

Trauma Benefit
If you suffer one of the Trauma Events listed below (and as defined on pages 22 to 27) which occurs while covered for Trauma Insurance, NobleOak will pay you the cover amount as a lump sum. NobleOak will require an unequivocal diagnosis by a Medical Practitioner (or by a Specialist Medical Practitioner if noted in the medical definition for the Trauma Event) before payment can be made.

When Trauma Insurance is taken with Life Insurance, you can apply for any level of cover up to your Life Insurance cover amount, to a maximum of $2 million. When applying for stand-alone Trauma Insurance, you can apply for any level of cover up to $2 million.

A Survival Period applies to stand-alone Trauma Insurance – see the definition on page 32.

Once a Trauma Benefit is paid, the Trauma Insurance cover ceases (except with Coronary Artery Angioplasty - through specific procedures, where cover ceases when the cover amount reduces to nil – see the table on the following page).
### Trauma Events Covered

<table>
<thead>
<tr>
<th><strong>Main Trauma Events</strong></th>
<th><strong>Other Trauma Events</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cancers - excluding specified early-stage cancers*</td>
<td>• Accidental HIV Infection - contracted through occupation or medical procedures*</td>
</tr>
<tr>
<td>• Coronary Artery Angioplasty - through specific procedures*</td>
<td>• Alzheimer’s Disease/Irreversible Organic Disorder - permanent and of specified severity</td>
</tr>
<tr>
<td>• Coronary Artery By-Pass through open chest surgery*</td>
<td>• Aplastic Anaemia - requiring specified treatment</td>
</tr>
<tr>
<td>• Heart Attack - with evidence of severe heart muscle damage*</td>
<td>• Bacterial Meningitis - resulting in significant permanent impairment</td>
</tr>
<tr>
<td>• Stroke - in the brain resulting in specified permanent impairment*</td>
<td>• Blindness - total and irreversible in both eyes</td>
</tr>
<tr>
<td>• Three Vessel Coronary Artery Disease - requiring specific treatment*</td>
<td>• Cardiomyopathy (heart failure) - resulting in significant impairment</td>
</tr>
</tbody>
</table>

* For Coronary Artery Angioplasty - through specific procedures, the benefit payable is 25% of the Trauma Insurance cover amount to a maximum of $25,000. Once paid, the Trauma Insurance cover amount will reduce by the amount of the benefit paid, with a corresponding reduction to premium. This benefit is payable upon each Coronary Artery Angioplasty - through specific procedures event, but is payable only once in any 12 month period (so if you have Coronary Artery Angioplasty - through specific procedures more than once in a 12 month period, the benefit is only payable once in respect of the Coronary Artery Angioplasty - through specific procedures events in the period, regardless of the number of those events).

# 90 day qualifying period applies. See exclusion details on page 14 & 15

• Accidental HIV Infection - contracted through occupation or medical procedures
• Alzheimer’s Disease/Irreversible Organic Disorder - permanent and of specified severity
• Aplastic Anaemia - requiring specified treatment
• Bacterial Meningitis - resulting in significant permanent impairment
• Blindness - total and irreversible in both eyes
• Cardiomyopathy (heart failure) - resulting in significant impairment
• Chronic Liver Failure - of specified severity
• Chronic Lung Disease - requiring long-term oxygen therapy
• Coma (impaired consciousness) – of specified severity and requiring specific treatment
• Dementia - resulting in significant cognitive impairment
• Diplegia - total and permanent
• Heart Valve Replacement - through specific procedures* |
• Hemiplegia - total and permanent
• Kidney Failure - requiring regular renal dialysis or renal transplantation
• Loss of Hearing - profound and irreversible (except by Cochlear implant)
• Loss of Independence - total and permanent
• Loss of Limbs and/or Sight - total and permanent
• Loss of Speech - total and irrecoverable
• Major Brain Injury - resulting in significant permanent impairment
• Major Burns - of specified severity and requiring specific treatment
• Major Organ Transplant of specified organs from a human donor, or placement on a waiting list*
• Motor Neurone Disease
• Multiple Sclerosis
• Muscular Dystrophy
• Paraplegia - total and permanent
• Parkinson’s Disease and specified Parkinson Plus Syndromes – with specified severity
• Pulmonary Arterial Hypertension (idiopathic and familial) – resulting in significant right heart failure
• Quadriplegia - total and permanent
• Surgery to Aorta - thoracic and abdominal aorta excluding its branches*
• Terminal Illness
• Viral Encephalitis - resulting in significant permanent neurological impairment

Full medical definitions are set out on pages 22 to 27
How a Trauma claim is paid

Trauma Insurance is available as:
- an optional extra with Life Insurance, or
- a stand-alone insurance.

Where Trauma Insurance is taken with Life Insurance, any claim paid will reduce the remaining Life Insurance cover amount (and TPD Insurance cover amount if also taken) by the amount of the Trauma Benefit paid.

For stand-alone Trauma Insurance, any claim paid will have no impact on any other insurance cover you hold with NobleOak.

In either case, apart from Coronary Artery Angioplasty - through specific procedures as described on page 13, once a Trauma Benefit is paid, the Trauma Insurance cover ceases.

Medical Advancement Protection

Where the criteria set out in the Medical Definitions for diagnosing a covered Trauma Event is superseded, inconclusive or impractical to apply because of medical advances, we will consider other medically recognised methods that conclusively diagnose the listed Trauma Event to at least the same severity.

The following requirements must be met in respect of such other diagnostic methods if we are to consider them:
- they are not considered experimental, they are medically necessary, and they are considered to be equivalent or superior to the original diagnostic techniques or investigations; and
- they must be deemed medically-acceptable in accordance with relevant medical practice standards and guidelines recognised by medical specialists in Australia.

Financial Advice Benefit

We understand that you may need some professional advice to ensure that the proceeds of a Trauma claim payment are managed appropriately. That is why we will reimburse the cost of engaging a qualified financial adviser, up to $2,000, to prepare a financial plan if we pay a Trauma benefit in excess of $200,000.

Premium Freeze Benefit

You can fix the cost of your cover at any time by contacting us with a request to freeze the premium amount. This means that:
- Your future premiums will be fixed at the amount you were paying on the date of notification; and
- Each year your cover amount will be adjusted to the amount of cover that can be purchased for the frozen premium.

You can contact us at any time to end the Premium Freeze Benefit and the premium freeze will end on the next anniversary of your cover.

Indexation

To help protect you against inflation, your cover amount will automatically be increased at each policy anniversary using the Consumer Price Index, or 3%, whichever is the greater. Your premium will be adjusted accordingly. See page 30 for details.

Premium Pause

If you become unemployed or need to take extended leave from employment other than for travel, for a maximum of 12 months, because of full time study, maternity/paternity leave or compassionate leave, then you can contact us and ask us to pause your premiums for up to twelve months.

The premium pause is available once your cover has been in place for more than 2 years. We will not pay for any Trauma Event which occurs during the premium pause or within 90 days of restarting your premium payments.

When your cover is active again as a result of the premium pause period ending and the subsequent 90 day period expiring, it will not be treated as a reinstatement or increase of cover.

Funeral Benefit

For stand-alone Trauma Insurance, we will pay a benefit of $5,000 if the Life Insured dies and no other benefits are payable under stand-alone Trauma Insurance. Payment will be made upon receipt of the death certificate.

Exclusions

A benefit will not be payable for Trauma Insurance where:
- You have selected stand-alone Trauma Insurance, and the Life Insured does not survive for a period of at least fourteen (14) days after the Trauma Event without the aid of an artificial life support system; or
- A Trauma Event marked with a ‘#’ in the table on the previous page is first diagnosed or occurs within 90 days of:
  - the Trauma Insurance start date
  - reinstatement of your Trauma Insurance, or
  - an increase in your Trauma Insurance
cover amount (but only to the extent of that increase).

This is the 90 day qualifying period referred to on page 13; or

• A Trauma Event is caused or contributed to by intentional self-inflicted injury or intended suicide by the Life Insured whether sane or insane within 13 months following the commencement, reinstatement or increase of the insurance cover (but only to the extent of that increase).

Benefits will be subject to any exclusion, which is specific to you and noted in any Special Acceptance Terms agreed with you in connection with your cover.

Replacement Cover

The 90 day qualifying period exclusion will not apply to your cover if it replaced an existing Trauma cover issued by us or another insurer, as long as:

• The insurance under the replaced cover was in place for at least 90 days immediately prior to the commencement of this policy,
• The replaced cover provided similar cover for the same trauma conditions or events that are expressed to be subject to the 90 day qualifying period under this cover,
• The replaced cover was cancelled immediately after the issue of this cover,
• All similar time period exclusions have expired under the replaced cover (including exclusions which were applied to the cover after its commencement due to, for example, reinstatements or increases),
• The cover amount under this cover is the same or less than the cover amount under the replaced cover, and
• No claim is payable or pending under the replaced cover.

Where your cover has replaced another cover issued by us or another insurer and the sum insured under your cover is greater than the sum insured under the replaced cover, then the 90 day qualifying period exclusion will apply to the difference in the sums insured, from the commencement of your cover under Premium Life Direct.
Income Protection Insurance

Choose cover of up to 75% of your income (max. $25,000 per month) in case you can’t work due to Sickness or Injury, helping you support yourself, your family and cover essential living expenses.

Please note: Because of applicable superannuation laws within Australia, if your Income Protection cover is held through your SMSF or through an Approved Superannuation Fund, not all benefits and features are available to you. An overview of the unavailable features and benefits is located on page 19.

