LOCAL GOVERNMENT SUPER

Fact sheet

Voluntary insurance

Introduction

Insurance is all about investing in peace of mind, as it helps to provide financial support in times of sickness, injury, disablement or death.

As a member of Local Government Super (LGS), you may have some basic insurance cover. However, this may not be enough to cover you and your family in times of need. For this reason, LGS provides additional voluntary insurance cover at competitive rates. This fact sheet explains the features of LGS's voluntary insurance cover, and how you can apply for it.

Important

Our voluntary insurance cover is provided through a group insurance contract with TAL Life Ltd (ABN 70 050 109 450, AFSL 237848) (Insurer). The Insurer is a specialist Australian life insurance company and an industry leader in the provision of life insurance arrangements to superannuation funds and administration platforms and is widely acknowledged in the market as a provider of quality products with superior service.

Cover is available at competitive rates and is underwritten by the Insurer on an individual member basis. Cover does not commence until the Insurer notifies you that they have accepted your cover or until you have accepted any conditions they have put on that cover if applicable.

From 1 July 2019, the government has introduced new legislation under the 'Protecting your super' package. Members who have not received contributions for 16 months or more will have their insurance cancelled unless they 'opt-in'. Furthermore, if a member's balance is under $6,000 and they have not received a contribution for 16 months, made or changed a binding beneficiary, changed their insurance arrangements, or declared they are not 'low balance inactive' members, thei insurance will be cancelled and their super account transferred to the Commissioner of Taxation.

From 1 April 2020, in accordance with the Putting Members' Interests First (PMIF) legislation, new members joining the fund must be at least 25 years of age and have at least $6,000 in their super account to receive automatic insurance cover. Members can apply for voluntary cover at any time.

The Trustee regularly reviews the insurance arrangements to ensure you have access to a market competitive voluntary insurance package. This fact sheet should be read in conjunction with the LGS Accumulation Scheme Product Disclosure Statement, available at lgsuper.com.au/PDS or from Member Services on 1300 LGSUPER (1300 547 873).

General information

What types of cover are available?

There are three types of voluntary insurance:

1. Lump Sum Death Only Cover
2. Lump Sum Death and Total and Permanent Disablement (TPD) Cover
3. Salary Continuance Insurance (SCI) Cover, available for either a two-year period or until age 65. This provides income protection for disablement, regardless of whether it is temporary or permanent.

In addition, Interim Accident Cover is available. Please refer to page 10 for more information on Interim Accident Cover.

Who can apply for cover?

Any member of the LGS Accumulation Scheme who is an Australian Resident can apply for:

- Lump Sum Death Only Cover (if aged between 15 and 70)
- Lump Sum Death and Total and Permanent Disablement Cover (if aged between 15 and 70)
- Salary Continuance Insurance Cover (if aged between 15 and 64 and working more than 15 hours per week).

How are premiums calculated and paid?

The premium you pay depends on the amount of cover you take, your age, gender, occupational classification and health status.

Premiums are deducted each month from your account, provided it has a sufficient balance.

What are the occupational classifications?

There are five occupational classifications for calculating premiums:

Class 1 Heavy Manual (Unskilled): Any occupation involving manual work that does not require qualifications or any supervisory element, e.g. garden maintenance or road workers.

Class 2 Heavy Manual (Skilled): Occupations involving manual work where the person holds trade qualifications or is in a supervisory capacity, e.g. tradesmen, linesmen or roadwork supervisors.

Class 3 Light Manual: Those occupations that are predominantly sedentary, but may involve up to 20% of light manual activity, e.g. retail sales or industry sales representative.

Class 4 White Collar: Occupations involving no manual work, e.g. clerical, administrative, managerial or some sales.

Class 5 Professional: Totally white-collar sedentary occupations where the individuals have tertiary qualifications that apply to their current occupation, or are in executive or managerial positions earning $100,000 or more per annum. The earning threshold may be reviewed annually in line with salary inflation.

Some members may not be eligible for cover due to risk factors, such as their condition of health or the high risk nature of their occupation. The above classifications are guidelines only and the final

determination is at the Insurer's discretion. The Insurer determines your occupational classification from the information you provide on your application for cover.

If you change occupations or believe that your current occupational classification is incorrect, it is your responsibility to contact us immediately.

What happens if you cease employment?

If you cease employment with your local government employer, your monies will be transferred to the Accumulation Scheme Public Offer division and any voluntary insurance you have taken out will continue, provided you have a sufficient balance in your LGS account to cover the premiums.

How do I apply for cover?

You apply by completing the *Voluntary Insurance Application* form which is available at lgsuper.com.au/forms or by calling from Member Services on 1300 LGSUPER (1300 547 873). Please note that if your application is incomplete, the processing of your application will be delayed, and may result in your application being denied.

Claiming a benefit

Please immediately advise LGS of any potential claims to enable a more efficient assessment. If you incur costs in completing the claim form, they are not recoverable from LGS.

The Insurer can ask you to attend an examination by a medical practitioner, another relevant professional of its choosing, or provide further medical evidence as often as it reasonably requires in order to substantiate the commencement or continuation of a disability or disablement. The Insurer can also ask you to have a blood test or similar test to determine your health status. You will be liable for any fees arising from non-attendance, but otherwise the Insurer will meet the costs of any medical assessment requested.

