Insurance claims guide

Income Protection Insurance

September 2023

IOOF Investment Management Limited (IIML) (ABN 53 006 695 021, AFSL 230524, RSE L0000406) is the trustee of the IOOF Portfolio Service Superannuation Fund (ABN 70 815 369 818) and the issuer of this Guide. IIML is a member of the Insignia Financial group of companies, comprising Insignia Financial Ltd (ABN 49 100 103 722) and its related bodies corporate.

We're here to help during a difficult time

We understand that making a claim can be daunting. That's why we want to help you understand the process.

The aim of this guide is to assist you when making a claim for Terminal Illness benefits. Keep in mind, this is a general guide, so some things may vary depending on individual circumstances, the trust deed and any policy.

Contents

The insurance policy

You'll find specific details about the terms and conditions of the insurance arrangement in the **Insurance Policy**.

If you'd like a copy of the **Insurance Policy** or **Insurance Guide**, please call us on 1800 913 118.

Do you have cover under other insurance policies?

It's important to check what other insurance policies you hold, particularly if you have more than one super account. If you have multiple insurance policies, you might be paying premiums for policies you don't need.

What's next?

In the following pages of this guide, you'll find claims process information to help you understand what's required to make a claim and what's involved at each step of the claims management process.

Support when you need it most

This Claims Guide will help you understand the process required for your claim, including how to start your claim as simply and quickly as possible so it can be assessed by the Insurer.

Our **Claims Philosophy** is to:

- communicate the process clearly
- treat our claimants, members and their beneficiaries with the utmost respect and empathy at all times
- do everything reasonable to pursue claims with the Insurer on the member's behalf that we consider have reasonable prospects of success, and
- make prompt payments on successful claims.

We adopt a professional, compassionate and positive approach to claims management and actively seek to keep members at the heart of everything we do. We acknowledge that each claim is unique and must be dealt with on its own merits and we're committed to being easy to deal with and providing outcomes to our members in a timely manner.

Managing your claim

Your claim is unique. That's why we'll take care to assess your personal situation on its own merits. When your claim is lodged with the Insurer, they'll appoint a dedicated claims assessor to guide you through the entire claims process. If you need help with the claims process, understanding what's required of you, completing claim forms or providing requested claim information, we'll work with you and the Insurer to find a solution.

You can appoint a representative to act on your behalf during the claims process.

We understand that making a claim can often be a challenging time. Our **Claims Philosophy** sets out our overall approach to managing claims in a respectful and empathic way for each unique claim made by our members. Be assured, if you're experiencing any personal or financial difficulties during this time, we'll take that into account in our dealings with you.

Important information and definitions

Role of the Trustee

As the Trustee, we have a duty to act in the best interests of all our beneficiaries. We'll do this by providing insurance arrangements that aim to help support you and your beneficiaries at a time when it is needed most.

Once you've supplied your requested information and documents, if we consider there is a reasonable prospect of success, we'll do everything reasonable to pursue your claim with the Insurer so that it's processed efficiently and fairly.

Role of the Insurer

The role of the Insurer is to provide us with insurance policies that support the insurance arrangements, and to assess, manage and pay claims covered by those policies.

We'll work with the Insurer to make sure that all successful claims are paid as quickly as possible.

Our Claims Process

Our insurance claims process typically has six key steps, and there are roles for us, the Insurer and you.

1. Make a claim
2. We check your eligibility
3. We submit your claim to the Insurer
4. The Insurer assesses your claim
5. We review the Insurer's decision
6. You'll be provided with an outcome

Step 1: Make a claim

If you want to make a claim, start by calling us on 1800 913 118 and we'll help you determine the best way to make a claim.

Step 2: We'll ask you some questions

We'll ask you some initial questions to make sure we send you the right claims documents.

If you need help with the claims process, understanding what's required of you, completing claim forms or providing requested claim information, we'll work with you and the Insurer to find a solution.

Remember, it's important to provide complete and correct details in your claims documents. If you've already submitted claims documents that may contain incorrect details, please contact us straight away.

