Avant's Trauma Cover and Children's Cover

Supplementary Product Disclosure Statement (SPDS)

Effective date 1 June 2019

Dr John Limbers
Avant member

About this SPDS

This SPDS is dated 1 June 2019 and supplements the information contained in Avant's Trauma Cover and Children's Cover Product Disclosure Statement of 19 December 2016 ('PDS'). This SPDS should be read together with the PDS before making a decision in relation to Avant's Trauma Cover and Children's Cover.

The purpose of this SPDS is to update the PDS with changes to:

- provide some information regarding the Financial Services Council's Life Insurance Code of Practice; and
- update the 'Complaints and dispute resolution' section of the PDS with information concerning the Australian Financial Complaints Authority (AFCA) which replaces the Financial Ombudsman Service (FOS) as the relevant independent external dispute resolution scheme.

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

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

Who we are

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

This SPDS is issued by NobleOak. NobleOak takes responsibility for the whole SPDS.

Avant Life Insurance (Avant) is a registered business name of Doctors Financial Services Pty. Limited ABN 56 610 510 328 (DFS). DFS provides administration services in relation to your plan on behalf of NobleOak.

Your contract

If you purchase Avant's Trauma Cover and Children's Cover, your contract will be made up of the PDS (as updated by this SPDS), your application for insurance, the Avant Benefit Fund Rules and relevant appendices. You may request a copy of the Avant Benefit Fund Rules at any time.

This SPDS updates the PDS with the following changes:

About this Product Disclosure Statement

At page 2, second column, beneath the section entitled 'Your contract', add the following new section:

The Life Insurance Code of Practice

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

Section 11 – Additional Information

At page 33, replace all the wording under the **Complaints and dispute resolution** heading with the following wording:

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

If you have a complaint about the service provided or your privacy, you can write to:

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

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

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

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

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

AFCA can be contacted as follows:

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

Their website is **afca.org.au**

Contact Information

For general queries about this SPDS, a referral to an insurance advisor or the administration of your plan, please contact:

Avant Life Insurance

Phone **1800 128 268**
Fax **1800 910 552**
Mail **Avant Life Insurance, PO Box 746, Queen Victoria Building, NSW, 1230**
Email **lifeadmin@avant.org.au**

The issuer of this SPDS (and the PDS) is NobleOak Life Limited ABN: 85 087 648 708; AFSL: 247 302

Phone **1300 551 044**
Fax **(02) 9299 7852**
Mail **GPO Box 4793, Sydney, NSW, 2001**

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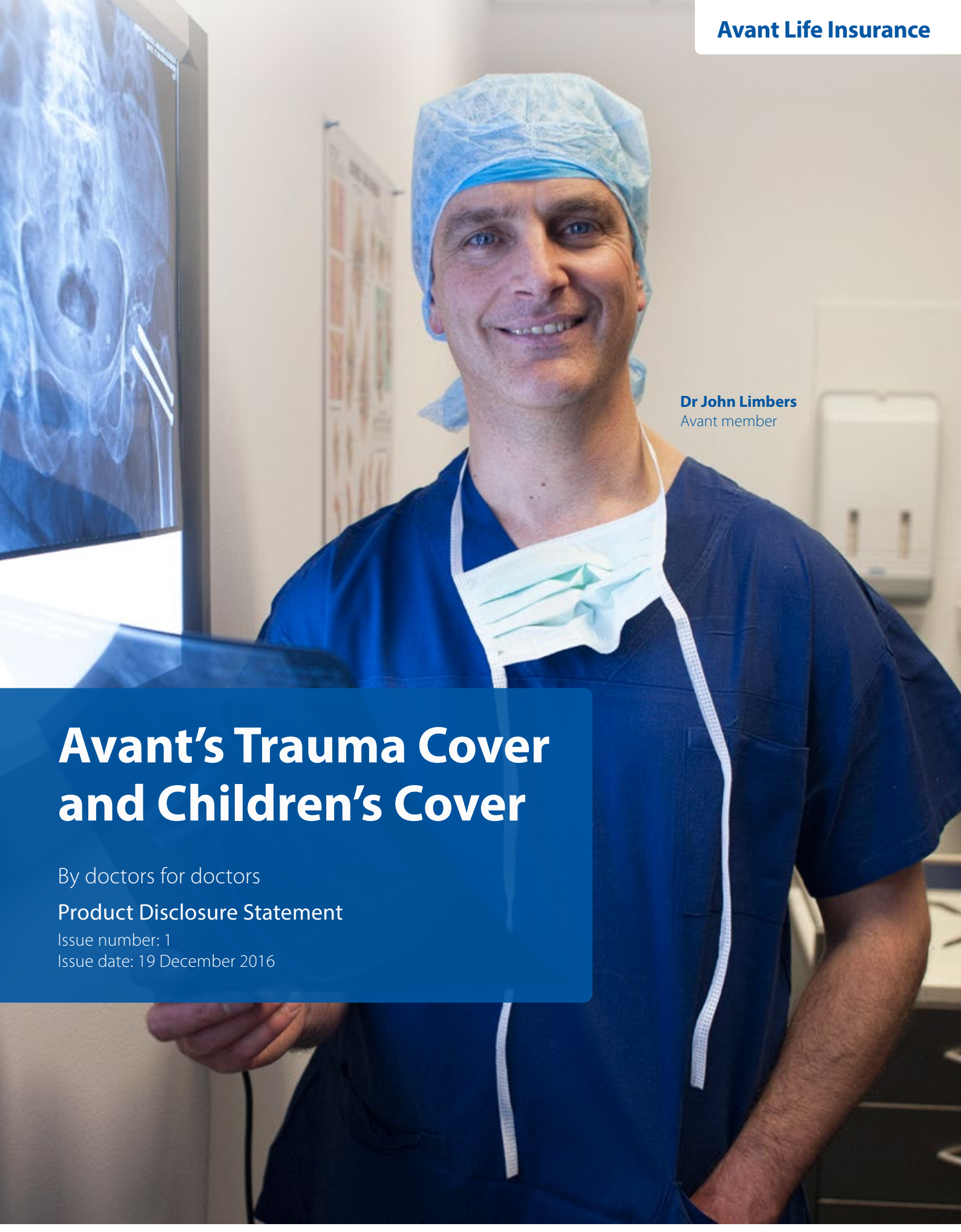


Dr John Limbers
Avant member

Avant's Trauma Cover and Children's Cover

By doctors for doctors

Product Disclosure Statement

Issue number: 1
Issue date: 19 December 2016

Avant mutual by doctors for doctors | life & wealth

In the event of the unexpected, your family needs financial security so you can focus on getting better.

Avant's Trauma Cover and Children's Cover

The Limbers family

Comprehensive protection against life's traumatic events for you and your family

Trauma Cover

If you suffer a major health trauma, Avant's Trauma Cover will provide you with the financial resources you need to make lifestyle or career adjustments to help you recover.

Trauma Cover benefits and features

- Receive a lump sum benefit payment of up to $2 million if you suffer one of 45 major health traumas.
- Receive a lump sum benefit payment of up to $200,000 if you suffer from one of 15 partial trauma events.
- Benefit from larger cover increases, more often and without medical tests. Increase your cover by up to 25% per year for events such as starting an internship or training program, becoming a fellow, a partner in a practice, starting your own practice, having children or taking out a mortgage.
- Enjoy cover that extends for longer – you are eligible for full benefits up until you turn 70.
- Claim on your full Trauma Cover six months after a trauma claim.

Children's Cover

If your child suffers a serious illness, injury or major health trauma, Avant's Children's Cover will provide you with the financial resources to ensure you, or a family member, can be there to care for your child and pay the cost of their treatment.

Children's Cover benefits and features

- Receive a benefit of up to $5,000 per month per child if your child is confined to bed.
- Receive a lump sum benefit payment of up to $200,000 if your child suffers from one of 36 major health traumas.
- A benefit of up to 25% of your *sum insured* will be paid if your child suffers from one of 13 partial trauma events.
- Available to parents, grandparents and legal guardians who are doctors and who own any plan from the Avant Life Insurance portfolio.

Simple options

- Choose between stepped or level premium payments for Trauma Cover.
- The flexibility to choose from a range of ownership options to suit your circumstances for Trauma Cover. This includes self-ownership, ownership by practice partners, another individual or by a company or trust.
- Option for your child's cover to continue even after they turn 21.

About this Product Disclosure Statement

The purpose of this Product Disclosure Statement (PDS) is to provide you with important product information so you can make the best choices for you and your family.

This PDS provides information about Avant's Trauma Cover as well as Avant's Children's Cover. Should you want information about other Avant Life Insurance products, please call us on 1800 128 268 or visit our website at: **www.avant.org.au/life.**

Understanding what we mean

To help you understand what Trauma Cover and Children's Cover is all about, general information about a benefit, feature, option or requirement is included at the start of each section and highlighted with a symbol of a stethoscope.