Total Disablement Benefit
If you become Totally Disabled, we will pay the Total Disablement Benefit. This is calculated as the amount of the Insured Monthly Benefit up to a maximum of 75% of your Pre-disability Income, less any Claim Offsets. These payments:
• Commence after the selected Waiting Period has been met and you are Totally Disabled at the end of the Waiting Period, and
• Continue for the duration of your Total Disablement, to a maximum of the Benefit Period.

Your payments are calculated on a daily basis (and for this purpose we treat a day as 1/30th of any calendar month) and payable monthly in arrears, so your first payment will generally occur about one month after the end of your Waiting Period.

Totally Disabled / Total Disablement means due to Sickness or Injury, you are:
• Unable to perform one or more duties of your Occupation that is important or essential in producing income,
• Not working (whether paid or unpaid), and
• Following the advice of a Medical Practitioner.

What you need to choose when you apply

1. Insured Monthly Benefit
You can choose a Monthly Benefit from $1,000 per month up to a maximum of 75% of your Monthly Income, to an overall maximum of $25,000 per month.

See page 30 for the definition of Income.

Please note that if immediately prior to Total Disablement you have been either:
• unemployed for 12 months or more, or
• on maternity/paternity leave for 24 months or more (and not in receipt of an Income),
your Pre-disability Income will be nil and no benefit will be payable in the event of a claim.

2. Your Waiting Period
You can choose a waiting period of either 30 days or 90 days. The waiting period begins on the first day off work due to the Sickness or Injury, as long as it is not more than 7 days before a Medical Practitioner examines you and certifies you as being Totally Disabled. No benefits are payable during the Waiting Period.

3. Your Benefit Period
You can choose a Benefit Period of 2 years or to age 65. The Benefit Period begins once the Waiting Period has ended, and continues for this period whilst you are Totally Disabled (or subsequently Partially Disabled) or upon the earlier of reaching age 65 or death.
Partial Disablement Benefit

Income Protection Insurance may also pay a reduced benefit if you return to work in a reduced capacity.

If you are Partially Disabled we will pay the Partial Disablement Benefit which is a proportion of the Insured Monthly Benefit. The amount paid will be reduced by any Claims Offsets as described below.

This payment:
- Commences after the selected Waiting Period has been met, and
- Continues for the duration of your Partial Disablement, to a maximum of the Benefit Period.

Partially Disabled / Partial Disablement means due to your Sickness or Injury:
- You are only working in your usual occupation or any other occupation, in a reduced capacity,
- You are not Totally Disabled,
- Your monthly Income is less than your Pre-disability Income, and
- You are under the regular care and attendance of a Medical Practitioner.

The Partial Disablement Benefit you receive will be the amount of your Insured Monthly Benefit up to a maximum of 75% of your Pre-disability income, reduced in proportion to the loss of Income sustained, calculated on a daily basis (a day being 1/30th of any calendar month) and payable monthly in arrears, using the formula:

\[
\text{Partial Monthly Benefit} = \frac{A - B}{A} \times C
\]

Where:
- \(A\) = Your Pre-disability Income.
- \(B\) = Your Income for that month. If your Income is 25% or less than your Pre-disability Income during the first 3 months after the Waiting Period, we will pay the full Total Disablement Benefit for the relevant period. If you receive no Income beyond those 3 months while still Partially Disabled, we will determine a reasonable Income under the circumstances based on the calculation above.
- \(C\) = The amount of your Insured Monthly Benefit (up to a maximum of 75% of your Pre-disability Income).

The amount you receive will be reduced by Claim Offsets, to ensure the total benefits being received don’t exceed your Income. See page 29 for how Claim Offsets work.

Indexation

To help protect you against inflation, whilst you are not on claim, the amount of your Insured Monthly Benefit will automatically be increased at each policy anniversary using the Consumer Price Index, or 3%, whichever is greater. Your premium will be adjusted accordingly. See page 30 for details.

Exclusions

Benefits will not be payable by us if your Sickness or Injury is caused or contributed to by:
- normal and uncomplicated pregnancy, childbirth or miscarriage, (and in this respect, we will not pay benefits if the claim is caused or contributed to by multiple pregnancy, threatened or actual miscarriage, participation in an IVF or similar programme, or discomfort commonly associated with pregnancy such as morning sickness, backache, varicose veins, ankle swelling, or bladder problems), or
- intentional self-injury or attempted suicide while sane or insane within the first 13 months following the commencement, reinstatement or increase of the insurance cover.

Benefits will be subject to any exclusion, which is specific to you and noted in any special acceptance terms applying in respect of your cover.

Other features of Income Protection

Waiver of Income Protection premium

We will waive your premium if you are eligible to receive a Total or Partial Disablement Benefit. This includes the situation where you have an entitlement to a Total or Partial Disablement Benefit, but the amount you are paid is reduced to nil due to Claim Offsets.

We will also waive your premium for a period if you receive a Specific Sicknesses and Injuries Benefit. We will waive your income protection premium for the following period commencing from the date your Specific Sicknesses and Injuries Benefit was first paid by us:
- 6 months, when the selected Waiting Period is 30 days, or
- 3 months, when the selected Waiting Period is 90 days.

If you also hold Life, TPD or Trauma Insurance with
us then whilst we are paying you a Total or Partial Disablement Benefit, we will also waive your premium on your Life, TPD and/or Trauma Insurance.

For the avoidance of doubt, annual payments (if applicable) will be pro-rated to a monthly basis.

**Recurring Disablement Benefit**
If you return to work for less than 6 months after receiving your most recent Total Disablement or Partial Disablement benefit, and suffer a recurrence from the same or a related cause, the claim will be treated as a continuation of the original claim. No waiting period will apply for this benefit.

**Specific Sicknesses and Injuries Benefit**
If you suffer a Specific Sickness or Injury as defined by the medical conditions set out on pages 22 to 27 we will pay upfront the Total Disablement Benefit for the following number of months:

- 6 months, when the selected waiting period is 30 days, or
- 3 months, when the selected waiting period is 90 days.

This benefit is paid regardless of whether or not you are Totally Disabled, and regardless of whether or not you can return to work.

We shall only pay one Specific Sicknesses and Injuries Benefit in or in respect of any 12 month period, regardless of the number of Specific Sicknesses or Injuries suffered during the period. We will not pay any other benefit under Income Protection Insurance, including the Nursing Care Benefit, in respect of the period for which We are paying this benefit. This benefit is not available during the first 90 days of commencing or reinstating cover.

If at the end of the applicable 6 month or 3 month period outlined above, you remain Totally or Partially Disabled as a result of the same Specific Sickness or Injury, we will assess you for a Total or Partial Disability Benefit as applicable. The Waiting Period applies from the end of the payment period for a Specific Sicknesses and Injuries Benefit, but it is reduced by the payment period for the Specific Sicknesses and Injuries Benefit paid.

Where the criteria set out in the Medical Definitions for diagnosing a covered specific Sickness or Injury is superseded, inconclusive or impractical to apply because of medical advances, we will consider other medically recognised methods that conclusively diagnose the listed Trauma Event to at least the same severity.

The following requirements must be met in respect of such other diagnostic methods if we are to consider them:

- they are not considered experimental, they are medically necessary, and they are considered to be equivalent or superior to the original diagnostic techniques or investigations; and
- they must be deemed medically-acceptable in accordance with relevant medical practice standards and guidelines recognised by medical specialists in Australia.

**One Benefit Payable**
Unless specifically stated otherwise, if you are concurrently eligible for more than one benefit, we will only pay one benefit and that will be the amount that is the highest.

We only pay one benefit at any time regardless of the number of Injuries or Sicknesses for a Life Insured.

**Death Benefit**
If you die while receiving a Total or Partial Disablement Benefit, your estate will be entitled to a lump sum benefit equal to 3 months of Total Disablement Benefits.

However, if your Income Protection insurance is held through a SMSF or through an Approved Superannuation Fund, and:

- You die while receiving a Total or Partial Disablement Benefit, we will pay a lump sum benefit equal to $10,000 or 3 months of Total Disablement Benefits, whichever is greater.
- You die whilst the cover is in force but you are not receiving a Total or Partial Disablement Benefit, we will pay a lump sum benefit of $10,000.

**Rehabilitation Expenses Benefit**
If you are receiving claim payments from us and your Medical Practitioner recommends, we may approve the following expenses to be paid:

- For any Total Disability claim, Partial Disability claim or claim under the Specific Sicknesses and Injuries Benefit, we will pay up to an additional 50% of the monthly benefit amount for up to 12 months for your participation in a rehabilitation program.
- For any Total Disability claim, we will reimburse up to 12 times the monthly benefit amount for
costs incurred for special equipment to help you re-enter the workforce.

- For any Total Disability claim, we will reimburse up to 3 times the monthly benefit amount for costs incurred for modifications to your workplace to allow return to gainful employment.

**Nursing Care Benefit**

If you are Totally Disabled and confined to bed, and a Medical Practitioner certifies in writing that you need the full-time care of a registered nurse for more than 3 consecutive days during the Waiting Period, you will be eligible for the Nursing Care Benefit.

We will pay you a daily proportion, monthly in arrears, of your Total Disablement Benefit while this nursing care continues, up to the end of the Waiting Period, for each day after the first 3 consecutive days.

The registered nurse must be independent from you (e.g. not a relative, a business partner, employee or employer).

**Claim Payment Benefit Increases**

After receiving a benefit for Total or Partial Disablement for 12 consecutive months, your Insured Monthly Benefit will automatically increase each year by the increase in the Consumer Price Index (CPI).

Where your cover is held via a SMSF or Approved Superannuation fund, any annual increase will be capped to a maximum of 5%.

Your benefit will again increase after each subsequent 12 months by the same method, as long as payments have continued to be made to you (without cessation) due to your Total or Partial Disablement.