What Waiting Periods are involved when claiming a benefit?

The Waiting Period when claiming a benefit, is the period where you are not working due to a disability and you cannot receive a benefit until it is satisfied.

For SCI, the Waiting Period is a continuous period of either 30, 60 or 90 days commencing on the first day of Total Disability depending on your cover.

What role does the Insurer play?

LGS provides voluntary insurance cover via a group insurance policy taken out with the Insurer.

As such, the Insurer assesses an application and decides whether to accept or reject that application. The Insurer may decline to accept your application unconditionally, or they may accept it subject to specified restrictions or premium loadings.

The premiums deducted from your member account for voluntary insurance cover are paid to the Insurer each month.

The Insurer also assesses all claims for benefits, but all benefits are paid to LGS in the event of a successful claim, and LGS then arranges for payment to you.

Check your insurance details are correct

It is important that you ensure your account balance can cover your premiums each month or your insurance will lapse. LGS does not accept responsibility or liability for ensuring your insurance cover does not lapse if you do not maintain sufficient funds to pay premiums.

It is important to check your LGS member statements to ensure your desired level of insurance cover is recorded. In some instances, you may receive a level of cover that is less than what you applied for due to the Insurer's assessment of your particular circumstances. Contact us immediately if you believe your level of cover is different from what you expected.

LGS and the Insurer rely on being kept informed of your situation to ensure that you are still eligible for cover. If you cease to be eligible and you have not notified LGS, you may still receive an LGS member statement showing a level of cover that you do not have.

Death Only Cover

Who can apply?

Any member of the LGS Accumulation Scheme who is an Australian Resident aged between 15 and 70 is eligible to apply for Death Only cover.

What cover is available?

You can nominate any amount of cover in $1,000 multiples. The minimum Death Only cover is $50,000 and there is no maximum Death Only cover amount.

What is the cost?

The cost of Death Only cover depends on your age, gender, occupational classification, health status and the amount of cover selected by you and approved by the Insurer. Premiums are calculated each month and adjusted when you have a birthday or change your level of cover.

The cost of cover is determined by first calculating the Base Premium. The Base Premium is calculated by multiplying the amount of cover (as multiples of $1,000) by the Premium Rate for your age (set out in the Base Premium rates table on page 19).

Once the Base Premium has been calculated, it is multiplied by the Rating Factor (see the table on the next page) which will give you your Annual Premium. To calculate the monthly premium, simply divide the annual premium by 12.

A summary of the three steps to calculating your monthly premium is shown below:

1. **Base Premium** = (Amount of cover / $1,000) x Premium Rate
2. **Annual Premium** = Base Premium x Rating Factor
3. **Monthly Premium** = Annual Premium / 12

To assist you with your calculations, an insurance calculator is available at lgsuper.com.au

The Insurer may adjust the premiums after assessing your application for cover.

Rating Factors (Death Only cover)

Occupation Category	5	4	3	2	1
Rating Factor	0.90	1.00	1.00	1.25	1.50

When is a benefit payable?

A benefit is payable if you die or become terminally ill while insured for Death Only Cover.

Terminal Illness benefit

If you are an insured person with death cover in force and you become terminally ill the Insurer will pay you the Sum Insured that applies to your cover up to a maximum of $2,500,000.

Terminal Illness and Terminally Ill means:

a) two Medical Practitioners have separately certified in writing, that an Insured Person suffers from an Illness, or has incurred an Injury, that is likely to result in the death of the Insured Person within a period ('the certification period') that ends not more than 12 months after the date of the certification;
b) at least one of the registered Medical Practitioners is a Specialist Medical Practitioner practicing in an area related to the Illness or Injury suffered by the Insured Person;
c) the Illness and certification referred to in paragraph (a) occurs while the Member continues to have cover under the Policy;
d) for each of the certificates, the certification period has not ended; and
e) the Insurer is satisfied, on medical or other evidence, that despite reasonable medical treatment, the Illness or Injury will lead to the Insured Person's death within 12 months of the date of the certifications.

If the amount paid to you as a result of terminal illness is the Whole Sum Insured then your cover will cease. However, if the amount paid is less than the Whole Sum Insured, then cover will continue in force for the remaining balance of the Whole Sum Insured subject to the conditions of the policy.

When does cover cease?

Cover ceases when the earliest of the following occurs:

- You reach age 71;
- The Insurer accepts a Death or a Terminal Illness[1] claim for you under this Policy or a Total and Permanent Disablement claim is paid which is higher than your Death cover;
- Sixty (60) days after the premium due still remains unpaid 180 days after date joined fund if a contribution has not been received for new members;
- You request to cancel your insurance cover – this will take effect on the date nominated by you or the date we receive the notification – whichever is the later date;
- Your account has been inactive for 16 months and you have not opted-in to keep your insurance;
- You cease to be a member of LGS;
- In the event of your death; or
- The policy is terminated by LGS or the policy is cancelled by the Insurer (appropriate notice of this change would be given).

[1] If an amount is paid as the result of a claim under this condition and is less than the Whole Sum Insured, cover will continue in force, subject to the conditions of the policy but only for the remaining balance of the Whole Sum Insured.