Any information we collect will be handled in accordance with our Privacy Policy which can be found ioof.com.au/privacy

Step 3: We submit your claim to the Insurer

Within 10 business days of receiving your completed claims documents, we will:

- acknowledge receipt of your claim
- check if it contains all the required information,
- conduct another assessment of your eligibility to claim (including whether you have insurance cover) and,
- give the claim to the insurer or tell you why you cannot make a claim and give you a chance to respond.

If we need more information or we believe you aren't eligible to claim, we'll contact you. When we have all the information needed and we're satisfied you may be eligible to claim, we'll direct your claims documents to the Insurer.

Step 4: The Insurer assesses your claim

When the Insurer receives your claim documents, it will start assessing your claim and appoint a **dedicated claims assessor** to manage your claim. The Insurer may need more information to assess the claim. It may also ask you to attend medical or vocational assessments. We or the Insurer will let you know if that's the case.

During the Insurer's assessment of your claim, the Insurer will provide a progress update of your claim every 20 business days. Additionally, if you have any queries with regards to your claim, you can also contact your dedicated claims assessor throughout the assessment of your claim.

Review of additional information or submissions

During the process we may need your help or authority to seek additional information. The Insurer may contact you directly for further information. You may also need to attend independent medical examinations or interviews during the assessment of your claim.

If we obtain or are provided with new information for assessment, or you make further representations or provide further information, we will have another 15 business days from when we receive this to review the information.

Procedural Fairness

If the Insurer's view on your claim is unfavourable, you'll be issued a Procedural Fairness Letter which includes the following for you to review:

1. the information used by the Insurer to assess your claim, and
2. the potential barriers to your claim.

You'll be given an opportunity to comment or correct information or errors in the documents used to assess your claim.

It is important that the Insurer gives you the opportunity to review all of the material obtained and used in the review of your claim, as well as a right to reply.

Once a response is received by or a reasonable time to provide a response has elapsed, you will be contacted about the next step of the claim process.

Step 5: We review the Insurer's Decision

Once the Insurer has made a decision about your claim, they will refer the decision to us for review.

If your claim is accepted by the Insurer

Please refer to step 6.

If your claim is declined by the Insurer

We will complete a review of the Insurer's decision within 15 business days of receiving the Insurer's notification.

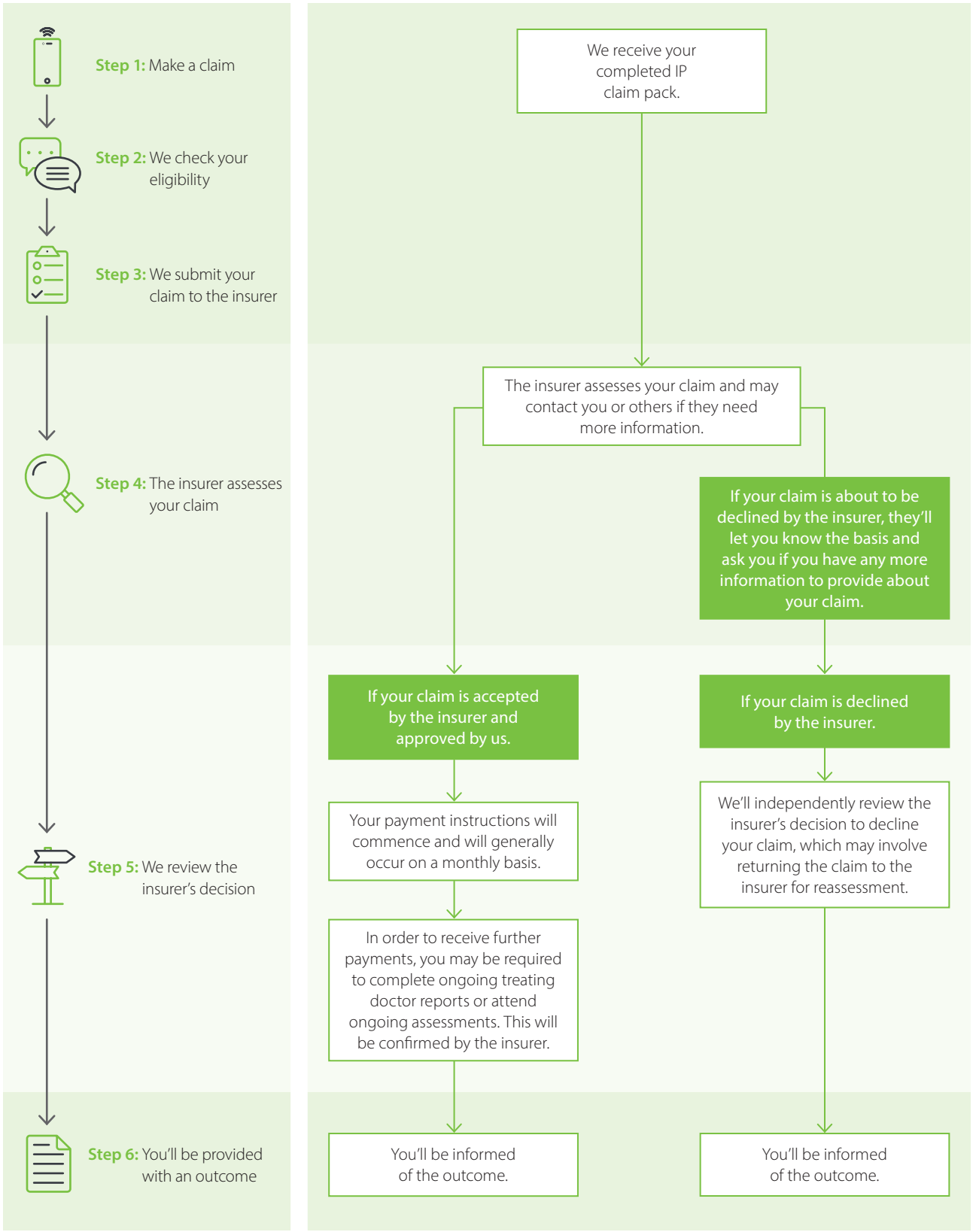
Once our review has been finalised and if we agree with the Insurer, we will notify you of this within 5 business days. We will also include any information relied on to form its view that has not already been provided to you.