The text below then provides further detail on the specific terms and conditions that apply.

While our aim is to provide straightforward explanations, some of the terms and words used have specific meanings, including some non-technical words commonly used. These words have been *italicised* and are explained in the 'Defined terms' section at the end of this document. You'll also note that we refer to Avant's Trauma Cover and Children's Cover as plans, rather than policies. After all, aren't they part of your plan for protecting yourself and your family's future?

Who we are

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

This PDS is issued by NobleOak. NobleOak takes responsibility for the whole PDS.

Avant Life Insurance (Avant) is a registered business name of Doctors Financial Services Pty. Limited ABN 56 610 510 328 (DFS). DFS provides administration services in respect of your insurance cover on behalf of NobleOak.

When reading this PDS, 'we'/ 'us'/ 'our' refers to NobleOak. 'You'/ 'your' refers to the insured person or plan owner, as the context requires.

This PDS is not advice

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

Up-to-date information

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

Your contract

If you purchase Avant's Trauma Cover or Children's Cover, your contract with us will be made up of this PDS, your application for insurance, the Avant Benefit Fund Rules and relevant appendices. You may request a copy of the Avant Benefit Fund Rules at any time.

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

Contents

To help you navigate through this PDS, it has been divided into the following sections:

Trauma Cover

A quick overview of Avant's Trauma Cover, including its benefits, features and options

Benefits

Receive either a full or a partial benefit payment if you suffer from one of 60 serious illnesses or injuries covered by this plan.

Trauma Benefit
page 8

Partial Trauma Benefit
page 8

Features

These features help you to easily adjust your cover as a result of changes to your personal and professional life. They also ensure your cover is the latest available and provide other useful features such as reinstatement of your Life Cover, TPD Cover and Trauma Cover after a Trauma Cover claim.

Cover Reinstatement
page 14

Future Needs Guarantee
page 15

Cover Indexation
page 16

Upgrade Guarantee
page 16

World Wide Cover
page 16

Guaranteed Renewable
page 17

Options

Trauma Cover can be tailored in four ways to ensure it most appropriately meets your needs.

Sum insured
page 18

Linked or standalone
page 18

Premium structure
page 19

Plan ownership
page 20

Interim cover

You are covered with all these benefits, features and selected options from the time you submit your completed application and authorise payment, until your application is approved, declined or withdrawn.

Complimentary interim cover
page 21

Children's Cover

A quick overview of Avant's Children's Cover, including its benefits, features and options

Benefits

Children's Cover will help ensure you can be with your child when they need you by providing you a regular income if they confined to a bed at home or in hospital. Additionally, you will receive a lump sum payment should your child suffer one of 49 trauma events covered by this plan, be diagnosed with a terminal illness or die.

Children's Support Benefit
page 10

Children's Trauma Benefit
page 10

Children's Partial Trauma Benefit
page 11

Children's Death and Terminal Illness Benefit
page 11

Features

These features help your Children's Cover keep its real value. They also ensure your cover is the latest available and offer other useful features like providing the option for your child to be covered beyond childhood.

Cover Indexation
page 16

Upgrade Guarantee
page 16

World Wide Cover
page 16

Guaranteed Renewable
page 17

Children's Cover Conversion
page 17

Options

There are only two decisions you need to make when it comes to Children's Cover – what *sum insured* best meets your needs and who will own the plan.

Sum insured

page 18

Plan ownership

page 20

Interim cover

Your child is covered with all these benefits and features for your selected *sum insured* from the time you submit your completed application and authorise payment, until your application is approved, declined or withdrawn.

Complimentary interim cover

page 21

2. Trauma Cover benefits

Trauma Benefit

When you suffer a major health trauma such as cancer, stroke or heart attack, more than your health is impacted. Apart from taking time off work to recover, you may need to make home modifications or lifestyle adjustments. Furthermore, as a doctor, you know that some medical treatments are not covered by Medicare, health insurance or are not currently available in Australia. Our Trauma Benefit will provide you a lump sum payment to help pay these costs if you suffer from one of the 45 trauma events covered by this plan.

If you're diagnosed with or suffer one of the 45 trauma events listed as full benefits in the table 'Trauma events' (see next page) and you survive 14 days from the date of that event, we will pay a lump sum payment to you.

Your Trauma Benefit amount will be equal to the amount you have chosen to insure under this plan (your Trauma Cover *sum insured*).

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

Partial Trauma Benefit

Not all serious illnesses or injuries are the same. While all may be traumatic, some are less severe or have a better prognosis for recovery; particularly when diagnosed or treated at an early stage. However, we recognise there may still be a need to take time off work, make lifestyle adjustments and pay for unplanned medical treatment costs. When you have Avant's Trauma Cover in place, we will provide you a partial benefit payment of up to 25% of your *sum insured* for an additional 15 trauma events.

If you're diagnosed with or suffer one of the 15 trauma events listed as partial benefits in the table 'Trauma events' (see next page) and you survive 14 days from the date of that event, we will make an advance payment of your Trauma Benefit. The Partial Trauma Benefit amount is 25% of your *sum insured* up to a maximum of $200,000.

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

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

The Partial Trauma Benefit is only payable once per listed event. However, there are exceptions. You may claim multiple times for angioplasty provided subsequent events occurred at least six months after the previous claim. More than one payment is also available for carcinoma in situ, provided it occurs on a different part of the body from the previous claim.

Trauma events

Cardiac conditions

Full benefits
Aortic surgery
Cardiomyopathy
Coronary artery bypass surgery*
Heart attack*
Heart valve surgery
Open heart surgery
Primary pulmonary hypertension

Partial benefits
Angioplasty*
Cardiac arrest (out of hospital)

Cancer and tumours

Full benefits
Benign brain tumour
Benign spinal cord tumour
Blood and lymphatic cancer*
Breast cancer*
Prostate cancer*
Skin cancer*
Other cancer*

Partial benefits
Benign brain tumour (diagnosed)
Benign spinal cord tumour (diagnosed)
Carcinoma in situ*
Lymphocytic leukaemia (early stage)*
Melanoma (early stage)*
Prostate cancer (early stage)*

Permanent conditions

Full benefits
Loss of hearing
Loss of independence
Loss of sight
Loss of a single limb
Loss of speech

Partial benefits
Crohn's disease (severe)
Loss of hearing in one ear
Loss of sight in one eye
Ulcerative colitis (severe)

Organ conditions

Full benefits
Kidney failure (chronic)
Liver failure (chronic)
Lung failure (chronic)
Organ transplant
Pneumonectomy

Blood conditions

Full benefits
Aplastic anaemia
Hepatitis B or C (occupationally-acquired)
HIV (medically-acquired)
HIV (occupationally-acquired)

Neurological conditions

Full benefits
Alzheimer's disease
Cognitive loss
Dementia
Encephalitis
Major head trauma
Meningitis
Meningococcal disease
Motor neurone disease
Multiple sclerosis
Muscular dystrophy
Paralysis
Parkinson's disease
Stroke*

Partial benefits
Brain surgery
Coma

Other events

Full benefits
Burns (severe)
Diabetes (severe)
Intensive care
Rheumatoid arthritis (severe)

Partial benefits
Diabetes (type 1 after age 30)*

Please see the 'Defined trauma events' section on page 34 for definitions of each of the above conditions.

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

3. Children's Cover benefits

Once you have chosen to protect yourself and your family with Avant Life Insurance, it can also make sense to extend your insurance to provide cover if your child or grandchild suffers one of the 49 trauma events covered by Avant's Children's Cover, becomes *terminally ill* or dies.

Children's Cover can be added to any Avant Life Insurance plan.

Children's Support Benefit

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

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

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

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

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

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

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

Children's Trauma Benefit

Similar to the benefits available under Trauma Cover, we will make a lump sum payment to you should your child be diagnosed or suffer a listed major health trauma.

If an insured child is diagnosed with or suffers, one of the 36 events listed as full benefits in the table 'Children's Cover trauma events' (see page 12) and they survive 14 days after the date of that event, we will pay the Children's Trauma Benefit to you.

The Children's Trauma Benefit amount will be equal to the amount you have chosen to insure under this plan (your Children's Cover *sum insured*).

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

Children's Partial Trauma Benefit

To help cover the costs of your child's illness or injury, we will pay 25% of your Children's Cover *sum insured* if they suffer a partial trauma event.

If your child is diagnosed with or suffers one of the 13 trauma events listed as partial benefits in the table 'Children's Cover trauma events' (see page 12) and they survive 14 days after the date of that event, we will make an advance payment of your Children's Trauma Benefit. The Children's Partial Trauma Benefit is 25% of your Children's Cover *sum insured* subject to a minimum of $10,000.

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

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

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

Children's Death and Terminal Illness Benefit

While planning for the death of a child and factoring in the associated costs can be an inconceivable task, the reality is that we may need to do it. Should your child die or be diagnosed with a *terminal illness*, we will provide a lump sum payment of $25,000 to assist with funeral costs, time off work and other expenses.