**Spouse Benefit**

If your spouse (i.e. your legal husband or wife or the person living with you as your spouse on a domestic basis in good faith) has to stop working because of your Total Disablement, we will pay, monthly in arrears, the lesser of the amount your spouse would have earned per month had he or she kept working, or a monthly benefit of $2,000, for up to 6 months.

The Spouse Benefit is subject to the following conditions:

- We must have been paying the Total Disablement Benefit to you for more than 90 days
- Your spouse must have been earning income from a full-time or permanent part-time occupation, and
- Your spouse must not have been your employee, or an employee of an entity which you wholly or partly own or owned.

**Premium Pause**

If you become unemployed or need to take extended leave from employment other than for travel, for a maximum of 12 months, because of full time study, maternity/paternity leave or compassionate leave, then you can contact us and ask us to pause your premiums for up to twelve months.

The premium pause is available once your cover has been in place for more than 2 years.

We will not pay for any Sickness or Injury, which occurs during the premium pause or within 90 days of restarting your premium payments.

**Compliance with SIS regulations**

Under SIS regulations, Income Protection insurance under superannuation doesn’t permit certain benefits to be paid. As such, if the cover is held by a SMSF (as a Trustee Member) or within an Approved Superannuation Fund we will not be able to pay the Specific Sicknesses and Injuries Benefit, Rehabilitation Expenses Benefit, Nursing Care Benefit or Spouse Benefit.

We will also not pay a benefit if payment of the benefit is inconsistent with a SIS Act Condition of Release.

To be eligible for any benefit, you must have ceased to be gainfully employed or ceased temporarily to receive any gain or reward under a continuing agreement to be gainfully employed.

Because of superannuation laws, we are able to pay benefits under Income Protection Insurance held through superannuation only where the laws permit. As such Trustee Members must cancel cover where the prevailing laws mean that a Life Insured is not eligible to be covered for monthly benefits, including where the Life Insured is totally and permanently disabled under Australian superannuation laws and the Trustee Member determines the Life Insured is no longer able to meet the definition of “temporary incapacity” under the Australian superannuation laws.
Total Disablement Benefit
If you become Totally Disabled, we will pay you a monthly benefit less any Business Expenses Claim Offsets, to help cover your share of the ongoing business expenses while you’re not working.

The Monthly Benefit payments commence after the Waiting Period has expired and continue for the duration of your Total Disablement to a maximum of the Benefit Period.

Your payments are calculated on a daily basis (and for this purpose we treat a day as 1/30th of any calendar month) and payable monthly in arrears, so your first payment will generally occur 2 months after your Sickness or Injury commenced.

Business Expenses insurance provides a
• Waiting Period of 30 days, and
• A benefit Period of 12 months.

Totally Disabled / Total Disablement means due to Sickness or Injury, you are:
• Unable to perform one or more duties of your Occupation that is important or essential in producing your Business Income,
• Not working (whether paid or unpaid), and
• Following the advice of a Medical Practitioner.

You select your Insured Monthly Benefit at time of application, which will be your Allowable Business Expenses (or, if you prefer, an amount you choose based on a portion of your Allowable Business Expenses) up to a maximum of $25,000 per month. In determining the maximum Insured Monthly Benefit that will be accepted, we will consider the benefits payable under any other Income Protection or Business Expenses Insurance policy (in force or proposed) in your name. If you do not disclose any such benefits when you apply for Premium Life Direct, we may reduce the amount of the claim amount otherwise payable if a claim occurs.

The amount you receive following a claim will be the lesser of:
• the Insured Monthly Benefit, and
• One twelfth (1/12) of the Allowable Business Expenses actually incurred in the 12 months immediately preceding the Total Disability, reduced by any Business Expense Claim Offsets.

See pages 28 and 29 for the definitions of Business Income, Allowable Business Expenses and Business Expense Claim Offsets.

Partial Disablement Benefit
Business Expenses insurance may also pay a reduced benefit if you return to work in a reduced capacity.

The Partial Disablement Benefit becomes payable providing you have met the Waiting Period, and continues for the duration of your Partial Disablement, to a maximum of the Benefit Period.

Partially Disabled / Partial Disablement means that due to your Sickness or Injury:
• You are working in your usual occupation or another occupation, in a reduced capacity,
• You are not Totally Disabled,
• Your monthly Business Income is less than your Pre-disability Business Income, and
• You are under the regular care and attendance of a Medical Practitioner.

The benefit payable will be proportionate to the loss of Business Income sustained. The benefit will be calculated on a daily basis and paid monthly in arrears. This amount will be the lesser of:
• the Insured Monthly Benefit, and
• One-twelfth (1/12) of the Allowable Business Expenses actually incurred by you in the operation of your profession, business or occupation during the 12 months immediately preceding your Total Disability and which continue during that Partial Disablement, reduced by:
  - any amounts that are reimbursed or received from elsewhere in respect of your disablement,
  - your share of the gross Business Income of the business for that period, and
  - any Business Expense Claim Offsets.

We will determine your share of the Allowable Business Expenses actually incurred, or share of gross Business Income, in line with the usual manner of apportioning profits and/or losses of the business between you and any co-owners of the business.

When you are Partially Disabled and not working, we will determine the gross Business Income for you. We will consider the opinion of your Medical Practitioner and any Medical Practitioners we have nominated.

Exclusions
Benefits will not be payable by us if your Sickness or Injury is caused or contributed to by:
• normal and uncomplicated pregnancy, childbirth or miscarriage, (and in this respect, we will not pay benefits if the claim is caused or contributed to by multiple pregnancy, threatened or actual miscarriage, participation in an IVF or similar programme, or discomfort commonly associated with pregnancy such as morning sickness, backache, varicose veins, ankle swelling, or bladder problems), or
• intentional self-injury or attempted suicide while sane or insane within the first 13 months following the commencement, reinstatement or increase of the insurance cover.

Benefits will be subject to any exclusion, which is specific to you and noted in any special acceptance terms agreed with you in connection with your cover.

Extended Benefit Period
If you remain Totally Disabled at the end of the Benefit Period, and the total benefit paid is less than 12 times the insured Monthly Benefit, we will continue to pay the benefit until the earliest of:
• a total payment equivalent to 12 times the Insured Monthly Benefit has been paid,
• a further 12 months have expired, and
• you cease to be Totally Disabled.

Waiver of Premium
If you are receiving a claim payment for Business Expenses Insurance, we will waive the premiums for the period the claim payments relate to, for Business Expenses Insurance.
The definitions for Cancers - excluding specified early-stage cancers, Heart Attack - with evidence of severe heart muscle damage and Stroke - in the brain resulting in specified permanent impairment meet the FSC life insurance industry standards.

**Accidental HIV Infection – contracted through occupation or medical procedures**

means infection with the human immunodeficiency virus (HIV) acquired by accident or violence during the course of the Life Insured’s normal occupation or through the medium of a blood transfusion, transfusion of blood products, organ transplant, assisted reproduction technique or other medical procedure or operation performed by a doctor or at a recognised medical facility. The Life Insured’s infection needs to be reported to the relevant health authority at the time of the accident or violent incident. Sero-conversion evidence of the HIV infection must occur within 6 months of the accident. HIV infection transmitted by any other means, including but not limited to sexual activity or non-medical intravenous drug use, is not Accidental HIV Infection – contracted through occupation or medical procedures under this cover.

You are encouraged to report an accident or violent incident giving rise to a potential claim to Us within 30 days. The Life Insured’s infection needs to be supported by a negative HIV Antibody Test taken within 7 days after the accident or violent incident.

**Alzheimers Disease/Irreversible Organic Disorder – permanent and of specified severity**

means a state of cognitive decline with loss of intellectual capacity, mental and social functioning, and/or having abnormal behaviour, arising from Alzheimer’s disease or an irreversible organic degenerative brain disorder. The unequivocal diagnosis must be clinically confirmed by a Specialist Medical Practitioner in the field, and be supported with a Mini-Mental State Examination score of 24 or less (or an equivalent level of deterioration assessed under another clinically-appropriate cognitive assessment instrument).

Neurosis and other psychiatric illnesses are excluded.

**Aplastic Anaemia – requiring specified treatment**

means chronic persistent bone marrow failure, which results in anaemia, neutropenia and thrombocytopenia requiring treatment over a period of at least two months by at least one of the following:
- blood product transfusion
- marrow-stimulating agents
- immunosuppressive agents
- bone marrow transplantation (including stem cell transplantation).

**Bacterial Meningitis - resulting in significant permanent impairment**

means bacterial infection of the meninges (the thin layers surrounding the brain and spinal cord) causing permanent and significant functional impairment. The diagnosis must be confirmed by a Specialist Medical Practitioner in the field. All other forms of meningitis, including viral, are excluded.

**Blindness - total and irreversible in both eyes**

means total irreversible loss of sight in both eyes, as certified by Specialist Medical Practitioner in the field. Loss of sight means that best corrected visual acuity is reduced to at least 6/60 visual acuity, or the visual field is reduced to at least 20 degrees of arc.

For clarity:
- Any loss of sight that is reversible through treatment or visual aids, including (but not limited to) cataracts, is excluded as it would not be considered irreversible;
- ‘best corrected visual acuity is reduced to at least 6/60’ means that even with the use of visual aids, the Life Insured needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres; and
- ‘visual field is reduced to at least 20 degrees of arc’
means that the Life Insured’s field of vision is less than 20 degrees in diameter.

Cancers - excluding specified early-stage cancers
means any malignant tumour diagnosed with histological confirmation and characterised by: a) the uncontrolled growth of malignant cells; and b) invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes leukaemia, sarcoma and lymphoma, and inaccessible brain tumours described as malignant on neuroimaging.