Exclusions

No benefit is payable:

- for a death claim arising directly or indirectly from suicide within the first 12 months of acceptance of cover; or
- for any event in respect of which the Insurer has placed an individual exclusion on cover; or
- where death or terminal illness is directly or indirectly caused by service in the armed forces of any national or international organisation other than the Australian Armed Forces Reserve; or
- for a claim arising directly or indirectly from an illegal or criminal act committed by the Insured Person; or
- for a terminal illness arising from an intentional self-inflicted act or intentional self-inflicted injury

Death and Total and Permanent Disablement Cover

Who can apply?

Any member of the LGS Accumulation Scheme who is an Australian Resident aged between 15 and 70 is eligible to apply for Death and TPD cover.

What cover is available?

You can nominate any amount of cover in $1,000 multiples. The minimum cover is $50,000. Note that the maximum cover levels are as follows:

- Death cover = no maximum
- Death & TPD cover = $3,000,000.

What is the cost?

The cost of Death and TPD cover depends on your age, gender, occupational classification, health status and the amount of cover selected by you and approved by the Insurer. Premiums are calculated each month and adjusted when you have a birthday and/or change your level of cover.

The cost of cover is determined by first calculating the Base Premium. The Base Premium is calculated by multiplying the amount of cover (as multiples of $1,000) by the Premium Rate for your age (set out in the Base Premium rates table on page 19).

Once the Base Premium has been calculated, this is multiplied by the Rating Factor (see the table on the next page) which will give you your Annual Premium. To calculate the monthly premium, simply divide the annual premium by 12.

A summary of the three steps to calculating your monthly premium is shown below:

1. **Base Premium** = (Amount of cover / $1,000) x Premium Rate
2. **Annual Premium** = Base Premium x Rating Factor
3. **Monthly Premium** = Annual Premium / 12

To assist you with your calculations, an insurance calculator is available at lgsuper.com.au

The Insurer may adjust the cost after assessing your application for cover.

Rating Factors (Death and TPD cover)

Occupation Category	5	4	3	2	1
Rating Factor	0.90	1.00	1.25	1.60	2.00

When is a benefit payable?

A death benefit is payable if you die or become terminally ill while insured for Death and TPD cover.

The following definition of TPD applies when the disablement occurs on or after 1 December 2015. If the date of disablement is prior to 1 December 2015, the previous definition applies. Please contact Member Services on 1300 LGSUPER (1300 547 873) for more information.

TPD means one of the following as determined by the terms of the Policy:

Definition 1: Education, Training or Experience

means that the Insured Person:

A. solely and directly as a result of Illness or Injury, has been continuously absent from engaging in or, being unemployed, unable to accept employment in:
   i. their occupation; and
   ii. any other occupation,

   for an uninterrupted period of at least six consecutive months immediately following the Date of Disablement;
B. is regularly attending and under the ongoing and appropriate care and treatment of a Medical Practitioner with respect to the Illness or Injury; and
C. in the Insurer's opinion is disabled to such an extent as to render them incapable of ever engaging in any occupation for which the Insured Person;
   a) is at the end of the six consecutive month period; and
   b) is by the time the Insurer forms their opinion, or can be expected following the time the Insurer forms their opinion, to become, reasonably suited by education, training or experience. In forming their opinion, the Insurer will have regard to factors including but not limited to:
      i. any rehabilitation, retraining, re-skilling, work or voluntary work that has been undertaken by the time the Insurer forms their opinion, or could reasonably be expected to be undertaken by the Insured Person within a reasonable time period; and
      ii. all evidence available to the Insurer for the period up to the time the Insurer form their opinion.

Definition 2: Everyday Working Activities

means where the Insured Person, in the Insurer's opinion:

A. solely and directly as a result of Illness or Injury which occurred after cover has commenced is permanently unable to perform at least three of six Everyday Working Activities without the physical assistance of another person, despite the use of appropriate assistive aids and appropriate prescribed medication and that permanent inability has lasted for at least an uninterrupted period of six consecutive months or more immediately following the Date of Disablement; where Everyday Working Activities means Mobility, Rising/Sitting, Communicating, Vision, Lifting and Manual Dexterity and:
   - **Mobility** means the ability to walk more than 200m on a level surface without stopping due to breathlessness or severe pain in the body

- **Rising/Sitting** means the ability to rise and sit using a chair with arms without the help of another person
- **Communicating** means the ability to hear (with hearing aid or other aid if normally used) and speak with sufficient clarity to be able to hold a conversation in a quiet room in the Insured Person's first language
- **Vision** means visual ability such that when tested (using visual aids if required), vision is measured at greater than 6/60 in the better eye using a Snellen eye chart.
- **Lifting** and carrying means the ability to lift (from bench height) and carry a 2kg weight, 10m and place back down at bench height
- **Manual Dexterity** means the Insured Person can use either or both hands or fingers to manipulate small objects with precision (such as picking up a coin or fastening shoelaces or buttons, using cutlery, or using a pen or keyboard; and

B. is regularly attending and under the ongoing and appropriate care and treatment of a Medical Practitioner with respect to the Illness or Injury;
C. is Permanently Incapacitated.

