Insurance claims guide

Total and Permanent Disability 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 Total and Permanent Disability (TPD) purchased through a Group Life insurance policy. Keep in mind, this is a general guide, so some things may vary depending on individual circumstances and your policy.

Contents

Support when you need it most 3
- Managing your claim 3
- Important information and definitions 3

Our Claims Process 4
- Step 1: Make a claim 4
- Step 2: We'll ask you some questions 4
- Step 3: We submit your claim to the Insurer 4
- Step 4: The Insurer assesses your claim 4
- Step 5: We review the Insurer's Decision 4
- Step 6: You'll be provided with an outcome 5

TPD claims process 5

Total and Permanent Disablement FAQ 6
- When would I make a claim? 6
- How will my claim be assessed? 6
- When won't a benefit be paid? 6
- What is Limited Cover and when does it apply? 6
- What forms need to be completed? 6
- Do I still pay premiums when I'm accepted for a TPD claim? 6
- What are the payment options if my TPD claim is approved? 6
- How are benefit payments taxed? 7
- Resolving complaints 7

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.

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 need 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 items 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 also 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 you 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

We will review the Insurer's decision within 5 business days of receiving the Insurer's notification. As part of our assessment, we will also assess whether you satisfy a condition of release for the funds to be released from the superannuation environment.

If your claim is declined by the Insurer

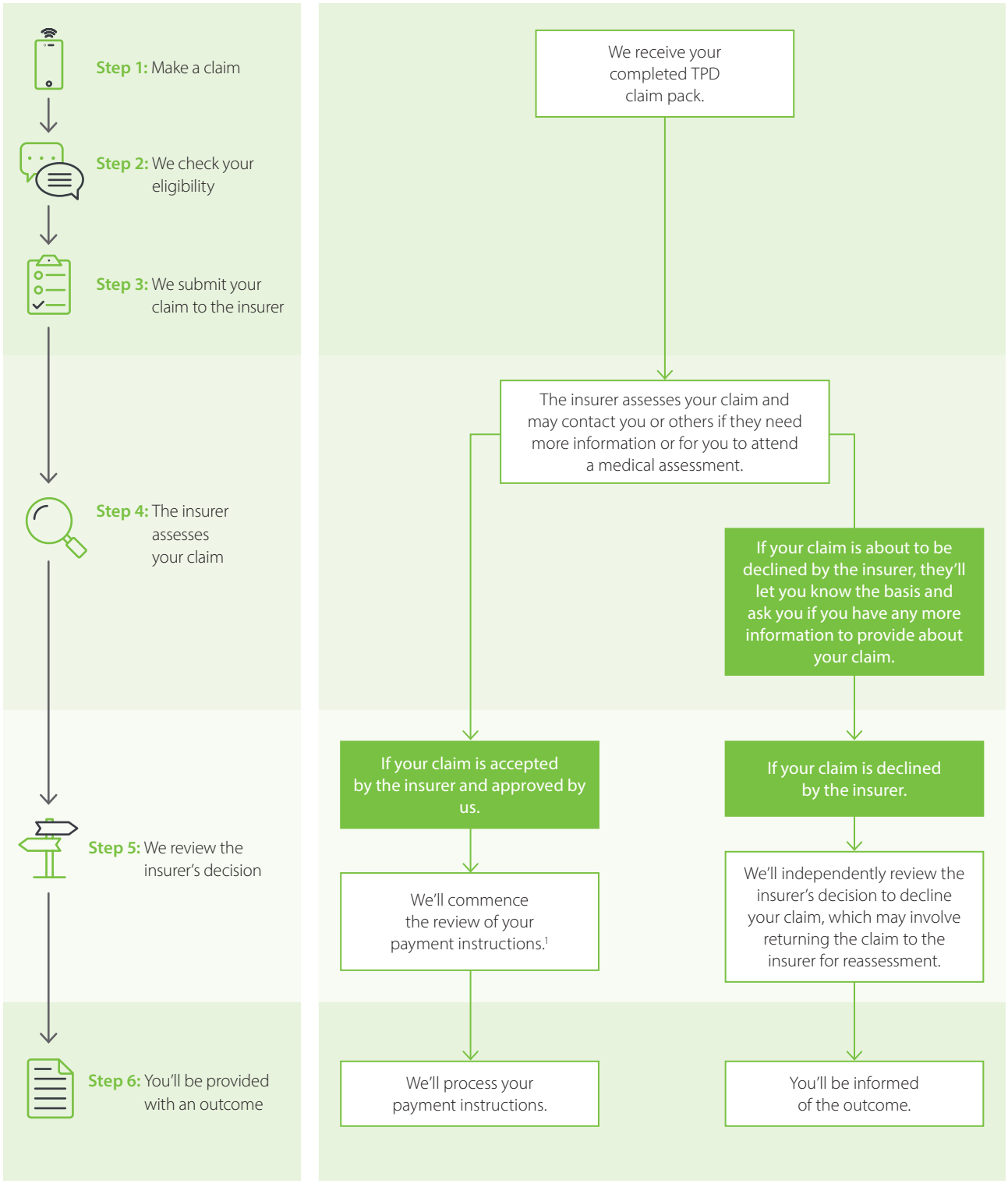
We will complete a review of the Insurer's decision within 15 business days of receiving the Insurer's notification. Once our review has been finalised and if we agree with the Insurer, we will notify you of this within 5 business days. We will also include any information relied on to form its view 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.

