AMP Group Salary Continuance

AMP Corporate Superannuation

Product Disclosure Statement – Part 2

Issue 2, 4 December 2006

The Product Disclosure Statement for AMP Group Salary Continuance is in 2 parts:
Part 1: The Summary of Features. Part 2: The Core Conditions – this document.
Issued by AMP Life Limited, ABN 84 079 300 379, AFSL No. 233 671.

Contents

The Product Disclosure Statement is in 2 parts:

Part 1: The Summary of Features.

Part 2: The Core Conditions – this document.

The purpose of this document
This Product Disclosure Statement is an important document. You should read both parts before you complete the application forms.

Please keep this document for future reference
This document describes the benefits, options and features that are available in AMP Group Salary Continuance.

In this document:

"you", or "your" refers to the policyowner,

"we", "our", or "us" refers to AMP Life Limited, and

"insured person", or "insured person's" or "insured persons" refers to members insured under the terms of the policy.

Any information contained in this document is general only and not based on your personal objectives, financial situation and needs. You are encouraged to consult a financial planner before acting to consider how appropriate this product is to your objectives, financial situation and needs.

Please note:
AMP Group Salary Continuance and this Product Disclosure Statement are issued by AMP Life Limited ABN 84 079 300 379. No other company in the AMP Group is responsible for any statements or representations made in this Product Disclosure Statement, or supports our obligations or has any liability to you in connection with AMP Group Salary Continuance. This product is not a bank deposit with AMP or any other company in the AMP Group.

Changes to this Product Disclosure Statement
We may update the information in this Product Disclosure Statement. Normally, you can obtain updated information simply by asking your financial planner, visiting amp.com.au/groupinsurance or calling us on 1300 653 456 (you can also ask us for a free paper copy of the updated information). However, if the change to the information is materially adverse, we will issue a Supplementary Product Disclosure Statement.

This offer is available only to persons receiving it (including electronically) within Australia. Applications from outside Australia will not be accepted.

AMP Group Salary Continuance

About AMP Group Salary Continuance

This product provides monthly income replacement benefits in respect of insured persons that become totally disabled. We will cover up to 75% of salary (subject to maximum benefit levels). Benefits are payable if an insured person is unable to work due to an illness or injury for a period greater than the waiting period.

AMP Group Salary Continuance provides insurance for groups of people who are linked by a common factor such as an employer, provided that there are a minimum of 10 insured persons who are employed in a non-hazardous environment.

This policy is not intended for persons participating in professional sports or hazardous pursuits.

About AMP

The AMP group is a leading financial solutions provider and a leading investment manager in Australia. The AMP group provides investment, insurance, superannuation and retirement solutions to more than 3 million Australians, managing over $87 billion.

About AMP Corporate Superannuation

AMP has been looking after Australian's superannuation for more than 60 years. AMP Corporate Superannuation is a part of AMP Life, and provides access to superannuation, insurance and retirement benefits for over 500,000 members in Australia. This means that AMP Corporate Superannuation has the experience and capabilities to create a superannuation solution suited to the needs of employers and their employee members. AMP Corporate Superannuation provides Australian businesses and their employees, with access to 5 products. SignatureSuper, SuperLeader and CustomSuper are issued by AMP Superannuation Limited. AMP Life also issues Group Life Insurance and Group Salary Continuance Insurance.

Secured by our Australian No. 1 Statutory Fund

The policy issued is backed by our Australian No. 1 Statutory Fund. As at 31 December 2005 the assets available in the Australian No. 1 Statutory Fund were more than 50% higher than the solvency requirements required under the Life Insurance Act.

AMP Group Salary Continuance at a glance

Insurance basis available

AMP Group Salary Continuance (GSC) is designed to pay you (the policyowner) monthly income replacement benefits if an insured person is unable to work due to an injury or illness for a period greater than the waiting period.

GSC benefits are payable while an insured person is not working in any occupation, is under the care of a doctor (for the definition of "Doctor" see "Definitions and descriptions for AMP Group Salary Continuance", page 22) and is disabled according to the terms of the definition of total disablement (for the definition of "Total Disablement" see "Definitions and descriptions for AMP Group Salary Continuance", page 23).

Insurance cover is provided to your insured persons 24 hours a day anywhere in the world, thus helping to provide more effective all round protection.

Flexible benefit designs

To enable you to tailor your insurance options to suit your needs we offer the following benefit design options:

- An agreed percentage of an insured person's salary up to a maximum amount of 75%.
- Waiting periods of 1, 2, 3, or 6 months.
- Benefit payment periods of 5 years (or retirement, if earlier), or to age 60, or to age 65 years.

You can divide your membership into categories and provide different benefit design options for each category.

You should refer to Part 1 – Summary of Features to determine what insurance basis has been selected.

Maximum cover

Under this product the maximum benefit is limited to the lower of:

- 75% of monthly salary, and
- $20,000 per month.

Who can be insured

Your employee's working status will determine if they are eligible for cover. GSC cover is only available to permanent employees regularly working 15 hours or more per week.

GSC cover is not available to:

- casual and contract employees, and
- non-executive directors.

The table below outlines the eligibility for GSC cover.

	Age
Minimum entry age	Age 16
Maximum entry age	Age 64
Cover expiry age	65th birthday

Policy benefits and conditions

This product offers competitive features, and provides a range of standard benefits and options that you can select to suit your needs. These are summarised below and should be read in conjunction with the Policy benefits and conditions on pages 5 to 8.

These include:

Total Disability benefit	A monthly benefit is provided if an insured person is totally disabled due to illness or injury for a period greater than the waiting period.
Partial Disability benefit	A monthly benefit if an insured person does any remunerative work but earns less than they did before a period of total disability for up to 2 years.
Rehabilitation benefit*	Reimbursement of the costs of any equipment, program or work which we agree the insured person needs for rehabilitation.
Recurrence of disablement	If an insured person suffers a recurrence of the same or related disability within 6 months the waiting period will be waived.
Extended cover	Cover is provided for leave of absence, parental leave and for insured persons working overseas.
Replacement cover	We provide insured persons with the option to continue their cover in an individual policy after they leave the plan.
Automatic acceptance	Is a pre-determined level that insured persons are covered for automatically provided they are At Work and the policy meets our conditions outlined on page 9.
Takeover provisions	We may agree to provide the same terms of cover insured persons held under a previous similar group policy. See details on page 12.
Superannuation option	An option that enables an additional benefit of up to 15% of salary to be paid directly to an insured persons superannuation plan.
Claims escalation option	An option at the end of each continuous 12 month period of payment of Total Disablement benefits, we will automatically increase benefit payments by CPI to a maximum of 10%.