The following are not covered:
• All tumours which are histologically classified as any of the following:
  a) pre-malignant;
  b) non-invasive;
  c) high-grade dysplasia;
  d) borderline or low malignant potential.
• Carcinoma in situ except carcinoma in situ of the breast where a total mastectomy with full removal of the breast has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
• All cancers of the prostate unless:
  a) histologically classified as having a Gleason score of 7 or above; or
  b) having progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system; or
  c) where a total prostatectomy has been undertaken where the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment.
• All cancers of the thyroid unless:
  a) having progressed to at least TNM classification T2N0M0; or
  b) where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
• All cancers of the bladder unless having progressed to at least TNM classification T1N0M0.
• Cutaneous lymphoma confined to the skin.
• Chronic lymphocytic leukaemia unless having progressed to at least Rai stage I.
• All non-melanoma skin cancers unless having spread to the bone, lymph node, or an other distant organ.
• All melanoma skin cancers unless having progressed to at least TNM classification T2bN0M0.

Cardiomyopathy (heart failure) - resulting in significant impairment
means a condition of impaired ventricular function resulting in significant physical impairment to the extent of Class 3 on the New York Heart Association classification of cardiac impairment. The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Chronic Liver Failure - of specified severity
means end-stage liver failure, together with permanent jaundice (yellow discolouration of the skin or eyes) and either ascites (abnormal build-up of fluid in the abdomen) or hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease). The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Liver failure as a result of alcohol or drug abuse is excluded.

Chronic Lung Disease - requiring long-term oxygen therapy
means end stage respiratory failure requiring long-term oxygen therapy. The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Coma (impaired consciousness) – of specified severity and requiring specific treatment
means a state of unconsciousness with abnormal response to external stimuli or internal needs with a Glasgow Coma Scale of 6 or less, requiring the use of a life support system for a period of at least 72 hours.

Coronary Artery Angioplasty - through specific procedures
means the treatment of the narrowing or blockage of one or more coronary arteries by balloon angioplasty (or similar intra-arterial catheter procedure) with or without the use of a stent.

Angiographic evidence is required to confirm the need for this procedure.

This benefit is payable once in any 12-month period.
Coronary Artery By-Pass through open chest surgery
means the actual undergoing of coronary artery by-pass surgery, including saphenous vein or internal mammary graft(s), for the treatment of coronary artery disease. The operation must be open chest with angioplasty contra-indicated, and must be considered medically necessary by a Specialist Medical Practitioner in the field.

Dementia - resulting in significant cognitive impairment
means the unequivocal diagnosis of dementia resulting in significant cognitive impairment, as confirmed by a Specialist Medical Practitioner in the field. Significant cognitive impairment means deterioration in the Life Insured's Mini-Mental State Examination scores to 20 or less, or an equivalent level of deterioration assessed under another clinically-appropriate cognitive assessment instrument.

Diplegia - total and permanent
means the total and permanent loss of function of both sides of the body (such as both arms or both sides of the face) due to spinal cord injury or disease, or brain injury or disease.

Heart Attack – with evidence of severe heart muscle damage
means the death of a portion of the heart muscle as a result of ischaemia (inadequate blood supply to the heart muscle), where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least three of the following:
   a) Symptoms of ischaemia consistent with a heart attack.
   b) New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB).
   c) Development of new pathological Q waves in the ECG.
   d) Imaging evidence of new regional wall motion abnormality present at least six weeks after the event.

If the tests specified in a) to d) above are inconclusive or unable to be met, then the definition will be met if at least three months after the event the insured's left ventricular ejection fraction is less than 50 per cent.

The following are not covered:
- A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease.
- Other acute coronary syndromes including but not limited to angina pectoris.

Heart Valve Replacement - through specific procedures
means the actual undergoing of either open heart surgery or a minimally invasive key-hole procedure to replace or repair cardiac valves, as a consequence of heart valve defects or abnormalities.

Hemiplegia - total and permanent
means the total and permanent loss of function of one side of the body (such as one arm and one leg of the same side of the body) due to spinal cord injury or disease, or brain injury or disease.

Kidney Failure - requiring regular renal dialysis or renal transplantation
means end stage renal failure, which presents as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation is carried out.

The definition will be met if, despite the need for regular dialysis or a kidney transplant as confirmed by a Specialist Medical Practitioner in the field, the Life Insured chooses renal supportive care.

Loss of Hearing - profound and irreversible (except by Cochlear implant)
means profound and irreversible loss of hearing (except by cochlear implant) in both ears, after which the better ear has an auditory threshold of greater than 81 decibels from the frequencies of 500 hertz to 3,000 hertz, as certified by a Specialist Medical Practitioner in the field.

Loss of Independence - total and permanent
means a condition as a result of a Sickness or Injury, that results in the Life Insured being totally and permanently unable to perform at least two (2) of the five (5) Activities of Daily Living without the standby assistance of another person, or suffering Severe Cognitive Impairment - permanent.
Loss of Limbs and/or Sight - total and permanent
means the total and permanent loss of any of the following:
- the use of both hands;
- the use of both feet;
- the sight in both eyes (to the extent of 6/60 or less*);
- the use of one hand and one foot;
- the use of one hand and the sight of one eye (to the extent of 6/60 or less); or
- the use of one foot and the sight of one eye (to the extent of 6/60 or less).

*‘to the extent of 6/60 or less’ means that even with the use of visual aids, the Life Insured needs to be at 6 metres or closer to see what someone with normal vision can see at 60 metres.

Loss of Speech - total and irrecoverable
means the total and irrecoverable loss of the ability to speak as a result of Sickness or Injury, which must be established and the diagnosis reaffirmed after a continuous period of three months of such loss, by a Specialist Medical Practitioner in the field. Loss of speech due to any psychological cause is excluded.

Major Brain Injury - resulting in significant permanent impairment
means physical head injury that results in permanent loss of at least 25% of either the brain's mental function or its physical control function, as defined in the most recent edition of the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'. The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

For the purposes of this definition, the meaning of 'physical head injury' includes a bump, blow, or jolt to the head, or a penetrating head injury.

Major Burns - of specified severity and requiring specific treatment
means thermal, electrical or chemical injury causing deep partial-thickness burns or full thickness burns to the skin requiring surgical debridement and skin grafting or flap reconstruction to at least:
- 20% of the total body surface area as measured by the Lund-Browder Chart or 'Rule of Nines', or
- 50% of both hands, or
- 50% of both feet, or
- the face.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Major Organ Transplant of specified organs from a human donor, or placement on a waiting list
means the Life Insured:
- undergoes the organ transplant, as a recipient, or
- upon specialist medical advice is placed on an official Australian acute care hospital waiting list to undergo organ transplant, or
- undergoes permanent mechanical replacement for one or more of the following organs: kidney, heart, liver, lung, pancreas, small bowel and bone marrow.

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

For the purposes of this definition:
- ‘Organ’ includes bone marrow; and
- ‘Waiting list’ means the waiting list of a Transplantation Society of Australia and New Zealand recognized transplant list.

Motor Neurone Disease
means a group of progressive neurodegenerative diseases that specifically affect motor neurones and result in permanent rapid weakening of the muscles that enable a person to move, speak, breathe and swallow. This means the unequivocal diagnosis of any of the following types of motor neurone disease, made by a Specialist Medical Practitioner in the field and supported with appropriate tests:
- Amyotrophic lateral sclerosis (ALS)
- Progressive muscular atrophy (PMA)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Flail arm (or leg) syndrome
- ALS-plus syndrome

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

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field and supported by relevant clinical/neurological findings, lesions on Magnetic Resonance Imaging (MRI) and the presence of oligo-clonal bands within cerebrospinal fluid (CSF) in accordance with the 2017 McDonald Criteria.
Muscular Dystrophy
means a hereditary condition marked by progressive weakness and wasting of the muscles. The unequivocal diagnosis must be made by a Specialist Medical Practitioner in the field.

Paraplegia - total and permanent
means the total and permanent loss of function of both the lower limbs due to spinal cord injury or disease, or brain injury or disease.

Parkinsons Disease and specified Parkinson Plus Syndromes – with specified severity
means a confirmed diagnosis of any one of the following progressive neurodegenerative disorders characterised clinically by the presence of parkinsonism and resulting in the Life Insured being unable to perform at least two of the Activities of Daily Living without the standby assistance of another person:
- Idiopathic Parkinson’s Disease
- Progressive Supranuclear Palsy
- Dementia with Lewy Bodies
- Multiple System Atrophy
- Corticobasal Degeneration

Parkinsonism means the presence of both of the following:
- Bradykinesia (slowness of movement plus a decrement in speed or progressive hesitations as movements are continued), and
- Rigidity (extreme stiffness or resistance with passive movement of the major joints whilst in a relaxed position) or slow resting tremor (observed in a fully resting limb and suppressed when initiating movement).

All other forms of parkinsonism are excluded, including drug induced parkinsonism.

Pulmonary Arterial Hypertension (idiopathic and familial) – resulting in significant right heart failure
means a confirmed diagnosis of idiopathic or familial (meaning of a spontaneous or unknown cause, or inherited) pulmonary arterial hypertension (increased blood pressure in the blood vessels of the lungs) with right ventricular enlargement (enlarged right side of the heart muscle) established by investigations including cardiac catheterisation, resulting in permanent physical impairment to the degree of at least Class III of the World Health Organisation Functional Classification of Pulmonary Hypertension*.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

*Class III of the World Health Organisation Functional Assessment of Pulmonary Hypertension* means:

Patients with pulmonary hypertension resulting in a slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity causes undue dyspnoea or fatigue, chest pain or near syncope.