If we disagree with the Insurer's decision to decline your claim, we will refer your claim back to the Insurer for reconsideration.

Step 6: You'll be provided with an outcome

Once we're satisfied with the Insurer's decision, we'll confirm the outcome of your claim in writing. If we require more time to assess your claim, we will ensure a progress update of your claim is provided every 20 business days.

Income protection claims process



Income protection FAQ

When would I make a claim?

You may start an IP claim if you're unable to work due to an illness or injury.

How will my claim be assessed?

There are different definitions which may apply to your claim. For example, you may be eligible to claim an IP benefit if the Insurer is satisfied that, due to illness or injury:

- You ceased being engaged in any occupation due to illness or injury, whether paid or unpaid
- You're totally unable to perform each and every income producing duty of your usual occupation, and
- you're under the ongoing regular care of a medical practitioner, and you're complying with the advice and following the treatment plan given by the medical practitioner

To find out which IP definition applies to you, refer to the **Insurance Guide**.

When won't a benefit be paid?

No Income arises from any of the following:

a intentional self-inflicted injury

b uncomplicated pregnancy or childbirth

c war or acts of war whether declared or not

d service in the armed forces of any national or international organisation (other than non-active service within Australian armed forces reserve units within Australia) where the service was in the five years prior to the Date of Disablement

e any exclusion or restriction the Insurer may apply to you as a condition of acceptance of cover.

Please refer to the **Insurance Guide** for more information when a benefit will not be paid.

What is Limited Cover and when does it apply?

Limited cover means that you are only covered for claims arising from an illness or injury where signs and symptoms first arose on or after the commencement date of your cover.

Limited cover generally applies to all new members and will cease once you are 'At Work' for either a period of 30 consecutive days or at least 24 months, depending on when your cover commenced.

For more information on this, please refer to your insurance letter where your conditions of cover are listed, or alternatively please contact us on 1800 913 118.

How long do I have to wait before I can make a claim?

You can lodge a claim immediately.

What information needs to be provided?

You, your doctors and employer will need to complete some of the following forms we'll send you:

- Illness or Injury Claim form (Completed by you)
- Tax File Number (TFN) Declaration (Completed by you)
- An Attending Doctors Statement (Completed by your treating doctor),
- Employer Statement (Completed by your employer)
- Claim Payment form
- Any payslips from employment for the past 12 months prior to the date of disability

When will I receive my first payment?