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

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

Children's Cover trauma events

Cardiac conditions

Full benefits
Aortic surgery
Cardiomyopathy
Coronary artery bypass surgery*
Heart attack*
Heart valve surgery
Open heart surgery
Primary pulmonary hypertension

Partial benefits
Angioplasty*
Cardiac arrest (out of hospital)

Cancer and tumours

Full benefits
Benign brain tumour
Benign spinal cord tumour
Blood and lymphatic cancer*
Breast cancer*
Skin cancer*
Other cancer*

Partial benefits
Benign brain tumour (diagnosed)
Benign spinal cord tumour (diagnosed)
Carcinoma in situ*
Lymphocytic leukaemia (early stage)*
Melanoma (early stage)*

Permanent conditions

Full benefits
Loss of hearing
Loss of sight
Loss of a single limb
Loss of speech

Partial benefits
Crohn's disease (severe)
Loss of hearing in one ear
Loss of sight in one eye
Ulcerative colitis (severe)

Organ conditions

Full benefits
Kidney failure (chronic)
Liver failure (chronic)
Lung failure (chronic)
Organ transplant
Pneumonectomy

Blood conditions

Full benefits
Aplastic anaemia
HIV (medically-acquired)

Neurological conditions

Full benefits
Cognitive loss
Encephalitis
Major head trauma
Meningitis
Meningococcal disease
Multiple sclerosis
Muscular dystrophy
Paralysis
Stroke*

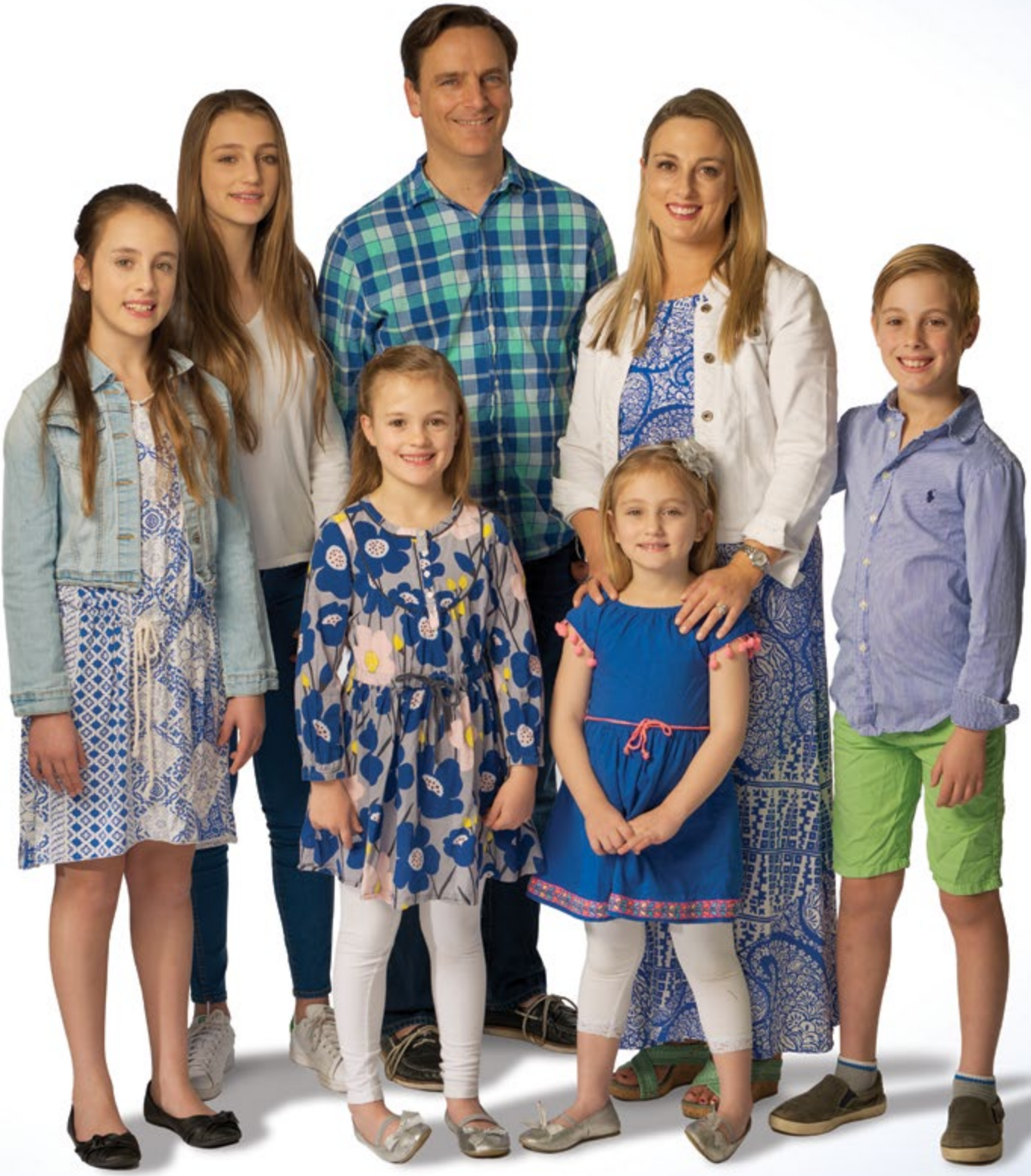
Partial benefits
Brain surgery
Coma

Other events

Full benefits
Burns (severe)
Diabetes (severe)
Intensive care

Please see the 'Defined trauma events' section on page 34 for definitions of each of the above conditions.

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



The Limbers family

When your child is sick, you want to know that you or another family member can be there to care for them while still financially supporting your family.

4. Features

Cover Reinstatement (Trauma Cover only)

If you have Trauma Cover linked to either Life Cover and/or Total and Permanent Disablement Cover (TPD Cover), one event may result in multiple claims being paid. So to avoid overlap between your plans and as a result, a higher premium, we reduce the benefits paid out when overlap occurs. For example, if you claim for a trauma benefit and that claim is paid, your Trauma Cover, Life Cover and any TPD Cover will be reduced by the amount of your claim. This means that only a reduced benefit or no benefit at all, would be paid if a further claim is made under these plans.

However, under our Cover Reinstatement feature, the original *sum insured* for your Trauma Cover, Life Cover and/or TPD Cover plans will be automatically reinstated six months after a Trauma Cover claim payout. Furthermore, only a reduced premium or no premium at all, will be charged for the period in which your cover is reduced.

Linked to Life Cover

If your Trauma Cover plan is linked to Life Cover, any claim that becomes payable under your Trauma Cover will reduce the *sum insured* on your Life Cover by the amount of the benefit payment. If we reduce your *sum insured*, your premiums will also be reduced. If your *sum insured* has been reduced to nil, then no premiums will be payable.

Linked to Life Cover and TPD Cover

If your Trauma Cover plan is linked to Life Cover and TPD Cover, any claim that becomes payable under your Trauma Cover will reduce the *sum insured* on both your Life Cover and TPD Cover plans by the amount of the benefit payment. If we reduce your *sum insured*, your premiums will also be reduced. If your *sum insured* has been reduced to nil, then no premiums will be payable.

Reinstatement

Under this Cover Reinstatement feature, we will automatically reinstate any reduced Trauma Cover, Life Cover and/or TPD Cover six months after your claim was received or the date your claim was paid, whichever is later. No medical evidence or information on your pastimes or occupation will need to be provided.

Premiums for your reinstated plan/s will also resume from the reinstatement date. If your original premium was stepped, then your premium for the reinstated plan will be based on your age at reinstatement. Alternatively, if your original premium was level, the same premium will apply (see 'Premium structure' on page 19).

Any exclusions or medical, occupational or pastimes loadings that applied to your original Trauma Cover, Life Cover and/or TPD Cover plans will also apply to the reinstated plans.

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

After your Trauma Cover, Life Cover and/or TPD Cover plans are reinstated, the Future Needs Guarantee feature and the Cover Indexation feature will no longer be available for the reinstated portions of your *sum insured* for these plan/s.

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

Cover Reinstatement will not be available if:

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

Future Needs Guarantee (Trauma Cover only)

Trauma Cover has been designed to grow with you as your personal life, medical career and financial position changes. If, for example, you become a parent, take out a mortgage or start a private practice, you may have a need for additional Trauma Cover. To make applying for increases as straightforward and easy as possible, we will allow you to increase your *sum insured* by up to 25% each year without the need to provide updated medical information or details about your pastimes or occupation for assessment.

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

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

You may increase your Trauma Cover up to the maximum yearly increase amount after one of the following events:

Personal events

- You are married, register a de facto relationship or enter into a de facto agreement.
- You or your partner give birth or legally adopt a child.
- Your first dependent child starts high school.
- You take out or increase your mortgage for your primary place of residence (excludes refinancing or redrawing).