You should refer to Part 1 – Summary of Features to determine what insurance benefits have been selected.

* For superannuation funds an insured person cannot receive these benefits in cash unless they are eligible to access their superannuation. Standard preservation rules will apply to payment of these benefits.

Risks in taking out insurance

- Your insurer becomes financially unable to pay your claim.
- You select a product that does not provide the type of cover you need.
- You do not comply with your duty of disclosure, as we may not pay all or part of an insured person's claim or may cancel your policy.
- You do not pay the insurance premiums and cover lapses for the insured persons within your plan.

Premiums

The premium you pay will take into consideration a number of factors, which include, benefit options selected, occupations,

ages and gender of insured persons, and the policy's past claims history.

Rates are usually guaranteed for a 3 year period.

However, if you prefer a one year rate guarantee period, reduced rates may apply.

If the policy has more than 50 insured persons, premiums are calculated on a unit rated basis.

You can pay premiums annually, monthly, half yearly or quarterly.

See pages 13 and 14 for further details.

You should refer to Part 1 – Summary of Features to determine what premium basis and payment frequency has been selected.

Taxation

Tax treatment of group salary continuance insurance differs depending on whether you are the trustee of a superannuation fund, or an employer arranging benefits directly for your employees.

Tax treatment may differ depending on individual circumstances, and if you are considering group salary continuance insurance, you should seek specialist taxation advice.

For general information on the tax treatment of premiums and claims paid under this insurance, see page 20.

Cooling off

If you are not satisfied with the policy, you can return it within the 14 day cooling off period. If any premiums have been paid within this period a refund will be made. Please refer to page 19 for further details.

Our enquiry and complaints process

If you require additional information regarding your policy you may contact us. We look forward to be able to service your needs.

You may also contact us if you have a complaint about this policy. We have an internal process to manage your complaints. If we are unable to resolve your complaint to your satisfaction, you may be able to refer the matter to the Financial Industry Complaints Service. See page 21 for further details.

Policy benefits and conditions

This section describes the policy benefits and conditions that generally apply for AMP Group Salary Continuance. Special conditions and benefits might apply and if so they will be described in Part 1 – Summary of Features.

Total Disability benefit

Group Salary Continuance cover (GSC) is an income replacement amount paid monthly if an insured person becomes totally disabled (for the definition of "Totally Disabled" see "Definitions and descriptions for AMP Group Salary Continuance", page 23), prior to the age GSC cover ends.

GSC cover is available to permanent employees regularly working 15 hours or more per week.

GSC cover is not available to:

- casual and contract employees, and
- non-executive directors.

What we pay?

GSC cover provides a percentage up to 75% of an insured person's salary (pre-disability salary) for a period up to the benefit payment period, should they become unable to work due to illness or injury.

Note: Please see Part 1 – Summary of Features to determine the benefit payment period for your policy.

Offsets – if an insured person receives income from other sources

If an insured person receives income amounts from other sources while we are paying the insured person, we will reduce the amount we pay. We will reduce the GSC cover to ensure the insured person does not receive more than 75% of their pre-disability income while they are totally disabled. However, we do not pay more than the maximum monthly benefit.

Payments that we take into account include:

- Income from their occupation.
- Regular payments from any social security, compensation scheme, government or government authority.
- Regular payments from any superannuation pension or insurance plan payable because of illness or injury.

If any of these amounts are paid other than monthly, we will convert them to monthly payments for our calculation.

We do not take investment income or other forms of unearned income into account.

Partial Disability benefit

The Partial Disability benefit provides an insured person with a portion of the GSC cover if the insured person becomes partially disabled (for the definition of "Partially Disabled" see "Definitions and descriptions for AMP Group Salary Continuance", page 22), prior to the age GSC cover ends.

An insured person is partially disabled if:

- they are totally disabled for the first 2 weeks of the waiting period (14 consecutive days), and
- an illness or injury which made them unable to work causes them to earn less than what they did before a period of total disability, and
- they have approval from their doctor to return to work and we agree, and
- they remain under the ongoing care and advice from their doctor.

When we pay the Partial Disability benefit the benefit is calculated as:

$$\frac{(A-B) \times C}{A}$$

Where:

A is the insured person's monthly earnings prior to total disability (pre-disability salary).

B is the insured person's current monthly earnings for their occupation.

C is the total monthly GSC cover.

Partial Disability benefits are only payable for a maximum period of 2 years.

Offsets – if an insured person receives income from other sources

If an insured person receives income amounts from other sources while we are paying an insured person, we will reduce the amount we pay. We will reduce the GSC cover to ensure the insured person does not receive more than 100% of their pre-disability salary while they are totally disabled. However, we do not pay more than the maximum monthly benefit.

Payments that we take into account include:

- Income from their occupation.
- Regular payments from any social security, compensation scheme, government or government authority.
- Regular payments from any superannuation pension or insurance plan payable because of illness or injury.

If any of these amounts are paid other than monthly, we will convert them to monthly payments for our calculation.

We do not take investment income or other forms of unearned income into account.

Returning to work during the waiting period

The waiting period starts when the insured person first becomes unable to work. If they return to work for 5 days or less during the waiting period, the waiting period will not begin again. If they return to work for more than 5 days, the waiting period will start again.

Recurrent disability

If the insured person returns to work and we stop paying, another claim for the same or a related cause will be treated as a new claim if they have worked in their usual occupation and received at least their usual income for 6 months or more. The waiting period and the benefit period will start again.

If a relapse occurs within 6 months of when the insured person's claim stopped we treat the relapse as a continuation of the previous claim and we will waive the waiting period. The benefit period does not restart.

Rehabilitation benefit*

We will reimburse the costs of any equipment, program or works that we agree the insured person needs for rehabilitation. We do this while the insured person is unable to work, both during the waiting period and while we are paying them a benefit.