Quadriplegia - total and permanent
means the total and permanent loss of function of the lower and upper limbs due to spinal cord injury or disease, or brain injury or disease.

Stroke - in the brain resulting in specified permanent impairment
means death of brain tissue caused by one of the following:
- a) Ischaemic infarction of brain tissue.
- b) Intracranial haemorrhage (cerebral, intraventricular or subarachnoid).

The diagnosis must be supported by both of the following:
- a) Evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event.
- b) Findings on MRI, CT, or other reliable imaging evidence consistent with the diagnosis of a new stroke.

The following are not covered:
- Transient ischaemic attacks.
- Brain damage due to an accident, injury, infection, or non-vasculitic inflammatory disease.
- Vascular disease affecting the eye or optic nerve.
- Ischaemic disorders of the vestibular system.
- Strokes caused by or related to illicit drug use or substance abuse.
- Migraine.
- Hypoxic events.

Words within the definition that have special meaning:

“Permanent neurological deficit with persisting symptoms” means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person’s life. It includes outcomes such as: numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual
impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function.

The following do not constitute “permanent neurological deficit with persisting symptoms”:
- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

**Surgery to Aorta - thoracic and abdominal aorta excluding its branches**
means surgical repair to the aorta to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

**Terminal Illness**
means the Life Insured:
- is diagnosed as terminally ill by two Medical Practitioners, of which one of the Medical Practitioners is a specialist practising in an area related to the illness or injury suffered by the Life Insured; and
- their joint or separate diagnoses certifies that the Life Insured suffers from an illness, or has incurred an injury, that is likely to result in death of the Life Insured within a period that ends not more than 24 months after the date of certification (where separate diagnoses are made, both diagnoses must provide the required certification; and the date of certification shall be taken to be the date of the most recent certification).

**Three Vessel Coronary Artery Disease - requiring specific treatment**
means undergoing angioplasty (with or without stent insertion) on three or more coronary arteries within a single procedure, or in two procedures no more than two months apart, as considered necessary by a Specialist Medical Practitioner in the field to treat severe coronary artery disease.

Angiographic evidence of triple vessel coronary artery disease prior to the first procedure is required to confirm the need for the procedure(s).

**Viral Encephalitis - resulting in significant permanent neurological impairment**
means viral infection of the brain tissue resulting in neurological deficit causing significant functional impairment as evidenced by a permanent inability to perform at least one of the Activities of Daily Living without the standby assistance of another person.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.
Other Definitions

Activities of Daily Living
Activities of Daily Living means the following five (5) activities of daily living:

1. **Bathing** means the ability to wash oneself either in a bath or shower or by sponge bath, without the standby assistance of another person. A person will be considered to be able to bathe themself even if the above tasks can only be performed by using equipment or adaptive devices.

2. **Dressing** means the ability to put on and take off all garments and medically-necessary braces or artificial limbs usually worn, and to fasten and unfasten them, without the standby assistance of another person. A person will be considered able to dress oneself even if the above tasks can be performed only by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.

3. **Eating** means the ability to get nourishment into the body by any means once it has been prepared and made available to you without the standby assistance of another person.

4. **Toileting** means the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing without the standby assistance of another person. A person will be considered able to toilet themself even if they have an ostomy and is able to empty it themself, or uses a commode, bedpan, or urinal, and is able to empty and clean it without the standby assistance of another person.

5. **Transferring** means the ability to move in and out of a chair or bed without the standby assistance of another person. A person will be considered able to transfer themself even if equipment such as canes, quad canes, walkers, crutches, grab bars or other support devices (including mechanical or motorised devices) is used.

Allowable Business Expenses
Allowable Business Expenses refers to the Life Insured's share of business expenses as listed below, and any others that have been specifically approved:

- Premises expenses: Cleaning, insurance, interest and fees on loan to finance the premises, property rates/taxes, rent, repairs and maintenance, security costs.
- Services expenses: Electricity, fixed telephone and fax lines, gas, internet service provider, mobile telephone, postage and couriers, water and sewerage.
- Equipment: Depreciation, motor vehicle leasing, insurance of vehicles and equipment, registration of vehicles, repairs and maintenance.
- Salaries and related costs: Salaries of employees who do not generate any business income, payroll tax and superannuation (SGC) contributions for these same employees.
- Other eligible expenses: Account-keeping fees, accounting and auditing fees, bank fees and charges, business insurances, professional association membership fees, regular advertising costs.

Anniversary Period
Anniversary Period means the twelve (12) month period effective from the commencement date of the Life Insurance Plan and each subsequent anniversary of the commencement date of the Life Insurance Plan.

Approved Superannuation Fund
An Approved Superannuation Fund is a superannuation fund in respect of which we have entered into an agreement with its trustee whereby certain Premium Life Direct insurance products are available for its members.

Business Expenses Claim Offsets
In the event of a Business Expense claim, we will reduce the amount otherwise payable, by:

- Your portion of the income of the business derived from trading during the period of disablement,
- The income generated by an employee hired after you became Totally Disabled to perform the work normally performed by you, and
- Any amount received from any other insurance policy for reimbursement of business expenses that was not disclosed to the Insurer when the present level of cover was applied for. The
amount will be reduced only to the extent that the combined claim payments from the Business Expenses Insurance and other insurance could otherwise exceed 100% of the Insured Monthly Benefit.

Business Income
Business Income means the monthly income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses, for the last twelve (12) months.

Claim Offsets
In the event of an Income Protection Insurance claim, we will reduce the monthly benefit amount otherwise payable by amounts received from other sources for loss of income in respect of your Sickness or Injury. Amounts that can be offset include:

- Payments made or receivable under sick leave, social security, worker’s compensation or motor accident claims or any claim made under any similar state or federal legislation.
- Other similar insurance payments including insurance payments from a superannuation plan that provides income payments due to sickness or injury.
- Any payment which is in the form of a lump sum or is exchanged for a lump sum is deemed to be the monthly equivalent of 1/60 of the lump sum over a period of 60 months.
- If the Life Insured’s worker’s compensation entitlement is in dispute, we will pay the monthly benefit determined excluding this entitlement on a conditional basis until the dispute is resolved. If you become entitled to compensation benefits, you will need to repay that part of any monthly benefit amount which would have not otherwise have been paid if not for the conditional payment.

Domestic Duties do not include duties performed outside the Life Insured’s home for remuneration or reward.

Financial Advice Benefit
The total amount payable under this benefit is the lesser of the actual fee paid for the financial planning advice and $2,000. It is payable on receipt of satisfactory evidence of the financial advice received and the payment made to the financial adviser. The financial adviser must be operating under an appropriate Australian Financial Services License and NobleOak must receive evidence within 12 months of the death/terminal illness, Trauma or TPD benefit payment. The Financial Advice Benefit is only payable once in respect of the Life Insured.

Future Increases Benefit
You can increase your cover amount by the lesser of $100,000 or 20% of the original cover amount without the need to provide further medical evidence if:

- An allowable event occurs, as defined in the table on the following page,
- You are less than 60 years of age when the allowable event occurs,
- You notify us within 90 days of the allowable event, or within the 30 days prior to or following
the next anniversary of your cover which follows the allowable event, and

- Your original cover was issued with a medical loading not greater than 50%.

Increases to the cover amount exercised under the Future Increases Benefit can only be requested once per 12-month Anniversary Period. The total value of increases cannot exceed 100% of the original cover amount provided to you when your cover started.

**Grief Counselling Benefit**

The total amount payable under this benefit is the lesser of the actual fee paid for the grief counselling services and $1,000. It is payable on receipt of satisfactory evidence of the counselling services received and the payment made to the service provider.

The provider of the services must be appropriately qualified and registered to provide grief counselling services. NobleOak must receive evidence within 12 months of the death/terminal illness benefit payment. The Grief Counselling Benefit is only payable once in respect of the Life Insured.

### Income

**Income**

Income in the case of a salaried person means the total pre-tax monthly remuneration paid by an employer, including salary, fees, commission, bonuses, fringe benefits and superannuation contributions made by an employer, averaged over a 12 month period.

Income in the case of a self-employed person, a working director or partner in a partnership means the monthly income generated by the business or practice due to the person's personal exertion or activities, less his or her share of necessarily incurred business expenses averaged over a 12 month period.

**Indexation**

Cover amounts, except in the case of Business Expenses Insurance, will be automatically increased at each anniversary based on the previous year’s increase in the Consumer Price Index or 3%, whichever is the greater.

Indexation increases stop at age 65 for Life and TPD Insurance, and age 60 for Trauma Insurance and Income Protection Insurance. Your premium will automatically adjust to reflect the increase in cover. You may cancel these automatic increases by contacting us.

<table>
<thead>
<tr>
<th>Allowable Event</th>
<th>Evidence Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>You take out or increase a mortgage on your primary place of residence</td>
<td>A copy of the mortgage documents.</td>
</tr>
<tr>
<td>You marry, officially register a partnership, or commence a de facto relationship recognised at law</td>
<td>A copy of the Marriage Certificate or evidence of the registration of the partnership with an Australian State or Territory (or satisfactory evidence of the partnership or de facto relationship such as a statutory declaration or similar sworn statement)</td>
</tr>
<tr>
<td>You or your partner gives birth to a child</td>
<td>A copy of the birth certificate that shows the Life Insured and/or their spouse/partner as a parent.</td>
</tr>
<tr>
<td>You or your partner adopts a child</td>
<td>A copy of the Adoption Certificate that shows the Life Insured and/or their spouse/partner as the adopting parent.</td>
</tr>
<tr>
<td>Your spouse dies</td>
<td>A copy of the death certificate</td>
</tr>
<tr>
<td>Your child starts secondary school</td>
<td>Evidence of enrolment in secondary school</td>
</tr>
<tr>
<td>You get divorced</td>
<td>A copy of the relevant Family Court document evidencing divorce</td>
</tr>
</tbody>
</table>
Injury
Injury means bodily injury occurring after the commencement of cover. It also includes any injury which was fully disclosed to us at the time of application for insurance cover (or application for increase in cover) and which we have accepted in connection with your application for cover or which we accepted in respect of the increased cover in connection with your application for increased cover, as the case may be (and subject to any special acceptance terms or exclusions advised by us).