Professional events

- You are admitted into a specialty training program.
- You qualify as a Fellow of your specialty.
- You become a partner or associate of your medical practice.
- You start a private practice.
- You increase your ownership in a practice in which you work.

Maximum yearly increase

The lesser of:

- 25% of your *sum insured* at the date you were last fully underwritten.
- The amount of your new mortgage or increase to the mortgage (where applicable).
- The value of your increased ownership in a practice in which you work (where applicable).
- $500,000.

The increase amount will be in addition to any increase that is the result of Cover Indexation (see page 16) and will be subject to the exclusions listed under 'When a benefit is not payable' (see page 31).

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

- your *sum insured* at the date you were last fully underwritten
- the current *sum insured* on a linked Life Cover plan less your current *sum insured* on your Trauma Cover plan; and
- $2,000,000 less your current *sum insured*.

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

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

The Future Needs Guarantee is not available if:

- you have a premium loading higher than 50% or you have more than one medical exclusion; or
- you're eligible, or about to be eligible, for a claim under Trauma Cover or a linked Life Cover and/or TPD Cover plan.

Other increases or decreases

It is possible to apply for a higher increase to your cover or a decrease, at any time. However, if you choose to increase your cover, we may request that you provide updated medical information. Increases to your cover are limited to the maximum *sum insured* allowed for your cover type (see 'Sum insured' on page 18 for further details).

Cover Indexation (Trauma Cover and Children's Cover)

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

Cover Indexation means that your *sum insured* for Trauma Cover and/or Children's Cover is automatically increased each year in line with the *CPI*. This feature helps to protect your cover against the effects of inflation.

Each year, you will be given the opportunity to decline the increase. If you do not decline the increase, your *sum insured* will increase and your premium will increase accordingly.

Any premium loadings, exclusions, or special terms applicable to your Trauma Cover and/or Children's Cover plans will also apply to increases exercised under this benefit.

Upgrade Guarantee (Trauma Cover and Children's Cover)

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

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

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

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

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

World Wide Cover (Trauma Cover and Children's Cover)

No matter where your medical career or personal life takes you, World Wide Cover means that you can rest assured you and your children are protected, regardless of where or when your death, illness or injury occurs.

Your Trauma Cover and Children's Cover plan will cover you 24 hours a day, anywhere in the world.

Guaranteed Renewable (Trauma Cover and Children's Cover)

The Guaranteed Renewable feature ensures you have the peace of mind knowing that your cover will remain the same, regardless of changes in health, provided you continue to pay your premiums when due.

Once your plan has been accepted, we cannot adversely alter its terms if your health, or the health of your child, declines while your Trauma Cover and/or Children's Cover plan is in place. You should note that we may still vary your premium in the circumstances set out under the heading 'Changes to premiums' on page 19 of this PDS.

Children's Cover Conversion (Children's Cover only)

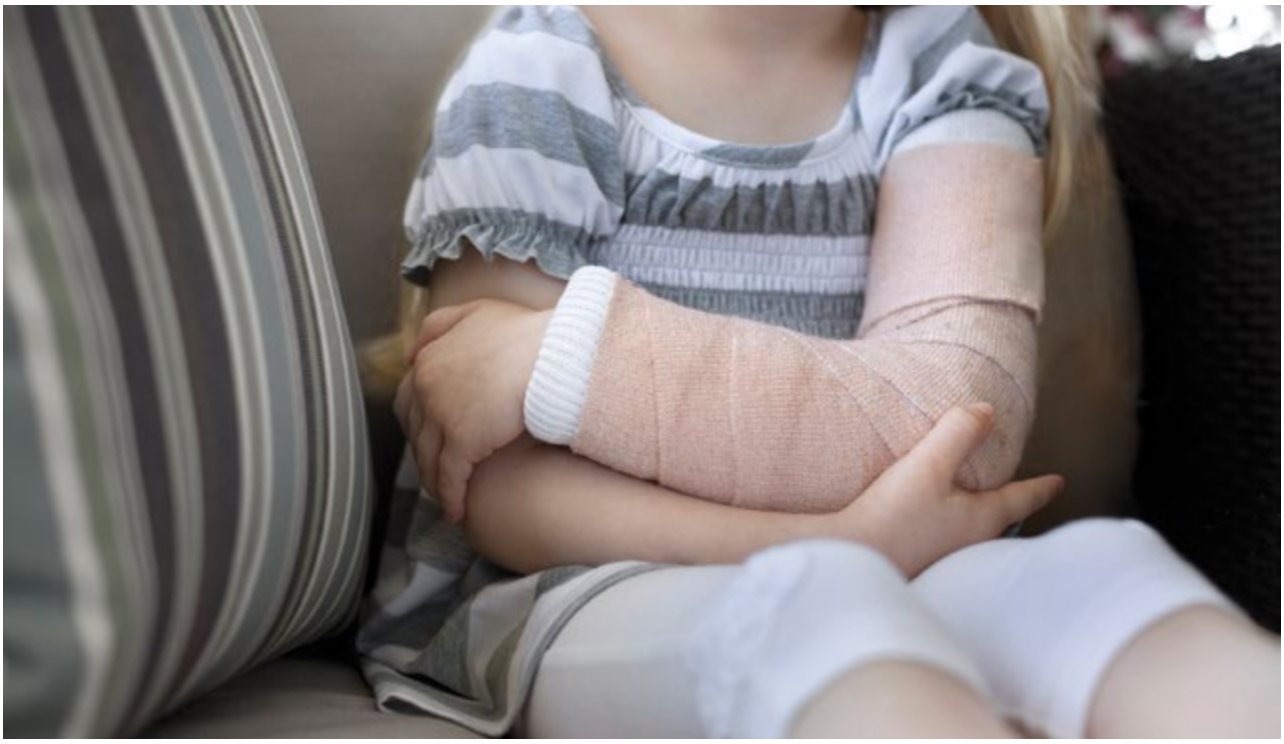
When you take out Children's Cover, you can know that you're purchasing the option to provide cover for your child's entire life, regardless of future health changes. Under our Children's Cover Conversion feature, we offer the opportunity for insured children to purchase their own Trauma Cover – Standalone plan or a Life Cover with Trauma linked plan, following their 21st birthday.

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

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

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

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



5. Options

Sum insured (Trauma Cover and Children's Cover)

Your *sum insured* is used to determine the lump sum benefit payment you will receive. Trauma Cover and Children's Cover give you the flexibility to choose the *sum insured* that best fits your needs or that you can afford, within defined limits.

You can select any *sum insured* between the limits in the following table:

Plan type	Minimum sum insured	Maximum sum insured
Trauma - Standalone Cover	$50,000	$2,000,000
Trauma - Linked to Life Cover	$50,000	$2,000,000 however no greater than the Life Cover plan that Trauma Cover is linked to.
Trauma - Linked to Life and TPD Cover	$50,000	$2,000,000 however no greater than the Life Cover or TPD Cover plan that Trauma Cover is linked to.
Children's Cover	$50,000	$200,000

Linked or standalone (Trauma Cover only)

If in addition to Trauma Cover, you also own Avant's Life Cover or Avant's Life Cover with TPD Cover, you may choose to structure your cover in one of three different ways. The structure you select will affect the premium you pay and what happens to your Life Cover or Life Cover with TPD Cover, in the event of a claim under your Trauma Cover plan.

There are three types of Trauma Cover for you to choose from:

- Trauma – Standalone Cover
- Trauma – Linked to Life Cover
- Trauma – Linked to Life and TPD Cover.

If you purchase Trauma –Standalone Cover, any claim that becomes payable under your Trauma Cover will not impact any other Avant Life Insurance plans you own.

If you purchase Trauma – Linked to Life Cover, any claim that becomes payable under your Trauma Cover will reduce the *sum insured* on your Life Cover plan by the amount of the benefit payment.

If you purchase Trauma – Linked to Life and TPD Cover, any claim that becomes payable under your Trauma Cover will reduce the *sum insured* on both your Life Cover and TPD Cover by the amount of the benefit payment.

The more plans your Trauma Cover is linked to, the lower your premiums will be.

Premium structure (Trauma Cover and Children's Cover)

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

As a general rule, if affordability today is your primary concern, stepped premiums will allow you to purchase what you need today for less money. However, if you intend to retain your Trauma Cover plan for the long term, level premiums may save you money and your premiums may become increasingly affordable over time.