Definition 3: Domestic Duties

means that the Insured Person:

A. solely and directly as a result of Illness or Injury:
    i. is unable to perform unpaid Domestic Duties; and
    ii. has not engaged in any Gainful Employment for a period of six consecutive months immediately following the Date of Disablement;
B. is unable to leave their home without the physical assistance of another person;
C. is regularly attending and under the ongoing and appropriate care and treatment of a Medical Practitioner with respect to the Illness or Injury; and
D. in the Insurer's opinion, is disabled to such an extent as to render them incapable of ever engaging in:
    a) those Domestic Duties; or
    b) in any Gainful Employment for which the Insured Person:
        i. is after six consecutive months immediately following the Date of Disablement; and
        ii. is by the time the Insurer form their opinion, or can be expected following the time the Insurer form their opinion, to become, reasonably suited by education, training or experience.

    In forming their opinion, the Insurer will have regard to factors including but not limited to:
        i. any rehabilitation, retraining, re-skilling, work or voluntary work that has been undertaken by the time the Insurer form their opinion, or could reasonably be expected to be undertaken by the Insured Person within a reasonable time period;
        ii. all evidence available to the Insurer for the period up to the time the Insurer forms their opinion.

Important note:

In the above definition, Domestic Duties means the unpaid duties performed by a person and may include (but are not limited to):

a) purchasing cleaning items;
b) cleaning the family home;
c) laundering and ironing clothing items for the household;
d) purchasing food items and preparing meals for the household; or
e) undertaking child rearing at the family home.

Insured Persons who are Gainfully Employed, seeking Gainful Employment or are performing unpaid Domestic Duties on less than a full-time basis will not be deemed to be performing Domestic Duties.

When does each TPD definition apply?

Definition 1 or Definition 2 applies:

for an Insured Person whose claim has been notified to the Insurer within five years of their Date of Disablement and who:

- at the Date of Disablement is less than 65 years of age; and
- was working 15 hours or more per week immediately prior to their Date of Disablement (averaged over the last 12 months) or earlier as determined by the Insurer.

Definition 2 applies:

for an Insured Person who:

- at their Date of Disablement is 65 years of age or more; and/or
- who was working less than 15 hours per week immediately prior to their Date of Disablement (averaged over the last 12 months) or earlier as determined by the Insurer; and/or
- notified the Insurer of their claim more than five years after their Date of Disablement.

Definition 3 applies:

for an Insured Person whose claim has been notified to the Insurer within five years of their Date of Disablement and who:

- at the Date of Disablement is less than 65 years of age; and
- immediately prior to the Date of Disablement, was not Gainfully Employed and was at home performing unpaid Domestic Duties.

Permanently Incapacitated

The TPD definition (Definition 2: Everyday Working Activities) contains a reference to an Insured Person being Permanently Incapacitated.

In order for a member to be considered to be Permanently Incapacitated the Insurer must be reasonably satisfied that the Insured Person's ill-health (whether physical or mental) makes it unlikely that the Insured Person will engage in Gainful Employment for which the Insured Person is reasonably qualified by education, training or experience.

Gainfully Employed/ Gainful Employment

Gainfully employed means employed for gain or reward, or in the expectation of 'gain or reward' in any business trade, profession, vocation, calling, occupation or employment.

Note: 'gain or reward' envisages the receipt of remuneration such as salary, wages, business income, bonuses, commissions, fees or gratuities, in return for personal exertion.

When does cover cease?

Cover ceases when the earliest of the following occurs:

- you reach age 71;
- in the event of your death;
- the Insurer accepts a TPD claim for you under this Policy, in which case a benefit is paid;
- 60 days after the premium due still remains unpaid;
- you request to cancel your insurance cover – this will take effect on the date nominated by you or the date we receive the notification – whichever is the later date;
- Your account has been inactive for 16 months and you have not opted-in to keep your insurance;
- you cease to be a member of LGS; or
- the policy is terminated by LGS or the policy is cancelled by the Insurer (appropriate notice of this change would be given).

Exclusions

No benefit is payable:

- for a death claim arising directly or indirectly from by suicide within the first 12 months of acceptance of insurance cover, or
- for TPD as a result of an intentional self-inflicted act or intentional self-inflicted injury, or
- for any event in which the Insurer has placed an individual exclusion on cover, or
- where death, Terminal Illness or Total and Permanent Disablement is directly or indirectly caused by service in the armed forces of any national or international organisation other than the Australian Armed Forces Reserve, or
- for a claim arising directly or indirectly from an illegal or criminal act committed by the Insured Person.

Interim Accident Cover for Death and TPD

What cover is available?

Interim Accident Cover is provided for up to 90 days while your application for cover is being assessed. Therefore, Accidental Death cover is available while your application for Death Only cover is being assessed, and the Accidental Total and Permanent Disablement cover is available while your application for TPD cover is being assessed.

Cover commences on the date the Insurer receives your fully completed personal statement.

Accidental Death is defined as death occurring directly from an accident. Accidental TPD is defined as total and permanent disablement occurring directly from an accident. Accident means an unforeseen violent, external and visible event that occurs accidentally during the period of Interim Accidental cover.

When does Interim Accident cover cease?