In order for payments to commence, your claim needs to have been approved, and you need to have been absent from work for your nominated waiting period (30, 60, or 90 days). You can check your waiting period online or on your annual statement. Payments are monthly and in arrears and are paid to your nominated bank account.

How long is my benefit paid for?

Depending on the terms of the policy, your benefit will be paid for a maximum of two or five years, or up to age 65 (if you continue to meet the relevant definition). You can check your applicable benefit period on your annual statement. Payment of a benefit will start to accrue from the first day after your waiting period has expired.

Will my premiums stop when I am on a claim?

Yes. Your IP premiums will be waived by the Insurer and we won't charge your super account. Once your claim has been finalised, your IP premiums may re-commence if you are eligible.

Can I claim on multiple policies?

It's important to check what other insurance policies you hold. For IP cover, you can generally only claim on one policy. If you have multiple policies, you might be paying premiums for policies you don't require or you're not eligible to claim on.

How much benefit will I receive and will my benefits be reduced (offset)?

IP insurance provides a monthly benefit while you're 'Totally Disabled'. The amount of monthly benefit payable will be the lesser of:

- 75% of your 'Monthly Income', and
- your agreed benefit (if any).

Also, your benefit may be offset. This means that the benefit amount is reduced if you receive other income while you are unable to work due to illness or injury. Examples of offsets include (but are not limited to) payments from:

- Another income protection insurance policy.
- Workers' compensation.
- Employer funded sick leave

Refer to your **Insurance Guide** (Limitations to Income Protection Benefits section) for more information on how benefits are calculated and examples of other income that may be offset against your benefit, as well as for details of terms such as 'Monthly Income', 'Totally Disabled' and 'At Work'.

How are benefits taxed?

If your claim is accepted, tax may be withheld from payments made to you. We do not provide tax advice, so you should seek personal tax and/or financial advice that takes in account your personal circumstances. A financial or tax adviser can provide advice taking into account your personal circumstances, needs and financial objectives.

What if I am unemployed?

No benefit is payable if you are unemployed on your Date of Disablement.

Resolving complaints

If you have a complaint about your claim please call us on 1800 913 118. If you'd prefer to put your complaint in writing, you can email us at Clientfirst@ioof.com.au or send a letter to GPO Box 264, Melbourne VIC 3001. We'll conduct a review and provide you with a response in writing.

If you're not satisfied with our resolution, or we haven't responded to you in 45 days, you can lodge a complaint with Australian Financial Complaints Authority (AFCA).

AFCA provides an independent financial services complaint resolution process that's free to consumers. You can contact AFCA at any time by writing to GPO Box 3, Melbourne, VIC 3001, at their website (afca.org.au), by email at info@afca.org.au, or by phone on 1800 931 678 (free call).

Case Study – IP Payments

How IP insurance helped Jill get back on her feet

Jill is a IOOF Employer Super member and has IP cover through the Fund.

She is 26 years old, a permanent full-time white collar employee and has a salary excluding super of $42,000. This is also her agreed benefit (as shown in her annual statements). Jill loves the outdoors and regularly goes rock climbing. However, one weekend while climbing, she falls and seriously injures her back. After an initial hospital stay of two months, her doctor informs her that she will need four months of in-hospital rehabilitation and a further nine months at home recuperating, before she can safely resume work. Jill immediately submits an IP claim. She is not receiving any amount (such as sick pay from her employer) that would offset her benefit.

Her benefit is calculated as follows:

Annual IP benefit
= Salary excluding super x 75%
= $42,000 x 75%
= $31,500

Monthly IP benefit
= $31,500 ÷ 12
= $2,625 per month

Jill is advised that her claim has been accepted and monthly payments will commence after the 90 day Waiting Period, when she will receive $2,625 per month (before tax) from her IP insurance.

Jill's claim timeline

- The date Jill was injured and unable to work and the commencement of the 90-waiting period – 1 April
- The day the 90-day waiting period expires – 30 June
- First benefit payment period – 30 June to 30 July
- First benefit payment date, made in arrears – 31 July

This helps cover Jill's living expenses, helping her focus on her recovery.

To contact us please call 1800 913 118 or email insurance@insigniafinancial.com.au

PLA-27038 (56583) 1023