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Insurance claims guide

Terminal Illness 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 517 124.

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. If 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 (if applicable) 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. This includes 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 (if applicable) so that it's processed efficiently and fairly.

Role of the Insurer (if applicable)

If your claim includes any insurance, 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, any 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

In addition to a super account balance, there may be insurance attached to the account. If you want to make a claim, start by calling us on 1800 517 124 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 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 sfg.com.au/portfolio/privacy

If your superannuation account did not include insured death cover, go to Step 6.

Step 3: We submit your claim to the Insurer

Within 10 business days of receiving your completed claim 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. 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 contact your dedicated claims assessor throughout the assessment of your claim.

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

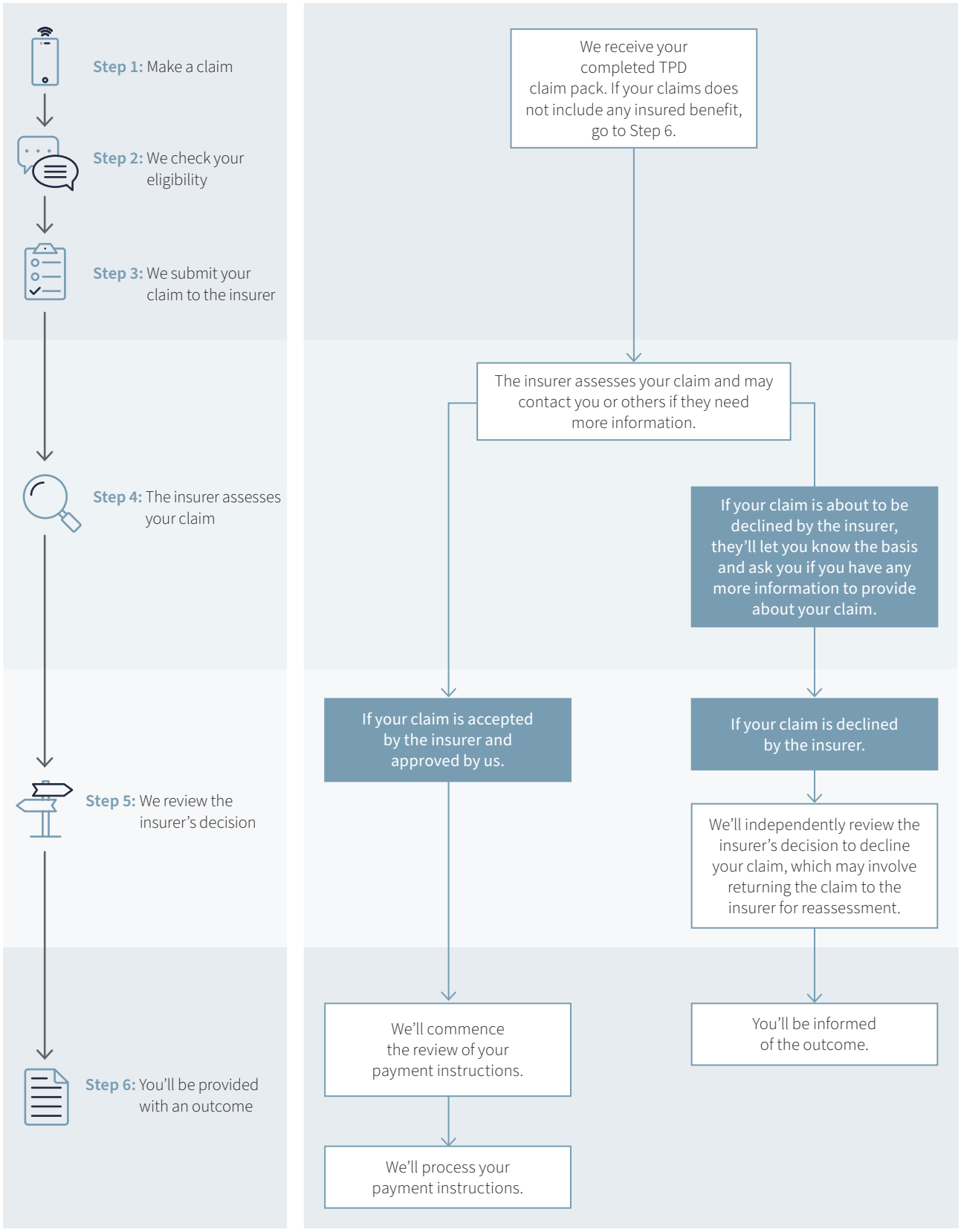
We will complete a review of the Insurer's decision within 15 business days of receiving the Insurer's notification. Once our review has been finalised and if we agree with the Insurer, we will notify you of this within 5 business days. We will also include any information relied on to form its view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

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.

Terminal Illness claims process



Terminal Illness FAQ

When would I make a claim?

You may make a claim for a Terminal Illness benefit if you have been diagnosed with a terminal illness and have a life expectancy of 24 months or less. There is no requirement for you to have stopped working to make a Terminal Illness claim.

How will my claim be assessed?

You may be eligible to make a Terminal Illness claim if two doctors, one of whom is a specialist in the field of your illness or injury, certify that your life expectancy is 24 months or less.

See the relevant Insurance Guide for more information on how your claim will be assessed.

When won't a benefit be paid?

Except for insurance cover provided under Customised Cover or Default Cover no insured Terminal Illness Benefit shall be payable where a claim arises:

a. 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
b. as a result of an intentional self-inflicted act or intentional self-inflicted injury by you, or
c. from any 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 only have insurance cover 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.

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

There's no waiting period to lodge a Terminal Illness claim. You can lodge your claim once you've been certified by two doctors.

What forms need to be completed?

Your doctors will need to complete the following forms as part of your claim submission:

- Treating Doctor's Report (Completed by your treating doctor), and
- Treating Doctor's Report (Completed by your treating specialist in the field of your illness or injury).

If you are also claiming any insurance, you will need to complete:

- Intent to claim life insurance Claim form (if you are also claiming any insurance).

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

No. Any premiums deducted from the date your claim is accepted will be refunded to your super account.

Do I have to repay my Terminal Illness benefit if I live longer than 24 months?

No. You won't have to repay your Terminal Illness benefit if you live longer than 24 months.

What are the payment options if my Terminal Illness claim is approved?

Approved Terminal Illness claims from an insured claim will be paid into your super account. Your insured benefit amount will stay in the cash account for 60 days, after which it will be 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, or
- to another complying super/pension account, via a rollover.

We recommend that you seek financial advice.

How are Terminal Illness benefits taxed?

Terminal Illness benefits are generally tax free if withdrawn from your super fund within the certification period. If you outlive the certification period and wish to withdraw at a later date, you are likely to be asked for two updated Medical Attendant Certificates in order for the benefit to be tax-free. You should obtain tax advice.

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 portfolioservice@sfg.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).

1800 501 204
sfg.com.au
email: sfginsurance@sfg.com.au

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PLA-27038 (56587) 1023