Interim Accident cover ceases when the earliest of the following occurs:

- The Insurer accepts or declines your application for cover;
- Your application for cover is withdrawn;
- LGS receives your completed and signed acceptance of any additional terms which apply to an offer of cover;
- You cease to be eligible to apply for the cover, i.e. you cease to be a member of LGS or you reach age 71;
- Ninety (90) days after the insurer receives your fully completed Personal Statement;
- You are no longer eligible for cover; or
- The policy is terminated by LGS or the policy is cancelled by the Insurer (appropriate notice of this change would be given).

What is the amount of Interim Accident cover?

The amount of Accident cover is the lesser of:

- the amount of cover that you have applied for, less any existing cover; and
- $750,000.

This is subject to the applicable exclusions discussed earlier.

Salary Continuance Insurance (SCI) Cover

Who can apply?

Any member of the LGS Accumulation Scheme who is aged between 15 and 64, is employed on either a permanent full-time or part-time basis (i.e. you are not a Casual Employee) and is an Australian Resident can apply for SCI.

What cover is available?

SCI provides partial income replacement following the expiry of either the 30, 60 or 90 day Waiting Period. There are two types of cover to choose from:

- Short-term: The benefit is payable for a maximum period of two years for any related disability
- Long-term: The benefit is payable for a maximum period to age 65.
  A Total Disability benefit is payable if an Insured person is totally disabled for the length of the waiting period. The Total Disability benefit provides a benefit of the lesser of:
    - the amount of cover approved by the Insurer, or
    - Seventy five percent (75%) of your Declared Earned Income prior to the disability occurring, plus the Superannuation Contributions Benefit (of ten percent (10%) of your Declared Earned Income), subject to a maximum of $300,000 p.a.

What is Declared Earned Income?

Declared Earned Income is the lesser of:

- your earnings most recently agreed by the Insurer and LGS in writing; or
- the amount calculated in accordance with the Earned Income definition (as shown on the next page).

What is Earned Income?

If you are an Insured Person and a permanent employee working more than 15 hours per week, Earned Income is your normal annual salary or wage agreed with your employer immediately before the commencement of Total Disability, plus:

a) any actual commissions paid by your employer in the 12 month period immediately before the commencement of Total Disability; and
b) any other regular payments that could be considered as part of your remuneration package paid by your employer in the 12 month period immediately prior to the commencement of Total Disability, which combined with paragraph (a) above, the Insurer will consider as part of your remuneration package; expressed as a monthly amount.

or

If you are an Insured Person who is self-employed, Earned Income is the monthly income generated by you from your personal exertion, calculated by averaging your net income per year for the two years immediately preceding commencement of Total Disability.

For the purposes of this definition 'net income' means your gross income from personal exertion less all expenses incurred by you in earning that income, but does not include:

- investment income;
- profit distributions; or
- similar payments.

or

If you are an Insured Person other than as specified above, your Earned Income is the amount equal to the average in the last 12 months immediately before the commencement of Total Disability of the following:

a) the wages or salary paid to you by your Employer;
b) any commission paid by your Employer to you; and
c) all other regular payments or Benefits provided to you by your Employer, which when combined with (a) and (b) above, the Insurer would reasonably consider as part of your remuneration package.

When should you review your level of cover?

As the maximum benefit is 75% of Earned Income (plus up to 10% for Superannuation Contribution Benefit), which will be determined at the time of disability, you may wish to review your level of cover when your Earned Income changes (e.g. if you have a salary increase you may wish to increase your cover). However, if your salary decreases (e.g. you move from full-time to part-time work of 24 hours per week) you may be paying for more cover than you will be entitled to claim in the event of Total Disability.

Benefit Offsets

Total Disability and Partial Disability benefits are subject to Benefit Offsets. Benefits are reduced by all amounts (that arise because of the sickness or accident that caused the Total or Partial Disability) payable from the following sources:

- benefits under other salary continuance policies;
- workers compensation, Statutory compensation, pension, social security or similar schemes or other similar State, Federal or Territory legislation;

- state or federal legislation such as the Department of Veteran Affairs;
- employer funded sick leave entitlements and other income payments;
- any other Disability Income paid in the form of a lump sum or is commuted for a lump sum, which is not compensation for pain or suffering.

What is the cost?

The cost of SCI depends on the type of cover (two years or to age 65), your age, gender, occupational classification, health status and the amount of cover selected by you and approved by the Insurer. The premiums are calculated each month and adjusted when you have a birthday or change your level of cover.

The cost of cover is determined by first calculating the Base Premium. The Base Premium is calculated by multiplying the amount of cover (as multiples of $1,000) by the Premium Rate for your age (set out in the table on page 20) then multiplying this by the Rating Factor.

Once the Base Premium has been calculated, it is multiplied by the Waiting Period Factor which will give you your annual premium. To calculate the monthly premium, simply divide the annual premium by 12.

A summary of the three steps to calculating your monthly premium is shown below:

1. **Base Premium** = (Amount of cover per month/$1,000) x Rating Factor x Premium Rate
2. **Annual Premium** = Base Premium x Waiting Period Factor
3. **Monthly Premium** = Annual Premium / 12.

To assist you with your calculations, an insurance quote calculator is available at lgsuper.com.au

The Insurer may adjust the premiums after assessing your application for cover.

Rating Factors

Occupation Category	5	4	3	2	1
Rating Factor	0.80	1.00	1.50	1.75	2.50

Waiting Period Factors

30 day	60 day	90 day
2.50	1.75	1.00

When is a benefit payable?