For us to reimburse any costs:

- we need the insured person's doctor to tell us in writing that the equipment, program or works are necessary for their rehabilitation, and
- we need a written estimate of the costs, and
- we must have agreed in writing to pay the costs before they are incurred.

Payments of rehabilitation benefits is in addition to any other benefits payable under the terms of this policy.

Rehabilitation expenses will be paid for a maximum period of 12 months.

When will we not pay?

- If we disagree with the doctor.
- Any part of the costs, which the insured person can recover from anywhere else.
- Any costs after the insured person reaches the age total disability cover ends.

Claims escalation – optional

Claims escalation is an option you can add to your policy.

At the end of each continuous 12 month period of payment of Total Disablement benefits, we will automatically increase benefit payments by CPI to a maximum of 10%.

After a claim ends the benefit reverts to the original amount.

* For superannuation funds an insured person cannot receive these benefits in cash unless they are eligible to access their superannuation. Standard preservation rules will apply to payment of these benefits.

Superannuation contribution cover option

The superannuation contribution cover is an optional feature that you can add to your policy, which provides your insured persons with additional assurance that during a period of either total or partial disablement superannuation contributions continue to be paid.

The amount of superannuation contribution cover is expressed as a percentage of salary, and is subject to a maximum of 15%.

The total sum of insured GSC cover, including superannuation contribution cover, cannot exceed the overall maximum insured amount of $20,000 per month.

If we pay you either a Total or Partial Disability benefit, we will also pay a claim under the insured person's superannuation contribution cover. You are paid the superannuation contribution as the policy owner in addition to the monthly benefit and this amount must be paid to the insured person's superannuation arrangements. We may request to be provided with satisfactory evidence of such payments, otherwise we may stop paying this benefit.

Payment of GSC benefits

We pay a GSC benefit when an insured person has been disabled for the waiting period and meets the definition of disability. We pay this in arrears, so we make the first payment one month after the waiting period ends.

If we are already paying because the insured person is totally disabled and then they become partially disabled, we keep paying on the same dates (the waiting period does not start again).

When GSC payments stop

Payments stop when:

- in our opinion the insured person is no longer disabled, or
- receiving Partial Disability benefits the insured person is able to earn their full income again, or
- 2 years of Partial Disability benefits have been paid, or
- the insured person dies, or
- the insured person engages in or performs any occupation or work for reward (except as agreed with us in writing during the waiting period), or
- the insured person reaches age 65 (or the nominated insurance cessation date for your plan if earlier), or
- the benefit payment period has ceased, or
- the benefit payments have been made for the total benefit payment period

whichever occurs first.

Maximum amount of GSC cover

GSC cover is limited to:

- 75% of monthly salary,

with an overall maximum insured amount of $20,000 monthly benefit.

Exclusions

We do not pay a GSC benefit when disablement is caused by:

- Intentional self-inflicted injury.
- Any act of war – whether declared or not.
- Any other specific limitation or restrictions applied by us and advised to you for an insured person before their cover commences.

Please note that we do not regard pregnancy or childbirth as either an illness or an injury, so we do not pay for this condition. However, we will pay if the insured person is unable to work because they suffer complications during pregnancy or while giving birth.

Insurance cover during unpaid leave

If an insured person is granted leave of absence or parental leave, and you continue to pay their premiums, we will continue to provide cover while they are on leave, for up to one year.

If an insured person becomes totally disabled during a period of unpaid leave, and provided we are advised of the expiry date of unpaid leave prior to the date of disablement, a GSC benefit could commence from the date the unpaid leave was to end, or the waiting period (whichever is later).

On return to work GSC cover will resume, without evidence of health on the same basis and up to the same level that applied before they started unpaid leave.

Please note:

- You should tell us in writing before unpaid leave starts so we can continue cover, or suppress premium charges if cover is to be suspended.
- For parental leave, we do not require you to tell us in advance. We will continue to charge premiums and provide cover to an insured person on parental leave, so long as they remain in the policy and premium payments continue, unless you tell us otherwise.

- If cover is to continue, the insured person's salary immediately before leave starts will be used to calculate the amount of cover during leave.
- If cover is suspended during unpaid leave, it will resume on return to work, without evidence of health, at the same level and on the same basis that applied before leave started. Any increases will be subject to normal underwriting requirements.
- If unpaid leave exceeds one year, cover will continue only if we agree with you on the terms and conditions in writing before leave starts.

Insurance cover while working overseas

If an insured person is seconded overseas we will continue to provide GSC cover for secondment periods of up to 2 years but only if:

- we are notified in writing before they leave Australia how long the secondment is likely to last, the location of secondment, and the occupations being performed, and
- we have advised you that cover will continue and the terms that will apply, and
- the premiums continue to be paid.

If an insured person is overseas and submits and is accepted for a claim, we may not pay for more than 3 months while the insured person is outside Australia or New Zealand, unless we agree to an extension.

If we do not pay after 3 months, then, when the insured person returns to Australia or New Zealand, we will start paying again if they are still totally disabled.

Replacement cover

Within 60 days of leaving service, an insured person can apply for cover under a new individual (retail) policy on their life, if:

- They are under age 55.
- No benefit is payable to the insured person under the GSC policy.
- The insured person has not left due to disablement or retirement.
- The policy is still in force.
- The insured person's new employer is not a company associated with the former employer, and also does not provide group salary continuance cover.
- The insured person does not join or becomes part of any armed forces.

A replacement policy will be provided subject to:

- Underwriting requirements for occupation, pastimes and smoking status being met.
- The insured person completes an AIDS declaration to our satisfaction (HIV test may be required).
- The minimum policy issue requirements applicable at the time are met.
- The application and correct premium are received within 60 days of leaving service.

Note: The option is only available to cover accepted on standard terms and conditions under the GSC policy. If the benefit has a loading, exclusion or a restriction the option will only be available to the cover below the automatic acceptance level.

Under the new individual policy:

- the benefit period cannot be increased, nor
- the waiting period decreased, nor
- the monthly benefit increased

from what the insured person had. In addition, the monthly benefit is limited to 75% of the insured person's new salary.

For an insured person to continue their cover, they must apply on the form(s) set by us. We must receive the form(s) within 60 days of them ceasing to be:

- a full-time permanent employee of the employer, or
- a part-time permanent employee of the employer working at least 15 hours per week.