Insured Monthly Benefit
For Income Protection insurance, this is the dollar amount of monthly insurance cover accepted by us following your application for cover (which may be increased or reduced from time to time as nominated by you and agreed to by us in writing). At time of application this is 75% of your monthly income.

The monthly benefit amount which will be paid upon a claim is calculated as described on pages 16 and 17.

For Business Expenses insurance, this is the dollar amount of monthly insurance cover accepted by us following your application for cover (which may be increased or reduced from time to time as nominated by you and agreed to by us in writing). At time of application this is the amount of your Allowable Business Expenses you have insured.

The monthly benefit amount which will be paid upon a claim is calculated as described on pages 20 and 21.

Medical Practitioner
Medical Practitioner means any medical practitioner registered with the Australian Health Practitioner Regulation Agency (AHPRA) who is not you or the cover holder, a member of your or their family, your or their business partner, or your or their employee or employer.

Occupation
Applies for the Total Disablement Benefit for both Income Protection Insurance and Business Expenses Insurance; and to TPD Insurance where the “Own” occupation definition applies

Occupation means the occupation that the Life Insured was engaged in immediately prior to the Sickness or Injury giving rise to the claim. Additionally, for TPD Insurance where the “Own” occupation definition applies, if the Life Insured was unemployed immediately prior to the Sickness or Injury giving rise to the claim, Occupation refers to the occupation they were engaged in the last time they were gainfully employed prior to the Sickness or Injury.

Pre-disability Income / Pre-disability Business Income
Pre-disability Income / Pre-disability Business Income means the average monthly Income (or Business Income for Business Expense Insurance) earned over the 12 months immediately prior to the Sickness or Injury.

The following applies to Income Protection insurance only:

Where a person is on maternity/paternity leave, and Total Disability occurs within 24 months of going on maternity/paternity leave, Pre-disability Income means the highest average of the Income for any period of 12 consecutive months in the two years immediately prior to the Life Insured becoming totally disabled.

For the sake of clarity if the person’s Income is nil then the person’s Pre-disability Income will be nil and no benefit will be payable in the event of a claim.

Reinstatements
If you cancel your cover or the cover ceases because of non-payment of premiums, you can apply to us to have it reinstated. Such reinstatement will depend on our terms and conditions at the time.

Severe Cognitive Impairment - permanent
Severe Cognitive Impairment – permanent means permanent deterioration or loss in intellectual capacity which requires another person’s assistance or verbal cueing to protect himself or herself or others, as measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:

• Short or long term memory;
• Orientation as to person (such as personal identity), place (such as location) and time (such as day, date and year); and
• Deductive or abstract reasoning.

The diagnosis must be confirmed by a Specialist Medical Practitioner in the field.

Sickness
Sickness means illness or disease which manifests itself
after the commencement of cover. It also includes any sickness which was fully disclosed to us and we accepted in connection with your application for cover or application for increase in cover (and subject to any special acceptance terms or exclusions advised by us).

**Waiting Period**

The Waiting Period is the number of days from the beginning of a period of Total Disablement or Partial Disablement during which no claim for Total Disablement or Partial Disablement is payable. The Waiting Period begins on the date the Life Insured first ceases work due to the Injury or Sickness causing the Total Disablement or subsequent Partial Disablement as long as it is not more than seven days before the Life Insured consults a Medical Practitioner about the Injury or Sickness and provides reasonable medical evidence about when the period of Total Disablement began.

During the Waiting Period the Life Insured must be Totally Disabled for at least the first 14 days of the Waiting Period. Following the first 14 days, the Life Insured may return to work for any number of days as long as throughout the Waiting Period the Life Insured remains either Totally or Partially Disabled. Any days worked will not be added to the Waiting Period.

The Waiting Period applies to Income Protection Insurance and Business Expenses Insurance. For Income Protection Insurance, it is either 30 or 90 days as applicable to your cover (see page 16); for Business Expenses Insurance, it is 30 days (see page 20).

**Specialist Medical Practitioner**

Specialist Medical Practitioner means a medical practitioner who practices in a specialty field and is listed on the Australian Health Practitioner Regulation Agency (AHPRA) Specialist Register who is not you or the cover holder, a member of your or their family, your or their business partner, or your or their employee or employer.

**Survival Period**

Survival Period means a period of at least 14 days that the Life Insured must survive after a Trauma Event without the aid of an artificial life support system. This only applies to stand-alone Trauma Insurance.

**Trustee Member**

Trustee Member means either the person or company that has the legal responsibility to ensure that the trust or superannuation fund is operated in accordance with the trust deed, and has been accepted as a Member of the Fund through Premium Life Direct.
Premiums, charges and taxes

Premiums
The premium you pay depends on:

• The amount of cover (which increases each year with the built-in inflation protection unless you have asked us to cancel the increases as noted on page 30) and the type of benefits selected
• your age – the premium generally increases with age
• your gender
• whether or not you smoke – premium rates are higher for smokers
• your occupation
• for Income Protection Insurance, the Waiting Period selected (the longer the Waiting Period, the lower the premium rate), and the Benefit Period selected (the longer the Benefit Period, the higher the premium rate), and
• when your cover started.

During the assessment of your application, we may apply a premium loading (such as a percentage on top of the standard premium rate) having regard to your state of health, family history or pastimes at that time.

Monthly premiums can be paid by direct debit from your nominated bank account or by VISA or MasterCard. Annual premiums can be paid by cheque or direct debit. Future premium rates are not guaranteed to remain the same as current rates. We reserve the right to change premium rates for all policies in a particular category. Our premium rates are available on request.

Please contact us for a quote or to consider alternative quotes.

What are the fees and charges?

All the fees and charges for the insurance cover are included in your premiums and there are no additional fees and charges payable by you.

Your premium includes the following components:

• Administration fee: The Trustee is entitled to an administration fee of up to 10% of the premium after the deduction of adviser’s remuneration (if any).

• Distribution Partner remuneration: When you purchase your insurance product through a distribution partner, NobleOak may pay remuneration to that partner in respect of your cover.

• Frequency loading: Monthly premium payments attract a 5% loading. There is no loading if you pay your premium annually and no cancellation fee if you cancel your cover during the year. In this case we would pro-rata refund the amount of unused annual premium.

Stamp duty

Insurance premiums attract State stamp duty at different rates for different products. This charge is included in the premium and we will be responsible for these payments.

GST

There is no GST payable on your premiums.

Taxation

Your premiums for Life, TPD and Trauma Insurance are not generally an allowable deduction from your assessable income. Any benefits you receive from these insurances will, in most instances, be tax-free.

Your premiums for Income Protection Insurance and Business Expenses Insurance generally tax-deductible, and any benefits received from these insurances are paid gross and are tax assessable to you.

Of course, individual circumstances can be different, and also taxation treatment is likely to differ where cover is taken under superannuation, so we generally recommend that you seek professional taxation advice if in doubt about your situation. These tax statements are necessarily general in nature and based on the continuation of present taxation laws and their interpretation.

See also page 37 for details of how you can manage the ongoing cost of your insurance.
Managing your cover

Your duty of disclosure
Before you enter into a contract with us, you and the life to be insured have a duty under the Benefit Fund Rules to disclose everything that you know, or could reasonably be expected to know, that is relevant to our decision whether to accept the risk and provide insurance terms. These matters must be disclosed before cover is started, increased or reinstated. However, this duty does not require you to disclose information:

- that reduces the risk to us;
- that is of common knowledge;
- that we know or ought to know in the ordinary course of our business, or
- where we have waived your duty.

Your duty to disclose relevant matters continues until we accept your cover. This same duty applies before your plan is extended, varied or reinstated.

What happens if you don’t comply with this? (Non-disclosure)
If you fail to comply with your duty of disclosure and we would not have entered into the insurance contract if you had told us, we may cancel your insurance cover within three years of entering into it.

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

- Reducing your sum insured. This would be worked out using a formula that takes into account the premium that would have been paid if you had told us everything as required (for any Death Benefit under Life Insurance, we may only reduce your cover amount within three years of the commencement date of your cover).
- Varying the terms of your insurance cover in a way that places us in the same position we would have been in if you had told us everything as required.

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

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

Where any new cover issued by NobleOak Life Limited has been granted on the basis of replacing existing life insurance cover held with another life insurance provider, that existing cover must be cancelled immediately on the acceptance of the new NobleOak cover. If the existing cover is not cancelled as was indicated and a claim arises, then the replacement cover issued by NobleOak will be null and void as from the inception date and all premiums paid will be refunded.

When does your cover start?
Your cover will start once it is accepted by NobleOak and communicated to you in writing. Until then, we may ask for more information to fully assess your application. Your duty to disclose any relevant information continues right up the point we accept your application.

When your insurance cover begins, you will be issued with an acceptance letter outlining the full details of your insurance. Please keep your letter together with this PDS for future reference.

You will also receive an annual advice from us confirming your insurance details, including your insured benefits (as indexed) and premium payable.

Cooling off period
Once you receive your welcome pack, you have a 30 day cooling off period to ensure your cover suits your needs. If you need to make any changes, please contact us as soon as possible. During the cooling off period, you may cancel your insurance cover and any premiums paid will be refunded in full. Otherwise, please keep your documentation in a safe place for future reference and in case of any future claims.