A benefit is payable if the Insured Person suffers Total Disability or Partial Disability, which has been caused solely as a result of an Injury or an Illness.

The Insurer will not begin to pay any Benefit until the completion of the Waiting Period.

The Waiting Period will commence on the first day the Insured Person is deemed to be Totally Disabled and continue for a minimum of 14 days followed by a period of Total Disability or Partial Disability extending to the end of the Waiting Period.

The length of the Waiting Period for the Insured Person is either 30 days, 60 days or 90 days.

What does Total Disability mean?

Own Occupation

Total Disability and Totally Disabled means that in the Insurer's opinion the Insured Person, while insured, as a direct result of an Illness or Injury:

a) is unable to perform at least one important income producing duty of his or her regular occupation;
b) is not working in any capacity, whether or not for reward; and
c) is under the regular care and following the advice of a Medical Practitioner and, in the Insurer's reasonable opinion, is complying with the advice and treatment given by that Medical Practitioner.

The Own Occupation definition applies to Insured Persons working 15 hours or more per week (averaged over the 26 week period prior to the date of disablement or such shorter period if employed less than 26 weeks immediately prior to the Date of Disablement).

Similar Occupation

Total Disability and Totally Disabled means that in the Insurer's opinion the Insured Person, while insured, as a direct result of an Illness or Injury:

a) is unable to perform the important income producing duties of any occupation for which he or she is suited by education, training or experience;
b) is not working in any capacity, whether or not for reward; and
c) is under the regular care and following the advice of a Medical Practitioner and, in the Insurer's reasonable opinion, is complying with the advice and treatment given by that Practitioner.

The Similar Occupation definition applies where at the time of disablement, the Insured Person was working less than 15 hours per week (averaged over the 26 week period prior to the date of disablement or such shorter period if employed less than 26 weeks immediately prior to the Date of Disablement).

Note: Casual employees will not be covered for SCI.

What does Partial Disability mean?

Partial Disability means that immediately following a period of at least 14 consecutive calendar days of Total Disability, and as a direct result of the same Illness or Injury that caused Total Disability, you:

- cannot work your pre-disability working hours or you are unable to perform at least one important income producing duty of your regular occupation, or you do not have the capacity to work at the same level you were working at prior to commencement of Total Disability;
- suffer a reduction in your Earned Income; and
- are under the regular care and following the advice of a Medical Practitioner and, in the Insurer's reasonable opinion, you are complying with the advice and treatment given by that Medical Practitioner in relation to the cause of the Partial Disability. All work undertaken by you must be approved by the Insurer and your Medical Practitioner.

Voluntary Insurance

When does the benefit payment cease?

Your benefit payments will cease when the earliest of the following occurs:

- The Total Disability or Partial Disability ceases;
- On the completion of the Benefit Period;
- You reach age 65; or
- Your death.

When does cover cease?

Cover ceases when the earliest of the following occurs:

- You reach age 65;
- Your death;
- Sixty (60) days after the premium due still remains unpaid;
- You request to cancel your cover– this will take effect on the date nominated by you or the date we receive the notification – whichever is the later date;
- Your account has been inactive for 16 months and you have not opted-in to keep your insurance;
- You cease to be a member of LGS;
- You commence unpaid leave without employer approval;
- After 12 months of employer-approved leave, unless otherwise agreed by the Insurer in writing before the expiry of the 12 month period; or
- The policy is terminated by LGS or the policy is cancelled by the Insurer (appropriate notice of this change would be given).

What happens if the disability recurs?

If you suffer a recurrence of either a Total Disability or a Partial Disability within six months of payments ceasing, then the relevant Waiting Period is waived and the successive periods of benefit payments are regarded as a single continuous period. The recurrence must be due to the same or a related Illness or Injury.

Are nursing costs covered?

If you suffer Total Disability during the Waiting Period and a Medical Practitioner certifies that you require the care of a registered nurse visiting at least once per day - and are confined to bed for more than two consecutive days as a result of that disability - a benefit will be paid for each day of such care (including the first two days) while that nursing care continues to be provided by a registered nurse for up to the end of the Waiting Period.

The daily amount of the Nursing Care benefit is one thirtieth (1/30th) of the benefit payable for the month.

Are rehabilitation costs covered?

If you are suffering from a Total Disability or Partial Disability the Insurer may, if it is reasonably considered that the program is likely to assist in the member's rehabilitation, pay for the cost of Approved Rehabilitation in addition to the benefits otherwise payable.

You should note that if total benefits due to you under the policy exceed what you would have earned had you not been disabled, the excess is required to be preserved in LGS under the superannuation preservation rules.

Are premiums payable while I am receiving a SCI benefit?

No premiums for SCI cover are required while a benefit is being paid.

Indexation increases

If you have long-term SCI cover and a benefit has been paid continuously for 12 months, the Insurer will, from the first payment of the benefit after each anniversary date, increase the benefit by the lesser of:

- the increase of the CPI for that period; or
- five percent (5%).

If benefit payments cease, the benefit will revert to the original sum insured.