Automatic acceptance and underwriting

This section describes the automatic acceptance terms and conditions along with the underwriting for AMP Group Salary Continuance. Special conditions and benefits might apply and if so they will be described in Part 1 – Summary of Features.

Competitive automatic acceptance levels

GSC is designed to automatically cover all persons who are eligible to become insured persons under the policy. Because of this, in most circumstances we are able to provide insured persons cover without having them to provide any individual health information, up to the automatic acceptance level.

You should refer to Part 1 – Summary of Features for the level of automatic acceptance (if any) that is applicable to your policy.

Automatic acceptance levels

The policy will be eligible for automatic acceptance up to the automatic acceptance level, if all of the following conditions are met and agreed to by us:

- There are clearly defined eligibility rules for each category of membership, (based on age, service or employment status).
- There is a clearly defined and fixed benefit formula for determining the level of benefit amounts for each category of insured persons which precludes individual selection.
- There must be at least 10 insured persons.
- All insured persons must be permanent employees.
- AMP is the only insurer of the benefits provided under the plan.
- Not more than 10% of insured persons may be resident overseas, and
- At least 75% of those eligible to join do so at the start of the policy, and at least 75% of those eligible to join in the future do so within 3 months of becoming eligible. For policies with less than 25 insured persons, 100% of insured persons must join at the start of the policy.

We also reserve the right to change the automatic acceptance level immediately should the number of insured persons vary by more than 20% since the date the automatic acceptance level was calculated, or in the event of invasion or war (declared or not) involving Australia or New Zealand. If the plan stops meeting any of these conditions (or if they are not complied with in practice), we can remove or vary evidence of health concessions.

All insured persons At Work (for the definition of "At Work" see "Definitions and descriptions for AMP Group Salary Continuance", on page 22) when the policy starts and all eligible employees who apply to be insured persons within 3 months of becoming eligible and are At Work performing normal duties and hours or are absent for reasons other than illness or injury (annual leave) at the date of application, will be granted cover without evidence of health up to the automatic acceptance level.

If an insured person's cover exceeds the automatic acceptance level, or they require additional cover outside normal eligibility conditions, then they will need to supply us with satisfactory health evidence so we can assess their application. Cover may be accepted, refused or offered on special terms.

Interim accident cover

If the insured persons default cover exceeds the plan's automatic acceptance level, they will need to apply for that part of their cover. While their application is being assessed, we will provide interim accident cover for that part of their cover, which exceeds their automatic acceptance level.

When does this cover start?

Interim accident cover will start from when we tell the insured person that they need to provide information about their health and we have received the insured person's fully completed application form. The insured person needs to be At Work performing their normal duties and work hours to be eligible for this cover.

When does this cover stop?

Cover will stop on the earliest of:

- 90 days from the date cover starts, or
- the date their application is approved, declined or withdrawn, or
- the date we advise the insured person of their cancellation of cover.

How much cover?

The GSC monthly benefit we pay is the lesser of:

- 75% of the insured person's salary at the commencement of the disability, or
- the GSC benefit calculated according to the default GSC benefit formula for the plan if it provides for a benefit less than 75% of the insured person's salary, or
- $5,000.
- AMP Life will only pay out that part of the benefit which would have been accepted under our standard underwriting rules and exclusions.

When will this benefit be paid?

We will only pay a GSC benefit if the insured person becomes unable to work solely as a result of an accident (for the definition of "Accident" see "Definitions and descriptions for AMP Group Salary Continuance", page 22) occurring during the period when they had interim accident cover. The benefit is paid monthly while they are unable to work, starting from the end of the waiting period, for a maximum of 12 months.

When won't we pay a benefit?

We will not pay when disablement is caused by intentional self-inflicted injury or suicide.

When isn't this cover available?

Interim accident cover will not be available to an insured person if they:

- have ever withdrawn an application for insured benefits (including through a super fund), or
- have ever applied for similar cover and cover was declined, or
- have applied for similar cover elsewhere.

Can interim accident cover change?

If we change the insurance we offer while their application for cover is being assessed, the interim accident cover may change. If interim accident cover does change, we will write and advise you of the change.

Sports and pastimes

Generally sports and pastimes will not be excluded unless an insured person exceeds the automatic acceptance level, is outside normal eligibility or is not entitled to automatic acceptance level, in which case normal underwriting and decisions will apply to these activities. This contract will not be offered for those playing or participating in professional sport.

Loadings and exclusions

Any loadings, exclusions, or declinature resulting from underwriting will only apply to the amount of benefit that was underwritten, and this will not affect the insured person's entitlement for cover up to the automatic acceptance level.

Underwriting requirements

If the insured person is not eligible for the AAL or if it is not available, the insured person will need to apply for cover.

The insured person will need to provide information about their health, pastimes and medical history, so we can assess their application. Depending on the evidence provided insurance cover may be accepted, declined, premiums increase, or exclusions applied.

We will also require evidence of health to underwrite the benefit in the event of:

- the benefit amount for an eligible insured person, at entry exceeding the automatic acceptance level, or
- the benefit amount for an insured person increasing above the automatic acceptance level.

Evidence of health requirements

Proposed GSC benefit	Evidence of health up to age 49	Evidence of Health age 50 and above	Forward Underwriting Limit
Up to $5,000	1	1	$5,000
$5,001 to $8,000	1 + 2	1 + 2	$10,000
$8,001 to $10,000	1 + 2 + 3	1 + 2 + 3	$12,000
Over $10,001	1 + 2 + 3	1 + 2 + 3 + 4	$20,000

Health requirements key:

1. Personal statement.
2. Blood tests (HIV antibodies, multiple biochemical analysis (MBA20), hepatitis B & C serology).
3. Medical examination (own doctor/paramedical).
4. ECG (resting).

Note: We retain the right to ask for further evidence of health if necessary, to make our decision.

Forward underwriting limit (next medical point)

Once we have underwritten and accepted an insured person, we will allow future increases in their cover in line with increases in their salary without further underwriting. Increases will apply until the benefit exceeds the Forward Underwriting Limit (FUL).

Forward underwriting is only available for future benefit increases according to the default benefit formula.

If the benefit increases above the FUL, we will underwrite again. If accepted we will apply a new FUL.