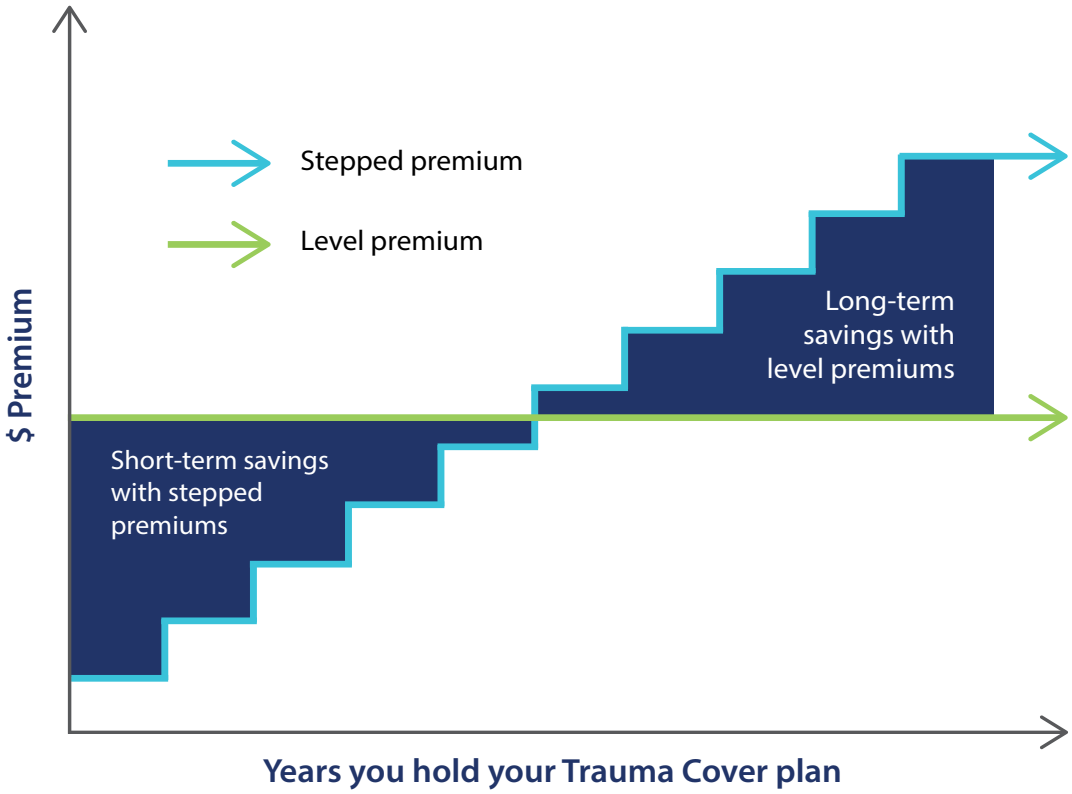
Only a level premium structure is available for Children's Cover.

Stepped premiums

If you select stepped premiums for your Trauma Cover plan, the amount you pay will generally increase at each plan *anniversary date* based on your age at the time of increase.

Level premiums

If you select level premiums for your Trauma Cover plan, 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* following your 65th birthday when they will convert to stepped premiums. Until this time, your premiums will only increase if you increase your *sum insured* or Cover Indexation is applied.



Children's Cover

Level premiums apply to Children's Cover. This means the amount you pay will be based on the age of your child at the plan commencement date.

Changes to premiums

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

Plan ownership (Trauma Cover and Children's Cover)

Legislation and taxation is often changing and there may be tax and/or cash flow reasons that make it beneficial for you to fund your Trauma Cover plan individually or through a company or trust. The choice is yours.

You can own a Children's Cover plan if you are the parent, grandparent or legal guardian of the insured child, provided you also own another Avant Life Insurance plan.

Trauma Cover

The two ownership options available for Trauma Cover are:

1. individual ownership – this can be the insured person or an individual aged 18 or over who is an Australian resident and has an insurable interest in the life of the insured person
2. ownership by a registered Australian corporation/ partnership/family trust which has an insurable interest in the life of the insured person.

If your Trauma Cover is linked to either a Life Cover plan and/ or TPD Cover plan, each plan can have different owners.

Ownership can be transferred from one entity to another throughout the life of your plan with the authority of the current owner.

Children's Cover

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

Ownership can be transferred from one person to another throughout the life of your plan with the authority of the current owner.

6. Complimentary interim cover (Trauma Cover and Children's Cover)

Once you have made the important decision to protect yourself and your family, you want to know your cover starts as soon as possible. This is why Avant's Trauma Cover and Children's Cover offer complimentary interim cover, subject to certain requirements, while your application is being processed. Your interim cover will commence as soon as your completed application and payment authority are received by us.

Interim cover benefits, features, options and conditions

As soon as we have received your completed application, you may be eligible for complimentary interim cover. All benefits, features and options of the Trauma Cover plan and/or Children's Cover plan that you have applied for are provided to you under your complimentary interim cover, subject to and in accordance with, the other provisions of Trauma Cover and Children's Cover.

Interim cover commencement date

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

Interim cover end date

Your interim cover ends on the earliest of:

- 4pm on the 90th day after the commencement date of interim cover
- the time and date we have accepted, declined or deferred your application
- the time and date your plan commences
- the time and date your application is withdrawn
- 4pm on the 14th day after notification is sent to you that cover applied for is subject to non-standard terms (such as a premium loading or an exclusion) and your acceptance of those terms has not been received
- 4pm on the 14th day after notification is sent to you that additional medical or financial information is required and those requirements have not been received.

Interim cover eligibility

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

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

Interim cover benefit amount

The interim Trauma Cover benefit amount will be the lesser of:

- the Trauma Cover *sum insured* you applied for; or
- the Trauma Cover *sum insured* we would have approved based on your application.

The interim Children's Cover benefit amount will be the lesser of:

- the Children's Cover *sum insured* you applied for; or
- the Children's Cover *sum insured* we would have approved based on your application.

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

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

- an intentional self-inflicted injury or act
- any cause that we would have applied as an exclusion or would not have accepted at all, under our usual underwriting and assessment guidelines.

If an interim Trauma Cover benefit is paid and your plan is or will be linked to Life Cover or Life Cover with TPD Cover, the amount of that benefit will reduce any benefit available under the linked plan/s.

Any notice of claim or payment made under interim Trauma Cover or interim Children's Cover will affect your application for these plans and as a result, your application may be declined.

7. When your cover starts and ends

Cover commencement date

Your Trauma Cover and Children's Cover plans will officially commence when we have approved your application and received your payment authority. Upon approval, we will provide you with a *plan schedule* that lists key information about your plan, its commencement date and the options you have chosen.

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

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

- the plan owner
- the insured person
- details of the insured person (such as gender, date of birth, occupation class and smoker status)
- the type of insurance provided
- your *sum insured*
- the cover commencement date
- any premium adjustments which apply
- any special conditions which apply to you in addition to those outlined within this PDS
- the premium payable for the following year and when it is payable.

Cooling-off period

If you're not completely satisfied that your Trauma Cover and/or Children's Cover plan will meet your needs, you may cancel it within 30 days of the commencement date for a full refund.

Simply contact us within the first 30 days of your plan's commencement date if you wish to cancel it. Provided you have not made a claim, we'll give you a full refund of any premiums you have paid.

When cover ends

As long as you pay your premiums when due, you can have the certainty of knowing that your current cover will continue until one of the below events occurs.

Your Trauma Cover plan will end on the earliest of:

- the plan *anniversary date* following your 70th birthday
- your death
- your *sum insured* is reduced to nil as a result of a benefit payment under a linked plan and you have previously exercised the Cover Reinstatement feature
- your request to cancel your plan is received by us (Note: if your Trauma Cover is linked to Life Cover, choosing to cancel your Life Cover will also cancel your Trauma Cover)
- we cancel your plan due to:
  - non-payment of premiums
  - your failure to comply with the duty of disclosure (as described on page 25)
  - a fraudulent claim
  - not meeting the eligibility requirements of your cover
- any other date applied under a special condition as shown on your *plan schedule*.

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

- the cancellation of the Avant Life Insurance plan which your Children's Cover plan is attached to
- the death of the insured child
- the plan *anniversary date* following the 21st birthday of the insured child
- the death of the plan owner
- the *sum insured* is reduced to nil as a result of a benefit payment
- your request to cancel your plan is received by us
- we cancel your plan due to:
  - non-payment of premiums
  - your failure to comply with the duty of disclosure (as described on page 25)
  - a fraudulent claim
  - not meeting the eligibility requirements of your cover
- any other date applied under a special condition as shown on your *plan schedule*.

Reinstatement

If your Trauma Cover and/or Children's Cover plan lapses as a result of missed premium payments, you may apply to us to have your cover reinstated.

You may apply to have your Trauma Cover and/or Children's Cover plan reinstated within one year of its lapse.

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

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

8. Applying for cover

Eligibility

Avant's Trauma Cover has been developed by doctors exclusively for doctors. If you're a *registered medical practitioner* between the ages of 20 and 60 who is currently employed, you are eligible to apply.

Avant's Children's Cover is available for the children or grandchildren of an insured person or plan owner of an Avant Life Insurance plan. The insured child must be between the ages of two and 16 to qualify.