TPD claims process



1 A benefit can only be paid when a condition of release under the Superannuation Industry (Supervision) Act 1993 is met

Total and Permanent Disablement FAQ

When would I make a claim?

Generally, you must have stopped work for a specified period before you can lodge a TPD claim. You'll find more about this in the **Insurance Guide**.

How will my claim be assessed?

You will be assessed in accordance with the terms of the insurance policy applicable to you. Some of the common requirements for eligibility for a TPD benefit are that the Insurer is satisfied that:

- you ceased work solely due to an illness or injury, and
- you satisfy a TPD definition.

Depending on your employment before your disablement, different TPD definitions may apply to you. Your claim will be assessed differently depending on whether you have been working or not and sometimes depending on your occupation. To find out which TPD definition applies to you, refer to the **Insurance Guide**.

The Insurer will assess your claim under the definition that applies to you. Generally this will be based on your ability to perform any suitable occupation given your education, training or experience – not just the occupation you held when you became injured or ill.

When reviewing your claim and determining whether you're unable to work, the Insurer may consider various matters, including your level of education, any further study, qualifications and certifications you've obtained, as well as skills and abilities you've acquired through paid and unpaid work, as well as hobbies or interests.

When won't a benefit be paid?

Except for insurance cover provided under Customised Cover or Default Cover no insured TPD Benefit is payable where a claim arises:

1. from attempted suicide (excluding voluntary assisted dying) occurring in the first 13 months after the date that the cover commences or is reinstated after having lapsed for any reason, or
2. as a result of an intentional self-inflicted act or intentional self-inflicted injury by you
3. from any such exclusion as the Insurer may apply to you as a condition of acceptance of cover.

Please refer to the **Insurance Guide** for more information about 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 form 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.

What forms need to be completed?

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

- Claim form (Completed by you)
- Two Treating Doctors' Reports (Completed by your treating doctors),
- Employer Statement (to be completed by your employer).
- Your resume and your most recent job description.

Do I still pay premiums when I'm accepted for a TPD claim?

Your TPD cover will cease from the day your claim is approved and any premiums for this cover that are paid for the period after this date will be refunded to your super account.

What are the payment options if my TPD claim is approved?

Approved TPD claims are generally paid into your super account, where they stay in the cash account for 60 days, after which they are invested in line with your existing investment instructions unless you advise us otherwise.

You can also apply for the proceeds to be released to you in the following ways:

- as a lump sum
- as a pension (subject to some limits), or
- to another complying super/pension account, via a rollover.

We recommend that you seek financial advice.

How are benefit payments taxed?

The Trustee may be required by law to withhold tax from payments made. The tax treatment of your superannuation, including your TPD benefit, may differ depending on whether you retain it within your superannuation account, transfer to a pension account or withdraw it from superannuation.

However, 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.

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 the 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).

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

PLA-27038 (56577) 1023