Commencement of liability, takeover and termination

This section describes commencement of liability, takeover and termination for AMP Group Salary Continuance. Special conditions and benefits might apply and if so they will be described in Part 1 – Summary of Features.

Commencement of liability

Where insured persons immediately before policy inception were covered under a group salary continuance policy substantially similar to this product, and we are provided with all information we require in relation to the insured persons to be covered and claims experience of the previous insurer, we may agree to provide takeover terms. Where agreed, we will generally cover new insured persons on the following terms below in "Takeover terms".

Takeover terms

For plans transferring from a previous insurer we may agree to take over the level of insurance benefits provided by the previous insurer to existing insured persons as long as the insurance basis is equivalent. The acceptance of takeover terms will be subject to the receipt and acceptance of all required takeover information by us.

The insured person's GSC cover in the plan will also commence on the date the plan commences if the insured person's were:

- At Work actively performing all the duties of their usual occupation on their last normal working day immediately before the date the plan commenced, or
- on approved leave for reasons other than illness or injury on their last normal working day immediately before the date the plan commenced and they were:
  - At Work actively performing all the duties of their usual occupation on the day before their first day of leave, and
  - not disabled due to an event (eg illness or injury) occurring on a date before the date the plan commenced while on paid or unpaid leave.

Otherwise, the insured persons GSC insurance cover in the plan on the commencement date will only be New Events Cover (for the definition of "New Events Cover" see "Definitions and descriptions for AMP Group Salary Continuance" on page 22).

The full GSC cover in the plan will commence once the insured person is At Work actively performing all the duties of their usual occupation on a day on or after the date the plan commenced.

These terms for commencement of insurance cover are in accordance with the industry standard, referred to as the IFSA Guidance Note No. 11.00 "Group Insurance Takeover Terms".

We can also tailor takeover terms to meet your needs. If so, they will be described in Part 1 – Summary of Features.

At Work certificate

On commencement of the risk we will require an At Work certificate in respect of all existing insured persons and any new eligible insured persons who were At Work on the commencement date.

Termination

Termination of the policy

We may terminate this policy when there are less than 10 insured persons, or if any premium or provisional premium remains unpaid for more than 30 days after the due date. (see page 14 if you stop paying premiums).

You may terminate your policy by giving us written notice at any time.

When the policy terminates we retain the liability for Total Disability benefits for any insured person who is not At Work on the date of termination because of illness, accident or injury which occurred after cover began but before termination.

Premium

This section describes the premium terms and conditions for AMP Group Salary Continuance. Special conditions and benefits might apply and if so they will be described in Part 1 – Summary of Features.

Guarantee

Generally we guarantee not to change your premium rates or unit rate for a specified period. However, we can vary the rates if the number of insured persons, the total amount of cover, the ratio of male to female, or the percentage of insured persons in any one occupational group, changes by more than 20% since the date the rates were last changed. We can also change the rates if you change your policy, if the government introduces a new tax, duty or charge, or changes an existing one, or in the event of war.

You should refer to Part 1 – Summary of Features to determine the premium rate guarantee that has been selected for your policy.

Premium rate alteration

After the rate guarantee period we will recalculate the applicable premium rate, which will be based on the experience of the policy and the membership details then applicable. The new premium rates will then be guaranteed for a similar period and similar conditions will apply to this guarantee.

When premiums can change

Any new rates will only apply to your policy from the date we recalculate your premium rates.

We will recalculate your premium rates at the end of your guarantee period. Your new rates will vary to reflect any changes in our standard base premium rates and your policy's risk profile.

How we calculate premium rates

We calculate your premium rates by adjusting our standard rates to reflect our assessment of your policy's risk profile. Our assessment depends on many factors including:

- The benefit options selected.
- Your insured person's occupations.
- The number of insured persons and the gender split.
- Your policy's past claims experience.

Your premium rates will also reflect any commission payable.

The number of variables means that we cannot give you an exact premium without knowing your circumstances. Your premium is based on the information that you provide to us will clearly be shown in Part 1 – Summary of Features.

Methods of calculating premiums

Unit rating

Unit rating will apply if your policy has 50 or more insured persons.

For a unit rated policy we use the policy specific premium rates and the distribution of insured persons and their cover to calculate a policy-wide premium rate (called a unit rate). The unit rate is expressed as a rate per $100 of monthly benefit.

The premium for each year is calculated by applying the unit rate to the total monthly benefit for the policy.

Individual rating may also apply to some insured persons of a unit rated policy. Usually, those who have been underwritten and accepted on special terms.

Simplified administration applies to unit rated policies. This imposes certain obligations on you, which are described in the Administration section on pages 15 and 16.

Individual rating

Individual rating applies to all policies with less than 50 insured persons.

For individual rated policies, every year we calculate each insured person's premium based on their age, gender, monthly benefit and the policy specific premium rates. The premium you pay is the sum of all the individual insured person's premiums.

Individual rating may also apply to some insured persons of a unit rated policy. Usually, those who have been underwritten and accepted on special terms.

You should refer to Part 1 – Summary of Features to determine the premium basis that has been selected for your policy.

Flexible premium frequency

Premium frequency can be tailored to suit your needs. Premiums can be paid annually, monthly, half yearly or quarterly.

If premiums are paid yearly in advance, a 4% discount will apply.

You should refer to Part 1 – Summary of Features to determine the premium frequency applicable to your policy.

Waiver of premium

If a GSC claim is being paid to an insured person, the daily proportion of premium due for the insured person is waived for the period they are on claim.

Once the insured person has returned to work the premiums will be payable from that date.

Policy discounts

A 5% timely payment discount applies if premiums are paid within 30 days of the due date on the premium invoice. This discount applies to the premium due for the next renewal year. If premiums are paid by any other frequency than yearly the discount only applies if all premiums have been received within 30 days of the premium invoice.

Any policy discounts will be applied in the premium statement at the next annual review.

Minimum premium

The minimum annual premium is $5,000.

Commission payable

Commission may be payable on your policy to a financial planner or institution. The level of commission is a percentage up to a maximum of 20% of premium excluding stamp duty. We will also pay an additional 10% of this amount for GST provided your adviser is registered for GST. This extra 10% must be remitted to the Australian Taxation Office (ATO). The commission is charged on top of the premium applicable to your policy.