To be eligible for Trauma Cover, at the time of application you must be:

- an Australian resident
- 20 to 60 years old
- a *registered medical practitioner.*

To be eligible for Children's Cover, the insured child must be:

- the child, grandchild or ward of an adult insured by, or the plan owner of, another Avant Life Insurance plan
- two to 16 years old.

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

Your application

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

To apply for Avant's Trauma Cover and/or Children's Cover, you first need to contact us on 1800 128 268 and we will refer you to an insurance advisor appropriate to your needs. Your insurance advisor will help with any questions you may have, outline the options that are available and provide you with a quote.

Once you are satisfied, your insurance advisor will assist you to complete and submit the application form, which includes questions about your health, financial situation, lifestyle and pastimes.

Duty of disclosure

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

Before we agree to issue your Trauma Cover and/or Children's Cover plan, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to provide your cover and on what terms.

You do not need to tell us anything that:

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

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

Non-disclosure

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

If you fail to comply with your duty of disclosure and we would not have entered into the insurance contract if you had told us, we may cancel your Trauma Cover and/or Children's Cover plan within three years of entering into it.

If we choose not to cancel your plan, we may elect to vary your plan 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 (as Children's Cover contains a Death Benefit, we may only reduce your Children's Cover *sum insured* within three years of the plan commencement date)
- varying the terms of your plan in a way that places us in the same position we would have been in if you had told us everything as required.

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

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

9. Paying for cover

Premiums

Your premium is the cost of Trauma Cover and/or Children's Cover. It is based on your, or the insured child's, individual circumstances at time of application such as age, gender, health and lifestyle, as well as the level of cover and options you have selected. If any risk factors change for the better after the plan has started, you can request a review and your premium may decrease.

How premiums are calculated

Your premium will depend on:

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

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

Premium illustration

You will be provided with an illustration that shows the cost of cover, options selected and any stamp duties that apply. You may also request a table of premium rates showing all rates and factors for Trauma Cover and/or Children's Cover. Further information on how premiums are calculated can be obtained by contacting us (see the back cover of this PDS for details).

Commission

Your insurance advisor works for a salary and does not receive a commission payment if you take out a Trauma Cover or Children's Cover plan with us. However, we may pay a level commission to the Australian Financial Services Licence (AFSL) holder for each year you hold your plan/s. If you receive personal advice, your insurance advisor will provide details of the commission payments in the Statement of Advice that they will give you. If commissions are paid, we pay these amounts out of your premium payments – they are not additional amounts you have to pay.

Taxation information

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

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

Payment options

Premiums can be paid by the following payment options:

	First payment	Monthly	Quarterly	Annually
Direct debit	Yes	Yes	Yes	Yes
Credit card	Yes	Yes	Yes	Yes
BPAY	No	No	No	Yes
Cheque	Yes	No	No	Yes

If you select to pay your premiums via credit card, we accept Visa and MasterCard.

Direct debit service agreement

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

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

The account holder understands and agrees that:

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

We agree that:

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

Disputes

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

Dishonoured debits

If a debit is unsuccessful, we will cancel the payment in respect of the dishonoured debit. In some instances, such as where your account has insufficient funds, we may notify you and attempt a second deduction from your account within 14 days. You should ensure that your account has sufficient funds before any second deduction. If we receive new information from you after a dishonour, we will process a one-off debit to pay the plan up to date. If two consecutive dishonours occur, we may cancel the authority. We may charge a dishonour fee to the relevant plan. Currently the fee is nil. The financial institution may also charge fees relating to the dishonour to the account, which is the account holder's responsibility.

Confidential information

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

Notices to us

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

10. Claims

How to make a claim

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

You should notify us as soon as reasonably possible after the occurrence of an event if you expect it will result in a claim. You can do this in the following ways:

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

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

Claim requirements

As well as your claim form, we may require additional information including the following items in a form satisfactory to us before we can make an assessment:

- your *plan schedule*
- evidence confirming the claimable event or condition and when it occurred
- supporting evidence from an appropriate specialist *independent medical practitioner* registered in Australia or New Zealand (or other country approved by us) if the claim is for illness or injury
- confirmatory investigations including, but not limited to, clinical, radiological, histological and laboratory evidence for illness or injury claims
- proof of your age.

Assessing your claim

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

You can rest assured that any future claim will be paid in accordance with the terms and conditions outlined in this PDS and the Avant Benefit Fund Rules.

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

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

When a benefit is not payable

You should be aware that exclusions apply to your Trauma Cover and/or Children's Cover plan. This means that in some cases, a claim may not be paid.

Trauma Cover exclusions

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

- the event was subject to a qualifying period and the *trauma date* occurred within that period
- you have previously received a benefit payment for that trauma event (excluding the exceptions outlined under 'Partial Trauma Benefit' on page 8)
- you have previously received a benefit payment for a trauma event and Trauma Cover has subsequently been reinstated (under the Cover Reinstatement feature) and the new trauma event is medically related to the original trauma event
- the event giving rise to the claim is caused directly or indirectly by an intentional, self-inflicted act
- the event giving rise to the claim occurred before the commencement date, reinstatement date or voluntary increase date (in respect of the increase amount only), unless clearly disclosed to and accepted by us
- the event giving rise to the claim was the direct or indirect result of any specific exclusion outlined on your *plan schedule*.

Children's Cover exclusions

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

- the event was subject to a qualifying period and the *trauma date* occurred within that period
- the event giving rise to the claim is caused directly or indirectly by a congenital condition that was present at or before the birth of the insured child
- a benefit payment for the same trauma event has already been paid (excluding the exceptions outlined under 'Children's Partial Trauma Benefit' on page 11)
- the event giving rise to the claim occurred before the commencement date, reinstatement date or voluntary increase date (in respect of the increase amount only), unless clearly disclosed to and accepted by us
- the event giving rise to the claim is caused directly or indirectly by an intentional, self-inflicted act
- the event giving rise to the claim is an inflicted act or omission by the plan owner or parent or guardian of the insured child
- the event giving rise to the claim was the direct or indirect result any of specific exclusion outlined on the *plan schedule*.

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

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

11. Additional information

Significant risks

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

There are a number of risks that you must be aware of before deciding to purchase Trauma Cover and Children's Cover including:

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

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

Further information

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

No cash value

Avant's Trauma Cover and Children's Cover do not have a surrender value or a cash-in value at any point.

Privacy

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

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

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

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

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

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

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

Complaints and dispute resolution

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

If you have a complaint about our service or your privacy in relation to Trauma Cover or Children's Cover, you can write to:
Avant Life Insurance, PO Box 746, Queen Victoria Building, NSW, 1230.

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

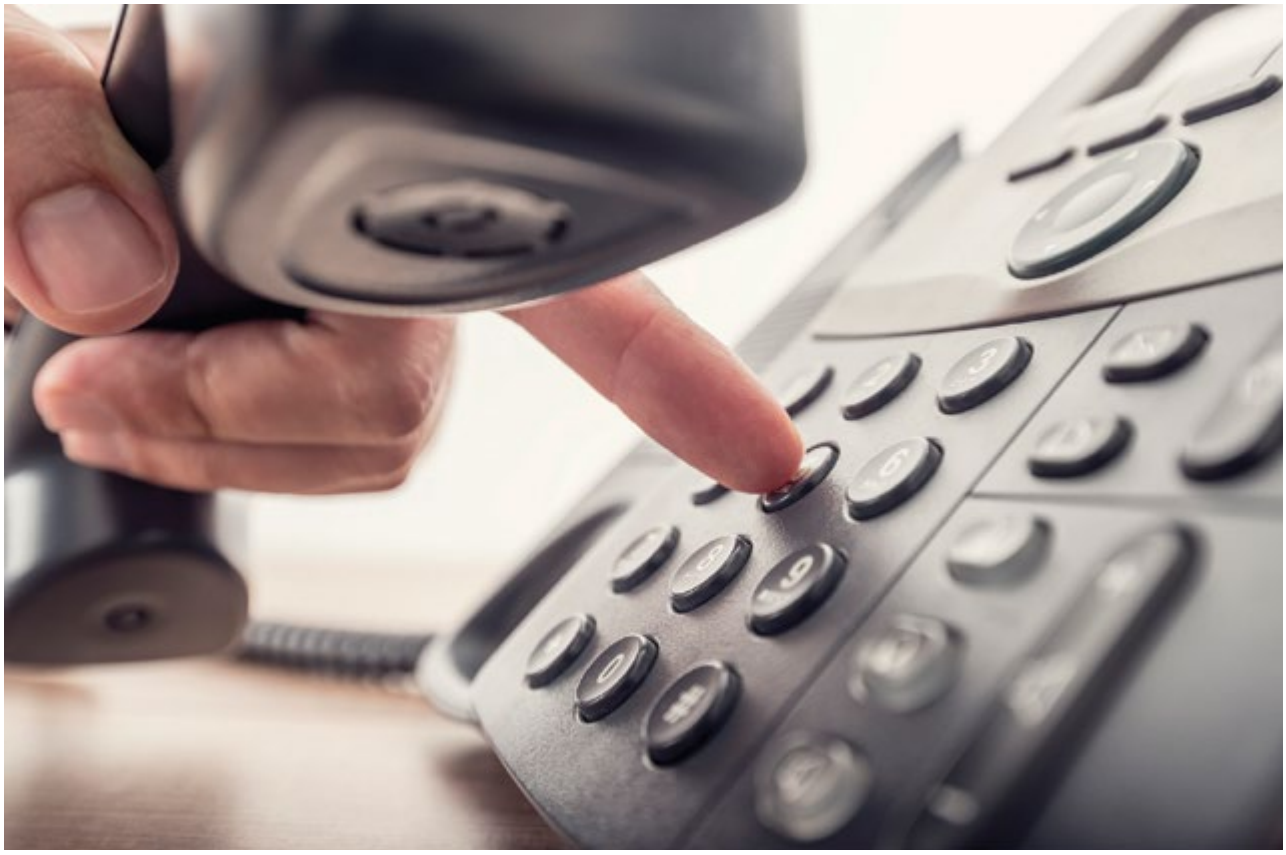
If your complaint has not been resolved to your satisfaction within 45 days of lodging your initial complaint (or, if you have agreed, within 90 days), you may contact the Financial Ombudsman Service (FOS).