Note that none of the insurances in this PDS have a surrender or cash value at any time.

Updating your details
To help us keep your details up-to-date please advise us of any change in your address, banking details or beneficiaries. You can do this by calling us or sending us an email.
Changing your insurance
You may apply at any time in writing to:
• decrease your cover – this would not require you to go through any further underwriting, or
• increase your cover – you would be required to complete a new application and go through the full underwriting process

Making a claim
In the event of a claim please ensure you notify us as soon as practically possible (ideally within 14 days). We will send you a claim form that explains the next steps required. For example, for Income Protection Insurance claims, we may require proof of income with the required medical evidence, together with the completed claim form to enable us to assess the claim and if approved, pay the benefit.

Note that we will pay for any further medical evidence that we seek to substantiate a claim. However, any expenses you incur to substantiate your claim and any travelling expenses to attend medical examinations are to be paid by you.

In some circumstances, it may be necessary for us to contact the Medical Practitioners you consulted prior to the commencement date of your cover, to verify the information disclosed when you applied for cover. In this case, we will need to obtain permissions from you or your beneficiaries to approach those parties, so the earliest we can start that process the better.

For any claim other than for a Death Benefit under Life Cover, acting reasonably we may require you to submit (at our expense) to an additional medical examination in Australia. If you are overseas at the time of claim, acting reasonably we may require you to submit (at our expense) to an additional medical examination by a health care practitioner where you are located at the time (and if it is not possible for us to appoint a health care practitioner in that location or where a suitably qualified practitioner is not available there, you must return to Australia at your expense for the examination).

If there are material differences between the medical history and what was disclosed, NobleOak has the right to review any claim made in accordance with the Benefit Fund Rules regardless of whether those differences are related to the cause of claim. This could mean that any claim is paid, partially paid or denied altogether.

NobleOak pays all genuine claims. As long as you have fully disclosed all your information accurately when you applied, you can rest assured that any claim in the future will be paid in accordance with the terms and conditions in this PDS. All claims will be paid in Australian dollars.

Please note that if a fraudulent claim is made, we will have no liability in respect of the claim and we may cancel the cover altogether. You should notify us of a claim in a timely manner unless it is impracticable to do so (otherwise we may reduce liability under the claim by an amount that fairly represents the extent to which our interests were prejudiced as a result of a delay in claim notification).

What are the risks in taking out insurance?
You should consider any risks that might apply before making an application under this PDS. Some of the risks may include:
• The insurance you take out may not meet your needs;
• The level of cover, or the terms that apply, may not be sufficient to give you the protection you require or desire; and
• You may not be able to increase cover to the desired level because of health or other issues.

Invasion or War
In the event of an invasion or an outbreak of war (whether declared or not) in which Australia is involved or the country of ordinary residence of the Life Insured, we may notify you of an increase in the premiums payable under your cover.

If you have not paid the increased premiums by their due date, we are not liable to pay any claims arising, caused or contributed to by war or invasion during the commensurate period of cover.

When does your cover end?
Your insurance cover will end on the earliest of: cancellation of your cover (by you, or by us where we have the right to do so), your non-payment of premium, or as described in the table (see table on following page).

Non-payment of premiums means that the premiums due for this cover have remained unpaid for at least 60 days and the cover being then cancelled by us.

Additionally, our liability to pay any claim under your cover ceases when you join the armed forces of any country.
Please note (with reference to the * in the table below) - except in the case of a Trauma Insurance benefit paid for Coronary Artery Angioplasty - through specific procedures, in which case the Trauma Insurance cover ends when the Trauma Insurance cover amount reduces to nil, as described on page 12.

<table>
<thead>
<tr>
<th>Cover Type</th>
<th>Ends on earliest of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>Death, the policy anniversary when aged 99, or upon payment of a Life Insurance claim (including for clarity a claim for the Terminal Illness Benefit). Also, the Death Benefit amount (including where paid as the Terminal Illness Benefit) is reduced by any amount paid under the optional TPD Insurance and/or the optional Trauma Insurance cover.</td>
</tr>
<tr>
<td>TPD Insurance</td>
<td>Death, Total and Permanent Disability, the policy anniversary when aged 75, or upon payment of a Life Insurance (including for Terminal Illness, as above) or TPD Insurance claim. After turning age 65, the TPD Benefit is reduced at each anniversary by 10% (of the value at age 65), until expiry by age 75, when TPD Insurance will be extinguished. Premiums will be reduced accordingly.</td>
</tr>
<tr>
<td>Trauma Insurance</td>
<td>Death, the policy anniversary when aged 70, or upon payment of a Life Insurance (including for Terminal Illness, as above) or Trauma Insurance* claim in full.</td>
</tr>
<tr>
<td>Stand-alone Trauma Insurance</td>
<td>Death, the policy anniversary when aged 70, or upon payment of a Trauma Insurance* claim in full.</td>
</tr>
<tr>
<td>Income Protection Insurance</td>
<td>Death, the policy anniversary when aged 65, or your retirement from the workforce.</td>
</tr>
<tr>
<td>Business Expenses Insurance</td>
<td>Death, the policy anniversary when aged 65, or your retirement from the workforce.</td>
</tr>
</tbody>
</table>
Managing the ongoing cost of your cover

Life Insurance premium rates generally increase as you get older. These are known as stepped premiums with the premium rate and the amount you pay for your cover generally increasing at each plan anniversary date based on your age. NobleOak only offers stepped premium rates.

Some insurers also offer what is known as level premium rates, where the amount you pay will be based on your age at your plan commencement date. Your premiums will remain the same until the plan anniversary date usually following your 65th birthday when they will convert to stepped premiums.

Level premiums are much higher than stepped premiums at initial policy commencement so at NobleOak we only offer stepped premiums. Generally speaking, if affordability is important to you, stepped premiums allow you to purchase what you need today for less money, and will provide you with more flexibility in the future should your circumstances change.

What options are available to manage the cost of my insurance as I get older?

A number of options can be considered to minimise the impact of future age based premium increases including,

- Requesting that automatic CPI increases are switched off. This means your sum insured will no longer increase in line CPI automatically each plan anniversary date.
- Provide NobleOak with notice to activate the Premium Freeze Benefit. This means that your future premiums will be fixed at the amount you were paying on the date of notification; and each year your cover will be reduced to the amount of cover that can be purchased for the frozen premium.
- At any time you can request NobleOak to reduce your sum insured or to reduce any of the optional benefits.

“What each and every one of us will be confronted by a major challenge in our lives. We can choose to shut down, retreat into our safety zone and not participate in life, or we can decide to learn from the experience and make a difference to the lives of those around us.”

- Walter Mikac
Privacy Statement

This Privacy Statement is a summary of our Privacy Policy. Please refer to our website for the full Privacy Policy if required at https://www.nobleoak.com.au/privacy-policy.

We recognise the importance of protecting your personal information that is collected and used by us and we will follow privacy practices and procedures to maintain your privacy and protect your information. At all times we will safeguard your personal information and that of any lives insured under your Plan as required by the Privacy Act 1988.

Your consent

By applying for cover under Premium Life Direct, you will be consenting to the collection, use and disclosure of your personal information in the manner set out below. If we are not provided with the required information, we will not be able to provide you with a quote for the insurance, consider your application or provide you with any insurance cover.

Collection of personal information

We collect your personal information that is necessary for the purposes of:
- providing premium quotes
- assessing and processing your application
- managing and administering the products and services you obtain
- assessing and processing any claims made under your insurance
- identifying you and protecting against fraud
- improving our insurance products, and
- advising you about other products or services that we may offer.

The type of personal information we may collect includes your name, date of birth, address, banking details, beneficiaries, health and employment information.

In most instances your personal information is collected directly from you when you apply for cover or request a variation in your cover. In some situations we may collect personal information from a third party, such as an alliance partner or lead provider, as well as health or similar professionals. To help us keep the information that we hold about you up-to-date, we ask that you advise us promptly of any changes to your name or contact details, or if you are concerned that any information that we hold about you is inaccurate, incomplete or outdated.

Disclosure and use of personal information

The personal information we collect from (or about you) may be disclosed by us to the following parties:
- Any doctor, hospital, clinic or other medical service in respect of whom you have provided us with a medical authority for the purpose of obtaining details about your medical history
- The reinsurer and any medical practitioners, legal advisers, claims investigators or other professionals that we may appoint to consider your application or to assess or provide assistance in determining any claim
- Any person we consider requires access to your information in order to process your application, manage or administer your plan, assess any claim or resolve any complaint
- Any person or entity to whom we outsource tasks or who do something on our behalf
- The licensed distributor of your insurance, but only necessary information
- Your legal adviser or any other representative acting on your behalf (including your financial planner or adviser or any insurance broker), or
- Any person as is required or authorised by law or where you have given consent to the disclosure.

All persons engaged to do something on our behalf (and any other person to whom we are authorised to provide your personal information) will be required to ensure our privacy requirements are met when using this information and they will only be permitted to use the information to perform the tasks which we have asked them.

Marketing

We may also use your information to inform you about any other products and services offered or promoted by us. In order to do this we may disclose your personal information on a confidential basis to such other licensed distributor that we may choose to do this through.
You may call or contact us at any time to let us know that you do not want to receive any further marketing communications from us.

**Privacy Policy**

Our Privacy Policy contains information about how you may access personal information held by us and how you can seek correction of such information. It also contains information about how you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint.