Commission (if applicable) will be included in your total premium and also in the specific premium rates applicable to your policy.

You should refer to Part 1 – Summary of Features to determine the commission (if any) applicable to your policy.

Variation in the event of war

In the event of an invasion or war in which Australia is involved, we may vary the premium rates. We will give notice of any variation.

If you stop paying premiums

If you do not pay each premium within 30 days of it being due, we will take steps to end the policy. We will remind you if we do not receive your premium.

You can end the policy at any time by giving us notice in writing.

Administration

This section describes the information that we require to administer AMP Group Salary Continuance.

Installation

We require the following information, to enable us to issue a policy document and establish administration records:

- Full name of the plan.
- Full name and ABN of the sponsoring employer.
- Full name of the policyowner.

If the policyowner is a company:

- The name of the company.
- The company's ABN, and
- The names of the authorised signatories.

Completion of the following forms and information:

- Employer Occupation Statement.
- Application for insurance.
- At Work certificate.
- The commencement date, annual review date and premium payment frequency.
- A list of all insured persons At Work on the commencement date, or absent for reason other than illness or injury, including:
  - Name and date of birth.
  - Gender.
  - Date joined employer.
  - If the policy is held by the trustee of a superannuation fund, date joined the superannuation fund.
  - Salary.
  - Monthly benefit.
- For any insured person absent from work or At Work in a reduced capacity, due to illness or injury, the above information, and
  - reason for absence, and
  - date returned to work.

Details from the previous insurer including:

- Assessment terms applying to all underwritten insured persons, including any loadings, restrictions, list of outstanding requirements and forward underwriting limits.
- The automatic acceptance level.
- Details of all claims and premiums paid over the last 5 years, as well as any pending claims.
- Confirmation of the insurance formula for cover and category eligibility rules.
- Advice as to the percentage for superannuation contribution benefit (if any).
- Advice as to whether an insured person's cover is updated annually (and at what date) or during the year as salary increases, etc occur.
- If the policy is held by the trustee of a superannuation fund, advice of the eligibility rules for the superannuation fund, and a copy of the sections of the trust deed relating to insurance cover and insured benefits.

Plan administration

Simplified administration applies to unit rated policies (which must have at least 50 insured persons when they start). If the number of insured persons on unit rating falls below 50, we will revert to individual rating.

The premium adjustment for unit rated plans is calculated as:

$$\frac{1}{2} \times P \times \frac{(S2 - S1)}{S1}$$

Where:

P is the previous year premium for the policy year.

S1 is the previous year sum insured.

S2 is the current year sum insured.

Simplified administration imposes certain obligations on you.

- If you cannot supply an At Work certificate for a new insured person at the next review date, we require evidence of health. If a claim is made for a new insured person, we will consider the claim only if they were:
  - accepted automatically (ie they joined within eligibility conditions and were At Work), or
  - accepted after being underwritten.
- If a new insured persons initial cover exceeds the automatic acceptance level, you need to notify us immediately so that we can arrange evidence of health. Any initial cover over the automatic acceptance level is subject to individual assessment.

At the end of the guarantee period, or earlier if the number of insured persons alters by more than 20%, we require a list of insured persons and their occupational profile. For individual rating we require this information each year. The list should be sorted and totalled by category, showing for each insured person all of the following:

- name and date of birth
- gender
- date joined employer
- salary
- amount of cover.

Note: If the policy has more than 50 insured persons, you will need to provide a copy of the list, in a format suitable for use in an Excel spreadsheet.

At the end of each policy year, we will require the following information:

- The total amount of cover under the policy.
- Number of insured persons being covered during the year.
- Insured persons requiring evidence of health because their cover has increased above the automatic acceptance level, or forward underwriting limit.
- A list setting out the name, date of birth, and amount of cover for each insured person whose cover is above the automatic acceptance level.

During the policy year, you must tell us immediately of any:

- insured persons who are not eligible for automatic acceptance (eg because they have joined more than 3 months from the date first eligible to do so), or
- insured persons whose cover increases above the automatic acceptance level or forward underwriting limit for the first time.

We will arrange evidence of health for these insured persons.

In addition, if any insured person is seconded overseas and requires insurance to continue, you need to tell us in advance and give details of the nature of the secondment. We normally allow cover to continue for up to 2 years but we may limit cover in these circumstances.

If the benefit design changes at either plan or category level or there are changes to the membership profile you also need to tell us immediately.

We may vary the quoted premium if a more detailed method of administration is required.

Sometimes you will need to assist us with underwriting requirements. In particular:

- If you cannot supply an At Work certificate for a new insured person at the next review date, we require evidence of health. If a claim is made for a new insured person, we will consider the claim only if they were:
  - accepted automatically (ie they joined within eligibility conditions and were At Work when they joined), or
  - accepted after being underwritten.
- If a new insured person's initial cover exceeds the automatic acceptance level, you need to notify us immediately so that we can arrange evidence of health. Any initial cover over the automatic acceptance level is subject to individual assessment.

Claims

This section is a brief summary of our claim requirements and procedures. We may vary these procedures depending on the particular claim or your particular needs.

Initiating a claim

You should notify us about all claims (and potential claims) as soon as possible. Do not wait until the end of the waiting period. Late notification can make assessment more difficult and delay the payment of benefits and in extreme cases, where our assessment is prejudiced by the delay, it may result in the payment of lesser entitlements.

We will contact you to tell you our requirements and give you the forms you will need.

You will need to give to us at your expense:

- Birth certificate or other acceptable evidence of date of birth and identity.
- Confirmation of the amount of cover.
- Confirmation of insured person's last day actively At work.
- Confirmation of insured person's termination date (if applicable).
- Initial Disablement Claim Form (completed by insured person).
- Advice of the insured person's bank account details (advised by insured person).
- Initial Medical Report & Certificate (completed by insured person's doctor).
- Employer report (completed by you).
- Any other relevant reports that you or the insured person may have which will assist us to make a determination on the claim.

Assessing a claim

We will liaise with you (or your intermediary) to collect all requirements.

We may arrange for independent medical examination(s) or request other information.

We will assess the claim.

If the claim is admitted – we will pay any benefit amount in respect of an insured person to you.