The FOS 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 the FOS cannot deal with your complaint, however they can advise you of these circumstances.

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

The FOS can be contacted as follows:

- 1300 780 808
- (03) 9613 6399
- info@fos.org.au
- Financial Ombudsman Service, GPO Box 3, Melbourne, VIC, 3001.



12. Defined trauma events

Cardiac conditions

Full benefits	
Aortic surgery	Surgery performed to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta performed either by open surgery or by thoracoscopic or laparoscopic minimally invasive 'keyhole' techniques. All percutaneous angioplasty and all other intravascular techniques are excluded.
Cardiomyopathy	Impaired ventricular function resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.
Coronary artery bypass surgery	The actual undergoing of coronary artery bypass surgery, which is considered medically necessary to correct or treat coronary artery disease. Angioplasty, and other intra-arterial or laser procedures are excluded.
Heart attack	The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following: ➤ signs and symptoms of ischaemia consistent with myocardial infarction ➤ ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]) ➤ development of pathological Q waves in the ECG ➤ imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. If the above tests are inconclusive or our noted diagnostic techniques are impractical to apply or have been superseded, we will consider other appropriate and medically recognised tests. A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease is excluded. Also excluded are other acute coronary syndromes including but not limited, to angina pectoris.
Heart valve surgery	The undergoing of surgery considered medically necessary to repair or replace cardiac valves as a consequence of heart valve defects or abnormalities that cannot be corrected by non-surgical techniques.
Open heart surgery	The undergoing of a thoracotomy for treatment of cardiac defect(s), cardiac aneurysm or benign cardiac tumour(s).
Primary pulmonary hypertension	Primary pulmonary hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

Partial benefits	
Angioplasty	The undergoing of angioplasty on one or more coronary arteries to correct a narrowing or blockage that is considered the appropriate and necessary treatment on the basis of angiographic evidence.
Cardiac arrest (out of hospital)	Cardiac arrest that is not associated with any medical procedure, is documented by an electrocardiogram, occurs out of hospital and is: ➤ cardiac asystole; or ➤ ventricular fibrillation with or without ventricular tachycardia.

Cancers and tumours

Full benefits	
Benign brain tumour	The presence of a non-cancerous tumour in the brain or pituitary gland which produces neurological deficit causing: ➤ significant permanent impairment; or ➤ the undergoing of radical surgery for its removal.
Benign spinal cord tumour	The presence of a non-cancerous tumour in the spinal cord which produces neurological deficit causing: ➤ significant permanent impairment; or ➤ the undergoing of radical surgery for its removal.
Blood and lymphatic cancer	The presence of a leukaemia, lymphoma, Hodgkin's disease and other haemopoietic malignancies. Chronic lymphocytic leukaemia less than RAI Stage 1 is excluded.
Breast cancer	The presence of a malignant tumour in the breast, which is confirmed by histological examination. Carcinoma in situ of the breast is covered only if it requires: ➤ the removal of the entire breast ➤ breast conserving surgery and radiotherapy; or ➤ breast conserving surgery and chemotherapy where chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells.
Prostate cancer	The presence of a malignant prostate tumour, which is confirmed by histological examination, where it is: ➤ a TNM clinical classification of at least T2 ➤ a Gleason score of at least 6; or ➤ required to undergo one of the following three treatments to arrest the spread of the malignancy: • prostatectomy • radiotherapy • chemotherapy using drugs specifically designed to kill or destroy cancer cells.
Skin cancer	The presence of a malignant skin tumour, which is confirmed by histological examination, where the tumour: ➤ has metastasised to other organs ➤ is a malignant melanoma and at least Clark Level 3 depth of invasion ➤ is a malignant melanoma with at least 1mm Breslow thickness ➤ is a malignant melanoma where the melanoma is showing signs of ulceration.
Other cancer	The presence of a malignant tumour other than breast, prostate or skin cancer, which is confirmed by histological examination. The following cancers are specifically excluded: ➤ cancers described as carcinoma in situ other than carcinoma in situ of the testicle if treatment requires the removal of the testicle ➤ basal cell and squamous cell carcinomas.

Cancers and tumours (cont'd)

Partial benefits	
Benign brain tumour (diagnosed)	The diagnosis of a non-malignant tumour of the brain or pituitary gland. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.
Benign spinal cord tumour (diagnosed)	The diagnosis of a non-malignant tumour of the spinal cord. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.
Carcinoma in situ	A carcinoma in situ characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method. Only carcinoma in situ of the following sites is covered: ➤ cervix uteri (excluded are cervical intraepithelial neoplasia (CIN) classifications CIN-1 and CIN-2) ➤ corpus uteri ➤ fallopian tube – the tumour must be limited to the tubal mucosa ➤ penis or testicle ➤ perineum ➤ vagina, vulva or breast.
Lymphocytic leukaemia (early stage)*	The presence of chronic lymphocytic leukaemia diagnosed as Rai stage 0, which is defined to be in the blood and bone marrow only.
Melanoma (early stage)*	The presence of one or more malignant melanomas of 1mm or less maximum thickness as determined by histological examination using the Breslow method, or less than Clark Level 3 depth of invasion as determined by histological examination. The malignancy must be characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.
Prostate cancer (early stage)*	Prostatic cancers that are not covered under the definition of prostate cancer, and are histologically described as TNM classification T1 according to the TNM staging method or a Gleason Score of either 2, 3, 4 or 5.

Neurological conditions

Full benefits	
Alzheimer's disease	The unequivocal diagnosis of Alzheimer's disease confirming dementia due to failure of the brain function with cognitive impairment for which no other recognisable cause has been identified.
Cognitive loss	A total and permanent deterioration or loss of intellectual capacity (supported by a score of 15 or less out of 30 in a Mini Mental State Examination or evidence from another neuropsychometric test that is acceptable to us) that has required the insured person to be under continuous care and supervision by another person for at least three consecutive months and at the end of that three-month period, the insured person is likely to require ongoing continuous care and supervision by another person.
Dementia	The diagnosis of permanent and irreversible dementia by neurological assessment confirming cognitive impairment characterised by a Mini Mental State Examination score of 24 or less out of 30 or evidence from another neuropsychometric test that is acceptable to us.

Neurological conditions (cont'd)

Full benefits	
Encephalitis	An inflammatory disease of the brain resulting in neurological deficit causing: ➤ at least 25 per cent impairment of *whole person function* that is permanent; or ➤ total and permanent inability to perform, without the assistance of another person, at least one of the *activities of daily living*.
Major head trauma	Accidental cerebral injury resulting in permanent neurological deficit: ➤ causing significant permanent impairment; or ➤ which results in a permanent and irreversible inability of the insured person to perform, without the assistance of another person, any one of the *activities of daily living*.
Meningitis	All potential manifestations of bacterial meningitis causing: ➤ significant permanent impairment; or ➤ a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*.
Meningococcal disease	Meningococcal septicaemia resulting in: ➤ significant permanent impairment; or ➤ a permanent and total inability to perform without assistance of another person, at least one of the *activities of daily living*.
Motor neurone disease	The unequivocal diagnosis of motor neurone disease.
Multiple sclerosis	The unequivocal diagnosis of multiple sclerosis on the basis of confirmatory neurological investigation following more than one episode of confirmed neurological deficit.
Muscular dystrophy	The unequivocal diagnosis of muscular dystrophy.
Paralysis	The permanent and total loss of use of one or more limbs resulting from disease, illness or injury of the brain or spinal cord.
Parkinson's disease	The unequivocal diagnosis of Parkinson's disease leading to permanent neurological deficit.
Stroke	A cerebrovascular event producing neurological sequela lasting at least 24 hours. This requires clear evidence on a computerised tomography (CT), magnetic resonance imaging (MRI) or similar scan that a stroke has occurred and confirming either: ➤ infarction of brain tissue; or ➤ intracranial or subarachnoid haemorrhage. Cerebral symptoms due to transient ischaemic attacks, reversible neurological deficit, migraine, cerebral injury resulting from trauma or hypoxia, disturbances of vision or balance due to disease of the eye, optic nerve or the vestibular apparatus of the ear are excluded.