Exclusions

A benefit is not payable under the Policy if your Total Disability or Partial Disability results directly or indirectly from:

- an intentional self-inflicted act or intentional self-inflicted Injury;
- uncomplicated pregnancy or childbirth;
- war, or acts of war, whether declared or not;
- any event or individual exclusion the Insurer has applied to the cover; or
- an illegal or criminal act committed by the insured person.

Interim Accident cover for SCI

When you apply for voluntary insurance, you will be covered for Interim Accident Cover from the date the Insurer receives a fully completed Personal Statement.

Accident means an unforeseen violent, external and visible event that occurs during the period of Interim Accident Cover.

Interim Accident Cover will provide you with cover in the event of an Accident while your application is being assessed. The amount payable is shown below.

What amount is payable?

The amount of Interim Accident cover is the lesser of:

- the amount of monthly cover that you have applied for, less the amount of the monthly benefit for which the cover is otherwise in force under the policy for the member; or
- $15,000 per month.

When does Interim Accident cover cease?

Accident cover ceases when the earliest of the following occurs:

- The Insurer accepts or declines your application for cover;
- Your application for cover statement is withdrawn;
- LGS receives a member's completed and signed acceptance of all terms which apply to an offer of cover;
- You cease to be eligible to apply for the cover, i.e. you cease to be a member of LGS or you reach age 65;

- Ninety (90) days after Interim Accident cover commenced;
- Death; or
- The policy is terminated by LGS or cancelled by the Insurer (appropriate notice of this change would be given).

What can I do if I have a problem or disagree with a decision made by the Insurer?

If you disagree with a decision made by the Insurer, or if you have any problems with the service you receive, it is recommended that you first contact our Member Services team on 1300 LGSUPER (1300 547 873), or in writing to:

Local Government Super
PO Box N835
Grosvenor Place NSW 1220

If you are not satisfied with the response provided, you may make a formal complaint. Written complaints should be addressed to:

Complaints Resolution Manager
Local Government Super
PO Box H290
Australia Square NSW 1215

You may also lodge a complaint online, via the 'Contact us' section of the website.

By law, we are required to have in place arrangements to properly consider and deal with complaints within 90 days of receipt. The Complaints Resolution Manager (who maintains a register of all complaints and actions) will ensure that your complaint is considered and provide you with a response as soon as possible. If we have not made a decision within 90 days of receipt of your complaint you may write to us and request our written reasons for our failure to make a decision within that period. Written reasons for not making a decision within 90 days of your complaint must be given within 28 days of receipt of your request. We will notify you of our decision on the complaint once it is made. In the case of decisions on complaints as to payment of death benefits, we must give you written reasons for our decisions. In the case of decisions on other complaints, you may request written reasons for our decisions. We must give you the reasons within 28 days of receipt of your request.

If you are not satisfied with the way we are dealing with your complaint, our response, or if we fail to respond to you within 90 days, you have the option of referring your complaint to the Australian Financial Complaints Authority.

Australian Financial Complaints Authority

The Australian Financial Complaints Authority (AFCA) is an independent external dispute resolution scheme authorised by the Minister for Revenue and Financial Services. AFCA provides fair and independent financial services complaint resolution that is free to superannuation funds' members.

AFCA can only consider matters which impact on a member personally and not in respect to the overall management of LGS.

The staff at AFCA will attempt to settle the matter by conciliation, which involves assisting you and LGS to come to a mutual agreement. If no agreement is reached by conciliation, AFCA will determine the matter.

The contact details for AFCA are:

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

Phone: 1800 931 678
Email: info@afca.org.au
Web: afca.org.au

For more information please visit AFCA's website at afca.org.au

Your duty of disclosure

Before you enter into a life insurance contract, you have a duty to tell the Insurer anything that you know, or could reasonably be expected to know, that may affect their decision to insure you and on what terms.

You have this duty until the Insurer agrees to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell the Insurer anything that:

- reduces the risk they insure you for; or
- is common knowledge; or
- they know or should know as an insurer; or
- they waive your duty to tell them about.

If you do not tell the Insurer something

In exercising the following rights, the Insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, they may apply the following rights separately to each type of cover.

If you do not tell the Insurer anything you are required to, and they would not have insured you if you had told them, they may avoid the contract within 3 years of entering into it.

If the Insurer chooses not to avoid the contract, they may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told them everything you should have. However, if the contract has a surrender value, or provides cover on death, the Insurer may only exercise this right within 3 years of entering into the contract.

If the Insurer chooses not to avoid the contract or reduce the amount you have been insured for, they may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If your failure to tell the Insurer is fraudulent, they may refuse to pay a claim and treat the contract as if it never existed.