If the claim is denied – we will advise you (or your intermediary) and outline our reasons (subject to any confidentiality constraints).

Admitted claims are reviewed regularly (usually monthly).

We will require the insured person and the treating doctor to complete monthly claim forms and return them to us. Income payments will be made monthly and in arrears.

You should consider your responsibility to inform the insured person of our decision and to provide the insured person with sufficient information to understand the decision.

Time limit for notification of disablement claims

You must tell us about any claims (and provide supporting medical evidence) within 7 months after the later of:

- when the illness, injury or accident began or happened, and
- when the insured person was last At Work.

If you tell us later than this, and we are prejudiced by the delay, we may reduce the amount we pay to reflect that prejudice.

If an insured person is overseas and submits and is accepted for a claim, we may not pay for more than 3 months while the insured person is outside Australia or New Zealand, unless we agree to an extension.

If we do not pay after 3 months, then, when the insured person returns to Australia or New Zealand, we will start paying again if they are still Totally Disabled.

Claims dispute resolution procedures

We will review our decision to decline a claim only if:

- there is new evidence that we have not considered that is material to our decision, and
- you (or your intermediary) tell us in writing why you disagree with our decision.

The claim will be reviewed by a senior claims assessor (consultant or manager) who may accept the claim in view of the further information.

If the senior claims assessor does not accept the claim, the claim will be referred to our claims review panel.

The panel consists of senior AMP officers with expertise in the following:

- medicine
- law
- underwriting
- claims assessment
- product management.

The panel will then make a determination in relation to the claim based on all of the facts relevant to the case.

Should the panel confirm the declinature or cessation of a claim an explanation will be provided.

In the event that a dispute remains the claimant may refer our decision to the Financial Industry Complaints Service. See page 21 for details on the Financial Industry Complaints Service.

General

Our service will be timely, personal and responsive to the needs of our customers.

Information will only be sought when it is essential to our decision.

We will consider speed and customer convenience in deciding how to obtain information.

We will always explain the reasons for our decisions.

We will respect the privacy of the individual and will treat all personal medical and financial information in accordance with our Privacy Policy. We may disclose information where required by law, or where it is necessary for us to obtain expert opinions to assess a claim.

We will seek to pay genuine claims quickly.

We are committed to developing caring relationships with our claimants. We will seek to do this through face-to-face contact where possible.

Whenever our own doctors or independent specialists provide information that may assist in the insured person's treatment, we will seek to convey this to the insured person's doctor, if the insured person consents.

General requirements

Insurance Contracts Act

The Insurance Contracts Act 1984 requires AMP to advise you of your duty of disclosure before entering into an insurance contract and the consequences of any non-disclosure. We suggest you also inform all persons who are or likely to become insured persons under a policy, of their duty of disclosure and the consequences of any non-disclosure.

Your duty of disclosure

Before you enter into any contract of insurance with an insurer, you have a duty to disclose to the insurer every matter that you know or a reasonable person in the circumstances could be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of life insurance.

However, your duty of disclosure does not require disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer.
- That is of common knowledge.
- That the insurer knows or, in the ordinary course of its business, ought to know, or
- Where the insurer has waived disclosure.

Non-disclosure

If you fail to comply with your duty of disclosure and AMP would not have entered into a contract on any terms if the failure had not occurred, we may avoid the contract within 3 years of entering into it. If your failure is fraudulent, we may avoid the contract at any time.

If we are entitled to avoid a contract of life insurance we may, within 3 years of entering into it, elect by written notice not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Automatic cover

You should tell us if you are aware of anything affecting your employees as a group (other than the information about their ages, occupations and claims experience that you have already given us) that is relevant to our decision whether to accept the risk of the insurance and, if so, on what terms.

But you do not need to tell us about the health of individual employees.

If employees do not qualify for automatic acceptance or their cover exceeds the automatic acceptance level, we will advise them of their duty of disclosure when we collect information about their health from them.

Cooling off period

You have 14 days in which to notify us in writing that you want to return the product and have the premiums repaid to you. This is known as the cooling off period. The 14 days commences:

- 5 days after we receive your letter confirming that you have accepted our quote, or
- the date you receive our letter confirming the issue of the policy

whichever is earlier.

However, you cannot return the product if you have exercised rights or powers under the product (for example, if you have made a claim).

If you cancel the policy within the cooling off period we will refund your premiums less:

- the reasonable administrative and transaction costs (including taxes and duties) we have incurred in setting up your plan, and
- that proportion of the premium which relates to cover provided before we received your notice.

GST

All premiums are exclusive of the Goods and Services Tax (GST).

Current legislation and its interpretation is that this insurance is not liable to the GST. Should this change and we become liable for any GST on the supply of anything under the policy, we may increase premiums to compensate us for the additional amount we will be required to pay to the Australian Taxation Office as GST.

AMP and your privacy

Our main purpose in collecting personal information from you is so we can establish and manage your CustomSuper account. If you choose not to provide the information necessary to process your application, then we may not be able to process it.

We may also use this information for related purposes – for example, providing you with ongoing information about financial services that may be useful for your financial needs.

These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services, that may be made available by us, other members of the AMP group, or by your financial planner.

We usually disclose information of this kind:

- To other members of the AMP group.
- If you are part of an employer sponsored plan, to the employer sponsor and the financial planner or broker responsible for the plan.
- To your financial planner or broker (if any).
- If you are applying for a personal insurance product, to the owner of the plan.
- To external service suppliers who supply administrative, financial or other services to assist the AMP group in providing AMP financial services.
- To the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost superannuation.
- To anyone you have authorised or if required by law.

If health information is collected in relation to this financial product, then additional restrictions apply. The primary purpose for obtaining this health information is for the insurer, AMP Life, to assess your application for new or additional insurance. AMP Life may also use this information for directly related purposes – for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims.

AMP Life may disclose this type of health information to:

- The financial planner or broker responsible for the plan.
- Your employer (if you are part of an employer sponsored plan), only to the extent necessary to process any claim you make.
- The Trustee.
- The owner of your personal insurance plan (if applicable).
- AMP Life's reinsurers.
- Medical practitioners.
- Any person AMP Life considers necessary to help either assess claims or resolve complaints, and
- Anyone you have authorised or if required by law.