Partial benefits	
Brain surgery	Any medical condition that requires intervention through a craniotomy.
Coma	A state of unconsciousness with no reaction to external stimuli or internal needs, resulting in a documented Glasgow Coma Scale of 6 or less, for a continuous period of at least 72 hours.

Permanent conditions

Full benefits	
Loss of hearing	The total, irreversible and irreparable loss of hearing, in both ears, whether aided or unaided.
Loss of independence	The total and irreversible inability to perform at least two of the *activities of daily living* without the assistance of another person.
Loss of sight	The irrecoverable loss of sight of both eyes. The extent of the visual loss must be such that the eyesight is reduced to or less than 6/60 central acuity or degree of vision of less than or equal to 20 degrees.
Loss of a single limb	The entire and irrevocable loss of use of an entire hand or foot.
Loss of speech	The total and permanent loss of speech both natural and assisted as a result of illness or injury. Loss of speech related to any psychological cause is excluded.

Partial benefits	
Crohn's disease (severe)	The diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, and requires permanent immunosuppressive medication.
Loss of hearing in one ear	The total, irreversible and irreparable loss of hearing in one ear, whether aided or unaided.
Loss of sight in one eye	The irrecoverable loss of sight in one eye. The extent of the visual loss must be such that the eyesight is reduced to or less than 6/60 central acuity or degree of vision of less than or equal to 20 degrees.
Ulcerative colitis (severe)	The diagnosis of ulcerative colitis that has failed to be controlled by standard therapy including cortisone treatment, and requires permanent immunosuppressive medication.

Organ conditions

Full benefits	
Kidney failure (chronic)	End stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which permanent regular renal dialysis is instituted or renal transplant undertaken.
Liver failure (chronic)	The unequivocal diagnosis of end stage liver failure with the diagnosis based on: ➤ permanent jaundice or ascites; and ➤ encephalopathy or cirrhosis on liver biopsy.
Lung failure (chronic)	End stage lung disease, including interstitial lung disease requiring permanent oxygen therapy or FEV 1 test results of consistently less than one litre.
Organ transplant	The insured person: ➤ medically requires and undergoes the organ transplant ➤ 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: 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.
Pneumonectomy	The removal of an entire lung when considered necessary and appropriate treatment.

Blood conditions

Full benefits	
Aplastic anaemia	Bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment, with at least one of the following: ➤ blood product transfusions ➤ marrow stimulating agents ➤ immunosuppressive agents ➤ bone marrow transplantation.
Hepatitis B or C (occupationally-acquired)	Infection with hepatitis B or hepatitis C where the virus was acquired as a result of an *accident* occurring during the course of the insured person's normal occupation and sero-conversion from hepatitis B surface antigen negative to hepatitis B surface antigen positive or hepatitis C antibody negative to hepatitis C antibody positive occurs within six months of the *accident*. Hepatitis B or C infection acquired by any other means including sexual activity or recreational intravenous drug use is excluded. A benefit will not be payable in the event of a medical cure being found for hepatitis B or C (as applicable), or if the insured person elected not to take an available medical treatment which results in the prevention of infection with hepatitis B or C prior to making a claim. Any *accident* giving rise to a potential claim must be reported to us within seven days of the *accident* and supported by a negative hepatitis B surface antigen test or negative hepatitis C antibody test taken after the *accident*. We must be given access to test independently all the blood samples used.
HIV (medically-acquired)	Infection with the human immunodeficiency virus (HIV) which we reasonably believe to have arose from one of the following medically necessary events which must have occurred to the insured person in Australia by a recognised and registered health professional: ➤ a blood transfusion ➤ transfusion with blood products ➤ organ transplant to the insured person ➤ assisted reproductive techniques ➤ a medical procedure or operation performed by a doctor or dentist. HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use, is specifically excluded. A benefit will not be payable in the event that a medical cure is found for acquired immune deficiency syndrome (AIDS) or the effects of the HIV virus or in the event of a treatment being developed and approved which makes the HIV virus inactive and non-infectious.
HIV (occupatioally-acquired)	Infection with the human immunodeficiency virus (HIV) where the virus was acquired as a result of an *accident* occurring during the course of the insured person's normal occupation and sero-conversion of the HIV infection occurs within six months of the *accident*. HIV infection acquired by any other means, including sexual activity or recreational intravenous drug use, is excluded. A benefit will not be payable in the event of a medical cure being found for acquired immune deficiency syndrome (AIDS) or the effects of the HIV virus or in the event of a treatment being developed and approved which makes the HIV virus inactive and non-infectious. Any *accident* giving rise to a potential claim must be reported to us within seven days of the *accident* and supported by a negative HIV antibody test taken after the *accident*. We must be given access to test independently all the blood samples used.

Other events

Full benefits

Burns (severe)	Tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness) burns to at least: ➤ 20% of the body surface area as measured by The Rule of 9 or the Lund & Browder Body Surface chart ➤ 50% of each hand ➤ 50% of the face.
Diabetes (severe)	Severe diabetes mellitus, either insulin or non-insulin dependent, as certified by a consultant endocrinologist and resulting in at least two of the following criteria: ➤ severe diabetic retinopathy resulting in visual acuity uncorrected and corrected of 6/36 or less in both eyes ➤ severe diabetic neuropathy causing motor and/or autonomic impairment ➤ diabetic gangrene leading to surgical intervention ➤ severe diabetic nephropathy causing chronic irreversible renal impairment (as measured by a corrected creatinine clearance below the laboratory/ies measured normal range).
Intensive care	An illness or injury that has resulted in: ➤ the insured person requiring continuous mechanical ventilation by means of tracheal intubation for at least 10 consecutive days (and 24 hours every day) in an authorised intensive care unit of an acute care hospital; and ➤ significant permanent impairment.
Rheumatoid arthritis (severe)	The unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. The diagnosis must be supported by, and evidence, all of the following four criteria: ➤ at least a six-week history of severe rheumatoid arthritis which involves three or more of the following joint areas: • proximal interphalangeal joints in the hands • metacarpophalangeal joints in the hands • metatarsophalangeal joints in the foot, or any joint of the wrist, elbow, knee or ankle ➤ simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone) ➤ typical rheumatoid joint deformity ➤ at least two of the following criteria: • morning stiffness • rheumatoid nodules • erosions seen on X-ray imaging • the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis. Degenerative osteoarthritis and all other arthritidies are excluded.

Partial benefits

Diabetes (type 1 after age 30)	The unequivocal diagnosis of insulin dependent diabetes mellitus (IDDM) after the age of 30.

13. Defined terms

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

Activities of daily living means the following five activities:

1. Dressing – which means putting on and taking off clothing
2. Toileting – which means using the toilet, including getting on and off
3. Maintaining continence – which means having good control of bowel and bladder functions
4. Feeding – which means getting food from the plate into the mouth
5. Mobilising – which means moving from place to place by walking, wheelchair or with the assistance of a walking aid and getting in and out of bed, a chair or a wheelchair.

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

Consumer Price Index (CPI) means the consumer price index as defined and published by the Australian Bureau of Statistics (or anybody which succeeds it). It is a weighted average of the eight Australian capital cities combined, for successive 12 month periods, finishing on 30 September each year, or such other date as determined by us. The finishing date and *CPI* determined will be the same for all plan owners and members.

Independent medical practitioner means a medical practitioner who:

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

Medically related illnesses or injuries means only illnesses or injuries that are directly or indirectly related to a medical event or sequence of medical events, which caused a Trauma Benefit to be paid.

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

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

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

Terminal illness (and terminally ill) means:

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

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

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

Whole person function is as defined in the American Medical Association publication *'Guides to the Evaluation of Permanent Impairment'* 6th Edition.

Contact Information

For general enquires in relation to this PDS, a referral to an insurance advisor or the administration of your plan, please contact:

Avant Life Insurance

Phone: 1800 128 268
Fax: 1800 910 552
Mail: Avant Life Insurance, PO Box 746, Queen Victoria Building, NSW, 1230
Email: lifeadmin@avant.org.au

The issuer of this PDS is:

NobleOak Life Limited (NobleOak)

ABN: 85 087 648 708; AFSL: 247 302
Phone: 1300 551 044
Fax: (02) 9299 7852
Mail: GPO Box 4793, Sydney, NSW, 2001

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