Base Premium rates

Death Only and Death and TPD rates[2]

Age next birthday	Death		Death + TPD	
	Male	Female	Male	Female
16	0.622	0.304	0.694	0.343
17	0.713	0.304	0.817	0.343
18	0.785	0.304	0.911	0.357
19	0.827	0.280	0.978	0.346
20	0.838	0.280	1.022	0.330
21	0.838	0.280	1.035	0.340
22	0.827	0.280	1.035	0.324
23	0.796	0.280	1.011	0.338
24	0.766	0.264	0.990	0.333
25	0.733	0.264	0.956	0.330
26	0.693	0.240	0.911	0.316
27	0.652	0.228	0.875	0.309
28	0.609	0.228	0.842	0.330
29	0.578	0.215	0.807	0.337
30	0.549	0.215	0.774	0.357
31	0.526	0.228	0.763	0.391
32	0.505	0.240	0.738	0.443
33	0.575	0.251	0.811	0.501
34	0.575	0.276	0.842	0.568
35	0.586	0.299	0.877	0.638
36	0.611	0.336	0.944	0.721
37	0.636	0.371	1.018	0.813
38	0.670	0.419	1.094	0.928
39	0.732	0.467	1.237	1.056
40	0.791	0.528	1.384	1.198
41	0.862	0.586	1.574	1.354
42	0.947	0.647	1.747	1.520
43	1.030	0.720	1.922	1.695

Age next birthday	Death		Death + TPD	
	Male	Female	Male	Female
44	1.128	0.804	2.092	1.892
45	1.247	0.874	2.309	2.023
46	1.354	0.960	2.513	2.232
47	1.486	1.055	2.984	2.508
48	1.618	1.138	3.238	2.752
49	1.761	1.235	3.590	3.029
50	1.917	1.343	3.895	3.446
51	2.075	1.439	4.315	3.789
52	2.242	1.546	4.771	4.156
53	2.434	1.655	5.226	4.396
54	2.625	1.761	5.728	4.912
55	2.829	1.882	6.409	5.276
56	3.045	2.002	6.918	5.689
57	3.285	2.122	7.442	6.142
58	3.536	2.252	8.228	6.645
59	3.800	2.387	9.687	7.352
60	4.100	2.518	10.600	8.432
61	4.424	2.661	11.492	9.333
62	4.771	2.807	12.278	11.148
63	5.156	2.948	13.500	12.460
64	5.576	3.117	14.795	13.305
65	6.041	3.285	16.445	14.163
66[3]	5.958	3.174	12.627	9.574
67[3]	6.365	3.324	14.008	10.819
68[3]	6.771	3.476	16.069	12.231
69[3]	7.178	3.627	18.132	13.824
70[3]	7.585	3.777	20.059	15.629
71[3]	8.285	4.250	23.088	17.667

[2] The Death Only and Death & TPD Base Premium rates are per $1,000 sum insured and are based on the Insured Person's age next birthday. An Insurance Administration Fee of 1.5% of premiums is included. The rates are net of any other fees, taxes or allowances. No commission is retained by LGS.

[3] For members over age 65, only TPD definition 3 (Everyday Working Activities) applies.

Salary Continuance Insurance rates[4]

Age next birthday	90 day wait two-year benefit		90 day wait To age 65 benefit	
	Male	Female	Male	Female
16	11.08	12.24	25.81	32.16
17	11.20	12.56	26.45	33.01
18	11.51	12.75	27.30	34.06
19	11.71	12.96	27.83	34.92
20	11.71	13.28	28.46	35.96
21	11.92	13.38	28.89	36.71
22	11.31	13.58	27.93	37.98
23	10.79	13.79	26.87	38.83
24	10.47	13.79	26.34	39.77
25	10.16	14.01	25.39	40.73
26	9.64	14.30	24.65	42.00
27	9.55	15.04	24.65	45.18
28	9.55	15.76	24.65	47.82
29	9.64	16.49	25.19	50.35
30	9.74	17.00	25.92	52.89
31	10.16	17.63	26.87	55.34
32	10.37	18.15	27.93	58.08
33	10.68	18.98	28.89	60.84
34	11.08	19.71	30.26	64.11
35	11.40	20.63	32.16	67.92
36	12.24	21.87	34.18	72.37
37	12.75	23.22	36.50	77.76
38	13.79	24.99	39.77	84.43
39	14.93	27.06	43.38	91.74
40	16.38	29.66	47.29	101.14

Age next birthday	90 day wait two-year benefit		90 day wait To age 65 benefit	
	Male	Female	Male	Female
41	17.83	32.55	52.27	111.61
42	19.59	35.88	57.35	122.84
43	21.36	39.39	63.26	135.63
44	23.22	43.54	69.82	150.34
45	25.81	48.01	77.55	166.32
46	28.31	52.77	86.01	183.56
47	31.42	58.27	95.96	202.60
48	35.35	64.49	107.06	223.24
49	39.39	71.03	119.45	244.71
50	44.07	78.28	133.20	267.78
51	49.35	86.05	148.64	291.78
52	55.36	94.25	165.68	315.81
53	62.01	102.95	183.78	339.61
54	69.68	112.29	203.45	363.61
55	78.28	122.24	224.82	386.16
56	87.92	132.91	246.82	407.52
57	98.50	143.70	269.14	425.62
58	110.21	155.20	291.37	440.11
59	123.38	167.03	313.06	449.85
60	138.00	179.36	332.30	453.65
61	154.18	192.32	347.96	449.21
62	171.90	205.40	357.58	435.87
63	192.54	219.91	355.68	407.84
64	174.29	189.32	307.77	334.32
65	87.60	82.74	154.78	146.00

[4] The Salary Continuance Base Premium rates per $1,000 monthly benefit and are based on the Insured Person's age next birthday. Rates are inclusive of an Insurance Administration Fee of 1.5% of premiums and 5% stamp duty. No commission is retained by LGS.

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