Under the National Privacy Principles, you may generally access personal information about you held by the AMP group. Also, you may let us know if you think any of it is inaccurate, incomplete or out of date. The AMP Privacy Policy Statement sets out the AMP group's policy on management of personal information. You may obtain a copy by contacting us on 1300 653 456 or visiting our website at www.amp.com.au.

Taxation

The following tax information provides general information only, and is based on current law applying at the date that this document was published.

Tax treatment may differ depending on individual circumstances, and if you are considering group insurance, you should seek specialist taxation advice.

Tax treatment of group salary continuance insurance differs depending on whether you are the trustee of a superannuation fund, or an employer arranging benefits directly for your employees.

Superannuation fund trustee

You will generally be entitled to an income tax deduction for the premiums paid. Unless you have the appropriate APRA determination, the deduction for premiums will only be available to the extent that the premiums relate to benefit periods of 2 years or less.

Any benefit payments made by us and received by you are generally not assessable to income tax. You cannot claim a tax deduction for the benefit payments that you make to an insured person.

The benefits received by the insured person will normally be assessable for income tax, and you would normally be required to withhold tax under the PAYG provisions.

Employer arranging benefits directly

Generally, you may, subject to your arrangements, be entitled to an income tax deduction for the premiums paid for this insurance and the premiums will not normally be subject to Fringe Benefits Tax (FBT).

Benefits paid to you will generally be taxable. If you pay the proceeds of the benefit to the employee you would normally be entitled to a tax deduction for that payment.

The amount received by the employee would generally be assessable for income tax in their hands, and you would normally be required to withhold tax under the PAYG provisions.

Complaints process

If you have a concern or complaint about your AMP Group Salary Continuance policy, contact your financial planner, or AMP on 1300 653 456.

We have established procedures to deal with any complaints. If you make a complaint we will:

- acknowledge its receipt within 5 days and ensure an appropriate person properly considers the complaint, and
- investigate your query or complaint promptly and we'll give you a written reply as soon as possible.

If we cannot resolve your complaint to your satisfaction within 45 days, then you have the right to lodge a complaint with the Financial Industry Complaints Service (FICS).

Our contact details are:

Customer Service Officer
AMP Group Insurance
Locked Bag 5057
PARRAMATTA NSW 2124

Independent complaints service

You can contact the Financial Industry Complaints Service (known as FICS) if you are unhappy about the way we have handled your complaint. FICS is an independent and impartial body.

FICS aims to help people with complaints they cannot resolve with their insurer. You should only contact FICS after you have spoken to us to try to solve your problem.

Their address is:

The Financial Industry Complaints Service
PO Box 579, Collins Street West Post Office
MELBOURNE VIC 8007
Phone: 03 9629 7050
Toll Free: 1800 335 405

Definitions and descriptions for AMP Group Salary Continuance

This section describes the standard insurance definitions for AMP Group Salary Continuance. Special conditions and benefits might apply and if so they will be described in Part 1 – Summary of Features.

Defined term	Meaning
Accident	Accident is bodily injury caused directly or solely by violent, external and visible means and independent of all other causes.
At Work	At Work means actively performing all duties of their usual occupation with their employer and not in receipt of (or entitled to) income benefits from any source including workers compensation benefits, statutory transport accident benefits and disability income benefits.
Doctor	Doctor means a legally qualified medical practitioner registered to practice in Australia, New Zealand, the United Kingdom, the United States of America, or Canada. The Medical Practitioner may not be the insured person, the insured person's business partner or a member of their immediate family.
New Events Cover	Means the GSC insurance cover does not cover disability arising from illness or injury which caused the insured person not to be At Work actively performing all of the duties of their usual occupation with their employer: • on the insured person's last normal working day immediately before the date the plan commenced, or • on the date the plan commenced, in respect of an event occurring in the period after the insured person's last normal working day immediately before the date the plan commenced.
Partial Disability	See definition for "Partially Disabled".
Partially Disabled	The insured person may be eligible for GSC benefits if their disability meets the following definition of disablement and it commences while they were an insured person of the plan. An insured person is partially disabled if: • they were totally disabled for the first 2 weeks of the waiting period (14 consecutive days), and • an illness or injury which made them unable to work causes them to earn less than what they did before a period of total disability, and • they have approval from their doctor to return to work and we agree, and • they remain under the ongoing care and advice from their doctor. When we pay the partial disability benefit the benefit is calculated as: $\frac{\textbf{(A-B) x C}}{\textbf{A}}$ Where: **A** is the insured person's monthly earnings prior to total disability (pre-disability salary). **B** is the insured person's current monthly earnings for their occupation. **C** is the total monthly GSC cover.

continued overleaf

Defined term	Meaning
Salary	For the purpose of determining insurance cover and calculating insurance benefits, salary is the total package from employment including commission, regular bonuses, fringe benefits (which is determined by the average taxable salary earned for the previous 3 years) and any other items relating to the insured person's own efforts. We do not include superannuation contributions made by an employer (if applicable) or investment income. However, we do include superannuation contributions made by an employer that are part of salary sacrifice arrangements between the insured person and employer. When the insured person owns (directly or indirectly) all or part of the business or practice, "net earnings" means income earned by the business or practice as a result of their personal exertion or activities less their share of the business expenses incurred in earning that income.
Total Disability	Refer to definition for "Total Disablement".
Totally Disabled	Refer to definition for "Total Disablement".
Total Disablement	The insured person may be eligible for GSC benefits if their disability meets the following definition of disablement and it commences while they were an insured person of the plan. An insured person is totally disabled if they suffer an illness or injury while in the active service of the employer and as a result they are: • unable to do their usual occupation because they are ill or injured, and • under the ongoing care of a doctor, and • not doing any remunerative work. When we assess the insured person's ability to do their usual occupation, the assessment is based on their capacity to carry out any one duty or combination of duties that are critical to the proper performance of their usual occupation.

Notes

advice
investments
banking
retirement income
superannuation
insurance

Contact

Customer Service Officer
AMP Group Insurance
Locked Bag 5057
PARRAMATTA NSW 2124

Phone 1300 653 456
Internet www.amp.com.au

AMP Life Limited ABN 84 079 300 379
33 Alfred Street Sydney NSW 2000

NS2603 11/06