You may obtain a copy of our Privacy Policy from our website: www.nobleoak.com.au/privacy-policy

**What if you have an enquiry or concern?**

If you have a enquiry, concern or complaint about your insurance cover or about any aspect of our service please tell us about it. In the first instance it’s best to talk with the person you have been dealing with at NobleOak to resolve your concern. You can contact us on 1300 041 494 or email enquiry@nobleoak.com.au. We will get back to you within 2 business days.

If you are not satisfied with how we have handled any aspect about your insurance you can raise a concern with our Client Care Manager. Send an email to clientcare@nobleoak.com.au or by calling 1300 041 494 and asking to speak with our Client Care Manager.

Our Client Care Manager will do the following:

- **Listen to your concern and confirm the nature of your concern with you**
- **Outline the actions to be taken by us to consider or investigate your concern**
- **Provide you with an agreed time frame to get back to you for each action**
- **Oversee the internal escalation at NobleOak to review your concern and if we find any errors or mistakes have been made in the handling of your matter then we will address these promptly, and**
- **Check if you require any additional support in progressing your concern**

including a support person nominated by you to assist you.


**External Dispute Resolution Service**

If we can’t deal with your complaint to your satisfaction, you may then refer the matter to the Australian Financial Complaints Authority (AFCA).

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

If your complaint has not been resolved to your satisfaction within 45 days of lodging your initial complaint (or, if you have agreed, within 90 days), you may contact the Australian Financial Complaints Authority (AFCA). AFCA is an independent body designed to help you resolve complaints relating to financial products, as well as complaints relating to financial advice and sales of financial and investment products. There are some circumstances where AFCA cannot deal with your complaint, however they can advise you of these circumstances. Complaints with AFCA may be resolved by a conciliation process or arbitration. The complaints procedure is free of charge and decisions made by AFCA are binding on us. Before you ask AFCA to help you, please try to resolve the issue with us first. AFCA’s contact details are -

GPO Box 3
MELBOURNE VIC 3001
Toll Free Number: 1800 931 678
Email: info@afca.org.au
Website: afca.org.au
Interim Accidental Cover

Interim Accidental Cover is provided to you while your application is under assessment. Subject to the eligibility and terms below, these benefits are provided at no extra cost to you.

Eligibility

Interim Accidental Cover is provided to applicants of Premium Life Direct, where the life to be insured meets the product’s eligibility requirements (see page 5), and either:

- the application form has been completed and signed by the life to be insured and received by NobleOak, or
- the application has been fully taken over the phone in respect of the life to be insured by NobleOak representatives.

Note that the application may be for a new benefit or an increase to an existing benefit. If the application is for an increase, then the cover described here only applies to that increased amount.

Accident means a bodily injury caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

When cover starts

Interim Accidental Cover starts the date we receive the fully completed application in respect of the relevant eligible life to be insured.

When cover ends

Interim Accidental Cover ends on the earliest of:

- 90 days after the date we receive the completed application in respect of the life to be insured
- the date we decline or defer the application in respect of the eligible life to be insured
- the date the applicant withdraws the application
- the date we approve the application
- the date we pay a claim or admit a claim for any Interim Accidental Benefits, or
- the date Premium Life Direct would otherwise terminate for that eligible life to be insured.

Interim Accidental Death Benefit

If the application for the eligible life to be insured is for Life Insurance, and the life to be insured dies as a result of an Accident between the application date and termination of the Interim Accidental Cover, we will pay the cover amount applied for up to a maximum of $1 million.

Interim Accidental Disablement Benefit

If the application for the eligible life to be insured is for Total and Permanent Disablement Insurance, and the life to be insured first becomes Accidentally Disabled between the application date and termination of the Interim Accidental Cover, we will pay the cover amount applied for up to a maximum of $500,000.

The cover amount of the eligible life to be insured for the purposes of the full Total and Permanent Disablement Insurance applied for will be reduced by the amount of any Interim Accidental Disablement Benefit paid.

Only one Interim Accidental disablement benefit will be paid in respect of an eligible life to be insured. Our refusal of any claim for payment of Interim Accidental Disablement Benefits will not affect any subsequent Total and Permanent Disablement Benefit claim.

Accidentally Disabled means that as a result of an Accident, the life to be insured suffers any one or more of the following: Quadriplegia - total and permanent, Major Brain Injury - resulting in significant permanent impairment, or the total and irreversible inability to perform at least four (4) Activities of Daily Living.

Interim Accidental Trauma Benefit

If the application for the eligible life to be insured is for Trauma Insurance, and the life to be insured first suffers an Accidental Trauma between the application date and termination of the Interim Accidental Cover, we will pay the cover amount applied for up to a maximum of $500,000.

The cover amount of the eligible life to be insured for the purposes of the full Trauma Insurance applied for will be reduced by the amount of any Interim Accidental Trauma Benefit paid.

Only one Interim Accidental Trauma Benefit will be paid in respect of an eligible life to be insured. Our refusal
of any claim for payment of Interim Accidental Trauma Benefits will not affect any subsequent Trauma Benefit claim.

Accidental Trauma means that as a result of an Accident, the life to be insured suffers any one or more of the following: Blindness - total and irreversible in both eyes, Coma (impaired consciousness) – of specified severity and requiring specific treatment, Diplegia - total and permanent, Hemiplegia - total and permanent, Major Brain Injury - resulting in significant permanent impairment, Major Burns - of specified severity and requiring specific treatment, Paraplegia - total and permanent, Quadriplegia - total and permanent, or Loss of Independence - total and permanent.

Interim Accidental Disability Cover

If the application for the eligible life to be insured is for Income Protection Insurance, and the life to be insured first suffers and continues to suffer Total Disablement as a result of an Accident between the application date and termination of the Interim Accidental Cover, we will pay the monthly cover amount applied for up to 24 months to a maximum of $200,000.

Our refusal of any claim for payment of Interim Accidental Disablement Benefits will not affect any subsequent Total Disablement Benefit claim.
Direct Debit Request Service Agreement

Definitions
Account means the account held at your financial institution from which we are authorised to arrange for funds to be debited. Agreement means this Direct Debit Request Service Agreement between you and us.

Banking Day means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia. Debit Day means the day that payment by you to us is due. Debit payment means a particular transaction where a debit is made. Direct Debit request means the Direct Debit Request between us and you. Us or we means NobleOak Services Limited (the Debit User) you have authorised by signing a direct debit request.

You means the customer who signed the direct debit request. Your financial institution is the financial institution where you hold the account that you have authorised us to arrange to debit.

1. Debiting your account
1.1 By signing a direct debit request, you have authorised us to arrange for funds to be debited from your account. You should refer to the direct debit request and this agreement for the terms of the arrangement between us and you.

1.2 We will only arrange for funds to be debited from your account as authorised in the direct debit request.

1.3 If the debit day falls on a day that is not a banking day, we may direct your financial institution to debit your account on the following banking day. If you are unsure about which day your account has or will be debited you should ask your financial institution.

2. Changes by us
2.1 We may vary any details of this agreement or a direct debit request at any time by giving you at least fourteen (14) days’ written notice.

3. Changes by you
3.1 Subject to 3.2 and 3.3, you may change the arrangements under a direct debit request by contacting us on the Client Service Line on 1300 551 044.

3.2 If you wish to stop or defer a debit payment, you must notify us in writing at least seven (7) days before the next debit day. This notice should be given to us in the first instance.

3.3 You may also cancel your authority for us to debit your account at any time by giving us seven (7) days’ notice in writing before the next debit day. This notice should be given to us in the first instance.

4. Your obligations
4.1 It is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the direct debit request.

4.2 If there are insufficient clear funds in your account to meet a debit payment: you may be charged a fee and/or interest by your financial institution; you may also incur fees or charges imposed or incurred by us; and you must arrange for the debit payment to be made by another method or arrange for sufficient funds to be in your account by an agreed time so that we can process the debit payment.

4.3 You should check your account statement to verify that the amounts debited from your account are correct.

4.4 If NobleOak Services Limited is liable to pay goods and services tax (GST) on a supply made in connection with this agreement, then you agree to pay NobleOak Services Limited on demand an amount equal to the consideration payable for the supply multiplied by the prevailing GST rate.

5. Dispute
5.1 If you believe that there has been an error in debiting your account, you should notify us directly on the Client Service Line on 1300 551 044 and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly.

5.2 If we conclude as a result of our investigations that your account has been incorrectly debited we will respond to your query by arranging for your financial institution to adjust your account (including interest and charges) accordingly. We will also notify you in writing of the amount by which your account has been adjusted.
5.3 If we conclude as a result of our investigations that your account has not been incorrectly debited we will respond to your query by providing you with reasons and any evidence for this finding.

5.4 Any queries you may have about an error made in debiting your account should be directed to us in the first instance so that we can attempt to resolve the matter between us and you. If we cannot resolve the matter you can still refer it to your financial institution which will obtain details from you of the disputed transaction and may lodge a claim on your behalf.

6. Accounts
You should check:
with your financial institution whether direct debiting is available from your account as direct debiting is not available on all accounts offered by financial institutions;
your account details which you have provided to us are correct by checking them against a recent account statement; and with your financial institution before completing the direct debit request if you have any queries about how to complete the direct debit request.

7. Confidentiality
7.1 We will keep any information (including your account details) in your direct debit request confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

7.2 We will only disclose information that we have about you: to the extent specifically required by law; or
for the purposes of this agreement (including disclosing information in connection with any query or claim).

8. Notice
8.1 If you wish to notify us in writing about anything relating to this agreement, you should write to
NobleOak Services Limited,
GPO Box 4793, SYDNEY
NSW 2001.

8.2 We will notify you by sending a notice in the ordinary post to the address you have given us in the direct debit request.

8.3 Any notice will be deemed to have been received on the third banking day after posting.